



**American Hospital  
Association**

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October 7, 2004

Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, S.W.  
Room 445-G  
Washington, DC 20201

**Ref: [CMS-1427-P] Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System (OPPS) and Calendar Year 2005 Payment Rates (69 *Federal Register* 50488), August 16, 2004.**

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,700 member hospitals and health care systems, and our 31,000 individual members, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule establishing new policies and payment rates for hospital outpatient services for calendar year 2005.

The AHA is concerned that in the proposed 2005 OPPS, many ambulatory payment classification (APC) rates continue to fluctuate dramatically, with payments much lower or higher in 2005 than in 2004. These changes make it extremely difficult for hospitals to plan and budget from year to year. In addition, a separate payment-to-cost analysis of the OPPS that the AHA performed using the 2003 Hospital OPPS Limited Data Set revealed troubling issues. Among them are more than 60 "broken" APCs that resulted in hospital losses of more than \$1.4 billion in payments in 2003. Even more troubling, several of the evaluation and management (E/M) services APCs – clinic and emergency department visits – were among the most "broken," resulting in losses of more than \$700 million. Also, there is a tremendous degree of variation across APCs in terms of payment-to-cost ratios. We would expect that three years after the implementation of the OPPS, these payment to cost ratios would be much more stable. Such dramatic variation in payments compared to costs puts full-service hospitals and their communities at risk because limited-service, or "niche," providers can easily identify and redirect patients with more lucrative APCs to their facilities, leaving full-service hospitals with a disproportionate share of patients with underpaid APCs. The AHA looks forward to sharing with CMS the results and implications of our analyses.



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Further, the entire OPSS is underfunded, paying only 87 cents for every dollar of hospital outpatient care provided to Medicare beneficiaries. Hospitals must have adequate funds to address critical issues like severe worker shortages, skyrocketing liability premiums, expensive drugs and technologies, aging facilities, expensive regulatory mandates and more. **The AHA will continue to work with Congress to address inadequate payment rates and updates in order to ensure access to hospital-based outpatient services for Medicare beneficiaries.**

The AHA also continues to be concerned that the amount carved out from base OPSS rates may be greater than the funds actually spent on pass-through payments for new technologies and outlier payments. For instance, in 2004 CMS withheld 1.3 percent of total estimated OPSS payments to fund new technologies through the pass-through payment methodology. Yet it is unknown how much the agency actually spent in 2004 or in prior years for new technologies. In addition, for the past three years, CMS set aside 2 percent of total estimated OPSS payments to fund outlier payments to hospitals. However, again, there has been no data released revealing how much of this amount was actually spent. With the significant changes to outlier policies proposed for 2005, the AHA is concerned that Medicare may not actually spend the 2 percent outlier target set-aside. **The AHA strongly urges CMS to release data on actual pass-through payments and outlier payments made in 2004 and in prior years, and to continue to report this data in the future.**

**The AHA is also extremely disappointed that the 2005 rule again does not propose national guidelines for facility E/M reporting.** While we are glad that CMS continues to develop and test the new codes, hospitals are still without a standard methodology for reporting E/M services. This puts hospitals at risk for lack of uniformity in coding and impairs the ability of CMS to gather consistent, meaningful data on services provided in the emergency department and hospital clinics. We believe that the E/M coding recommendations provided to CMS over a year ago from an expert panel co-chaired by the AHA and the American Health Information Management Association (AHIMA) will meet hospitals' needs.

Attached are our detailed comments regarding CMS' proposed changes to the OPSS, including those related to the calculation of 2005 rates and weights, transitional pass-through payments, payments for devices and drugs, outliers, transitional corridor payments, and evaluation and management services.

The AHA appreciates the opportunity to submit these comments. If you have any questions please feel free to contact me or Roslyne Schulman, senior associate director for policy, at (202) 626-2273.

Sincerely,

Rick Pollack  
Executive Vice President

Attachment

**Attachment**

**American Hospital Association  
Comments on CY 2005 Medicare Hospital Outpatient PPS  
October 7, 2004**

**Physical Examinations (Sec. 611 of MMA)**

Consistent with provisions in Sec. 611 of the MMA, CMS proposes to provide for coverage of an initial preventive physical examination in various settings, including the hospital outpatient department, within the first six months after the beneficiary's first Part B coverage begins; that coverage period may not begin before January 1, 2005.

The AHA requests that CMS clarify two operational issues related to this new benefit. First, because the physical examination benefit is only available within six months of enrollment, **CMS should clarify the mechanism by which hospitals can validate that the beneficiary is within the requisite eligibility period.** One option CMS could consider is issuing to beneficiaries a notification explaining the benefit and its expiration date. This notification should be added quickly to CMS' files so hospitals and physicians can use it to verify beneficiary eligibility.

Second, since the statute prohibits coverage of laboratory tests within the initial physical examination, **CMS should clarify who, physician or hospital, is responsible for informing the beneficiary of tests that may be needed and whether the tests are covered by Medicare.** Otherwise, hospitals will be burdened with providing many Advanced Beneficiary Notifications (ABNs) regarding noncoverage of such tests. CMS communication to beneficiaries should also clearly inform them of the possibility that non-covered services may result from this examination.

**APC Relative Weights**

Current law requires that CMS review and revise the relative payment weights for APCs at least annually. The AHA continues to support the agency's use of hospital data, and not data from other sources, to set the payment rates, as this information more accurately reflects the costs hospitals incur to provide outpatient services. However, since the implementation of the OPSS in August 2000, payment rates for specific APCs have fluctuated dramatically. For 2005, the proposed rates continue to show significant volatility. There are several reasons for these changes.



First, in the proposed rule, CMS uses the most recent claims data for outpatient services to set 2005 rates, using approximately 119 million final action claims for hospital outpatient department services furnished from January 1, 2003 through December 31, 2003. In addition, CMS uses more recent cost reports, from 2001 and 2002. **The AHA supports the use of the most recent claims and cost report data to set the 2005 payment rates.**

Second, CMS continues its efforts to include more claims data in the calculation of the APC payment rates, especially those “multiple procedure claims” that contain charges for more than one service or procedure. CMS is proposing to expand the number of Healthcare Common Procedure Coding System (HCPCS) codes it bypasses on a claim – from 123 in 2004 to 383 in 2005 – for the purposes of creating “pseudo” single-procedure claims. This list of bypassed codes was developed using a new empirical approach described in the rule. CMS also proposes to continue using “date of service matching” – in which charges are attributed to separately payable HCPCS codes based on the code’s date of service – as a tool for creation of “pseudo” single claims. **In general, the AHA continues to support the use of multi-procedure claims, as we believe that these data improve hospital cost estimates. The AHA supports the expanded list of codes for bypass, as it appears unlikely that these codes would have charges that would be packaged into other services or procedures. We also continue to support the use of “date of service matching” in the development of the 2005 outpatient payment rates.**

However, the AHA is concerned that, while the proposed rule provides a detailed description of the methodology employed to calculate the APC weights, it does not provide adequate information for hospitals to evaluate the impact of each of the proposed policy changes independently or in combination. Questions like, “What would the weights be without the changes?” and “How much of the volatility in the weights is due to the changes?” cannot be answered due to this lack of data. **The AHA requests that CMS provide a public use file that shows the impact of each individual proposed change in methodology so health care providers can review the file to determine how the changes would affect their own operations, and provide a basis for submitting thoughtful comments to CMS.**

#### Calculating Device-Dependent APC Medians and Proposed Required Use of “C” Codes

Establishing payment rates for device-dependent APCs and the coding of devices has been a challenge for hospitals since the implementation of OPSS. In August 2000, new technology devices were coded separately. Nine months later, Congress mandated that devices be rolled into categories and identified with “C” codes. In 2002, CMS “folded-in” 75 percent of transitional pass-through payments into the base APC rates. In 2003, a number of devices on the pass-through list expired and were rolled into the base APC rates and hospitals were instructed not to use “C” codes to identify devices that no longer received pass-through payments. For 2004, CMS used only claims on which hospitals had reported devices using the “C” codes to establish the median cost for certain APCs and CMS reinstated, on a voluntary basis, the reporting of “C” codes for devices.

The 2003 claims data, used for setting 2005 rates, do not contain any “C” code data on device use because CMS eliminated device coding requirements for hospitals in that year. For 2005, CMS concludes that it is transitioning to the use of claims data exclusively for these services to ensure the appropriate relativity of the median costs for all payable OPPS services.

Therefore, CMS is proposing to determine the median costs for device-dependent APCs in 2005 based on the greater of median costs calculated using 2003 claims data, or 90 percent of the APC payment median in 2004 for such services. Also, for 2005, CMS proposes to reinstate the requirement that hospitals bill certain device-dependent procedures using the appropriate “C” codes for these devices. This requirement is limited to only those 16 APCs to which the use of 2004 medians would apply. CMS indicates that it intends this requirement to improve the quality of claims data so the agency can use all available single bill claims data to establish medians for device dependent APCs by the CY 2007 OPPS.

The AHA has several comments regarding the proposed payment methodology for device-dependent APCs and CMS’s intent to transition toward the use of claims data exclusively for these services.

**First, due to the numerous changes in coding requirements, we recommend that median cost for the device-dependent APCs listed in Table 19 of the rule be based upon the greater of median costs from the 2003 data or 100 percent of the APC payment median in 2004.**

CMS also requests comments on its proposal to require the use of “C” codes for certain APCs. After four years of significant changes in the capture and coding of devices, CMS once again is proposing a change that would require hospital coding and billing staff to be re-educated and re-trained, and would require significant system changes within hospitals. While “C” codes would be required for only 16 APCs in 2005, CMS states it is considering gradually expanding the device coding requirements to minimize the marginal annual coding burden on hospitals and begin to improve the data for these APCs.

The AHA agrees that it is appropriate for CMS to require hospitals to report “C” codes for devices because this information is important to calculate median costs for device specific APCs and for improving the quality of hospital claims data. Unfortunately, because of the complexity and burden associated with “C” code reporting, hospitals have not consistently reported charges for the devices used when billing for related services – even when there was the possibility of a separate pass-through payment. **Recognizing the complexity of “C” coding and the fact that hospitals have had to adjust to many changes with regards to “C” codes, the AHA recommends the following steps in order to ensure a smooth transition:**

- CMS should implement a grace period of no less than 90 days after implementation of the 2005 OPPS (April 1, 2005) to allow hospitals to make system changes and educate coders on the required “C” codes proposed on table 20. During this grace period, the FIs should be capable of accepting and processing these “C” codes, but should not return the claim to the provider if the “C” code is not present on the claim.

- AHA believes that CMS's proposed gradual expansion of device coding requirements over time will be confusing for hospitals and their coding staff. Instead, CMS should publish its intent to require full device "C" coding for the 2006 OPSS. Therefore, in addition to the 16 APCs listed in table 20 for the 2005 OPSS, we recommend that the remainder of the device "C" codes should be mandated for implementation in 2006. This date-certain advanced notice will give hospitals a full year to prepare for a smoother transition into full device "C" code reporting.
- The 2005 final rule should explicitly identify the "C" codes that will be required for 2005, as well as the complete list of valid "C" codes for 2006 implementation, in order for providers to start processing the changes as quickly as possible.
- CMS should encourage device manufacturers to assist hospitals by providing the appropriate "C" code information as part of the device packaging. We also recommend that CMS work with the Food and Drug Administration to expedite the placement of "C" codes on device packaging.
- We also urge CMS to consider simplifying the "C" codes to be consistent with the information routinely reported by physicians in operative reports. Because most of the devices being coded do not have pass-through payments and result in no additional payments, we recommend that these codes be collapsed and simplified. For example for APC 0082, Non-coronary angioplasty or atherectomy, there are seven separate catheter "C" codes. This could be simplified to one "C" code for "transluminal catheter." On the other hand, if there is a need to distinguish between atherectomy and angioplasty catheters, there could be two "C" codes for "transluminal angioplasty catheter" and "transluminal atherectomy catheter." The added complexity in the existing seven codes is that they distinguish whether the catheter is rotational or directional. This type of information is not usually documented in the record, and it is not information that a hospital coder would know.
- CMS should ensure that the Outpatient Code Editor (OCE) and the FI systems are ready to implement this change. FIs should be required to provide a 30-day notice to providers indicating their readiness. Payment of provider claims should not be held back if FI systems are not ready.

### **Proposed Payment Changes for Drugs, Biologicals, Radiopharmaceutical Agents, and Blood and Blood Products**

#### Pass-Through

The rule proposes removing 13 drugs from the new technology pass-through payment list effective January 1, 2005; 19 drugs would remain on the list and continue to receive pass-through payment. **The AHA supports CMS's proposal to remove these 13 drugs from the pass-through list.**

#### Drugs, Biological, and Radiopharmaceuticals NonPass-Throughs

In the rule CMS proposes to apply an exception to the general packaging rule to one particular class of drugs: the injectible and oral forms of anti-emetic treatments. **The AHA supports CMS's proposed exception that will allow separate payment for all six injectible and oral**

**forms of anti-emetic products and agrees that this will help to ensure enhanced beneficiary access to the most appropriate drug.**

#### HCPCS Codes

Effective January 1, 2004, Section 621(a)(1) of the MMA requires CMS to pay 95 percent of Average Wholesale Price (AWP) for an outpatient drug or biological for which a HCPCS code has not been assigned. In Transmittal 188, issued on May 28, CMS instructed hospitals to bill for a drug or biological that is newly approved by the FDA by reporting the National Drug Code (NDC) for the product along with a new HCPCS code, C9399, Unclassified drug or biological. When C9399 appears on a claim, the Outpatient Code Editor (OCE) suspends the claim for manual pricing by the fiscal intermediary. The FIs price the claim at 95 percent of its AWP using the Red Book and process the claim for payment. In the rule, CMS proposes to formalize this methodology for 2005 and to expand it to include payment for new radiopharmaceuticals to which a HCPCS code is not assigned.

For electronic reporting, hospitals report the NDC code using the HIPAA 837i standard that requires use of the appropriate data segment (Loop 2400 SV205). We request that CMS consider a different approach for the paper UB-92. Currently, the UB-92 paper instructions from CMS require providers to use the Remarks field to report the NDC. The use of the Remarks field creates payment delays because this data field requires manual review and pricing. **Instead, the AHA recommends that CMS adopt a new revenue code subcategory to report these newly FDA-approved drugs and biologics.** The hospital could use the new revenue code along with the reported NDC in the revenue-code description field. Establishing a new revenue code field, to be used with the description field, allows clearinghouses to scan the paper UB-92 and then convert the data into the appropriate HIPAA standard for auto adjudication. The FI would then no longer have to suspend these paper claims for manual pricing, because it would build logic into the system to auto-adjudicate these claims. The hospital would then continue to report C9399 (HCPCS code indicating Unclassified drug or biological) in the HCPCS field, the units in the Unit field, the date the drug was administered in the date field, and finally, the price of these drugs in the Total Charges field.

#### Drug Administration

Currently, Medicare pays separately for the administration of drugs through one of four “Q” codes. Each code is to be reported once per visit regardless of how many drugs are administered. Data have shown that costs appear to vary widely based on whether the drug is packaged or in a separately payable APC. This is because payment for administration is included in the payment for packaged drugs, yet a separate, additional payment is made for the administration of separately payable drugs. In the 2004 proposed rule, CMS expresses concern about inappropriate payment for drugs and drug administration.

For 2005, CMS has proposed to use the current procedural terminology (CPT) codes for drug administration but to crosswalk the CPT codes into APCs that reflect how the services would have been paid under the “Q” codes. **We applaud CMS for supporting the APC Advisory Panel’s recommendation to adopt CPT codes for chemotherapy and non-chemotherapy**

**drug administration. The AHA supports accurate payment for drugs and drug administration, and is pleased with this proposal.** Using CPT codes will simplify the administrative burden for the coding of drug administration. Hospital providers currently use CPT codes to report drug administration to all non-Medicare payers. Eliminating the “Q” codes for drug administration will standardize the way hospitals report this service across all payers. In addition, the CPT codes will distinguish between the clinical and cost differences of the different types of chemotherapy administration – something that the current “Q” codes do not do. The “Q” codes only take into account the route of administration and not the site or the complexities involved with different types of chemotherapy administration.

Hospital coders will need to learn Medicare’s requirements for the use of CPT codes for drug administration. In particular, clarification is needed regarding the following codes:

- 90780 (intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour), and
- 90781 (each additional hour; up to eight (8) hours)

**We request that CMS affirm that a physician need NOT administer the infusion or be physically present at the time of drug administration for a hospital provider to bill codes 90780 or 90781.** Codes 90780 and 90781 are crosswalked to code Q0081. None of the current “Q” codes for drug administration require the physician to provide the service, nor do they require the physician to provide direct supervision.

The AHA welcomes the opportunity to work with CMS on coding education, as well as on the development of appropriate future rate setting for drug administration.

### Blood and Blood Products

CMS proposes several changes to its payment methodology for blood and blood products. First, the agency proposes to establish new APCs that would allow each blood product to be in its own APC, as well as to reassign some of the HCPCS codes to new APCs. Second, CMS proposes to set payment rates for all blood and blood products based on 2003 claims data, utilizing an actual or simulated hospital blood-specific CCR to convert charges to costs for blood and blood products. For certain low-volume products, CMS would combine claims data for 2002 and 2003.

While this approach results in modest payment increases for many blood and blood product APCs, payment rates for certain low-volume APCs will decline significantly under this methodology. **To ensure continued beneficiary access to low-volume blood products, the AHA recommends that CMS freeze the reimbursement rates for 2005 at the 2004 levels for those low-volume blood products listed in Table 31 in the proposed rule whose rates would fall under the proposed rule’s methodology.**

The Advisory Panel on APC Groups and other groups representing the blood and blood product industry have recommended that CMS use external data for setting payment weights and rates. **If CMS chooses to use external data in an interim fashion, then the external data needs to**

**be valid, reliable, publicly available, reflective of geographic variations in costs, and subject to audit. However, the AHA continues to strongly prefer that hospital OPPS payments be based on hospital data.**

**Further, we strongly agree with CMS about the need to issue clear guidance for billing for blood, addressing issues such as the blood deductible and differences between donor and non-donor states.** There remains a great deal of confusion regarding the correct way to code and bill for blood and blood products and we urge CMS to expedite the review and release of this guidance. **We further recommend that CMS share its draft guidance for review by the Outpatient Medicare Technical Advisory Group (MTAG) and/or the National Uniform Billing Committee (NUBC) to make sure it is correct, comprehensive and reflects the billing provider prospective.** The AHA issued such guidance in 2001 and again this year in its “*AHA Coding Clinic<sup>TM</sup> for HCPCS,*” and would welcome the opportunity to work with CMS to clarify billing issues further.

### **Observation Services**

Medicare provides a separate observation care payment for patients with congestive heart failure, chest pain, and asthma. In the rule, CMS has proposed to simplify how it pays for observation services, including eliminating current requirements to provide specific diagnostic tests and modifying instructions to indicate that observation time ends when the patient is discharged from the hospital or admitted as an inpatient. **The AHA supports these proposed changes as they will result in a simpler and more reasonable process for providing necessary outpatient observation services.**

### **Inpatient Procedures**

CMS proposes to remove 22 codes from the “inpatient only” list – a list that identifies services that are unable to receive payment if they are performed in an outpatient setting and assign them to clinically appropriate APCs.

**We continue to urge CMS to eliminate the “inpatient only” list.** Physicians, not hospitals, determine where procedures can be safely performed, as well as whether a patient’s condition warrants an inpatient admission. If a physician determines that a service can be safely performed in an outpatient setting, under current rules, the hospital is penalized if that procedure happens to be on the “inpatient only” list.

**If the “inpatient only” list is not eliminated for 2005, CMS should consider developing an appeals process** to address those circumstances in which payment for a service provided on an outpatient basis is denied because it is on the “inpatient only” list. This would give the provider an opportunity to submit documentation to appeal the denial, such as physician’s intent, patient’s clinical condition, and the circumstances that allow this patient to safely be sent home without an inpatient admission.

**We also recommend that CMS clarify its criteria used to determine when a procedure is removed from the “inpatient only” list, as the agency seems to rely on information for which the source of data is unclear.** That is, if hospitals cannot bill and be reimbursed for these services in outpatient settings, where is CMS obtaining the claims data used in determining that “the procedure is being performed in multiple hospitals on an outpatient basis”?

### **Evaluation and Management (E/M) Services**

Since the implementation of OPSS, hospitals have coded clinic and emergency department (ED) visits using the same CPT code as physicians. CMS has recognized that existing E/M codes correspond to different levels of physician effort but do not adequately describe non-physician resources. Although hospitals were anticipating that CMS would propose a national, uniform E/M coding system in 2003, the agency chose not to do so. As a result, in 2003 the AHA and the American Health Information Management Association convened an independent panel of experts to develop a set of coding guidelines for CMS.

Specifically, the panel recommended that CMS should:

1. Make payment for emergency department and clinic visits based on four levels of care.
2. Create HCPCS codes to describe these levels of care as follows:
  - Gxxx1 - Level 1 Emergency Visit
  - Gxxx2 - Level 2 Emergency Visit
  - Gxxx3 - Level 3 Emergency Visit
  - Gxxx4 - Critical Care provided in the Emergency Department
  - Gxxx5 - Level 1 Clinic Visit
  - Gxxx6 - Level 2 Clinic Visit
  - Gxxx7 - Level 3 Clinic Visit
  - Gxxx8 - Critical Care provided in the Clinic
3. Replace all the HCPCS currently in APCs 600, 601, 602, 610, 611, 612, and 620 with GXXX1 through GXXX8.
4. Crosswalk payments from GXXX1 to APC 610, GXXX2 to APC 611, etc.

In the 2004 rule, CMS stated it was considering proposed national coding guidelines recommended by the panel, and planned to make any proposed guidelines available on the OPSS Web site for public comment. CMS also proposed to implement new E/M codes only when it is also able to implement guidelines for their use. This guidance would be issued after ample opportunity for public comment, systems change and provider education.

**The AHA is disappointed that the 2005 rule again does not propose national guidelines for facility E/M reporting.** While we are glad that CMS continues to develop and test the new codes, hospitals are still without a standard methodology for reporting E/M services. This lack of uniformity not only puts hospitals at risk for multiple interpretations of the level of service that should be coded and billed, but also affects CMS’ ability to gather consistent, meaningful data on services provided in the emergency department and hospital clinics. We believe that the

E/M coding recommendations made by the independent panel will adequately meet hospitals' needs.

### **Wage Index**

CMS proposes to use the final fiscal year (FY) 2005 hospital inpatient wage index to calculate the payment rates and coinsurance amounts that they will publish in the final rule. The wage index in this proposed rule is based on the FY 2005 hospital inpatient PPS proposed rule wage index. These indices reflect major changes for 2005 relating to redefined hospital labor market areas as a result of the Office of Management and Budget's revised definitions of geographical statistical areas; implementation of an occupational mix adjustment as part of the wage index; hospital reclassifications and redesignations – including the one-time reclassifications under section 508 of the MMA; and the wage index adjustment based on commuting patterns of hospital employees under section 505 of MMA. CMS proposes to adjust 60 percent of the APC payment by the wage index, as is currently done.

Subsequent to the publication of the proposed OPPS rule, CMS released a final inpatient rule that included transitional relief for a number of hospitals that would see their wage index decline due to the new labor market areas. For example, CMS will provide temporary one-year relief for hospitals with wage areas that changed due to the revised geographic definitions under which hospitals would receive a 50/50 blend calculated from the old and new definitions. In addition, CMS will allow hospitals redesignated from urban to rural areas to maintain their urban designation for three years. **The AHA assumes that these changes will be incorporated into the OPPS 2005 final regulation.**

### **Outlier Payments**

Outlier payments are additional payments to the APC amount to mitigate hospitals' losses when treating high-cost cases. For 2005, CMS proposes to maintain the outlier pool at 2 percent of total OPPS payments. Further, to address concerns from the Medicare Payment Advisory Commission (MedPAC) that a significant portion of outlier payments are made for high volume, lower cost services rather than for unusually high cost services, CMS proposes to add a new fixed-dollar threshold of \$625 that would have to be met in order for a service to qualify for an outlier payment. The cost of a service would have to be both more than 1.5 times the APC payment rate and at least \$625 more than the APC rate. When the cost of a hospital outpatient service exceeds these thresholds, the outlier payment would be 50 percent of the amount by which the cost of the service exceeds 1.5 times the APC payment rate.

The AHA supports the continued need for an outlier policy in all prospective payment systems, including the OPPS and supports revisions that better target outlier payments to unusually high cost services. **The AHA supports CMS' proposal to add a fixed dollar threshold to better target these payments to high cost services.**

**The AHA seeks further clarification from CMS regarding how the \$625 fixed-dollar threshold was calculated.** In the inpatient final rule, CMS indicated its charge estimate was too

high, and lowered the threshold considerably. If CMS is using the same estimates of charges for the purpose of this OPSS proposed rule, then the agency should make consistent adjustments to its methodology for calculating the threshold in the OPSS final rule. In addition, we are concerned about the lack of timely release of the data that would allow hospitals to perform an analysis to replicate CMS' calculation of the fixed-dollar threshold and to estimate the impact of any changes on their revenues. **We request that in the future CMS release the limited data set data files in a timelier manner.**

In addition, for the past three years, CMS set aside 2 percent of total estimated OPSS payments to fund outlier payments to hospitals. For 2005, CMS is again proposing to set aside 2 percent for outliers. However, CMS does not publicly release data regarding how much of the outlier set-aside was actually spent in prior years. With the significant changes to outlier policies proposed for 2005, the AHA is concerned that Medicare may not actually spend the 2 percent outlier target set-aside. **Therefore, the AHA strongly urges CMS to release data on actual outlier payments made in 2004 and in prior years, and to continue to report this data in the future.**

#### **Computed Tomography Angiography**

The AHA agrees with the American College of Radiology (ACR) that the costs of computed tomography angiography (CTA) continue to be reported by hospitals at a lower rate than computed tomography (CT) alone. The AHA believes that this is because hospital coders and administrators misunderstand CTA, and because coding changes have resulted in inaccurate reporting of costs and charges for this procedure. We believe this misunderstanding is due to the code changes in 2001, and some confusion over whether the procedure requires one code or two. This confusion was demonstrated during the September 2004 APC Advisory Panel discussion, in which one panel member believed the procedure required two codes, and another panel member thought CPT instructions directed the user to assign a single code. According to the American Medical Association's (AMA) *CPT Assistant* publication, CTA requires only one code. However, during an AMA CPT Symposium advice was provided that two codes were required. We believe that hospitals may not have clearly understood the coding change and neglected to include a combined charge (CT and angiography) into the single combination CTA code.

**We agree with the ACR's recommendation that CMS consider alternate claims aggregation methods of valuing the CTA APC payment weight until there is improvement in the hospital cost data for this procedure. In addition, we are working with the ACR to provide coding education to hospital coders on these important procedures.**