CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Advisory Panel on Hospital Outpatient Payment (HOP)
February 27–28, 2012

Recommendations

Drugs and Biologicals

The Panel recommends that CMS require hospitals to bill all drugs that are described by Healthcare Common Procedure Coding System (HCPCS) codes under revenue code 636.

The Panel recommends that CMS exclude data from hospitals that participate in the 340B program from its ratesetting calculations for drugs.

The Panel recommends that CMS freeze the packaging threshold at $75 until the drug payment issue is more equitably addressed.

The Panel recommends that CMS pay hospitals for separately payable drugs at a rate of average sales price (ASP) plus 6 percent.

Visits and Observation Issues

The Panel recommends that CMS examine data for discharge status, point of entry, age, primary and secondary diagnoses, and type of hospital (teaching, non-teaching, rural, urban) for patients receiving greater than 48 hours of observation services, if available, and report the findings to the Visits and Observation Subcommittee.

The Panel recommends that CMS continue to report clinic/emergency department visit and observation claims data and, if CMS identifies changes in patterns of utilization or cost, that CMS bring those issues to the Visits and Observation Subcommittee.

The Panel recommends that the Visits and Observation Subcommittee review claims data for HCPCS code G0379, *Direct admission of patient for hospital observation care*, and consider the appropriate Ambulatory Payment Classification (APC) group for the code.

The Panel recommends that the work of the Visits and Observation Subcommittee continue.

APC Groups and SI Issues

The Panel recommends that the results of CMS' study on unconditionally packaged HCPCS code G0378, *Hospital observation service, per hour*, be presented to the Visits and Observation Subcommittee.

The Panel recommends that CMS delete HCPCS code G0259, *Injection procedure for sacroiliac joint; arthrography*, and HCPCS code G0260, *Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography*, and instead use CPT code 27096, *Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed*, with a SI of T, and assign CPT code 27096 to APC 0207, *Level III Nerve Injections*.

The Panel recommends that CMS provide data to the APC Groups and SI Subcommittee on the following arthrography services, so that the Subcommittee can consider whether the SI for these services should be changed from N to S:

- ☐ HCPCS code 21116, *Injection procedure for temporomandibular joint arthrography*
- ☐ HCPCS code 23350, *Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography*
- ☐ HCPCS code 24220, *Injection procedure for elbow arthrography*
- ☐ HCPCS code 25246, *Injection procedure for wrist arthrography*
- ☐ HCPCS code 27093: *Injection procedure for hip arthrography; without anesthesia*
- ☐ HCPCS code 27095: *Injection procedure for hip arthrography; with anesthesia*
- ☐ HCPCS code 27096, *Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or ct) including arthrography when performed HCPCS code*
- ☐ 27370, *Injection procedure for knee arthrography*
- ☐ HCPCS code 27648, *Injection procedure for ankle arthrography*

The Panel recommends that CMS change the SI for HCPCS code 19290, *Preoperative placement of needle localization wire, breast*; from N to Q1 and continue to monitor the frequency of the code when used in isolation.

The Panel recommends that Judith Kelly, R.H.I.T., R.H.I.A., C.C.S., remain the chair of the APC Groups and SI Subcommittee.

The Panel recommends that the work of the APC Groups and SI Subcommittee continue.

Data Issues

The Panel recommends that Kari S. Cornicelli, C.P.A., FHFMA, serve as the acting chair of the Data Subcommittee for the February 2012 HOP Panel meeting.

The Panel recommends that the work of the Data Subcommittee continue.

Supervision of Outpatient Services

The Panel recommends that CMS designate the following services as appropriately conducted under general supervision in accordance with applicable Medicare regulations and policies:

- ☐ HCPCS code 90804, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient*
- ☐ HCPCS code 90806, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient*
- ☐ HCPCS code 90808, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient*
- ☐ HCPCS code 90810, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient*
- ☐ HCPCS code 90812, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient*
- ☐ HCPCS code 90814, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient*
- ☐ HCPCS code 90816, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient*
- ☐ HCPCS code 90818, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient*
- ☐ HCPCS code 90821, *Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient*

- ☐ HCPCS code 90823, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient*
- ☐ HCPCS code 90826, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient*
- ☐ HCPCS code 90828, *Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient*
- ☐ HCPCS code 90846, *Family psychotherapy (without the patient present)*
- ☐ HCPCS code 90847, *Family psychotherapy (conjoint psychotherapy) (with patient present)*
- ☐ HCPCS code 90849, *Multiple-family group psychotherapy*
- ☐ HCPCS code 90853, *Group psychotherapy (other than of a multiple-family group)*
- ☐ HCPCS code 90857, *Interactive group psychotherapy*
- ☐ HCPCS code G0177, *Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)*
- ☐ HCPCS code G0410, *Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes*
- ☐ HCPCS code G0411, *Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes*
- ☐ HCPCS code 51701, *Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)*
- ☐ HCPCS code 90471, *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*
- ☐ HCPCS code 90472, *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)*
- ☐ HCPCS code 90473, *Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)*
- ☐ HCPCS code 90474, *Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)*
- ☐ HCPCS code 99406, *Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*
- ☐ HCPCS code 99407, *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*

The Panel recommends that CMS designate HCPCS code 94640, *Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device),* as a non-surgical extended duration therapeutic service.