March 8, 2019

Tiffany Swygert
Director, Division of Outpatient Care
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Swygert:

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goal is 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 offer recommendations regarding the Endovascular APCs (5191-5194) for the CY 2020 OPPS/ASC proposed rule.

First, we support and agree with CMS' decision in the 2019 OPPS/ASC final rule to maintain the four-level structure for the Endovascular APCs, and we believe that CMS should continue this structure for 2020. We believe that this structure strikes the right balance between groupings within the context of a prospective payment system and granularity that recognizes differential resource costs. We also believe that the current four-level structure supports clinical homogeneity regarding the relative complexity of the various procedures, many of which represent increasing complexity within a code series.

As stated in our comment letter to the CY 2019 OPPS ASC proposed rule, the resource and cost requirements for 36902 and 36904 are similar because both procedures involve the use of one insertable device (e.g., balloon angioplasty catheter or thrombectomy device) and they should be assigned to the same APC. Similarly, the resources and costs for 36903 and 36905 are similar because they both involve the use of two devices (balloon angioplasty catheter and either thrombectomy device or stent device) and more time than either 36902 and 36904; therefore, 36903 and 36905 should be assigned to a higher paying APC than 36902 and 36904. Lastly, 36906 should be in a higher paying APC than all of the other dialysis access circuit codes because this procedure requires three devices (balloon angioplasty catheter, thrombectomy device and stent device) and takes longer to perform.

We believe that CMS could further improve the resource homogeneity while maintaining appropriate clinical homogeneity by reassigning the following codes in the proposed rule (our analysis is based on the 2020 Panel Run Two Times Listing):

1. Reassign the three highest cost codes in APC 5192 (37187, 37224, and 37184) from APC 5192 to APC 5193.

2. Reassign the 9 highest cost codes in APC 5193 (92924, 37244, 0236T, 37242, 61626, 37225, 0237T, 0505T, 0234T) from APC 5193 to APC 5194.

These code reassignments would eliminate overlap among cost ranges for significant codes in consecutive APCs in the Endovascular APC series, which would improve the resource homogeneity among the APCs in this series without any significant adverse effects on the payment rates for individual codes.

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. Thank you for considering these suggestions and please let us know if you have any questions. Also, thank you for your efforts on the 2020 OPPS/ASC proposed rule, which we look forward to reviewing. 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,

Michael D. Shapiro, MD, MBA, FACP, CPE
RPA President

Cc: David Rice