PHILIPS

Submitted via e-mail

September 24, 2018

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington DC

Dear Administrator Verma:

On behalf of Philips Healthcare (Philips), I am pleased to have the opportunity to submit these comments on the 2019 Hospital Outpatient Prospective Payment Proposed Rule (the HOPPS Proposed Rule). Philips provides solutions that span the health continuum, including imaging, patient monitoring, and cardiac care systems; medical alert systems; sleep management and respiratory solutions; healthcare informatics solutions and services; and a complete range of comprehensive telehealth programs.

Our comments are divided into two sections. The first section addresses CMS' proposal to extend the Medicare payment reductions for clinic visits that are currently applicable to new off-site provider-based clinics to those established prior to November 2, 2015 (hereafter "Grandfathered Off-Campus Clinics'). The second section addresses proposed Medicare payment and policy changes impacting services of particular interest to Philips and its customers.

## I. Extension of Medicare Payment Reductions to Clinic Visits Provided by Grandfathered Off-Campus Clinics.

In the HOPPS Proposed Rule, CMS proposes to reduce by 60% Medicare payment for clinic visits provided by off-campus provider based facilities that are not subject to the payment reductions enacted by Section 603 of Section 1833(t)(1)(B) of the Social Security Act (Section 603). CMS proposes to implement these reductions under the statutory authority of Section 1833(t)(2)(F) of the Act. In addition, CMS proposes to implement this reduction in a manner that is not budget neutral, such that Medicare payments made to hospitals under HOPPS, in the aggregate, are estimated to be reduced by an estimated $610 million.

For the reasons set forth in the comments filed by the American Hospital Association, we believe that the statutory authority for this proposed reduction and for the proposal to implement this proposed reduction in a manner that is not budget neutral are legally problematic. Moreover,

while it may be true that recent years have brought an increase in hospital provision of clinic visits in off-campus facilities, we believe that this movement has been triggered by multiple factors, including the emphasis by payers (including Medicare) on the provision of value-based, integrated care, which incentivizes hospitals to exercise greater control over physician practice patterns and adherence to clinical practice protocols. In addition, the enactment of the ACA has made insurance payment available for services provided to formerly uninsured patients, thereby removing impediments to hospitals' expanding their service areas into geographic areas that were previously uninsured or underinsured. Other factors contributing to the growth in hospital outpatient provision of clinic visits and other physicians' services relate to the growing administrative and other costs of physicians' maintaining their own private practices and Medicare payment reductions for many services under the PFS. In short, while the proportion of patient visits occurring in hospital outpatient settings may have increased, we do not believe that the Medicare payment differential between payments made under the Physician Fee Schedule (PFS) and those made under HOPPS are the sole driver of this change, as suggested by the HOPPS Proposed Rule. This view is supported by the fact that the differential in Medicare payment between hospital outpatient clinic services and office visits is longstanding, but the surge in hospital outpatient visits is a relatively recent phenomenon.

Nor is it clear to us how the proposed Medicare payment reductions for Grandfathered Off-Campus Clinics will mitigate the growth in off-campus clinic visits provided by hospitals. In fact, we would anticipate that off-campus hospital-based clinics faced with the drop in Medicare revenues described in the Proposed Rule will be incentivized to increase the volume of services provided to both Medicare and non-Medicare patients.

> *Philips recommendation: For the reasons set forth above and those stated in the comments filed by the American Hospital Association and other hospital groups, we urge CMS to refrain from implementing the proposed Medicare payment reductions for clinic visits provided by Grandfathered Off-Site Clinics.*

We are also concerned about the suggestion in the HOPPS Proposed Rule that CMS is considering the extension of similar payment reductions to other services provided in Grandfathered Off-Site Clinics, presumably including imaging services. We note that Medicare payment for many imaging services provided in provider-based facilities impacted by Section 603 is substantially BELOW current technical component payment for those same services under the PFS. Any extension of the proposed clinic visit payment reductions to imaging services would incentivize all off-site clinics to provide imaging services only on their main hospital campuses, thereby reducing patient access and increasing wait times.

> *Philips recommendation:. Philips urges CMS to refrain from extending the proposed off-campus clinic visit payment reductions to other off-campus hospital outpatient services. .*

## II. Payment and Policy Changes Impact Other Specific Services

We also wish to comment on a number of other proposed changes set forth in the HOPPS Proposed Rule.

### A. Imaging

Philips supports the comments filed by the Medical Imaging &Technology Alliance (MITA) with respect to the HOPPS Proposed Rule. In addition, we have a number of comments regarding HOPPS policies related to imaging services as set forth in the Proposed Rule.
First, CMS is proposing to delay for another year technical changes to the MR and CT cost to charge ratios, and will continue to exclude cost-to-charge data from hospitals that allocate MR and CT equipment and related costs based on square footage and similar imprecise allocation methodologies. The continued exclusion of this data from cost-to-charge calculations results in proposed Ambulatory Payment Classification (APC) rates for MR and CT that are higher than they would be if the change were implemented.

> *Philips recommendation: Philips strongly supports CMS' proposal to further delay implementation of the new methodology for determining the cost-to charge ratios for MR and CT cost centers.*

Second, we note that while the number of imaging procedure APCs will remain unchanged, the HOPPS Proposed Rule includes substantial Medicare payment reductions for both Level 1 and Level 2 contrast-enhanced imaging procedures --reductions in the range of -15% to -20%--and that four of the seven APCs for imaging procedures involve violations of the two times rule. We are concerned that reductions of this magnitude have the potential to impact access to these critical services, especially in off-campus hospital outpatient clinics, where Medicare payment is limited to 40% of otherwise applicable Medicare payment rates. In light of this policy, many advanced imaging services will be paid at a payment rate that is in the range of $80 in off-campus settings, which may be located in rural or medically underserved areas.

> *Philips recommendation: We recommend that CMS closely examine the APCs for imaging procedures to ensure that the payment is adequate to cover the costs involved and to minimize the exceptions to the two times rule that are needed*.

Third, we strongly support CMS' efforts to combat opioid addiction, and we believe that it is appropriate for CMS to encourage the provision of alternative treatments for pain management. Separate payment for non-opioid prescription drugs, often furnished using image-guided procedures, is an effective alternative to the prescription of potentially addictive opioids; however, the packaging of non-opioid drug costs into the payment rates for these procedures, in both Ambulatory Surgical Center and hospital outpatient settings, is a deterrent to this form of alternative treatment.

> *Philips recommendation: We urge CMs to finalize its proposal to pay separately for non-opioid drugs furnished in conjunction with pain management procedures*.

Finally, we note that, under the HOPPS Proposed Rule, Medicare payment for MRI-guided high intensity focused ultrasound (MRgUS) procedures (HCPCS 0071T) would increase.

> *Philips recommendation: Philips supports the proposed increase in Medicare payment for MRI-guided high intensity focused ultrasound procedures*.

B. **Payment for Endovascular Ambulatory Payment Classification (APC) Groups in the Calendar Year (CY) 2019**

## 1. Challenges with the Current Endovascular APC Structure

The existing family of Endovascular APCs is comprised of approximately 70 distinct endovascular procedures, assigned to just four payment groups, with gaps in payment of over $5,000 between current level 2 (APC 5192) and level 3 (APC 5193), and between level 3 and level 4 (APC 5194). Over 680,000 interventions were assigned to these APCs in CY 2017:

Table 1

| APC | Description | 2019 Proposed OPPS Payment | Total Frequency |
|---|---|---|---|
| 5191 | Level 1 Endovascular Procedures | $2,830 | 342,910 |
| 5192 | Level 2 Endovascular Procedures | $4,755 | 106,975 |
| 5193 | Level 3 Endovascular Procedures | $9,765 | 179,040 |
| 5194 | Level 4 Endovascular Procedures | $15,504 | 55,522 |
| | | Total | 684,447 |

Sources: Analysis by DirectResearch, CMS 2019 OPPS Proposed Rule, Addendum A &APC Cost Statistics File.

We note that these same procedures, if performed on an inpatient basis, would map to approximately 20 Medicare Severity Diagnosis-Related Groups (MS-DRGs) under the Inpatient Prospective Payment System (IPPS). We understand that the IPPS and HOPPS are different payment systems with different methodologies for grouping procedures, but we do find this difference striking and believe it underscores the need and opportunity for more granularity in recognizing the varying costs and clinical characteristics of the procedures assigned to the Endovascular APCs.

One specific concern with the broadness of this family of APCs is that the large number of procedures assigned to each APC, along with high total volume within each APC, prevent technology costs from being adequately and accurately reflected in the HOPPS payment rates. For example, as illustrated in the table below, in CY 2017 hospitals performed peripheral balloon angioplasty procedures described by Current Procedural Terminology (CPT) code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty) approximately 51% of the time with a drug-coated balloon (DCB}, described by Healthcare Common Procedure Coding System (HCPCS) code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser).

The geometric mean cost for 37224 cases involving DCB (identified by the presence of HCPCS code C2623 on the same claim) are considerably higher than the mean cost for 37224 cases when HCPCS code C2623 does not appear on the same claim, by a margin of $2,126 (claims for CPT 37224 without C2623 represent plain balloon angioplasty cases). The difference between DCB cases and the overall mean cost of APC 5192 is even more striking, at $3,719. As this table demonstrates, despite significant uptake of DCB, the higher costs of those claims have a negligible impact on the payment rate for the associated procedure because those costs are diluted by the large volume of less expensive procedures assigned to the same APC:

Table 2

| CY 2019 OPPS Proposed Rule Data | | | | |
|---|---|---|---|---|
| | **Single Frequency** | **Geometric Mean Cost** | **Difference Relative to DCB Cases** | |
| | | | **$** | **%** |
| **37224 with C2623 (DCB)** | 5,259 | $8,562 | --- | --- |
| **37224 without C2623 (non-DCB)** | 4,985 | $6,436 | ($2,126) | -25% |
| **37224 (all claims)** | 10,244 | $7,452 | ($1,110) | -13% |
| **Overall APC 5192** | 105,895 | $4,843 | ($3,719) | -43% |

Sources: Analysis by DirectResearch, CMS 2019 OPPS Proposed Rule CPT and APC Cost Statistics.

Similarly, hospitals may also choose drug-covered technology when performing peripheral stenting procedures described by CPT code 37226 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed). Despite significantly higher costs for procedures involving coated/covered stents, such as a drug eluting stent (DES), described by HCPCS code C1874 (Stent, coated/covered, with delivery system), compared to a bare metal stent (BMS), those cases do not have a significant impact on the overall APC mean cost, which is 26% lower:

Table 3

| CY 2019 OPPS Proposed Rule Data | | | | |
|---|---|---|---|---|
| | **Single Frequency** | **Geometric Mean Cost** | **Difference Relative to DES Cases** | |
| | | | **$** | **%** |
| **37226 with C1874** | 3,122 | $13,472 | --- | --- |
| **37226 without C1874 (BMS)** | 5,572 | $10,831 | ($2,641) | -20% |
| **37226 (all claims)** | 8,694 | $11,714 | ($1,758) | -13% |
| **Overall APC 5193** | 177,401 | $9,945 | ($3,527) | -26% |

Sources: Analysis by DirectResearch, CMS 2019 OPPS Proposed Rule CPT and APC Cost Statistics.

As shown in both of these examples, the costs of DCB and DES have negligible impact on their respective APC payments because of the high volume of other procedures assigned to those APCs. Furthermore, the overall costs of these procedures, regardless of whether drug-covered or non-drug-covered technology is used, is significantly higher than the overall costs of the APCs to which they are assigned. This means that on average, hospitals expend significantly

more resources than they are paid on every peripheral angioplasty and peripheral stenting revascularization procedure described by these codes that they perform, even when they utilize the least expensive (and least effective) technology to perform the procedure. Selection of the more effective and incrementally more expensive drug-covered devices exacerbates those losses.

Thus, despite robust evidence from randomized controlled trials and large-scale population studies demonstrating that these technologies provide substantial patient improvements and long-term savings to the payer/health system, we are concerned that the current APC structure poses a significant access barrier to these technologies for patients. We find this particularly troubling because peripheral arterial disease (PAD) is a chronic, progressive disease that causes significant morbidity and reduced quality of life. Symptomatic PAD has a major detrimental impact on patients' quality of life, and significant functional disability, with patients often requiring frequent retreatment to reduce symptoms, and prevent and treat ischemic events. Both DCB and DES have demonstrated improvements in the treatment of femoral popliteal artery disease by reducing vascular restenosis and the need for repeat interventions.

These improvements were recognized by CMS with the approval of both inpatient new technology add-on payment (NTAP, effective October 1, 2015 through September 30, 2017) and transitional-pass-through payment (TPT, effective April 1, 2015 through December 31, 2017) for DCB, and NTAP for peripheral DES (effective October 1, 2013 through September 30, 2015). The special payment status granted by CMS to these technologies recognizes the substantially lower reintervention rates relative to plain balloon angioplasty or bare-metal stenting, not only in the near-term (12 months) post treatment but longer-term as well, up to 5 years [1-9]. Several in-depth economic analyses have found these more advanced PAD therapies to be favorable to payers and health systems, since the upfront costs due to the more expensive, more effective, newer technologies are more than offset within 2 years from the initial procedure due to reduced repeat interventions [10, 11].

## 2. Requested Revisions to the Endovascular APCs - Step #1

We urge CMS to create additional levels of APCs within the Endovascular APC family in order to improve the accuracy and adequacy of the HOPPS payment rates. We believe that a 6-level structure will reduce the extent to which individual procedures are both under- and over-paid within these APCs by bridging the significant gaps of over $5,000 that exist between proposed level 2 (APC 5192) and level 3 (APC 5193), and between proposed level 3 and level 4 (APC 5194). A more granular APC structure will also create more opportunity for differences in procedure costs to have a meaningful impact on the overall APC costs across the family of Endovascular APCs.

Specifically, we recommend CMS create a 6-level Endovascular APC structure reflecting the following cost bands in the CY 2019 OPPS final rule:

Table 4

| APC | Description | Approximate Cost |
|---|---|---|
| 5191 | Level 1 Endovascular APC | $2,000 to $4,000 |

| | | |
|---|---|---|
| 5192 | Level 2 Endovascular APC | $4,000 to $6,750 |
| 519X/New 5193 | Level 3 Endovascular APC | $6,750 to $9,000 |
| Current 5193/New 5194 | Level 4 Endovascular APC | $9,000 to $11,000 |
| 519Y/New 5195 | Level 5 Endovascular APC | $11,000 to $14,000 |
| Current 5194/New 5196 | Level 6 Endovascular APC | $14,000+ |

This structure can be effectuated by reassigning procedures with costs greater than $6,750 up one level, from current APC 5192 to a new Level 3 APC (519X), and reassigning procedures with costs up to approximately $9,000 down one level, from current APC 5193 to the new Level 3 APC. Additionally, the new structure would require procedures with costs greater than approximately $11,000 in current APC 5193 to be moved up one level to a new Level 5 APC (519Y) (with the exception of CPT code 37226 when bare-metal stenting is performed, as described under Request #2), and those procedures with costs less than $14,000 to be moved down one level from current APC 5194 to the new Level 5 APC. In order to ensure stability for low-volume procedures, we recommend CMS not reassign any procedures with a single frequency of less than 100.

We have included a table outlining the specific code movements as an attachment to this letter. In addition, the spreadsheet submitted under the Cook, Philips, Medtronic joint submission, shows that the impact of these code movements would be very moderate, resulting in small changes to the payments for procedures that remain in the existing APCs. The payment impact is more pronounced (both positively and negatively) for the codes that are reassigned to the new APCs, but we believe the reassignments result in payments that are better in line with costs relative to the existing 4-level structure. Importantly, we note that this request to create additional levels of APCs within the Endovascular APC family is consistent with the recommendations of the Advisory Panel on Hospital Outpatient Payment (HOP Panel) at its August 2017 meeting, for CMS and the Panel to examine the number of APCs for endovascular procedures in 2018 and to see if more granularity is needed.

**Requested Revisions to the Endovascular APCs – Step #2**

In order to ensure further that the costs of DCB and DES have a meaningful impact on payment, and to address the difference between the costs of procedures using drug-covered technologies compared to non-drug-covered technologies, we ask that CMS create new procedural HCPCS codes for hospitals to use to distinguish peripheral interventions involving DCB and DES, and to differentiate their payment in accordance with their cost.

This request stems from our concerns outlined above regarding the significant gaps in payments relative to the costs of procedures involving these technologies, which share the following similarities:

- Both technologies represent a significant advancement in treatment of PAD, as the first drug- based therapies for peripheral vessels, and both use an active anti-restenotic drug to suppress neointimal hyperplasia and smooth muscle cell proliferation;

- Both technologies have been recognized by CMS with NTAP status;

- The costs for cases with DCB and DES are significantly higher than the average costs of cases in the APCs to which they are assigned; and

- Both drug-coated and drug-eluting technologies have proven, long-term confirmatory evidence of substantial clinical effectiveness compared to plain balloon angioplasty for PAD.

Procedures involving non-drug-covered technologies (i.e., plain angioplasty balloons and BMS) would continue to be billed using their respective CPT codes (37224 and 37226), and would continue to be assigned to their current APCs (5192 and 5193 (Existing Level 3/ New Level 4), respectively). Placement of these procedures in separate, lower-paying APCs from the corresponding drug-covered procedures will ensure that hospitals can select the technology that best meets each patient's clinical needs without balancing the costs of the encounter against the payment they will receive.

During the period of CY 2019 to CY 2020, while hospital claims data are being collected for the new procedural HCPCS codes, CMS could model the costs for these cases using CY 2017 and CY 2018 claims data for CPT codes 37224 and 37226 when they appear with C2623 and C1874, respectively. The modeled costs of these procedure and device code combinations using the CY 2017 claims released with the CY 2019 OPPS proposed rule, within the revised 6-level Endovascular APC family, are outlined below:

Table 5

| New HCPCS Code | Description | Current Coding | Modeled Cost | APC Placement |
|---|---|---|---|---|
| CXXX1 | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal **drug-coated balloon** | 37224 + C2623 | $8,562 | 519X/ New 5193 |
| CXXX2 | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal **drug-eluting** stent placement(s), includes angioplasty | 37226 + C1874 | $13,472 | 519Y/ New 5195 |

Sources: Analysis by DirectResearch, CMS 2019 OPPS Proposed Rule Data Set.

We note that this solution is consistent with the previous use of procedural HCPCS codes to distinguish intracoronary DES placement from BMS placement, which we believe is a directly relevant precedent. In all instances, it is the addition of the anti-restenotic drug component to the underlying device that results in the significant clinical advancement as well as a higher incremental cost.

We believe that this two-pronged solution will create a distribution of costs (shown in the table below) that will improve resource homogeneity across the Endovascular APC family, while ensuring more accurate and adequate payment for peripheral DCB angioplasty and DES

stenting procedures. It also is consistent with the recommendations of the HOP Panel in August 2017.

Table 6

| CY 2019 OPPS Proposed Rule | | Create 2 New Endovascular APCs; Assign GXXX1 to APC 519X and GXXX2 to 519Y | |
|---|---|---|---|
| **APC** | **Modeled** | **APC** | **Modeled Cost** |
| 5191 Level 1 | $2,882 | 5191 Level 1 | $2,881 |
| 5192 Level 2 | $4,843 | 5192 Level 2 | $4,575 |
| 5193 Level 3 | $9,945 | 519X New Level 3 | $7,922 |
| 5194 Level 4 | $15,789 | 5193 Existing Level 3/ New Level 4 | $10,771 |
| | | 519Y New Level 5 | $12,827 |
| | | 5194 Existing Level 4/ New Level 6 | $16,431 |

Sources: Analysis by DirectResearch, CMS 2019 Proposed Rule, Addendum A.

In addition to facilitating more accurate payment for peripheral interventions involving drug-covered technologies, distinguishing these procedures within this new 6-level structure from procedures involving non-drug-covered technologies will neutralize the financial incentive that exists under the current system for hospitals to attempt to dampen their losses by using the lowest cost technology. We believe that such an incentive to provide a lower-value service is contrary to the interest of Medicare beneficiaries and the Medicare program in the long term.

### 3. Two Times Rule Violation

In the event that CMS decides to maintain the existing 4 level C-APC structure for the Endovascular APCs or desires to further evaluate the 6-Level recommendation during 2019, we ask CMS to reassess code combinations that violate the 2 times rule. CMS indicates in the proposed 2019 OPPS rule, they did not observe any violations of the 2 times rule within the current Endovascular Procedures C-APC structure. However, from our analysis of the CMS 2019 OPPS Proposed Rule Data containing calendar year 2017 Medicare hospital outpatient facility claims, we determined claims with CPT 37224 and HCPCS C2623 in APC 5192, violates the 2 times rule. In order to create a reasonable comparison of clinical and resource homogeneity within APC 5192, we first excluded CPT code 0339T as it is an outlier with only 3 total frequency claims and a geometric mean cost of $848.67. Of the remaining CPT procedure codes, CPT code 36902 has a geometric mean cost of $4,008, with a two-times cost of $8,016. Based on an analysis of a subset of claims (Table 2), CPT code 37224 when reported with a DCB using HCPCS C2623 results in a geometric mean cost of $8,535.42. This, (along with CPT code 37184 at a geometric mean cost of $9,108.02) violate the two-times rule and justifies reassignment of claims with CPT 37224 and HCPCS C2623 to the current level 3 Endovascular C-APC (5193) in accordance with Section 1833(t)(2) of the Act. We ask that CMS consider this alternative request in lieu of any possible concerns associated with the industry consensus regarding the 6 level payments.

Table 5

| Analysis of APC 5192 with subsets for CPT 37224 with and without C2623 | | | | |
|---|---|---|---|---|
| CY 2019 OPPS Proposed Rule Data August 2018 | | | | |
| | Single Frequency | Geometric Mean Cost | Difference Relative to DCB Cases | |
| | | | $ | % |
| **37224 with C2623 (DCB)** | 5,253 | $8,535 | --- | --- |
| **37224 without C2623 (non-DCB)** | 4,969 | $6,452 | ($2,083) | -25% |
| **37224 (all claims)** | 10,222 | $7,450 | ($1,085) | -13% |
| **Overall APC 5192** | 105,895 | $4,843 | ($3,692) | -43% |

Table 6

| HCPCS | SI | APC | Payment Rate | Single Frequency | Total Frequency | Minimum Cost | Maximum Cost | Median Cost | Geometric Mean Cost |
|---|---|---|---|---|---|---|---|---|---|
| 0339T | J1 | 5192O | $4,755.58 | 3 | 3 | $382.42 | $2,467.75 | $647.70 | $848.67 |
| 36902 | J1 | 5192O | $4,755.58 | 51599 | 52138 | $705.26 | $23,707.29 | $3,991.38 | $4,008.00 |
| 37184 | J1 | 5192O | $4,755.58 | 98 | 98 | $2,159.54 | $41,485.05 | $9,094.02 | $9,108.02 |

Sources: Analysis by Navigant, CMS 2019 OPPS Proposed Rule CPT and APC Cost Statistics.

Table 7

| HCPCS | SI | APC | Payment Rate | Single Frequency | Total Frequency | Minimum Cost | Maximum Cost | Median Cost | Geometric Mean Cost | CV | Deleted Code Used in APC Costs |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0339T | J1 | 5192O | $4,755.58 | 3 | 3 | $382.42 | $2,467.75 | $647.70 | $848.67 | 97.359 | |
| 36902 | J1 | 5192O | $4,755.58 | 51599 | 52138 | $705.26 | $23,707.29 | $3,991.38 | $4,008.00 | 60.242 | |
| 9345E | J1 | 5192O | $4,755.58 | 483 | 492 | $1,554.26 | $17,443.45 | $4,854.44 | $4,969.76 | 42.843 | |
| 9345R | J1 | 5192O | $4,755.58 | 18930 | 19163 | $1,441.13 | $18,709.57 | $4,896.16 | $5,000.95 | 43.434 | |
| 37248 | J1 | 5192O | $4,755.58 | 3398 | 3435 | $823.97 | $32,440.47 | $4,951.33 | $4,990.67 | 67.035 | |
| 9345S | J1 | 5192O | $4,755.58 | 1749 | 1772 | $1,506.75 | $18,729.99 | $5,106.67 | $5,199.50 | 43.834 | |
| 9345D | J1 | 5192O | $4,755.58 | 1138 | 1149 | $1,474.27 | $21,918.13 | $5,247.76 | $5,488.70 | 46.547 | |
| 9346A | J1 | 5192O | $4,755.58 | 242 | 243 | $2,070.28 | $14,822.24 | $5,254.27 | $5,372.93 | 37.778 | |
| 36904 | J1 | 5192O | $4,755.58 | 1918 | 1939 | $927.77 | $34,346.27 | $5,472.96 | $5,453.92 | 63.038 | |
| 9345G | J1 | 5192O | $4,755.58 | 1011 | 1022 | $1,822.59 | $19,172.52 | $5,564.10 | $5,484.34 | 38.588 | |
| 9345Q | J1 | 5192O | $4,755.58 | 51 | 51 | $1,980.88 | $21,417.14 | $5,812.75 | $5,819.45 | 51.150 | |
| 37246 | J1 | 5192O | $4,755.58 | 1998 | 2014 | $1,239.60 | $31,622.73 | $6,190.42 | $6,067.98 | 56.111 | |
| 37220 | J1 | 5192O | $4,755.58 | 1610 | 1619 | $1,376.38 | $29,951.62 | $6,318.35 | $6,406.26 | 53.227 | |
| 92986 | J1 | 5192O | $4,755.58 | 272 | 277 | $1,975.63 | $29,633.59 | $6,371.11 | $6,384.80 | 52.853 | |
| 37183 | J1 | 5192O | $4,755.58 | 341 | 342 | $1,230.63 | $26,814.15 | $6,650.23 | $6,531.22 | 62.894 | |
| 92920 | J1 | 5192O | $4,755.58 | 6991 | 7047 | $1,712.65 | $29,719.53 | $6,786.36 | $6,795.44 | 50.731 | |
| 9345A | J1 | 5192O | $4,755.58 | 45 | 46 | $2,205.97 | $13,738.45 | $7,300.46 | $7,348.42 | 31.703 | |
| 37187 | J1 | 5192O | $4,755.58 | 165 | 167 | $1,369.53 | $27,830.97 | $7,318.46 | $6,956.90 | 66.862 | |
| 37224 | J1 | 5192O | $4,755.58 | 10244 | 10318 | $1,808.03 | $31,848.30 | $7,404.92 | $7,451.54 | 48.014 | |
| 37184 | J1 | 5192O | $4,755.58 | 98 | 98 | $2,159.54 | $41,485.05 | $9,094.02 | $9,108.02 | 62.137 | |

Sources: Analysis by Navigant, CMS 2019 OPPS Proposed Rule CPT and APC Cost Statistics.

We appreciate the opportunity to comment on the HOPPS Proposed Rule. If you have any questions or if we can provide any additional information regarding Philips' position on these issues, please do not hesitate to contact me at Lucy McDonough at Lucy.McDonough@Philips.com.

Sincerely yours,

Lucy McDonough
Director Market Access North America
Philips