CMS-1392-P-712 **Medicare**

Submitter : Mr. Edward Karlovich **09/12/2007**

Organization : UPMC Hospital

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachment, several issues

CMS-1392-P-712-Attach-1.DOC

#712

September 12, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop: C4-26-05
Baltimore, MD 21244-1850

Via: UPS Delivery and
http://www.cms.hhs.gov/eRulemaking

ATTENTION: CMS-1392-P

RE: CMS-1392-P
Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year (CY) 2008 Payment Rates; Proposed Rule (Vol., 72, No. 148), August 2, 2007

Dear Sir or Madam:

On behalf of the University of the Pittsburgh Medical Center (UPMC) we are submitting one original and two copies of our comments regarding the Center for Medicare and Medicaid Services (CMS) proposed rule (Federal Register / Vol. 72, No. 148 / August 2, 2007 pages 42627 - 43130) "Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; ... Proposed Rule". We are also submitting these comments electronically to http://www.cms.hhs.gov/eRulemaking.

The following is a detailed explanation of UPMC concerns and issues with the OPPS CY 2008 proposed rule.

Section "OPPS: Packaged Services"

Issue 1: Proposed Packaging Approach (FR page 42652)

***Proposed CY 2008 Rule*:** CMS is proposing a shift in OPPS payment from the concentrated effort over the past seven years of identifying and refining service-specific payment for services rendered to patients to a more encounter or episode-of-care-based payment approach. CMS considers this proposed packaging (and bundling) approach a first step toward "value-based purchasing" which is a performance-based payment model rather than a volume-based payment model. CMS believes this shift is necessary as the implementation of OPPS has not slowed outpatient spending or volume growth. MedPAC confirmed that much of the growth in service volume from 2003 to 2005 resulted from increases in the number of

services per beneficiary who received care, rather than from increases in the number of beneficiaries served. CMS indicates that by expanding the packaging of supportive ancillary services and by bundling payment for multiple independent services into a single OPPS payment an incentive will be created for hospitals to monitor and adjust service volumes and resource efficiencies themselves. To start this process CMS is proposing in CY 2008 to package (by HCPCS) the payment for dependent services, in seven categories, into the payment for the independent services with which they are furnished. The seven service categories are as follows:

- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Diagnostic radiopharmaceuticals
- Contrast media
- Observation services

Response: While UPMC believes in providing better quality services at fair and reasonable prices, we are concerned that CMS is accelerating too hastily in the direction of an outpatient episode-based payment system. It is apparent in reading the proposed rules and background materials that CMS has begun to shift its OPPS payment approach in CY 2008 from identifying and establishing accurate service-specific payments toward an episode-based payment system. CMS considers the proposed seven category packaging approach (noted above) as a first step towards an episode-based payment system process. CMS also acknowledges that they believe an episode-based payment system will help alleviate the "tremendous growth in OPPS volumes and expenditures" of approximately ten percent growth per year, by encouraging providers to use resources more effectively. See Federal Register (FR) excerpts below, from FR of 8-2-2007:

> (FR page 42649) – "During the evolution of the OPPS over the past 7 years, significant attention has been concentrated on service specific payment for services furnished to particular patients, rather than on creating incentives for the efficient delivery of services t hrough encounter or episode-of-care-based payment. Overall packaging included in the clinical APCs has decreased, and the procedure groupings have become smaller as the focus has shifted to refining service-level payment."
>
> (FR page 42649) – "As illustrated in Table 5, total spending has been growing at a rate of roughly 10 percent per year under the OPPS, and the Medicare T rustees project that total spending under the OPPS will increase by more than $3 billion from CY 2007 through CY 2008 to nearly $35 billion."

UPMC believes that caution is critical and that CMS should not be attempting to establish outpatient quality and efficiency payment rates, through packaging and bundling of services, before both hospitals and physicians are adequately prepared

for these planned and significant payment changes. As CMS mentioned this proposed packaging approach is the first step in a total reversal of seven years of APC refinement of more accurate service payments toward an episode-based payment approach that appears to be budget driven. This proposed and planned payment approach described by CMS will soon place providers in severe financial risk with outpatient payment system modifications that are not simple, predictable or stable for providers. We believe a more cautious approach is necessary, requiring issues to be resolved before CMS proceeds with an episode or value-based driven OPPS payment system. We would urge CMS not to adopt these proposed packaging steps at this time. Issues such as best-treatment approaches and APC bench-marks; establishment and availability of good outpatient quality measures and availability of peer group data; provider risk floors; physician monitoring education; hospital staff training; beneficiary education; are all concerns that should be addressed. Another issue that needs to be considered by CMS is medical liability costs. The growth of physician medical malpractice liability costs and settlements encourages physicians to practice "defensive medicine". This could cause physicians to perform more tests and procedures in order to reduce exposure to lawsuits. Since this proposed rule contains no incentives for physicians to limit service volumes the hospital is at risk for this additional cost. We believe CMS needs to take a more global approach and provide some physician incentives to address this concern without placing the full responsibility on the provider as Medicare moves towards an episode-based payment system. In addition the simultaneous implementation of significant outpatient payment system reform at a time when providers are required to adapt to a new inpatient MS-DRG system places a tremendous burden on limited hospital resources and the quality improvement managers. We would urge CMS to postpone implementation of the seven packaged and bundled service categories and continue the current payment methodology for those service categories in question for a minimum of one year. We believe the above questions and provider risk concerns should be resolved by CMS and national healthcare organizations before the proposed packaging approach payment modifications are implemented.

Issue 2: "Proposed Development of Composite APCs" (FR page 42677)

***Proposed CY 2008 Rule*:** CMS is proposing the development of a composite APC, and a change in the definition of "service" for purposes of payment under OPPS. CMS proposes "to view a service, in some cases, as not just the diagnostic or treatment modality identified by one individual HCPCS code but as the totality of care provided in a hospital outpatient encounter that would be reported with two or more HCPCS codes for component services." As with packaging CMS believes that the payment approach for CY 2008 OPPS needs to create incentives for hospitals to provide services more efficiently than under the current OPPS, especially considering the significant growth in outpatient volume and spending.

Two specific sets of services identified by CMS for composite APCs are:

"Low dose rate (LDR) prostate brachytherapy" and
"Cardiac electrophysiologic evaluation and ablation services"

Response: As discussed in our packaging response, UPMC cannot support the development of composite APC's at this time and urges CMS to withdraw this proposal until the packaging questions and provider risk issues can be resolved.

Section "OPPS: Partial Hospitalization"

Issue 3: Partial Hospitalization (FR page 42691)

Proposed CY 2008 Rule: CMS proposed to adopt for CY 2008 an alternate method for computing the partial hospitalization program (PHP) median per diem costs. Under this new costing method, partial hospitalization per diem payments would drop from its CY 2007 rate of $233.37 to $178.00 in CY 2008. This is a proposed rate reduction of approximately (24%). CMS describes below how they propose to alter their current computation method to arrive at the proposed methodology. They also indicate how they have considered this alternative computation method during the past two years but rejected it because the method for producing median costs were too low to cover the costs of the PHP program which they believed typically spanned 5 to 6 hours. At this time CMS also indicated that over 65% of the CMHC data reflects "low unit days" of 3 or less hours of service and is included in the proposed rate of $178 per day. CMS Proposed methodology states:

> (FR page 42692) – "Our current method for computing per diem costs is as follows: we use data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs. We use CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line-item charges as reported on bills to estimate the provider's cost for a day of PHP services. Per diem costs are then computed by summing the line-item costs on each bill and dividing by the number of days of PHP care provided on the bill. These computed per diem costs are arrayed from lowest to highest and the middle value of the array is the median per diem cost.
>
> We have developed an alternate way to determine median cost by computing a separate per diem cost for each day rather than for each bill. Under this method, a cost is computed separately for each day of PHP care. When there are multiple days of care entered on a claim, a unique cost is computed for each day of care. All of these costs are then arrayed from lowest to highest and the middle value of the array would be the median per diem cost.
>
> We believe this alternative method of computing a per diem median cost produces a more accurate estimate because each day gets an equal weight towards computing the median. We have considered this alternative method for several years, but in light of the volatility of the data, we have not believed it would provide a reasonable and appropriate median per diem cost. In light of the stabilizing trend in the data, and in light of the robustness of recent data analysis, we now believe it is appropriate to propose the adoption of this method."

Response: UPMC does not support the adoption of this proposed alternative costing methodology for the partial hospitalization per diem rate (APC 0033) and we do not

support the proposed Partial hospitalization rate of $178 per day for CY 2008 for the reasons indicated below:

As CMS has stated above and on various pages of the proposed rule, the volatility of the CMHC cost and charge data and its significant fluctuation over the years places the reliability of the CMHC data in doubt and produces cost levels that are too low to cover the expected PHP program cost per day based on 5 or 6 hours of service. See excerpts below:

> (FR page 42691) – "In the CY 2006 and CY 2007 OPPS updates, the data have produced median costs that we believe were too low to cover the cost of a program that typically spans 5 to 6 hours per day."
>
> (FR page 42690) – "Historically, the median per diem cost for CMHCs greatly exceeded the median per diem cost for hospital-based PHPs and has fluctuated significantly from year to year, while the median per diem cost for hospital-based PHPs has remained relatively constant ($200-$225). We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies."
>
> (FR page 42692) – "We have considered this alternative method for several years, but in light of the volatility of the data, we have not believed it would provide a reasonable and appropriate median per diem cost."

At this time we still believe the cost projections could be flawed due to inaccurate CMHC data, inappropriate default Cost-to-Charge Ratios (CCRs) or possibly the comparison of half day rates to our full day costs. Currently our internal computations reflect a partial hospitalization program per diem cost of approximately $273.43 per day for our facility; however our programs typically span between 5 and 6 hours per day. The CMS computations indicate significant CMHC "low unit days" of three or less hours per day. In fact CMS indicates that the CMHC data is more than 64% of "low unit days". Assuming the $178 rate is based on approximately 3 hour days, a five hour (or full day) rate should be approximately $296. At this time we urge CMS to consider the following:

1. Establish Partial program per diems for full day (between 4 and 6 hours of care) and for half day (2 to 3 hours for a half day rate), since it is obvious that the majority of CMHCs and many hospital-based programs are not performing the same level of care or treatment that CMS originally expected. If more accuracy is necessary then several rate levels could be established based on the actual treatment hours performed. This would help alleviate the disparity between partial program payments and cost for providers trying to meet Medicare's full day treatment levels of between 4 and 6 hours. We would recommend full day rates of $297 ($178 / 3 * 5 hrs) and half day rates of $178 (based on your current analysis).
2. Withdraw the alternative costing methodology proposal since a large portion of its costs and rates are based on CMHC data which historically has been inconsistent and inaccurate. CMS did not provide any cost / rate data comparing the current or original partial program rate methodology to the proposed alternative

methodology. Instead CMS just reported its alternative methodology using CMHC data which it has rejected for several years as inaccurate due to extreme fluctuations between calendar years. We would urge CMS to exclude the CMHC data from the rate computations as unreliable, and use hospital-based partial program data only, until accurate CMHC PHP data and accurate CCRs are available.

3. Require fiscal intermediaries (FIs) to work with hospitals and CMHC providers to establish separate Partial Hospitalization Program lines on their appropriate Medicare cost reports (i.e. Hospital CMS-2552-96) to arrive at real CCRs for partial hospitalization programs rather than the default Psychiatric, Clinic or overall outpatient CCRs lines currently being used by CMS to estimate partial program costs. We suspect that nationally the cost-to-charge ratios for the partial hospitalization programs are being understated by applying overall CCRs and or clinic CCRs which penalize the most structured, clinically intensive partial programs which generally provide four or more services per day. The need for more accurate CCRs is clearly demonstrated by the repeated cost fluctuation and required use of default cost centers by CMS, in the computation of partial program rates. Therefore it is time the cost report data lines are updated to an adequate detail level. A separate Partial Hospitalization Program cost center should be established.
4. Begin to include CMHC data from the CMS-2088-92 cost reports in the Healthcare Cost Report Information System (HCRIS). The inclusion of this data would provide full transparency for industry review and analysis.
5. Analyze the group psychotherapy APC to better understand the reasons for the decline in the APC rate over the last couple of years.

Our partial hospitalization program and others who are working to provide the most structured, and clinically intensive programming, cannot sustain another 24% payment reduction (as proposed) on top of the 15% and 5% rate reductions taken in the last two years, without a severe service reduction. Cumulatively these rate reductions of 44% leave an inadequate partial payment rate of $178 compared to our current costs of approximately $273. We urge CMS to implement our partial hospitalization program recommendations as noted above so service reductions or program closings will not be necessary. With fewer partial hospitalization programs Medicare would surely face increased inpatient hospitalizations and higher overall Medicare expenditures.

Section: "OPPS: Device-Dependent APCs"

Issue 4: Proposed Payment for Devices when Devices are Replaced with Partial Credit to the Hospital (FR page 42723)

Proposed CY 2008 Rule: CMS has indicated that they believe hospitals should report occurrences of devices being replaced under warranty or when given a partial credit so that CMS may be able to identify systematic failures of devices or device problems

through claims analysis and CMS can make appropriate payment adjustments in these cases. At this time CMS is proposing to establish a new HCPCS "partial credit modifier" to be reported on cases in which the device credit is equal to 20 percent or greater of the cost of the new replacement device. Medicare will then apply a payment reduction of 50 percent of the full offset rate established for select APCs (21) on select HCPC devices (31) for CY 2008.

(Note: The proposed APCs affected by this proposed rule are shown in Table 38 page 42726 and the proposed devices for which the full or partial credit modifiers must apply are shown on Table 39 page 42727).

Response: At this time we urge CMS to withdraw this proposed rule, as it is not always apparent from the manufacture at the time of billing what percentage discount (if any) will be given on a replacement device. In some instances the device has to be returned to the manufacture for examination before any discount decision is made. Other venders make determinations based on unexpired warranty periods. However, the official determination by the manufacturers is not always known or available at the time of surgery or billing.

In addition we believe that any manufacture discount that a hospital would receive would already be included in its annual hospital cost-to-charge- ratios (CCRS) and would already be factored into the annual APC weighting changes. As such we do not believe this proposed rule change is necessary.

Section: "OPPS: Specified Covered Outpatient Drugs"

Issue 5: Proposed Payment for Specified Covered Outpatient Drugs (FR page 42733)

***Proposed CY 2008 Rule*:** CMS indicated their proposal to pay for acquisition and overhead costs of non-pass through separately payable drug and biologicals under the OPPS at ASP + 5 percent for CY 2008, while in CY 2007 and CY 2006 CMS maintained payment rates at ASP + 6 percent.

Response: At this time we do not support your proposal to reduce the drug and biological payment levels below the current ASP + 6 percent, for several reasons. They include:

1. Current calculation problems:
   a. ASP is based on the price that manufacturers charge distributors, including any prompt pay discounts. These prices and discounts often are not passed along to providers but are included in the calculation of the ASP.
   b. ASP is based on sales to all entities, including group purchasing organizations and large hospital systems on one end of the spectrum

and one-physician oncology practices on the other. It means that many hospitals, particularly the smaller ones without purchasing power, will purchase drugs above ASP.

c. There appears to be a two-quarter lag in the calculation of ASP, meaning that reimbursement is based on prices that are six-months old. Since manufacturers typically raise prices two to three times per year, there is potential for hospitals to suffer losses each time they administer drugs. Even as a large volume buyer, UPMC currently pays greater than ASP for many of our most highly utilized drugs and, in some cases, pay greater than ASP + 6%.

2. Inconsistent payment rates across settings. This proposal would result in lower payment for drugs and biologicals provided in hospital outpatient departments (proposed ASP + 5 percent) than for the same drugs and biologicals furnished in a physician office setting (paid ASP + 6 percent). We do not support the proposed hospital rate reduction to a level lower than what is paid to physicians and urge CMS not to reduce payment below the current rate of ASP + 6 percent.

Section "OPPS: Specified Covered Outpatient Drugs"

Issue 6: Pharmacy Overhead Carve out (FR page 42735)

***Proposed CY 2008 Rule*:** CMS has proposed the following pharmacy overhead carve out for FY2008:

> (FR page 42735) "We are proposing to instruct hospitals to remove the pharmacy overhead charge from the charge for the drug or biological and instead report the pharmacy overhead charge on an uncoded revenue code line on the claim beginning in CY 2008. This proposed change, from a CY 2007 policy where hospitals include pharmacy overhead in their charges for the drug or biological to a CY 2008 policy of including the pharmacy overhead charges on an uncoded revenue code line, would allow us to package pharmacy overhead costs for drugs and biologicals into payment for the associated procedure, likely a drug administration procedure, in future years when the CY 2008 claims data become available for rate setting. We are proposing to apply this policy to the reporting of charges for all drugs and biologicals, including contrast agents, irrespective of the item's packaged or separately payable status for the CY 2008 OPPS. We are not proposing to apply this policy to the reporting of overhead charges for radiopharmaceuticals given the explicit instructions they gave hospitals beginning in CY 2006 to include the charges for radiopharmaceutical overhead and handling in the charges for the radiopharmaceutical product. This proposal would not change our current policy of packaging payment for pharmacy overhead with payment for another item or service. Rather, in

future years it would only change the types of items or services with which pharmacy overhead is packaged."

Response: We do not support the adoption of the pharmacy overhead charge carve out as proposed for CY 2008 for the following reasons:

- Charge Identification & Capture – There would be an enormous administrative reporting burden on department managers, billing staff and accountants to identify and split the current charge for all drugs and biologicals into two separate charge fees, one for the cost of the drug, another for the pharmacy overhead charge.
- Billing System Updates – Generating a separate, uncoded line item for pharmacy overhead would require significant updates to the current billing system. This change would affect all payers and require software modifications in order to rebundle or roll "pharmacy overhead" back into the drug charge for other payers and would double the size of our drug service lines.
- Create Other Payer Problems – This will create massive confusion and billing problems for all other third-party and secondary payers who would now see all drug and biologicals split into two separate fees (Drug charge" and "pharmacy overhead" as requested by Medicare) plus a third charge for "Drug Administration fee".

We again believe that the adoption of this proposed rule would create more confusion and problems for the beneficiaries and all other third parties and urge that it not be adopted. Instead we would propose a cost report modification to capture the drug and overhead cost separately. A suggested approach could be as follows:

We suggest CMS modify the current hospital cost reports by splitting the "pharmacy" line and "Drugs Sold to Patient" lines into two lines, one line to capture drug costs and the other for all other costs. The line splits could be labeled "Pharmacy - drug costs" and "Pharmacy – All Other Costs" while the Drugs Sold to Patients line could be split as "Drugs Sold to Patients - Drug cost only" and "Drug Sold to Patients – All Other Costs & Overhead". The cost reports could then provide CMS with the proper portion of drug cost versus all other direct and indirect pharmacy overhead costs. CMS or the provider could then pro-rate their Drug charges between these two Drugs Sold to Patients lines to arrive at the overall cost to charge ratios. (Note: While the CCRs would be identical for each of the drugs sold to patient lines, CMS could then use the cost reports to determine the portion of drug costs versus all other pharmacy overhead costs).

We believe cost report modification (with the FI's assistance) is the less complex approach rather than providing CMS with the overall hospitals "drug costs" and "pharmacy overhead" splits that they are trying to collect.

Section "OPPS: Proposed Hospital Coding and Payments for Visits"

Issue 7: Proposed Hospital Coding and Payments for Visits (FR page 42751)

Proposed CY 2008 Rule: CMS has not proposed national visit reporting guidelines for clinic visits or Emergency Room visits in CY 2008, instead CMS is proposing to allow hospitals to continue to use their own internal guidelines for visit reporting. CMS identified six original guiding principles and five additional principles that a provider's internal guidelines on visit reporting should follow. In addition CMS requested provider comments on whether a need for national guidelines still exists or if the current system where hospitals create and apply their own internal guidelines to report visits is more practical and appropriately flexible for hospitals.

CMS also proposed eliminating the five Office consultation HCPCS codes (99241 through 99245) and indicated that providers use the existing new or established patient visit codes to appropriately describe the service provided.

Response: Due to the obvious difficulty in developing a national coding guidance acceptable to most parties from the various E/M coding models, we prefer to keep our own internal guidelines for the reporting of E/M services. As such we do not support any change at this time. We do support the elimination of Office consultations codes as unnecessary and believe the existing office visit codes should suffice.

Section "OPPS: Observation Services"
Issue 8: Observation Services (FR page 42674)

Proposed CY 2008 Rule: CMS has indicated that they believe it is appropriate to package payment for all observation services reported with HCPCS code G0378 "Hospital observation service per hour" into the primary APC service beginning in CY 2008. CMS indicates that observation services are ideal for packaging because they are always provided as a support service in conjunction with other independent separately payable hospital outpatient services such as emergency department visit, surgical procedure, or another separately payable service.

Response: We do not support the CMS proposal to package "all observation services" into the medical condition with which it was provided. We believe that the previous approach utilized by CMS during CY 2007 was the correct approach. That approach recognized:

- Medicare beneficiaries must have access to medically necessary observation care.
- Observation payments made only for beneficiaries actually receiving observation care services.

- Observation care payment is restricted to clinically appropriate observation care.
- Observation is limited to medical conditions which would benefit from the observation care by avoiding significant morbidity and mortality issues by an inappropriate discharge to home while at the same time avoiding unnecessary inpatient admissions.
- Establishment of additional criteria, tests, physician determinations, minimum and maximum hours of observation.
- Establishment of Outpatient Claim Edit (OCE) logic to recognize all required elements for separate payment processing and to recognize required packaging criteria.
- Observation services are generally performed on all patients after a surgical procedure and for that reason observation services were properly recognized as packaged for that surgical procedure.

As can be seen above, the previous approach recognized that some observation care was appropriate for separate payment as determined from clinical and financial analysis in prior years for specific Medicare patient populations. However the current proposal to package "all observation services" as part of other APC payments clearly overpays some claims for services not received and underpays other claims for observation services that were received. In addition, we believe this packaging approach could lead to many more inpatient admissions for patients with chest pain, congestive heart failure or asthma. It might also place some patients at higher risk if they are discharged to home earlier than would have occurred under the previous payment methodology. For these reasons we would urge CMS to maintain the current observations payment process and not package "All observation services" as proposed.

Section: "Quality Data"

Issue 9: Proposed Hospital Outpatient Measures – Five Emergency Department (ED) AMI Measures (FR page 42800)

***Proposed CY 2008 Rule*:** CMS proposes to establish a separate Hospital Outpatient Quality Data reporting program (HOP QDRP) and is proposing ten quality measures that are appropriate for measuring hospital outpatient quality of care. These ten measures reflect consensus among affected parties, and are set forth by one or more of the national consensus building entities. Five measures relate to Emergency Department (ED) and five others relate to hospital outpatient settings.

Response: UPMC suggests that a separate reporting system for hospital based outpatient services will add costs to the total infrastructure as new systems and resources will need to be hired to train to take on this new responsibility. In addition we believe there are no approved outpatient vendors of choice, with functional

reporting systems, as ORYX is still evaluating their participation. This is leaving hospitals in a difficult position with little time for resolution. We do have an existing system for collecting and reporting inpatient measures to CMS with trained personnel and we encourage CMS to consider utilizing the existing infrastructure to save valuable hospital resources particularly for the Emergency Department (ED) measures proposed as the medical records for outpatients in the ED have the same processes for review and abstraction as the inpatient records. While this is a possibility for ED measures we would still need additional staff and resources for this option.

Issue 10: Proposed Hospital Outpatient Measures – Five Additional Non-Emergency Department AMI Measures (FR page 42800)

Proposed CY 2008 Rule: CMS has also proposed 5 additional quality measures (beyond the ED measures) for hospital outpatient clinic settings.

Response: These five additional (non-ED) measures will be a burden in terms of cost and the time to implement and train on the methods and systems required to collect and submit information. We encourage CMS to consider delaying these 5 (of the total 10) measures until a system for collecting and reporting can be evaluated and existing electronic systems can be modified to collect this data as a by-product of the care process. Hospital based clinics have much less of a medical records infrastructure and staff, and taking on additional abstraction and systems work, which has not yet been clearly defined could be problematic. UPMC urges a delay in the reporting of these outpatient non-ED quality measures to allow for appropriate planning and for national testing. CMS proposed a very aggressive timeline to implement a new data collection process for the outpatient setting. We believe the development of a new data collection mechanism where there is not a process currently in place will be very costly. UPMC suggests a three year phase-in approach allowing sufficient time for the ambulatory measures to be collected.

Issue 11: Thirty Additional Hospital Outpatient Measures for Subsequent Years (FR page 42801)

***Proposed CY 2008 Rule*:** CMS is seeking public comment on thirty additional measures, beyond the 10 measures identified above. These measures are being considered for use in assessing the care of services provided by hospital outpatient settings, for the determination of CY 2010 and subsequent calendar year payments.

Response: UPMC encourages CMS to consider the lack of operational outpatient data collection processes, at this time. Premature requests for more outpatient measures before processes can be established and functional should not be considered. Organizations with only manual processes and records will have a very challenging time and will incur additional costs to find the appropriate cases to perform chart review for multiple measures, reviewing inclusion and exclusion

criteria and evaluating other factors in the chart. For example, to identify a medication reconciliation measure, the rule proposes that the measure is the "Percentage of patients aged 65 and older discharged from any inpatient facility and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medications list in the medical record documented". While this may be a very good clinical measure, the logistics of the data collection may be better suited once a more mature electronic environment exists across care continuum. UPMC does not believe these additional measurements should be considered at this time due to the unresolved collection and reporting problems discussed above.

Issue 12: Diabetes Care Outcome Measurement (FR page 42800)

***Proposed CY 2008 Rule*:** CMS requests comments on their rationale for choosing a diabetes outcome measure.

Response: UPMC believes the diabetes measure is difficult for providers due to the socio-economic status of many of our patients and their inability or unwillingness to adhere to the prescribed care. Providers should not be held accountable for diabetic patients who are not being treated for primary care and are only receiving specialty care from other clinics.

Conclusion

We appreciate the opportunity to submit these comments on your proposed changes on the "Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY2008 Payment Rates...Proposed Rule" and hope they are considered before any final rules are published.

If you have any questions regarding our comments please telephone Paul Stimmel at (412) 623-6719.

Sincerely,

Edward Karlovich
Chief Financial Officer
Academic and Community Hospitals

CC: Lewandowski, C.
Stimmel, P.
System CFO's

CMS-1392-P-713 **Medicare**

Submitter : Liz Quintana **09/12/2007**

Organization : West Virginia University
Dietitian/Nutritionist

Category :

Issue Areas/Comments

GENERAL

GENERAL

I appreciate the opportunity to comment on the Cardiac Rehabilitation Services in CMS Proposed Rule regarding revisions to payment policies under 2008 Hospital Outpatient Prospective Payment System.

I am the Registered Dietitian for the Dr. Dean Ornish Program for Reversing Heart Disease at West Virginia University Hospitals in Morgantown, WV. The Ornish Program is a comprehensive lifestyle modification program based on a low-fat, whole foods eating plan, moderate exercise, stress management and group support. Over 30 years of conducting randomized controlled trials and demonstration projects, Dr. Ornish and his colleagues have consistently shown that they can motivate people throughout the U.S. to make and maintain bigger changes in diet and lifestyle, achieve better clinical outcomes and larger cost savings than have ever before been reported. They proved, for the first time, that the progression of even severe coronary heart disease can be reversed in most patients by making comprehensive lifestyle changes. They also have shown that there were 2? times fewer cardiac events such as heart attacks, operations, and hospital admissions for patients participating in the Ornish program. These findings were published in leading peer-reviewed medical journals, including Journal of the American Medical Association, The Lancet, American Journal of Cardiology, The New England Journal of Medicine, Circulation, Journal of Cardiopulmonary Rehabilitation, Journal of the American College of Cardiology, and others.

In addition to randomized controlled trials, Dr. Ornish has conducted three demonstration projects that confirmed these findings in over 2,000 patients throughout the U.S. The results from WVU and our patients are among those in these data sets. Our clinical and cost outcomes parallel those in the clinical trials. In the first demonstration project, Mutual of Omaha found that almost 80% of patients who were eligible for bypass surgery or angioplasty were able to safely avoid it for at least three years, saving almost $30,000 per patient in the first year. In the second demonstration project, Highmark Blue Cross Blue Shield found that their overall health care costs were reduced by 50% in the first year and by an additional 20-30% in subsequent years. We have also found that the Ornish

Program achieved similar improvements in Medicare patients as in these earlier demonstration projects and randomized controlled trials.

In 5 years of experience, we have worked with a large number of patients in WV who are need of cardiac services, and I have seen first-hand the benefits of the Ornish Program. Our patients have successfully used the Ornish Program to help prevent and reverse heart disease and other health concerns significantly improving cardiovascular risk factors through the comprehensive lifestyle change program.

We pleased that CMS recognized the need to clarify coding and payment for these services that can dramatically improve the health and quality of life for Medicare beneficiaries with heart disease. CMS must do more to support the expanded use of cardiac rehabilitation programs □ especially those with published, peer-reviewed research showing that they achieve quantifiable results. Under that revised NCD, Medicare requires cardiac rehabilitation programs to provide a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling. Revised NCD contemplates contractors extending coverage, on a case-by-case basis, to 72 sessions. By explicitly citing the Ornish program, the NCD clarify CMS's intention to provide coverage under Medicare.

We urge CMS to state clearly and explicitly in final rule that multiple sessions of cardiac rehab can be covered on the same day. We also ask CMS to explain that it is reasonable and necessary to cover 72 cardiac rehab sessions when multiple sessions are provided in 1 day.

CMS-1392-P-714 **Medicare**

Submitter : Dr. Susan Gutierrez **09/12/2007**

Organization : Dr. Susan Gutierrez
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1392-P-714-Attach-1.TXT

#714

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.
- Establish new HCPCS II "G-codes" to differentiate between rechargeable and non-rechargeable neurostimulators.
- 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,

Susan Gutierrez, M.D.
5601 Norris Canyon Rd. Suite 340
San Ramon, CA 94583

CMS-1392-P-715 **Medicare**

Submitter : Ms. Linda Rosenberg **09/12/2007**

Organization : National Council for Cmty Behavioral Healthcare
Health Care Provider/Association

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

CMS-1392-P-716 **Medicare**

Submitter : Mrs. Janet Samolyk **09/12/2007**

Organization : Aurora Sinai Medical Center
Health Care Professional or Association

Category :

Issue Areas/Comments

Packaging Drugs and Biologicals

Packaging Drugs and Biologicals

The use of contrast agents adds an additional expense to the Echocardiogram Study-as contrast is expensive. In our facility contrast is used in 30% of the procedures: 2-D and stress echocardiograms. It should not be considered as standard or a part of a routine study. The additional cost and time in administration of the imaging agent, the starting of the intravenous line and obtaining the images should be reimbursable.

CMS-1392-P-717 **Medicare**

Submitter : Elaine Lonneman **09/12/2007**

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 abuses of services. However, as a patient with beging Essential Blepharospasm (amovement 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 debititating dystonic symptons (and they are a god send). These injections are critically important to my ability to function normally.

I respectfully request that CMS not change the payment formula for physician injectable drugs for 2008, and instead maintiain the current payment formula. Any reduction in reimbursement will lead to fewer injectors in an area where we have too few knowledgeable injestors in the first palce. 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 penalities to providers, depending on where the injections are given.

Sincerely,

CMS-1392-P-718 **Medicare**

Submitter : Mrs. Linda Thorpe **09/12/2007**

Organization : East Morgan County Hospital
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

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 chief financial officer at East Morgan County Hospital (EMCH) in Brush, CO.

East Morgan County Hospital was designated as an Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Jan 01, 1997 and the Northeastern Colorado Family Health Center was designated as a Rural Health Clinic. The hospital and clinic was then grand fathered in as a Critical Access Hospital. The clinic did have a name change in from Northeastern Colorado

Family Health Center to Brush Family Medicine in 2002. EMCH/BFM may be considering an additional off-site clinic in Fort Morgan in the future. Morgan County has been designated as an underserved area with the recruitment of additional providers and growth in population this option would benefit the community with additional access to healthcare.

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 Thorpe
CFO

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

CMS-1392-P-719 **Medicare**

Submitter : Mr. Todd Cozzens **09/12/2007**

Organization : Picis, Inc. & LYNX Medical Systems, Inc.
Private Industry

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1392-P-719-Attach-1.PDF

#719

[Submitted electronically]

September 7, 2007

The Honorable Kerry Weems
Acting 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: Proposed Changes to the Hospital Outpatient Prospective Payment System (OPPS) and CY 2008 Payment Rates

Dear Mr. Weems:

Picis and LYNX Medical Systems, Inc., join in submitting comments on the proposed OPPS rule published in the *Federal Register* on August 2, 2007. Picis is a leading global provider of innovative healthcare information systems designed to transform the delivery of patient care information in the high-acuity areas of the hospital, including the emergency department, operating and recovery rooms and intensive care units. Headquartered in Wakefield, Massachusetts, Picis has licensed systems for use in more than 1,300 hospitals in 19 countries.

LYNX Medical Systems provides software tools and services that help hospitals improve emergency department clinical documentation, reduce compliance risk, and ensure accurate and consistent code assignment for appropriate reimbursement. LYNX, a division of Picis, currently serves more than 350 healthcare organizations, representing over 15 million annual encounters.

Our comments focus on hospital coding and payment for emergency department and clinic visits, including the issue of national guidelines for hospital coding of such visits, the proposed packaging of observation services, and other proposed changes affecting hospital observation services.

OPPS: Hospital Coding and Payment for Visits

For CY 2008, the Centers for Medicare & Medicaid Services (CMS) proposes to maintain the current distinctions between Type A and Type B emergency department visits, but invites public comments regarding any additional operational clarifications that could be made to help hospitals determine

whether an emergency department is considered to be Type A or Type B. **Picis and LYNX support a redefinition/clarification of the Type A and Type B designations.** CMS has chosen to define Type B emergency department services to broadly include "fast track" or carved out patients within or adjacent to the emergency department in areas that are open less than 24 hours per day. We believe instead that a common portal to the emergency department (that is, common triage, available 24 hours a day, 7 days a week) should allow all services provided to patients routed through such a common portal to be considered Type A services. In our view, this would be more consistent with the level of resources being expended to address the needs of the patients presenting themselves to a hospital organized in this fashion.

To simplify hospital billing, CMS also proposes to end recognition of the CPT codes for facility outpatient clinic consultations for purposes of OPPS payment, expecting instead that hospitals will bill the appropriate new or established patient visit codes. **Picis and LYNX Medical Systems support this change.** Consultations are a physician service. Facility resources are expended to support a physician consultation service but these resources can be effectively captured and reported using visit service codes. Requiring a separate methodology to define the five levels of outpatient consultations is burdensome to providers and entities providing coding services for primary care and specialty clinics.

The proposed rule also reviews the previous history related to the development of national guidelines for hospital coding of emergency department and clinic visits, including work done by the Hospital Evaluation and Management Coding Panel convened by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA). CMS notes that it has met with a number of groups regarding possible national guidelines. In this regard, LYNX appreciates CMS's acknowledgement, albeit anonymous, that the agency met with us to discuss our problem-based algorithm for coding emergency department and clinic visits. In addition to our discussions with CMS, we have also been in regular communication with other stakeholders, and we have also had the opportunity to enter into dialogue with the AHA-AHIMA Hospital Evaluation and Management Coding Panel about our Algorithm and its benefits. We have also, of course, been working very closely with our hospital customers and providing them with the tools they need to properly code both emergency department and clinic visit services. In this regard, we have found that our basic system works well even for specialty clinics, with only modest changes in the problem list being required to meet their needs.

In the proposed rule, CMS acknowledges that it is currently actively engaged in evaluating and comparing various guideline models and continues to welcome additional public input on "this important and complex area of the

OPPS." CMS specifically invites public comment "as to whether a pressing need for national guidelines continues at this point" and goes on to note that creation of national guidelines for emergency department and clinic visits is proving to be more challenging than originally expected. In sum, CMS is not proposing to implement national visit guidelines for clinic or emergency department visits for CY 2008. Further, since the agency continues to commit to providing a minimum of 6 to 12 months notice to hospitals prior to implementation of any national guidelines, it acknowledges that this means that no such guidelines would be implemented prior to CY 2009.

Picis and LYNX continue to support the development and implementation of national coding guidelines for outpatient services. There is a need for standardization and consistency in the definition and reporting of facility resource utilization. Absent national guidelines there are many different types of guidelines in use by multiple entities. For example, we are seeing an emerging trend for payers to develop their own coding/audit guidelines and apply them to services coded using other methodologies. If this trend continues, hospitals will have to develop payer-specific guidelines to meet each payer's specific compliance expectations. This will pose an administrative burden to hospitals and companies providing coding services to multiple entities. National guidelines could undoubtedly provide a means for addressing this problem. **Having said this, we nevertheless believe that the need for national guidelines is not urgent and that great care needs to be exercised in developing and testing such guidelines.** In fact, we believe quite strongly that any potential guidelines need to be carefully tested prior to being proposed for use. This seems especially important given CMS's finding that the status quo is producing, in the aggregate, a relatively normal distribution of both clinic and emergency department visit levels, a result that understandably remains a very important goal for any national guidelines. We also share CMS's view that hospitals will need a minimum of 6 to 12 months notice prior to implementation of any national guidelines.

In the interim, Picis and LYNX stand ready to work with CMS and other stakeholders to identify, test and refine national guidelines. Not surprisingly, of course, we believe that LYNX's problem-based system could form the basis for such guidelines. As LYNX noted in comments submitted to CMS on October 5, 2006, problem-based guidelines offer several distinct advantages over other available alternatives, including:

- The ability to produce a relatively normal distribution of five service levels;
- A closer link to the hospital resources typically involved in providing a certain level of visit services;
- A reduced risk of gaming or upcoding compared to purely intervention-based guidelines;
- Ease of use by hospital personnel;

- The ability to produce more consistent coding decisions; and
- The promise of a valuable tool for examining care effectiveness and efficiency (that is, how well different hospitals do in addressing the same presenting problem or patient's reason for visit) and for constructing a pay-for-performance system.

Absent national guidelines, CMS expects internal hospital coding guidelines to continue to meet six principles, that is, that they continue to:

- Follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code;
- Be based on hospital facility resources and not on physician resources;
- Be clear to facilitate accurate payments and be usable for compliance purposes and audits;
- Meet the HIPAA requirements;
- Only require documentation that is clinically necessary for patient care; and
- Not facilitate upcoding or gaming.

CMS now also proposes the following five additional principles:

1. The coding guidelines should be written or recorded, well-documented and provide the basis for selection of a specific code.
2. The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
3. The coding guidelines should not change with great frequency.
4. The coding guidelines should be readily available for fiscal intermediary (or, if applicable, Medicare Administrative Contractor) review.
5. The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

CMS invites public comment on the above guideline principles, "specifically whether hospitals' guidelines currently meet these principles, how difficult it would be for hospitals' guidelines to meet these principles if they do not meet them already, and whether hospitals believe that certain standards should be added or removed."

Picis and LYNX believe these five new principles are quite reasonable. Further, we believe that hospitals using our problem-based algorithm for coding emergency department and clinic visits would have no difficulty meeting them. **We would, however, recommend one clarification.** With respect to the 4th and 5th new principles, while it is reasonable that CMS's contractors have access to a hospital's coding guidelines and be able to understand them and/or audit records using them, the best way for clients

using a software-based coding system to meet these principles is with an electronic auditing tool. This approach has worked quite well for LYNX's clients in the past when working with third-party consultants and it meets the intent of these principles. Therefore, LYNX feels that CMS should explicitly acknowledge that a software or web-based audit tool made available by a hospital or coding entity would meet these principles.

OPPS: Packaged Services

CMS proposes to package payment for several categories of services for CY 2008, including all observation care reported under HCPCS code G0378 (Hospital observation services, per hour); payment would be packaged as part of the payment for the separately payable services with which the observation service is billed.

Picis and LYNX strongly oppose the proposed packaging of observation services for chest pain, congestive heart failure and asthma. Packaging makes sense when it relates to a service commonly provided along with the service into which it is packaged. It also can make sense when the service in question is less frequently provided, but is relatively low cost or considered more discretionary in nature. Neither of these scenarios applies in the case of observation services for patients with chest pain, congestive heart failure and asthma. The costs and resource utilization for such patients are obviously much higher than those for patients requiring only a given level of emergency department visit service. Patients requiring observation care for the three conditions in question have a higher acuity and their length of stay with observation is prolonged. Further, hospitals that may specialize in the care of patients with cardiac problems and/or asthma could find themselves severely disadvantaged under the proposed packaging because the costs they incur in providing observation services for patients with these conditions would not be adequately covered if not paid separately. In sum, we urge CMS to maintain separate payment for observation services provided to patients with chest pain, congestive heart failure and asthma.

OPPS: Observation Services

In light of its proposed packaging of all observation services, CMS concludes that there is no need to accept the Ambulatory Payment Classification (APC) Panel's recommendations to add two diagnoses (syncope and dehydration) to the list of diagnoses for which observation care would be separately payable or consider other possible additions. **Picis and LYNX strongly disagree with CMS.** We, therefore, urge the agency to reconsider the APC Panel's recommendations with respect to syncope and dehydration. We also encourage CMS to maintain an open mind about the potential need to add other conditions to the list in the future.

We hope the preceding input is helpful. If you have any questions about our comments or wish to discuss them further, please contact Candace E. Shaeffer, RN, MBA, RHIA, Chief Compliance Officer for LYNX Medical Systems, at 1-800-767-5969 or via e-mail at CandaceS@lynxmed.com.

Sincerely,

Todd C. Cozzens
Chief Executive Officer, President and Vice Chairman

Michael DeTolla
Senior Vice President

CMS-1392-P-720 **Medicare**

Submitter : Mrs. Michelle Spurlock **09/12/2007**

Organization : Our Lady of Peace Psychiatric Hospital

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

Our Lady of Peace is in agreement with the stance taken by the National Association of Psychiatric Health Systems (NAPHS) regarding the proposed changes to Medicare Outpatient PPS. Our Lady of Peace was the first hospital in Kentucky that was Medicare approved to provide partial hospitalization program (PHP) treatment. With 16 years of experience in the provision of this level of care, we are quite aware of the critical need these programs provide. We currently provide a number of specialized PHP options for patients who are either stepping down from inpatient and are at risk of relapse and, most often, as a step to prevent hospitalization. We have programs specialized in treating adults with serious mental illness, for geriatrics as well as for adults with general psychiatric diagnosis and/or with a substance abuse diagnosis. It is the goal of our treatment teams to keep patients out of the hospital by providing them with these alternatives.
The Medicare beneficiaries who are enrolled in these programs have acute psychiatric needs and are still in need of very structured programming provided by highly trained staff. With the plan to further reduce inpatient lengths of stay, the need for this level of care will become more important to reduce readmission and relapse rates. If the rates are reduced to the proposed $178 per diem, this will have a negative impact on the care options available to people in need of treatment and result in higher costs for providers and the Medicare program.

We respectfully ask you to maintain the reimbursement rate at the current $233 per day level.

Sincerely,

JoAnne DeLorenzo Maamry President & CEO Our Lady of Peace
Gerald Moore, M.D.Medical Director
Michelle Spurlock Assistant Vice President