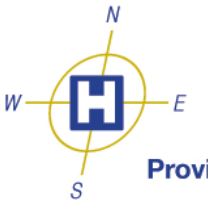


Provider Roundtable

Avera Health (IA, MN, NE, ND, SD)

Ascension Health (AL, AZ, AR, CT, DC, FL, GA, ID, IL, IN, KS, KY, LA, MD, MI, MO, MN, MS, NY, OK, PA, TN, TX, WA, WI)

Baptist Health South Florida (FL)

Carolinas HealthCare System (NC, SC)

Community Hospital Anderson (IN)

Erlanger Medical Center (TN)

Forrest General (MS)

Franciscan Missionaries of Our Lady Health System (LA)

Hartford Hospital (CT)

Holy Name Medical Center (NJ)

Kaiser Permanente, Southern California Permanente Medical Group (CA)

Ohio Valley Health Services and Education Corporation (OH, WV)

Robert Wood Johnson University Hospital (NJ)

University of Pittsburgh Medical Center (PA)

September 6, 2016

Mr. Andy Slavitt, MBA
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: *CMS-1656-P, Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Payment to Certain Off-campus Outpatient Departments of a Provider; Proposed Rule (Vol. 81, No. 135), July 14, 2016*

Dear Mr. Slavitt,

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers who gathered to generate comments on the 2017 Outpatient Prospective Payment System (OPPS) Proposed Rule, as published in the *Federal Register* on July 14, 2016.

The PRT includes representatives from 14 different health systems, with a combined total of more than 300 hospital facilities, serving patients in 35 states. PRT members are employees of hospitals. As such, we have financial interest in fair and proper payment for hospital services under OPPS, but *do not* have any specific financial relationship with vendors.

The members collaborated to provide substantive comments with an operational focus that we hope CMS staff will consider during the annual OPPS policymaking process. We appreciate the opportunity to provide our comments to CMS. A full list of the current PRT members is provided in Attachment A.

Please feel free to contact me at 765-298-2110 or via email at: *trinker@ecommunity.com*.

Sincerely,

Terri Rinker, MT (ASCP), MHA
PRT Chair and
Revenue Cycle Director
Community Hospital Anderson
Anderson, IN

Proposed Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Status That Are Not Packaged

CMS proposes to maintain the payment for separately payable drugs and biologicals without pass-through status at the average sales price (ASP) plus 6 percent (ASP+6%). The PRT appreciates that CMS is maintaining the current payment level, but we continue to believe that this payment level is not sufficient to cover both our acquisition and pharmacy overhead costs.

> **The PRT recommends that CMS increase payment for separately payable drugs and biologicals without pass-through status to adequately cover providers' acquisition *and* pharmacy overhead costs.**

Drug Packaging Threshold

For CY 2017, CMS proposes to increase the drug-packaging threshold to $110. The PRT continues to disagree with CMS' use of a drug-packaging threshold in the hospital setting, since a similar threshold is not used in the physician office setting. We understand the need for packaging, as well as the "efficiency incentives" CMS hopes to create through larger payment bundles. Nonetheless, as CMS reviews and moves toward more payment parity across sites of service, the need to eliminate the drug-packaging threshold is increasingly important.

The PRT submits that CMS will not be able to effectively address Part B drug payment unless — and until — it can acquire consistent information on Part B drugs in all settings. The packaging threshold prevents CMS from obtaining needed information on Part B drugs' use in hospital settings, since many providers do not see the need to go through the operational steps to report HCPCS codes for drugs that do not have any direct reimbursement impact. The PRT believes that this reporting will only be accomplished by requiring HCPCS reporting for each drug, and by separately paying for each drug at the ASP+6% rate, which is the current payment methodology recognized in Part B, non-outpatient hospital settings.

> **The PRT urges CMS to eliminate the drug-packaging threshold in the hospital setting.**

General Rate-Setting Concerns

Strapping and Cast Application – APC 5101 & 5102

CMS proposes to change the status indicator for APCs 5101 and 5102 from S to T based upon the presumption that the procedures assigned to these APCs are primarily associated with surgical treatments. The PRT disagrees with this assessment and the proposed change.

Correct coding guidelines prevent the reporting of a casting or strapping procedure when performed as part of a surgical procedure. There are, however, certain scenarios when the patient

presents to the Emergency Department (ED) and a cast/strapping application is performed in order to stabilize a fracture or dislocation until the patient can see an orthopedist. Most patients are then discharged from the ED with an appointment to see an orthopedist for further treatment of the fracture/dislocation. In this common scenario, the casting/strapping procedure is performed without a corresponding surgical procedure.

In cases where the fracture is of a severity that cannot be reduced in the ED and requires more immediate orthopedic attention, the fracture could still be casted/strapped in the ED and the patient would go to surgery later in the day. The ED still applies the cast/strap in order to stabilize the fracture, but the reapplication of the cast/strap post-surgery would not be reported separately. Independent resources are expended in order to provide quality care to the beneficiary in both the ED and the subsequent surgical procedure, but the two are not directly related.

Another scenario is the patient who arrives in the ED after a motor vehicle accident with a fracture/dislocation and a head or chest injury. The fracture/dislocation is addressed in the ED with a strapping/cast application. The physician also determines that the patient requires observation services for active monitoring of the head/chest injury. The observation service is unrelated to the casting/strapping procedure, but is provided to monitor the patient due to other injuries. If casting/strapping procedures are assigned status indicator of T, the observation C-APC will not be triggered even though the observation services are related to the head/chest injury, not the casting/strapping procedure. While the PRT understands the prospective payment system methodology, we do not believe that the packaging methodology is appropriate in this scenario.

We also note that many hospitals have established wound care centers to treat patients with chronic non-healing wounds. Care of these wounds does not always involve an associated surgical treatment. Patients who present for treatment at a wound clinic may have multiple wounds located at different body sites. For such wounds located at different body sites, separate and distinct treatment is required (e.g., a cast on the left leg and a compression wrap on the right arm). In one encounter, multiple services may be provided to distinct sites, with distinct treatment requirements and cumulative resource utilization. For example, in this scenario the total contact cast on the left leg is unrelated to the debridement performed for the wound on the right thigh. Changing the SI for these APCs will result in reimbursement discounting when provision of care does not result in lower treatment costs or lower resource expenditures for the second service.

The PRT recommends that CMS maintains status indicator S for these APCs.

Assignment of OPPS Status Indicators

New Codes Missing OPPS Status Indicators and APC Assignments

The PRT applauds CMS for adding the temporary HCPCs codes listed in the table below for CY 2017 for use until the American Medical Association (AMA) can establish permanent CPT codes. We agree with CMS on the importance of these services.

gddd1	Resource-intensive mobility-assist technology (add-on)
gmmm1	Moderate sedation services with GI procedure, initial 15 minutes
gppp1	Initial psychiatric collaborative care
gppp2	Subsequent psychiatric collaborative care
gppp3	Add'l monthly managed psychiatric collaborative care
gppp6	Cognitive and functional assessment
gppp7	Comprehensive assessment & care planning for CCM
gpppx	Care management for behavioral health conditions by clinical staff

The PRT respectfully requests CMS to review each of these new HCPCs codes with regard to OPPS payment policy. The PRT notes that these codes *do not* have a status indicator defined or APC payment rate assigned in the proposed OPPS Addendum B. When clinicians practice in hospital outpatient departments and order, perform, and/or supervise the services defined by these new CPT/HCPCS codes, the hospital bears the facility expense. Therefore, these codes should have OPPS status indicators and proposed APC assignments. For example, GDDD1 (for mobility-assistive devices) is not listed in the OPPS Addendum B published with the Proposed Rule. While the PRT understands that this code is identified as an "add-on" code and therefore should be assigned OPPS SI of N, we would not expect all of these codes to have a SI of N. Even if that were to be the case, status indicators should be assigned in order to validate hospitals billing the code separately, and to enable hospital providers to model payment expectations based on OPPS methodology.

The PRT respectfully requests CMS to review each of these new HCPCs codes and assign an OPPS status indicator and APC assignment as appropriate under the OPPS methodology.

Additional Explanation of Changes Needed

During our review of the CY 2017 Proposed Rule, the PRT noticed that the status indicators for two CT codes have changed from "Q1" for conditionally packaged to "N" for unconditionally packaged. These codes are 76380 (*CT, Limited and/or follow-up study*) and 76497 (*unlisted CT procedure*) As a result of this change, if either of these CT studies is the only service performed during an encounter, providers will not be paid for their services. We note that these codes are not "add on" codes.

The Proposed Rule does not include a preamble discussion regarding the reason for these changes. It is imperative for CMS to explain, in detail, the agency's rationale for changing a status indicator, particularly when it is changed from payable or conditionally packaged to unconditionally packaged. Without understanding the rationale behind such changes, providers cannot make meaningful comments to CMS.

In the cost file, the PRT noted that CPT 76380 was billed 2,338 times as a single claim. While this may be a small number when compared to other codes, we question if CMS really believes that providers do not deliver this service independently. Because these services represent

"follow-up," "limited," and "unlisted" services, the volume would be expected to be small compared to the universe of imaging claims.

It is unclear to the PRT why CMS is proposing to change a conditionally packaged service that is clearly being provided as the only service (as demonstrated by the 2,338 claims) into an unconditionally packaged service that will not be paid.

These same questions apply to CPT 76497. Does this proposed change stem from there being very few instances where the procedures are the only service provided, such that CMS does not believe the service matters — even when it is provided for the care of a beneficiary? Does CMS believe that the data and reimbursement are not important for the services represented by this code?

The PRT respectfully requests CMS *not* change the status indicator for these services (or any other similar codes) until the agency has provided more information about the rationale for the changes to the provider community. In addition, the PRT requests that, in the future, CMS clearly explain the rationale for these types of changes in the Proposed Rule, particularly when a service is changed to become unconditionally packaged.

The PRT requests that CMS not change the status indicator for these CPT codes. We also request that CMS provide more complete information in future proposed rules about the reason for such changes.

Proposed OPPS Payment for Devices

Device-Intensive Procedure Edits

The PRT recognizes and supports CMS' proposal to amend regulations at §419.44(b)(2) to reflect the fact that CMS will designate procedures, rather than APCs, as device-intensive. We applaud CMS for proposing to modify the methodology for assigning device-intensive status to just those procedures that require device implantation *and* have at least one individual HCPCS Level II Category C code with the cost of the device representing greater than 40 percent of the procedure cost, regardless of the APC assignment.

CMS originally implemented device-to-procedure and procedure-to-device edits in response to hospitals' concerns that devices and other products were not consistently reported (including devices associated with device-related procedure APCs and radiolabeled products associated with nuclear medicine procedures). We understood and supported CMS' concern that, if hospitals failed to report devices or radiolabeled products, the agency would lack the necessary cost data for these items to package into the appropriate procedure APC. The PRT appreciated and supported CMS' introduction of these edits, which enabled the agency to obtain complete claims and cost information for use in future rate-setting.

In the CY2014 Proposed Rule, CMS indicated that these edits were burdensome to hospitals and no longer needed, due to hospitals' current experience in coding and reporting these services

fully. Commenters have expressed concerns about the change to allow the inclusion of "any device" on the claim to resolve the edit. In fact, the PRT hospitals and others have consistently and repeatedly asked CMS to reinstate the specific edits — despite any perceived burden — because of our understanding of the importance of accurate claims data in the OPPS rate-setting process. While we agree that providers are responsible for correct coding, we again ask CMS to restore the previous specific device-to-procedure and procedure-to-device edits to ensure costs are appropriately captured for future rate-setting.

The PRT notes that many implanted devices are truly "systems" that contain multiple components. If CMS does *not* require all device components on a claim, and a provider inadvertently omits the code from the claim, complete cost data will not be collected and will not be included for future claims analysis, accurate rate-setting, and the appropriate application of the offset for the specific device.

CPT 33225 provides an example to illustrate this concern. CPT 33225 (*Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator*) is not listed in Addendum P as a device-dependent procedure; however, this procedure was subject to device-to-procedure code edits in 2014 prior to the edit modification. CPT 33225 is a packaged CPT code that requires a specific, additional pacing lead. The previous procedure-to-device edits required hospitals to report this procedure with device code C1900 (*Lead, left ventricular coronary venous system*) in addition to the main procedure. Since the edit modification, once the code for the generator or a code for a lead is reported, there is no mechanism to insure that all four of the device codes are correctly reported.

Yet, CMS continues to maintain the claims processing edits such that *any* device code satisfies the edit, whether it is based on device-intensive APCs or for the proposed device-intensive procedures. The 2016 OPPS Final Rule indicated, however, that *"only the procedures that require the implantation of a device that are assigned to a device-intensive APC will require a device code on the claim"* and that the *"claims processing edits are such that any device code, when reported on a claim with a procedure assigned to APC listed in Table 42 will satisfy the edit.*" [Emphasis added.] This language implies that device coding requirements were intended *exclusively* for procedures that had implanted devices assigned to a device-intensive APC. Therefore, this policy appears to eliminate certain claims from being identified via the device-edit policy (i.e., those containing procedures within an APC that had significant device costs but were not assigned to device-intensive APCs).

The PRT believes that the removal of procedure-to-device and device-to-procedure edits allowed code mismatches in the 2015 data and continues to allow such mismatches in the 2016 claims data. Ultimately, the mismatches result in both incorrect cost data and incorrect APC reimbursement rates. The complete device-to-procedure and procedure-to-device edits not only enabled providers to ensure that costs were reported accurately and billed correctly, but also assured CMS that its rate setting methodology was accurate and reasonable. The edits help providers in an environment of increased payment packaging by fostering more accurate data collection for future rate setting.

Finally, CMS acknowledges that a device offset at the HCPCS procedure code-level would typically better represent a procedure's device cost, compared to an APC-wide *average* device offset based on the average device cost across *all* procedures within an APC. While we agree, we are concerned that CMS does not recognize that some device-intensive procedures include *more than one* Level II Category C device code. Therefore, while the offset at the HCPCS code-level is a significant improvement, it will still result in offsets that are too large when only one device utilized in the procedure has pass through status.

The PRT requests that CMS reestablish specific device-to-procedure and procedure-to-device edits to ensure the accuracy of data reported by hospitals and captured by CMS.

The PRT appreciates that Addendum P provides a list of devices and their offset amount for the device-intensive procedures. However, in reviewing the addenda that accompany the proposed rule, the PRT noted a discrepancy in the offset amounts between Addendum P and Addendum J. As noted above, the PRT agrees that a HCPCS code-level device offset better represents a procedure's device cost than an APC-wide average device offset. This appears to be the intent of CMS' proposal, but the actual calculations in the Addenda are not clear. The PRT requests clarification of this discrepancy.

The PRT requests CMS to clarify the discrepancy between Addendum P and Addendum J.

Proposed Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices

For CY2017, CMS proposes to continue to adjust the OPPS payment for device-intensive procedures by the credit a provider receives for a replaced device. Under the proposed policy, hospitals would continue to be required to report the credit in the "amount" portion for value code ''FD'' when the hospital receives a credit for a replaced device with a cost 50 percent or more than the cost of the device.

The PRT asks CMS to reinstate the procedure code list that is subject to the no cost/full credit and partial credit devices in light of the change from device-intensive APCs to device-intensive procedures. This CMS-approved listing will assist hospitals to more easily operationalize existing processes to meet CMS requirements.

The PRT recommends that CMS reinstate the procedure code list that is subject to the no cost/full credit and partial credit devices.

Process to Report a Device-Intensive Procedure when Performed with a Device without a Level II Category C Code for the Device

PRT members note that there are certain device-intensive procedures that lack a Level II Category C-code for the device used. For example, CPT code 37241 (*Vascular embolization of an occluded vein*) groups to APC 5192, which is a device-intensive APC, according to Table 52

in the 2016 Final Rule. While the I/OCE requires this procedure to be accompanied by a device Category C code, this procedure can be performed using a needle to inject/infuse the embolization agent, rather than a catheter. The "best" C-code option for this procedure is C1757 defined as Catheter, thrombectomy/embolectomy.

CMS has not provided instructions on how providers can submit a claim in order to report (and/or appeal) that the service was performed with a device other than one with a current Level II HCPCS Category C-code. Some providers may improvise and report an applicable C-code with a token charge, knowing that CMS will not use these claims in rate-setting. The PRT believes, however, it is important for CMS and its contractors to know when advancements in medicine allow a procedure to be effectively performed with a different device or with a lower-cost device than the device the agency expects to be used. This information can help determine whether the procedure should be dropped from the device-intensive list if the device's cost falls below the 40 percent threshold. For example, if the physician determines that a needle can be effectively used rather than a catheter, it is important for CMS to obtain this information.

The PRT recommends that CMS create one generic category C-code that providers can use to report situations when the device used for a procedure does not have a Level II HCPCS Category C-code. In such situations, providers would put a remark in Form Locator 80 to indicate the actual type of device used. Providers would use the appropriate revenue code and their individual charge structure, along with the code, to report the device. This one generic code would satisfy the procedure-to-device edits, as well as enable CMS to monitor procedures and support the rate-setting process.

> **The PRT requests that CMS create one generic category C-code for providers to report when a device used does not have a specific Level II HCPCS Category C-code.**

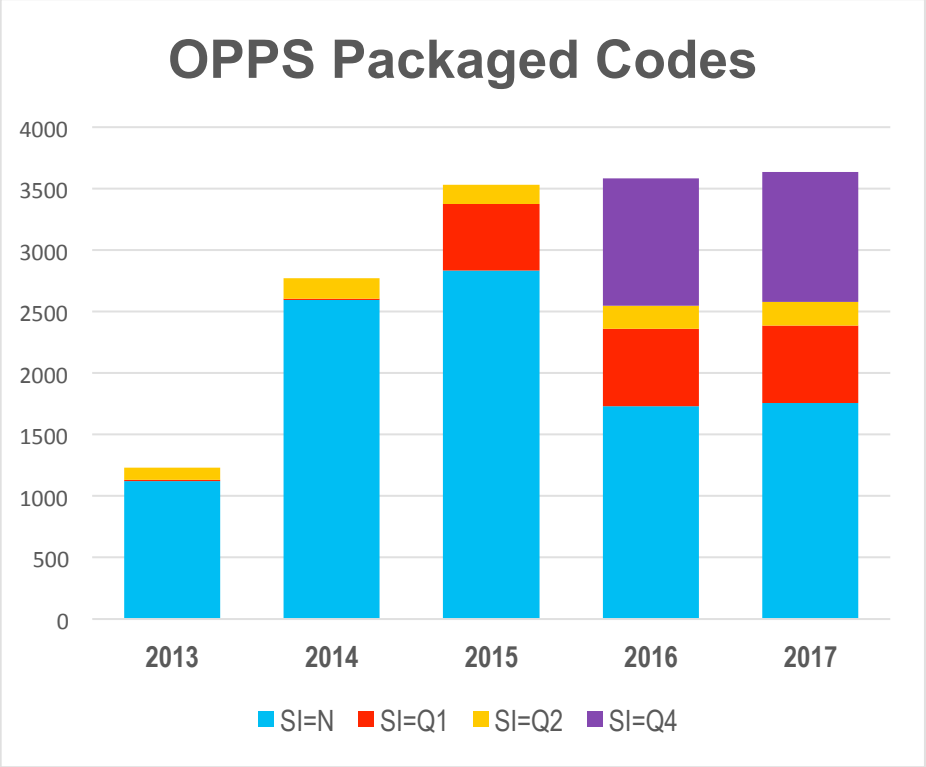
Packaging Policies

Proposed Changes to Packaged Items and Services

In recent years, CMS implemented a number of packaging proposals including the packaging of most clinical laboratory services in 2014; the discontinuation of status indicator (SI) X, and a corresponding increase in the number of conditionally packaged codes in 2015; as well as the implementation of comprehensive APCs (discussed elsewhere in these comments). CMS continues to articulate that these changes are intended to transform the OPPS into a system that is more prospective and less like a fee schedule.

While the PRT generally understands and supports this transition, we continue to be concerned about the rapidity with which these packaging initiatives have been implemented and, in particular, the potential long-term consequences of the indiscriminate packaging of ancillary services. This "bottom-up" packaging schema is based solely upon the status indicator of the particular services billed on the claim, irrespective of whether or not the services collectively represent a related service. The graph below illustrates the drastic increase in the number of

packaged ancillary services represented by SIs N, Q1, Q2, and Q4.



Proposed Clinical Diagnostic Laboratory Test Packaging Policy

In the CY2017 OPPS Proposed Rule, CMS proposes to delete modifier L1, which providers use to identify laboratory services that are unrelated to other services billed on the same claim. Unrelated laboratory tests are billed on the same claim as other hospital outpatient services, but are ordered for a different diagnosis and by a different practitioner. In its proposal, CMS reasons that unrelated laboratory tests are not significantly different from most other packaged laboratory tests provided in the hospital outpatient department (HOPD). CMS also states that multiple hospitals have informed the agency that the L1 modifier is not useful because hospitals cannot determine, at the time of billing, when a laboratory test has been ordered by a different physician and for a different diagnosis.

The PRT notes, however, that CMS offers no data to support its belief that unrelated laboratory tests are not significantly different from most other packaged laboratory tests. While the PRT understands and generally supports the concept of packaging *related* services, we do not agree that it is reasonable to package *unrelated* services, as CMS now proposes. We also note that CMS has recognized and reimbursed unrelated labs since the inception of its lab packaging policies.

The L1 modifier was first implemented in July 2014 in order to identify separately payable laboratory services either because either there were only laboratory services on the claim or

because the laboratory services were unrelated to other OPPS services on the same claim. In 2016, CMS changed the SI of conditionally packaged laboratory services from SI=N to SI=Q4. This change remanded the L1 modifier to a single function, which is to identify unrelated laboratory services when billed on a claim with another OPPS service. Given the changes associated with the use of the L1 modifier since July of 2014, and the changes in the implementation of the laboratory packaging policies in general, many providers have found it difficult to implement the use of the L1 modifier in this relatively short period of time.

The PRT asks CMS to reconsider its proposal to delete the L1 modifier and, instead, to continue to monitor its use. Our reasons for this request are as follows:

1. Given the large number of OPPS packaging policies, providers need a mechanism to identify separately payable (i.e., unrelated) laboratory services when billed with other OPPS services. This is particularly important given the long-standing billing constraint that hospital providers may only bill a single UB on a given date of service.

2. Hospitals have had little time to become competent in the use of the L1 modifier. When the L1 modifier was introduced in July of 2014, its primary purpose was to give providers a mechanism to identify lab-only claims, which were initially billed on a 141 type claim. Given the introduction of SI=Q4 in 2016, providers have had little time to update their systems for the new singular use of the L1 modifier, which is to identify *unrelated* laboratory services. While some providers may report difficulty in appending modifier L1, this fact does not mean the agency should eliminate the separate payment of unrelated laboratory services for *all* providers.

3. Providers have worked diligently over the past few years to update their electronic medical record systems (EMR) to accommodate many regulatory requirements, including Meaningful Use. The PRT believes that many hospital EMR systems can be programed to appropriately append the L1 modifier to unrelated laboratory services, given the time to assess and adjust their logic. CMS should allow providers adequate time to automate the use of the L1 modifier.

   The PRT strongly opposes the elimination of the L1 modifier for reporting unrelated laboratory services. We encourage CMS to maintain L1 and continue monitoring its use.

<u>Exception for Non-packaging of Advanced Diagnostic Lab Tests (ADLTs)</u>

The PRT appreciates CMS' recognition that new, yet-to-be-approved advanced diagnostic laboratory tests (ADLTs) will have a different usage pattern than more conventional clinical laboratory tests, and therefore should not be packaged. We encourage CMS to continue to identify similar laboratory tests that should not be included in its conditional packaging of clinical laboratory tests.

The PRT supports CMS in its identification of ADLTs that should not be packaged.

In addition, the PRT continues to harbor concerns about the current and future consequences of the indiscriminate packaging of laboratory tests in 2014 and 2015, during which time laboratory tests were inappropriately assigned SI=N. As CMS is aware, the use of SI=N to implement what is essentially a conditional packaging payment policy resulted in the packaging of laboratory tests into non-OPPS services (e.g., preventive services, medical nutrition therapy, or other preventive services paid under the MPFS or CLFS to hospitals when billed on a UB).

We believe that this packaging was not CMS' intent but was, rather, an unforeseen and unfortunate consequence of the assignment of SI=N. Given that 2017 APC payment rates are based upon 2015 claims data, it is *imperative* that the costs associated with what we believe are inappropriately packaged laboratory tests are included in calculating 2017 APC rates. We are still unclear, as we review the OPPS rate-setting document, how the costs of these packaged laboratory tests are included in APC rate-setting.

> **We request that CMS explain how the costs of these packaged laboratory services were used in the rate-setting for 2016 and 2017.**

Conditional Packaging Status Indicators "Q1" and "Q2"

CMS proposes to change the conditional packaging logic for status indicators Q1 and Q2 in 2017 so packaging occurs at the claim level rather than on the date of service. While the PRT understands CMS' rationale for this change, we have the following concerns about this proposal.

The PRT notes that certain repetitive services may erroneously become entangled in this policy change. As specified in CMS' guidance, repetitive services are services that are repeated over a span of time and billed by institutional providers on a monthly claim. Certain repetitive services are assigned SI=Q1, most notably pulmonary rehabilitation services.

Medicare benefit categories for cardiac and pulmonary rehabilitation programs were codified in the Medicare Improvements for Patients and Providers Act of 2008. Section 144 of the statute provides for payment and coverage of pulmonary and cardiac rehabilitation services under a Cardiac Rehabilitation Program, an Intensive Cardiac Rehabilitation Program, and a Pulmonary Rehabilitation Program. Since payment for these services was instituted under a statutory provision, we believe that the assignment of SI=Q1 to G0424 (*Pulmonary rehabilitation with exercise)* is an oversight. We request that CMS reassign the status indicator for G0424 to SI=S prior to considering any change in the packaging policy for status indicators Q1 and Q2. The PRT notes that cardiac rehabilitation services are assigned SI=S, so our request is consistent with how the OPPS treats the other statutory benefit.

> **The PRT asks CMS to carefully consider the potential unintended consequences of claim level packaging of Q1 and Q2 repetitive services. In particular, the PRT requests CMS change the status indicator for pulmonary rehabilitation services to SI=S.**

In addition, the PRT continues to have concerns regarding the unselective, bottom-up packaging of ancillary services. This type of packaging becomes particularly problematic when multiple Q1 and Q2 services are performed and billed on a claim without a separately payable APC service (e.g., S, T, or V service). This occurs commonly with certain services provided in the HOPD, such as respiratory services, cardiology services, X-ray services, allergy testing services, and referred pathology services. Because OCE packaging logic limits payment to the single highest-paying Q1 or Q2 code regardless of the number of services provided, this packaging schema results in inadequate payment — and will result in future rate-setting anomalies.

We remain cognizant of CMS' goal to transform the OPPS into a more prospective payment system. To address this issue, however, the PRT submits that there are certain groups of Q1 and Q2 services that are commonly performed together without a separately payable APC service, which would benefit from the creation of composite APCs.

CMS notes that it developed composite APCs to provide a single payment for groups of services typically performed together during a single clinical encounter and that result in the provision of a complete service. CMS further notes that *"combining payment in this way enables hospitals to manage their resources with maximum flexibility by monitoring and adjusting the volume and efficiency of services themselves"* and that an *"advantage to the composite APC model is CMS can use data from correctly coded multiple procedure claims to calculate payment rates for the specified combinations of services."*

We believe, given the exponential increase in conditionally packaged codes, provisions must be made to promote appropriate payment and future rate-setting of these services when they are performed and billed without a separately payable APC service.

> **The PRT recommends that CMS examine the creation of ancillary composite APCs, which have the potential to address the issues of concern while remaining true to the packaging concepts that CMS values.**

Referred Pathology Services

Pathology services are a segment of clinical laboratory services that, like all clinical laboratory services, must meet Clinical Laboratory Improvement Act (CLIA) requirements; are billed using laboratory revenue codes (03XX); are reported on the Medicare cost report according to CMS' cost reporting principles as clinical laboratory expenses; and are reported using CPT codes found in the laboratory section of the CPT coding manual. Chapter 16 of the *Medicare Claims Processing Manual* indicates that a diagnostic laboratory test is considered a laboratory service for billing purposes when it is performed by a hospital laboratory for its outpatients and its non-patients.

The *Medicare Benefit Policy Manual* defines a nonhospital patient as an individual who is neither an inpatient nor an outpatient of a hospital. The *Manual* further states that, when the hospital laboratory performs tests for nonhospital patients, the laboratory is functioning as an independent laboratory, and still bills the A/B MAC (A). Non-patient services are billed on a

14X type claim. Section 30.3 of Chapter 16 of the *Medicare Claims Processing Manual* states "Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule (CLFS) will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS."

The following examples are provided to illustrate the inadequate reimbursement that occurs when pathology services are provided and billed on a claim without a primary service, identified as services assigned status indicators J1, J2, S, T, or V.

Example 1: Colon Biopsies

A 71-year-old male with lower abdominal pain and a family history of colon cancer has an endoscopy procedure in a local ambulatory surgical center. Biopsies are collected from five distinct anatomical locations and sent to the hospital for analysis. Note that, because of OCE packaging logic, payment is limited to a single line item even though each specimen required a separate and distinct pathological analysis.

Description	CPT	Status Indicator	APC	Individual Payment Rate	Actual Payment
Duodenal Biopsy	88305	Q1	5671	$39.39	$39.39
Antral Biopsy	88305	Q1	5671	$39.39	$0.00
Fundus Biopsy	88305	Q1	5671	$39.39	$0.00
Distal Esophagus Biopsy	88305	Q1	5671	$39.39	$0.00
Illeum Biopsy	88305	Q1	5671	$39.39	$0.00
Alcian Blue Special Stain	88313	Q1	5732	$25.20	$0.00
Total				**$222.15**	**$39.39**

Example 2: Skin Biopsies

A 68-year-old male presents to an independent physician office for assessment of skin lesions that have increased in size. The physician collects shave biopsies from four suspicious lesions and sends them to a local hospital laboratory for analysis. Malignancy is suspected in two of the lesions and immunostains are performed. Like the previous example, payment is inadequate given the resource use, since the I/OCE limits payment to a single line item.

Description	CPT	Status Indicator	APC	Individual Payment	Actual Payment

				Rates	
Mid upper back shave biopsy	88305	Q1	5671	$39.39	$0.00
Mid lower back shave biopsy	88305	Q1	5671	$39.39	$0.00
Left lower back shave biopsy	88305	Q1	5671	$39.39	$0.00
Immunostain HMB-45	88342	Q2	5673	$173.20	$173.20
Immunostain Melan A	88341	N		$0.00	$0.00
Immunostain Cytokeratin	88341	N		$0.00	$0.00
Right upper shoulder shave biopsy	88305	Q1	5671	$39.39	$0.00
Immunostain HMB-45	88342	Q2	5673	$173.20	$0.00
Immunostain Melan A	88341	N		$0.00	$0.00
Immunostain Cytokeratin	88341	N		$0.00	$0.00
Total				**$503.96**	**$173.20**

Example 3: Cervical Biopsies

A 66-year-old female visits a gynecologist complaining of post-menopausal vaginal bleeding. The physician examines the patient and collects cervical specimens and sends them to the hospital laboratory for analysis. This common scenario, which requires separate and distinct pathological analysis, is inadequately reimbursed due to the conditional packaging schema.

Description	CPT	Status Indicator	APC	Individual Payment Rates	Actual Payment
Cervical biopsy: 12:00 position	88305	Q1	5671	$39.39	$0.00
Cervical biopsy: 03:00 position	88305	Q1	5671	$39.39	$0.00
Cervical biopsy: 06:00 position	88305	Q1	5671	$39.39	$0.00
Cervical biopsy: 09:00 position	88305	Q1	5671	$39.39	$0.00
p16 Immunostain	88342	Q2	5673	$173.20	$173.20
Total				**$330.76**	**$173.20**

Example 4: Breast Biopsies

A gynecologist refers a 67-year-old female with a breast mass to a free-standing imaging facility for mammography and stereotactic biopsy. Calcified and non-calcified specimens are obtained and sent to the local hospital laboratory for analysis. The pathology workup demonstrates malignancy, and immunostains are performed to determine diagnosis and inform treatment. As in previous examples, payment is limited to a single line item resulting in inadequate payment today and rate-setting anomalies in the future.

Description	CPT	Status Indicator	APC	Individual Payment Rate	Actual Payment
Left Breast Calcifications at 1:00	88305	Q1	5671	$39.39	$0.00
Left Breast No Calcifications at 1:00	88305	Q1	5671	$39.39	$0.00
ER Immunohistochemistry	88342	Q2	5673	$173.20	$0.00
PR Immunohistochemistry	88341	N		$0.00	$0.00
HER-2/NEU Immunohistochemistry	88341	N		$0.00	$0.00
Ki–67 Morphometric Analysis	88360	Q2	5673	$173.20	$173.20
Total				**$425.18**	**$173.20**

Suggested Composite APC for Pathology Services

In order to remedy these payment insufficiencies and future rate setting anomalies resulting from the packaging of the costs of a number of conditionally packaged services into a single conditionally packaged code, the PRT requests CMS implement composite APCs for pathology services when such services are billed on a claim without a separately payable APC service, such as illustrated in the previous examples. Such a composite APC schema can be structured as illustrated in the following table.

Suggested Composite APCs for Pathology Services	Suggested Composite APC Description
80XX	2 – 4 pathology specimens (88302 – 88309) with or without special stains (88312, 88313, 88314)

80XX	5 or more pathology specimens (88302-88309) with or without special stains (88312, 88313, 88314)
80XX	2 – 4 pathology specimens (88302 – 88309) with immunostains (88341, 88342, 88344, 88346, 88350, 88360, 88361)
80XX	5 or more pathology specimens (88302 – 88309) with immunostains (88341, 88342, 88344, 88346, 88350, 88360, 88361)

Additional Suggested Composites

In addition to the creation of pathology composites, the PRT believes that there are a number of other conditionally packaged services that are frequently performed in the HOPD, which should be evaluated for the creation of composite APCs. In analyzing 2015 claims data, we identified a number of conditionally packaged services that are commonly billed on a claim without a separately payable APC service in multiples of two or more.

As a result of this finding, the PRT recommends the creation of the following additional "ancillary" composites.

X-Ray Composite

The PRT requests that when two or more SI=Q1 X-ray services are billed on a claim without a separately payable APC service, a composite APC be triggered. Much like the existing imaging composites, there would be a composite for "with contrast" and a composite for "without contrast." We have attached a spreadsheet of the codes identified from the 2017 proposed Addendum B that we believe would be eligible for this new composite. (See Attachment B.)

Suggested Composite APCs for Q1 X-ray Services	Suggested Composite APC Description
80XX	2 or more Q1 x-ray services, no contrast
80XX	2 or more Q1 x-ray services, one or more includes contrast

Respiratory Services

We request that when two or more SI=Q1 respiratory services are billed on a claim without a separately payable APC service, a composite APC be triggered. We have attached a spreadsheet of the codes identified from the 2017 proposed Addendum B that we believe would be eligible for this new respiratory composite. (See Attachment B.)

Cardiology Services

We request that when two or more SI=Q1 cardiology services are billed on a claim without a

separately payable APC service, a composite APC be triggered. We have attached a spreadsheet of the codes identified from the 2017 proposed Addendum B that we believe would be eligible for this new cardiology composite. (See Attachment B.)

Allergy Testing Services

We request that when two or more SI=Q1 allergy testing services are billed on a claim without a separately payable APC service, a composite APC be triggered. We have attached a spreadsheet of the codes identified from the 2017 proposed Addendum B that we believe would be eligible for this new allergy testing composite. (See Attachment B.)

Suggested Additional Composite APCs	Suggested Composite APC Description
80XX	2 or more Q1 respiratory services (94010 - 94799)
80XX	2 or more Q1 cardiology services (93005 - 93292)
80XX	2 or more Q1 allergy testing services (95004 - 95199)

As with existing composites, when the criteria for a specific composite is triggered, payment would be made using the composite payment rate rather than the payment rate for the individual service(s). As with current policy, if multiple composites are triggered on the same claim, payment would be made for each composite independently; that is, the composites would "stand alone" and be paid separately, irrespective of whether there is another separately payable composite on the same claim. The PRT recognizes and understands that the ancillary composites would not be applicable if there are separately payable services on the same claim (i.e., SI=S, T, or V) or if a comprehensive APC is triggered (SI=J1 or J2).

Instructions and Guidance Regarding Reporting Modifiers

The Provider Roundtable is concerned with the expanding number of modifiers being proposed and required by CMS in order to appropriately and successfully process a claim. Our concern is primarily two-fold:

1. The acceptance and appropriate processing of the number of modifiers required in various instructions from CMS.
2. The rate-setting process utilized by CMS being affected by not only the number of modifiers but also the order in which the modifiers are reported.

CMS has long acknowledged that the National Uniform Billing Committee (NUBC) is the governing body that has oversight of the elements, reporting, and changes to the UB-04 claim format. Given this fact, the PRT is very concerned by:

- the apparent discrepancies in information concerning the number of modifiers that can be submitted on an individual claim line;

- the number of modifiers accepted by CMS' claims processing systems;
- the number of modifiers that are stored for use in the rate-setting process;
- the use of incomplete data for claims processing and rate-setting if all modifiers submitted are not retained by CMS' processing systems; and
- the order in which modifiers should be reported to ensure the most important modifiers are reported first, if hospital claims are limited to a specific number.

Our research has found significant variations in guidance and instructions between what is required by CMS and what is documented by the National Uniform Billing Committee (NUBC) and the Uniform Billing Editor regarding the reporting of modifiers. These variations include:

1. *The Official UB-04 Data Specification Manual 2017* as published by the National Uniform Billing Committee states that the UB-04 field for the HCPCS code and modifiers allows up to 14 positions. Field attributes per the manual state, *"For HCPCS, the field consists of 5 positions for the base code plus 8 positions for up to four HCPCS modifiers; thus, the field contains one extra/unused position."*

2. *The Official UB-04 Data Specification Manual 2017* additionally states under the heading of 'HCPCS Modifiers (Level I and Level II)', *"The UB-04* ***accommodates up to four modifiers, two characters each."*** [Emphasis added.]

3. *The Medicare Claims Processing Manual* (Pub. 100-04) chapter 23, section 20.3, "Use and Acceptance of HCPCS Codes and Modifiers" states:

"Carriers/MACs and DME MACs are required to ***accept at least 2-position numeric or alpha modifiers*** *and* ***process both modifiers*** *completely through the claims processing system (including any manual portion) as far as payment history. Intermediaries* ***must be able to accept at least five modifiers*** *and process them completely through the system. It is not acceptable merely to be able to accept multiple modifiers and then drop one before complete systems processing. Dropping of a modifier leads to incomplete and inaccurate pricing profiles.*" [Emphasis added.]

An additional reference is the *Uniform Billing Editor*; although not published by the NUBC or CMS, this is considered to be one of the premier guides for understanding billing concepts related to the UB-04. *The Uniform Billing Editor* contains instructions in Appendix 5 (Modifiers Used for Facility Reporting) that supports the discrepancy regarding the number of modifiers.

- *"The UB-04* ***accommodates up to four modifiers per line*** *and electronic versions 5.0 and 6.0 flat files.* ***If more than two modifiers need to be reported*** *next to a CPT code, repeat the CPT procedure code with the additional modifier appended."* [Emphasis added.]

The PRT understands that the 837I electronic claim form is the mechanism that allows providers to submit and CMS to receive up to four modifiers per line item. The conflicting statements noted above between CMS and NUBC documentation cause concerns regarding the actual number of modifiers that can be successfully reported by providers and successfully received by CMS.

CMS must recognize that the difference in the number of modifiers that is allowed by CMS for claims processing conflicts with the official claim file published by the NUBC. It is essential to recognize this difference and generate refined processes and/or instructions to ensure providers can report as many modifiers as necessary, in a manner compliant with CMS' processing systems, so that all data are retained and available for use in reimbursement and rate-setting activities.

The PRT requests that CMS provide clarification regarding how modifiers are validated for rate-setting purposes and whether a priority for reporting exists. CMS is continuing to expand the number of required modifiers, yet CMS' standard analytic file only displays *two* modifiers. The PRT seeks clarification from CMS about what happens to the additional modifiers that are required to correctly report the service. If these modifiers are not included in the standard analytic file, how does CMS utilize the information for OPPS analysis and for rate-setting?

These are very concerning questions, and the PRT believes that CMS is obligated to share this information with the provider community. If CMS uses only the first two modifiers for rate-setting, it appears that the data being utilized is incomplete and undermines the rate-setting process for future OPPS payments. If CMS does use only the first two modifiers, the agency should designate an "order of reporting." This is necessary for CMS to ensure that, when it utilizes a year's worth of claims data for rate-setting, the data that are most integral to the analysis and rate-setting processes are available.

Therefore, the PRT strongly recommends that ALL modifiers reported and accepted on a claim be part of CMS' analysis and rate-setting processes. If all positions are equally important, and all positions are retained by CMS' systems, then the positioning of modifiers should not be an issue for providers. If, however, payment and rate-setting depend on the modifiers' position, CMS must give providers clear and specific instructions and guidance for reporting. Further, these instructions must not conflict with the NUBC.

We provide the following text from *The Uniform Billing Editor* instructions in Appendix 5 (Modifiers Used for Facility Reporting) as an example of the type of instruction that could be provided to ensure that correct data are provided and retained in the CMS claims data:

- *"When there are two modifiers reported, the modifiers affecting payment should be listed first."*
- *"The use of modifiers apply to services/procedures performed on the same calendar day."*
- *"When it is appropriate to use a modifier, the most specific modifier should be used first. For example, when modifiers E1-E4, FA-F9, LC, CL, RC, and TA-T9 apply, they should be used before modifiers LT, RT, or 59."*

<u>Specific Inconsistencies Noted Between CMS and NUBC Documentation/Guidance</u>

The PRT also requests that CMS update and correct the language regarding the number of modifiers allowed to be reported on a claim, in order to be consistent with the NUBC's official

claims-processing requirements. The citations from the CMS' *Medicare Manuals* and from NUBC's *Official UB-04 Data Specifications Manual,* provided below, clearly conflict.

A. CMS' Medicare Manuals:

Publication 100-04, Chapter 23, Section 20.3 indicates that the MACs must be able to accept at least 5 modifiers and process them completely through the system:

- "Physicians and suppliers must use HCPCS codes on the Form CMS-1500 or its electronic equivalent and providers must use HCPCS codes on the Form CMS-1450 or its electronic equivalent for most outpatient services. The service or procedure can be further described by using 2-position modifiers contained in HCPCS.
- Modifiers to HCPCS Level I codes for medicine, anesthesia, surgery, radiology, and pathology are on the HCPCS codes file from CMS. Modifiers for Level II alpha-numeric codes are with the Level II codes published by CMS. Alpha-numeric and CPT-4 modifiers may be used with either alpha-numeric or CPT-4 codes. A/B MACs (B) and DME MACs are required to accept at least 2-position numeric or alpha modifiers and process both modifiers completely through the claims processing system (including any manual portion) as far as payment history. A/B MACs (A) or (HHH) **must be able to accept at least five modifiers and process them completely through the system. It is not acceptable merely to be able to accept multiple modifiers and then drop one before** complete systems processing. Dropping of a modifier leads to incomplete and inaccurate pricing profiles." [Emphasis added.]

Publication 100-04, Chapter 25, Section 75.5 confirms that the UB form (CMS-1450) accommodates up to four modifiers, of two characters each:

- HCPCS Modifiers (Level I and Level II)
- Form CMS-1450 accommodates up to four modifiers, two characters each. See AMA publication CPT 20xx (xx=to current year) Current Procedural Terminology Appendix A – HCPCS Modifiers Section: "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use". Various CPT (Level I HCPCS) and Level II HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication.

B. NUBC's Official UB-04 Data Specifications Manual 2017 (Pages 171-172):

The NUBC shared its plans with the PRT that the next version of the 837I will accommodate up to eight modifiers; however, implementation of this plan will take several years. We note that, **at the present time, the HIPAA standard 837I does not allow for more than four modifiers on a claim:**

- Reporting HCPCS Modifiers

- "UB-04: Situational. Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.
- 005010: Situational. Required when a (first, second, third or fourth) modifier clarifies or improves the reporting accuracy of the associated procedure code."

- Field Attributes
  - "Includes 14 positions"

- Notes
  - "(b) For HCPCS, the field consists of 5 positions for the base code plus 8 positions for up to four HCPCS modifiers; thus the field contains on extra/unused position."
  - "HCPCS Modifiers (Level I and Level II)

    The UB-04 accommodates up to four modifiers, two characters each.

    See AMA publication CPT 200x (x=to current year) Current Procedural Terminology, Appendix A – HCPCS Modifiers Section: "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use".

    Various CPT (Level I HCPCS) and Level II HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication."

The PRT requests that CMS update and correct the language regarding the number of modifiers allowed to be reported on a claim in order to be consistent with the official claims processing requirements issued by the NUBC.

The PRT strongly recommends that CMS accept and use *all* modifiers that are reported and accepted on a claim for the agency's analysis and rate-setting processes.

<u>Proposed Changes to the Inpatient-Only List</u>

CMS proposes to remove the following six procedures from the Inpatient-only List for CY2017:

1. *22840*: Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure);
2. *22842*: Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure);

3. *22845*: Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure);
4. *22858*: Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure);
5. *31584*: Laryngoplasty; with open reduction of fracture; and
6. *31587*: Laryngoplasty, cricoid split.

The PRT has consistently recommended that CMS eliminate the Inpatient-Only List in our previous comments. Most recently, we made this recommendation in our comments for the CY2016 Proposed Rule. We reiterate this recommendation once again, since we continue to believe that procedures should be performed in the most appropriate setting, and not in a setting determined by a predetermined list of inpatient services.

We note that age alone should *not* be used as the sole factor to determine whether a procedure is appropriately provided in the inpatient and/or outpatient setting. Medicare beneficiaries may be, and often are, healthier and hardier than some younger patients covered by other types of insurance. The PRT reiterates that *the appropriate surgical setting should be determined based on the physician's assessment of the individual patient's clinical picture*, *in conjunction with the desires of the patient and his or her family*.

If CMS insists on maintaining the Inpatient-only List, the PRT supports the agency's proposal to remove the six procedures listed above from the list. In addition, we request that CMS also remove a related procedure from the List: CPT 22850 (*Removal of posterior non-segmental instrumentation [e.g., Harrington rod])*. If the placement of the posterior instrumentation will not be considered an inpatient-only procedure in the future, it is only logical that its *removal* should not be considered inpatient-only either.

The PRT requests that CMS add CPT 22850 to the list of codes to be removed from the Inpatient-only List.

CMS requests comments on whether CPT code 27447 (*Total Knee Arthroplasty [TKA] or Total Knee replacement)* should be removed from the Inpatient-only List. Most of the PRT outpatient surgery departments are equipped to safely provide TKA procedures when a patient's surgeon deems the outpatient setting to be appropriate. Based on discussions with orthopedic surgeons, the PRT submits that it is clinically appropriate for some Medicare beneficiaries to have the option of their TKA being performed in an outpatient hospital setting. This determination would be made by the surgeon in consultation with the individual beneficiary.

Many PRT providers participate in the Comprehensive Care for Joint Replacement (CCJR) Model. Other PRT member organizations have orthopedic surgeons who participate in the Bundled Payment for Care Improvement Model. While we understand that removing healthier patients from the model to have a procedure done as an outpatient may make it difficult to establish a target, we believe CMS can, and must, find a way to account for this. Leaving

procedures on the Inpatient-only List simply because they are part of a bundled payment model increases CMS' costs and — more importantly — exposes patients to unnecessary risks. Under the OPPS, there is a bundled payment for outpatient surgeries, especially those that are device-dependent. A TKA is a type of "device dependent" procedure, since it is always performed with an implant. The PRT notes that this follows CMS' intent for bundled payments for procedures, although the current payment structure does not include reimbursement for professional services.

The PRT lacks the resources and expertise to model specific methods for adjusting the CCJR. We do, however, recommend that CMS maintain the CCJR target for one year and collect associated outpatient claims data. We assume, based on past experience, that performing these procedures in the outpatient setting will result in lower costs. As eligible patients move to the outpatient setting (based on physician determination of the individual's clinical situation), the average inpatient cost would increase, but there would be savings based on the shift.

We propose that the savings from the outpatient procedures could be split three ways, as follows:

1. Some of the savings could be used to fund the inpatient target until it can be stabilized;
2. Some of the savings could be used to reward providers for using newer (and frequently more expensive) techniques that enable patients to have the surgery as an outpatient;
3. Some of the savings could be returned directly to the Medicare program.

The PRT asks that CMS add CPT 27447 to the list of codes to be removed from the Inpatient-only List.

Inpatient-Only Status Indicator and Separate Procedures Logic

The PRT notes that many providers do not submit outpatient claims to CMS when an inpatient-only procedure was performed and the scenario does not meet the criteria for appending modifier –CA (*Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission*). The claims edit information indicates that these claims cannot be submitted or paid. Based upon our understanding of the I/OCE logic, however, if the inpatient-only procedure is on the separate procedure list and is performed in support of a status indicator T or J1 procedure, then the outpatient claim will be processed and paid with the inpatient-only procedure becoming a line item rejection.

The logic states:

> *Inpatient-only procedures that are on the separate-procedure list are bypassed when performed incidental to a surgical procedure with Status Indicator T, or effective 1/1/2015, if reported on a claim with a comprehensive APC procedure (SI = J1). The line(s) with the inpatient-separate procedure is rejected and the claim is processed according to usual OPPS rules.*

The PRT requests that CMS create two new status indicators, such as "C1" and "C2", in order to segregate the Inpatient-only List of procedures currently identified by the single status indicator "C." This is similar to CMS' proposal to separate status indicator "E" into "E1" and "E2" in the interest of improved clarity and transparency.

This request is made in order for identification of the inpatient-only procedures that are considered separate procedures in the I/OCE "Special Processing Procedures." In the interest of transparency, it is important that providers understand that, when an inpatient-only procedure is a separate procedure, it should be billed to CMS in order for the I/OCE logic to be applied, and based on the I/OCE logic, the outpatient claim will process and pay according to OPPS rules while the inpatient-only (separate) procedure will reject at the line-item level.

It is equally important for there to be a unique status indicator for the separate procedure designation in order for providers to work with their internal claims-processing systems vendors to modify internal edits to allow the claim to process based on a specific status indicator. Claims with the -CA modifier can process appropriately because there is something that identifies that specific inpatient-only line item as being appropriately reported on an outpatient claim. The industry needs an easy method for identifying the inpatient-only procedures that are classified as "separate procedures" rather than having to go into the I/OCE data files.

The new status indicator designations will be beneficial across the industry:

- CMS will receive more claims and cost data from providers for these scenarios;
- Vendors will gain more specific information to work with provider edits/system improvements;
- Claims processing will continue to be automated rather than requiring a manual review of every outpatient claim that has an inpatient-only procedure code on the claim to determine that the procedure is or is not a "separate procedure;"
- Status indicator changes are already a standard process in the industry based on longstanding OPPS methodology with both providers and vendors already accustomed to this process; and
- More accurate and transparent information will be available to CMS, providers, and across the industry.

The PRT asks CMS to identify the inpatient-only procedures that are on the separate-procedure list with a unique status indicator (for example "C1") similar to the process that CMS plans for separating the current status indicator "E" into "E1" and "E2."

Comprehensive APCs (C-APCs)

C-APCs: Progression and Provider Impact

CMS finalized and implemented the C-APC concept in the 2014 OPPS/ASC Final Rule. Although the policy was finalized in 2014, its effective date was delayed until January 1, 2015, to allow additional time for analysis, public comment, and systems preparation. In the end, C-APCs were implemented with modifications and clarifications that were made in response to public comments. The PRT greatly appreciates that CMS listened to the provider community and delayed implementation for one year. Since that time, however, CMS seems to be rapidly forging ahead with the expansion of C-APCs, with little regard for providers' ability to analyze the impact of the proposed changes prior to their implementation.

In 2016, CMS proposed and finalized nine additional C-APCs. This was coupled with a significant restructuring of APCs, implementation of many status indicator changes, and greatly expanded packaging. The PRT did not support this change for reasons that included the fact that then-current rate-setting data did not include the impact of the CY 2015 initial implementation of C-APCs. The number of CPT codes affected in 2016 jumped from approximately 200 to almost 800 codes, which represented a nearly 300 percent increase.

For CY2017, CMS proposes an additional 25 C-APCs, which brings the total number of CPT codes impacted to over 2700; this is, frankly, an untenable and astronomical increase. The PRT believes adding this large number of C-APCs at one time is ill-advised. Hospital providers have not had enough time to review all of the data in order to make meaningful and data-driven comments before the agency's deadline. Whether the codes are new for the coming calendar year or are existing codes (with or without changes to definitions), providers have minimal ability to delve into the proposed changes' impact in less than 60 days from an implementation timing perspective. Several thousand codes are involved in this current proposal, many of which are new and, therefore, lack any type of claims or cost data.

Thirty-one of the new codes are being assigned status indicator J1 to reflect that they are considered a primary service. Yet, CMS does not provide any detailed explanation why these codes were selected to be primary services. This information is crucial in order to expedite providers' review of both the codes and the proposed C-APCs.

Based on the limited data review that the PRT was able to conduct in this short time-frame, we submit that some of these codes qualify for a complexity adjustment under the Comprehensive APC model, but are not listed in Addendum J as eligible for a complexity adjustment. In order for providers to understand the reimbursement methodology, the PRT requests that CMS provide a detailed discussion regarding why procedures represented with a new CPT/HCPCS code have been selected as a primary service, and why procedures are or are not included in the complexity adjustment methodology. The PRT understands there are no claims data for new codes; however, these codes are assigned to an APC based on clinical homogeneity and some aspect of cost relatability. Because the complexity adjustment is determined at the individual code level, however, providers lack the information to understand CMS' rationale when no data are provided and no explanation is included in the Proposed Rule.

> **The PRT respectfully asks that CMS include a detailed discussion of the process for determining when new codes are designated as primary services and how the determination is made for new codes regarding the applicability of a complexity adjustment.**

We are also concerned with the use of two-year-old data as the basis for this proposal. Medicine and technology are changing rapidly; for that reason, data from two years ago are likely to be obsolete and inaccurate for use in setting 2017 payment rates. To address this situation, we recommend that CMS utilize a subset of recent claims (i.e., 2016 claims) to

establish appropriate APC groupings based on current cost data. Because of the advances in medicine and medical technology, the use of more recent claims data will — at the very least — validate that the Comprehensive APC is current in regard to cost. We understand that the OPPS uses prior claims data, but including data from *more recent* claims would prevent the sometimes large swings of cost and regrouping from occurring.

The PRT recommends that CMS utilize a subset of recent claims to establish appropriate APC groupings based on current cost data.

Additionally, we request that CMS delay implementation of some of these C-APCs in order to provide the public with more time to review and understand the impact of newly proposed C-APCs. The industry is just now receiving full data related to the impact from the initiation of the C-APCs in 2015. Adding this large volume of new C-APCs is premature without providing stakeholders with ample time to evaluate the impact of the 2015 changes. The PRT asks CMS to establish a limit to the number of new proposed C-APCs each year, in order to give hospital providers adequate time to review and respond to the agency's proposals.

In the narrative, CMS provides little to no rationale or explanation about the methodology and selection of codes to be included in the proposals for CY 2017. Following are a few examples of questions and observations that we have developed based upon our limited, overarching review.

Example A: What is the rationale for moving "larger size" excisions to SI J1 while leaving "smaller size" excisions as SI T? For instance:

11640	Exc f/e/e/n/l mal+mrg 0.5cm<	CH	T	5071	7.0928	$531.31
11641	Exc f/e/e/n/l mal+mrg 0.6-1	CH	T	5071	7.0928	$531.31
11642	Exc f/e/e/n/l mal+mrg 1.1-2	CH	T	5071	7.0928	$531.31
11643	Exc f/e/e/n/l mal+mrg 2.1-3	CH	J1	5072	16.5036	$1,236.27
11644	Exc f/e/e/n/l mal+mrg 3.1-4	CH	J1	5072	16.5036	$1,236.27
11646	Exc f/e/e/n/l mal+mrg >4 cm	CH	J1	5073	30.1175	$2,256.07

* Is lesion size really an appropriate indication of whether the service should be "comprehensive" or not?

Example B: What is the reason within a CPT family of service (e.g. Esophagogastroduodenoscopy [EGD] procedures) where some codes remain SI T whereas some become SI J1?:

43235	Egd diagnostic brush wash	43235		T	5301	8.9730	$672.16
43236	Uppr gi scope w/submuc inj	43236		T	5301	8.9730	$672.16
43237	Endoscopic us exam esoph	43237	CH	J1	5302	17.6151	$1,319.53
43238	Egd us fine needle bx/aspir	43238	CH	J1	5302	17.6151	$1,319.53

43239	Egd biopsy single/multiple	43239		T	5301	8.9730	$672.16
43240	Egd w/transmural drain cyst	43240	CH	J1	5303	33.1825	$2,485.67
43241	Egd tube/cath insertion	43241	CH	J1	5302	17.6151	$1,319.53
43242	Egd us fine needle bx/aspir	43242	CH	J1	5302	17.6151	$1,319.53
43243	Egd injection varices	43243	CH	J1	5302	17.6151	$1,319.53
43244	Egd varices ligation	43244	CH	J1	5302	17.6151	$1,319.53
43245	Egd dilate stricture	43245	CH	J1	5302	17.6151	$1,319.53
43246	Egd place gastrostomy tube	43246	CH	J1	5302	17.6151	$1,319.53
43247	Egd remove foreign body	43247		T	5301	8.9730	$672.16
43248	Egd guide wire insertion	43248		T	5301	8.9730	$672.16

* Should an EGD with band ligation (CPT 43244) or balloon dilation (CPT 43245) really be any more complex than an EGD with biopsy (CPT 43239) or foreign body removal (CPT 43247)?

Example C: In the Colonscopy family (CPTs 45378-45393), why was only one code, CPT 45389 (stent placement), selected for inclusion as a SI J1 while all other codes remained SI T?

Additionally, the PRT is concerned about the rapid expansion of C-APCs and the proper accounting of resources for encounters where the patient arrives via the Emergency Department. On the surface, it seems plausible that many of the proposed J1 changes will affect services that commonly occur in the Emergency Department setting. To that end, we ask CMS to conduct detailed analysis of all J1 services to ensure that Emergency Department visits are properly accounted for within C-APC rates; including the necessity of enacting a complexity adjustment.

The PRT recommends that CMS analyze and report to the public the potential for adding a complexity adjustment for ER Level Visits (i.e. CPT code 99281, 99282, 99283, 99284, 99285, 992991).

Finally, we recommend that CMS create a "new code destined for a C-APC" type of grouping as a preliminary step to forming new C-APCs. Under this suggested process, all new CPT/HCPCS codes would be assigned to the grouping until claims data are available to use in assigning these codes to an appropriate C-APC. This methodology resembles the one currently used for new technology, which has proven to be effective in fostering positive assignment and groupings based on both cost and clinical homogeneity. We recommend that CMS limit the establishment of new C-APCs and code additions to existing C-APCs to those that the provider community has had sufficient time and adequate data to assess.

CMS has noted that part of the purpose for the larger payment bundles is to give hospitals the means to be flexible regarding the utilization of resources. In order to do that, however, it is imperative that hospitals have the needed time to validate and reproduce the methodologies. The

early release of a preliminary data set and additional details about the proposed changes to C-APCs would enhance transparency as well as enable providers to analyze the new proposals and provide more specific and meaningful comments/presentations to both members of the HOP Panel and CMS. Even more helpful would be for CMS to release a public version of the I/OCE software that would allow providers to model the impact of CMS' Proposed Rules with both their own data and a preliminary data set.

We respectfully request that CMS provide preliminary data on future additions to C-APCs and allow additional time for data analysis, which will result in more meaningful discussion of alternatives at the HOP Panel's Summer meeting.

The PRT is concerned about accuracy in rate-setting and payment processes and the impact on beneficiary access to health care. We understand that both packaging and larger payment bundles are part of any prospective payment system. We also understand that prospective payment systems do not reimburse for itemized services. Yet, the PRT firmly believes that any changes to the system must be made thoughtfully and deliberately — and that providers must have time to review the impacts and submit data-driven comments to CMS. This is particularly important because many other payers follow CMS' lead; hence, the agency's policy changes impact patients beyond the Medicare population.

The PRT requests that CMS limit the number of annual new proposed C-APCs to give providers time to review and respond to the proposals.

We urge CMS to limit the establishment of new C-APCs and code additions to existing C-APCs to those the provider community has had sufficient time and adequate data to assess.

The PRT requests that CMS include a detailed discussion of the process for determining when new codes are designated as primary services and how the determination is made for new codes regarding the applicability of the complexity adjustment.

<u>Delay Assigning New CPT Codes to Existing C-APCs</u>

CMS proposes to assign new CPT codes to C-APCs 5192, 5193, and 5194. Providers lack familiarity and experience with these new CPT codes, and are not able to analyze the data in order to respond meaningfully to CMS about the agency's proposal. The PRT is also concerned about the new CPT codes' impact on data collection, as noted above. We submit that utilizing new codes has the potential to negatively impact future assessment and assignment to C-APCs. We recommend that new procedure codes *not* be automatically included in a C-APC *unless* there is a "one-to-one" crosswalk from a deleted code to the new code.

While the AMA may have provided CMS with instruction about the use of 2017 CPT codes, the proposed rule (albeit the availability of Addendum P) does not include any narrative and/or instructional notes related to the CPT adds, changes, and deletions for the coming year.

For all practical purposes, until the AMA formally publishes the 2017 narrative and definitions (e.g. "xxxxx has been deleted, to report use yyyyy"), providers cannot perform analysis or make meaningful comment since we primarily have to "guess" the intention of the code usage. This is true not only C-APCs but for all affected APC assignments.

The PRT asks CMS to delay the implementation of C-APCs 5192, 5193, 5194 because of the assignment of new CPT codes within these C-APCs.

Proposed APC 5191

CMS proposes to implement C-APC 5191 which includes both CPT code 93451 (Right Heart Catheterization) and CPT 93505 (Endomyocardial Biopsy). The PRT notes that CPT 93451 and CPT 93505 can be performed together or as separate procedures. Therefore, the PRT asks CMS to retain these procedures as primary services and to not implement C-APC 5191.

The PRT asks CMS to not implement C-APC 5191.

C-APC: Observation (including carve-outs)

As expressed to CMS in March 2016, the PRT is deeply concerned with providers' on-going operational burdens stemming from the requirement to "carve out" observation hours when therapeutic services that require active monitoring are also provided during the observation service period (reference IOM 100-04, Chapter 4, Section 290.2.2).

CMS originally conceived this carve-out construct in CY2008 to discourage and/or prevent "double payment" of separately payable services and a Composite Extended Assessment and Management (EAM) during the initial deployment of the EAM APCs (i.e., APCs 8002 [Level I Extended Assessment and Management Composite] and 8003 [Level II Extended Assessment and Management Composite]).

For CY2016, CMS deleted Composite EAM and implemented the Comprehensive (C-APC) methodology for observation services. A single comprehensive payment is made when qualifying observation requirements are met; all other previously separately payable services (excluding preventive services and certain Part B inpatient services) are now packaged and deemed to be "adjunctive services" to the C-APC.

With C-APC implementation, and the elimination of separate APC payments for therapeutic procedures that might require active monitoring, the PRT believes it is meaningless and burdensome to require providers to continue to carve-out observation hours from the time patients receive other therapeutic services during the observation period. The PRT continues to believe, as we have since 2008, that all observation hours should be reported. We also maintain that the vast majority of payable observation services exceed 24 hours; the "carve out" process deducts only minimal hours in general, and, therefore, has virtually *no impact* on the 8-hour threshold that qualifies the visit for the C-APC payment.

We note, as we have in the past, that the beds occupied by patients who are receiving observation services cannot be turned over or used for any other patients. This is true even when the patient receiving observation services leaves his or her room in order to receive another service in another department. The hospital continues to incur the costs for the bed (and non-billable services such as discharge planning, meal preparation, or processing physician orders) while the patient receives other monitored services. The patient continues to be monitored and observed upon his or her return. Therefore, accurate cost accounting principles will apply where the costs in the routine cost centers will be compared to the total revenue (i.e., all hours) — preventing inappropriate cost-shifting.

In addition, as we shared with CMS staff in 2008, we do not believe that reporting *all* time that a patient is assigned to an observation bed produces an incorrect representation of the costs associated with providing that bed for that specific patient. CMS has stated on many occasions that hospitals should report *"the full charges associated with all hospital resources utilized."* In the 2008 Final Rule, CMS stated: *"…we proposed that hospitals that furnish the observation care in association with independent services must bill those services on the same claim so that the costs of the observation services can be appropriately packaged into payment for the independent services."*

CMS also stated: *"Those are more general requirements that encourage hospitals to provide medically reasonable and necessary care and help to ensure the proper reporting of observation services on correctly coded hospital claims that reflect the full charges associated with all hospital resources utilized to provide the reported services….We are retaining as general reporting requirements for all observation services those criteria related to physician order and evaluation, documentation, and observation beginning and ending time as listed in section XI of this final rule with comment period."* [Emphasis added.]

The PRT implores CMS to delete the following paragraph from the CMS Claims Processing Manual, Pub. 100-04, Chapter 4, Section 290.2.2:

> *"Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services."*

C-APC for Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

The PRT agrees with the HOP Panel's recommendation that CMS proceed with the creation of a

C-APC for Allogeneic HSCT. We are concerned, however, with CMS' use of *all* claims to establish the payment rate for the proposed C-APC. We note that a correctly coded claim for Allogeneic HSCT includes charges that reflect the costs for donor search and cell acquisition reported by providers using revenue code 0819 (or in the future through the newly proposed revenue code 0815) and for the actual stem cell transplantation procedure reported with CPT code 38240. But, CMS appears to have created the C-APC rate using all claims, including claims that are *missing* donor search and cell acquisition charges — this is problematic.

CMS' billing guidance instructs providers to report donor search and acquisition costs under revenue code 0819 on the same date of service on which the stem cell transplant procedure code 38240 is billed. Despite CMS' guidance, however, providers continue to struggle with billing for both components of this overall service completely and accurately.

To facilitate accurate reporting in the future, the PRT believes that CMS should create an edit that requires the presence of the donor acquisition revenue code (0819 today and 0815 in the future) and CPT code 38240; this will not only be beneficial to providers but also will help CMS receive accurate and complete claims, which will improve rate-setting integrity.

The PRT recommends that CMS set rates for the newly proposed C-APC for allogeneic stem cell transplant based only on correctly coded claims, which are those that include both CPT code 38240 and charges under revenue code 0819.

The PRT also recommends that CMS create an edit that requires the revenue code for donor acquisition charges (i.e., revenue code 0819 today, revenue code 0815 in the future) be present on the same date of service as CPT code 38240, and that claims failing this edit be returned to providers.

APC Reconfiguration Changes

1. APC 5571, Level 1 Computed Tomography with Contrast

CMS proposes to move CPT codes 70545 (MR angiography head with contrast) and CPT 70548 (MR angiography neck with contrast) from APC 5572 (Level 2 Diagnostic Radiology with contrast) to APC 5571 **(**Level 1 Computed Tomography with Contrast and Computed Tomography Angiography**)**. The geometric mean of APC 5572 is $488.49, and the geometric mean of APC 5571 is $291.46. The PRT believes these two CPT codes are appropriately assigned to APC 5572, based on the geometric mean of $389.19 and $394.29.

CPT	Geometric Mean
70545	$389.19
70548	$394.29

The PRT recommends that CMS retain CPT codes 70545 and 70548 in APC 5572.

2. APC 5182, Level 2 Vascular Procedures

CMS proposes to move CPT codes 75731, 75746, and 75810 from APC 5526 (Level 6 X-Ray and Related Services) to APC 5181 (Level 1 Vascular procedure). The PRT believes these CPT codes are, however, more closely aligned by geometric mean to APC 5182 (Level 2 Vascular procedure), which has a geometric mean of $2,440, than to APC 5181, which has a geometric mean of $906.86. The geometric mean for CPT 75731 is $2,527.29; for CPT 75746 is $2,140.58; and for CPT 75810 is $1,717.16. Thus, the CPTs are more appropriately placed in APC 5182 than APC 5181.

CPT	Geometric Mean
75731	$2,527.29
75746	$2,140.58
75810	$1,717.16

The PRT recommends that CMS assign CPT codes 75731, 75746, and 75810 to APC 5182.

3. APC 5531 Level 1 Ultrasound and Related Services

CMS proposes to move APC 5531 (Level 1 Ultrasound and Related Services) to APC 5521 (Level 1 Diagnostic Radiology without Contrast). CMS proposes to move the following CPTs from APC 5531 to APC 5521: CPT 76641 (Ultrasound breast complete); CPT 77642 (Ultrasound breast limited): CPT 76816 (Obstetric Ultrasound follow-up per fetus); CPT 76821 (Middle cerebral artery echo); CPT 76857 (Ultrasound exam pelvic limited); and CPT 93893 (Tcd emboli detect with injection). The geometric mean for CPT 76641, 76642, 76816, 76821, and 93893 are as follows:

CPT	Geometric Mean
76641	$94.20
76642	$93.27
76816	$93.27
76821	$149.19
76857	$98.13
93892	$97.24

Based on the data, the PRT notes that these CPT codes are more aligned by geometric mean to APC 5522 (Level 2 X-Ray and Related Services), which has a geometric mean of $122.70, than to APC 5521, which has a geometric mean of $66.19.

The PRT recommends that CMS move CPT 76641, 76642, 76816, 76821 and 93893 to APC 5522 rather than APC 5521.

4. APC 5522 Level 2 X-Ray and Related Services

CMS is proposing to move APC 5532 (Level 2 Ultrasound and Related Services) to APC 5522 (Level 2 X-Ray and Related Services). All of the procedures listed in APC 5532 are ultrasound-related services (see chart, below). We believe that these procedures should remain in the "Ultrasound and related services" APC, due to clinical and resource homogeneity in the ultrasound modality.

CPT	Description
76815	Ob us limited fetus(s)
93888	Intracranial limited study
76830	Transvaginal us non-ob
76801	Ob us < 14 wks single fetus
93931	Upper extremity study
76775	Us exam abdo back wall lim
93980	Penile vascular study
76705	Echo exam of abdomen
76817	Transvaginal us obstetric
76536	Us exam of head and neck
93979	Vascular study
76828	Echo exam of fetal heart
76872	Us transrectal
76870	Us exam scrotum
76881	Us xtr non-vasc complete
76805	Ob us >/= 14 wks sngl fetus
93882	Extracranial uni/ltd study
76856	Us exam pelvic complete
76770	Us exam abdo back wall comp
76818	Fetal biophys profile w/nst
93971	Extremity study
76776	Us exam k transpl w/doppler
76873	Echograp trans r pros study
93926	Lower extremity study
76513	Echo exam of eye water bath
76819	Fetal biophys profil w/o nst

The PRT recommends the procedures listed under APC 5532 remain in APC 5532.

Hospital Outpatient Quality Reporting Program Updates

The PRT appreciates CMS' goal to promote higher quality and more efficient health care for Medicine beneficiaries by implementing quality reporting programs. With multiple programs occurring in multiple settings, we appreciate CMS' efforts to align various quality reporting programs' clinical quality measure requirements. Consistency among these measures will reduce the operational burden needed to comply with multiple sets of quality measures.

Despite supporting this overall goal, however, the PRT continues to have a broad concern applicable to many of these proposed quality measures. Specifically, we note that follow-up for several of these procedures usually occurs *outside the hospital outpatient department*. Many patients are seen for follow-up in their physician's office. This means that hospitals have *no way* of assessing the patient's outcomes, as reported by these quality measures. In addition, the post-procedure management in the physician office is often limited by day of the week (i.e., Monday through Friday), which results in patients seeking care through a hospital Emergency Department or urgent care center on the weekends and after normal work hours.

The PRT believes it is unfair to use these measures to penalize *hospitals* for negative outcomes, when hospitals are not consistently responsible for the post-procedure management for these patients.

> **The PRT once again endorses the concept of further selection of measures for the Hospital OQR. We recommend, however, that *all* quality measures selected have an easily identifiable correlation with clinical outcomes for services provided in the hospital outpatient department.**

Proposed New Hospital OQR Program Quality Measures for the CY 2020 Payment Determination and Subsequent Years

OP-35: Admission and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy

The PRT recognizes that CMS seeks to reduce adverse patient outcomes associated with chemotherapy treatment in the hospital outpatient setting.

CMS notes that the "side effects" included in the measure are "predictable and manageable" and are potentially preventable through appropriately managed outpatient care and increased communication with patients. These side effects are: anemia, dehydration, emesis, fever, nausea, neutropenia, pain, pneumonia, and sepsis. In the proposed measure, CMS suggests that admission within 30 days of chemotherapy for these conditions necessarily results from chemotherapy's side effects, rather than as a natural progression of the patient's neoplastic disease.

The PRT notes that some of these conditions may be due to the patient's cancer itself, rather than a result of chemotherapy. Because of the often-debilitated state of cancer patients (whether receiving chemotherapy or not), they are more susceptible to disease processes that may be inherent to their cancer diagnosis, or just a fact that their immune system is compromised due to the effects of their cancer or their debility. It may be virtually impossible for a physician to determine if the condition is specifically due to chemotherapy effects (as the measure suggests) versus the natural progression of the underlying disease process. Only on a limited basis are ICD-10-CM codes granular enough to link the symptom or condition to the chemotherapy specifically. The PRT seeks clarification from CMS about ways that providers can indicate whether the condition is or is not a side effect of the chemotherapy.

Consider the scenario in which a patient who received chemotherapy services in a hospital outpatient department experiences a fall in their home, and presents to the ED with back pain. The ED diagnosis (i.e., back pain) would qualify this patient for measure OP-35 and would reflect poorly on the facilities' care of cancer patients, even though this condition is unrelated to the patient's cancer care

It is also difficult to comprehend how conditions such as pneumonia and sepsis can be considered a controllable and preventable "side effect" of chemotherapy in this population, which typically has suppressed immunity.

The PRT requests more transparency on the risk-adjustment methodology for this proposed measure. The Proposed Rule provides only vague references to demographics, cancer types, clinical comorbidities, and treatment exposures that impact the risk adjustment. We believe that the patient's stage of cancer and co-diagnoses significantly impact the timing and severity of the symptoms, as well as the timing of their treatment.

We cannot stress enough the impact of the patient's socio-demographic status (SDS) on their care and outcome. The PRT asks that CMS strongly consider factoring in the SDS in the measure calculation method.

Although the measure is well-defined, the PRT is concerned about the burden it will place on hospitals that have little control of the treatment plan and post-procedure management for patients who receive chemotherapy in the outpatient department. The measure should be attributed *only* to circumstances in which the subsequent inpatient admission or ED visit occurs at the same facility in which the chemotherapy was administered. A hospital that receives a patient for care in the ED or inpatient hospital unit has absolutely no control over whether or not a treatment plan to support the management of a patient's condition was adequately administered in *another* hospital's outpatient department. For this reason, the PRT does *not* support the use of this measure of hospital outpatient department quality. We believe it is unfair to penalize *hospitals* for negative outcomes and other inadequate results from a service that may have occurred elsewhere — especially since the literature highlights the proposed conditions as *potentially preventable* in this population.

The PRT recommends that CMS delay the implementation of this proposed measure until a method of clearly associating the "potentially preventable" conditions to the chemotherapy can be developed, sociodemographic status can be factored in, and more transparency on the risk-adjustment models can be provided.

Alternatively, if CMS insists on implementing this measure, the PRT recommends that the agency redesign this measure to include cases in which the provision of outpatient hospital-based chemotherapy service was at the same facility in which the unplanned hospital inpatient admission or ED visit occurred within 30 days of the hospital outpatient chemotherapy.

OP-36: Hospital Visits after Hospital Outpatient Surgery

The PRT agrees with CMS on the importance of reducing adverse patient outcomes associated with surgery. We support CMS' definition of same-day surgery as those listed on Medicare's list of covered ASC procedures. The fact that these surgeries do not typically require an overnight stay, are reviewed annually and updated by Medicare, and allow opportunity for a public comment make this subset of procedures well-aligned with the measure's target.

In the 2017 Proposed OPPS Rule, CMS discusses its plan for addressing claims impacted by the 3 Day Window. CMS proposes to identify these instances by linking the hospital claims with physician claims for the same day surgery in the hospital setting with a physician's claim for an inpatient admit within three days lacking a corresponding hospital facility claim.

The PRT has the same concerns regarding sociodemographic status with this proposed measure as with OP-35 discussed earlier in this comment letter.

We also have concerns regarding the proposed risk adjustment variables. The convoluted approach of adjusting for surgical procedure complexity using RVUs and the introduction of a complicated anatomical body system classification system make the risk-adjustment methodology unclear and difficult to understand.

While the PRT agrees that-risk adjustment is appropriate, we are concerned about using this method. In our experience, the documentation of co-morbid conditions on same-day surgery is very limited because of the nature of the service. To depend upon extensive documentation in a same day surgery record to determine risk is problematic. Surgeons who bring a patient in for a specific ambulatory-type procedure typically limit their documentation to conditions that are relevant to the specific body system related to the surgical procedure.

CMS proposes to enforce this measure on inpatient admissions occurring directly after a same-day surgery episode of care. The PRT notes that providers submit a single claim for this scenario. How does CMS propose to identify these cases?

The PRT recommends that CMS delay the implementation of this proposed measure until the issues above are addressed, sociodemographic status can be factored in, and more transparency on the risk adjustment models can be provided.

OP- 37a-e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare

The PRT understands the need for a standardized assessment of a patient's overall experience for surgeries or procedures performed within a hospital outpatient department.

CMS proposes that hospitals will be required to contract with a CMS-approved vendor to collect survey data and report to CMS on behalf of the hospital. The inpatient version of this measure (HCAHPS) uses a self-administered survey. The PRT seeks clarification from CMS about why the outpatient version of this (very similar) survey does not use same administration method.

The Hospital Value-Based Payment Program proposes to remove HCAHPS pain management dimension questions due to confusion about the questions' intent and public health concerns about the prescription opioid overdose epidemic. The PRT shares these public health concerns. We do not understand why the proposed outpatient version of the survey includes questions related to pain management. We understand that the question, "At any time after leaving the facility, did you have pain as a result of your procedure?" is a control question; yet, we are concerned that it leads to patient perceptions about their overall care that may, in turn, result in negative responses throughout the survey.

There are 37 questions on the proposed OAS CAHPS survey, while the HCAHPS contains only 21 items. The PRT questions the need for a longer survey on short hospital outpatient stays compared to inpatient stays.

The Measures Application Partnership (MAP) notes that these measures are also included within other programs. The PRT supports MAP's recommendation that CMS consider how these measures are related to other existing ambulatory surveys in order to ensure that patients and facilities are not overburdened by multiple surveys.

> **The PRT requests that CMS carefully compare the proposed OAS CAHPS survey questions to the inpatient/HCAHPS version of the survey.**
>
> **The PRT recommends that CMS align the outpatient version of patient's experience of care survey with the current inpatient version from a content, timeline and administration method standpoint.**
>
> **We request that CMS review these requirements to prevent duplication of effort on the part of providers and provide a uniform process for beneficiaries who will be completing the surveys.**

<u>Electronic Submission of Data</u>

The PRT agrees that the evolution and infrastructure of EHR increases the capacity for electronic reporting of measures and creates opportunities to replace the burdensome chart-abstraction method of data submission.

The PRT supports the concept of using data collected from electronic health records, but we continue to oppose CMS having *direct access* to a facility's EHR for data abstraction. We believe that specific data submission from the EHR could be developed in order to provide necessary information electronically without increasing hospital burden. We would support access within our facility system firewalls to data in the EHR only when it specifically addresses the quality measure.

> **We do not support the use of a direct portal for CMS to have open access to all data within a patient's electronic health record. We encourage the development of systems to enable hospitals to submit only specific data elements in an electronic format. We approve of the terms in the EHR incentive program that provides a foundation for hospitals to send — and for CMS to receive — quality measures through electronic submission.**

We also note that a requirement to submit data electronically may be premature and there is little confidence that health care providers are prepared to do so with great accuracy. Within the next four to five years, the prevalence and capability of EMRs will be greatly expanded and the integrity of data will be such that the electronic submission of quality measures data will be both achievable and beneficial.

Conclusion

In conclusion, although the PRT supports efforts to promote quality of care provided in hospital outpatient departments, we ask CMS to consider the volume of measures and what a recent Institute of Medicine Report aptly describes as "measure madness." We respectfully ask CMS to more broadly identify the goal of quality measures and work with providers to achieve that goal through establishing a limited number of measures that provide consistent and meaningful data.

Implementation of Section 603 of the Bipartisan Budget Act of 2015 Relating to Payment for Certain Items and Services Furnished by Certain Off-Campus Departments of a Provider

Section 603 made two amendments to section 1833 of the Social Security Act, in part requiring the Secretary to establish a new payment policy for applicable items furnished by an off-campus provider-based department (PBD) on or after January 1, 2017. CMS proposes to define PBDs that were billing for covered OPD services furnished prior to November 2, 2015, as having "excepted" status and these PBDs would continue to be paid under the OPPS.

In order to implement Section 603, CMS is proposing to:

1. Define whether certain items and services furnished by an off-campus PBD may be considered to be excepted and continue to be paid under the OPPS;
2. Establish requirements for off-campus PBDs to maintain excepted status; and
3. Describe the applicable payment system for non-excepted items and services.

Justification for a Delay in Implementation

The PRT cannot express strongly enough its emphatic position that CMS *must* postpone implementation of Section 603 so the agency has time to design, consider, and implement a thoughtful transition that carefully considers stakeholder impact. Only by doing so will CMS be able to avoid the following negative impacts and consequences:

- The addition of costs to the Medicare program for non-excepted items and services under non-OPPS payment systems due to significant changes in OPPS payment policy since 2014, which we believe has not been evaluated by CMS, Congress, MedPAC, OIG or GAO. The PRT believes that implementation of Section 603 may actually result in *higher* program costs for off-campus non-excepted PBD services that will be paid under the MPFS rather than under OPPS' current packaging policies;
- The imposition of significant administrative burden to both hospitals and CMS related to the proposal that non-excepted items and services be billed on a non-institutional claim form (i.e., 1500 claim);
- The lack of payment for non-excepted off-campus PBDs that perform services and procedures that fall outside of office-based services, as there is no facility payment for these types of services under the MPFS;
- The exclusion of any new and changed hospital services at currently excepted off-campus PBDs, as this will significantly limit outpatient hospital service delivery; and
- Changes in the underlying payments that will impact CMS' value-based purchasing and CMMI models, since providers' ability to manage and reduce expenses to Medicare beneficiaries will be confounded, if not made impossible.

There are additional significant system readiness and operational issues with CMS' proposal of expanded clinical families. According to the definition, when a patient has a single encounter at an off-campus PBD, the services needed by and provided to that patient could result in one service being an excepted service, and another being a non-excepted service (because it is grouped into a clinical family that was not previously performed or billed at that location). CMS proposes that the PBD should track the service and bill based upon whether the single service was provided prior to November 2015.

This is impossible to operationalize in the manner and timeframe CMS proposes. The agency itself acknowledges that it cannot alter its claims processing systems in order to meet the requirements of Section 603 by January 1, 2017. Hospitals are, likewise, incapable of altering their systems in this very short time-frame. We simply cannot track individual services performed at a single department during a single encounter in order to bill some of those services on a UB and others on a 1500 claim. In order for hospitals to comply with the billing requirement, services may have to be delivered in different locations in order to be billed on a UB. This is simply not acceptable for patients, particularly Medicare beneficiaries, who often have transportation and mobility issues.

Regardless of what form CMS' final policies take, it is absolutely impossible for hospitals to make the numerous significant administrative and procedural changes necessary to implement Section 603 between the Final Rule's release (occurring in the beginning of November, 2016) and January 1, 2017. In addition to the significant and unintended consequences outlined above, the insufficient time for providers to implement and operationalize this payment policy change is

reason enough to justify a delay. CMS recognizes and acknowledges that the agency itself is not ready to implement this system, and it is unreasonable to expect providers to do so. The agency should afford providers as much time as the agency itself needs (if not more) before implementation.

The PRT emphatically urges CMS to postpone implementation of Section 603.

Expansion of Services at Existing Non-Excepted Off-Campus PBDs

CMS references the current provider-based regulations found at 42 CFR 413.65 throughout its presentation of Section 603 implementation proposals. As CMS states, these regulations define a department of a provider as follows:

> *Department of a provider means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility.*

This existing definition is consistent with how hospital departments operate. Indeed, the requirements for provider-based status are designed to ensure integration with the main hospital, and specifically state that provider-based departments (PBDs) are designed to furnish health care services of the same type as those furnished by the main provider.

The concept of the department as a whole having PBD status rather than the individual services has been in place since the beginning of PBD determination. This concept must be maintained, since this is how hospitals operate and deliver health care to all types of outpatients. This is what patients treated in PBDs require and deserve. Services evolve at both the main provider and at on- and off-campus departments, as the practice of medicine evolves and patients' needs change. Therefore, once it is determined that an off-campus department meets PBD requirements (including billing under the hospital CCN prior to November 2, 2015), then *all* current and future services provided at that department location must be excepted. By definition, these off-campus provider based services are required to be *"of the same type as those furnished by the main provider."*

CMS' proposal to limit the expansion of clinical services at existing off-campus PBDs from those services billed as of November 2, 2015 is untenable for hospitals. CMS' proposal to limit excepted PBDs to those certain services that were billed up to November 2, 2015, treats PBDs as if they are frozen in time, and does not recognize that services evolve along with evidence-based medicine. CMS' concept risks stifling both innovation and beneficiaries' access to care.

The PRT does not believe Congress intended to limit the expansion of outpatient off-campus

hospital services. Instead, we believe the goal was to address the conversion of existing freestanding physician practices to outpatient hospital off-campus PBDs. This distinction is critically important because the site-neutral policies that Congress and MedPAC have executed, by definition, should be limited only to those services that are possible to be performed in a freestanding physician practice.

CMS proposes to track whether services provided at an existing excepted off-campus PBD are expanded after November 2, 2015. Services considered to be expanded services at that PBD would not be payable under OPPS. CMS plans to determine expanded services based on APC-based clinical families. As previously stated, hospital "departments" deliver all forms of services of the same type as those furnished in the main hospital. Often, the same equipment and personnel are used to deliver these services. These services may not have been previously performed at a particular PBD yet, but could be delivered upon a moment's notice to meet the patient's clinical needs. Indeed, this is the intent of the direct supervision coverage requirement for outpatient hospital therapeutic services.

For example, if a patient has an appointment at an excepted off-campus PBD for advanced imaging services, and needs a drug administration service for a clinical condition at the same encounter, the supervising physician and nurse would be able to perform that drug administration service. If this service had not been billed as of November 2, 2015, CMS proposes that the drug administration service would be considered an expanded clinical service and not be payable under OPPS, even though it supported the provision of an excepted service. Hence, utilizing the November 2015 statutory effective date for determining new off-campus PBDs as the impetus to freeze services provided at an existing off-campus PBD ignores the importance of delivering the right care at the right time. In addition, the freeze of services is in direct conflict with the definition of a PBD as defined in 42 CFR 413.65, as the service is provided on the main campus of the hospital We believe that this interpretation is unrealistic and contradicts the intent of Section 603. The PRT does agree with using the date of November 2, 2015, to define exempted PBDs, but at the department level, not at the provision of service level.

The PRT also cautions that the proposed use of APCs to define clinical families is not logical or practical, simply because of the way that APCs are defined and maintained from one year to the next. Each year, CMS changes the composition of APCs, the definition of APCs, and the CPT/HCPCS codes contained in individual APCs. Thus, APCs are constantly changing due to the OPPS' structure, the annual rate-setting recalibration process, and annual CPT/HCPCS changes. As a result, clinical families change from one year to the next, and should not be used to dictate what services are considered excepted vs. non-excepted. Clinical families are not an appropriate measure of whether an expansion of services has occurred. Hence, the PRT seeks clarification about how the assignment of a procedure to a specific APC constitutes a "new" or "additional service" since the procedure is the same — only the APC assignment has been altered as part of the annual OPPS recalibration. The PRT submits that this creates another operational burden (if not nightmare), as it will be impossible for both CMS and providers to track.

Under the current proposal and given the annual changes to APC families, it is very possible that,

after 5 or 10 years, *all* services at existing excepted off-campus PBDs could be deemed to be "expanded clinical services" because health care services have either new CPT/HCPCS codes or new APC assignments that change the APC clinical families as defined in November 2015. The PRT asks if it is CMS' intent that ultimately *no* excepted off-campus PBDs be reimbursed under the OPPS? This is the logical progression of CMS' current proposal.

The PRT notes that CMS did not assign a clinical family to the new technology APCs, drugs, and a host of other services. It is not clear whether the lack of a clinical family assignment means that the concept does not apply, and that these services can continue to be provided at excepted off-campus PBDs without "triggering" an expansion of services. We seek clarification about what will happen when CMS reassigns a CPT code representing a new technology APC service to an APC within a clinical family: would that service suddenly be considered to be an expansion of services and therefore non-excepted even though it is not an expansion of services under CMS' definition?

The PRT recommends that Section 603-excepted PBDs (i.e., the locations and personnel and equipment) that were billing services under the provider's CCN prior to November 2, 2015, should be exempted — period. By CMS' own definition, the provider-based entity is a department of the main provider, and is intended to furnish the same services as the main provider; therefore, any concept of expanded services does not, and should not, apply.

> **The PRT recommends that CMS revisit its proposal to limit expansion of clinical services at existing off-campus PBDs from those services billed as of November 2, 2015, in order to better reflect the reality of medicine as an evolving science.**
>
> **The PRT urges CMS not to use APC clinical families to identify service expansion, and rather except all off-campus PBDs that were billing services under the provider's CCN prior to November 2, 2015, period.**

Relocation of Departments

As discussed, once a hospital has ensured that an off-campus department meets all the requirements of 42 CFR 413.65, then that PBD meets the definition of a hospital department. After that, the main provider should be completely free to relocate that department based on leasing arrangements, natural disasters, and/or other physical plant or operational reasons. Congress' intent with Section 603 was to no longer pay hospitals, under OPPS, for any new or additional off-campus provider-based departments. Therefore, as long as a provider is not adding an additional off-campus department beyond the number that existed as of November 2, 2015, the relocation of an existing excepted off-campus PBD should not be considered to be a new or additional off-campus PBD. The particular PBD already existed and because there are specific reasons for its relocation to another site, it does not constitute the creation of a new PBD. For this reason, its exception status should continue to apply in perpetuity.

> **The PRT recommends that CMS clarify that relocation of an existing excepted off-campus PBD will not result in any change to the organization's exception.**

Required 1500 Billing

CMS is proposing that hospitals would not be allowed to submit UB/837I claims for services provided in non-excepted off-campus PBDs. CMS also states this may be a temporary one-year solution because the agency is unable to make the necessary changes to its claims processing systems in time for a January 2017 effective date. CMS' proposal is to shift significant administrative burden from the agency to providers simply because CMS cannot make associated changes to its systems by January 1, 2017. This proposal not only shifts the administrative burden, but also imposes a huge financial burden, as many hospitals do not possess systems or software to produce or bill 1500 claims. The majority of hospitals would not be able to make this change as of the January 1, 2017 effective date.

CMS requests specific comment regarding whether there are difficulties with providers billing on 1500 claims for non-excepted off-campus PBDs. Simply and emphatically, **yes**. Hospital systems are created to generate UB04/837I claims and not 1500 claims. Entirely different software and processes are required to bill 1500 claims. It is imperative that CMS' Section 603 implementing regulations continue to allow non-excepted off-campus PBD services to be billed on institutional claims (i.e., UB04/837I). It is true that some larger integrated delivery systems have the software to bill both UB04/837I and 1500/837P; these organizations are not, however, the majority of providers, and they will require a significant amount of programming and process changes, since providers will continue to bill these services on UB04/837I claims for non-Medicare patients.

Furthermore, non-excepted items and services will still be provided by hospital departments, the fact that it is an institutional provider is not changing. Therefore, this provision constitutes a violation of the HIPAA Administrative Simplification Act requirements, which dictates that facilities bill institutional services *only* on a UB04/837I. We simply cannot understand how, given this requirement, CMS can deem this proposal to be an acceptable "temporary solution."

Although we reject this proposal, the PRT provides the following, additional comments in response to CMS' specific request for comments.

Even if CMS' systems cannot process UB-04 claims for payment of services provided in non-excepted off-campus PBDs, the services should be allowed to be submitted on UB04/837I. This would at least allow hospitals to submit the correct information to the CMS system. It would enable CMS to receive and collect data on all hospital outpatient services, both those to be paid under OPPS and those to be paid under another payment methodology.

The PRT is concerned that if the billing for these non-excepted off-campus PBDs is required on 1500 claims, the information related to hospital services and encounters provided in hospital PBDs will be completely lost for cost allocation and cost report settlement purposes. This information is crucial for proper hospital cost reporting and reconciliation to hospital ledgers for all services and departments, not only those excepted and paid via the OPPS. It is extremely important that revenue for non-excepted off-campus PBDs flow through the PS&R, even if the

revenue is not reimbursed via OPPS methodology. These departments are hospital departments by definition, and are different than a freestanding physician practice that is owned and operated by a hospital. Free-standing physician practices owned and operated by a hospital are not hospital departments, by definition; rather, they are "other, non-hospital entities," which do bill on 1500 claim forms. By contrast, non-excepted off-campus PBDs are full-fledged hospital departments whose payment will not be via the OPPS system based on a specific calendar date; however, the costs are included in the hospital general ledger and for correct cost apportionment should be included in the PS&R.

The PRT notes that CMS currently reimburses for some services billed on a UB/837I via the MPFS. These services include therapy and preventive services billed on the UB/837I under the hospital CCN. These services are billed on the same UB04/837I as other OPPS services, yet are paid under the MPFS. The PRT submits that CMS should follow the already accepted process for adjudicating claims submitted by PBDs. This becomes more efficient and even preferable for CMS if the definition of exempt and non-exempt is based on the date that a PBD existed and billed for services as a HOPD, rather than an extension of services.

> **The PRT strongly believes any implementation of Section 603 should be delayed to ensure the continued billing of all on- and off-campus PBDs (both excepted and non-excepted) is performed via UB04/837I claims.**

MPFS as the Designated Payment System

The PRT is very concerned with CMS' proposal that the MPFS be the only non-OPPS payment system that applies to all services rendered in non-excepted PBDs. CMS' proposal appears to be based on the erroneous assumption that all non-excepted PBDs perform office-based procedures for which the MPFS has a practice expense RVU that covers some degree of facility expense.

This assumption is invalid. There are numerous services — particularly surgeries — for which the MPFS lacks practice expense value for the facility component (i.e., the total non-facility RVUs equal the total facility RVUs). For example, there are approximately 2,400 HCPCS codes that have no facility practice expense component in the MPFS. This occurs due to the fact that these services are always performed in either an HOPD or an Ambulatory Surgery Center (ASC) and only a professional service would be billed under the MPFS. The following chart lists just a few of these codes.

Example Services with No Facility Payment under MPFS - Only Outpatient Payment is under Either ASC or OPPS		
HCPCS	SI from Add B July 2016	DESCRIPTION
97607	T	Neg press wnd tx </=50 sq cm
97608	T	Neg press wound tx >50 cm
66982	T	Cataract surgery complex
66983	T	Cataract surg w/iol 1 stage
66984	T	Cataract surg w/iol 1 stage
52320	T	Cystoscopy and treatment
52325	T	Cystoscopy stone removal
52327	T	Cystoscopy inject material

The PRT cannot reiterate strongly enough that there is simply *no facility payment* built into the MPFS for these services. CMS' proposal to limit the designated payment system solely to the MPFS would *result in no payment being made for outpatient hospital services that are not "office procedures."* The hospital would provide all facility expense associated with these surgeries and other services without being able to obtain any payment at all. The PRT does not believe this was CMS' intent in selecting the MPFS for reimbursement. We strongly urge CMS to rectify this issue before the agency moves forward with any Section 603 implementation.

The MPFS payment is solely for the procedure's *professional service*. If a 1500 claim was submitted under the physician's NPI, no payment would be associated with the hospital's facility expense, including for implantable devices, drugs, nursing care, etc. This is simply unacceptable. Section 603 does not preclude payment to hospitals for non-excepted off-campus PBD services; it just specifies that the payment not be made via the OPPS. Therefore, CMS' proposal to declare the MPFS as the sole other payment system available, even if just for one year, ignores a huge number of medically necessary procedures that are often performed by hospital PBDs and for which payment must be made.

Furthermore, there are services for which there is no outpatient facility payment under the MPFS and ASC payment systems. The only outpatient payment is available through the OPPS. The PRT requests that CMS clarify how these services will be paid, and presents a few of the relevant codes in the following chart.

Example Services with No Facility Payment under MPFS or ASC - Only Outpatient Payment is under OPPS		
HCPCS	SI from Add B July 2016	DESCRIPTION
35458	J1	Repair arterial blockage
38120	J1	Laparoscopy splenectomy
43281	J1	Lap paraesophag hern repair
43289	J1	Laparoscope proc esoph
43647	J1	Lap impl electrode antrum
58290	J1	Vag hyst complex
58291	J1	Vag hyst incl t/o complex
58292	J1	Vag hyst t/o & repair compl

CMS must ensure that hospitals are able to submit claims and be reimbursed for their facility expenses.

Legal and Regulatory Concerns

The PRT notes that organizations that do not employ clinicians will have to negotiate agreements with clinicians to either reassign billing to the hospital, or remit the practice expense payment for facility services to the hospital. The time and effort needed to ensure compliance with the Stark and Anti-Kickback Statute will be significant. Given the complexity of Stark Law requirements, expert legal counsel will be needed to draft these agreements — resulting in increased costs to Medicare providers and to the Medicare program itself. We also believe that this will have an effect on the claims used under MACRA for clinicians' MIPS reporting. Clinicians will not be able to count claims under another NPI/TIN combination. This will further complicate clinicians' ability to meet MIPS targets, something for which they may not be prepared.

Additionally, the PRT has concerns over regulatory issues. Currently, 42 CFR 410.26 (b) 5 states that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for incident to services. The PRT asks for clarification whether a provider may bill a 1500 claim under the physician providing the direct supervision of the service provided at the non-excepted off-campus PBD.

The PRT urges CMS to ensure that the payment system is used appropriately and adequately reimburses providers for the services they provide including the associated facility expenses and technical components of tests and surgical procedures.

Guidelines for Implementation of a Payment System No Earlier than 2018

In the preamble discussion of Section 603 implementation policies, CMS explains the Congressional intent to eliminate incentives for hospital acquisition of physician practices and resulting higher payments for the same types of services as can be performed (or used to be performed) in the physician practices. CMS refers to this practice as "vertical integration."

CMS' 2017 proposals (specifically, to limit the payment system to MPFS, apply the 1500 billing requirement, and prevent expansion or relocation of off-campus PBD services) extend well beyond services that are commonly performed in free-standing physician practices. CMS' policies extend to hospital departments that perform services that are not performed in physician practices, but that are only performed in facility settings such as ASCs and hospital outpatient departments.

Thus, by the agency's own admission, CMS' policies exceed Congressional intent. They will also result in significant "collateral damage" to providers that have legitimate off-campus PBDs that were not created via the acquisition of a physician practice, but were, instead, created as a hospital department, as described in 42 CFR 413.65.

Therefore, the PRT urges CMS to implement policies that adhere to the following parameters:

- Services must be able to continue to be billed on a UB04/837I consistent with the Administrative Simplification Act and requirements for institutional claims, since these non-excepted departments would be full-fledged PBDs albeit, unable to be paid under OPPS;
- The applicable fee schedule should be limited only to those services able to be performed in physician offices and outpatient hospital departments;
- The fee schedule should be designed to be site-neutral, but should recognize facility resources required to perform the service in an office or clinic setting; and
- The instructions to hospitals should include cost reporting instructions and applicable detail in the PS&R to provide for reasonable and appropriate reconciliation of hospital ledgers to the cost report.

<u>Unintended Consequences of this Proposal</u>

OPPS No Longer Results in Higher Payment for all Services

The PRT is concerned that the MedPAC, GAO, and OIG analysis for site neutrality was performed prior to implementation of the significantly expanded packaging policies under the OPPS, which began in 2014. The PRT lacks the resources to do a full-scale claim analysis with assumptions, but we priced-out an outpatient hospital encounter to review. Our findings indicate that MPFS payment, together with CLFS payment, actually results in *higher* payment under CMS' proposal, compared to the current OPPS payment, even including the physician professional component.

The following chart illustrates the impact of current OPPS packaging policies on provider-based reimbursement when compared with payment under the MPFS.

	2014	2015	2016
Excepted Off-Campus PBD			
G0463 Clinic Visit	$ 92.53	$ 96.22	$ 102.12
85027 CBC	$ -	$ -	$ -
83036 A1C			$ -
81002 UA			$ -
84443 TSH			$ -
94010 Spirometry	$ 88.74	$ -	$ -
93005 EKG Tracing			$ -
Subtotal OPPS	$ 181.27	$ 96.22	$ 102.12
99213 Facility MPFS	$ 51.58	$ 51.07	$ 51.56
93010 EKG Interpretation MPFS	$ 8.40	$ 8.45	$ 8.42
Subtotal MPFS	$ 59.98	$ 59.52	$ 59.98
Total Part B Payment	**$ 241.25**	**$ 155.74**	**$ 162.10**
Freestanding Clinic - All Services			
99213 Non-Facility MPFS	$ 73.08	$ 72.86	$ 73.40
85027 CBC	$ 8.83	$ 8.81	$ 8.81
83036 A1C	$ 13.22	$ 13.22	$ 13.22
81002 UA	$ 3.48	$ 3.48	$ 3.48
84443 TSH	$ 22.89	$ 22.89	$ 22.89
94010 Spirometry	$ 36.18	$ 36.43	$ 36.52
93000 EKG Global	$ 16.25	$ 16.61	$ 16.63
Total Part B Payment	**$ 173.93**	**$ 174.30**	**$ 174.95**

The PRT recommends that CMS conduct modeling of payment for off-campus PBDs using claims with modifier –PO to determine if there is still significant additional payment under OPPS. This analysis could inform Congress and CMS as they progress with implementation policies.

CMS' Section 603 Implementing Proposals' Impact on Episode Payment Models (EPMs)

CMS often holds providers accountable for improving the quality of care and for coordinating care in a way that reduces CMS' costs. As part of these efforts, CMS has implemented several episode payment models. These models use Medicare payment for patient cohorts and episodes of care for a period in the past, then compare results with the same patient cohorts after implementation of the model. Examples of current payment models include OCM, CPC+, BPCI, CJR, and the newly proposed cardiac EPMs.

The PRT is concerned by the challenges and dangers of implementing the proposed Section 603 payment changes in the middle of these on-going innovation projects. CMS lacks sufficient information to accurately estimate the number or type of non-excepted off-campus PBDs

compared to those excepted to model the change to the baseline targets. More important, those targets will be constantly changing under CMS' proposal that current excepted off-campus PBDs would not be able to expand services. The PRT has estimated that, in many instances, Medicare payment may actually *increase* under the MPFS system due to OPPS' significant packaging of services; this fact means that the targets could be potentially unreachable for some of the models. And, they provide providers and CMS alike with no abilty to estimate or make appropriate adjustments.

> **The PRT believes that the models are too important for CMS to jeopordize the EPM outcomes by interjecting such a payment change in the middle of the on-going episode payment models. For this reason, the PRT asks CMS to delay implementation until it has data on the number and type of non-excepted PBDs and can account for the impact to the EPMs with stakeholder input.**

Beneficiary Access to Care

One reason for the expansion of off-campus PBDs is the need to bring hospital services closer to where beneficiaries reside. Many in the Medicare beneficiary population are more vulnerable and less mobile than some other patient populations. As with many people, beneficiaries value proximity to their home as an important determination for the selection of providers. With the shift of a significant number and type of services from inpatient to outpatient settings, hospitals have been able to successfully bring hospital care closer to patients' homes and better meet patients' needs.

CMS' Section 603 policy jeopardizes this benefit, however. It risks not only the elimination of expansion of off-campus outpatient hospital services, but also the erosion of services that already exist. This is because, for 2017, CMS essentially proposes no payment for these services. Even if this situation is only temporary, the future of off-campus hospital services is very uncertain. Again, the PRT notes that CMS states that Congress' intent was to limit hospital acquisition of physician practices as off-campus PBDs paid under OPPS. However, CMS' implementing proposals apply this limitation to *all off-campus PBD services*, including those services incapable of being performed in physician practices; CMS also proposes to apply this limitation to existing off-campus PBDs that Section 603 exempts with the proposed clinical family expansion policy.

Therefore, if hospitals close off-campus locations and no longer have an option to organize new ones because the payment methodology is not known and not quantifiable, it will create a significant barrier to outpatient hospital care for this vulnerable population. This outcome conflicts with CMS' goal to increase quality, improve population health, and reduce costs. The agency also risks jeopardizing its objective of site neutrality. This occurs at a time when CMS is asking hospitals to be the entity most directly accountable for value-based initiatives and alternative payment models designed to better coordinate care and reduce expense.

Finally, the PRT is concerned that hospitals will respond by ensuring only professional services that are personally performed by physicians and NPPs are provided in non-excepted off-campus

PBDs and will redirect any ancillary services to be performed in on-campus or excepted off-campus PBDs where it would not represent an expansion of services. As depicted in the chart below, the non-facility payment for the personally performed professional services plus the single payment for a conditionally packaged service results in higher payment when compared to the charts above for either freestanding or OPPS-reimbursed PBDs. We do not think this is what either Congress or CMS intends and request that CMS proceed very cautiously and perform analyses based on its current OPPS payment policy before proceeding with proposals.

Non-excepted PBD Visit w/On-Campus Hospital Diagnostics paid via OPPS	2014	2015	2016
99213 Non-Facility MPFS	$ 73.08	$ 72.86	$ 73.40
93010 EKG Interpretation	$ 8.40	$ 8.45	$ 8.42
Subtotal MPFS	$ 81.48	$ 81.31	$ 81.82
Excepted On-Campus PBD			
85027 CBC	$ -	$ -	$ -
83036 A1C	$ -	$ -	$ -
81002 UA	$ -	$ -	$ -
84443 TSH	$ -	$ -	$ -
94010 Spirometry	$ 88.74	$ 161.22	$ 129.75
93005 EKG Tracing	$ -	$ -	$ -
Subtotal OPPS	$ 88.74	$ 161.22	$ 129.75
Total Part B Payment	$ 170.22	$ 242.53	$ 211.57

Additional Technical Questions

The PRT asks CMS under what claim form are Medicare Part C patients to be billed for these departments? Is this negotiable with the individual plans? Should providers assume that they would be required to submit 1500 claims for non-contracted Part C plans?

The PRT also seeks clarification about how hospitals should bill for the technical component of diagnostic tests. Does the hospital submit a 1500 claim with modifier TC appended to the CPT code under the supervising radiologist's NPI? Will hospitals be required to globally bill these services, even though "global billing" does not apply to hospitals? We note that doing so would result in different charges being made for different payers, which raises cost accounting and other cost-reporting issues.

Conclusion

The PRT emphatically urges CMS to postpone implementation of Section 603 until the agency has time to design, consider, and implement a thoughtful transition. This is absolutely necessary to avoid the many, significant negative outcomes that are likely to occur if the proposal is implemented in its current form and on the proposed time table. The PRT recommends CMS take steps to:

Postpone implementation of Section 603 due to the severely negative potential impacts this proposal will have, particularly with respect to the on-going EPMs.

Ensure that the agency, hospitals, and other stakeholders have sufficient time to model, consider, plan for, and implement any finalized policy.

Revise its proposal to limit expansion of clinical services at existing off-campus PBDs from those services billed as of November 2, 2015, which is untenable for hospital facilities and does not reflect today's reality of medicine as an evolving science.

Except *all* off-campus PBDs that were billing services under the provider's CCN prior to November 2, 2015 period, and clarify that relocation of an existing excepted off-campus PBD will not result in any change to the organization's exception; exceptions should apply in perpetuity.

Relinquish its plan to use APCs to define clinical families, given the annual changes to APC composition, and the on-going evolution of medical technology and clinical practice.

Ensure the continued billing of all on- and off-campus PBDs (both excepted and non-excepted) is performed via UB04/837I claims, as required by the HIPAA Administrative Simplification Act.

Adjust its proposal that the MPFS be the only non-OPPS payment system that applies to all services rendered in non-excepted PBDs, as this bars hospitals from submitting claims, and being reimbursed, for their facility expenses used to care for Medicare beneficiaries.

Provide appropriate and adequate reimbursement for providers' services, associated facility expenses, and technical components of tests and surgical procedures.

Model payments for off-campus PBDs to generate data to guide the agency's implementation policies.

Attachment A: Provider Roundtable Members

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Attachment B - PRT Comments on Proposed OPPS Rule CY2017: Allergy Composite

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95004	Percut allergy skin tests	CH	Q1	5735	3.5451	$265.56	.	$53.12
95012	Exhaled nitric oxide meas		Q1	5732	0.3364	$25.20	.	$5.04
95017	Perq & icut allg test venoms		Q1	5732	0.3364	$25.20	.	$5.04
95018	Perq&ic allg test drugs/biol		Q1	5732	0.3364	$25.20	.	$5.04
95024	Icut allergy test drug/bug		Q1	5733	0.7613	$57.03	.	$11.41
95027	Icut allergy titrate-airborn		Q1	5732	0.3364	$25.20	.	$5.04
95028	Icut allergy test-delayed		Q1	5732	0.3364	$25.20	.	$5.04
95044	Allergy patch tests	CH	Q1	5735	3.5451	$265.56	.	$53.12
95052	Photo patch test		Q1	5732	0.3364	$25.20	.	$5.04
95056	Photosensitivity tests		Q1	5733	0.7613	$57.03	.	$11.41
95060	Eye allergy tests		Q1	5734	1.2770	$95.66	.	$19.14
95065	Nose allergy test		Q1	5732	0.3364	$25.20	.	$5.04
95071	Bronchial allergy tests		Q1	5722	3.0927	$231.67	.	$46.34
95180	Rapid desensitization	CH	Q1	5735	3.5451	$265.56	.	$53.12
95199	Allergy immunology services		Q1	5731	0.1643	$12.31	.	$2.47

Attachment B - PRT Comments on Proposed OPPS Rule CY2017: Cardiology Composite

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93005	Electrocardiogram tracing		Q1	5733	0.7613	$57.03	.	$11.41
93017	Cardiovascular stress test		Q1	5722	3.0927	$231.67	.	$46.34
93024	Cardiac drug stress test	CH	Q1	5735	3.5451	$265.56	.	$53.12
93041	Rhythm ecg tracing	CH	Q1	5733	0.7613	$57.03	.	$11.41
93050	Art pressure waveform analys		Q1	5732	0.3364	$25.20	.	$5.04
93225	Ecg monit/reprt up to 48 hrs		Q1	5734	1.2770	$95.66	.	$19.14
93226	Ecg monit/reprt up to 48 hrs		Q1	5734	1.2770	$95.66	.	$19.14
93260	Prgrmg dev eval impltbl sys		Q1	5741	0.4634	$34.71	.	$6.95
93261	Interrogate subq defib		Q1	5741	0.4634	$34.71	.	$6.95
93270	Remote 30 day ecg rev/report		Q1	5741	0.4634	$34.71	.	$6.95
93278	Ecg/signal-averaged		Q1	5733	0.7613	$57.03	.	$11.41
93279	Pm device progr eval sngl		Q1	5741	0.4634	$34.71	.	$6.95
93280	Pm device progr eval dual		Q1	5741	0.4634	$34.71	.	$6.95
93281	Pm device progr eval multi		Q1	5741	0.4634	$34.71	.	$6.95
93282	Prgrmg eval implantable dfb		Q1	5741	0.4634	$34.71	.	$6.95
93283	Prgrmg eval implantable dfb		Q1	5741	0.4634	$34.71	.	$6.95
93284	Prgrmg eval implantable dfb		Q1	5741	0.4634	$34.71	.	$6.95
93285	Ilr device eval progr		Q1	5741	0.4634	$34.71	.	$6.95
93286	Peri-px pacemaker device evl		N					
93287	Peri-px device eval & prgr		N					
93288	Pm device eval in person		Q1	5741	0.4634	$34.71	.	$6.95
93289	Interrog device eval heart		Q1	5741	0.4634	$34.71	.	$6.95
93290	Icm device eval		Q1	5741	0.4634	$34.71	.	$6.95
93291	Ilr device interrogate		Q1	5732	0.3364	$25.20	.	$5.04
93292	Wcd device interrogate		Q1	5741	0.4634	$34.71	.	$6.95

Attachment B - PRT Comments on Proposed OPPS Rule CY2017: Repiratory Composite

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
94010	Breathing capacity test		Q1	5721	1.7010	$127.42	.	$25.49
94011	Spirometry up to 2 yrs old		Q1	5721	1.7010	$127.42	.	$25.49
94012	Spirmtry w/brnchdil inf-2 yr		Q1	5722	3.0927	$231.67	.	$46.34
94014	Patient recorded spirometry	CH	Q1	5735	3.5451	$265.56	.	$53.12
94015	Patient recorded spirometry		Q1	5722	3.0927	$231.67	.	$46.34
94150	Vital capacity test		Q1	5721	1.7010	$127.42	.	$25.49
94200	Lung function test (mbc/mvv)		Q1	5734	1.2770	$95.66	.	$19.14
94250	Expired gas collection		Q1	5733	0.7613	$57.03	.	$11.41
94375	Respiratory flow volume loop		Q1	5722	3.0927	$231.67	.	$46.34
94400	Co2 breathing response curve	CH	Q1	5721	1.7010	$127.42	.	$25.49
94450	Hypoxia response curve		Q1	5721	1.7010	$127.42	.	$25.49
94452	Hast w/report		Q1	5734	1.2770	$95.66	.	$19.14
94453	Hast w/oxygen titrate		Q1	5734	1.2770	$95.66	.	$19.14
94610	Surfactant admin thru tube		Q1	5791	2.1531	$161.29	.	$32.26
94620	Pulmonary stress test/simple		Q1	5734	1.2770	$95.66	.	$19.14
94640	Airway inhalation treatment		Q1	5791	2.1531	$161.29	.	$32.26
94642	Aerosol inhalation treatment		Q1	5791	2.1531	$161.29	.	$32.26
94644	Cbt 1st hour		Q1	5734	1.2770	$95.66	.	$19.14
94645	Cbt each addl hour		N					
94660	Pos airway pressure cpap		Q1	5791	2.1531	$161.29	.	$32.26
94664	Evaluate pt use of inhaler		Q1	5791	2.1531	$161.29	.	$32.26
94667	Chest wall manipulation		Q1	5734	1.2770	$95.66	.	$19.14
94668	Chest wall manipulation		Q1	5733	0.7613	$57.03	.	$11.41
94669	Mechanical chest wall oscill		Q1	5791	2.1531	$161.29	.	$32.26
94680	Exhaled air analysis o2		Q1	5721	1.7010	$127.42	.	$25.49
94681	Exhaled air analysis o2/co2		Q1	5722	3.0927	$231.67	.	$46.34
94690	Exhaled air analysis		Q1	5732	0.3364	$25.20	.	$5.04
94726	Pulm funct tst plethysmograp		Q1	5722	3.0927	$231.67	.	$46.34
94727	Pulm function test by gas		Q1	5721	1.7010	$127.42	.	$25.49
94728	Pulm funct test oscillometry		Q1	5722	3.0927	$231.67	.	$46.34
94729	Co/membane diffuse capacity		N					
94750	Pulmonary compliance study		Q1	5721	1.7010	$127.42	.	$25.49
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94780	Car seat/bed test 60 min		Q1	5732	0.3364	$25.20	.	$5.04
94781	Car seat/bed test + 30 min		N					
94799	Pulmonary service/procedure		Q1	5721	1.7010	$127.42	.	$25.49

Attachment B - PRT Comments on Proposed OPPS Rule CY2017: Xray Composite

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70030	X-ray eye for foreign body		Q1	5521	0.8454	$63.33	.	$12.67
70100	X-ray exam of jaw <4views		Q1	5521	0.8454	$63.33	.	$12.67
70110	X-ray exam of jaw 4/> views	CH	Q1	5521	0.8454	$63.33	.	$12.67
70120	X-ray exam of mastoids		Q1	5521	0.8454	$63.33	.	$12.67
70130	X-ray exam of mastoids	CH	Q1	5521	0.8454	$63.33	.	$12.67
70134	X-ray exam of middle ear	CH	Q1	5523	2.9201	$218.74	.	$43.75
70140	X-ray exam of facial bones		Q1	5521	0.8454	$63.33	.	$12.67
70150	X-ray exam of facial bones		Q1	5522	1.5672	$117.40	.	$23.48
70160	X-ray exam of nasal bones		Q1	5521	0.8454	$63.33	.	$12.67
70190	X-ray exam of eye sockets		Q1	5521	0.8454	$63.33	.	$12.67
70200	X-ray exam of eye sockets	CH	Q1	5521	0.8454	$63.33	.	$12.67
70210	X-ray exam of sinuses		Q1	5521	0.8454	$63.33	.	$12.67
70220	X-ray exam of sinuses		Q1	5521	0.8454	$63.33	.	$12.67
70240	X-ray exam pituitary saddle		Q1	5521	0.8454	$63.33	.	$12.67
70250	X-ray exam of skull	CH	Q1	5521	0.8454	$63.33	.	$12.67
70260	X-ray exam of skull		Q1	5522	1.5672	$117.40	.	$23.48
70300	X-ray exam of teeth		Q1	5521	0.8454	$63.33	.	$12.67
70310	X-ray exam of teeth	CH	Q1	5524	5.8861	$440.92	.	$88.19
70320	Full mouth x-ray of teeth		Q1	5523	2.9201	$218.74	.	$43.75
70328	X-ray exam of jaw joint		Q1	5521	0.8454	$63.33	.	$12.67
70330	X-ray exam of jaw joints		Q1	5521	0.8454	$63.33	.	$12.67
70350	X-ray head for orthodontia		Q1	5521	0.8454	$63.33	.	$12.67
70355	Panoramic x-ray of jaws		Q1	5521	0.8454	$63.33	.	$12.67
70360	X-ray exam of neck		Q1	5521	0.8454	$63.33	.	$12.67
70370	Throat x-ray & fluoroscopy	CH	Q1	5522	1.5672	$117.40	.	$23.48
70371	Speech evaluation complex	CH	Q1	5523	2.9201	$218.74	.	$43.75
70380	X-ray exam of salivary gland	CH	Q1	5522	1.5672	$117.40	.	$23.48
71021	Chest x-ray frnt lat lordotc		Q1	5521	0.8454	$63.33	.	$12.67
71022	Chest x-ray frnt lat oblique		Q1	5521	0.8454	$63.33	.	$12.67
71023	Chest x-ray and fluoroscopy	CH	Q1	5521	0.8454	$63.33	.	$12.67
71030	Chest x-ray 4/> views		Q1	5521	0.8454	$63.33	.	$12.67
71034	Chest x-ray&fluoro 4/> views		Q1	5522	1.5672	$117.40	.	$23.48
71035	Chest x-ray special views		Q1	5521	0.8454	$63.33	.	$12.67
71100	X-ray exam ribs uni 2 views		Q1	5521	0.8454	$63.33	.	$12.67
71101	X-ray exam unilat ribs/chest	CH	Q1	5521	0.8454	$63.33	.	$12.67
71110	X-ray exam ribs bil 3 views		Q1	5522	1.5672	$117.40	.	$23.48
71111	X-ray exam ribs/chest4/> vws		Q1	5522	1.5672	$117.40	.	$23.48
71120	X-ray exam breastbone 2/>vws		Q1	5521	0.8454	$63.33	.	$12.67
71130	X-ray strenoclavic jt 3/>vws		Q1	5521	0.8454	$63.33	.	$12.67
72020	X-ray exam of spine 1 view		Q1	5521	0.8454	$63.33	.	$12.67
72040	X-ray exam neck spine 2-3 vw	CH	Q1	5521	0.8454	$63.33	.	$12.67
72050	X-ray exam neck spine 4/5vws		Q1	5522	1.5672	$117.40	.	$23.48
72052	X-ray exam neck spine 6/>vws		Q1	5522	1.5672	$117.40	.	$23.48
72070	X-ray exam thorac spine 2vws		Q1	5522	1.5672	$117.40	.	$23.48
72072	X-ray exam thorac spine 3vws		Q1	5522	1.5672	$117.40	.	$23.48

Attachment B - PRT Comments on Proposed OPPS Rule CY2017: Xray Composite

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
72074	X-ray exam thorac spine4/>vw		Q1	5522	1.5672	$117.40	.	$23.48
72080	X-ray exam thoracolmb 2/> vw		Q1	5521	0.8454	$63.33	.	$12.67
72081	X-ray exam entire spi 1 vw		Q1	5521	0.8454	$63.33	.	$12.67
72082	X-ray exam entire spi 2/3 vw		Q1	5522	1.5672	$117.40	.	$23.48
72100	X-ray exam l-s spine 2/3 vws	CH	Q1	5521	0.8454	$63.33	.	$12.67
72110	X-ray exam l-2 spine 4/>vws		Q1	5522	1.5672	$117.40	.	$23.48
72114	X-ray exam l-s spine bending		Q1	5522	1.5672	$117.40	.	$23.48
72120	X-ray bend only l-s spine		Q1	5521	0.8454	$63.33	.	$12.67
72170	X-ray exam of pelvis		Q1	5522	1.5672	$117.40	.	$23.48
72190	X-ray exam of pelvis	CH	Q1	5521	0.8454	$63.33	.	$12.67
72200	X-ray exam si joints		Q1	5522	1.5672	$117.40	.	$23.48
72202	X-ray exam si joints 3/> vws		Q1	5522	1.5672	$117.40	.	$23.48
72220	X-ray exam sacrum tailbone		Q1	5521	0.8454	$63.33	.	$12.67
73000	X-ray exam of collar bone		Q1	5521	0.8454	$63.33	.	$12.67
73010	X-ray exam of shoulder blade		Q1	5521	0.8454	$63.33	.	$12.67
73020	X-ray exam of shoulder		Q1	5521	0.8454	$63.33	.	$12.67
73030	X-ray exam of shoulder		Q1	5521	0.8454	$63.33	.	$12.67
73050	X-ray exam of shoulders		Q1	5521	0.8454	$63.33	.	$12.67
73060	X-ray exam of humerus		Q1	5521	0.8454	$63.33	.	$12.67
73070	X-ray exam of elbow		Q1	5521	0.8454	$63.33	.	$12.67
73080	X-ray exam of elbow		Q1	5521	0.8454	$63.33	.	$12.67
73090	X-ray exam of forearm		Q1	5521	0.8454	$63.33	.	$12.67
73092	X-ray exam of arm infant		Q1	5522	1.5672	$117.40	.	$23.48
73100	X-ray exam of wrist		Q1	5521	0.8454	$63.33	.	$12.67
73110	X-ray exam of wrist		Q1	5521	0.8454	$63.33	.	$12.67
73120	X-ray exam of hand		Q1	5522	1.5672	$117.40	.	$23.48
73130	X-ray exam of hand		Q1	5521	0.8454	$63.33	.	$12.67
73140	X-ray exam of finger(s)		Q1	5521	0.8454	$63.33	.	$12.67
73501	X-ray exam hip uni 1 view		Q1	5521	0.8454	$63.33	.	$12.67
73502	X-ray exam hip uni 2-3 views		Q1	5521	0.8454	$63.33	.	$12.67
73503	X-ray exam hip uni 4/> views		Q1	5522	1.5672	$117.40	.	$23.48
73521	X-ray exam hips bi 2 views		Q1	5522	1.5672	$117.40	.	$23.48
73522	X-ray exam hips bi 3-4 views		Q1	5522	1.5672	$117.40	.	$23.48
73551	X-ray exam of femur 1		Q1	5521	0.8454	$63.33	.	$12.67
73552	X-ray exam of femur 2/>		Q1	5521	0.8454	$63.33	.	$12.67
73560	X-ray exam of knee 1 or 2		Q1	5521	0.8454	$63.33	.	$12.67
73562	X-ray exam of knee 3		Q1	5521	0.8454	$63.33	.	$12.67
73564	X-ray exam knee 4 or more	CH	Q1	5521	0.8454	$63.33	.	$12.67
73565	X-ray exam of knees		Q1	5521	0.8454	$63.33	.	$12.67
73590	X-ray exam of lower leg		Q1	5521	0.8454	$63.33	.	$12.67
73592	X-ray exam of leg infant		Q1	5521	0.8454	$63.33	.	$12.67
73600	X-ray exam of ankle		Q1	5521	0.8454	$63.33	.	$12.67
73610	X-ray exam of ankle		Q1	5521	0.8454	$63.33	.	$12.67
73620	X-ray exam of foot		Q1	5521	0.8454	$63.33	.	$12.67
73630	X-ray exam of foot		Q1	5521	0.8454	$63.33	.	$12.67

Attachment B - PRT Comments on Proposed OPPS Rule CY2017: Xray Composite

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73650	X-ray exam of heel		Q1	5521	0.8454	$63.33	.	$12.67
73660	X-ray exam of toe(s)		Q1	5521	0.8454	$63.33	.	$12.67
74000	X-ray exam of abdomen		Q1	5521	0.8454	$63.33	.	$12.67
74010	X-ray exam of abdomen		Q1	5521	0.8454	$63.33	.	$12.67
74020	X-ray exam of abdomen		Q1	5521	0.8454	$63.33	.	$12.67
74022	X-ray exam series abdomen		Q1	5522	1.5672	$117.40	.	$23.48
74210	Contrst x-ray exam of throat		Q1	5522	1.5672	$117.40	.	$23.48
74220	Contrast x-ray esophagus		Q1	5522	1.5672	$117.40	.	$23.48
74230	Cine/vid x-ray throat/esoph		Q1	5522	1.5672	$117.40	.	$23.48
74240	X-ray upper gi delay w/o kub		Q1	5522	1.5672	$117.40	.	$23.48
74241	X-ray upper gi delay w/kub		Q1	5522	1.5672	$117.40	.	$23.48
74246	Contrst x-ray uppr gi tract		Q1	5522	1.5672	$117.40	.	$23.48
74247	Contrst x-ray uppr gi tract		Q1	5522	1.5672	$117.40	.	$23.48
74250	X-ray exam of small bowel		Q1	5522	1.5672	$117.40	.	$23.48
74260	X-ray exam of small bowel		Q1	5523	2.9201	$218.74	.	$43.75
74270	Contrast x-ray exam of colon		Q1	5522	1.5672	$117.40	.	$23.48
74290	Contrast x-ray gallbladder	CH	Q1	5522	1.5672	$117.40	.	$23.48
74710	X-ray measurement of pelvis		Q1	5521	0.8454	$63.33	.	$12.67
75571	Ct hrt w/o dye w/ca test	CH	Q1	5521	0.8454	$63.33	.	$12.67
76010	X-ray nose to rectum	CH	Q1	5521	0.8454	$63.33	.	$12.67
76100	X-ray exam of body section		Q1	5522	1.5672	$117.40	.	$23.48
76101	Complex body section x-ray		Q1	5522	1.5672	$117.40	.	$23.48
76120	Cine/video x-rays	CH	Q1	5521	0.8454	$63.33	.	$12.67
76125	Cine/video x-rays add-on		N					
76380	Cat scan follow-up study		Q1	5521	0.8454	$63.33	.	$12.67
76496	Fluoroscopic procedure		Q1	5521	0.8454	$63.33	.	$12.67
76497	Ct procedure		Q1	5521	0.8454	$63.33	.	$12.67
76499	Radiographic procedure		Q1	5521	0.8454	$63.33	.	$12.67
77071	X-ray stress view		Q1	5521	0.8454	$63.33	.	$12.67
77072	X-rays for bone age		Q1	5522	1.5672	$117.40	.	$23.48
77073	X-rays bone length studies		Q1	5521	0.8454	$63.33	.	$12.67
77074	X-rays bone survey limited		Q1	5522	1.5672	$117.40	.	$23.48
77075	X-rays bone survey complete		Q1	5522	1.5672	$117.40	.	$23.48
77076	X-rays bone survey infant	CH	Q1	5523	2.9201	$218.74	.	$43.75