

ADVISORY PANEL ON AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS

APC Panel Biannual Meeting – August 2005

PANEL'S RECOMMENDATIONS

Observation

The Panel recommends that the Centers for Medicare & Medicaid Services (CMS) reevaluate expanding the list of diagnoses eligible for separate payment for observation.

The Panel recommends that CMS further clarify the definition of observation end-time, specifically as it relates to the description of discharge time in the proposed rule published in the *Federal Register* on July 25, 2005.

The Panel recommends that CMS offer billing guidance on the new HCPCS G codes for observation in relation to the currently required evaluation and management visit codes.

The Panel recommends that CMS emphasize that observation status is typically assigned for 8-48 hours.

The Panel recommends that CMS clarify hospitals' ability to issue an advance beneficiary notice for those circumstances under which observation hours are not paid separately (i.e., observation for conditions other than congestive heart failure, chest pain, or asthma) or are not otherwise included in payments for other services.

The Panel recommends that CMS establish a mechanism to reimburse separately for observation services when specific HCPCS codes with status indicator T are also present on the claim for the same date of service.

Packaging

The Panel recommends no change to the 2005 status indicator of CPT code 76397 (N - packaged), ultrasound guidance for vascular access, but requests that CMS collect available hospital claims data on that code for further consideration by the Packaging Subcommittee by the next scheduled meeting.

The Panel recommends no change to the 2005 status indicator of CPT code 38792 (N – packaged), sentinel node identification, but requests that CMS collect available hospital claims data on that code for further consideration by the Packaging Subcommittee by the next scheduled meeting.

The Panel recommends no change to the 2005 status indicator of CPT code 42550 (N – packaged), injection for salivary x-ray.

The Panel recommends that CMS collect additional data on CPT code 36500, venous catheterization for selective blood organ sampling, and the corresponding radiological supervision and interpretation code, 75893, including a list of other codes with which these codes are most frequently billed, for consideration by the Packaging Subcommittee.

The Panel recommends no change to the 2005 status indicator of CPT code 0069T (N – packaged), acoustic heart sound services.

The Panel recommends that CMS collect additional data on CPT 94762, overnight pulse oximetry, including a list of other codes with which this code is most frequently billed, for consideration by the Packaging Subcommittee.

Drugs, Drug Handling, and Drug Administration

The Panel recommends that CMS change the status indicator for CPT code 90660, intranasal influenza vaccine, to L, and that the code be reimbursed on a reasonable- cost basis.

The Panel recommends that CMS reimburse for administration of the intranasal influenza vaccine on par with the payment rates for other flu vaccine administration services proposed for assignment to APC 350 for 2006.

The Panel recommends that CMS delay implementation of the proposed codes for drug handling cost categories until January 2007 so that further data and alternative solutions for making payments to hospitals for pharmacy overhead costs can be collected, analyzed by CMS, and presented to the Panel at its winter 2006 meeting.

The Panel recommends that CMS reconsider carefully the proposal to pay 2 percent of average sales price (ASP) for hospital pharmacy overhead costs to ensure that it is in line with hospital costs and that CMS take into account external data gathered during the comment period.

The Panel recommends that CMS pay for the pharmacy overhead costs of both packaged and separately paid drugs, employing a mechanism that adds only minimal additional administrative burden for hospitals.

The Panel recommends that CMS evaluate all the drug codes to be paid at ASP plus 6 percent and pay particular attention to those that drop or rise precipitously.

The Panel recommends that CMS evaluate data as it is gathered to assess the adequacy of payment for the second and subsequent hours of drug administration in the outpatient hospital setting.

Specific APCs

The Panel recommends that CMS maintain CPT codes 95965, 95966, and 95967, magnetoencephalography (MEG), in their 2005 new technology APCs. The Panel also recommends that CMS collect more external hospital cost data and provide a detailed review of data for the Panel's consideration at its next meeting.

The Panel accepts CMS's proposed creation of APC 429 for 2006 and the inclusion of HCPCS C9713, which describes use of the GreenLight Laser System, in this APC.

The Panel recommends that CMS work with stakeholders to assign CPT 0071T and 0072T, focused ultrasound ablation of uterine leiomyomata including magnetic resonance guidance, to an appropriate New Technology APC(s).

The Panel recommends that CMS place CPT 0062T and 0063T in either APC 50 or APC 51, as CMS determines appropriate, based upon cost data gathered.

For APC 651, *The Panel recommends* that CMS evaluate the analysis proposed by the Coalition for the Advancement of Brachytherapy, using only the subset of claims that include brachytherapy source C codes to calculate median costs, in advance of finalizing the proposed rule.

The Panel recommends that CMS make CPT 37250, for noncoronary intravascular ultrasound, subject to Outpatient Prospective Payment System (OPPS) device code edits, and that the code remain in APC 416 for 2006 as recommended by CMS.

Blood and Blood Products

The Panel recommends that CMS use its 2005 payment rates as the floor for payment rates for all blood and blood products for 2006; specifically, CMS should pay the greater of 1) the simulated median as determined by 2004 data or 2) the 2005 payment median.

Device-Related APCs

The Panel recommends that for 2006, CMS base the payment rates for APCs 107 and 108, which provide payments for cardioverter defibrillator implantations, on their 2005 payment rates plus 3.2 percent.

For determining 2006 payment rates for APC 384, which provides payment for services to place gastrointestinal stents, *The Panel recommends* that CMS use only those claims containing a device HCPCS code to calculate the median cost for APC 384.

The Panel recommends that for APC 384, CMS move CPT codes 43269 and 43268 for endoscopic retrograde cholangiopancreatography services into a new APC to distinguish them from gastrointestinal stent placement services that do not require fluoroscopy which should remain in APC 384.

The Panel recommends that CMS adopt the proposed reconfiguration of APCs 040 and 225 for neurostimulator electrode implantation as submitted by Medtronic, creating three APCs that are clinically homogenous and coherent in use of resources. As proposed, APC 040 would include CPT codes 63650, 64555, 64560, and 64561; APC 225 would include CPT codes 64553 and 64573; and a new APC would include CPT codes 64577, 64580, 64575, 64581, and 63655.

Multiple Diagnostic Imaging Procedures

The Panel recommends that CMS postpone implementing the proposal to reduce payment for the second and subsequent imaging services when multiple diagnostic imaging procedures are performed in one session for 1 year to gather more data on the implications for hospitals of the changes. The Panel further *recommends* that CMS work with the American College of Radiology and other stakeholders in this process.

Administrative Business

The Panel recommends that CMS continue the work of the Packaging, Data, and Observation Subcommittees.

Other Issues

The Panel recommends that CMS review site of service data on single-level laminectomy services, which currently have status indicator C and are on the inpatient-only list, to determine whether the procedures are being performed in the hospital outpatient setting with enough frequency to be assigned to APCs for payment under the OPFS.