Submitter : Mr. Anthony Johnston **Date & Time:** 10/06/2004 12:10:06

Organization : Liberty Hospital

Category : Nurse

Issue Areas/Comments

Issues 21-30

Payment Rate for APCs

I feel the published APC rate to take effect in 2005 is improperly calculated. Please see my attached letter written in MS Word for my full comments.

CMS-1427-P-144-Attach-1.doc

October 5, 2004
VIA ELECTRONIC MAIL

www.cms.hhs.gov/regulations/ecomments

Secretary Tommy G. Thompson
Center for Medicare & Medicaid Services
Attention: CMS-1427-P
P.O. Box 8010
Baltimore, MD 21244-8018

Re: CMS–1427–P; APC 0659 Hyperbaric Oxygen Therapy

I wish to express some concerns with the reimbursement changes published as "Department of Health and Human Services Centers for Medicare & Medicaid Services' 2005 Hospital Outpatient Prospective Payment System proposed rule ("Proposed Rule") that sets forth new reimbursement rates for hyperbaric oxygen therapy treatment ("HBOT"). 69 Fed. Reg. 50448 (Aug. 16, 2004)."

I am the manager of a hospital-based department providing hyperbaric oxygen treatments. Liberty Hospital is a non-profit 235-bed facility on the northeast edge of Kansas City, Missouri, metropolitan area. There are nine hospital based centers here in the greater metropolitan area if the Kansas side of the city is included, but only four, including ourselves, are set up to provide care to urgent/emergent patients to include those on ventilators or from intensive care units while the others focus almost solely on outpatient ambulatory wound care. This represents a large difference in cost of operation between the two types of centers with qualifications of staff, equipment capabilities and other factors such as on-call pay that do not seem to be reflected in your cost of operation calculations.

The proposed changes in reimbursement may threaten our ability to continue to provide these high intensity services. I am additionally concerned how the primarily wound care directed facilities will react to this change since they are largely operated by contract companies such as Diversified Wound Therapy and Curative. If this proposed change remains in effect, I am concerned these for-profit enterprises will abandon hyperbaric therapy and there will suddenly be an insufficient number of facilities to meet the needs of the Kansas City metropolitan area.

I am supportive of the Hyperbaric Oxygen Therapy Association (HOTA) position and the findings of the Lewin Group they have contracted with. I ask that the following actions be taken:

1. Leave the HBOT reimbursement rate at CY 2004 levels until CMS has an opportunity to develop and perform a calculation that will accurately detail HBOT costs and cost-to-charge ratios.

2. Due to the differences in which the hospitals have reported costs, adopt the overall cost to charge ratio (CCR) of .47

3. Apply the Lewin Group methodology to the 389 hospitals that reported hyperbaric claims for the year **2003.**

4. Adopt the Lewin Group approach at $118.21 per 30-minute increment.

I appreciate your consideration for this very important matter.

Sincerely,

Anthony Johnston, CHRN
Hyperbaric Coordinator
Liberty Hospital
P.O. Box 1002
Liberty, MO 64069-1002
v. (816) 407-2045
f. (816) 792-7298
ajohnston@libertyhospital.org

Submitter : Mrs. Lynn Stofer **Date & Time:** 10/06/2004 01:10:28

Organization : Lahey Clinic

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

My hospital is a 285 bed acute care hospital located in the Boston marketplace. As a major health care provider in our local area, we implant medical devices and perform other procedures on a number of Medicare beneficiaries in the outpatient setting. I am writing to express my concerns with the proposed rule, "Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates; Proposed Rule?, published in the Federal Register on August 16, 2004.

Payment Rates for Device- Dependent APCs

In the proposed rule, the payment rates for procedures involving some devices were significantly decreased. As a health care provider of these services, these payment reductions are a serious concern. Changes should be made to the 2005 proposed payment rates for ICD and other device implant procedures to be more closely aligned with the actual costs involved in providing these devices and services.

The 2005 proposal to base median costs for some device dependent APCs on the greater of (1) median costs calculated using CY 2003 claims data or, (2) 90% of the payment median for CY 2004 for such services results in an unsustainable financial burden for our institution. The resulting APC rates are lower than our institution?s cost for the ICD device, leaving us with a loss for the device acquisition cost and no payment for our procedural costs. These losses make it very difficult for us to continue to offer device implant procedures to Medicare patients in the outpatient hospital setting, especially given the cross subsidization required from other patients.

To rectify this issue, our facility requests that CMS calculate the 2005 payment rates for ICD and other device implant procedures using 2004 medians with an inflation factor. The resulting payment rates would be more in line with our facility?s costs of performing these services. If that is not possible, CMS should, at the very least, consider the September APC Advisory Panel recommendation to utilize the greater of (1) median costs calculated using CY 2003 claims data, or (2) 95% of the APC payment median used in CY 2004 for these device dependent APCs.

Charges for High Cost Devices

Although we understand the methodologies used by CMS to determine hospital costs under OPPS, as an institution, it is very difficult to assign charges high enough to represent our true costs associated with purchasing some of the more high cost devices. One of our major concerns with assigning appropriate charges has to do with the patient reaction to seeing these high charges on their bills. Another concern is related to the numerous contractual obligations our institution has with other payers. If we were to charge the amounts required to represent true costs to Medicare for high costs devices, other payers, because of the contracts that we currently hold, would grossly overpay our institution.

Because of these and other concerns related to the OPPS methods of determining costs, I respectfully request that CMS investigate other options to appropriately determine hospital costs for high-cost devices that do not require mark-ups commensurate with low cost supplies.

C-Codes

CMS is proposing to make the billing of C-codes mandatory, but only for a selected list of device related procedures that map to just 16 APCs. CMS has indicated that claims billed without the appropriate C-code for these APCs would be returned to hospitals. Requiring hospitals to bill only a small portion of the available device C-codes will not only be difficult to facilitate administratively at our institution, it will limit our ability to display our institution?s true cost for all other device-related APCs not subject to this requirement. If C-codes are required for adequate payment, a better alternative would be for CMS to mandate the use of all c-codes.

Thank you for this opportunity to provide comments on this very important payment update.

Submitter : Mr. Shahin Motakef **Date & Time:** 10/06/2004 01:10:08

Organization : East Texas Medical Center

Category : Hospital

Issue Areas/Comments

Issues 21-30

Payment Rate for APCs

Dear Mr. Thompson:
Thank you for the opportunity you have given us to comment on the proposed changes to the Medicare Hospital OPPS and CY2005 Payment Rates set forth in the proposed rule (69 Fed. Reg. 50448, Aug. 16, 2004). I am The Vice President of Professional Services at East Texas Medical Center, a 462 bed acute care hospital located in Tyler, Texas. We have been providing HBOT for approximately five years and are the sole provider of HBOT treatment for East Texas.

Although I realize that the Government is always adjusting rates in order to compensate providers at a fair rate, in this case the proposed rates are well below our cost and we may be forced to discontinue this program if the rates are not increased to at least cover our cost.

We support the Hyperbaric Oxygen Therapy Association?s (HOTA) position and the Lewin Group?s findings regarding the error in this calculation. We understand CMS has inappropriately applied each Hospital?s Respiratory Therapy department?s cost-to-charge ratio (CCR) to HBOT charges, regardless of the department which actually contains the HBOT charges.

We support any one of the The Lewin Group?s four recommendations:
? Apply the Lewin Group?s methodology to all hospitals that submitted HBOT claims in CY2003.
? Adopt the Lewin Group?s proposed reimbursement rate of $118.21 for the APC.
? Calculate the reimbursement rate for HBOT using each hospital?s overall cost-to-charge ratio. CMS?s rules for calculating the median cost indicate if the cost-to-charge ratio cannot be calculated, the overall hospital cost-to-charge ratio is to be used.
? Leave the HBOT reimbursement rate at CY 2004 levels until CMS has an opportunity to perform a corrected calculation.
Although we understand using The Lewin Group?s median cost calculation of $118.21 would only change overall HBOT payments by approximately $17 million, this will have a significant impact on our Hospital.
Thank you for your consideration in this important matter.

Shahin Motakef
Vice President of Professional Services
East Texas Medical Center

Submitter : Dr. David Humphrey **Date & Time:** 10/06/2004 02:10:38

Organization : Mission Hospitals

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This is a comment is in regards to the proposal of for new reimbursement rates for HBOT.

Our hospital system is nearly 700 beds located in Asheville, NC. We provide wound care and hyperbaric therapy to western North Carolina.

If the proposed rates are finalized, the hyperbaric services may be discontinued based on financial viability of this service.

We support the of the Hyperbaric Oxygen Therapy Association position and the Lewin Group's findings. We would like to see the reimbusement rate for HBOT to be left at the CY 2004 levels until CMS has an opportunity to calculate an appropriate cost-to-charge ratio. We are also in support of the adoption of the overall cost-to-charge ratio of 0.47 and the Lewin Group methodology and approach to the proposed incremental cost of hyperbaric treatment.

Thank you for your consideration in this matter.

Sincerely,
David A. Humphrey, MD

CMS-1427-P-148

Submitter : Ms. Patricia Read **Date & Time:** 10/06/2004 02:10:04

Organization : NCH Healthcare System

Category : Hospital

Issue Areas/Comments

Issues 21-30

Payment Rate for APCs

Dear Tommy Thompson:
The NCH Healthcare System is a 539 bed healthcare system located in southwest Florida. We have been providing HBOT for the past year and are the sole provider of this care for our county. The decrease in payment indicated by the proposed rule for APC 0659, hyperbaric oxygen therapy (HBOT) treatment, will not cover the cost of providing this service. This threatens our ability to provide this service.

The Hyperbaric Oxygen Therapy Association?s (HOTA) position is reasonable and we support the Lewin Group?s findings regarding the error in this payment rate. We support the Lewin Group?s alternatives:
? Apply the Lewin Group?s methodology to all hospitals that submitted HBOT claims in CY2003.
? Adopt the Lewin Group?s proposed reimbursement rate of $118.21 for the APC.
? Calculate the reimbursement rate for HBOT using each hospital?s overall cost-to-charge ratio. CMS?s rules for calculating the median cost indicate if the cost-to-charge ratio cannot be calculated, the overall hospital cost-to-charge ratio is to be used.
? Leave the HBOT reimbursement rate at CY 2004 levels until CMS has an opportunity to perform a corrected calculation.
Correcting this calculation would have a significant impact on our Hospital, even though using the Lewin Group?s estimate of $118.21 per half-hour would only change HBOT payments by $17 million.
Thank you for your attention and your consideration of this matter.

Sincerely,
Patricia A. Read
Administrative Director, Ambulatory and Volunteer Services

CMS-1427-P-149

Submitter : **Date & Time:** **10/06/2004 03:10:24**

Organization : **American Academy of Neurology**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments.

CMS-1427-P-149-Attach-1.doc

AMERICAN ACADEMY OF NEUROLOGY

1080 Montreal Avenue
St. Paul, Minnesota 55116

tel: 651.695.1940
fax: 651.695.2791

www.aan.com

October 5, 2004

Mark McClellan, MD, PhD, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1427-P
P.O. Box 8010
Baltimore, MD 21244-8018

Re: Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates; CMS-1427-P

Dear Dr. McClellan:

On behalf of the American Academy of Neurology, we thank you for the opportunity to comment on the Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates, as published in the August 16, 2004 Federal Register. We wish to comment on the APC assignments of several codes.

Non-Invasive Vascular Diagnostic Studies

The transcranial Doppler limited study (93888) was moved from APC 267 to APC 266. It should be restored to APC 267, the same category as the complete TCD study (93888).

Electrodiagnostic Testing

Sensory NCV (CPT 95904), motor nerve conduction study (CPT 95900) and EMG, other (CPT 95870) should be returned to APC 0218, which appropriately reflects the costs involved.

Autonomic Testing

The autonomic testing codes remain at inappropriately low levels. In 2001, the codes were in APC 0216, and we believe they should never have been moved. We ask CMS to reexamine the APC for CPT 95921, 95922, and 95923. The time, supplies, and expensive equipment required for each test demand that a higher value than the proposed $66 and $38 be given to the codes. The components of these three codes most closely match the evoked potentials in APC 0216.

EEG and Other Procedures

EEG monitoring/computer (95953) is a 24-hour code and should be moved back into APC 209, the same category as video EEG long-term monitoring (95951).

EEG monitoring with no video (CPT 95956) is a 24-hour procedure. The proposed reimbursement of $131 in APC 0214 is not acceptable for such an intensive procedure. We urge you to move CPT 95956 to APC 0209 to more appropriately reflect the costs of this 24-hour procedure. Since CPT 95951 is also a 24-hour EEG code that involves 16 or more channel telemetry, 95956 should be moved to the same APC 209.

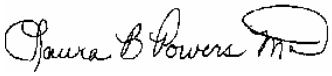
Recommendations

In conclusion, the AAN urges CMS to:

- Restore CPT 93888 to APC 267
- Restore CPT 95870, 95900, and 95904 to APC 0218 with a value of $66 per procedure
- Move CPT 95921, 95922, and 95923 to APC 0216 at a reimbursement of $150
- Restore CPT 95953 to APC 209
- Move CPT 95956 to APC 209

Thank you for the opportunity to comment on the proposed rule. We appreciate the changes CMS has made in the past and look forward to working with CMS to continue improving the APC process. If you have any questions, we can provide documentation to support our requests. Please contact Amanda Bettmann, Medical Economics Manager, at 651.695.2718 or Abettmann@aan.com.

Sincerely,



Laura Powers, MD
Chair, AAN Medical Economics and Management Committee

CMS-1427-P-150

Submitter : Dr. joseph treat **Date & Time:** 10/06/2004 03:10:24

Organization : Dr. joseph treat

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a medical director of a hopital outpatient cancer center I offer the following comments as requested by CMS regardingproposed 2005 hospital outpatinet payment system. We currenty use darbepoetin and erythropoetin an a 220/Q2week or 40,000units q weekly schedule respectively. We think this saves both our institution and Medicare cost. It also provdes the best convenience to our patients. We see no rationale for applying an equitable adjustment. Sincerely Joseph Treat MD Medical Director Fox Chase Temple Cancer Center Philadelphia

Submitter : Mrs. Lisa Withers **Date & Time:** 10/06/2004 04:10:55

Organization : Providence St Peter Hospital

Category : Hospital

Issue Areas/Comments

Issues 1-10

New Technology APCs

Administrator Mark McClellan
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
ROOM 445-G
200 Independence Avenue, S.W.
Washington, DC 20201
ATTN: FILE CODE CMS-1427-P
New Technology APCs (Section II.F)
Re: Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates; Proposed Rule
Dear Administrator McClellan:
Providence St Peter Hospital applauds your recent efforts under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to make new medical technologies more available to Medicare beneficiaries. We appreciate the opportunity to comment on the CMS proposed regulation regarding changes to the Medicare hospital outpatient prospective payment system (Federal Register, Vol. 69, No. 157, August 16, 2004).
Our comments focus on the proposed 2005 payment rates for FDG positron emission tomography (PET) imaging procedures. We strongly recommend that CMS continue to assign FDG PET procedures to New Technology APC 1516 in 2005. Herein, we provide background information on this important imaging modality, as well as support for continuation of current payment levels for PET.
Overview of PET Imaging
PET is a remarkable noninvasive diagnostic imaging breakthrough with tremendous benefits for patients with cardiac, cancer, and neurological disorders. With PET imaging, the molecular errors that cause disease can be accurately identified and understood in terms of the very nature of disease.
PET provides physicians with information about the body?s chemistry, cell function and location of disease differently than alternative conventional anatomic imaging modalities such as CT or MRI. Certain diseases cause abnormalities of blood flow or metabolism before anatomic changes are apparent, and these diseases can be detected by PET at a time when the anatomic imaging studies are normal. Moreover, PET can evaluate tissue metabolism to determine the presence or absence of malignancy whereas anatomic imaging depends on size of lesions in certain locations to determine the likelihood of malignancy.
PET assists physicians in the diagnosis and management of a range of patient illnesses. PET provides the opportunity to reduce unnecessary surgeries, decrease the number of other diagnostic procedures, and help physicians select the best course of treatment for their patients.
A Reduction in the 2005 PET Payment Rate Would Threaten Beneficiary Access
We appreciate the careful consideration by CMS in developing the 2005 proposed payment for FDG PET procedures, as well as the agency?s acknowledgement of the potential for limited beneficiary access to this technology. In the proposed rule, CMS considered three options for the payment of PET scans:
? Option 1: Continue to assign FDG PET procedures to New Technology Ambulatory Payment Classification (APC) 1516.
? Option 2: Assign FDG PET procedures to a clinically appropriate APC priced according to the median costs of the scans, based on 2003 claims data.
? Option 3: Set the payment for FDG PET procedures based on a 50-50 blend of the median cost and the New Technology APC payment amount.

We strongly support option 1-- to continue the current assignment of FDG PET procedures in New Technology APC 1516 in CY 2005. Continuation of current payment levels for these services is essential to ensure patient access to this important technology. Currently, PET imaging is concentrated in a relatively small number of hospitals throughout the country. With Medicare representing the largest single payer of hospital services, significant payment rate reductions (as proposed in payment rate options 2 and 3) may result in these facilities abandoning or limiting PET imaging, while other facilities may fail to adopt this critical technology.
Further, we urge CMS to carefully consider the combined impact of the PET payment options with the

CMS-1427-P-152

Submitter : Dr. Scott Bailey **Date & Time:** 10/06/2004 04:10:24

Organization : Arizona Heart Hospital

Category : Hospital

Issue Areas/Comments

Issues 21-30

Payment Rate for APCs

Dear Tommy G. Thompson:
The Arizona Heart Hospital is a 59 bed hospital located in Metro Phoenix Arizona. The proposed changes to the Medicare Hospital OPPS Payment Rates, in the 69 Fed. Reg. 50448, have the median cost for APC 0659, hyperbaric oxygen therapy treatment declining to $82.91 from the 2004 payment of $164.93.

We have been providing hyperbaric oxygen therapy (HBOT) for six years in the greater Phoenix area. The program has benefited some 1,200 patients who suffer from vascular desease as well as diabetes. The lower payment will not cover the cost of providing this care, threatening our patients access to this effective and efficient treatment.

The Arizona Heart Hospital endorses the findings of the Lewin Group report, supporting the reimbursement rate of $118.21 per 30-minute treatment. The report makes it clear; Respiratory Therapy's ratio of costs-to-charges was applied to HBOT charges, regardless of which department actually contained the HBOT costs & charges.To correct this error, CMS should utilize one of the following: (1) Apply the Lewin Group methodology to all hospitals; (2) Adopt the Lewin Group proposed reimbursement rate of $118.21 per 30-minute increment; (3) Calculate the reimbursement rate for HBOT using each hospital's overall cost-to-charge ratio. CMS rules for calculating the median cost indicate if the cost-to-charge ratio cannot be calculated; or (4) Leave the HBOT reimbursement rate at CY 2004 levels.
We understand using The Lewin Group median cost calculation of $118.21 would greatly reduce the overall HBOT payments by approximately $17 million. This will also have a significant impact on our Hospital with a total reduction over $150,000 annually.
With the many challenges that face heath care today and the need to provide cost effective treatment for the Medicare patient population the proposed reduction down to $82.91 will force us to strongly consider discontinuing our program. With a reimbursement level that does not cover our cost the 1,200 patients we have served over the past six years will be faced with a much higher cost alternative. If these programs are discontinued the patients will seek care in our already over loaded Emergency Departments, with a much higher cost to the Medicare system. Please take the time to recognize the calculation error and make a reasonable decision to have a national median reimbursement of $118.21.

Very Truly Yours,

Scott Bailey, MBA
VP Finance, Arizona Heart Hospital

CMS-1427-P-153

Submitter : Dr. David Bjorkman **Date & Time:** 10/06/2004 05:10:30

Organization : American Society for Gastrointestinal Endoscopy

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 1-10

New Technology APCs

Please see our attached letter.

CMS-1427-P-153-Attach-1.doc

1520 Kensington RD Suite 202
Oak Brook, Illinois 60523
630/573-0600 / FAX 630/573-0691
E-mail: info@asge.org
Internet: www.askasge.org

October 6, 2004

Mark McClellan, MD, PhD, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1427-P
Room 445–G, HHH Bldg.
200 Independence Ave., SW
Washington, DC 20201

Re**:** Hospital Outpatient Prospective Payment System
Proposed Rule, August 16, 2004 (CMS-1427-P)
Update for Calendar Year 2005

The American Society for Gastrointestinal Endoscopy appreciates the opportunity to comment on the proposed hospital outpatient payment rule for 2005. We wish to offer comments on the proposed payment classification of two gastroenterology procedures: the Capsule Endoscopy (CE) and the Stretta Procedure.

New Technology APC's

Code 91110, capsule endoscopy, is currently assigned to APC 1508, a New Technology APC paying $650. Under the proposed rule, this service would be moved to APC 141, Upper GI endoscopy, with a payment level of $464.52. This payment rate is grossly inadequate since the single use capsule itself costs $450. In essence, under this payment rate, a total of $14 is available to cover the staff costs, equipment, billing, and all of the associated hospital overhead. The median cost of $493 for code 91110 was derived from the median costs for the predecessor code, G0262.

Capsule endoscopy is a unique, minimally invasive diagnostic procedure that allows the physician the ability to view the entire 22 feet of the small bowel; the duodenum, jejunum, and the ileum. The procedure is neither clinically homogeneous nor similar to the other optical endoscopic procedures listed in APC 0141- Upper Endoscopy in terms of resource use. Moreover, none of the other procedures in APC 0141 involve the use of a costly, single-use, disposable device in order to perform the procedure.

The proposed APC classification (0141, Upper GI Endoscopy) has a national average payment of $464.52. We believe this level of payment will become a disincentive for hospitals to provide this service to Medicare beneficiaries. We believe it will greatly lessen the ability of Medicare beneficiaries to obtain access to this valuable diagnostic procedure, resulting in a reduction in Medicare beneficiary access to care.

The cost of each single-use, disposable, wireless digital video camera capsule is $450. If this procedure is mapped into APC 141, as noted above, only $14 would remain to cover the cost of staff, and the cost of the capital component, the treatment / procedure room and other hospital overhead costs associated with performing this procedure. We are concerned this payment rate will make it virtually impossible for hospitals to offer this valuable service to Medicare beneficiaries.

In our judgment, the procedure is neither clinically homogenous with the endoscopic procedures listed in APC 0141 nor homogenous in terms of resource utilization. Unlike upper GI endoscopic procedures which deal with procedures that view only the first 1/3 (duodenum) of the GI tract, CE is a diagnostic procedure that deals with the entire (22 feet) of the GI tract; it allows viewing of the duodenum, jejunum, and the ileum. In addition, CE involves resources very different from other procedures listed in APC 0141. In this connection, we would note that CE has the additional cost of the disposable, digital wireless video camera capsule costing $450 that must be procured for each examination.

We recognize that the proposed payment rate was derived from charges from claims collected data for the predecessor code, G0262. However, we believe the charge data for G0262 is very unreliable and should not be used to set the payment level for this procedure. We strongly suspect that hospitals did not fully understand how to interpret the G0262 code during 2003, which led them to establish charge levels for this code that did not fully reflect their costs.

In the time period from 2001 through 2004, Capsule endoscopy was assigned several different coding mechanisms for claims reporting and payment. In the early years, coding instructions from Medicare contractors were varied and inconsistent. Some contractors required single codes, some used 'A' codes or unlisted codes for the additional charges of the disposable wireless, digital, camera capsule, and others used combinations of multiple codes with and without modifiers, prior to the establishment of the temporary code; G0262 in 2003. Keeping up with the number of coding changes was difficult and resulted in confusion among hospitals, physicians and even some Medicare contractors. Thus, it is unlikely that documentation over the last three years has been uniform and accurate. We suspect that many hospitals did not adjust their level of charges to reflect the fact that G0262 was intended to include the procedure and the disposable wireless, digital, video camera.

ASGE would recommend one of three alternatives:

1. Retain the New Technology APC 1508, payment rate of $650 until sufficient charge data is gathered from collected claims reported with the newly assigned permanent Category I CPT code; 91110

2. Consider limiting the rate reduction for 2005 to 10% of the 2004 rate. This is similar in concept to the proposal being considered for limiting reductions of "device dependent" APC's.

3. Alternatively, this procedure should be reassigned to an APC that is clinically descriptive of the capsule endoscopy procedure. A marginally acceptable choice could be APC 0142 – Small Intestine Endoscopy as it clinically defines the capsule endoscopy procedure. Again, however, the payment rate of $503 for APC 0142 remains too low for the hospital to cover their costs of providing the procedure.

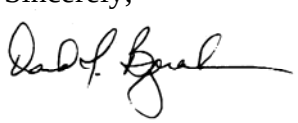
Our clear preference is Alternative 1; retain the Capsule Endoscopy procedure in the New Technology APC 1508, with its current payment rate of $650. However, either of the other alternatives would be an improvement.

We also wish to comment on code C9701, the so-called Stretta procedure. This code currently is assigned to APC 1557 with a payment rate of $1,850. CMS proposes to reassign this service to APC 442 with a payment rate of $1,274. This payment will be inadequate considering the costs of providing the service. The disposable supplies for the Stretta Procedure costs in excess of $1,100 and involves a catheter at a cost of $1,030, a guidewire at a cost of $60, a pressure relief pack valve costing $22. In addition, this procedure involves the use of specialized equipment costing in excess of $33,000. Finally, to perform the procedure the physician essentially does two upper GI endoscopies under sedation for which CMS has established a payment rate of $464. Based on the costs of performing this service, the $1,850 current rate seems appropriate.

CMS is apparently basing its proposed payment classification on the median cost data for C9701. However, there were only 33 "single" claims used in determining this cost. Given the miniscule amount of data for this procedure and since the cost inputs clearly demonstrate the inadequacy of the proposed payment rate, we ask CMS to continue to assign this procedure to APC 1557. We would note that this service was approved for a Category I CPT code effective January 1, 2005. We are concerned that access to this promising new technology will be severely jeopardized if this proposed payment rate is implemented.

Thank you for the opportunity to provide these comments.

Sincerely,



David Bjorkman, MD, MSPH
President

CMS-1427-P-154

Submitter : Mr. L. David Wells **Date & Time:** 10/06/2004 05:10:43

Organization : Citrus Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I have read the information referencing to decrease reimbursement for PET Scanning. I am opposed to any reduction in the current payment system because, once again, you limit Medicare patients access to quality imaging services that are critical to their medical outcome. Unfortunately, I understand there is no choice but the three options listed. There is no other option but OPTION 1: Continue in CY 2005 the current assignment of scans to new technology APC 1516 prior to assigning to a clinical APC. $1,450.00. We will be forced to discontinue our PET services if there is any payment reduction.
Thank you.
L. David Wells

Submitter : Mrs. **Date & Time:** 10/06/2004 06:10:27

Organization : Mrs.

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Tommy G. Thompson,

Garden Park Medical Center is pleased to have this opportunity to comment on the proposed changes to Medicare Hospital OPPS and CY2005 payment rates. In the proposed rule, the median cost for APC 0659, hyperbaric oxygen therapy (HBOT) treatment dropped more than half to $82.91 from $164.93.

We have been providing hyperbaric oxygen therapy for approximately three years. We are a 130 bed hospital in south Mississippi. This decrease in payment will prevent our ability to provide this proven modality for treating otherwise expensive wounds.

Garden Park Medical Center concurs with the Hyperbaric Oxygen Therapy Association and The Lewin Group?s understanding of how CMS has inappropriately applied cost to charge ratios to HBOT charges, understanding median costs. We believe this needs to be corrected, as suggested by The Lewin Group, by one of the following alternatives:

1. If CMS has sufficient time, apply The Lewin Group methodology to all hospitals that submitted HBOT claims in CY2003.

2. Adopt The Lewin Group?s proposed reimbursement rate of $118.21 per 30-minute increment for HBOT.

3. Calculate the reimbursement rate for HBOT using each hospital?s overall cost-to-charge ratio. Because there is currently no standardization for which cost center HBOT costs and charges are located, CMS will be unable to appropriately determine the correct cost-to-charge ratio to apply to claims.

4. Leave the HBOT reimbursement rate at CY2004 levels until CMS has an opportunity to develop and perform a calculation that will appropriately reflect HBOT costs.

This issue will have a significant impact on our facility and I appreciate your time.

Sincerely,

Regina Ramazani, CFO

CMS-1427-P-156

Submitter : Mr. Joseph Corigliano **Date & Time:** 10/06/2004 06:10:14

Organization : Conroe Regional Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 21-30

Cost-to-Charge Ratios

This comment concerns the Department of Health and Human Services Centers for Medicare & Medicaid Services' 2005 Hospital Outpatient Prospective Payment System proposed rule ("Proposed Rule") that sets forth new reimbursement rates for hyperbaric oxygen therapy treatment ("HBOT"). 69 Fed. Reg. 50448 (Aug. 16, 2004).

Conroe Regional Medical Center (CRMC) in Conroe, TX is a comprehensive 360-bed tertiary referral center servicing communities within a 100-mile reach of Montgomery County. The Center for Wound Care & Hyperbaric Medicine is a hospital department that provides specialized wound care and diabetes management services to patients with chronic, non-healing wounds.

The need for this type of specialized service in the Greater Montgomery County area is evidenced by our average, monthly patient census (600-700 patients). If the proposed rate reduction for hyperbaric oxygen therapy is finalized, the viability of the program and patient access to comprehensive wound managememt services will be jeopardized.

I support the Hyperbaric Oxygen Therapy Association (HOTA) position and the Lewin Group's findings as they relate to HBOT reimbursement rates. Specifically, I support the consideration of the following four alternatives:

(1) Leave the HBOT reimbursement rate a CY 2004 levels until CMS has an opportunity to develop and perform a calculation that will accurately detail HBOT costs and cost-to-charge ratios.
(2) Due to the differences in which hospitals have reported costs, adopt the overall cost-to-charge ratio (CCR) of .47.
(3) Apply the Lewin Group methodology to the 389 hosptials that reported hyperbaric claims in the year 2003.
(4) Adopt the Lewin Group approach at $118.21 per 30 minute increment.

Thank you very much for your consideration in this matter.

Sincerely,
Joseph Corigliano

Submitter : Ms. Cheryl Thomas **Date & Time:** 10/06/2004 06:10:22

Organization : Monongalia General Hospital

Category : Hospital

Issue Areas/Comments

Issues 1-10

Physical Examinations

Dear CMS,

While I am encourage by Medicare's endeavor into preventative care, I'm not sure that the 'Welcome to Medicare Physical' benefit is going to be utilized by beneficiaries with financial constraints. While a good many of our seniors struggle financially to carry Part B coverage and pay for costly medications, many cannot afford Medigap coverage for Part A and B deductibles and co-insurance. It is my opinion that applying the cost of the physical toward the Part B deductible is going to discourage beneficiaries from accessing this benefit. Therefore, I am proposing that the 'Welcome to Medicare Physical' be a full coverage benefit, further encouraging our seniors seek preventative care.

Sincerely,
Cheryl Thomas
Case Manager

Submitter : Mrs. Terri Rinker **Date & Time:** 10/06/2004 07:10:00

Organization : Community Hospital Anderson

Category : Hospital

Issue Areas/Comments

Issues 11-20

Drug Coding and Billing

Under Part B, self-administered drugs such as insulin and other prescription medications are non-covered. Patients who are outpatient hospital patients of the Emergency Department, provider-based clinics, outpatient surgery or observation patients are often administered these drugs under physician order for medically necessary conditions. These drugs are non-covered and are billed to patients as patient liability. Note that CMS has clearly instructed hospitals that they cannot routinely write-off these non-covered charges. Patients are very confused and outraged at having to pay for these drugs. Note that for patient safety and quality of care reasons, patients often cannot bring these medications into the hospitals and self-administer while they are treated for other conditions.

Hospitals need clarification regarding the following:

(1) Will the new Part D benefit for prescription medications apply to self-administered prescription drugs that are dispensed from hospital pharmacies?
(2) If yes, how will beneficiaries avail themselves of this benefit? Will hospitals have complex billing instructions to submit to various prescription plans? Hospital pharmacies are not equipped to bill drugs in the same manner as retail pharmacies.
(3) Alternatively, will hospitals have to provide drug coding and other detail on billing statements for beneficiaries that they submit to the prescription plan for reimbursement of their payment made to the hospital? If so, what is expected of hospitals?
(3) If Part D is not to cover these prescription drug expenses, how are hospitals to respond to beneficiaries who expect Medicare coverage of their prescription drugs under the new Part D benefit?

Hospitals respectfully request instructions on these questions and beneficiaries also need guidance.

Medication Therapy Management Performed by Hospitals

As discussed in the proposed rule, medication therapy management (MTM) is direct patient care. Many hospitals perform this service due to the needs of the Medicare beneficiary population and their complex prescription drug management issues. For example, in geriatric provider-based clinics, a pharmacist, based upon physician order, will assess the patient. The patient?s medication use, diet and medical history will be reviewed and the pharmacist will interview and assess the patient face-to-face. Often the pharmacist makes significant recommendations to the physician for medication adjustments. These visits are billed as a hospital visit under OPPS. At times, the service may be rendered as a pharmacy consult to an inpatient. Various hospitals, may or may not be separately billing this service when provided to inpatients.

Will hospitals lose the ability to perform this service under the MTM provisions for Part D? Will hospitals have to contract with the PDP or MA? Can this service continue to be rendered by the hospital separate from the MTM of the PDP or MA? If so, will this service be assigned a HCPCS code for separate tracking under OPPS? If the service meets the same medical necessity requirements for payment under OPPS, what is CMS? guidance on separate reporting of this service on inpatient claims paid under IPPS?

Thank you for consideration of these comments.

Submitter : Mr. Scott Rauch **Date & Time:** 10/06/2004 08:10:44

Organization : Reid Hospital

Category : Hospital

Issue Areas/Comments

Issues 21-30

Payment Rate for APCs

October 6, 2004

Tommy G. Thompson
Secretary Of Health And Human Services
U.S. Department of Health and Human Services

Dear Mr. Thompson,

We appreciate this opportunity to comment on the proposed changes to the Medicare Hospital OPPS and CY 2005 payment rates. It is our understanding that in the proposed rule the ABC medium cost for 0659, Hyberbaric Oxygen Therapy (HBOT) care was reduced more than half from 164.93 to 82.91. We have found that there is a significant need for this service in our community and have made a significant investment in our facilities and in training our physicians in HBOT.

Reid Hospital and Health Care Services is a two hundred and eighty bed hospital located in east central Indiana, which is located in Richmond, Indiana.

This decease in payment for this service is going to cause great problems in us being able to meet the need for this proven care. To not care for these wounds in the early stages is going to mean hospitalization and probable amputations, which will ultimately become much more expensive for Medicare, and is going to dramatically negatively affect the quality of life for many of the American recipients of Medicare in our community and throughout the nation.

It is my understanding that the LEWIN Group and the Hyberbaric Oxygen Therapy Association are working with CMS to assist in determining an appropriate reimbursement for services rendered. The alternatives they are proposing all seem reasonable and are still reductions to meet ultimate goals of CMS by stretching Medicare dollars. Please consider one of their alternatives as an option versus the current proposed ruling, which will virtually shut down our center and many other centers throughout the nation.

Sincerely

Scott C. Rauch
Vice President

CMS-1427-P-160

Submitter : Mr. Daniel Buche **Date & Time:** 10/06/2004 09:10:07

Organization : Brazosport Memorial Hospital

Category : Hospital

Issue Areas/Comments

Issues 21-30

Payment Rate for APCs

October 6, 2004

Dear Mr. Thompson:

I am the CEO of a small urban hospital in Lake Jackson Texas. Brazosport Memorial Hospital is a 165 bed facility that serves a population of approximately 160,000.

In our geographic area we see a large number of patients needing wound care and hyperbaric oxygen therapy. Our service has been in operation for over 5 years and we are the sole provider in our service area. The proposed changes to the Medicare Hospital OPPS Payment Rates in the 69 Federal Register 50448, have the median cost for APC 0659 hyperbaric oxygen therapy treatment declining to $82.91 from the 2004 payment of $164.93. The lower payment will critically threaten our program and patient access to treatment.

Brazosport Memorial Hospital endorses the findings of the Lewin Group?s report, sponsored by the Hyperbaric Oxygen Association. Although we understand using the Lewin Group?s median cost calculation of $118.21 would only change overall HBOT payments by approximately $17 million, this will have significant impact on our hospital.

Best regards,

Daniel L. Buche
Chief Executive Officer

Submitter : Mr. Joseph Vescio **Date & Time:** 10/06/2004 09:10:11

Organization : Saint Clare's Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Saint Clare's Health System strongly urges CMS to adopt the methodology of implementing final inpatient wage index amounts for outpatient wage index purposes for CY 2005, which is consistent with prior year OP PPS implementation and which promotes equity and consistency in this area.

CMS-1427-P-162

Submitter : Mr. Joseph Vescio **Date & Time:** 10/06/2004 09:10:57

Organization : Saint Clare's Health System

Category : Hospital

Issue Areas/Comments

Issues 21-30

Wage Index

Saint Clare's Health System strongly urges CMS to adopt the methodology of implementing final inpatient wage index amounts for outpatient wage index purposes for CY 2005, which is consistent with prior year OP PPS implementation and which promotes equity and consistency in this area.

CMS-1427-P-162-Attach-1.doc

CMS-1427-P-162-Attach-2.doc

CMS-1427-P-162-Attach-3.doc

October 6, 2004

Dr. Mark McClellan
CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1427-P
P.O. Box 8010
Baltimore, MD 21244-8018

Re: File Code CMS-1427-P

Dear Dr. McClellan:

Saint Clare's Health System welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled *Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment Systems and Calendar Year (CY) 2005 Payment Rates; Proposed Rule*, 69 Fed. Reg. 50448 (August 16, 2004).

Our comments relate to the "Wage Index"section of the proposed rule.

Please be advised that Saint Clare's Health System generally supports the CMS final rulemaking related to "Special Circumstances of Hospitals in All-Urban States" contained in the Federal Fiscal Year (FFY) 2005 final inpatient rule published in the August 11, 2004 Federal Register. The FFY 2005 final inpatient rule adopted a methodology that imputes a wage index floor for those states that are deemed to be "All-Urban States." It is clear that the absence of a floor for the Medicare wage index calculation creates an uneven playing field between the All-Urban States (currently three under the final inpatient rule) and the remaining forty-seven states. Imputing a wage index floor for the All Urban State adds symmetry, equity and consistency to the reimbursement methodology.

Saint Clare's Health System strongly supports the contention that the imputed wage index floor should also apply **to outpatient hospital services effective with CY 2005**. Unfortunately, the proposed outpatient rule does not recognize this contention since the proposed inpatient wage index amounts (that is, the wage indexes that CMS proposed for the hospital inpatient PPS rules as published in the May 18, 2004 Federal Register) are currently scheduled to be implemented for outpatient services beginning with CY 2005. Utilizing the proposed inpatient wage index amounts circumvents the implementation of the "Special Circumstances of Hospitals in All-Urban States" for outpatient purposes for CY 2005 since this provision was not adopted until the final inpatient rulemaking.

It should be noted that since the inception of the outpatient prospective payment system (OP PPS) in August 2000, final inpatient wage index amounts consistently have been implemented by CMS in the final OP PPS rulemaking. This provision is in accordance with 42 CFR § 419.43(c). The proposed outpatient rule for CY 2005 deviates from prior established methodology with regard to wage index implementation.

Saint Clare's Health System strongly urges CMS to adopt the methodology of implementing final inpatient wage index amounts for outpatient wage index purposes for CY 2005, which is consistent with prior year OP PPS implementation and which promotes equity and consistency in this area.

Thank you for considering these important comments and we look forward to your response.

Respectfully submitted,

Joseph Vescio
Administrative Director, Finance

October 6, 2004

Dr. Mark McClellan
CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1427-P
P.O. Box 8010
Baltimore, MD 21244-8018

Re: File Code CMS-1427-P

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Saint Clare's Health System strongly urges CMS to adopt the methodology of implementing final inpatient wage index amounts for outpatient wage index purposes for CY 2005, which is consistent with prior year OP PPS implementation and which promotes equity and consistency in this area.

Thank you for considering these important comments and we look forward to your response.

Respectfully submitted,

Joseph Vescio
Administrative Director, Finance

October 6, 2004

Dr. Mark McClellan
CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1427-P
P.O. Box 8010
Baltimore, MD 21244-8018

Re: File Code CMS-1427-P

Dear Dr. McClellan:

Saint Clare's Health System welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled *Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment Systems and Calendar Year (CY) 2005 Payment Rates; Proposed Rule*, 69 Fed. Reg. 50448 (August 16, 2004).

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It should be noted that since the inception of the outpatient prospective payment system (OP PPS) in August 2000, final inpatient wage index amounts consistently have been implemented by CMS in the final OP PPS rulemaking. This provision is in accordance with 42 CFR § 419.43(c). The proposed outpatient rule for CY 2005 deviates from prior established methodology with regard to wage index implementation.

Saint Clare's Health System strongly urges CMS to adopt the methodology of implementing final inpatient wage index amounts for outpatient wage index purposes for CY 2005, which is consistent with prior year OP PPS implementation and which promotes equity and consistency in this area.

Thank you for considering these important comments and we look forward to your response.

Respectfully submitted,

Joseph Vescio
Administrative Director, Finance

Submitter : Ms. Patricia Andersen **Date & Time:** 10/06/2004 10:10:02

Organization : Oklahoma Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See accompanying comment letter

CMS-1427-P-163-Attach-1.doc

October 8, 2004

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1427-P
P.O. Box 8010
Baltimore, MD 21244-8018

Re: CMS-1427-P; Medicare Program, Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Rates; (*Federal Register,* August 16, 2004)

Dear Dr. McClellan:

The Oklahoma Hospital Association (OHA), on behalf of our nearly 150 hospital members, welcomes the opportunity to comment on the proposed Calendar Year (CY) 2005 Medicare Outpatient Prospective Payment System (OPPS) rule.

Wage Index *(Federal Register page 50541)*

CMS indicates that the final inpatient wage index will be used in the outpatient final rule. However, CMS does not mention the one-year temporary relief provided in the inpatient final rule for hospitals harmed by the redefinition of wage areas. Under this relief, hospitals experiencing a wage index decrease due to labor market changes receive a blend of 50% of the wage index based on the new definitions and 50% based on the old boundaries.

We urge CMS to specify that the OPPS wage index will include the one-year temporary relief for facilities that experienced a loss caused by geographic redefinitions, which was provided under the federal fiscal year (FFY) 2005 Medicare Inpatient Prospective Payment System (IPPS).

Outlier Payments *(Federal Register page 50542)*

CMS proposes to require that costs must exceed 1.5 times the Ambulatory Payment Classification (APC) rate and exceed a $625 fixed-dollar threshold to qualify for outlier payments. This would eliminate outlier payments for low-cost services and provide higher outlier payments for relatively expensive procedures. **The OHA supports the continued need for an outlier policy in all prospective payment systems, including the OPPS, and supports revisions that better target outlier payments to unusually high cost services.**

However, we are concerned that the proposed thresholds for outlier payment may be too high. In the proposed FFY 2005 IPPS rule, CMS suggested a substantial increase in the outlier threshold based on inflated charge estimates that did not take into account the charge decreases that many hospitals implemented in 2003 and 2004. In 2003, CMS issued a rule requiring the use of data that are more up-to-date when determining a hospital's cost-to-charge ratio (CCR); specifically, a hospital's most recent final or tentatively settled cost report. It also instructed fiscal intermediaries, in certain situations, to retrospectively reconcile outlier payments when a hospital's cost report is settled. Because of these changes, many hospitals decreased their charges and the overall rate of increase declined. In response to comments, CMS lowered its charge increase assumptions substantially in the inpatient final rule.

CMS states that the new methodology will continue to pay 2% of total OPPS payments as outliers. However, CMS does not provide details of this estimate. **The OHA urges CMS to provide details of the assumptions used to set the outpatient outlier thresholds. CMS should review assumptions regarding charge increases to ensure that they do not inappropriately inflate charges in setting the OPPS outlier thresholds.**

In addition, the OHA joins the American Hospital Association (AHA) in advocating an outlier policy that would consider costs at the claim level, rather than at the individual service level. This would be easier to administer and would result in payments that are more equitable for high cost patients.

Cost-to-Charge Ratios *(Federal Register page 50527)*

CMS uses default CCRs for hospitals that are determined to have invalid CCRs. These include new hospitals, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds, or hospitals that have recently given up their all-inclusive rate status. CMS is proposing to update the default CCRs for CY 2005 based on the most recent available cost reports (2002 cost reports for most hospitals). Under the proposal, most areas would experience a decrease in the default CCR. The lower CCRs would result in decreased payments for hospitals using the default.

The default CCRs often result in inequitable payments for hospitals that have recently given up their all-inclusive rate status. **CMS should instruct fiscal intermediaries to work with those facilities that have given up their all-inclusive rate status to quickly determine an appropriate CCR that will provide an accurate estimate of costs for each facility.**

Blood and Blood Products *(Federal Register page 50521)*

CMS proposes to set payment rates for all blood and blood products based on a facility's CY 2003 claims data, utilizing an actual or simulated hospital blood-specific CCR to convert charges to costs for blood and blood products. For certain low volume products, CMS would combine claims data for CYs 2002 and 2003. While this approach results in modest payment increases for many blood and blood product-related APCs, payment rates for most low volume APCs will decline significantly under this methodology.

The OHA recommends that CMS freeze the reimbursement rates for 2005 at the current 2004 levels for those low-volume blood products (as reported on Table 31 of the proposed rule) that experience a rate decrease. OHA believes this is necessary to ensure continued beneficiary access to these blood products.

New Technology APCs *(Federal Register page 50468)*

CMS indicates that a number of positron emission tomography (PET) scans currently classified into New Technology APC 1516 have sufficient data for assignment to clinical APCs. However, this would reduce payments for PET scans and CMS is concerned that this might hinder beneficiary access to this technology. Therefore, CMS is considering three options as the proposed payment for PET scans in CY 2005:

- Option 1: Continue in CY 2005 the current assignment of the scans to New Technology APC 1516 before assigning to a clinical APC. APC 1516 has a rate of $1,450.00.
- Option 2: Assign the PET scans to a clinically appropriate APC priced according to the median cost of the scans based on CY 2003 claims data. Under this option, PET scans would be assigned to APC 0420: PET imaging, with a rate of $898.64.
- Option 3: Transition assignment to a clinical APC in CY 2006 by setting payment in CY 2005 based on a 50-50 blend of the median cost and the CY 2004 New Technology APC. CMS would assign the scans to New Technology APC 1513 for payment with a rate of $1, 1150.00.

THE OHA agrees that the substantial payment decreases that would result from Option 2 could hinder beneficiary access to necessary care. Option 3 limits the decrease but still results in a 20.7% rate reduction. **The OHA supports the continued assignment of PET scans to APC 1516 as proposed under Option 1 until CMS can determine an equitable rate for these services.**

Observation Services *(Federal Register page 50532)*

CMS established separate payment for observation services under the OPPS for three medical conditions: chest pain, congestive heart failure, and asthma. A number of accompanying requirements were established, including provision of specific diagnostic tests to beneficiaries based on their diagnoses. CMS has responded to comments from the hospital community by

proposing to eliminate the requirements for specific diagnostic tests. In addition, CMS is proposing to modify the rules so that time in observation care would end when the outpatient is actually discharged from the hospital or admitted as an inpatient The OHA **supports these changes, which will result in more accurate billing and provide payment for more clinically appropriate care.**

CMS also proposes to exclude from the rate calculation any claims that report more than 48 hours of observation care. **The OHA believes that CMS should reevaluate the final payment rate for APC 0339, including those claims exceeding 48 hours of observation care**. These observation service claims have been paid by Medicare and reflect services that were reviewed and determined to be medically necessary. The costs for such covered services should be included in calculating the payment rates.

Inpatient Procedures (*Federal Register page 50536)*

CMS identifies certain procedures that are typically provided only in an inpatient setting. These procedures are assigned a status of "C: inpatient procedure, not payable under the OPPS." Hospitals were advised to admit these patients to receive payment. CMS rejected an APC Advisory Panel recommendation to eliminate the list of inpatient-only procedures.

The OHA joins AHA in recommending that the inpatient-only list be eliminated, as recommended by the APC Advisory Panel. Hospitals are unable to receive any payment for services on this list that are performed in the outpatient setting. Yet, physicians, not hospitals, determine what procedures should be performed and whether a patient's condition warrants an inpatient admission. We believe it is appropriate to leave this clinical decision making process in the hands of physicians.

Device-Dependent APCs *(Federal Register page 50491)*

CMS is proposing to modify payments for 43 "device-dependent" APCs. These are APCs for services that CMS has determined cannot be provided without an associated medical device. CMS has consistently experienced problems in determining payment rates for the procedures that include packaged devices. When APC rates were calculated for these procedures using claims data, the resulting rates were often substantially less than the cost of the device. In CY 2005, CMS proposes to determine rates for device-dependent APCs based on the greater of:

- median costs calculated using CY 2003 claims data, or
- 90% of the APC payment median for CY 2004 for such services.

CMS states that the proposal to limit decreases to 90% of the CY 2005 rate allows for cost variations from year to year. However, the 10% decrease assumes that costs may have gone down compared to CY 2004. There is no evidence to support this assumption. **The OHA recommends that median cost for the device-dependent APCs be based upon the greater of CY 2003 median costs or 100% of the APC payment median in CY 2004.**

Devices *(Federal Register page 50500)*

CMS proposes to retire six devices from pass-through status after December 31, 2004. In 2005, these items will be treated as packaged items with no separate payment provided. Instead, the cost for these devices will be incorporated into the rates of associated procedure APCs.

The "retirement" of pass-through devices and drugs highlights a basic problem of under-funding for the OPPS. Total funds do not increase as new devices and drugs are removed from pass-through status and are incorporated into the APC rates. As a result, payments for other services are decreased to ensure overall budget neutrality. The OHA will continue to advocate for new funding that will ensure adequate payment for new technologies while protecting payments for basic outpatient services.

The OHA appreciates having the opportunity to comment on the proposed rule. If you have any questions regarding our comments, please contact me at (405) 427-9537.

Sincerely,

Patricia D. Andersen
Vice-President-Finance & Information Services
The Oklahoma Hospital Association