

**Asante Health System, OR  
Avera Health, SD  
Carolinas Healthcare System, NC  
Catholic Healthcare West, CA  
Community Hospital Anderson, IN  
Forrest General Hospital, MS  
Health First, Inc., FL  
Mercy Medical Center, IA  
Nix Health Care System, TX  
OhioHealth Corporation, OH  
Our Lady of Lourdes Regional Medical Center, LA  
Saint Joseph's Hospital, WI  
Saint Mary's Hospital, MN  
San Antonio Community Hospital, CA  
Southwestern Vermont Medical Center, VT  
Sparta Community Hospital, IL  
White River Medical Center, AR**

October 8, 2004

**Submitted Electronically: <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-1427-P  
August 16, 2004 OPPS Proposed Rule**

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 2005 OPPS Proposed Rule, as published in the *Federal Register* on August 16, 2004. The providers listed above appreciate the opportunity to submit these comments for consideration by CMS. A full list of PRT members is provided in **Appendix A**.

#### Introduction

The Provider Roundtable (PRT) is a group of providers representing 17 different health systems from around the country. Like many others, our hospitals, and the many departments within our institutions, continue to struggle with the implementation of OPPS. Providers are often too busy or unaware of the overall process to submit comments to CMS on their own, however. Therefore, the members of the PRT collaborated, to provide substantive comments with an operational focus which CMS' staff can 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. The issues we discuss below are presented in the order in which they were raised in the proposed rule, which does not necessarily reflect the order of importance to providers.

## General Comments Regarding Financial Impact

The PRT wishes to make some general comments on the changing nature of the APC payment rates and the resulting impact on our hospitals. In the “device APC” section of the proposed rule, CMS implies that a 10% shift in payment rates from one year to the next is acceptable. The PRT hopes that even 10% APC payment rate fluctuations will decrease over time, as the APC payment system becomes more stable. Until then, providers can typically find ways to manage a 10% decrease in APC payment rates, such as by absorbing the loss, reducing internal costs, or simply riding out the payment impact and hoping that rates will rise in the future. Clearly, this is much easier to do when only a few APCs in a product or service line are impacted by the 10% payment rate decrease. If most, or all, APCs in a particular product line decrease by 10% or more, it becomes difficult—if not impossible—for providers to absorb the financial impact. When APC payment rates decrease by more than 20%, providers can do very little other than taking the loss, or eliminating or closing down particular service lines.

The PRT understands that some APC payment rate fluctuations are due to the reassignment of CPT codes into APCs—either as a result of restructuring existing APCs due to the “two times” rule, or by moving CPT codes out of the “new technology” APCs and placing them in clinically meaningful APCs. We understand that other fluctuations result from the claims data CMS uses to set payment rates, and realize that there may be other reasons for payment rate fluctuations. A shift of 20% or more, however, is a clear sign that the APC system is not yet stable; such a shift may result from incomplete, inaccurate, or otherwise poor data, or from a flaw in the payment rate calculation methodology.

Significant changes in payment rates impact provider decisions about what services they will be able to continue to provide and, hence, impact beneficiaries’ access to care. The PRT recommends that CMS create some sort of an overall dampening method to address APC payment swings of greater than 20% from one year to the next.

The PRT would like CMS to be aware that large payment rate decreases (i.e., 20% or more) have an enormous impact on hospitals and truly influence providers’ decisions about what services to offer. More and more frequently, hospitals are decreasing or consolidating their service offerings, and taking a hard look at new services before implementing them—regardless of the benefit to the beneficiary population. These decisions not only clearly impact Medicare beneficiaries’ choices and access to care but also place providers in a difficult situation. The PRT’s examination of the 2005 proposed APC payment rates indicates that there are a number of APCs for which the payment rate decreased more than 20%. Examples include: PET scans, hyperbaric oxygen therapy, some blood and blood products, some drugs and radiopharmaceuticals, and others.

The PRT asks CMS to review all APCs with a payment change in excess of 20% and to isolate the reason for the change. For example, the payment rate change may be the result of a statutory requirement, an improvement in provider claims data, or a change in calculation methodology. For some factors, CMS will not be able to affect the payment rate change. If, however, the large change in APC payment rates resulted from claims data or a change in calculation methodology, the PRT believes that CMS should create a

mechanism to dampen the payment impact (for both the low and high ends). Without implementation of some sort of mechanism, providers will never gain full confidence in the system, which is still considered new.

### **APC Groups**

The proposed 2005 OPPS changes, if finalized, would reduce peripheral intervention hospital revenue by \$1,200 per case (as described on page 50457 of the August 16, 2004 *Federal Register*). This change comes from reassigning most of the Supervision & Interpretation CPT codes for peripheral therapies from APC 280, Level 3 angiography to APC 668, Level 1 angiography.

The result of this reassignment is an enormous reduction in the payment rate, which would fall from the current amount of \$1,042 to \$385 per code in 2005. The PRT recognizes that CMS is moving other CPT codes to higher-paying APCs, yet we raise this issue, in general, to highlight the need for some sort of mechanism (such as dampening) to offset large payment swings like this.

Restructuring CPT codes from APC 279 and 280 to APC 668 will significantly impact many facilities. This will be exacerbated further by the fact that the majority of these procedures also have a surgical component code with a lower proposed payment rate for 2005. This means that providers will face a double hit in the payment rate for the overall services being provided. Supplies (including guidewires, diagnostic catheters, sheaths, occlusive devices, stents, dilating vascular catheters, stent deployment devices, etc.) are also used with many of these procedures. Since these are packaged, the overall procedure payment is expected to cover the cost of them. In addition, conscious sedation and recovery time is also common with these patients and, again, packaged; yet the dramatic reduction in payment rates will not cover these costs.

We highlight this as just one more example of how CMS must carefully review the dramatic payment rate changes and create a mechanism whereby some level of dampening can be applied in cases where payment rates fall by more than 20% from one year to the next.

### **Moving G0264 out of APC 0600 – Low-level clinic visits**

Like CMS, the PRT believes that the two times violation of this APC 600 warrants further investigation. The PRT does not understand why the APC Advisory Panel decided not to move G0264 (to be used for patients directly admitted to observation for conditions other than congestive heart failure, chest pain, or asthma) out of APC 600 and into another APC. We support CMS' recommendation to the Panel that G0264 be moved out of APC 600. The PRT continues to agree with CMS that APC 600 violates the two times rule and deserves further consideration for a higher clinic level visit. The PRT believes CMS should not accept the Panel's recommendation and should, in fact, move G0264 into another APC. Our reasons are listed below.

HCPCS code G0264 should be moved from a low-level clinic visit to a much higher level clinic visit due to the resources involved in directly admitting a patient to observation.

These resources are far greater than the resources expended to care for a low-level clinic visit patient. Examples of the types of services typically provided (and hence the facility resources consumed) for a direct admission are included below:

- Patient registration, room assignment, set up and transport
- Comprehensive nursing clinical admission assessment, initial vital signs
- Initiation of physician orders
- Coordination and scheduling of ancillary services
- Administration of medications
- Assessment of discharge planning needs, arrangement for social services intervention.

From the perspective of the facilities' resources consumption, the services provided to these patients are equal in intensity and resources to those expended on an inpatient admission. Since many hospitals lack separate observation units, these patients are located on medical-surgical and telemetry units, and the patient care provided by nursing is similar in scope to inpatient care simply based on the patient's physical location in the hospital.

In lieu of national Evaluation and Management (E/M) coding guidelines or criteria from CMS, the PRT used the published "Recommendations for Standardized Hospital Evaluation and Management Coding of Emergency Department and Clinic Services" submitted to CMS in 2003 by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) to assign an E/M code to direct admit to observation patients. Based on our application of these guidelines, the services provided to patients directly admitted to observation consistently met the criteria for a High Level Clinic Visit. Moreover, several PRT members also used their own internally created E/M guidelines to assign direct admit to observation patients into an E/M level, and again found that all direct admit patients qualified for the highest level E/M visit code per their individual guidelines. We believe the reason for the consistency of our results is that these patients clearly require many resources. The PRT recommends that CMS move HCPCS code G0264 from APC 600 to APC 0602 for a high-level clinic visit.

### **New Technology APCs**

Medicare proposed removing 24 procedures that are currently assigned to new technology APCs into clinically appropriate APCs. The PRT disagrees moving a number of these CPT/HCPCS codes for the reasons outlined below:

- The PRT requests clarification on whether CMS intended to place the add-on CPT code 96571 in APC 0014 (as stated in the *Federal Register*) or if this was an error. We believe this code should be assigned to APC 0015.
- The PRT does not support the movement of the proton-beam therapy code out of a new technology APC and into a separate APC. We do not believe CMS has complete and accurate enough data to assign this APC into a separate APC. We request that CMS keep this service in a new technology APC for another year.

- The PRT does not support the movement of PET Scans from the new technology APC 1516 into another APC. If CMS finalizes its proposal to pay for PET through APC 420, hospitals that primarily see Medicare beneficiaries may not be financially able to continue offering this service. A low reimbursement will hinder patients' access to this technology, especially in rural areas where it is most needed. We understand CMS has proposed three different payment rate options and is interested in provider feedback on the best option for 2005.

Most hospitals use outside vendors to provide PET scans to their patients. As such, PET scans are often deemed a "purchased service." The average cost of the service, and the billed charge submitted to Medicare, should reflect both the direct cost of purchasing the service (the cost paid to the outside vendor) and the overhead costs the provider accrues. Some providers are likely to report the total charge with this in mind, but we are also aware of others that simply report the cost paid to the outside vendor as their charge. The latter method is clearly incorrect and the PRT recognizes that the onus is on providers to report correctly. When a small number of claims are used to generate the median cost for this service, however, such a mistake on the part of a few providers is likely to skew the data in such a way that generates low proposed payment rates for all providers.

The average cost for a PET scan provided by an outside vendor includes the scan and a skilled technologist who scans the patient. One PRT hospital that uses an outside vendor pays on a "per day" basis, and the hospital has the option to scan as many patients as possible on any given day. The cost to this hospital for each PET scan is approximately \$750. This is the *actual* cost of the scan itself and reflects what the hospital pays the outside vendor. It does not reflect the hospital's own overhead costs. These costs include staff time (on average two hours and 45 minutes that includes the technician's time, transcription, scheduling, medical records, billing) and supplies for each patient that include an IV set, saline bag, and other miscellaneous supplies.

The PRT has experience with this issue and believes that many hospitals do not report complete charge information to CMS. Hence, the 2003 charge data CMS worked with may have been incomplete, generating a skewed picture of the median cost for this service. Therefore, the PRT strongly recommends that CMS select Option 1 and continue to pay for PET with FDG for at least one more year through the new technology APC 1516.

*Please note that HCPCS code G0288 is a purchased service for many hospitals whose direct expense is over \$600.00. We believe that CMS may have skewed cost data for this service. Hospitals are often reluctant to mark up the cost of purchased services, particularly in light of compliance concerns with uninsured patients and their non-discounted claims for hospital services. Please retain this service in a new technology APC that pays at least \$500 or more until more cost data is obtained.*

- The PRT believes that CMS will obtain more appropriate cost data in the future for HCPCS code G0262 (which has a very large proposed payment decrease for 2005) if a C-code is assigned for the capsule. This is a new technology service, and many providers have just started providing it. The device (or capsule in this case) costs approximately

\$400. We believe that it was not billed consistently in 2003, with the result that CMS had lower-than-average charges, and hence cost data, for this procedure. Therefore, we believe CMS should do two things for this service: first, assign a C-code to the capsule and include it in Table 20, so that providers know they must bill it along with the procedure code G0262. Second, this service should be considered as a device-dependent new technology and be kept in a new technology APC.

### **Inpatient Only List**

The PRT appreciates CMS' proposal to remove 22 procedure codes from the Inpatient List. In principle, however, we continue to strongly support the APC Advisory Panel's recommendation that CMS eliminate the list altogether. Rather than using an Inpatient List to control provider behavior, the PRT suggests that CMS rely on its Peer Review Organizations (PROs) or Quality Integrity Organizations (QIOs) to examine any questionable cases. These organizations are best equipped to handle issues related to care provided in inappropriate sites of service. Some reasons for our position that the list should be eliminated are provided below:

The decision to admit a patient is a medical decision requiring a physician and a specific order to admit to an inpatient status. In the past, CMS has focused on "medically necessary" services, and hospitals have worked diligently to educate physicians regarding inpatient admission criteria and providing and documenting medically necessary services. The Inpatient Only List inhibits providers from making medically necessary decisions about which patients require hospital admission. Hospitals are thereby put in the difficult position of either asking physicians to admit patients who may not meet inpatient criteria, or providing expensive "Inpatient Only" procedures to patients in the outpatient setting and not being reimbursed.

The Inpatient Only List is very difficult to implement given that physicians resent being told what can and cannot be done for patients when they believe certain services are medically necessary and can be provided safely in an outpatient setting.

Sometimes patients are scheduled for procedures that are not on the Inpatient Only List and can be performed safely and effectively in the outpatient setting (and therefore the physician makes no plans to admit the patient). During some procedures, however, a surgeon might perform a second procedure that *is* on the Inpatient Only List, or which modifies the original procedure so that it becomes one on the Inpatient Only List. The surgeon either is unaware that the second procedure is on the Inpatient Only List, or still feels that the patient can safely remain an outpatient, and proceeds.

In the above circumstance, in order to be paid, the hospital must find a way to immediately identify the second procedure as being on the Inpatient Only List so that the physician may be approached about admitting the patient to inpatient care. If the physician does not agree to do so, the hospital has no recourse and loses the reimbursement. In most hospitals, identification that the second procedure is on the Inpatient Only List does not occur until the record reaches the coding department following discharge. Once a patient is discharged, their admit status cannot be changed to an inpatient admission status. The hospital is forced to bill the claim as an outpatient knowing there will be no reimbursement.

Codes are assigned by the coding department, and this can rarely be done before the patient is discharged, granting no opportunity to identify the patient and request that the physician admit him or her as an inpatient. In the event that CMS chooses not to eliminate the Inpatient Only List, the PRT requests that CMS remove the following CPTs from List prior to implementation in January 1, 2005:

1. *CPT code 58260 (vaginal hysterectomy not including tubes and or ovary)*: Peer review journal articles have demonstrated for 14 years that this procedure can be safely performed in the outpatient setting using standard criteria to determine when it is safe to send the patient home (e.g., when her pain is controlled and she has the ability to void). For some patients, this may happen in as little as 8-10 hours. Supporting documentation is listed below.
  - A. "Outpatient Vaginal Hysterectomy: A Pilot Study." *Obstetrics and Gynecology*. July 1992, p. 145-149.
  - B. "Randomized Comparison of Laparoscopy-Assisted Vaginal Hysterectomy with Standard Vaginal Hysterectomy in an Outpatient Setting." *Obstetrics and Gynecology*. December 1992, p. 895-901.
  - C. "The Outpatient Vaginal Hysterectomy." *American Journal of Obstetrics and Gynecology*. June 1993, p. 1875-1880.
  - D. "Outpatient Vaginal Hysterectomy in a Community Hospital." *Wisconsin Medical Journal*. August 1994, p. 422- 425.
  - E. "Outpatient Hysterectomy: Determinants of Discharge and Rehospitalization in 133 Patients." *American Journal of Obstetrics and Gynecology*. December 1994, p. 1480-1487.
  - F. "Outpatient Vaginal Hysterectomy as a New Trend in Gynecology." *AORN Journal*. November 1995, p. 810-814.
2. *CPT code 63075 (Discectomy)*: Published studies in the following journal references indicate this procedure can be safely performed in an outpatient setting.
  - A. "Day Surgery for Cervical Microdiscectomy: Is it Safe and Effective?" *Journal of Spinal Disorders*. Vol 9, No 4, 1996, p. 287-293.
  - B. "NASS: Cervical-Spine Surgery in an Ambulatory Surgery Center is Safe." Presented November 7, 2003 in San Diego CA by Maury M. Breecher, PhD, MPH.
3. *CPT 44603 (Suture, small intestine), 44602 (Suture, small intestine), and 44604 (Suture, large intestine)*: As a stand-alone procedure, these may require inpatient care. If part of the intestine were nicked during surgery, however, this code would be used. It would not however require inpatient care.
4. *CPT 49000 (Exploration of abdomen)*: This is a not a well-defined code and is a "separate procedure". A separate procedure is one that is commonly carried out as an integral part of a larger procedure. The laparotomy is usually considered the surgical approach and as such is not separately codeable unless it is the only procedure performed when pathology is not found. In cases where the exploratory laparotomy is the only procedure coded it should be allowed and payable as an outpatient.

The PRT strongly disagrees with CMS' proposal to remove procedures from the Inpatient Only List when more than 60% of the procedures are provided in the outpatient setting. So long as payment is tied to the procedure being performed in the inpatient setting, providers will be discouraged from finding new and safe ways to perform the procedures on an outpatient basis—despite advances in new technologies. In addition, it may be appropriate for the same procedure code to sometimes be performed as an inpatient procedure, and sometimes as an outpatient procedure, based on medical necessity. This should be based on each physician's judgment rather than on the Inpatient Only List.

The PRT requests that CMS review both hospital and physician utilization rates for these procedures, since physicians do not have the same restrictions about where procedures must be provided as do hospitals. This is just one of several examples of policy and/or payment differentials between hospitals and physicians noted by the PRT in our comments.

### **Physical Examinations**

The PRT supports expansion of Medicare benefits to preventive services. We understand that Section 611 of Pub. 108-173 provides for coverage (under Medicare Part B) of an initial preventive physical examination for new beneficiaries, effective for services furnished on or after January 1, 2005. This new benefit includes an ECG as part of an initial preventive physical examination.

The PRT wishes to highlight numerous billing and operational concerns with the definition of one HCPCS code—GXXXX for Initial Preventive physical examination including ECG tracing and interpretation—and offers alternative options for CMS' use in implementing this provision required by the MMA.

In many hospitals, ECGs may be performed in a separate department from that in which the physician examination occurs. In these instances, the technician who charges for the ECG service has no way to distinguish an ECG related to the preventive exam from all other ECG tracings performed in that setting. This is a significant problem, as hospitals are required to separately report the technical component of the ECG from the professional component.

Also, not all primary care physicians have ECG machines. It is not clear if these providers would, therefore, not be allowed to conduct a beneficiary's initial preventive exam service (which is inclusive of the ECG), or if these providers are allowed to order the required ECG and send patients to a hospital for it. The PRT does not believe that the MMA intended to limit access to this important service, and assume that physicians without ECG machines would be allowed to refer patients to a hospital for this service. This process raises several problems, however. Will the physician provider be paid in full for the initial preventive exam (including the ECG), despite the fact that the ECG was not provided by the physician? How will a hospital report ECGs related to the preventive exam, given that one all-inclusive code is being proposed?

Given the operational challenges with coverage of this new service, the PRT proposes that CMS create four separate G-codes:

1. **GXXXX**: This code should be used for the global Initial Preventive physician exam including ECG tracing and interpretation—the code would *only* be applicable for the physician’s office and would be reported on the HCFA 1500 claim form. This is consistent with CMS’ proposal in the proposed rule.
2. **GYYYY**: This code should be used for an Initial Preventive physician exam that *excludes* ECG tracing and interpretation, but *includes* an order for the ECG tracing and interpretation. This would be the payment rate for the exam portion only. Under the physician fee schedule, this code would have a facility and non-facility fee; under OPPS, this G-code would be assigned to an APC for the technical component of a preventive physician exam only.
3. **GZZZZ**: This code would be used for the professional interpretation of the preventive ECG tracing equal to physician fee schedule 93010.
4. **GAAAA**: This code would be used for the technical component of a preventive ECG tracing. This would be paid as CPT code 93005 under the physician fee schedule, if billed on the HCFA 1500, and as CPT code 93005 paid via APC 0099, if billed by a hospital under OPPS.

This coding convention more closely aligns the current definitions of preventive exams and ECG testing. It would allow the examining physician to be the ordering physician for the ECG, but allows the ECG tracing and interpretation to be performed separately. The payment level for an Initial Preventive physician exam that excludes ECG tracing and interpretation can be the payment amount for the global code minus the physician fee schedule amounts for the ECG tracing and ECG interpretation. Having the requirement for the ECG order in the preventive exam ensures that the exam will include the ECG analysis, even if not personally performed by the examining physician. This allows hospitals to set up an order just for the preventive ECG and map it to a separate billing code for the tracing only. Furthermore, the ordering diagnosis for the preventive ECG tracing will likely be V81.2: screening for other and unspecified cardiovascular conditions. This test will not pass local coverage decisions for Medicare payment. Having a specific HCPCS code with instructions for correct diagnosis coding for the preventive ECG coverage will allow ECG providers to correctly bill this service and obtain coverage and payment under the new preventive benefit.

### **Proposed Use of Single Procedure Claims**

The PRT is pleased to see that CMS used more single procedure bills to set payment rates for 2005. If the PRT understands correctly, the expanded bypass list resulted in the use of many more claims for rate setting. Again, we are supportive of this, but remain concerned that several E/M codes appear on the bypass list.

If our understanding is correct, a code can only be on the bypass list if it appeared on a claim no more than 5% of the time with packaged services. While the PRT did not run any analyses to verify CMS’ logic, we doubt that the E/M codes on the bypass list occurred less than 5% of the time. We do not believe that the E/M codes on the bypass occurred with no packaged revenue or other HCPCS code 95% of the time. If this is true, we can accept the codes being placed on the bypass list, but the PRT members would like

to express caution. We expect to see them more often than not on claims with other separately payable and packaged services. Also, the PRT does not understand why E/M CPT code 99242 is not on the bypass list, given that the remaining codes in the range are present. We question if this was an oversight or suspect that the code did not meet CMS' criteria. The PRT asks CMS to review and verify that it is, in fact, appropriate to bypass any of these E/M codes.

In addition, the PRT suggests that CMS add an upfront exclusion of all add-on codes. By definition, add-on codes are CPT codes that should never appear as the only procedure on a claim. CMS has created separate APC for some add-on CPT codes (e.g., 93320, 93321, 93325) but many others are packaged (e.g., 93571 and 93572). The PRT recommends that all add-on CPT codes be treated as bypass codes for the purposes of defining single procedure claims. The result would be that other incidental and packaged services on the claim would be packaged to the main procedure code if that was the only other APC on the claim; this could result in the use of more claims data.

### **Proposed Required Use of “C” Codes for Devices**

CMS proposes to require providers to report device C-codes for the procedures listed in Table 20. The PRT appreciates that CMS is taking a step forward and also appreciates CMS' comment that: “We make this proposal cautiously, as we realize that it imposes a burden on hospitals to code the devices.” We are excited about this requirement, as we believe it will result in CMS having much better data to use in setting future device related APC payment rates.

The PRT urges CMS to immediately require device C-codes for *all* device-dependent APCs rather than phasing in the requirement. The PRT would rather add all of the C-codes back into their Charge Description Masters once, rather than doing so gradually. In fact, many providers have not deleted the C-codes, despite the fact that CMS stopped accepting them in 2003. Providers simply deactivated these codes and can easily reactive them if CMS finalizes this proposal.

While the PRT agrees with the CMS proposal to make device C-code reporting mandatory, the members would like reporting to occur for *all* C-codes by January 1, 2005, rather than just those in Table 20. The PRT also believes that CMS must create “C” code edits in the Outpatient Code Editor to ensure that providers are only submitting correctly coded and fully completed claims. Providers are unlikely to comply with the C-code requirement unless this type of edit exists.

If all C-codes are not required as of January 1, 2005, the PRT asks CMS to, at a minimum, add the following C-codes to Table 20:

#### **C1813: Prosthesis, penile, inflatable**

- 54401 -- Insertion of penile prosthesis; inflatable (self-contained)
- 54405 -- Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
- 54410 -- Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same

#### C2622: Prosthesis, penile, non-inflatable

- 54400 -- Insertion of penile prosthesis; non-inflatable (semi-rigid)
- 54416 -- Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session

#### C1715, C1720, or C2616

- 55859 Prostate Brachytherapy

#### C1781

- 49568 implantation mesh for umbilical hernia

Finally, in order to make the requirement for all C-codes easier for CMS to implement, the PRT has provided a detailed cross-walk in **Appendix B** of all the C-codes that were in place in 2002 and the corresponding procedure codes.

#### **Payment for Non-Pass Through and Non-Packaged Drugs**

It appears that CMS is using the same methodology to calculate payment rates for single source, brand, and generic drug payments as was used for the 2004 calculations, yet the 2005 proposed payment rates are much lower for many separately payable drugs. The PRT understands why this is the case for single source drugs, but does not understand why some of the 2005 proposed payment rates for brand name and generic drugs are much lower.

The PRT suspects that some of the brand and generic payment decreases may result because the calculated median cost from the 2003 claims database was a blend of the cost of the brand name and generic versions of the drug (since only one HCPCS code existed and was used to report providers' use of either brand or generic). In this case, the calculated cost cannot be compared to the payment ceilings set forth by the MMA (68% of AWP for brand name drugs and 46% of AWP for generic drugs) in order to determine whether the AWP ceiling will be used to set the price or if the actual claims data will be used. The proposed rule does not clarify how CMS generated the proposed APC payment rates for these two classes of drugs. The discussion implies that payment rates for both brand and generic drugs were derived by comparing the median cost from 2003 claims data to the AWP ceilings. If this is the case, it may explain why some of the brand and generic drug proposed payment rates for 2005 are much lower than the current payment rates.

In addition, the PRT requests that CMS examine every HCPCS J-code for drugs to make sure the dosage definitions for the HCPCS codes are set at the lowest available manufacturers' dosage. When this is not the case, many problems arise in provider billing and pharmacy dispensing systems. For example, HCPCS code J1260 injection, dolasetron mesylate has a 10 mg descriptor. However, the common dosage is 12.5 mg (even in the pediatric population). Manufactures, such as Abbott supply this drug in 12.5 mg ampules while Aventis supplies this drug in multi-dose vials of 100 mg. Therefore, the PRT urges CMS to change the dosage descriptor for HCPCS code J1260 drug to 12.5 mg. Another issue related to this, is the HCPCS description not matching the customary dispensing packaging. For example, the description for HCPCS code Q0166 is "oral 1

mg” yet the standard packaging comes in one *microgram*. The PRT believes that the descriptor for this drug should be in micrograms with a corresponding per unit payment rate.

### **HCPCS Codes**

The PRT supports CMS’ proposal to finalize the instructions provided on May 28, 2004 through Transmittal 188, Change Request 3287, for reporting new drugs without HCPCS codes. This process allows providers to be paid quickly for newer and typically more expensive drugs. The PRT requests, however, that CMS provide guidance on whether C9399 can be used to report new oral drugs, or if this code is simply limited to injectible drugs. This should be clarified in the final rule, since all of the language related to the issue addresses, “newly approved FDA drugs as of January 1, 2004.” It is not clearly specified what types or classes of drugs are included or excluded. The PRT feels that guidance on this issue is critical so that individual FIs will not have to decide when they will accept HCPCS C9399.

### **Drug Administration**

The PRT supports CMS’ proposal to require providers to use CPT codes to report drug administration services. By allowing the use of CPT codes, providers will be able to more appropriately report their chemotherapy infusion and injection and non-chemotherapy infusion services between various payers. While we are happy to see CMS moving forward with this proposal, we are still concerned about the lack of guidance given to providers and address this further below.

Although we are very pleased with the progress CMS is making in this area, we continue to be very concerned about the differential that exists today and that is expected to grow in the future between payment for the same set of services in the physician office setting vs. the hospital setting. Moreover, provisions from the MMA are beginning to result in physician office based providers sending more complex chemotherapy patients to the hospital setting where we take a loss on these patients given some of the current provisions in place by Medicare. We cannot turn these patients away, yet physician office based providers can and are doing so.

As the PRT stated in comments related to 1372-IFC MMA provisions, we are concerned about the unit of service limit set for Q0083 in the hospital setting (limit = 1) and the multiple units of service allowed for the equivalent CPT code 96408, in the physician office based setting.

1372-IFC changed reporting methodology of CPT 96408 under the physician fee schedule that, since 1991, had only been allowed to be reported once per day (just as hospitals have only been allowed to report Q0083 once per day). Physicians in 2004 are now allowed to bill 96408 for each drug administered, but the hospital is still limited to reporting one unit regardless of the number of drugs administered.

Coupled with significant changes in RVU values for Chemotherapy CPT codes in 2004, this has created a significant distortion between what hospitals and physician office settings are reimbursed for chemotherapy administration by other than infusion

technique, despite the fact that the services are essentially identical in both settings as they are provided by nurses.

CMS acknowledged in 1372-IFC that additional resources were involved in the administration of each subsequent drug. The PRT emphatically agrees with this and expects that if CMS believes this is true for the physician office based setting then it would be true for the same reasons for the hospital setting and should therefore be applied under OPSS. We believe this was an oversight by Congress and are asking CMS to rectify this immediately. Otherwise the distortion in reimbursement that already exists between the hospital and physician office based setting will worsen.

If CMS makes final the proposal to use the CPT drug administration codes under OPSS, then hospitals should be paid for multiple units of CPT code 96408 for each drug administered just as physician office based providers are allowed to do so. If this change is made as we recommend for 2005, then CMS will need to modify the OCE editor to allow multiple units of "Q0083" to be paid rather than defaulting to a unit of 1 as indicated in the proposed rule.

The PRT asks CMS to carefully consider the following points as they also relate to inconsistencies between the hospital setting and the physician's office setting. First, the PRT wishes to state that we do not minimize or trivialize the concerns that physicians have about drug payments and chemotherapy administration reimbursement for the physician office setting. Physicians deserve to be paid appropriately for the services they provide as do hospital based providers. All care settings struggle to provide high quality care at less-than-cost reimbursement. We simply want to point out the disadvantages hospital-based chemotherapy clinics face due to conflicting payment rates and rules established by CMS for essentially the same service.

- The estimated 2005 reimbursement for the physician's office setting is much higher than hospitals' for similar infusion services. For instance, a three hour chemotherapy infusion in the physician's office will pay \$247.47 (CPT code 96410 x 1 unit + CPT code 96412 x 2 units for the additional hours) under the Physician Fee Schedule (PFS) and only \$165.60 to hospitals under OPSS (based on a unit of 1 limit for Q0084 regardless of the hours of infusion). Additionally, in the physician's office, all drugs are paid for separately regardless of the median cost of the drug unlike in the hospital setting where Medicare considers payment for all drugs with a median cost less than \$50 to be included in the administration payment rate; in this case the \$165.60 covers the administration regardless of duration as well as drugs with median costs less than \$50. A clear payment differential exists between these two sites of service, which we believe is inappropriate.
- If a patient were to receive 3 chemotherapy injections in a physician's office setting, the estimated 2005 payment would be \$368.88 (CPT code 96408 x 3 units), while those same three injections provided by hospitals under OPSS would only be paid \$62.31 (HCPCS Q0083 with a unit limit of one regardless of the number of drugs administered). Again, the hospital's administration payment would be inclusive of drugs with a median cost less than \$50, while the physician's office is able to receive separate additional payment for each of the drugs.

- The rules regarding the units of service allowed should be more consistent between the two settings as the costs are a reflection of the room time, nursing time, monitoring, etc. Patients who receive three hours of infusion or three injections utilize more resources, and hence the costs are higher. This seems to be recognized in the physician's office setting, but not in the hospital setting which is in fact strange given that hospitals typically perform the longer infusions, and yet, even for one unit, they are paid less considering that they do not receive separate payment for each and every drug.
- For all types of drug administration (but principally related to Q0081, Q0083 and Q0084), the PRT recognizes that the CPT codes (90780 – 90781, 96408, 96410 – 96412) will allow CMS to collect better and more complete data on hospital infusion times and code-specific usage for use in future rate setting. We also understand that the payment rates for 2005 are based on the Q-code data from 2003, as there is no other choice. However, we urge CMS to at least address our concern about the chemotherapy injection unit of service issues so that hospitals are not restricted for the next two years to being paid for only one unit for this service while physicians in their office settings are allowed to report a unit for each drug administered, and hence not subject to any units of service restrictions.
- We request that CMS move towards greater consistency between the physician and hospital setting so that inequities like the ones described above in terms of units of service and relative value are minimized

The PRT requested, and CMS responded on page 63450 of the November 7, 2003 Federal Register by stating *"CMS will develop program instructions regarding how the drug administration codes should be used. We will attempt to address the specific questions identified in the comments in the course of developing those instructions. When the instructions are issued, they will be binding on all Medicare fiscal intermediaries under their contract with CMS..."*

The national guidance has not yet been issued—which is critical, given that we continue to see differences in how F.I.s instruct providers to code and bill for injection and infusion services. The PRT looks forward to the promised national guidance on drug administration. If the proposed change from reporting Q-codes to CPT codes for drug administration is made final, then we believe this is the perfect time for CMS to release a Transmittal instructing all FIs on coding, billing, and reimbursement rules for infusion and injection services.

As we stated last year, many unanswered questions remain that should be addressed by CMS. The PRT has outlined many common questions and problem areas below in anticipation that CMS will address these issues in Transmittals to the F.I.s.

- CMS should make sure that the CCI edits used under OPPS do not prohibit reporting the CPT drug administration codes along with any other existing injection codes. If such edits exist in the CCI edits, then they must be removed as they do not currently exist between the Q-codes and injection codes.
- CMS has previously instructed to use modifier -59 on injection codes, however this was prior to the creation of OPPS-specific CCI tables. Is modifier -59 truly required or simply requested to be reported with an injection code when reported during the same session as an infusion? Or is it no longer necessary due to the specific OPPS CCI

tables being created? Different FIs have different rules; therefore, we request clarification from CMS.

- CPT code 90781 is reported for each additional hour of infusion after the initial hour. Can this code be reported as soon as the infusion time reaches 61 minutes or only when the infusion time reaches at least 90 minutes? The same question applies to the chemotherapy infusion codes.
- How is a "Piggy-back infusion" (IVPB) coded? A "piggy-back infusion" is a bag of fluid (of any amount) in which a medication is mixed and where the fluid or medication solution is connected (e.g., piggy-backed) to a "primary" intravenous line for infusion. The PRT believes that IVPB's are reportable interventions, yet there are several clinical scenarios from which to determine proper coding. In the absence of a specific HCPCS code for this service, we request that CMS provides coding guidance on how to report IVPB's using the appropriate CPT/HCPCS codes.
- How is a medication administered via patient controlled analgesia (PCA) pump billed? The PCA pump is connected to the patient via a "primary" intravenous line and infuses medication (generally an analgesic) in small doses triggered by the patient. The nurse must set the pump with the ordered dosage, load the syringe or cassette, monitor the patient's use of medication, and monitor the effectiveness of the medication. How should providers bill for the initial service as well as for each additional cassette of drug loaded and programmed into the pump? Because this is neither an injection nor an infusion, it is unclear what code(s) providers should use.
- The PRT believes that it is appropriate to bill for injections given in the Post Anesthesia Care Unit (PACU, previously known as the Recovery Room) and extended recovery settings when the medications are given for a documented pain complaint. We seek validation of this belief.
- What is a routine prophylactic versus a therapeutic medication in relation to preoperative medications? Is it appropriate to bill for therapeutic medication administration prior to surgery? An example would be a preoperative antibiotic given to a patient with a prosthetic heart valve in a procedure where a prophylactic antibiotic is not normally given.
- Is an infusion defined as therapeutic (and therefore separately billable) based on the patient's clinical condition and medical necessity rather than defined on the rate of infusion or solution given? For example, a 50 cc/hr solution of normal saline infused into an 80 year-old, frail woman with cardiomyopathy admitted for dehydration due to nausea and vomiting would be considered therapeutic, while a 50 cc/hr solution of normal saline given to keep the vein open is not therapeutic.
- Are medications and therapeutic infusions ordered prior to and following chemotherapy administration separately billable (i.e., pre-and-post hydration or pre procedure anti-emetic injections)?

## **Blood and Blood Products**

The PRT supports CMS' revised methodology for calculating blood costs. We appreciate the time and effort CMS has invested in using more appropriate cost-to-charge ratios for computing blood and blood product costs. The PRT asks CMS to apply this same methodology to calculate costs for devices, hyperbaric oxygen, and all other services. For some of these other service areas, it may be important to additionally review how (and where) in the cost report providers account for revenues and expenses, and whether or not they are being reclassified. If revenues and expenses are not accounted for in the same cost center, and also are not reclassified during the cost reporting process, a gap will exist and result in either very low or very high cost-to-charge ratios.

The PRT additionally requests that CMS clarify a matter for providers that we believe will dramatically result in more accurate blood and blood product charge data. Providers appear to still be unclear that they are allowed to mark up their blood cost even when they obtain blood from the American Red Cross. Some providers know they are allowed to do this in order to account for facility overhead expenses, but others fear they will face compliance risks if they do so. The PRT therefore asks CMS to include clarifying language regarding this issue either in the 2005 final OPPS rule or in the January 2005 OPPS coding and billing update transmittal. The result will be that CMS receives more accurate and complete data for setting future payment rates.

## **Status Indicators**

The PRT recommends that CMS review all HCPCS codes currently assigned a status indicator of "N" for packaged service. There has been a great deal of confusion about the services with these status indicators. Some providers are not reporting these codes because they are considered packaged; others are forced to report a clinic visit E/M code along with an "N" status service simply to receive payment for the "N" status service. Examples of the latter situation include: vaccine administration or immunization (CPT code 90471), collection of blood from an implanted venous access device (CPT code 36540), withdrawal of arterial blood (CPT code 36600), pulse oximetry (CPT code 94760 etc.) and others.

The PRT examined a number of HCPCS codes and their current status indicators, and provides the following suggestions for changing these status indicators starting in 2005:

- CPT code 36540: If this is the only service provided, providers have to additionally report an E/M visit code in order to be paid. This service requires a nurse and is not provided by a lab technician; therefore, we believe it should have a status indicator of "X".
- CPT code 36600: The PRT recommends that CMS assign this a status indicator of "T" since it is not bundled into the E/M level. An arterial blood draw requires more effort and carries more risk to the patient than a simple venipuncture. Yet, arterial blood draw is not paid for separately, while the simple venipuncture is paid under the lab fee schedule.
- CPT code 90471 and 90472: The PRT recommends that CMS assign both of these

codes a payment status indicator of “X”, since patients may present just for the vaccine. Currently, when this happens, providers are forced to report a clinic visit code in order to obtain payment. This is contrary to the way CMS reimburses for other injections, and causes confusion for hospital staff responsible for charging the service. Moreover, it makes it difficult to set up charges for these services, since other payers reimburse based on the CPT codes for vaccine administration. Lastly, this situation potentially inflates the cost assigned for administering these vaccines as these codes could be assigned the same payment rate as injection code 90782.

- CPT code 94760: The PRT recommends CMS assign this code a payment status indicator of “X”.
- CPT code 94761/94762: The PRT recommends CMS assign both of these codes a payment status indicator of “X”, since these services consume time and resources and typically last through the night.
- CPT Code 76001: The PRT recommends CMS assign this code a status indicator of “X”. Hospitals should be able to report fluoroscopy over one hour, which takes more time and resources than a fluoroscopy under one hour (represented by 76000). At some point during OPSS, CPT code 76001 had a status indicator of “S”, but the PRT considers this to be more of an ancillary service, as there are a small number of services where fluoroscopy goes over one hour. We believe that, when this happens, separate payment should be made.
- CPT 97602 (non-selective wound care): This can be a highly resource intensive visit in hospitals’ wound care clinics where dressing changes and wound assessments occur. Often, it is the only service provided at the visit. Non-Medicare payers require 97602 reported as the sole CPT code when this is the only service provided during the encounter. Alternatively, CMS has instructed providers to bill a low-level clinic visit, such as 99211 along with the 97602 code for non-selective wound care. The PRT believes that the latter process is inappropriate, since it requires breaking out one service into two charges—which is difficult to perform in a hospital billing system. When both 99211 and 97602 are billed to other payers, providers are accused of unbundling a single service into two CPT codes. Yet, trying to stop the charge for 97602 and artificially dividing it on to a bill (as 99211 and 97602) simply for Medicare requires manual intervention for each claim. Our recommended solution would be to simply change the status indicator for 97602 to “X” and instruct providers to report this without an E/M code when it is the only service provided.
- 42550 and other X-ray injection codes: Many X-ray injection codes, such as 42550, have “N” status indicators. This presents a problem in the limited situations where the patient has a reaction to the injection and no X-ray is taken. Hospitals should be able to bill and be paid for the injection when it is the only service rendered, rather than coding the entire X-ray with modifier –52 and the injection code, as we currently must do to be paid. In addition, other payers typically believe the hospital has incorrectly reported the X-ray code when the X-ray was not performed. This is another example of staff being required to keep the

rules separate for Medicare versus other payers. While the PRT understands that this will happen in some situations, it should not be the norm, as it increases providers' administrative burden. The situation would easily be remedied if CMS changed the status indicator for the X-ray injection codes.

- Q0081 (or its successor CPT codes): The PRT recommends this code be assigned a status indicator of "X".
- G0269 Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioseal plug, vascular plug): This procedure has a C-code C1760 associated with it. CMS has both the device C-code and the procedure code G0269 packaged into other endovascular APCs. The endovascular APCs would be more appropriately priced if separate payment existed for the additional procedure of placing the occlusive device that also included payment for the device. This would enable CMS to create an edit for claims so that G0269 and C1760 are required to be billed together along with the procedure codes and paid separately through an APC payment.

### **Observation Services**

The PRT commends CMS and the APC Advisory Panel's Observation Subcommittee for the thoughtful work they have performed in studying the administrative issues regarding billing for observation services, and for taking steps to propose changes that will result in overall simplification for hospitals. We appreciate CMS' proposal to eliminate the requirement for concomitant diagnostic testing, and to change observation discharge to reflect physical discharge (rather than when the physician writes the discharge order). These changes will eliminate some of the manual processes hospitals have implemented over the past two years.

Both the PRT and the APC Advisory Panel believe that CMS should make appropriate and separate payment for all medically necessary outpatient observation stays. While we understand CMS' desire to have a well-defined set of services that are regularly provided to patients with a certain diagnosis who are placed in observation, we are certain this is unrealistic for most conditions. For example, while dehydration may have services such as infusion (Q0081) and electrolyte lab testing (80051), other diagnoses are not suggestive of regularly provided services. Abdominal pain, for example, may have greatly differing services due to the numerous clinical pathways that may be chosen, all of which are dependent upon the underlying causes and the associated signs and symptoms. Regardless of the diagnosis in question, however, medically necessary observation services are a separate and distinct service provided in a different bed or unit, just as they are provided in the case of CHF, asthma, or chest pain.

In the case of surgical observation, the PRT requests that CMS supply guidance to providers on reporting extended recovery services. Information about CMS' expectation that hospitals report routine recovery room services (despite its being packaged) will ensure submission of more complete charge data from hospitals. Lastly, hospitals and physicians continue to struggle with assigning/billing postoperative services. More accurate data will be generated if CMS could clarify when it considers routine recovery to end (e.g., in 4-6 hours), and when extended recovery and/or observation services

begin. CMS should further clarify that both routine and extended recovery should be reported on the claim with the surgical procedure(s).

Short of eliminating the remaining criteria and/or expanding the diagnoses for which separate observation payment is warranted, we encourage CMS and the APC Advisory Panel to continue examining the issues that remain, including the following:

- CMS states: “The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.” The language is confusing and vague. It may, moreover, expose providers to liability issues. We believe it would be simpler if CMS required that the physician and medical record support the medical necessity of the observation services.
- Simplify the reporting rules and create an objective standard for determining the medical necessity of the services, then make *all* F.I.’s apply the rules consistently. An objective standard for determining the need for observation services could be established by adopting proprietary guidelines (such as InterQual) as the national standard. CMS has previously adopted other proprietary systems for reporting under Medicare (e.g. CPT), so the process has a precedent. The PRT recommends that the QIOs be responsible for monitoring the reporting of services and issue denials similar to the monitoring performed on the inpatient side. This should relieve providers’ hesitancy to bill for observation services by eliminating their fear of fraud and abuse charges. It will additionally provide CMS with more complete data for the purpose of making administrative decisions.
- Tie physician reimbursement to hospital reimbursement and stop expecting hospitals to control how physicians practice medicine. If the case doesn’t meet the criteria for separate APC payment under G0244, then CMS could deny payment under 99217-99220, 99234-99236 for the physician under RBRVS.

### **E/M Services Guidelines**

CMS’ proposal to continue its examination of criteria for levels of care through an independent review of records will be very beneficial and result in better guidelines. The PRT suggests, however, that the guidelines developed should not focus solely on the emergency room and “urgent care”-type clinics. CMS should examine the variability within provider-based clinics: primary care clinics vs. specialty based clinics vs. chronic disease management clinics.

Providers are increasingly establishing many different clinics that are related to specific disease entities. Examples include clinics that provide treatment for chronic wounds (wound care clinics) and clinics that offer chronic care management for conditions such as diabetes, pain, congestive heart failure, or OBGYN. The spectrum of care ranges from simple clinic care that requires few resources to chronic care (or specialty clinics) that are involved in coordinating ancillary services and more complex discharge planning activities. Specialty clinics provide services, tests, and measurements that are not separately payable by Medicare under OPPS, yet facility resources, including nursing time, are expended in running these clinics.

In developing their own E/M guidelines, PRT members discovered that it is difficult to account for the resources expended in caring for specialty clinic patients solely by using the traditional criteria used to develop guidelines for the ED or urgent care clinics. Specialty clinics are beneficial in improving patients' quality of care because they offer specially trained nursing staff and see patients on an outpatient and periodic basis. During these visits the nurse (under the physician's orders) reinforces medical orders, conducts tests and measures to see if any part of the medical treatment plan needs to be changed. Nurses also provide education to enhance patients' understanding of how to manage a chronic illness. This education can reduce repeated outpatient visits to the hospitals, as well as an inpatient stay, both of which lead to cost-savings for Medicare.

### **Outlier Payments**

The PRT understands CMS' proposal to redirect outlier payments from "lower cost" (and relatively simple) procedures to more complex (and expensive) procedures for which not only is the costs for individual cases could be exceptionally high but also hospitals placed at greater financial risk. Yet, we believe that several of the 21 low cost services identified in the MedPAC report may have resulted in a large proportion of outlier payments, due to the presence of packaged charges on the claim.

For example, Medicare does not pay separately for most observation stays (other than chest pain, congestive heart failure, and asthma). The PRT believes that one reason high-level and low-level clinic visits may have resulted in outlier payments is due to packaged observation charges. The claims data used in the MedPAC study did not include the new G-codes Medicare created for direct admit; therefore, we believe it is plausible that providers reported an E/M clinic visit code for direct admits to observation. In fact, it is possible that other "low cost" APCs (such as X-rays and EKGs) were also present on observation service and/or on emergency department visit claims. In the latter cases, packaged dollars might be much higher than on expensive procedure visits where only one or two line items may have been reported. We believe the impact of packaged drug charges is the primary reason that drug administration resulted in high outlier dollars.

The PRT recommends that CMS conduct its own study and also ask for additional information from MedPAC on the impact of packaged charges for services that resulted in outlier payments. If CMS intends to continue to increase packaging in the future, the impact of packaged dollars cannot be ignored when examining services eligible for outlier payment.

## **Vaccine Reimbursement**

CMS proposes to repackage Rabies and Typhoid vaccines to the administration code since the median cost for these vaccines now falls below the \$50 drug threshold. Currently, both the vaccine administration CPT code (90471) and some of the vaccine product codes (e.g. Tetanus Toxoid, CPT 90703) are considered packaged services. Therefore, they do not generate any reimbursement when reported, unless the provider also reports an evaluation and management visit code (see our discussion above with respect to status indicator changes).

The PRT believes it is inappropriate to ask providers to report an E/M clinic visit code when the only service provided was an “injection.” This is particularly true in the case of patients receiving booster tetanus shots or a series of rabies shots, where the shot is the only service received, yet providers are forced to report an E/M code in order to be paid. Some providers are so uncomfortable with this practice—and so worried about their compliance risk—that they are actually adding language to their internally developed E/M guidelines to cover themselves for reporting E/M codes in these situations. Others are simply absorbing the cost of these services and not reporting them at all.

The problem remains, however, since most providers are confused about why they are required to report an E/M code when no E/M service was provided. This situation is particularly difficult to communicate to coding and nursing staff. Training staff to charge differently for Medicare vs. non-Medicare is challenging enough. Asking staff to charge for injection services as a broad category, and differently for vaccine versus drug administration, is becoming a logistical nightmare.

To provide an example: if a patient comes to the clinic for a subcutaneous administration of Procrit, providers bill for the drug and the administration separately and are reimbursed for both. Because the patient is only seen for a service that has a reimbursable CPT code, it is inappropriate to charge for a clinic visit as well; internal staff are aware of this. The same situation occurs for patients who receive antibiotics and chemotherapy. If a patient receives a vaccine, however, providers charge for the drug, its administration, and a clinic visit; doing so is the only way to receive payment for certain vaccines, since the vaccine is also packaged now. Hospital providers spend an enormous amount of time teaching staff proper charge capture and this dissonance in the rules causes confusion and errors.

An easy way for Medicare to support providers in the area of vaccine administration would be for CMS to simply assign the vaccine administration codes 90471 and 90472 a status indicator of “X”, and a payment rate equivalent to the payment rate for injection code 90782. We realize this is a lower payment rate, but the PRT believes that it is appropriate and will, in the long run, save providers time and resources.

## **Proposed Treatment of Specific APCs: APC 0659, Hyperbaric Oxygen Therapy**

On pages 50495-50496 of the *Federal Register*, CMS proposes a median cost of \$82.91 for APC 0659, which approximately reflects a 50% reduction in payment compared to the current 2004 payment rate for C1300.

Although CMS has carefully examined the 2003 claims data used to calculate the proposed payment rate, the PRT believes this data may be flawed in the same way CMS found the blood data to be flawed. The PRT believes there may be a significant distortion in the cost-to-charge ratios that CMS used to calculate HBOT costs. The PRT requests that CMS undertake the same level of review of HBOT cost to charge ratios as it did for blood and blood products. Reviewing the revenue centers used to report HBOT, and comparing them to how the revenue and expenses information is accounted for in the cost report, may reveal telling information about variations in RCCs across different providers.

The PRT urges CMS to use only the CCR for revenue code 413 for providers that use this revenue code. For those that do not, Medicare should create a revenue code in the same manner as was done for blood product costs.

### **Conclusion**

The Provider Roundtable thanks CMS and its staff for reviewing and considering our comments. Although we are a relatively new group, we hope to continue working together and providing CMS with comments and suggestions in the future. 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 one of our spokespeople, 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: Members of the Provider Roundtable**

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**Appendix B: Supplement to Table 20 - Device C-code to Procedure APC Cross-walk**

<b>HCPCS Code</b>	<b>OPPS Status Indicator</b>	<b>Long Description</b>	<b>Procedure APC</b>
C1713	H	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	046
			048
			057
C1714	H	Catheter, transluminal atherectomy, directional	080
			081
			082
C1715	H	Brachytherapy needle	312
C1716	H	Brachytherapy seed, gold 198	312
C1717	H	Brachytherapy seed, high dose rate iridium 192	312
C1718	H	Brachytherapy seed, iodine 125	312
C1719	H	Brachytherapy seed, non-high dose rate iridium 192	312
C1720	H	Brachytherapy seed, palladium 103	312
C1721	H	Cardioverter-defibrillator, dual chamber (implantable)	090
C1722	H	Cardioverter-defibrillator, single chamber (implantable)	090
C1723	D	Catheter, ablation, non-cardiac	152
C1724	H	Catheter, transluminal atherectomy, rotational	080
			081
			082
C1725	H	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	080
			081
			082
C1726	H	Catheter, balloon dilatation, non-vascular	141
			144
			146
			151
			152
			161
			162
			163
C1727	H	Catheter, balloon tissue dissector, non-vascular (insertable)	131
C1728	H	Catheter, brachytherapy seed administration	312
C1729	H	Catheter, drainage	122
			152
			153
C1730	H	Catheter, electrophysiology, diagnostic, other than 3d mapping (19 or fewer electrodes)	084
			085
			087
			094
C1731	H	Catheter, electrophysiology, diagnostic, other than 3d mapping (20 or more electrodes)	084
			085
			087

**Appendix B (continued): Supplement to Table 20 - Device C-code to  
Procedure APC Cross-walk**

C1732	H	Catheter, electrophysiology, diagnostic/ablation, 3d or vector mapping	084
			085
			086
			087
C1733	H	Catheter, electrophysiology, diagnostic/ablation, other than 3d or vector mapping, other than cool-tip	084
			085
			086
			087
C1750	H	Catheter, hemodialysis, long-term	115
C1751	H	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	032
			111
			117
			118
C1752	H	Catheter, hemodialysis, short-term	093
C1753	H	Catheter, intravascular ultrasound	080
			081
C1755	H	Catheter, intraspinal	222
			223
C1756	H	Catheter, pacing, transesophageal	087
C1757	H	Catheter, thrombectomy/embolectomy	081
			088
			093
			120
C1758	H	Catheter, ureteral	121
			160
			161
			162
			163
C1759	H	Catheter, intracardiac echocardiography	670
C1760	H	Closure device, vascular (implantable/insertable)	080
			081
			083
			264
			280
C1762	H	Connective tissue, human (includes fascia lata)	182
C1763	H	Connective tissue, non-human (includes synthetic)	182
C1764	H	Event Recorder, Cardiac	109
C1766	H		084
			085
			086
			087
C1767	H	Generator, neurostimulator (implantable)	222
C1768	H	Graft, vascular	080
			081
			088

**Appendix B (continued): Supplement to Table 20 - Device C-code to  
Procedure APC Cross-walk**

C1769	H	Guide wire	080
			081
			082
			083
			086
			087
			089
			141
			264
C1770	H	Imaging coil, magnetic resonance (insertable)	0336
			0284
			0337
C1771	H	Repair device, urinary, incontinence, with sling graft	132
			195
C1772	H	Infusion pump, programmable (implantable)	089
			093
			222
C1773	H	Retrieval device, insertable (used to retrieve fractured medical devices)	089
C1776	H	Joint device (implantable)	048
			057
C1777	H	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	089
			090
C1778	H	Lead, neurostimulator (implantable)	222
C1779	H	Lead, pacemaker, transvenous vdd single pass	089
			090
C1780	H	Lens, intraocular (new technology)	246
C1781	H	Mesh (implantable)	154
C1782	H	Morcellator	131
			190
C1784	H	Ocular device, intraoperative, detached retina	237
			248
C1785	H	Pacemaker, dual chamber, rate-responsive (implantable)	090
C1786	H	Pacemaker, single chamber, rate-responsive (implantable)	090
C1787	H	Patient programmer, neurostimulator	222
C1788	H	Port, indwelling (implantable)	093
			225
C1789	H	Prosthesis, breast (implantable)	030
C1813	H	Brachytherapy seed, nucletron iridium 192 hdr, mds nordion theasphere (yttrium-90) brachytherapy seed, mds nordion gamma med iridium-192 hdr brachytherapy seed	181
			182
C1815	H	Brachytherapy seed, nycomed amersham i-125 (oncoseed, rapid strand)	181
			182
C1816	H	Receiver and/or transmitter, neurostimulator (implantable)	222
			225
C1817	H	Septal defect implant system, intracardiac	083

**Appendix B (continued): Supplement to Table 20 - Device C-code to  
Procedure APC Cross-walk**

C1874	H	Stent, coated/covered, with delivery system	080
			081
			083
C1875	H	Stent, coated/covered, without delivery system	080
			081
			083
C1876	H	Stent, non-coated/non-covered, with delivery system	080
			081
			083
			162
			163
C1877	H	Stent, non-coated/non-covered, without delivery system	080
			081
			083
C1878	H	Material for vocal cord medialization, synthetic (implantable)	073
			075
C1879	H	Tissue marker (implantable)	029
C1880	H	Vena cava filter	091
			187
C1881	H	Dialysis access system (implantable)	093
C1882	H	Cardioverter-defibrillator, other than single or dual chamber (implantable)	089
C1883	H	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	089
			090
			225
C1885	H	Catheter, transluminal angioplasty, laser	080
			081
			082
C1887	H	Catheter, guiding (may include infusion/perfusion capability)	032
			080
			084
			082
			084
			085
			086
			088
			264
C1891	H	Infusion pump, non-programmable, permanent (implantable)	089
			093
			222
C1892	H	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	084
			085
			086
			087
C1893	H	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	084
			085
			086
			087

**Appendix B (continued): Supplement to Table 20 - Device C-code to  
Procedure APC Cross-walk**

C1894	H	Introducer/sheath, othe than guiding, intracardiac electrophysiological, non-laser	032
			080
			081
			082
			084
			085
			086
			087
C1895	H	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	089
			090
C1896	H	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	089
			090
C1897	H	Lead, neurostimulator test kit (implantable)	102
			222
			222
C1898	H	Lead, pacemaker, other than transvenous vdd single pass	090
C1899	H	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	090
C2615	H	Sealant, pulmonary, liquid	070
C2616	H	Brachytherapy seed, yttrium-90	312
C2617	H	Stent, non-coronary, temporary, without delivery system	151
			152
C2619	H	Pacemaker, dual chamber, non rate-responsive (implantable)	090
C2620	H	Pacemaker, single chamber, non rate-responsive (implantable)	090
C2621	H	Pacemaker, other than single or dual chamber (implantable)	090
C2622	H	Prosthesis, penile, non-inflatable	181
			182
C2625	H	Stent, non-coronary, temporary, with delivery system	151
			152
C2626	H	Infusion pump, non-programmable, temporary (implantable)	093
C2627	H	Catheter, suprapubic/cystoscopic	161
			162
			163
C2628	H	Catheter, occlusion	080
			081
			083
C2629	H	Introducer/sheath, other than guiding, intracardiac electrophysiological, laser	083
			084
			085
			086
			087
C2630	H	Catheter, electrophysiology, diagnostic/ablation, other than 3d or vector mapping, cool-tip	086
C2631	H	Repair device, urinary, incontinence, without sling graft	182
			195