

APC 0336: Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast

A commenter requested that we change CPT code 76393 (MR guidance for needle placement) from a packaged status to a separately payable status within APC 0336. Based on clinical homogeneity considerations, the Panel agreed with the commenter and recommended that CPT code 76393 be changed from a status indicator of N to a status indicator of S and placed in APC 0335. We propose to accept the Panel's recommendation.

bb. Plain Film Except Teeth; Plain Film Except Teeth Including Bone Density Measurement.

APC 0260: Level I Plain Film Except Teeth.

APC 0261: Level II Plain Film Except Teeth Including Bone Density Measurement.

APC 0272: Level I Fluoroscopy.

A commenter requested that we move CPT codes 76120 (Cine/video x-rays) and 76125 (Cine/video x-rays add-on) from APC 0260 to APC 0261. However, a presenter to the Panel argued that these CPT codes are fluoroscopic procedures that should not be grouped with Level I radiography procedures. The Panel recommended that we move CPT code 76120 from APC 0260 to APC 0272 and that CPT code 76125 remain in APC 0260. This change makes the APCs more clinically coherent. We propose to accept the Panel's recommendation.

cc. Chemotherapy Administration by Other Technique Except Infusion.

APC 0116: Chemotherapy Administration by Other Technique Except Infusion.

A presenter to the Panel requested that we split APC 0116 into three APCs according to the method of administration: (a) Subcutaneous or intramuscular administration (CPT code 96400); (b) "push" administration (CPT code 96408); and (c) central nervous system administration (CPT code 96450). The presenter also requested that existing CPT codes should replace the more nonspecific Q codes for administration of chemotherapy because the CPT codes would provide more detailed data on methods of chemotherapy administration, which could be used for future payment policy decisions. Another presenter agreed with this request and stated that CPT codes are preferable to Q codes because other payers require CPT codes.

The Panel agreed with the above suggestions to split APC 0116 into 3 APCs according to the method of administration. The Panel recommended that we require hospitals

to use the existing CPT codes (for example, 96400, 96408, and 96450) for administration of chemotherapy and map them to APCs 0116, 0117, and 0118, as appropriate. The Panel also recommended that payment rates be based on current Q code cost data until cost data for the CPT codes are available. These cost data would be used to determine whether to change the APC structure for chemotherapy administration.

We propose not to accept the Panel's recommendations to split APC 0116 into 3 APCs and to use CPT codes for administration of chemotherapy. We would consider such a split in the future but would like to first address the administration of drugs issue. We believe that making a change in APC 116 would be too complicated for hospitals given the changes for administration in general that we are considering in this proposed rule for implementation in CY 2004. We will consider such a split for APC 116 for CY 2005. We also believe the use of CPT codes would be burdensome to hospitals, would require extensive education, and would result in a significant amount of miscoding. The CPT codes for infusion therapy are based on the service furnished per hour. We do not believe that all hospitals routinely record the start and stop time for infusion therapy and that doing so in order to be able to bill the proper number of hours of infusion therapy could be very burdensome for them. Moreover, the historic cost data on which we base the payment for the service is reported on a per visit basis (much easier to cull from the record than the number of hours of service) and if we changed to CPT codes for these services, we would be unable to convert the charge/cost data now on a per visit basis to a per hour basis (as required by the CPT code) for budget neutrality purposes. Please see section VI of this proposed rule for further discussion on payments for drugs and drug administration.

dd. Capturing the Costs of Drugs and Biologicals Packaged Into APCs.

APC 0290: Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans.

APC 0291: Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans.

APC 0292: Level III Diagnostic Nuclear Medicine Excluding Myocardial Scans.

APC 0294: Level II Therapeutic Nuclear Medicine.

APC 0666: Myocardial Add-on Scans.

We told the Panel that APCs 0290 and 0291 appear to violate the 2 times rule. Several presenters to the Panel expressed concern that our cost data are

inadequate because of confusion over coding due to changes in codes and coding instructions for these procedures, poor hospital reporting of radiopharmaceutical use, and the use of single (not multiple) claims in determining costs. One presenter claimed that the current cost data used for CPT code 78122 (Whole blood volume determination) underestimated real costs because of confusion about whether to code radiopharmaceuticals on a "per dose" basis or "per millicurie" basis. This presenter requested that we move CPT code 78122 from APC 0290 to the higher paying APC 0292.

Other presenters agreed with these concerns and said they were applicable to payments for all drugs, not just radiopharmaceuticals. These commenters were also concerned about the loss of drug-specific data due to packaging because hospitals would have no incentive to code, and thereby, identify, packaged drugs.

Pass-through payments for 236 drugs, biologicals, and radiopharmaceuticals expired as of 2003, and these items are now paid either separately or packaged with the procedures with which they are associated. Drugs and radiopharmaceuticals with median costs for administration of \$150 or less were packaged. Beginning in 2003 claims data will not provide specific cost information for packaged items. We requested input from the Panel for methods to determine drug costs.

Panel members were concerned that packaging the costs of radiopharmaceuticals into procedures would result in underpayments for the service because we lack adequate data on the cost of radiopharmaceuticals. They were also concerned about creating incentives to use radiopharmaceuticals based on cost rather than clinical efficacy. The Panel recommended that we consider grouping drugs and radiopharmaceuticals into new APCs taking into account both their cost and clinical use. The Panel further recommended that, if new APCs for radionuclides are created, the descriptors should be as simple as possible and use of confusing units of measure should be limited.

Due to the packaging of radiopharmaceuticals into the APC payments for nuclear medicine procedures, we, along with commenters have expressed concern to the Panel regarding whether the current nuclear medicine APC structure is homogeneous in terms of resource consumption. We have reviewed information about the use and cost of various