Revised 4/3/2006

ADVISORY PANEL ON AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS

Bi-Annual Meeting - March 1-2, 2006

APC Panel Recommendations

PACKAGING ISSUES

1. **The Panel recommends** that CMS maintain the packaged status of HCPCS code 0152T , *Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, chest radiograph(s).*
2. **The Panel recommends** that CMS pay separately for HCPCS code 0069T, *Acoustic heart sound recording and computer analysis; acoustic heart sound recording and computer analysis only (List separately in addition to codes for electrocardiography*).
3. **The Panel recommends** that CMS pay separately for CPT code 96523, *Irrigation of implanted venous access device for drug delivery systems site, post surgical or interventional procedure (e.g. angioseal plug, vascular plug,* if there are no separately payable OPPS services on the claim.
4. **The Panel recommends** that CMS pay separately for CPT code 36540, *Collection of blood specimen from a completely implantable venous access device,* if there are no separately payable OPPS services on the claim.
5. **The Panel recommends** that CMS pay separately for CPT code 36600, *Arterial puncture, withdrawal of blood for diagnosis*, if there are no separately payable OPPS services on the claim.
6. **The Panel recommends** that CMS pay separately for CPT code P9612, *Catheterization for collection of specimen, single patient, all places of service,* if there are no separately payable OPPS services on the claim.
7. **The Panel recommends** that CMS maintain the packaged status of CPT code 36500, *Venous catheterization for selective organ blood sampling.*
8. **The Panel recommends** that CMS pay separately for CPT code 75893, *Venous sampling through catheter, with or without angiography (e.g., for parathyroid hormone, renin), radiological supervision and interpretation*, if there are no separately payable OPPS services on the claim.
9. **The Panel recommends** that CMS maintain the packaged status of the following:
   - CPT code 74328, *Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation*
   - CPT code 74329, *Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation*
   - CPT code 74330, *Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation*
10. **The Panel recommends** that CMS maintain the packaged status of HCPCS code G0269, *Placement of occlusive device into either a venous or arterial access site, post surgical or intervention procedure.*

11. **The Panel recommends** that CMS maintain the packaged status of the following:
    - CPT code 76937, *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)*
    - CPT code 75998, *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)*
12. **The Panel recommends** that CMS maintain the packaged status of the following:
    - CPT code 76001, *Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)*
    - CPT code 76003, *Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)*
    - CPT code 76005, *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction*
13. **The Panel recommends** that CMS continue to separately pay for CPT code 76000, *Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (e.g., cardiac floruoscopy).*
14. **The Panel recommends** that CMS provide separate payment for the following:
    - CPT code 94760, *Noninvasive ear or pulse oximetry for oxygen saturation; single determination*
    - CPT code 94761, *Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise)*
    - CPT code 94762, *Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (separate procedure)*
15. **The Panel recommends** that CMS pay separately for CPT code 38792, *Injection procedure; for identification of sentinel node,* if there are no separately payable OPPS services on the claim.
16. **The Panel recommends** that CMS bring data to the next Panel meeting that show the following:
    - How the costs of packaged items and services are incorporated into the median costs of APCs
    - How the costs of these packaged items and services influence payments for associated procedures
17. **The Panel recommends** that the Packaging Subcommittee continue until the next APC Panel meeting.

OBSERVATION ISSUES

18. **The Panel accepts** the Observation Subcommittee's report, including the request to review additional data at the 2007 winter meeting of the APC Panel.
19. **The Panel recommends** that the Observation Subcommittee continue until the next APC Panel meeting.

DATA AND DEVICE-RELATED APC ISSUES

20. **The Panel recommends** that CMS continue exploring the benefits of reverse editing for devices that are reported on claims without HCPCS codes for procedures describing their insertion or implantation.
21. **The Panel recommends** that the Data Subcommittee continue until the next APC Panel meeting.
22. **The Panel recommends** that CMS maintain the following in APC 0087, Cardiac Electrophysiologic Recording/Mapping:
    - CPT code 93609, *Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)*
    - CPT code 93613, *Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)*
    - CPT code 93631, *Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction*

INPATIENT-ONLY LIST ISSUES

23. **The Panel recommends** that CMS consult with the relevant medical specialty societies before removing the following from the inpatient list:
    - CPT code 61720, *Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus*
    - CPT code 62000, *Elevation of depressed skill fracture; simple, extradural*
    - CPT code 64802, *Sympathectomy, cervicothoracic*
    - CPT code 57292, *Construction of artificial vagina; with graft*
    - CPT code 57335, *Vaginoplasty for intersex state*
    - CPT code 16035, *Escharotomy; initial incision*
24. **The Panel recommends** that CMS remove CPT code 21181, *Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial*, from the inpatient list.

BRACHYTHERAPY ISSUES

25. **The Panel recommends** that CMS reevaluate proposed payment for brachytherapy services in APC 0651, Complex Interstitial Radiation Source Application, for 2007.
26. **The Panel recommends** that CMS formally work with the Coalition for the Advancement of Brachytherapy, American Brachytherapy Society, and the American Society for Therapeutic Radiation and Oncology to evaluate the methodology for setting brachytherapy service payment rates in APC 0651, Complex Interstitial Radiation Source Application, going forward.

SPECIFIC APC ISSUES

Fracture/Dislocation Procedures

27. **The Panel recommends** that CMS continue to evaluate the refinement of APC 0046, Open/Percutaneous Treatment Fracture or Dislocation, into at least three APC levels, with consideration of a fourth level should data support this additional level.

MEG Procedures

28. **The Panel recommends** that CMS move the following from their current New Technology APCs to clinical APC(s):
    - CPT code 95965, *Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)*
    - CPT code 95966, *MEG, recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)*
    - CPT code 95967, *MEG, recording and analysis; for evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)*

Mesh/Prosthesis Procedures

29. **The Panel recommends** that CMS move CPT code 57267, *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)*, from APC 0154, Hernia/Hydrocele Procedures, to a clinically and resource-appropriate APC.

Skin Replacement & Skin Substitute Procedures

30. **The Panel recommends** that CMS move the following CPT codes to APC 0027, Level IV Skin Repair:
    - CPT 15170, *Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*
    - CPT 15175, *Acellular dermal replacement, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*
    - CPT 15320, *Allograft skin for temporary wound closure, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*
    - CPT 15340, *Tissue cultured allogeneic skin substitute; first 25 sq cm or less*
    - CPT 05360, *Tissue cultured allogeneic dermal substitute; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children*
    - CPT 15365, *Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*
    - CPT 15420, *Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*
    - CPT 15430, *Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children*

31. **The Panel recommends** that CMS move the following to APC 0025 (Level II Skin Repair):
    - CPT 15171, *Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*
    - CPT 15176, *Acellular dermal replacement, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*
    - CPT 15321, A*llograft skin for temporary wound closure, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*
    - CPT 15341, *Tissue cultured allogeneic skin substitute; each additional 25 sq cm*
    - CPT 15361, *Tissue cultured allogeneic dermal substitute; trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*
    - CPT 15366, *Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children*
    - CPT 15421, *Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)*
    - CPT 15431, *Acellular xenograft implant; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof (List separately in addition to code for primary)*

Artificial Cornea Procedure

32. **The Panel recommends** moving CPT code 65770, *Keratoprosthesis,* to a more appropriate APC in order to make appropriate payment.

Percutaneous Renal Cryoablation

33. **The Panel recommends** that CMS move CPT 0135T, *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy,* from APC 0163, Level IV Cystourethroscopy and other Genitourinary Procedures, to APC 0423, Level II Percutaneous Abdominal and Biliary Procedures.

Radiology

34. **The Panel reaffirms** the 2005 recommendation that CMS postpone implementation of the multiple procedure reduction policy for imaging services as included in the CY 2006 OPPS proposed rule for CY 2007, so CMS can gather more data on the efficiencies associated with multiple imaging procedures that may already be reflected in OPPS payment rates for imaging services.
35. **The Panel recommends** that CMS review payment rates for computed tomography and computed tomographic angiography procedures to ensure that their payment rates are comparatively consistent and that they accurately reflect resource use.
36. **The Panel recommends** that CMS invite comments on ways that hospitals can uniformly and consistently report charges and costs related to radiology services.

Medication Management Therapy Services

37. **The Panel recommends** that CMS provide guidance to hospitals on how and when the these codes should be used, instruct hospitals to report the services under revenue code 940 on the UB-92, and create a new APC—with a nominal payment—for the following:
    - CPT 0115T, *Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, with assessment and intervention if provided; initial encounter*
    - CPT 0116T, *Medication therapy management; subsequent encounter*
    - CPT 0117T, *Medication therapy management; each additional 15 minutes*
38. **The Panel recommends** that CMS implement the previous assignment in July, if possible; otherwise, implementation should be set for CY 2007 at the latest.

DRUG & DRUG ADMINISTRATION, BIOLOGICAL & RADIOPHARMACEUTICAL ISSUES

Drug Administration

39. **The Panel recommends** that CMS use the bypass methodology presented for additional hours of drug infusion in developing a drug administration payment structure that includes a methodology to pay for infusion services by the hour.

Drugs and Biologicals

40. **The Panel recommends** that CMS examine pharmacy overhead cost issues and work with appropriate associations to study how to measure pharmacy overhead costs.
41. **The Panel recommends** that CMS also solicit feedback on how pharmacy overhead costs should be reimbursed in the future.
42. **The Panel recommends** that CMS maintain the $50 packaging threshold or, if the threshold is reevaluated, that CMS provide the Panel with data that indicate the costs of packaged drugs that are incorporated into drug administration payment rates.

Radiopharmaceuticals

43. **The Panel recommends** that CMS work with stakeholders to continue to develop a methodology to pay for radiopharmaceuticals.

IVIG

44. **The Panel recommends** that CMS work with the Plasma Protein Therapeutics Association and other stakeholders to develop appropriate payments for intravenous immunoglobulin (IVIG).
45. **The Panel recommends** that CMS maintain separate payment for IVIG preadministration-related services as long as it remains appropriate.
46. **The Panel recommends** that CMS reevaluate payments for IVIG administration, especially considering the resource intensity of IVIG infusions.