January 27, 2014

Marilyn B. Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1600-FC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-1600-FC: Proposed Rule for Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear 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 renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease. We are writing to provide comments on selected portions of the 2014 Medicare Fee Schedule Final Rule.

RPA’s comments will focus on the following issues:

- **CMS’ Proposal to Use OPPS and ASC Rates in Developing Practice Expense RVUs**
- **CMS’ Ongoing Refinement of CPT Codes 35475 and 35476**
- **Ongoing Reduction of Relativity Between Inpatient Dialysis Services and Associated Evaluation and Management Services**

**CMS’ Decision to Not Finalize Proposal to Use OPPS and ASC Rates in Developing Practice Expense RVUs**

RPA commends CMS for its responsiveness to community input in determining that it should not finalize its proposal to use that current year’s OPPS or ASC practice expense data as a point of comparison in establishing practice expense relative value units (PE-RVUs) for services under the fee schedule. RPA is sensitive to the Agency’s fiduciary responsibilities, and we appreciate the effort to develop innovative proposals to carry out those duties. We support ongoing review of PE RVUs to ensure that these values accurately reflect the cost of providing services in a particular setting, and we also concur that comparing the costs of providing care among different sites of services can be useful.
As noted in our comments on the proposed rule, however, we do believe that such efforts must be: (1) as transparent as possible with regard to the processes through which all of the comparator values are determined, and: (2) focused enough to avoid affecting services and settings of care that would be otherwise negatively impacted by such a broad proposal. On the issue of transparency, CMS should publish the PE inputs used in the OPPS and ASC settings; this would offer stakeholders the opportunity to provide meaningful input on the comparisons between the PE values assigned to services across the various settings.

Regarding services and settings of care that may be unintentionally impacted by such a change, the example we would offer is the vascular access care provided to patients with chronic kidney disease (CKD). It is critically important for CKD patients to have such procedures performed in a timely manner, so as not to disrupt the patient’s dialysis treatment schedule and to be consistent with Medicare’s clinical requirements associated with the provision of dialysis. This aspect of care is greatly enhanced when services are delivered in non-facility settings, such as vascular access centers, which are more focused and responsive to the needs of CKD patients, in general, than hospital outpatient departments. Given these severe reductions, we are concerned that the vascular access care provided by interventional nephrologists in non-facility settings would be at risk, and may be shifted to outpatient hospital settings, compromising beneficiary access to timely care, an important aspect of the quality of care for those on dialysis.

RPA does as noted appreciate CMS’ flexibility in accounting for the views of the medical provider community in not moving to finalize the proposed change, and we urge the Agency to address concerns about transparency and impact on specific settings of care before reconsidering such a proposal.

**CMS’ Ongoing Refinement of CPT Codes 35475 and 35476**

RPA has been encouraged by the ongoing refinement process through which CMS has revised the RVUs for CPT codes 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel) and 35476 (Transluminal balloon angioplasty, percutaneous; venous). In the 2013 Medicare fee schedule the RVUs for these services were reduced by 28% for 35475 and 15% for 35476, due in part to CMS adopting different comparator codes on which to base work RVUs for these services from those recommended by the AMA’s Relative Value Update Committee (RUC). In the final rule for 2014, CMS stated that commenters “universally disagreed with our reference codes for CPT codes 35475 and 35476”, which prompted the Agency to have these services reviewed by a multispecialty refinement panel. The refinement panel recommended median work RVUs identical to those originally recommended by the RUC, and after reevaluation, CMS concurred, finalizing work RVUs based upon the refinement panel median.

RPA is genuinely encouraged by how this process unfolded, having brought concerns to CMS’ attention, the Agency acting on these concerns through the refinement panel process, and subsequently restoring the work RVUs to the values recommended by the RUC. However, we do feel compelled to point out that despite the restoration of the work values, and even with the substantial increase in the conversion factor for at least the first quarter of calendar year 2014, actual reimbursement for these services will still experience a reduction, albeit slight (1.6% for 35475 and 2.5% for 35476), in 2014. Among the catalysts for RPA raising the issue of the work
values for the angioplasty codes with CMS was our concern for the viability of vascular access care provided by interventional nephrologists in non-facility settings, and while we are appreciative of the process, reimbursement for the services is still reduced, and thus Medicare beneficiary access to these services is further threatened.

**Ongoing Reduction of Relativity between Inpatient Dialysis Services and Associated 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 2014. 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 indicated in Addendum B for the 2014 fee schedule final rule, the PE RVUs for CPT code 90935 (inpatient hemodialysis, single evaluation, which serves as the anchor for the inpatient dialysis code family) will be 0.49, while the PE RVUs for CPT code 99232 will be 0.55, 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, and RPA believes that this is a rank-order anomaly that the Agency should correct administratively.

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,

Robert J. Kossmann, MD
President