CMS-1392-P-518 **Medicare**

Submitter : A. Todd Howell **09/10/2007**

Organization : Holy Trinity Hospital
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider CAHs

Necessary Provider CAHs

Attached is a letter.

CMS-1392-P-518-Attach-1.DOC

#518

September 14, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Delivered Via On-Line Form: *http://www.cms.hhs.gov/eRulemaking*

Subject: CMS-1392-P – Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting the Critical Access Hospital (CAH) program. I am a hospital administrator at Holy Trinity Hospital in Graceville, Minnesota.

This is the situation at our hospital:

- We received our CAH status in 10/31/2001. This move has taken us to unprofitable to a profitable status.
- We have an attached provider-based rural health clinic and another provider-based rural health clinic about 15 miles away in Chokio, MN.
- We are considering putting a provider-based RHC in Beardsley, MN in the future.
- If the Beardsley, MN clinic was not a RHC, it would not be able to function primarily due to lower expected volumes.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering these comments. Please contact me if you have any questions.

Sincerely,

A. Todd Howell
Administrator

CMS-1392-P-519 **Medicare**

Submitter : Mr. William Black **09/10/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

Dear Mr. Weems:

I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient with blepharospasm, apraxia and meige syndrome all which are types of dystonia (a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS's proposal to reduce the payment rate to hospitals for physician- injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. These injections are critically important to my ability to function.

I respectfully request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain the current payment formula. Any reduction in reimbursement will lead to fewer injectors in an area where we have too few knowledgeable injectors in the first place. Anyone can inject botulinum toxin. Not just anyone can inject it successfully to relieve the spasms. I went through four doctors before finding one that was knowledgable enough to know where to locate the injections for relief. Also, this change in policy would destroy the uniformity of payments made across settings that ensures there are no economic rewards or penalties to providers, depending on where the injections are given.

Thank you for allowing me to provide these comments.

Sincerely,

William Black
5309 Manson Road
Julian, North Carolina

CMS-1392-P-520 **Medicare**

Submitter : Candler Marriott **09/10/2007**

Organization : none
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

Dear Mr. Weems:

I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a daughter of a patient with Benign essential blespharspasm, a type of dystonia (a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS's proposal to reduce the payment rate to hospitals for physician-injected drugs. My mom receives injections of botulinum toxin to alleviate the debilitating dystonic symptoms. These injections are critically important to her ability to function normally.

I respectfully request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain the current payment formula. Any reduction in reimbursement will lead to fewer injectors in an area where we have too few knowledgeable injectors in the first place. Anyone can inject botulinum toxin. Not just anyone can inject it successfully to relieve the spasms. Also, this change in policy would destroy the uniformity of payments made across settings that ensures there are no economic rewards or penalties to providers,

depending on where the injections are given.

Thank you for allowing me to provide these comments.

Sincerely,
Candler P. Marriott

CMS-1392-P-521 **Medicare**

Submitter : Mr. Dan Rohrbach **09/10/2007**

Organization : Bridges Medical Center
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

September 10, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Delivered Via On-Line Form: http://www.cms.hhs.gov/eRulemaking

Subject: CMS-1392-P □ Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to

proposals made affecting the Critical Access Hospital (CAH) program. I am a CAH hospital CEO in Ada, Minnesota.

We are a critical facility in our region which is primarily a rural farming community. With out the CAH designation our facility would not be able to continue operation. We currently run a 3 provider clinic and have plans to open a 2nd provider based clinic in a even more remote location in our service area. Without the current reimbursement model, we will not be able to open this clinic and the healthcare in this region will suffer.

The Medicare population in our service area is over 70%. We serve all of those patienst with 2 physicians and one mid-level provider. Without the CAH designations our community would have an enormous burden of caring for the Medicare population.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering these comments. Please contact me if you have any questions.

Sincerely,

Dan Rohrbach
CEO / Administrator
Bridges Medical Center, Ada Minnesota

CMS-1392-P-522 **Medicare**

Submitter : Mr. Ernie Schmid **09/10/2007**

Organization : Texas Hospital Association
Health Care Professional or Association

Category :

Issue Areas/Comments

GENERAL

GENERAL

Comment letter attached

CMS-1392-P-522-Attach-1.DOC

#522

TEXAS HOSPITAL ASSOCIATION

Kerry Weems, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1392-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Mr. Weems:

The Texas Hospital Association, which represents more than 500 Texas hospitals, offers the following comments regarding the proposed outpatient prospective payment system (OPPS) rules for CY 2008 payment rates.

Increasing Packaged Services
THA supports efforts to package more services into larger payment bundles. However, we understand that underlying analysis behind the proposal needs further examination. Particular attention is needed regarding the proposal to package observation services. CMS should simplify and clarify definitions and instructions for the reporting of observation services. THA urges CMS to exclude at this time observation services from its final packaging proposal. THA supports separate payable status for observation services and CMS' use of the Outpatient Claims Editor logic to automatically determine whether observation services on a claim are separately payable.

Composite APCs
THA urges CMS to evaluate the impact of the new bundles on payment adequacy, and access to care before expansion of this new policy to other services.

SPECIFIED COVERED OUTPATIENT DRUGS
As proposed, payments could provide incentives to treat patients in inappropriate settings. CMS should reassess this proposal.

Pharmacy Overhead Costs
The proposal adds administrative burden. Hospitals are required to evaluate and re-price thousands of drugs in their charge masters by January 1. This is an unreasonable expectation.

QUALITY DATA
Quality Measures
CMS should continue the precedent of tracking HQA in the implementation of the hospital quality reporting programs. HQA does not proceed with measures that do not receive NQF endorsement. CMS should proceed in the same manner when the agency finalizes the list of measures for implementation. CMS should provide funding to fully

field-test the outpatient measures. All future measures must be NQF endorsed and HQA adopted.

Timing of Implementation
Hospitals have made it very clear that the timeline for implementation of outpatient reporting will be extremely difficult if not impossible to meet, due to the complexities of building data collection information systems. Even hospitals with developed electronic health records will need time to comply. Smaller hospitals are dependent upon vendors. Development cost will be significant. THA supports AHA's recommendation that encourages "...**CMS to delay data collection on the outpatient measures until the measures have been fully field-tested and received NQF endorsement, the data specifications have been finalized, and the data collection software is fully operational.** There is no requirement in the statute that data collection begin on January 1, 2008. For CY 2009 payment purposes, data collection could begin later in the year when the hospitals and vendors are fully prepared to commence the program."

Data Submission Timeframe
CMS must make sure data collection software is available on the first day of the data submission period. Programming must be complete and tested.

Data Validation
For 2009, data validation should be conducted as a learning tool for hospitals. There should be no minimum reliability threshold required for the annual payment update. Reliability thresholds should start at lower levels and gradually rise to 80 percent.

Reconsiderations Process
The reconsideration process must be straightforward, transparent and timely. Clear guidance on how to submit appeals must be provided, and CMS must expedite appeal decisions.

PARTIAL HOSPITALIZATION
THA submitted a separate comment letter on this topic.

REPLACED DEVICES
THA supports the AHA recommendation that the reduced payment threshold be increased from 20 percent to 50 percent.

CMS should consider industry concerns about proper billing of devices being evaluated during a warranty service period. Hospitals frequently do not know whether a manufacturer will agree that a returned device is covered under the warranty.

HOSPITAL CLINIC VISITS
CMS should not implement new codes that differentiate between new and established patient clinic visits. Payments should be based upon resources used, not based upon whether a patient has been seen in the hospitals within the last three years.

Emergency Department Critical Care Visits
Payment for critical care services should be allowed when 15 minutes of critical care or the patient expires in spite of the administration of critical care services.

Proposed ED Treatment of Guidelines for 2008
CMS should develop or approve national guidelines for the reporting of hospital ED or clinic visits.

Inclusion of Separately Payable Services in Visit Levels
THA agrees with AHA that "In the absence of national guidelines, clarification from CMS as to whether separately payable procedures may now be included in hospital-specific guidelines is clearly needed."

Respectfully,

/ES/

Ernie Schmid, FACHE
Director, Policy Analysis

CMS-1392-P-523 **Medicare**

Submitter : Dr. Kevin Wei **09/10/2007**

Organization : Oregon Health Physician

Category :

Issue Areas/Comments

Packaging Drugs and Biologicals

Packaging Drugs and Biologicals

To Whom It May Concern:

I am writing to urge CMS to NOT eliminate separate payment for echo contrast agents when used in hospital outpatient settings.

I am the Director of the Adult Echocardiography Laboratory at Oregon Health & Science University. I am also a practicing general cardiologist. I am concerned about CMS's proposal to eliminate separate payment for contrast agents used in echos performed in hospital outpatient settings.

My most serious concern is that elimination of separate payment for echo contrast agents would lead to further underutilization of contrast in patients with suboptimal acoustic windows. This would lead to an increase in the number of non-diagnostic or inaccurate echo studies, which has been shown to result in further downstream resource utilization (e.g. patients will be referred for more expensive procedures like MRI, SPECT or cath) because the echo results were inconclusive. Underutilization of echo contrast agents is therefore not in the best interest of Medicare patients, or for Medicare itself, as it would invariably increase the need for more invasive or costly procedures.

Echo contrast agents have been shown to improve the accuracy of echo for evaluation of cardiac function, increase reader confidence, and decrease intra- and inter-observer variability. Echo contrast agents have also been shown to be cost effective because they decrease the need for further testing. Because contrast agents are relatively costly in comparison with the echo itself, packaging these agents with the underlying echo procedure would produce a greater financial disincentive against their use.

If CMS nonetheless decides to package echo contrast, it is required by statute to create separate

payment groups for contrast-enhanced and unenhanced procedures, which would require the creation of new HCPCS codes to separate these procedures.

Again, for the above reasons, I would urge CMS to NOT eliminate separate payment for echo contrast agents when used in hospital outpatient settings.

Thank you for your attention to this matter.

Sincerely,

Kevin Wei, MD
Associate Professor of Medicine
Director, Adult Echocardiographic Laboratory
Oregon Health & Science University

CMS-1392-P-524 **Medicare**

Submitter : Mrs. Linda Deville **09/10/2007**

Organization : Bunkie General Hospital Hospital

Category :

Issue Areas/Comments

Necessary Provider CAHs

Necessary Provider CAHs

See attachment.

CMS-1392-P-524-Attach-1.DOC

#524

BUNKIE GENERAL HOSPITAL
427 Evergreen Street
P.O. Box 380
Bunkie, LA 71322
Telephone (318) 346-6681
Fax (318) 346-6780

Linda F. Deville, CEO

September 10, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Delivered Via On-Line Form: *http://www.cms.hhs.gov/eRulemaking*

Subject: CMS-1392-P – Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting the Critical Access Hospital (CAH) program. I am a CAH Administrator at Bunkie General Hospital in Bunkie, La.

Bunkie General Hospital opposes the provider designation and background and reasons are listed below:

- Bunkie General Hospital received its CAH designation in May 2004 due to hospitals financial viability and medical staff retention issues.
- Bunkie General Hospital operates two (2) Rural Health Clinics that primarily serve the 71322 Zip Code. Each clinic has one (1) Doctor and one (1) Nurse Practitioner.
- Bunkie General Hospital recently signed a transfer agreement to accept patients that need the services of the hospital with two physician clinics within the parish and is

considering acquiring the clinics and converting to a RHC status. The clinics being considered by Bunkie General Hospital reside in remote rural area and see primarily Medicare, Medicaid. With limited Medicaid reimbursement, these clinics are financially strapped and limit services to patients. If BGH acquires these clinics, the patient would have access to services provided by hospital such as Medication Assistance Program, Medicaid Enrollment Centers, etc.

- The Bunkie area has recently seen a downturn in the economy with the closure of Wal Mart and a Martco, a paper mill manufacturing company. The employees of these facilities have no health insurance and add to the already 25% of the population with no health insurance. By converting these clinics to RHC, BGH would improve access to the uninsured, which it appears would not be allowed under the new mileage restrictions of the proposed rule.
- Bunkie, La. resides in Avoyelles Parish and the parish is designated as a Health Professional Shortage Area and a Medically Underserved Area.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering these comments. Please contact me if you have any questions.

Sincerely,

Linda Deville
Chief Executive Officer

CMS-1392-P-525 **Medicare**

Submitter : Mr. robert aymar **09/10/2007**

Organization : Mr. robert aymar
Individual

Category :

Issue Areas/Comments

Payment for Diagnostic Radiopharmaceuticals

Payment for Diagnostic Radiopharmaceuticals

Kindly do the right thing for those (few) suffering and with limited resources. DON'T CUT REIMBURSEMENT FOR BEXXAR TREATMENTS.
Doing so will prevent many from receiving a possible cure.
Thanking you in advance for making the right decision.

Payment for Therapeutic Radiopharmaceuticals

Payment for Therapeutic Radiopharmaceuticals

Do nnot reduce reimbursement of Bexxar treatmnets as it will hurt those least able to pay for the proceedure(s)by sstripping their limeted assets or wprse yet, preventing a possible cure because of inaffordability.
Thank you in advance for doing the right thing for those suffering.

CMS-1392-P-526 **Medicare**

Submitter : Mr. Terry Brenny **09/10/2007**

Organization : Stoughton Hospital
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

See attached letter sent to Mary Collins, DHHS, CMS, Baltimore MD regarding very serious community issues with proposed CMS rule 42 CFR
485.610 (e). Thank You.
Terry Brenny

CMS-1392-P-526-Attach-1.DOC

CMS-1392-P-527 **Medicare**

Submitter : Ms. Martha Rossi **09/10/2007**

Organization : Mercy Jeannette
Nurse

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

With such a short timeframe before implementation,the impact of this requirement for small hospitals will prove to be very burdensome and difficult to achieve by 2008. Constraints of resources: both human and finanical along with information systems upgrades and vendor software not to mention education on and collection of data will dramtically impact day to day operations of the facilty as we are trying to maintain compliance and provide quality of care to all patient area. An extension to implementation date would be reasonable a resolution.

CMS-1392-P-528 **Medicare**

Submitter : Dr. Steven Zimmet **09/10/2007**

Organization : Zimmet Vein and Dermatology
Physician

Category :

Issue Areas/Comments

Device-Dependent APCs

Device-Dependent APCs

I appreciate the effort CMS has undertaken to establish a comprehensive process for APC and ASC payment.

I have reviewed RVUs as well as the facility cost to provide services for CPT code 36478 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser, first vein treated). I am concerned about equipment expense. New technologies frequently require the purchase of capital equipment. This cost of capital, to be absorbed into the cost of doing business, must be compensated in a manner that is affordable to physicians in all practice settings as well as be reasonable to the payor.

Based on the CMS utilization formula for equipment cost per minute, I find a discrepancy in the equipment expense.

The Federal Register, Volume 72, July 12, 2007 identifies equipment expense for □all physicians□ at 4.08. Based on the CMS equation:

(1/(minutes/yr * usage)) * price * ((interest rate/(1-(1/(1 + interest rate) * life of equipment))))

+ Maintenance)

The allowed equipment expense is 4.08. When calculated using the ASP for the equipment used, the calculation is 4.75.

Payment for CPT code 36478, in the hospital outpatient department is in APC 0092 with an unadjusted national average payment of $1,684.02. Other procedures in that category include:
a. 37650: Ligation femoral vein
b. 37760: Ligation of perforator veins

c. 37765: Stab phlebectomy of varicose veins
d.
I request that 36478 be moved to APC 0091 with an unadjusted national average payment of is $2,780.84. Other procedures in this category include:
e. 37700: Ligation and division of long Saphenous vein at SFJ or distal interruptions
f. 37718: Ligation, division and stripping, short saphenous vein
g. 37722: Ligation, division and stripping GSV from SFJ to knee or below
h. 37735: Ligation, division and complete stripping of GSV or LSV with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia

i. 36478: Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency, first vein treated

CPT code 36478 is more clinically related to the procedures in APC 0091 than to those in APC 0092.

In previous years, low cost laser fibers (not matched to the laser for compatibility) were available from various companies. A successfully litigated patent infringement suit resulted in these fibers being removed from the market in March 2008. Although there has been no increase in fiber cost, the potential to reduce cost through the use unmatched fibers has been removed. We believe resource consumption for CPT code 36478 is more closely related to APC 0091.

I request that you move CPT code 36478 from APC 0092 to APC 0091.

CPT code 36478 has been moved form ASC group 9 to ASC group 8. I request that CPT code 36478 be placed back into group 9.

CMS-1392-P-529 **Medicare**

Submitter : Ms. Marilyn Echlov **09/10/2007**

Organization : none
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

I have dystonia (a movement disorder resulting from sustained involuntary muscle spasm) and have concerns about CMS's proposal to reduce the payment rate to hospitals for physician injected drugs. I have been told that in the near future I will need these injections in order to keep my eyes open and to assist me in keeping my life as normal as possible. This is called blephorospasm. Thank you for your support of BEBRF and this important legislative effort.

CMS-1392-P-530 **Medicare**

Submitter : Nancy Williams **09/10/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

Dear Mr. Weems,
I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient of Benign Essential Blepharospasm (a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS's proposal to reduce the payment rate to hospitals for physician-injected drugs. I receive injections of botulism toxin to alleviate the debilitating dystonic symptoms. These injections are critically important to function normally.
I respectfully request that CMS NOT change the payment formula for physican-injectable drugs for 2008, and instead maintain the current formula. Any reduction in reimbursement will lead to fewer injectors in an area where we have too few knowledgeable injectors in the first place. Anyone can inject botulism toxin. Not just anyone can inject if successfully to relieve the spasms. Also, this change in policy would destroy the uniformity of payments made across settings than ensure there are no economic rewards or penalities to providers, depending on where the injections are given.
Thank you for allowing me to provide these comments.
Sincerely,
Nancy J. Williams

PA State Coordinator - BEBRF, Inc.
P.O. Box 129
Clifford, PA. 18413

CMS-1392-P-531 **Medicare**

Submitter : Ms. Linda Phillips **09/10/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

Dear Mr. Weems:
I have serious concerns about CMS's proposal to reduce the payment rate to hospitals for physician-injected drugs. My sister, Susan Phillips, receives botox injections for her benign essential blepharospasm. These injections are critical for her to function on a daily basis. I respectfully request that CMS not change the payment formula for physician-injectable drugs for 2008 and instead maintain the current payment formula.

Thank you,
Linda Phillips

CMS-1392-P-532 **Medicare**

Submitter : **09/10/2007**

Organization :
Hospital

Category :

Issue Areas/Comments

IVIG Preadministration-Related Services

IVIG Preadministration-Related Services

See attached document concerning IVIG Preadministration-Related Services.

CMS-1392-P-532-Attach-1.DOC

#532

Asante Health System, OR
Avera Health, SD
Carolinas Healthcare System, NC
Community Hospital Anderson, IN
Erlanger Medical Center, TN
Forrest General Hospital, MS
Health First, Inc., FL
Lovelace Health System, NM
Mercy Medical Center, IA
Our Lady of the Lake Regional Medical Center, LA
Palomar Pomerado Health, CA
Saint Joseph's Hospital, WI
St. Joseph's/Candler Health System, GA
Saint Mary's Hospital, MN
Sheltering Arms Rehabilitation Hospitals, VA
Sisters of Mercy Health System, MO
Twin Lakes Regional Medical Center, KY
University Health System, TX
Vanguard Health System, TN

The Provider Roundtable (PRT) is a group of providers representing 19 different health systems from around the country. The PRT was formed in order to help providers submit substantive comments that have an operational focus and can be used by CMS staff in preparing future OPPS rules. PRT members are employees of hospitals. As such, they have financial interest in fair and proper payment for hospital services under OPPS, but no specific financial relationship with vendors.

IVIG Pre-administration-Related Services

The Provider Roundtable compliments CMS on the proposal to continue separate payment for IVIG pre-administration services for CY 2008. We also agree with the clinical APC assignment of G0332 as noted in the proposed rule.

However, we have significant concerns with the $38.52 proposed payment rate for 2008 given that we are currently paid $75 for this service. The 2008 proposed payment rate for G0332 is derived from 2006 provider claims data, which is likely flawed as G0332 was first introduced in 2006. The PRT believes a variety of factors may be distorting the proposed payment rate such as revenue code selection by individual hospitals, differences in the cost-to-charge ratios (CCRs) mapped to those revenue codes, and the actual dollar charge reported by providers. A survey of our member hospitals reflected a variety of revenue codes assigned for this service, although most are reporting this service under revenue code 260. Table 1 below shows the different revenue codes and corresponding CCRs reported by our members and it is clear that there is wide variation in the CCRs that influences the cost derived from reported charges.

Hospital	Rev code	CCR
Hospital 1	260	0.2645
Hospital 2	260	0.2889
Hospital 3	761	1.2400
Hospital 4	260	0.1674
Hospital 5	260	0.1640
Hospital 6	260	0.3200
Hospital 7	260	0.4940
Hospital 8	949	0.3370
Hospital 9	260, 636	0.1642
Hospital 10	636	0.2419
Hospital 11	260	0.0923
Hospital 12	260, 636	0.1925
Hospital 13	636	0.5174
Hospital 14	636	0.1622
Hospital 15	260, 636	0.1778
Hospital 16	260	0.1470
Hospital 17	260	0.2801
Hospital 18	260	0.3463
Hospital 19	636	0.1765

Moreover, we understand CMS had a large number of single claims available for rate setting. However, we know many providers simply reported a line item charge of $75 which is equal to the APC payment rate and others likely reported even lower charges. In both cases, the CCRs typically associated with the most frequently billed revenue codes would result in very low cost estimates for this important service. Therefore, the PRT requests that CMS verify that line items of G0332 with a charge of $75.00 were excluded from the rate setting process based on the following statement from the CY2007 OPPS final rule: "We also deleted claims for which the charges equal the revenue center payment (that is, the Medicare payment) on the assumption that where the charge equals the payment, to apply a CCR to the charge would not yield a valid estimate of relative provider cost" (page 87 CMS-1506-FC). When new codes are introduced it takes hospitals time to appropriately determine the cost and hence what the reported charge should be. If hospitals randomly selected a charge amount for this service during the early months of 2006 without giving thoughtful consideration to the resources involved, then CMS more than likely has many claims with inappropriately low charges (i.e., $75 or less) that we believe should be excluded from rate setting. While it is not specifically stated in the rule, we believe it would be appropriate for CMS to exclude line-items from the rate-setting process where the reported charge is less than the OPPS payment rate. The PRT asks CMS to comment on this issue and to verify whether it excluded line-items from the rate-setting process for this service where the reported charge was less than or equal to $75.

The PRT recommends CMS continue to pay IVIG pre-administration at the current rate of $75 for at least one more year so that it has the ability to evaluate 2007 claims data to verify at that time if in fact the 2007 claims data would support a reduction in payment for OPPS in 2009. Until such verification with at least two years of claims data can be done, we do not believe it is prudent for CMS to decrease the payment rate by almost 50% as this will place a financial burden on our hospitals for this important service.

If CMS staff has questions about the information presented in this document, please contact the PRT spokesperson listed below:

Sincerely yours,

Denise Williams, RN, CPC-H
Vanguard Health System
Nashville TN
(615) 665-6052

CMS-1392-P-533 **Medicare**

Submitter : **09/10/2007**

Organization :
Hospital

Category :

Issue Areas/Comments

Cardiac Rehabilitation Services

Cardiac Rehabilitation Services

See attached document concerning Cardiac Rehabilitation services.

CMS-1392-P-533-Attach-1.DOC

#533

Asante Health System, OR
Avera Health, SD
Carolinas Healthcare System, NC
Community Hospital Anderson, IN
Erlanger Medical Center, TN
Forrest General Hospital, MS
Health First, Inc., FL
Lovelace Health System, NM
Mercy Medical Center, IA
Our Lady of the Lake Regional Medical Center, LA
Palomar Pomerado Health, CA
Saint Joseph's Hospital, WI
St. Joseph's/Candler Health System, GA
Saint Mary's Hospital, MN
Sheltering Arms Rehabilitation Hospitals, VA
Sisters of Mercy Health System, MO
Twin Lakes Regional Medical Center, KY
University Health System, TX
Vanguard Health System, TN

The Provider Roundtable (PRT) is a group of providers representing 19 different health systems from around the country. The PRT was formed in order to help providers submit substantive comments that have an operational focus and can be used by CMS staff in preparing future OPPS rules. PRT members are employees of hospitals. As such, they have financial interest in fair and proper payment for hospital services under OPPS, but no specific financial relationship with vendors.

Cardiac Rehabilitation

The Provider Roundtable (PRT) does not support CMS' recommendation to change how cardiac rehabilitation services are reported. The proposed changes include creating new HCPCS codes for cardiac rehabilitation, and reporting charges on a per-hour rather than per-session basis.

The current CPT codes for cardiac rehab are:

- 93797 - Outpatient cardiac rehab; without continuous ECG monitoring (per session)
- 93798 – Outpatient cardiac rehab; with continuous ECG monitoring (per session)

The proposed new HCPCS codes are:

- GXXX1 - Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per hour)
- GXXX2 - Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per hour)

The PRT fails to see the rationale for changing from CPT to HCPCS coding, or from a non-time-based rate to a time-based rate. Cardiac Rehabilitation services are predominantly provided within a 45–90 minute time-frame per session. The increases in volume that have been seen over the last several years are attributable to inherent changes in the Medicare population's demographics.

The PRT believes that this proposed change presents a difficult problem for hospitals to meet Medicare requirements to bill all patients the same price for the same service. Hospitals would have to create per-hour charges to bill CMS while continuing to bill per-session charges to all other payers. Hospitals would bill one set of codes to Medicare and bill the current CPT codes to other payers which results in providers having to implement manual billing processes contributing to overhead and administrative cost and an increase in operational burden while doing nothing to advance the quality of the clinical care. We are concerned that hospitals will be vulnerable to compliance issues if they were to report different charges and codes to different payers for the same service.

In addition, the PRT questions how CMS formulated the proposed payment rates for the newly proposed "per hour G-codes" from the "per session CPT codes" present in the 2006 claims database. The PRT believes that implementing this coding change will impair future claims data as a result of the difficulties that hospitals will experience in attempting to implement two different coding systems for cardiac rehabilitation. We strongly feel that if CMS were to implement the proposed G-codes for Cardiac Rehabilitation services that it will simply see erroneous and aberrant claims data in the future as hospitals will certainly experience operational challenges in implementing these new G-codes for Medicare while continuing to report CPT codes to other payers. The fact is that two sets of codes will exist with totally different time elements for reporting the same cardiac rehabilitation services being provided. This will cause confusion for clinical as well as billing staff.

Further, this proposed rule change conflicts with CMS' stated goal of utilizing CPT codes rather than HCPCS codes and conflicts with current NCD guidelines which define cardiac rehabilitation services on a per-session basis. The PRT recommends that CMS rescind this proposal and continue to allow providers to report existing CPT codes for Cardiac Rehabilitation services.

If CMS staff has questions about the information presented in this document, please contact the PRT spokesperson listed below:

Denise Williams, RN, CPC-H; Vanguard Health System, TN, (615) 665-6052

Sincerely yours,

Denise Williams, RN, CPC-H
Vanguard Health System
Nashville TN
(615) 665-6052

CMS-1392-P-534 **Medicare**

Submitter : **09/10/2007**

Organization :
Hospital

Category :

Issue Areas/Comments

ASC Impact

ASC Impact

See attached document concerning ASC Impact under the proposed rule.

CMS-1392-P-534-Attach-1.DOC

#534

Asante Health System, OR
Avera Health, SD
Carolinas Healthcare System, NC
Community Hospital Anderson, IN
Erlanger Medical Center, TN
Forrest General Hospital, MS
Health First, Inc., FL
Lovelace Health System, NM
Mercy Medical Center, IA
Our Lady of the Lake Regional Medical Center, LA
Palomar Pomerado Health, CA
Saint Joseph's Hospital, WI
St. Joseph's/Candler Health System, GA
Saint Mary's Hospital, MN
Sheltering Arms Rehabilitation Hospitals, VA
Sisters of Mercy Health System, MO
Twin Lakes Regional Medical Center, KY
University Health System, TX
Vanguard Health System, TN

The Provider Roundtable (PRT) is a group of providers representing 19 different health systems from around the country. The PRT was formed in order to help providers submit substantive comments that have an operational focus and can be used by CMS staff in preparing future OPPS rules. PRT members are employees of hospitals. As such, they have financial interest in fair and proper payment for hospital services under OPPS, but no specific financial relationship with vendors.

ASC Impact: Proposed Update of the Revised Ambulatory Surgical Center Payment System

The PRT appreciates CMS' desire to remove site-of-service differentials that often result from the incentives created by different payment systems in place in different settings, such as hospitals and ambulatory surgery centers or hospitals and the physician office setting. However, while we are in favor of streamlining payment system differences, we are concerned that ASCs may underestimate the severity of certain types of patients and/or cases, particularly from the 700+ codes added to their list of available new services. It is the PRT's experience when ASCs provide services that they perhaps may not be fully equipped or staffed for, that hospitals and patients are the ones to suffer as patients are transferred to the hospital for continued care, either as prolonged recovery time or an observation stay. The PRT is concerned that while CMS is working to streamline payment inequities between the hospital and the ASC, it may simply end up reintroducing different inequities where hospitals lose money on patients transferred over from ASCs and patients who end up having to be seen and cared for by multiple providers. The PRT expects to see an increase in the number of patients transferred from ASCs in the future and we believe CMS will see an increase in the incidence of observation claims, or when the observation service does not meet medical necessity requirements, the hospital will be forced to issue an ABN to the beneficiary, thereby further adding to the beneficiary's cost.

The PRT encourages CMS to monitor this situation closely by collecting data. To this end, the PRT recommends that CMS develop one or more mechanisms for capturing transfers from the ASC to the hospital setting, and presents the following suggestions:

- Develop a discharge code for the ASC to indicate that the patient was sent to a hospital for recovery or observation; or
- Develop an admit source code for the hospital to indicate that the patient has come from an ASC; or
- Develop a separate G-code for hospitals to indicate a direct admit from an ASC.

The PRT members note that the preferred mechanism should be one that will work for all payers, and therefore prefer one of the first two options listed above as not all non-Medicare payers accept HCPCs codes.

In addition to correcting the site-of-service payment differentials, the PRT encourages CMS to develop consistent quality indicators between hospitals and ASCs. The PRT strongly believes that Medicare beneficiaries should receive the same high quality of care regardless of the site in which that service is provided.

If CMS staff has questions about the information presented in this document, please contact the PRT spokesperson listed below:

Denise Williams, RN, CPC-H; Vanguard Health System, TN, (615) 665-6052

Sincerely yours,

Denise Williams, RN, CPC-H
Vanguard Health System
Nashville, TN

CMS-1392-P-535 Medicare

Submitter : Mr. Chris Noland **09/10/2007**

Organization : Tri-State Memorial Hospital
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

September 10, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Delivered Via On-Line Form: http://www.cms.hhs.gov/eRulemaking

Subject: CMS-1392-P □ Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to

proposals made affecting the Critical Access Hospital (CAH) program. I am the hospital administrator at Tri-State Memorial Hospital in Clarkston, WA.

Our community is in a crisis situation with regard to access to primary care for Medicare patients. All physicians have closed their practices to new Medicare patients resulting in many seeking care in our Emergency Room which is much more costly than in a clinic setting.

I am attempting to build a Rural Health Clinic and employ appropriate providers to meet this grave

need for access. This legislation would make it unfeasible for my hospital to be able to provide care to this group of patients. The ramifications would be extremely negative for Medicare patients in our area and result in greater costs since they will not be getting the preventative care they need until they become so sick they are seen in the ER and possibly admitted. It would be very short sited to reduce this access to care which would result in harm for patients served by Rural Health Clinics, and much greater costs overall for Medicare. If you feel situations exist where this program is being used inappropriately, please address it on that basis and do not □throw the baby out with the bath water□.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering these comments. Please contact me if you have any questions.

Sincerely,

Christopher W. Noland MHA, FACHE
Chief Executive Officer
Tri-State Memorial Hospital
Clarkston, WA 99403
509-758-4650

CMS-1392-P-535-Attach-1.DOC