



December 31, 2019

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Dept. of Health and Human Services  
Attention: CMS-1717-FCP.O. Box 8013  
Baltimore, MD 21244-1850

**Re: CMS-1717-FC; Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs et al.**

Dear Administrator Verma:

The Renal Physicians Association (RPA) appreciates this opportunity to submit comments on the CY 2020 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule. RPA is the professional organization of nephrologists; its 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 care of patients with kidney disease.

Our comments will discuss the following issues:

- **Endovascular Procedures Ambulatory Payment Classifications (APCs) 5191-5194**
- **ASC device intensive designation for codes 36903, 36904, 36905 and 36906**
- **APC level assignment for percutaneous fistula codes C9754 and C9755**

**Endovascular Procedures APCs 5191-5194**

RPA fully supports CMS' decision in the 2020 OPPS/ASC rulemaking process to maintain the 4-level APC structure for endovascular procedures. All four of the APCs in this series (5191-5194) are comprehensive APCs. As noted in our comments on the proposed rule, RPA agrees with CMS' 2020 proposal and believes that the expansion from three endovascular APC levels to four levels in 2017 still remains an appropriate APC structure for 2020. Further, RPA believes that all of CMS' proposed APC assignments (which are unchanged from 2019) for the separately paid dialysis access codes 36902, 36903, 36904, 36905, and 36906 are appropriate.

### **Device intensive designation for codes 36903, 36904, 36905 and 36906**

RPA welcomed and supported CMS' proposal to assign ASC device intensive status to CPT codes 36903 and 36906 in the proposed rule, and in this vein we appreciate the decision outlined in the final rule to designate CPT code 36904 (percutaneous thrombectomy) as device intensive; this is a logical and appropriate determination based on the 30 percent device offset percentage for the code.

Given that, we are perplexed by the fact that CPT code 36905 evidently does not exceed the 30 percent threshold and thus is not eligible to be assigned device-intensive status. This is based on the fact that CPT code 36905 includes all of what is described by 36904 plus the addition of a transluminal balloon angioplasty. CPT code 36904 includes a thrombectomy device and 36905 includes this thrombectomy device plus an angioplasty balloon, both of which are costly devices. We acknowledge CMS' assertion in the final rule that this decision is based on most currently available data, but to the nephrologists who provide these services it does not make sense.

RPA believes that a more careful examination of the device costs for 36905 will reveal that the device offset for CPT code 36905 will exceed the 30 percent threshold that should qualify it for ASC device intensive status in 2020. ***Therefore, we respectfully request that CMS perform further review of the equipment and supply costs associated with CPT code 36905 to confirm its status relative to the 30 percent threshold and consider revising its status if appropriate at the earliest possible juncture.***

### **APC level assignment for codes C9754 and C9755**

RPA commends CMS for its decision to revise the APC assignment for HCPCS code C9754 and C9755 to APC 5194 for CY 2020. These codes are for the percutaneous creation of a dialysis fistula—innovative new procedures that increase options for dialysis patients to have a successful arteriovenous fistula for dialysis access. There are several important benefits to the more widespread availability of these services. These procedures are important to making fistula access possible for patients refusing open surgery and where skilled surgeons are not readily available, both of which commonly occur. Additionally, because anesthesia is not required for the percutaneous approach, these procedures can reduce the time needed to have a fistula created and thus the time patients require catheter access for dialysis. CMS made the correct decision for these codes and we appreciate the Agency's thoughtfulness and vision.

RPA welcomes the opportunity to work collaboratively with CMS in its efforts to improve the quality of care provided to the nation's ESRD patients, and we stand ready as a resource to CMS in its future work in refining reimbursement for vascular access services. 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](mailto:rblaser@renalmd.org).

Sincerely,

A handwritten signature in black ink, reading "Jeffrey A. Perlmutter MD". The signature is written in a cursive, flowing style with a prominent initial "J" and a long, sweeping underline.

Jeffrey A. Perlmutter, MD  
RPA President