Advisory Panel on Ambulatory Payment Classification (APC) Groups

Meeting Report

March 5–6, 2008

Centers for Medicare & Medicaid Services (CMS)

7500 Security Boulevard, Auditorium

Baltimore, MD 21244-1850

PANEL MEMBERS PRESENT AT THIS MEETING

Patrick A. Grusenmeyer, Sc.D., F.A.C.H.

Hazel Kimmel, R.N., C.C.S., C.P.C.

Michael D. Mills, Ph.D.

Thomas Munger, M.D., F.A.C.C.

Agatha L. Nolen, M.S., D.Ph.

Louis Potters, M.D., F.A.C.R.

James Rawson, M.D.

Michael A. Ross, M.D., F.A.C.E.P.

Judie S. Snipes, R.N., M.B.A., F.A.C.H.E.

Patricia Spencer-Cisek, M.S., A.P.R.N.-B.C., A.O.C.N. ®

Kim Allan Williams, M.D., F.A.C.C., F.A.B.C.

Robert Matthew Zwolak, M.D., Ph.D., F.A.C.S.

CMS STAFF PRESENT

E. L. Hambrick, M.D., J.D., CMS Medical Officer, *Chair*

Shirl Ackerman-Ross, M.M.S., *Designated Federal Official* (DFO)

Jeffery Rich, M.D., Director, Center for Medicare Management (CMM)

Carol Bazell, M.D., M.P.H., Director, Division of Outpatient Care (DOC)

Marjorie Baldo, LCDR, U.S.P.H.S., M.S., R.H.I.A., C.C.S., C.C.S.-P, Staff, DOC

Raymond Bulls, Staff, DOC

Carrie Bullock, Staff, DOC

Dana Burley, M.S.P.H., B.S.N., Staff, DOC

Erick Chuang, M.S., Staff, DOC

Alberta Dwivedi, Staff, DOC

Anita Heygster, B.S., Staff, DOC

Heather Hostetler, J.D., Staff, DOC

Rebecca Kane, M.S., Staff, DOC

Barry Levi, M.B.A., Staff, DOC

Sheila Roman, M.D., CMS Medical Officer

Christina Smith Ritter, Ph.D. Staff, DOC

Tamar Spolter, M.H.S., Staff, DOC

Gift Tee, M.P.H., Staff, DOC

WELCOME AND CALL TO ORDER

E. L. Hambrick, M.D., J.D., Chair, welcomed the members, CMS staff, and the public. (The proceedings of the meeting follow. The agenda appears in Appendix A; a listing of only the recommendations appears in Appendix B. A list of presentations appears in Appendix C.)

Jeffrey Rich, M.D., Director, CMM, welcomed the Panel on behalf of CMS leadership. Dr. Rich thanked the members for taking the time to provide their input to the Agency, noting that the Panel's recommendations are an important component in CMS's policy development process.

Dr. Hambrick welcomed two new members of the Panel: Patrick A. Grusenmeyer and Agatha L. Nolen. She said that Hazel Kimmel will complete her term on the Panel following this meeting and Louis Potters, M.D., and Judie S. Snipes complete their terms in September, so that CMS is soliciting nominations for new members.

Dr. Hambrick briefly reviewed the Panel's Charter and defined the scope of issues that the Panel can address.

OVERVIEW OF CHANGES TO THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) AND CALENDAR YEAR (CY) 2009 PAYMENT RATES

Carol Bazell, M.D., M.P.H., Director, DOC, described some significant policy changes for the CY 2008 OPPS that took place with the publication of the final rule on November 27, 2007. Dr. Bazell said that some codes were assigned to different APC groups to address violations of the "2 times rule" (i.e., in a given APC, the median cost of the most costly significant service should be no more than two times the median cost of the least costly significant service). Significant changes were made in the following areas:

- **Quality Measures**: The Tax Relief and Health Care Act of 2006 extended the requirements for hospitals to report quality measures. Beginning in CY 2009, when a hospital fails to meet hospital outpatient quality reporting standards established by the Secretary, its annual OPPS update would be reduced by 2 percentage points.
- **Expanded Packaging**: For CY 2008, CMS is packaging payment for more services because it believes that packaging promotes efficiency and provides hospitals with more flexibility to provide the most cost-effective services and products. In response to public comments and recommendations from the Panel, CMS finalized several changes to the CY 2008 proposal, including packaging payment for imaging supervision and interpretation only when the service appears on a claim with a surgical procedure.
- **Composite APCs**: For CY 2008, CMS developed several composite APCs because it believes that such APCs create incentives for providers to carefully utilize their resources to provide common combinations of services most efficiently. Composite APCs allow CMS to set payment rates based on claims representing the most common clinical scenarios. Specifically, CMS established new composite APCs for extended assessment and management, low dose rate prostate brachytherapy, and cardiac electrophysiologic evaluation and ablation services.

- **Drugs and Biologicals**: CMS pays for drugs and biologicals on the basis of average sales price (ASP) plus 5 percent and packages payment drugs that cost less than $60 per day.
- **Radiopharmaceuticals**: Diagnostic radiopharmaceuticals are packaged into payment for their associated nuclear medicine procedures. In CY 2008, claims for nuclear medicine procedures that do not include a diagnostic radiopharmaceutical are returned to the provider automatically without payment so that the claim can be corrected. The CY 2008 final rule indicates that payment for therapeutic radiopharmaceuticals is based on mean costs from claims data. However, the Medicare, Medicaid, and SCHIP Extension Act of 2007 dictates that from January 1 to June 30, 2008, payment for therapeutic radiopharmaceuticals and brachytherapy sources is based on charges reduced to cost by hospital-specific cost-to-charge ratios.
- **Ambulatory Surgical Centers (ASCs)**: CMS applies a budget-neutral ASC-specific conversion factor to determine payment rates for most services provided in ASCs.

DATA ISSUES

CMS staff member Anita Heygster said that about 96 million single and "pseudo" single procedure claims were used to set rates for CY 2008. She provided an overview of the methodology that CMS uses to evaluate data and to set median costs for CY 2008, and she noted that a detailed discussion is available on the OPPS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under supporting documentation for the CY 2008 OPPS/ASC final rule with comment period. Ms. Heygster said that for CY 2008, the number of APCs for procedural services was reduced to 451 from 495 in CY 2007, largely by consolidating clinically similar APCs with very low volumes. She added that for CY 2008 there are 21 APCs that contain violations of the 2 times rule, down from 37 APCs with such violations in CY 2007.

Data Subcommittee's Report

Dr. Potters, Chair, Data Subcommittee, said that the Subcommittee appreciated the information provided by CMS staff on charges reduced to costs based on revenue code to cross center crosswalks. Dr. Potters said the Subcommittee accepts the concept of composite APCs in general, including those recently implemented for low dose rate prostate brachytherapy and cardiac electrophysiologic evaluation and ablation services, and the rest of the Panel members concurred.

- **Recommendation:** The Panel recommends that the Data Subcommittee continue its work.
- **Recommendation:** The Panel recommends using median cost data to pay for brachytherapy sources in CY 2009, as was presented by CMS staff and reviewed by the Data Subcommittee.
- **Recommendation:** The Panel recommends that CMS provide additional data to support packaging radiation oncology guidance services for review by the Data Subcommittee.

- **Recommendation:** The Panel recommends that CMS continue to package diagnostic radiopharmaceuticals for 2009.

PACKAGING ISSUES

Tamar Spolter, CMS staff, said that CMS believes packaging gives providers an incentive to deliver services in the most efficient, cost-effective manner and gives them flexibility to negotiate with vendors and establish protocols to ensure that they use hospital resources as efficiently as possible. Packaging also contributes to the stability of payment rates over time, because it provides more opportunities to average the cost of higher-cost cases that require more ancillary services with lower-cost cases that require fewer ancillary services.

Ms. Spolter described four approaches that CMS takes to packaging services: unconditionally packaged codes, in which the cost of a packaged code is always packaged with a single major procedure on the same claim; T-packaged codes, in which payment for a code is packaged when billed with a code assigned status indicator "T;" STVX-packaged codes, in which payment for a code is packaged when billed with a code assigned status indicator "S," "T," "V," or "X;" and composite APCs, in which a single payment rate is established for a combination of major services that are frequently performed together.

Packaging Subcommittee's Report

James Rawson, M.D., Chair, Packaging Subcommittee, said that the Subcommittee reviewed information provided by CMS and came to consensus on several recommendations for specific procedures.

- **Recommendation**: The Panel recommends that the Packaging Subcommittee continue its work.
- **Recommendation**: The Panel recommends that Healthcare Common Procedure Coding System (HCPCS) code A4306, *Disposable drug delivery system, flow rate of less than 50 mL per hour*, remain packaged for CY 2009.
- **Recommendation**: The Panel recommends that Current Procedural Terminology (CPT) code 36592, *Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified*, be treated as an STVX-packaged code for CY 2009 and assigned to the same APC as CPT code 36591, *Collection of blood specimen from a completely implantable venous access device*, until adequate data are collected that would enable CMS to determine its own payment rate.
- **Recommendation**: The Panel recommends that CPT code 74305, *Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation*, be treated as a T-packaged code for CY 2009 and that CMS consider assigning this code to APC 0263, *Level I Miscellaneous Radiology Procedures*.

Public Presentations

Radiation Oncology Guidance

Martin Fuss, M.D., Professor, Department of Radiation Medicine, Oregon Health Sciences University, said that CMS's packaging approach limits the adoption of new technology (Presentation A). He described new technology for continuous, real-time, adaptive radiation therapy that automatically adjusts if the target tissue moves during radiation delivery. Dr. Fuss said application has been made for a CPT code for the technology and asked that the technology be assigned to an APC.

In a letter, James E. Hugh III, M.H.A., C.H.B.M.E., R.O.C.C., Senior Vice President, American Medical Accounting and Consulting, said that packaging services for radiation therapy is inappropriate because the services are not provided 100% of the time with any other CPT code (Presentation B).

Intravascular Ultrasound and Intracardiac Echocardiography

Deb Lorenzo, Manager, Health Economics & Reimbursement, Boston Scientific, asked the Panel to recommend that CMS reinstate separate payment for CPT code 37250, *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel;* CPT code 37251, *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel;* CPT 92978 code, *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel;* CPT code 92979, *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel;* and CPT code 93662, *Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation*, because they represent procedures that are performed infrequently and for which the costs are not adequately captured with the primary procedures with which they are now packaged (Presentation C).

- **Recommendation**: The Panel recommends that CMS reinstate separate payment for the following intravascular ultrasound and intracardiac echocardiography codes:
    - CPT code 37250, *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel*
    - CPT 37251 code, *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel*
    - CPT 92978 code, *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel*
    - CPT 92979 code, *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel*

- CPT code 93662, *Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation*

DeChane Dorsey, Esq., of the Advance Medical Technology Association (AdvaMed) asked that CMS communicate its method for determining which codes should be considered for packaging, educate hospitals about including the costs of items that are packaged on claims, and increase transparency by identifying packaged codes associated with APCs via a crosswalk.

Valerie Rinkle of the Asante Health System asked that CMS clearly define what is meant by "integral" to a procedure when making packaging decisions.

NUCLEAR MEDICINE PROCEDURES AND RADIOPHARMACEUTICALS

In response to a request from the Panel, CMS staff analyzed claims for nuclear medicine procedures with and without diagnostic radiopharmaceuticals included on the claim. As of January 1, 2008, the Outpatient Code Editor rejects nuclear medicine procedures claims that do not include a diagnostic radiopharmaceutical. CMS staff member Rebecca Kane said that, in general, the median cost of those nuclear medicine APCs for which hospitals were least likely to include a diagnostic radiopharmaceutical increased when CMS recalculated the median cost with the diagnostic pharmaceutical included. For one APC, the median cost increased 69 percent.

Radioimmunotherapy

Ms. Kane described CMS's efforts to model a composite APC for radioimmunotherapy. Four criteria were established for inclusion in the composite APC; the criteria represent an episode of care from the first "cold" dose of radioimmunotherapy to the administration of a "hot" dose. Very few claims contained all four criteria for inclusion in the composite APC, and the estimated median cost for the composite was just over $19,000.

Public Presentations

Robin Joyce, M.D., M.M.S., Instructor, Department of Medicine, Harvard Medical School, asked that CMS classify Zevalin (ibritumomab tiuxetan) as a biologic and assign it to an APC based on its ASP (Presentation D). She said Zevalin is an effective treatment for indolent non-Hodgkin's lymphoma, but the cost is prohibitive, and the CY 2008 OPPS payment rate is inadequate.

Roger A. Hunter, Executive Director, New Product Planning & Policy, GlaxoSmithKline, said his company provided CMS with three quarters of ASP data on Bexxar therapeutic regimen (tositumomab and iodine I 131) (Presentation E). He added that the costs used by CMS staff to model the composite APC understate hospital costs, and as modeled, the composite APC would vastly underpay hospitals for the service. Denise Merlino of the Society for Nuclear Medicine said a survey that her organization provided to CMS demonstrated that the costs used by CMS to model the composite APC grossly underestimate hospital costs. Jack Singer of Cell Therapeutics, Inc., suggested that hospitals do not use these radioimmunotherapy procedures frequently enough to understand how to bill appropriately for them.

Mr. Hunter said the Bexxar therapeutic regimen (tositumomab and iodine I 131) is approved as a single course of treatment for patients with non-Hodgkin's lymphoma. He maintained that the current payment rate does not adequately cover the cost of the regimen and asked that Bexxar be exempt from bundling and the components paid separately.

Ms. Rinkle of the Asante Health System noted that hospitals using the composite APC for radioimmunotherapy would not be able to submit a claim until the episode of care was complete, which could be a month or more, and the delay in billing would present cash flow problems.

Ms. Merlino said CMS should consider external data to establish appropriate, separate (i.e., not packaged) payment rates when it becomes clear that the cost of a radiopharmaceutical is not adequately captured by CMS's methodology.

Mark Pascu of the Leukemia and Lymphoma Society urged CMS to establish payment rates that support access to these forms of radioimmunotherapy so that clinicians are not forced to go back to using more toxic drugs.

Gordon Schatz of the Council on Radionuclides and Radiopharmaceuticals (CORAR) agreed with Mr. Hunter that the components of the Bexxar regimen meet the criteria for specified covered outpatient drugs and suggested that CMS use the manufacturer's data as the basis for payment. Brian Carey of Cell Therapeutics, Inc., added that using ASP as the basis for payment is a more transparent approach that addresses concerns about hospital miscoding. Denise Williams of Vanguard Health Systems spoke to the complexities of billing and payment across states that are compounded by CMS billing rules.

Jugna Shah, on behalf of the Alliance of Dedicated Cancer Centers (ADCC), said CMS claims data did not adequately capture the costs of radioimmunotherapy and ASP would be a better approach to identifying charges. Ms. Merlino added that the Society of Nuclear Medicine would support a composite APC for radioimmunotherapy if ASP data were used to calculate costs. She said that ASP data are available for all radiopharmaceuticals. Mr. Schatz said that using ASP as a basis for payment is problematic for other radiopharmaceuticals but should be considered for Zevalin and Bexxar.

Ms. Rinkle added that CMS should provide hospitals with explicit instructions for billing using a composite APC for radiotherapy because the process differs from billing for other radiation oncology procedures, and Nelly Leon-Chisen of the American Hospital Association agreed.

- **Recommendation**: The Panel recommends that CMS continue pursuing a radioimmunotherapy composite APC that uses existing claims and stakeholder data to establish appropriate payment rates for radioimmunotherapy protocols.
- **Recommendation**: The Panel recommends that, as CMS develops a radioimmunotherapy composite APC, CMS provide specific guidance to hospitals on appropriate billing for radioimmunotherapy.

Diagnostic and Therapeutic Radiopharmaceuticals

Public Presentations

Kathy Francisco, Managing Partner, The Pinnacle Health Group, asked that CMS establish separate payments for high-cost, low-volume diagnostic radiopharmaceuticals and that it use external data to validate its own cost data (Presentation F). She said that CMS underpays for the diagnostic radiopharmaceutical ProstaScint (capromab pendetide), and it does not fit into the APC to which it is assigned. Ms. Merlino said the Society for Nuclear Medicine agrees that ProstaScint should be paid separately.

In a letter, Tamar Thompson & Fred E. Longenecker, Co-Chairs, Clinical Practice & Reimbursement Committee, CORAR, asked that CMS establish separate payments for certain high-cost diagnostic radiopharmaceuticals or create composite APCs; that CMS recognize HCPCS codes A9542, *Indium in-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries,* and A9544, *Iodine i-131 tositumomab, diagnostic, per study dose*, as part of the therapeutic regimens for Zevalin and Bexxar; and that CMS accept external data for ratesetting (Presentation G).

Lisa Saake of Covidien said that packaging high-cost radiopharmaceuticals discourages hospitals from treating cancer patients. Michael Manyak, M.D., said that ProstaScint is unique and hospitals have no less-expensive alternatives. Mr. Schatz of CORAR asked that CMS reevaluate the current payment structure for tumor imaging to ensure that procedures are grouped according to clinical comparability and resource homogeneity.

- **Recommendation**: The Panel recommends that CMS present data at the first 2009 Panel meeting on usage and frequency, geographic distribution, and size and type of hospitals performing nuclear medicine examinations and using radioisotopes to ensure that access is preserved for Medicare beneficiaries.

INPATIENT LIST

CMS staff member Dana Burley presented a list of procedures that CMS identified as possible services for removal from the inpatient list:

- CPT code 21172, *Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)*
- CPT code 21386, *Open treatment of orbital floor blowout fracture; periorbital approach*
- CPT code 21387, *Open treatment of orbital floor blowout fracture; combined approach*
- CPT code 27479, *Arrest, epiphyseal, any method (e.g., epiphysiodesis); combined distal femur, proximal tibia and fibula*
- CPT code 54535, *Orchiectomy, radical, for tumor; with abdominal exploration*
- CPT code 61850, *Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical*

Ms. Burley also presented utilization data on CPT code 20660, *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)*, and CPT code 64818, *Sympathectomy, lumbar*, in response to the Panel's request for more data on which to base a recommendation regarding removal from the inpatient-only list. Ms. Burley pointed out that removing a procedure from the inpatient list enables the physician to determine where the procedure should be provided for a given patient and allows the hospital to be paid for the procedure regardless of whether it is performed on an inpatient or outpatient basis.

Stephanie Stinchcomb of the American Urological Association asked that the following codes be removed from the inpatient-only list but did not provide any supporting data:

- CPT code 50580, *Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus*
- CPT code 51845, *Abdomino-vaginal vesical neck suspension, with or without endoscopic control (eg, stamey, raz, modified pereyra)*
- CPT code 51860, *Cystorrhaphy, suture of bladder wound, injury or rupture; simple*
- CPT code 54332, *One stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap*
- CPT code 54336, *One stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap*

- **Recommendation**: The Panel recommends that CMS seek input from the American Urological Association on removal of CPT code 54535, *Orchiectomy, radical, for tumor; with abdominal exploration*, from the inpatient-only list and that CMS seek input from the American Association of Neurological Surgeons and the Congress of Neurological Surgeons on the removal of CPT code 61850, *Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical*, from the inpatient-only list.
- **Recommendation**: The Panel recommends that CMS remove the following procedures from the inpatient list:
    - CPT code 21172, *Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)*
    - CPT code 21386, *Open treatment of orbital floor blowout fracture; periorbital approach*
    - CPT code 21387, *Open treatment of orbital floor blowout fracture; combined approach*
    - CPT code 27479, *Arrest, epiphyseal, any method (e.g., epiphysiodesis); combined distal femur, proximal tibia and fibula*

- CPT code 20660, *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)*

OBSERVATION AND VISIT ISSUES

CMS staff member Heather Hostetler said that, although the Panel had recommended otherwise, for CY 2008, CMS is continuing to recognize the CPT codes that distinguish between new and established patients for clinic visits because CMS sees meaningful cost differences between visits for new versus established patients. For CY 2008, CMS has adopted the APC Panel's recommendation not to recognize the CPT consultation codes, 99241-99245. Hospitals could build consultation services into their internal hospital guidelines.

Ms. Hostetler explained the composite APCs established in CY 2008 for extended assessment and management services. APC 8002, *Level I Extended Assessment and Management Composite*, describes an encounter that includes a high-level (level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (8 hours or more). APC 8003, *Level II Extended Assessment and Management Composite*, describes an encounter that includes a high-level (level 4 or 5) emergency department (ED) visit or critical care services in conjunction with observation services of substantial duration. She gave an overview of the criteria for composite APC payment, CY 2008 payment rates, and current median costs for the two composite APCs.

Observation and Visit Subcommittee's Report

Ms. Snipes, Chair, Observation and Visit Subcommittee, thanked CMS staff for the data and assistance provided to the Subcommittee. She pointed out that the principle and admitting diagnoses in the extended assessment and management composite APCs closely matched the Subcommittee's perception that the diagnoses related to observation care would include cardiac conditions, syncope, abdominal pain, urinary tract infection, and dehydration.

John Settlemeyer, speaking on behalf of the Provider Roundtable, asked the Panel to request more data from CMS on CPT code 99291, *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes,* and APC 0617, *Critical Care,* because changes to reporting the CPT code may result in services not being adequately captured in payment for APC 0617.

Ms. Rinkle of Asante Health System requested that CMS announce policy changes through its formal rulemaking process or published guidance only, and not through frequently asked questions posted on the Web site or other informal means. Ms. Kimmel added (later in the meeting) that guidance on billing gets overlooked when it is buried in a final rule and should be presented in *MLN Matters* articles or other educational sources.

- **Recommendation**: The Panel recommends that the Observation and Visit Subcommittee be renamed the Visits and Observation Subcommittee and that the Subcommittee continue its work.

- **Recommendation**: The Panel recommends that CMS continue to pay Type B ED visits for levels 1, 2, and 3 at the corresponding clinic visit levels. The Panel also recommends that CMS consider using clinic visit level 5 as the basis of payment for ED Type B level 4 visits and ED Type A level 5 as the basis of payment for ED Type B level 5 visits. Given the limited data presently available for ED Type B visits, the Panel also recommends that CMS reconsider payment adjustments as more claims data become available.
- **Recommendation**: The Panel recommends that CMS provide at the second 2008 Panel meeting additional observation length-of-stay frequency distribution data, with additional detail at the 24–48-hour and >48-hour levels for review by the Observation and Visit Subcommittee.
- **Recommendation**: The Panel recommends that CMS provide frequency and median cost data on the following to the Panel at the second CY 2008 Panel meeting for review by the Observation and Visit Subcommittee:
    - ED Type A and B visits
    - Extended assessment and management composite APCs
    - New and established patient clinic visits
- **Recommendation**: The Panel recommends that CMS provide data on CPT code 99291, *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*, and APC 0617, *Critical Care*, for review by the Observation and Visit Subcommittee during the second CY 2008 Panel meeting.

APC PLACEMENT ISSUES

Suprachoroidal Delivery of Pharmacologic Agent

CMS staff member LCDR Marjorie Baldo, USPHS, explained that CPT code 0186T, *Suprachoroidal delivery of pharmacologic agent (does not include supply of medication)*, is new for CY 2008 and was assigned to APC 0236, *Level II Posterior Segment Eye Procedures*. She pointed out that the drug used with the procedure would be reported under a separate code.

John McInnes, M.D., Attorney, Arnold & Porter, L.L.P., asked that CPT code 0186T be assigned to APC 0237, *Level III Posterior Segment Eye Procedures*, to better account for the cost of the procedure (Presentation H). Adam Martidis, M.D., Retinal Surgeon, Retina Institute of California, said the procedure represents a revolution in the field, but it is more time-consuming and technically challenging than comparable procedures. He pointed out that data so far come from phase 1 trials in one center but there are plans to expand the trial to seven centers.

- **Recommendation**: The Panel recommends that CMS share with the Panel the claims data on CPT code 0186T, *Suprachoroidal delivery of pharmacologic agent (does not include supply of medication)*, at the first CY 2009 Panel meeting and that CMS reevluae the placement of CPT code 0186T in APC 0236 on the basis of those data.

Implant Injection for Vesicoureteral Reflux

CMS staff member Alberta Dwivedi said that CMS received comments that payment for CPT code 52327, *Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material*, was inadequate. She noted that the procedure is used primarily for pediatric patients, and CMS received only about 200 claims for it in CY 2007.

Grant Bagley, M.D., J.D., Attorney, Arnold & Porter, L.L.P., explained that the CPT code was created before a truly effective bulking agent was identified (Presentation I). He said the payment rate does not adequately reflect the use of new implant material (Deflux) that makes the procedure viable. John Edmonson, M.D., F.A.A.P., Pediatric Urologist, Children's Urology of Virginia, added that cystourethroscopy with Deflux is very effective in treating children with vesicoureteral reflux and precludes the need for open surgery, but the cost of the implant material is becoming prohibitive.

Martha Christian, Director, Strategic Reimbursement, P.R.G., said her analysis of the CMS claims data suggests that hospitals may be misusing CPT code 52327. She said the implant material alone costs about $1,000 and requested that CMS assign CPT code 52327 to a higher-paying APC, such as APC 0385, *Level I Prosthetic Urological Procedures*, which includes high-cost devices, although she said it was difficult to identify an appropriate APC for the code.

Ms. Stinchcomb of the American Urological Association said her organization supports the recommendation to move CPT code 52327 to an APC that better recognizes the cost of the implant material.

- **Recommendation**: The Panel recommends that CMS consider assigning CPT code 52327, *Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material*, to a more appropriate APC.

Renal Cryoablation

CMS staff member Raymond Bulls said that for CY 2008, CPT code 50593, *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy*, replaced CPT code 0135T, *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy*. Hospitals continue to be required to report the accompanying HCPCS device code C2618, *Probe, cryoablation*. In response to public comments to the CY 2008 OPPS/ASC proposed rule, CMS evaluated CY 2006 claims data that included CPT code 0135T reported with and without HCPCS code C2618. Although the median cost of claims with the device code was somewhat higher than the cost of those without the device, CMS concluded that the procedure was appropriately assigned to APC 0423, *Level II Percutaneous Abdominal and Biliary Procedures*, for CY 2008. The median cost APC 0423 is $2,860 based upon the CY 2007 claims data available for this APC Panel meeting.

Dr. Bagley, representing Endocare, Inc., and Galil Medical, Inc., said that APC 0423 significantly underpays for CPT code 50593 and asked that CMS create a new, device-dependent APC for higher cost percutaneous renal cryoablation procedures (Presentation J). Ms.

Stinchcomb said the American Urological Association supports the request. Lisa Hayden of Galil Medical said it has been difficult to educate hospitals on proper coding for this procedure and the associated device, and instituting a device-dependent APC would encourage hospitals to improve their billing.

APC Payment Issues

Thomas Novelli, Director, Federal Affairs, Medical Device Manufacturing Association, contended that expanding the OPPS packaging will lead to less efficient use of resources, limited access to innovative treatment options, and greater instability in payments (Presentation K). He asked that CMS require hospitals to include C-codes on claims for all device-dependent APCs in CY 2009. The Panel agreed that CMS should evaluate the effectiveness of expanded packaging in containing costs while maintaining beneficiary access to high-quality care.

- **Recommendation**: The Panel recommends that CMS report to the Panel at the first Panel meeting in CY 2009 the impact of packaging on net payments for patient care.

Drug Administration APCs

Ms. Kane said that on the basis of evaluation of CY 2007 data—the first year in which hospitals used the full set of CPT codes for drug administration—CMS concluded that the six-level APC structure for drug administration codes resulted in several violations of the 2 times rule. Ms. Kane presented a possible four-level APC structure for the Panel's consideration that eliminates the violations and maintains logical categories of services with respect to their resource use.

Ms. Shah of ADCC cautioned the Panel against making a hasty decision to collapse the drug administration codes into a four-level APC structure on the basis of only 1 year's worth of data. Ms. Rinkle of Asante Health System agreed, saying that hospitals have difficulty determining what to charge when new codes are implemented, so additional data are needed. Ms. Leon-Chisen of the American Hospital Association added that CPT recently clarified the hierarchy for reporting the initial service using the drug administration CPT codes, so CY 2007 data may be inconsistent. Ms. Kimmel suggested CMS consider disregarding data from claims submitted within the first 4 weeks after new codes are implemented to allow for adjustment on the part of hospitals.

- **Recommendation**: The Panel recommends that CMS not implement the four-level APC structure described to the Panel by CMS staff for drug administration codes until more data are available and that CMS provide the Panel a crosswalk analysis of the data.

Closed Fracture Treatment

LCDR Baldo pointed out that APC 0043, *Closed Treatment Fracture Finger/Toe/Trunk*, includes approximately 150 procedures and thus may not accurately distinguish the more expensive from the less resource-intensive fracture treatment procedures. APC 0043 has been exempt from the 2 times rule for the past 7 years under OPPS. LCDR Baldo presented a potential reconfiguration of APC 0043 into three APCs on the basis of clinical characteristics and resource costs, recognizing that all three would contain many procedures that are very low in volume.

LCDR Baldo explained that CMS places unlisted codes in the lowest-paying APC. Ms. Rinkle of Asante Health System asked CMS to reconsider that policy, but Ms. Kimmel countered that the policy encourages hospitals to determine the appropriate code for a procedure. Kathy Dorale of Avera Health said that if one code is out of synch with a prescribed code set, an unlisted code must be used.

- **Recommendation**: The Panel recommends that CMS adopt the approach described to the Panel by CMS staff to split APC 0043, *Closed Treatment Fracture Finger/Toe/Trunk*, into three APCs.

Psychotherapy

Ms. Spolter pointed out that APC 0323, *Extended Individual Psychotherapy*, has violated the 2 times rule for several years and would continue to do so in CY 2009 if no changes were made. She noted that if CPT codes that describe psychotherapy services provided as part of a partial hospitalization program were removed from APC 0323, there would be no violations of the 2 times rule in APC 0323. The services described by those CPT codes are captured by other CPT codes specifically for the outpatient setting.

- **Recommendation**: The Panel recommends that CMS adopt the restructuring described to the Panel by CMS staff of APC 0323, *Extended Individual Psychotherapy*, taking out the following codes, which apply specifically to services provided as part of partial hospitalization program, and that a similar restructuring be considered for APC 0322, Brief Individual Psychotherapy:
  - CPT code 90816, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient*
  - CPT code 90817, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services*
  - CPT code 90818, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient*

- CPT code 90819, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management*
- CPT code 90821, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient*
- CPT code 90822, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services*
- CPT code 90823, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient*
- CPT code 90824, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services*
- CPT code 90826, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient*
- CPT code 90827, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services*
- CPT code 90828, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient*
- CPT code 90829, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services*

DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS

CMS staff member Rebecca Kane outlined the methodology for determining payment rates. She said that, for packaged drugs, CMS updates the packaging threshold annually according to the Producer Price Index for prescription drugs, rounding to the nearest $5. For CY 2008, the packaging threshold is $60 per day. For separately payable drugs, CMS pays at a rate of ASP plus 5 percent in CY 2008. CMS continues to pay for drugs and biologicals using its current methodology, which combines both acquisition costs and pharmacy overhead.

Public Presentations

Edward Stemley, Director, Pharmacy Practice Managers, American Society of Health System Pharmacists (Presentation L); John Siracusa of the Biotechnology Industry Organization (Presentation M); Ernest Anderson, Jr., M.S., R.Ph., of the Association of Community Cancer Centers (Presentation N); Ms. Shah of the ADCC (Presentation O); and Mary Jo Braid-Forbes of the Moran Company presented testimony as a group in support of a budget-neutral methodology that would pay more appropriately for acquisition costs and pharmacy overhead.

Ms. Braid-Forbes said that the Moran Company concluded that the CMS model assumes that pharmacy overhead is captured by marking up drugs and biologicals by an average percentage across the board, while most hospital pharmacies mark up drugs and biologicals by a fixed dollar amount. Under the CMS model, as the packaging threshold dollar amount rises, the percentage over ASP will decline and rapidly reach negative numbers. Because ASP is an accurate reflection of average acquisition costs, CMS should apply the ASP-plus formula that it uses for separately payable drugs to determine payment for packaged drugs instead of relying on flawed data from hospital charges reduced to cost. Ms. Braid-Forbes said this approach would decrease payment rates for non-drug APCs across the system by very small amounts (less than 1 percent in most cases) and free up millions of dollars, which could be redistributed for payment of pharmacy overhead costs. Hospitals would continue to submit claims as they do now, and CMS would apply a different methodology (one it already uses and for which it has accurate and up-to-date information from manufacturers).

In response to questions about how the ASP-plus methodology applied to separately payable drugs has affected rural and inner-city hospital pharmacies, Ms. Braid-Forbes said her impact analysis showed that hospitals who provide a wide range of services have not suffered under the ASP-plus methodology but cancer centers have been disproportionately affected because of their high pharmacy costs.

Panel members raised concerns about the possibility of creating negative incentives or other unintended consequences by tying infrastructure costs such as pharmacy overhead to ASP, given that ASP is determined by the pharmaceutical manufacturers. Other countered that CMS already relies on ASP for calculating several types of payment rates.

Ms. Shah requested that CMS not increase the value of the packaging threshold for drugs and biologicals beyond the adjustment for inflation. For separately payable drugs and biologicals, she asked that CMS pay at a rate no less than ASP plus 6 percent for CY 2009.

- **Recommendation**: The Panel recommends that CMS work with stakeholders representing hospital pharmacies to develop further recommendations on the validity of the methodology proposed of analyzing the overhead costs in packaged drugs for redistribution to separately paid drugs and that CMS conduct an impact analysis on the proposed methodology with consideration for rulemaking for CY 2009.
- **Recommendation**: The Panel supports CMS's current methodology of adjusting the threshold dollar amount for packaging drugs and biologicals on the basis of the Producer Price Index.

CLOSING

Panel members reviewed the collected recommendations and refined them following further discussion. Dr. Hambrick thanked the Panel members for their service and the CMS support staff for their hard work. She gave special thanks to Shirl Ackerman-Ross (DFO for the Panel) and to contractors John O'Leary (audio specialist) and Dana Trevas (reporter) for their assistance. Dr. Hambrick also thanked outgoing member Ms. Kimmel for her years of service to the Panel.

The meeting adjourned at 4:00 p.m. on Thursday, March 6, 2008.

Appendix A

AGENDA

March 5, 6, and 7[1], 2008

ADVISORY PANEL ON AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS' MEETING

DAY 1 - Wednesday, March 5, 2008

Public registrants may enter the Centers for Medicare & Medicaid Services' (CMS) Central Office Building <u>after</u> 12:15 p.m.

AGENDA

01:00[2] **Opening** - Day 1
Welcome, Call to Order, and Opening Remarks
Jeffrey Rich, M.D., Director, Center for Medicare Management

01:15 **Panel Organization and Housekeeping Issues**
E. L. Hambrick, M.D., J.D., Chair, APC Panel

01:30 **CMS-1392-F:** Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2009 Payment Rates, et al, **Federal Register**

1. **Overview** - Carol Bazell, M.D., M.P.H., Director, Division of Outpatient Care (DOC)
2. Discussion
3. Panel's Comments

01:45 **DATA**

1. **Overview** - Anita Heygster, CMS Staff
2. **Data Subcommittee's Report** - Louis Potters, M.D., F.A.C.R., Chair
3. Discussion
4. Panel's Comments/Recommendations

02:15 **PACKAGING**

1. **Overview –** Tamar Spolter, M.H.S., CMS Staff
   – Anita Heygster, CMS Staff

2. **Packaging Subcommittee Report** - James V. Rawson, M.D. – Chair
   a. Discussion
   b. Panel's Comments/Recommendations

3. **Radiation Oncology Guidance**
   a. **Presentation** – Charles Thomas, M.D., Prof. & Chair **A**
   – Martin Fuss, M.D., Professor
   Dept. of Radiation Medicine
   Oregon Health Sciences University
   b. **Comment Letter –** James E. Hugh, III, MHA, CHBME, ROCC® **B**
   Senior Vice President, AMAC®
   c. Discussion
   d. Panel's Comments/Recommendations

4. **Intravascular Ultrasound and Intracardiac Echocardiography**
   a. **Presentation**
   – Tom Meskan, Director **C**
   Health Econ. & Reimbursement (HE&R), Boston Scientific (BS)
   – Deb Lorenzo, Manager, HE&R, BS
   b. Discussion
   c. Panel's Comments/Recommendations

03:15 *Break*

03:30 **NUCLEAR MEDICINE PROCEDURES AND RADIOPHARMACEUTICALS**

1. **Overview –** Rebecca Kane, M.S., CMS Staff

2. **Radioimmunotherapy**
   a. **Presentation** – Robin Joyce, M.D., M.M.S., Instructor **D**
   Dept. of Medicine, Harvard Medical School
   b. **Presentation** – Roger A. Hunter, Executive Director **E**
   New Product Planning & Policy
   GlaxoSmithKline
   c. Discussion
   d. Panel's Comments/Recommendations

3. **Diagnostic and Therapeutic Radiopharmaceuticals**
   a. **Presentation –** Kathy Francisco, Managing Partner **F**
      The Pinnacle Health Group
   b. **Comment Letter –** Tamar Thompson & Fred E. Longenecker **G**
      Co-Chairs, Clinical Practice & Reimbursement Committee
      Council on Radionuclides & Radiopharmaceuticals, Inc.
   c. Discussion
   d. Panel's Comments/Recommendations

05:00 **ADJOURN**

AGENDA

March 5, 6, and 7, 2008

Advisory Panel on Ambulatory Payment Classification (APC) Groups' Meeting

DAY 2 - Thursday, March 6, 2008

Public registrants may enter the CMS Central Office Building <u>after</u> 7:45 a.m. **TAB**

08:30 **Opening** - Day 2
Welcome and Call to Order
E. L. Hambrick, M.D., J.D., Chair, APC Panel

08:45 **INPATIENT LIST**
1. **Overview –** Dana Burley, R.N., M.S.P.H., CMS Staff
2. Discussion
3. Panel's Comments/Recommendations

09:30 **OBSERVATION AND VISITS**
1. **Overview –** Heather Hostetler, J.D., CMS Staff
2. **Observation and Visit Subcommittee's Report -** Judie Snipes, R.N., M.B.A., Chair
3. Discussion
4. Panel's Comments/Recommendations

09:45 **APC PLACEMENT ISSUES**
Public Presentations and Comments

1. **Suprachoroidal Delivery of Pharmacologic Agent**
   a. **Overview –** LCDR Marjorie Baldo, USPHS, M.S., CMS Staff
   a. **Presentation –** Adam Martidis, M.D., Retinal Surgeon, Retina Inst. of CA **H**
   – John McInnes, M.D., Attorney, Arnold & Porter LLP
   b. Discussion
   c. Panel's Comments/Recommendations

TAB

2. **Implant Injection for Vesicoureteral Reflux**
   a. **Overview –** Alberta Dwivedi, CMS Staff
   b. **Presentation –** John Edmondson, M.D., FAAP, Pediatric Urologist **I**
      Children's Urology of VA
      – Grant Bagley, M.D., J.D., Attorney, Arnold & Porter LLP
      – Martha Christian, Director, Strategic Reimbursement, PRG
   c. Discussion
   d. Panel's Comments/Recommendations

10:30 *Break*

10:45 **APC PLACEMENT ISSUES- Public Presentations and Comments *(continued)***

3. **Renal Cryoablation**
   a. **Overview** – Raymond Bulls, CMS Staff
   b. **Presentation –** Grant Bagley, M.D., J.D., Attorney, Arnold & Porter LLP **J**
   c. Discussion
   d. Panel's Comments/Recommendations

4. **APC Payment Issues**
   a. **Presentation** – Thomas Novelli, Director, Federal Affairs **K**
      Medical Device Manufacturers Association
   b. Discussion
   c. Panel's Comments/Recommendations

5. **Drug Administration APCs**
   a. **Overview –** Rebecca Kane, M.S., CMS Staff
   b. Discussion
   c. Panel's Comments/ Recommendations

6. **Closed Fracture Treatment APC**
   a. **Overview –** LCDR Marjorie Baldo, USPHS, M.S., CMS Staff
   b. Discussion
   c. Panel's Comments/Recommendations

7. **Psychotherapy APC**
   a. **Overview –** Tamar Spolter, M.H.S., CMS Staff
   b. Discussion
   c. Panel's Comments/Recommendations

12:00 *Lunch*

01:00 **DRUGS, BIOLOGICALS, AND PHARMACY OVERHEAD**
Public Presentations and Comments

1. **Overview** – Rebecca Kane, M.S., CMS Staff

2. **Presentation –** Edward Stemley, Director, Pharmacy Practice Managers **L**
American Society of Health-System Pharmacists

3. **Presentation –** John Siracusa, Manager, Medicare Reimbursement **M**
Biotechnology Industry Organization

4. **Presentation –** Ernest R. Anderson, Jr., M.S., R.Ph. **N**
Pharmacy Dept., Lahey Clinic &
Chairman, ACCC OPEN Advisory Board

5. **Presentation –** Jugna Shah, Consultant **O**
Alliance of Dedicated Cancer Centers

6. Discussion

7. Panel's Comments/Recommendations

03:00 *Break* (Cumulative list of Panel's recommendations will be compiled.)

03:30 **Closing**
1. Summary of the Panel's Recommendations for 2009
2. Discussion
3. Final Remarks

05:00 **Adjourn**

Appendix B

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Advisory Panel on Ambulatory Payment Classification (APC) Groups

Recommendations: March 5–6, 2007

Data Issues

1. The Panel recommends that the Data Subcommittee continue its work.

2. The Panel recommends using median cost data to pay for brachytherapy sources in calendar year (CY) 2009, as presented by the Centers for Medicare & Medicaid Services (CMS) staff and reviewed by the Data Subcommittee.

3. The Panel recommends that CMS provide additional data to support packaging radiation oncology guidance services for review by the Data Subcommittee at the next APC Panel meeting.

Packaging Issues

4. The Panel recommends that the Packaging Subcommittee continue its work.

5. The Panel recommends that CMS report to the Panel at the first Panel meeting in CY 2009 regarding the impact of packaging on net payments for patient care.

6. The Panel recommends that HCPCS code A4306, *Disposable drug delivery system, flow rate of less than 50 mL per hour*, remain packaged for CY 2009.

7. The Panel recommends that CPT code 36592, *Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified*, be treated as an STVX-packaged code for CY 2009 and assigned to the same APC as CPT 36591 code, *Collection of blood specimen from a completely implantable venous access device*, until adequate data are collected that would enable CMS to determine its own payment rate.

8. The Panel recommends that CPT code 74305, *Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation*, be treated as a T-packaged code for CY 2009 and that CMS consider assigning this code to APC 0263, *Level I Miscellaneous Radiology Procedures*.

9. The Panel recommends that CMS reinstate separate payment for the following intravascular ultrasound and intracardiac echocardiography codes:

    - CPT code 37250, *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel*
    - CPT code 37251, *Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel*
    - CPT code 92978, *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel*
    - CPT code 92979, *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel*
    - CPT code 93662, *Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation*

Inpatient List Issues

10. The Panel recommends that CMS seek input from the American Urological Association and other relevant stakeholders on removal of CPT code 54535, *Orchiectomy, radical, for tumor; with abdominal exploration,* from the inpatient list and that CMS seek input from the American Association of Neurosurgeons, the Congress of Neurosurgeons, and other relevant stakeholders on the removal of CPT code 61850, *Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical,* from the inpatient list.

11. The Panel recommends that CMS remove the following procedures from the inpatient list:
    - CPT code 21172, *Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)*
    - CPT code 21386, *Open treatment of orbital floor blowout fracture; periorbital approach*
    - CPT code 21387, *Open treatment of orbital floor blowout fracture; combined approach*
    - CPT code 27479, *Arrest, epiphyseal, any method (e.g., epiphysiodesis); combined distal femur, proximal tibia and fibula*
    - CPT code 20660, *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)*

Observation and Visit Issues

12. The Panel recommends that the Observation and Visit Subcommittee be renamed the Visits and Observation Subcommittee and that the Subcommittee continue its work.

13. The Panel recommends that CMS continue to pay Type B emergency department (ED) visits of levels 1, 2, and 3 at the corresponding clinic visit levels. The Panel also recommends that CMS consider using clinic visit level 5 as the basis of payment for Type B ED level 4 visits and Type A ED level 5 as the basis of payment for Type B ED level 5 visits. Given the limited data presently available for Type B ED visits, the Panel also recommends that CMS reconsider payment adjustments as more claims data become available.

14. The Panel recommends that CMS provide at the second CY 2008 Panel meeting additional length-of-stay frequency distribution data, with additional detail at the 24–48-hour and >48-hour levels for review by the Observation and Visit Subcommittee.

15. The Panel recommends that CMS provide frequency and median cost data on the following to the Panel at the second CY 2008 Panel meeting for review by the Observation and Visit Subcommittee:
    - Type A and B ED visits
    - Extended assessment and management composite APCs
    - New and established patient clinic visits

16. The Panel recommends that CMS provide data on CPT code 99291, *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*, and APC 0617, *Critical Care*, for review by the Observation and Visit Subcommittee during the second CY 2008 Panel meeting.

APC Placement Issues

Suprachoroidal Delivery of Pharmacologic Agent

17. The Panel recommends that CMS share with the Panel claims data for CPT code 0186T, *Suprachoroidal delivery of pharmacologic agent (does not include supply of medication)*, assigned toAPC 0236, Level II Posterior Segment Eye Procedures, for CY 2008 in order to allow reevaluation of the APC assignment of CPT code 0186T when data become available.

Implant Injection for Vesicoureteral Reflux

17. The Panel recommends that CMS consider assigning CPT code 52327, *Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material*, to a more appropriate APC.

Drug Administration

18. The Panel recommends that CMS not implement the 4-level APC structure described to the Panel by CMS staff for drug administration codes until more data are available and that CMS provide the Panel a crosswalk analysis of the data.

Closed Fracture Treatment

19. The Panel recommends that CMS adopt the approach described to the Panel by CMS staff to split APC 0043, *Closed Treatment Fracture Finger/Toe/Trunk*, into three APCs.

Psychotherapy

20. The Panel recommends that CMS adopt the restructuring described to the Panel by CMS staff of APC 0323, *Extended Individual Psychotherapy*, taking out the following codes, which apply specifically to services provided in an inpatient, partial hospital or residential care setting, and that a similar restructuring be considered for APC 0322, *Brief Individual Psychotherapy*:

    - CPT code 90816, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;*
    - CPT code 90817, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services*
    - CPT code 90818, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;*
    - CPT code 90819, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management*
    - CPT code 90821, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;*
    - CPT code 90822, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services*
    - CPT code 90823, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient;*
    - CPT code 90824, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services*
    - CPT code 90826, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;*
    - CPT code 90827, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services*

- CPT code 90828, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient;*
- CPT code 90829, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services*

Drugs, Biologicals, and Radiopharmaceuticals Issues

21. The Panel recommends that CMS continue to package diagnostic radiopharmaceuticals for CY 2009.

22. The Panel recommends that CMS present data at the first CY 2009 Panel meeting on usage and frequency, geographic distribution, and size and type of hospitals performing nuclear medicine studies using radioisotopes in order to ensure that access is preserved for Medicare beneficiaries.

23. The Panel recommends that CMS continue pursuing a radioimmunotherapy composite APC that uses existing claims and stakeholder data to establish appropriate payment rates for radioimmunotherapy protocols.

24. The Panel recommends that, as CMS develops a radioimmunotherapy composite APC, CMS provide specific guidance to hospitals on appropriate billing for radioimmunotherapy.

25. The Panel recommends that CMS work with the stakeholders representing hospital pharmacies to further develop recommendations on the validity of the methodology proposed by the stakeholders of analyzing the pharmacy overhead costs associated with packaged drugs for redistribution to separately paid drugs and that CMS conduct an impact analysis of the proposed methodology, with consideration for rulemaking for CY 2009.

26. The Panel supports CMS' current methodology of adjusting the threshold dollar amount for packaging drugs and biologicals on the basis of the Producer Price Index for prescription drugs.

Appendix C

PRESENTATIONS

The following organizations provided written testimony for the Advisory Panel on Ambulatory Payment Classification Groups meeting March 5–6, 2008:

Presentation A: Oregon Health Sciences University

Presentation B: American Medical Accounting and Consulting

Presentation C: Boston Scientific

Presentation D: Beth Israel Deaconess Medical Center

Presentation E: SmithKline Beecham Corp./GlaxoSmithKline

Presentation F: Cytogen Corp.

Presentation G: Council on Radionuclides and Radiopharmaceuticals, Inc.

Presentation H: iScience International

Presentation I: Deflux

Presentation J: Galil Medical, Inc., and Endocare, Inc.

Presentation K: Medical Device Manufacturers Association

Presentation L: American Society of Health System Pharmacists

Presentation M: Biotechnology Industry Organization

Presentation N: Association of Community Cancer Centers

Presentation O: Alliance of Dedicated Cancer Centers