

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

October 6, 2003

**By Hand**

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

**Re: File Code CMS-1471-P  
August 12, 2003 OPPS Proposed Rule**

Dear Mr. Scully:

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 2004 OPPS Proposed Rule, as published in the *Federal Register* on August 12, 2003. 68 Fed. Reg. 47966. The providers listed above appreciate the opportunity to submit these comments for consideration by CMS. A full list of PRT members is provided in **Appendix A**.

**Introduction**

The Provider Roundtable (PRT) is a group of providers representing 18 different health systems from around the country. Like many others, our hospitals, and the many departments within our institutions, continue to struggle with the implementation of OPPS. Providers are often too busy or unaware of the overall process to submit comments to CMS on their own, however. We have therefore organized ourselves in an attempt to provide substantive comments with an operational focus so that CMS' staff

can take this information into consideration during the OPSS policy making and recalibration process each year.

In addition to operational challenges, when transitional corridor payments are eliminated in 2004, most of us will face new and additional financial impacts. This will be compounded if other new provisions (such as the detailed drug and device code, new chemotherapy administration coding requirements and others) are implemented without giving providers adequate preparation time.

In most cases, our group has a consistent message and/or recommendation on the issues of concern. In order to have all of our voices presented, some sections of this comment letter include both a majority and minority opinion. We appreciate the opportunity to provide CMS with our comments, as we recognize that providers must become involved in the comment process if OPSS is to improve with time. The issues we discuss below are presented in the order they were raised in the proposed rule, which does not necessarily reflect the order of importance to providers.

### **Single vs. Multiple Claims Methodology**

On page 47988, CMS requests comments on excluding the APCs listed in Table 9 in the identification of single versus multiple claims. The PRT believes that, since these APCs are typically provided without any other bundled service on the same date of service, they can be ignored when defining single procedure claims. The sole exception is APC 0706 for New Technology – Level I (\$0–\$50). Since this APC is simply based on cost, we cannot say whether or not a bundled service would be provided on the same date of service with a service that ends up being assigned to this APC. Therefore, CMS should remove this APC from Table 9.

### **APCs with Median Cost Decreases of 10% or More**

In Table 8 on pages 47984 and 47985, CMS states that it does not believe there is a need to adjust the APCs with median cost decreases by 10% or more. The Provider Roundtable disagrees with this notion, given that significant changes in payment rates impact provider decisions about what services they will be able to continue providing hence impacting beneficiary access to care. The PRT recommends that CMS apply the same dampening mechanism to device-related APCs as it did for 2003, and as it proposes to do so for drugs and blood products in 2004.

The Provider Roundtable strongly disagrees with CMS' logic of applying discounting to the second and subsequent APC by 50% when the proportion of the APC attributable to a device is more than 50%. We believe CMS should change the status indicator for all device-related APCs to an "S" where the device comprises more than 50% of the overall the payment rate.

In addition, the PRT would like CMS to be aware of the fact that providers are making more and more service delivery decisions based on the financial impact of APCs/OPSS on their organizations. The question of expanding service lines, eliminating them, or consolidating them is quite often dependent on how persuasive clinic managers are with their finance departments, or revenue cycle management teams, despite losses that may result from fluctuating APC payment rates from year to year. The PRT offers

the following examples of the types of services that are being curtailed, consolidated or eliminated in light of payment rate changes from year to year, in order to limit the facilities' overall financial exposure under OPSS.

Further, providers note that, once hospitals eliminate services, they are reluctant to re-introduce them even if reimbursement eventually increases as hospitals do not monitor reimbursement levels or vendor's costs closely once services have been eliminated.

One of the PRT hospital systems shared that it has implemented a "New Technology Committee". This committee's mission is to study the financial implications of new devices, drugs, and biologicals prior to making any purchasing or service offering decisions. A not-for-profit organization, this hospital system is dedicated to serving all patients regardless of their ability to pay. Therefore, it has to use its funds carefully and appropriately, and consider the greater good when adopting new technologies. To date, this committee has reviewed the following items and taken the following decisions:

- *Zevalin*: Although only one treatment is required, each treatment costs approximately \$22,000. The research conducted by this hospital system showed that more than half of the time, it would be given to Medicare patients. The hospital system finally took the decision to provide Zevalin; however, it is only being provided in one of the system's hospitals, due to continuing concerns over financial liability (specifically, commercial payer coverage and all beneficiaries' inability to meet the high co-payment).
- *Niagra PV System and/or Prostate Cryoablation*: Both of these new treatments can be used for the treatment of benign prostatic hypertrophy (BPH). Research shows that they are less invasive and have fewer complications than traditional scope BPS and laser procedures. Moreover, they are considered to be outpatient treatments. The procedures do not have a separate CPT code; and therefore group to the regular laser ablation of the prostate. Unfortunately, after much negotiation, the hospital decided it could not afford to rent or buy the laser. Once again, more than half of the patient population seeking the treatments has Medicare as their primary payer, and the hospital system computed an approximate loss of \$1,000 per case. The hospital system has not decided whether to implement these therapies or not, and is waiting either for the laser's manufacturer to lower the price, or for CMS to increase reimbursement.
- *Aranesp*: The hospital system has not implemented this therapy due to a projected loss of \$450 per month, based on an average monthly treatment cycle. (With Procrit, the loss would only be about \$144 per month.) Aranesp has been shown to be as effective as Procrit and is only administered subcutaneously twice a month, while Procrit requires six subcutaneous injections per month. The beneficiary would be better off with fewer administration visits; however, this hospital will not switch to Aranesp unless the cost drops or CMS increases reimbursement.

Another PRT hospital system shared that, after three straight years of large revenue losses related to their outpatient infusion clinics, it consolidated the services into one geographic location. Previously clinics operated on the north, west, and south sides of the city, and patients traveled less than 30 minutes to receive services. Consolidation of these

services resulted in double the travel time for many patients. This decision was taken to limit financial losses incurred by this hospital system, as many patients now seek these services elsewhere. Moreover, the vacated clinic spaces are being used to provide more profitable services, or services on which the hospital breaks even. While this was a difficult decision, it was a necessity for the hospital, although it was not necessarily in the patient population's best interest.

Another PRT hospital system requires their surgery staff to discuss both the purchase of new surgical products (implants, equipment, etc.) and the introduction of new and expensive technologies with the revenue management department prior to moving forward with any decisions. The hospital examines the payer mix for beneficiaries who would typically receive these new services to assess the financial impact on the facility. Based on this analysis of the costs and the payment rates from the major payers (i.e., Medicare, Medicaid, Worker's Compensation, Managed Care, etc.) services provided these beneficiaries typically result in lost revenues for the facility. In many cases, the hospital has decided not to implement a service or technology. When payment rates fluctuate for a particular service from one year to the next, the facility becomes even more reluctant to implement new technologies and services.

Another PRT hospital system has re-negotiated contracts with vendors that provide items such as brachytherapy seeds and penile implants as a result of the reduction in Medicare reimbursement for these procedures. This facility determined that it could no longer provide these services unless vendors reduced costs or Medicare increased reimbursement. In this case, the provider was fortunate and the vendor reduced costs for these items, but this will not always be the case.

Again, these examples are offered so CMS can better understand how fluctuating payment rates in the hospital setting, as well as payment differentials across different outpatient settings, truly influence provider's decisions about what services to offer. More often than not, hospitals are decreasing or consolidating their service offerings and taking a hard look at new services before implementing them—regardless of the benefit to the beneficiary population. While CMS' intention may be for the healthcare marketplace to function in this way, these decisions clearly impact Medicare beneficiaries' choice and access to care.

### **Procedures on the Inpatient-Only List**

Currently, the PRT has no objections to the codes on the inpatient-only list, provided that CMS makes additional claims processing concessions. CMS should also be aware of several other issues, however, with respect to how providers, payers, and others in the health care community view and use the inpatient-only list created by CMS under OPSS. These issues and suggestions are outlined below.

The existence of the inpatient-only list results in hospitals being denied for payment if procedures from this list are provided to Medicare beneficiaries in the hospital outpatient setting. We do not understand why CMS denies hospitals payment for these procedures, when CMS continues to pay physicians' professional fees when physicians bill for these same procedures when performed in an outpatient setting. Many physicians provide these procedures in outpatient settings, despite hospitals attempts to educate them and to enforce Medicare's rules so that losses are not incurred. Because physicians' payment is

not affected, many continue to provide these procedures because they feel that the technology is available, they view this as cutting edge, or believe it is to the patient's benefit.

CMS may believe that hospitals should control physicians by creating disincentives or revoking privileges to force physician compliance with the OPPI inpatient-only list. While this may appear reasonable, it is not. It is nearly impossible to control physicians in this area. It is particularly hard for hospitals located in geographic locations where physicians are desperately needed. We believe that CMS needs to create consistent incentives and disincentives across care settings. With respect to the inpatient-only list, this means releasing the same inpatient-only list as part of the physician's fee schedule. In this way, CMS would align hospitals' and physicians' incentives on procedures it feels are either unsafe or inappropriate for Medicare beneficiaries to receive in outpatient settings.

A second issue that hospitals face with respect to the inpatient-only list has to do with patients who need to be stabilized prior to being transferred. Sometimes, this requires a procedure from the inpatient-only list to be provided yet, other than admitting the patient to the inpatient setting for purely administrative reasons; there is no mechanism that will result in payment in the outpatient setting.

The PRT recommends that CMS allow payment for procedures on the inpatient-only list when provided to patients in order to stabilize the patient immediately prior to transfer. This can be easily done through the Outpatient Code Editor (OCE), since the UB-92 claim form would contain both the discharge disposition code "02" and a procedure code from the inpatient-only list. In these instances, the OCE should ignore the payment status indicator of "C" assigned to the inpatient-only procedure code, thus making the claim eligible for payment. Creating a mechanism to pay for these procedures in this instance is not unlike CMS' decision to pay hospitals for patients who die in the outpatient setting after receiving an inpatient-only procedure. A few examples of inpatient only procedures that are performed to stabilize the patient prior to transfer are listed below.

Several of the PRT hospitals are small, rural facilities that must often stabilize patients prior to transfer. These providers routinely provide CPT procedure code 37195, Thrombolytic for Stroke. Under the current OPPI rules, the hospitals have to admit these patients and provide an inpatient order in order to receive reimbursement, even though the patient will be transferred immediately after being stabilized. The PRT believes it would be more appropriate to allow providers to provide these services in the outpatient setting. This may save the Medicare program money in the long run, as these patients would not have to be admitted and paid under the inpatient rate. It would also minimize the providers' administrative burden. Therefore, the PRT recommends that CMS allow payment for CPT code 37195 when provided to patients with a discharge disposition status of "02" through APC 0676, Level II Transcatheter Thrombolysis. This is the same APC CPT code 92977, Dissolve Clot Heart Vessel and therefore appropriate for CPT code 37195.

Another PRT hospital occasionally sees patients in the outpatient setting for cardiac catheterization procedures (CPT: 33967 Intra-aortic Balloon), although the hospital does not provide bypass surgery. This hospital is located two blocks from another hospital that

does provide bypass surgery. The PRT hospital has seen patients who become unstable during the cardiac catheterization procedure and must be transferred to the nearby hospital. Prior to transferring the patient, the PRT hospital must stabilize the patient by inserting an intra-aortic balloon pump, which is on the inpatient-only list. The PRT hospital will not be paid for this procedure, even though it is necessary to stabilize the patient. To be paid, the hospital would have to admit the patient simply to stabilize them prior to the transfer. For the same reason as above, the PRT recommends that either CMS remove this procedure from the inpatient-only list, or provide payment for this and other procedures from the inpatient-only list when they occur with the discharge disposition status "02".

The third and final issue that we would like to bring to CMS' attention has to do with how the McKesson InterQual SIMplus seems to interpret CMS' inpatient-only list. If a service or procedure is on the list, the InterQual criteria considers the procedure as one that can *only* be performed as an inpatient procedure, and *never* as an outpatient procedure. Similarly, procedures that are not on the inpatient-only list and which have an APC payment assigned to them are automatically considered outpatient procedures. This conflicts with CMS' statements in various sections of the Hospital Manual where *inpatient*, *outpatient*, and *observation care* are defined. When a generally accepted criteria (such as the McKesson InterQual criteria) states that CMS says the procedure is an outpatient procedure simply because it has an APC and is not on the inpatient-only list, then providers will see patients as outpatients solely based on this information, regardless of the patients' needs.

The PRT recognizes that this is not CMS' intent in creating the inpatient-only list; therefore, CMS should clarify in the final 2004 OPSS rule that the existence of the list merely indicates what CMS will not pay for in the outpatient setting when provided to Medicare beneficiaries. The list does not prohibit hospitals from providing these services in the outpatient setting if the services are medically appropriate and/or if the technology is available. More importantly, CMS should clarify that just because services are not on the list does not mean that they *have* to be provided in the outpatient setting. Medical necessity should be the driving factor determining whether patients are admitted or treated in the outpatient setting.

### **Observation Services**

The Provider Roundtable members recognize that CMS is not currently seeking comments on Observation-related issues. However, given that a subgroup of the APC Advisory Panel is studying this issue, the PRT requests that, when CMS publishes the final rules for 2004, it ask for public comment focusing on specific provider operational issues so that the APC Advisory Panel can begin considering them prior to the 2004 meeting.

### **E/M Guidelines**

The Provider Roundtable applauds CMS for continuing to move forward with the development and implementation of National Facility Coding Evaluation and Management Codes and Guidelines. Specifically, we appreciate CMS' acknowledgement that this move will be challenging for providers, and that adequate time and education will be required. We recommend a six-month implementation period

from the time of final rule-making to the implementation of the new E/M codes and guidelines, as providers need to change systems and internal processes.

The PRT agrees that there is no need to differentiate between new and established patients and, in principle, agrees with the guidelines proposed by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) as long as certain modifications are made to the final guidelines. To that end, we have provided a number of comments using the AHA/AHIMA template so that CMS can easily see where we suggest enhancements to the examples. This information is provided in **Appendix B**. CMS should feel free to request an electronic version of the chart from our spokespeople.

CMS should understand that nursing personnel are not always involved in assigning levels. Regardless of what model is used, we all need to be aware of the fact that hospitals assign levels in different ways. Some have coders assign levels, while others have been successful at having nursing do this. Regardless of the system used, there is a strong need for training on assigning levels, and time to ensure that the guidelines are implemented consistently across all hospitals.

Given that CMS has been very clear that the E/M levels should not contain separately payable procedures, the PRT requests CMS to carefully review the items included in the AHA/AHIMA model. Additionally, procedures that have a status indicator of “N” should be included in the E/M level guidelines, as the visit is in part assigned by the procedures packaged into it. However, providers should continue to separately report “N” status procedures for proper charging and data capture. CMS needs to pay close attention to this; otherwise the charge data it collects from providers will continue to be inconsistent.

Examples of separately reimbursable procedures include:

- Level III, “precipitous delivery of a baby” and “continuous irrigation of eye using therapeutic lens (e.g. Morgan lens).
- Examples provided for bedside diagnostic testing include billable items

The only major disagreement among the PRT members is whether three levels are more appropriate than five. Therefore, we offer a majority and minority opinion on this issue.

*Majority Opinion: Three levels are better than five for the following reasons:*

- Simplicity and ease of use by providers
- The number of E/M levels should correspond to the number of payable APCs
- There is less room for error in assigning the correct level since the categories are broader
- Documentation requirements will not be burdensome
- Having three levels on the facility side will create a natural distinction between facility and physician E/M codes
- In terms of reimbursement, patients use similar enough amounts of resources to be grouped into three levels.

*Minority Opinion: Five levels are more appropriate than three for the following reasons:*

- Consistency with other payers reimbursing facilities based on a five level system. Lack of consistency will result in internal systems problems since all patients may have to be coded with five levels and then mapped to three levels for Medicare
- Five levels allow for greater clinical and resource use differentiation, particularly for emergency department patients
- Five levels provide better definition of contributory factors, improving clarity and reducing administrative burden.
- Five levels provide more data for CMS to base future decisions on. Once the data are lost, CMS won't be able to go back easily. It is better to start with five levels for the first few years of national codes and guidelines and then determine if three levels are more appropriate
- Current nursing acuity levels and triage are based on five levels
- A wide range of services provided, particularly in the emergency department, do not fit well into three levels
- The Emergency Room Nurses' Association recommends five triage levels, from a nursing perspective patients do not fall into just three categories

Most of the PRT members who shared the minority opinion could live with three levels on the clinic side, but continue to prefer five levels for Emergency Department visits. The providers sharing the majority opinion agreed with this view, though they were less optimistic that CMS would implement three levels for the clinic and five for the emergency department. None of the members felt it would be problematic to live with this type of system, but everyone agrees that CMS should make a separate APC payment for each level, unlike the current system.

In fact, all but one of the providers sharing the minority opinion (five levels) would switch to the majority opinion (three levels) if CMS was unwilling to pay for each of the five levels. One member pointed out that CMS might not start there, but if five levels are not used, CMS would never be persuaded to pay on five levels because the data will be lost. Based on this, a number of the members agreed that, with the new system in place, it might be best for CMS to keep five levels from a coding perspective but pay according to three levels until the APC Advisory Panel can assess whether there is a large variation in resource consumption once the new guidelines are implemented.

In summary, if the AHA/AHIMA model is implemented with three levels, the PRT feels strongly that modifications need to be made. Please see **Appendix B** for additional suggested additions, deletions and modifications.

### **Requirement to Report a Line Item Date-of-Service for All Line Items**

On page 47983 and 47984, CMS requests feedback from providers on the potential obstacles and the time required to implement the requirement of reporting a date-of-service on every line item. The PRT supports this idea, and believes it will ultimately result in more complete and usable data for CMS to use in setting future payment rates.

We have concerns about implementation of this requirement as it applies to series bills and the requirement to report multiple visits on the same date of service on the same

claim, however. These may appear to be different, yet in many cases they merge for series patients who have to return to the hospital for an unrelated condition on the same date as their repetitive service.

Reporting of all services on the same claim triggers edits that force providers to use modifiers that would otherwise not be required if the truly separate visits were allowed to be billed individually. This requirement exists because separate visits sometimes result in some of the same tests and/or procedures being performed. Such visits should not be subject to OCE, CCI or other FI specific edits when they are actually separate visits, nor should these line-items require modifiers simply to pass edits

Several PRT members discussed these issues with the internal revenue cycle teams in their hospitals; and most agreed that the advantages of eliminating series bills would outweigh the disadvantages. In addition, almost all members of the PRT agreed that a number of LMRP issues and billing issues would be eliminated if they could report separate visits on separate claims even if they occurred on the same date of service.

For example, a series patient who receives a non-chemotherapy infusion at 8:00 am may return to the Emergency Department at 5:00 pm because of nausea, dehydration and/or chest pain. This patient would receive a non-chemotherapy infusion service again but, unless a modifier is placed on it, CMS would not allow payment for this line-item. Since the diagnosis code(s) reported for the second visit would be different from the series visit, these two visits should be considered separate and distinct from a medical necessity perspective. If CMS is worried about overpaying providers, it should implement a cross-claim editing function in its internal systems to monitor inappropriate provider billing, rather than requiring providers to report all services on the same date-of-service on one bill.

Single bills are more accurate and reduce much of the back end re-work, particularly in the case of multiple unrelated visits on the same date of service. With respect to series bills, the PRT believes that the elimination of the series requirement will not necessarily increase the burden of the registration staff, since they should still be able to register a series patient once a month. Even if this is not possible for all providers, the PRT believes that the duplication of the registration function is less expensive than the consumption of resources to manage back end/medical necessity and claim denials issues.

Therefore, at a minimum, we request that CMS makes optional the reporting of series bills and multiple same-day visits on a single claim. This would allow providers the choice of billing multiple visits on the same date-of-service on separate claims or on a single claim. Providers would also be able to choose to continue to submit series bill as they currently do or to bill each patient visit on separate claims

### **Requirement to Report a HCPCS or CPT Code for Drugs, Biologicals, and Devices**

We recognize and are concerned about the operational impact providers will face because of expanded HCPCS coding, although we believe that this level of coding detail is essential to the development of accurate claims and future rate-setting. While we agree with CMS' proposal to report detailed drug and device codes, providers need at least six months to prepare systems and staff for this change. CMS should give providers a grace period through March 31, 2004 and begin editing for these codes as of April 1, 2004.

Our assumption is that CMS would *only* require detailed drug and device coding for items that were separately reportable under OPDS beginning in August 2000 and all new drug and device codes since that time. We do not support detailed reporting of all drugs and supplies, particularly those that are routine, low cost, and currently only reported using a packaged revenue code (i.e., 25X or 27X). Reinstating codes that used to exist will be easier for providers than implementing totally new codes for these drugs and devices.

In addition to requiring the C-codes, the PRT suggests that CMS implement a mechanism to edit for the C-codes in specific revenue codes. Providers can easily comply if CMS provides appropriate guidance on which revenue codes providers are to use with specific HCPCS codes. If all providers comply, then CMS will have even more refined, accurate, and complete data going forward. If only revenue codes are required (and not the specific HCPCS codes), we do not believe that CMS will be able to match specific devices and their costs to specific procedures. The vast majority of the PRT members would rather work to adapt internal systems to report the detailed codes rather than let CMS simply average out device costs to determine how much to package into various procedures. That level of averaging is not appropriate and can cost providers a great deal of money, particularly on procedures requiring high cost devices. Moreover, having detailed codes for drugs and devices helps our coders know that a claim is complete, which is very important for the internal process.

Guidelines for coding should come from CMS, rather than from the individual vendors. Also, when new category C codes are released, CMS should post these on a web site with a clear description of the category and what it should be used for as it is often difficult for providers to determine what the code involves (e.g. C-9123: Trans Cyte).

Finally, CMS needs to be aware that when it does not pay separately for items or services, providers are less likely to pay attention to accurate and complete reporting. This is why we believe it may be appropriate for CMS to create additional OCE edits to line-item reject provider claims if they do not comply with the reporting requirements. While we are not necessarily in favor of additional OCE edits, we do favor having accurate and complete data from all hospital providers. If only a few providers work hard to report accurate and complete data while others do not, the data from the ones who report correctly may be irrelevant when they are averaged out by others' poor reporting.

We ask CMS to carefully consider the implications of requiring additional HCPCS coding, and to think forward to mitigate any future changes in policy or methodology. Providers should not be exposed to changes in 2005 and 2006 if CMS does not get it right from the outset, as these changes require considerable resource to implement.

### **Payment for Generic Drugs, Drug Median Costs, Patient Safety, and Blood**

#### *Generic Drugs*

CMS should be aware of the fact that the mere introduction of a generic alternative does not automatically translate into generic usage and lower cost. Migrating to generic equivalents is affected by when the brand name product goes off-patent, when generic equivalents become available, when hospitals determine they are safe, and when contract issues can be resolved.

Many providers adopt generic equivalents as soon as they are available, as long as they have an AB rating from the FDA. (AB rating means that the FDA has deemed the generic product to be equivalent in potency and dissolution characteristics to the reference, or brand name product.) Other providers do not buy generic products from vendors unless they are familiar with the drugs, even with an AB rating. Some providers wait until they are sure that there are no problems caused by differences between generic and brand name products, such as those caused by preservatives. For example, the generic Propofol Injection is produced by Baxter, a well-known company. Nevertheless, the generic product uses sulfites as a preservative, and some providers will not buy it, because some patients may have adverse reactions to this preservative.

Two other issues may prevent providers from immediately switching over to generic drugs. The first concerns contracting. Established contracts may prevent providers from switching immediately, and may result in a several year time-lag. While future contracts may be written differently, the generic requirement will cause problems for providers until their contracts are renewed with purchasing groups. Secondly, it is quite common for shortages of generic equivalents to occur when they first appear.

If CMS is going to make this proposed change final for 2004, then it should certainly increase the time for generic drug payment reduction. CMS should not implement generic drug payment reductions until generic equivalent have been available for at least one year. In addition, CMS should address how OPPS will pay for new and expensive therapies in the coming years. Finally, we strongly urge CMS to expedite the time it takes to assign new HCPCS codes to new drugs.

#### *Patient Safety Issues and Drug Units of Service Reporting*

CMS should be aware of the patient safety issues that exist across providers due to drug units of service billing. Billing the correct drug units is an operational nightmare for providers given that the way the drug is purchased, ordered, dispensed, administered, coded and billed can all be different. We provide the following example to illustrate how much of a manual process it can be to order the right quantity of a drug, have the pharmacy dispense enough of it for the patient, and to ensure that the right amount is billed on the UB-92 using the most appropriate/payable J-code. C9205, Oxaliplatin, 5 mg., is a drug available only in 50 mg and 100 mg vials. Most adult patients need a dose of 147 mg. It is extremely difficult to track the correct ordering and dosage in the Pharmacy Information System to comply with pharmacy laws, while also providing billing with the correct information on price and dosage based on a 5 mg dose. Aside from these logistical issues, there is a real patient safety concern, given that in one of the PRT hospitals a 50 mg Oxaliplatin vial is assigned a CDM code of C9205 (5 mg). The dispensing order then is amended to read "30 vials of 5 mg". It is up to the *pharmacist* to recall that this is a billing label, and that the correct does is three 50 mg vials (to create a 147 mg dose).

While we indicated above that the PRT agrees with CMS' proposal to require detailed drug coding, we are very concerned about the units of service reporting issues that providers face, as well as the patient safety issues that the ordering, billing and reporting issues can create. Expanding the J-code requirement to packaged drugs with no separate APC payment will greatly add to the possibilities of error in administering these drugs.

The PRT asks CMS to examine J-code dosage definitions and use the lowest dose available from the drug manufacturer in all cases.

### *Blood Products*

The PRT is deeply concerned not only with the payment rate decreases for blood and blood products from 2003 to 2004, but also with the overall payment rates as they are very low compared to our actual costs. In **Appendix C**, we have presented the per-unit cost of blood from more than half of the members in our group representing 12 different states. This information includes the difference between the 2003 and 2004 payment rates as well as the difference between the 2004 payment rate and our average direct cost for purchasing blood from the Red Cross and other blood vendors. These costs do not include ordering, verifying, or dispensing the blood once it is received. Therefore our actual total cost for blood is even higher than what we have presented in **Appendix C**. Nevertheless, CMS can see that the payment rates continue to decrease, resulting in mounting losses for hospitals. Given that beneficiary access to blood is critical, the PRT urges CMS to reconsider its payment methodology for blood. We urge CMS to consider paying providers for their actual costs to obtain blood. CMS may consider using value codes and amounts for providers to report actual blood processing costs. In addition, the PRT makes the following additional comments and recommendations:

- The APC Advisory Panel recommended making the blood product transfusion code a per-unit code. We agree with this recommendation since time, effort and supplies significantly increase with each unit administered.
- The PRT is concerned with the underpayment associated with CPT code 86891. The APC payment for this procedure (intraoperative blood salvage) is approximately \$14.00. Red Cross personnel perform the intraoperative blood salvage procedure and the direct cost to the hospital is over \$600 and around \$500 for post-operative salvage.
- Autologous blood and directed donor blood do not have a separate CPT code. They are paid under the standard CPT codes, even though the hospital's cost to obtain them is higher. (The Red Cross states that it is passing on the additional costs involved with processing these types of units.) Even more distressing, providers can only charge the autologous blood unit to the patient if they actually receive it. If patients do not receive it, the hospital must absorb the cost. This does not occur with directed units that can be placed back into the general blood supply. This is another example of how hospitals are expected to absorb the loss of physicians practice patterns, as the hospital pays for any unused autologous units ordered by the physician. The PRT asks CMS to align hospital and physician incentives with respect to what is allowed from a billing perspective.
- Reimbursement does not include special needs patients, for whom the provider has to do a national search for the blood. This can cost as much as \$1,000 per unit, yet the provider does not get reimbursed for these costs. The PRT requests CMS to research this issue and to create an APC that covers the cost for this.

## **Drug Administration Payment for Non-Chemo Infusion and Chemo Administration**

On pages 47877- 48003 CMS outlines several new options for paying for non-chemotherapy infusion and chemotherapy administration services in 2004. The PRT members unanimously agree that Options 2 and 3 are simply not viable. On page 47999, CMS states: “coders would have to look up the drugs administered to know which code to bill.” This statement assumes that coders have the responsibility to code injections, which they do not. Coders often do not code services that are set up in the Charge Description Master (CDM), such as injections and infusions. Given that these services are typically charged through the CDM, that there is a shortage of coders, and that nursing staff is already overworked and being asked to do more and more with respect to E/M reporting under OPSS, the PRT cannot support implementation of either Option 2 or 3. Of the remaining two options (1 and 4), the PRT members were torn; they felt that both options essentially require the same level of operational effort from providers, particularly since our group supports CMS’ proposal to require detailed drug coding next year.

A number of the PRT members were interested in keeping the status quo since none of the other options seemed much better. In terms of operational impact, however, the group realizes that both options 1 and 4 require the same amount of work on the part of providers in terms of continuing to report the administration codes. The only difference we see with option 1 is that CMS would not differentiate payment based on the type of drug administered. If CMS chooses to maintain the status quo, we prefer to use the CPT codes for chemotherapy administration rather than Q-codes. From the information provided in the *Federal Register*, it was clear that the APC Advisory Panel, AHA, and AHIMA support the use of these codes. As providers, we also support it, given that we already use them for other payers. Despite the fact that CMS believes it is an administrative burden to report the start and stop times for infusions, PRT members noted that they already do so, and it would not be an additional burden. If CPT codes are not implemented, we see no difference between option 1 and option 4; in that case, we prefer option 4, as it seems to attempt to tie the type of drug to the type of administration. However, without further analysis and more details from CMS on how the median cost numbers were generated, it is difficult to know whether we, as providers, would be better or worse off.

CMS raised a number of other issues in this section of the proposed rule that we address below:

- We agree with the proposal to eliminate Q0085. If this is not ultimately accepted, CMS should release very clear guidance on when providers should report this code so that better data are generated in the future.
- We disagree with the suggestion that Q0081, Q0083, and Q0084 are to be reported once per date of service. We believe that any combination of these codes should be allowed for separately identifiable events and when medically necessary. For example, if two encounters occur on the same day for chemotherapy infusion (e.g. once in the morning and again in the afternoon), Q0084 may be reported twice. In addition, as stated elsewhere, it is possible to have a chemotherapy infusion visit (Q0084) in the morning with hydration (Q0081) and another visit in the afternoon for a completely unrelated condition

that may warrant another hydration (Q0081 with modifier -59). These situations should be allowed. Therefore, the PRT disagrees with CMS' statement that these codes should only be reported once per date of service.

### **Issues Related to Cost-Shifting of Patients to the Hospital Setting**

The PRT would like CMS to know that more and more patients are being shifted to the hospital setting from the physician offices due to inequities in coverage decisions and payment rates. We are especially concerned about this with respect to the changes being proposed for chemotherapy administration, as well as drug prices and administration payments in the physician's offices that are currently being addressed by Congress. We offer a number of examples for CMS to better understand our concerns:

Physicians "cherry pick" which patients are sent to the infusion clinic. For certain medications, such as Remicaid, the physicians send patients to the hospital setting so that they do not have to absorb the revenue loss that accompanies giving this medication to a Medicare beneficiary. Unfortunately, the hospitals' losses on this drug are even higher than the physicians'. We believe this is happening with selected chemotherapeutic agents as well. Unfortunately, it appears the proposed rule for Payment Reform for Part B Drugs, published by CMS on August 20<sup>th</sup>, 2003, will not help with this issue and could make it worse. Although CMS hopes that all the pressure will decrease the price of medications, we are concerned that it will simply result in Medicare beneficiaries having less access to these drugs in the short-term. Over the long-term, we worry that there will be a reduction in the production of life-saving drugs that target illnesses found in older populations.

One of the four hospitals in a Provider Roundtable's county opts not to provide outpatient medication and infusion services to patients, due to the low reimbursement, continual changes, and the bundling of drugs into chemotherapy administration and non-chemotherapy infusion services. Under APCs, the majority of drugs are bundled into the medication administration service and the facility receives no extra payment for the drug, yet the administration payment for the drug did not increase in 2003. Physicians send patients who need outpatient medications for which the physicians are not reimbursed to one of the Roundtable facilities. Some physicians will request that the patient purchase the needed medication and return to the office for the drug to be given to the patient. The physician then bills only the office visit and the administration of the drug, but not the drug itself. Because these drugs are status N, the facility cannot issue an ABN to make the patient responsible for the drug.

In most cases, physicians are paid more than hospitals for the drug, based on the single drug pricer payment rates. In some cases, the physician payment is almost double the hospital's payment under APCs. If the proposed payment reform for Part B drugs lowers the amount the physician receives, more patients may be shifted to the hospital for drug administration.

One PRT member's clinical pharmacist indicated that a physician's Hematology and Oncology clinic requires an up-front 20% co-payment from Medicare patients. If the patient does not have supplemental insurance, or can't pay the co-payment, he or she is sent to the hospital. The hospital does not collect the Medicare co-payment up-front

which may be another reason that patients are being shifted to the hospital for chemotherapy administration.

Another reason that patients are sent to the hospital is because they often need care on holidays, weekends, and after office hours. This can only be provided at hospitals open 24-hours a day. Outpatient chemotherapy department complain that any time a physician's office is closed, patients requiring a flush of their access device or a simple dressing change are sent to the hospital for care.

In addition, more and more physicians are choosing to leave the hospital setting for ambulatory settings in certain service lines where payments are more favorable under the Physicians Part B payment rules compared to hospital payment (e.g. MRI). This results in hospitals losing profitable outpatient services, while continuing to receive the unprofitable ones.

We raise these issues so that CMS can be aware that a site of service differential in payment and/or coverage results that can either result in patient dumping from the physicians' office setting to the hospital setting or in physicians leaving the hospital setting for an ambulatory surgery or clinic setting. Therefore, we urge CMS to move forward very carefully as new drug and administration payments are proposed for the physician versus the hospital setting.

**Issues Related to Payment Status Indicator**

There has been some confusion regarding procedure HCPCS codes with status indicator "N". CMS needs to review all HCPCS codes with an "N" status because the procedure may be the only service rendered at an outpatient encounter (for example, a vaccine immunization, CPT code 90471). CMS needs to provide national coding and billing instruction that state either that the E/M code should be reported when an "N" status procedure is the only one performed, or consider establishing an APC payment rate for each of these procedures.

The PRT looked at a number of HCPCS codes and their status indicators, and has some suggestions for changes to the status indicators for the codes listed below:

HCPCS CODE	STATUS TO BE CHANGED
36540	Collection of blood from an implanted venous access device – current status indicator is "N"
36600	Withdrawal of arterial blood; current status indicator is "N"
90471 & 90472	Immunization or vaccine administration, and for each additional administration – current status indicator is "N"
94760	Pulse Oximetry – current status indicator is "N"
94761/94762	Pulse Oximetry Multiple and Pulse Oximetry Continuous current status indicator is "N"

For the codes listed above, the PRT offers the following comments:

- CPT code 36540: If this is the only service provided, then providers will have to also report an E/M visit code in order to be paid. This service is not provided by a lab technician, as it requires a nurse.
- CPT code 36600: The PRT recommends that CMS assign this a status indicator of "T" since it is not bundled into the E/M level and cannot be paid separately since it has an "N" status. Moreover, an arterial blood draw requires more effort

- and carries more risk to the patient than a simple venipuncture yet it is not paid for separately while the simple venipuncture is under the lab fee schedule.
- CPT code 90471 and 90472: The PRT recommends that CMS assign both of these codes a payment status indicator of “X” since patients may present just for the vaccine. If this happens, then the provider is forced to report a clinic visit code in order to obtain payment.
  - CPT code 94760: The PRT recommends CMS assign this code a payment status indicator of “X”.
  - CPT code 94761/94762: The PRT recommends that CMS assign both of these codes a payment status indicator of “X” since these services consume time and resources and typically last through the night.

For the codes listed in the table below, the PRT urges CMS to change all of the status indicators to “C”. These codes are all add-on codes to procedures on the inpatient-only list; therefore, it seems reasonable that these codes should also have a status indicator of “C”.

<b>Add-ons to inpatient procedures – should be “C” status.</b>	
61316	Implt cran bone flap to abdo – current status is “N”
61517	Implt brain chemotx add-on – current status is “N”
62148	Retr bone flap to fix skull – current status is “N”
62160	Neuroendoscopy add-on – current status is “N”

### **Discontinue the Creation of Unnecessary HCPCS Codes When CPT Codes Exist**

CMS is currently establishing new “temporary” HCPCS codes, such as G-codes, to replace existing CPT codes, combine existing CPT codes or create new codes for new technologies. CMS has indicated that its intention is to decrease the creation of Medicare-specific HCPCS codes (e.g. G-codes), yet it seems that more and more codes continue to be created. For example, in *Program Memorandum A-03-076*, Change Request 2887, effective October 1, 2003, CMS instructs in Section VIII to report G-0297 or G-0298 in place of CPT 33240 and to report G-0299 or G-0300 in place of CPT 33249. CMS implemented these new HCPCS codes for Implantable Cardiac Defibrillators without an explanation to the provider community on why they were created to replace the CPT codes. This is a prime example of CMS creating unnecessary HCPCS codes when there are perfectly acceptable CPT codes that could be used to report the given service.

The PRT urges CMS to move carefully before creating new Medicare-specific codes, as providers face many operational issues when new G-codes are created. Some of these issues are listed below:

*CDM Maintenance:* Changing codes in the CDM requires constant maintenance, as codes are created and go in and out of use. The pass-through code changes are a prime example: providers had to change from item-specific codes to category-specific codes, then had to delete the codes this year, and may have to reinstate them next year. Most hospitals do not have date-specific fields for HCPCS codes, so claim rejections occur with code changes.

*Existing CPT Codes Merging Into G-codes:* CPT codes that used to be separately identifiable as components now seem to be assigned one G-code, creating CDM havoc. A

sample of this is the prostate brachytherapy G-codes. G0261, for example, now includes placement of the seeds, insertion of the needles and catheters, and cystoscopy. Prior to this change, these items were individually identified line-items in the CDM, so combining them necessitates price restructuring, additions/deletions of line-items, and other tasks to facilitate accurate billing. In addition, internal policies and procedures need to be created to accommodate CMS' policies. These changes are usually not consistent with other payer's policies.

Internal Systems Issues: Facilities have difficulty passing HCPCS codes from the Health Information Management system to the appropriate "operating room" line in the Patient Financial Services system. Manual intervention is often required by coders and billers to have all of the charges report correctly on the final bill.

Non-Medicare Payers: Most payers will not accept the Medicare G-codes. As in the brachytherapy example, the CDM still needs all of the line-items that existed prior to the Medicare change (e.g. to one G-code) in order to bill non-Medicare payers for proper payment.

Fiscal Intermediary Issues: FI's also have difficulty applying the new codes. Providers often receive conflicting advice that is not timely from the FI's. One example is with HCPCS code J0151, Adenosin 90 mg. Claims were rejected by some FIs, and providers were told to hold claims and rebill them after April 2003. Then, providers were told to hold the bills until July 2003. As of August 2003, claims were still being held pending FI readiness. It is costly and time consuming for providers to hold these claims and to submit them separately when the FI is finally ready.

Packaged G-codes: There are new G-codes for packaged procedures. An example is G0289: knee arthroscopy, surgical with debridement in a different compartment of the same knee. Physicians generally do not state the amount of time spent on any particular part of a knee procedure. In order to correctly use this code (29877), physicians would have to be educated to document this procedure differently in order to generate G0289, only to have it be packaged and other payers not to recognize it. There is little incentive for providers to comply with this unusual coding scenario when an appropriate CPT code already exists.

Clinical departmental education: Coders and clinical department managers need constant ongoing education regarding the changes that can occur at the quarterly update, in addition to the annual ICD-9-CM and CPT4 changes. This creates an ongoing administrative burden and increased cost to hospitals.

Other reporting requirements: Hospitals use CPT codes in their databases for other reasons: physician reappointment, patient volume statistics, reporting to outside agencies, etc. Creating two codes that represent the same procedure is problematic and not conducive to accurate statistical reporting.

The PRT recommends that CMS not create new HCPCS codes when existing CPT-4 codes are available. In addition, CMS should review all current HCPCS codes, particularly the newly developed G-codes, and discontinue those with an equivalent CPT code. CMS should instruct providers to use the CPT code rather than the G-code once G-codes are deleted. New G-codes should only be introduced on a quarterly basis.

## **Reduce FI Inconsistencies by Releasing National Guidance on Various Topics**

Although CMS has released clear guidance to FIs on how they should process and edit Medicare claims under OPPS, many FIs around the country are implementing additional rules that either directly conflict with national guidance or are inconsistent with rules (or lack thereof) implemented by other FIs. The PRT believes this is a critical issue for CMS to address for two reasons. First, if some FIs allow certain billing scenarios with which CMS disagrees, those FIs will pay out more than CMS intended. Second, CMS will continue to receive inconsistent data from hospitals around the country based on FI edits that are in place. There are numerous cases of FI inconsistencies that we have found. We are offering examples only for those that we believe CMS is concerned about currently, hoping that CMS will provide very clear national guidance on these issues.

### *1. Non-Chemotherapy Infusion, Chemotherapy Administration, and Injection Charging*

The PRT commends CMS for taking the first step to offering some clear information on the difficult area of reporting chemotherapy administration and non-chemotherapy infusion services. We believe this is a great first step, but many unanswered questions remain. These questions reflect our knowledge of how FIs interpret CMS' code descriptions and intent regarding APC payment differently. We suggest that CMS review the Kansas FIs website with respect to the chemotherapy administration and non-chemotherapy infusion billing, and compare the guidance and examples on their site with that of other FIs such as Empire Medicare, United Government Service, and Medicare Northwest (to name a few). It is clear that the Kansas FI allows both the non-chemotherapy infusion code and a chemotherapy infusion code on the same date of service, even when the non-chemotherapy infusion is provided for pre-hydration services. Medicare Northwest, on the other hand, describes the amount of time that must elapse between the two services, and mentions that the services can be sequential but cannot occur during the same visit. Medicare Northwest also states that if both services are reported a modifier is required, yet other FIs do not have this requirement. This information impacts how providers bill and whether they are paid. The PRT requests that CMS carefully review this information and release a national Program Memorandum that covers this information along with answers to the following questions:

#### Specific Infusion Charging Scenarios

- *Piggy-Back Infusions:* Often an infusion is ordered for a solution of one drug and additional drugs are also infused into the same IV line. This is referred to as a "piggyback infusion". There is no CPT/HCPCS code for a nurse connecting a new piggyback drug to the IV line and regulating the flow. There is no way for CMS to associate each drug with a procedure. We recommend that CMS define a HCPCS code for a piggyback IV bag.
- *Units of Service:* CMS needs to clearly indicate how many units of service are allowed for injection codes 90782, 90783, and 90784; the proposed rule seems to imply that these can only be reported once per day and we believe this is a typographical error.

- *Pain Control Pump*: Providers need clear guidance on how to code a pain control pump. In one example, an IV is started to infuse pain medicine loaded into a pain control pump. The nurse loads in the cassette of medication and programs the pump. When the medication is used, a new cassette is loaded and programmed into the pump based upon physician order. The PRT questions whether CMS consider this a non-chemotherapy infusion to be reported with Q0081? Also, how should providers bill for each additional cassette of drug loaded and programmed into the pump? Because this is neither an injection nor an infusion, it is unclear what code providers should use. This may be a valid place for HCPCS codes: one for initiation of a pump and another for each pump refill.
- *Double infusion*: In the emergency department, a patient often needs rapid infusion, so an IV is set up in each arm and drugs are infused rapidly into both. CMS seems to consider this one infusion since Q0081 is only allowed once per day. Clearly, starting two IVs is more resource-intensive than starting only one. Several PRT members recall a CMS statement that the Q0081 could be reported twice: once with the HCPCS code only and once with the HCPCS code and modifier -59. The PRT requests that CMS clarify this so that all providers can be aware of instances when it would be medically appropriate to report two codes.
- *Use of Q-codes for Non-Cancer Diagnosis*: Most FIs make it clear that the chemotherapy administration Q-codes are only to be used when the drug being administered in an anti-neoplastic and for a cancer diagnosis. However, several members of the PRT have seen at least one FI pay for claims with a Q-code and a non-cancer diagnosis. CMS should clearly indicate whether Q-codes can be used for diagnoses other than cancer and, if they cannot, require all FIs to follow the same rules.

#### Injection Charging Issues:

With respect to injection and other infusion charging scenarios, we request that CMS include the following information in the Program Memorandum released on the infusion reporting. We have provided our impression of how CMS considers the following injection codes with respect to separate versus bundled payments:

- 90782, IM injection – The PRT believes that IM sedation given pre-operatively is always bundled into the charge for the surgical procedure.
- 90784, IVP injection – The PRT believes that IVP sedation given pre-operatively is always bundled into the charge for the surgical procedure.
- Q0081 – The PRT believes that maintenance of an IV to keep the vein open is not therapeutic, and therefore is NOT separately billable to Medicare under OPPTS.
- Q0083 – The PRT believes that this code should be defined as an injection code. Therefore, providers should be allowed to report it each time a chemotherapy drug is injected just as multiple units of 90782, 90784, and 90788 are allowed to be billed for each injection of a non-chemotherapy drug. Additionally, in the Proposed Rule for “AWP reform” (*Federal Register*: August 20, 2003, page. 50439), CMS discusses multiple pushes and proposes to allow physicians to report 96408 once per day for each drug administered. If CMS finalizes this on the physician side, then the PRT assumes that CMS will make the same change on the hospital side so that providers would be allowed to report multiple units or

occurrences of Q0083 for each drug that is administered under either drug administration option 1 or 4.

## 2. *Modifiers*

*Issue One: Modifier 52, 73, or 74: Are procedures to be coded to the extent of completion?*

- FI policies vary on coding a discontinued colonoscopy. Several FIs indicate that CPT code 45378 should be reported with either modifier -73 or -74 when the splenic flexure cannot be viewed. Others indicate a sigmoidoscopy should be reported. Coding guidelines tell providers to code to the highest codeable procedure available, but this has not been confirmed by CMS and the PRT requests guidance on this.
- The question of whether conscious sedation is considered anesthesia or not has plagued the provider community since the beginning of OPPS; CMS has yet to provide a definitive answer. Therefore, both providers and FIs have different interpretations of conscious sedation. Clearly, this impacts the modifier a provider uses when a service is discontinued. The PRT requests that CMS clarify whether conscious sedation is considered to be anesthesia.
- We would like to confirm the policy concerning surgery cancelled in a pre-operative or holding area. Often, the patient is prepared for surgery and an infusion is started, then there is a clinical indication that the surgeon believes surgery should be cancelled. While this is documented, it occurs before the patient is taken to the procedure suite or operating room. The definition of modifier -73 is that the procedure must be cancelled *in the room where the surgery is to occur*. Even though the patient did not get to the procedure room, surgical supplies have been opened and other resources consumed. Under current rules, however, it seems that providers have no way to recoup these costs because modifier -73 would not be allowed. The PRT believes that the simplest way to address this situation is to allow providers to use modifier -73 in this situation as long as the patient is in a holding room or a pre-operative suite. If this is not an acceptable alternative, the PRT requests CMS to provide guidance on the use of an E/M visit code to account for the pre-surgical assessment resources expended.

*Issue Two: Modifier 59*

- The PRT would like CMS to address the new NCCI edit requiring a modifier -59 on CPT code 90784 when reported with Q0081, Q0083, Q008484 and Q0085. The PRT objects to this NCCI edit. The definition of 90784 is push injection; by definition, 90784 is a push injection of a drug separate from the infusion as represented by Q0081 or Q0084 or the injection represented by Q0083 since that code is for a chemotherapy drugs only. This NCCI edit seems illogical to the PRT, based on the definition of the codes. Unless this edit is eliminated, CMS will see a proliferation in codes with modifier -59. The PRT is also very concerned about the latest CCI edit for 90784 and the Q-codes present in version 9.3 of the edits that will go into effect for hospitals on January 1, 2004. This version of the CCI edits takes the current edit and makes it worse by NOT allowing 90784 to occur with Q0081, Q0083, Q0084, or Q0085. We have to believe that this is a major oversight in the revision of the CCI

edits, as it is quite common to see these Q-code reported on the same date of service with CPT code 90784. We urge CMS to review the CCI edits prior to January 1, 2004, and issue a correction via a Program Memorandum.

### 3. *Revenue Code to CPT Edits*

CMS has been very clear that FIs should not create revenue code to CPT edits unless already required by CMS. CMS has fully described what FIs are allowed to edit for in several Program Memos, yet a number of the PRT hospitals have FIs that have implemented a revenue code to CPT edit not released by CMS. This results in edits and payment denials for some providers but not others. While FIs have the discretion to create claim and line item level edits, our understanding is that FIs are NOT allowed to create their own CPT to revenue code edits. If our understanding is correct, we urge CMS to aggressively enforce this requirement and hold FIs that violate it responsible, as providers are facing unnecessary and unfair payment denials.

### **Conclusion**

The Provider Roundtable thanks CMS and its staff for reviewing and considering our comments. Although we are a new group, having met for the first time to respond to the proposed 2004 OPSS rule, we hope to continue working together and providing CMS with comments and suggestions in the future. We hope the operational issues we have outlined will be especially helpful to CMS in considering future system changes. If you have any questions or require additional information, please contact one of our spokespeople, listed below:

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A complete list of our members is included in **Appendix A**.

Sincerely yours,

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Marion G. Kruse, BSN, RN, MBA