



September 13, 2022

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1772-P
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating

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 the 2023 HOPPS/ASC proposed rule. Our comments will address the following issues:

- **Complexity Adjustments for 2023**
- **Review of Procedural Costs for C9780**

Complexity Adjustments for 2023

In the proposed rule, CMS notes current policy does not include additional payment for services corresponding to add-on codes in the ASC setting, and acknowledges that this “could potentially create financial disincentives for providers to offer these services in ASCs, which could potentially result in Medicare beneficiaries encountering difficulties accessing these combinations of services in ASC settings.” The Agency goes on to state that:

To address this issue, we propose a new ASC payment policy that would apply to certain code combinations in the ASC payment system where CMS would pay for those code combinations at a higher payment rate to reflect that the code combination is a more complex and costlier version of the procedure performed, similar to the way in which the OPSS APC complexity adjustment is

applied to certain paired code combinations that exhibit materially greater resource requirements than the primary service.

Among the code combinations that would be captured by the new ASC payment policy are services included in the dialysis circuit code family encompassing vascular access care, where CPT codes 36901, 36902, 36904 and 36905 might be combined with add-on codes addressing central venous angioplasty or stent (codes 36907 and 36908), or the add-on code addressing coil embolization (code 36909)

RPA fully supports this proposal and commends CMS for its identification of unintended payment policy gaps where beneficiary access to care can be compromised. This is especially true in this era of increased emphasis on kidney care, where effective and timely provision of services to persons with kidney disease requiring vascular access services can not only result in reduced costs to the Medicare program but can enhance patient outcomes. **RPA supports CMS' proposal to identify code combinations where appropriate and resource-based additional payment provided by the complexity adjustment for add-on services will eliminate barriers to necessary vascular access services.**

Review of Procedural Costs for C9780

RPA has long appreciated CMS' willingness to consider coverage for and assign appropriate reimbursement to emerging technologies that facilitate efforts to provide high quality care to Medicare beneficiaries. Typical of this foresight is the creation of the HCPCS code C9780, for insertion of central venous catheter through central venous occlusion via inferior and superior approaches (e.g., inside-out technique). RPA believes this new service is critical in the care of a small subset of patients where catheter access is required for life-sustaining dialysis, but the thoracic central veins are occluded. In that instance, there is no other FDA approved device that can obtain access across the occlusion into the right atrium where a dialysis catheter will provide adequate function.

Given how critically important it is for this service to be available to appropriate patients, we urge the Agency to review the most recent estimated procedural costs for the service, and if necessary, reconsider the ambulatory payment classification (APC) to which C9780 is currently assigned. **RPA urges CMS to review the procedural costs for HCPCS code C9780 and reconsider the APC designation for the service if appropriate.**

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 work on the HOPPS/ASC payment system. 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.

Sincerely,



Timothy A. Pflederer, MD FASN FASDIN
RPA President