

Process and Information Required for a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS)

(Effective January 1, 2002)

Please note: For process and information required to apply for transitional pass-through payment status for **drugs and biologicals**, or for assignment and payment for **new pass-through device categories**, go to the main OPSS web page, currently at <http://cms.hhs.gov/medlearn/refopps.asp> to see the latest instructions. (NOTE: Due to the continuing development of the new cms.hhs.gov web site, this link may change.)

This announcement describes in detail the process and information required for applications requesting a new technology APC designation under the Medicare hospital outpatient prospective payment system (OPPS). These instructions apply solely to requests submitted on or after January 1, 2002 for assignment to a *new technology APC*.

Refer to the final rule in the November 30, 2001 *Federal Register* (66 FR 59897) for a full discussion of the criteria and information needed for a new technology APC designation. The final rule can be found at <http://cms.hhs.gov/regulations/hopps/default.asp>.

Because CMS intends to make information used in the rate setting process under the OPSS available to the public for analysis, applicants are advised that any information submitted, including commercial or financial data, is subject to disclosure for this purpose.

We will accept new technology APC applications on an ongoing basis. However, we must receive applications sufficiently in advance of the first calendar quarter in which new technology APC payment is sought to allow time for analysis, decision-making, and computer programming. The table below indicates the earliest date that new technology APC status could be implemented once a completed application and all additional information are received.

CMS Must Have Complete Application and All Necessary Information by the first business date in	Earliest Date To Be Considered For Pass-Through Status Effective. . .
March	July 1
June	October 1
September	January 1
December	April 1

PLEASE NOTE: A longer evaluation period may be required if an application is incomplete, if further information is required or if a more extensive evaluation is required in order to determine eligibility.

An application is not considered complete until—

Process and Information Required to Apply for a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS) Page 2

- All required information has been submitted, AND
- All questions related to such information have been answered.

What kinds of services are appropriate for a “new technology” APC?

- New technology APCs are reserved for a comprehensive service or procedure that is truly new and significant enough to warrant having its own code under the Healthcare Common Procedure Coding system (HCPCS). However having a unique HCPCS code is not, in and of itself, sufficient to be considered for a new technology APC.
- New technology APCs are intended to provide payment under the OPSS for complete services or procedures that cannot be appropriately billed under an existing HCPCS code or APC. The most important criterion in determining whether a technology is “truly new” is the inability to describe appropriately, and without redundancy, the complete service with a current individual HCPCS code or combination of codes.
- A service that qualifies for a new technology APC may be a complete, stand-alone service (for example, water-induced thermotherapy of the prostate) or it may be a service that would always be billed in combination with other services (for example, coronary artery brachytherapy). We are not making eligibility for new technology APCs contingent on hospitals not billing other HCPCS codes in conjunction with a proposed new technology procedure.
- A new technology service or procedure, even though billed in combination with other, previously existing procedures, describes a distinct procedure with a beginning, middle, and end.

What kinds of services are NOT appropriate for a “new technology” APC?

- A device, drug, biologic, radiopharmaceutical, product, or commodity for which transitional pass-through payment could be made under section 1833(t)(6) of the Social Security Act is not appropriate for a new technology APC.
- Items, materials, supplies, apparatuses, instruments, implements, or equipment whose costs are appropriately packaged into existing APC groups and that are used to accomplish more comprehensive services or procedures which are appropriately described by existing HCPCS codes are not eligible payment under a new technology APC.
- Drugs, supplies, devices, and equipment do not describe a distinct procedure with a beginning, middle, and end, and therefore are not be eligible for new technology APCs.
- Items, supplies or equipment used as a tool or that serve as an aid in performing a variety of procedures, such as a scalpel, are not appropriate for a new technology APC.
- Integral components of HCPCS codes such as preparing a patient for surgery or preparation and application of a wound dressing for wound care are not eligible for consideration for a new technology APC.

To be considered for a new technology APC does a service or procedure have to have been given its own CPT code (Level I HCPCS) or received prior approval for an alphanumeric code (Level II HCPCS)?

No. Lacking an appropriate CPT code (Level I HCPCS) or alpha-numeric Level II HCPCS code, a service or procedure might only be described by using a combination of several existing codes. This coding mixture may not fully and accurately define the service and fail to take into account all the resources required to deliver the comprehensive service. If, upon review, we find that the service meets the criteria for a new technology APC, we would consider creating a Level II HCPCS code to describe the procedure comprehensively. Hospitals would use the new Level II HCPCS code to bill under the OPSS for the new technology service rather than relying on a random combination of existing codes in an

Process and Information Required to Apply for a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS) Page 3

attempt to approximate a description of the service. The Level II HCPCS code would be assigned to the new technology APC whose payment level most closely represents in the aggregate all of the resources needed to furnish the service.

Does having a HCPCS code mean that Medicare will pay for a service under the OPSS?

No. Neither assignment of a HCPCS code nor approval of a service for a new technology APC assures coverage of the specific item or service in a given case. To receive payment, a new technology service must be considered reasonable and necessary; and each use of a new technology service is subject to medical review for determination of whether its use was reasonable and necessary.

If CMS assigns an alphanumeric HCPCS code to a service in order to allow payment for the service under the OPSS in a new technology APC, does that mean the service will subsequently be approved for a national Level I or Level II HCPCS?

No. The American Medical Association is solely responsible for the creation of codes under the Current Procedural Terminology (CPT), also known as Level I HCPCS codes. National HCPCS codes (Level II alphanumeric codes) are established separately, in accordance with the annual HCPCS cycle that is described at <http://cms.hhs.gov/medicare/hcpcs/default.asp>. The code that CMS assigns to facilitate billing and payment in a new technology APC is independent of the other two coding systems and intended solely for hospitals to use when billing under the OPSS.

If a new national HCPCS code, either Level I or Level II, is created explicitly for a service during the AMA or CMS annual coding update process, does that mean the service automatically qualifies for payment under a new technology APC?

No. In order to be paid for under a new technology APC, a service or procedure has to meet the definition of services eligible for a new technology APC and all of the applicable criteria for assignment to a new technology APC. Those criteria are listed below.

How are new technology APCs different from other APC groups?

- New technology APCs are defined solely on the basis of cost and not the clinical characteristics of a service.
- The payment rate for each new technology APC is based on the midpoint of a range of costs, not on a relative payment weight.

Which APC groups are new technology APCs?

The new technology APC groups are numbered from 970 through 985 plus APC 989 and from 706 through 721 plus APC 725. Services assigned to APCs 970 through 985 and APC 989 are subject to multiple procedure payment reductions. Services assigned to APCs 706 through 721 and APC 725 are not discounted when furnished with other procedures or services.

Who may apply? Device manufacturers, hospitals, or any interested party may apply to have a new service assigned to a new technology APC.

What are the criteria that a service must meet to be eligible for a new technology APC?

To be assigned to a new technology APC, the following criteria have to be met.

- The service is one that could not have been adequately represented in the claims data being used for the most current annual OPSS payment update.

Process and Information Required to Apply for a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS) Page 4

- The service does not qualify for an additional payment under the transitional pass-through provisions established under section 1833(t)(6) of the Social Security Act and in Subpart G, Transitional Pass-through Payments in the regulations at 42 CFR 419.
- The service cannot reasonably be placed in an existing APC group that is appropriate in terms of clinical characteristics and resource costs.
- The service falls within the scope of Medicare benefits under section 1832(a) of the Act.
- The service is determined to be reasonable and necessary in accordance with section 1862(a)(1)(A) of the Social Security Act.

How long is a service eligible for payment in a new technology APC

A service is paid under a new technology APC until sufficient claims data have been collected to allow CMS to assign the procedure to an existing APC group that is appropriate in clinical and resource terms. We expect this to occur within two to three years from the time a new HCPCS code becomes effective. However, if we are able to collect sufficient claims data in less than two years, we would consider reassigning the service to an appropriate APC. Or, if we do not have sufficient data at the end of three years upon which to base reassignment to an appropriate APC, we would keep the service in a new technology APC until adequate data become available.

What has to be in an application for classification to a new technology APC?

To enable CMS to make an appropriate determination that the criteria for a new technology APC designation are met, applications for an additional device category **must** include all of the information listed below. A separate application is required for each distinct new technology APC classification that is being requested. An application that does not include all of the following information is considered incomplete and cannot be acted upon:

1. The name by which the service is most commonly known.
2. A clinical vignette, including patient diagnoses that the service is intended to treat, the typical patient, and a description of what resources are used to furnish the service by both the facility and the physician. For example, for a surgical procedure this would include staff, operating room, and recovery room services as well as equipment, supplies, and devices, etc.
3. A list of any drugs or devices used as part of the service that require approval from the Food and Drug Administration (FDA) and information to document receipt of FDA approval/clearances and the date obtained.
4. A description of where the service is currently being performed (by location) and the approximate number of patients receiving the service in each location.
5. An estimate of the number of physicians who are furnishing the service nationally and the specialties they represent.
6. Information about the clinical use and efficacy of the service such as peer-reviewed articles.
7. The CPT or HCPCS Level II code(s) that are currently being used to report the service and an explanation of why use of these HCPCS codes is inadequate to report the service under the OPSS.
8. A list of the CPT or HCPCS Level II codes for all items and procedures that are an integral part of the service. This list should include codes for all procedures and services that, if coded in addition to the code for the service under consideration for new technology status, would represent unbundling.
9. A list of all CPT and HCPCS Level II codes that would typically be reported in addition to the service.
10. A proposal for a new HCPCS code, including a descriptor and rationale for why the descriptor is appropriate. The proposal should include the reason why the service does not

Process and Information Required to Apply for a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS) Page 5

- have a CPT or HCPCS Level II code, and why the CPT or HCPCS Level II code or codes currently used to describe the service are inadequate.
11. An itemized list of the costs incurred by a hospital to furnish the new technology service, including labor, equipment, supplies, overhead, etc.
 12. Name(s), address(es), e-mail addresses and telephone number(s) of the party or parties making the request and responsible for the information contained in the application. If different from the requester, give the name, address, e-mail address, and telephone number of the person that CMS should contact for any additional information that may be needed to evaluate the application.
 13. Other information as CMS may require to evaluate specific requests or that the applicant believes CMS may need to evaluate the application.

WHERE TO SEND APPLICATIONS

Mail **three** copies of each completed application to the following address:

OPPS New Tech APC
Division of Outpatient Care
Mailstop C4-05-17
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Questions pertaining to the pass-through payment application process may be sent via e-mail to the Division of Outpatient Care mailbox, OutpatientPPS@cms.hhs.gov or by phone to 410-786-0387.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0860. The time required to complete this information collection is estimated to average 10 (hours/minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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