

Proposed 2007 Hospital Outpatient Department (HOPD) Rule

Improve your charge capture and educate your staff on coding changes today

by Linda Gledhill, MHA,
and Barbara Constable, RN, MBA

For hospitals, 2007 will be all about “quality care,” with payment increases tied to mandatory reporting of identified quality measures. The proposed 2007 hospital outpatient department (HOPD) rule expanded quality measures to include hospital outpatient departments. Hospitals that are currently required to report quality data for inpatient services will now need to include outpatient department data when reporting on the 21 Hospital Quality Alliance (HQA) approved clinical quality measures. Hospitals that do *not* include the outpatient data will have their payments reduced by 2 percent. In other words, the Centers for Medicare & Medicaid Services (CMS) has suggested deducting 2 percentage points from the proposed 3.4 percent inflation update.

The Ambulatory Care Quality Alliance (AQA) and HQA have formed a new steering committee. Over the next year, the committee will work closely with CMS to develop unique quality measures for outpatient departments. The committee will also focus on price and quality “transparency” in an effort to provide consumers with quality information for making healthcare decisions.

Improving Charge Capture

With less than two months left in CY 2006, community cancer centers should be taking a look at *how* they update their chargemaster and identifying ways for refining,



PHOTOGRAPH/COMSTOCK

improving, or streamlining this process. Updating the way you submit and capture charges should be a team effort, and here are a few tips to help you get started.

Your clinical team should bring to the table technology trends, material and labor needs, and clinical information on your market competitors. Your marketing department should be responsible for providing information on patient population, disease trends, a review of market prices, and assistance in transparency pricing. The financial team should contribute up-to-date information on payer contracts and payer mix. Taken together, this information should provide your cancer program with a “snapshot” of the upcoming year.

Improving charge capture is challenging and labor intensive for many community cancer centers—particularly those that do not have a clear plan for integrating and implementing upcoming reimbursement changes. Some cancer programs may want to consider bringing in outside experts to identify key areas for improve-

ment. Oncology consultants, for example, can help develop and implement a chargemaster with competitive pricing. Bottom line: accurate chargemasters and effective claims processes are key and need to be reviewed and updated throughout the year.

Drug Administration

In the 2007 proposed HOPD rule, CMS will continue to use the CY 2006 OPDS drug administration coding structure. This method combines CPT codes with several C-codes and does *not* use the concepts of initial, sequential, and concurrent drug administration currently in place in private physician offices. One significant change: CMS proposes to now pay for additional hours of infusion, both therapeutic and chemotherapy. In previous years, these additional hours had been “packaged” in with the first hour’s payment.

Table 1 shows the proposed administration coding system for therapeutic infusion, push technique, and chemotherapy infusion, including 2006 payment

Table 1: Proposed 2007 Drug Administration Coding

C-Code	Description	2006 Payment Rates	2007 Proposed Payment Rates
C8950	IV Therapeutic Infusion, 1st hour	\$120.77	\$112.94
C8951	IV Therapeutic Infusion, hours 2-8 each	no payment	\$25.49
C8952	Therapeutic Push Technique	\$47.82	\$48.99
C8953	Chemotherapy Push Technique	\$68.37	\$97.84
C8954	Chemotherapy Infusion, 1st hour	\$189.04	\$154.86
C8955	Chemotherapy Infusion, hours 2-8 each	no payment	\$48.99
C8957	Infusion greater than 8 hours	\$113.20	\$154.86

Source: The Pritchard Group, LLC, in Rockville, Md.

Table 2: Proposed 2007 Clinic Visit G-codes and Payment Rates

HCCPS Code	Description	Current CPT	Payment
GXXX1	Level 1 Hospital Clinic Visit	99201, 99211	\$49.93
GXXX2	Level 2 Hospital Clinic Visit	99202, 99212, 99213, 99241, 99242	\$62.12
GXXX3	Level 3 Hospital Clinic Visit	99203, 99214, 99243	\$83.67
GXXX4	Level 4 Hospital Clinic Visit	99204, 99215, 99244	\$105.50
GXXX5	Level 5 Hospital Clinic Visit	99205, 99245	\$130.38

Source: The Pritchard Group, LLC, in Rockville, Md.

rates and proposed payment rates for 2007. (Note: under the proposed rates for 2007, all treatments would have to be longer than 1 hour and 31 minutes to reach 2006 payment levels.)


Facility Clinic Visits

In the proposed HOPD rule, CMS indicated that the current CPT codes (99201-99245) reflect the activities of physicians and do not “describe the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters.” The

agency continues to recommend that each hospital develop guidelines that accurately represent the intensity of hospital resources used for each charge level. For FY 2007, CMS is proposing to use HCPCS codes to describe hospital clinic and emergency department and critical care visits.

For clinic visits, CMS has proposed a set of five new G-codes to replace CPT clinic visit codes for new patients, established patients, and consultations (see Table 2). The specific G codes have not been published as yet, but Table 2 illustrates the proposed assignments and

payment rates. CMS also indicates that the G-codes may be recognized by other payers.

In addition to the clinic visit G-codes listed in Table 2, CMS has proposed 12 additional new G-codes: five for general emergency room visits, five for special emergency room visits, and two critical codes. 

Linda B. Gledhill, MHA, is an oncology consultant in Frederick, Md. Barbara Constable, RN, MBA, is director of The Pritchard Group, LLC, an oncology consulting firm in Rockville, Md.