

August 28, 2009

Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Attention: CMS-1414-P  
7500 Security Blvd.  
Baltimore, MD  
21244-8013

Acting Administrator Frizzera -

On behalf of our organizations and the professionals we represent, the American Society for Blood and Marrow Transplantation (ASBMT), the National Marrow Donor Program (NMDP) and AABB appreciate the opportunity to comment on the proposed changes to the Hospital Outpatient Prospective Payment System (OPPS).

We are particularly concerned about the following recommended changes listed in the CY 2010 OPPS proposed rule:

- CPT code 38205: Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic – change of status indicator from “S” to “E”
- CPT code 38240: Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic – change of status indicator from “S” to “C”
- CPT code 38242: Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions – change of status indicator from “S” to “C”.

CMS indicates that the rationale for these changes is the understanding that these procedures are performed exclusively on an inpatient basis. However, allogeneic hematopoietic cell transplantation (HCT) is currently being performed in both the inpatient and outpatient settings and is considered safe, clinically appropriate for many patients, and standard of care in the both settings. Thus, our organizations respectfully request that CMS maintain the current outpatient payment status indicators for these CPT codes in order to continue allowing these procedures to be provided in the most appropriate care setting for the patient. This will also allow physicians and hospitals to maintain maximum clinical flexibility.

In recent years, there has been substantial growth in the numbers of transplants performed in the Medicare population. This growth is closely linked to the introduction of reduced intensity, non-myeloablative preparative regimens. Reduced intensity conditioning makes outpatient transplantation and donor lymphocyte infusions possible due to reduced regimen-related toxicity. Patients with limited co-morbidities could benefit from outpatient transplantation due to a decreased risk of nosocomial infections, increased patient comfort, and decreased costs. This option also allows hospitals to benefit from the optimized allocation of bed resources. Changing the status indicators for CPT codes 38240 and 38242 would require the unnecessary hospitalization of patients who could be appropriately treated in the outpatient setting.

If made final, CMS' proposed status indicator change for CPT code 38205 would force hospitals to report their cell harvesting charges on inpatient bills only. However, as stated above,

transplants can be provided to patients in the outpatient setting and hospitals need to maintain the option to report the cell harvesting charges on an outpatient bill.

We presented our concerns to the APC Advisory Panel on August 6<sup>th</sup>. The committee voted unanimously to recommend that the proposed changes not be adopted for the final rule.

In summary, we ask that CMS maintain the current status indicators for CPT codes 38205, 38240 and 38242. In addition, we ask that CMS revise its manual guidance to reflect that hospitals report cell harvesting charges on the recipient's inpatient or outpatient transplant bill depending on whether the transplant occurred. If CMS disregards this recommendation and finalizes its current proposal, it will eliminate reimbursement for outpatient transplantation, donor lymphocyte infusions and cell harvesting. This will create a strong incentive for hospitals to unnecessarily admit patients who could have otherwise been treated in the outpatient setting.

Our organizations have appreciated our recent opportunities for discussion with CMS regarding the unique complexities of coding and reimbursement for allogeneic unrelated transplantation. As we noted in our earlier letter, there are several areas unique to allogeneic HCT that currently lack clear reimbursement guidance. Currently, there is not a way for facilities to recover the costs of search and procurement of donor cells when transplants are performed in the outpatient setting. Further, there is no opportunity for cost reimbursement related to costs incurred prior to an allogeneic transplant when the transplant does not occur due a change in the patient's health status. We look forward to continuing the discussion regarding coding and billing instruction and appropriate reimbursement rates for allogeneic HCT services.

For additional information, please contact Michael Boo at [mboo@nmdp.org](mailto:mboo@nmdp.org) or 612-627-5855.

Sincerely,

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