

ADVISORY PANEL ON AMBULATORY PAYMENT CLASSIFICATION GROUPS

Recommendations – First Meeting of 2004

February 18-20, 2004

The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) made the following recommendations at its first biannual meeting from February 18 through 20, 2004:

Tab A

A-1: The Panel recommends that a new subcommittee be created to discuss the issue of packaged codes that currently receive no additional payment. Among the issues to be considered are: 1) all packaged Current Procedural Terminology (CPT) codes, not just those presented for discussion at the meeting, 2) instructions for consistency of billing throughout the Centers for Medicare & Medicaid Services (CMS) regional offices and fiscal intermediaries, 3) appropriate status indicators for procedures, and 4) whether CPT code 97602, low-level wound care, should be assigned to its own APC or incorporated into an existing APC. The subcommittee should prepare a report for the Panel's August 2004 meeting.

Tab B

B-1: The Panel recommends that CPT codes 44901, 49021, 49041, and 49061 be removed from the inpatient-only list. The Panel further recommends that the inpatient-only list be eliminated: CMS should review the list with professional specialty societies and hospital associations and—through congressional action if necessary—reallocate funds from inpatient to outpatient reimbursement consistent with clinical practice. This should include, but not be limited to, those procedures moving off the inpatient-only list. Reimbursement for procedures transitioning from primarily inpatient to primarily outpatient performance should be reviewed in an ongoing manner. If a process for eliminating the inpatient-only list cannot be established in a timely manner (e.g., within 1 year), in the interim, the Panel should evaluate the inpatient-only list with the help of professional societies and hospitals to recommend specific changes to the APC Panel.

Tab C

C-1: The Panel recommends that CMS establish new HCPCS codes and new APCs per source for the brachytherapy sources: high-activity iodine 125 per source and high-activity palladium 103 per source.

Tab D

D-1: The Panel recommends that the Free-standing Cancer Centers work with professional societies and other stakeholders to further develop its proposal to reconfigure radiation oncology APCs and provide data for discussion at the August 2004 meeting of the APC Advisory Panel.

D-2: The Panel recommends that CPT code 77418 for intensity-modulated radiation therapy (IMRT) be returned to the new technology APC 1510 for 1 year.

D-3: The Panel recommends that when CMS applies a dampening formula, CMS should highlight the adjustment in the published rule, so providers understand the reimbursement amount and can plan for future years. (NOTE: The adjustment may be limited, and future payments for the APC may be less.)

Tab F

F-1: The Panel recommends that CMS evaluate concerns about denials of appropriate reimbursement for cobalt-60 stereotactic radiosurgery and determine whether there are impediments between the Central Office and the fiscal intermediaries.

Tab H

H-1: The Panel recommends that CMS staff reevaluate the codes in APCs 41 and 42 and propose restructuring that would improve the homogeneity of codes within these APCs.

H-2: The Panel recommends no changes to APC 97.

H-3: The Panel recommends no changes to APC 99.

H-4: The Panel accepts the recommendations of the CMS staff to preserve three levels of angiographic coding (currently APCs 668, 279, and 280) and recommends that CMS adopt the proposed new configuration for the 2005 rule.

H-5: The Panel recommends that CPT codes 36568 and 36569 be moved to APC 187.

H-6: The Panel recommends that CPT code 36582 be moved to new technology APC 1522, which has an S status indicator.

H-7: The Panel recommends moving CPT codes 36557 and 36558 to APC 115.

H-8: The Panel recommends moving CPT codes 0046T and 0047T to APC 21.

H-9: The Panel recommends no changes to CPT code 76937 but asks that the status indicator for this code be reevaluated at a later meeting. The new subcommittee on packaged codes should also review this code.

H-10: The Panel recommends moving CPT code 27041 to APC 20.

H-11: The Panel recommends no other changes to APC 19.

H-12: The Panel recommends no changes to APC 235.

H-13: The Panel recommends moving CPT code 44970 to APC 131.

H-14: The Panel recommends moving CPT codes 46020 and 46706 to APC 150 and CPT codes 45005 and 45020 to APC 155.

H-15: The Panel recommends moving CPT codes 64420, 64630, 64640, and 62280 to APC 206 and CPT code 62282 to APC 203.

H-16: The Panel recommends moving CPT codes 65286, 66030, and 66625 to APC 232.

H-17: The Panel recommends moving CPT code 88346 to APC 344.

Tab H (*continued*)

H-18: The Panel recommends moving CPT code 90636 to APC 356.

H-19: The Panel recommends moving CPT codes 90740, 90723, and 90693 to APC 355 and asks for more information on the costs related to CPT code 90375.

H-20: The Panel recommends moving CPT code 94015 to APC 367.

H-21: The Panel recommends that CMS work with professional societies and hospital associations to identify the hospital acquisition costs of high-cost devices for use as an additional parameter in validating cost data.

H-22: The Panel recommends no changes to APC 600.

H-23: Regarding the use of CPT code 29580 with modifier 22, and in concert with evaluation and management codes, the Panel tabled the discussion until further data are received.

Tab J

J-1: There are different interpretations by QIOs and FIs regarding whether CMS guidelines allow for reimbursement when a patient is admitted as an inpatient and subsequently whose status is changed to observation; the Panel recommends that CMS clarify this issue definitively for all quality improvement organizations, regional offices, and fiscal intermediaries.

J-2: The Panel recommends that CMS eliminate mandatory use of diagnostic, condition-specific tests as criteria for payment under observation codes.

J-3: The Panel recommends that the payment for observation services be expanded beyond the three clinical conditions of congestive heart failure, chest pain, and asthma to include all clinical conditions for which observation status is appropriate based on medical necessity.

J-4: The Panel recommends that CMS clearly define appropriate categorization and billing instructions for 24-48-hour observation stays.

J-5: The Panel recommends when a postinterventional patient experiences an unanticipated need for extended care based on medical necessity, the patient should be given observation status and receive additional reimbursement. The Panel requests CMS monitor these claims and report findings back to the APC Panel.

J-6: When a procedure has an anticipated recovery time that exceeds the 4–6 hours already built into the procedure's APC, the additional cost should be reported using revenue code 71x or another appropriate revenue code. This information should be clarified specifically by CMS to fiscal intermediaries.

J-7: The Panel recommends that CMS allow observation hours to count toward the 3-day requirement for admission to a skilled nursing facility.

Tab J (*continued*)

J-8: The Panel recommends that CMS evaluate alternative criteria for qualifying for admission to a skilled nursing facility care.

J-9: To eliminate the need for manual evaluation of charts to record start and stop times of admission and discharge, the Panel recommends that CMS consider the following changes: the start time for observation should be the time after a physician has ordered observation based on medical necessity and the patient is placed in a bed for the purpose of observation; and stop time should be the time the patient is discharged from the hospital.

Tab K

K-1: The Panel supports the proposed definitions of an emergency department visit and a clinic visit put forth by the AHA and AHIMA in their model.

K-2: The Panel recommends that CMS work to develop a national definition of levels of emergency department and outpatient clinical services.

K-3: The Panel recommends that categorization of the level of discharge instructions be commensurate with the level of service provided for an emergency department or clinic encounter.

Tab L

L-1: The Panel recommends that CMS proceed with evaluation of the APCs and codes identified in Tab L for possible placement on the bypass list. The Panel also suggests claims from APC 313 be evaluated closely.

L-2: The Panel recommends that CMS continue to evaluate ways to increase the amount of useful data from single claims.

Tab M

M-1: The Panel asks CMS to devise a methodology that reasonably collects data on the costs of medical devices.

M-2: Until a better methodology for collecting device cost data is in place, the Panel recommends that device-related APCs for 2005 be set using the 2002 claims data that were used to create the 2004 Outpatient Prospective Payment System, with the addition of an appropriate adjustment for inflation.

M-3: Until a better methodology for collecting device cost data is in place, the Panel recommends that the use of C codes be mandatory, not voluntary.

M-4: In addition to not using data more recent than 2002 (item M-2), the Panel recommends that CMS accept and consider external data on costs of devices, particularly high-cost devices.

M-5: The Panel recommends that CMS move CPT code 33225 to APC 1513, which has an S status indicator.

Tab N

N-1: A commenter requested that CPTs 93571 and 93572 be moved to APC 670. The Panel asks CMS to review the data submitted in relation to the request; if the data support such a move, the Panel recommends that CMS move CPTs 93571 and 93572 to APC 670.

Tab O

O-1: The Panel recommends that CMS continue to evaluate the possible use of CPT codes in place of Q codes for chemotherapy and nonchemotherapy infusions; the Panel supports the use of CPT codes.

O-2: The Panel recommends that CMS clarify its billing instructions regarding infusions in different outpatient settings, e.g., operating rooms, observation areas, and emergency departments.

Tab P

P-1: The Panel recommends that CMS work swiftly and diligently to implement the use of methodology to enable filing and payment of claims for drugs newly approved by the FDA.

P-2: The Panel recommends that CMS consider temporary or placeholder codes that can be assigned rapidly after FDA drug approval to allow providers to file claims on new drugs.

P-3: The Panel recommends that CMS consider biologics, plasma-derived products and their recombinant analogs, and radiopharmaceuticals as sole-source drugs. The Panel further recommends that CMS use the FDA's *Approved Drug Products with Therapeutic Equivalence Evaluations*, also known as the *Orange Book*, as a resource to determine whether other drugs fall into the category of sole-source or multiple source.

P-4: The Panel recommends that providers be required to use the revenue codes 343 and 344 for diagnostic and therapeutic radiopharmaceuticals when they become effective later this year.

P-5: The Panel recommends that CMS work with the General Accounting Office to expand the list of drugs included on the hospital acquisition cost survey, subject to the mandates of the Medicare Modernization Act.

P-6: The Panel recommends that CMS revisit the issue of low-osmolar contrast media—including, but not limited to, codes noted by the American College of Radiology—and gather data on changing the reimbursement as appropriate.

Tab Q

Q-1: The Panel recommends that CMS use recent external data to derive reasonable costs of blood products for reimbursement purposes and adjust payments accordingly.