

Letter to CMS HOPD on C-APC 8011

In the 2025 OPPTS Proposed Rule, CMS discusses changes to C-APC packaging. You state, “For CY 2025, we do not propose any changes to the overall packaging policy discussed. We propose to continue to conditionally package the costs of selected newly identified ancillary services into payment for a primary service where we believe that the packaged item or service is integral, ancillary, supportive, dependent, or adjunctive to the provision of care that was reported by the primary service HCPCS code.” I would like CMS to reconsider their packing rules for C-APC 8011, Observation services.

As you are aware, in the 2016 OPPTS Final Rule, you defined the parameters for payment of C-APC 8011 which includes a requirement for payment that the claim “Does not contain a procedure described by a HCPCS code to which we have assigned status indicator “T.” We believe this requirement violates the basic tenet of your packaging concept in that the primary service provided to such patients is the 8 or more hours of Observation services and the SI=T procedure which is provided is ancillary to that primary service.

For example, the patient who has a syncopal episode and requires a laceration repair that is coded with a SI=T HCPCS code, such as HCPCS 12032, and then is hospitalized for observation services for more than 8 hours, and usually more than 24 hours, would result in a claim that hits that exclusion for payment for C-APC 8011. The ancillary service, the repair of the laceration, would exclude payment for the Observation services, the primary service provided to the patient.

The same situation occurs with patients placed outpatient with observation services who are determined to need gastrointestinal endoscopy during their outpatient hospitalization. Once again, the endoscopy procedure, an SI=T procedure, negates the eligibility for payment of C-APC 8011.

In essence, in these situations, under the current payment rules, the hospital provides more necessary services to the patient but is paid significantly less than if that SI=T procedure was not done. Since there is no payment for C-APC 8011, with a base payment rate for 2024 of \$2,610.71, the hospital will instead receive line item payment for the ED facility visit (\$270-\$612), the SI=T procedure (\$370-900), and perhaps a small payment for an EKG or other minor study.

The request is that CMS remove the rule that the presence of an SI=T procedure exclude payment of C-APC 8011 but instead reverse the process and have that SI=T procedure bundle into C-APC 8011, as do SI= Q procedures.