ADVISORY PANEL ON AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS

August 23–24, 2006

Panel Recommendations

Observation Subcommittee

1. The Panel recommends that CMS consider adding syncope and dehydration as diagnoses for which observation services qualify for separate payment.

2. The Panel recommends that CMS perform claims analyses and present data that would allow CMS to consider revising criteria for separately payable observation services when certain procedures that are assigned status indicator T (e.g., insertion of bladder catheter or laceration repair) are reported on the same claim with an emergency department visit and observation services, and all other criteria for separate observation payment (e.g., qualifying diagnosis code, number of hours, etc.) are met.

3. The Panel recommends that CMS expand the scope (and change the name) of the Observation Subcommittee to include issues related to policies regarding emergency department and clinic visits.

Packaging Subcommittee

4. The Panel recommends that for CY 2007 CMS package new Current Procedural Terminology (CPT) codes 0174T, *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 concurrent with primary interpretation (List separately in addition to code for primary procedure)*, and 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.*

5. The Panel recommends that CMS continue to package revised CPT code 0069T, *Acoustic heart sound recording and computer analysis only*, for CY 2007.

6. The Panel recommends that CMS assign CPT code 96523, *Irrigation of implanted venous access device for drug delivery systems*, status indicator Q as a "special" packaged code for CY 2007.

Miscellaneous APC Issues

7. The Panel recommends that CMS maintain the CPT codes 78814, *Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)*; 78815, *Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation*

correction and anatomical localization; skull base to mid-thigh; and 78816, *Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body*, in New Technology APC 1514, New Technology – Level XIV ($1,200-$1,300), at the current payment rate of $1,250 for CY 2007.

8. The Panel recommends that CMS move HCPCS codes G0248, *Demonstration, at initial use, of home INR monitoring for patient with mechanical heart valve(s) who meets Medicare coverage criteria, under the direction of a physician; includes: demonstrating use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing*, and G0249, *Provision of test materials and equipment for home INR monitoring to patient with mechanical heart valve(s) who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; per four tests*, to APC 0421, Prolonged Physiologic Monitoring, for CY 2007.

9. The Panel recommends that for CY 2007 CMS move CPT code 36566, *Insertion of tunneled centrally inserted central venous access device, requiring two catheters via two separate venous access sites; with subcutaneous port(s)*, to an APC with a payment rate no less than that of New Technology APC 1524, New Technology – Level XXIV ($3,000-$3,500), with a payment rate of $3,250 and no more than that of New Technology APC 1564, New Technology – Level XXVII ($4,500-$5,000), with a payment rate of $4,750 and also require that claims for the procedure be subject to a device edit for the device code C1881, *Dialysis access system (implantable)*.

10. The Panel recommends that CMS consider external data to validate whether current claims data for CPT code 65770, *Keratoprosthesis*, were properly coded and, if necessary, adjust its payment rate from CY 2007 forward. The Panel further recommends that CMS implement a device edit for the procedure and the device code C1818, *Integrated keratoprosthesis*. The Panel requests that CMS staff report the findings from this data assessment to the Panel at its next full Panel meeting.

11. The Panel recommends that CMS consider redefining the proposed new critical care G-codes as follows and that CMS use the presence or absence of claims charge data under revenue code 68x reported in association with critical care CPT codes 99291, *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*, and 99292, *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*, to determine payment rates for two new critical care APCs to which the two new G-codes would be assigned:
    - Gccc1: Patient critically ill/injured and no trauma response team activation
    - Gccc2: Patient critically ill/injured with trauma response team activation

12. The Panel recommends that CMS remove the following CPT codes for colpopexy and vaginal hysterectomy from the inpatient list and assign them to appropriate clinical APCs, e.g., APCs 194, Level VIII Female Reproductive Proc; 195, Level IX Female Reproductive Proc; and 202, Level X Female Reproductive Proc:

a. 57282, *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus);*
b. 57283, *Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy);*
c. 58260, *Vaginal hysterectromy, for uterus 250 grams or less;*
d. 58262, *Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s);*
e. 58263, *Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s), with repair of enterocele;*
f. 58270, *Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele;*
g. 58290, *Vaginal hysterectomy, for uterus greater than 250 grams;*
h. 58291, *Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s);*
i. 58292, *Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s), with repair of enterocele;*
j. 58294, *Vaginal hysterectomy, for uterus greater than 250 grams; with repair of enterocele.*

13. The Panel recommends that CMS review the resources required for new CPT codes 0171T, *Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level,* and 0172T, *Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level (List separately in addition to code for primary procedure*) and recommend appropriate APC assignments for them for CY 2007.

14. The Panel again recommends that CMS use readily available external data to validate costs determined by its claims data.

15. The Panel recommends that CMS reconsider its methodology to develop payment rates for blood and blood products to more accurately reflect the true costs of blood and blood products to hospitals, including using external data.

16. The Panel recommends that CMS evaluate the proposed percentage offsets related to recalled devices to ensure that they take into account administrative resources required to provide the replacement devices.

17. The Panel recommends that when CMS assigns a new service to a new technology APC, the service should remain there for at least 2 years until sufficient claims data are collected.

18. The Panel recommends that CMS consider external data in evaluating the proposed CY 2007 payment rate for HCPCS code A9600, *Strontium Sr-89 Chloride, therapeutic, per millicurie*.

19. The Panel recommends that CMS eliminate the drug packaging threshold for all drugs and radiopharmaceuticals with HCPCS codes.

20. The Panel recommends that CMS continue using the current CY 2006 methodology of payment at charges reduced to costs for radiopharmaceuticals and brachytherapy sources for 1 year.

21. The Panel recommends that CMS maintain the payment rates for drugs at their average sales price (ASP) plus 6 percent for CY 2007.

22. The Panel recommends that CMS recognize only the American Medical Association's (AMA) CPT codes for outpatient hospital reporting of drug administration services in CY 2007.

23. If CMS does not recognize only the AMA CPT codes for drug administration services for CY 2007, the Panel recommends that CMS allow hospitals to separately bill and receive payments for therapeutic infusions and hydration infusions provided in the same encounter.

24. The Panel recommends that CMS make payment for a second or subsequent intravenous push of the same drug by instituting a modifier, developing a new HCPCS code for the procedure, or implementing another methodology in CY 2007.

25. The Panel recommends that CMS provide payments for all intravenous pushes and therapeutic injections for pain management and other clinical conditions, regardless of the setting (e.g., post-operative anesthesia care unit, cardiac catheterization laboratory).

26. The Panel recommends that CMS work with stakeholders to better understand the costs involved in the preparation of pharmaceutical agents for chemotherapy, and that CMS develop a new payment methodology that acknowledges and provides appropriate payment for those costs. The Panel requests that CMS staff report their findings at the next full Panel meeting.

27. The Panel recommends that CMS allow providers to use all available HCPCS codes for reporting drugs to reduce the administrative burden associated with reporting drugs only using HCPCS codes with the lowest increments in their descriptors.

28. The Panel recommends that CMS provide claims analyses of the contributions of packaged costs (considering packaged drugs and other packaging) to the median cost of each drug administration service.

29. The Panel recommends that CMS renew all of the Panel's existing Data, Observation, and Packaging Subcommittees.