CENTERS FOR MEDICARE AND MEDICAID SERVICES

Advisory Panel on Ambulatory Payment Classification (APC) Groups
February 18–19, 2009

Data Issues

1. The Panel recommends that CMS reassign CPT code 76098, *Radiological examination, surgical specimen,* to APC 0260, *Level I Plain Film,* and place CPT code 76098 on the bypass list.

2. The Panel recommends that the work of the Data Subcommittee continue.

Packaging Issues

3. The Panel recommends that CMS pay separately for radiation therapy guidance services performed in the treatment room for 2 years and then reevaluate packaging on the basis of claims data.

4. The Panel recommends that CMS continue to analyze the impact of increased packaging on beneficiaries, providing more detailed versions of the analyses presented at the February 2009 meeting of services initially packaged in calendar year (CY) 2008 at the next Panel meeting. The Panel requests that, in the more detailed analyses of radiation oncology services that would be accompanied by radiation oncology guidance, staff stratify the data according to the type of radiation oncology service, specifically, intensity modulated radiation therapy, stereotactic radiosurgery, brachytherapy, and conventional radiation therapy.

5. The Panel recommends that CMS continue to analyze the impact on beneficiaries of increased packaging of diagnostic radiopharmaceuticals, providing more detailed analyses at the next Panel meeting. The Panel requests that, in the more detailed analyses of packaging of diagnostic radiopharmaceuticals by type of nuclear medicine scan, the staff break down the data according to the specific CPT codes billed with the diagnostic radiopharmaceuticals.

6. The Panel recommends that CPT code 36592, *Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified*, remain assigned to APC 0624, *Phlebotomy and Minor Vascular Access Device Procedures,* for CY 2010.

7. The Panel recommends that the work of the Packaging Subcommittee continue.

Brachytherapy Sources

8. The Panel recommends that, for CY 2010, CMS pay for brachytherapy sources using a prospective payment methodology based on median costs.

Visits and Observation Issues

9. The Panel recommends that CMS present at the next Panel meeting an analysis of the most common diagnoses and services associated with Type A and Type B emergency department visits, including analysis by hospital-specific characteristics.

10. The Panel recommends that CMS issue guidance clarifying the correct method for reporting the start time of observation services.

11. The Panel recommends that CMS present at the next Panel meeting an analysis of 2008 claims data for clinic, emergency department (Types A and B), and extended assessment and management composite APCs.

12. The Panel recommends that the work of the Visits and Observation Subcommittee continue.

Inpatient List

13. The Panel recommends that CMS remove the following procedures from the inpatient list for CY 2010:

    - CPT code 21256, *Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)*
    - CPT code 27179, *Open treatment of slipped femoral epiphysis; single or multiple pinning of bone graft (includes obtaining graft); osteoplasty of femoral neck (Heyman type procedure)*
    - CPT 51060 code, *Transvesical ureterolithotomy*

    The Panel recommends that CPT code 64818, *Sympathectomy, lumbar,* remain on the inpatient list for CY 2010.

APC Issues

14. The Panel recommends that CMS continue to work with stakeholders to examine different options for APCs for multiple imaging sessions and multiple imaging procedures.

15. The Panel recommends that CMS combine APC 0039, *Level I Implantation of Neurostimulator*, and APC 0222, *Level II Implantation of Neurostimulator*, into one APC, and maintain APC 0315, *Level III Implantation of Neurostimulator*, as is for CY 2010.

16. The Panel recommends that CMS continue the assignments of CPT code 0171T, *Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar, single level*, and CPT code 0172T, *Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar, single level, each additional level*, to APC 0052, *Level IV Musculoskeletal Procedures Except Hand and Foot*, for CY 2010; institute procedure-to-device claims processing edits for HCPCS code C1821, *Interspinous process distraction device (implantable)*; and then reevaluate the APC assignments of these CPT codes in one year.

17. The Panel recommends that CMS study the claims data for any APC for which the calculated payment reduction would be greater than 10 percent and take action to correct any issues that may artificially reduce these payments. The Panel requests that CMS staff provide the Panel at the next meeting with a list of APCs with a proposed CY 2010 payment change of greater than 10 percent.

18. The Panel recommends that CMS staff evaluate the implications of creating composite APCs for cardiac resynchronization therapy with a defibrillator or pacemaker and report its findings to the Panel.

Drugs, Biologicals, Radiopharmaceuticals, and Pharmacy Overhead

19. The Panel recommends that CMS use the average sales price (ASP) methodology to pay for therapeutic radiopharmaceuticals and, where ASP data are not available, pay based on mean costs from claims data.

20. The Panel recommends that CMS pay for the acquisition cost of all separately payable drugs at no less than ASP plus 6 percent.

21. The Panel recommends that CMS package payment at ASP plus 6 percent on claims for all drugs that are not separately paid and use the difference between these rates and CMS' costs derived from charges to create a pool to provide more appropriate payment for pharmacy service costs. The Panel further recommends that CMS pay for pharmacy service costs using this pool and applying a tiered approach to payments based on some objective criteria related to the pharmacy resources required for groups of drugs.

22. If CMS does not implement recommendations 20 and 21, then the Panel recommends that CMS exclude data from hospitals that participate in the 340B program from its ratesetting calculations for drugs and that CMS pay 340B hospitals in the same manner as it pays non-340B hospitals.