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Dear Mr. Chan and Dr. Soracoe,

I reviewed the rule by the Centers for Medicare & Medicaid Services (CMS), published in the Federal Register on 12/28/2020 (page 84501), regarding comments on CPT code 49436 (*Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter*). While CMS decided not to nominate 49436 as potentially misvalued, I was encouraged that the impact of valuing this code in the office setting would be further studied.

When code 49436 was launched in 2007, it was not envisioned to be a procedure that would be performed in the office, and therefore, nonfacility pricing was not requested. Since that time, practitioners who regularly utilize the embedded catheter strategy prefer the office location for externalization, while acknowledging that catheters may need to be externalized in the facility setting when a patient is emergently hospitalized for hyperkalemia, fluid overload, acidemia, an urgent need for angiography, or any situation aggravated by an acute decline in renal function, e.g., Covid-19 infection. The original evaluation of the code 49436 did not include practice expense inputs for the office setting for correct reimbursement of the service. The supplies are numerous, for example: site prep supplies, drapes, staff attire, local anesthetic, syringes, needles, scalpels, catheter transfer/extension set, catheter adapter, irrigation, heparin, dressings and non-disposable instruments.

In my previous correspondence dated January 22, 2020 and September 9, 2020, I requested that CMS add nonfacility pricing to code 49436. I provided documentation that 49436 could be safely performed in the office setting. In my publication (Crabtree et al. Am J Surg 2013; 206:464-71), 96.4% of the externalization procedures were performed in the office. In the publication by Elhassan et al. (Perit Dial Int 2011; 31:558-64), the senior author (Teitelbaum) advised me that he performed 100% of the externalization procedures in the office. He communicated to me that he provided this information to you in his nomination letter.

Medicare site-of-service data shows that 55.9% and 3.3% of CPT 49436 claims in 2018 were performed in the Hospital Outpatient Department (HOPD) and Ambulatory Surgical Center (ASC), respectively. Below are the National Average CMS reimbursements by sight of performance of CPT 49436 in year 2020:

Physician Payment	Nonfacility	Hospital Outpatient Department	Ambulatory Surgical Center
\$195.61	None	\$1,427.29	\$663.06

Not recovering resource expenses for performing 49436 in the office is a driver to utilize the more expensive facility locations for the procedure. Otherwise, many surgeons shun the embedding catheter technique altogether because of the anticipated hassle of having to arrange for the second procedure in HOPD or ACS settings.

Resource costs for performing the procedure in the office is expected to be less than what is reimbursed by CMS for the facility. I have attached a video of 49436 performed in the office so that you may appreciate the magnitude of the procedure and an idea of the supplies involved (play video file through the attached PPT). I would be happy to provide a detailed itemized list of supplies and costs for your evaluation.

Large dialysis organizations, e.g., DaVita and Fresenius, enthusiastically support embedded catheters as a strategy to increase home dialysis therapy. After predialysis education, approximately 50% of patients will select peritoneal dialysis (PD) as their renal replacement therapy; however, only a little over 10% will end up on their selected modality. The gap between what they choose and what they end up using is caused by unexpected final decline in renal function, restrictions in operating room access (made even worse during the COVID-19 pandemic), and patient procrastination due to progressive uremic cognitive impairment. The outcome is crash in-center hemodialysis with a central venous catheter. An embedded catheter implanted far in advanced of anticipated need is protection against such catastrophes. Externalization of the embedded catheter in the office avoids the aggravation and delays in scheduling this procedure in the HOPD or ASC. The patient is able to go straight to full volume PD without a break-in period, avoids a central venous catheter, and remains on track for home dialysis therapy.

I would look forward to working with you to develop a nonfacility reimbursement for CPT 49436. This can be a win-win-win effort for the patient, provider, and payer. How often does a triple win come along?

Respectfully yours,



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