

clinical category specified in the code provides a reasonable means for interim payment until such time as there is a code that specifically describes what is being paid. It encourages the creation of codes where appropriate and mitigates against overpayment of services that are not clearly identified on the bill. Our assignment of CPT code 90779 to APC 0436 is consistent with this policy. The hospital cost data for unlisted HCPCS codes, including CPT code 90779, are not used for ratesetting and, furthermore, the costs of unlisted HCPCS codes are not subject to the 2 times rule. For additional information on the 2 times rule, we refer readers to sections III.B.2 and 3 of this final rule with comment period.

After consideration of the public comments received, we are finalizing our CY 2009 proposal, without modification, to implement a five-level APC structure for drug administration services, with final assignment of all HCPCS codes as proposed. Table 34 below displays the five finalized APC groups for drug administration services for CY 2009. We note that several of the CY 2008 CPT codes for drug

administration services have been renumbered for CY 2009. We provide both the CY 2008 CPT codes and the CY 2009 CPT codes, along with the CY 2009 long code descriptors, in Table 34 below.

*Comment:* Several commenters requested that CMS reconsider the proposed packaged status of CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion). The commenters noted that the service described by this code, for which hospital claims data are first available in CY 2007, requires additional facility resources. They believed that because CMS now has claims data upon which to set a specific payment rate for the service, the OPSS should pay separately for CPT code 90768 in CY 2009.

*Response:* We agree with commenters that this code was first introduced in CY 2007 under the OPSS and that we have cost data for this CPT code based on historical hospital claims data. However, we believe that this code remains appropriate for packaging. As we discussed in the CY 2008 OPSS/ASC final rule with comment period (72 FR

66787 through 66788), in deciding whether to package a service or pay for it separately, we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services; how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed; and whether the expected cost of the service is relatively low. CPT code 90768, by definition, is always provided in association with other intravenous infusions, and we continue to believe that it is most appropriately packaged under the OPSS. Furthermore, to reduce the size of the APC payment groups and establish separate payment for this currently packaged ancillary and supportive service would be inconsistent with our overall strategy to encourage hospitals to use resources more efficiently by increasing the size of the OPSS payment bundles.

After consideration of the public comments received, we are finalizing our CY 2009 proposal, without modification, to package payment for CPT code 90768 for CY 2009.

TABLE 34—CY 2009 DRUG ADMINISTRATION APCS

Final CY 2009 APC	Final CY 2009 approximate APC median cost	CY 2008 HCPCS code	CY 2009 HCPCS code	CY 2009 long descriptor
0436 .....	\$24	90471	90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid).
		90472	90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid)(List separately in addition to code for primary procedure).
		90473	90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).
		90474	90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).
		90761	96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure).
		90766	96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).
		90771	96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure).
		90772	96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
		90779	96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion.
		95115	95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection.
		95117	95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections.
		95145	95145	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom.
		95165	95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses).

TABLE 34—CY 2009 DRUG ADMINISTRATION APCS—Continued

Final CY 2009 APC	Final CY 2009 approximate APC median cost	CY 2008 HCPCS code	CY 2009 HCPCS code	CY 2009 long descriptor		
0437 .....	\$35	95170	95170	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses).		
		96549	96549	Unlisted chemotherapy procedure.		
		90767	96367	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).		
		90770	96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).		
		90773	96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial.		
		90774	96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.		
		90775	96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure).		
		95144	95144	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials).		
		95148	95148	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms.		
		0438 .....	\$72	96401	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic.
96402	96402			Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic.		
96405	96405			Chemotherapy administration; intralesional, up to and including 7 lesions.		
96415	96415			Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure).		
90760	96360			Intravenous infusion, hydration; initial, 31 minutes to 1 hour.		
90769	96369			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s).		
95146	95146			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms.		
95147	95147			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms.		
96406	96406			Chemotherapy administration; intralesional, more than 7 lesions.		
96411	96411			Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure).		
0439 .....	\$126	96417	96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure).		
		96423	96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure).		
		90765	96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.		
		95149	95149	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms.		
		96409	96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug.		
		96420	96420	Chemotherapy administration, intra-arterial; push technique.		
		96522	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial).		
		96542	96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents.		
		0440 .....	\$184	95990	95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular).
				95991	95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician.
96413	96413			Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug.		

TABLE 34—CY 2009 DRUG ADMINISTRATION APCs—Continued

Final CY 2009 APC	Final CY 2009 approximate APC median cost	CY 2008 HCPCS code	CY 2009 HCPCS code	CY 2009 long descriptor
		96416	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump.
		96422	96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour.
		96425	96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump.
		96440	96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis.
		96445	96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis.
		96450	96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture.
		96521	96521	Refilling and maintenance of portable pump.
		C8957	C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than eight hours), requiring use of portable or implantable pump.

**IX. OPSS Payment for Hospital Outpatient Visits**

*A. Background*

Currently, hospitals report visit HCPCS codes to describe three types of OPSS services: clinic visits, emergency department visits, and critical care services. CPT indicates that office or other outpatient visit codes are used to report evaluation and management (E/M) services provided in the physician’s office or in an outpatient or other ambulatory facility. For OPSS purposes, we refer to these as clinic visit codes. CPT also indicates that emergency department visit codes are used to report E/M services provided in the emergency department, which is defined as an “organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.” For OPSS purposes, we refer to these as emergency department visit codes that specifically apply to the

reporting of visits to Type A emergency departments. Furthermore, for CY 2007 we established five new Level II HCPCS codes to report visits to Type B emergency departments (defined as dedicated emergency departments that incur Emergency Medical Treatment and Labor Act (EMTALA) of 1986 (Pub. L. 99–272) obligations but that do not meet the Type A emergency department definition, as described in more detail below). These new Level II HCPCS codes were developed because there were no CPT codes at that time that fully described services provided in this type of facility. CPT defines critical care services to be reported with critical care CPT codes as the “direct delivery by a physician(s) of medical care for a critically ill or critically injured patient.” Under the OPSS, in Transmittal 1139, Change Request 5438, dated December 22, 2006, we stated that the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active

face-to-face critical care of a critically ill or critically injured patient. We also established HCPCS code G0390 (Trauma response team associated with hospital critical care service) in CY 2007 for the reporting of a trauma response in association with critical care services. We refer readers to section III.D.7.f. of this final rule with comment period for further discussion of payment for a trauma response associated with hospital critical care services.

Currently, CMS instructs hospitals to report the CY 2008 CPT codes that describe new and established clinic visits, Type A emergency department visits, and critical care services, and the six Level II HCPCS codes to report Type B emergency department visits and trauma activation provided in association with critical care services. These codes are listed below in Table 35. As we stated in the proposed rule (73 FR 41506), we are not changing the visit HCPCS codes that hospitals report for CY 2009.

TABLE 35—CY 2009 CPT E/M AND LEVEL II HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

CY 2009 HCPCS code	CY 2009 descriptor
<b>Clinic Visit HCPCS Codes</b>	
99201 .....	Office or other outpatient visit for the evaluation and management of a new patient (Level 1).
99202 .....	Office or other outpatient visit for the evaluation and management of a new patient (Level 2).
99203 .....	Office or other outpatient visit for the evaluation and management of a new patient (Level 3).
99204 .....	Office or other outpatient visit for the evaluation and management of a new patient (Level 4).
99205 .....	Office or other outpatient visit for the evaluation and management of a new patient (Level 5).
99211 .....	Office or other outpatient visit for the evaluation and management of an established patient (Level 1).
99212 .....	Office or other outpatient visit for the evaluation and management of an established patient (Level 2).
99213 .....	Office or other outpatient visit for the evaluation and management of an established patient (Level 3).
99214 .....	Office or other outpatient visit for the evaluation and management of an established patient (Level 4).
99215 .....	Office or other outpatient visit for the evaluation and management of an established patient (Level 5).