CMS-1506-P-1

Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates

Submitter :

Date & Time: **08/10/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

Medicare Contracting Reform Impact

Medicare Contracting Reform Impact

The proposed changes to the ASC payment system will certainly put a lot of gastroenterologists out of business.

CMS-1506-P-2 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Ms. Lisa Hart** **Date & Time:** **08/15/2006**

Organization : **Cleveland Clinic East**

Category : **Hospital**

Issue Areas/Comments
OPPS: New HCPCS and CPT Codes

OPPS: New HCPCS and CPT Codes

The following comments are in reference to information contained in the "Proposed Hospital Coding and Payments for Visits" section beginning on page 316. The proposal to use G codes for emergency room levels of care is confusing and does not seem to make much sense if CMS is not adding any guidelines for the use of the codes. We were under the impression that emergency department (ED) E/M guidelines would be available for FY 2007, and many hospital ED facilities are already using the ones developed by AHIMA & AMA as their facility standards. By changing from the 992** codes to G codes only serves to add confusion and additional work for the coders, and require the burden of having to change chargemasters and retrain those who charge. Medicare would probably be the only one that will accept the G codes, so that will require us to code/bill other third party payers with the 992** codes. It is becoming increasingly difficult to have to separate out what you have to code differently for each payer and I see no difference between the assignment of G codes versus local HCPCS codes that Medicaid used to use. The purpose of the HIPAA transaction standards was to "STANDARDIZE" billing information across payers, but CMS continually adds new HCPCS codes every year that other payers cannot or will not accept. Other payers do not think that "coding" is standardized under the transaction standards and it would be desirable for to CMS clarify this for all payers. It seems to defeat the purpose, and causes an administrative BURDEN instead of adminstrative simplification for all hospitals.
Recommendations:

1) Clarify the underlying reason for wanting to use G codes instead of the 992** codes - it will not provide LESS confusion for hospital providers, it will cause MORE. If reason is not clear, then do not change them!
2) Clarify the HIPAA transaction standards and define if ICD-9-CM & HCPCS/CPT codes are considered part of these standards and clarify to ALL payers that the use of these codes should be based on Medicare coding/billing rules.
3) Consider using revenue codes or admission source codes as a way to ascertain whether the patient was seen in an urgent care center (limited hours) or a hospital ED (24 hrs)
4) Please realize that each year the proposals made by CMS rarely, if every, simplify any coding, billing or documentation process for hospitals and continue to add to the increase in the cost of care because of the additional trained professionals necessary to decipher, implement, change processes, and train hospital personnel to get that additional $48 charge for an infusion. It really gives the appearance that CMS is somewhat confused and lacks a clear understanding of what providers actually do, and don't realize that they add to the increase in the cost of health care so every penny they try to save is paid out in some other way.

Thank you for reading these comments.

CMS-1506-P-3 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Vickie Lyons** **Date & Time:** **08/16/2006**

Organization : **Pitt County Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

OPPS: Drug Administration

OPPS: Drug Administration

Currently in 2006 there are two different guidelines for CPT verses Medicare billing for infusions. Medicare separates non-chemotherapy infusions and chemotherapy infusions. CMS states that you can have one initial infusion for chemotherapy & one initial infusion for non-chemotherapy. CPT guidelines states you can only have one initial infusion no matter the type of infusion. Another difference is that CPT code 90766 is up to 8 hours. HCPCS code C8951 does not limit the number of hours. So would we limited the number of hours if we are using CPT 90766 but not for HCPCS C8951?

CMS-1506-P-4 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Mr. Scott Lucas** **Date & Time:** **08/16/2006**

Organization : **Mr. Scott Lucas**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Re the proposed changes to reimbersement on PET Scans and the pharmaceuticals used:(HOPPS for 2007) The proposed rates of reimbersements are on average 45% or more below our actual costs on scanning and 41% below our actual costs on the Radiopharmaceutical dose. Because Medicare patients represent a large number of our PET Scan patients I am wondering if at some point we will be faced with a decision about whether or not to offer PET Scans at such a loss. We are a rural hospital and we use a mobile service which of course has substantially higher costs than a fixed site would. We have to pay them a higher rate and we have to pay for larger doses to be transported a greater distance for use. Rural hospitals have enough troubles without one more thing to loose money on. If you live out here you expect the kind of care you get in the cities. Medicare can deny that care indirectly by careless reimbersement cuts.

CMS-1506-P-5 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Mrs. Valerie Rinkle**

Organization : **Asante Health System**

Date & Time: **08/18/2006**

Category : **Hospital**

Issue Areas/Comments

OPPS: Drug Administration

OPPS: Drug Administration

I have a significant concern with the proposal to continue the C codes for drug administration. Our hospital has had to implement all the CPT codes for drug administration for commercial insurances and for Oregon Medicaid and then try to cross walk to C codes for Medicare. The cross walk is not simply a cross walk, so we have to stop accounts and separately code them for Medicare - a significant labor burden.

Moreover, a major concern is Medicare/Medicaid cross over claims. Oregon Medicaid refuses to recognize the C codes for calculating their co- payment or secondary payment. The hospital has no opportunity to recode cross over claims. We are losing secondary dollars because Medicaid refuses to recognize these codes.

We have already incurred the implementation and training effort on the 2006 CPT codes for drug administration including the initial service definitions.

If CMS were to adopt all of the drug administration CPT codes and eliminate the C codes, the only remaining issue is whether hospitals would have to break out separate lines for 90766 and 96415 infusions lasting over 9 hours like we had to do for 90781.

Hopefully, CMS is working with AMA to make this change to the CPT definitions. If not, we would rather line break for the each additional hours than have to continue C codes for drug administration.

With any replacement HCPCS codes for hospital use, CMS should mandate that State Medicaid programs accept those codes for secondary payment calculations since hospitals have to bill Medicare according to their requirements when the primary payer.

CMS-1506-P-6 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Mrs. Valerie Rinkle** **Date & Time:** **08/18/2006**

Organization : **Asante Health System**

Category : **Hospital**

Issue Areas/Comments

Visits

Visits

CMS issued coding and billing instructions concerning critical care at the outset of the OPPS. On page 17 of Chapter II for Claims Processing System Modification for OPPS (the FI training manual) there is no indication that a time threshold of 30 minutes or more was required before reporting CPT code 99291. In addition, on page 18452 of the April 7, 2000 rule CMS clearly states: we believe it would be burdensome for hospitals to keep track of minutes for billing purposes. Therefore, we will pay for critical care as the most resource intensive visit possible as defined by CPT code 99291. Therefore, it is clear that CMS intended for hospitals to report critical care when the patient met the definition of being critically ill or injured, but that the time threshold did not apply.

Given the above information, we cannot understand why CMS is now proposing a time threshold for reporting the newly proposed critical care codes. The 30-minute time threshold for CPT 99291 applies to physician billing for their professional services, but not to hospitals under OPPS as the APC payment is covering the hospital staff and facility resources expended when critical care is reported -- these resources are expended immediately, not after 30 minutes. In addition, CMS should recognize what it recognized previously - that it will be just as burdensome to keep track of 30 minutes, one hour, or each additional 30 minutes.
If CMS plans to impose this time-based reporting, then it must clearly inform providers of the documentation requirements and how to determine what time counts towards the definition of critical care. Why would reporting of hospital resources used to take care of a critically ill/injured patient be dependent upon physician time? Often multiple hospital staff are working on a critically ill/injured patient simultaneously - do we count the time per person or is it dependent upon physician time only? Other questions that need to be answered include, Must the physician be in attendance for the entire duration? Is CMS looking to ultimately match hospital with physician coding for critical care? If so, why are the new Gccc1 and Gccc2 proposed at all?

CMS-1506-P-7 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Mrs. Valerie Rinkle** **Date & Time:** **08/18/2006**

Organization : **Asante Health System**

Category : **Hospital**

Issue Areas/Comments

Visits

Visits

G codes for visits has the advantage of no longer confusing commercial payors who try to hold hospitals to using CPT E/M guidelines for reporting hospital clinic and ED visits. However, there are concerns with G codes for Medicare and CPT codes for other payers. While G codes are supposed to be recognized by Medicaid and Commercial payers according to HIPAA transaction code standards, other payers do not have to recognize these codes for payment.

Currently, our Oregon Medicaid accepts claims with G0378 for each hour of observation when it crosses over as a Medicare/Medicaid claim, but they do not accept the charges for calculating their co-payments. We are losing co-payments as a result. In other words, the claim does not reject (so the codes are accepted), but the codes do not result in secondary payment like they would if we could report the service using the CPT code. What good is accepting a code on a claim if correct payment is not made? We lose Medicaid secondary payment on every observation account when we would receive proper Medicaid secondary payment if we were able to bill Medicare using the Medicaid preferred CPT code 99218 (even though each hour of hospital observation does not match the definition of this CPT code).

If Medicare is going to implement G codes, they must require State Medicaid programs to recognize the G codes for calculating appropriate secondary payments. This applies to any Medicare mandated HCPCS codes that replace CPT codes.

For the long term, CMS should ask AMA to create regular CPT codes for hospital visits separate from the physician E/M codes and not leave the hospital visit codes as level II HCPCS G codes that commercial and Medicaid payers may not pay.

It will be impossible for hospitals to charge all payers the same for the same service (a current Medicare billing requirement), if some payers recognize CPT codes for visits and Medicare requires G codes when new guidelines for visit reporting are finalized by Medicare.

In order for hospitals to bill all payers the same price for the same service that would be defined by the hospital visit guidelines finalized by CMS, then all payers must accept the codes that are associated with the guidelines.

If asking hospitals to report the G codes for Medicare now, much like physicians had to do with G codes for drug administration, is the necessary step before CPT creates CPT codes for hospital visits for 2008 so that CMS and CPT adopt guidelines for hospital visits, then this is a necessary step in the development of hospital visit CPT codes.

CMS-1506-P-8 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Mr. Michael Uran** **Date & Time:** **08/21/2006**

Organization : **Trinity Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

Radiology Procedures

Radiology Procedures

Re: Change of PET Studies (78811-78816) From APC 1513 or 1514 to APC 308 in 2007 OPPS proposal.

I am very much opposed to this change and ask for your reconsider-ation of it as will result in a large financial loss for us to continue to provide this service as well as poorer oncology patient outcomes. Trinity Health is a full service Sole Community provider, with cancer care being one of our main service lines. Because we cannot justify an in-house PET unit, we contract with a mobile provider at a cost of $1430.00 per scan performed for the service and delivery of the drug. This is basically the rate for the whole state of North Dakota for PET costs. We provide approximately 320 PET procedures annually, resulting in a projected loss of over $180,000 annually for this integral service, should this proposal be implemented.

The proposed payment of $865.30 will make provision of this service not financially feasible and result in inferior patient care as response to cancer treatments will not be monitored for response as well, resulting in poorer outcomes and wasted costs of ineffective drug. The clinical value of this procedure in oncology has been demonstrated well over the past several years and undoubltedly has improved patient outcomes and saved significant cost by allowing immediate changes in treatment when a course of therapy is known to be ineffective.
Please reconsider this proposal, as it will undoubtedly result in significant negative consequences as defined above.
Mike Uran

CMS-1506-P-9 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Date & Time:** **08/22/2006**

Organization :

Category : **Hospital**

Issue Areas/Comments

APC Relative Weights

APC Relative Weights

APC Relative Weights

I would like to comment on the relative weights and APC assignments for CPT/HCPCS code range 12001 13152. I have noticed that the relative weights for nine of the possible thirteen CPT codes for complex wound repair are the same as the relative weights for the CPT codes for simple and intermediate wound repairs. Four of the complex wound repair CPT codes have a relative weight of 5.0931 while the other nine have a relative weight of 1.4924. For example, CPT code 13151, represents a larger wound that would require as much time and potentially more supplies than CPT code 13150, yet it has a relative weight that is much less than 13150. Can you explain the rationale for the assignments of these relative weights and APC assignment?

CMS-1506-P-10 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Mrs. Catherine Morris** **Date & Time:** **08/23/2006**

Organization : **Diomed, Inc.**

Category : **Nurse**

Issue Areas/Comments

Policy and Payment Recommendations

Policy and Payment Recommendations

http://www.cms.hhs.gov/eRulemaking

Policy and Payment Recommendations - Comment

BILLING CODE 4120-01-P
CMS-1506-P 679

ADDENDUM A.--OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007

It appears the codes 36478 (endovenous laser treatment, 1st vein) and 36479 (endovenous laser vein, add on) have been moved from APC 0091 to APC 0092. Perhaps this was an error.

Of note, codes 36475 (endovenous RF 1st vein) and 36476 (endovenous RF vein add on) remain in APC 0091. These are very similar technologies. In fact, FDA approval for endovenous laser treatment was based on the predicate device for endovenous radiofrequency.

Both technologies carry an inherent cost of both capital equipment and patient specific device supplies. Provider cost to provide either service is approximately equal (within $200/patient).

The United States Department of Health and Human Services BESS database of submitted physician fees for code 36478 in 2006 demonstrates a range of charges from $2,710 to $5,725 with an average of $3,896.

Codes 36478 and 37475 have a fully implemented facility RVU of 9.63.

Both procedures are in the ASC payment Group 9.

We are requesting that codes 36478 and 36479 be returned to APC 0091.

CMS-1506-P-11 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Mrs. Betty McKenzie** **Date & Time:** **08/23/2006**

Organization : **Via Christi Regional Medical Center**

Category : **Hospital**

Issue Areas/Comments

Policy and Payment Recommendations

Policy and Payment Recommendations

As a site that is just finishing completion of a Cyberknife Radiosurgery treatment, I am strongly opposing the chagnes to the payments for the 1st and sequential treatments for this service. Kansans have just had this opportunity as a treatment modality. It will cost us over $5M to offer this service to our community. Only if an insurance carrier would pay, have the citizens been able to go to a surrounding state to receive this treatment. There are cancer patients with tumors near critical body structures that will benefit from this therapy, when there may not have been an alternative before or the only choice of surgery with side effects/complications that may have limited this as a treatment option. There are also patients with metastasis to other sites that will benefit from this therapy in our community.
As listed, the only choice the patients have had in the past was to travel to another state. A site has recently opened in Kansas City and now we will be opening a site to benefit the rest of the state of Kansas. It is saddend to see a large decrease in reimbusement proposed since this is still consider a new alternative therapy for almost the entire state of Kansas. I know that there are other states as well that may not be able to offer this to their citizens. I don't think that it is fair to penalize those that are just getting a facility built and available to meet the community/state needs. This has been a hugh investment and a very long process to get approval and support to get to this place of finally offering a new therapy for our cancer patients in Kansas.
Please consider leaving the payment structure the same into the 2007 payment year.
Sincerely,
Betty McKenzie, RN, MSN
Director of Clinical Programs (including our new Cyberknife Building)

CMS-1506-P-12 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Dr. Robert Falk** **Date & Time:** **08/24/2006**

Organization : **Jewish Hospital and St. Mary's Health Care**

Category : **Physician**

Issue Areas/Comments

OPPS

OPPS

I would like to express my opinion in the strongest terms that the dramatic reduction in OPPS reimbursement for HCPC code G0288 is excessive and will ultimately result in poorer patient care and surgical outcomes. As a radiologist with an interest in and expertise in the pre- and post- surgical evaluation of abdominal aortic aneurysms treated with stent grafts, I have no financial stake in this argument, since the reimbursement is to the hospital only as a technical charge. However, I am intimately familiar with the work and effort inviolved in creating these data sets for the treating surgeon, and the reimbursement rates we are seeing are totally unreasonable. The rate has gone from about $600 in 2003 to a proposed $191 in 2007. This will result in shortcuts being encouraged or the evaluation not being performed at all. Patients will suffer from more complications as a result of poorly fitting stents. Abdominal aortic aneurysms are common and serious conditions, and we now have a less invasive and much less costly treatment with stent grafts. They MUST be sized accurately for good results and this requires extensive evaluation of the CT data, often taking over an hour to perform on a 3D workstation. The RVU values assigned must reflect this.
Thank you for your consideration,
Robert L. Falk, MD

CMS-1506-P-13 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Ms. Marilyn Niedzwiecki** **Date & Time:** **08/25/2006**

Organization : **Childrens Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

OPPS Comments Indicator

OPPS Comments Indicator

I wanted to comment on the proposed codes for E & M's for the facility. I would recommend you do not make hospitals change to G-codes or change anything until you have final guidelines. Changes are very diffucult to teach as busy as hospitals are and clinical personnel do not like change. When developing the levels, I would recommend you consider only 3 or 4 plus critical care. It is very hard to move between 6 levels and keep it consistent. At our facility, I have developed 4 levels due to Medicaid and Medicare differences. In addition I have critical care. None of my interventions are "chargeable" procedures and this works really well. I would be happy to share my levels with anyone from CMS. I have a clinical, coding, and financial background and developed them to be user friendly and fair to all.
I also recommend that you do not incorporate "time" as a factor in levels, including critical care. It is unreasonable to expect a busy ED track time on interventions.
Thank you,

Marilyn Niedzwiecki
mniedzwi@childrensmemorial.org

OPPS: Drug Administration

OPPS: Drug Administration

I would recommend that Medicare convert to CPT codes. Most payers want the CPT code and Illinois Medicaid requires this. It is a burden to have to walk the codes between payers. The CPT codes are very complete and tell the coding story much better than the C-codes. This would be a great change.

CMS-1506-P-14 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Miss. Dena Simpson**

Organization : **Hutcheson Medical Center**

Date & Time: **08/25/2006**

Category : **Hospital**

Issue Areas/Comments

Visits

Visits

With the implementation of the Medicare hospital outpatient prospective payment system (HOPPS) in August 2000, hospitals have been coding emergency department using the same CPT E/M codes as physicians. But, these E&M codes describe professional services, NOT the services provided by the facility. Physician reporting refers to CPT descriptors related to history, examination and complexity of medical decision-making. Hospitals reporting refer to facility resources consumed by hospital staff. 1
2. CMS requires each hospital to develop its own internal set of guidelines to report services by mapping them to the levels of effort represented by the CPT Codes. The only Medicare requirements are that these services must be documented and medically necessary, and that the mapping should reasonably reflect the intensity of the hospital s resources. 2
3. Under OPPS, 31 codes are used to indicate visits, with payment differentials for more or less intense services. Because CPT is more descriptive of practitioner than of facility services, hospitals must use CPT guidelines when applicable, or crosswalk hospital coding structures to CPT.3
4. Hutcheson Medical Center consistently uses a Resource Intensity point scoring system. Our critical care model is clinical intervention based. The nature of the patient s critical condition determines the need for these interventions and documentation in the patient medical record substantiates the critical care services. Therefore if the physician documents critical care and the patient meets all the criteria for a critically ill or injured patient, but falls below the 30-minute timeframe, critical care is still reported. This differs from an ICU situation critical care situation of monitoring the patient. In the ER, critical care is aggressively utilizing all resources available to save a life.
Scenario: EMS contacts ER to advise of transport of critical patient. ER prepares by gathering our resources of staff, equipment and supplies in anticipation of patient s arrival in life threatening situation. Patient arrives in full code but the team works with the patient until it is apparent their efforts are futile. Although we were prepared to attend the patient for as long as demanded, the code lasted only 6 minutes. However, we expended a high consumption of resources in the attempts to save a life.

Based on the above evidence, we respectfully request a reversal of the decision for denial on critical care for this claim and all claims with the 30- minute requirement for critical care.

1 Recommendation for Standardized Hospital E&M Coding by Panel appointed by CMS, page 1 of 16, 5 of 16 and 11 of 16
2Federal Register, Vol. 70, No. 19 page 4861(January 31, 2005)
3Medicare OPPS, Section 160- Coding for Clinic and Emergency Visits (Rev.1, 10-03-03)

CMS-1506-P-15

Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates

Submitter :

Date & Time: **08/25/2006**

Organization :

Category : **Critical Access Hospital**

Issue Areas/Comments

Visits

Visits

What time counts towards the definition of critical care? Why would the physician's time be the sole criteria for the hospital to report its significant staff resources expended for critically ill or injured patients? The documentation requirements or the basis to count time are not defined.

CMS-1506-P-16 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Mrs. Janice Eckrote** **Date & Time:** **08/25/2006**

Organization : **Susquehanna Health**

Category : **Hospital**

Issue Areas/Comments

OPPS Impact

OPPS Impact

"Visits" - The comment is regarding new critical care codes Gccc1 & Gccc2. Under the proposed rule, CMS appears to move hospitals to the same definition of critical care time as physicians; i.e. critical care time cannot be reported until after 30 minutes of critical care time has elapsed. At the onset of OPPS in 2000 (p. 18452 of the April 7, 2000 rule), CMS intended for hospitals to report critical care when the patient met the definition of being critical ill with time not being a factor. It made sense since the services provided by hospital personnel often involve three, four, or more staff simultaneously attending to the patient, i.e. the services were expended immediately not just after 30 minutes. Additionally, there are associated resources immediately provided to the critically ill patient. Additionally, if CMS intends to impose a new time-based reporting requirement for hospital critical care, a definition of documentation requirements or the basis to count time must be given so that hospitals know what time counts towards critical care.

CMS-1506-P-17 **Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates**

Submitter : **Carolyn Walker**

Organization : **Multicare Health System**

Date & Time: **08/28/2006**

Category : **Hospital**

Issue Areas/Comments

Visits

Visits

This is with regard to the proposed time threshold for reporting the new critical care codes (Gccc1 & Gccc2). Although it makes sense to discuss time spent on a case in the professional fee setting, facilities have significant challenges reporting time spent. We currently track start and end times for various procedures (notably infusions); however, when a critical pt presents for care, the case may merit the attention of several staff at once. Since the hospital's fees are set to cover the cost of caring for the patient; this creates an enigma - is the time considered as the elapsed time from when the pt arrives? Is it the elapsed time multiplied by the number of staff the pt's care requires? What about accounting for other resources involved in pt care? Thankfully our clinical staff are more interested in providing quality pt care than they are in whether our reimbursement is being reduced, so the good news is our pts will still receive the care they need. The drain on staff, however, must be considered as our clinical managers are called upon to balance their need to staff at levels commensurate with the care delivered and the decline in reimbursement that would surely result from such a short-sighted plan. CMS even recognized this requirement as outside the realm of clinical staff rendering care when it stated '...We believe it would be burdensome for hospitals to keep track of minutes for billing purposes. Therefore, we will pay for critical care as the most resource intensive visit possible as defined by CPT code 99291. (p.18452 OPPS Final Rule [04/07/2000])'. It would appear that CMS is either reversing its earlier finding or moving forward with what it perceives as an assist in deficit reduction. Thank you for the opportunity to comment.

Submitter : **Mrs. Kim Freeman** **Date: 08/30/2006**

Organization : **St. Luke's Hospital - Allentown Campus**

Category : **Nurse**

Issue Areas/Comments

OPPS Impact

OPPS Impact

Our ED has reviewed the proposed E&M coding guidelines. We find the proposed changes and find it cumbersome.

Submitter : **Ms. M.B. Schuh** **Date: 08/31/2006**

Organization : **St.Anthony's Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Visits

Visits

I suggest you identify a modifier to be used for separately payable services that are used to in determining a visit level for clinic or emergency room. The OCE could be configured, as it is now for a number of CPT codes, to check whether the appropriate modifier has been assigned. A review of past claims data should be able to identify those services that have been separately paid when reported with one of the existing clinic, emergency or critical care visit codes that should have the OCE edit attached to the code. The modifier would indicate that the service should not be separately paid for the visit as it is packaged in the visit

Submitter : **Ms. M.B. Schuh** **Date: 08/31/2006**

Organization : **St. Anthony's Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

Visits

Visits

Differentiation between new and established patients, etc. You cite the median cost difference between varying level 3 visits. I don't think you should ignore these differences in establishing the guidelines since you've proven a new patient is more resource intensive than an established patient.

Submitter : **Mrs. Tamar Thompson** **Date: 09/01/2006**

Organization : **Bracco Diagnostics, Inc.**

Category : **Drug Industry**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comment letter regarding Myocardial PET Scans and the 2 Times Rule.

CMS-1506-P-21-Attach-1.DOC

Attach # 21

LIFE FROM INSIDE

August 30, 2006

Administrator Mark McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments on Proposed 2007 HOPPS Rule – CMS-1506-P

Dear Administrator McClellan:

Thank you for providing Bracco Diagnostics Inc. with this opportunity to submit comments on the 2007 proposed hospital outpatient prospective payment system (HOPPS) rule published in the August 23, 2006 Federal Register. Bracco Diagnostics Inc. is a global manufacturer of contrast imaging agents and radiopharmaceuticals used in medical imaging procedures. The products that we offer are used in many outpatient hospital procedures performed in radiology departments, cardiac catheterization laboratories, and nuclear medicine departments across the United States. In this letter, we are specifically commenting on the exemption of Ambulatory Payment Classification (APC) 0307 myocardial PET imaging procedures from the 2 times rule and the proposed payment changes for myocardial Positron Emission Tomography (PET) perfusion imaging, multiple studies.

<u>HOPPS 2 Times Rule</u>

Last year, we commended the Centers for Medicare and Medicaid Services (CMS) for creating two separate APCs (0306 and 0307) for myocardial PET imaging procedures. We maintain this position and continue to support *separate* APC groupings for myocardial PET imaging procedures in 2007.

Splitting the single studies and viability studies into an APC separate from the multiple studies is consistent with the clinical resources and homogeneity of this and other nuclear medicine studies such as:

1. Myocardial perfusion Planar: single study (78460) is classified under APC 0398 and reimbursed at $100.06. Multiple studies (78461) are classified under APC 0377 and reimbursed at $158.84.
2. Tomographic SPECT: single study (78464) is classified under APC 0398 and reimbursed at $100.06. Multiple studies (78465) are classified under APC 0377 and reimbursed at $158.84.

107 College Road East Princeton NJ 08540 Telephone (609) 514-2200 Fax (609) 514-2429

3. Cardiac blood pool imaging Planar: single studies (78472) is classified under APC 0398 and reimbursed at $100.006. Multiple studies are classified under APC 0376 and reimbursed at $119.77.

Additionally, maintaining the two separate APCs allows CMS to collect claims data and to set payment based on more appropriate clinical and economic resources for these procedures in the future. CMS should also consider the significant number of coding policy changes that it implemented regarding PET imaging procedures in 2005 and the impact that these changes may have had on claims data for that calendar year:

1. CMS released claims processing transmittal 518 on April 8, 2005. This transmittal instructed hospitals to discontinue the use of specific "G" codes in the Healthcare Common Procedural Coding System (HCPCS) resource and begin using Current Procedural Terminology (CPT) codes to report covered PET procedures.

2. Then, on April 15, 2005 CMS rescinded transmittal 518 and replaced it with claims processing transmittal 527 that notified hospitals of HCPCS/CPT changes for PET and PET/CT scans and editorial changes within Publication 100-04, chapter 13, section 60, have been made to reflect coding changes and coverage policy changes within Publication 100-03, section 220.6.

3. These transmittals did not provide instruction to hospitals on how to code and report the use of appropriate radiopharmaceuticals used in PET procedures. Consequently, hospitals were confused and did not know if radiopharmaceuticals should be coded and reported for separate payment or if the radiopharmaceuticals were packaged into the procedural payment.

4. Later, On October 31, 2005 CMS responded to this confusion by updating its Medicare claims processing manual to instruct providers to begin billing the appropriate HCPCS codes that accurately described the radiopharmaceutical used in the PET imaging procedures.

5. Recently, in 2006 CMS released two additional claims processing transmittals that communicated the appropriate codes and billing requirements for radiopharmaceuticals used in PET imaging procedures

    A. Transmittal 822 dated February 1, 2006 that notified hospitals of updates to radiopharmaceutical imaging agents HCPCS codes applicable to PET imaging procedures. This transmittal was re-communicated and maintained the same number/date and instructed hospitals to replace HCPCS code Q3000 with A9555 for reporting the use of Rubidium 82 (Rb82) in myocardial PET perfusion imaging procedures (CPT codes 78491 and 78492) and to replace C1775 with A9552 to report Fluorodeoxyglucose F18 (FDG) used in myocardial PET viability studies (78459) and other non-cardiac PET procedures (78608, 78609, and 78811-78816). This transmittal also included instruction to the physician office directing the use HCPCS code A4641 to report the use of Rb82 and FDG. However, the transmittal only instructed Fiscal Intermediaries to update their systems to reflect these changes. It did not instruct Medicare Carriers to update their systems in response to this change. This

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additional instruction was confusing to some hospitals. Consequently, many hospitals thought that these radiopharmaceuticals were packaged because A4641 is not separately payable under HOPPS. These hospitals either chose not to report the use of these radiopharmaceuticals or began reporting A4641to identify Rb82 or FDG used in PET procedures.

B. CMS later released transmittal 923 on April 28, 2006. This transmittal clarified instruction to Medicare Carriers to update their systems to reflect the HCPCS coding and billing changes for these radiopharmaceuticals.

It is likely that hospitals were slow in adapting the coding guidance and updating their chargemasters for myocardial PET imaging procedures. As several hospital representatives stated during the August 23 and 24 2006 APC Advisory Panel meetings, it typically takes hospitals 1-2 years to fully implement coding guidance and to update their chargemasters respectively. This slow transition may have resulted in inconsistent billing practices and flawed claims cost data for 2005. The 2006 claims data might also be flawed due to the additional coding and billing changes for radiopharmaceuticals used PET imaging procedures. Therefore, we believe that the 2007 claims data is most likely a better source to determine the clinical and economic resources utilized in myocardial PET perfusion studies and viability studies. **For these reasons, we recommend that CMS promote the stabilization of hospital coding and reporting practices for myocardial PET imaging procedures by retaining APC classification 0306 and 0307 for myocardial PET imaging procedures. CMS should continue to place both single study myocardial PET imaging procedures (78491) and viability studies (78459) within APC classification 306. Multiple studies for myocardial PET perfusion imaging (78492) should remain in APC classification 0307.**

Myocardial PET Scans

We are concerned that CMS' proposed payment reductions for myocardial PET procedures will compromise Medicare beneficiary access to high quality services involving new technologies. Hospitals need payment consistency to support budgetary allowances that have been made for calendar year 2007. Implementing the proposed payment rate of $718.75 for each myocardial PET imaging procedure would result in hospitals ceasing to provide these procedures because they could no longer afford to furnish them under these rates.

We do understand that CMS believes that using current claims data is the most appropriate method for determining reimbursement rates for procedures performed in the outpatient hospital environment. Respectfully, as we have stated in the above comments, we believe that the 2005 claims data is flawed. The year to year inconsistency in the median cost reported by hospitals only further implies that there are significant deficiencies in the 2005 claims data.

In past hospital outpatient prospective payment final rules and regulations CMS has stated that a substantial fall in payment rates for some APCs suggest the need for some approach to moderate the changes[1]. We believe that the 71% reduction that CMS

[1] November 1, 2002 Hospital Outpatient Prospective Payment System Final Rules and Regulations, Federal Register Vol. 67, No. 212, page 66749.

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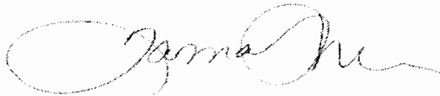
proposes for multiple myocardial PET perfusion imaging procedures (78492) based on 2005 claims data qualifies as a substantial fall in payment. **Therefore, we are recommending that CMS dampen the 2006 payment rate ($2,484.88) for myocardial PET imaging procedures by 15% each year over the next 2-3 years. Implementing a dampening payment policy (as CMS has done in the past for devices) would allow CMS to reimburse hospitals at an equitable rate while continuing to collect increasingly stable claims data that could be used to set appropriate payment rates based on accurate resource utilization.**

Bracco recognizes the challenges that CMS faces in revising payment methodologies and would welcome the opportunity to meet with CMS to expand upon our recommendations in greater detail. Thank you for the opportunity to comment on this important rule. Should you have any questions, please do not hesitate to contact me at 609-514-2274 or via email at tamar.thompson@diag.bracco.com.

Respectfully,



Tamar Thompson, RMA, CCS, CCS-P
Manager, Reimbursement Services
Nuclear Medicine

attachment:

CMS Dampening Policy:
November 1, 2002 Hospital Outpatient Prospective Payment System Final Rules and Regulations, Federal Register Volume 67, No. 212, page 66749:
http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1206fc1.pdf#search=%22November%201%2C%202002%20Hospital%20Outpatient%20Prospective%20Payment%20System%20Final%20Rules%20Regulations%2C%20Federal%20Register%20Vol.%2067%2C%20No.%20212%2C%20page%2066749%22

Submitter : **Valerie Rinkle** **Date: 09/05/2006**

Organization : **Asante Health System**

Category : **Hospital**

Issue Areas/Comments

Visits

Visits

Please see attachment.

CMS-1506-P-22-Attach-1.DOC

A-Hearing 22

Asante believes that CMS needs to provide hospitals with general guidance on the use of the clinic or hospital outpatient visit guidelines. The reason general guidance is needed is due to the fact that treating physicians and non-physician practitioners order outpatient hospital services for their patients that the specific guidelines will never be able to delineate. These services are currently described in the Medicare Benefit Policy – Basic Coverage Rules in Publication 100-02 Chapter 6. Most hospital personnel are not as familiar with these rules and publications. Without general guidance published with the visit level guidelines, CMS and their contractors will be inundated with questions about hospital encounters that are not specifically addressed by the visit level guidelines. In this environment of compliance, hospitals will be reluctant to use visit level guidelines for these encounters unless CMS specifically authorizes hospitals to do so. It appears that CMS intends for the guidelines to be just that – "guidelines" and that CMS intends for the guidelines to be applied by hospitals with flexibility to ensure beneficiaries are not robbed of legitimate outpatient hospital services and that hospitals continue to be paid under OPPS for legitimate covered outpatient hospital services.

Below are suggested general guidelines to be applied before the specific visit level guidelines are applied. We have also supplied the citations that the general guidelines refer to and rely upon.

GUIDELINES FOR BILLING OUTPATIENT HOSPITAL VISIT SERVICES

HCPCS CODES: Gxxx1-Gxxx5 & Gzzz1-Gzzz5

Criteria for an outpatient hospital encounter to be coded with a visit code:

1. **Patient is a registered outpatient of the hospital as defined in 42 CRF 210.2**
2. **Patient visit meets the definition of a outpatient hospital encounter as defined in 42 CFR 210.2**
3. **Services are medically necessary & ordered for the patient by a treating physician/non-physician practitioner as defined in Publication 100-2, Chapter 6 – Hospital Services Covered under Part B section 20.3 outpatient diagnostic services or 20.4 outpatient therapeutic services**
4. **Services are documented in the hospital's medical record**
5. **No other specific CPT/HCPCS code exist (i.e., CPT/HCPCS coding rules are followed) for the service provided**

Note that if a specific CPT/HCPCS code exists for the service, for example, debridement by an RN or a cast applied by a technician, the hospital should bill with the appropriate CPT code for debridement or casting. However, there are numerous services that a physician or non-physician practitioner orders for the hospital to provide to an outpatient such as "remove PICC line," or "educate on ostomy use," or "educate on diet to control unacceptable weight loss" for which there is no specific

CPT/HCPCS code and for which a visit code is the only choice. Physicians and non-physician practitioners order these and many other unique, yet medically necessary services to be performed by the hospital. These are not merely orders without the ongoing involvement of the physician/non-physician practitioner. The services fully meet the definition of outpatient therapeutic services.

There are some services that the physician or non-physician practitioner may have the ability or office resources to perform, but they choose rather to order the hospital to perform the services. There are other services for which the hospital has better experienced and specialized personnel to perform the services for the beneficiary. In either case, the hospital, once it has a valid order from a treating physician/non-physician practitioner, is obligated to provide the service and as long as the service meets the definitions of an outpatient encounter and a covered outpatient hospital service, it should be billable to CMS with either the specific CPT/HCPCS or a visit code. We believe the general guidelines will allow the specific visit guidelines to have the flexibility to appropriately apply to these situations. We urge CMS to publish such general guidance.

Citations w/emphasis added in bold.

42 CFR 210.2 Defines Hospital Outpatient

Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient **and receives services** (rather than supplies alone) **directly from the hospital or CAH.**

42 CFR 210.2 Defines Outpatient Hospital Encounter

Encounter means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

Medicare Benefit Policy - Basic Coverage Rules (PUB. 100-02)
Chapter 6 - Hospital Services Covered Under Part B
20 - Outpatient Hospital Services

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of the patient. **Part B covers both the diagnostic and the therapeutic services furnished by hospitals to outpatients.**

20.3 - Outpatient Diagnostic Services

A service is "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.

20.4 - Outpatient Therapeutic Services

Therapeutic services which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians in the treatment of patients. Such services include clinic services and emergency room services.

To be covered as incident to physicians' services, the services and supplies must be furnished as an integral, although incidental, part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. **The services and supplies must be furnished on a physician's order by hospital personnel and under a physician's supervision.** This does not mean that each occasion of service by a nonphysician need also be the occasion of the actual rendition of a personal professional service by the physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. A hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment. The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises; the hospital medical staff that supervises the services need not be in the same department as the ordering physician. However, if the services are furnished outside the hospital, they must be rendered under the direct personal supervision of a physician who is treating the patient.

Submitter : **Ms. Teresa Walker** **Date: 09/05/2006**

Organization : **St. Charles Medical Center**

Category : **Hospital**

Issue Areas/Comments

Visits

Visits

I believe requiring the hospital to monitor Critical Care time documented by physicians would be an incredibly burdensome task at the worst possible time, during clinically critical period when resources are generally stretched to the max.

Submitter : **Dr. Adam Schussheim** **Date: 09/06/2006**

Organization : **Dr. Adam Schussheim**

Category : **Physician**

Issue Areas/Comments

Myocardial PET Scans

Myocardial PET Scans

The cut from $2484.88 to $718.75 for APC 0307 will decimate myocardial PET and force the closure of multiple facilities. This valuable service will not be able to be provided to the people of Connecticut (my home statc). It is beyond logic how the cost of performing a test could fall by 75% in one year. The data cannot be reliable and for CMS to blindly follow these data is irrcsponsible. Myocardial PET is more complicated than any other PET scan and requires state-of-the-art equipment costing more than $2 Million. Scan acquisition is longer and requircs more sophisticated staff. Finally, the tests have proven downstream cost savings often obivating the need for cardiac catheterization which saves the health system a $15,000 admission and saves the paticnt from exposure to unnecessary risks of complications.

Such a rapid fall in rates also precludes prudent planning for the future and undermines confidence for the development of any technological advances.

I would urge reconsideration of this rate. I agree that the cost differential between a single and multiple studies is not three-fold but is it not equivalcnt. APC 0307 at $2000 is more reasonable with APC 0306 at its current lcvel. Or if you really need to eliminate APC 0306, then average the two towards $1500.

In summary, the proposed cuts are Draconian and capricious. They are based on dubious data for how else could somcthing fall in cost more than 75% in onc ycar. At the proposed lcvel, it will not be possible to provide the service.

Thank you for your considcration.

- Adam Schussheim, MD

Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

OPPS: Cost-to-Charge Ratios

OPPS: Cost-to-Charge Ratios

Please see the attached comments from the PRT

CMS-1506-P-25-Attach-1.DOC

HHS-F
25

Asante Health System, OR
Avera Health, SD
Baptist Healthcare System, KY
Carolinas Healthcare System, NC
Community Hospital Anderson, IN
Forrest General Hospital, MS
Health First, Inc., FL
Mercy Medical Center, IA
Our Lady of Lourdes Regional Medical Center, LA
Saint Joseph's Hospital, WI
Saint Mary's Hospital, MN
Sisters of Mercy Health System, MO
Southwestern Vermont Medical Center, VT
University of Colorado Hospital, CO
University Health System, TX
White River Medical Center, AR

October 10th, 2006

CHECK THIS INFO:
Submitted electronically and in hard copy: http://www.cms.hhs.gov/regulations/ecomments
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: File Code CMS-1506-P

Dear CMS:

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers from around the country who gathered to provide comments on the 2007 Outpatient Prospective Payment (OPPS) Proposed Rule, as published in the *Federal Register* on August 23, 2006. The providers listed above appreciate the opportunity to submit these comments for consideration by CMS. A full list of the current PRT members is provided in **Appendix A**.

Introduction

The Provider Roundtable (PRT) is a group of 17 different hospitals and health systems representing over 50 hospitals from around the country. Like many others, our hospitals, and the departments within our institutions, continue to struggle with OPPS and its many coding and billing complexities. Providers are often too busy, or unaware of the overall process, to submit comments to CMS on their own. Therefore, the members of the PRT collaborated to provide substantive comments with an operational focus which CMS' staff should consider during the OPPS policymaking and recalibration process each year.

We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

1. Relative Weights & Cost-to-Charge Ratios

CMS is " ... *specifically inviting comments on ways that hospitals can uniformly and consistently report charges and costs related to all cost centers, not just radiology, that also acknowledge the ubiquitous tradeoff between greater precision in developing CCRs and administrative burden associated with reduced flexibility in hospital accounting practices.*"

The PRT believes that one of the best means for CMS to provide guidance to hospitals to consistently report charges and costs related to all cost centers is to provide specific examples in the OPPS final rule preamble and in transmittals that explain how provider line item charges on claims and hospital CCRs are used to develop APC payment rates.

Using simple singleton claim examples will help illustrate two things to hospitals: (1) the importance of correctly pricing their procedures and supplies and drugs and (2) ensuring that the cost center where the cost of the service is reflected in the cost report is the same cost center used by CMS in the revenue center crosswalk. Providing such examples may also encourage hospitals to provide comments back to CMS on its crosswalk. If the cost center or CCR is not the correct CCR, then CMS should encourage hospitals to reclassify expense and revenue whenever appropriate or provide comment to CMS as to why the cost center is not appropriate to use in the crosswalk. In this manner, CMS is not mandating changes in hospital accounting practices, but encouraging hospitals to self-adjust those practices based on the knowledge of how the claims and cost report data is used. Finally, CMS must also instruct Fiscal Intermediary staff to allow hospitals to reclassify expense and revenue whenever appropriate.

Examples should be taken from revenue centers or cost areas where there has been a lot of controversy such as blood and blood products and implants/devices.

CMS could use a pacemaker example such as the one below.

Rev Code	HCPCS	Charges	Primary Cost Center Line for CCR from CrossWalk	Secondary Cost Center Line for CCR from CrossWalk	Calculated Cost
250		$134.15	5600 Drugs charged to patients = 0.34		$45.61
258		$174.22	5600 Drugs charged to patients = 0.34		$59.23
275		$8,200.00	3540 Prosthetic Devices = NA	5500 Supplies charged to patients = .23	$1,886.00
320	71090	$175.60	4100 Diagnostic Radiology = .51		$89.56
361	33213	$5,216.24	3700 Operating Room = .42		$2,190.82
Total		$13,900.21			$4,271.22

In this example, hospitals would be able to clearly see that if they defined cost center 3540 for prosthetic devices in their cost report, then their pacemaker charges are being reduced to cost using that CCR rather than the more appropriate CCR which is likely to be 5500 Supplies charged to patients. Hospitals do not typically report pacemaker costs with prosthetic costs. Pacemakers are implants that must be reported under revenue code 275 for pacemaker, not prosthetics. CMS uses the CCR for 5500 for revenue code 278 charges for other implants like stents, therefore, it is a better cost center for pacemaker 275 than prosthetics.

By providing such an example, hospitals would be able to clearly see that all expense and revenue related to items billed under revenue code 275 should be either be reclassified on hospital cost reports into cost center 3540 or 5500. Hospitals would also be able to understand why their pacemaker cost that is significantly more than $1,886 (in the example) is calculated as such. This will encourage hospitals to apply proper mark ups to their devices so that CMS payment calculations result in a close approximation of actual costs which will help improve the APC median cost calculations over time.

The PRT notes that it is crucial that if CMS provides these examples and hospitals respond by trying to correctly classify revenue and expense, that the Fiscal Intermediary (FI) audit staff allow reclassifications to take place and do not reverse them in audit adjustments.

CMS could use another example for blood products and blood administration.

Rev Code	HCPCS	Charges	Primary Cost Center Line for CCR from CrossWalk	Secondary Cost Center Line for CCR from CrossWalk	Calculated Cost
258		$76.25	5600 Drugs charged to patients = 0.34		$25.93
272		$53.64	5500 Supplies charged to patients = .23		$12.34
390	P9040	$280.00	4700 Blood Storage, Processing = .54		$151.20
391	36430	$662.22	4700 Blood Storage, Processing = .54		$357.60
Total		$1,072.11			$547.06

From this example, hospitals would be able to understand the impact of not marking up their blood product processing costs from Red Cross. Furthermore, hospitals would likely comment that using cost center 4700 with revenue code 391 is not appropriate. From the Revenue Crosswalk published on CMS' web site, CMS uses hospital's charges under revenue code 391 for blood product administration services and reduces those charges to cost using the cost-to-charge ratio from cost report line 4700 for blood products. This is not a logical choice for charges reported in revenue code 391. Blood administration services billed using revenue code 391 are for nursing services. The primary CPT code billed under revenue code 391 is 36430 for transfusion of blood or blood components. Transfusions are performed by nursing personnel on clinic outpatients or on observation outpatients. The expense of nursing personnel should not reside in the blood bank cost center and it would not make sense to reclassify those revenue and expenses to the blood bank cost center. The blood bank cost center retains the cost of blood and

blood product processing and the supplies, staff and equipment to track and keep these blood products safe, but NOT the actual administration expense. It is inappropriate to map revenue code 391 to 4700. A better mapping would be to 6200 or 6201 for observation and to 6000 for clinic.

Another suggestion is for CMS to conduct a survey of its FI auditing staff and the validity of revenue code to cost center crosswalk. For example, CMS can survey FIs to find out what cost centers hospitals typically report pacemakers (275), defibrillators and other implants (278), isotopes (343 and 344) and other items for which the APC payment rates have been controversial. CMS would learn from such a survey where adjustments in the crosswalk should be made over time.

Finally, the PRT has reviewed the revenue code to cost center crosswalk and provided line-by-line comments where appropriate. This is being submitted as a separate Excel attachment. We hope that CMS makes adjustments in the crosswalk as indicated by these comments.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A**.

Sincerely yours,

Members of the Provider Roundtable

Appendix A: Current Members of the Provider Roundtable

Jennifer L. Artigue, RHIT, CCS
Dir. Revenue Mmgt, CDM & Medical Records
Our Lady of Lourdes Regional Medical Center
Lafayette, LA

Kathi L Austin, CPC, CPC-H, CCP
Corporate Director Revenue Integrity
Sisters of Mercy Health System
St. Louis, MO

Barbara Bunge, RHIA, CCS, CCS-P
Coding Quality Specialist, HIM
Mercy Medical Center
Cedar Rapids, IA

Kathy Dorale, RHIA, CCS, CCS-P
Director of Health Information Management
Avera Health
Sioux Falls, SD

Janet V. Gallaspy, BS, RN, CPUR, CPC-H
Medical Auditor, Corporate Compliance
Forrest General Hospital
Hattiesburg, MS

Jerry Hill, MA
Charge Management Coordinator
University Health System
San Antonio, TX

Marion G. Kruse, BSN, RN, MBA
Columbus, OH

Carol Leffeler, RN, BA
CDM Coordinator
White River Medical Center
Batesville, AR

Monica Lenahan, CCS
Coding Manager
University of Colorado Hospital
Denver, CO

Bonnie Malterer, RHIT, BA
APC Coordinator, Outpatient Coding Supervisor

St. Mary's Hospital
Duluth, MN

Yvette Marcan, RN, MA, RHIA, CCS
APC Coordinator
Health First, Inc.
Melbourne, FL

Terri Rinker, MT(ASCP), DLM, MHA
Reimbursement Manager
Community Hospital Anderson
Anderson, IN

Valerie A. Rinkle, MPA
Revenue Cycle Director
Asante Health System
Medford, OR

Julie Rodda, RHIT
Coding Specialist
St. Joseph's Hospital
Marshfield, WI

John Settlemyer, MBA/MHA
Director, Financial Services/CDM
Carolinas Healthcare System
Charlotte, NC

Marianne Seymour, RHIT, CCS
Medical Necessity Coordinator
Southwestern Vermont Medical Center
Bennington, VT

Denise Williams, RN, CPC-H
Charge Management Coordinator
Baptist Healthcare System
Louisville, KY

Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on Behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

OPPS: Cost-to-Charge Ratios

OPPS: Cost-to-Charge Ratios

Please accept the attached Excel file as a supplement to our previously submitted comments.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Transparency of Health Care Information

Transparency of Health Care Information

Please see attachment.

CMS-1506-P-27-Attach-1.DOC

HHOPPS
27

Asante Health System, OR
Avera Health, SD
Baptist Healthcare System, KY
Carolinas Healthcare System, NC
Community Hospital Anderson, IN
Forrest General Hospital, MS
Health First, Inc., FL
Mercy Medical Center, IA
Our Lady of Lourdes Regional Medical Center, LA
Saint Joseph's Hospital, WI
Saint Mary's Hospital, MN
Sisters of Mercy Health System, MO
Southwestern Vermont Medical Center, VT
University of Colorado Hospital, CO
University Health System, TX
White River Medical Center, AR

September 7, 2006

Submitted electronically and in hard copy: http://www.cms.hhs.gov/regulations/ecomments
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Transparency Initiative

The PRT agrees that health care consumers should have access to information on the price and quality of healthcare items and services. We are in firm support of publishing geographically-based Medicare payment information on the CMS website. We are, however, concerned about publishing facility-specific pricing for services without specific guidelines to facilities instructing us on exactly what to include in describing the price for a service. Facilities should be provided with and expected to follow a standard definition and description of a "price" for an item are a service to allow beneficiaries to adequately compare prices – particularly for outpatient services as hospitals have discretion about whether to "package" certain services/charges together and report a single line item or to separately report each item. It is not clear to us how CMS will be able to provide price comparisons of like services. Consumers cannot be expected to sort through concepts of packaging or sum together prices for several line items in order to come up with an equivalent "apples to apples" comparison of similar services. In other words, for outpatient services, if providers are including different items in the price of a single service (represented by a line item), accurate comparison cannot occur. We ask CMS to carefully review this issue and determine how best to proceed so that consumers are able to achieve what is expected from the transparency initiative.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A**.

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Cedar Rapids, IA

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Louisville, KY

Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

Please see attached comments from the PRT.

CMS-1506-P-28-Attach-1.DOC

Attach 28

Asante Health System, OR
Avera Health, SD
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September 7, 2006

Submitted electronically and in hard copy: http://www.cms.hhs.gov/regulations/ecomments
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: File Code CMS-1506-P

Dear CMS:

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers from around the country who gathered to provide comments on the 2007 Outpatient Prospective Payment (OPPS) Proposed Rule, as published in the *Federal Register* on August 23, 2006. The providers listed above appreciate the opportunity to submit these comments for consideration by CMS. A full list of the current PRT members is provided in **Appendix A**.

Introduction

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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Outpatient Quality Initiative

The PRT believes the Quality Initiative is an important and laudable project, however, we are concerned about the significant increase in hospital resources that will be required to collect additional data if Medicare implements separate outpatient quality measures. We ask CMS to bear in mind that the volume of outpatient cases is much higher when compared to inpatient volume. Based on the current model of 100% data collection, we believe hospitals will need to hire additional staff and/or increase vendor workload resulting in increased cost simply to meet the additional data demands. Moreover, this issue will be further compounded by the projected increase in Medicare beneficiaries over the next decade.

Now that CMS is linking hospital outpatient department payments to the submission of quality indicators and expects to expand this in the future, we believe the timing is appropriate to now require physicians to participate in a similar Quality Initiative program so that their payments are also linked to quality indicators. We believe the upcoming completion of the MAC project is an excellent opportunity to link physician reimbursement to quality indicators where their actions directly impact patient outcomes. This will allow CMS to tie both physician and hospital reimbursement to quality indicators. Finally, the PRT encourages CMS to calculate an outpatient case-mix index for each hospital as part of its Quality Initiative program.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A**.

Sincerely yours,

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Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Medication Therapy Management Services

Medication Therapy Management Services

Please see attached comments from the PRT.

CMS-1506-P-29-Attach-1.DOC

Attach # 29

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Re: File Code CMS-1506-P

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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Medication Therapy Management Services

The PRT presented a proposal to the APC Advisory Panel at the March 2006 meeting to recognize and provide separate APC payment for Category III CPT Codes related to MTM. CMS did not adopt the Panel's final recommendation on this issue. The PRT is pleased to see that CMS did not move forward as the Panel's recommendations did not reflect the original intent of our proposal. We agree, in principal, that CMS has no need to distinguish MTM services provided specifically by a pharmacist, as this would mean providers would have to keep up with differing methods of reporting incident-to services depending on the staff providing the service.

We appreciate that CMS has validated the fact that these services are already accounted for within the OPPS system. We seek clarification from CMS regarding the term "component of", as it relates to clinic visits, however. While we agree that MTM might be performed as a component of emergency visits, procedures, and diagnostic tests, we also know that MTM is often performed as a stand-alone service in the clinic setting meeting all of the incident-to and coverage requirements. To that end, we ask CMS to specifically state, as it did in July 2003 (see the embedded FAQ below from the CMS web-site though no longer visible online), that a clinic visit may be reported to identify these services, if they are separately identifiable from other OPPS services on the same date.

Answer ID
2101
Topic
Payment/Billing
Category
Prospective Payment System (PPS) Outpatient Hospital
Date Created
07/22/2003 06:40 AM
Date Updated
10/06/2003 06:44 AM

If a patient receives medication management services on the same date that their medication level is tested, may a hospital bill a low-level clinic visit (CPT code 99211) in addition to the CPT code for the laboratory test?

Question

When medication management services (such as anticoagulation therapy management services) are furnished to an outpatient in a hospital outpatient clinic on the same date that the patient's medication level is tested, may a hospital bill a low-level clinic visit (CPT code 99211) in addition to the CPT code for the laboratory test?

Answer

When face-to-face medication management is provided by qualified hospital staff on the same date of the laboratory test to an outpatient in a hospital outpatient clinic, a hospital may bill CPT 99211 if the services are medically necessary and constitute a distinct, separately identifiable E/M service that is consistent with the hospital's criteria for a low-level clinic visit.

Example: A registered outpatient who is being treated with coumadin for deep venous thrombosis (DVT) receives face-to-face counseling from qualified hospital staff, such as interpretation of the test, discussion of dietary concerns, evaluation of the patient, and modification of the treatment regimen, on the same date that prothrombin time is tested. The hospital could bill CPT 99211 for the medication management services in addition to CPT 85610 for the laboratory test. The interpretation of frequently recurring laboratory tests such as PT or INR and the communication of normal test results to a patient or patient's care giver is not by itself sufficient for the 99211 code. Factors which may support the 99211 code could include the need to adjust medication dose based on the test result or patient's clinical status.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A**.

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Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Packaged Services

Packaged Services

Please see attached comments.

CMS-1506-P-30-Attach-1.DOC

Attach 30

Asante Health System, OR
Avera Health, SD
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Re: File Code CMS-1506-P

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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Packaged services

The PRT would like to thank CMS for designating specific CPT codes as "special packaged codes" and for allowing separate payment for them when billed on a date of service without any other OPPS payable service. Many of the codes given this status are ones that the PRT has submitted to the APC Advisory Panel's Packaging Subcommittee. We support and appreciate the work of this subcommittee and urge that it continue to work on this and other data issues.

The PRT understands that CMS is clarifying for future claim submission that if a packaged service (status indicator "N") is the sole service performed at a visit and there are no other separately identifiable services to justify a hospital visit code, that the hospital cannot bill a visit code in lieu of the packaged service procedure, even when it is the sole service rendered and there are no other services on the claim, OPPS services or otherwise. Note that packaged OPPS services are packaged only to other OPPS services, not to other fee schedule service such as lab or rehabilitation. The PRT has a data concern with respect to this instruction. While we agree that the situation should be very rare, CMS is now preventing a hospital from even submitting the claim to CMS at all. How will CMS ever obtain the data to determine whether the service may need to be reclassified to a "special packaged code?" The PRT believes that it is important for hospitals to be able to report these situations even if they result in no separate OPPS payment at the time. Is it possible for a claim with a single "N" status line item that is "returned to provider" (RTP) to be read into the claims database so that CMS is able to evaluate these claims? If not, isn't it a concern to CMS that a valid outpatient hospital encounter is not reported to CMS, particularly when CMS is concerned about quality of outpatient care? There is a mandatory Part B claim submission requirement – in this case, the hospital is unable to report a claim to CMS. The PRT believes that the claims should be able to be resubmitted to CMS with a remark in the remarks field so that CMS can obtain the claims data for future analysis.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A**.

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Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Medicare Contracting Reform Mandate

Medicare Contracting Reform Mandate

Please see attached comments from the PRT.

CMS-1506-P-31-Attach-1.DOC

AHachmt 31

Asante Health System, OR
Avera Health, SD
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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Medicare Contracting Reform and Establishment of MACs

The PRT supports CMS' current effort to replace the current fiscal intermediary (FI) and carrier structure by creating Medicare Administrative Contractors (MAC's). PRT members are aware of significant inconsistencies in payment policy across FIs throughout the country and have brought these to CMS' attention via e-mail and through the Hospital and Quality Open Door Forum calls. The most aggregious inconsistencies are the ones where an FI simply misinterprets official national guidance released by CMS and releases contradictory instructions to its providers. This causes a great deal of confusion and results in CMS receiving poor, inconsistent, and incorrect data not to mention the harm done to Medicare beneficiaries who are charged differently across the country even though national guidance exists. In addition, when different fiscal intermediaries govern two hospitals in the same geographic area, even more confusion results.

By consolidating intermediaries and carriers into single MAC's, we expect to see more consistency in payment policy over time. Inconsistencies within a geographic area should also be eliminated as a result of assigning MAC's by region. Finally, we anticipate that CMS will instruct MACs to review LCD and other policies to ensure consistency in coverage between settings of care and to align payment policy and incentives between physicians and hospitals within the discretionary boundaries of the MACs.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A.**

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Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Treatment of Fracture/Dislocation

Treatment of Fracture/Dislocation

Please see attached PRT comments.

CMS-1506-P-32-Attach-1.DOC

Attach... 32

Asante Health System, OR
Avera Health, SD
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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Other APCs

The PRT would like to take this opportunity to thank CMS for making changes to the APCs involving fractures, as we believe the change from one to three APCs for these services better recognizes the differences in hospital resource utilization. Additionally, we appreciate the movement of CPT code 57267 from APC 0154 to 0195, as this better reflects clinical and resource homogeneity. Lastly, we applaud CMS for continuing to support the appropriate reimbursement of HBOT through the use of overall hospital CCR, as opposed to the respiratory therapy cost center.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A.**

Sincerely yours,

Members of the Provider Roundtable

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Baptist Healthcare System
Louisville, KY

Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

OPPS Status Indicator

OPPS Status Indicator

Please see attached comments from the PRT.

CMS-1506-P-33-Attach-1.DOC

Attach II

33

Asante Health System, OR
Avera Health, SD
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September 7, 2006

Submitted electronically and in hard copy: http://www.cms.hhs.gov/regulations/ecomments

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: File Code CMS-1506-P

Dear CMS:

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers from around the country who gathered to provide comments on the 2007 Outpatient Prospective Payment (OPPS) Proposed Rule, as published in the *Federal Register* on August 23, 2006. The providers listed above appreciate the opportunity to submit these comments for consideration by CMS. A full list of the current PRT members is provided in **Appendix A**.

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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

OPPS Payment Status Indicators and Comment Indicators

CMS has made yearly refinements to the Status Indicators (SIs) used under OPPS as well as the Comment Indicators. The PRT thanks CMS for these efforts and notes that the refinements help providers tremendously in the implementation of OPPS changes and in the ongoing management of systems and processes necessary for complete and accurate billing and appropriate OPPS payment. Providers use the SIs assigned to HCPCS codes to better understand Medicare payment policy. With the ASC proposal to move towards payment policy based on OPPS, the importance of SIs becomes even more crucial for understanding CMS' payment policy for different services. In the spirit of providing suggestions and ideas for continued refinements, the PRT would like to propose that the current SI "B" be split into two different SIs because the current definition of SI "B" means two different things. The current definition is:

> "B" = Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x). Not paid under OPPS [because]
>
> - Code may be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS.
>
> - An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.

From the above, it is clear that SI "B" means the HCPCS code is not paid either because (1) the code is not paid under OPPS, but may be paid when submitted on a different bill type, or (2) an alternative code will be paid under OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).

As a general rule, we believe each SI definition should be "pure" and have only one meaning. Therefore, we propose CMS change the definition of SI B so that it only means the first item above, (1) the code is not paid under OPPS, but may be paid when submitted on a different bill type and create a new, separate SI "Z" to mean the second item from above (2) an alternative code will be paid under OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).

These changes will facilitate an understanding of what each SI means for both hospitals and ASCs.

Furthermore, the PRT requests that CMS publish a separate addendum as part of the OPPS rule that lists the alternative HCPCS Level II codes for OPPS that should be used for all codes that are assigned the newly proposed SI "Z" as described above. This supplemental information will be very helpful to hospitals and ASCs as they will not have to search for the alternate code if CMS simply provides it as part of the final OPPS rule each year. This will also facilitate improved accuracy of the claims data CMS receives under OPPS.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

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Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Radiology Procedures

Radiology Procedures

Please see the attached comments from the PRT.

CMS-1506-P-34-Attach-1.DOC

Attach # 34

Asante Health System, OR
Avera Health, SD
Baptist Healthcare System, KY
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Re: File Code CMS-1506-P

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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Radiology Procedures

The PRT agrees with CMS' position to NOT apply a 50% discount percentage when two or more diagnostic imaging procedures from the same family of codes are provided during one session. We are aware this was CMS' proposal last year and understand based on its own analysis that certain economies of scale are already captured in the cost report when multiple diagnostic imaging procedures are provided. Therefore, we agree with CMS' position not to apply discounting to multiple diagnostic imaging procedures when provided during the same visit

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

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Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Device-Dependent APCs

Device-Dependent APCs

Please see the attached comments from the PRT.

CMS-1506-P-35-Attach-1.DOC

AH-2006 35

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Re: File Code CMS-1506-P

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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Device Dependent APCs

The PRT would like to comment on several issues related to device dependent APCs. First, we understand the logic behind the device offset and its application when a device-dependent APC procedure is performed and there is no device cost or the cost is minimal due to a recall or warranty replacement situation. However, we are unclear how the offset will be applied to device-dependent APCs with a status indicator of "T", which are subject to multiple procedure discounting. Is CMS proposing to first apply the device offset and then reduce the residual APC amount by another 50 percent? This would effectively pay a nominal amount for the actual procedure. The PRT is concerned that this would not be appropriate to cover the cost of the procedure, packaged drugs, or supplies, even in cases where there is no cost associated with the device.

The second issue the PRT is concerned about relates to devices under warranty reported with condition code 50. CMS proposes to implement an adjustment for device replacements through the use of an appropriate modifier that would be specific to a device replacement without cost or crediting of the cost of the device by the manufacturer. Hospitals would be required to report the modifier with the specific procedure when two conditions are met. The first condition occurs when the procedure is assigned to one of the APCs in Table 21 of the proposed Rule. The second condition occurs when the device for which the manufacturer furnished a replacement device (or provided credit for the device being replaced) is included in Table 22 of the proposed Rule. (The adjustment would only apply to devices included in Table 22 so that the adjustment is not triggered by the replacement of an inexpensive device whose cost does not constitute a significant proportion of the total payment rate for an APC.) The presence of the modifier would trigger the payment adjustment for the APCs in Table 21 of the proposed rule. CMS recognizes that the current FB modifier may not be appropriate for cases in which the replacement device is more expensive than the device that is being removed. CMS also recognizes that the modifier's use may need to be expanded to encompass all potential APC payment scenarios.

On occasion, devices that have been recalled or deemed defective are replaced with an upgraded device and the cost to the hospital for the upgraded device is greater than the cost of the replaced device. The device manufacturer may give the hospital a credit for the sales price of the device being replaced, and the hospital may than have to pay the manufacturer the difference in the prices of the two devices. Hospitals have asked CMS how to bill Medicare for these differences and in Transmittal R903CP, CMS instructed hospitals to report the HCPCS code for the upgraded device and condition code 50, denoting "Product Replacement for Known Recall of a Product – Manufacturer or the Food and Drug Administration has identified the product for recall and therefore replacement"; and the charge for the upgraded replacement device equaling the difference between the replaced device's usual charge and the upgraded device's usual charge. The Transmittal instructs providers not to report the FB modifier because the device is not being furnished without cost by the manufacturer.

The PRT agrees with this proposal, providing that CMS gives assurance that device costs with condition code 50 will be included with the modifier requirement or excluded from the claims data when determining median cost calculations in instances when there is a difference in the device cost billed to Medicare. If this does not occur, device costs will be underestimated. The PRT seeks confirmation that such devices reported with condition code 50 only will not be used in the median cost calculation and asks for clarification of this issue in the final Rule.

Finally, the PRT supports CMS' suggestion of expanding the current device edits in the OCE to include additional edits. We understand CMS is in the process of creating device HCPCS C-code to procedure edits and support this effort. We also encourage CMS to create similar edits for other procedures and services where natural linkages are expected. For example, we believe CMS can link certain radiology procedures requiring contrast agents with codes for the contrast agents. In addition, CMS could create also edits for nuclear medicine procedures and radiopharmaceuticals. We understand creating such edits is no easy task and that they must be carefully constructed. Therefore, we encourage CMS to continue researching expansion of edits in order to generate even more correctly coded claims to use in the APC rate setting process.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A.**

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Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Policy and Payment Recommendations

Policy and Payment Recommendations

Please see the attached comments on drug payment policy from the PRT.

CMS-1506-P-36-Attach-1.DOC

AHccAF
36

Asante Health System, OR
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We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Drugs, Biologicals, and Radiopharmaceuticals

The PRT understands CMS will use a variety of payment methodologies to pay for drugs, depending on whether the drug is a pass-through, packaged, or separately payable and depending on whether average sales price (ASP) data or other data is available. The PRT continues to believe CMS is incorrect in its assumption that using a percentage increase over the ASP to set payment rates for most separately payable and pass through drugs is sufficient to cover both our cost acquisition and pharmacy handling costs. We, like others, commented on this issue last year and urged CMS to find an administratively simple way to capture pharmacy handling data. We were disappointed that no progress has been made and urge CMS to continue exploring methods to capture this information so that future drug payment rates are more appropriate.

The PRT does not support CMS' proposal to pay for drugs at ASP + 5%. This 1% decrease over how we are paid today is not appropriate and furthermore, results in another site of service differential between the physician and hospital setting given that physicians are still being reimbursed at ASP+6%. The PRT cannot understand how or why CMS would allow such a differential to exist, particularly since physicians are paid for each and every drug, while hospitals are not due to the existence of the drug packaging threshold. Finally, given that CMS does not allow for multiple APC payments for multiple injections of the same drug/substance, we lose out on the administration payment and also on the drug reimbursement if the drug being injected is packaged. Therefore, the PRT urges CMS at a minimum to continue reimbursing separately payable drugs using ASP + 6% as is done today.

Related to the previous comment about packaged drugs, the PRT strongly believes CMS should eliminate the drug packaging threshold and allow separate payment for all HCPCS coded drugs, biologicals, and radiopharmaceuticals regardless of their median cost. While we understand that this methodology goes against OPPS packaging principles, we believe that there are inherent advantages to adopting this payment methodology, including the items mentioned above. Beyond that, we believe CMS' own statement that it will serve to speed the creation of procedural APC medians through the use of more single procedure bills is another reason to accept this recommendation. Making such a change will not result in any sort of burden to providers given that providers should already be reporting each and every HCPCS code reflecting the services rendered to a patient regardless of whether the item, service, drug, etc. results in separate payment. Therefore, there would be no additional coding or billing burden for providers. Last year CMS stated that it wanted providers to report all HCPCS codes, regardless of payment status, to encourage data collection for claims analysis. We agree with this and have diligently worked to report complete and accurate claims data even if certain line items have generated no additional payment to date. In addition, by paying for all HCPCS coded drugs separately, CMS will move closer to aligning payment policy across the physician and hospital settings. We believe this level of payment consistency is important across care settings, particularly to ward off any sort of "physician cherry-picking" that might come into play.

Finally, with respect to Brachytherapy and Radiopharmaceuticals, the PRT believes it is

important for CMS to continue basing payments on cost due to the fact that the claims data may be incomplete and incorrect given the frequent code and descriptor changes. CMS has not had the advantage of claims data from 2006 where payment was based on charges reduced to cost and the revised codes were used for billing. Therefore, relying on median cost data as the basis of setting APC payment rates for these services could impact beneficiary access to care as we suspect the calculated payment rates will be severely understated due to the known data issues

IVIG

For CY 2006, CMS created a new HCPCS G-code,G0332 for *pre-administration related services for IV infusion of immunoglobulin (IVIG), per infusion encounter* to offset hospital expenses associated with the extra work related to the problems experienced due to the unavailability of the IVIG product. In the 2007 OPPS Proposed Rule, CMS states that its review of the IVIG marketplace indicates that a separate IVIG pre-administration payment is no longer necessary in CY 2007.

Our own pharmacy directors continue to experience a significant shortage of IVIG as each hospital is allotted a specific (limited) quantity of IVIG based on our past purchase history. After each hospital has exhausted its allotment, the hospital has to scramble to obtain more of the product, often from the "gray" market, as there is a known shortage. Not only are we forced to purchase from the "gray" market, but, in fact, we also face paying an approximately 25-40 percent higher rate and must accept whatever form of the drug we are able to locate. Because different forms of IVIG require different levels preparation, obtaining "extra" IVIG often results in increased costs due to the extensive preparation resources our facilities have to expend to mix the drug.

The PRT realizes that CMS will begin, in CY2007, paying for additional hours of infusion. According to the Proposed Rule, this reimbursement is intended to cover the additional nursing resources ("significant clinical staff time to monitor and adjust infusion based on patients' evolving condition") incurred during additional hours of infusion and not for obtaining IVIG. We urge CMS to not confuse appropriate payment for IVIG as a product with its proposal for paying for additional hours of infusion therapy. These are two different things.

Due to the continued difficulty in the acquisition of IVIG, the PRT recommends allowing payment for code G0332 for as long as the shortage of IVIG continues.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health System. A full list of the provider roundtable members is included below in **Appendix A**.

Sincerely yours,

Members of the Provider Roundtable

Appendix A: Current Members of the Provider Roundtable

Jennifer L. Artigue, RHIT, CCS
Dir. Revenue Mmgt, CDM & Medical Records
Our Lady of Lourdes Regional Medical Center
Lafayette, LA

Kathi L Austin, CPC, CPC-H, CCP
Corporate Director Revenue Integrity
Sisters of Mercy Health System
St. Louis, MO

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Coding Quality Specialist, HIM
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Cedar Rapids, IA

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Director of Health Information Management
Avera Health
Sioux Falls, SD

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Medical Auditor, Corporate Compliance
Forrest General Hospital
Hattiesburg, MS

Jerry Hill, MA
Charge Management Coordinator
University Health System
San Antonio, TX

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University of Colorado Hospital
Denver, CO

Bonnie Malterer, RHIT, BA
APC Coordinator, Outpatient Coding Supervisor

St. Mary's Hospital
Duluth, MN

Yvette Marcan, RN, MA, RHIA, CCS
APC Coordinator
Health First, Inc.
Melbourne, FL

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Bennington, VT

Denise Williams, RN, CPC-H
Charge Management Coordinator
Baptist Healthcare System
Louisville, KY

Submitter : **Mrs. Valerie Rinkle** **Date: 09/07/2006**

Organization : **Asante on behalf of the Provider Round Table**

Category : **Hospital**

Issue Areas/Comments

Visits

Visits

Please see the attached comments on observation care.

CMS-1506-P-37-Attach-1.DOC

Attach #
37

Asante Health System, OR
Avera Health, SD
Baptist Healthcare System, KY
Carolinas Healthcare System, NC
Community Hospital Anderson, IN
Forrest General Hospital, MS
Health First, Inc., FL
Mercy Medical Center, IA
Our Lady of Lourdes Regional Medical Center, LA
Saint Joseph's Hospital, WI
Saint Mary's Hospital, MN
Sisters of Mercy Health System, MO
Southwestern Vermont Medical Center, VT
University of Colorado Hospital, CO
University Health System, TX
White River Medical Center, AR

September 7, 2006

Submitted electronically and in hard copy: http://www.cms.hhs.gov/regulations/ecomments
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: File Code CMS-1506-P

Dear CMS:

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers from around the country who gathered to provide comments on the 2007 Outpatient Prospective Payment (OPPS) Proposed Rule, as published in the *Federal Register* on August 23, 2006. The providers listed above appreciate the opportunity to submit these comments for consideration by CMS. A full list of the current PRT members is provided in **Appendix A**.

Introduction

The Provider Roundtable (PRT) is a group of 17 different hospitals and health systems representing over 50 hospitals from around the country. Like many others, our hospitals, and the departments within our institutions, continue to struggle with OPPS and its many coding and billing complexities. Providers are often too busy, or unaware of the overall process, to submit comments to CMS on their own. Therefore, the members of the PRT collaborated to provide substantive comments with an operational focus which CMS' staff should consider during the OPPS policymaking and recalibration process each year.

We appreciate the opportunity to provide CMS with our comments, and recognize that providers must become involved in the comment process if OPPS is to improve with time.

Observation Services & ASCs

The PRT asks CMS to provide specific and definitive guidance concerning observation cases that exceed 48 hours. We note that, on page 65830 of the November 15, 2005 *Federal Register*, CMS states (in the Final OPPS Rule) that it would "not adopt as final its proposal to exclude claims with G0244 that reported more than 48 hours from the median cost calculation." This was after PRT comment to CMS which noted that claims with more than 48 hours are accepted into the CMS data base only after Fiscal Intermediary (FI) scrutiny. CMS released Change Request 3311, which allowed FIs to override the Medicare CWF edit on claims with units of observation hours greater than 48. This Change Request was subsequently rescinded. Change Request 4259 (released on December 16, 2005) for 2006 OPPS indicates that, "in only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours." Section 290.1.4 states that the 2006 changes to observation billing were made so that "hospitals are able to provide consistent coding and billing under all circumstances in which they deliver observation care... the units of service [for G0378] should equal the number of hours the patient is in observation status."

Fiscal Intermediaries continue to reject claims for observation when the units of service are greater than 48. This means that a hospital which believes it has a case that qualifies as rare and exceptional -- and that can withstand FI scrutiny -- is unable to get the claim into the FI for review, much less into the CMS claims database. The hospital must arbitrarily reduce the hours to equal 48 hours and place the remaining hours as non-covered hours. Yet, according to the CMS definition of "observation", these hours should be covered and either packaged (if the case does not qualify for separate observation payment) or be included in the median cost calculation for APC 0339.

CMS must make a definitive decision and communicate this decision to both hospitals and FIs alike. CMS must clarify if <u>all</u> hours of observation care beyond 48 hours are non-covered. If they are not, CMS needs to release a clear transmittal to both hospitals and FIs regarding acceptance and review of observation claims with more than 48 units on G0378. In addition, the PRT seeks clarification on whether the 2007 OPPS median cost calculation for APC 0339 includes claims with more than 48 hours of observation.

The second issue the PRT would like to raise with respect to observation is CMS' proposal to use midnight as a defining measure of an overnight stay for ASC facility services. We believe that this suggestion makes sense not only for a freestanding ASC, but for outpatient hospital patients as well.

We note that an ASC would not be able to keep a patient at its facility if it becomes apparent that overnight monitoring is medically necessary. In such a case, the ASC would follow its required hospital transfer agreement and transfer the patient to a hospital. These patients are unlikely to meet acuity and severity of illness requirements to qualify as hospital inpatients, therefore, their admission status would be "observation". The hospital would be able to bill

HCPCS code G0379 for a direct admission (assuming the patient did not arrive through the ED) to observation. The hospital would bill each hour of observation under HCPCS code G0378. The only payable APC (assuming no other interventions than medically necessary monitoring) in this case would be APC 0604 for HCPCS code G0379, assuming the patient's complications did not meet the clinical criteria for the separately payable observation APC conditions of chest pain, CHF, or asthma.

The PRT raises the above issue because we are concerned about the payment inequity in the above case and the case in which the patient receives the exact same surgery at a hospital as an outpatient and develops the same complication requiring an overnight stay with the hospital transferring the patient to a floor for observation. In this case, the hospital would not be able to bill HCPCS code G0379, because an *internal* transfer case does not qualify as a direct admission to observation. Even if CMS changes the description on G0379 and allows the hospital to bill this code for post-surgical direct admission to observation, there would be no APC payment under the current outpatient code editor logic since APC 0604 is not payable if there is a procedure (status indicator "T" or "S") on the same day or the day before the observation service.

The PRT is not only concerned about this payment disparity, but also about the ASCs' ability to transfer cases to hospitals when payment is limited because hourly observation qualifies for payment in limited clinical cases. The vast majority of transferred ASC cases will not have chest pain, CHF, or asthma. We therefore urge CMS to consider midnight a defining criteria and instruct hospitals to report any medically necessary time beyond midnight on the day of hospital outpatient surgery as hourly observation with code G0378. We further ask CMS to once again consider separate APC payment for observation regardless of the clinical condition. This is particularly important now with the expansion of allowable procedures in ASCs and the resulting fact that ASCs may have to transfer more cases to the hospital. Additionally, the PRT asks CMS to stress that ASCs should not transfer cases for routine recovery, nor should they begin cases late in the day when routine recovery could extend beyond midnight thinking that they can simply transfer the case to the hospital.

Finally, for quality of care monitoring, CMS should consider a new source of admission code for "transfer from an ASC" to be used by hospitals when reporting cases transferred in from an ASC. This will allow hospitals and CMS to capture useful data.

Conclusion

The Provider Roundtable would sincerely like to thank CMS and its staff for reviewing and considering our comments. Although we are still a relatively new group, the PRT members are very encouraged by the policy-making process and appreciate how our input can have an impact on future year's rules and policies. We are very grateful to CMS for considering our comments in past years as well as again this year. We hope the operational issues we have outlined will be helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact our spokesperson Valerie Rinkle, listed below.

Comments were submitted electronically by Valerie Rinkle, MPA, Asante Health

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