

**REPORT  
of the  
Advisory Panel  
on  
Ambulatory Payment Classification  
(APC) Groups**

**January 21–22, 2003**

**Centers for Medicare & Medicaid Management  
Central Office, Multipurpose Room  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850**

**APC ADVISORY PANEL MEMBERS PRESENT AT THIS MEETING:**

Paul Rudolf, M.D., J.D., Chair  
Michelle Burke, R.N., M.S.A.  
Leslie Jane Collins, R.N., B.S.N.  
Geneva Craig, R.N., M.A.  
Lora DeWald, M.Ed.  
Robert (“Bob”) E. Henkin, M.D.  
Lee H. Hilborne, M.D., M.P.H.  
Stephen T. House, M.D.

Kathleen Kinslow, C.R.N.A., Ed.D.  
Mike Metro, R.N., B.S.  
Gerald V. Naccarelli, M.D.  
Beverly K. Philip, M.D.  
Karen Rutledge, B.S.  
William A. Van Decker, M.D.  
Paul E. Wallner, D.O., F.A.C.R.

**CMS STAFF PRESENT:**

Liz Cusick, Deputy Director, CMM; Tom Gustafson, Ph.D., Director, HAPG; Parashar Patel, Deputy Director, HAPG; Cindy Read, Director, DOC; Ron DeiCas, M.D.; Laurie Feinberg, M.D.; Ken Simon, M.D.; Shirl Ackerman-Ross, Panel Coordinator; Sabrina Ahmed; Melissa Dehn; Deborah Hunter; Mark Hartstein; Marsha Mason-Wonsley, R.N.; and Jean Stiller.

**WELCOME AND OVERVIEW OF THE AGENDA**

Liz Cusick, Deputy Director for the Center for Medicare Management, welcomed the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) on behalf of Tom Grissom, Director of the Center for Medicare Management, who was unable to attend. Dr. Paul Rudolf, the Panel's chair, outlined the agenda for the meeting (see Appendix A). He noted that data provided to the Panel members as background on drug costs would need to be updated before the proposed rule is published and was, therefore, not considered public information.

A variety of revisions to individual APCs were on the agenda for the Panel's consideration. Dr. Rudolf reminded members that reimbursement rates for individual APCs are based on claims that specify a single APC; claims that contain multiple APCs are disregarded for methodological reasons. Dr. Rudolf said the Centers for Medicare and Medicaid Services (CMS) is seeking ways to improve the methodology to include more claims in determining reimbursement rates (see agenda item JJ). He said CMS is also seeking methods to track the costs of drugs, biologicals, and medical devices when those items are no longer identified by separate APCs but rolled into APC packages (see agenda items EE, HH, and II).

Dr. Rudolf said he hoped the CMS staff would be able to provide background materials to Panel members earlier in advance of the next meeting. He said CMS plans to publish the next proposed rule on APCs in May or June and asked members to consider possible dates for a one-day Panel meeting in July or August of 2003 to discuss the proposed rule. Dr. Rudolf also noted that several Panel members are reaching the end of their terms and nominations are being accepted for the open seats on the Panel. Dr. Rudolf then thanked several individuals from the CMS staff for their hard work in organizing the meeting and providing data.

(The proceedings of the Panel meeting follow. A listing of only the recommendations may be found in Appendix B.)

### OLD BUSINESS

No old business was presented.

### NEW BUSINESS

***Agenda Item A. Debridement and Destruction (APCs 12 and 13):*** Dr. Ken Simon of the CMS staff said these APCs appeared to violate the "two-times rule" (the highest-cost reimbursed item in a given APC may not cost more than two times the lowest-cost reimbursed item). He recommended rearranging the Current Procedural Terminology (CPT) codes in these APCs, and the Panel agreed.

*The Panel recommends* moving the CPT codes for debridement and destruction 15793, 15786, 11001, 16025, 16000, 15851, and 11302 from APC 13 to APC 12 and 11057 from APC 12 to APC 13.

***Agenda Item B. Excision/Biopsy (APCs 19, 20, and 21):*** Dr. Simon said two of these APCs appeared to violate the two-times rule and recommended rearranging some CPT codes and creating a new APC. The Panel disagreed, saying that upcoming changes in the CPT guidelines would either address the issue or result in the need for more changes.

*The Panel recommends* no changes to the codes for excision/biopsy (APCs 19, 20, and 21) because anticipated CPT changes will substantially affect the use of the codes. The Panel will review the issue next year if 2003 data are available.

***Agenda Item C. Thoracentesis/Lavage Procedures and Endoscopy (APCs 71, 72, and 73):*** Dr. Simon said these APCs appeared to violate the two-times rule and recommended rearranging some of the CPT codes among these APCs. The Panel agreed.

*The Panel recommends,* for the codes for thoracentesis/lavage procedures and endoscopy, moving CPT code 31505 from APC 72 to APC 71, CPT 31575 from APC 71 to APC 72, and CPT 31720 from APC 72 to APC 73.

***Agenda Item D. Cardiac and Ambulatory Blood Pressure Monitoring (APC 97):*** Dr. Laurie Feinberg of the CMS staff said this APC appears to violate the two-times rule and asked the Panel for suggestions for fixing the problem. The Panel, however, felt changes would not have any positive effects.

*The Panel recommends no changes to the codes for cardiac and ambulatory blood pressure monitoring (APC 97).*

***Agenda Item E. Electrocardiograms (APCs 99 and 340):*** CMS staff noted APC 99 appears to violate the two-times rule. The Panel felt changes would not have any positive effects.

*The Panel recommends no changes to the codes for electrocardiograms (APC 99).*

***Agenda Item F. Cardiac Stress Tests (APC 100):*** Dr. Richard Cohen, professor at Harvard University and the Massachusetts Institute of Technology and medical/scientific advisor to Cambridge Heart, Inc. (which markets the Microvolt T-Wave Alternans [MTWA] Testing technology) requested that CMS move the code for MTWA, CPT 93025, out of APC 100 (see Presentation Appendix 1). Dr. Cohen said the actual cost for MTWA is significantly higher than other devices in the same APC. Because the technology is often billed in conjunction with other APCs (such as mechanical or pharmaceutical approaches to raising the heart rate), few single-APC claims were available to evaluate the presenter's contention. The Panel felt there were insufficient data to merit moving the code. CMS staff agreed to look at the existing claims and seek additional CPT coding information on MTWA.

*The Panel recommends no changes to the code for cardiac stress tests (APC 100) until more data are available for review.*

***Agenda Item G. Revision/Removal of Pacemakers or Automatic Implantable Cardioverter Defibrillators (APC 105):*** CMS staff said this APC appears to violate the two-times rule but felt this resulted from incorrectly coded claims. The Panel felt the coding instructions do not clearly state that device removal and insertion require two separate codes in this case.

*The Panel recommends no changes to the codes for revising or removing pacemakers (APC 105).*

***Agenda Item H. Sigmoidoscopy (APCs 146 and 147):*** CMS staff said it is not clear why the relatively simple procedures of anoscopy and rigid sigmoidoscopy have higher median costs than the more complex procedure of flexible sigmoidoscopy. These APCs contain a mix of all these procedures. Panel members suggested the high costs may come from the need to perform an otherwise minor office procedure in hospital because of patient complications. Others suggested claims may be incorrectly coded, as it is not clear how to code when the clinician does not complete the intended procedure because of patient considerations (that is, should the claim include a modifier or the code for "as far as you get").

***Agenda Item H. Sigmoidoscopy (APCs 146 and 147): (continued)***

The Panel recommends no changes to the codes for sigmoidoscopy (APCs 146 and 147). However, the Panel would like the staff to further evaluate the reasons for the apparently aberrant costs for seemingly simple procedures through data analysis, looking specifically at anesthesia revenue centers. In addition, the Panel recommends CMS clarify the appropriate coding, when the procedure that is performed is not as extensive as the procedure that had been planned.

***Agenda Item I. Anal/Rectal Procedures (APCs 148, 149, and 155):*** CMS staff said some of these APCs violate the two-times rule and suggested rearranging some of the CPTs within these codes. The Panel felt changes to APC 148 would have no positive effects but agreed that changes to APC 155 would resolve the two-times rule violation appropriately.

The Panel recommends no changes to APC 148 but does recommend moving CPT code 46040 from APC 155 to APC 149.

***Agenda Item J. Insertion of Penile Prosthesis (APC 182):*** Dr. Craig Donatucci, representing the Sexual Medicine Society of North America, requested that APC 182 be split into two APCs, depending on whether the procedure involves inflatable or non-inflatable penile prostheses, as proposed by the Coalition for the Advancement of Prosthetic Urology (see Presentation Appendices 2, 3a, and 3b). He said the complexity of the procedure, the cost of the devices, and related resources were all significantly higher with inflatable prostheses. The Panel agreed that the current APCs needed to be reconfigured.

The Panel recommends deleting APC 179 and APC 182 and creating the following two new APCs:

- \* 179a, containing CPT codes 53440, 54400, 53444, 54416, and, if the data show no violation of the "two-times" rule, 52282
- \* 179b, containing CPT codes 53447, 54401, 54410, 54405, and 53445.

***Agenda Item K. Female Reproductive Procedures (APCs 195 and 202):*** A commenter requested the CPT code for adjusting a sling for urinary incontinence be given its own APC. CMS staff suggested the procedure be moved to an APC with other similar procedures that require a device, and the Panel agreed.

The Panel recommends moving CPT codes 57109, 58920, and 58925 from APC 202 to APC 195.

***Agenda Item L. Surgical Hysteroscopy (APC 190):*** Lori Fontaine of Boston Scientific Corporation requested that CPT code 58563 for surgical hysteroscopy with endometrial ablation be moved to its own APC (see Presentation Appendix 4). She said Boston Scientific's HydroThermAblator (HTA) system is a new, more expensive device that should be reimbursed at a higher rate than other ablation technologies. Panel members felt that when new technologies proved more effective, clinicians used them more frequently and the volume of claims increased,

***Agenda Item L. Surgical Hysteroscopy (APC 190): (continued)***

thus meriting review. Without substantial evidence of effectiveness, however, the Panel was reluctant to create APCs that offer an incentive to use a more expensive device. It was noted that cryoablation is included in a “new technology” APC, while the HTA system is included with older, less costly techniques. Thus, cryoablation may be reimbursed at a higher rate, giving its manufacturers an unfair competitive advantage.

Stephanie Mensh of AdvaMed expressed concern about the length of time between the introduction of new technology and its assignment to an adequate APC for reimbursement. She also expressed concern that packaging devices and drugs in the same APC as a procedure prevents CMS from gathering data about real costs.

In light of the suggestions about APC 190 and the various technologies used with surgical hysteroscopy, *the Panel recommends* that CMS coding and payment policies 1) take into account different methods of endometrial ablation associated with hysteroscopy, 2) adequately reflect the resources used for the various procedures, 3) avoid creating a competitive advantage or disadvantage, and 4) collect data needed to track costs on the type of technologies used for future consideration. Also, *the Panel reached no conclusion* as to whether HTA should be included in the new technology APC.

***Agenda Item M. Nerve Injections (APCs 203, 204, 206, and 207):*** Commenters requested various changes to these APCs to increase the reimbursement rates. CMS staff said the configuration of CPTs in these APCs was more clinically cohesive than it used to be but it is still disorganized. The Panel felt the current arrangement was sufficient but that botulinum toxin injections would be a concern if they were moved into an APC package.

*The Panel recommends* no changes to the codes for nerve injection (APCs 203, 204, 206, and 207). However, if the code regarding botulinum toxin injection becomes packaged, the Panel would like to review it.

***Agenda Item N. Laminotomies and Laminectomies; Implantation of Pain Management Device (APCs 208 and 223):*** Dr. David Charles, Director of the Movement Disorders Clinic at Vanderbilt University, representing Medtronic, requested CPT 62351 (implantation of a catheter; laminectomy required) be moved from APC 208 to APC 223 to better capture the device cost that may be involved with the procedure (see Presentation Appendix 5). The Panel felt not enough data were available to support the request.

*The Panel recommends* no changes to the codes for laminotomies and laminectomies (APCs 208 and 223). However, the Panel would like to review data collected from the associated Health Care Financing Administration Common Procedure Coding System (HCPCS) codes in 1 year.

**Agenda Item O. Extended EEG Studies and Sleep Studies; Electroencephalogram (APCs 209, 213, and 214):** CMS staff said APC 213 appears to minimally violate the two-times rule. A commenter suggested CPT code 95955 be moved from APC 214 to APC 213, and the Panel agreed.

*The Panel recommends moving CPT code 95955 from APC 214 to APC 213.*

**Agenda Item P. Nerve and Muscle Tests (APCs 215, 216, and 218):** CMS staff said APC 218 appears to violate the two-times rule. Various suggestions for rearranging CPT codes within APCs 215, 216, and 218 were proposed by CMS staff and commenters. The Panel felt the CMS staff's proposed changes were reasonable.

*The Panel recommends moving CPT codes 95858, 95870, 95900, and 95903 from APC 218 to APC 215.*

**Agenda Item Q. Implantation of Drug Infusion Device (APC 227):** This APC contains only two codes: one for programmable infusion pumps, one for non-programmable pumps. A commenter requested splitting this APC into two APCs. The CMS staff said its cost data did not show a significant cost difference between the two devices and APC 227 does not violate the two-times rule.

*The Panel recommends no changes to APC 227.*

**Agenda Item R. Ophthalmologic APCs (APCs 230, 235, 236, and 698):** Dr. Ron Deicas of CMS said APCs 230 and 235 violated the two-times rule but reflected the Panel's previous recommendations. He proposed rearranging some of the CPT codes within these APCs. Gail Daubert of Alcon Laboratories expressed concern that the pass-through device category "New Technology: Intraocular Lens" was discontinued and these devices are now included in a packaged APC for cataract procedures (see Presentation Appendix 6). She maintained that Congress intended the New Technology: Intraocular Lens category to be paid separately for 5 years. She asked the Panel to ensure that future new intraocular lens devices be considered for a new pass-through category.

*The Panel recommends moving CPT code 67820 from APC 230 to APC 698 and CPT 67110 from APC 235 to APC 236.*

*The Panel also requests that CMS staff monitor data from codes in APC 235 for possible review next year.*

**Agenda Item S. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures (APCs 341 and 345):** CMS staff said these APCs appear to minimally violate the two-times rule and suggested moving several CPT codes from these APCs into a new APC. Susan Reardon of Ortho-Clinical Diagnostics said APC 341 included both skin tests and blood tests, which are not comparable in terms of resources (see Presentation Appendix 7). She supported the CMS proposal to group the transfusion-related CPTs into a new APC. The Panel felt the change was appropriate, but the potential effect on blood banks should be explored before making such a change.

***Agenda Item S. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures (APCs 341 and 345): (continued)***

The Panel recommends moving CPT codes 86880, 86885, 86886, and 86900 from APC 341 and CPT code 86901 from APC 345 to a new APC. The Panel further recommends that CMS seek the input of the American Association of Blood Banks regarding the suggested changes.

***Agenda Item T. Otorhinolaryngologic Function Tests (APCs 363 and 660):*** CMS staff said APC 660 appears to violate the two-times rule and suggested rearranging some of the CPT codes in these APCs.

The Panel recommends moving CPT codes 92543 and 92588 from APC 660 to APC 363.

***Agenda Item U. Tube Changes and Repositioning (APCs 121 and 122):*** CMS staff said APC 121 violates the two-times rule and suggested rearranging several CPT codes in APCs 121 and 122.

The Panel recommends moving CPT codes 47530, 51710, 50688, and 62225 from APC 121 to APC 122.

***Agenda Item V. Myelography (APC 274):*** CMS staff said APC 274 appears to minimally violate the two-times rule and suggested rearranging some of the CPT codes in APCs 274 and 274a. Dr. Bill Thorwarth of the American College of Radiology (ACR) said his organization supports the suggested changes.

The Panel recommends moving CPT codes 72285 and 72295 from APC 274 to APC 274a.

***Agenda Item W. Therapeutic Radiologic Procedures (APCs 296 and 297):*** CMS staff said APCs 296 and 297 appear to minimally violate the two-times rule as a result of changes recommended by the Panel last year.

The Panel recommends no changes to APC 296 and APC 297.

***Agenda Item X. Vascular Procedures; Cannula/Access Device Procedures (APCs 103 and 115):*** A commenter requested CPT code 36860 be moved to APC 115. Dr. Thorwarth of the ACR said the procedure (clearing a cannula without balloon angioplasty) is more similar to other procedures in APC 115 and does not fit well in its current miscellaneous APC. The Panel felt there were not yet sufficient data available to justify moving the code to the higher-paying APC.

The Panel recommends no changes to APC 103 or APC 115. However, if cost data for catheter clearing with and without balloon angioplasty suggest a need for revision, the Panel will consider the issue in the future.

***Agenda Item Y. Angiography and Venography Except Extremity (APCs 279, 280, and 668):*** A commenter requested CPT code 75978 be moved from APC 668 to APC 280 and that CPT code 75774 be moved from APC 668 to APC 279. Dr. Thorwarth of the ACR said CPT 75798, venous angioplasty, is commonly used among dialysis patients and therefore often requires multiple intraoperative attempts to succeed. Thus, it should continue to be reimbursed as a level-3 procedure. The Panel felt the distribution of CPT codes among these APCs was not clinically homogenous and required some revision.

*The Panel recommends* CMS staff consult with representatives of the American College of Radiology and others with relevant expertise to rearrange CPT codes in APCs 279, 280, and 668. The Panel will discuss the proposed changes at its next meeting.

***Agenda Item Z. Computed Tomography (CT), Magnetic Resonance (MR), and Ultrasound Guidance Procedures Currently Packaged:*** CMS staff said the agency bundled these guidance procedures for tissue ablation into one code with the expectation that they would be used with a variety of procedures. Dr. Thorwarth of the ACR said these three types of guidance differed significantly in cost and time required and should be separated. He also felt hospitals needed more education on the appropriate application of these codes. Another commenter felt CPT codes 76362, 76394, and 76490 should be changed from status N to status S and included with appropriate clinical or new technology APCs. NOMOS Corporation submitted written testimony requesting that CMS maintain separate payment codes for ultrasound guidance procedures (see Presentation Appendix 8). The Panel felt combining these three procedures made it difficult for hospitals to track their use for the purpose of allocating funds. Some preliminary suggestions were made for specific APCs in which to include the three CPT codes.

*The Panel recommends* moving each CPT code to a specific APC as follows (CMS staff will determine whether the APCs below are appropriate):

- \* CPT 76362 (CT) to APC 332
- \* CPT 76394 (MR) to APC 335
- \* CPT 76490 (ultrasound) to APC 268

*The Panel also recommends* the status indicator codes for CPT codes 76362, 76394, and 76490 be revised as appropriate, when they are moved to new APCs.

***Agenda Item AA. Magnetic Resonance Imaging and Magnetic Resonance Angiography Without Contrast (APC 336):*** A commenter requested that CPT code 76393 be changed from status N to status S. Dr. Thorwarth of the ACR said that having a separate guidance code allows one to see whether procedures were performed with or without guidance.

*The Panel recommends* moving code CPT 76393 to APC 335.

*The Panel also recommends* the status indicator code for CPT 76393 be revised as appropriate, when it is moved to a new APC.

***Agenda Item BB. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement (APCs 260 and 261):*** A commenter requested that CPT codes 76120 and 76125 be moved from APC 260 to APC 261. Dr. Thorwarth of the ACR said he felt these codes (for cineradiography and videoradiography) are fluoroscopic procedures that should not be grouped with level-1 radiography procedures.

For the radiography codes, *the Panel recommends* moving CPT 76120 to APC 272.

***Agenda Item CC. Chemotherapy Administration by Other Technique Except Infusion (APC 116):*** Jugna Shah of Nimmit Consulting, representing 11 freestanding cancer centers, requested that APC 116 be split into three APCs according to the method of administration: a) subcutaneous or intramuscular administration (CPT 96400) and "push" administration (CPT 96408), b) central nervous system administration (CPT 96450), and c) brain administration (CPT 96450) (see Presentation Appendix 9). Ms. Shah also said APCs 117 and 118 contained nonspecific HCPCS Q codes in place of the more specific CPT codes for non-infusion chemotherapy. She requested that existing CPT codes replace the more cumbersome Q codes for chemotherapy, which would provide more detailed data on methods of chemotherapy for future reimbursement decisions without affecting the current payment system.

A representative from the American Hospital Association added that CPT codes are preferable to Q codes because other payers require CPT codes, and Panel members agreed. Ms. Shah said hospitals should have clear guidance from CMS if the coding guidelines are revised. She also suggested that new APCs be considered, when CMS addresses packaging of drugs with procedures for chemotherapy. At the Panel's request, Ms. Shah agreed her organization would provide a "crosswalk" that indicates, for non-infusion chemotherapy, which CPTs correspond with current APCs.

*The Panel recommends* that CMS require hospitals to use the existing CPT codes for administration of non-infusion chemotherapy and map them to APCs 116–120 as appropriate (updating the pay rates according to the usual process). The use of the CPT codes will result in data that can be used to determine whether the APCs for chemotherapy should include a range of CPT codes.

***Agenda Item DD. Diagnostic Nuclear Medicine Excluding Myocardial Scans (APCs 290, 291, 292, 294, and 666):*** CMS staff said APCs 290 and 291 appear to violate the two-times rule. Sabrina Ahmed of CMS explained that the pass-through for 236 drugs, biologicals, and radiopharmaceuticals expired as of 2003. These items are now either paid separately or packaged with procedures. Reimbursement decisions are based on median costs; \$150 is the threshold below which most drugs are likely to be included in a package. Because data from claims in 2003 and beyond will not provide specific cost information for packaged items, Ms. Ahmed described several proposed methods for determining drug costs.

Cindy Read of CMS said CMS gathers drug charge data from hospital claims and applies a cost-to-charge ratio to determine costs. Several panel members said CMS should seek actual drug costs for its decision making. Dr. Rudolf said current law specifies costs be gathered from claims data. Panel members raised concerns about the impact on hospitals of the packaging approach.

***Agenda Item DD. Diagnostic Nuclear Medicine Excluding Myocardial Scans (APCs 290, 291, 292, 294, and 666): (continued)***

Dr. Kenneth McKusick of the Nuclear Medicine APC Task Force said CMS does not have accurate cost data because of confusion over HCPCS codes, poor hospital reporting, the use of single but not multiple claims in determining costs, and other reasons (see Presentation Appendix 10). He asked that a better system for capturing costs be developed and said his organization plans to propose a new system within a few months.

Mr. Gordon Schatz, representing the Council of Radionuclides and Radiopharmaceuticals, supported Dr. McKusick's comments (see Presentation Appendix 11). He added that 10 APCs are now used to account for 193 nuclear medicine procedures. His organization believes APCs 286, 290, 291, 292, and 294 violate the two-times rule. He asked the Panel to review those APCs. He suggested creating a package APC that consists of radiopharmaceuticals and can be added on to a procedure code.

Mr. John Reyes-Gara of the Daxor Corporation requested that CPT 78122 (whole blood volume determination) be moved to APC 292 (see Presentation Appendix 12). He said current cost data used by CMS underestimate real costs, and confusion exists about units used per dose versus units of supply.

Panel members raised concerns that packaging nuclear medicine APCs will not adequately track real costs. They were also concerned about underpayment on the one hand and creating incentives to use agents with a higher reimbursement on the other.

For drugs and biologicals, *the Panel recommends* CMS consider grouping drugs and radiopharmaceuticals in new APCs by both their clinical use and their cost in some reasonable proportion, taking into account ways to avoid "gaming" of the system and unjustified cost drift but recognizing legitimate cost differences. *The Panel further recommends* that, if new APCs for nuclear medicine are created, the descriptors should be as simple as possible, and use of units of measure that could be confusing to coders and clinicians should be limited.

***Agenda Item EE. Capturing the Costs of Drugs and Biologicals Packaged Into APCs:*** CMS staff asked the Panel for recommendations for ensuring that the costs of drugs and biologicals packaged into APCs are appropriately reimbursed.

Dr. Thorwarth of the ACR suggested that if CMS continues to use the packaging approach, the APCs should accurately reflect the costs of drugs and biologicals used (see Presentation Appendix 13). He said that hospitals will not have an incentive to provide detailed coding on claims, if the reimbursement does not require it; as a result, CMS will have poorer data on which to base decisions.

Dr. Jeffrey Shogun of the Association of Community Cancer Centers said cancer care providers lose money when they provide chemotherapy for Medicare beneficiaries (see Presentation Appendix 14). He also noted that the use of single claims for chemotherapy reimbursement gives a distorted picture of patients, because those for whom single claims are filed tend to have fewer visits and to tolerate treatment drugs that are more powerful than those

*Agenda Item EE. Capturing the Costs of Drugs and Biologicals Packaged Into APCs: (continued)* administered to more typical patients. Dr. Shogun asked that CMS slow down the process of APC packaging until all the costs are better understood.

Patrick Biblio of Organogenesis recommended that reimbursement for packaged APCs take into account comparable product pricing, measures of efficacy, and dosages (see Presentation Appendix 15).

Stuart Langbein of the Pharmaceutical Research and Manufacturers of America (PhRMA) said CMS has failed to recognize that drugs and biologicals are often less expensive and less invasive forms of treatment than medical devices or procedures (see Presentation Appendix 16). He said packaging has resulted in decreased reimbursement rates for the most commonly used agents, creating disincentives for hospitals to use them and limiting Medicare beneficiaries' access to them. He suggested all drugs should be paid separately, using HCPCS codes as identifiers, so CMS can gather necessary data. He asked the Panel to recommend that drug reimbursement rates be given a high priority for CMS review.

Sharon Cohen of the Biotechnology Industry Organization said the current CMS methodology is biased against more expensive drugs (see Presentation Appendix 17). The cost-to-charge ratio does not take into account that the hospital mark-up for lower-cost drugs is more than it is for higher-cost drugs. She urged CMS to craft an interim solution to APC packaging. Ms. Cohen further asked that CMS exclude "orphan" drugs from packaging.

Ms. Shah, representing freestanding cancer centers, again expressed concern about the loss of data when drugs are packaged. She said internal billing systems may prevent hospitals from using detailed HCPCS codes. She claimed providers were confused by a January Outpatient Prospective Payment System (OPPS) memo about options for including drugs in claims. She recommended CMS issue a Program Memo advising providers to list packaged drugs in revenue code 636. This would not affect payment and would provide data for future rate setting.

Similar comments were offered in written statements submitted by Neltner Billing and Consulting Service, which represents oncologists (see Presentation Appendix 18), and the Coalition for the Advancement of Brachytherapy (see Presentation Appendix 19).

*The Panel suggests that CMS reevaluate the packaging process on a broad scale and not just according to its effect on specific APC reimbursement rates*

*The Panel recommends that, when new APCs are created, the descriptors should be as simple as possible and the use of units of measure that could be confusing to coders and clinicians should be limited.*

With specific regard to drugs and biologicals, *the Panel recommends* CMS consider grouping drugs and radiopharmaceuticals in new APCs by both clinical use and cost in some reasonable proportion, taking into account ways to protect against the "gaming" of the system and unjustified cost drift yet also recognizing legitimate cost differences.

**Agenda Item FF. Endoscopy Lower Airway (APC 76):** Tom Byrne of Boston Scientific Corporation requested CPT code 31631 (bronchoscopy with tracheal stent placement) be moved out of APC 76 because the median cost exceeds the two-times rule (see Presentation Appendix 20). Also, because the procedure always requires radiologic guidance, no single claims are available from which to draw data for reimbursement decisions. The Panel suggested that a new APC comprised of the four highest-cost procedures in APC 76 would result in a more homogenous grouping.

*The Panel recommends* creating a new APC for the bronchoscopy CPT codes 31640, 31641, 31630, and 31631.

**Agenda Item GG. Gastrointestinal Endoscopic Stenting Procedures (APCs 141, 142, 143, and 147):** A commenter requested that a new APC be created comprised of all the gastrointestinal endoscopic stent codes. Mr. Byrne of Boston Scientific Corporation said his company submitted the suggestion but withdrew it because specialists did not support it. The Panel felt the resource requirements for placing all gastrointestinal endoscopic stents were similar.

*The Panel asked* CMS staff to create a model for later review of the payment implications of creating a new APC code that contained the following gastrointestinal endoscopic stent CPT codes: 43219 and 43256 transferred from APC 141; 44370, 44379, and 44383 transferred from APC 142; 44397 and 45387 transferred from APC 143; and 45327 and 45345 transferred from APC 147.

**Agenda Item HH. Device-Related Procedures (APCs 81, 83, 104, 222, 223, 227, 229, and others):** Commenters asked that the status indicators for these APCs (all of which include high-cost devices) be changed from T to S. CMS staff asked the Panel to consider whether there are situations in which CMS should not apply its multiple procedure discount policy.

Ms. Mensh of Advamed said the policy is untenable for hospitals, which do not pay less for devices when they are used in the context of a multiple-procedure claim (see Presentation Appendix 21). She suggested that CMS apply the reduction only to the non-device portion of the claim. Alternatively, she recommended CMS only apply the discount policy when the device cost is below a predetermined proportion of the APC cost.

The Medical Devices Manufacturers Association submitted a letter advancing these same proposals (see Presentation Appendix 22).

Dr. David Charles of Medtronic asked that APCs 222, 223, and 227 be exempt from the multiple procedure discount policy because the cost of the respective devices makes up more than 50 percent of the APC cost (see Presentation Appendix 23). Panel members were concerned that exemptions from the discount policy could result in incentives to use more devices than necessary.

Dr. Thorwarth of the ACR asked whether CMS could devise a mechanism for hospitals to account for the use of multiple devices and use the data to capture the average number of devices used and the full costs. Ms. Mensh said many hospitals have not been coding or billing for devices.

***Agenda Item HH. Device-Related Procedures (APCs 81, 83, 104, 222, 223, 227, 229, and others): (continued)***

*The Panel recommends* no changes to the status indicators for any of the device-related APCs discussed. However, *the Panel asks* that CMS staff analyze its data to determine whether CMS may be underpaying for devices when the multiple procedure discounting policy is applied. *The Panel further recommends* that CMS develop some methodology to track device costs.

***Agenda Item II. Capturing the Costs of Devices That Are Packaged Into APCs:*** Dr. Rudolf noted that because most C codes have been discontinued, future CMS data would not show device costs. CMS staff asked the Panel to consider how device costs could be accurately represented in packaged APCs.

*The Panel recommends* that CMS develop some methodology to track device costs.

***Agenda Item JJ. Discussion of Ways to Increase the Use of Multiple Claims to Set APC***

***Payment Rates:*** Ms. Jugna Shah of the freestanding cancer centers said CMS currently reimburses for multiple claims based on the date of service. She recommended that CMS divide all claims by the dates of service to increase the amount of data gathered from multiple claims (see Presentation Appendix 24). To further increase the number of multiple claims that could be used, Dean Rossiter of the Wellington Group (also representing the freestanding cancer centers) recommended CMS ignore the status K code for the purpose of gathering data.

Other suggestions were to exclude from consideration those APCs with small dollar values and to create a new code or APC specifically for the insertion and removal of devices. A representative of the American Hospital Association, however, said new codes were cumbersome to implement.

*The Panel recommends* that CMS staff explore ways to increase the number of claims used to set pay rates. The following are some potential methodologies to be considered: sort multiple claims by date of service; exclude K codes from evaluation; and/or exclude those APCs with nominal costs (the definition of "nominal" can be determined by modeling a variety of possible dollar amounts).

*The Panel also requests* that no new G codes be assigned; if new codes are needed, the Panel suggests CMS staff work with the American Medical Association's CPT Board to identify possible new codes.

**OTHER NEW BUSINESS**

The Panel established a subcommittee to review observation issues, such as allowable International Classification of Diseases (ICD) codes and operational issues. The subcommittee will consist of Panel members Lora DeWald, Lee Hillborne, Stephen House, and Mike Metro, but other Panel members are welcome to take part. The subcommittee will report its findings to the Panel in 1 year.

## APPENDIX A

### Agenda for the APC Advisory Panel Meeting, January 21-22, 2003

#### DAY ONE

Registration for members : 7:45-8:30 AM

Welcome: 8:30-8:45 AM

Liz Cusick, Deputy Director (for Tom Grissom, Director)  
Center for Medicare Management (CMM), CMS

Paul Rudolf, M.D., J.D.  
Chair, Advisory Panel on APCs

Introduction: 8:45-9:00 AM

Chair and Members of Panel Members

- A. Debridement and Destruction (APCs 12-13): 9:00-9:15 AM
- B. Excision/Biopsy (APCs 19, 20, 21): 9:15-9:30 AM
- C. Thoracentesis/Lavage Procedures and Endoscopy (APCs 71, 72, 73): 9:30-9:45 AM
- D. Cardiac and Ambulatory Blood Pressure Monitoring (APC 97): 9:45-10:00 AM
- E. Electrocardiograms (APCs 99 and 340 ): 10:00-10:15 AM
- F. Cardiac Stress Tests (APC 100): 10:15-10:30 AM
- G. Revision/Removal of Pacemakers of AICD or Vascular (APC 105): 10:30-10:45 AM
- H. Sigmoidoscopy (APCs 146-147): 10:45-11:15 AM
- I. Anal/Rectal Procedures (APCs 148, 149, 155): 11:15-11:30 AM
- J. Insertion of Penile Prosthesis (APC 182): 11:30 AM-12:00 Noon

LUNCH : 12:00-1:00 PM

- K. Female Reproductive Procedures (APCs 195, 202): 1:00-1:30 PM
- L. Surgical Hysteroscopy (APC 190): 1:30-1:45 PM
- M. Nerve Injections (APCs 203, 204, 206, 207): 1:45-2:00 PM
- N. Laminotomies and Laminectomies; Implantation of Pain Management Device (APCs 208, 223): 2:00-2:30 PM
- O. Extended EEG Studies and Sleep Studies; Electroencephalogram (APCs 209, 0213, and 214): 2:30-2:45 PM

- P. Nerve and Muscle Tests (APCs 215, 216, and 218): 2:45-3:15 PM
- Q. Implantation of Drug Infusion Device (APC 227): 3:15-3:45 PM
- R. Ophthalmologic APCs (APCs 230, 235, 236, and 698): 3:45-4:00 PM
- S. Skin Tests and Miscellaneous Red Blood Cell Tests; Transfusion Laboratory Procedures (APCs 341-345): 4:00-4:15 PM
- T. Otorhinolaryngologic Function Tests (APCs 363, 660): 4:15-4:30 PM
- U. Tube changes and repositioning (APCs 121-122): 4:30-4:45 PM
- V. Myelography (APC 274): 4:45-5:00 PM

## DAY TWO

- W. Therapeutic Radiologic Procedures (APCs 296-297): 8:30-8:45 AM
  - X. Vascular Procedures; Cannula/Access Device Procedures (APCs 103, 115): 8:45-9:00 AM
  - Y. Angiography and Venography except Extremity (APCs 279, 280, and 668): 9:00-9:15 AM
  - Z. CT, MR, and U/S Guidance procedure currently packaged: 9:15-9:45 AM
  - AA. Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast (APC 336)
  - BB. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement (APCs 260 and 261): 9:45-10:00 AM
  - CC. Chemotherapy Administration by Other Techniques Except Infusion (APC 116): 10:15-10:30 AM
  - DD. Diagnostic Nuclear Medicine Excluding Myocardial Scans (APCs 290, 291, 292, 294, and 666): 10:30-11:30 AM
  - EE. Capturing the Costs of Drugs and Biologicals packaged into APCs: 11:30 AM-12:30 PM
- LUNCH: 12:30-1:30 PM
- FF. Endoscopy Lower Airway (APC 76): 1:30-1:45 PM
  - GG. Gastrointestinal Endoscopic Stenting Procedures (APCs 141, 142, 143, and 147): 1:45-2:00 PM
  - HH. Device-related Procedures (APCs 81, 83, 104, 222, 223, 227, 229, and others): 2:00-3:00 PM
  - II. Capturing the Costs of Devices that are packaged into APCs: 3:00-4:00 PM
  - JJ. Discussion of Ways to Increase the Use of Multiple Claims to Set APC Payment Rates: 4:00-5:00 PM

## Appendix B

### Collected Recommendations of the APC Advisory Panel, January 21-22, 2003

(Key: A, B, etc. refers to agenda item; please see above)

A: The Panel recommends moving the CPT codes for debridement and destruction 15793, 15786, 11001, 16025, 16000, 15851, and 11302 from APC 13 to APC 12 and 11057 from APC 12 to 13.

B: The Panel recommends no changes to the codes for excision/biopsy (APCs 19, 20, and 21) because anticipated CPT changes will substantially affect the use of the codes. The Panel will review the issue next year if 2003 data are available.

C: For the codes for thoracentesis/lavage procedures and endoscopy, the Panel recommends moving CPT code 31505 from APC 72 to APC 71, CPT 31575 from APC 71 to APC 72, and CPT 31720 from APC 72 to APC 73.

D: The Panel recommends no changes to the codes for cardiac and ambulatory blood pressure monitoring (APC 97).

E: The Panel recommends no changes to the codes for electrocardiograms (APC 99).

F: The Panel recommends no changes to the code for cardiac stress tests (APC 100) until more data are available for review.

G: The Panel recommends no changes to the codes for revising or removing pacemakers (APC 105).

H: The Panel recommends no changes to the codes for sigmoidoscopy (APCs 146 and 147). However, the Panel would like the staff to further evaluate the reasons for the apparently aberrant costs for seemingly simple procedures through data analysis, looking specifically at anesthesia revenue centers. In addition, the Panel recommends CMS clarify the appropriate coding when the procedure performed is not as extensive as the procedure planned.

I: Regarding the codes for anal/rectal procedures, the Panel recommends no changes to APC 148. The Panel recommends moving CPT code 46040 from APC 155 to APC 149.

J: Regarding the codes for penile prostheses and other urologic devices, the Panel recommends deleting APC 179 and APC 182 and creating two new APCs, 179a and 179b, containing the following CPT codes:

179a: CPT codes 53440, 54400, 53444, 54416, and, if the data show no violation of the "two-times" rule, 52282

179b: CPT codes 53447, 54401, 54410, 54405, and 53445

K: The Panel recommends moving CPT codes 57109, 58920, and 58925 from APC 202 to APC 195.

L: In light of the suggestions about APC 190 and the various technologies used with surgical hysteroscopy, the Panel recommends that CMS coding and payment policies 1) take into account different methods of endometrial ablation associated with hysteroscopy, 2) adequately reflect the resources used for the various procedures, 3) avoid creating a competitive advantage or disadvantage, and 4) collect data needed to track costs on the type of technologies used for future consideration.

M: The Panel recommends no changes to the codes for nerve injection (APCs 203, 204, 206, and 207). However, if the code regarding botulinum toxin injection becomes packaged, the Panel would like to review it.

N: The Panel recommends no changes to the codes for laminotomies and laminectomies (APCs 208 and 223). However, the Panel would like to review data collected from the associated Health Care Financing Administration Common Procedure Coding System (HCPCS) codes in 1 year.

O: Regarding the codes for EEG and sleep studies, the Panel recommends moving CPT code 95955 from APC 214 to APC 213.

P: Regarding the codes for nerve and muscle tests, the Panel recommends moving CPT codes 95858, 95870, 95900, and 95903 from APC 218 to APC 215.

Q: The Panel recommends no changes to the code for implantation of drug infusion devices (APC 227).

R: Regarding the ophthalmologic codes, the Panel recommends moving CPT code 67820 from APC 230 to APC 698 and CPT 67110 from APC 235 to APC 236. The Panel asks that CMS staff monitor data from codes in APC 235 for possible review next year.

S: For the codes for skin tests and miscellaneous red blood cell tests, the Panel recommends moving CPT codes 86880, 86885, 86886, and 86900 from APC 341 and CPT code 86901 from APC 345 to a new APC. The Panel further recommends that CMS seek the input of the American Association of Blood Banks regarding the suggested changes.

T: For the codes for otorhinolaryngologic function tests, the Panel recommends moving CPT codes 92543 and 92588 from APC 660 to APC 363.

U: For the codes for tube changes and repositioning, the Panel recommends moving CPT codes 47530, 51710, 50688, and 62225 from APC 121 to APC 122.

V: Regarding the code for myelography, the Panel recommends moving CPT codes 72285 and 72295 from APC 274 to APC 274A.

W: Regarding the codes for therapeutic radiologic procedures, the Panel recommends no changes to APC 296 and APC 297.

X: Regarding the codes for vascular cannula/access device procedures, the Panel recommends no changes to APC 103 or APC 115. However, if cost data for catheter clearing with balloon angioplasty and without balloon angioplasty suggest a need for revision, the Panel will consider the issue in the future.

Y: Regarding the codes for angiography and venography, the Panel recommends CMS staff consult with representatives of the American College of Radiology and others with relevant expertise to rearrange CPT codes in APCs 279, 280, and 668. The Panel will discuss the proposed changes at its next meeting.

Z: Regarding the codes for computed tomography (CT), magnetic resonance (MR), and ultrasound guidance procedures that are currently packaged, the Panel recommends moving each CPT code to a specific APC as follows (CMS staff will determine whether the APCs below are appropriate): CPT 76362 (CT) to APC 332; CPT 76394 (MR) to APC 335; CPT 76490 (ultrasound) to APC 268. The Panel also recommends the status indicator codes for CPT codes 76362, 76394, and 76490 be revised as appropriate when they are moved to new APCs.

AA: The Panel recommends moving the magnetic resonance guidance code CPT 76393 to APC 335. The Panel also recommends the status indicator code for CPT 76393 be revised as appropriate when it is moved to a new APC.

BB: For the codes regarding radiography, the Panel recommends moving CPT 76120 to APC 272.

CC: The Panel recommends that CMS require hospitals to use the existing CPT codes for administration of non-infusion chemotherapy and map them to APCs 116–120 as appropriate (updating the pay rates according to the usual process). The use of the CPT codes will result in data that can be used to determine whether the APCs for chemotherapy should include a range of CPT codes.

DD: For drugs and biologicals, the Panel recommends CMS consider grouping drugs and radiopharmaceuticals in new APCs by both clinical use and cost in some reasonable proportion, taking into account ways to avoid "gaming" of the system and unjustified cost drift but recognizing legitimate cost differences. The Panel also suggests that, if new APCs for nuclear medicine are created, the descriptors should be as simple as possible, and use of units of measure that could be confusing to coders and clinicians should be limited.

EE: For drugs and biologicals, the Panel recommends CMS consider grouping drugs and radiopharmaceuticals in new APCs by both clinical use and cost in some reasonable proportion, taking into account ways to avoid gaming of the system and unjustified cost drift but recognizing legitimate cost differences. If new APCs are created, the descriptors should be as simple as possible, and use of units of measure that could be confusing to coders and clinicians should be limited.

FF: The Panel recommends creating a new APC for the bronchoscopy CPT codes 31640, 31641, 31630, and 31631.

GG: The Panel asked CMS staff to create a model for later review of the payment implications of moving the following gastrointestinal endoscopic stent CPT codes into a new APC: 43219, 43256 (from APC 141), 44370, 44379, 44383 (from APC 142), 44397, 45387 (from APC 143), 45327, and 45345 (from APC 147).

HH: The Panel recommends no changes to the status indicators for any of the device-related APCs discussed. However, the Panel asks that CMS staff analyze its data to determine whether CMS may be underpaying for devices when the multiple procedure discounting policy is applied. The Panel further recommends that CMS develop some methodology to track device costs.

II: The Panel recommends that CMS develop some methodology to track device costs.

JJ: The Panel recommends that CMS staff explore ways to increase the number of claims used to set pay rates. Some potential methodologies to be considered are as follows: sort multiple claims by date of service; exclude K codes from evaluation; exclude those APCs with nominal costs (the definition of "nominal" can be determined by modeling a variety of possible dollar amounts). The Panel also requests that no new G codes be assigned; if new codes are needed, the Panel suggests CMS staff work with the American Medical Association's CPT Board to identify possible new codes.

Meeting was adjourned at 5 PM.

## PRESENTATION APPENDICES

The following documents were presented at or submitted for the Panel meeting, January 21–22, 2003, and are appended here for the record:

- Presentation Appendix 1: Richard Cohen, Microvolt T-Wave Alternans Testing (agenda F)
- Presentation Appendix 2: Sexual Medicine Society of North America, Inc. (agenda J)
- Presentation Appendix 3a: Coalition for the Advancement of Prosthetic Urology (agenda J)
- Presentation Appendix 3b: Current and Proposed APC Assignments for Prosthetic Urology Procedures (agenda J)
- Presentation Appendix 4: Boston Scientific Corporation (agenda L)
- Presentation Appendix 5: Medtronic (agenda N)
- Presentation Appendix 6: Alcon Laboratories (agenda R)
- Presentation Appendix 7: Ortho-Clinical Diagnostics (agenda S)
- Presentation Appendix 8: NOMOS Corporation (agenda Z)
- Presentation Appendix 9: Freestanding Cancer Centers (agenda CC)
- Presentation Appendix 10: Nuclear Medicine APC Task Force (agenda DD)
- Presentation Appendix 11: Council on Radionuclides and Radiopharmaceuticals (agenda DD)
- Presentation Appendix 12: Daxor Corporation (agenda DD)
- Presentation Appendix 13: American College of Radiology (agenda EE)
- Presentation Appendix 14: Association of Community Cancer Centers (agenda EE)
- Presentation Appendix 15: Organogenesis (agenda EE)
- Presentation Appendix 16: Pharmaceutical Research and Manufacturers of America (agenda EE)
- Presentation Appendix 17: Biotechnology Industry Organization (agenda EE)
- Presentation Appendix 18: Neltner Billing and Consulting Services (agenda EE)
- Presentation Appendix 19: Coalition for the Advancement of Brachytherapy (agenda EE)
- Presentation Appendix 20: Boston Scientific Corporation (agenda FF)
- Presentation Appendix 21: AdvaMed (agenda items HH, II, & JJ)
- Presentation Appendix 22: Medical Devices Manufacturers Association (agenda HH)
- Presentation Appendix 23: Medtronic (agenda HH)
- Presentation Appendix 24: Freestanding Cancer Centers (agenda JJ)