

CENTERS FOR MEDICARE & MEDICAID SERVICES

Advisory Panel on Ambulatory Payment Classification (APC) Groups

Recommendations: September 5–6, 2007

Panel Subcommittees

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

Observation

2. The Panel recommends that CMS not finalize the proposal to implement observation packaging for 2008, as it would be detrimental for patients receiving medically necessary services and increase costs. The Panel requests that CMS provide additional data on observation in order to understand trends and utilization; further, the Panel requests that this data be presented for review at the next meeting, specifically:
 - Whether claims reflect misuse or overutilization of observation services
 - More distinct frequency and utilization data for the three conditions for which observation services are now separately payable
 - Association of observation services with emergency department and clinic visits
 - Analysis of the frequency of claims for observation services compared with the inpatient error rate
 - Frequency distribution showing length of stay data for observation services
3. If observation services must be packaged, the Panel recommends that CMS create a composite emergency department/clinic and observation APC (or a group of composite APCs) that is only paid when both services are provided. If the composite APC were paid, neither the clinic nor emergency department visit would be paid separately. Coding and service requirements currently applicable to separately payable observation would remain the same, with the exception that there would be no clinical condition restriction on payment for the composite APC. Payment rates for this composite APC would need to be adjusted based on readily available historical data.
4. With the significant changes in packaging proposed for 2008, especially as related to observation, the Panel recommends that CMS evaluate the potential negative impact on beneficiaries.

Data

5. The Panel recommends that CMS explore whether hospitals could report a modifier to reflect the amount of a partial credit for a device as a percentage of the amount of the replacement device. This approach would signify that there was a partial credit and provide data for use in determining the amount of reduction that could be taken in future years.

Recommendations: September 5–6, 2007 (continued)

Packaging

6. The Panel recommends that contrast agents be packaged as proposed in the proposed rule.
7. The Panel recommends that image processing services be packaged as proposed in the proposed rule.
8. The Panel recommends that the packaging of intraoperative testing services be implemented as proposed in the proposed rule and that CMS consider applying “Q” status to CPT code 96020, *Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report.*
9. The Panel recommends that image guidance services be packaged as proposed in the proposed rule, except for radiation oncology image guidance procedures.
10. The Panel recommends that CMS delay packaging imaging supervision and interpretation services because of excessive reductions in payment for services that would be paid separately only if they were provided with other minor procedures that are already packaged.
11. The Panel recommends that CMS work with stakeholders to develop an alternative model for packaging imaging supervision and interpretation services and present it at the next APC meeting.
12. The Panel recommends that CMS set the packaging threshold for diagnostic radiopharmaceuticals at a median cost of \$200 per day, and that CMS continue to pay for diagnostic radiopharmaceuticals that cost more than \$200 using the current methodology.
13. The Panel recommends that CMS review nuclear medicine procedure claims, identify those associated with a radiopharmaceutical and those not associated with a radiopharmaceutical, and present the findings at the next APC meeting for consideration of whether a claims edit is needed.
14. The Panel recommends that CMS create a composite APC for BEXXAR[®] or related therapies and present it for the Panel’s consideration at the next APC Panel meeting.
15. The Panel recommends that CMS provide in the Final Rule crosswalks and information clarifying how newly packaged services map back to primary procedures, e.g., by simulating median costs for HCPCS codes with and without packaging.

Recommendations: September 5–6, 2007 (*continued*)

APC Placement

Continuous Glucose Monitoring

16. The Panel recommends that CMS retain APC 0421, Prolonged Physiologic Monitoring, with its current composition, including CPT code 95250, *Ambulatory continuous glucose monitoring of interstitial fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording*; HCPCS code 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 HCPCS code 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 4 tests*.

Implantation of Gastric Neurostimulator Electrodes

17. The Panel recommends that before finalizing the proposal for 2008, CMS reevaluate its decision to place CPT code 43647, *Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum*, a device-dependent code, in APC 0130, Level-I Laparoscopy, which is not device-dependent.

Cardiac Rehabilitation Services

18. The Panel recommends that CMS continue to use the existing CPT codes for cardiac rehabilitation services (CPT code 93797, *Physician services for outpatient cardiac rehabilitation; without continuous electrocardiographic [ECG] monitoring [per session]*, and CPT code 93798, *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring [per session]*) and not replace them with the proposed HCPCS G-codes GXXX1, *Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per hour)*, and GXXX2, *Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per hour)*.

Bone Marrow and Stem Cell Processing Services

19. The Panel recommends that before finalizing the proposal for 2008, CMS reevaluate its decision to place the following CPT codes in APC 0110, Transfusion:
- CPT code 38210, *Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion*
 - CPT code 38211, *Transplant preparation of hematopoietic progenitor cells; tumor cell depletion*
 - CPT code 38212, *Transplant preparation of hematopoietic progenitor cells; red blood cell removal*
 - CPT code 38213, *Transplant preparation of hematopoietic progenitor cells; platelet depletion*
 - CPT code 38214, *Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion*
 - CPT code 38215, *Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer*

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20. The Panel also recommends that before finalizing the proposal for 2008, CMS reevaluate its decision to place the following CPT codes in APC 0344, Level IV Pathology:
- CPT code 38207, *Transplant preparation of hematopoietic progenitor cells, cryopreservation and storage*
 - CPT code 38208, *Transplant preparation of hematopoietic progenitor cells, thawing of previously frozen harvest, without washing*
 - CPT code 38209, *Transplant preparation of hematopoietic progenitor cells, thawing of previously frozen harvest, with washing*

Uterine Fibroid Embolization

21. The Panel recommends that CMS consider moving CPT code 37210, *Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and image guidance necessary to complete the procedure*, to another APC, such as APC 0067, Level III Stereotactic Radiosurgery, or APC 0229, Transcatheter Placement of Intravascular Shunts, to improve the clinical and resource homogeneity of the procedure within the APC.

Drugs and Pharmacy Overhead

22. The Panel recommends that CMS continue to reimburse for separately payable drugs at a rate of the average sales price plus 6 percent for 2008.
23. The Panel recommends that hospitals not be required to separately report charges for pharmacy overhead and handling. The Panel further recommends that pharmacy overhead and handling costs be recognized within drug charges and be paid through the packaged or separate drug payment (as appropriate based on the drug packaging threshold).
24. The Panel recommends that CMS continue to evaluate alternative methods to standardize the capture of pharmacy overhead costs in a manner that is simple to implement at the organizational level, similar to the three-phase approach recommended by the Panel at its March 2007 APC Panel meeting.

Miscellaneous

25. The Panel recommends that CMS provide more data at the next APC Panel meeting on HCPCS code A4306, *Disposable drug delivery system, flow rate of less than 50 mL per hour*.