Report
of
the Advisory Panel
on
Ambulatory Payment Classification Groups

September 1–2, 2004

Centers for Medicare & Medicaid Services

Multipurpose Room
7500 Security Boulevard
Baltimore, MD 21244-1850

ADVISORY PANEL ON APC GROUPS (THE PANEL) MEMBERS PRESENT AT THIS MEETING:

Marilyn K. Bedell,, M.S., R.N., O.C.N.
Albert E. Einstein, Jr., M.D.
Robert E. Henkin, M.D.
Lee H. Hilborne, M.D., M.P.H.
Stephen T. House, M.D.
Katherine Kinslow, C.R.N.A., Ed.D.
Mike Metro, R.N., B.S.
Sandra Metzler, M.B.A.
Gerald V. Nacarelli, M.D.
Frank G. Opelka, M.D., FACS
Beverly K. Philip, M.D.
Lou Ann Schaffenberger, M.B.A., R.H.I.A., C.C.S.
Lynn R. Tomascik, R.N., M.S.N., C.N.A.A.
Timothy Gene Tyler, Pharm.D.
William A. Van Decker, M.D.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) STAFF PRESENT:

E. L. Hambrick, M.D., Chair, APC Panel, Medical Officer, CMS
Shirl Ackerman-Ross, Designated Federal Officer (DFO), APC Panel

Herb Kuhn, Director, Center for Medicare Management (CMM)
Tom Gustafson, Ph.D., Deputy Director, CMM
Elizabeth Richter, Director, Hospital & Ambulatory Policy Group
Cindy Read, Director, Division of Outpatient Care (DOC)
Joan Sanow, Deputy Director, DOC
Carol Bazell, M.D., Medical Officer, CMS
Kenneth Simon, M.D., Medical Officer, CMS

Sabrina Ahmed, DOC
Dana Burley, DOC
Anita Heygster, DOC
Chris Ritter, DOC
Cindy Yen, DOC

WELCOME AND CALL TO ORDER

E. L. Hambrick, M.D., Chair of the Panel, welcomed the Panel members to the meeting. (The proceedings of the APC Panel meeting follow. The agenda appears in Appendix A; a listing of only the recommendations appears in Appendix B.) Dr. Hambrick noted that CMS is in the midst of the public comment period for the Medicare Physician Fee Schedule and the Hospital Outpatient Prospective Payment System (HOPPS) proposed rules for 2005. Therefore, recommendations should be limited to the contents of those proposals. Dr. Hambrick reviewed the Panel's charter and explained the "two-times rule," i.e., in a given APC, the highest median-cost item should be no more than two times the lowest median-cost item. (The Secretary can make exceptions to the two-times rule as deemed appropriate.)

Tom Gustafson, Ph.D., Deputy Director of the Center for Medicare Management, praised the Panel members for their contributions. He said that APC Panel exemplifies two of CMS Administrator Mark McClellan's priorities for the Agency: a transparent, open process of decisionmaking and input from individuals with the highest level of technical expertise.

OLD BUSINESS

No old business was presented.

NEW BUSINESS

Overview of CMS-1427-P, Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates

CMS Staffer Dana Burley identified some highlights of the proposed changes for 2005, including proposals for a mandatory return to the use of some C codes for devices, measures to improve payment for blood and blood products, discontinuation of Q codes, and new methods of payment for pass-through drugs, biologicals, and radiopharmaceuticals.

Overview of Data Development, Median Cost Setting, and Outlier Policy

CMS Staffer Anita Heygster described the proposed methodology for setting the APC medians. Because of changes in the methodology for identifying usable claims, the 2005 proposed rates are based upon more robust data and more claims than were the 2004 rates. CMS Staffer Chris Ritter explained proposed changes to the methodology for reimbursing outliers (i.e., claims in which a hospital's cost is substantially higher than the APC payment).

Data Subcommittee's Report

Dr. Henkin, Chair of this Subcommittee, said that the Data Subcommittee reviewed the proposed methodological changes and felt they were appropriate, although some areas still need improvement. The Panel accepted the report of the Subcommittee and made the following recommendations:

> *The Panel recommends* that CMS post on the Web site the revenue code to cost center crosswalk that it uses to select the cost-to-charge ratio used to reduce a charge to estimated cost and solicit comments from a broad range of hospital types to evaluate the feasibility of the crosswalk. The Panel recommends that CMS specifically request that a hospital organization seek comments from its members on this topic.
>
> *The Panel recommends* that CMS staff continue to explore ways by which multiple procedure claims could be used to calculate APC payment rates.
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> *The Panel recommends* that CMS develop frequency distributions of the data on APCs with low percentages of single claims and that the Data Subcommittee analyze such data with the goal of finding strategies that increase the amount of claims data that can be used to set medians for these APCs.
>
> *The Panel recommends* that the Data Subcommittee further evaluate how best to capture

and address the costs of devices associated with procedures.

Packaging Subcommittee's Report

Dr. Van Decker, Chair of this Subcommittee, said that the Packaging Subcommittee looked at all the Current Procedural Terminology (CPT) codes with a status indicator (SI) of N. The Subcommittee identified some areas for change for some CPT codes, which could be provided as the sole service on a given date, so that these services could receive payment. The Panel accepted the report of the Packaging Subcommittee and made the following recommendations:

The Panel recommends that it review packaged codes individually instead of making a global decision for all packaged codes.

The Panel recommends that CMS assign a modifier to CPT codes 36540 (collect blood venous device), 36600 (withdrawal of arterial blood), 51701 (insert bladder catheter), and 97602 (wound[s] care, non-selective) to be used when these codes are on a claim without any other separately payable code on the claim for the same date of service. The Panel will revise this subset of codes once data become available.

The Panel recommends that CMS educate providers and intermediaries on the correct billing procedures for the packaged CPT codes 36540, 36600, 51701, and 97602.

The Panel recommends that CMS not change the SI for CPT 76397 (ultrasound guidance for vascular access). The Panel will review the data on this code as they become available.

The Panel recommends that the Packaging Subcommittee continue to meet throughout the year to discuss other problematic packaged codes.

Observation Issues

CMS Staffer Joan Sanow said the intent of bundling, or packaging, observation into other codes was to allay concerns about misuse of observation. For 2005, the Agency proposes to remove the criterion that certain diagnostic tests must appear on the claim to enable payment for observation. Mr. Metro said the current rules indicate that observation will not be paid if the claim includes a procedure with a T SI on the day of or the day prior to observation; however, cardiac catheterization carries a T SI and may be performed appropriately and frequently in conjunction with observation prior to the cardiac catheterization.

The Panel recommends that observation services be reimbursed when claims that would otherwise meet the criteria for observation payment also include cardiac catheterization (despite the SI of T for cardiac catheterization).

Observation Subcommittee's Report

Dr. Hilborne, Chair of this Subcommittee, said the Observation Subcommittee appreciates the proposed changes to some of the rules for payment but remains concerned about several other aspects of the rules. The Panel accepted the report of the Observation Subcommittee and made the following recommendations:

> *The Panel recommends* that the category of separately payable observation services be expanded beyond the three currently accepted clinical conditions (congestive heart failure, chest pain, and asthma) to include all clinical conditions for which observation status is appropriate based on medical necessity.
>
> *The Panel recommends* that CMS evaluate alternative criteria for qualifying for admission to a SNF.
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> *The Panel recommends* that CMS allow observation hours to count toward the 3-day requirement for admission to a SNF.
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> *The Panel recommends* that CMS solicit the input of professional organizations on the inpatient-only list; organizations should provide to CMS data about those procedures on the inpatient-only list that are currently being performed safely on an outpatient basis.
>
> *The Panel recommends* that CMS clarify when a hospital can appropriately change a patient's status from inpatient to outpatient or observation.

Blood and Blood Products

CMS Staffer Cindy Yen described proposed changes in payment for blood and blood products for 2005, including the establishment of new APCs for each blood product and the CMS new methodology for calculating blood median costs. The Agency will continue to reimburse for blood and blood products separately from other services. Beth Daniell of the American Red Cross said that hospitals continue to underreport costs for blood, which makes CMS claims data inaccurate. She asked that CMS 1) support increased payments for all blood products, 2) use supplier-provided external data when appropriate, 3) use external data for low-volume products and freeze the payment rates at current levels until appropriate cost points can be established, and 4) improve HOPPS claims data by issuing clear and comprehensive blood billing guidance to hospitals (Presentation 1). Tom Snyder, a consultant speaking on behalf of the American Association of Blood Banks, said that the organization supports the recommendations of the Red Cross (Presentation 2).

> *The Panel recommends* that CMS freeze payment rates for the low-volume blood products noted in Table 31 of the Notice of Proposed Rulemaking (NPRM) at the 2004 level for 2005.

The Panel recommends that CMS consider external industry data combined with hospital-supplied data to set future payment rates for low-volume blood products.

The Panel recommends that CMS issue clear and comprehensive guidance to hospitals on appropriate billing of blood and blood products.

Device-Dependent APC Issues

CMS Staffer Anita Heygster explained that proposed 2005 payment rates for device-dependent APCs are based on data from 2003, when hospitals stopped using C codes on their claims. As a result, payment for some device-insertion APCs calculated from the claims data alone would decrease significantly. Therefore, the Agency has proposed to adjust some device-dependent APCs for 2005. The use of C codes has been reinstituted on a voluntary basis, and CMS has proposed to require C codes for a selected number of device-insertion APCs. Ms. Heygster said that the Agency is becoming increasingly confident about the accuracy of data collected and is hoping that the 2007 payment rates will clearly and appropriately reflect the relative values of device-dependent APCs.

Mitchell Sugarman of Medtronic, Inc., asked that the embolization protective system, currently coded as C1884, continue to receive pass-through status for one additional year (Presentation 3). Mr. Sugarman stated that during 2003, the first year that C1884, embolization protective system, received pass-through payment, the offset to pass-through payment was inappropriately applied. He stated that the embolization protective system does not represent a replacement technology but was a completely new technology. CMS revised its offset policy for 2004. Since the device was first introduced and given a C code, similar devices have come on the market, and their use is increasing. Without a C code, providers are less likely to use these devices in the outpatient setting, Mr. Sugarman said.

The Panel recommends that CMS evaluate whether current statutes allow the Agency to extend the pass-through status of C1884 and, if allowable, that the Agency consider doing so.

Robert Thompson of Medtronic, Inc., said the 2005 proposed payment for implantable cardioverter defibrillators (used in APCs 107 and 108) is lower than the 2004 rate and lower than the acquisition cost, partly because of charge compression (Presentation 4). He asked that CMS 1) return to the 2004 rate for 2005, 2) require use of C codes for these devices to better capture claims data, 3) address the problem of charge compression for high-cost devices, and 4) continue using external data to set payment rates for these devices.

Stephanie Mensh of AdvaMed said claims data were more accurate when C codes were required for device-dependent APCs and asked that CMS require hospitals to use C codes for all device-dependent claims (Presentation 5). She supported the continued use of external data for rate-setting. AdvaMed is concerned that 18 of the 25 Healthcare Common Procedure Coding System (HCPCS) codes slated to be moved from new technology APCs into clinical APCs (see Table 14 of the NPRM) will receive lower payment. AdvaMed supports and offers education to hospitals on correct claims coding.

The Panel recommends that CMS collect C code data for all devices associated with C codes.

The Panel recommends that its Data Subcommittee evaluate the issue of the payment of high-cost devices used only in a fraction of cases in a given APC.

Louis L. Pisters, M.D., M.D. Anderson Cancer Center, said that hospitals underreport the costs of cryosurgery of the prostate (APC 674); as a result, the payment is inadequate (Presentation 6). He asked that the CMS use external data to calculate the 2005 payment rate or that CMS establish a minimum rate of payment equal to the 2004 rate plus inflation.

Donald W. Moran of the Moran Company said charge compression consistently results in claims data that underreport the true costs of high-cost devices (Presentation 7). He recommended that CMS apply the model that will be used for drug payment, which relies on external data to calculate the average sales price.

Ronald J. Podraza of Reimbursement Principles, Inc., representing RITA Medical Systems, Inc., asked that CMS reconsider its proposal to move CPT 47382, percutaneous radio frequency ablation of a liver lesion, from its current new technology APC to clinical APC 423 (Presentation 8).

Mary Walchak of the Alliance for Orthopedic Solutions asked that CMS consider restructuring APC 46, orthopedic fracture fixation procedures, because it violates the two-times rule substantially and underpays for some orthopedic procedures (Presentation 9) utilizing fixation devices. She suggested new APCs and HCPCS codes for upper and lower extremity fixation devices. Kenneth M. Chekofsky, M.D., of the Warren Orthopedic Institute also said APC 46 lumps together procedures of substantially differing costs, including open and closed reduction and internal and external fixation, and requested CMS consider creating new or alternative codes (Presentation 10).

Grant P. Bagley, M.D., J.D., representing the Coalition for the Advancement of Prosthetic Urology, asked that CMS maintain the 2004 configuration of the prosthetic urology APCs 385 and 386 for 2005 (Presentation 11). The current configuration was recommended by the Panel previously in an effort to group procedures by clinical complexity and devices used and to gather correlating claims data.

The Panel recommends that CMS retain the 2004 configuration of APCs 385 and 386 for 2005.

Gary A. Goetzke of ArthroCare Corporation asked that CMS move CPT 62287, percutaneous disc decompression, from APC 220 to APC 208 for better clinical homogeneity and cost reimbursement (Presentation 12).

The Panel reviewed written comments submitted by Cochlear Americas (Presentation 13) and the Medical Device Manufacturers Association (Presentation 14). In consideration of the concerns raised throughout the discussion, the Panel suggested the following:

> *The Panel recommends* that CMS evaluate the current structure of C codes for devices and consider approaches or education that would make it easier for hospitals to understand how and when to assign C codes to devices or categories of devices.
>
> *The Panel recommends* to CMS that the device-dependent APCs noted in Table 19 of the NPRM for 2005, except APCs 425 and 418, include an adjustment of plus or minus 5 percent against the 2004 payment median costs, for 2005 OPPS only.

Miscellaneous APC Issues

Dr. Bagley, representing Carl Zeiss Surgical, Inc., said the new technology INTRABEAM does not fit appropriately with either of the APCs 312 and 651 to which it is assigned (Presentation 15). CMS pays separately for the brachytherapy sources used in connection with the other procedures assigned to these APCs, but INTRABEAM is not a typical brachytherapy treatment. Because INTRABEAM is a unique device that externally stimulates an internally implanted device, Dr. Bagley asked that it be moved to a new technology APC. Michael Osborne, M.D., Principal Investigator for Carl Zeiss Surgical's clinical trial of INTRABEAM, gave more details about how the device works.

Gordon J. Harris, Ph.D., Director of 3D Imaging for Massachusetts General Hospital, explained how computed tomography angiography (CTA) went from being reimbursed according to the cost of computed tomography (CT) plus the cost of three-dimensional imaging to a current payment rate less than the cost of CT alone (Presentation 16). He asked that CMS set the 2005 HOPPS payment to that of CT plus three-dimensional imaging, as it has for the proposed 2005 Physician Fee Schedule.

> *The Panel recommends* that CMS gather input from the American Medical Association, American College of Radiology, American Hospital Association, CPT Editorial Panel, and other interested parties on the appropriate coding and payment of CTA and report its findings to the Panel for consideration at its next meeting.

Dr. Bagley, representing Medical Metrx Solutions, Inc., said G0288, reconstruction of CTA of the aorta for planning vascular surgery (APC 417 under the 2005 proposed rule), is widely misreported by hospitals under various revenue codes, resulting in data that underreport the costs (Presentation 17). He asked that the G code be maintained in the new technology APC 1506 or that external data be used to set the rates for APC 417 for 2005.

Dr. Mark Fillinger of Dartmouth Hitchcock Medical Center said when the definition for G0288 was expanded to include other manufacturers' devices, hospitals became confused about proper coding.

Scott Reid of Boston Scientific asked that CMS move CPT 58563, hysteroscopic endometrial

ablation, from APC 387 to APC 202 to improve clinical homogeneity (Presentation 18).

> *The Panel recommends* that CMS place CPT 58563, hysteroscopic endometrial ablation, and HCPCS 0009T, endometrial cryoablation with ultrasound guidance, in APC 387.

Tom Byrne of Boston Scientific said that in February 2004, the Panel recommended moving CPT codes 36568 and 36569 for peripherally inserted central venous catheters to APC 187 (Presentation 19). Mr. Byrne said the rationale behind the recommendation was not clear and asked that the CPT codes remain in APC 32.

> *The Panel recommends* that CMS evaluate the placements of CPT codes 36555 through 36597 in APC 32 and APC 187 and bring relevant data to the APC Panel for consideration at its next meeting.

M. Mitchell Latinkie of the Proton Therapy Consortium asked that CMS maintain the codes for intermediate and complex proton therapy (CPTs 77523 and 77525) in their current new technology APC at 2004 payment rates because there are so few data on which to base the proposed move to a clinical APC (Presentation 20). Allan Thornton, M.D., of the Proton Therapy Consortium added that proton therapy has a long history of use.

> *The Panel recommends* that CMS keep CPT codes 77523 and 77525 in their current 2004 new technology APC.

John Rieke, M.D., representing Xoft Micro Tube, Inc., asked that CMS create an APC and new HCPCS codes for new brachytherapy sources that are not reimbursed under the current system (Presentation 21).

The Panel reviewed comments submitted by Olympus (Presentation 22), W.L. Gore and Associates (Presentation 23), and C.R. Bard (Presentation 24).

Overview of Drugs, Biologicals, and Radiopharmaceuticals

CMS Staffer Sabrina Ahmed described the proposed changes to HOPPS for drugs, biologicals, and radiopharmaceuticals. The Agency proposes maintaining the $50 threshold (i.e., items under $50 are packaged while those above $50 are separately payable), with an exception for antiemetic drugs. The proposed rule also addresses items with pass-through status that expire at the end of 2004, sole-source drugs, orphan drugs, and guidance for hospitals on payment for flu and pneumococcal vaccine.

Jayson Slotnik of the Biotechnology Industry Organization suggested that CMS work closely with the Government Accounting Office and the Medicare Payment Advisory Commission (MedPAC) in the collection and analysis of drug pricing data reported by the manufacturers (Presentation 25). He asked that CMS apply its rate-setting methodology for specified covered outpatient drugs to all separately paid drugs and biologicals.

Beth Roberts of Hogan and Hartson urged that CMS review the survey being proposed by the Government Accounting Office for data collection.

The Panel reviewed comments submitted by Johnson & Johnson about the proposal to change the SI for HCPCS J2790 (Presentation 26). In the absence of a Johnson & Johnson representative, Dr. Jerry Holmberg explained that both J2788 and J2790 represent different doses of Rho D immune globulin but should both have an SI of K.

> *The Panel recommends* that CMS change HCPCS J2790 from SI N, as stated in the proposed rule, to SI K.

The Panel reviewed comments submitted by the Council on Radionuclides and Radiopharmaceuticals (Presentation 27) and the Nuclear Medicine APC Task Force (Presentation 28).

The Panel DFO pointed out that in order for the three subcommittees to remain in existence, the Panel would have to make motions to that effect.

The Panel recommends that the three subcommittees (Data, Packaging, and Observation) of the Advisory Panel remain in existence.

Closing

The Panel reviewed the recommendations from the meeting. Dr. Hambrick thanked the outgoing Panel members, Drs. Beverly Philip and Bob Henkin, for their service on the Panel. She also thanked the CMS support staff—especially, Shirl Ackerman-Ross, DFO—for their hard work.

Dr. Hambrick adjourned the meeting at 5 p.m. on Thursday, September 2, 2004.

Appendix A

AGENDA

September 1, 2, and 3, 2004

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

DAY 1 - Wednesday, September 1, 2004
Note: Attendees may enter the CMS Central Office Building after 12:15 p.m.

01:00 Opening - Day 1
- a. Welcome, Call to Order, and Introduction of New Members
  (Elizabeth Richter, Director, Hospital and Ambulatory Policy Group)
- b. Opening Remarks
  (Tom Gustafson, Ph.D., Deputy Director, Center for Medicare Management)
- c. Swearing-in of New Members

01:30 Panel organization and housekeeping issues
E. L. Hambrick, M.D., Chair

01:45 Overview of CMS-1427-P, Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates
- a. Dana Burley, Division of Outpatient Care (DOC), CMS Staff
- b. Panel's Comments/Recommendations

02:15 *Break*

02:30 Overview of data development, median cost setting, and outlier policy
- a. Anita Heygster, DOC, CMS Staff
- b. Chris Ritter, DOC, CMS Staff
- c. Panel's Comments/Recommendations

		COMMENTS BOOK PAGE	PANEL BINDER TAB
03:00	Data Subcommittee's Report		
	a. Full Panel's Discussion		
	b. Panel's Recommendations		
03:30	Packaging Subcommittee's Report		
	a. Full Panel's Discussion		
	b. Panel's Recommendations		
04:00	Blood and Blood Products		**1**
	a. Cindy Yen, DOC, CMS Staff		
	b. Presentations/Comments		
	i. **Beth Daniell,** Executive Director Hospital Customer Service & Donor Strategy American Red Cross	**1**	
	ii. **Theresa L. Wiegmann, J.D.** Director of Public Policy & Special C American Association of Blood Banks	**7**	
	c. Panel's Recommendations		
05:00	Adjourn		

AGENDA

September 1, 2, and 3, 2004

APC Panel Meeting

DAY 2 – Thursday, September 2, 2004

Note: * Public registrants may enter the CMS Central Office Building after 7:45 a.m.
****Breaks will be taken at the discretion of the Chair.**

		COMMENTS BOOK PAGE	PANEL BINDER TAB
08:30	Opening - Day 2		
	c. Welcome and Call to Order		
	d. E. L. Hambrick, M.D., Chair		
08:45	Device-dependent APC Issues		5
	a. Anita Heygster, DOC, CMS Staff		
	b. Presentations/Comments		
	1. **Gary A. Goetzke**, Director Coverage and Reimbursement Policy ArthroCare, Corp. **Lewis Sharps, MD** Orthopaedic Surgery and Sports Medicine	**11**	
	2. **Mitchell Sugarman** Director, Reimbursement Medtronic, Inc.	**15**	
	3. **Bob Thompson** Director, Reimbursement, Economics and Health Policy Medtronic, Inc.	**23**	
	4. **Stephanie Mensh** Vice President, Payment and Policy AdvaMed	**37**	
	5. **Louis Leon Pisters, MD** Associate Professor M.D. Anderson Cancer Center	**41**	
	6. **Jim Bechtold**, Chair Alliance for Orthopedic Solutions	**60**	
	7. **Donald W Moran**, President The Moran Company	**66**	

		COMMENTS BOOK PAGE	PANEL BINDER TAB
8.	**Ronald J. Podraza**, CEO Reimbursement Principles, Inc. On behalf of RITA Medical Systems, Inc.	**88**	**5**
9.	**Kenneth M. Chekofsky, MD, MBA** Warren Orthopedic Institute	**90**	
10.	**Grant P. Bagley, MD, J.D**., Consultant, CAPU **Jean L. Fourcroy, MD**, Consultant, CAPU	**101**	
c.	Panel's Recommendations		
12:00	*Lunch*		
01:00	Miscellaneous APC Issues		**6**
a.	Presentations/Comments		
1.	**Gordon J. Harris, Ph.D.** Director, 3D Imaging Mass General Hospital	**145**	
a.	**Michael Osborne, MD**, Principal Investigator **Grant P. Bagley, MD, J.D**., Consultant Carl Zeiss Surgical, Inc.	**157**	
3.	**Dr. Mark Fillinger** **Grant P. Bagley, MD, J.D**., Consultant Medical Metrx Solutions, Inc.	**189**	
4.	**Scott Reid**, Manager Boston Scientific	**167**	
5.	**Tom Byrne**, Director Boston Scientific	**178**	
6.	**Allan Thornton, MD** **M. Mitchell Latinkie** **Jenifer Levinson** **Daniel N. Mendelson** Proton Therapy Consortium	**122**	
7.	**John Rieke, M.D**., Consultant (Miscellaneous Other Issues) Xoft micro Tube, Inc.	**113**	
b.	Panel's Recommendations		

		COMMENTS BOOK PAGE	PANEL BINDER TAB
03:00	Drugs, Biologicals, and Radiopharmaceuticals (Overview)		**7**
	a. Sabrina Ahmed, DOC, CMS Staff		
	b. Presentations/Comments		
	1. **Susan Reardon** Director, Federal Affairs Johnson & Johnson	**202**	
	2. **Jayson Slotnik** Director, Medicare Reimbursement & Economic Policy BIO	**205**	
	a. Panel's Recommendations		
05:00	Adjourn		

AGENDA

September 1, 2, and 3, 2004

APC Panel Meeting

DAY 3 - Friday, September 3, 2004

Note: **1. Public registrants may enter the CMS Central Office Building <u>after</u> 7:45 a.m.**
2. There may be a continuation of any unfinished business from Days 1 and/or 2.

08:30 Opening - Day 3
- g. Welcome and Call to Order
- h. E. L. Hambrick, M.D., Chair

08:35 Observation Issues
- a. Joan Sanow, Deputy Director, DOC, CMS Staff
- b. Comments
- c. Panel's Recommendations

09:45 *Break*

10:00 Observation Subcommittee Report

10:15 Full Panel Discussion

10:45 Closing
- a. Summary of the Panel's Recommendations for 2005
- b. Final Remarks

11:30 Adjourn

Appendix B

Collected Recommendations of the APC Advisory Panel, September 1–2, 2004

Data Subcommittee's Report

The Panel recommends that CMS post on the website the revenue-code-to-cost-center crosswalk that CMS uses to select the cost-to-charge ratio used to reduce a charge to estimated cost and solicit comments from a broad range of hospital types to evaluate the feasibility of the crosswalk. The Panel recommends that CMS specifically request a hospital organization seek comments from its members on this topic.

The Panel recommends that CMS staff continue to explore ways by which multiple procedure claims could be used to calculate APC payment rates.

The Panel recommends that CMS develop frequency distributions of the data on APCs with low percentages of single claims and that the Data Subcommittee analyze such data with the goal of finding strategies that increase the amount of claims data that can be used to set medians for these APCs.

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The Panel recommends that CMS clarify when a hospital can appropriately change a patient's status from inpatient to outpatient or observation.

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The Panel recommends that CMS issue clear and comprehensive guidance to hospitals on appropriate billing of blood and blood products.

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The Panel recommends that CMS evaluate the current structure of C codes for devices and consider approaches or education that would make it easier for hospitals to understand how and when to assign C codes to devices or categories of devices.

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The Panel recommends to CMS that the device-dependent APCs noted in Table 19 of the NPRM for 2005, except APCs 425 and 418, include a dampening effect of plus or minus 5 percent for 2005 only.

Miscellaneous APC Issues

The Panel recommends that CMS gather input from the American Medical Association, American College of Radiology, American Hospital Association, CPT Editorial Panel, and other interested parties on the appropriate coding and payment of computed tomography angiography and report its findings to the Panel for consideration at its next meeting.

The Panel recommends that CMS place CPT 58563, hysteroscopic endometrial ablation, and HCPCS 0009T, endometrial cryoablation with ultrasound guidance, in APC 387.

The Panel recommends that CMS evaluate the placements of CPT codes 36555 through 36597 in APC 32 and APC 187 and bring relevant data to the APC Panel for consideration at its next meeting.

The Panel recommends that CMS keep CPT codes 77523 and 77525 in their current 2004 new technology APC.

Drugs, Biologicals, and Radiopharmaceuticals

The Panel recommends that CMS change HCPCS J2790 from SI N, as stated in the proposed rule, to SI K.

General

The Panel recommends that the three subcommittees of the Advisory Panel remain in existence.

Appendix C
Presentations

The following documents were presented at or submitted for the Panel meeting, September 1–2, 2004, and are appended here for the record:

Presentation 1: American Red Cross
Presentation 2: American Association of Blood Banks
Presentation 3: Medtronic
Presentation 4: Medtronic
Presentation 5: Advanced Medical Technology Association (AdvaMed)
Presentation 6: M.D. Anderson Cancer Center
Presentation 7: The Moran Company
Presentation 8: Reimbursement Principles, Inc./RITA Medical Systems, Inc.
Presentation 9: Alliance for Orthopedic Solutions
Presentation 10: Warren Orthopedic Institute
Presentation 11: Coalition for the Advancement of Prosthetic Urology
Presentation 12: ArthroCare Corporation
Presentation 13: Cochlear Americas
Presentation 14: Medical Device Manufacturers Association
Presentation 15: Carl Zeiss, Inc.
Presentation 16: Massachusetts General Hospital
Presentation 17: Medical Metrx Solutions
Presentation 18: Boston Scientific, Inc.
Presentation 19: Boston Scientific, Inc.
Presentation 20: Proton Therapy Consortia
Presentation 21: Xoft Micro Tube, Inc.
Presentation 22: Olympus America, Inc.
Presentation 23: W.L. Gore and Associates
Presentation 24: C.R. Bard, Inc.
Presentation 25: Biotechnology Industry Association
Presentation 26: Johnson & Johnson
Presentation 27: Council on Radionuclides and Radiopharmaceuticals, Inc.
Presentation 28: Nuclear Medicine APC Task Force