CMS-1392-P-659 **Medicare**

Submitter : Mr. Rusty Phillips **09/11/2007**

Organization : Jennings Behavioral Health, LLc
Social Worker

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

Comment Letter on CMS-1392-P Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2008 Payment Rates □ Proposed Rule

See Attachment

CMS-1392-P-659-Attach-1.RTF

#659

September 11, 2007

Jennings Behavioral Health, LLC.
619 North Main Street
Jennings, LA. 70546

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

FILE CODE: CMS-1392-P OPPS: PARTIAL HOSPITALIZATION

Re: Comment Letter on CMS-1392-P Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2008 Payment Rates – Proposed Rule

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting Partial Hospitalization Programs. I am a Director of Outpatient Services at Jennings Behavioral Health, LLC in Jennings, Louisiana.

The current standard of Practice for Partial Hospitalization Programs is an average of 4 – 5 professional services per day. Services provided in a Partial Hospitalization Program are on a group and individual basis. Partial Hospital Programs require extensive amounts of professional services, inclusive of nursing, social work, therapy, ancillary services and psychiatry. The proposed rate reductions are insufficient to cover the cost of caring for an acutely ill person with mental illness.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to reduction in rates for Partial Hospitalization Programs. As stated above, such provisions would have a devastating impact on the access to quality health care in my community.

Specifically, the proposed rule referenced above continues to place extreme hardship on providers of Partial Hospitalization Programs. The rate proposed for 2008 once again falls below the actual cost of providing such services. Cost analysis demonstrates that the proposed APC rate is insufficient to provide the cost of care to the mentally ill in these programs. I do recognize that CMS is following a methodology that mathematically reflects the number proposed, but that methodology reflects many variables that provide for an incorrect cost per day. CMS has proposed

a gross APC of $179.88 for a day of services in a partial hospitalization program, which results in a net payment of approximately $125.00 for most Louisiana providers due to wage indexing and co-pay deductions.

At the current time the co-pay is reimbursable as a bad debt if the patient cannot pay, but there is not a permanent guarantee that those funds will remain. This is the fourth consecutive year of cuts for partial program mental health services which have totaled over 42% over the last 4 years (2008-23.37%proposed; 2007-4.55%, 2006-12.59%, 2005-1.91%). These severe cuts, when most outpatient services received increases over the last 4 years, indicates that there are obvious issues with the proper setting of the APC rates for a day of partial care. These rates are insufficient to cover the cost of caring for an acutely ill person with mental illness. In the proposed rule, CMS recognized that this program represents "the most resource intensive of all outpatient mental health treatment". This program is just one step down from an inpatient psychiatric stay that has actually higher requirements than an inpatient stay.

CMS noted in the final rule that they would accumulate appropriate data and determine if refinements to the per diem methodology were warranted. The current proposed rule once again acknowledges that cost data from CMHC's and hospitals has fluctuated greatly. The median costs varied by large amounts. Due to CMS's acknowledgement that the base data varies so greatly, it is not appropriate to propose such a cut for this service. The proposed cut of approximately 23% is not reflective of the cost pattern for the freestanding CMHC partial programs in our association. In the two prior years, CMS acknowledges that appropriate cost finding data was not available; therefore recommending 15% cuts for both years. **However, CMS did appropriately cost find and set the rate for the components of the psychiatric services rendered in a partial program. It is unclear why CMS continues to say that a full partial day should not equal the cost of the separate services in an outpatient hospital setting.**

COMMENT I - DECREASE IN PARTIAL HOSPITAL PAYMENT BY 23.37% WHILE LOUISIANA PARTIAL COSTS INCREASED SUBSTANTIALLY

Louisiana has seen an unprecedented increase over the past two years in costs for staffing, repairs and maintenance, supplies and insurance.

In the aftermath of Hurricanes Rita and Katrina in 2005, the cost of doing business in Louisiana has risen substantially. Insurance rates across the State have risen from 50-200% (Insurance Journal 10/24/2006), Nursing Salaries have increased by 10-15% (Louisiana Nurses Association, 2005), use of high cost staffing agencies have increased by 25% and cost for labor has increased by 7.4% Statewide and 28.7% in New Orleans (US Bureau of Labor and Statistics 4th Quarter 2005). Louisiana has lost 2046 RN's by application for change of address to another State since the storms (Louisiana State Board of Nursing, 2005). This added to an already strained nursing supply has substantially increased labor costs.

The proposed wage index in Louisiana has been lowered post hurricane instead of adjusted upward. This results in a much lower payment rate for Louisiana. Mississippi had a very slight wage index increase that is not nearly reflective of the true labor cost increase. The time lag on the wage indexing is a huge factor for Hurricane Zone providers. The wage index decrease makes the assumption that the cost of labor has actually decreased since the hurricanes. That would mean that despite the biggest shortage in staffing for hospitals in the past 20 years as well as the loss of professional and paraprofessional staff, salaries have gone down. Any employer in the Gulf Coast states can verify that this is not correct. Wages have increased substantially.

COMMENT II - PAYMENT FOR PARTIAL HOSPITALIZATION VERSUS OUTPATIENT

The Payment for Partial Hospitalization Services includes a full program, inclusive of Nursing Staff, Psychiatrists, Medical Doctors, Psychologists, Masters Prepared Therapists, Chemical Dependency Counselors, Activity Therapists, Occupational Therapists and Medical Technicians. All therapies provided are included in the one daily rate for APC 033.

In contrast, Outpatient Hospital Psychiatric Services do not require a multidisciplinary team, there are no requirements for nursing staff, and services may consist of one Psychiatrist and one Therapist. In addition, the criteria for admission for patients treated at this level are much less than for PHP, resulting in a much lower patient acuity.

It is clear the rates for PHP should be adequately set to reimburse providers appropriate for the setting and level of care. Partial Hospitalization Programs should be reimbursed at a minimum, the average payment rates set for Psychiatric Outpatient Services. CMS acknowledges that they do have appropriate cost finding for these individual outpatient codes. (HCPCS 90801-90862 or APC 322-325)

CMS has clearly defined what a partial day of service must include and local medical review policy takes that a step further. Detailed below are two tables reflective of a typical day of

services offered in a partial day program utilizing the outpatient psychiatric service rates proposed by CMS.

TYPICAL DAY 1

HCPCS	APC	DESCRIPTION	RATE
90853	325	GROUP PSYCHOTHERAPY SESSION	$ 64.45
90818	323	INDIVIDUAL PSYCHOTHERAPY SESSION	$106.49
90853	325	GROUP PSYCHOTHERAPY SESSION	$ 64.45
90853	325	GROUP PSYCHOTHERAPY SESSION	$ 64.45
TOTAL		**TOTALS FOR PARTIAL DAY SERVICES**	**$299.84**

TYPICAL DAY 2

HCPCS	APC	DESCRIPTION	RATE
90853	325	GROUP PSYCHOTHERAPY SESSION	$ 64.45
90818	323	INDIVIDUAL PSYCHOTHERAPY SESSION	$106.49
90847	324	FAMILY THERAPY SESSION	$141.61
TOTAL		**TOTALS FOR PARTIAL DAY SERVICES**	**$312.55**

This argument has been dismissed for 4 years now by CMS. If you are truly finding the cost of these separate services, it only makes logical sense to combine them to get the total cost in a partial program.

In addition to these core services, partial programs provide on call services to clients 24 hours a day 7 days per week. The typical partial services program day tables above yield an average componentized rate of $306. These component costs are not reduced when given in a partial setting. If anything, they can run higher due to the inability to share costs like hospital programs can. How can CMS propose a daily rate of $179.88 for the intense services offered? Does CMS wants to simply close this program altogether when there is a severe need for the services for the chronic mentally ill?

COMMENT III – REQUIRED IMPACT STATEMENT AND AVAILABILITY OF DATA STUDIES

In reviewing all of the documentation available at no charge and the impact statements; there was no evidence that any Louisiana CMHC provider that had been included in the impact statement. In fact, CMS notes on page 735 that they are not showing the estimated impact of the proposed changes on CMHCs alone because they can easily estimate their impact. CMS by law is required to calculate and disclose this specific impact – especially for small providers – which all of the CMHC's that I deal with fall under. The impact is DRASTIC, SEVERE, SUBSTANTIAL - 23.37%. Could CMS make a 23.37% cut to their entire budget?

QUESTIONS FOR CMS

1. ARE THE 2008 PROPOSED APC RATES FOR PSYCHIATRIC OUTPATIENT SERVICES CODES APC 322-325 (HCPCS 90801-90862) PROPERLY SET AND BASED UPON SUBSTANTIATED DATA?

2. DO YOU RECOGNIZE THAT A PARTIAL DAY PROGRAM IS MORE INTENSE THAN AN OUTPATIENT PSYCHIATRIC SERVICE AND ACTUALLY IS COMPRISED OF A MINIMUM OF 3-4 INTENSE SERVICES?
3. IF A PARTIAL DAY PROGRAM IS OFFERING 3-4 SERVICES THAT YOU DO HAVE ADEQUATE COST DATA ON WITH APPROPRIATE RATES COMPUTED, WHY CAN'T YOU SIMPLY CALCULATE A PARTIAL DAY COST BASED UPON YOUR ADEQUATE COST DATA FOR THE PSYCHIATRIC SERVICES OFFERED?
4. WHY WERE NO CMHC/PARTIAL FREESTANDING PROGRAMS CONSIDERED IN YOUR IMPACT STATEMENT? ISN'T THAT REQUIRED BY REGULATION?
5. COULD CMS TAKE A 23.37% CUT IN THEIR 2008 BUDGET?

Once again, we are asking your consideration to leave the APC rate for code 033 at the 2007 rate or set it as a total of 4 of your calculated outpatient psychiatric component costs. In either case, this would not equate to a 23.37% cut. An alternative request would be to freeze at the 2005 rates to assist the Hurricane Zones until a proper impact study could be commissioned.

I appreciate your consideration of my comments,

Rusty L. Phillips, MSW, LCSW
Director of Outpatient Services

CMS-1392-P-660 **Medicare**

Submitter : Dr. Eric Horwitz **09/11/2007**

Organization : Fox Chase Cancer Center
Physician

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

Please see attachment.

CMS-1392-P-660-Attach-1.DOC

#660

FOX CHASE
CANCER CENTER

Eric M. Horwitz, M.D.
Clinical Director, Department of Radiation Oncology
Associate Professor

333 Cottman Avenue
Philadelphia, Pennsylvania 19111-2497
215 728 2995
FAX 215 214 1629

September 11, 2007

Kerry N. Weems
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: Comments to Proposed Rule
File Code: CMS- 1392-P

Dear Administrator Weems:

I am writing this letter with respect to the Hospital Outpatient Prospective Payment System Proposed Rule for CY 2008. The comments below focus on the packaging proposal for guidance procedures used with external beam radiation therapy, a mainstay of my practice. Foremost, I am concerned that the Proposed Rule in its current format will provide a financial disincentive for hospital outpatient services to use important and clinically relevant guidance technologies as part of my radiation treatment practice.

I am a radiation oncologist and the Clinical Director in the Department of Radiation Oncology at Fox Chase Cancer Center in Philadelphia, Pennsylvania. We are one of the few NCI designated National Comprehensive Cancer Centers. My area of specialty is prostate cancer which is the only cancer that I treat. We treat almost 2000 new patients per year including almost 400 prostate cancer patients. We have one of the largest experiences in the United States treating men with prostate cancer with high dose radiation. We have one of the longest experiences since 1998, using some form of imaging technology (ultrasound, implanted fiducial marker seeds, and Calypso beacons) to guide radiation and have published extensively on our clinical results and low treatment toxicity.

Tumor targeting, namely ensuring that the radiation beam is correctly aimed continuously at the tumor, is absolutely essential in addressing the key goals of radiation oncology: to optimize the delivery of radiation to the tumor while keeping radiation-induced complications to a minimum. Each day's treatment session requires consistent, accurate daily setup and monitoring of the tumor target to ensure that we deliver radiation in an effective manner. For example, to fully harness the clinical benefits of radiation treatment for patients afflicted with prostate cancer, it is critical to know the position of the

tumor throughout treatment to successfully treat the tumor and avoid complications to surrounding structures such as the rectum, reproductive organs, and the bladder.

The Proposed Rule, if implemented, would financially reward hospital outpatient departments to provide services using existing and potentially inferior guidance methods in conjunction with radiation therapy treatment. This includes subjective methods such as laser and tattoos, which do not provide the precise, real-time monitoring that comprehensive guidance solutions can provide in radiation therapy delivery. The packaging proposal recommended in the Proposed Rule would create a disincentive in the adoption of emerging technologies such as the Calypso 4D Localization System – a system that we have put into use this year. This decision will only serve to slow clinical advancements in radiation therapy delivery options. Most hospitals would have difficulty justifying use of guidance technologies without separate coding and payments. Entities like [name your institution] are in the process of determining the actual cost and utilization patterns associated with guidance technologies used in conjunction with external beam radiation therapy delivery.

Further, the Proposed Rule inappropriately assumes uniformity in treatment approaches for services such as external beam radiation therapy. Individual patient characteristics, stage of the disease, and associated treatment approaches vary dramatically and require customized treatment delivery and guidance. CMS's Proposed Rule assumes consistency of treatment for life-threatening diseases, such as prostate cancer. As each patient's treatment is unique, we require the option to use the various types of guidance technologies available to us based on the patient's individual case. Having specific codes and payments for a range of guidance technologies is important in the practice of radiation oncology so we may analyze the utilization with specific codes to better understand use and the cost to deliver these new procedures.

Packaging guidance technologies with therapeutic delivery in radiation oncology will serve to diminish the quality of care Medicare beneficiaries receive from my institution. This broad sweeping Proposed Rule, in its current format, eliminates distinct and separate payment which will make it difficult for hospitals to justify adoption of new, and clinically more effective, radiation oncology guidance technologies, like the Calypso 4D Localization System. Furthermore, the overall utilization data for guidance procedures needs to be studied before CMS makes such significant changes in radiation oncology packaging and payments.

Therefore, I urge CMS to accept the recommendation of the APC Panel that occurred on September 6, 2007 to exclude radiation oncology guidance procedures from packaging in the Final Rule. Further assessment of costs related to specific procedures needs to be undertaken before implementing such a significant change to the radiation oncology practice.

Please feel free to contact me with any clinical questions on radiation oncology and treatment.

Respectfully

Eric M. Horwitz, M.D.
Clinical Director
Department of Radiation Oncology

CMS-1392-P-661 **Medicare**

Submitter : Mr. Rusty Phillips **09/11/2007**

Organization : Jennings Behavioral Health - Sulphur Center
Social Worker

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

Comment Letter on CMS-1392-P Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2008 Payment Rates □ Proposed Rule

See Attached letter

CMS-1392-P-661-Attach-1.RTF

#661

September 11, 2007

Jennings Behavioral Health – Sulphur Center
110 East Darbonne Street
Sulphur, LA. 70663

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

FILE CODE: CMS-1392-P OPPS: PARTIAL HOSPITALIZATION

Re: Comment Letter on CMS-1392-P Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2008 Payment Rates – Proposed Rule

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componentized rate of $306. These component costs are not reduced when given in a partial setting. If anything, they can run higher due to the inability to share costs like hospital programs can. How can CMS propose a daily rate of $179.88 for the intense services offered? Does CMS wants to simply close this program altogether when there is a severe need for the services for the chronic mentally ill?

COMMENT III – REQUIRED IMPACT STATEMENT AND AVAILABILITY OF DATA STUDIES

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QUESTIONS FOR CMS

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Once again, we are asking your consideration to leave the APC rate for code 033 at the 2007 rate or set it as a total of 4 of your calculated outpatient psychiatric component costs. In either case, this would not equate to a 23.37% cut. An alternative request would be to freeze at the 2005 rates to assist the Hurricane Zones until a proper impact study could be commissioned.

I appreciate your consideration of my comments,

Rusty L. Phillips, MSW, LCSW
Director of Outpatient Services

CMS-1392-P-662 **Medicare**

Submitter : Mr. Daniel Colon **09/11/2007**

Organization : Redbud Community Hospital
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

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

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 Senior Vice President for Operations for Adventist Health Redbud Community Hospital in Clearlake CA. Redbud Community Hospital received Critical Access Hospital designation April 12, 2005.

My hospital operates three provider-based rural health clinics, one each in Middletown, Kelseyville and Clearlake, CA. We are currently developing business plans to open two new facilities □ an additional facility in Kelseyville and a new facility in Lucerne, CA. Services provided in Kelseyville include two full-time family practitioners, part-time behavioral health, part-time diabetic education and part-time podiatric services. We are not able to expand due to facility and property limitations.

The Lucerne area is a medical shortage area with one private practice internal medicine physician who plans to retire April 2009, and a for-profit rural health clinic that plans to close

by the end of this year. Our hospital would like to purchase one of these practices to continue providing medical services to this needy community.

If the proposed regulations take effect on January 1, the Lucerne Medicare beneficiaries will potentially be without medical providers after April 2009.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site rural health 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,

Daniel Colon
Senior VP Operations
Redbud Community Hospital
15630 18th Avenue
Clearlake, CA 95422
707-995-5820

CMS-1392-P-663 **Medicare**

Submitter : Mr. Kenneth Boyd **09/11/2007**

Organization : Girard Medical Center
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

As the leader of a CAH I would hope that CMS would see that the proposed regulation would contradict the original intent of the CAH designation. As the center for healthcare in the communities we serve it is vital that we are able to offer services to our communities as they are deemed necessary. In many of our communities the populations we serve are aging, and the proposed rule of not allowing psychiatric or rehab DPU's lies in distinct contrast with our mission. Even though we are less than 35 miles from the next healthcare facility, we are approximately 50 miles from the nearest facility that offers Geriatric Psychiatric services. We are currently evaluating the need, and have determined one exists, but due to the possible implications of the proposed regulation we would be unable to meet the needs of geriatric patients throughout our service area. I would recommend that before finalizing the regulation as written that CMS fully understand the negative impact this could have on patients, not just in our service area, but in communities across the country.
Thank you,
Kenny Boyd

CMS-1392-P-664 **Medicare**

Submitter : Dr. Roberto Duran **09/11/2007**

Organization : Cardona Pain And Anesthesia Professionals INC
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1392-P-664-Attach-1.DOC

#664

September 10, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1392–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-1392-P

Dear Mr. Kuhn:

Thank you for the opportunity to comment on the Proposed Rule CMS-1392-P, "Proposed Changes to the Hospital Outpatient P rospective Payment System (HOPPS) and CY 2008 Payment Rates" (the Proposed Rule) published in the *Federal Register* on August 2, 2007. My comments cover two main issues related to the HOPPS and ambulatory surgery center (ASC) payment methodologies.

I. ASC Procedures

There are several specific procedure issues we ask CMS to review and address. I believe that two procedures that have not been included on the ASC payment list, but that are paid under the HOPPS and should also be included on the ASC list. These procedures are described by CPT codes 22526 (percutaneous intradiscal electrothermal annuloplasty, single level) and 22527 (percutaneous intradiscal electrothermal annuloplasty, one or more additional levels). There is no reason why ASCs should not be entitled to payment for these two procedures. The procedures are safely done in ASCs, and they are not procedures routinely performed in a physician's office. I ask CMS to include both procedures on the ASC list in the final rule.

ASIPP also is concerned that procedures 72285 (discography - cervical or thoracic - radiological supervision and interpretation) and 72295 (discography – lumbar - radiological supervision and interpretation) have been packaged in all circumstances under the ASC proposed rule. These services are payable separately in the HOPD in certain circumstances and I believe the same should be true for ASCs.

Lastly, I ask CMS recalculate the payment rate of CPT code 64517. The proposed payment rate for this procedure is $178 for CY 2008. While I do recognize that the payment for the procedure following the transition period will be $295, a payment of $178 seems too low.

II. IMPLANTATION OF SPINAL NEUROSTIMULATORS

I ask that CMS create a new APC for implanting rechargeable neurostimulators upon expiration of the new technology transitional pass-through payment at the end of 2007.

I am concerned that the CMS proposal to pay rechargeable and non-rechargeable neurostimulator procedures under the same APC (0222) ($12,314 in hospital outpatient departments and $10,925 in ASCs) will impair Medicare Beneficiaries access to neurostimulation therapy utilizing rechargeable devices. The proposed payment structure could lead to such financial pressures on

the facilities purchasing these devices and ultimately cause the restrictive use of this technology despite the fact that rechargeable devices represent a major improvement in neurostimulation therapy for patients with chronic pain. If access to the rechargeable technology is inhibited than Medicare beneficiaries in need of this type of treatment for chronic pain will be relegated to non-rechargeable technology and subject to the risks and co-insurance costs associated with repeat surgical procedures for battery replacement. This outcome seems inconsistent with CMS's own determination that this technology offers beneficiaries substantial clinical improvement over non-rechargeable implantable which was evidenced by the decision to grant rechargeable implantable neurostimulators new technology pass-through payments for 2006 and 2007.

Implantable neurostimulators ensure that chronic pain patients have consistent pain control without interruption. The clinical benefit of the first generation non-rechargeable neurostimulator technologies is limited by the need for repeat surgical procedures for battery replacement any where from every two to four years depending on the usage of the device. Unfortunately, what we know from experience is that many physicians using non-rechargeable battery devices will utilize program settings that require less power in order to conserve the life of their non-rechargeable battery. This practice compromises the patient's opportunity to obtain optimal pain relief on a day-to-day basis; but patients choose this option as opposed to undergoing another surgical procedure. Rechargeable neurostimulators are capable of delivering continuous stimulation, even at high levels, to optimize patient relief without concern of rapid battery depletion.

Approximately 25 to 30 percent of all the neurostimulator implant procedures performed each year are required to replace a depleted, non-rechargeable battery. Thus, in the long term, the use of rechargeable devices likely would result in cost savings to the Medicare program and beneficiaries due to the decreased need for battery replacement procedures. The need for fewer surgeries also would reduce the chances that patients will experience operative complications such post-operative infection or other possible co-morbidities.

I ask CMS to create an APC for procedures using rechargeable implantable neurostimulators that is separate and distinct from the proposed APC grouping (0222) to create greater resource consistency. While we appreciate that CMS wants to bundle similar procedures that may utilize a variety of devices with different costs, it is inappropriate to bundle procedures when the absolute difference in cost is so significant. CMS's own analysis of the claims data associated with APC 0222 (shown in Table 35 of the preamble) reveals significantly higher costs for procedures associated with rechargeable neurostimulators ($18,089 median cost) than non-rechargeable neurostimulators ($11,608 median cost).

While I recognize the difference in median costs does not create a two times rule violation, the difference in median cost is not insignificant. CMS has assigned pass-through devices to a new APC or to a different, existing APC in absence of a "two-times" rule violation and for median costs differences significantly less than $1,000. I urge CMS to take a similar approach here. The creation of two separate APCs would result in more appropriate payment for both types of procedures—rechargeable and non-rechargeable neurostimulator procedures—based on their relative costs. To implement our recommendation, we further recommend that CMS create a G-Code to distinguish between implanting a rechargeable and a non-rechargeable neurostimulator.

Moreover, ensuring the payment rate is appropriate under the HOPPS system will result more appropriate payment in the ASC setting. Today, ASCs receive reimbursement for rechargeable generators through the DMEPOS fee schedule (L8689- rechargeable generator). With the current proposal ASC reimbursement will be based on 100% of the device component and approximately 65% of the service component of the APC payment. If the device component, as determined from the OPPS claims data, is based on a mix of rechargeable and non-rechargeable device costs, payments to ASCs will vastly underpay for the actual equipment, which costs the same in all

settings. Now that the two payments systems are inextricably linked it is even more incumbent upon CMS to ensure that payments are adequate under the HOPPS or Medicare beneficiaries may be left without an option to have this procedure performed at a HOPD or an ASC.

In summary my recommendations to CMS are:

- Create a new APC for procedures using rechargeable neurostimulators to recognize the full device and facility costs associated with these procedures.
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- Alternatively, CMS could continue using the device C-code, C-1820, to assign rechargeable neurostimlutor procedures to a new APC.
- Maintain non-rechargeable neurostimulator procedures in APC 0222.

***

Thank you for your consideration of my comments.

Sincerely,

Roberto L Duran M.D

CMS-1392-P-665 **Medicare**

Submitter : Betty Parker **09/11/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

As a patient with Spasmodic Dysphonia (vocal cords to not move) & Cervical Dystonia (a movement disorder resulting from sustained involuntary muscle spasms which are very painful), 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. I cannot function normally without these injections. The involuntary muscle spasms are pulling my head to my right shoulder. I cannot speak without the injections every few months. The injections are critically important to my ability to function normally. There is no known cure for Dystonia, therefore, I am looking at a future without being able to speak or move freely without the Botox injections.

I please 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. Not just anyone can inject it successfully to relieve spasms. A change in policy would destroy the uniformity of payments made that ensures there are no economic rewards or penalties to providers, depending on where the injections are given.

Thank you attention to this matter.

Sincerely,

Betty J. Parker, 284 Pelham Street, Alexander City, AL 35010
256-329-2793

CMS-1392-P-666 **Medicare**

Submitter : Dr. David Hollifield **09/11/2007**

Organization : OrthoQuest PC
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1392-P-666-Attach-1.DOC

#666

September 10, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1392–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-1392-P

Dear Mr. Kuhn:

Thank you for the opportunity to comment on the Proposed Rule CMS-1392-P, "Proposed Changes to the Hospital Outpatient P rospective Payment System (HOPPS) and CY 2008 Payment Rates" (the Proposed Rule) published in the *Federal Register* on August 2, 2007. My comments cover two main issues related to the HOPPS and ambulatory surgery center (ASC) payment methodologies.

I. ASC Procedures

There are several specific procedure issues we ask CMS to review and address. I believe that two procedures that have not been included on the ASC payment list, but that are paid under the HOPPS and should also be included on the ASC list. These procedures are described by CPT codes 22526 (percutaneous intradiscal electrothermal annuloplasty, single level) and 22527 (percutaneous intradiscal electrothermal annuloplasty, one or more additional levels). There is no reason why ASCs should not be entitled to payment for these two procedures. The procedures are safely done in ASCs, and they are not procedures routinely performed in a physician's office. I ask CMS to include both procedures on the ASC list in the final rule.

ASIPP also is concerned that procedures 72285 (discography - cervical or thoracic - radiological supervision and interpretation) and 72295 (discography – lumbar - radiological supervision and interpretation) have been packaged in all circumstances under the ASC proposed rule. These services are payable separately in the HOPD in certain circumstances and I believe the same should be true for ASCs.

Lastly, I ask CMS recalculate the payment rate of CPT code 64517. The proposed payment rate for this procedure is $178 for CY 2008. While I do recognize that the payment for the procedure following the transition period will be $295, a payment of $178 seems too low.

II. IMPLANTATION OF SPINAL NEUROSTIMULATORS

I ask that CMS create a new APC for implanting rechargeable neurostimulators upon expiration of the new technology transitional pass-through payment at the end of 2007.

I am concerned that the CMS proposal to pay rechargeable and non-rechargeable neurostimulator procedures under the same APC (0222) ($12,314 in hospital outpatient departments and $10,925 in ASCs) will impair Medicare Beneficiaries access to neurostimulation therapy utilizing rechargeable devices. The proposed payment structure could lead to such financial pressures on

the facilities purchasing these devices and ultimately cause the restrictive use of this technology despite the fact that rechargeable devices represent a major improvement in neurostimulation therapy for patients with chronic pain. If access to the rechargeable technology is inhibited than Medicare beneficiaries in need of this type of treatment for chronic pain will be relegated to non-rechargeable technology and subject to the risks and co-insurance costs associated with repeat surgical procedures for battery replacement. This outcome seems inconsistent with CMS's own determination that this technology offers beneficiaries substantial clinical improvement over non-rechargeable implantable which was evidenced by the decision to grant rechargeable implantable neurostimulators new technology pass-through payments for 2006 and 2007.

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settings. Now that the two payments systems are inextricably linked it is even more incumbent upon CMS to ensure that payments are adequate under the HOPPS or Medicare beneficiaries may be left without an option to have this procedure performed at a HOPD or an ASC.

In summary my recommendations to CMS are:

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- Alternatively, CMS could continue using the device C-code, C-1820, to assign rechargeable neurostimlutor procedures to a new APC.
- Maintain non-rechargeable neurostimulator procedures in APC 0222.

***

Thank you for your consideration of my comments.

Sincerely,

David G Hollifield MD
OrthoQuest PC
2336 Wisteria Dr Suite 230
Snellville, GA 30078

CMS-1392-P-667 **Medicare**

Submitter : Mr. Sean Wendell **09/11/2007**

Organization : Beacon Behavioral Health
Other Health Care Professional

Category :

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1392-P-667-Attach-1.PDF

#667

BEACON
Management, Inc.

September 10, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-P
Mail Stop: C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Sirs:

Re: Response to Proposed Changes to the CY2008 Hospital Outpatient PPS-CMS-1392-P Partial Hospitalization (APC 0033)

On behalf of Beacon Management, I appreciate the opportunity to submit comments regarding CMS's proposed OPPS rates concerning APC Code 0033 - Partial Hospitalization Programs and 0322, 0323, 0324, 0325 – Outpatient Psychiatric Services

Beacon Management is deeply concerned about the direct impact a fourth consecutive rate reduction will have on partial hospitalization and hospital outpatient services. We believe this rate cut will jeopardize the very existence of the partial hospitalization benefit itself.

Beacon Management is a member of The Association of Ambulatory Behavioral Healthcare (AABH) and we support their response to this situation which is as follows:

1. **CMS data does not support a PHP per diem rate of $179.88 by its' own methodology of calculation.**

CMS-1392-p, on pp. 255-256, describes the CMS methodology utilized to calculate the current proposed rates. Page 255 states "We use CCRs from the most recently available hospital and CMHC cost reports". Unfortunately, this data is aggressively **stale**. The costs utilized are at least **1 to 3 years old and are used to project rates 2 years forward.** A review of the data utilized for the CY 2008 rates would indicate that as much as 50% of the cost data could be 3 years old from 2004. Page 255 of the report goes on to say that "All of these costs are then arranged from lowest to highest and the middle value of the array would be the median per diem cost". This process guarantees that 50% of the providers will be providing services and be receiving reimbursement below their daily costs. Combining cost data several years old with recent units of service does not accurately reflect the costs the providers endure.

2. **CMS does not support a PHP per diem rate of $179.88.**

CMS has identified the true Median Cost of APC 325 for group therapy at $66.17. With a minimum of 4 services per day (many programs offer more), CMS would recognize the minimum cost at $264.68 per day. These data are inconsistent with a rate of $179.88 and indicate that a higher payment rate is necessary to prevent providers from running substantial deficits that will risk financial viability.

9938 Airline Highway, Suite 200 • Baton Rouge, LA 70816
Phone: 225.810.4040 • Toll-Free: 888.810.4041 • Fax: 225.810.4050

3. The current methodology is not conducive to this APC code.

Unlike the other 1100+ APC codes which generally represent individual medical procedures, Partial Hospitalization is a complete service industry, that encompasses a complete business setting rather than one simple process such as a Corneal Transplant (0244) or a Transfusion (0110). There is precedent in other CMS OPPS service industries to exclude the services from the APC code listing and treat them independently. Two examples are Home Health and Hospice Care. Home health was just finalized for CY2008 with a set rate and a 3 percent increase if certain quality data standards are met or a 1 percent increase if the standards are not met. Positive performance results in reimbursement rewards. PHP could be treated the same. This would stabilize the rates and generate future rate predictability for these services.

4. The preliminary rate of $179.88 is excessively severe.

The CMS table on p. 257 of CMS-1392-p reflects 4 median per diem costs as determined by CMS. The projected rate of $179.88 is the lowest of the four samples. This would penalize all CMHCs providing four or more units of service per day and all hospitals in either category. All current PHP LCD's of the Fiscal Intermediaries state the CMS requirements that "Partial Hospitalization Programs must **offer** a minimum of 20 hours a week of structured program provided over at least a five-day period." The minimum patient participation is three hours per day of care with a minimum of 12 hours per week." AABH would offer 2 suggestions. First, enforce the minimum service requirement to assure PHPs are **offering** at least 20 hours of structured programming per week. Second, days of service with less than 4 services are being paid within the rules of CMS and Medicare. Programs should not be penalized for following the rules.

In further regard to the Hospital-based PHPs, CMS data indicated that over 66% of paid claims were for 4 or more units of service. The median cost of $218 for hospitals is $40 below the projected reimbursement rates. A decision of this nature would end these services in Hospital-based locations.

5. CMS's calculations for the CY 2008 PHP per diem payment are diluted.

CMS states that per diem costs were computed by summarizing the line item costs on each bill and dividing by the number of days on the bills. This calculation can severely dilute the rate and penalize providers. All programs are strongly encouraged by the fiscal intermediaries to submit all PHP service days on claims, even when the patient receives less than 3 services. Programs must report these days to be able to meet the 57% attendance threshold and avoid potential delays in the claim payment. Yet, programs are only paid their per diem when 3 or more qualified services are presented for a day of service. If only 1 or 2 services are assigned a cost and the day is divided into the aggregate data, the cost per day is significantly compromised and diluted. Even days that are paid but only have 3 services dilute the cost factors on the calculations. With difficult challenges of treating the severe and persistently mentally ill adults, these circumstances occur frequently.

6. The proposed PHP per diem rate also severely compromises Hospital Outpatient Services.

CMS pays hospital facilities for Outpatient Services on a per unit basis **up to** the per diem PHP payment. As previously shown, CMS has identified Group Therapy APC 0325 with a true Median Cost of $66.17. Most patients involved in the Outpatient Services are participating 1-3 days and generally receive 4 or more services on those days. While programs provide 4 services the per diem limit will only allow them to be "paid their cost" for about 2.75 services (3 x $66.17 = $198.51). The program is $18.63 short for the 3rd service and the 4th service is provided for no reimbursement.

7. Cost Report Data frequently does not reflect Bad Debt expense for the entire year.

As the cost report data is proposed surrounding Bad Debt, many "recent" bad debt copays of the last 4-5 months of the fiscal year have not completed the facility's full collection efforts and therefore are not eligible for consideration of bad debt on the cost report. Those that are, can only be recovered up to 55%. These costs are not being considered in the CMS data and severely short change the rate calculations.

8. Data for settled Cost Reports fail to include costs reversed on appeal.

CMS historically has reduced certain providers' cost for purposes of deriving the APC rate based on its observation that "costs for settled cost reports were considerably lower than costs from "as submitted cost reports". (68 Federal Register 48012) While CMS's observation is true, it fails to include in the provider's costs, those costs denied/removed from "as submitted" cost reports, and subsequently reversed on appeal to the Provider Reimbursement Review Board ("PRRB"), subsequently settled pursuant to the PRRB's mediation program, or otherwise settled among the provider and intermediary. During the relevant years at issue, providers of PHP incurred particularly significant cost report denials, but also experienced favorable outcomes on appeal. Because the CMS analysis did not take into consideration what were ultimately the allowable costs, its data are skewed artificially low. The cost data used to derive the APC rate should be revised to account for these costs subsequently allowed.

Based on the above issues, AABH would recommend that CMS take the following course of action:

1. Allow the PHP per diem to remain the same as the CY2007 per diem rate of $234.73.

2. Beacon Management encourages CMS to go with AABH to the legislature and support a legislative amendment to:

    - Remove PHP from the APC codes and have independent status using Home Health as an example
    - Establish the current rate of $234.73 as the base per diem rate for services
    - Annually adjust the base rate by a conservative inflation factor such as the CPI
    - Establish quality criteria to judge performance and that influences future rate reimbursement

Thank you, for the opportunity to respond to this critical issue.

Respectfully,

Sean Wendell

Sean Wendell, CPA
Chief Executive Officer
Beacon Management, Inc

CMS-1392-P-668 **Medicare**

Submitter : Ms. Alyssa Delaney **09/11/2007**

Organization : The Delta Group
Health Care Industry

Category :

Issue Areas/Comments

Quality Data

Quality Data

What is considered a Hospital Based Outpatient Clinic? Would this be a hospital owned clinic?

CMS-1392-P-669 **Medicare**

Submitter : Dr. Paul S Webster **09/11/2007**

Organization : Doctors' Pain Management
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1392-P-669-Attach-1.RTF

#669

Doctors' Pain Management Associates

PAUL S. WEBSTER, M.D.
Board Certified, American Board of Pain Medicine
Board Certified, American Board of Anesthesiology

Interventional Pain Medicine Specialists

September 10, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1392–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-1392-P

Dear Mr. Kuhn:

Thank you for the opportunity to comment on the Proposed Rule CMS-1392-P, "Proposed Changes to the Hospital Outpatient P rospective Payment System (HOPPS) and CY 2008 Payment Rates" (the Proposed Rule) published in the *Federal Register* on August 2, 2007. My comments cover two main issues related to the HOPPS and ambulatory surgery center (ASC) payment methodologies.

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***

Thank you for your consideration of my comments.

Sincerely,

Paul S. Webster, MD

CMS-1392-P-670 **Medicare**

Submitter : Mr. JOHN OSSE **09/11/2007**

Organization : CROOK COUNTY MEDICAL SERVICES DISTRICT
Critical Access Hospital

Category :

Issue Areas/Comments

GENERAL

GENERAL

September 11, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Subject: CMS-1329-P-Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY2008 Payment Rates: Proposed Changes Affecting Necessary Provider Designation 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 an interim- hospital administrator at Crook County Medical Services District (CCMSD)in Sundance, Wyoming, population 1160,located in Crook County, population 5887.

CCMSD became a CAH in 2003. CCMSD includes a 16 bed acute care hospital, 32 bed nursing home, ambulance service, home health agency and hospice program. In addition, CCMSD operates three rural clinics. One is located in the hospital, one in Moorcroft, population 819, and one is Hulett (near Devil's Tower), population 410. The clinics are approximately 35 miles from the hospital. The clinics are staffed by four family practice physicians who rotate between the clinics as well as a nurse practioner and physician assistant. All are employed by CCMSD. Residents in the area utilize the clinics to the extent that we are recruiting a fifth family practice physician. The clinic in Moorcroft is being replaced by a larger faciltiy due to the condition of the building and utilization by local residents.

https://aimscms.fda.gov:8443/cmsView/docdispatchserv?error_page=/ErrorPage.jsp&r_object_id=090f3d... 9/13/2007

The Crtical Access Hospital program was the salvation of many hospitals providing health care to citizens in rural and remote areas of our nation. Many Critical Access Hospitals, such as ours, have been successful in extending medical services to communities in remote areas. Citizens in many of these areas are elderly and access to healthcare is often difficult at best. Larger medical facilities are reluctant to create outeach clinics due to distance and low patient volume making it unprofitable whereas Critical Access Hospitals, due to the current reimbursement program and closer proximity to remote areas have been successful in serving the medical and health needs of these citizens.

Due to these concerns, I respectively ask that you withdraw the provisions in ths rule pertaining to off-site clnics owned by CAH's. As stated above, such provisions would have a devastating impact on the access of quality heatlh care in our rural and remote communties. 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 fexibility to provide the care needed to seniors in rural and remote areas.

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

Sincerely,

John M. Osse, Interim-Administrator
Crook County Medical Services District
P O Box 517
Sundance, WY 82729

(307) 283-3501
ccmsadm@vcn.com

CMS-1392-P-671 **Medicare**

Submitter : Betty Parker **09/11/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

I would like to commend CMS for seeking to improve patient care and keeping down the related costs to eliminate abuse of services. However, as a patient with Spasmodic Dyphonia (vocal cords to not move)& Cervical Dystonia (muscle spasms & knots in neck, head & shoulders pulling my head to right side), I have serious concerns about CMS's proposal to bundle the payment rate to hospitals for physician-injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. Both the guidance service and the botulinum toxin injections I receive are critically important for my ability to function normally and have relief of the pain associated with dystonia. I request that CMS not package the payment of these services together, but continue to pay for them separately. The proposed change may result in hospitals pressuring doctors not to utilize this equipment and the injections being ineffective because it does not get to the right muscles to have benefit for me.

Thank you for your time and concerns.

Betty J. Parker
284 Pelham Street, Alexander City, AL 35010
256-329-2793

CMS-1392-P-672 **Medicare**

Submitter : **09/11/2007**

Organization : Benign Essential Blepharospasm Research Foundation
Other Association

Category :

Issue Areas/Comments

OPPS: Packaged Services

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Dear Mr. Weems,

On behalf of the Benign Essential Blepharospasm Research Foundation, I am writing to request that you reconsider the plans to reduce payment for injectable drugs to 105 percent of average sales price.

Blepharospasm is a form of dystonia which results in unremitting, bilateral, forcible closure of the eyelids. It is variably progressive and may increase in frequency and duration until the patient is rendered functionally blind. In addition, many will develop facial spasms (Meige), and other forms of dystonia. The daily activities that most take for granted such as reading, watching television, driving, and eating, become increasingly difficult. Many patients are unable to work.

The treatment of choice as prescribed by their physicians is injections of botulinum toxin. This requires that the injector be very knowledgeable about the condition and be well trained in injecting specifically for it. Often patients find it difficult to locate such doctors. We have great concerns that if CMS reimburses hospitals less than they do physicians who perform the identical injecting in their own offices, patients will face increasing difficulty in receiving the

treatment they need.

We applaud CMS□s efforts to balance the difficult responsibilities of assisting patients to receive proper medical care while reining in rising costs and abuses by those who use the system. However, we request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain the current payment formula and pay hospitals 106 percent of the Average Sales Price.

Thank you for considering our comments.

Nilda Rendino
BEBRF Eastern District District Director

Specified Covered
Outpatient Drugs

Specified Covered Outpatient Drugs

Dear Mr. Weems,

On behalf of the Benign Essential Blepharospasm Research Foundation, Inc., we are writing to request that you reconsider the proposal to reduce payment to hospitals for injectable drugs to 105 percent of average sales price.

Blepharospasm is a form of dystonia which results in unremitting, bilateral, forcible closure of the eyelids. It is variably progressive and may increase in frequency and duration until the patient is rendered functionally blind. The daily activities that most take for granted such as reading, watching television, driving, and eating, become increasingly difficult. In addition, many will develop facial spasms (Meige), and other forms of dystonia. Many patients are unable to work.

The treatment of choice as prescribed by their physicians is injections of botulinum toxin. This requires that the injector be very knowledgeable about the condition and be well trained in

injecting specifically for it. Often patients find it difficult to locate such doctors.
We are very concerned that any reduction in reimbursement for botulinum toxin injections will lead to more problems with access to care if the doctors or hospitals think that the reimbursement rate is inadequate to cover their costs. Also, this change in policy would destroy the uniformity of payments across settings that ensures there are no economic rewards or penalties to providers, depending on the setting where the injections are given.

We applaud CMS□s efforts to balance the difficult responsibilities of assisting patients to receive proper medical care while reining in rising costs and abuses by those who use the system. However, we request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain the current payment formula and pay hospitals 106 percent of the Average Sales Price.

Thank you for considering our comments.

Nilda Rendino
BEBRF Eastern District Drector