

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Advisory Panel on Ambulatory Payment Classification (APC) Groups February 17–18, 2010

Recommendations

Visits and Observation Issues

1. The Panel recommends that CMS study the feasibility of expanding the extended assessment and management composite APC methodology to include services commonly furnished in conjunction with visits and observation services, such as drug infusion, electrocardiogram, and chest x-ray.
2. The Panel recommends that CMS continue to report on clinic and emergency department visits and observation services in the claims data and, if CMS identifies changes in patterns of utilization or cost, that it bring those issues before the Visits and Observation Subcommittee for future consideration.
3. The Panel requests that CMS provide information about the common diagnoses and services furnished with critical care services.
4. The Panel recommends that the work of the Visits and Observation Subcommittee continue.

Packaging Issues

5. The Panel recommends that CMS consider whether CPT code 31627, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation*, should be packaged or paid separately; if it should be paid separately, CMS should investigate the appropriate APC assignment. The Panel suggests CMS use bronchoscopic ultrasonography as a clinical example for comparison.
6. The Panel recommends that CMS make CPT codes 96368, *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion*, and CPT code 96376, *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular, each additional sequential intravenous push of the same substance/drug provided in the facility (List separately in addition to code for primary procedure)*, separately payable in the CY 2011 OPPTS/ASC final rule at an appropriate payment rate as determined by CMS.
7. The Panel recommends that CMS conditionally package payment for the guidance procedures that would accompany breast needle placement (specifically CPT code 19290, *Preoperative placement of needle localization wire, breast*; CPT code 19291, *Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)*);

CPT code 19295, *Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)*; CPT code 77031, *Stereotactic localization guidance for breast biopsy or needle placement (e.g., for wire localization or for injection)*, each lesion, radiological supervision and interpretation; CPT code 77032, *Mammographic guidance for needle placement, breast (e.g., for wire localization or for injection)*, each lesion, radiological supervision and interpretation; CPT code 76942, *Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation*) when these guidance services are performed separately.

8. The Panel encourages the public to submit common clinical scenarios involving currently packaged HCPCS codes and recommendations of specific services or procedures for which payment would be most appropriately packaged under the OPPS for review by the Packaging Subcommittee members.
9. The Panel recommends that CMS continue providing analysis on an ongoing basis of the impact on beneficiaries of the multiple imaging composite APCs as data become available.
10. The Panel recommends that the work of the Packaging Subcommittee continue.

Data Issues

11. The Panel recommends that CMS present to the Data Subcommittee an analysis of the effect of using a different lower-level threshold in the overall cost-to-charge-ratio error trim as part of the standard methodology.
12. The Panel recommends that the work of the Data Subcommittee continue.

APC Placement Issues

13. The Panel recommends that CMS remove the following procedures from the inpatient list:
 - HCPCS code 21193, *Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft*
 - HCPCS code 21395, *Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)*
 - HCPCS code 25909, *Amputation, forearm, through radius and ulna; re-amputation*
14. To support stem cell transplantation, the Panel recommends that CMS consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue.

15. The Panel recommends to CMS that HCPCS code 15340, *Tissue cultured allogeneic skin substitute; first 25 sq cm or less (Apligraf)*, and HCPCS code 15341, *Tissue cultured allogeneic skin substitute; each additional 25 sq cm (Apligraf)*, remain in APC 0134, *Level II Skin Repair*.

Drugs, Biologicals, Radiopharmaceuticals, and Pharmacy Overhead

16. The Panel recommends that CMS analyze claims data for the tumor imaging APCs in terms of the average, median, and range of costs of packaged diagnostic radiopharmaceuticals.
17. The Panel recommends that CMS continue to evaluate the impact of its drugs and biologicals overhead payment policy on hospitals.
18. The Panel recommends that CMS (1) reallocate a larger portion (relative to the CY 2010 final rule) of the pharmacy overhead costs from packaged drugs to separately payable drugs, and (2) evaluate the impact on hospitals (categorized by type and size) of such reallocation and present that analysis to the Panel at its next meeting.