



GE Healthcare

3000 N. Grandview Blvd.
Waukesha, WI 53188

August 31, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1414-P
P.O. Box 8013
Baltimore, MD 21244-1850.

ATTN: FILE CODE CMS-1414-P

Re: Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates

Dear Ms. Frizzera:

GE Healthcare (GEHC) appreciates this opportunity to comment on the proposed rule with comment period issued by the Centers for Medicare and Medicaid Services (CMS) concerning changes to the Medicare Hospital Outpatient Prospective Payment System for calendar year 2010 (Federal Register, Vol. 74, No. 137, July 20, 2009) (Proposed Rule).

GEHC, a \$17 billion unit of General Electric Company that is headquartered in the United Kingdom, has expertise in medical imaging and information technologies, medical diagnostics, patient monitoring systems, performance improvement, drug discovery, and biopharmaceuticals manufacturing technologies. GEHC's broad range of products and services enables healthcare providers to offer patients earlier and better diagnosis and treatment of cancer, heart disease, neurological diseases, and other conditions that threaten the quality and length of life. Worldwide, GEHC employs more than 46,000 people committed to serving healthcare professionals and their patients in more than 100 countries.

Overview of Comments

Our comments and recommendations focus on the following issues:

APC assignments for echocardiography procedures: GEHC supports the revisions to the echocardiography APC titles and assignments, appreciates CMS efforts to develop accurate payments for echocardiography services with or without contrast, and recognizes the attention CMS has given to stakeholder concerns about these APC assignments. We would like, however, to recommend one revision to the APC assignments for these services; specifically, GEHC requests that CPT code 93318 remains in APC 270 where it was originally assigned and is most clinically similar.

Multiple imaging composite APCs: GEHC recommends that CMS apply the multiple imaging composite APC payment rule only to those procedures performed on the same patient on the same date of service during the same session. CMS could designate the use of a modifier, such as modifier -59 (distinct procedural service) to identify cases when such procedures are performed on the same date of service, but not during the same session.

Impact of packaged services on adoption of new technologies: We believe that for packaged services such as guidance and intraoperative services, CMS should have provisions to provide separate, additional payment for innovative procedures. We urge the agency to consider a two-to-three year data collection period during which separate payment would be made for these packaged services (or any new applications of these services). The data thus collected could be used to evaluate the clinical utilization and financial effects of the new services. Based on this information, CMS could determine whether to propose packaging for the services or whether to maintain separate payment.

Impact of packaged services on beneficiary access: We appreciate CMS's willingness to fully analyze the impact of packaging on beneficiary access, not only in terms of access to innovative technologies (as described above), but also with respect to the utilization of these packaged services. We believe it is important to compare utilization of these services billed under the OPPI in CY 2007, before the expanded packaging went into effect, to the frequency of those same services post-packaging -- at the CPT code-level.

Definition of pass-through eligibility period for new drugs and biologicals: GEHC is agreeable to the use of first sales date as a proxy for pass-through eligibility as long as CMS exercises their authority to allow the full three years for pass-through status. Sales are often sparse upon launch of a drug into the marketplace. Moreover, the first sale(s) of the drug may not be for Medicare beneficiaries. Thus, using first date of sale and extending the pass-through eligibility timeframe for the full three years is a balanced approach that will give CMS an appropriate size sample of claims upon which to evaluate costs.

Proposed payment for therapeutic radiopharmaceuticals: GEHC plans to submit an Average Sales Price (ASP) for A9600 Strontium Sr-89 chloride, therapeutic, per millicurie. We understand that the information (third quarter 2009 sales) must be submitted by November 1, 2009 in order for CMS to base the first quarter 2010 payment on the ASP. We support the development of the crosswalk because it will aid in the accurate coding and billing of the drugs.

APC-specific comment: tumor imaging: We urge CMS reassess the packaged diagnostic radiopharmaceuticals within APCs, particularly the tumor imaging. In particular, we question the rationale for the change in APC assignment for code 78803, Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT). The proposed reassignment moves the code from APC 0408 to 0414 with a change in payment from \$1003.85 to \$523.75. The use of "single/pseudo single claims" in proposing the payment rates may not take into account the cost of the radiopharmaceutical as well as other scans as that may have occurred on other dates of service and claims.

Hospital Quality Data Reporting Program: GEHC recommends that, although the statute does not require that each measure be endorsed by the NQF or that the Secretary limit measures to those adopted by stakeholder organizations not meeting the requirements of voluntary consensus organizations under the National Technology Transfer and Advancement Act (NTTAA), CMS should seek NQF approval under HOP QDRP to maintain consistency in the approval mechanisms for quality measures across physician and hospital services. We believe that endorsement by the NQF is

particularly important for new types of measures, such as efficiency measures, where credibility of the measures is not yet established.

Prior to adoption of the CY2010 imaging measures and the proposed CY2012 imaging measures, GEHC recommends that CMS obtain NQF endorsement of CY2010 imaging efficiency measures: OP-9 (Mammography Follow-Up Rates) and OP-10 (Abdomen CT – Use of Contrast Material) and the four new imaging efficiency measures proposed for CY2012. Reviews by the American College of Radiology and the Hospital Quality Alliance would further strengthen development and acceptability of imaging-related measures.

We also urge that these efficiency measures not be used for measurement of quality until sufficient time has passed for providers to understand the measures and to modify their practices before they are measured and reported publicly.

Proposed CY2010 Publication of HOP QDRP Data: GEHC believes that publication of non-validated data seriously undermines the credibility of the data. Assuring data validity should be a pre-requisite of any public reporting process. We strongly urge CMS to revisit its proposal to publicly report non-validated data.

Use of registries and EHR to report hospital quality measures: GEHC strongly supports the use of registries and EHRs to report quality data.

Physician supervision requirements: GEHC commends CMS for harmonizing supervision requirements across sites of service and appreciates the clarity that this proposed change provides to supervision requirements in hospital settings.

Proposed APC assignment and status indicator for CPT Code 76098: GEHC respectfully recommends that CMS accept the APC Advisory Panel recommendation to assign CPT code 76098 to APC 0260, place it on the bypass list, and maintain a status indicator of “X”.

Detailed Comments

APC Assignments for Echocardiography Procedures

For preparation of the CY 2010 HOPPS Proposed Rule, CMS has, for the first time, claims data available from hospitals for echocardiography services performed with contrast (or without contrast followed by with contrast), which are reported with HCPCS codes C8921 through C8928. Generally, CMS proposes to use its standard methodology for setting the CY 2010 OPPS payment rates for these echocardiography services performed with contrast, taking into consideration HCPCS code-specific median costs from CY 2008 claims. For those codes where the AMA revised several CPT codes effective CY2009 or where CY2008 claims data is unavailable, CMS proposes to use an alternative rate setting methodology that is similar to the approach CMS used for CY 2009. CMS is also proposing to revise the titles of the existing series of echocardiography APCs to more accurately describe the groups of services.

GEHC supports the revisions to the echocardiography APC titles and assignments, appreciates CMS's efforts to develop accurate payments for echocardiography services with or without contrast, and the attention CMS has given to stakeholder concerns about these APC assignments.

We would like, however, to recommend one revision to the APC assignments for these services. Specifically, CPT code 93318 (*Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis*) is currently assigned to APC 270 (Level III Echocardiogram Without Contrast) and is proposed to be assigned to APC 269 (Level II Echocardiogram Without Contrast). Since CPT code 93318 is clinically homogeneous to CPT code 93312 (*Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report*), **we would recommend that CPT code 93318 remains in APC 270 where it was originally assigned.**

The median cost for CPT code 93318, (for which there are 319 single frequency claims) is \$482.68. By comparison, its mean cost is \$707.08 indicating such procedures can be costly and suggesting the volatility of the median cost estimate. The sizeable difference between the median and mean costs is, in part, due to the relatively low volume of procedures for this code. By comparison, CPT code 93312 has a slightly higher median cost of \$580.64 (for which there are 28,088 single frequency claims), but a lower average cost of \$640.40. The high volume of procedures for this code results in a tighter distribution. Given the volatility in costs for CPT code 93318, we believe that clinical homogeneity should be a primary determinant of APC assignment, such that CPT code 93318 remains in APC 270 along with CPT code 93312.

Multiple Imaging Composite APCs

In the HOPPS Final Rule for CY 2009, CMS finalized its proposal to pay for multiple images performed on the same patient on a single date of service through composite APCs. CMS created five multiple imaging composite APCs: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite).

During the February 2009 meeting of the APC Panel, the APC Panel expressed concern that the same efficiencies that may be gained when multiple imaging procedures are performed during the same sitting may not be gained if a significant amount of time passes between the second and subsequent imaging procedures, when the patient may leave not only the scanner, but also the radiology department or hospital. The APC Panel recommended that CMS continue to work with stakeholders to examine different options for APCs for multiple imaging sessions and multiple imaging procedures. In the proposed rule, CMS indicated its willingness to do so.

GEHC would like to thank CMS for accepting the APC Panel recommendation to continue to consider refinements to multiple imaging composite APCs. We believe that there may be several instances where the multiple imaging composite APC may not adequately provide payment. Specifically, multiple imaging composite APCs may not provide adequate payment when there is more than one imaging session on the same date of service. For example, some trauma patients presenting to the emergency department may receive one imaging procedure from the list of procedures in a particular multiple imaging composite APC as part of the initial diagnosis of the patient condition, but then as additional patient symptoms surface over the course of the emergency room visit (which can sometimes take several hours), the patient is referred for an additional imaging procedure within that same composite APC. In such instances, the patient will require equivalent facility services in each session. For example, services such as greeting the patient, providing education and obtaining consent, retrieving prior exams, setting up an intravenous infusion, and preparing and cleaning the room would be required for both procedures. The efficiencies supposedly made under multiple

imaging composite APCs would not apply when such procedures are separated by extensive periods of time during the hospital outpatient visit (i.e. separate sessions on same date of service).

GEHC would like to recommend that CMS apply the multiple imaging composite APC payment rule only to those procedures performed on the same patient on the same date of service during the same session. CMS could designate the use of a modifier such as modifier -59 (distinct procedure service) to identify cases when such procedures are performed on the same date of service, but not during the same session.

Impact of Packaged Services on Adoption of New Technologies

In CY2008, CMS finalized its proposal to package payment for HCPCS codes describing the “dependent” items and services into the payment for the “independent” services with which they are furnished. CMS identified seven categories of dependent services: guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast media and observation services.

CMS packages guidance services, image processing services, and intraoperative services regardless of whether they represent existing or new technologies. GEHC continues to believe that these packaging methods create disincentives for hospitals to use innovative technologies in those cases in which important clinical advantages can be gained over existing alternatives. Such disincentives do not exist in other sites of service paid under the Medicare Physician Fee Schedule, where innovative technologies receive separate payment. For hospital outpatient departments (and ambulatory surgery centers), packaging obscures the amounts Medicare pays for these “dependent” services”, preventing stakeholders and providers from understanding the rate calculations. Packaging is already delaying hospital adoption of new technologies and applications that beneficiaries genuinely need for improved health outcomes.

For example, in the case of image-guidance procedures, we believe that CMS packaging policy has deterred use of services that clinical leaders believe are necessary for effecting adequate treatment for beneficiaries. This is true for existing guidance procedures being applied in new clinical applications, such as use of ultrasound guidance to address nerve blocks or to aid injections to major joints for rheumatology treatments. Despite articles in the published literature that document the benefits of ultrasound visualization in nerve blocks, several GEHC customers in the hospital outpatient and ambulatory surgery center environments say that they will not adopt this technology due to the failure of Medicare payment policy to take into account the technology’s incremental costs. Because Medicare’s rates carry financial disincentives to the use of ultrasound guidance, providers are in fact discouraged from using it. For example, an analysis of 2009 APC payment rates indicated that only 12 percent of the 2009 APC payment rate of \$243 for APC 0206 Level II Nerve Injections would support radiology costs.¹ This amount significantly under-represents the cost to deliver ultrasound guidance to deliver a nerve block for an injection of anesthetic agent in the sciatic nerve. GEHC believes that CMS should exclude new applications of guidance technologies from packaging where guidance has not been previously considered in the base procedure code.

We applaud CMS for providing for temporary additional payments or “transitional pass-through payments” for new diagnostic radiopharmaceuticals and contrast agents. Under Section 1833(t)(6) of the Act, CMS can make transitional pass-through payments for at least 2 years but not more than 3

¹ C, Hogan., Direct Research LLC. August 22, 2008. *OPPS 2009 Proposed, Packaged Radiology Costs as Percent of Total Median Costs, Using Methods Analogous to CMS Device Percent Calculation.*

years after the product's first payment as a hospital outpatient service under Part B.² In the case of pass-through contrast agents and diagnostic radiopharmaceuticals, their pass-through payment amount would be equal to ASP+6 percent. Upon expiration of pass-through status, payment for these products would be packaged into the associated procedures.

We believe that for the remaining packaged services, especially guidance and intraoperative services, CMS should also have provisions to provide separate, additional payment for innovative procedures when the procedure has not been previously considered in the base procedure code. We urge the agency to consider a two-to-three year data collection period during which separate payment would be made for these packaged services (or any new applications of these services). The data thus collected could be used to evaluate the clinical utilization and financial effects of the new services. Based on this information, CMS could determine whether to propose packaging for the services such that it is adequately reflected in the APC rate or whether to maintain separate payment.

Impact of Packaged Services on Beneficiary Access

In February 2009, the APC Advisory Panel recommended that CMS continue to analyze the impact of increased packaging on beneficiaries. CMS accepted this recommendation and will continue to analyze and to share more data with the APC Panel.

We appreciate CMS's willingness to fully analyze the impact of packaging on beneficiary access, not only in terms of access to innovative technologies (as described above), but also with respect to the utilization of these packaged services. We believe it is important to compare utilization of these services billed under the OPPI in CY 2007, before the expanded packaging went into effect, to the frequency of those same services post-packaging -- at the CPT code-level.

Definition of Pass-Through Eligibility Period for New Drugs and Biologicals

CMS proposes to conform their regulations to the statutory provisions concerning the pass-through eligibility period. To that end, they propose to change the start date of the pass-through payment eligibility period for a drug or biological from the first date on which pass-through payment is made to the date of the first sale of the drug in the United States following approval by the Food and Drug Administration.

CMS notes that it cannot identify the first date of payment because of the two-year lag in availability of claims data. However, they believe first date of sale is an appropriate proxy for the date on which the pass-through payment eligibility would begin.

GEHC is agreeable to the use of first sales date as a proxy for pass-through eligibility as long as CMS exercises its authority to allow the full three years for pass-through status. Sales are often sparse upon launch of a drug into the marketplace. Moreover, the first sale(s) of the drug may not be for Medicare beneficiaries. Thus, using first date of sale and extending the pass-through eligibility timeframe for the full three years is a balanced approach that will give CMS an appropriate size sample of claims upon which to evaluate costs. It will also allow additional time for clinical trials to demonstrate outcome results.

² Federal Register. Vol. 74. No. 137. July 20, 2009. p. 35308-10

Proposed Payment for Therapeutic Radiopharmaceuticals

CMS proposes to allow manufacturers to submit ASP information for separately payable therapeutic radiopharmaceuticals. The agency stipulates that the data would need to be provided for a patient-specific unit dose or patient-ready form in order to properly calculate the ASP amount for a given HCPCS code.

GEHC, as well as others, have met with CMS several times over the last few years to discuss potential methodologies for reporting ASP. Thus, we were pleased to be able to submit an ASP for C9247 Inj. lobenguane, I-123, dx earlier this year.

Similarly, we plan to submit an ASP for A9600 Strontium Sr-89 chloride, therapeutic, per millicurie. We understand that the information (third quarter 2009 sales) must be submitted by November 1, 2009 in order for CMS to base the first quarter 2010 payment on the ASP.

CMS has specifically requested public comment on the development of a crosswalk for use for therapeutic radiopharmaceuticals, similar to the NDC/HCPCS crosswalk for separately payable drugs and biologicals posted on the CMS website. **We support the development of the crosswalk because it will aid in the accurate coding and billing of the drugs.**

APC-Specific Comment: Tumor Imaging

GE Healthcare, other manufacturers, and professional societies have discussed with CMS on several occasions the inadequacy of the payment rates for certain APCs. The stakeholders believe that there are clear violations of the two-times rule in the tumor imaging APCs.

Generally, GE Healthcare is supportive of CMS's packaging policies in the context of a prospective payment system. However, the cost of many of the drugs in the tumor imaging APCs is significantly higher than the overall payment rate for the procedure. Hospitals are not fairly compensated for the drugs and that can have an adverse effect on access or quality of care.

Once again, we urge CMS to consider the composition of the APCs. In particular, we question the rationale for the change in APC assignment for code 78803, Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT). The proposed reassignment moves the code from APC 0408 to 0414 with a change in payment from \$1003.85 to \$523.75. The use of "single/pseudo single claims" in proposing the payment rates may not take into account the cost of the radiopharmaceutical as well as other scans as that may have occurred on other dates of service and claims.

Hospital Quality Data Reporting Program

For CY2010 under the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), CMS has already approved four "claims-based" imaging quality measures. Two of the four imaging efficiency measures (OP-8 and OP-11) have been endorsed by the National Quality Foundation (NQF), a national consensus building entity. CMS proposes to continue to use all four of these imaging measures in CY2011, even those two measures (OP-9 and OP-10) which were considered by NQF, but rejected.

For CY2012, CMS is proposing four new "claims-based" imaging measures:

- OP-12 SPECT MPI and stress echocardiography for preoperative evaluation for low-risk non-cardiac surgery risk assessment
- OP-13 Use of Stress echocardiography or SPECT MPI post-revascularization coronary artery bypass graft
- OP-14 Use of computed tomography in emergency department for headache
- OP-15 Simultaneous use of brain computed tomography and sinus computed tomography

None of these measures have been endorsed by the NQF. Rather, they were developed under contract with The Lewin Group (a consulting group wholly owned by UnitedHealth Group) with the support of the National Imaging Associates (a radiology benefit manager engaged by several insurers) and Dobson & DaVanzo. In late 2008, Lewin provided for a 30-day comment period on these measures, but there was no voting process to endorse these measures.

Although GEHC appreciated the opportunity to participate in the 30-day comment period provided by The Lewin Group at the end of 2008, we believe that a more extensive consensus-building process is necessary to finalize quality measures under HOP QDRP. For example, a consensus-building process would ensure consideration of each measure in terms of appropriateness guidelines developed by the American College of Radiology and other professional societies. Attention to these guidelines is clearly important in light of recent legislation that requires CMS to conduct demonstration projects regarding physician compliance with appropriateness requirements (Medicare Improvements for Patients and Providers Act of 2008, §135). We believe CMS's Measurement Management System that relies on the use of Technical Expert panels is not as rigorous as the one used by NQF. We have noted that the statute does not require that each measure be endorsed by NQF or other national consensus building entities. Further, GEHC understands that the statute does not require that the Secretary limit measures to those adopted by stakeholder organizations meeting the requirements of voluntary consensus organizations under the National Technology Transfer and Advancement Act (NTTAA), such as the Hospital Quality Alliance (HQA) or AQA.

GEHC recommends that, although the statute does not require that each measure be endorsed by the NQF or that the Secretary limit measures to those adopted by stakeholder organizations not meeting the requirements of voluntary consensus organizations under the National Technology Transfer and Advancement Act (NTTAA), CMS should seek NQF approval under HOP QDRP to maintain consistency in the approval mechanisms for quality measures across physician and hospital services. This would ensure that measure development benefits not only from a public comment process, but also from a consensus-building process involving multiple stakeholders. Notably, CMS indicates in the Physician Fee Schedule Proposed Rule that the Secretary has contracted with the consensus organization NQF; hence, in the future, each proposed 2010 Physician Quality Reporting Initiative (PQRI) quality measure would need to be endorsed by the NQF or another consensus organization.

We believe that endorsement by the NQF is particularly important for new types of measures, such as efficiency measures, where credibility of the measures is not yet established. In sum, prior to adoption of the CY2010 imaging measures and the proposed CY2012 imaging measures, GEHC recommends that CMS obtain NQF endorsement of CY2010 imaging efficiency measures: OP-9 (Mammography Follow-Up Rates) and OP-10 (Abdomen CT – Use of Contrast Material) and the four new imaging efficiency measures proposed for CY2012. Reviews by the American College of Radiology and the Hospital Quality Alliance would further strengthen development and acceptability of imaging-related measures.

We also urge that these efficiency measures not be used for measurement of quality until sufficient time has passed for providers to understand the measures and have had an opportunity to modify their practices before they are measured and reported publicly. Providers are not yet clear on how this data will be used. We believe that comparisons of these measures across providers will not be sufficient to determine whether there are patterns of overutilization. Clearly, CMS must carefully integrate information on the clinical context of these measures before making conclusions with regard to efficiency – especially since CMS presents these measures as measures of “quality”.

Proposed CY2010 Publication of HOP QDRP Data

CMS states section 1833(t)(17)(E) of the Act requires the Secretary to establish procedures to make data collected under the HOP QDRP available to the public; however, it does not require that such data be validated before it is made public. Under existing procedures for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, data submitted by hospitals are publicly reported regardless of whether those data are successfully validated for payment determination purposes. For these reasons, CMS is proposing to make data collected for quarters beginning with third quarter of CY 2008 (July - September 2008) under the HOP QDRP publicly available, regardless of whether those data have been validated for payment determination purposes.

GEHC believes that publication of non-validated data seriously undermines the credibility of the data. Assuring data validity should be a pre-requisite of any public reporting process. We strongly urge CMS to revisit its proposal to publicly report non-validated data.

Use of Registries and EHR to Report Hospital Quality Measures

In addition to claims-based measures, CMS is considering registries and electronic health records (EHRs) as alternative ways to collect data from hospitals. Many hospitals submit data to and participate in existing registries. In the past, CMS has also stated its intention to explore mechanisms for data submission using EHRs. Establishing such a system will require interoperability between EHRs and CMS data collection systems, additional infrastructure development on the part of hospitals and CMS, and the adoption of standards for the capturing, formatting, and transmission of data elements that make up the measures. However, once these activities are accomplished, the adoption of measures that rely on data obtained directly from EHRs will enable CMS to expand the HOP QDRP measure set with less cost and burden to hospitals.

GEHC agrees with CMS’s approach to include use of registry reporting and EHR submission. We agree with CMS strongly that it is important to move away from dependence on claims-based data. Increased use of registries and EHRs will enhance the types and value of measures that can be used for HOP-QDRP. In addition, we suggest the following:

- Allow submission of computed measures from registries and EHRs rather than requiring submission of only detailed patient level data.
- We suggest that CMS look for alternatives to claims-based or encounter-based reporting for structural measures, such as those focusing on use of Information Technology.

Physician Supervision Requirements

CMS is proposing to require that all hospital outpatient diagnostic services furnished directly or under arrangement, whether provided in the hospital, in a provider-based department, or at a nonhospital location, follow Medicare Physician Fee Schedule supervision requirements for individual tests.

Currently, the Medicare PFS requirements apply to Part B suppliers (e.g. physician offices and independent diagnostic testing facilities (IDTF)) and “provider-based departments”; however, varying positions have been taken for other hospital settings.

GEHC commends CMS for harmonizing supervision requirements across sites of service and appreciates the clarity that this proposed change provides to supervision requirements in hospital settings.

Proposed APC Assignment and Status Indicator for CPT Code 76098

Currently CPT code 76098 (*Radiological examination, surgical specimen*) is assigned to APC 0317 (Level II Miscellaneous Radiology Procedures) with a status indicator “x” (paid under OPPS, separate APC payment). CMS is proposing to treat CPT code 76098 as “T-packaged code” for CY2010 with continued assignment to APC 0317. A “T-packaged code” identified with status indicator “Q2” describes a code whose payment is packaged when one or more separately paid surgical procedures with a status indicator of “T” are provided during the hospital encounter. According to CMS, assignment of CPT code 76098 would result in more claims being available to set the median costs for the surgical procedures with which CPT code 76098 is most commonly billed (for example, CPT code 19101 *Biopsy of breast, percutaneous, needle core, not using image guidance; open incisional*).

In response to comments by the American College of Radiology made in February 2009, the APC Advisory Panel recommended that CMS reassign CPT code 76098, *Radiological examination, surgical specimen* to APC 0260 (Level I Plain Film), and place CPT code 76098 on the bypass list. This APC assignment would be more clinically appropriate and would allow for more multiple claims to be used in rate setting for major breast surgery procedures.

GEHC respectfully recommends that CMS accept the APC Advisory Panel recommendation to assign CPT code 76098 to APC 0260, place it on the bypass list, and maintain a status indicator of “x”.

GEHC very much appreciates the opportunity to submit comments on these important issues. If you have any questions on our comments, please do not hesitate to contact me at hubert.zettel@ge.com.

Sincerely,



Hugh Zettel
Strategic Reimbursement Executive