

December 19, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2015 Payment Rates; Final Rule CMS-1613-FC

Dear Administrator Tavenner:

We are writing in response to the Calendar Year (CY) 2015 Hospital Outpatient Prospective Payment System (HOPPS) Final Rule, published November 10, 2014 in *Federal Register* Vol. 79 No. 217 p. 66770. The Society of Nuclear Medicine and Molecular Imaging's (SNMMI) more than 18,000 members set the standard for molecular imaging and nuclear medicine practice by creating guidelines, sharing information through journals and meetings, and leading advocacy on key issues that affect molecular imaging and therapy research and practice. We appreciate the opportunity to provide comments to assist the Centers for Medicare & Medicaid Services (CMS) in further refining the HOPPS.

We offer comments and recommendations on the following topics addressed in this final rule:

- Ancillary Services - Expanded Packaging Categories
- Off-Campus Provider-Based Departments
- New or Revised APC Placements
 - Parathyroid Codes - 78071 & 78072
 - Nuclear Medicine Therapy Services
 - Global Nuclear Medicine APC Changes for CY 2016
- CMS Offset File

Ancillary Services - Expanded Packaging Categories

CMS finalized the deletion of status indicator "X" and the majority of the services previously assigned "X" will now be assigned to status indicator "Q1." CMS has long packaged items and services that are integral, ancillary, supportive, dependent, or adjunctive to a primary service. They now believe that ancillary services should also be packaged when they are performed with another service, but should continue to be separately paid when performed alone. If a CPT code has status indicator "Q1" and appears on a claim alone, it will be paid separately. Conversely, if other major services are provided on that same date of service, the services will be packaged into the major procedure. However, the final rule does not provide a clarifying statement or percentage tables to illustrate the effects of this expanded packaging. **As a result, SNMMI continues to have concerns with expanded packaging and is disappointed that CMS did not provide impact tables by specialty, APC or CPT codes. Furthermore,**

SNMMI asks that CMS conduct additional analysis in the CY 2016 Rule to better understand the impact and ensure Medicare beneficiaries' access is not negatively impacted by increased packaging.

Off-Campus Provider-Based Departments

In the proposed rule, CMS stated that they are continuing to seek a better understanding of how the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments (PBD) affects payments under the MPFS and OPPS, as well as beneficiary cost-sharing obligations. To better understand the effects of this trend, CMS sought public comment regarding the best method for collecting information and data that would allow them to analyze the frequency, type and payment for physicians' and outpatient hospital services furnished.

In the final rule, CMS stated that while many commenters agreed that there was a need to collect information on the frequency, type, and payment of services furnished in off-campus PBDs of hospitals, some expressed concern that the HCPCS modifier would create an additional administrative burden for providers. In response, there will be a one year voluntary reporting period of the new HCPCS modifier. Reporting the new HCPCS modifier for services furnished at an off-campus PBD will not be mandatory until January 1, 2016, in order to allow providers time to prepare. **SNMMI appreciates that CMS made the reporting period voluntary for one year, we remain concerned that it will be mandatory after January 1, 2016. We request that CMS provide details clarifying which hospital claims will need to contain this modifier as many sites have told us they are unclear if this new modifier would apply to their campus or not. Additionally, it would be helpful if CMS defined a list of services by CPT code where the modifier would clearly apply showing examples to assist in the voluntary time period. We continue to believe that reporting a HCPCS modifier for off-campus provider-based departments would be an administrative burden. Instead, SNMMI suggests that CMS discuss the possibility of providing a check box (such as purchased services) on the claim form to indicate these specific provider based departments. We look forward to seeing modifications and clarifications in future rules prior to the mandatory implementation date.**

New or Revised APC Placements

Parathyroid Codes - 78071 & 78072 - Nuclear Medicine Therapy Services - Global Nuclear Medicine APC Changes

SNMMI remains concerned with individual APC placements for a variety of nuclear medicine procedures and services. While CMS did not accept any of the line item services for parathyroid or therapy services in the final rule, SNMMI continues to have global concerns regarding the APC structure as a whole. We plan to meet with CMS in the future in regard to the CY 2016 Rules with some potential new APC structures.

CMS Offset File

CMS continues to provide off-set files only with the final rule, therefore providing comments can only occur after these files are released rather than during the open comment period following the proposed rule. The SNMMI remains concerned with the format and implementation of these off-set files as CMS

lists all the unconditionally packaged products together, such as, diagnostic radiopharmaceuticals, stress agents, contrast agents and skin substitutes while only reporting out one total offset payment amount by APC category. Unfortunately, with the final construct file, without separate offset files for each category of unconditionally packaged group, CMS would remove too much money when a pass-through product of a diagnostic radiopharmaceutical or a stress agent becomes available. For example, HCPCS code A9568 is most commonly reported with CPT code 78811 or 78814, paid in the only APC PET grouping APC 0308. This is an APC that packages PET services, cardiac procedures and oncology procedures, which would always package the radiopharmaceutical and the pharmaceutical stress agent. As a result, the offset amount for CY 2015 is \$227.57. This reimbursement is accounting for both the packaged RPs and the packaged stress agent drugs. For a more accurate and appropriate result, CMS should clarify which portion is attributable to the diagnostic radiopharmaceutical and which is attributable to the packaged stress agent. Without this clarification, when removing the \$227.57 payment from the procedure payment (\$1,285.72), CMS would also be removing the costs and payment for the stress agents, and thus underpaying for this service on average. **This is an issue today for CY 2015 as you can see from our example and we believe that this issue will be of great concern in the near future and should be rectified as soon as possible. Therefore, SNMMI respectfully recommends that CMS create an offset file separating the diagnostic radiopharmaceuticals from the contrast and stress agents and any skin substitutes.**

SNMMI appreciates the opportunity to comment on this HOPPS CY 2015 Final Rule to the CMS. As always, SNMMI is ready to discuss any of its comments or meet with CMS on the above issues. In this regard, please contact Susan Bunning, Vice President, Government Affairs, by email at sbunning@snmmi.org or by phone at 703-326-1182.

Respectfully Submitted,



Gary L. Dillehay, MD, FACNM, FACR
Immediate Past President, SNMMI