

Ardent Health Services, TN
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
OhioHealth Corporation, OH
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 16, 2005

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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-1501-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 2006 Outpatient Prospective Payment (OPPS) Proposed Rule, as published in the *Federal Register* on July 25, 2005. 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 providers representing 18 different hospitals and health systems 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 OPSS is to improve with time.

1. Relative Weights

Bypass list

If the PRT understands correctly, the expanded bypass list that CMS is using resulted in the creation and use of more single procedure claims for the purposes of setting APC relative weights. We are very supportive of this, but remain concerned about two E/M codes that appear on the bypass list. If our understanding is correct, a code is placed 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 an analysis to verify this, we find it difficult to imagine that E/M codes 99213 and 99214 occurred less than 5% of the time with packaged services. The PRT would like to express caution about keeping these E/M codes on the bypass list, given that we typically provide both packaged services and other separately payable services when reporting CPT codes 99213 and 99214. Therefore, we urge CMS to remove these codes from the bypass list.

The PRT urges CMS to carefully consider add-on CPT codes and how they impact multiple procedure claims. For add-on CPT codes with SI "N", we recommend that the charges associated with the add-on CPT code first be packaged to the main CPT code so that the existence of two separately- payable APCs on the same claim with a packaged add-on code would not result in the claim being a multiple procedure claim. If the charges of the packaged add-on code are added to the main procedure code, then the remaining two APC payable services would be freed up as singleton claims. Therefore, by packaging charges associated with packaged add-on codes to the associated main procedure codes, CMS will be able to use more claims.

With regard to add-on CPT codes with APC assignment, we urge CMS to check whether the main procedure CPT and the add-on CPT are the only APC-payable services along with packaged line items that cause the claim to be a multiple procedure claim. If so, we urge CMS to use the main procedure CPT and the add-on CPT as a pair and apportion the packaged charges between these codes so that a correctly coded claim will be used in setting future rates.

A list of all add-on codes can be found in Appendix D of the CPT book.

2. Packaged services

The PRT would like to thank CMS and the APC Advisory Panel for the work they have done in reviewing codes with a packaged status indicator, particularly for services that may be the sole service rendered during an encounter.

First, we concur with the proposal to move bladder catheterization codes into separately payable APCs. Likewise, we thank CMS and the Panel for assigning APCs to vaccine administration CPT codes. These are excellent steps forward and we encourage both CMS and the APC Advisory Panel's Subcommittee on Packaging to continue reviewing other packaged codes that may warrant separate payment, either through an APC payment or through the use of the newly

proposed status indicator “Q”. To that end, and in response to the APC Panel’s request for additional detail, the PRT offers the following recommendations to CMS on several codes that we believe warrant separate payment, particularly when they are the only service provided to a Medicare outpatient in the hospital setting.

The PRT urges CMS to change the status indicators for the following codes for 2006:

- A. Non-selective Debridement CPT 97602. This code, introduced by CMS in January 2001, has a long and arduous history under OPSS. The description of the code is: “removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.”

From the outset, CMS assigned status indicator “N” for packaged services to this code. The rationale was not published until Transmittal A-02-129, in which CMS states: “CPT code 97601 is a physical therapy service and is paid under the Medicare Physician Fee Schedule. Payment for CPT code 97602 is recognized under the OPSS as a packaged service (i.e., the service is not separately paid under OPSS); however, the cost of the service is packaged into whatever other service is provided on that date. It is common for 97602 to be performed at the time of another physical therapy service in which case payment for 97602 is packaged into payment for the other physical therapy service. If a service coded under 97602 is performed at the time of a clinic or emergency visit, the E/M service must be documented in accordance with the hospital’s documentation guidelines for clinic and emergency visits. If the only service provided to a beneficiary is 97602, the hospital may bill outpatient visit code 99211. Payment for 97602 will be packaged into the payment for 99211. If a hospital provides and bills for 97601 or 97602 and a clinic or emergency department visit, the clinic or emergency visit must be separately identifiable and documented in accordance with the hospital’s guidelines for documenting clinic and emergency visits.”

CMS views these codes as physical therapy codes. These codes are not merely physical therapy codes, but also registered nurse codes. In fact, PRT providers report that registered nurses perform more wound management care in hospital settings than therapy providers. Physicians order patients to come to the hospital for wound care management services. Non-selective debridement is the only service the patient receives.

CPT Assistant gives an excellent example in their May 2002 issue: “A 70-year-old male who developed lower extremity ulcers as a result of venous insufficiency. The assessment reveals yellow necrotic tissue adherent to the wound base. The wound margin is undurated and inflamed. There is minimal clear serous drainage noted. It is determined that the patient would benefit from autolytic debridement. The wound and surrounding skin is lightly cleansed with a nontoxic cleanser. The wound is measured at 4.8cm x 3.1cm and the depth is undeterminable. An occlusive dressing (hydrocolloid/hydrogel) is then applied. The dressing is secured with a secondary dressing. The patient is instructed to inspect the bandage daily for break-through drainage.”

This type of visit takes a nurse between 30-45 minutes to assess, make the dressing change, and then instruct the patient. The only procedure performed is non-selective debridement, which is reported with CPT code 97602 along with billable supplies. Since no other service was provided, hospital charging staff are reluctant to report another service, even though CMS has stated that CPT code 99211 can be reported in order to generate reimbursement for the packaged service. This is problematic, not only because this is not intuitive for staff charging for the services they have provided, but also because non-Medicare payers only want to see the CPT code reported for the service actually rendered. Forcing hospitals to report an E/M code to receive reimbursement is a round-about way for paying for the non-selective debridement service. In response to our having raised this issue last year, and again in February at the APC Advisory Panel meeting, CMS stated that this code has moved to the Physician Fee Schedule (MPFS) where in 2005 it has a status indicator of "B". This further hurts hospitals because now the code cannot even be reported. Language in the 2006 NPRM (on page 42962) states: "under the MPFS, a separate payment is never made for a 'bundled' service and, because of this designation, the provider does not receive separate payment for non-selective wound care described by CPT 97602. While this code now falls under the MPFS rules, payment policy for this 'bundled' service has not changed and separate payment is not made."

CMS does not appear to realize that this neither helps hospitals nor solves the fundamental problem. In fact, CMS has now placed hospitals in the terrible position of having medically necessary visits meet the definition of an outpatient encounter and providing covered outpatient hospital therapeutic services with no means of payment under either MPFS or OPSS – unless, of course, hospitals once again report CPT code 99211. Furthermore, hospitals are not allowed to render services to Medicare beneficiaries and simply not charge for those services, as this would raise a compliance issue.

The PRT urges CMS to carefully review the use of this code and discuss, with its own clinicians, what this service is and why it can (and does) occur as the only service provided to outpatients in the hospital setting. To facilitate CMS' review, we have provided CMS' own definitions of what constitutes a hospital outpatient, a hospital encounter, and how non-selective wound care meets the definition of coverage of outpatient therapeutic services under OPSS.

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 Critical Access Hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH. *Non-selective wound care patients are registered outpatients of the hospital.*

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. *The nurse or therapist has*

direct personal contact with the patient to treat the patient. This falls under scope of practice laws for nurses and also therapists. Medical staff physicians order wound care services from the nurse or therapist on behalf of their patient that they are managing in their offices. Wound care nurses and therapists report the care back to the ordering physician.

Publication 100-02, Chapter 6. Section 20.4.1 - Coverage of 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. *Non-selective wound care patients meet the definition of covered outpatient therapeutic hospital services.*

Non-selective wound debridement will continue to be provided to Medicare outpatients in the hospital setting under OPSS. If CMS does not provide separate payment for this when it is the only service rendered, then hospitals who understand CMS' guidance will continue to be forced to report CPT code 99211. Others may not even charge for the service since it has a status indicator "A" under OPSS, but under the MPFS it has a status indicator "B" resulting in no separate payment.

Therefore, the PRT strongly urges CMS to assign the newly proposed status indicator "Q" to CPT code 97602 so that separate payment can be made when this is the only payable service provided under OPSS. The OCE can package payment for 97602 when there is another APC-payable service on the claim, and generate a separate APC payment, using the same payment assigned to APC 600.

- B. Collect Blood Venous Device 36540.** CMS continues to assign this code a status indicator "N". Physician's offices often order patients to go to a hospital for blood work in cases where the patient has a venous access device. Drawing blood for lab work from a venous device requires that a registered nurse assess the patient, and then use a sterile kit with a needle to access the device, draw the blood, and flush the port afterwards to ensure patency. It typically takes 15-20 minutes to perform this procedure. This is a much more resource-intensive service than a simple venipuncture, yet venipuncture is paid separately under the Clinical Lab Fee Schedule, while CPT code 36540 is considered packaged.

Again, hospitals will only receive reimbursement for this service when it is the sole service provided if they report an E/M visit code. As stated above, this is not intuitive for the individual charging for these services. Moreover, private payers only want the hospital to report the actual service provided -- in this case, CPT code 36540 and not the E/M code. If CPT code 36540 remains packaged under OPSS with status indicator "N", then many hospitals will just report the E/M code 99211 instead of 36540. They will do so because it is extremely difficult to take a single service and break it into two charges (99211 and 36540) just to report that 36540 was the only service rendered. For this reason, CMS will lack accurate data on 36540. Furthermore, claims with 99211 represent a myriad of services, not just low-level clinic visits.

Therefore, the PRT strongly urges CMS to assign the newly proposed status indicator “Q” to CPT code 36540 so that separate payment can be made when this is the only payable service provided under OPSS. The OCE can package payment for 36540 when there is another APC-payable service on the claim, and generate a separate APC payment, using the same payment assigned to APC 600.

- C. Withdrawal of Arterial Blood 36600. CMS continues to assign this code a status indicator “N”. Similar to the comment above about separate payment being made for a simple venipuncture, we do not understand why CMS will not make separate payment for an arterial blood draw -- which requires more effort and carries more risk to the patient than a simple venipuncture. This code is reported when blood is drawn from an artery for diagnostic purposes – most often as a means of drawing Arterial Blood Gases. Currently, CMS reimburses for the ABG, but not the arterial stick. It is possible to attempt to draw arterial blood and not be successful. Arterial sticks require specialized training to perform.

The PRT strongly urges CMS to assign the newly proposed status indicator “Q” to CPT code 36600 so that separate payment can be made when this is the only payable service provided under OPSS. The OCE can package payment for 36600 when there is another APC-payable service on the claim, and generate a separate APC payment, using the same payment assigned to APC 600.

- D. Injection Procedure for Sentinel Node ID 38792. This X-ray injection code, like others such as CPT code 42550, are assigned status indicator “N” and separate reimbursement is not made for them. The PRT agrees that separate reimbursement should not be made for these injection codes when they are provided along with a separately payable procedure APC. Cases exist, however, when the injection is the only service provided -- particularly when the procedure cannot be completed due to the patient having a reaction to the injection and no X-ray was taken, or where the injection is provided by the hospital outpatient department and the procedure provided by a different facility/provider. In such admittedly infrequent cases, hospitals should be able to recoup reimbursement for these services without being forced to report the entire procedure with a modifier -52 for reduced services. In fact, if providers report the actual procedure, CMS will make greater payments than it would if CMS simply paid for the injection procedure itself.

Therefore, the PRT strongly urges CMS to assign the newly proposed status indicator “Q” to CPT code 38792 so that separate payment can be made when this is the only payable service provided under OPSS. The OCE can package payment for 38792 when there is another APC-payable service on the claim, but can generate a separate APC payment using the same rate as proposed for Level I injection codes when this is the only billed service.

- E. Irrigation of implanted venous access device for drug delivery systems – (expected 2006 CPT code 96523).** Irrigation of implanted venous access device for drug delivery systems – (expected 2006 CPT code 96523). In Table 27, page 42739, CMS proposes to assign this new service/code a status indicator “N”. The PRT cautions CMS against doing this, since occasions exist when irrigation of an implanted venous access device is the only service rendered to hospital outpatients. If this service is not separately payable, then hospitals will be faced with the problem of having to report an E/M visit code in order to receive payment. CMS should understand that private practice physicians often send patients to the hospital with an order to “flush the venous access device”. Under this order, a Registered Nurse assesses the patient and the device. A sterile kit with sterile needle is used to access the device to ascertain whether the device is patent by receiving blood flow with aspiration and flushing of the device. In the instance of a new device, there is additional time spent to remove the original dressing and redress the site. If allowed to go untreated, these conditions could lead to more invasive and expensive procedures, including removal of the existing device and implantation of a new device. This service would not be expected to generate separate reimbursement when it is provided on the same day as other services such as IV infusion therapy, IV push medications, blood transfusions, or blood draws. In fact, it is likely that this service will be a component NCCI edit to the above procedures and will not be able to be reported or billed when the other services are provided. Currently, hospitals must report the flush service when it is the only service provided during the visit with an E/M code in order to receive payment for the resources expended.

We appreciate the new code for this service and urge CMS to assign the newly proposed status indicator “Q” to CPT code 96523 so that separate payment can be made when this is the only payable service provided under OPSS. The OCE can package payment for 96523 when there is another APC-payable service on the claim, and generate a separate APC payment, using the same payment assigned to APC 600.

The PRT urges CMS to assign the following packaged codes to a specific APC for payment:

- A. Fluoroscopy Greater than One Hour 76001.** Hospitals should be able to report fluoro over one hour and receive separate reimbursement for this service, since it takes more time and resources than are required for fluoro under one hour (which is represented by CPT code 76000). CPT code 76001 initially started as “N” status, then was changed to “S” status and paid, then changed back to “N” again. There are a small number of cases in which fluoro is required for over an hour, and hospitals should receive separate reimbursement for this service to cover the resources they have expended. CPT 76001 is not an add-on code. A fluoroscopy procedure is either under one hour (and the provider reports 76000) or over one hour (and the provider reports 76001). Therefore, the PRT urges CMS to change the status indicator of CPT code 76001 from “N” to “X” and assign it to APC 0272.
- B. Bladder Catheterization for Specimen P9612.** In keeping with CMS’ excellent decision to separately pay for bladder catheterizations under OPSS, the PRT urges CMS to do the same for CPT code P9612. This procedure occurs in the Emergency and other

Departments when the patient is unable to perform the steps necessary for a “clean catch” sample and the nurse catheterizes to obtain a clean urine sample for clinical lab testing. This service requires the same level of effort and resource use as CPT code 51701. Therefore, the PRT urges CMS to treat it in the same manner as CPT code 51701 by assigning it to APC 0340 and making separate payment for this service.

- C. Placement of occlusive device G0269. HCPCS code G0269 is a procedure which has a specific device associated with it. CMS has packaged both the procedure code G0269 and the device C-code (C1760) into endovascular APCs. This makes an assumption that this device and procedure are performed 100% of the time with other endovascular procedures. The reality is that this is one option for sealing the entrance site at the conclusion of an endovascular procedure. The PRT believes that payment would be more accurate to allow separate payment for the G0269. The PRT also believes that G0269 should be classified as a device-dependent APC, requiring the reporting of both G0269 and C1760 on the claim. C1760 would be appropriately packaged into G0269. This would enable CMS to create an edit for claims so that G0269 and C1760 must both be reported and paid separately through an APC payment.
- D. Continuous Overnight Oximetry Monitoring 94762. The PRT recommends that the status indicator for CPT code 94762 -- Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure) -- be changed from “N” for packaged service to “X” and assigned to APC 0369 (Level III Pulmonary Tests).

Overnight Pulse Oximetry (94762) is indicated when the patient has a condition for which intermittent arterial blood gas sampling, or intermittent pulse oximetry measurement, is likely to miss important variations (e.g., sleep apnea); or when the patient has a chronic condition resulting in hypoxemia and there is a need to assess supplemental oxygen requirements and/or a therapeutic regimen. Medical literature indicates that identification of hypoxic patients in chronic obstructive pulmonary disease is important because there is a demonstrated survival benefit from long-term oxygen therapy (LTOT) in these patients.

Patients suffering from hypoxemia may experience different levels of oxygen desaturation while resting versus exertion and at night. Resting or single determinations of oxygen saturation via pulse oximetry or via arterial blood gases are the standard methods of making a determination of need for LTOT. A single measurement will not measure the patient's oxygenation during sleep or during daily living activities, however. Patients who would truly benefit from oxygen therapy may be missed if a single determination indicates an adequate SaO₂ at rest or if, during a short walk, the patient is able to maintain a SaO₂ that fails to meet medical necessity for oxygen therapy. Conversely, single determinations may identify a brief drop in PaO₂ which falsely indicates a need for oxygen therapy and thereby increases CMS expenditures for oxygen therapy.

For patients with symptoms of suspected sleep apnea, continuous measurement during a period of sleep would be instrumental to the diagnosis of the patient's problem.

Polysomnography is a more complex and expensive test that is often used to diagnose sleep apnea. The polysomnography codes are currently assigned to APC 0209 and reimbursed at \$661.97. Overnight pulse oximetry can be administered at a lower cost to rule out hypoxia during sleep, and avoid the more expensive testing for many patients.

When pulse oximetry is the only service provided to a patient in the outpatient setting, hospitals must report an E/M service in order to receive payment. Under OPSS rules, provision of this service has shifted to other settings. Physician clinics receive reimbursement for oximetry testing but usually do not have the hours of operation and resources to conduct overnight testing. This leaves testing in the patient's home as the only other option. To obtain valid test results in this setting, however, the patient must understand how to set-up and perform the procedure and must correctly follow through with it. It is not uncommon for poor or unusable results to be obtained via at-home testing, which leads to repeat testing and frustration for both the patient and family.

Assigning 94762 to a payable APC would accomplish two things. It would allow hospitals to provide a valuable service with appropriate reimbursement, and would potentially decrease the amount of money CMS expends for assessments for oxygen therapy and evaluation of patients with sleep apnea. With a proposed payment for 2006 of \$162.58, APC 0369 includes other procedures with similar resource intensity (94070, 94621, and 94772) and would be an appropriate assignment for 94762.

Therefore, the PRT strongly urges CMS to assign CPT code 94762 to APC 0369 for 2006.

3. Two-times rule

CMS proposes to move CPT codes 75820 and 75822 from APC 0281 to APC 0668, and to move CPT code 75790 to APC 279. The PRT does not understand why CMS did not propose assigning all three CPT codes to the same APC -- APC 0279 -- since the resources required to perform all three are similar for the following reasons:

1. The supplies required to perform the services described by CPT codes 75820, 75822, and 75790 are similar. All three require the use of guidewires, catheters, local anesthetic, and contrast.
2. CPT code 75822 is a bilateral procedure; hence, the supplies required and the overall resource use is greater since two different sites are accessed in order to perform the procedure. For this reason, it does not make sense to move CPT 75822 to APC 0668, as APC 0668 has a lower payment rate than APC 0279, the more appropriate APC.
3. CPT code 75658 (which is already in APC 279) is similar to CPT codes 75820, 75822, and 75790. The only difference is whether a vein is accessed versus an artery in an extremity.

For these reasons, the PRT respectfully requests that CMS move CPT codes 75820, 75822, and 75790, to APC 0279. For clarity, we also recommend that CMS change the title of APC 0668: “Level I Angiography and Venography except Extremity” to exclude language referring to extremities since none of the other CPT codes assigned to this APC relate to extremities.

4. New Technology APC

The PRT has two concerns with respect to the smoking cessation codes G0375 and G0376. Our first concern has to do with why the codes are assigned to New Technology APCs, given that smoking cessation counseling is not a “New Technology” and there are other, existing, APCs to which the codes could be assigned. The second has to do with CMS’ proposed payment reduction resulting from moving these codes from their current New Technology APC placement with payment a rate of \$25.00 to two lower-paying APCs. The lower payment rate will neither support hospital programs to provide the counseling services nor encourage separate reporting of smoking cessation counseling for tracking purposes.

In the document, “Process and Information Required for a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS)”, posted on the CMS HOPPS web page with an effective date of July 26, 2005, CMS indicates the following criteria for a service to be eligible for a new technology APC:

- The service is one that could not have been adequately represented in the claims data being used for the most current annual OPSS payment update.
- The service does not qualify for an additional payment under the transitional pass-through provisions established under section 1833(t)(6) of the Social Security Act and in Subpart G, Transitional Pass-through Payments in the regulations at 42 CFR 419.
- **The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs.**
- The service falls within the scope of Medicare benefits under section 1832(a) of the Act.
- The service is determined to be reasonable and necessary in accordance with section 1862(a)(1)(A) of the Social Security Act.

The Smoking Cessation codes G0375 and G0376 are defined as counseling services with the word “visit” as part of the codes’ descriptions. Counseling is generally considered part of the provider’s evaluation and management service; indeed, information published on the new smoking cessation codes (Transmittals 36 and 562) indicates that smoking cessation counseling provided for less than three minutes is: “bundled into the normal evaluation and management visit”. In a hospital facility, the service will be provided in an outpatient department as a clinic visit subsequent to an order by the patient’s physician. The resources required to provide smoking cessation counseling are similar to those required for a facility low-level clinic visit. This means both G0375 and G0376 can “reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs”, making the New Technology APCs an inappropriate assignment for these codes. The PRT recommends that CMS assign HCPCS codes G0375 and G0376 to APC 0600 instead of to the proposed New Technology APCs.

Not only does the assignment of these codes to a clinic visit APC make more sense, but it also will result in more adequate reimbursement for the services. Following work conducted by the Medicare Healthy Aging Initiative, the smoking cessation counseling codes were developed to encourage physician and hospital providers to offer counseling for smoking cessation and to allow CMS to separately track the services for frequency and effectiveness. The new codes were implemented in March of 2005 with a reimbursement rate of \$25.00. Even at this below-cost reimbursement, hospitals began to develop business plans and made decisions to offer the new smoking cessation service because clinicians agree that smoking cessation is important for Medicare beneficiaries that smoke. If the lower payment rates proposed in the 2006 OPSS rule are finalized, CMS may see smoking cessation counseling provided primarily in the physician's office rather than the hospital outpatient setting. CMS should set reimbursement at a level that allows hospitals to support this important service and encourages them to separately report G0375 and G0376 for tracking purposes. Therefore, the PRT urges CMS to assign both G0375 and G0376 to APC 600 for a low-level clinic visit.

If CMS does not accept the above recommendation, then CMS must clarify the final payment rates and assignment of G0375 and G0376, since Table 10 and Addendum B are inconsistent and show different payment rates for the codes. Table 10 shows HCPCS code G0375 assigned to APC 1491 with a payment rate of \$5.00 and G0376 assigned to APC 1492 with a payment rate of \$15.00. Addendum B shows both codes assigned to APC 1491; the APC with the lesser payment rate of \$5.00.

Stereotactic radiosurgery (Cobalt-60)

The PRT is concerned about CMS' proposal to combine Cobalt 60-based SRS planning and treatment delivery codes G0242 and G0243 respectively. These are two separate services and modalities and should be considered as such. Combining these two codes deviates from the general standard of practice, currently in place for charging Radiation Oncology services, in which the plan of the treatment and the actual delivery of the treatment are separately charged.

Combining the planning service with the actual treatment delivery assumes two things. First, that the plan is the same each time; in reality the plan is different based on the diagnosis, the number of lesions being treated, and the size and location of each lesion. In other words, two patients that both have one lesion may not have the same plan: one lesion could require two shots to treat due to its size, while the other could require a greater number of shots. The planning phase is often quite intricate and time-consuming, and must be done with great care, since one dose of gamma radiation could be lethal.

The second, and perhaps the more important, reason why the two codes should not be combined is because there are instances in which planning occurs but the treatment is not provided. Radiation Oncologists at one of the PRT hospitals stated that: "a treatment cannot be provided without the plan, but the plan can be provided/created without the treatment ever being delivered". If the two codes are combined, CMS may end up overpaying if a payment is made using the code for the day the plan is created as well as the day the treatment is delivered (only in cases when both are not provided on the same day). A more likely scenario is that CMS will end

up requiring hospitals to report modifier -52 with the code when the plan is created but the treatment is not delivered. While this can be done, CMS will still pay 100% of the procedure payment rate and when the same code is billed again on the day of treatment, CMS will again make 100% of the APC payment unless some sort of special cross-claim logic is created in the APC to find such claims so that no overpayments are made.

Sometimes, after the patient has been framed and the MRI scan has been accomplished, problems arise that result in the actual treatment being delayed. Examples include when a lesion is outside of the framed area, or multiple lesions appear from the initial MRI scan. In these instances, additional planning is necessary to adequately treat the additional areas. Under the proposed rule, the only billable item is the planning with the delivery reported on the day of the actual treatment delivery. Without separate codes, CMS might end up reimbursing for both services (since they will occur on different days) and making double payment. CMS might require hospitals to report modifier -52 in these cases but, since reimbursement is still being made at 100%, providers would again receive full payment on both the planning day and the treatment delivery day. This becomes a problem administratively because of the adjustments that need to be made “behind the scenes” to reduce charges and to make sure the modifier is attached.

Finally, it should come as no surprise to CMS that hospitals have been confused about reporting these codes as well as the planning code for linear accelerator-based SRS (G0338) since CY 2004. For this reason, CMS should proceed carefully in its use of the 2004 claims data to set 2006 payment rates. The PRT believes that, by keeping things as they are for one more year, CMS will be more likely to collect reliable data for use in setting 2008 payment rates.

The PRT also understands that CMS has requested comments on the use of existing CPT codes instead of the planning and treatment delivery G-codes for Cobalt-based SRS. While this will be another change in Radiation Oncology coding/billing, the PRT favors this proposal over combining planning and treatment into one code, as the codes for planning and treatment are currently separate in the CPT.

5. Device-Dependent APCs

Over the past several years CMS has employed a variety of methodologies to set rates for device-dependent APCs, and those methodologies have changed from year to year. This has been necessitated because providers have historically not appropriately reported charges and codes for procedures and devices, based on whatever reporting mandate was in place. By using 2004 claims data, CMS faces the obstacle of setting 2006 payments without complete and accurate information for device-dependent APCs.

Since the reporting of reinstated device HCPCS codes was optional in 2004, most providers had no sense of urgency in accurately reporting the codes. Thus, CMS does not have adequate data to use in creating the payment rates for device-dependent APCs for 2006. CMS has proposed using all single bills using claims data both with and without C-codes in setting APC rates, and has proposed to limit the downward adjustment to 85% of CY 2005 payment rates. The PRT does not believe this is enough of an adjustment, however, given that the incorrectly reported claims

data are similar to the situation that occurred in 2005, when no device coding existed because the codes had been deactivated.

The PRT recommends that CMS freeze payment rates for device-dependent APCs in 2006 at the current 2005 payment rates. This will minimize the instability providers have experienced with the payment rates over the past several years. Furthermore, by freezing the payment rates at the 2005 level, CMS may prevent even greater payment rate fluctuation in 2007 when device C-coded claims data from 2005 are used to set payment rates. We believe the 2007 median cost data for device dependent APCs will be more similar to the current 2005 payment rates than to the ones proposed for 2006, even with the proposed 15% dampening.

At an absolute minimum, if CMS does not freeze the rate, the PRT urges CMS to employ the methodology used for this year's device-dependent OPSS payment rates: to limit the adjustment of 2006 median calculations to 95% of the CY 2005 OPSS payment median, resulting in only a 5% payment decrease.

Finally, the PRT does not believe CMS is using claims data with device C-codes with a nominal line item charge (i.e., \$1.00) to set payments; nor do we believe these claims should be used to create median costs and APC relative weights. In the final rule, we ask that CMS confirm that line items with a nominal charge were not used to set median costs.

Claims subject to a device recall should also not be used to develop median costs and relative weights, as these line items presumably also carry a nominal charge. CMS may need to provide clear guidance on how providers should not report devices recalled on the claim form using a special condition code or a value code. This would enable claims with the condition or value codes to be isolated for review and exclusion from the rate-setting process.

The PRT believes that CMS erred when it stopped making separate payment for high-cost devices and instead packaged the "costs" into the related procedure APC, thus providing payment for both the device and the procedure through one APC payment. As CMS is aware, providers are not perfect in reporting items that do not generate separate payment. Unless the majority of hospitals are diligent about reporting all of their services (including packaged services) accurately and completely, payment rates will not reflect the data reported by those providers that do report correctly, since the data are averaged together. If CMS paid for high-cost devices separately, it would certainly receive accurate and complete data. Since the majority of devices are packaged, and since reporting them has been optional, the claims data remain incomplete and inconsistent.

The PRT urges CMS to review the concept of paying for high-cost devices separately rather than "packaging" the costs into the procedure payment rate. A standard definition of high-cost devices would need to be created, and we recommend defining high-cost devices as those with a cost greater than 50% of the APC payment rate.

6. Pass-Through Device Categories

The PRT would like to thank CMS for soliciting providers' input regarding devices. The questions CMS asked were well thought-out and concise. We whole-heartedly support the inclusion of natural orifices as an opening when defining a device. This change will allow non-invasive technology to continue to grow.

In addition, this definition will be much easier for both those charging for the services at the point of care and coding staff to understand and operationalize. This is a positive change for both providers and beneficiaries; the PRT appreciates the detailed discussion provided in the proposed rule.

7. Drugs

The PRT understands that CMS' has proposed to pay for all separately payable drugs (except new drugs without HCPCS codes) using average sales price (ASP) plus 6%, which is similar to estimates in the physician office setting of "average acquisition cost". In addition, CMS proposes to pay an additional 2% of ASP to cover the handling cost or pharmacy overhead component of drug payments. Both components are reflected in the drug APC payment rates as published in Addendum B of the 2006 OPSS proposed rule.

The PRT has concerns about the proposal to pay an additional 2% of ASP for handling costs and CMS' proposal that hospitals will be required to report new drug handling C-codes starting January 1, 2006 in order to capture drug handling charge data which CMS may use to create separate drug handling APCs in the future.

Before we detail our concerns about these two issues, the PRT offers the following comments about brand vs. generic codes, payment for new drugs without HCPCS codes, determining how to package drugs in the future, and IVIG.

Brand vs. Generic

By using the ASP model, CMS no longer needs to collect brand vs. generic drug data and has, therefore, proposed to eliminate the use of the brand name drug C-codes. The PRT strongly supports the recommendation to eliminate these codes, as it will simplify how providers charge for brand and generic drugs. The PRT requests, however, that CMS clarify how it determines the average sales price used to reflect payment for both brand and generic drugs since the drugs available for purchase vary. The PRT seeks clarification about whether CMS has taken an average price based on the volume of brand vs. generic drugs purchased by providers during a given quarter.

New Drugs Without HCPCS codes

The PRT supports CMS' continued method for paying for all new drugs without HCPCS codes using C9399 and the rules published in the May 28, 2004 Transmittal 188, Change Request 3287, for reporting new drugs without HCPCS codes.

Non-Pass-Through Drugs (determining how to set a threshold for packaged drugs in the future)

The PRT understands that CMS has requested comments on how to package drugs starting in 2007. The PRT appreciates the opportunity to comment and strongly believes CMS should provide separate payment for all infused and injectible drugs regardless of the “per day median” cost, and only continue to package oral drugs. This approach would create consistency in payment policy between the hospital and physician settings. CMS has already begun this process by aligning payment for many separately payable drugs this year (and even more so in 2006), as well as by proposing to require the same drug administration CPT codes in both settings starting in 2006.

The PRT believes that CMS cannot intend to create consistency in some areas while leaving large differentials in others. For example, physicians receive higher payments for drug administration services and are paid for multiple administrations and hours of infusion service; hospitals are not. There are, of course, reasons for this differential, based on the lack of hospital data, but this lack is expected to be eliminated as CMS collects more data from hospitals in the future. In other areas, such as drug packaging, there is no shortage of data and CMS should align payment policies and incentives so that physicians and hospitals are treated equitably beginning in 2007.

Therefore, the PRT recommends that CMS pay separately for all infused and injectible drugs, most of which, we believe, have a HCPCS code.

Intravenous Immune Globulin (IVIG)

In April 2005, CMS eliminated two existing immune globulin (IVIG) HCPC codes (J1563 and J1564) and replaced them with four new “Q” codes. The new Q-codes are still based on 1gram and 10mg dosages, but distinguish between lyophilized and non-lyophilized forms of IVIG. The payment rates for the four new codes are the same regardless of formulation, and remain similar to the payment rates released for the J-codes in January 2005. Both the 1g codes have a payment rate of \$80.68 while the 10mg codes have a payment rate of \$.75. The PRT does not understand why CMS made this change given the additional burden such changes place on providers.

Other payers may not recognize the different codes used by CMS, forcing providers to maintain separate charges for both codes in their CDMs based on payer type. Providers also have to manually change the billed codes into codes recognized by non-CMS payers in order to bill secondary insurers for the patient’s Medicare co-pay.

In addition, it is not clear why the new codes distinguish between lyophilized and non-lyophilized IVIG. Given the shortages of IVIG, hospital pharmacies purchase whichever version is available in order to supply it to patients. In fact, pharmacy staff cannot ensure a consistent inventory of IVIG and must physically check their inventory to identify which drug form is in on the shelf before putting a charge in the computer.

While changes in 2005 have led to operational problems such as those described above, the issue for 2006 is expected to be worse given the proposed payment rate reductions for IVIG. In 2006,

CMS proposes different payment rates for each of the four IVIG codes, and decreases in payment rates ranging from 24% to 51%. Such reductions are unacceptable, given patients' need for IVIG. The PRT strongly urges CMS to revert to its original J-codes and maintain IVIG payment rates at the January 2005 level.

2006 Proposed Drug Payment Rate Methodology

The PRT has no fundamental problem with CMS' use of ASP+6% to set the average acquisition cost. We are concerned, however, about CMS's proposal to reimburse providers' handling costs and overhead expenses at 2% of ASP. Given that MedPAC found that pharmacy handling costs represent 26% to 28% of the total cost of providing drugs, it seems unreasonable for CMS to allocate just a fraction of that estimate to the drug payment rate to cover hospital handling costs/overhead expenses.

The PRT understands that CMS reviewed three different data sets to generate the final proposal for reimbursing separately payable drugs in 2006. On page 42725, CMS states that it compared the following: 1) GAO acquisition data for 55 separately payable drugs accounting for 86% of Medicare spending for specified covered outpatient drugs; 2) ASP data from 475 drugs payable under OPSS (CMS does not include the percentage of payment these drugs constitute); and 3) mean cost data from calendar year (CY) 2004 claims (which differs from the 'median' cost calculation used in all prior years of OPSS rule-making).

From this comparison, CMS determined that ASP+8% would cover both the average acquisition cost (ASP+6%) and pharmacy handling (ASP+2%), which appears to be over-simplistic. The PRT assumes that CMS did not calculate the impact of using a 'median cost' from CY 2004 claims on the 2006 proposed payment rates. CMS has arguably accounted for drug handling and overhead in the 'median' cost payments for these drugs, yet CMS proposes to pay for them using 'mean' costs. The PRT requests that CMS conduct and release an impact estimate on the 2006 proposed payment rates, by drug, of the difference between using the "median cost" vs. the "mean cost" to come up with the ASP+6%+2% model.

The PRT's group of 18 providers estimated our individual pharmacy handling costs and found them to range from 28.71% to 133.11% of total pharmacy costs. In preparing our estimates we used cost report line numbers for both direct pharmacy costs (Worksheet B, Part 1, Column 0, Line 56) and indirect pharmacy costs (Worksheet B, Part 1, Column 27, Line 56 Less Worksheet B, Part 1, Column 0, Line 56). If PRT members can compute this simple analysis and quickly estimate our pharmacy handling costs as a percentage of total pharmacy cost, it should be feasible for CMS to conduct a similar analysis using cost report data from all hospitals. Despite the fact that the data would be two to three years old, CMS would nonetheless have another data source showing an estimate of average pharmacy handling costs as a percentage of total costs for all Medicare providers.

The PRT is challenged to create a recommendation that is fair and appropriate for estimating pharmacy handling costs, particularly in the short time since publication of the proposed rule. Despite the results from our own survey data, the PRT recognizes that it is unreasonable to ask CMS to increase ASP+2% to ASP+100% -- or even ASP+30% -- to cover pharmacy handling

costs. We strongly urge CMS to gather additional data and study this issue further. Therefore, we recommend that CMS simply dampen drug payment rates in 2006 so they are no lower than 95% of the current 2005 drug payment rates. CMS has done this with other APC services, and we believe it is appropriate for drug payment rates.

Capturing Drug Handling/Overhead Cost Data using C-codes in 2006

The PRT also wishes to comment on CMS' proposal to require hospitals to report one of the three newly proposed drug handling C-codes to reflect separate line item drug handling charges. The PRT wishes to describe the extremely serious financial and operational consequences that will result if CMS finalizes its proposal to require C-codes for drug handling charges for 2006.

Financial considerations

It is important for CMS to consider that Medicare providers must charge all payers in the same way. This is specified in Provider Reimbursement Manual (Publication 15, Part I, Chapter 22, §2204). It is impossible for providers to report a J-code drug to Medicare with a dollar amount that does not include handling costs, and a different (higher) charge to another payer using the same J-code. CMS seems to believe that other payers will follow its lead in separately recognizing and paying C-codes for drug handling -- but this is not necessarily true. In an environment of cost containment and cost pressures, private payers maximize their own best interest, even when this means being inconsistent with CMS. Many hospitals currently struggle with other payers to recognize some J-codes for drugs.

Even in the unlikely event that other payers follow CMS' lead, they will not all be ready on January 1, 2006, and a differential will exist from the beginning of the new process. Even if other payers accept both the HCPCS code for the drug, and a C-code for the handling charge, providers are likely to lose money if they are currently being paid on a percent of charges associated with the HCPCS drug code. In order to stay revenue neutral, therefore, hospitals would have to charge Medicare one (lower) charge for the J-code while charging a different (higher) charge to other payers. This is not allowable, however, as providers must bill consistently regardless of payer. Therefore, CMS should carefully consider how its new proposal to require drug handling C-codes will impact providers in general, and not just in terms of Medicare.

CMS should recognize that pharmacy handling costs are already built into the overall drug charge. For this reason, the use of special codes to capture only the handling charge will create additional work for providers. They are unlikely to report the codes accurately or set charges correctly since no separate/additional payment will be made for the use of these codes for the foreseeable future.

It appears that CMS expects providers to adjust the charge of each drug and then create new charges for each drug handling category. It is not clear if CMS expects the handling charge reported to only reflect the "handling effort/expense" of the pharmacist or total overhead for pharmacy. For example, proposed Category 2 includes "single IV solution/sterile preparation (adding a drug or drugs to a sterile IV solution)" and "compounded/reconstituted IV preparations (requiring calculations performed correctly and then compounded correctly)". A nurse can add a drug or drugs to a sterile IV solution; for example, mixing the pre-measured powder antibiotic

that is packaged in a vial connected to a small bag of IV fluid (e.g., Ancef). A licensed pharmacist handles all drugs that must be compounded or reconstituted, and calculated based on the patient's body weight (e.g., Adenosine). This requires precise calculations and formulations of the drugs to ensure that the correct dosage is administered. Where there is a difference in cost between the handling performed by a nurse and that performed by a pharmacist, it is not clear if hospitals are required to report a blended or average cost. Alternatively, CMS might expect hospitals to report the actual cost based on the discipline that handles the drug.

This is just one example of how hospitals will have to develop appropriate handling charges for each C-code. Hospitals will not reduce their charges for drugs, as this would cause havoc with hospital revenue. Any change in drug pricing will take careful planning and time, far more than is available between publication of the final rule and the codes' proposed implementation date on January 1, 2006.

Operational considerations (coding, billing and charging issues)

The proposed use of the drug handling C-codes also raises a number of operational questions that CMS must consider before moving forward with implementation. The PRT questions whether CMS expects multiple line items to be reported per date of service if multiple drugs from the same drug handling family are provided. Alternatively, CMS might expect that only one drug handling C-code from each category, as applicable, would be reported on a given date of service with multiple units of service if multiple drugs from the same category are administered.

It is also not clear whether CMS will require providers to report a single revenue code with the pharmacy handling C-codes, or whether the revenue codes will need to match the actual drug revenue code reported. If the revenue code has to match the drug revenue code, then providers will have to create multiple Charge Description Master line items; this will result in increased burden to maintain the CDM. For example, if CMS allows providers to report handling charges using revenue code 636, then only three charges (one for each handling C-code) would be added to the CDM. If providers have to report handling charges using the exact same revenue code as the drug HCPCS, however, many more line items will need to be added to the CDM (i.e., handling charges will need to be set up under revenue codes 250, 636, 637, 259, etc.). The latter process is cumbersome to build and maintain.

Claims processing systems allow reporting of items under revenue codes in one of two ways: either by rolling up all items into one line item that reflects the total quantity and total charge billed under that revenue code; or by reporting a detailed listing of charges on individual line items. The revenue code assignment will dictate whether the handling codes are rolled up into one line item with everything else reported in that revenue code, or detailed out on the claim in a single line item per C-code with multiple quantities on a particular date of service. Again, claims processing systems cannot summarize some line items and detail others if all are reported with the same revenue code. Depending on the revenue code(s) assigned for these handling codes, the claim could become very long and burdensome for both the provider and payers.

Another example of an operational concern involves whether the C-code charge can be generated automatically or if it will have to be added manually on the back end of the billing cycle. Many hospitals utilize point-of-service charging in areas such as the Emergency Room, outpatient

oncology units, PACU, etc. Medications in these areas are charged as they are ordered and administered. Requiring an additional charge to be entered for handling the medications will create a high compliance risk. First, many of these areas have secure systems (such as a Pyxis or Omnicell) for storing medications. When a medication is removed for administration, the charge is sent electronically from this system to the hospital's billing system. Adding a handling charge will require manual intervention, since these systems are not set up to assess an automated handling charge.

A sampling of other operational issues and questions related to the use of drug handling C-codes are listed below:

- If a physician's order states, "Demerol 50 mg and Phenergan 25mg to be given intramuscularly" and the nurse obtains a vial of Demerol and a vial of Phenergan and draws up the prescribed dosages into a single syringe, would CMS expect one or two handling charges to be reported? We believe that CMS expects a one-to-one relationship between the drug and the handling charge; therefore, in this scenario, two handling charges would be reported since both medications were obtained, prepared ("handled"), and injected.
- For drugs reported with a HCPCS code, is the handling charge reported per dose of the drug, per vial/amp of drug used, or per billing increment based on the HCPCS code description? Should additional units of the handling code be reported based on the number of administrations if small amounts of the drug are prepared to be given over a period of time? For example if the physician order states: "Percocet 1 or 2 tablets for pain", and the patient requests and receives two tablets, would the provider report one handling charge? If the patient requests only one tablet but later requests the second tablet, would the provider report one or two handling charges? Each of these options results in a different quantity being reported in the units of service field for the handling C-code line item.
- Will CMS create OCE edits requiring a one-to-one match between a drug HCPCS code and a drug handling C-code?
- When a drug is prepared but not administered to a patient, due to a change in condition or physician order, will providers be allowed to report the drug handling charge since resources were expended to prepare the drug? In other words, will CMS allow a handling charge to be reported without a corresponding drug HCPCS code? If CMS plans to edit using the OCE, it will be challenging unless providers are given explicit instructions on how to report handling charges for drugs that are prepared but not administered to the patient.
- Does CMS only expect providers to only report a handling charge for separately payable drugs?
- Will CMS make a handling payment for packaged drugs using ASP+2% or another model? How will CMS determine what this payment should be if the drugs are not reported with HCPCS?
- How does CMS define "handling" or "pharmacy overhead"? According to the MedPAC report, the dimensions of handling costs considered include: management, including

regulatory compliance; storage, including inventory management; preparation, including review of drug orders and dosage calculations; transport within the hospital; and disposal of products. Within each of those categories are labor, benefits, space, equipment, supplies, and support contracts (to provide services such as waste disposal). It is not clear where other costs should be reported, such as: hospital administration, human resources, information technology, continuing education, hospital housekeeping, utilities, interest expenses, and other costs not directly related to pharmacy but which are currently spread over all hospital departments

If CMS decides to move forward with the implementation of the drug handling C-codes despite these concerns, the PRT requests clarification on what status indicator CMS plans to assign to these codes.

Ultimately, the use of separate codes to capture pharmacy handling costs will only increase the operational burdens that hospitals face, and simultaneously increase their costs. The PRT urges CMS to review the coding and billing requirements necessary to implement such a mechanism correctly and to truly consider the data that might be received. Before proceeding with this proposal, the PRT believes CMS should study alternate mechanisms including using provider cost report data to determine the average drug handling percentage across all Medicare providers.

Therefore, the PRT recommends that CMS not implement the proposed drug handling C-codes in 2006. Instead, we recommend that CMS study alternate mechanisms for obtaining handling cost data, including using the cost report to compute an average pharmacy handling percentage that may be used in the future along with the ASP+6% model. We offer our specific thoughts on how CMS might use the cost report below.

The PRT believes CMS can use existing cost report data instead of requiring providers to report the drug handling C-codes. We believe that CMS has the needed worksheet/line item detail from the cost report but, if not, CMS can work with the Fiscal Intermediaries who do have it. Moreover, there is a precedent under OPPS for CMS to instruct its FIs to provide specific cost report calculation details to its providers to obtain specific data required by CMS and FIs and to make appropriate payments. Examples include the detailed guidance CMS released regarding calculation of the payment-to-cost ratio in the early years of OPPS and, more recently, the guidance related to calculating the outpatient cost-to-charge ratio. In both cases, providers were able to respond to their FIs who, in turn, use the data for payment purposes. We believe that CMS can use a similar method to obtain each provider's pharmacy handling percentage and urge CMS to conduct this exercise as soon as possible.

Several PRT members conducted such a calculation using 2004 fiscal year end Medicare cost report data. Both directly assigned pharmacy overhead expenses were identified plus "stepped down" indirect overhead expense. We do not expect CMS to use the calculated overhead percentage from one, two, or even 20 hospitals. We do believe, however, that CMS can conduct a similar analysis using cost report data from all hospitals, or provide explicit guidance to providers through the FIs that results in the uniform collection of the pharmacy overhead percentage from all providers.

We believe that CMS will receive many comments on this issue and that estimates of pharmacy overhead will range greatly. CMS should recognize that this is, in part, due to the different interpretations of pharmacy handling costs/overhead expenses. The PRT is concerned that the terminology used by CMS about “expenses above and beyond acquisition expense” may inadvertently lead to the exclusion of certain categories of legitimate overhead expenses. Conversely, it might inadvertently include direct expenses that are not handling/overhead expenses.

For example, the indirect expense of maintaining electronic medical records for medication administration records is crucial and valid as a pharmacy expense, especially given the Institute of Medicine initiatives to automate pharmacy drug dispensing to prevent errors. This is clearly a legitimate pharmacy handling or overhead expense. An example of another legitimate expense that should not be categorized as handling/overhead is a face-to-face pharmacist consultation with patients for medication therapy management. If CMS accepts the PRT recommendation, and provides instructions for FIs to use with providers to collect a pharmacy handling percentage estimate, the instructions should contain a comprehensive definition of what can and cannot be included in the estimate so that CMS will receive comparable data.

Self-Administered Drugs

Finally, the PRT requests CMS to clarify two issues related to requirements for reporting self-administered drugs. The first has to do with whether or not handling C-codes must be reported for these items, and if the costs will be considered non-covered similarly to the drugs themselves being non-covered. If the drug handling C-codes are non-covered, the PRT seeks clarification if CMS see this payment as being the beneficiary’s responsibility.

Our second issue, with respect to self-administered drugs, concerns beneficiary questions that may arise from the new Part D coverage beginning on January 1, 2006. The Medicare Online Manual Publication 100-04, Chapter 1 Section 60 gives hospitals two choices for billing non-covered self-administered drugs: 1) bill A9270 with modifier -GY in the non-covered column of the claim with other covered services to communicate that this is a statutory non-covered charge for which the patient is liable; or 2) separate the non-covered charges onto a separate claim with condition code 21.

The UB-92 claim form will contain the same minimal drug detail regardless of which billing method the hospital chooses. Drug line-items will show the revenue code, the date of service, units of service, and the total charge for the line-item. There will be no specific detail related to the actual drug that was administered if HCPCS code A9270 is billed. Furthermore, when the denial is obtained from Medicare and the liability reported on the beneficiary’s explanation of benefits (EOB), the statement that the hospital sends the beneficiary will not (as it does not today) contain any detail on the actual drug that was administered.

For example, a beneficiary has an outpatient visit and receives aspirin for pain and atenolol for high blood pressure. Both of these drugs are non-covered, self-administered drugs. The hospital chooses to submit these charges on a separate claim form (option 2, described above). The UB-92 claim form submitted to Medicare shows the following:

Revenue Code	Revenue Code Description	Date of Service	Units	Charges
637	Pharmacy Self Administered	9/1/2005	4	\$5.00

The beneficiary will receive a hospital statement showing the following:

Date	Service Description and Quantity	Total Amount
9/1/2005	Pharmacy Quantity 4	Amount \$5.00

With the new Part D prescription drug benefit beginning January 1, 2006, patients will expect their prescription drugs to be covered. Indeed, CMS has confirmed that prescription drugs will be covered, with its statement on page 4268 of the January 28, 2005 Final Rule.

The PRT is struggling with how hospitals can help beneficiaries understand why they will continue to receive hospital statements and bills for prescription drug charges when the beneficiary has the new prescription drug Part D benefit and believes that their prescription drugs are covered under Part D. The PRT seeks guidance from CMS about how to respond to beneficiaries who want hospitals to help them apply for and receive Part D coverage for prescription drugs. The PRT is deeply concerned that beneficiaries will be confused about the new coverage process, and is interested in working with CMS to address these issues now so that the implementation of Part D is successful next year.

8. Vaccines and Vaccine Administration

The PRT appreciates CMS' proposed changes for vaccines and vaccine administration and urges CMS to make these changes final. The status indicator changes proposed for influenza and pneumococcal vaccines will greatly aid with immunizations provided in emergency room settings. We would like CMS to clarify, however, that the status indicator change for HCPCS codes G0008 and G0009 will not impact our current method of roster billing for these vaccines when administered in hospital outpatient departments. We do not believe this is the case, but would appreciate CMS clarifying this in the final rule.

In addition, the PRT strongly supports CMS' proposal to pay separately for vaccine administration services -- as shown in Table 28 -- and urges CMS to make these changes final for 2006.

The PRT would like CMS to clarify what we believe to be a typo in the middle column of page 42739. We believe CMS intends for hospitals to report administration of the hepatitis B vaccine using codes 90741 and 90742, rather than codes 96471 and 96472 as listed in the proposed rule.

9. Drug Administration

Last year, the PRT supported CMS' proposal to require providers to use CPT codes to report drug administration services, as this would ease the operational burden of reporting Q-codes to Medicare and CPT codes to other payers. CMS proposes to continue requiring hospitals to report CPT codes, and the PRT continues to support that process, in principle. The new 2006 drug administration CPT codes are, however, fundamentally different from the current 2005 CPT codes in the number of codes available, the description of the codes, the logic behind the codes, and the narrative CPT text providing guidance on how to use the codes. As a result of these differences, hospitals face an exponentially greater challenge in implementing the new codes and rules than they did when the change was made from Q-codes to 2005 CPT codes.

CMS stated that it could not release the actual 2006 CPT codes and descriptions because they were unavailable. Instead, CMS has released the expected descriptions of these codes, based on the temporary HCPCS G-codes that physicians use in their private practice settings. The PRT thanks the AMA for responding to requests to release an advance copy of the 2006 CPT drug administration codes and descriptions, which enabled providers to review the actual codes as part of the formal OPSS comment period.

The PRT understands that, although many more codes will be required for reporting drug administration services, CMS still intends to pay hospitals under OPSS on a "per visit" basis, as is done today. This means that hospitals will bill all of the relevant CPT codes that correspond to the services provided. But, payment will continue to be limited by the OCE's collapse of multiple billed services that group into the same APC into a single APC payment, unless modifier -59 is present to indicate that a separate encounter occurred on the same date of service. CMS must continue to make "per visit" payments for another year, as it lacks CPT code-level data upon which to base more refined drug administration payment rates. CMS should recognize, however, that the 2006 CPT book includes many more drug administration codes, and that the new codes and descriptions are completely different in their "logic". This means that providers will need to receive comprehensive and detailed guidance from CMS, along with clinical examples and plenty of time, if they are to adapt to the new codes and rules.

Before proceeding with our specific recommendations related to the use of the 2006 drug administration codes, the PRT reminds CMS that drug administration services are generally assigned ("charged") at the departmental level or at the point of service. Thus, drug administration CPT codes are embedded in the Charge Description Master (CDM) and departmental staff (often clinical staff) are responsible for charging the appropriate codes based on the services provided to the patient under their care. Drug administration services typically are not coded by Health Information Management/Medical Records or individual coders, and this change cannot easily be made, given the shortage of coding staff and the increased delay in submitting claims to Medicare likely to result if drug administration services also have to be coded by HIM/Medical Records staff.

To that end, the PRT asks CMS to consider the following very carefully:

- The new CPT codes were created at the 11th hour last summer and converted to temporary G-codes for use in the physician setting in 2005. The G codes were created to provide physicians with a way to bill for each and every instance, or combination, of drug administration service(s) provided, to off-set the significant drug payment decreases required by the Medicare Modernization Act (MMA). Physicians in their private settings receive payment for almost every single G-code today and, hence, will receive payment for every 2006 CPT code billed. Furthermore, physicians receive separate payment for each drug administered. This is not the case in the hospital setting.
- CMS must recognize that “one size does not fit all” when it comes to the use of CPT codes. We have seen this discrepancy with many different codes including the conscious sedation bulls-eye codes in Addendum I, evaluation and management codes, critical care codes, modifiers and others. CMS has been forced to provide separate guidance to hospitals on how to “interpret”, “use”, and even “ignore” certain CPT codes (or parts of the CPT description) because the codes are not applicable in the hospital setting. The PRT asks CMS to keep this history in mind as it reviews our comments and recommendations below.
- It will be virtually impossible for hospitals to implement separate codes for initial, subsequent, and concurrent injections and infusions, since patients “flow” through hospitals in a way that is fundamentally different from how they are treated in a physician’s private setting. In hospitals, which operate on a 24-hour basis, patients often move from one care area, or department, to another; charges are commonly entered by each department in “real-time”, without the departments necessarily knowing what services other departments have already charged. The concept of “initial” as the primary reason for the visit is impossible to automate using the CDM.
- The new codes and descriptions are not intuitive, and will be a nightmare for clinical and coding staff to accept. One example is the concept of only reporting one “initial” service code, where initial means the “primary reason for the visit”. A second example is reporting an additional hours’ code or an additional sequential injection code when the first hour or first injection have not been reported. These requirements simply do not make sense and are artifacts of codes created and defined by physicians for physicians’ office use last year. Clinical staff charging at the point of service will not comprehend charging for an additional hour’s hydration code when the first hour hydration code has not been charged. In fact, hospitals will have to “un-train” staff because CMS has previously stated that an additional hour code (i.e., 90781) should not be reported without the first hour code (i.e., 90780). The new 2006 CPT codes rely on the concept of “initial service”, which means that all other services provided must automatically be reported as “additional” “subsequent”, or “concurrent”. The fundamental problem hospital charging staff will have with this concept is that it crosses routes of drug administration and will therefore be intuitively difficult to accept.
- Two new CPT codes, 90767 and 90768, for sequential and concurrent infusion respectively, do not follow the hourly structure of the other infusion, hydration, and chemotherapy

infusion codes. The proposed 2006 CPT code narrative, released early by the AMA for review, states: “these codes are reported once per sequential infusion or once per encounter for concurrent infusion”. It will be burdensome for hospital staff to apply four different sets of definitions for similar services: initial, additional, sequential, and/or concurrent.

If the descriptions and rules for these CPT codes are implemented in the hospital setting without exception, and as written in the 2006 CPT drug administration section, it will be impossible for hospitals to implement them without heavily involving medical records staff and coders. These staff will be required to code each drug administration claim rather than allowing these services to be charged at the point of care. Furthermore -- and possibly the most difficult issue to accept as a result of the “initial service” concept -- CMS could inadvertently stop paying for services in the future. The PRT does not believe that CMS intends for this to happen, and hopes that this is simply an oversight, but it is one that must be addressed in the final rule. We offer an example below, followed by our recommendation for how to handle it:

A patient is scheduled for a one hour chemotherapy infusion visit. During the course of that visit, an emergency medical condition arises and the patient is taken to the emergency department where hydration is provided, followed by an intravenous injection. The patient is then stabilized but needs to be observed. The physician orders two hours of observation and orders another two hours of hydration to continue. In this example, drug administration services are charged in three different departments. Even if we accept that each department will know what the others provided, and are able to comply with the concept of “initial service”, hospitals continue to face a payment reduction given the status indicators that CMS assigned to the descriptions of drug administration services in the 2006 proposed OPSS rule for expected new codes. The table below shows the codes, descriptions, status indicators, APCs, and payment rates generated today -- as well as those expected in 2006 if CMS forces hospitals to abide by the concept of reporting only one “initial” service code.

2005 CPT/HCPCS and Units	SI	Description	2005 APC	2005 Payment Rate	2006 CPT/HCPCS and Units	SI	Description	2006 APC	2006 Proposed Payment Rate
96410 x 1 unit	S	Chemotherapy by infusion, up to one hour	117	168.29	96413 x 1 unit	S	Chemotherapy administration; intravenous infusion technique; up to one hour, single or initial substance/drug.	117	192.14
90780 x 1 unit	T	Infusion by other than chemotherapy, up to one hour	120	111.80	90761 x 3 units	N	Intravenous infusion, hydration; each additional hour, up to eight (8) hours.	N/A	0.00
90781 x 2 units	N	Infusion by other than chemotherapy, each additional hour up to 8	N/A	0	N/A	N		N/A	0
90784 x 1 unit	X	Intravenous IV push injection	359	49.54	90775 x 1 unit	X	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug.	359	49.33
TOTAL				329.63	TOTAL				241.47

As the table indicates, no payment will be generated for the hydration service started in the emergency department and continued in observation, since hospitals will not be allowed to report another initial service code (chemotherapy is the initial service) . If the 2006 CPT codes are implemented without exceptions and clarification, the nomenclature will result in non-payment for services that hospitals currently are paid for today,

resulting in a significant decrease in payment as shown above which we do not believe is what CMS intended.

If CMS allows hospitals to ignore the concept and word “initial” in each CPT drug administration code, the hospitals would in fact be able to report the following codes to describe the services provided in the above example

2006 CPT/HCPCS and Units	SI	Description	2006 APC	2006 Proposed Payment Rate
96413 x 1 unit	S	Chemotherapy administration; intravenous infusion technique; up to one hour, single or initial substance/drug.	117	192.14
90760 x 1	S	Intravenous infusion, hydration; initial, up to one hour.	120	119.83
90761 x 2	N	Intravenous infusion, hydration; each additional hour, up to eight (8) hours.	N/A	0
90775 x 1 unit	X	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug.	359	49.33
TOTAL				361.30

Ignoring the word “initial” would free hospitals to report the payable CPT code 90760, which automatically resolves the non-payment problem illustrated in the first table above and mitigates the financial impact that we again do not believe CMS intends.

If CMS does not allow providers to ignore the word “initial”, it will have to find another way to make the additional hours codes payable when used in conjunction with some other “initial” services code.

We do not believe that CMS expects to deny payment in 2006 for the same medically necessary services for which it pays today. CMS can make the codes payable by creating special logic in the OCE, or by requiring hospitals to use modifiers, but both of these solutions are administratively burdensome and inferior to our recommendation that CMS allow providers to ignore the concept and word “initial” in every 2006 CPT drug administration code.

This example clearly illustrates that the codes and descriptions created for the physician setting, now a permanent part of the CPT book, simply cannot work in the hospital setting unless certain exceptions are made and tailored guidance provided. Again, it is not feasible to use codes that were created explicitly for use in one setting in a second setting that is fundamentally different in its structure, staffing, coding/billing/charging, and other operational functions.

The PRT reviewed each 2006 drug administration CPT code in detail and applied the codes to current clinical examples to see if the codes were easy to use, and to identify the key questions raised. We took the time to do this in order to provide CMS with recommendations that the PRT believes are the most reasonable to facilitate an easy implementation of the 2006 drug administration CPT codes starting on January 1, 2006:

- CMS should clearly instruct providers what parts of the CPT text, code descriptions, and narrative hospitals may ignore for reporting under OPSS. At a minimum this means the concept and word “initial” should be ignored for the purposes of reporting drug administration services to CMS. This also extends to the multiple references to “physician supervision” and advanced practice training for administering staff. The PRT expects CMS to follow precedent and instruct providers to disregard this language. CMS has a history of instructing providers to “ignore” certain parts of the CPT definition and/or narrative as it relates to the provision of services in the hospital setting (as described above), and this should not be a problem in 2006.
- The PRT urges CMS to benefit the provider community by working with the AMA to include an introductory, two- to three-page “caveat” section in the CPT book. This section would clearly state which CPT codes, language, guidance, and narrative information hospitals can ignore because the information is irrelevant in this setting. This would be enormously helpful in reassuring hospital staff that they are allowed to disregard (or ignore) the parts of the CPT that are inapplicable. This will likely reduce the questions that CMS receives from hospitals and others about this topic, while increasing the accuracy and completeness of claims data and aiding future rate setting.
- CMS should carefully review the 2006 CPT codes, along with all of the previous transmittals released in relation to OPSS billing for drug administration services, to determine what will carry over for 2006 and what needs to be updated. CMS should not simply re-release the 2005 guidance to physicians for hospitals to use in 2006. The hospital guidance must contain numerous clinical examples including combinations of services, patients that cross departments, and visits that extend overnight or over more than one date of service. The clinical examples should also include documentation time, as that is now a critical piece of the puzzle in determining what codes to report.
- CMS should clearly define all concepts associated with the terms “sequential”, “concurrent”, “diagnostic”, “prophylactic”, and “therapeutic”.
- CMS should define what solutions are administered as hydration with codes 90760/90761 and confirm that these solutions should be reported under revenue code 258 for IV solutions.
- CMS should clearly define what is meant by the administration of “single or initial substance/drug” (e.g. as in 90774), and provide examples of when it would be inappropriate to report these codes. Today, hospitals report an administration for each medically necessary drug administered. For example, if two drugs are mixed together and administered via one syringe, then only one administration code is reported. If the

same drug is injected more than once in a period of time due to medically necessary reasons, then multiple administrations are charged, even though the same drug is being given. The PRT requests clarification about how this will change with the new 2006 CPT codes.

- CMS must only apply the “initial” service concept on a service-location basis (e.g., each department would charge for what happens in their department based on the applicable codes), as opposed to a visit or claim level basis, even though payment will still be made on a “per visit” basis. This is critical in a hospital setting since patients can receive treatment across multiple departments. The simplest way to achieve this to allow hospitals to simply ignore the “initial” service concept as recommended above.
- Today, CMS only expects to see modifier -59 reported with drug administration services when two or more separate and distinct visits occur on the same date of service. We request that CMS confirm that this is still the only time it expects hospitals to report modifier -59 with respect to drug administration services.
- Our final recommendation is for CMS to carefully review the Excel table that follows below. It includes 2006 CPT drug administration codes for which the PRT makes specific recommendations to CMS.

Table: PRT Recommendations on Problematic 2006 Drug Administration CPT Codes

2005 CPT Code	2006 CPT Code (Preview)	2006 Description (Preview)	PRT Recommendation	Expected Result of Accepting the Recommendation
90780	90760	Intravenous infusion, hydration; initial, up to one hour.	Ignore the word "initial". Clearly define hydration.	Providers can report this for pre-or-post hydration given with chemotherapy or other services (as is allowed today)
90781	90761	Intravenous infusion, hydration; each additional hour, up to eight (8) hours.	Clarify how to report infusions > 8 hours. If similar to today with an additional line item, then reiterate this.	Minimizes confusion for providers
90780	90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour.	Ignore "initial" and explain how this code is different from the hydration code.	Providers consider hydration as a therapeutic service. Therefore, clarifying the difference between the two will minimize confusion.
90781	90766	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour, up to eight (8) hours.	Clarify how to report infusions > 8 hours. If similar to today with an additional line item, then reiterate this.	Minimizes confusion for providers
n/a	90767	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to one hour.	Define what additional sequential means in terms of the sequence of events or if the sequence does not matter then state that clearly	Minimizes confusion for providers
n/a	90768	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion.	Specify concurrent; does this relate to two or more items being infused at the exact same time per nursing documentation?	Minimizes confusion for providers
90784	90774	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.	Ignore "initial" and indicate this code should be reported for the first injection provided. Clarify definition of single substance/drug.	Minimizes confusion for providers
90784	90775	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug.	Clarify definition of new substance/drug; if the same drug is given over time, then would multiple units of 90774 be allowed? If two drugs are mixed and provided through one injection, would two codes be submitted to signify the "new drugs"? Implementing the use of this code will be difficult so CMS should provide clear guidance and monitor its use as hospitals are likely to report multiple injections using 90774	Minimizes confusion for providers

PRT Recommendations on Problematic 2006 Drug Administration CPT Codes (continued)

2005 CPT Code	2006 CPT Code (Preview)	2006 Description (Preview)	PRT Recommendation	Expected Result of Accepting the Recommendation
96400	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic.	Publish and maintain a set of non-hormonal anti-neoplastic drug codes	Takes the guesswork away from hospitals about identifying non-hormonal cancer drugs
96400	96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic.	Publish and maintain a set of hormonal anti-neoplastic drug codes	Takes the guesswork away from hospitals about identifying hormonal cancer drugs
96408	96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug.	Ignore "initial". Clarify definition of single substance/drug.	Minimizes confusion for providers
96408	96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug.	Implementing the use of this code may be difficult so CMS should provide clear guidance and monitor its use since hospitals are more likely to report multiple units of CPT code 96409.	Minimizes confusion for providers
96410	96413	Chemotherapy administration; intravenous infusion technique; up to one hour, single or initial substance/drug.	Ignore "initial". Clarify definition of single substance/drug.	Minimizes confusion for providers
96412	96415	Chemotherapy administration; intravenous infusion technique; each additional hour, 1 to 8 hours.	Clarify how to report infusions > 8 hours. If similar to today with an additional line item, then reiterate this.	Minimizes confusion for providers
96412	96417	Chemotherapy administration; intravenous infusion technique; each additional sequential infusion (different substance/drug), up to one hour.	Clarify sequential	N/A
96423	96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours.	Clarify how to report infusions > 8 hours. If similar to today with an additional line item, then reiterate this.	Minimizes confusion for providers
96425	96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump.	Clarify how to report infusions > 8 hours. If similar to today with an additional line item, then reiterate this. CMS should also define what is meant by "portable" pump.	Minimizes confusion for providers
n/a	96523	Irrigation of implanted venous access device for drug delivery systems	Change the status indicator to "Q" as described in the packaged services section of our comments	Allows payment for this at the low level E/M visit payment when it is the only service provided without forcing providers to report an E/M code

Without the benefit of a grace period, it is essential that CMS think about the implementation effects of this massive coding/billing change. Given that these services are now Charge Master driven, providers need time to either make a process change (e.g., begin to have HIM code these services); or update and test charging and billing systems, create charges for the new codes, update encounter forms, and train staff at the point of service about how to select the new codes to report the services provided.

CMS should not underestimate the magnitude of this change. Nor should CMS discount the enormous amount of time and resources hospitals expend to educate and train staff, update all systems and forms, and monitor the use of new codes to prevent mistakes. Therefore, the PRT urges CMS to implement coding and billing guidance related to the use of the 2006 CPT drug administration codes if not in the Final Rule, then no later than November 30th, 2005. This would provide hospitals with at least 30 days to educate and train their staffs prior to the January 1, 2006 implementation date. This guidance should be comprehensive and timely. It should also include at least one clinical example for each new code and combination of codes that describe expected medical record documentation. Finally, the guidance should be free from contradictions and errors so that CMS is not required to release additional guidance and corrections many months after the codes are in place, as was necessary this year.

10. Blood and blood products

The PRT thanks CMS for continuing to dampen the payment rate fluctuations for blood and blood products. We also appreciate the detailed guidance CMS released earlier this year. We encourage CMS to release guidance on blood and blood products on an annual basis, as hospitals continue to struggle with reporting this correctly. We also urge CMS to explicitly state that hospitals should be charging for blood transfusion/administration the same way in both the inpatient and outpatient settings.

While instructions from CMS speak to reporting blood administration services for OPSS, it is hard to tell what this means for charging inpatients. Medicare retains the cost apportionment rule in the Provider Reimbursement Manual (Publication 15, Part I, Chapter 22, §2203) which states: “so that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient.”

The Provider Reimbursement Manual (Publication 15, Part I, Chapter 22, §2204) concerning Medicare Charges states: “Medicare charges refer to the regular rates for various covered services which are charged to beneficiaries for inpatient or outpatient services. The Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service. (See §2202.4.)”

It is not clear what this means for blood administration. For stand-alone ancillary departments, such as an infusion room or the Emergency Department, blood administration services are usually charged the same to both inpatients and outpatients. This may not be the same for nursing units with both inpatients and observation outpatients, however.

Some hospitals do not separately charge blood administration services to inpatients -- the hospital and/or their Fiscal Intermediary consider the service to be included in the room and board rate. Medicare OPPS rules, however, clearly delineate how these services must be coded and charged for outpatients, including observation patients. These patients are often in a bed next to an inpatient on a nursing floor. PRT would like clarification on whether blood administration services performed on nursing units should be charged to inpatients as well as to outpatients. According to the rules above, blood administration services should be separately charged in the same manner to patients seen both in the inpatient and outpatient setting.

11. Observation Services

The PRT commends CMS and the APC Advisory Panel's Observation Subcommittee for the continued and thoughtful work they have performed in studying the administrative issues related to coding and billing and the payment criteria for the separately payable observation APC, and for taking additional steps to propose a set of changes that will result in further streamlining the reporting of these services.

The PRT's understanding of the current proposal is that providers would use a single G-code to report medically necessary observation on an hourly basis, regardless of the diagnosis or the actual hours in observation. This means, for instance, that providers could report two hours of observation time provided to a patient admitted to observation from the Emergency Department with abdominal pain using the newly proposed GXXXX. The UB-92 would show one line item with GXXXX, the date of service, and two (2) in the units of service field that correspond with two hours in observation. CMS' claims processing system and/or the OCE editor would determine that the reporting of GXXXX in this situation does not meet criteria for separate payment of APC 0339, since one of the required diagnosis code for the separately payable observation was not present on the claim and since less than eight hours of observation were provided per the units reported on the line item of GXXXX. The PRT fully supports and appreciates CMS' use of programming logic to determine whether separate payment is warranted rather than requiring providers to make that determination as a part of their coding and billing process.

Additionally, CMS has proposed HCPCS code GYYYY to replace existing HCPCS codes G0263 and G0264 for reporting patients directly admitted to observation. The PRT also supports this change, since the burden of determining which G-code to report will be removed and will no longer be dependent on whether or not certain criteria are met. We understand and agree that CMS' claims processing logic will determine whether payment for GYYYY is warranted and this will be based on whether criteria are present to trigger payment for GXXXX. In other words, if payment is not made for GXXXX, then CMS will make payment through its claims processing logic for GYYYY at the low-level clinic visit APC 0600.

The PRT whole-heartedly supports this logic and believes this simplification in how providers report separately payable observation will result in providers reporting all observation services more completely and accurately. This, in turn, will provide CMS with the data it needs to determine if additional conditions warrant separate payment for observation in the future.

The only additional change the PRT requests for 2006 is the addition of specific diagnoses for COPD that parallel the current “well-defined set of hospital services” for asthma. The PRT believes that CMS should expand the diagnosis codes that meet reimbursement requirement for the separately payable observation APC related to asthma to include all of the asthma diagnoses, including chronic obstructive lung disease codes as well.

Currently, the following diagnosis codes will support separate payment for observation services for asthma:

- 493.01 - Extrinsic asthma with status asthmaticus
- 493.02 - Extrinsic asthma with acute exacerbation
- 493.11 - Intrinsic asthma with status asthmaticus
- 493.12 - Intrinsic asthma with acute exacerbation
- 493.21 - Chr obstructive asthma with status asthmaticus
- 493.22 - Chr obstructive asthma with acute exacerbation
- 493.91 - Asthma, unspecified with status asthmaticus
- 493.92 - Asthma, unspecified with acute exacerbation

CMS included some patients with chronic obstructive pulmonary disease (COPD) when it included diagnoses 493.21 and 493.22, but excluded others. The assignment of the asthma and COPD codes can vary widely depending on the specificity of the physician when listing the final diagnoses. Physicians are frequently non-specific in stating a diagnosis, which can lead to non-payment even when the level of care and services provided to the patient remain the same. In addition, a patient may have combinations of disorders. A patient with asthma may have elements of bronchitis, and a patient with bronchitis may have elements of asthma.

Respiratory practitioners will confirm that, in a hospital setting, the care of the patient with asthma, bronchitis, and COPD is very similar as far as the diagnostics performed, the medications ordered, and the clinical care provided. ABG, SaO₂, chest x-ray, nutritional assessments, and sputum and blood cultures are frequently performed as diagnostic tests for each. Medications may be delivered via nebulizer, inhalers, oral, or intravenous routes and include bronchodilators, corticosteroids, and possibly antibiotics. Clinical assessments, care planning, and patient education are also similar.

Therefore, the PRT requests the following diagnosis codes be added to the asthma codes currently covered as payable diagnoses for the separately payable observation APC under OPSS, and the category be expanded to cover both patients with asthma as well as COPD:

- 466.0 - Acute bronchitis
- 466.11 - Acute bronchiolitis due to RSV
- 466.19 - Acute bronchiolitis due to oth infcts organsm
- 491.21 - Chr obstructv bronchitis, w acute exacerbation
- 491.22 - Chr obstructive bronchitis, w acute bronchitis
- 496 -- Chr obstructive pulmonary disease

Once again, the PRT wishes to thank CMS and the APC Advisory Panel for listening to the operational burdens that providers face and for taking the appropriate steps to reduce them. Finally, we urge CMS to work diligently to ensure that the final rules for the separately payable observation APC, as published in the *Federal Register*, are promptly imported into the CMS Online Manual via appropriate “Changes in Manual Instructions”. Last year, as CMS is aware, several contractors continued to require diagnostic testing in their local coverage determinations for the separately payable observation APC simply because the language from the final rule and subsequent transmittals had not yet been incorporated into 100-4, §290.4.2. We urge CMS to make sure that FIs implement the finalized changes correctly and in a timely fashion.

12. Inpatient-Only List

The PRT appreciates CMS’ proposal to remove 25 procedure codes from the Inpatient-only List. We continue to strongly support the APC Advisory Panel’s recommendation that CMS eliminate the list altogether, however. Rather than using an Inpatient-only 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. We have provided some of the reasons that the PRT believes the list should be eliminated below:

The decision to admit a patient is a medical decision based on a physician’s assessment and requiring 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 as well as 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, in this manner, put in the difficult position of either asking physicians to admit patients who may appropriately be cared for in the outpatient setting, or providing expensive “Inpatient-only” procedures to patients in the outpatient setting and without being reimbursed.

In addition, the Inpatient-only List is very difficult to implement, since physicians resent being told what can and cannot be provided for patients when they believe the services are medically necessary and can be provided safely in an outpatient setting. This issue is beyond preventive measures that a hospital can reasonably take as it is ultimately the physician’s order and intent that dictates the admit status.

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; 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 has to provide the service because to do otherwise would be poor medical practice.

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. In many cases this is unrealistic. When it is feasible, but the physician does not agree, the hospital has no recourse except to lose the reimbursement if it is to act in the best interest of the patient. 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, the 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.

In the event that CMS chooses not to eliminate the Inpatient-only List, the PRT requests that CMS post the Inpatient-only List on the physicians' web-page of the CMS web-site and provide background detail on the Inpatient-only List. We also request that CMS discuss this issue on the Physician Open Door Forum, in the MPFS proposed and final rules. We also request that CMS require carriers to post the Inpatient-Only list in their educational materials. In this fashion, CMS will educate physicians and facilitate hospitals' education efforts with physicians.

The PRT also requests CMS to review Category III CPT Codes as soon as they are released to determine if they belong on the Inpatient-only List. We urge CMS to provide its rationale for new codes and services added to the Inpatient-only List in a proposed rule so that providers can submit comments. The PRT also asks that CMS clarify in the final rule that just because services are NOT on the Inpatient-only List does not mean that they can only be provided in the outpatient setting. In other words, CMS should make clear that it has NOT created an "outpatient-only list". This will help providers to communicate clearly with other payers who often use a code's absence from the CMS' Inpatient-only List to identify services that can only be provided in the outpatient setting. We know this is not the intent, which is why we kindly request CMS to state that fact in the final 2006 OPPS rule.

Finally, the PRT continues to urge CMS to consider removing the following codes from the Inpatient-only List as they can -- and often are -- provided safely in the outpatient setting:

- *CPT code 58260 (vaginal hysterectomy not including tubes and or ovary)*
- *CPT code 63075 (Diskectomy)*
- *CPT 44603 (Suture, small intestine), 44602 (Suture, small intestine) and 44604 (Suture, large intestine)*
- *CPT 49000 (Exploration of abdomen)*
- *CPT 58940 (Oophorectomy, partial or total, unilateral or bilateral)*

The PRT again asks CMS to go beyond using the 60% threshold in determining what procedures are acceptable to be 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 the physician's judgment and individual patient situation rather than on the Inpatient-only List.

Please note that some Fiscal Intermediaries are now instructing hospitals to move the Inpatient-Only CPT to the non-covered column of the UB92 claim and re-submit the claim to allow payment for the other services under OPPTS. The PRT is concerned that, under this system, some hospitals receive payment when other hospitals do not. The PRT asks CMS to issue instructions to ensure that every FI handles such situations in the same way as it is not being implemented consistently by all FIs.

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

13. Status Indicators

The PRT supports the creation of status indicator “Q” to indicate packaged services that are subject to separate payment under OPPTS payment criteria. It is not clear, however, whether this status indicator is going to be assigned to any CPT/HCPCS codes starting January 1, 2006. The PRT believes that this status indicator should be assigned to several codes representing services which can be, or are, the only services provided to patients on a given date of service. We described several of these services in detail in the section on packaged services and encourage CMS to refer to that section for our rationale for assigning the following codes status indicator “Q” in 2006:

- Non-selective Debridement CPT code 97602
- Collect Blood Venous Device 36540
- Withdrawal of Arterial Blood 36600
- Injection Procedure for Sentinel Node ID 38792
- Irrigation of implanted venous access device for drug delivery systems (expected 2006 CPT code 96523)

If we understand the purpose of Status Indicator “Q” correctly, and the above codes were to be assigned a status indicator “Q” for 2006, then separate payment would be made for each of the codes above when the services provided are the only OPPTS payable service on a date of service. Payment would be made through APC 0600. If other OPPTS payable services are provided, then the OCE would not make separate payment for the above codes and would, instead, treat the service as if it were still a status indicator “N” service. If our understanding is incorrect, the PRT would appreciate CMS clarifying the payment implications associated with services assigned Status Indicator “Q”.

14. Payment Reduction of Diagnostic Imaging Services

The PRT understands that CMS has proposed to apply a 50% discount when two or more diagnostic imaging procedures from the same family of codes are provided during one session because CMS assumes the provider gains economies to scale. The PRT agrees with CMS that some economies to scale are generated when similar radiology procedures are performed during the same session, but we disagree with CMS’ proposal to reduce the payment rate of the second and subsequent APCs by 50%.

Such a reduction ignores the fact that some of the economies to scale are already reflected in the cost-to-charge ratio used by CMS to arrive at the median cost data. Furthermore, the PRT notes that CMS does not currently pay hospitals for procedures that take longer as a result of problems with the patient's clinical condition. If CMS implements a reduction in payments, a modifier (such as modifier -22) should also be established to indicate increased costs, when incurred. The PRT recommends the additional payment be made at the same percentage as the reduction in payment being considered. CMS should instruct hospitals to apply the increased cost modifier to any affected radiology procedure; and provide specific guidelines as to what events constitute increased cost, as well as documentation needed to support the modifier.

In addition, CMS states in the proposed rule that private payers are already discounting in the same manner as proposed by CMS. In fact, none of the PRT's 18 members has a single payer that applies such a reduction in payment; we caution CMS against drawing assumptions about what private payers are doing and the extent to which they follow Medicare's lead.

The PRT also has questions about the family of codes CMS proposes. For example, the PRT disagrees with CMS' proposal to discount CPT code 76830 (transvaginal ultrasound, non-ob) when provided during the same "session" as CPT code 76700 (echo exam of abdomen). Routinely, when a patient has a transvaginal ultrasound following ultrasound of the abdomen, the patient must leave the room to empty her bladder, the room must be set up again for this separate procedure, and a different probe installed. In this situation, we do not believe economies of scale exist that would warrant a 50% payment reduction for the second procedure. Therefore, if CMS chooses to move forward with its proposal, the PRT urges removal of the transvaginal procedure represented by CPT code 76830 from the list of services included in Family 1.

A second example is provided by CT Abdomen and CT Angio Abdomen. To the best of our knowledge, these services are never provided during the same session, yet CMS has assigned them to the same family of codes. Again, if CMS proceeds with its proposal we recommend that it only assign procedures to the same family if the procedures are commonly performed during the same session, and exclude those that are rarely performed in the same session.

The PRT is also not clear on what CMS means by separate "session". If CMS proceeds with this proposal, the term "session" must be explicitly defined so that providers know when they can and should use modifier -59 to signify that multiple diagnostic radiology procedures were performed on the same date of service, but NOT during the same session. CMS will need to define "session" in a way that distinguishes it from other terms, such as "encounter" or "visit", so that hospitals will use modifier -59 appropriately in order to be paid 100% for both or all of the subsequent procedures provided (if done during different sessions).

The PRT urges CMS to delay implementation of this proposal until it has fully studied and analyzed both provider claims and cost report data to determine if, in fact, a further reduction in payment is warranted or if economies to scale are already being captured through the departmental cost-to-charge ratio. In addition, the PRT encourages CMS to consider working with the AMA to simply create new CPT codes that describe commonly combined procedures so that data can be more systematically collected and payment rates naturally be set from provider charges for these combined procedures as reported through the claims data. Furthermore, this

would ensure that the ordering physician intended for both exams to be performed and a single radiologist report would be produced that addresses the combined exams.

15. **Interrupted Procedures (modifiers -52, -73, & -74)**

Since implementation of the OPSS in 2000, CMS has required hospitals to report modifiers -52, -73, -74 to indicate procedures that were terminated before their completion. Over the years providers have struggled to understand how to use these modifiers, in particular whether conscious sedation is considered anesthesia by CMS or not. Clarification on this issue was released earlier this year, and while helpful CMS needs to continue addressing other questions providers have about the use of these modifiers.

For CY 2006, CMS is proposing to decrease payment for services when modifiers -52 and -74 are reported. The PRT disagrees with this proposal and explains why below.

Modifier -52

The PRT requests that CMS continue making full payment (100% of the APC payment) for services reported with modifier -52. The PRT believes that the same level of resources is consumed whether the service is provided in full or discontinued part way through the procedure. Clearly, procedures that are cancelled or discontinued at the very start due to patient's being nervous or worried should not be charged. The procedures under discussion are already underway, which is why the PRT believes that the same amount of resources (and, in many cases, even more resources) are consumed than would be required to complete the normal procedure. This is true both for modifier -52, and even more so for modifiers -73 and -74, which are discussed below.

An example is CPT 74485 (dilation of nephrostomy, ureters or urethra), in which a patient presents for dilation of both ureters due to bilateral strictures, and multiple dilating balloons are used. In a hypothetical case, the dilating balloon is passed into the stricture in the right ureter, the balloon is inflated, and the stricture is opened. The balloon is then moved to the left ureter. The balloon, however, will not cross the stricture, and a smaller balloon must be selected. In this case, several balloons of different sizes are used in an attempt to dilate the stricture. The patient is likely to complain of discomfort which may result in the physician terminating the procedure. Because this CPT code includes "ureters", the scenario described would be correctly reported with modifier -52. The resources and supplies required for the failed procedure are actually higher than for an uncomplicated, completed procedure. If the attempt to dilate the left ureter had been successful, fewer supplies and resources would have been used, and the procedure reimbursed at 100 percent. However, because the left stricture required multiple attempts to dilate (the stricture), the hospital incurred the cost for more balloons and consumed more procedure time.

The PRT does not believe that circumstances such as "equipment failure" are an acceptable reason to apply modifier -52. Several attempts and time may be exhausted to complete a procedure that is not successful -- such as an attempt to re-position a patient to complete a procedure, or several attempts to establish a picc-line insertion. In both scenarios, resources and

supplies are utilized. All of the same resources have been exhausted even though the procedure is ultimately reduced. In some cases, more resources are utilized due to the patient's size or difficult anatomy, or because several attempts are made that increase time and overhead. The PRT believes it is inappropriate for CMS to reduce payment for procedures reported with modifier -52 from 100% to 50% and urges CMS to better understand provider operations and resource consumption before implementing such a decision. Given the relatively low frequency with which this modifier appears in the claims data, the PRT believes providers are either still very confused about when to report these modifiers (and are simply not reporting the services at all), or they are just not canceling or discontinuing as many procedures as some might think. Without further review, providers who truly must discontinue procedures and who incur the expenses will face unwarranted financial impact .

Modifier -73

The PRT concurs with the APC Advisory Panel and recommends that CMS make full APC payment for services reported with modifier -73 because of significant use of hospital resources in preparing the patient for the treatment or operating room. The PRT further requests that CMS remove the language "taken into the treatment room," from the current policy because, in many cases, it prevents the legitimate application of modifier -73.

Patients are often prepared for surgery in various settings of hospital based on space availability, including pre-operative and holding areas. Preparation in these areas incurs the same costs as if the preparation occurred in the treatment or operating room. The current definition of modifier -73 requires the surgery to be cancelled in the room where the surgery is to occur. Although the patient may not go to the treatment room, sterile surgical supplies have been opened and other resources (such as staff time and scheduling) consumed; providers cannot recoup these costs because modifier -73 is not allowed.

For example, a patient is registered, a medical record is created, and an initial assessment completed. The patient changes into a hospital gown and is taken to a bed or other space in a pre-treatment room or holding area. The nursing staff takes the patient's vitals and provides education in preparation for the procedure. An IV may be initiated at this time to start medications; many physicians order pre-operative medications to be given while the patient is in the holding room. Some of these medications have a sedative property, but are not considered to be anesthesia. At this point, the procedure room has been prepared for the patient, and sterile supplies opened, in order to expedite beginning the procedure as soon as the patient is taken into the procedure room and positioned on the table. Hospitals manage their resources by ensuring that procedure rooms are ready and supplies available for procedures before the patient enters the room. (Research indicates that patients become anxious and worried if there is a delay in beginning the procedure when they enter the procedure room. In addition, waiting to set-up and open supplies until after the patient enters the room causes cumulative delays in the surgical suite.) In this hypothetical case, the patient experiences elevated blood pressure during the final pre-procedure processing while the patient is still in the holding area, and the physician decides that the procedure must be discontinued. Clinical care must still be provided to the patient after the point of discontinuation until he or she is stable and ready for discharge

In this case, the hospital has expended a large number of resources in caring for this patient pre-operatively, but the current reimbursement to the facility is "\$0.00". The hospital cannot bill the procedure with modifier -73 since the patient did not enter the procedure/operating room. The reality is that in many cases of cancelled procedures even more hospital resources are expended than are involved in a normal procedure. Some providers bill nothing in the above example since the patient was not taken into the procedure room, while others are reporting an E/M visit code to recoup some of their costs.

Therefore, the PRT requests that CMS allow providers to use modifier -73 for cancellation of procedures for patients in a holding room or a pre-operative suite when the patient is clinically prepared for surgery and resources have been utilized. When a procedure is cancelled prior to clinical preparation of the patient, there is little resource utilization and modifier -73 would be inappropriate and providers are aware of this, but CMS could reiterate this point in the final guidance. If CMS does not change the description of modifier -73 to allow hospitals to report it with procedures cancelled prior to the patient entering the treatment room, then it should clearly tell providers that they are allowed to report an appropriate E/M visit code to recoup some of the costs incurred.

Modifier -74

The PRT concurs with the APC Advisory Panel's recommendation that 100% of the APC payment be made for services reported with modifier -74. This is CMS' current policy and the PRT believes it should not change in any way, as providers typically face full and often increased costs when modifier -74 is used. CMS suggests that the same costs are not incurred when a procedure is canceled and suggests that providers are able to report additional services provided and receive payment for them. The PRT strongly disagrees with these statements and believes CMS should rethink its position. In many circumstances, a procedure is cancelled due to the patient's anatomy or a complication of the patient's condition. This may extend the procedure time beyond the normal period. A hospital is not allowed to receive additional payment for the prolonged procedure time. Physicians (professional services) recoup unusual procedure services with modifier -22, but hospitals do not have the luxury of doing so.

The PRT does not believe that resources are necessarily reduced when a procedure is cancelled. For example, an endoscope procedure may only be partially completed because the surgeon encounters a mass before the scope can be advanced to the furthest point (as described by the CPT code). Several attempts and time may be exhausted to maneuver around the mass and evaluate the extent of the disease. In many cases, additional costs are consumed in an attempt to complete the procedure. Full payment should be allowed for the completion of the procedure, since the full use of resources was exhausted.

Hospitals do their best to manage their resources by screening patients for possible complications that may cause the procedure's cancellation. Because each patient is unique, however, it would be impossible to anticipate and avoid all complications. Complications include -- but are not limited to -- excessive bleeding, hypotension, hypertension, tachycardia, bradycardia, and reactions to anesthesia drugs or gases. The physician and/or anesthesiologist attempt to manage complication(s) and complete the procedure, but there are times when it is in the patient's best

interest to discontinue the procedure. The decision point for discontinuation will vary based on the individual situation. If a patient has a reaction to an anesthesia drug or gas, the procedure may be discontinued before an incision is made, however, significant resources have already been expended.

Once anesthesia is initiated, the hospital has every expectation that a procedure will be completed and, therefore, supplies are opened and ready for use during the procedure. (In fact, surgery departments report that expensive implants are not usually opened until the physician is sure which implant will be used; at that point, the patient is already in the surgery/treatment room.) Once the usual supplies are opened and the patient has entered the room, the supplies cannot be used for a different case. To wait to open each item until the physician is ready to use it would increase procedure time, require additional staff in the procedure room to anticipate the physician's needs, and could cause the patient to be anesthetized longer than necessary. Once anesthesia is administered, there is no turning back in terms of hospital resources being expended. The post-procedure care of the patient does not change: anesthesia must be reversed, the patient must be recovered, and post-operative pain control managed. In fact, complications that cause a procedure to be interrupted often require longer recovery times than would be necessary for a completed procedure, which results in increased cost to the hospital which is not covered.

Supplies and recovery time are all packaged services and the costs are covered by the APC for the procedure; therefore, reducing the reimbursement when modifier -74 is appended will negatively impact hospitals. Many hospitals bill for surgical procedures based on the time the patient is actually in the surgical suite or procedure room. These facilities are already reporting any decrease in procedure time which will reflect the decreased cost through the claims and cost data used by CMS to set future APC payment rates.

The PRT also disagrees with CMS's assertion that additional services are separately payable under OPSS and therefore the hospital's costs need not be paid through the APC payment for the planned procedure. Initiation of other APCs that are currently separately payable will not recoup costs for the cancelled procedure. Most of the services required to stabilize a patient are the same charges inherent to the procedure, such as anesthesia, recovery, staff, related supplies, and drugs (which are generally packaged).

APC payments made for additional services are intended to cover the costs for providing those services, and cannot be counted on to cross-subsidize the loss taken on the payment rate for the cancelled procedure. Services provided that generate separate APC payment would simply cover the cost of providing those APCs. Moreover, certain services that are provided as part of a surgical procedure (such as injections and infusions) are inherent to the procedure and not separately reportable. This means that, if the procedure is cancelled, providers would have to begin thinking about charging for those services, which is counter-intuitive to their training NOT to report these services because they are a part of the procedure. In short, the PRT disagrees with the contention that separate APCs billed would cover the costs associated with the cancelled procedure.

Finally, CMS should recognize that the majority of the upfront costs in providing a service occur in the procedure's first hour. When the physician reaches a point at which a procedure cannot be completed, the resources have already been expended. Again, CMS' own data shows that the use of modifier -74 is infrequent. Therefore, the PRT urges CMS to continue making 100% APC payment for services that are discontinued in order to provide hospitals adequate reimbursement to cover the costs they have incurred.

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

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