DESCRIPTION OF SERVICES UNDER THE MONTHLY CAPITATION PAYMENT (MCP)

DEFINITION

The Monthly Capitation Payment (MCP) is a capitated payment arrangement developed and implemented by the Health Care Financing Administration (HCFA) to reimburse nephrologists for the care of patients with End-Stage Renal Disease (ESRD) on dialysis under the Medicare program. This arrangement is a global service payment for outpatient dialysis, and ongoing evaluation and management of dialysis related problems in these patients on an outpatient basis. While evaluation and management of dialysis related problems and the metabolic aberrations of ESRD are included in the MCP, non-renal-related and non-renal end organ disease evaluation and management and all non-dialysis procedures are excluded from the MCP and are reimbursable according to the Medicare Fee Schedule (MFS) for the accepted CPT codes for those services.

When these patients require hospitalization in an acute hospital setting, reimbursement of nephrologists may convert to inpatient reimbursement codes. When patients are hospitalized and nephrologists are reimbursed according to inpatient reimbursement codes, payment of the MCP is suspended for the period of hospitalization.

The following narrative describes those services which should be provided under the MCP and describes services which are not provided under the MCP.

SERVICES INCLUDED IN THE MCP

The Nephrologist . . .

1. Assesses and determines the need for outpatient chronic dialysis therapy.

2. Assesses the need for a specified diet and the need for nutritional supplementation for the control of chronic renal failure and specifies the quantity of total protein, high biologic protein, sodium, potassium, and amount of fluids to be allowed during a given time period. For diabetic patients with chronic renal failure, the prescription usually includes specification of the number of calories in the diet.

3. Assesses which mode(s) of chronic dialysis (types of hemodialysis or peritoneal dialysis) are suitable for a given patient and recommends the type(s) of therapy for a given patient. Not all forms of chronic dialysis therapy are suitable for all patients.
4. Assesses and determines which type of dialysis access is best suited for a given patient, and arranges for creation of dialysis access. When the nephrologist personally establishes the dialysis access by inserting a temporary dialysis catheter or implanting a permanent dialysis catheter, these procedures are NOT included in the MCP. Adopted December 1992 Renal Physicians Association

5. Assesses whether or not the patient meets preliminary criteria as a renal transplant candidate and presents this assessment to the patient and family.

6. Prescribes the parameters of intradialytic management.

For chronic hemodialysis therapies, this includes the type of dialysis access, the type and amount of anticoagulant to be employed, blood flow rates, dialysate flow rate, ultrafiltration rate, dialysate temperature, type of dialysate (acetate versus bicarbonate) and composition of the electrolytes in the dialysate, size of hemodialyzer (surface area) and composition of the dialyzer membrane (Conventional versus High Flux), duration and frequency of treatments, the type and frequency of measuring indices of clearance, and intradialytic medications to be administered.

For chronic peritoneal dialysis therapies, this includes the type of peritoneal dialysis (such as CAPD, CCPD, etc.), the volume of dialysate, concentration of dextrose in the dialysate, electrolyte composition of the dialysate, duration of each exchange, and addition of medications to the dialysate, such as heparin, and the type and frequency of measuring indices of clearance. For diabetics, the quantity of insulin to be added to each exchange is prescribed.

7. Assesses whether or not the patient has significant renal failure-related anemia, determines the etiology(s) for the anemia based on diagnostic tests, and prescribes therapy for correction of the anemia, such as vitamins, oral or parenteral iron, and hormonal therapy such as erythropoietin.

8. Assesses whether or not the patient has hyperparathyroidism and/or renal osteodystrophy secondary to chronic renal failure and prescribes appropriate therapy, such as calcium and phosphate binders for control of hyperphosphatemia.

Based upon assessment of parahormone levels, serum calcium levels, and evaluation for the presence of metabolic bone disease, the nephrologist determines whether oral or parenteral therapy with Vitamin D or its analogs is indicated, and prescribes the appropriate therapy.

Based upon assessment and diagnosis of aluminum bone disease, the nephrologist may prescribe specific chelation therapy with desferoxamine and the use of hemoperfusion for removal of aluminum and the chelator.

9. Assesses whether or not the patient has dialysis-related arthropathy or neuropathy and adjusts the patient’s prescription accordingly, and refers the patient for any additional needed specialist evaluation and management of these end-organ problems.
10. Assesses whether or not the patient has fluid overload resulting from renal failure and establishes an estimated "ideal (dry) weight." The nephrologist determines the need for fluid removal independent of the dialysis prescription and implements such measures when indicated.

11. Determines the need for and prescribes antihypertensive medications and their timing relative to dialysis when the patient is hypertensive in spite of correction of fluid overload. Adopted December 1992 Renal Physicians Association

12. Periodically reviews the dialysis records to ascertain whether or not the patient is receiving the prescribed amount of dialysis and orders indices of clearance, such as urea kinetics, in order to ascertain whether or not the dialysis prescription is producing adequate dialysis. If the indices of clearance suggest that the prescription requires alteration, the nephrologist orders changes in the hemodialysis prescription, such as blood flow rate, dialyzer surface area, dialysis frequency, and/or dialysis duration (length of treatment).

For peritoneal dialysis patients, the nephrologist may order changes in the volume of dialysate, dextrose concentration of the dialysate, and duration of the exchanges.

13. Periodically visits the patient during dialysis to ascertain whether or not the dialysis is working well and whether or not the patient is tolerating the procedure well (physiologically and psychologically). During these visits, the nephrologist determines whether or not alteration in any aspect of a given patient's prescription is indicated, such as changes in the estimate of the patient's dry weight, and reviews the treatment with the nurse or technician performing the therapy. The frequency of these visits will vary depending upon the patient's medical status, complicating conditions, and other determinants. (Please refer to Appendix A).

14. Performs periodic physical assessments, based upon the patient's clinical stability, in order to determine the necessity for alterations in various aspects of the patient's prescription. Similarly, the nephrologist reviews the results of periodic laboratory testing in order to determine the need for alterations in the patient's prescription, such as changes in the amount and timing of phosphate binders or dose of erythropoietin.

15. Periodically assesses the adequacy and function of the patient's dialysis access. (Please refer to Appendix B).

16. Assesses patients on peritoneal dialysis for evidence of peritonitis and orders appropriate tests and antibiotic therapy.

17. Periodically reviews and updates the patient's short-term and long-term care plans with staff.

18. Coordinates and directs the care of patients by other professional staff, such as dieticians and social workers.
19. Completes or certifies a multitude of forms and prescriptions that are required, but are not otherwise reimbursed, for the dialysis patient. Examples include durable equipment prescriptions, home health care services, and other medical necessity certifications. Adopted December 1992 Renal Physicians Association
SERVICES THAT ARE NOT INCLUDED IN THE MCP

1. All procedures are excluded; examples are as follows:
   a. Temporary hemodialysis catheter placement
   b. Permanent hemodialysis catheter placement
   c. Temporary peritoneal dialysis catheter placement
   d. Permanent peritoneal dialysis catheter placement
   e. Repair of existing dialysis accesses
   f. Placement of catheter(s) for thrombolytic therapy
   g. Thrombolytic therapy (systemic, regional or access catheter only; hemodialysis or peritoneal dialysis)
   h. Thrombectomy of clotted cannula
   i. Arthrocentesis
   j. Bone marrow aspiration
   k. Bone marrow biopsy

2. Interpretation of tests that have a professional component are excluded; examples are as follows:
   a. Electrocardiograms (12 lead, Holter monitor, Stress Tests, etc.)
   b. Echocardiograms
   c. 24-hour blood pressure monitor
   d. Nerve conduction velocity and EMG studies
   e. Flow doppler studies
   f. Bone densitometry studies
   g. Biopsies
   h. Spirometry and complete pulmonary function tests

3. Evaluation for renal transplantation is excluded. While the nephrologist assesses whether or not the patient meets preliminary criteria as a renal transplant candidate under the MCP, the complete evaluation for renal transplantation is not included in the MCP.

4. Evaluation of potential living transplant donors is excluded.

5. The training of patients to perform home hemodialysis, self hemodialysis, and the various forms of self peritoneal dialysis are excluded.

6. The general medical non-dialysis-related management of diabetes mellitus is excluded.

7. The general non-renal-related (non-dialysis) evaluation and management of all dialysis patients is excluded.

8. The nephrologist may elect not to include acute hospital care services in the MCP. If this election is made, the MCP is suspended for the period of time that the patient is receiving care under hospital codes.

9. All physician services that antedate the initiation of outpatient dialysis are excluded.
EXECUTIVE SUMMARY

The RPA/ASN believes it is increasingly clear that a minimal frequency of direct nephrologist/patient interaction should be defined. We recognize that the geographic spread of the ESRD patient population, the proliferation of freestanding dialysis facilities, and the delegation of traditional physician duties necessitated by a shrinking nephrologist workforce have affected treatment trends in dialysis. The RPA/ASN also believes that any definition of minimal frequency should not be used as a standard of care, as this usage would not consider the myriad complexities of ESRD care. The RPA/ASN recognizes that great diversity exists in both nephrology practices and ESRD patients, and that the optimal frequency for direct interactions between patient and physician is best defined by these parties.

BACKGROUND

During 1993, greater than 257,000 Americans were treated for end-stage renal disease (ESRD) under the Medicare Program. This figure represents a more than doubling in the prevalence of ESRD over the last decade, corresponding to an annual increase of 10% in its overall prevalence. The rising prevalence of treated ESRD can be attributed primarily to the rapid increase in the incidence of treated ESRD. Because the majority of new ESRD patients are treated by in-center hemodialysis, an increase has likewise occurred in the number of institutions providing ESRD services for these patients. The percentage of patients treated in freestanding dialysis units has increased from 65% in 1989 to 71% in 1994.

Numerous factors have affected the movement of ESRD patients from receiving their dialysis treatments in hospital-based dialysis units to freestanding facilities. Some of the reciprocating factors that have greatly increased the number of dialysis units and have appropriately shifted patients_ treatment locations are: (1) the abolition of individual state _Certificates of Need_ laws (such as in Massachusetts), (2) an increase the number of for-profit dialysis vendors (6% increase from 1989 to 1994), (3) disproportionate ESRD program expansion in selected urban areas (such as the African-American and Latino communities), (4) inadequate reimbursement from payers to the facility providers of dialysis services to sustain and/or to expand the more costly treatments provided in hospital-based dialysis units(such as Medicare or managed care organizations), and (5) increasing restrictions by payers on reimbursement for travel to and from dialysis treatments.

In urban areas, that are the geographic source of the majority of patients with ESRD, new freestanding dialysis units are increasingly situated using the patients’_ place of residence as the principal consideration. In such well-defined geographic areas that reflect high local prevalence rates for ESRD, vigorous competition between vendors of dialysis services has encouraged an expansion of such community-based dialysis units. This _relocation_ of dialysis units has generally been well received by the patients. As the number and geographic distribution of dialysis facilities expands, most patients have greater access to
hemodialysis treatments in their community of residence and employment. Travel to and from dialysis treatments becomes less burdensome on patients’ time, more economical, and less disruptive towards the maintenance of a predialysis lifestyle and employment. Therefore, this predominantly ambulatory ESRD patient population has moved away from the hospitals, and their juxtaposed nephrologists, offices, to their communities of residence and employment.

The Renal Physicians Association (RPA) and American Society of Nephrology (ASN) believe it is of critical importance to clarify a position on the frequency that nephrologists should be present in the outpatient setting for direct patient contact. As the largest professional organizations representing the practicing nephrologist, and dedicated to the delivery of quality patient care, we feel that a minimal frequency of direct nephrologist/patient interaction should be defined.

Analysis

1. Impact of Changes in ESRD Prevalence and Treatment Trends on Dialytic Practices - Although ESRD patients have routinely benefited by the shift in dialysis unit location, one of the unfortunate and undesired consequences on nephrology practice is the increased necessity for nephrologists to fragment their services between patients in freestanding dialysis units, hospitals, and their offices. Furthermore, some nephrologists have relinquished certain clinical dialysis duties to other non-physician members of the dialysis care team, in part because of the expanding deficit in the nephrology workforce (See position paper entitled, _Nephrology Workforce_). Because it is rare for a clinical nephrologist to limit his/her practice to the care of ESRD patients in a dialysis unit alone, the expanding number of patients and dialysis units increasingly fragments the physician’s time. For many nephrologists, it is temporally impossible to be present in the various dialysis units at times during which their patients are being treated. In addition, few nephrologists have attempted to alleviate their hardship by limiting their patients’ access to convenient community dialysis units. The burden is especially problematic for nephrologists who practice in areas that are medically underserved. In 1993, the three ESRD Networks that reported the greatest point prevalence rate for treated ESRD were predominantly composed of rural states. In such areas, the very small number of available nephrologists must expend an inordinate amount of time in travel to and from the dialysis unit. Thus, these individuals are disadvantaged in manpower, time, and by geography.

Secondly, as the nephrologist has reluctantly become less available in the dialysis unit, some nephrologists have delegated tasks to the dialysis nurse, the advanced practice nurse, dietitian, and social worker, while retaining responsibility for patient care as the dialysis care team leader. Some of these tasks include clinically evaluating patients before a dialysis treatment, making adjustments in the dialysis prescription such as changes in the estimated dry weight or heparinization, following up on non-major medical problems, reviewing routine laboratory tests, and instructing patients about their diet, medications, and health-related behaviors. In the absence of a decline in patient outcomes, other than patient _satisfaction_, the notion has become that it may be not necessary to routinely see dialysis patients either in the office and/or the dialysis unit, but rather as medical necessity dictates.
Thirdly, without clear guidance from payers, regulators, and/or the appropriate professional societies, many nephrologists are uncertain of the frequency that dialysis patients should be seen for a meaningful direct physician/patient interaction that addresses patient problems and/or maintains optimal dialytic health.

2. The Desirability of Direct Nephrologist/ESRD Patient Contact - The RPA/ASN is unaware of any information that demonstrates that the frequency of nephrologist interactions with their patients directly influences patient mortality. However, patient satisfaction with their care and confidence in the quality of their treatments clearly are improved by their nephrologist being routinely present and participating in their care. The quality of the personal encounters that many patients need within the dialysis unit cannot be fulfilled by other non-nephrologist members of the dialysis care team. Furthermore, routine nephrologist involvement in dialytic care may enhance patient compliance and thereby, indirectly impact patient outcomes in a favorable manner.

The minority of nephrologists that do not see their patients with appropriate regularity unfavorably impacts the individual patient, the dialysis nurses, and the nephrology profession. Physician absences from freestanding dialysis units and infrequent direct patient contact undermine the veracity of the appropriate arguments that outpatient dialysis is a nephrologist’s responsibility, not a nursing procedure (See position paper entitled, The Role of NonPhysician Medical Personnel in Delivering Nephrologic Care). RPA/ASN has advocated the exclusivity of dialytic nephrology practice to appropriately trained board-certified nephrologists. Appropriate nephrologic care involves evaluation and management of nephrologic problems, not simply fulfilling orders pursuant to the dialysis prescription.

3. The Intent in Defining a Minimum Frequency of Nephrologist/ESRD Patient Visits - It is critical to distinguish a recommendation for a minimum frequency from a statement of an optimum frequency. The RPA/ASN can not, nor should not, attempt to define an optimal frequency for interactions between an ESRD patient and his/her nephrologist. The optimal frequency for this exchange should be dictated principally by medical necessity. The patient should be seen with sufficient frequency to ascertain that nephrologic problems are promptly recognized and appropriate solutions implemented. Issues like the chronicity of the problem, the availability of nonphysician medical personnel to manage the problem under the nephrologist’s supervision, hardship associated with travel to meet the patient, and the patient’s desires for frequency of visitation should be secondary considerations. Thus, if the patient has been stable and healthy, and is a home peritoneal or hemodialysis patient for whom travel to the dialysis unit creates difficulty, the appropriate number of visits for this patient may be few. Alternatively, if the patient routinely has major interdialytic morbidities such as ischemic chest pain and blood pressure liability, the frequency of physician visits should increase.

An increasing number of managed care organizations (MCO) are exploring the feasibility of using the ESRD patient’s internist or generalist to manage dialytic care for their subscriber patients. Under this scenario, a nephrologist is available on-call to the internist and/or dialysis nurse; the monthly capitated payment (MCP) for ESRD care would be provided to the non-nephrologist. The dialytic nephrologist would be reimbursed on a fee-for-service basis at a greatly discounted rate. Likewise, many nursing leaders, and their corresponding professional societies, have stated that the
nephrologist’s presence is not critical in the dialysis unit, and have suggested that the nephrologist provide _intellectual_ support to an MCP-reimbursed dialysis nurse practitioner. It is therefore important that the professional nephrology community take a position to define a minimal frequency of direct nephrologist/ESRD patient interaction, in order to contravene the stance of these putative nephrologist surrogates.

4. Benefits of Establishing a Minimal Frequency for Direct Nephrologist/ESRD Patient Contact - A variety of arguments have been posed against the recommendation of a minimum frequency for direct nephrologist/ESRD patient interactions. These include concerns that this would excessively escalate the role of the physician’s presence on site in the dialysis facility; unfairly cajole the physician to visit the patient in a setting that is suboptimal for confidential discussions and for the performance of a detailed physical examination; dismiss the unique alliance between the nephrologist and his/her patient in deciding what is the best environment to deliver nephrologic care; and do not impact the quality of patient care.

The RPA/ASN believes, however, that patients stand to benefit from a recommendation for a minimal frequency of purposeful and direct nephrologist/ESRD patient interactions. For those patients that are under the care of the minority of nephrologists who do not see them with regularity, a guideline for minimal performance in this area is provided. The intensity of patient monitoring and the quality of patient care will be improved by these nephrologists as they respond to the recommendations. Likewise, this guideline will provide all ESRD consumers with minimum expectations for this component of their nephrologist’s performance. For the nephrologists, who are increasingly having to apportion their efforts between commitments in the office, hospital, and in freestanding dialysis units, guidance is provided. Lastly, for the regulators and payers, a minimal professional performance guideline is provided that will assist in the external monitoring of the processes of ESRD patient care.

Recommendations

In generating these recommendations, the RPA/ASN emphasizes that these suggestions are not intended to be used as a standard. The RPA/ASN recognizes that great diversity exists in both nephrology practices and the recipients of renal care, and that the optimal frequency for direct and purposeful interactions between these individuals is best defined by these parties. Furthermore, we appreciate that in those locales where the nephrologist is geographically or manpower compromised, it may be impossible to always fulfill even the minimum recommended frequency of direct nephrologist/ESRD patient contact. However, the RPA/ASN anticipates that these circumstances will occur infrequently, and that due diligence will be exerted by both patients and nephrologists to fulfill this minimum level of interaction.

1) All adult ESRD patients being treated by in-center hemodialysis should be seen by a nephrologist weekly, except in hardship circumstances where this is not feasible (e.g., patient unwillingness, unfavorable geography, or manpower limitations). All adult ESRD patients being treated by in-center hemodialysis should be observed on hemodialysis by a nephrologist at least once monthly.
2) All adult ESRD patients being treated by a home dialysis modality such as continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis, or home hemodialysis should be seen by a nephrologist at least once every two months.

3) The nephrologist/ESRD patient interactions should be substantive, and in general should comply with the scope of work for the MCP (see position paper entitled, Nephrologist Scope of Work Under the Monthly Capitated Payment). Approved by RPA Board, 7/13/96

4) All pediatric hemodialysis and peritoneal dialysis patients (0-19 years of age) should be seen by a nephrologist at least as often as adult dialysis patients, as described above. More frequent nephrologist, patient and family contact is generally recommended for these patients. Adopted December 1992
APPENDIX B

RENAL PHYSICIANS ASSOCIATION
DETAILED EXAMPLES OF NEPHROLOGIST SERVICES
PROVIDED FOR PATIENT'S DIALYSIS ACCESS
UNDER THE MONTHLY CAPITATION PAYMENT (MCP)

The specific details of each aspect of the services included within the MCP bundle of services is beyond the scope of the "Description of Services" document. This appendix provides more detailed examples of the services provided when the nephrologist periodically assesses the adequacy and function of the patient's dialysis access (See Description of Services, #15).

For temporary or permanent hemodialysis catheters, this includes confirmation of proper function of the "arterial" and "venous" lumens of the catheter. If the "arterial" lumen does not permit adequate aspiration blood flow rates or the "venous" lumen demonstrates occlusion or elevated pressures, the nephrologist orders appropriate aspiration and/or flushing of the catheter. If it becomes necessary for the nephrologist to instill thrombolytic enzymes, such as urokinase, or to replace the catheter, these services are NOT included in the MCP. The nephrologist also assesses the exit site to ascertain whether or not there is evidence of exit site inflammation and/or infection. If evidence of infection is identified, the nephrologist orders appropriate cultures, catheter care or removal and appropriate antibiotic therapy.

For hemodialysis arteriovenous shunts, such as Scribner or Thomas shunts, the nephrologist orders appropriate aspiration and/or flushing of the cannula. If it becomes necessary for the nephrologist to perform a thrombectomy using a balloon-tipped catheter, such as a Fogarty embolectomy catheter, or to instill a thrombolytic enzyme, such as urokinase, these services are NOT included in the MCP.

For a hemodialysis arteriovenous fistula or subcutaneous graft fistula, this consists of evaluation of blood flow rates and ascertaining whether or not there is evidence of the presence of elevated intradialytic "venous" pressures which would suggest the development of outflow stenosis. The nephrologist also assesses whether or not the fistula demonstrates signs of infection or occlusion along its course. If there is evidence of infection, the nephrologist orders appropriate cultures, antibiotics and surgical consultation. If there is evidence of occlusion, the nephrologist may choose to open the occluded vessel with thrombolytic therapy or may seek consultation for surgical thrombectomy and possible revision or replacement. If the nephrologist places a catheter in the occluded fistula for thrombolytic therapy, this is NOT included in the MCP.

For hemodialysis accesses where abnormal amounts of blood recirculation are suspected, the nephrologist orders appropriate studies to determine the amount of recirculation.

For peritoneal dialysis catheters, the nephrologist assesses the inflow and outflow of the catheter and inspects the exit site for evidence of inflammation and/or infection. If there are signs of infection, appropriate cultures, antibiotics and surgical revision or replacement of the catheter is ordered. If the nephrologist performs thrombolytic therapy, surgical revision, removal or replacement procedures on the dialysis catheter, this is NOT included in the MCP.