CENTERS FOR MEDICARE & MEDICAID SERVICES

Advisory Panel on Ambulatory Payment Classification (APC) Groups

Recommendations: March 7–8, 2007

Data Issues

1. The Panel recommends that the Centers for Medicare & Medicaid Services (CMS) edit and return for correction claims that contain a Healthcare Common Procedure Coding System (HCPCS) code for a separately paid drug or device but do not also contain a HCPCS code assigned to a procedural APC (i.e., status indicators (SIs) "S," "T," "V," or "X"). This process should improve the claims data and may increase the number of single bills available for ratesetting.

2. The Panel recommends that CMS delete G0297, *Insertion of single chamber pacing cardioverter defibrillator pulse generator*; G0298, *Insertion of dual chamber pacing cardioverter defibrillator pulse generator*; G0299, *Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator*; and G0300, *Insertion or repositioning of electrode lead(s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator*, and require hospitals to report Current Procedural Terminology (CPT) codes 33240, *Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator*, or 33249, *Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator*, as applicable for the insertion of implantable cardioverter defibrillators. The requirement for reporting device HCPCS codes will enable CMS to continue identifying costs when different types of devices are implanted. Current Outpatient Code Editor (OCE) edits requiring providers to report device HCPCS codes for these procedures will enable CMS to continue isolating the costs of implanting different types of devices.

3. The Panel recommends that CMS review the list of packaged revenue codes for consistency with Outpatient Prospective Payment System (OPPS) policy and ensure that future versions of the OCE edit claims accordingly.

Drugs, Biologicals, and Radiopharmaceuticals

4. The Panel recommends that CMS pay separately for CPT 90768, *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (list separately in addition to code for primary procedure)*, at the same rate as CPT 90767, *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (list separately in addition to code for primary procedure*).

5. The Panel recommends that CMS implement a three-phase plan to address OPPS payment pharmacy overhead costs:

   Phase 1: Work with appropriate stakeholders to develop a system of defined pharmacy overhead categories (e.g., low, medium, and high cost) for outpatient drugs requiring different levels of pharmacy resources and reimburse pharmacy overhead costs by set fees for the categories through New Technology APCs, keeping the CY 2007 Average Sales Price (ASP) plus 6 percent payment methodology for separately paid drugs intact. The Panel recommends that CMS consider gradual implementation of the categories, possibly beginning with the highest level.

   Phase 2: CMS should be cognizant of the Government Accountability Office and Medicare Payment Advisory Commission reports estimating pharmacy overhead costs and accept outside survey data from stakeholders.

   Phase 3: Establish payment rates for pharmacy overhead costs based on claims data (ultimately) for outpatient hospital administration of drugs (i.e., a hospital pharmacy overhead category HCPCS code would need to be reported, along with the appropriate charge for each administration of a drug in the hospital outpatient department).

6. The Panel recommends that CMS allow hospitals to report all HCPCS codes for drugs.

7. The Panel recommends that CMS continue to work with stakeholders on issues related to payment for radiopharmaceuticals, e.g., evaluating claims data for different classes of radiopharmaceuticals and ensuring that a nuclear medicine procedure claim always includes at least one radiopharmaceutical agent reported.

8. The Panel recommends that CMS consider use of external data and work with stakeholders to determine the correct code descriptor units for each radiopharmaceutical, including HCPCS A9524, *Iodine I-131 iodinated serum albumin, diagnostic, per 5 microcuries*.

Miscellaneous APC Issues

9. The Panel recommends that CMS move CPT 78492, *Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress*, into its own clinical APC.

10. The Panel recommends that CMS work with stakeholders to determine a more appropriate APC placement for the following CPT codes:

    - CPT 0144T, *Computed tomography, heart, without contrast material, including image postprocessing and quantitative evaluation of coronary calcium*

    - CPT 0145T, *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology*

10. *(continued)*

- CPT 0146T, *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium*

- CPT 0147T, *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium*

- CPT 0148T, *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium*

- CPT 0149T, *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium*

- CPT 0150T, *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology in congenital heart disease*

- CPT 0151T, *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing, function evaluation (left and right ventricular function, ejection-fraction and segmental wall motion) (list separately in addition to code for primary procedure)*

11. The Panel recommends that CMS move HCPCS 0071T, *Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue*; and HCPCS 0072T, *Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue*; to APC 0067, Level III Stereotactic Radiosurgery.

12. The Panel recommends that CMS investigate whether CPT 36430, *Transfusion, blood or blood components*, should identify when multiple units are transfused and trigger a discounted payment for the second and subsequent administrations of additional units of blood or blood components.

13. The Panel supports CMS' possible reorganization of the skin repair APCs into five levels but urges CMS to give special consideration to the assignment of those codes listed as CPT add-ons.

Devices

14. The Panel recommends that CMS keep services in New Technology APCs until data are sufficient to assign them to clinical APCs, but for no longer than 2 years.

Observation

15. The Panel recommends that CMS add syncope and dehydration to the list of clinical conditions eligible for separate observation payment.

16. The Panel recommends that CMS make no changes to the criteria for separate observation payment related to the performance of "T" status procedures. However, if CMS adds syncope and dehydration to the list of conditions eligible for separate observation payment, the Panel requests that CMS re-examine the claims data once CMS collects a year of observation claims data including the additional conditions so the Panel can reconsider this recommendation at a future meeting.

17. The Panel recommends that CMS direct hospitals to report for payment the CPT codes for non-emergency department (ED) outpatient clinic visits at five levels, making no distinction between reporting and payment for new and established patients.

18. The Panel recommends that CMS eliminate the "new" and "established" patient distinctions in the reporting of non-ED outpatient clinical visits.

19. The Panel recommends that CMS *not* recognize the CPT consultation codes (CPT 99241; *Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making;* CPT 99242, *Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making*; CPT 99243, *Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity*; CPT 99244, *Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity*; and CPT 99245, *Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity*). CMS should instruct hospitals to build consultation services into their internal hospital guidelines related to reporting outpatient clinic visit levels based on the complexity and resources used for these outpatient visits.

20. The Panel recommends that CMS continue to evaluate the types of diagnostic conditions that might qualify for separate observation payment in the future.

Packaging

21. The Panel recommends that CMS place CPT 76937, *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)*, on the list of special packaged codes (SI "Q").

22. The Panel recommends that CMS evaluate providing separate payment for trauma response activation when it is reported on a claim for an ED visit, regardless of the level of the ED visit.

23. The Panel recommends that CMS place CPT 0175T, *Computer aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation*, on the list of special packaged codes (SI "Q").

24. The Panel recommends that CMS place CPT 0126T, *Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment*, on the list of special packaged codes (SI "Q") and consider mapping the code to APC 340, Minor Ancillary Procedures.

25. The Panel recommends that CMS place CPT 0069T, *Acoustic heart sound recording and computer analysis only*, on the list of special packaged codes (SI "Q") and that CMS exclude APC 0096, Non-Invasive Vascular Studies, as a potential placement for this CPT code.

26. The Panel recommends that HCPCS A4306, *Disposable drug delivery system, flow rate of less than 50 mL per hour*, remain packaged and that CMS present additional data on this system to the Panel when available.

27. The Panel recommends that CMS reevaluate the packaged OPPS payment for CPT 99186, *total body hypothermia*, based on current research and availability of new therapeutic modalities.

Inpatient-Only List

28. The Panel recommends that CMS remove the following CPT codes from the inpatient-only list:

    - **CPT 21360**, *Open treatment of depressed malar fracture, including zygomatic arch and malar tripod*

    - **CPT 21365**, *Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches*

    - **CPT 21385**, *Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation)*

28. *(continued)*

- **CPT 25931**, *Transmetacarpal amputation; re-amputation*
- **CPT 27006**, *Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)*
- **CPT 27720**, *Repair of nonunion or malunion, tibia; without graft, (e.g., compression technique)*
- **CPT 27722**, *Repair of nonunion or malunion, tibia; with sliding graft*
- **CPT 50580**, *Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive or radiologic service; with removal of foreign body or calculus*
- **CPT 51535**, *Cystotomy for excision, incision, or repair of ureterocele*
- **CPT 58805**, *Drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure); abdominal approach*
- **CPT 60271**, *Thyroidectomy, including substernal thyroid; cervical approach*
- **CPT 61770**, *Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for replacement of radiation source*
- **CPT 69970**, *Removal of tumor, temporal bone*

The Panel *does not* recommend that CMS remove CPT codes 64818, *Sympathectomy, lumbar*; and 20660, *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure).* However, the Panel recommends that CMS continue to collect utilization data on CPT codes 64818 and 20660 for consideration at the next Panel meeting.

Panel Subcommittees

29. The Panel recommends that the Observation and Visit, Data, and Packaging Subcommittees continue their work.