December 27, 2012

Marilyn B. Tavenner, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1590-FC
P.O. Box 8013
Baltimore, MD 21244-8013

Subject: CMS-1590-FC Medicare Program; Revisions to Payment Policies Under the Physician Payment Schedule and Other Revisions to Part B for CY 2013; Final Rule

Dear Acting Administrator Tavenner:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with kidney disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with kidney disease. We are writing to provide comments on selected portions of the 2013 Medicare Fee Schedule Final Rule.

RPA’s comments will focus on the following issues:

- **CMS Refinement of RUC-Approved Values on CPT Codes 35475 and 35476**
- **Ongoing Reduction of Relativity Between Inpatient Dialysis Services and Associated Evaluation and Management Services**

**CMS Refinement of RUC-Approved Values on CPT Codes 35475 and 35476**

In the final rule, CMS outlines and discusses in Table 43 and the subsequent text its decisions for refining recommendations from the AMA’s Relative Value Update Committee (RUC) for the *Cardiovascular System: Arteries and Veins* family of services. As part of this section of the rule, the Agency offers its rationale for reducing the RUC-recommended values for CPT codes 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel), and 35476 (Transluminal balloon angioplasty, percutaneous; venous). CMS notes in the passage that it agrees with the approach utilized by the RUC to revalue the services, but believes that for both codes
different CPT codes were more similar to the services under review and were “therefore a better starting point for the reductions.”

RPA not only strongly believes that CMS made incorrect decisions with regard to its clinical rationales provided for the codes chosen as the starting points, but we also are concerned on a broader policy basis that the refinements could compromise both the vascular access care provided to chronic kidney disease patients and the Fistula First program. Our comments on this issue will first outline our concerns with the Agency’s clinical rationales before discussing the potential impact of this change on vascular access care in general and the Fistula First program.

Clinical Discussion on CMS Selection of Comparable Service Codes

RPA believes that the comparable services chosen by CMS are less clinically accurate than those chosen by the RUC and have led to an inappropriate reduction of the work RVU’s for CPT codes 35475 and 35476 in the final rule. Based upon responses to the completed surveys, and extensive facilitation during the April 2012 RUC meeting, the RUC recommended CPT code 37224 as a comparable service code for 35475 and CPT code 37220 as a comparable service code for 35476. CMS instead chose CPT codes 37220 and 37191, respectively, as the starting points for these services.

Below we offer our clinical line of reasoning as to why the CMS-chosen starting points are not appropriate, and we request that CMS change to the more accurate codes. The following comments were developed collaboratively by RPA and the American Society of Diagnostic and Interventional Nephrology (ASDIN), and were included in the RUC’s comments on the fee schedule final rule as well. The reference services and descriptors chosen by the RUC and CMS, respectively, are noted in bulleted format below.

CPT Code 35475

- **RUC Selected Comparable Service:** CPT code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty)
- **CMS Selected Comparable Service:** CPT code 37220 (Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty)

CPT code 35475 is utilized by interventional nephrologists and other specialists when flow limiting stenosis of an artery in the inflow circuit of a dialysis access is identified. In typical circumstances, the operator has access to the circulation in the dialysis graft or fistula and must utilize a catheter and wire to maneuver through the access, arterial anastomosis and into feeding artery in order to cross the stenosis and perform angioplasty. This work involves time and effort to traverse several different vessels in different directions. The stenosis that is eventually treated with angioplasty is not a direct extension of the vessel that is initially cannulated. CPT code 37224 is very analogous to this situation. To perform angioplasty of the femoral-popliteal artery, the operator must
typically cannulate the opposite side femoral artery and use a catheter and wire to maneuver up the arteries supplying that side then traverse down the opposite side arteries to treat the stenosis. Similar to 35475, the stenosis that is eventually treated with angioplasty is not a direct extension of the vessel that is initially cannulated. The procedure for CPT code 37220 however is very different. In performing angioplasty of the iliac arteries, the operator typically cannulates the femoral artery which is a direct continuation of the iliac artery to be treated. There is no need for catheter manipulation, traversing multiple vessels or changing directions. The RUC took these procedural differences into account in utilizing reference code 37224 for its recommendation regarding the work RVU’s for 35475.

CPT Code 35476

- **RUC-Selected Comparable Service:** CPT code 37220 (Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty)
- **CMS Selected Comparable Service:** CPT code 37191 (Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy),

CPT code 35476 is utilized by interventional nephrologists and other specialists when flow limiting stenosis of the dialysis access or central veins is identified. Because the dialysis graft or fistula is directly attached to the arterial system, flow and pressures within these vascular structures a much more similar to arteries than to veins. Indeed, typical flows within an access and draining central veins are often more than 1000ml/minute and the vessel walls remodel and thicken to histologically resemble arteries. While some catheter and wire manipulation may be required to reach the stenosis in the long dialysis access, the site of angioplasty is typically a direct extension of the vessel initially cannulated. CPT code 37220 is very analogous to this situation. The operator cannulates a high flow vessel and performs angioplasty on a vessel that is a direct extension of the site of cannulation. CPT code 37191 is not similar. This code relates to a procedure in a lower flow vein and does not include the work or risk of angioplasty, including vessel rupture. The arterial code 37220 is much more similar to 35476 and that is why the RUC chose this code as the comparable service.

**Impact of Angioplasties Refinements on Vascular Access Care and Fistula First**

As with other changes proposed in the Medicare Fee Schedule in recent years, RPA is concerned that the reduction in value for angioplasty services will have an unintended effect of compromising the availability of this service in the physician office setting, the most patient-centric and cost efficient site of service for this care. As background, there have been tremendous advances in the availability and provision of vascular access services in recent years. This is due in part to technological advances and policy changes that allow these services, including angioplasties, to be provided in the physician’s office setting (site of service 11). The issue of successful vascular access care is of sufficient
consequence that CMS itself is a leading partner in the Fistula First Breakthrough Initiative (FFBI) program, whose mission is to “improve the survival and quality of life of hemodialysis patients by optimizing vascular access selection - which for most patients will be an AV fistula - to lower infection, hospitalization and mortality rates while preserving vital Medicare resources.” In fact, according to the Fistula First website, the rate of fistula placement has virtually doubled in the last ten years, from approximately 32% in mid-2003 to over 60% in early 2012, and RPA believes there is at least some causal relationship between the increased availability of vascular access care in sites such as the physician’s office setting and this increase.

However, RPA is concerned that if RVU cuts of the magnitude outlined in the final rule (approximately 28% for 35475 and 15% for 35476) are allowed to proceed, the challenges to nephrologists providing these services in the physician office setting will be substantial enough to force them to discontinue doing so. In that situation, the most likely site of service will be the outpatient hospital setting, which will: (1) be significantly inconvenient for the patient; (2) potentially threaten the health outcomes for the patient due to the increased risk of infection and missed dialysis sessions; and (3) result in increased costs to the Medicare program overall. Therefore, RPA believes that not only are the decisions that CMS made in choosing different CPT codes from the RUC as the starting points for refinement of the angioplasty RVUs clinically inappropriate, but will more broadly do harm to vascular access care in general and the Fistula First program specifically.

**RPA therefore urges CMS to reverse its decision and assign the RUC-recommended values to CPT codes 35475 and 35476 for 2013.**

**Ongoing Lack of Relativity Between Inpatient Dialysis Services and Component Evaluation and Management Services**

RPA continues to believe that the relationship between the family of inpatient dialysis services and the evaluation and management (E&M) service (CPT code 99232, level two hospital visit) that serves as its primary practice expense component code will be out of alignment in 2013. Recall that in the Medicare Physician Fee Schedule Final Rule for CY 1995 published on December 8, 1994, and in Transmittal 1776, Change Request 2321 of the Medicare Claims Manual, HCFA/CMS states in both documents that:

“We will bundle payment for subsequent hospital visits (CPT code 99231 through 99233) and follow-up inpatient consultations (CPT codes 99261 through 99263) into the fee schedule amounts for inpatient dialysis (CPT codes 90935 through 90947).”

While follow-up inpatient consultations (CPT codes 99261 through 99263) have been deleted from the fee schedule for payment purposes, the subsequent hospital visit codes are of course still part of the fee schedule. However, as part of the 2013 fee schedule, the PE RVUs for CPT code 90935 (inpatient hemodialysis, single evaluation, which serves as the anchor for the inpatient dialysis code family) will be 0.53, while the PE RVUs for
CPT code 99232 will be 0.59, even though as the Agency noted above, payment for subsequent hospital component codes is supposed to be bundled into the payment for inpatient dialysis. Thus, the PE RVUs for inpatient dialysis will be less than that of its component code.

RPA therefore urges CMS to revise the practice expense values for the inpatient dialysis code family to ensure that they are not less than that of its component codes.

As always, RPA welcomes the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation’s kidney patients, and we stand ready as a resource to CMS in its future endeavors. Any questions or comments regarding this correspondence should be directed to RPA’s Director of Public Policy, Rob Blaser, at 301-468-3515, or by email at rblaser@renalmd.org.

Thank you,

[Signature]

Ruben L. Velez, MD
President