

January 22, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Attention: CMS-1715-IFC  
P.O. Box 8016  
Baltimore, MD 21244-8016

Sent Electronically: *MedicarePhysicianFeeSchedule@cms.hhs.gov*

Subject: **Potentially Misvalued Code**  
Request for Nonfacility Pricing of CPT Code 49436

Dear Administrator Verma:

Peritoneal dialysis catheter embedding may accompany any manner of inserting a tunneled intraperitoneal catheter for dialysis. Instead of leaving the external limb of the catheter tubing emerging from the skin surface, it is plugged and embedded in a subcutaneous track. Catheter embedding is performed in advance of anticipated need for dialysis so that peritoneal access is readily available should an urgent need to start therapy arise. CPT code 49436, *Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter*, was established in 2007 to report externalization of the embedded catheter.

In my practice, 96.4% of catheters were externalized in the office. Practitioners who regularly utilize the embedded catheter strategy prefer the office location for externalization of embedded catheters. The only time catheters should be externalized in the facility setting is when a patient is emergently hospitalized for hyperkalemia, fluid overload, the urgent need for angiography, or any situation aggravated by an acute decline in renal function.

From CMS 2018 site of service data, 32% of embedded catheters were externalized in the office. However, there is no nonfacility payment to cover the resources utilized (ie, clinical staff time and necessary supplies and equipment). Unfortunately, a number of externalization procedures are being performed in the outpatient and ACS settings with the idea that the patient may need to undergo immediate general anesthesia and laparoscopy in the event that the catheter is found to be nonfunctional. Since only 7-15% of catheters are nonfunctional upon externalization, this is a tremendous waste of resources. Others perform the externalization procedure in the outpatient and ASC to simply avoid the non-reimbursed resource costs of doing the procedure in the office. Many surgeons shun the embedding catheter technique altogether because of the anticipated hassle of having to arrange for the second procedure in the outpatient or ACS settings.

The embedded catheter strategy is in alignment with the July 10, 2019 "Executive Order on Advancing American Kidney Health"<sup>1</sup> that encourages increased use of home dialysis. After balanced predialysis education, approximately half of patients will choose peritoneal dialysis as their mode of renal replacement therapy; however, only 10% will end up using their chosen modality. Sudden final deterioration in renal function or the necessity of urgent radiologic interventions with intravenous contrast administration often result in unplanned starts on hemodialysis with a central venous catheter. Patients with embedded catheters implanted in

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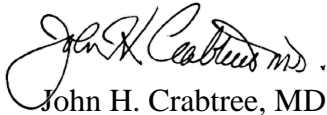
<sup>1</sup> Accessed 1/21/20 at <https://www.whitehouse.gov/presidential-actions/executive-order-advancing-american-kidney-health/>

advance of anticipated need can avoid this scenario with immediate exteriorization of the catheter and start of full volume peritoneal dialysis.

Providing a nonfacility payment for externalizing the embedded catheter when appropriate will promote the catheter embedment procedure. By promoting the ability to perform the externalization procedure in the convenience of the office with reimbursement of costs, more surgeons and nephrologists will utilize the embedding catheter strategy. Providing a nonfacility payment benefits Medicare by reducing costs and making this procedure more convenient for patients.

I appreciate the opportunity to make this request. Please do not hesitate to contact me at [johncrabtree@sbcglobal.net](mailto:johncrabtree@sbcglobal.net) if I can provide additional information.

Sincerely,



John H. Crabtree, MD