



PHP

Asplen 72  
Kane  
Snow  
Hart Bazell

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## **SOUTHWEST AMBULATORY BEHAVIORAL SERVICES, INC.**

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September 12, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1501-P  
Mail Stop C4-26-05  
7500 Security Blvd.  
Baltimore, MD 21244-1850

Re: Comment to CMS-1501-P Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates – Proposed Rule

I am a "free standing" Community Mental Health Center and have been continuously providing PHP since January 1997. The proposed rule referenced above effectively decreases the net daily partial hospitalization reimbursement rate for my facility to approximately \$169. per day net of beneficiary co-pay. This drastic and unwarranted decrease in the PHP daily rate causes me to consider whether or not I can remain viable and continue offering services. If these cuts are implemented and facilities like mine (especially rural providers) are forced to close due to the reimbursement rate, many Medicare Beneficiaries will no longer have access to the mental health care they need and should have under 1833(t)2. The APC rate for PHP code 033 is not sufficient to keep these agencies open.

I have not received outlier payments for the past two years. The only reimbursement I receive is the daily APC payment. That payment is not representative of the partial program costs. The OPSP final rule (FR Vol. 65, No. 68, April 7, 2000) requires representation of the median cost of providing partial hospitalization services. CMS noted in the final rule that they would accumulate appropriate data and determine if refinements to the per diem methodology was warranted. The current proposed rule acknowledges that appropriate cost data from CMHC's has not been utilized due to aberrant data. The proposed cut of approximately 15% is not reflective of the cost pattern for this freestanding CMHC. The inflation rate alone for the medical industry is approximately 3.5%.

For 2006 the national APC proposed rate for PHP code 033 is \$241.57. (inclusive of co-pay of \$48.31). For many providers due to wage index and co-pay, the actual daily remittance rate is approximately \$169. For 2006 the APC payment rate will drop by approximately \$41 or 15%. This is an effective \$169 average daily payment rate for Louisiana providers due to wage index and coinsurance. This is not sufficient to run a program as intense as a partial program. My program consists of 4 to 5 group/individual psychotherapy sessions per day. Based upon CMS Outpatient PPS Psychiatric data, the mean costs for this service would be \$329.24 to \$404.35 (CMS cost analysis attached).

**"THE RIGHT ALTERNATIVE TO INPATIENT CARE"**

Inpatient hospitals can provide an Intensive Outpatient Program that is much less intense and can still be reimbursed at the daily rate of APC Code 033. They are not required to furnish anything but a couple of services, not the four (4) core services that are required of CMHCs to be able to get reimbursed for the PHP portion at the APC Code 033.

The APC panel sets the payment rates for the outpatient services including APC Code 033. The Federal Register issued on February 28, 2003 (Vol. 68, No. 40) pages 9671-9672 specifically states, "Qualified nominees will meet those requirements necessary to be a Panel member. Panel members must be representatives of Medicare providers (including Community Mental Health Centers) subject to the OPPTS, with technical and/or clinical expertise in any of the following areas) To my knowledge, CMHC representation has not been provided on the APC panel even though qualified nominees have been submitted in the past.

Medicare regulations state that partial hospitalization may be provided *in lieu* of inpatient hospitalization, so the acuity level of the patients and the amount of therapy provided is similar. With similar requirements and such a dramatic reimbursement difference, it is clear why many partial hospitalization programs in the country have closed. It is almost impossible to find a hospital based PHP in Louisiana. If "free standing" CMHCs are forced to close, where will the chronically mentally ill Medicare Beneficiary go for services. My assessment is that our inpatient psych hospitals will be overflowing with patients if they haven't already harmed themselves or others and are incarcerated.

Medicare Beneficiaries will have very little access to appropriate services for their illness that will render the same successful outcomes. The State Offices of Mental Health is not able to absorb these patients, and hospital beds are already few and far between and more expensive to operate. The state of Louisiana does not provide a partial day reimbursement program for Medicaid patients; therefore there are more Louisiana providers (CMHC's) relying on Medicare to be able to provide this needed benefit. I currently provide services to 20-30 beneficiaries each day.

I am first requesting that Louisiana providers and other rural state providers be afforded some protection and/or a waiver to the proposed changes as CMS has done for rural hospitals. Access to services is paramount, especially with the devastation to lives in Louisiana, Mississippi, and Alabama with Hurricane Katrina. At least, I am requesting that a fair rate be paid for an intensive day of outpatient PHP services. A payment decrease of 15% for APC Code 033 is definitely too drastic for the intense services delivered based upon CMS cost analysis data of the components involved. In recognition by CMS that medical costs have increased an average of 3.5%, I am requesting that the current payment rate for partial hospitalization programs not be cut. In light of the recent tragedy in our state caused by Hurricane Katrina, the services for these patients will be extremely important. We are asking to leave the 2005 rate in place for 2006 to avoid interruption of services for these patients.

Respectfully,



E. Paul Broussard, CFO

Attachment

**ATTACHMENT: CMS MEDIAN COST DATA PER hcpcs\_medians-1501p.xls CMS1501-P**

**BREAKDOWN OF CMS PUBLISHED COSTS FOR OUTPATIENT PSYCHIATRIC SERVICES**

**The following information is from the CMS 1501-P calculated median costs for services.**

This information is based on CMS gathered data for the HCPCS codes, provided within an outpatient hospital setting. Please take into account that the cost for providing these outpatient services is generally less than that in a partial hospital program, due to the additional components which are expected to be included within a day of partial hospitalization, as well as the additional acuity of the patients being treated.

CMS has clearly defined what must be included in a day of partial hospitalization. The Local Medical Review Policy calls for a minimum of 4 hours per day, five days per week. The minimum which will pass through the OCE is 3 separate therapies per day, a minimum of four out of every seven days. It has clearly been defined and expected that providers will exceed this minimum level.

The average provider of Partial Hospital Services within Louisiana provides 4 therapies per day, five days per week. CMS has also specified that each therapy must be a minimum of 45 minutes. The following is a chart which provides data on the costs of the HCPCS codes which are included within APC 33.

<b>CPT</b>	<b>Description</b>	<b>True Median Cost</b>
90853	Group Therapy	82.31
90847	Family Psychotherapy w/patient present	140.10
90818	Individual Psychotherapy in a Partial Hospital Setting 45-50 minutes	99.63

**Based on the figures above, an average day of services median cost for 4 group sessions would be \$329.24 For a day with mixed sessions it would be \$404.35 median cost (2 group sessions, one individual session, one family therapy session) How can a rate of \$241.57 be appropriate for APC 033?**

Under the proposed rule Louisiana providers will be receiving \$169.00 per day (due to wage index and copay). Clearly this rate is inadequate. We are only requesting that providers be paid a rate which at a minimum covers the cost of providing services.

Please consider the above information for inclusion in comment to the proposed rule 1501-P.

THE UNIVERSITY  
OF KANSAS HOSPITAL  
**KUMED**

Health System Finance  
Budget, Reimbursement,  
and Cost Accounting

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Ahmed  
Haygster  
Kane  
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September 13, 2005

Centers for Medicare and Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1501-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Sir or Madam:

The University of Kansas Hospital appreciates the opportunity to comment on CMS's proposed 2006 outpatient PPS rule. We are a 475-bed teaching hospital with approximately 400 residents.

**Device-Dependent APCs – Section IV.A.**

We would like to comment on the inaccuracy of calculating costs using claims with single procedures. For many of these procedures, it would be very unlikely to implant a device and properly code the account with only one procedure charge. The fact that CMS is relying on claims with only one procedure causes concern that only claims that have been improperly coded or unusual cases are driving reimbursement rates.

For example, for APC 0082 – Coronary Atherectomy, the CY 2006 proposed unadjusted cost is 20% less than the CY 2005 cost. This data is based on 27 claims (7%) out of a total population of 359. Those 27 claims do not represent typical or average cost.

We understand that CMS is attempting to minimize the impact of the low volume of qualifying claims by adjusting median costs to the greater of the median cost from claims data or 85% of the CY 2005 median cost. However, this attempt does not resolve the issue, because a low volume of qualifying claims existed in CY 2005 as well.

Another example is APC 0087 – Cardiac Electrophysiologic Recording/Mapping. The CY 2006 proposed unadjusted cost is 61% less than the CY 2005 cost based on 330 claims (2%) out of a total population of 12,969. Again, it is difficult to understand how 2% of the claim population could be considered representative of that population.

A method for analyzing claims with multiple procedures should be possible to develop. Additionally, average direct costs of the devices would be easily identifiable from either vendors or providers. This direct cost of devices should be used as one variable in the determination of the APC payment amount.

**Device-Dependent APCs – Section IV.B.**

We recognize that the APC Panel and CMS have separately reviewed APC 0107 – Insertion of Cardioverter-Defibrillator & 0108 – Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads because of the significantly low number of qualifying single procedure claims. However, the concluding proposal of setting the median costs at 85% of the CY 2005 cost is unreasonable.

In CY 2005, the reimbursement rates were less than our direct costs. Another 15% reduction in reimbursement is inappropriate. Again, the direct cost of the implant should be one variable in setting the rate of reimbursement.

#### **Non Pass-Throughs – Section V.B.a.(5)**

We understand that CMS is implementing changes based on the MedPAC conclusion that the handling costs for drugs, biologicals, and radiopharmaceuticals delivered in the hospital outpatient department are not insignificant. CMS is proposing the creation of 3 Cxxxx codes for hospitals to use in separately charging for drug handling fees for drugs that are separately payable. We have concerns about the complexity of this billing system.

- 1) The MedPAC Survey found that hospitals' current pharmaceutical charges include their handling costs as well as their acquisition costs. The OPSS proposal recommends charging separately for drug handling only for drugs that are separately payable. It would be difficult for hospitals to implement two different charge methodologies based on whether or not CMS considers the drug separately payable.
- 2) It is frustrating that CMS would require hospitals to implement this significant change with a costly implementation for data collection purposes. The proposed rule states that this data will be used to "consider making future payments under the OPSS using the proposed C-codes."
- 3) How will medical necessity be addressed for these new C-codes? For example, Epoetin has medical necessity criteria. If the Epoetin charge is denied because of medical necessity, how will the drug handling charge be paid? In other words, how can the claim identify which drug handling charge is associated with each drug?
- 4) We agree with the CMS proposal to increase the payment amounts for the pharmaceutical to cover overhead costs. The increase in formula from ASP+6% to ASP+8%, however, still does not cover actual overhead. Our overall pharmaceutical overhead is 18%, excluding non-Pharmacy hospital overhead. The Federal Register states that "we believe that an additional 2 percent of the ASP would provide adequate additional payment for the overhead costs." What is the basis of the belief that 2 percent accurately represents an overhead factor?
- 5) There is a significant shortage of Immune Globulin IntraVenous (IGIV) products at this time. The manufacturers have convinced the FDA that there is not a shortage (the FDA recently issued a statement as such); however, most hospitals across the country cannot obtain enough product to meet patient needs. In addition, IGIV hospital outpatient reimbursement is insufficient to cover costs for this product. This is primarily due to the ASP calculation being done infrequently, while a national shortage is driving up the costs of these agents. While a significant cost increase has already occurred from 2004 through 2005, the anticipated cost increase for these agents between now and 2006 is **30%**. With the infrequent re-assessment of ASP, reimbursement will be far below costs, even with ASP +6% +2%. Further complicating the production of these agents is the fact that the American Red Cross will no longer produce IVIG, and all of the remaining manufacturers are switching from a lyophilized powder product to a liquid preparation for these drugs. The new preparations are even more expensive than the old ones. It is critical for affected patients that CMS address reimbursement for this agent on a more proactive basis.

#### **Drug Coding and Billing – Section V.C.**

We agree with the proposal to discontinue the use of separate HCPCS codes based on whether the drug administered was brand name or generic. We agree that a single payment rate should be established considering the prices for both the brand name and generic forms. It is too difficult to administer the use of different HCPCS codes for the same drug.

**Multiple Diagnostic Imaging Procedures – XIV.A.**

Per the proposed rule, the technical component payment for multiple imaging procedures performed on contiguous areas of the body would be reduced. Med PAC states that "Medicare's payment rates are based on each service being provided independently and that the rates do not account for efficiencies that may be gained when multiple studies using the same imaging modality are performed in the same session. Those efficiencies are especially likely when contiguous body areas are the focus of imaging because the patient and equipment have already been prepared for the second and subsequent procedures yielding resource savings in areas such as clerical time, technical preparation, and supplies, elements of hospital costs that are reflected in APC payment rates under the OPPS."

It would seem reasonable that the APC rates for imaging procedures would need to be increased prior to discounting for multiple procedures, so that the aggregate APC payments are still comparable to providers' costs. Currently, the University of Kansas Hospital is already receiving APC payments that are significantly below our costs for these procedures. For example, for imaging procedures that fall under Family #2, our FY 2005 cost is \$693,000. We are currently receiving only \$619,000 in Medicare reimbursement (based on 2005 rates) for these procedures. Under the proposed rule's discounting provision, those 2005 payments would be reduced to \$454,000. Using the proposed 2006 rates, we would only receive \$441,000. This is actually a decrease of \$14,000 from the 2005 rates adjusted for the proposed discounting. This does not make sense.

We request that you consider increasing the FY 2006 rates to compensate for the loss due to discounting.

Sincerely,



Sally Enevoldson  
Director of Reimbursement

75

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**Cordis**

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Hart  
Bazell



**Biosense Webster.**

a Johnson-Johnson company

September 12, 2005

Mark McClellan, M.D.  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Mail Stop C-4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Attention: CMS-1501-P

**Subject: "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates; Proposed Rule"**

**Requests concerning APC 87:**

1. The use of correctly coded claims in future years
2. Reassignment of CPT codes

Dear Dr. McClellan:

Cordis Corporation and Biosense Webster are pleased to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule, published July 25, 2005 in the Federal Register, Volume 70, No. 141. Cordis and Biosense Webster are members of the Johnson and Johnson family of companies and leading manufacturers of coronary, peripheral and neurovascular advanced medical technologies.

We would like to thank CMS for its willingness to work with manufacturers, and especially for the agency's commitment to continued improvement of the claims data. The impact on Cordis of the proposed 2006 Ambulatory Payment Classifications (APC) rates is positive versus 2005 for many of Cordis' products. However, while some of Cordis' cardiology and endovascular procedures benefit from increases that approximate more appropriate reimbursement, Biosense Webster has a concern about the APC for electrophysiological three dimensional recording and mapping – APC 87. APC 87 is continuing to experience an unrepresentative cost median with a 32% decline over 4 years from \$2,670 in 2002 to a proposed payment of \$1,822 in FY 2006.

Biosense Webster appreciates that the adjustment to APC 87 by CMS of the “true” 2006 median cost again foregoes the drastic payment reduction that would be experienced by hospitals providing 3-dimensional electrophysiological recording and mapping, but the adjustment does not alleviate our concern for future years. As shown in Table 1 below, had CMS used the 2006 median APC cost of \$853.76 (Table 15, NPRM) from the 2004 claims data to develop the payment for APC 87, payment would have decreased by 65%.

Table 1

APC	Description	2006 Proposed Payment	2006 True APC Median Cost	% Difference
87	Cardiac EP recording/3 Dimensional Mapping	\$1,822	\$854	65%

FY 2006 is the last year that CMS intends to make across the board median adjustments, relying in future years on mandatory device reporting and claim editing. Biosense Webster is concerned that hospitals could experience a significant decrease in APC 87 payment in future years due to documented charge compression, CMS single procedure methodology, and poor reporting of device C-codes by hospitals.

#### Use of Correctly Coded Claims

For its review of the 2006 Proposed Rule, Biosense Webster joined other manufacturers through AdvaMed and contracted Direct Research Incorporated to perform analysis of the 2004 Medicare claims data used by CMS for rate development. In previous years CMS had used only correctly coded claims, i.e. those claims with C-codes for device-dependent APC(s). Of course, the use of correctly coded claims was not feasible with the 2004 claims data because C-codes were optional during this time period. A revenue code proxy was developed and used to “screen” claims, similar to the C-code screen used by CMS in previous years. **As seen in Table 2, when the “correctly coded” proxy screen is applied and only claims containing packaged revenue center costs (i.e. device costs) are employed for rate development, the median increases by 81% - strong evidence that the median cost is not accurately represented in the CMS claims data used for rate development. Biosense Webster urges CMS to use only correctly coded claims for rate development for APC 87 in future years.**

Table 2

APC	Total Claims	Single Procedure Claims	Median Cost of Single Procedure Claims	Median Cost After Screen	% Difference
87	12,583	321	\$819	\$1,483	81%

#### Payment to Cost Ratios

Currently, hospitals are not being reimbursed enough to cover the cost of the three dimensional catheter and the reference patch used in the procedure, which has a \$3,350 list price. Steep future declines occurring when CMS ceases to adjust the median will worsen the picture. Hospitals will no longer make the procedure available to Medicare recipients if they cannot cover their costs.

Direct Research also developed a hospital-level profile of selected APC and HCPCS codes for hospitals

billing a code 10 or more times. Of 48 hospitals billing CPT code 93613, three dimensional recording and mapping in APC 87, payment to cost ratios for the APC ranged from a low of .40 to a high of 1.18. Of hospitals billing code 93613, 85%, or 41 hospitals received less than 80% of their cost.

**Violation of the 2 Times Rule**

In FY 2005 CMS exempted APC 87 from the 2 Times Rule as an exception, but it is not found in this year’s Table 8 Proposed APC Exceptions to the 2 Times Rule for CY 2006. Cordis believes that APC 87 is in violation of the 2 Times Rule and agrees with its absence from Table 8, i.e. that it should not be exempted by CMS.

The standard of the BBA of 1997 is that items and services within a group cannot be considered comparable with respect to the use of resources if the highest median cost item or service within a group is more than 2 times greater than the lowest median cost item or service within the same group. The BBRA of 1999 allows CMS to make exception to the 2 Times Rule. As demonstrated in Table 3, in 2006 the median cost for add-on code CPT 93613, 3 dimensional recording and mapping at \$1,342.65 is more than 97 times greater than 93615 which also still groups to APC 87. This difference seems clearly in violation of the intent of the 2 Times Rule and may have previously been exempted on the basis of low volume. However, the exhibited volume of APC 87 in Table 15 Proposed Median Cost Adjustments for Device-Dependent APCs for CY 2006 is 12,969 procedures.

Biosense Webster provides a partial solution to the 2 Times Rule violation that is discussed below in the section titled “CPT Codes Assigned in APC 87”.

Table 3

CPT Code	Description	CMS 2006 “True” Median Cost	“Single” Procedure Frequency
93600	Bundle of His recording	\$ 584	20
93602	Intra-atrial recording	\$ 368.85	9
93603	Right ventricular recording	\$ 878.43	9
<b>+93609</b>	<b>Map tachycardia, add-on</b>	<b>\$1,067.20</b>	<b>64</b>
93610	Intra-atrial pacing	\$ 176.98	24
93612	Intra-ventricular pacing	\$ 168.68	11
<b>+93613</b>	<b>Electrophys map 3D, add-on</b>	<b>\$1,342.65</b>	<b>16</b>
93615	Esophageal recording	\$ 13.84	10
93616	Esophageal recording w/pacing	\$ 30.50	11
93618	Heart rhythm pacing	\$1,211.61	64
93623	Stimulation pacing, heart	\$ 693.40	90
<b>93631</b>	<b>Heart pacing, mapping</b>	<b>\$1,727.29</b>	<b>2</b>

**CPT Codes Assigned in APC 87**

Biosense Webster respectfully requests the reassignment of the “mapping” codes – 93609, 93613, and 93631 from APC 87 to a more clinically and resource-aligned group: APC 86, Ablation Heart Dysrhythmia Focus. The 2006 unadjusted median for APC 86 is \$2,670.78. Codes 93609 and 93613

are both “add-on” codes that can not be reported except in conjunction with codes which group to APC 86, which are the codes 93620 - Comprehensive electrophysiologic evaluation, 93651 - Intracardiac catheter ablation of arrhythmogenic focus, treatment of atrial foci and 93652 - Intracardiac catheter ablation of arrhythmogenic focus, treatment of ventricular tachycardia. **It is appropriate that codes that for clinical reasons can only be billed with the codes 93620, 93651, 93652 be placed in the same clinically and resource coherent APC.**

### Summary

Biosense Webster makes 2 requests:

1. In future years CMS should only use correctly coded claims for payment rate development.
2. CPT codes 93609, 93613, and 93631 should be reassigned to APC 86 for improved clinical and resource alignment.

CMS has stated its concerns about the impact of the Outpatient Prospective Payment System on access to care for Medicare beneficiaries. Cordis and Biosense Webster certainly share this concern. Thank you for the opportunity to comment on this proposed rule.

Sincerely,



Brian G. Firth  
Vice President of Medical Affairs, Health Economics  
and Reimbursement  
Cordis Corporation, a Johnson & Johnson company

76

Paymt./Devices  
Payment Rates  
APC/D-D

Levi  
Heygster  
Kane  
Snow  
Hart  
Bazell

Cochlear

September 12, 2005

Mark McClellan, MD, PhD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1501-P  
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Re: Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates; **File code: CMS-1501-P; Issue Identifier: Device-dependant APCs**

Dear Dr. McClellan:

Cochlear™ Americas, the world's largest manufacturer and distributor of cochlear implants, welcomes the opportunity to comment on CMS' proposed rule, CMS-1501-P, published on July 25, 2005. Cochlear Americas appreciates the considerable effort CMS has put into the development of the outpatient prospective payment system (OPPS). Cochlear values your willingness to work with us to preserve, and improve, Medicare beneficiaries' access to the vital outcomes associated with cochlear implantation.

If adopted as proposed, payment for cochlear implantation (APC 0259; 69930; L8614) in calendar year 2006 would decline by 14%, a decline that is inconsistent with the reality of the cost of the procedure. The proposed reduction in payment reflects a large discrepancy between the median device cost derived from the CY 2004 OPPS claims -- \$16,408 -- and the industry average selling price of \$21,827. Hospitals do not purchase cochlear implant devices for \$16,408.

We respectfully request that a payment rate of \$27,192 for APC 0259 be published in the final rule for 2006. Alternatively, we ask CMS to set a floor on the 2006 device-related APC rates at 100% of the 2005 rates plus the basket update for APC 0259.

Hear now. And always

We recognize that a system as complex as OPSS will encounter challenges as it evolves into balanced methodology capable of ensuring hospital costs are covered, beneficiary access to technology is maintained and CMS stewardship of the Fund is sustained. In an effort to contribute meaningful data to the OPSS process, Cochlear and the other two cochlear implant manufacturers each independently commissioned The Lewin Group to replicate CMS methodology and analyze 2004 OPSS claims data. Lewin's report, Analysis of Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates for Cochlear Implantation Device/Systems, is attached for your review. The following comments will focus upon device-dependent APCs and Lewin's key findings.

Lewin's replicate analysis generally corroborated CMS' work. There is a significant difference however, between the OPSS median device cost, as calculated by Lewin using OPSS data and CMS methods, and the actual hospital device acquisition cost as derived from independently provided data.

Although not included in CMS-1501-P, Lewin calculated the device portion -- \$16,048 -- of the CMS proposed APC payment of \$21,739. Lewin's methodology for extracting the device portion is included in the attached report. The Lewin Group was also asked to use external data (i.e., industry average selling price) to derive a true payment rate for APC 0259. By definition, the industry average selling price is the cochlear implant device/system list price net of discounts, i.e., the actual hospital acquisition cost.

Under separate agreements, the three cochlear implant manufacturers (comprising 100% of device sales) submitted proprietary pricing and utilization information to Lewin. Using that information, Lewin calculated a "new" payment rate using a revised relative weight -- based upon the ratio of costs using external data over CMS derived costs -- multiplied by the CY 2006 conversion factor. The new payment rate, which reflects hospital device costs plus payment for the procedure, is \$27,192. Table 1 compares the CMS proposed payment with the Lewin-derived payment using external data.

**Table 1. Comparison of CMS' Proposed Payment in 2005 and Payment Using External Data**

	CMS	New Lewin
Proposed APC payment	\$21,739	\$27,192
Device cost	\$16,048	\$21,827
Implied procedure costs	\$5,691	\$5,365

Using external data and replicating CMS methods can generate a payment closer to the actual cost of the device and the procedure.

#### The cost gap

There was a sizeable gap between the OPSS proposed device cost and the actual costs borne by hospitals. We believe there are four principle reasons for this "cost gap": 1) the reliance upon Medicare claims as the sole source for data to determine payment, 2) unintended consequences of current analytical methodology, 3) hospital charging practices, and 4) hospital device and technology billing.

#### Consequences of current analytical methods

Historically, OPSS payment for cochlear implants has been well below cost. In the initial stages of OPSS development, little useful data was collected during the pass-through period (ending December 2002). In 2003, hospitals' loss per Medicare surgery was approximately \$5,000. Provider billing errors have also influenced the data used to analyze cost.

During the past two years however, provider billing has improved and CMS has gradually increased payment for APC 0259; better billing could be a factor in improved payment. Although APC payment in 2004 and 2005 still did not cover the cost of the cochlear implant device alone, there was positive change. It was anticipated that CMS methodology would advance and thus result in payment rates based upon actual costs.

In 2006, the proposed APC payment rate is less than the average selling price of the device. We believe the link between hospital charges and the CMS methodology that derives cost from charges contributed to the proposed reduction in payment. In Lewin's report, the relationship among hospital charges, cost-to-charge ratios (CCR) and simulated cost was studied<sup>1</sup>. Lewin's report demonstrates that the variances inherent in the formula used by CMS to compute cost does not support the calculation of a median cost reflective of actual cost.

#### Hospital charge practices

Payment rates for device-dependent procedures are based on cost data generated by CMS' cost calculation methods. Due to "charge compression", this often results in inaccurate device costs relative to average selling price, i.e., the actual hospital acquisition cost, of devices. Specifically, hospitals apply lower mark-ups to calculate charges for high-cost devices that results in CMS under-reimbursement of these devices relative to other outpatient services.

Hospital charge practices are driven by contract considerations and payment arrangements with commercial/private health plans. In addition, adjustments to hospital chargemaster pricing systems often lag behind changes in purchasing costs. Many hospitals engage in charge compression to avoid "sticker shock" to patients and private health insurance plans. Contracts including reimbursement based upon a percentage payment of charges would be dramatically affected if costly devices were marked-up consistent with other outpatient services. Seventy percent of all cochlear implant surgeries are performed for individuals covered by commercial or private health plans.

#### Hospital device and technology billing

Although hospital coding and billing practices have improved (see Appendix B of the attached Lewin report), many hospitals are still not coding cochlear implantation accurately. Cochlear urges CMS to speed up efforts to educate hospitals on the importance of accurate coding for devices including the use of C-codes, reporting charges and the consistent use of revenue codes. Lewin's report includes many

examples of the impact of specific hospital billing practices, particularly in the assignment of revenue center codes<sup>3</sup>.

### Summary

In conclusion, we are encouraged by the recent improvements in OPPS payment for cochlear implants. In spite of problems with payment methodology, past actions by CMS have been beneficial to hospitals and patients.

The proposed 2006 OPPS payment is not reflective of hospital acquisition costs, that is, the OPPS median device cost calculated by Lewin (\$16,408) is significantly different than the industry average selling price extracted from data provided by manufacturers (\$21,827). The \$16,408 device cost inherent to the CMS calculations does not represent the reality of hospital cost. The attached report by The Lewin Group provides substantial data and analysis supporting our comments, and presents an alternative payment based upon CMS methods and external cost data.

Cochlear Americas has concluded the following:

- Current cost calculation methods have produced unintended consequences in the form of OPPS payment for cochlear implants that is not viable for hospitals or beneficiaries;
- When the medians used to calculate payment for cochlear implants fall below the previous adjusted medians, or when external data is presented that demonstrate the insufficiency of the proposed payment rate, CMS should incorporate this stakeholder data and make adjustments that more accurately represent the cost of the device and procedure;
- The effect of non-Medicare payment arrangements and contracts on factors used in CMS' cost calculations cannot be underestimated;
- Issues as complex as charge compression, and other issues related to hospital charging practices, require communication among medical device companies, the hospital industry, and CMS. We support the alternative mechanisms to address hospital charging practices submitted by AdvaMed<sup>2</sup>.

- Hospitals cannot take a loss on a per procedure basis. The proposed payment rate for cochlear implant devices/systems is economically unsustainable, and would disadvantage Medicare beneficiaries by reducing access to cochlear implant devices/systems, as well as to follow-up mapping (or programming of the speech processor) which is critical to optimizing patient outcomes with the device.

Cochlear Americas recommends the following:

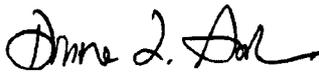
- A payment rate of \$27,192 for APC 0259 is published in the final rule for 2006. The "new" rate, derived by Lewin, represents payment based upon convincing device and procedure cost data. We ask that CMS recalibrate the relative weight of APC 0259 so that the 2006 OPSS payment rate continues to more closely reflect hospital costs of the cochlear implantation procedure;
- Alternatively, we ask CMS to set a floor on the 2006 device-related APC rates at 100% of the 2005 rates plus the basket update for APC 0259. Although this will not alleviate the chronic underpayment cochlear implants have experienced over the past years, it will provide a greater level of continuity until the issues included in these comments, and in Lewin's insightful report, are addressed. We believe that the proposed 85% floor on payment rate reductions results in too much of a decrease in value for APC 0259.

We appreciate the efforts CMS has made in the past and recognize that the OPSS payment rate has increased in recent years even though payment has remained below hospital cost. We believe the process employed to calculate device costs under OPSS, while an improvement from previous years, results in unintended consequences for hospitals and Medicare beneficiaries. These consequences prevent hospitals from covering their minimum costs which translate into losses and ultimately into reduced access for Medicare beneficiaries.

Dr. McClellan  
September 12, 2005  
Page 6 of 7

Cochlear implants have proven to vastly improve the health, functioning, independence, and overall well-being of many Americans. Cochlear Americas appreciates the opportunity to submit comments regarding CMS-1501-P and looks forward to working with CMS to ensure access to those Medicare beneficiaries that qualify for this life changing technology. Thank you for your attention and consideration in this matter.

Sincerely,



Donna Sorkin  
Vice President Consumer Affairs



John McClanahan  
Senior Director, Reimbursement & Funding

Enclosure

#### **References**

1. Analysis of Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates for Cochlear Implantation Devices/Systems. The Lewin Group. Pages 10-12, September 7, 2005
2. Hospital Outpatient Prospective Payment System Proposed Rule (CMS-1501-P) Update for Calendar Year 2006. AdvaMed. Pages 9-12, September 2005.
3. Analysis of Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates for Cochlear Implantation Devices/Systems. The Lewin Group. Appendix A, September 7, 2005.



*The* LEWIN GROUP

**Analysis of Proposed Changes to the  
Hospital Outpatient Prospective  
Payment System and Calendar Year  
2006 Payment Rates for Cochlear  
Implantation Devices/Systems**

*Prepared for:*

**Advanced Bionics, Cochlear Americas, and Med-El  
Corporation**

*Prepared by:*

**The Lewin Group, Inc.**

*September 7, 2005*

**Analysis of Proposed Changes to the  
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Implantation Devices/Systems**

*Prepared for:*

**Advanced Bionics, Cochlear Americas, and Med-El  
Corporation**

*Prepared by:*

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K. Jeannine Dollard, M.P.A.**

*September 7, 2005*

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## Table of Contents

I. INTRODUCTION .....	1
II. SUMMARY OF RESULTS & FINDINGS.....	2
III. ANALYTIC METHODS.....	3
A. Overview .....	3
B. Detailed Methods Discussion .....	4
1. Creating the Working Dataset.....	4
2. Determining the CY 2004 OPPTS Median APC Cost.....	5
3. Determining the CY 2004 OPPTS Median Cochlear Implant Device/System Cost .....	5
4. Determining the CY 2004 Weighted Average Selling Price Net of Discounts .....	6
5. Calculating the CY 2004 Median APC Cost Using the Weighted Average Selling Price Net of Discounts.....	6
6. Calculating a "New" APC Payment using a "New" Relative Weight and the CY 2006 Conversion Factor.....	7
IV. RESULTS.....	8
A. Primary Results .....	8
B. Other Results .....	9
C. Discussion .....	10

**Appendix A**

**Appendix B**

**Appendix C**

**Appendix D**

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## I. INTRODUCTION

Three years ago, The Lewin Group was commissioned separately by Advanced Bionics, Cochlear Americas, and Med-El Corporation to provide technical assistance in assessing the methodology used by The Centers for Medicare & Medicaid Services (CMS) to develop the proposed CY 2003 payment rates for cochlear implant devices/systems. The Lewin Group's initial analysis found that the proposed payment did not reflect the actual cost of the device, largely due to provider miscoding of the device. Next, Lewin recalculated the median Ambulatory Payment Classification (APC) cost by substituting a weighted average selling price that had been individually provided by manufacturers for the device cost found on the claims. Ultimately, in the Final Rule, the APC payment rate better reflected the cost of the device to hospitals as well as outpatient facility costs associated with the device procedure.

In 2004, Advanced Bionics, Cochlear Americas, and Med-El Corporation again separately commissioned The Lewin Group to replicate CMS' methodology and the proposed payment rate for cochlear implant devices/system (APC 0259). On August 16, 2004 CMS published the proposed rule entitled Changes to the Hospital Outpatient System and Calendar Year 2005 Payment Rates in the *Federal Register*. In this NPRM, CMS proposed a median APC payment of \$23,686 for CY 2005, with a final payment subsequently set at \$25,307. Because hospitals had additional experience with coding under the Hospital Outpatient Prospective Payment System (OPPS) and because more data on hospital charges were available from CY 2003 claims, it was hypothesized that the proposed CY 2005 payment rate might adequately reflect actual hospital costs for the APC.

Once again, in 2005, The Lewin Group was commissioned to replicate CMS' methodology underlying the proposed payment rate for cochlear implant devices/systems (APC 0259). On July 18, 2005 CMS published a NPRM containing the proposed payment rate of \$21,739 for APC 0259 for CY 2006, a fourteen percent decrease from the CY 2005 final payment rate of \$25,307.

In replicating CMS' analysis, we found the median cost of APC 0259 to be \$21,046, with a median device cost of \$16,408. There is a large discrepancy between the median device cost in the CY2004 OPPS claims and the average selling price of the device. Lewin analysis of the CMS claims suggests that CMS proposed payment for CY2006 is not economically viable for the hospitals or the manufacturers of cochlear implant devices/systems.

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## II. SUMMARY OF RESULTS & FINDINGS

- There is a large discrepancy between the median device cost derived from the CY 2004 OPPS claims (\$16,408) and the average selling price (device list price net of discounts) of \$21,827.
- CMS proposed a budget neutral adjusted APC payment of \$21,739 for CY 2006. Lewin duplicated CMS' analysis and recalculated the median APC cost using the average selling price for the device as \$25,743, which is slightly more than the CY2005 payment of \$25,307.
- The Lewin Group calculated a budget neutral APC payment of \$27,192 which reflects the actual cost of the device and the hospital facility costs associated with the cochlear implantation procedure.
- The proposed payment rate for cochlear implant devices/systems is economically unsustainable, and would disadvantage Medicare beneficiaries by reducing access to cochlear implant devices/systems, as well as to follow-up mapping (or programming of the speech processor) which is critical to optimizing patient outcomes with the device.

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### III. ANALYTIC METHODS

#### A. Overview

Before performing the analyses, Lewin had to create the working dataset from the CY 2004 Outpatient Prospective Payment System limited dataset of hospital outpatient claims (claims for January 1, 2004 – December 31, 2004 which were final as of July 20, 2005). To create the working dataset, Lewin applied the methodology described by CMS in the proposed rule to remove “multiple procedures” claims, leaving claims with a single APC related to CPT 69930 (cochlear device implantation). We then created “pseudo” single claims from the previously removed multiple procedure claims by applying the methodology described in the *Federal Register*.

First, bypass codes (*Federal Register*, July 25, 2005, Table 1) were eliminated from the claims. Next, date of service matching was used to create additional “pseudo” single claims. Single and “pseudo” single claims were then combined to create the APC working dataset. (See *Figure 1* on page 5.) To finalize the APC working dataset, non-packaged HCPCS codes (codes without a status indicator of “N”) and non-packaged revenue codes (*Federal Register*, July 25, 2005, Table 2) were removed from the claims.

With the working dataset finalized, the first objective of our analysis was to determine the CY 2004 median cost for APC 0259, as well as the cost of the cochlear implant device/system. To estimate the median APC cost, we totaled the costs of the device and procedure as well as packaged HCPCS (codes with a status indicator of “N”) and packaged revenue codes (*Federal Register*, July 25, 2005, Table 2) for each claim. Finally, we computed the median APC 0259 cost for all single and pseudo-single claims in our working dataset.

Our second objective was to determine the CY 2004 median cost of the device from the claims in our APC working dataset. In 2004, providers were not required to list the device separately on claims; therefore, a two step process was used to identify device costs. First, device costs for claims listing L8614 were identified. Second, on the remaining claims, we examined revenue codes 0270, 0272, 0274, and 0278 to identify additional devices that had not been separately coded. These revenue codes were selected for examination because the device, L8614, was frequently coded to these revenue centers when separately listed. (See *Figure 2* on page 6.) A device unit cost was computed for each claim and the median device cost was determined.

Our final objective was to recalculate the APC median and to determine a “new” budget neutral APC payment rate using a weighted average selling price (device list price net of discounts). We first calculated the weighted average selling price using confidential hospital invoice data supplied separately by each of the three manufacturers. The three manufacturers together represent 100% of the cochlear device market nationally. We then substituted the weighted average selling price for the device cost in the CY 2004 OPSS claims and recalculated an APC cost based on this information. Finally, we compared Lewin-derived APC costs (using the weighted average selling price) to APC costs derived from the CY 2004 OPSS claims. We used the median ratio to adjust the relative weight for the procedure and then calculated a “new” CY 2006 APC payment amount by multiplying the “new” relative weight by the conversion factor.

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## B. Detailed Methods Discussion

### 1. *Creating the Working Dataset*

Our first step in creating a working dataset was to extract all claims involving CPT code 69930 (cochlear device implantation) and/or L8614 (the device code) from among the approximately 54.6 million records in the Limited Dataset (LDS) of OPSS claims for CY 2004. This initial dataset contained a total of 962 claims. Claims that had the device L8614 coded, but did not have the corresponding CPT code for cochlear implantation, 69930, were then excluded. This created our original APC dataset, which included 939 claims.

Next, we used the methodology described by CMS in the proposed rule to eliminate multiple procedure claims and to create "pseudo" single claims from our original dataset, leaving only claims with a single APC related to CPT 69930. Two types of multiple major procedure claims were removed from the file:

- Claims in which ancillary costs cannot be associated with individual HCPCS codes because they are supportive of some or all services furnished to the patient – therefore, all claims with more than one procedure showing a status indicator of "S", "T", "V", or "X" were excluded; and
- Claims with packaged HCPCS codes coded with status indicator "N" that include more than one primary procedure (status code "S" or "T") were excluded.

In summary, in this step we extracted all of the singleton claims having only one primary procedure that could be grouped to an APC (aside from laboratory and incidentals such as packaged drugs and venipuncture). Claims could include HCPCS codes with status indicators "A," "C," "E," "G," "H," or "N," as long as there was a single primary procedure within a single APC. We also eliminated claims having a single procedure code but a zero charge. This step resulted in a dataset containing 280 true single procedure claims.

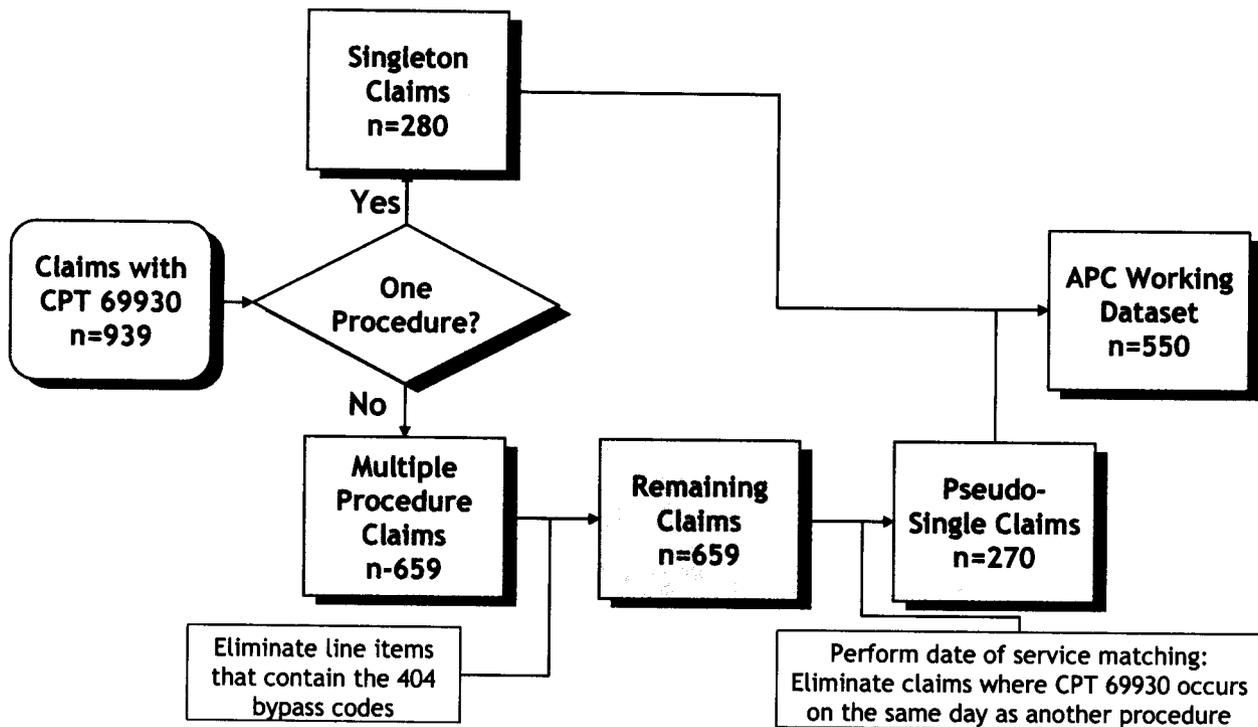
After true singletons were identified, the multiple procedure claims were evaluated to identify "pseudo" single claims. The first step in extracting "pseudo" single claims from multiple procedure claims is to eliminate line items that contain CMS' bypass codes. The bypass codes are procedure codes found to include no packaged costs and their individual costs can, therefore, be eliminated from claims with CPT 69930. Included on this list of bypass codes were chest x-ray codes (HCPCS 71010 or 71020) and an EKG code (HCPCS 93005).

Next, the dates of service were examined on the multiple procedure claims. Ultimately, "pseudo" single claims are those on which multiple procedures occur but the dates of service are different for all procedures. In this case, a multiple procedure claim would have CPT 69930 on one date of service, but different procedures on other dates of service. To create "pseudo" single claims from multiple procedure claims, the costs for the non-CPT 69930 procedure as well as any packaged costs associated with that procedure were eliminated. What remains are only the costs associated with CPT 69930. Claims could include HCPCS codes with status indicators "A," "C," "E," "G," "H," or "N," as long as there was now only a single primary procedure within a single APC.

The extraction of “pseudo” single claims from the multiple procedure claims produced an additional 270 usable claims for a combined dataset containing 550 claims. The final step was eliminating line items from the 550 claims that were not in packaged revenue centers or did not contain either the device, the procedure, or packaged HCPCs (status indicator of “N”).

Figure 1 depicts the methodology employed to create the final APC working dataset.

**Figure 1:  
Methodology Used to Create APC Working Dataset**



## 2. Determining the CY 2004 OPPS Median APC Cost

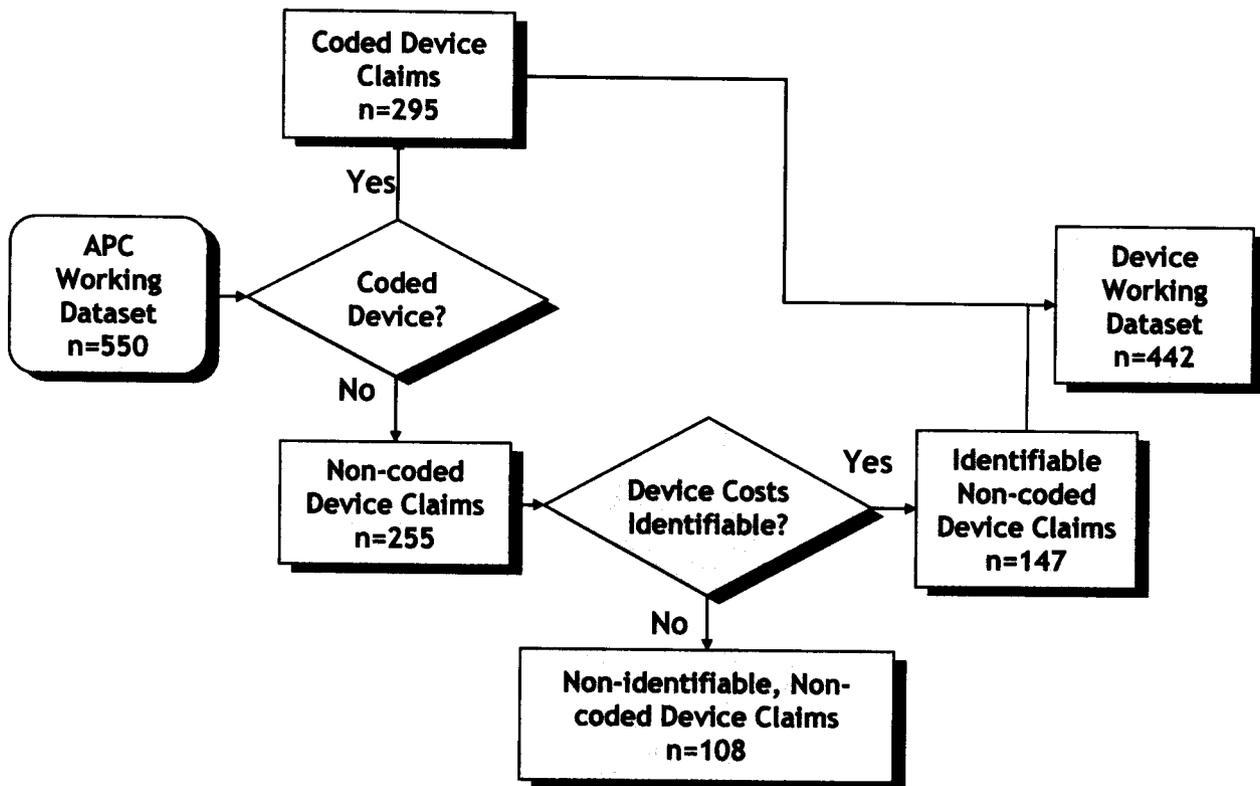
The 550 claims Lewin extracted for the APC working dataset had to include the CPT code for the cochlear implantation procedure (69930). Using this APC working dataset, we computed the APC costs for each claim. These APC costs were then converted into logs and the geometric mean was calculated. Outliers, claims with log costs that were more than three standard deviations from the geometric mean, were eliminated from the calculation of the median APC cost. Once outliers were excluded there were 544 claims in the dataset. (These results are very close to those reported by CMS; CMS reports using a total of 554 claims to calculate the APC median cost.) From the remaining claims, Lewin calculated the range, mean, median and standard deviation of the CY 2004 OPPS APC cost.

## 3. Determining the CY 2004 OPPS Median Cochlear Implant Device/System Cost

Our second objective was to determine the median cost of the device from the OPPS claims. To calculate the median device cost, only claims with identifiable device costs were used. (Figure 2)

The claims we kept had to include both the CPT code for the cochlear implant procedure (69930) and a device cost which could appear in revenue centers 0270, 0272, 0274 or 0278 and was or was not additionally coded L8614. Specific device costs were identified either through their HCPCS code or through revenue center designation and were used to determine the total device cost for each claim. The device working dataset included 442 claims. To calculate the median device cost, outliers were excluded based on the geometric mean and three standard deviations—this left 431 claims. Lewin then calculated the mean and median cost for the cochlear implant device/system for CY 2004.

**Figure 2:  
Methodology Used to Create Device Working Dataset**



#### **4. Determining the CY 2004 Weighted Average Selling Price**

Next, Lewin calculated an actual weighted average selling price (device list price net of discounts) using confidential data supplied by the three manufacturers—Advanced Bionics, Cochlear Americas, and Med El Corporation.

#### **5. Calculating the CY 2004 Median APC Cost Using the Weighted Average Selling Price**

Using the results of step four above, Lewin substituted the weighted average selling price for the device cost in each claim in the device working dataset. Using the weighted average selling price, Lewin recalculated the CY 2004 median APC cost.

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**6. Calculating a "New" APC Payment using a "New" Relative Weight and the CY 2006 Conversion Factor**

The final step in the Lewin analysis was to derive a "new" budget neutral CY 2006 APC payment rate. The new payment rate was derived by calculating a new relative weight and applying the CY 2006 conversion factor. To determine the new APC relative weight, Lewin first divided the APC cost calculated using the average selling price by the APC cost calculated from CY 2004 OPPS claims for each claim. This provided a ratio of these two costs for each claim. The median ratio across all claims was then identified and used to calculate a new relative weight. The "new" relative weight was then multiplied by the CY 2006 conversion factor to determine the "new" CY 2006 APC payment rate.

## IV. RESULTS

Tables 1 - 4 below summarize the results of our analyses of the CY 2004 OPSS claims for the cochlear implant device/system.

### A. Primary Results

In our analysis, we found the CY 2004 OPSS median APC cost to be \$21,046, with a mean of \$25,706 and a standard deviation of \$20,760.<sup>1</sup> For the implant device, we found a median device cost of \$16,408 in CY 2004, with a mean device cost of \$20,684. See Table 1.

**Table 1:  
Results of the Lewin Group Analysis of CY 2004 OPSS Claims**

	<b>APC Cost N = 544</b>	<b>Device Cost N = 442</b>
range	\$1,563 - \$152,934	\$1,839 - \$138,506
mean	\$ 25,706	\$ 20,684
<b>median</b>	<b>\$ 21,046</b>	<b>\$ 16,408</b>
standard deviation	\$ 20,760	\$ 17,087

Tables 2 and 3 contain the weighted average selling price as well as the results of the Lewin analysis using the weighted average selling price of the device. The weighted average selling price for the device is \$21,827 and when this selling price is substituted for the device cost listed in the OPSS claims, the new median APC cost is \$25,743.

**Table 2:  
Weighted Average Selling Price**

<b>Weighted Average Selling Price</b>	\$ 21,827
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**Table 3:  
Lewin Group Analysis Using Weighted Average Selling Price**

	<b>APC Cost N = 431</b>
range	\$22,692 - \$51,913
mean	\$ 27,393
<b>median</b>	<b>\$ 25,743</b>
standard deviation	\$ 6,054

<sup>1</sup> Lewin Group analysis of CY 2004 OPSS claims

To compute the “new” Lewin payment rate, first the ratio of the average selling price-based APC cost and the OPPS APC cost was calculated for each claim. The median of these cost ratios is 1.25 (*Table 4*). Also, shown in *Table 4* is the CMS proposed relative weight and the “new” Lewin APC relative weight.

**Table 4:  
Data Used to Calculate the “New” Lewin APC Payment Rate**

<b>Median of Claims Cost Ratios Avg Selling Price APC Cost/OPPS APC (a)</b>	<b>2006 Proposed Relative Weight (b)</b>	<b>“New” Lewin Relative Weight (c) = (a) * (b)</b>
1.250825	366.3317	458.2168487

To determine the “new” Lewin-derived APC payment found in *Table 5* below, the “new” Lewin APC relative weight is multiplied by the CMS 2006 conversion factor of 59.343. The “new” Lewin APC payment rate is \$27,192.

**Table 5:  
CMS Proposed CY 2006 APC Payment Rate vs. “New” Lewin APC Payment Rate**

	<b>Proposed CY 2006 Payment Rate</b>	<b>“New” Lewin CY 2005 Payment Rate</b>
2006 APC Payment Amount	\$ 21,739	\$ 27,192

## **B. Other Results**

In addition to performing the analyses described above, The Lewin Group used the dataset of 544 claims to identify the following data inconsistencies:

- The median CY 2004 OPPS APC cost for claims with a coded device differed from claims without a coded device. For claims with the code L8614 affixed, the median APC cost for the claims was \$21,460 while the median APC cost for claims without a coded device was \$19,622 (a difference of \$1,838). The means for these two categories of claims exhibit a greater discrepancy, \$28,108 for claims with a coded device and \$23,051 for claims without a coded device - a difference of \$5,057.
- For claims in which the device was coded (N=295) the median device cost was found to be \$16,408 when outliers were excluded. This is different than the median device cost calculated from claims that did not have the device itself coded. For claims which did not have coded devices, we identified device costs on 147 claims. All of these claims had non-coded device costs/charges linked to revenue center 0278. These 147 claims were then used to calculate the median device cost for non-coded devices. The result was a median device cost of \$15,302—a difference of \$1,106 (\$16,408 vs. \$15,302).
- One provider submitted thirteen claims in which device L8614 costs were assigned to revenue center 0272 (medical/surgical supplies-sterile supply). Other providers submitted a total of four claims in which device L8614 costs were assigned to this revenue center.

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Additionally, there were a total of 43 claims with the device coded that were assigned to revenue center 0274. A total of 60 claims with the device coded were assigned to the incorrect revenue center. (*Appendix A*)

- Providers also coded the procedure incorrectly. One provider submitted six claims for CPT 69930 in which the costs/charges were assigned to revenue center 0490 (ambulatory surgical care – general). A total of 19 claims were assigned to revenue center 0490. A different provider submitted five claims on which CPT 69930 was listed, but linked to revenue center 0369 (operating room services – other). In total 32 claims were submitted in which the procedure was linked to an incorrect revenue center. (*Appendix A*)
- One possible result of educational efforts concerning proper coding was that all providers who actually listed the device on the claim also properly coded the procedure with 69930. (*Appendix B*)
- In addition to analyzing the CY 2004 OPPS claims, we also built two tables which compare costs for CY 2004 OPPS claims to costs for CY 2003. One chart presents costs by CPT and the other displays costs by revenue center. One remarkable difference is the change in median cost, before removal of outliers, for L8614 from CY2003 to CY2004 from \$22,339 in 2003 to \$17,135 in 2004. (*Appendix C*) [Note that with outliers removed, the median device cost was \$16,408.]
- Also notable is that in nearly all instances, the median for revenue centers associated with cochlear implants have declined. (*Appendix C*)

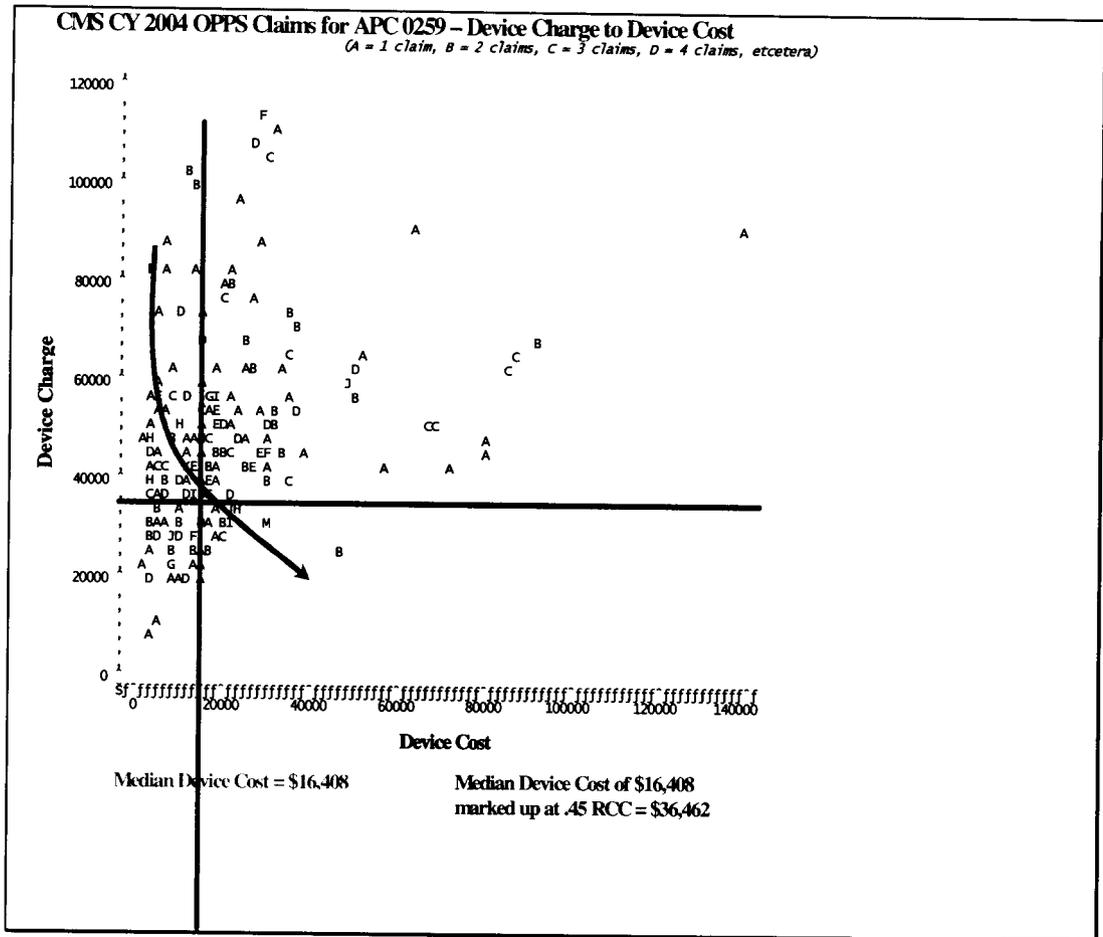
### **Analysis of Charges vs. Costs**

In an attempt to understand the relationship between the charges and costs on the claims, we examined each of approximately 20 percent of the individual claims. We found numerous instances in which charges and costs diverged significantly (e.g., claims with charges of nearly \$28,000 and costs of approximately \$7,000). We also found numerous claims in which the cost was significantly higher than the charge (e.g., costs of \$80,000 and charges of approximately \$67,000).

We calculated the ratio of cost to charges (RCC) for each claim. We found that the RCC ranged from 0.043 to 1.769, with a mean RCC of 0.445. Because each revenue center has its own RCC, assignment of the device to the appropriate revenue center is critically important. (As noted in the section above, 60 claims had the device in the wrong revenue center.)

We then multiplied the CMS median cost of \$16,408 by the mean RCC, obtaining a corresponding charge of \$36,462. We plotted the charges vs. costs to create a picture of the distribution. (These are contained in Figure 3 below.) The large number of claims in which the device cost is low relative to a high charge for the device (claims to the left of the red line indicating the median device cost) indicates a low RCC.

**Figure 3: Charges vs. Costs**



We then plotted the 50 claims with the widest divergence between charges and costs (lowest RCC) as well as the 50 claims with the highest RCC. These distributions are below, and show the extreme variance that these data contain, precluding their being used as the sole source of data for determining the cost of the device. A median cost from these data will not be reflective of the actual cost to hospitals of this device.



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## C. Discussion

The 2002 and 2004 Lewin analyses identified that the proposed CY 2003 APC and proposed CY 2005 APC payment rates were not set high enough to cover the cost of the cochlear implant device alone. This was thought to be largely due to provider coding errors which were attributed to the newness of the OPSS system and changes in pass-through payment methodology. Now that the OPSS system has been in place for several years, it was hypothesized that CMS' calculated payment rates would more accurately reflect hospital APC costs because a greater number of the claims would be correctly coded.

While hospital coding has improved, this year's study demonstrates that the proposed APC payment does not cover the cost of the device, leaving no funds for the hospital to cover facility service costs related to the procedure. The proposed APC payment rate, \$21,739, is \$88 less than the weighted average selling price (manufacturer's price net of discounts) of \$21,827. Had the median device cost reflected the weighted average selling price of \$21,827 the proposed CY 2006 APC payment would have provided approximately \$5,331 to cover the cost of other hospital services associated with the procedure. The "new" Lewin derived OPSS APC 0259 payment rate of \$27,192 would more accurately reflect the cost of the device and would maintain the implicit facility cost of the procedure of \$5,365 (\$27,192 - \$21,827).

In the final CY 2005 OPSS regulation, CMS set the APC cost for 0259 at \$25,307. The weighted average selling price for the cochlear device was \$22,350, which comprised an economically viable situation in that the APC payment covered the hospital facility costs as well as the cost of the device.

The 2005 NPRM proposed CY 2006 payment for APC 0259 of \$21,739 is slightly less than the average selling price of the device. This means that the hospital outpatient prospective payment system would not cover any of the hospital's facility costs for the procedure. Obviously, this is untenable for both the hospitals and the manufacturers. Furthermore, this payment jeopardizes access to the cochlear implant device by Medicare beneficiaries, disadvantaging all of those Medicare beneficiaries who could benefit from implantation.

Lewin has calculated a budget neutral 2006 APC rate of \$27,192, which is an eight percent increase over last year's final payment of \$25,307. At this level, the payment would cover the cost of the device (\$21,827) and leave roughly \$5,000 to cover hospital facility costs associated with implantation of a cochlear device.

# APPENDIX A

## Providers Who Assigned Device L8614 to an Incorrect Revenue Center - CY2004 Claims

Medicare Provider #	Hospital Name	State	# of Claims	Revenue Center	Revenue Center Description	Total Claims by Revenue Center
340053	PRESBYTERIAN HOSPITAL	NC	3			
450193	ST LUKES EPISCOPAL HOSPITAL	TX	1	0272	Medical/surgical supply - sterile supply	17
520177	FROEDTERT MEMORIAL LUTHERAN HOSPITAL	WI	13			
010139	BROOKWOOD MEDICAL CENTER	AL	2			
050224	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	CA	1			
110010	EMORY UNIVERSITY HOSPITAL	GA	1			
120001	QUEENS MEDICAL CENTER	HI	1			
260022	NORTHEAST REGIONAL MEDICAL CENTER	MO	1			
260065	ST JOHNS REGIONAL HEALTH CENTER	MO	1			
260141	UNIVERSITY OF MISSOURI HOSPITAL & CLINICS	MO	1			
300003	MARY HITCHCOCK MEMORIAL HOSPITAL	NH	1			
330247	MANHATTAN EYE EAR THROAT HOSPITAL	NY	1	0274	Medical/surgical supply - prosthetic/orthotic devices	43
330285	STRONG MEMORIAL HOSPITAL	NY	2			
360137	UNIVERSITY HOSPITALS OF CLEVELAND	OH	6			
380009	OHSU HOSPITAL	OR	5			
470003	FLETCHER ALLEN HOSPITAL OF VERMONT	VT	3			
500005	VIRGINIA MASON MEDICAL CENTER	WA	8			
500027	SWEDISH MEDICAL CENTER	WA	1			
500044	DEACONESS MEDICAL CENTER	WA	5			
510007	ST MARY'S MEDICAL CENTER	WV	3			

**Providers Who Assigned Procedure 69930 to an Incorrect Revenue Center - CY2004**

Medicare Provider #	Hospital Name	State	# of Claims	Revenue Center	Revenue Center Description	Total Claims by Revenue Center
060034	SWEDISH MEDICAL CTR	CO	2			
330078	CATHOLIC HEALTH SYSTEM AT SISTERS OF CHARITY	NY	1	0361	Operating room services - minor surgery	8
330189	ALBANY MEDICAL CENTER/SOUTH CLINICAL CAMPUS	NY	5			
310051	OVERLOOK HOSPITAL	NJ	3	0369	Operating room services - other	3
040114	BAPTIST HEALTH MEDICAL CENTER-LITTLE ROCK	AR	1			
070036	JOHN DEMPSEY HOSPITAL	CT	4			
240080	FAIRVIEW UNIVERSITY MEDICAL CENTER	MN	6			
280013	NEBRASKA MEDICAL CENTER, THE	NE	2	0490	Ambulatory surgical care - general	19
310001	HACKENSACK UNIVERSITY MEDICAL CENTER	NJ	1			
310119	UMDNJ UNIVERSITY HOSPITAL	NJ	2			
430027	SIOUX VALLEY HOSPITAL UNIVERSITY MEDICAL CENTER	SD	3			
490032	VIRGINIA COMMONWEALTH UNIVERSITY HEALTH SYSTEM	VA	1	0510	Clinical - general classification	1
040016	UAMS MEDICAL CENTER	AR	1	0710	Recovery room - general classification	1

**APPENDIX B**

**Providers Who Listed Device L8614, But Listed A Procedure Other Than 69930 – CY2004**

Medicare Provider #	Hospital Name	State	# of Claims	CPT	Procedure Description	Total Claims by CPT
	For all claims with Device L8614, CPT 69930 also appears on the claim					295

# APPENDIX C

## Costs by CPT/HCPCS Code: CY 2004 & CY 2003

(Note: Outliers have not been excluded)

CPT/ HCPCS	2004 Cochlear Claims						2003 Cochlear Claims					
	Freq	% of Claims (N=544)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation
00120	4	0.7%	62.35	215.45	173.92	74.63	-	0.0%	-	-	-	-
93012	1	0.2%	64.86	64.86	64.86	-	-	-	-	-	-	-
94760	9	1.7%	8.63	53.07	21.05	13.82	3	0.6%	13.12	28.93	23.66	9.13
94761	8	1.5%	9.44	84.25	33.54	31.00	4	0.8%	29.84	106.65	60.34	37.46
99141	2	0.4%	45.35	267.66	156.50	157.19	-	-	-	-	-	-
99219	5	0.9%	193.18	1,070.30	471.31	351.97	2	0.4%	113.78	113.78	113.78	-
C1713	11	2.0%	45.22	31,399.52	5,274.33	11,281.09	-	-	-	-	-	-
C1729	3	0.6%	4.51	5.42	5.12	0.52	-	0.0%	-	-	-	-
C1760	4	0.7%	13.13	131.29	45.17	57.61	-	-	-	-	-	-
C1763	1	0.2%	32.29	32.29	32.29	-	-	-	-	-	-	-
C1781	9	1.7%	31.39	279.11	68.27	79.38	-	0.0%	-	-	-	-
G0264	1	0.2%	21.27	21.27	21.27	-	1	0.2%	267.64	267.64	267.64	-
J0290	1	0.2%	4.15	4.15	4.15	-	-	0.0%	-	-	-	-
J0295	4	0.7%	6.03	23.45	13.95	8.02	1	0.2%	16.57	16.57	16.57	-
J0330	27	5.0%	1.83	15.37	6.53	3.37	21	4.2%	0.64	8.24	3.61	1.66
J0360	1	0.2%	5.39	5.39	5.39	-	3	0.6%	6.59	15.89	10.64	4.76
J0460	3	0.6%	1.56	10.45	4.95	4.80	1	0.2%	3.76	3.76	3.76	-
J0630	11	2.0%	4.16	8.34	4.54	1.26	16	3.2%	3.60	16.96	6.13	4.46
J0694	1	0.2%	3.53	3.53	3.53	-	-	-	-	-	-	-
J0696	12	2.2%	41.23	97.31	56.98	23.92	11	2.2%	4.15	85.03	48.68	21.55
J0697	7	1.3%	10.03	39.61	16.43	10.86	2	0.4%	18.42	50.87	34.64	22.95

(Note: Outliers have not been excluded)

CPT/ HCPCS	2004 Cochlear Claims							2003 Cochlear Claims						
	Freq	% of Claims (N=544)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation		
J0744	1	0.2%	48.65	48.65	48.65	-	1	0.2%	10.28	10.28	10.28	-		
J0780	1	0.2%	2.83	2.83	2.83	-	1	0.2%	10.28	10.28	10.28	-		
J1094	6	1.1%	1.88	13.09	5.87	4.10	1	0.2%	1.63	16.07	5.95	3.65		
J1100	54	9.9%	0.40	20.95	6.24	3.90	25	5.0%	1.52	4.71	3.40	1.28		
J1160	1	0.2%	5.34	5.34	5.34	-	6	1.2%	0.94	1.86	1.47	0.41		
J1170	6	1.1%	1.04	10.19	5.64	4.24	4	0.8%	2.88	94.29	25.04	14.18		
J1200	5	0.9%	1.00	13.16	4.47	4.95	57	11.4%	0.97	0.97	0.97	-		
J1260	50	9.2%	9.01	74.95	22.72	12.03	1	0.2%	2.21	2.21	2.21	-		
J1580	1	0.2%	1.13	1.13	1.13	-	1	0.2%	13.53	13.53	13.53	-		
J1590	1	0.2%	37.60	37.60	37.60	-	2	0.4%	1.63	62.89	6.85	11.14		
J1644	3	0.6%	2.85	19.92	9.62	9.06	29	5.8%	1.68	13.77	4.91	2.81		
J1720	3	0.6%	1.78	6.10	3.60	2.24	17	3.4%	2.21	2.21	2.21	-		
J1790	8	1.5%	5.02	18.02	10.18	3.58	1	0.2%	22.13	57.68	39.90	25.14		
J1815	3	0.6%	0.31	2.79	1.31	1.31	4	0.8%	2.59	10.44	5.81	3.42		
J1885	11	2.0%	1.61	8.87	5.57	1.79	5	1.0%	4.71	13.02	9.62	3.49		
J1940	3	0.6%	2.85	4.65	3.45	1.04	2	0.4%	2.21	2.21	2.21	-		
J1956	2	0.4%	36.85	86.79	61.82	35.31	2	0.4%	1.63	62.89	6.85	11.14		
J2000	2	0.4%	2.29	4.66	3.48	1.68	1	0.2%	1.68	13.77	4.91	2.81		
J2175	16	2.9%	0.80	11.14	6.06	2.84	1	0.2%	2.21	2.21	2.21	-		
J2180	1	0.2%	0.52	0.52	0.52	-	1	0.2%	13.53	13.53	13.53	-		
J2271	2	0.4%	6.10	18.32	12.21	8.64	8	1.6%	3.33	6.96	5.04	1.20		
J2275	13	2.4%	2.47	34.14	9.87	9.19	11	2.2%	0.88	7.63	4.09	1.62		
J2370	23	4.2%	1.31	12.58	5.15	2.26	35	7.0%	1.75	19.51	5.54	4.37		
J2550	34	6.3%	2.01	16.27	5.49	3.12	9	1.8%	3.07	19.19	8.76	4.42		
J2710	21	3.9%	2.75	33.08	8.55	6.24	11	2.2%	0.88	7.63	4.09	1.62		
J2912	17	3.1%	2.01	36.78	16.40	11.29	2	0.4%	2.58	7.10	4.84	3.20		
J3360	1	0.2%	5.08	5.08	5.08	-	1	0.2%	22.57	22.57	22.57	-		
J3370	1	0.2%	14.08	14.08	14.08	-	1	0.2%	22.57	22.57	22.57	-		

(Note: Outliers have not been excluded)

CPT/ HCPCS	2004 Cochlear Claims					2003 Cochlear Claims					Standard Deviation	
	Freq	% of Claims (N=544)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max		Mean
J3490	9	1.7%	5.70	20.03	16.79	5.25	3	0.6%	5.18	24.43	18.01	11.11
J3490	11	2.0%	2.51	153.80	35.61	55.84	3	0.6%	4.85	9.62	6.44	2.75
J7030	5	0.9%	0.99	19.71	9.23	7.45	-	0.0%	-	-	-	-
J7040	5	0.9%	9.48	111.45	39.74	41.45	-	0.0%	-	-	-	-
J7050	2	0.4%	18.66	21.45	20.05	1.97	-	0.0%	-	-	-	-
J7051	1	0.2%	0.60	0.60	0.60	-	-	-	-	-	-	-
J7060	1	0.2%	5.18	5.18	5.18	-	-	-	-	-	-	-
J7120	26	4.8%	1.22	63.97	16.67	15.44	12	2.4%	1.28	54.63	13.46	14.60
J7500	1	0.2%	1.74	1.74	1.74	-	2	0.4%	168.70	386.13	277.42	153.75
L8613	1	0.2%	1,482.70	1,482.70	1,482.70	-	2	0.4%	358.87	408.63	383.75	35.19
L8699	1	0.2%	8,964.02	8,964.02	8,964.02	-	2	0.4%	-	-	-	-
Q0061	1	0.2%	42.95	42.95	42.95	-	-	-	-	-	-	-
Q0179	3	0.6%	28.03	28.03	28.03	-	-	-	-	-	-	-

Legend of Highlighted CPT/HCPCS Codes:

- 69930 Implant cochlear device
- 99218 Observation care
- J0170 Adrenalin epinephrin inject
- J0690 Cefazolin sodium injection
- J2250 Inj midazolam hydrochloride
- J2270 Morphine sulfate injection
- J2405 Ondansetron HCL Injection, per 1 mg
- J2765 Metoclopramide HCL Injection up to 10 mg
- J3010 Fentanyl citrate injection
- L8614 Cochlear device/system

**Costs by Revenue Center: CY 2004 & CY 2003**

(Note: Outliers have not been excluded)

Revenue Center	2004 Cochlear Claims						2003 Cochlear Claims					
	Freq	% of Claims (N=544)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation
0251	91	16.7%	2.85	269.10	24.32	41.53	87	17.4%	0.88	192.75	34.24	41.42
0252	65	11.9%	2.35	184.00	28.38	32.62	46	9.2%	2.02	329.15	29.96	51.18
0254	3	0.6%	6.55	6.95	6.68	0.23						
0259	101	18.6%	0.51	277.45	38.94	52.04	91	18.2%	0.02	272.50	36.90	51.33
0260	1	0.2%	42.95	42.95	42.95	-						
0271	118	21.7%	0.87	662.73	54.14	90.98	91	18.2%	0.80	7,315.55	166.55	768.07
0279	18	3.3%	0.53	34,238.05	5,495.76	11,600.28	23	4.6%	0.39	19,901.29	1,464.13	4,219.67
0361	8	1.5%	38.32	2,737.25	1,029.97	1,038.02	18	3.6%	16.72	20,583.47	4,007.19	5,007.59
0369	3	0.6%	945.57	1,827.82	1,533.73	509.36	8	1.6%	1,214.01	2,612.00	1,653.53	558.74
0372	1	0.2%	45.35	45.35	45.35	-	1	0.2%	82.50	82.50	82.50	
0379	4	0.7%	57.75	96.77	77.44	19.65	6	1.2%	10.61	69.33	38.85	24.40
0460	17	3.1%	8.63	84.25	26.93	23.61	8	1.6%	13.12	74.91	44.39	25.76

(Note: Outliers have not been excluded)

Revenue Center	2004 Cochlear Claims						2003 Cochlear Claims					
	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation
0490	19	3.5%	\$ 919.76	\$ 2,604.04	\$ 1,930.97	\$ 483.84	25	5.0%	\$ 240.92	\$ 3,180.38	\$ 1,065.89	\$ 687.02
0510	1	0.2%	224.75	224.75	224.75							
0719	16	2.9%	83.65	549.39	287.49	121.79	21	4.2%	57.03	400.45	226.53	92.81
0732	1	0.2%	64.86	64.86	64.86							
0760	12	2.2%	74.76	132.99	103.87	16.65	9	1.8%	63.00	196.91	101.51	43.04
0762	89	16.4%	13.54	1,070.30	241.33	222.89	105	21.0%	6.65	863.61	192.02	169.84

### Legend of Revenue Center Codes

0250	Pharmacy-general
0251	Pharmacy-generic drugs
0252	Pharmacy-nongeneric drugs
0254	Pharmacy-incidenta
0258	Pharmacy-IV solutions
0259	Pharmacy-other pharmacy
0260	IV therapy-general
0270	Medical/surgical supplies-general
0271	Medical/surgical supplies-nonsterile supply
0272	Medical/surgical supplies-sterile supply
0274	Medical/surgical supplies prosthetic/orthotic devices
0278	Medical/surgical supplies-other implants
0279	Medical/surgical supplies-other devices
0360	Operating room services-general classification
0361	Operating room services-minor surgery
0369	Operating room services-other operating room services
0370	Anesthesia-general
0372	Anesthesia-incident to other diagnostic service
0379	Anesthesia-other
0460	Pulmonary function-general
0490	Ambulatory surgical care-general
0510	Clinical-general
0636	Drugs requiring specific identification-detailed coding
0710	Recovery room-general
0719	Recovery room-other
0732	EKG/ECG-telemetry
0760	Treatment or observation room-general
0762	Treatment or observation room-observation room

## APPENDIX D

### Most Commonly Found Disallowed CPT/HCPCS Codes - CY2004

CPT/HCPCS Code	Procedure Description	# of Claims on which CPT appears
95920	Intraoperative neurophysiology testing, per hour	163
90784	Therapeutic, prophylactic or diagnostic injection; intravenous	57
92584	Electrocochleography	51
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity	49
Q0081	Infusion therapy, using other than chemotherapeutic drugs, per visit	34
99201	Office or other outpatient visit	28
95927	Short-latency somatosensory evoked potential study, stimulation or any/all peripheral nerves or skin sites, recording from the central nervous system, in trunk or head	26
92516	Facial nerve function studies	19
94640	Pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes	16
94664	Demonstration and / or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	14

(Source: Multiple Procedure Claims)

**Disallowed CPT/HCPCS Codes by Medicare Provider Number**

Medicare Provider #	Hospital Name	State	CPT	# of Claims on which CPT appears
030103	MAYO CLINIC HOSPITAL	AZ	86920	1
			86927	1
			93325	1
			99219	2
050324	SCRIPPS MEMORIAL HOSPITAL LA JOLLA	CA	20926	1
060014	PRESBYTERIAN/ST LUKE'S MEDICAL CTR	CO	69631	1
060022			76000	1
			94761	1
060024	UNIVERSITY OF COLORADO HOSP AUTHORITY	CO	94760	1
070022	YALE-NEW HAVEN HOSPITAL	CT	69667	5
100022	JACKSON HEALTH SYSTEM	FL	15770	2
			20922	1
			69620	1
100128	TAMPA GENERAL HOSPITAL	FL	11420	1
			64716	1
			69670	2
			78461	1
			78478	1
			93017	1
			93325	1
94799	1			
110161	NORTHSIDE HOSPITAL	GA	69799	1
130006	ST LUKES REGIONAL MEDICAL CENTER	ID	69631	1
140091	CARLE FOUNDATION HOSPITAL	IL	69620	1
150056	CLARIAN HEALTH PARTNERS, INCORPORATED	IN	11441	1
			94762	2
160058	UNIVERSITY OF IOWA HOSPITAL & CLINICS	IA	69310	1
			93732	1
170122	VIA CHRISTI REGIONAL MEDICAL CENTER	KS	99211	1
190015	NORTH OAKS MEDICAL CENTER	LA	69666	1
			69667	1
220075	MASSACHUSETTS EYE AND EAR INFIRMARY	MA	99212	2
230038	SPECTRUM HEALTH-DOWNTOWN CAMPUS	MI	69620	1
			69631	1
230046	UNIVERSITY OF MICHIGAN HOSPITAL	MI	69501	1
			94760	2
			94799	12
250001	UNIVERSITY OF MISSISSIPPI MED CENTER	MS	92603	1
250004	NORTH MISSISSIPPI MEDICAL CENTER	MS	00120	2
			94761	2
250138	RIVER OAKS HOSPITAL	MS	00120	1
			94010	3
260027	RESEARCH MEDICAL CENTER	MO	69436	1

(Source: Multiple Procedure Claims)

Medicare Provider #	Hospital Name	State	CPT	# of Claims on which CPT appears
260065	ST JOHNS REGIONAL HEALTH CENTER	MO	36600	1
			71275	1
			93325	1
260138	ST LUKES HOSPITAL OF KANSAS CITY	MO	90782	5
280013	NEBRASKA MEDICAL CENTER,THE	NE	11421	1
			95868	4
330100	NEW YORK EYE AND EAR INFIRMARY	NY	17999	1
330169	BETH ISRAEL MEDICAL CENTER	NY	70134	1
330203	CROUSE HOSPITAL	NY	76000	6
340040	PITT COUNTY MEMORIAL HOSPITAL	NC	93325	1
340061	UNIVERSITY OF NORTH CAROLINA HOSPITAL	NC	70240	5
340113	CAROLINAS MEDICAL CENTER/BEHAV HEALTH	NC	99211	3
360051	MIAMI VALLEY HOSPITAL	OH	90782	1
360085	OHIO STATE UNIVERSITY HOSPITAL	OH	00120	3
			69310	1
360180	CLEVELAND CLINIC FOUNDATION	OH	93744	1
370028	INTEGRIS BAPTIST MEDICAL CENTER	OK	15740	1
			67900	1
			69711	1
370091	SAINT FRANCIS HOSPITAL, INC	OK	70240	1
380009	OHSU HOSPITAL	OR	20926	5
			69620	1
			94761	3
390050	ALLEGHENY GENERAL HOSPITAL	PA	69450	1
			69643	1
420004	MEDICAL UNIVERSITY HOSPITAL	SC	69990	1
			86927	1
			93017	1
440019	BAPTIST HOSPITAL OF EAST TENNESSEE	TN	90782	1
440039	VANDERBILT UNIVERSITY HOSPITAL	TN	20926	1
440082	ST THOMAS HOSPITAL	TN	69667	3
450021	BAYLOR UNIVERSITY MEDICAL CENTER	TX	31525	1
			36430	1
			69799	1
			69949	1
			76000	1
			86927	1
450040		TX	94010	2
450068	MEMORIAL HERMANN HOSPITAL	TX	67912	1
450184	MEMORIAL HERMANN HEALTHCARE SYSTEM	TX	69949	1
450388	METHODIST HOSPITAL	TX	14020	1
			64999	1
			69310	1
490007	SENTARA NORFOLK GENL HOSP	VA	76000	1

(Source: Multiple Procedure Claims)

Medicare Provider #	Hospital Name	State	CPT	# of Claims on which CPT appears
490032	VIRGINIA COMMONWEALTH UNIVERSITY HEALTH SY	VA	69399	1
			94760	2
			99141	1
			99219	3
490057	SENTARA VIRGINIA BEACH GENERAL HOSPITAL	VA	69424	1
			69436	1
500005	VIRGINIA MASON MEDICAL CENTER	WA	21235	1
			69641	1
			69711	1
			69820	1
			69910	1
			69990	1
			70240	2
			76375	1
500027	SWEDISH MEDICAL CENTER	WA	20926	1
			69720	3
500129	TACOMA GENERAL ALLENMORE HOSPITAL	WA	69720	1
			94761	2
520177	FROEDTERT MEMORIAL LUTHERAN HOSPITAL	WI	69670	1

(Source: Multiple Procedure Claims)

24 of 77

77-0

SCOD/A/D

(24)

Ahmed  
Kane  
Snow  
Hart  
Bazell

Date: Aug. 31, 2005

Mr. Herb Kuhn  
Director, Center for Medicare Management  
Centers for Medicare and Medicaid Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

ATTN: FILE CODE CMS-1501-P

Re: Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates -- Drugs, Biologicals, and Radiopharmaceuticals Non Pass-throughs

Dear Mr. Kuhn:

**Joy Pryor** is submitting this public comment to bring to your attention an error in the proposed rule, CMS-1501-P, "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates" relating to the payment rates for the wound-healing products Apligraf (C1305) and Dermagraft (C9201).

These products have been paid in the hospital outpatient prospective payment system as specified covered outpatient drugs and should continue to be paid in 2006 similar to other such drugs. Patient access to these important products is jeopardized by the payment rates in the proposed rule. We respectfully request that the payment rates for Apligraf and Dermagraft be corrected in the final rule.

Apligraf and Dermagraft are unique living human tissue substitutes for the treatment of chronic ulcers. These products have preserved and improved the quality of life of thousands of diabetics and other elderly patients who suffer from chronic leg and foot ulcers. Many of these patients would have had to undergo limb amputations without the benefits of Apligraf and Dermagraft.

As you know, in the proposed Hospital Outpatient Rule for calendar year 2006 the Centers for Medicare and Medicaid Services proposed to pay specified covered outpatient drugs at average sales price (ASP) plus six percent for the acquisition cost of the drug. The rule proposes to pay a pharmacy overhead charge of an additional two percent which results in a total payment for specified covered outpatient drugs of ASP plus eight percent.

Letter to Mr. Kuhn, Centers for Medicare and Medicaid Services

August 23, 2005

Page 2 of 2

In 2002 both Apligraf and Dermagraft were paid as a biological under the pass through list. Following the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, both products have been paid for as sole-source biologicals in 2004 and in 2005 under the specified covered outpatient drug provision. Both products were included in the General Accountability Office (GAO) survey of acquisition costs for specified covered outpatient drugs dated June 30, 2005 (GAO-05-581R). The GAO report included the relevant ASP rates for each product.

However, in the proposed rule both Apligraf and Dermagraft would be incorrectly paid based on rates derived from claims data in stead of payment at ASP plus eight percent. Accordingly, both products experienced a significant decrease in payment:

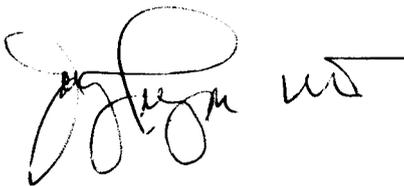
Apligraf -- 2005 outpatient rate \$1,130.88; 2006 proposed outpatient rate \$766.84

Dermagraft -- 2005 outpatient rate \$529.54; 2006 proposed outpatient rate \$368.32

There may have been some confusion in the proposed rule because the products are reimbursed in the physician's office under codes with different descriptors. In the physician office setting, Apligraf and Dermagraft have been paid based on the ASP + six percent methodology under J7340 (Metabolic active Dermal/Epidermal tissue) and J7342 (Metabolically active Dermal tissue) respectively.

Thank you for your attention to this issue and we look forward to working with you to correct the issue in the final rule.

Sincerely,

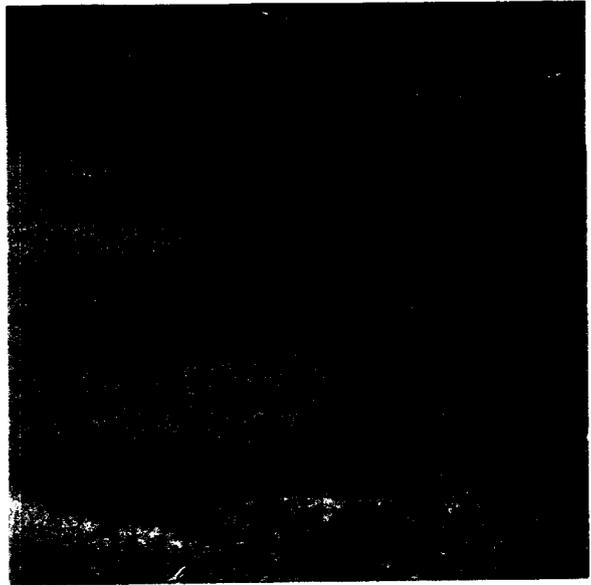


Jay Pryor



Central Washington Hospital

Handwritten: Kates S/T



Handwritten: 78

September 6, 2005

Mark McClellan, M.D., Ph.D., Administrator  
Centers for Medicare and Medicaid Services  
Dept. of Health and Human Services  
Attn: CMS-1501-P  
P.O. Box 8016  
Baltimore, MD 21244-8018

Re: CMS-1501-P Proposed changes to Hospital OPPS 2006

Dear Dr. McClellan,

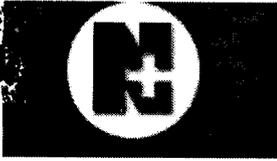
I would like to express concern regarding the reimbursement proposed for APC 0051 for HCPCS codes C9718-C9719 (status indicator T). Kyphoplasty is the least invasive surgical approach for compression fractures which primarily effect the elderly. Unfortunately, the cost associated with this procedure is not remotely covered by the APC payment even with outlier computations. The integral Kyphopak has a wholesale cost of \$3503.00 for a single level with an additional cost of \$2358.00-\$3503.00 for a second level. The proposed reimbursement of \$2167.63 with 50% discount for the second level totals \$3251.45. This falls severely short of the cost of the supply and doesn't cover any surgical suite expenses or nursing care. I am also uncertain why HCPCS C9718-C9719 does not have the status indicator of C. The ICD-9 procedure code 81.66 cross links to CPT 22851 which is an "IP Only" code. According to the development staff of *Ingenix* CPT 22851 is appropriate because of the use of methylmethacrylate. The *Ingenix Cross Coder* for 2005 was printed before CMS created the C9718-C9719 SI "T" therefore the assigned CMS codes did not make it into the 2005 version of the book. Furthermore, McKesson has added Kyphoplasty to the April 2005 *InterQual* "Guidelines for Surgery and Procedures in the Inpatient Setting". These patients do generally stay overnight because of necessary monitoring post-op. Please either reconsider the reimbursement under OPPS or match the status indicator of "C" (Inpatient only) considering Ingenix and McKesson's information.

Handwritten: Heygster, Ushnirova, Kane, Sprawl, Hart, Kozell

Sincerely,

Kathy Poltz  
Kathy Poltz RN  
Reimbursement Nurse Auditor  
Central Washington Hospital  
(509) 665-6002

cc: Warren Arnold, Dir. Reimbursement



# NORWALK HOSPITAL

79

Michael R. Marks, M.D. MBA  
Coastal Orthopaedics, 40 Cross St #300, Norwalk, CT 06851  
Direct Line: 203-845-2200 Email [mmarks1988@aol.com](mailto:mmarks1988@aol.com)

September 6, 2005

**By U.S. Mail**

Mark McClellan, M.D., Ph.D., Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**Attn: CMS-1501-P**  
P.O. Box 8016  
Baltimore, MD 21244-8018

APC/GEN  
NT  
Pynd Rates

Heygster  
Burley  
Hunter  
Spolter  
Hostetler  
Kane  
Janow  
Hart  
Bazell

**Re: CMS-1501-P Proposed changes to Hospital Outpatient PPS for 2006  
Kyphoplasty – Updating Billing Codes and APC Assignment**

Dear Dr. McClellan:

I am an orthopedic surgeon, the Immediate Past President of the Connecticut State Orthopaedic Society and the incoming Chief of Staff at Norwalk Hospital in Connecticut. I have been performing kyphoplasty procedures for several years. In my leadership role with the Orthopaedic Society, I requested that CMS recognize kyphoplasty as a new technology procedure eligible for payment under the Medicare Hospital Outpatient Prospective Payment System. I was pleased to work with CMS staff and even more pleased when CMS established the following new codes for the kyphoplasty procedures, effective January 1, 2005:

C9718 Kyphoplasty, one vertebral body, unilateral or bilateral

C9719 Kyphoplasty, each additional level

Also, I and several colleagues requested new CPT codes for kyphoplasty procedures which will be effective January 1, 2006. Because of my involvement with the coding process and my role as a hospital administrator, I am keenly interested in CMS proposed changes to the Hospital Outpatient PPS for 2006. My comments and recommendations are summarized below and explained in more detail in the following sections.

- Kyphoplasty was assigned to APC 51 on an "interim" basis for 2005.
- New CPT codes for kyphoplasty, effective January 1, 2006 will include "biopsy" which will preclude hospitals from billing and receiving separate payment for a biopsy procedure as they do today.
- CMS will need to take special note of the "biopsy" procedure included in the new CPT codes for kyphoplasty and add in costs of the biopsy procedure when determining the APC assignment and hospital outpatient payment for kyphoplasty for 2006 (and at least two years going forward).
- Based on the hospital resources/costs for kyphoplasty which are detailed below, I urge CMS to assign "*kyphoplasty with biopsy, one vertebral body*" to a clinically appropriate APC with a payment rate of \$8,000.
- Hospital charge data from 135 cases at 31 hospitals demonstrated that the average charge for kyphoplasty, one level was \$16,100 and the median charge was \$15,729.

- Assigning kyphoplasty with biopsy to an appropriate APC with payment reflective of the costs involved will facilitate delivery of this important procedure to Medicare patients in the most appropriate clinical setting (inpatient and outpatient).
- More equitable and balanced payment is needed under the hospital outpatient PPS. Under the Medicare hospital DRG system kyphoplasty procedures are grouped to several DRGs with a various payment rates as follows: DRG 233 - \$9,716; DRG 234 - \$5,789; and DRG 486 - \$23,522. The significantly higher DRG payment for kyphoplasty may create a bias to admit and furnish kyphoplasty on an "inpatient" basis where the Medicare payment is several thousand dollars higher.
- About 25% of Medicare patients could safely receive "kyphoplasty procedures" on an outpatient basis. Therefore, CMS should increase the outpatient payment so it is more in line with hospitals costs to eliminate any financial barriers to furnishing kyphoplasty in this setting and in the process, save the Medicare program money.
- Recommended APC assignment for kyphoplasty, with biopsy, one level is as follows:  
APC 0681 Knee arthroplasty - \$8,103

In the alternative, CMS could create a new APC:

APC xxxx Vertebral spinal augmentation and stabilization using balloon inflation - \$8,750

As a stop gap measure, for a year until claims data is available, CMS could assign kyphoplasty to-

APC 0425 Level II Arthroplasty with Prosthesis - \$5,920

- We assume that the CPT codes for kyphoplasty procedures would be assigned "T" status indicators and therefore subject to the multiple procedure reduction. Consequently, it may be appropriate to assign the CPT code for *kyphoplasty, additional level* to APC 0681 or the new APC if one is created because the payment rate would be reduced 50%.

### Specialized Devices/Technology Required for Kyphoplasty

There is variety of specialized single-use (disposable) devices needed to furnish kyphoplasty as well as specialized equipment. Below, I have listed the costs for furnishing kyphoplasty using for the most part direct, actual costs at Norwalk Hospital. For personnel costs, I used the "standard" costs values that are used by CMS for the physician fee schedule. I believe that hospital costs for personnel may be slightly higher but, on average, these values may reflect hospital costs on a national basis and should be of use to CMS.

Kyphoplasty device costs for one (1) level \$4,000

The \$4,000 cost includes the following:

- Inflatable bone tamp 1st fracture kit - \$3,500
- Biopsy device - \$130
- Polymethylmethacrylate - \$100 (1 box)
- Cement Mixer - \$125
- OR supplies, drapes, prep tray, etc. \$1,450

▪ OR room (1.5 hrs.)	\$2,430
▪ OR circulating nurse (RN @\$0.51 min)	\$75
▪ Drugs (anesthesia, antibiotics, etc. not separately billable)	\$100
▪ Scrub nurse, ancillary hospital staff	\$75 +
▪ Pre-op, post-op recovery room, etc.	\$200
▪ Admitting, discharge, etc.	Costs not calculated
▪ <u>Minimum</u> hospital resources for first level	<b><u>\$8,330+</u></b>

Kyphoplasty device costs for **additional** level \$2,583

The \$2,583 cost includes the following:

▪ Kyphoplasty 2nd Level Kit - \$2,358	
▪ Cement mixer - \$125 and cement - \$100	
▪ Additional 45 minutes of OR time	\$1,215
▪ Additional 45 minutes of nursing staff time	\$22 (per 45 min.)
▪ <u>Minimum</u> hospital resources	<b><u>\$3,820+</u></b>

Total hospital resources for kyphoplasty two levels - **\$12,150**

As shown above, the resources (costs) used for kyphoplasty support the request to reassign kyphoplasty for 2006 and establish payment that more reflective of hospitals costs.

As recommended, an APC assignment for kyphoplasty, one level, with a payment rate of about \$8,000 and an APC assignment for kyphoplasty, additional level, with a payment rate of about \$4,000 (discounted 50%) would mean that the overall Medicare payment would be about \$12,000 for a multiple level kyphoplasty procedure.

### **Hospital Charge Data for Kyphoplasty Supports Higher Paying APC**

For 2005, kyphoplasty procedures were temporarily assigned to APC 51 until hospital charge data was available. To facilitate the agency's assignment of kyphoplasty procedures to an appropriate APC, I contacted my colleagues and requested hospital charge data for kyphoplasty procedures. I am happy to report that in addition to hospitals in Connecticut, hospitals from Florida, Indiana, Illinois, New York, North Carolina, Texas and Virginia, have provided charge data for over 130 kyphoplasty procedures.

The "average" charge from these hospitals for kyphoplasty outpatient procedures is over \$16,000 and the median charge was \$15,729 (see attached charge data summary). I understand that APC payment is based on CMS's calculations from charges and recognize that you may have even more compelling data, perhaps from the inpatient claim file. For this reason, I wanted to reiterate my request to reassign kyphoplasty procedures to a more clinically appropriate APC with a payment rate of about \$8,000 which would be more in line with hospital resources. The clinical and hospital community is in agreement with respect to this request for APC reassignment.

In closing, addressing reimbursement, including payment and coding for kyphoplasty to ensure that Medicare patients have access to this important procedure in all practice settings, is one of my primary goals, and achieving this goal involves a concerted effort on the part of all interested parties, especially Medicare. I hope you share my goal and I look forward to continuing to work with CMS on this important matter.

Thank you for your time, attention, and consideration. If you have any questions or need additional information, please feel free to contact me.

Sincerely,



Michael R. Marks, M.D., MBA  
Norwalk Hospital

Enclosures

1. Summary of Hospital Charge/Cost Data
2. CMS Meeting – Kyphoplasty Power Point Presentation

cc: Gail L. Daubert

**CHARGEMASTER DATA COLLECTION- OUTPATIENT**

Provider	City/State	Date of Service	Levels	Billed Charges	ICD-9 or C-9719 C-9718	Payer
Regional Medical Center	Madisonville, KY	06/02/2005	2	\$16,714.52	C9718 C9719	Medicare
Rapid City Regional Hospital	Rapid City, SD	03/11/2005	2	\$16,768.42	C9718 C9719	Medicare
Nash Hospitals	Charlotte, NC	05/30/2005	2	\$18,379.46	C9718 C9719	BC Of NC
Methodist Hospital-Houston	Houston, TX	03/09/2005	2	\$41,172.49	C9718 C9719	Medicare
Mercy San Juan Hospital	Carmichael, CA	05/05/2005	2	\$40,152.00	C9718 C9719	Medicare
Martha Jefferson	Charlottesville, VA	03/22/2005	2	\$11,531.60	C9718 C9719	Medicare
Martha Jefferson	Charlottesville, VA	02/14/2005	2	\$17,109.70	C9718 C9719	Medicare
Martha Jefferson	Charlottesville, VA	01/10/2005	2	\$11,766.55	C9718 C9719	Medicare
Loma Linda University Medical Center	Los Angeles, CA	05/04/2005	2	\$19,764.82	C9718 C9719	AARP
Florida Hospital	Orlando, FL	05/06/2005	2	\$9,586.47	C9718 C9719	Medicare
Florida Hospital	Orlando, FL	03/02/2005	2	\$9,491.67	C9718 C9719	Medicare
Florida Hospital	Orlando, FL	08/13/2004	2	\$10,423.68	C9718 C9719	Medicare
Ellis Hospital	Schnectedy, NY		2	\$24,153.40	C9718 C9719	Medicare
Ellis Hospital	Schnectedy, NY		2	\$37,190.40	C9718 C9719	Medicare
Central Washington Hospital	Wenatchee, WA	04/12/2005	2	\$20,896.00	C9718 C9719	Medicare
Central Washington Hospital	Wenatchee, WA	04/07/2005	2	\$18,669.00	C9718 C9719	Medicare
Altru	Grand Forks, ND	03/31/2005	2	\$27,531.25	C9718 C9719	Medicare
Washoe Medical Center	Reno, NV	04/06/2005	2	\$20,899.75	C9718 22899	Medicare
Regional Medical Center	Madisonville, KY	07/05/2005	1	\$16,222.13	C9718	Medicare
Virgina Hospital Center	Merrifield, VA	06/20/2005	1	\$18,651.60	C9718	Medicare
Virgina Hospital Center	Merrifield, VA	05/04/2005	1	\$18,920.20	C9718	Medicare
Virgina Hospital Center	Merrifield, VA	04/13/2005	1	\$20,502.80	C9718	Medicare
Virgina Hospital Center	Merrifield, VA	02/08/2005	1	\$19,115.80	C9718	Medicare
Virgina Hospital Center	Merrifield, VA	01/20/2005	1	\$20,941.25	C9718	Medicare
Virgina Hospital Center	Merrifield, VA	01/18/2005	1	\$20,067.70	C9718	Medicare
St. Margaret Mercy Health Center	Hammond, IN	04/20/2005	1	\$10,160.96	C9718	Blue Cross
Ruby Memorial	Morgantown, WV	01/24/2005	1	\$20,671.43	C9718	Medicare
Rapid City Regional Hospital	Rapid City, SD	07/07/2005	1	\$6,078.95	C9718	Medicare
Rapid City Regional Hospital	Rapid City, SD	04/15/2005	1	\$22,733.09	C9718	Medicare
Rapid City Regional Hospital	Rapid City, SD	04/15/2005	1	\$5,403.55	C9718	Medicare

Provider	City/State	Date of Service	Levels	Billed Charges	ICD-9 or C-9719 C-9718	Payer
Rapid City Regional Hospital	Rapid City, SD	03/08/2005	1	\$11,051.35	C9718	Medicare
Methodist Hospital-Houston	Houston, TX	03/09/2005	1	\$26,903.00	C9718	Medicare
Methodist Hospital-Houston	Houston, TX	03/09/2005	1	\$27,011.90	C9718	Medicare
Methodist Hospital-Houston	Houston, TX	02/22/2005	1	\$25,908.00	C9718	Medicare
Martha Jefferson	Charlottesville, VA	03/30/2005	1	\$11,183.10	C9718	Medicare
Martha Jefferson	Charlottesville, VA	03/30/2005	1	\$13,746.60	C9718	Medicare
Martha Jefferson	Charlottesville, VA	03/23/2005	1	\$9,946.25	C9718	Medicare
Martha Jefferson	Charlottesville, VA	03/11/2005	1	\$13,565.97	C9718	Medicare
Martha Jefferson	Charlottesville, VA	03/10/2005	1	\$15,743.05	C9718	Medicare
Martha Jefferson	Charlottesville, VA	02/07/2005	1	\$7,541.81	C9718	Medicare
Martha Jefferson	Charlottesville, VA	02/04/2005	1	\$10,090.50	C9718	Medicare
Martha Jefferson	Charlottesville, VA	02/02/2005	1	\$10,099.40	C9718	Medicare
Martha Jefferson	Charlottesville, VA	01/27/2005	1	\$11,056.55	C9718	Medicare
Martha Jefferson	Charlottesville, VA	01/19/2005	1	\$10,167.90	C9718	Medicare
Good Samaritan	West Islip, NY	05/06/2005	1	\$11,636.82	C9718	Medicare
Good Samaritan	West Islip, NY	04/19/2005	1	\$19,765.00	C9718	Medicare
Good Samaritan	West Islip, NY	04/12/2005	1	\$11,929.60	C9718	Medicare
Good Samaritan	West Islip, NY	03/11/2005	1	\$12,287.60	C9718	Medicare
Good Samaritan	West Islip, NY	02/16/2005	1	\$4,243.86	C9718	Medicare
Good Samaritan	West Islip, NY	01/27/2005	1	\$19,897.00	C9718	Medicare
Florida Hospital	Orlando, FL	06/22/2005	1	\$7,595.61	C9718	Medicare
Ellis Hospital	Schnectedy, NY		1	\$24,153.40	C9718	Medicare
Community Hospital of Monterey	Monterey, CA	04/25/2005	1	\$11,673.89	C9718	AARP Healthcare
Community Hospital of Monterey	Monterey, CA	04/19/2005	1	\$15,312.24	C9718	Medicare
Community Hospital of Monterey	Monterey, CA	04/13/2005	1	\$14,275.45	C9718	Medicare
Community Hospital of Monterey	Monterey, CA	03/28/2005	1	\$10,972.15	C9718	United Healthcare
Central Washington Hospital	Wenatchee, WA	05/26/2005	1	\$12,059.00	C9718	Medicare
Central Washington Hospital	Wenatchee, WA	04/25/2005	1	\$11,935.00	C9718	Medicare
Central Washington Hospital	Wenatchee, WA	04/13/2005	1	\$11,607.00	C9718	Medicare
Central Washington Hospital	Wenatchee, WA	03/23/2005	1	\$12,691.00	C9718	Medicare
Central Washington Hospital	Wenatchee, WA	03/17/2005	1	\$12,322.00	C9718	Medicare
Central Washington Hospital	Wenatchee, WA	02/24/2005	1	\$11,683.00	C9718	Medicare
Regional Medical Center	Madisonville, KY	01/04/2005	1	\$12,260.44	C9218	Medicare
Regional Medical Center	Madisonville, KY	01/03/2005	1	\$13,057.40	C9218	Medicare
Washoe Medical Center	Reno, NV	03/28/2005	1	\$15,783.25	22899	CDS Insurance

Count of Provider	
Provider	Total
Advocate Christ Medical Center	1
Altru	1
Baptist Golden Triangle	7
Cape Cod Hospital	1
Catholic Hospital Long Island	7
Central Washington Hospital	9
Columbia Hospital	1
Community Hospital of Monterey	4
Community Hospitals of Indiana	2
Ellis Hospital	3
Florida Hospital	9
Good Samaritan	7
Holmes Reg. MC	10
Loma Linda University Medical Center	1
Martha Jefferson	13
Mary Rutan Hospital	1
Mercy San Juan Hospital	2
Methodist Hospital-Houston	4
Mission Hospitals	2
Moses Cone	15
Nash Hospitals	1
Norwalk Hospital	7
Overlake Hospital	2
Rapid City Regional Hospital	6
Regional Medical Center	4
Ruby Memorial	2
St. Francis-Indianapolis	1
St. Joseph Health Center	1
St. Margaret Mercy Health Center	1
St. Nicholas Hospital	1
Virgina Hospital Center	6
Washoe Medical Center	4
Yakima Valley Memorial Hospital	12
<b>Grand Total</b>	<b>148</b>
<b>Total # of Facilities</b>	<b>33</b>

Provider	City/State	Date of Service	Levels	Billed Charges	ICD-9 or C-9719 C-9718	Payer
Washoe Medical Center	Reno, NV	09/20/2004	2	\$47,925.00	22899	Medicare
Washoe Medical Center	Reno, NV	05/07/2004	1	\$17,500.25	22899	Medicare
Ruby Memorial	Morgantown, WV	12/20/2004	1	\$19,889.63	22899	Medicare
Rapid City Regional Hospital	Rapid City, SD	04/07/2005	1	\$23,482.02	22899	Medicare
Moses Cone	Greensboro, NC	03/14/2005	1	\$4,519.98	22899	Partners Medicare
Moses Cone	Greensboro, NC	03/11/2005	2	\$18,785.81	22899	Medicare
Moses Cone	Greensboro, NC	03/10/2005	2	\$18,805.64	22899	Medicare
Moses Cone	Greensboro, NC	03/09/2005	1	\$9,820.53	22899	Medicare
Moses Cone	Greensboro, NC	03/08/2005	2	\$18,738.21	22899	Medicare
Moses Cone	Greensboro, NC	03/02/2005	1	\$9,799.86	22899	Medicare
Moses Cone	Greensboro, NC	02/15/2005	1	\$10,166.33	22899	United Healthcare
Moses Cone	Greensboro, NC	02/10/2005	1	\$9,811.49	22899	Medicare
Moses Cone	Greensboro, NC	02/03/2005	1	\$9,965.14	22899	Medicare
Moses Cone	Greensboro, NC	01/07/2005	1	\$9,021.39	22899	Medicare
Mercy San Juan Hospital	Carmichael, CA	11/16/2004	2	\$40,827.00	22899	Blue Cross/Medicare
Central Washington Hospital	Wenatchee, WA	02/14/2005	2	\$20,145.00	22899	Asuris/Reg
Mary Rutan Hospital	Cleveland, OH	06/01/2005	1	\$11,410.44	733.13	Aetna
Yakima Valley Memorial Hospital	Yakima, WA	07/22/2005	1	\$15,164.05	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	07/12/2005	2	\$23,318.80	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	06/10/2005	2	\$26,461.95	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	06/03/2005	1	\$13,714.05	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	05/20/2005	1	\$14,322.80	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	05/10/2005	1	\$14,365.15	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	05/06/2005	1	\$16,647.50	81.66	Medicare

Provider	City/State	Date of Service	Levels	Billed Charges	ICD-9 or C-9719 C-9718	Payer
Yakima Valley Memorial Hospital	Yakima, WA	05/02/2005	1	\$15,944.35	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	05/02/2005	1	\$14,987.40	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	03/25/2005	1	\$15,729.30	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	03/21/2005	1	\$15,653.10	81.66	Medicare
Yakima Valley Memorial Hospital	Yakima, WA	03/11/2005	1	\$18,435.65	81.66	Medicare
Moses Cone	Greensboro, NC	03/24/2005	1	\$11,400.77	81.66	Partners Medicare
Moses Cone	Greensboro, NC	03/10/2005	2	\$18,545.22	81.66	Partners Medicare
Moses Cone	Greensboro, NC	01/21/2005	1	\$9,540.90	81.66	United Healthcare
Moses Cone	Greensboro, NC	01/18/2005	1	\$9,680.86	81.66	United Healthcare
Good Samaritan	West Islip, NY	01/13/2005	2	\$24,624.42	81.66	Medicare
Community Hospitals of Indiana	Indianapolis, IN	02/09/2005	2	\$17,418.01	81.66	Medicare
Community Hospitals of Indiana	Indianapolis, IN	02/01/2005	1	\$12,473.30	81.66	Medicare
St. Nicholas Hospital	Sheboygan, WI	04/25/2005	1	\$7,712.90		Medicare
St. Joseph Health Center	St. Louis, MO	05/17/2005	1	\$18,776.89		Gold Advantage
St. Francis-Indianapolis	Indianapolis, IN	01/10/2005	1	\$9,895.25		Medicare
Overlake Hospital	Bellevue, WA	03/24/2004	2	\$18,950.00		
Overlake Hospital	Bellevue, WA	03/03/2004	2	\$22,996.00		
Norwalk Hospital	Norwalk, CT	08/30/2004	1	\$16,037.00		
Norwalk Hospital	Norwalk, CT	08/30/2004	1	\$15,898.00		
Norwalk Hospital	Norwalk, CT	08/23/2004	1	\$13,418.00		
Norwalk Hospital	Norwalk, CT	08/16/2004	1	\$13,970.00		
Norwalk Hospital	Norwalk, CT	07/19/2004	1	\$13,579.00		
Norwalk Hospital	Norwalk, CT	03/01/2004	1	\$12,735.00		
Norwalk Hospital	Norwalk, CT	01/19/2004	1	\$13,660.00		
Moses Cone	Greensboro, NC	02/17/2005	1	\$17,916.34		BCBS of NC
Mission Hospitals	Asheville, NC	09/23/2004	1	\$14,262.00		
Mission Hospitals	Asheville, NC	04/01/2004	1	\$12,003.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	2	\$29,419.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	2	\$36,152.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	1	\$16,119.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	1	\$18,066.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	1	\$17,150.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	2	\$26,549.00		

Provider	City/State	Date of Service	Levels	Billed Charges	ICD-9 or C-9719 C-9718	Payer
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	2	\$23,104.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	1	\$15,574.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	1	\$19,099.00		
Holmes Reg. MC	Melbourne, FL	6 M/E 3/31/04	1	\$15,850.00		
Florida Hospital	Orlando, FL		1	\$16,500.00		Medicare
Florida Hospital	Orlando, FL		1	\$16,500.00		Medicare
Florida Hospital	Orlando, FL		1	\$16,500.00		Medicare
Florida Hospital	Orlando, FL		1	\$16,500.00		Medicare
Florida Hospital	Orlando, FL		1	\$16,500.00		Medicare
Columbia Hospital	Milwaukee, WI	07/02/2004		\$11,463.00		
Catholic Hospital Long Island	Manchester, NH	05/06/2005	1	\$11,636.82		Empire Medicare
Catholic Hospital Long Island	Manchester, NH	04/19/2005	2	\$19,765.00		Empire Medicare
Catholic Hospital Long Island	Manchester, NH	04/12/2005	1	\$11,929.60		Empire Medicare
Catholic Hospital Long Island	Manchester, NH	03/11/2005	1	\$12,287.60		Empire Medicare
Catholic Hospital Long Island	Manchester, NH	02/16/2005	1	\$4,243.86		Empire Medicare
Catholic Hospital Long Island	Manchester, NH	01/27/2005	2	\$19,897.00		Empire Medicare
Catholic Hospital Long Island	Manchester, NH	01/13/2005	2	\$24,624.42		Empire Medicare
Cape Cod Hospital	Hyannisport, MA	07/19/2004	1	\$12,762.00		
Baptist Golden Triangle	Columbus, MS		1	\$10,676.90		
Baptist Golden Triangle	Columbus, MS		2	\$23,801.89		
Baptist Golden Triangle	Columbus, MS		2	\$32,458.20		
Baptist Golden Triangle	Columbus, MS		1	\$10,805.90		
Baptist Golden Triangle	Columbus, MS		1	\$10,657.80		
Baptist Golden Triangle	Columbus, MS		2	\$22,678.65		
Baptist Golden Triangle	Columbus, MS		2	\$21,064.00		
Advocate Christ Medical Center	Oak Lawn, IL	11/12/2003	1	\$11,274.00		

TOTAL # OUTPATIENT CASES	148
TOTAL # FACILITIES-OUTPATIENT	33
AVERAGE	\$16,589.77
HIGH	\$47,925.00
LOW	\$4,243.86
MEDIAN	\$15,736.18

Note: The highlighted charges for Florida Hospital are an average of 5 cases  
The charges are included as 5 entries of \$16,500 each.

Note: Site of service question for Community Hospitals of Indiana and Good Samaritan (W. Islip, NY)

**APC Reassignment for  
Kyphoplasty  
Needed to Ensure Beneficiary Access  
CMS-Division of Outpatient Care  
Baltimore, Maryland**

**August 24, 2005**

**Michael R Marks, M.D., MBA**

**Immediate Past-President, Connecticut Orthopaedic Society**

**Incoming Chief of Staff – Norwalk Hospital**

**Board of Trustees – Norwalk Hospital**

# Executive Summary

- Overview of kyphoplasty procedure to treat vertebral compression fractures (VCFs)
- Economic disincentives for hospital outpatient departments will compromise beneficiary access and may impose greater costs on Medicare
- Hospitals need kyphoplasty assigned to a more clinically appropriate APC with adequate payment especially with new CPT on the horizon

# Clinical Overview

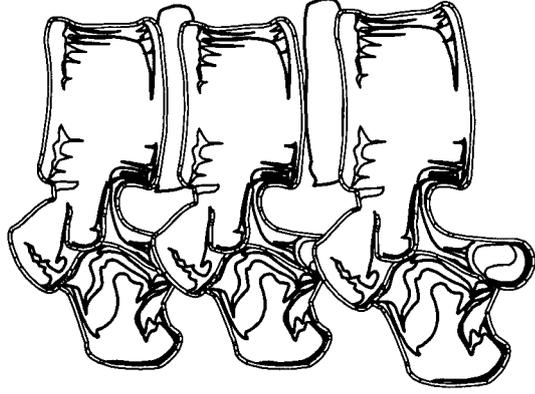
- Kyphoplasty combines fracture fixation with restoration of vertebral alignment and height using a patented balloon bone tamp and bone cement
- Benefits
  - Fixation and stabilization of fracture
  - Eliminate pain associated with spinal compression
  - Corrects deformity (kyphosis) and should improve pulmonary function and reduce the incidence and severity of other medical consequences of VCFs that impair activities of daily living
- Benefits documented in Peer-reviewed journals

## Impact of VCFs Beyond the Spine

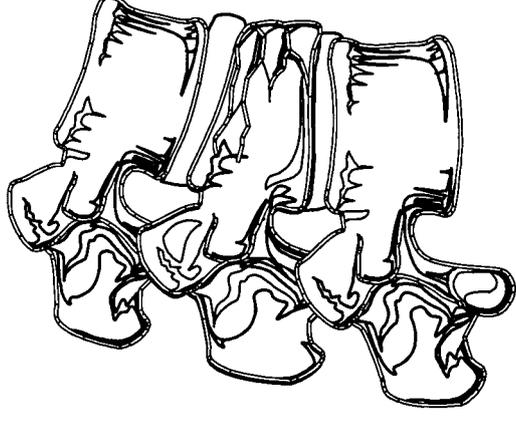
- Pulmonary compromise due to thoracic restriction (Schlaich 1998)
- Gastric distress (loss of appetite, bloating) due to abdominal restriction
- Compensatory mechanisms (e.g. tilting pelvis, bending knees) reduces gait velocity, affects balance, creates chronic fatigue
- Increased mortality related to fracture severity (Kado et.al 1999) & hyperkyphosis (Kado et.al. 2004)

# Indication

- Treatment of vertebral fractures
  - osteoporosis
  - trauma
  - cancer



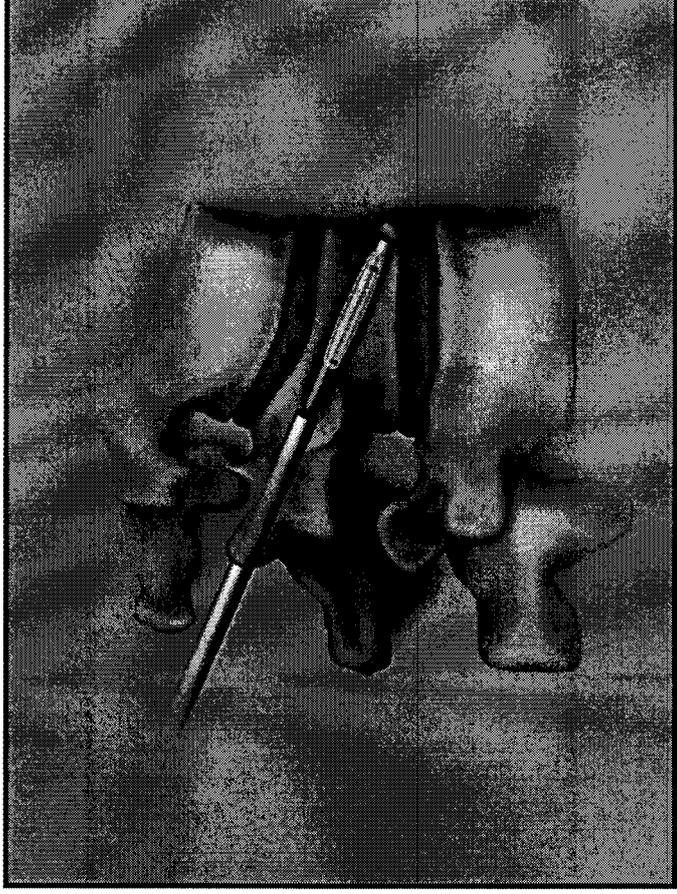
**Normal Vertebrae**



**Vertebral Compression Fracture**

# Kyphoplasty Procedure

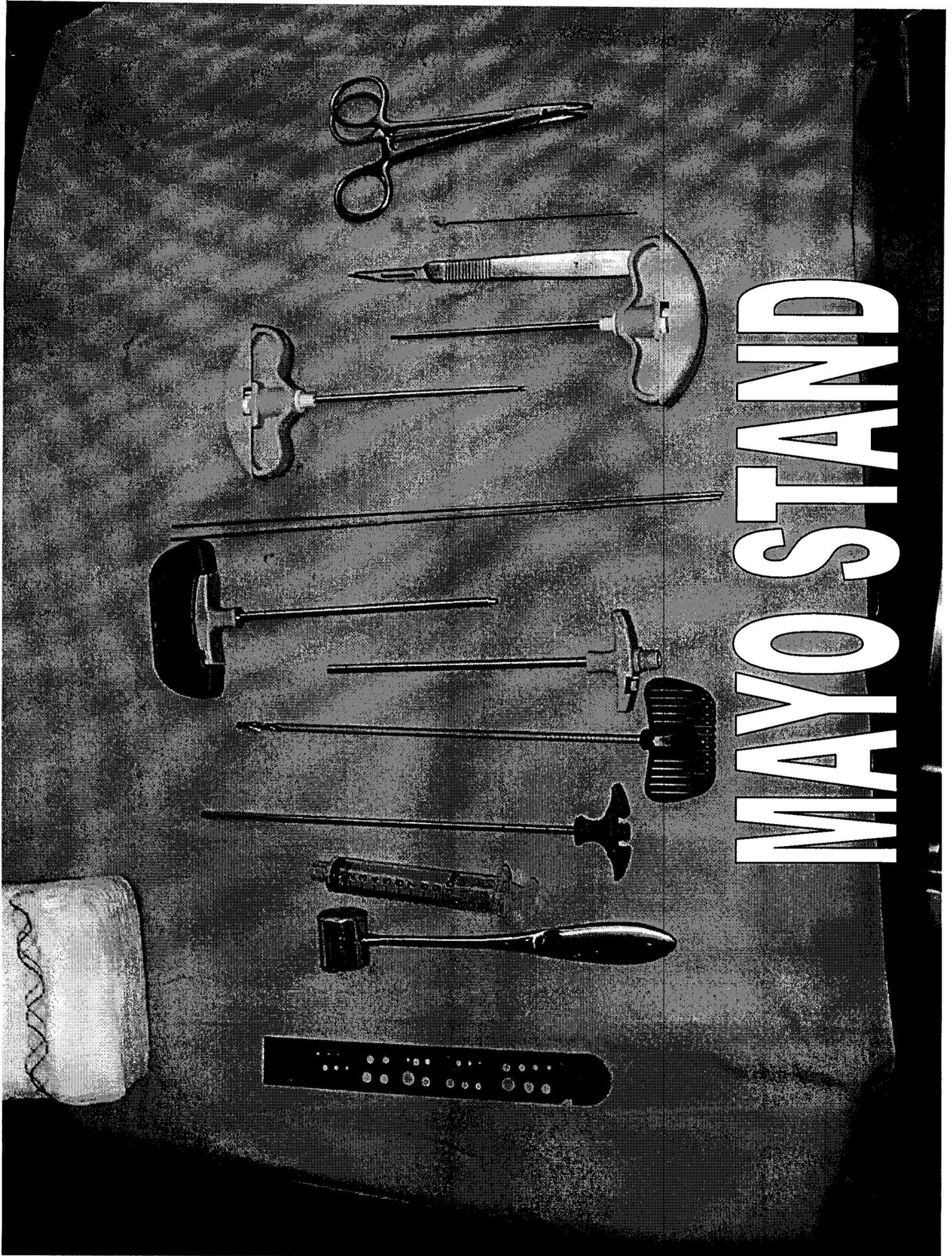
Specialized equipment and supplies



# Typical Outpatient

- Patient 65-75 years old with VCF
- Female
- General good health
- Severe, persistent back pain
- Progressive spinal deformity due to vertebral collapse

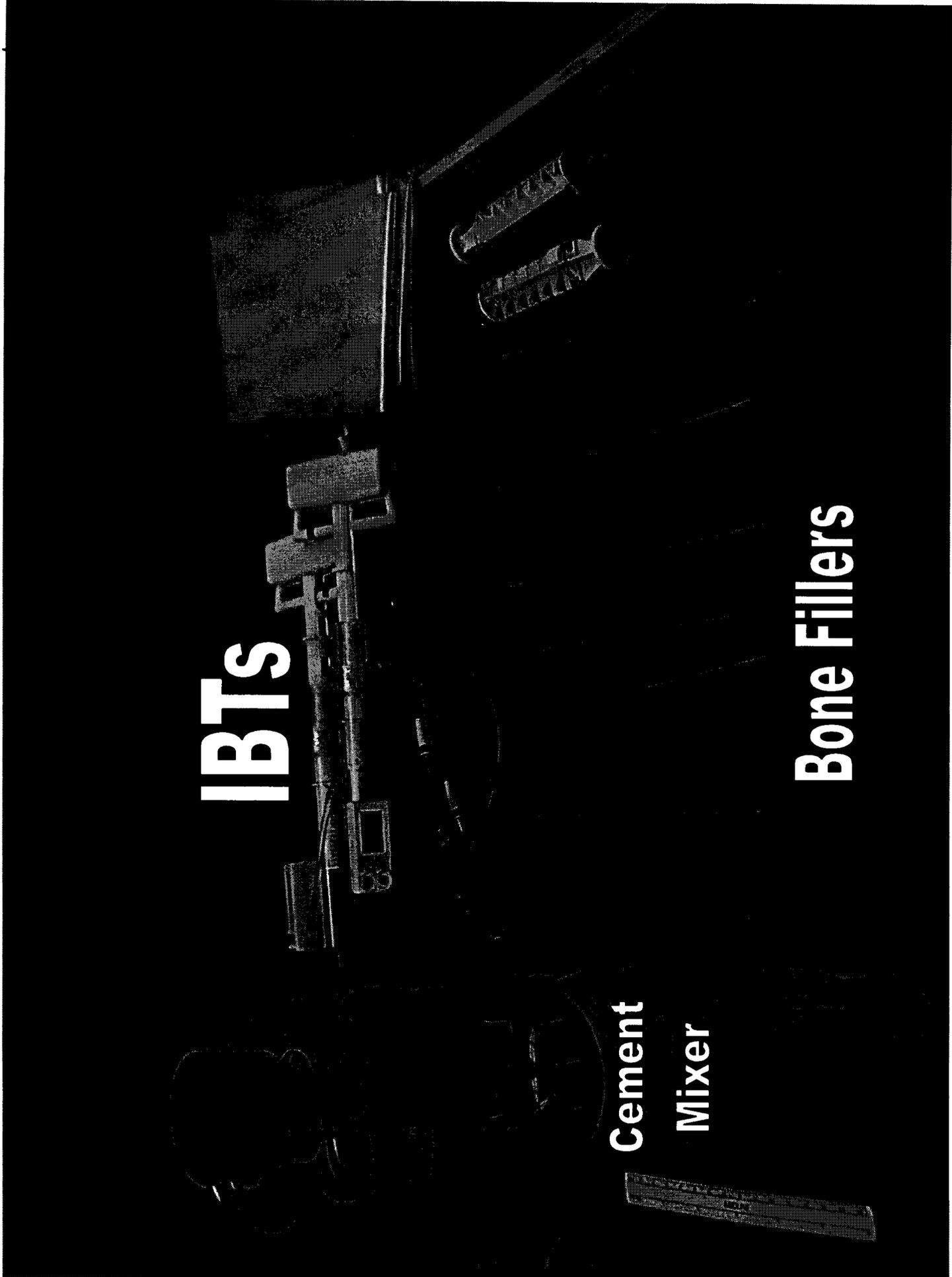
# MAYO STAND



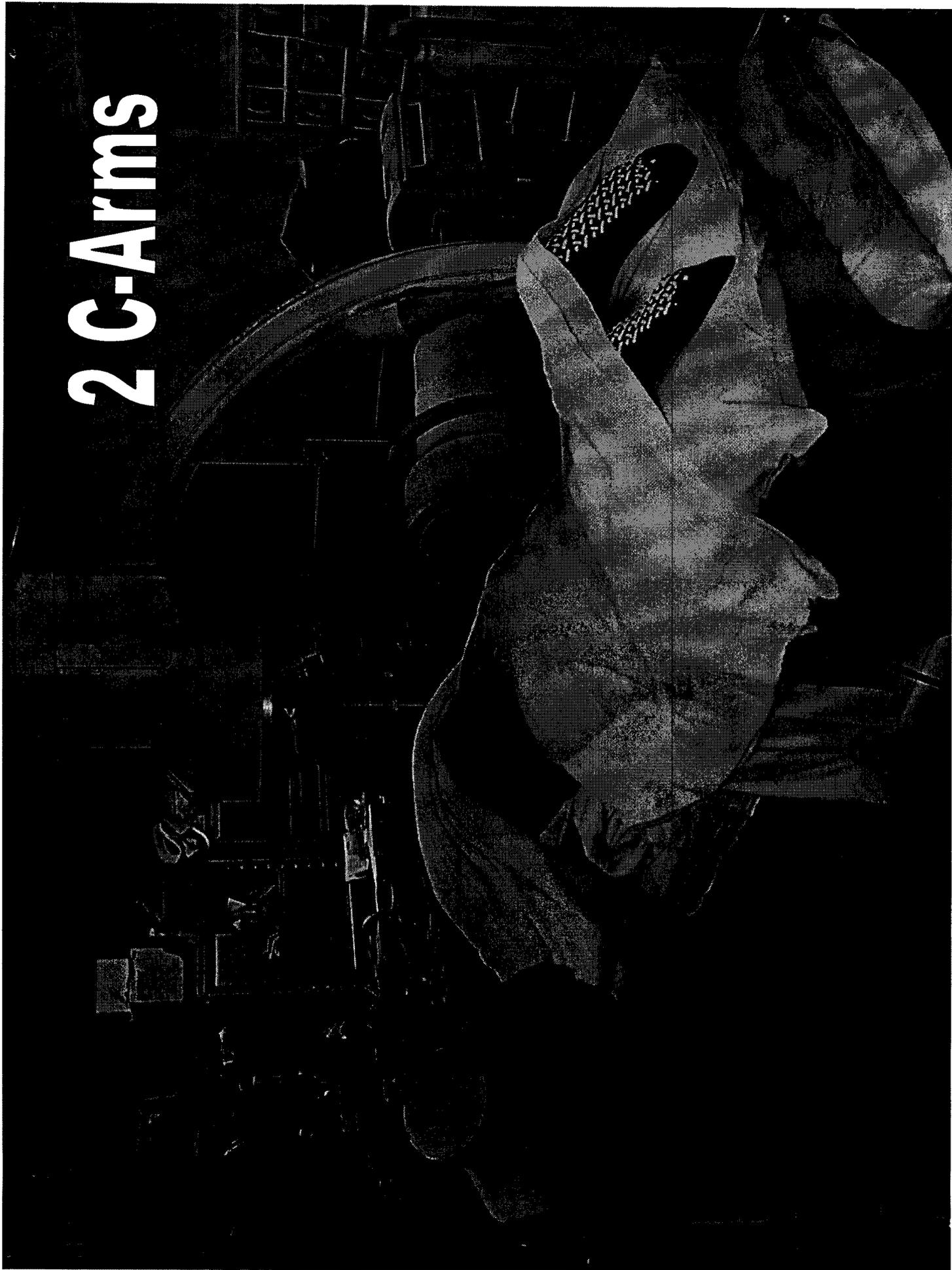
**IBTS**

**Cement  
Mixer**

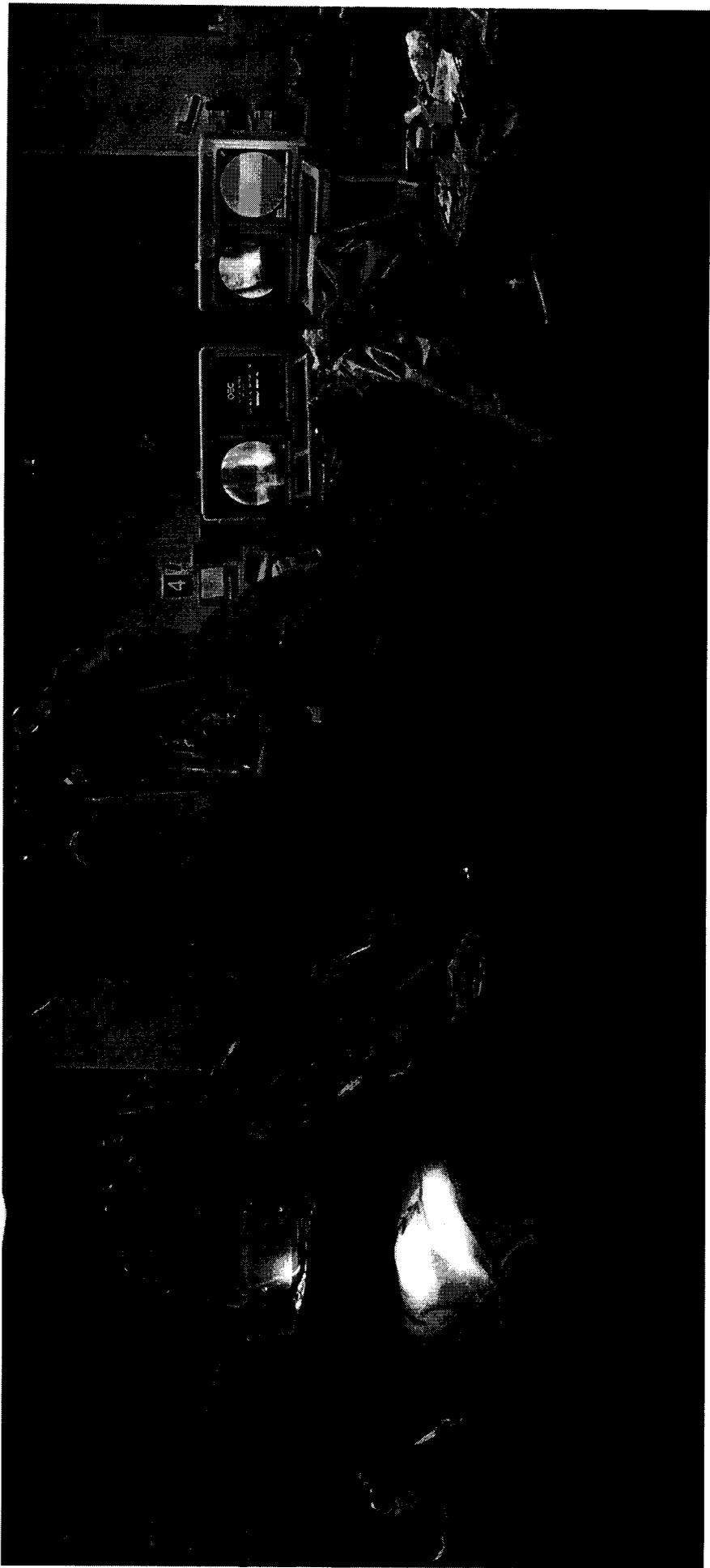
**Bone Fillers**



# 2 C-Arms



# OR Set Up – Ready to Begin



# Vertebral Body Access

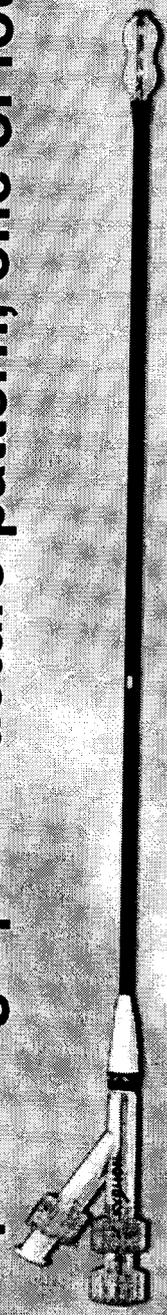
- Localize fracture, plan trajectory, mark spine
- Skin incision
- Special Jamshidi needle is used to enter vertebral body (transpedicular or extrapedicular)
- Guide pin inserted
- Osteointroducer is advanced into the posterior aspect of the vertebral body

# Channel Creation & Biopsy

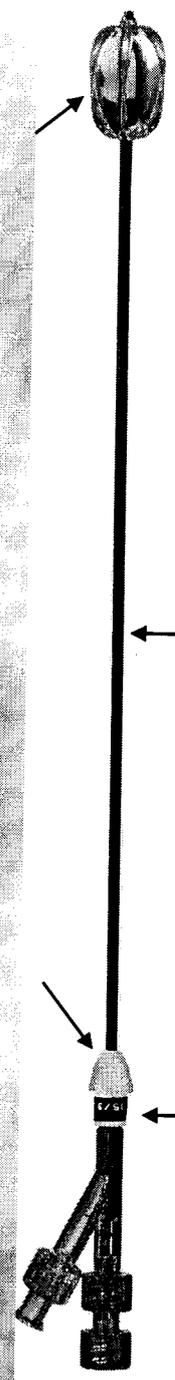
- Working cannula creates access into the vertebral body bilaterally
- Biopsy is performed
- Channel is either drill or tamped open creating a tunnel for insertion of the inflatable bone tamp (IBT)

# Inflatable Bone Tamps

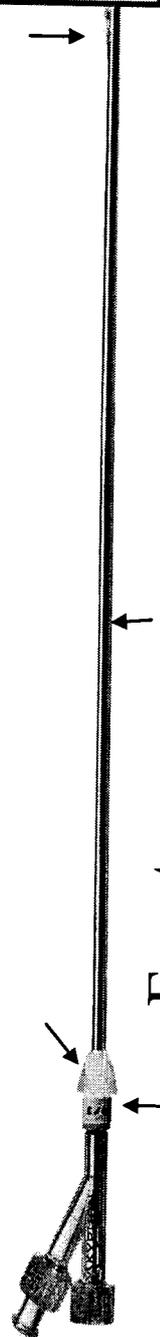
Depending upon fracture pattern, one of four IBTs is inserted



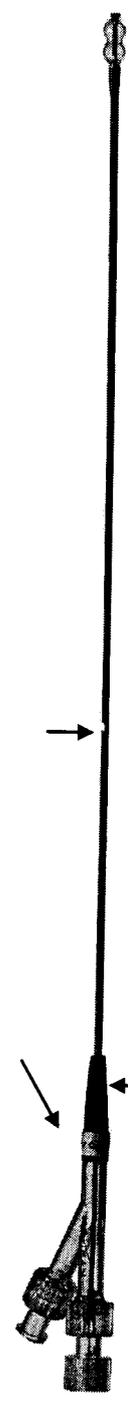
Xpander



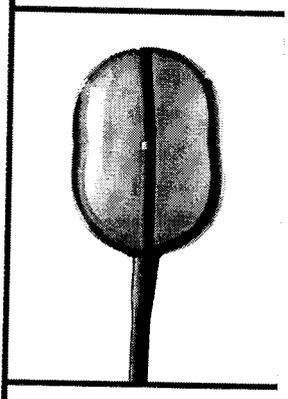
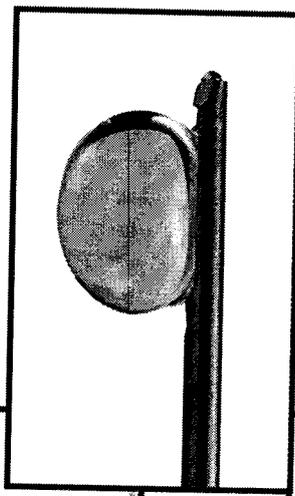
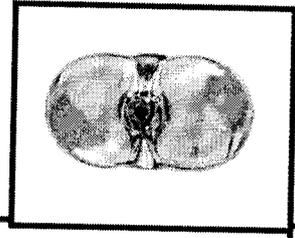
Elevate



Exact



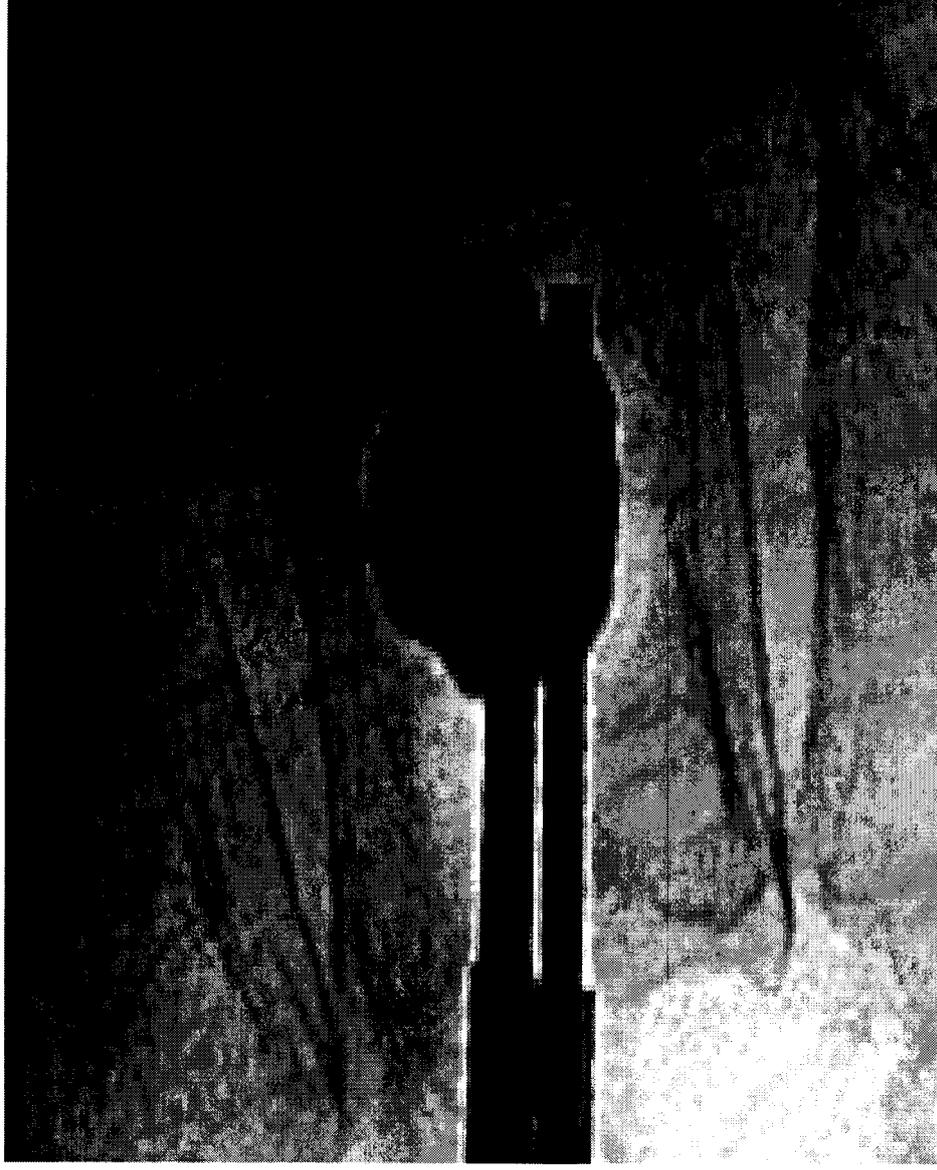
Express



# Reducing Fracture

- Inflation of balloons are closely observed with bi-plane fluoroscopy until the end-points (vertebral alignment, height restoration or balloon fill) are achieved
- Balloons are filled with radiopaque dye
- Bone is compacted so a cavity is created
- Cavity is observed when the balloons are deflated and removed

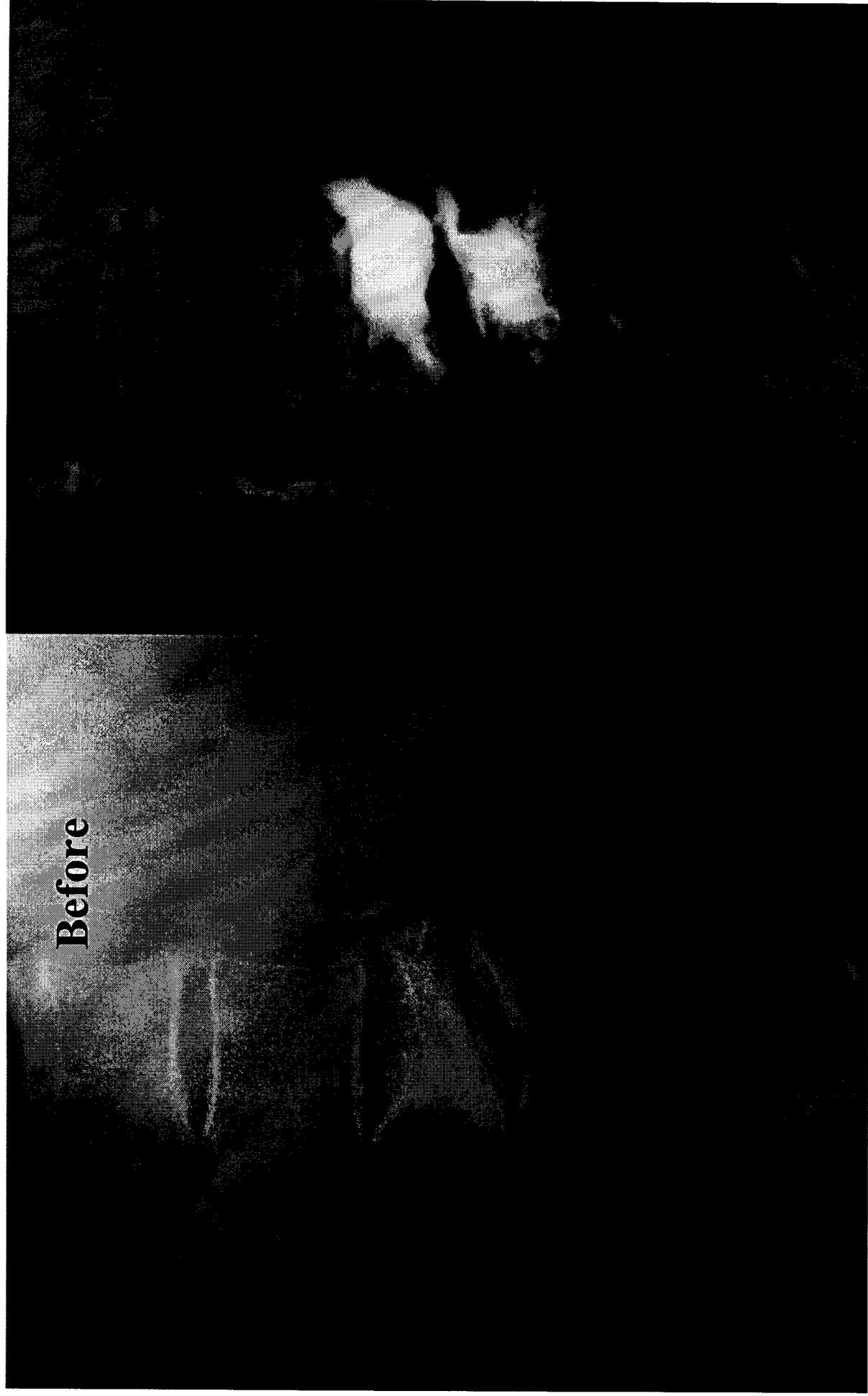
X-Ray illustrating how bone cement is deposited into vertebral bone cavity created by the inflatable bone tamp



# Fracture Fixation/Stabilization

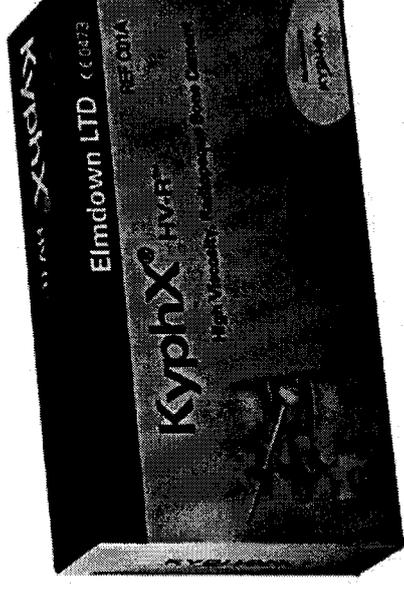
- Vertebral cavity is slowly filled with special HV-R bone cement using a bone void filler
- Cement filling process is critical, especially pressure used for filling and volume/amount used
- Patient is monitored and kept in position until bone filler hardens
- Instruments are removed
- Incision is closed with absorbable suture, followed by steri-strips and surgical dressing

# Pre and Post Op – Fracture Fixation and Correction of Kyphosis



# Kyphoplasty-Specialized Technology

- Inflatable bone tamp – 1<sup>st</sup> fracture kit - \$3,500



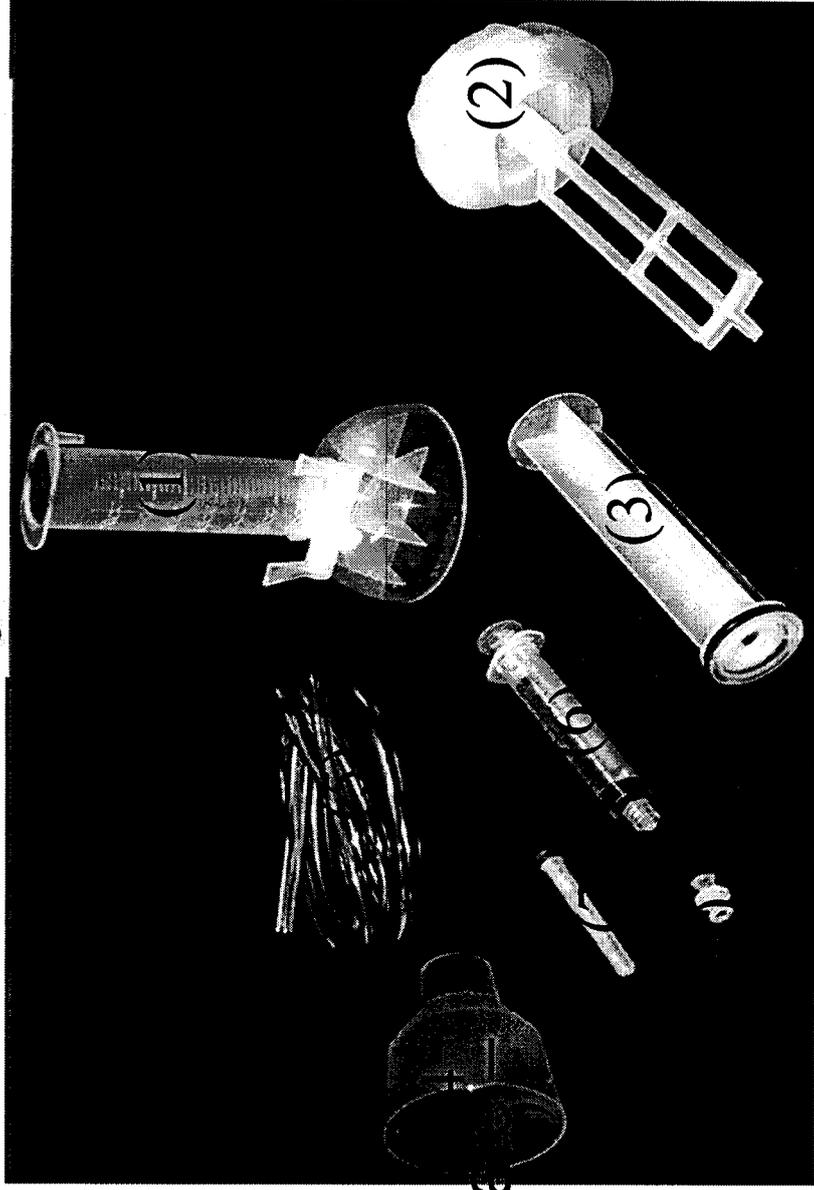
- 2<sup>nd</sup> Level Kit - \$2,358

- Curette - \$195

- Biopsy device - \$130

- Polymethylmethacrylate  
\$100

- Cement mixer - \$125



# Hospital Outpatient Resources for

## Kyphoplasty

- Direct device costs \$4,000
- OR supplies, drapes, prep tray, etc. \$1,450
- OR room (1.5 hrs.) \$2,430
- OR circulating nurse (RN @\$.51 min) \$75
- Drugs (anesthesia, antibiotics, etc) \$100
- Scrub nurse, ancillary hospital staff \$75
- Pre-op, post-op recovery room, etc. \$200
- Admitting, discharge, etc.

▪ Minimum hospital resources \$8,330+

# APC Assignment Principles

- Clinically Similar Procedures
- Similar Resources (costs)
- New Technology APC assignment based on costs of resources (e.g., price lists, etc. supplied by requestor)

# 2004/2005 APC for Kyphoplasty

- Requested New Tech APC - payment **\$8,750**
  - Based on initial cost estimates of resources
- Current APC assignment – APC 51 - \$2,043
- Charge data from 135 cases at 31 hospitals
- Average charge - \$16,100. Median - \$15,729

# Current APC Payment Financial Barrier

- Current APC assignment creates a financial barrier to delivering kyphoplasty in hospital outpatient setting
- Inpatient DRG payment is several thousand dollars higher
- Kyphoplasty assigned to DRGs 233, 234, 442, 443 & 486
- Inpatient DRG payment - \$5,800 - \$21,000

# Need to Assign Kyphoplasty to More Appropriate APC

- Consistent with long-standing policy, cost data submitted to CMS should be used as basis for APC assignment
- Equitable hospital outpatient payment is needed to facilitate patient access to this procedure in an outpatient setting

# New CPT Codes for Kyphoplasty

- New CPT codes for kyphoplasty should be effective January 1, 2006
- New code descriptors include “biopsy”
- Hospitals will not be able to bill separately for “biopsy” procedure which they are currently doing
- Change in coding makes APC assignment more critical

# Summary and Recommendations (1)

- Kyphoplasty important clinical treatment for serious spine problems
- Need to assign kyphoplasty to APC with adequate payment to ensure patients have access to kyphoplasty in most appropriate clinical setting

# Summary and Recommendations (2)

- Recommended APC Placement for Kyphoplasty
  - APC 0681 Knee Arthroplasty - \$8,103
- Alternate APCs
  - APC 0425 Level II Arthroplasty with Prosthesis - \$5,920
  - Create new APC APC xxxx Vertebral spinal augmentation and stabilization using balloon inflation - \$8,750

# Michael R Marks, MD, MBA

- Orthopaedic Spine Surgeon, Norwalk, CT
- Immediate Past-President of the Connecticut Orthopedic Society
- Member of the American Spinal Injury Association, North American Spine Society, American Academy of Orthopaedic Surgeons
- Incoming Chief of Staff and Board of Trustees Norwalk Hospital
- Board Certified by the American Board Of Orthopaedic Surgery (1990, recertified thru 2010)
- MBA, University of Tennessee (2001)



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Comprehensive Behavioral  
Health Continuum

September 1, 2005

Mark B. McClellan, M.D., Ph.D., Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1501-P  
Mail Stop: C4-26-05  
7500 Security Blvd.  
Baltimore, MD 21244-1850

**RE: CMS-1501-P: Proposed Changes to the Hospital Outpatient PPS**  
**"PARTIAL HOSPITALIZATION" COMMENTS**

Dear Dr. McClellan:

I am writing to comment on proposed partial hospitalization (PHP) and community mental health issues.

The proposed changes to the outpatient prospective payment system (PPS) could negatively affect the partial hospitalization benefit. Although providers are committed to finding ways to ensure that their patients have access to this essential level of care, partial hospital capacity in the behavioral healthcare system remains a concern. Many partial programs have closed or limited the number of patients they can accept, and fewer partial hospital slots now exist nationwide.

A 15% decrease in the per diem rate may negatively impact the availability of partial hospitalization. A prospective payment system should provide stability and predictability in payment. A PPS system cannot endure significant adjustments every year based on historical costs. Changes of 15% undermine the system because providers need to rely on a predictable methodology for determining payment.

Selecting the 15% reduction may protect providers from more onerous cuts, but it is in itself not an acceptable solution. The volatility in the CMHC data continues to be inadequately explained.

There are many administrative costs (transportation, food) that are not Medicare-reimbursable. But they are real costs to the provider and need to be considered. There are also highly prescriptive administrative and regulatory responsibilities that providers must meet in order to offer the benefit. These contribute significantly to costs.

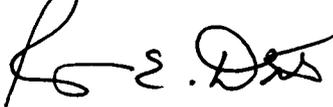
To: Mark B. McClellan, M.D., Ph.D.  
September 1, 2005

Selecting the 15% reduction may protect providers from more onerous cuts, but it is in itself not an acceptable solution. The volatility in the CMHC data continues to be inadequately explained.

There are many administrative costs (transportation, food) that are not Medicare-reimbursable. But they are real costs to the provider and need to be considered. There are also highly prescriptive administrative and regulatory responsibilities that providers must meet in order to offer the benefit. These contribute significantly to costs.

We request the 2006 PHP payment remain at \$ 281.33, until further study with reliable data is conducted. This current proposal of a 15% reduction is a devastating and hazardous approach if the intent is to keep the benefit alive.

Sincerely,

A handwritten signature in black ink, appearing to read "R. E. Detor". The signature is fluid and cursive, with a large initial "R" and "D".

Robert E. Detor  
President & CEO

**APPENDIX A**

**Providers Who Assigned Device L8614 to an Incorrect Revenue Center - CY2004 Claims**

Medicare Provider #	Hospital Name	State	# of Claims	Revenue Center	Revenue Center Description	Total Claims by Revenue Center
340053	PRESBYTERIAN HOSPITAL	NC	3			
450193	ST LUKES EPISCOPAL HOSPITAL	TX	1	0272	Medical/surgical supply - sterile supply	17
520177	FROEDTERT MEMORIAL LUTHERAN HOSPITAL	WI	13			
010139	BROOKWOOD MEDICAL CENTER	AL	2			
050224	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	CA	1			
110010	EMORY UNIVERSITY HOSPITAL	GA	1			
120001	QUEENS MEDICAL CENTER	HI	1			
260022	NORTHEAST REGIONAL MEDICAL CENTER	MO	1			
260065	ST JOHNS REGIONAL HEALTH CENTER	MO	1			
260141	UNIVERSITY OF MISSOURI HOSPITAL & CLINICS	MO	1			
300003	MARY HITCHCOCK MEMORIAL HOSPITAL	NH	1			
330247	MANHATTAN EYE EAR THROAT HOSPITAL	NY	1	0274	Medical/surgical supply - prosthetic/orthotic devices	43
330285	STRONG MEMORIAL HOSPITAL	NY	2			
360137	UNIVERSITY HOSPITALS OF CLEVELAND	OH	6			
380009	OHSU HOSPITAL	OR	5			
470003	FLETCHER ALLEN HOSPITAL OF VERMONT	VT	3			
500005	VIRGINIA MASON MEDICAL CENTER	WA	8			
500027	SWEDISH MEDICAL CENTER	WA	1			
500044	DEACONESS MEDICAL CENTER	WA	5			
510007	ST MARY'S MEDICAL CENTER	WV	3			

Providers Who Assigned Procedure 69930 to an Incorrect Revenue Center – CY2004

Medicare Provider #	Hospital Name	State	# of Claims	Revenue Center	Revenue Center Description	Total Claims by Revenue Center
060034	SWEDISH MEDICAL CTR	CO	2			
330078	CATHOLIC HEALTH SYSTEM AT SISTERS OF CHARITY	NY	1	0361	Operating room services - minor surgery	8
330189	ALBANY MEDICAL CENTER/SOUTH CLINICAL CAMPUS	NY	5			
310051	OVERLOOK HOSPITAL	NJ	3	0369	Operating room services - other	3
040114	BAPTIST HEALTH MEDICAL CENTER-LITTLE ROCK	AR	1			
070036	JOHN DEMPSEY HOSPITAL	CT	4			
240080	FAIRVIEW UNIVERSITY MEDICAL CENTER	MN	6			
280013	NEBRASKA MEDICAL CENTER, THE	NE	2	0490	Ambulatory surgical care - general	19
310001	HACKENSACK UNIVERSITY MEDICAL CENTER	NJ	1			
310119	UMDNJ UNIVERSITY HOSPITAL	NJ	2			
430027	SIOUX VALLEY HOSPITAL UNIVERSITY MEDICAL CENTER	SD	3			
490032	VIRGINIA COMMONWEALTH UNIVERSITY HEALTH SYSTEM	VA	1	0510	Clinical - general classification	1
040016	UAMS MEDICAL CENTER	AR	1	0710	Recovery room - general classification	1

**APPENDIX B**

**Providers Who Listed Device L8614, But Listed A Procedure Other Than 69930 -- CY2004**

Medicare Provider #	Hospital Name	State	# of Claims	CPT	Procedure Description	Total Claims by CPT
	For all claims with Device L8614, CPT 69930 also appears on the claim					295

# APPENDIX C

## Costs by CPT/HCPCS Code: CY 2004 & CY 2003

(Note: Outliers have not been excluded)

CPT/ HCPCS	2004 Cochlear Claims						2003 Cochlear Claims					
	Freq	% of Claims (N=544)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation
00120	4	0.7%	62.35	215.45	173.92	74.63	-	0.0%	-	-	-	-
93012	1	0.2%	64.86	64.86	64.86	-	-	-	-	-	-	-
94760	9	1.7%	8.63	53.07	21.05	13.82	3	0.6%	13.12	28.93	23.66	9.13
94761	8	1.5%	9.44	84.25	33.54	31.00	4	0.8%	29.84	106.65	60.34	37.46
96141	2	0.4%	45.35	267.96	156.50	157.19	-	-	-	-	-	-
99219	5	0.9%	193.18	1,070.30	471.31	351.97	2	0.4%	113.78	113.78	113.78	-
C1713	11	2.0%	45.22	31,399.52	5,274.33	11,281.09	-	-	-	-	-	-
C1729	3	0.6%	4.51	5.42	5.12	0.52	-	0.0%	-	-	-	-
C1760	4	0.7%	13.13	131.29	45.17	57.61	-	-	-	-	-	-
C1763	1	0.2%	32.29	32.29	32.29	-	-	-	-	-	-	-
C1781	9	1.7%	31.39	279.11	68.27	79.38	-	0.0%	-	-	-	-
G0284	1	0.2%	21.27	21.27	21.27	-	1	0.2%	267.64	267.64	267.64	-
J0290	1	0.2%	4.15	4.15	4.15	-	-	0.0%	-	-	-	-
J0295	4	0.7%	6.03	23.45	13.95	8.02	1	0.2%	16.57	16.57	16.57	-
J0330	27	5.0%	1.83	15.37	6.53	3.37	21	4.2%	0.64	8.24	3.61	1.66
J0360	1	0.2%	5.39	5.39	5.39	-	3	0.6%	6.59	15.89	10.64	4.76
J0460	3	0.6%	1.56	10.45	4.95	4.80	1	0.2%	3.76	3.76	3.76	-
J0630	11	2.0%	4.16	8.34	4.54	1.26	16	3.2%	3.60	16.96	6.13	4.46
J0694	1	0.2%	3.53	3.53	3.53	-	-	-	-	-	-	-
J0696	12	2.2%	41.23	97.31	56.93	23.92	11	2.2%	4.15	95.03	48.68	21.55
J0697	7	1.3%	10.03	39.61	16.43	10.86	2	0.4%	18.42	50.87	34.64	22.95

(Note: Outliers have not been excluded)

CPT/ HCPCS	2004 Cochlear Claims						2003 Cochlear Claims					
	Freq	% of Claims (N=544)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation
J0744	1	0.2%	48.65	48.65	48.65	-	-	-	-	-	-	-
J0780	1	0.2%	2.83	2.83	2.83	4.10	1	0.2%	10.28	10.28	10.28	-
J1094	6	1.1%	1.88	13.09	5.87	3.90	25	5.0%	1.63	16.07	5.95	3.65
J1100	54	9.9%	0.40	20.95	6.24	-	-	-	-	-	-	-
J1160	1	0.2%	5.34	5.34	5.34	4.24	6	1.2%	1.52	4.71	3.40	1.28
J1170	6	1.1%	1.04	10.19	5.64	4.95	4	0.8%	0.94	1.86	1.47	0.41
J1200	5	0.9%	1.00	13.16	4.47	12.03	57	11.4%	2.88	94.29	25.04	14.18
J1260	50	9.2%	9.01	74.95	22.72	-	1	0.2%	0.97	0.97	0.97	-
J1580	1	0.2%	1.13	1.13	1.13	-	-	-	-	-	-	-
J1590	1	0.2%	37.60	37.60	37.60	9.06	-	-	-	-	-	-
J1644	3	0.6%	2.85	19.92	9.62	2.24	1	0.2%	13.53	13.53	13.53	-
J1720	3	0.6%	1.78	6.10	3.60	3.58	4	0.8%	2.59	10.44	5.81	3.42
J1790	8	1.5%	5.02	18.02	10.18	1.31	5	1.0%	4.71	13.02	9.62	3.49
J1815	3	0.6%	0.31	2.79	1.31	1.79	-	-	-	-	-	-
J1886	11	2.0%	1.61	8.87	5.57	1.04	2	0.4%	22.13	57.68	39.90	25.14
J1940	3	0.6%	2.85	4.65	3.45	35.31	29	5.8%	1.63	62.89	6.85	11.14
J1956	2	0.4%	36.85	86.79	61.82	1.68	17	3.4%	1.68	13.77	4.91	2.81
J2000	2	0.4%	2.29	4.66	3.48	2.84	1	0.2%	2.21	2.21	2.21	-
J2175	16	2.9%	0.80	11.14	6.06	-	-	-	-	-	-	-
J2180	1	0.2%	0.52	0.52	0.52	-	-	-	-	-	-	-
J2271	2	0.4%	6.10	18.32	12.21	8.64	-	-	-	-	-	-
J2275	13	2.4%	2.47	34.14	9.87	9.19	8	1.6%	3.33	6.96	5.04	1.20
J2370	23	4.2%	1.31	12.58	5.15	2.26	11	2.2%	0.88	7.63	4.09	1.62
J2550	34	6.3%	2.01	16.27	5.49	3.12	35	7.0%	1.75	19.51	5.54	4.37
J2710	21	3.9%	2.75	33.08	8.55	6.24	9	1.8%	3.07	19.19	8.76	4.42
J2912	17	3.1%	2.01	36.78	16.40	11.29	-	-	-	-	-	-
J3360	1	0.2%	5.08	5.08	5.08	-	2	0.4%	2.58	7.10	4.84	3.20
J3370	1	0.2%	14.08	14.08	14.08	-	1	0.2%	22.57	22.57	22.57	-

(Note: Outliers have not been excluded)

CPT/ HCPCS	2004 Cochlear Claims						2003 Cochlear Claims					
	Freq	% of Claims (N=544)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation
J3480	9	1.7%	5.70	20.03	16.79	5.25	3	0.6%	5.18	24.43	18.01	11.11
J3490	11	2.0%	2.51	153.80	35.61	55.84	3	0.6%	4.85	9.62	6.44	2.75
J7030	5	0.9%	0.99	19.71	9.23	7.45	-	0.0%	-	-	-	-
J7040	5	0.9%	9.48	111.45	39.74	41.45	-	0.0%	-	-	-	-
J7050	2	0.4%	18.66	21.45	20.05	1.97	-	0.0%	-	-	-	-
J7051	1	0.2%	0.60	0.60	0.60	-	-	-	-	-	-	-
J7060	1	0.2%	5.18	5.18	5.18	-	-	-	-	-	-	-
J7120	26	4.8%	1.22	63.97	16.67	15.44	12	2.4%	1.28	54.63	13.46	14.60
J7500	1	0.2%	1.74	1.74	1.74	-	-	-	-	-	-	-
L8613	1	0.2%	1,482.70	1,482.70	1,482.70	-	2	0.4%	188.70	386.13	277.42	153.75
L8699	1	0.2%	8,964.02	8,964.02	8,964.02	-	2	0.4%	358.87	408.63	383.75	35.19
Q0061	1	0.2%	42.95	42.95	42.95	-	-	-	-	-	-	-
Q0179	3	0.6%	28.03	28.03	28.03	-	-	-	-	-	-	-

Legend of Highlighted CPT/HCPCS Codes:

- 69930 Implant cochlear device
- 99218 Observation care
- J0170 Adrenalin epinephrin inject
- J0690 Cefazolin sodium injection
- J2250 Inj midazolam hydrochloride
- J2270 Morphine sulfate injection
- J2405 Ondansetron HCL injection, per 1 mg
- J2765 Metoclopramide HCL injection up to 10 mg
- J3010 Fentanyl citrate injection
- L8614 Cochlear device/system

### Costs by Revenue Center: CY 2004 & CY 2003

(Note: Outliers have not been excluded)

Revenue Center	2004 Cochlear Claims						2003 Cochlear Claims					
	Freq	% of Claims (N=544)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation
0251	91	16.7%	2.85	269.10	24.32	41.53	87	17.4%	0.88	192.75	34.24	41.42
0252	65	11.9%	2.35	184.00	28.38	32.62	46	9.2%	2.02	329.15	29.96	51.18
0254	3	0.6%	6.55	6.95	6.68	0.23						
0259	101	18.6%	0.51	277.45	38.94	52.04	91	18.2%	0.02	272.50	36.90	51.33
0260	1	0.2%	42.95	42.95	42.95	-						
0271	118	21.7%	0.87	662.73	54.14	90.98	91	18.2%	0.80	7,315.55	166.55	768.07
0279	18	3.3%	0.53	34,238.05	5,495.76	11,600.28	23	4.6%	0.39	19,901.29	1,464.13	4,219.67
0361	8	1.5%	38.32	2,737.25	1,029.97	1,038.02	18	3.6%	16.72	20,583.47	4,007.19	5,007.59
0369	3	0.6%	945.57	1,827.82	1,533.73	509.36	8	1.6%	1,214.01	2,612.00	1,653.53	556.74
0372	1	0.2%	45.35	45.35	45.35	-	1	0.2%	82.50	82.50	82.50	24.40
0379	4	0.7%	57.75	96.77	77.44	19.65	6	1.2%	10.61	69.33	38.85	25.76
0460	17	3.1%	8.63	84.25	26.93	23.61	8	1.6%	13.12	74.91	44.39	

(Note: Outliers have not been excluded)

Revenue Center	2004 Cochlear Claims					2003 Cochlear Claims					Standard Deviation	
	Freq	% of Claims (N=499)	Min	Max	Mean	Standard Deviation	Freq	% of Claims (N=499)	Min	Max		Mean
0490	19	3.5%	\$ 919.76	\$ 2,604.04	\$ 1,930.97	\$ 483.84	25	5.0%	\$ 240.92	\$ 3,180.38	\$ 1,065.89	\$ 687.02
0510	1	0.2%	224.75	224.75	224.75							
0719	16	2.9%	83.65	549.39	287.49	121.79	21	4.2%	57.03	400.45	226.53	92.81
0732	1	0.2%	64.86	64.86	64.86	16.65	9	1.8%	63.00	196.91	101.51	43.04
0760	12	2.2%	74.76	132.99	103.87	222.89	105	21.0%	6.65	863.61	192.02	169.84
0762	89	16.4%	13.54	1,070.30	241.33							

### Legend of Revenue Center Codes

0250	Pharmacy-general
0251	Pharmacy-generic drugs
0252	Pharmacy-nongeneric drugs
0254	Pharmacy-incidenta
0258	Pharmacy-IV solutions
0259	Pharmacy-other pharmacy
0260	IV therapy-general
0270	Medical/surgical supplies-general
0271	Medical/surgical supplies-nonsterile supply
0272	Medical/surgical supplies-sterile supply
0274	Medical/surgical supplies prosthetic/orthotic devices
0278	Medical/surgical supplies-other implants
0279	Medical/surgical supplies-other devices
0360	Operating room services-general classification
0361	Operating room services-minor surgery
0369	Operating room services-other operating room services
0370	Anesthesia-general
0372	Anesthesia-incident to other diagnostic service
0379	Anesthesia-other
0460	Pulmonary function-general
0490	Ambulatory surgical care-general
0510	Clinical-general
0636	Drugs requiring specific identification-detailed coding
0710	Recovery room-general
0719	Recovery room-other
0732	EKG/ECG-telemetry
0760	Treatment or observation room-general
0762	Treatment or observation room-observation room

## APPENDIX D

### Most Commonly Found Disallowed CPT/HCPCS Codes - CY2004

CPT/HCPCS Code	Procedure Description	# of Claims on which CPT appears
95920	Intraoperative neurophysiology testing, per hour	163
90784	Therapeutic, prophylactic or diagnostic injection; intravenous	57
92584	Electrocochleography	51
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity	49
Q0081	Infusion therapy, using other than chemotherapeutic drugs, per visit	34
99201	Office or other outpatient visit	28
95927	Short-latency somatosensory evoked potential study, stimulation or any/all peripheral nerves or skin sites, recording from the central nervous system, in trunk or head	26
92516	Facial nerve function studies	19
94640	Pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes	16
94664	Demonstration and / or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	14

(Source: Multiple Procedure Claims)

## Disallowed CPT/HCPCS Codes by Medicare Provider Number

Medicare Provider #	Hospital Name	State	CPT	# of Claims on which CPT appears
030103	MAYO CLINIC HOSPITAL	AZ	86920	1
			86927	1
			93325	1
			99219	2
050324	SCRIPPS MEMORIAL HOSPITAL LA JOLLA	CA	20926	1
060014	PRESBYTERIAN/ST LUKE'S MEDICAL CTR	CO	69631	1
060022			76000	1
			94761	1
060024	UNIVERSITY OF COLORADO HOSP AUTHORITY	CO	94760	1
070022	YALE-NEW HAVEN HOSPITAL	CT	69667	5
100022	JACKSON HEALTH SYSTEM	FL	15770	2
			20922	1
			69620	1
100128	TAMPA GENERAL HOSPITAL	FL	11420	1
			64716	1
			69670	2
			78461	1
			78478	1
			93017	1
			93325	1
94799	1			
110161	NORTHSIDE HOSPITAL	GA	69799	1
130006	ST LUKES REGIONAL MEDICAL CENTER	ID	69631	1
140091	CARLE FOUNDATION HOSPITAL	IL	69620	1
150056	CLARIAN HEALTH PARTNERS, INCORPORATED	IN	11441	1
			94762	2
160058	UNIVERSITY OF IOWA HOSPITAL & CLINICS	IA	69310	1
170122	VIA CHRISTI REGIONAL MEDICAL CENTER	KS	93732	1
			99211	1
190015	NORTH OAKS MEDICAL CENTER	LA	69666	1
220075	MASSACHUSETTS EYE AND EAR INFIRMARY	MA	69667	1
			99212	2
230038	SPECTRUM HEALTH-DOWNTOWN CAMPUS	MI	69620	1
			69631	1
230046	UNIVERSITY OF MICHIGAN HOSPITAL	MI	69501	1
			94760	2
			94799	12
250001	UNIVERSITY OF MISSISSIPPI MED CENTER	MS	92603	1
250004	NORTH MISSISSIPPI MEDICAL CENTER	MS	00120	2
			94761	2
250138	RIVER OAKS HOSPITAL	MS	00120	1
			94010	3
260027	RESEARCH MEDICAL CENTER	MO	69436	1

(Source: Multiple Procedure Claims)

Medicare Provider #	Hospital Name	State	CPT	# of Claims on which CPT appears
260065	ST JOHNS REGIONAL HEALTH CENTER	MO	36600	1
			71275	1
			93325	1
260138	ST LUKES HOSPITAL OF KANSAS CITY	MO	90782	5
280013	NEBRASKA MEDICAL CENTER,THE	NE	11421	1
330100	NEW YORK EYE AND EAR INFIRMARY	NY	95868	4
330169	BETH ISRAEL MEDICAL CENTER	NY	17999	1
330203	CROUSE HOSPITAL	NY	70134	1
340040	PITT COUNTY MEMORIAL HOSPITAL	NY	76000	6
340061	UNIVERSITY OF NORTH CAROLINA HOSPITAL	NC	93325	1
340113	CAROLINAS MEDICAL CENTER/BEHAV HEALTH	NC	70240	5
360051	MIAMI VALLEY HOSPITAL	NC	99211	3
360085	OHIO STATE UNIVERSITY HOSPITAL	OH	90782	1
			00120	3
360180	CLEVELAND CLINIC FOUNDATION	OH	69310	1
			93744	1
370028	INTEGRIS BAPTIST MEDICAL CENTER	OK	15740	1
			67900	1
			69711	1
370091	SAINT FRANCIS HOSPITAL, INC	OK	70240	1
380009	OHSU HOSPITAL	OR	20926	5
			69620	1
			94761	3
390050	ALLEGHENY GENERAL HOSPITAL	PA	69450	1
			69643	1
420004	MEDICAL UNIVERSITY HOSPITAL	SC	69990	1
			86927	1
			93017	1
440019	BAPTIST HOSPITAL OF EAST TENNESSEE	TN	90782	1
440039	VANDERBILT UNIVERSITY HOSPITAL	TN	20926	1
440082	ST THOMAS HOSPITAL	TN	69667	3
450021	BAYLOR UNIVERSITY MEDICAL CENTER	TX	31525	1
			36430	1
			69799	1
			69949	1
			76000	1
			86927	1
450040		TX	94010	2
450068	MEMORIAL HERMANN HOSPITAL	TX	67912	1
450184	MEMORIAL HERMANN HEALTHCARE SYSTEM	TX	69949	1
450388	METHODIST HOSPITAL	TX	14020	1
			64999	1
			69310	1
490007	SENTARA NORFOLK GENL HOSP	VA	76000	1

(Source: Multiple Procedure Claims)

Medicare Provider #	Hospital Name	State	CPT	# of Claims on which CPT appears
490032	VIRGINIA COMMONWEALTH UNIVERSITY HEALTH SY	VA	69399	1
			94760	2
			99141	1
			99219	3
490057	SENTARA VIRGINIA BEACH GENERAL HOSPITAL	VA	69424	1
			69436	1
500005	VIRGINIA MASON MEDICAL CENTER	WA	21235	1
			69641	1
			69711	1
			69820	1
			69910	1
			69990	1
			70240	2
			76375	1
500027	SWEDISH MEDICAL CENTER	WA	20926	1
			69720	3
500129	TACOMA GENERAL ALLENMORE HOSPITAL	WA	69720	1
520177	FROEDTERT MEMORIAL LUTHERAN HOSPITAL	WI	94761	2
			69670	1

(Source: Multiple Procedure Claims)

Impact  
C-F  
Outlier  
Copycat  
APC weights  
Observation  
Commit NT  
WI  
RBP  
VAP  
E/M

Ritter  
Gift Tee  
Heugster  
Hostetter  
Levi  
Hunter  
Burley  
Kane  
Sawow  
Hart  
Bazzell

September 12, 2005

**[VIA ELECTRONIC FILING/OVERNIGHT DELIVERY]**

The Honorable Mark B. McCellan, M.D., Ph.D.  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
ATTN: CMS - 1501-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**RE: CMS-1501-P-Medicare Program: Changes to Outpatient Prospective Payment System, and FY 2006 Rates: Proposed Rule, July 25, 2005 Federal Register**

Dear Dr. McCellan:

On behalf of Sparrow Hospital, we wish to take this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule for the FY 2006 Outpatient Prospective Payment System (OPPS), published July 25, 2005 in the Federal Register.

In proposing comments on the OPPS, our belief is that the adequacy of Medicare payments, to cover the cost of services provided, is crucial for ensuring the future viability of the country's, and Michigan's, non-profit hospitals. This is even more critical for the safety net hospitals throughout the country and throughout Michigan, such as Sparrow Hospital, which is Lansing area's only disproportionate share hospital (DSH) and Level I Trauma Center.

Last year, Medicare payments to Sparrow Hospital fell substantially short of covering the operating costs associated with Sparrow Hospital caring for Medicare beneficiaries. In fact, Sparrow Hospital's Medicare reimbursement was over \$26.9 million less than the cost of providing services to Medicare beneficiaries for 2004. When excluding the DSH payments received from Medicare, for the purpose of supplementing the nominal reimbursement received under the State's Medicaid program, the Medicare losses increased to about \$32.2 million for 2004 for Sparrow Hospital.

Clearly, there is an inadequacy of Medicare payments to DSH hospitals and Level I Trauma Centers of a substantial magnitude, which the proposed OPPS rule does not remediate for Sparrow Hospital. These changes will further threaten the future viability of DSH hospitals and Level I Trauma Centers, and correspondingly inhibit

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Michigan  
by providing  
compassionate  
cost-effective  
health care.

access to healthcare services for Medicare beneficiaries and other residents in the Lansing area.

Therefore, the following comments are offered in an effort to assist CMS in modifying the FY 2006 OPPS Proposed Rules to mitigate potential negative impact of rules on DSH and Level I Trauma Centers, as well as provide an opportunity for improving the adequacy of Medicare payments to DSH and Level I Trauma Centers such as Sparrow Hospital.

### PAYMENT RATE FOR APCs

#### “Conversion Factor” (Federal Register Page 42694) -----

In the July 25, 2005 OPPS Proposed Rule, CMS provides a 3.2% market basket update in payment rates for hospital outpatient services but the average outpatient payment will increase only by 1.9% due to offsetting reduction from expiring MMA provisions like the expiration of a provision that provided a payment floor for sole-source drugs. The proposed conversion factor of \$59,343 is \$2,360 higher than the 2005 final rule amount.

**We strongly recommend that the average payment to hospitals be increased from 1.9% to 3.2% (market basket) so that providers like Sparrow would not receive lower payments for services in 2006 as compared 2005, when the payment rate is adjusted for inflation.**

#### “Outlier Payments” (Federal Register Page 42701)-----

The 2005 OPPS Proposed Rule, CMS has indicated that the cost of the service would have to exceed 1.75 (2005 = 1.50) times the APC payment rate and the cost must exceed the sum of the APC rate of the APC rate plus a \$1,575 (2005 = \$1,175) fixed dollar threshold. These two changes ensure that the estimated 2006 aggregate outlier payments would equal 1% of total OPPS payments, down from 2% outlier pool used in 2005.

This is a proposal that we strongly disagree with because it will substantially restrict outlier payment for a lot of outpatient services provided to Medicare beneficiaries because it penalizes hospitals like Sparrow that employ sophisticated technology to treat sicker Medicare patients. Even under the current (2005) outlier threshold calculation most hospitals still have to lose a lot of money before Medicare participates in the funding of these unusually costly cases.

**We strongly recommend that the outlier pool be maintained at 2% of total OPPS payments. To reach this goal the cost threshold and the fixed dollar threshold would have to be 1.50 times APC rate and \$1,175 respectively. Under the proposed scenario the hospital will have to lose more than three quarters of the payment amount before Medicare participates or makes payment towards outlier cases.**

**“Beneficiary Copayment” (Federal Register page 42702)**

The CMS implemented Section 1833(t)(B) of the Act that requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate for that service does not exceed a specified percentages. For all services paid under OPSS in 2006 and thereafter, the CMS is proposing that the specified percentage is 40% of the APC payment. Section 1833(t)(3)(B)(ii) of the act further states that for covered services furnished in a year the national unadjusted coinsurance amount cannot be less than 20% of the OPD fee schedule amount.

**We recommend that the CMS maintain the coinsurance amount at above 40% of the APC payment since the proposed payment rate for 2006 is lower than the 2005 payment rate when adjusted for inflation.**

**“APC Relative Weights” (Federal Register page 42681)-----**

The CMS currently pays hospitals full APC payments for each diagnostic imaging procedure noted on a claim, regardless of how many procedures are performed using a singular modality or whether or not contiguous areas of the body are studied in the same session. In 2006 CMS proposes to reduce payment in 2006 by 50 percent for the second and subsequent imaging procedures when all the procedures are performed during single patient encounter and all are within an identified “family” of procedures that are commonly billed on the same day. CMS has identified 11 “families” of imaging procedures by imaging modality and contiguous body area.

CMS argues that when multiple imaging studies occur in a single session, most of the clinical labor activities are not performed twice and many of the supplies are not furnished twice. The proposed rule notes that items and services that comprise hospital facility costs under the OPSS are generally very similar to those that are counted on in the technical component portion of the physician fee schedule for diagnostic imaging procedures and, thereby justifies applying the result of this analysis to multiple imaging performed in the hospital outpatient department.

**We recommend that the CMS continue to pay hospitals full APC payments for each diagnostic procedure until a more extensive resource usage study is done to justify this substantial cut in OPSS payment. The use of a study based on the physician fee schedule “technical component” data is not adequate for the implementation of this change since the physical plant, equipment and staff at physician office is less sophisticated than at a hospital outpatient setting. The OPSS payment system was implemented because CMS did realize that there is a resource usage differential at a hospital outpatient department and a physician office.**

**“Observation Services” (Federal Register Page 42742)**

CMS currently provides a separate observation care payment for payment for patients with congestive heart failure (CHF), chest pain (CP) and asthma. In order to reduce administrative burden on hospitals when attempting to differentiate between packaged and separately payable observation services. In the rule, CMS proposes to:

- Discontinue HCPCS codes G0244 (observation care by facility to patient), G0263 (direct admission with CHF, CP, asthma), and G0264 (assessment other than CHF, CP, asthma)
- Create two new HCPCS codes to be used by hospitals to report all observation services:
  - GXXXX- Hospital observation services, per hour
  - GYYYY- Direct admission of patient for hospital observation care
- Shift determination of whether or not observation services are separately payable under APC 0339 from the hospital billing department to the outpatient PPS claims processing logic.

**We strongly support these proposed changes as they will result in a much simpler, less burdensome and more reasonable process for providing necessary outpatient services.**

**“Commitment to New Technologies” (Federal Register Page 42679)-----**

In the 2006 OPPS proposed rule CMS stated its commitment to ensuring that Medicare beneficiaries will have timely access to new medical treatments and technologies. Qualifying new medical devices may be paid on a cost basis by means of transitional pass-through payments, in addition to the APC payments for the procedures that utilize the devices.

**We support the commitment by the CMS to ensure that Medicare beneficiaries will have timely access to new medical treatments and technologies. Sparrow believes that the proposed rule will spur research and development in medicine that will ultimately lead to the general well-being of all patients.**

**“Wage Index” (Federal Register Page 42695) -----**

The basic methodology for determining prospective payment rates for Outpatient Department (OPD) services under OPSS is set forth in existing regulation at §419.31 and 419.32. The payment rate for services and procedures for which payment is made under the OPSS is the product of the conversion factor. The national OPSS rate is a factor of the conversion rate and the proposed FY 2006 scaled weight for the APCs.

However, to determine the payment that would be made under the OPSS to a specific hospital for an APC for a service other than the drug, in a circumstance in which the multiple procedure discount does not apply. One of the steps in this determination is to multiply the applicable wage index by the labor-related portion. The wage index adjustment provision clearly states that the labor-related portion is to be calculated at 60% of the national standard rate. Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of the hospital costs that are labor-related.

For inpatient services, the Secretary had determined prior to the enactment of Public law 108-173, a variable labor-related share of 71.066 percent and 62 percent for wage index of 1.0 or greater and less than 1.0 respectively. The Secretary decided to apply the varied wage index level because the application of the 62-percent labor share would result in lower payments for any hospital with a wage index greater than 1.0.

Based on the above statement we would like to recommend that for OPSS reimbursement, hospitals with area wage index of less than 1.0, the labor-related share should be 50 percent, so that hospitals in wage index areas of less than 1.0 would not be adversely impacted by the proposed 60 percent uniform labor-related share. We believe that the uniform 60 percent labor share will result in lower payments for any hospital with a wage index of less than 1.0.

**"Blood and Blood Products" (Federal Register page 42740)-----**

The CMS proposes to continue to pay for blood and blood products through individual APCs for each product. CMS also proposes to establish payment rates for blood and blood products based on the 2004 claims data, utilizing and actual or simulated hospital blood-specific CCR to convert charges to cost for blood and blood products. For 2006 CMS proposes to base median cost for blood and blood products in 2006 on the greater of: (i) simulated medians calculated using 2004 claims data; or (ii) 90 percent APC payment median for such products.

Sparrow continues to prefer that hospital OPSS payments be based on hospital specific data and urges the CMS to proceed very cautiously in considering whether to utilize blood industry data for blood. If the CMS does opt to use external data in an interim fashion, then it is crucial that the external data needs to be valid, reliable, publicly available, reflective of geographic variations in costs and subject to audit.

**"Inpatient Procedures" (Federal Register Page 42745)-----**

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Prior to the implementation of the OPPS Medicare paid reasonable cost for services provided in the outpatient department. The fiscal intermediaries determined the appropriateness of providing certain services in the outpatient setting. During this period CMS did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, there should be payable only when provided in that setting. Unfortunately section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid under OPPS. The Secretary has exercised this authority and has provided the "inpatient only list" based on the following criteria:

- ❑ Most outpatient departments are equipped to provide the services to the Medicare population.
- ❑ The simplest procedure described by the code may be performed in most outpatient departments.
- ❑ The procedure is related to codes that we have already removed from the inpatient list.
- ❑ That it has been determined that the procedure is being performed in multiple hospitals on an outpatient basis or
- ❑ That it has been determined that the procedure can be appropriately and safely performed as an ASC, and is on the list of approved ASC procedures or proposed by us for addition to the ASC.

In 2006 CMS proposes to remove 25 procedures from the inpatient list and assign 23 of these procedures to clinical appropriate APCs. The "inpatient only list continues to shrink but we find it absolutely unnecessary and should be eliminated

**Sparrow continues to find the criteria outlined above to be very troubling because nowhere is the judgment of the physician mentioned. Given the current fast rate at which new medical procedures and medicines are developed, it will be prudent to make a determination as to which procedures could be treated in the inpatient and outpatient setting solely based on the judgment of the beneficiaries physician.**

**"E&M Services" (Federal Register page 42740)-----**

CMS plans to make available for public comment the proposed coding guidelines which is under consideration for Evaluation and Management (E/M) Services at a later date. We are disappointed that CMS is not proposing to implement the new E/M coding system for hospital billing of emergency department and clinic visits as part of the proposed 2006 OPPS rules. We are also concerned that the CMS has not provided a standard system or guidelines for application to hospital outpatient E/M services. Since the implementation of the outpatient PPS, hospitals have coded clinic and ED visits using the same current procedural terminology (CPT) code as

physicians. CMS has recognized that existing E/M codes correspond to different levels of physician effort but do not adequately describe non-physician resources.

**Sparrow Hospital strongly supports the E/M coding recommendations from the AHA-AHIMA expert panel and we advocate that it be adopted. We also urge the CMS to provide a standard system or guidelines for application to hospital outpatient E/M services expeditiously.**

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Sparrow Hospital is committed as part of its mission statement, to provide quality, compassionate, cost effective care to all patients in the Lansing area, including Medicare beneficiaries. Notwithstanding this, as noted in the opening paragraphs of this letter, the inadequacy of Medicare payments to cover the costs of services provided to hospitals across the country, in Michigan, and to Sparrow Hospital specifically, is significantly impacting Sparrow Hospital's ability to fulfil its mission to the Lansing community. The fact that Sparrow Hospital lost over \$30 million under the Medicare program last year is unsustainable for an organization that is a disproportionate share hospital and a Level I Trauma Center, as well as a regional referral center for many specialty services. We implore you to strongly consider our comments above, as we believe that our recommendations, if incorporated into the final OPSS Rules, will lead to some relief of these unsustainable trends for DSH hospitals such as Sparrow.

If you have any questions or comments about the stated issues above, please contact me at (517)364-6020 or at [ebbie.erzuah@sparrow.org](mailto:ebbie.erzuah@sparrow.org).

Thank you for your attention to these matters.

Sincerely,



**Ebbie N. Erzuah**  
Finance Director – Government Programs  
Edward W. Sparrow Hospital Association

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# Association for Ambulatory Behavioral Healthcare

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82

PHP

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Snow  
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September 14, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1501-p  
Mail Stop: C4-26-05  
7500 Security Blvd.  
Baltimore, Maryland 21244-1850

**Re: Partial Hospitalization Response to Proposed Changes to the Hospital  
Outpatient PPS-CMS-1501-p**

On behalf of the Association of Ambulatory Behavioral Healthcare (AABH), we genuinely appreciate the opportunity to submit comments regarding CMS's proposed OPSS rates concerning Partial Hospitalization Services under APC 0033.

AABH represents over 350 providers of partial hospitalization and other ambulatory behavioral health services across the country. Our members consist of hospitals, community mental health centers (CMHCs), individual providers, and volunteers dedicated to cost effective patient treatment within the ambulatory continuum. Since 1975, AABH has worked cooperatively with state and federal agencies, professional groups, payers and others to provide research and training, and to better define and support the understanding of ambulatory approaches to behavioral healthcare. Our members subscribe to a code of ethics requiring the highest standards for professional and programmatic conduct, and share a common belief that individuals with acute mental illness have a better chance of recovery and healthy functioning if treated in the same communities where they work, attend school, and maintain family relationships. Based on our long-standing work in this area, we wish to work in partnership with CMS to ensure preservation and proper recognition of Medicare's partial hospitalization benefit.

AABH is deeply concerned about the serious impact a rate reduction of 14% will have on partial hospitalization and hospital outpatient services. We propose that this extensive daily rate reduction will endanger the provision of the partial hospitalization benefit itself. We all too well remember the dramatic decrease in the number of facilities and programs, hospital and CMHC based that occurred five years ago, and the concurrent events that took place in response, sending the industry into an unprecedented deterioration and greatly reducing even basic services to an already underserved population. In our opinion, the industry is now only beginning to recover from the

devastating circumstances of the past, and is finally beginning to rebuild the critical services. We are not discounting the problems that existed in the past regarding the outpatient psychiatric benefit, specifically the partial hospital provision. We have become an ongoing member-proclaimed watchdog of the industry. We have taken on the role of monitoring the provision of these services through conferences and benchmarking procedures. In that, however, we feel it is also our responsibility to watch out for the service providers, assuring that they are fairly reimbursed for their services.

**The Association of Ambulatory Behavioral Healthcare respectfully comments as follows:**

**1. CMS data does not support a PHP per diem rate of \$241.57.**

During the identification of the proposed rate (before the correction notice) in CMS-1501-p, CMS referenced the CY 2005 combined hospital-based and CMHC median per diem costs of \$289.00. As providers in the medical industry, we are all well aware that the industry inflation rate is approximately 3.5%, which creates an approximate cost of \$299.12 per day for the coming year. We are all-to-well aware that salaries, benefits, insurance, supplies, utilities, etc. have not been reduced, but have been inflated. These figures strongly conflict with a per diem rate of \$241.57.

In addition, CMS has identified the true Median Cost of HCPCS 90853 for group therapy at \$82.31. With a minimum of 4 services per day (many programs offer more), CMS would recognize the minimum cost at \$329.24 per day. These data are inconsistent with a rate of \$241.57 and indicate that a higher payment rate is necessary to prevent PHP from running substantial deficits that will risk financial viability.

**2. Medicaid cuts substantially impact copays.**

At the proposed CMS rate of \$241.57, the Medicare payment is actually 80% or \$193.26 with the copay of \$48.31. Not all, but many Medicare recipients eligible for this benefit are also Medicaid recipients for their copay.

Many states (example-West Virginia) have recognized partial services as a Medicaid benefit. Unfortunately, their reimbursement rates are generally one-third to one-half of the Medicare rate at best. These states have declared that when crossover claims are submitted for the copay, that if the provider has already received payment above the state rate, then they do not pay any of the copay. This in essence creates a per diem rate of \$193.26 for CY 2006, further below the unacceptable rate of \$241.57.

**3. CMS's calculation for the CY 2006 PHP per diem payment is diluted.**

CMS states that per diem costs were computed by summarizing the line item costs on each bill and dividing by the number of days on the bills. This calculation can severely dilute the rate and penalize providers. All programs are strongly encouraged by the fiscal intermediaries to submit all PHP service days on claims, even when the patient receives less than 3 services. Programs must report these days to be able to meet the 57% attendance threshold and avoid potential delays in the claim payment. Yet, programs are only paid their per diem when 3 or more qualified services are presented for a day of service. If only 1 or 2 services are assigned a cost and the day is divided into the aggregate data, the cost per day is significantly compromised and diluted. Even days that are paid but only have 3 services dilute the cost factors on the calculations. With difficult challenges providers have in treating the severe and persistently mentally ill adults, these circumstances occur frequently.

**4. The proposed PHP per diem rate also compromises Hospital Outpatient Services.**

CMS pays hospital facilities for Outpatient Services on a per unit basis up to the per diem PHP payment. As previously shown, CMS has identified Group Therapy HCPCS code 90853 with a true Median Cost of \$82.31. Most patients involved in the Outpatient Services are participating 1-3 days and generally receive 4 or more services on those days. In order to provide appropriate care, programs will provide 4 services per day, yet the per diem limit will only allow them to be "paid their cost" for 3 services (3 x \$82.31= \$246.93). The fourth service, although provided, is not currently reimbursable.

**5. Cost Report Data frequently does not reflect Bad Debt expense for the entire year.**

As the cost report data is proposed surrounding Bad Debt, many "recent" bad debt copays of the last 4-5 months of the fiscal year have not completed the facility's full collection efforts and therefore are not eligible for consideration of bad debt on the cost report. Those that are, can only be recovered up to 55%. These costs are not being considered in the CMS data and severely short change the rate calculations.

**6. Data for settled Cost Reports fail to include costs reversed on appeal.**

CMS historically has reduced certain providers' cost for purposes of deriving the APC rate based on its observation that "costs for settled cost reports were considerably lower than costs from 'as submitted' cost reports." (68 Federal Register 48012) While CMS's observation is true, it fails to include in the provider's costs, those costs denied/removed from "as submitted" cost reports, and subsequently reversed on appeal to the Provider Reimbursement Review Board ("PRRB"),

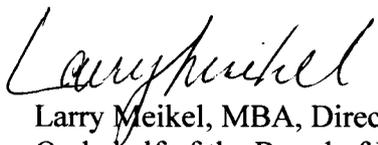
subsequently settled pursuant to the PRRB's mediation program, or otherwise settled among the provider and intermediary. During the relevant years at issue, providers of PHP incurred particularly significant cost report denials, but also experienced favorable outcomes on appeal. Because the CMS analysis did not take into consideration what were ultimately the allowable costs, its data are skewed artificially low. The cost data used to derive the APC rate should be revised to account for these costs subsequently allowed.

Based on the above issues, AABH would recommend that CMS take the following course of action:

1. Allow the PHP per diem to remain the same as the 2005 per diem rate of \$281.33 while CMS continues to examine the data and research the numerous problems identified.
2. Consider a methodology that uses an average over time. Blending a three or four year average cost and/or rate would help eliminate a drastic cut of the per diem such as the 14% proposed cut for CY 2006.
3. Allow energy, time and resources to develop a reasonable payment methodology by working with organizations such as AABH. AABH would welcome the opportunity to study and research data with CMS to develop a payment rate that is fair, consistent and predictable.

Thank you, for the opportunity to respond to this critical issue.

Respectfully,



Larry Meikel, MBA, Director  
On behalf of the Board of Directors  
Association for Ambulatory Behavioral Healthcare