American Journal of Respiratory and Critical Care Medicine®

American Journal of Respiratory Cell and Molecular Biology®

Proceedings of the American Thoracic Society®

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September 2, 2014

The Honorable Marilyn B. Tavenner, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

RE: **CMS–1613–P**

Administrator Tavenner:

On behalf of the 15,000 members of the American Thoracic Society (ATS), we offer our comments on the 2015 proposed Hospital Outpatient Prospective Payments System. The ATS is medical professional association dedicated to the prevention, detection, treatment and cure of respiratory disease, critical care illness and sleep disordered breathing. The ATS pursues its mission through education, research and advocacy. Many of our members treat Medicare beneficiaries. As such, we have a keen interest in the proposed polices impacting the Medicare program. We offer the following comments.

Modifier to Track Hospital Owned Physician Practice Billing
We understand that CMS is also proposing to implement a new HCPCS modifier for providers to report with every code for physician and hospital services furnished in an off-campus, provider-based department of a hospital. While ATS supports the collection of this data in order to ensure accurate and appropriate payment rates across different settings, we believe there are less burdensome methods that would capture the same information. For example, CMS can readily obtain this information through place of service indicators or on facility addresses instead of creating a new HCPCS modifier. Should CMS require a mechanism on the claim an alternative to a modifier would be to model against a check box on the claim for purchased services.

G0239 Proposed APC Reassignment
The ATS opposes CMS's proposal to reassign G0239 (other respiratory procedures, group) from APC 0077 to APC 0450. This proposal was made without discussion, making it challenging to respond to this policy proposal.

The ATS notes that G0239 is part of a family of codes, (G0237, G0238, G0239) used in coding for respiratory therapy provided to Medicare beneficiaries who need pulmonary rehabilitation but do not have COPD. For patients with COPD, the correct code is G0424. While these codes describe essentially identical services, there are important differences in the G0424 code versus the G0237, G0238, G0239 family of codes.

Both are time-based codes, but G0424 is an 1-hour code while G0237,G0238,and G0239 are 15 minute codes. While G0237,G0238, and G0239 are 15 minute increment codes, they are typically billed in blocks for 4 or 1-hour.

Both G0424 and G0237,G0238, and G0239 have had a challenging start in the Medicare program. While both code sets represent valuable services provided to Medicare beneficiaries, hospitals have been slow to fully understand the appropriate use and charge reporting of these codes. CMS recognized this problem and in the 2012 HOPPS final rule, encouraged hospitals to more completely and accurately report charge data related to this services. Below is text from the final rule…

In recent years, the CMS and the AMA's CPT Editorial Panel have increasingly created new codes that use a single HCPCS code to report combinations of services that were previously reported by multiple HCPCS codes or multiple units of a single HCPS code. For example, effective January 1, 2010, CMS created HCPCS code G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session) to represent a comprehensive program of pulmonary therapy and the CPT Editorial Panel created CPT code 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan) to report all devices furnished under a single IMRT treatment plan. As we have stated before, we expect hospitals to carefully review each new HCPCS code when setting charges for the forthcoming year. However, in particular, hospitals should be especially careful to thoughtfully establish charges for new codes that use a single code to report multiple services that were previously reported by multiple codes. It is vital in these cases that hospitals carefully establish charges that fully include all of the charges for all of the predecessor services that are reported by the new code. To fail to carefully construct the charge for a new code that reports a combination of services that were previously reported separately, particularly in the first year of the new code, under-represents the cost of providing the service describing by the new code and can have significant adverse impact on future payments under the OPPS for the individual service described by the new code. (source; 2012 HOPPS Final Rule, Federal Register 11/30/2011 page 74224)

While the above text references G0424, it could have just as easily referenced the G0237, G0238, G0239 codes.

To more accurately capture hospital charge data associated with G0424 and G0237, G0238, and G0239, ATS recommends that CMS establish revenue codes to use when reporting these services. We further recommend CMS not make any APC changes to G0239 until data from the revenue code reporting can be collected and analyzed.

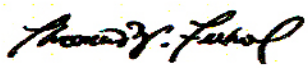
APC Adjustments

The ATS notes with concern that in this rule, CMS has proposed a significant number of APC changes to codes that significantly impacts the reimbursement for the underlying code. In most cases, the APC changes are done without explicit notice and provide no background discussion for why CMS is proposing the change. CMS's "stealth" APC changes leave the provider community with little to no insight on why CMS's is proposing the change and how to constructively respond to the proposed APC change.

The ATS strongly recommends that for future proposed rules, when APC changes result in a change of 10% or more in the reimbursement for the code, that CMS explicitly recognize the APC change and provide some background information on why CMS is proposing the change. We believe making explicit recognition of the APC change and providing the background rationale will allow the provider community to respond with thoughtful and constructive comments.

The ATS appreciates the time and effort CMS staff put into drafting proposed rules and the considerable effort CMS staff put into reading and evaluating public comments. We hope our comments will assist CMS in its efforts to continue to efficiently manage the Medicare program and ensure that safe, effective and quality medical care is offered to all Medicare beneficiaries.

Sincerely,



Thomas Ferkol, MD
President, American Thoracic Society.