



## Medicare Hospital Version

### KEY CONCEPTS OUTLINE

#### Module 9: Hospital Outpatient Departments, including Clinics

##### I. Coverage of Hospital Outpatient Therapeutic Services

- A. Most hospital outpatient therapeutic services paid under OPPTS or paid to CAHs on a cost basis must be furnished “incident to” a physician’s service to be covered. <See 42 C.F.R. § 410.27; 76 Fed. Reg. 74369-70>

**Caution:** Do not confuse “incident to” coverage requirements for hospital services with “incident to” billing requirements for professional services. The term “incident to” is defined differently for the two settings, including different definitions of the term “direct supervision”. Professional services “incident to” billing is not applicable in an institutional setting such as a hospital.

1. Commentary in the preamble of the *CY2012 OPPTS Final Rule* indicates “incident to” requirements do not apply to therapeutic services not paid under the OPPTS. <76 Fed. Reg. 74369-70>

Therapeutic services not paid under the OPPTS include physical therapy occupational therapy, speech-language pathology, diabetes outpatient self-management training, medical nutrition therapy, kidney disease education.

- B. Overview: Hospital outpatient therapeutic services must meet four requirements to be covered by Medicare as “incident to”:
1. The service must be furnished in the hospital or a department of the hospital;
  2. There must be an order for the service;
  3. The service must be an integral, though incidental, part of a physician or non-physician practitioner’s (NPP) service; and
  4. The service must be rendered under the correct level of supervision. <42 C.F.R. § 410.27; *Medicare Benefit Policy Manual*, Chapter 6 § 20.5.1>

### C. Location

1. The service must be furnished directly or under arrangement by the hospital and must be furnished in the hospital or in a department of the hospital. <See 42 C.F.R. 410.27(a)(1)(i) and (iii); *Medicare Benefit Policy Manual*, Chapter 6 § 20.5.2>

A department must meet regulatory requirements at 42 C.F.R. 413.65 to be considered part of the hospital or “provider-based”. Provider in this context is defined as hospital, CAH, or other facility. In general, the regulation requires the department be integrated into the operations of the hospital.

#### a. Exceptions

- i. Mental health services may be furnished to the patient remotely in their home through communication technology, discussed in a later module. <42 C.F.R. 410.27(a)(1)(iii)>
- ii. Chronic care management (CPT code 99490), a non-face-to-face care management service furnished by clinical staff under the direction of a physician or other qualified health professional to a beneficiary who is not physically present in the hospital. <87 Fed. Reg. 72013>
- iii. Remote monitoring services for beneficiaries who are not physically present in the hospital but who use a monitoring device that transmits data to hospital staff. <87 Fed. Reg. 72013>

### D. Order

1. The service is furnished on the order of a physician or NPP working within their scope of practice. <*Medicare Benefit Policy Manual*, Chapter 6 § 20.5.2>
  - a. The CERT contractor found many improper payments for hospital outpatient services were due to lack of documentation, including failure to provide a signed physician order for the service rendered. <*Medicare Quarterly Provider Compliance Newsletter*, Volume 8 Issue 1, October 2017>

Presumably, services would be considered to have been furnished on the order of a physician if they are furnished during an encounter in which the physician or NPP sees the patient and renders the service.

#### E. Integral, though Incidental

1. The service must be furnished as an integral, though incidental, part of the physician's or NPP's services in the course of diagnosing or treating the patient. <See 42 C.F.R. 410.27(a)(1)(ii); *Medicare Benefit Policy Manual*, Chapter 6 § 20.5.2>
2. The physician or NPP is not required to see the patient during each hospital outpatient encounter, however, the physician or NPP must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, change the treatment regimen. <*Medicare Benefit Policy Manual*, Chapter 6 § 20.5.2>
3. A service would not be covered as "incident to" a physician's or NPP's services if the physician or NPP merely wrote an order for the service and referred the patient to the hospital without being involved in the management of the course of treatment. <*Medicare Benefit Policy Manual*, Chapter 6 § 20.5.2>
4. An emergency department visit, regardless of level, would not be covered if the patient leaves before seeing a physician or NPP because the service would not be provided incident to a physician's or NPP's services. <See CMS FAQ 2297>

#### F. Physician Supervision

1. CMS has designated general supervision as the minimum required level of supervision for all hospital outpatient therapeutic services, except cardiac, intensive cardiac, and pulmonary rehabilitation. <See 42 C.F.R. 410.27(a)(1)(iv); 84 *Fed. Reg.* 61363; *Medicare Benefit Policy Manual*, Chapter 6 § 20.5.3>
  - a. General supervision requires the service be furnished under the physician's or NPP's overall direction and control but does not require they be present during the service. <See 42 C.F.R. 410.27(a)(1)(iv)(A); *Medicare Benefit Policy Manual*, Chapter 6 § 20.5.3>
  - b. The NPPs eligible to provide supervision of hospital outpatient therapeutic services are clinical psychologists, licensed clinical social workers, marriage and family therapists, mental health counselors, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives. <See 42 C.F.R. 410.27(g)>

The regulation for coverage of hospital outpatient *diagnostic* services at 42 C.F.R. 410.28 includes Certified Registered Nurse Anesthetists (CRNAs) in the list of NPPs eligible to provide supervision, but they are not included in the list of NPPs eligible to provide supervision for *therapeutic* services.

- c. CMS may designate a higher level of supervision (i.e., direct or personal supervision) through notice and comment rulemaking for specific hospital outpatient therapeutic services. Currently, no services have been designated to require higher than general supervision. <42 C.F.R. 410.27(a)(1)(iv)(B); 84 Fed. Reg. 61361>
  - i. CMS noted that hospitals may require a higher level of supervision for particular services through their own policies and bylaws if they believe it is necessary to ensure the quality and safety. <84 Fed. Reg. 61362>
  - ii. Direct supervision means the physician or NPP must be immediately available to furnish assistance and direction throughout the performance of the procedure, but they need not be physically present when the procedure is performed. <42 C.F.R. 410.27(a)(1)(iv)(B)(1)>
  - iii. Personal supervision means the physician or NPP must be in the room during the performance of the procedure. <42 C.F.R. 410.27(a)(1)(iv)(B)(2)>
- 2. For cardiac, intensive cardiac, and pulmonary rehabilitation, a physician, physician assistant, nurse practitioner or clinical nurse specialist must be immediately available and accessible as defined in 42 C.F.R. 410.47 and 410.49. <See 42 C.F.R. 410.27 (a)(1)(iv)(B)(1); 42 C.F.R. 410.47 and 410.49>
  - a. Through December 31, 2024, the presence of the physician or NPP includes virtual presence through audio/video real-time communication technology (excluding audio-only). <See 42 C.F.R. 410.27 (a)(1)(iv)(B)(1)>
- 3. Supervision requirements prior to January 1, 2021
  - a. Prior to January 1, 2021, Non-Surgical Extended Duration Therapeutic Services (NSEDTSs) required direct supervision at initiation of the services, followed by general supervision. This requirement was waived during the COVID PHE.
  - b. Prior to January 1, 2020, direct supervision was the default level of supervision for hospital outpatient therapeutic services, except specified services requiring general supervision and NSEDTSs.
    - i. For historical purposes, CMS makes available the document “*Hospital Outpatient Therapeutic Services That Have Been Evaluated for a Change in Supervision Level*” on the OPPTS Home Page, last updated 5/8/20.

Link: OPPTS Home Page under Medicare-Related Sites - Hospital

## II. Hospital Outpatient Departments, including Clinics

- A. Hospital outpatient departments, also known as provider-based departments, provide facility services in conjunction with a patient encounter, for which the hospital is paid under applicable payment systems, including the OPFS, MPFS, CLFS. <81 Fed. Reg. 79710>
- B. A physician or NPP professional service may or may not be provided in conjunction with the facility service provided in a hospital outpatient department. Payment for professional services is excluded from payment under hospital payment systems and must be submitted separately on a professional services claim. <81 Fed. Reg. 79710>
- C. The total payment for an encounter in a hospital outpatient department or clinic may be higher than if it were operated as a freestanding physician's office. <81 Fed. Reg. 79699>

Example: A physician sees an established patient in an on-campus hospital clinic that is consider a department of the hospital. The physician services are appropriately submitted as a level 4 office visit (99214) and the facility services are appropriately submitted as a hospital outpatient clinic visit (G0463). The allowable national payment amounts for 2024:

Claim Type	Service	Freestanding	Hospital Department	Difference
CMS-1500	Allowable for Professional Services (99214)	\$126.07	\$ 94.63	-\$31.44
UB-04	Allowable for Facility Services (G0463)	None	\$125.95	\$125.95
	Total Allowable	\$126.07	\$220.58	\$ 94.51

## III. Off-Campus Hospital Outpatient Departments

- A. Off-campus department services are excluded from reimbursement under the OPFS and are reimbursed under the MPFS or another applicable fee schedule, unless the department they are provided in is defined as "excepted". <See 42 C.F.R. 419.48; Bipartisan Budget Act of 2015, Section 603; 42 C.F.R. 419.22; 81 Fed. Reg. 79698-700>
1. Handout 17 has a diagram illustrating on- and off-campus departments and modifiers used for these departments.

## B. Definition of Campus

1. A hospital's campus is defined as the physical area within 250 yards of the main buildings of the hospital or in any other area determined by the CMS Regional office to be on the hospital's campus. <42 C.F.R. 413.65(a)(2)>
2. For determining the campus of the hospital, the 250-yard distance is measured from any point of the physical facility of the main campus to any point at the department (i.e., "as the crow flies"). <81 Fed. Reg. 79703>

Tip: The same distance is used in determining the campus of the hospital for purposes of the Emergency Medical Treatment and Active Labor Act (EMTALA). The hospital's Compliance Office may be able to assist in determining departments considered on-campus and off-campus.

## C. "Excepted" Off-Campus Departments

1. CMS uses the term "excepted" to refer to off-campus hospital departments that meet an exception allowing their services to continue to be paid under OPSS after January 1, 2017. <81 Fed. Reg. 79700>

Three types of off-campus departments are considered "excepted":

- Departments at and within 250 yards of a remote location
- Emergency departments
- Grandfathered departments, furnishing services prior to November 2, 2015 or qualifying for a mid-build exception

### 2. Remote Locations

- a. Remote locations, and off-campus departments within 250 yards of a remote location, are defined as "excepted". <See 42 C.F.R. 419.48(b)>
- b. A remote location is a facility created or acquired by the hospital for the purpose of providing inpatient hospital services under the name, ownership and control of the hospital, and includes the physical facility, personnel, and equipment needed to deliver the services. <42 C.F.R. 413.65(a)(2)>
- c. A remote location does not include a satellite facility, which provides inpatient services in a building or on the campus of another hospital. <42 C.F.R. 413.65(a)(2); 42 C.F.R. 412.22(h)(1)>

### 3. Emergency Departments

- a. Off-campus dedicated emergency departments are defined as “excepted”. <See 42 C.F.R. 419.48(a)>
- b. Non-emergency services provided in emergency departments are considered “excepted” services because the department they are provided in is defined as “excepted”. <81 Fed. Reg. 79702>
- c. Modifier -ER (“Items and services furnished by a provider-based off-campus emergency department”) must be reported on all claim lines for services provided in off-campus emergency departments. <83 Fed. Reg. 59003-4; Medicare Claims Processing Manual, Chapter 4 § 20.6.18>

### 4. Grandfathered Departments

- a. Off-campus departments meeting the following requirements are defined as “excepted”:
  - i. Off-campus departments furnishing services prior to November 2, 2015, billed under the OPPS within timely filing limits, <See 42 C.F.R. 419.48>;
  - ii. Off-campus departments that were “mid-build” on November 2, 2015 and meet requirements included in the 21<sup>st</sup> Century Cures Act, Sections 16001 and 16002. <The 21<sup>st</sup> Century Cures Act>
- b. Relocation
  - i. A grandfathered off-campus department will lose its “excepted” status if it impermissibly relocates. <See 42 C.F.R. 419.48(a)(2)>
  - ii. Relocation means the department moved from the address listed for the department on the hospital’s 855A enrollment form, including unit number. <81 Fed. Reg. 79704-5>
  - iii. Relocation is permissible (i.e., the department will not lose its “excepted” status) if the relocation is a temporary or permanent relocation due to extraordinary circumstances outside the hospital’s control (e.g., natural disasters). <81 Fed. Reg. 79705>
  - a) CMS has published “Extraordinary Circumstance Relocation Exception Guidance for an Off-Campus Provider-Based Department (in accordance with regulations at 42 CFR 419.22 and 419.48)” on the OPPS Home Page.

During the COVID PHE, CMS adopted **an alternate method** for relocation of all or part of a PBD, including to a patient's home, to allow services to continue to be billed as excepted services during the PHE. The hospital was required to notify CMS of the relocation to continue to bill as "excepted". For departments providing services not paid under the OPPS (e.g., therapy), no notification was required because the "exception" only affects payment under the OPPS.

c. Change of Ownership

- i. A grandfathered off-campus department will lose its "excepted" status if it is transferred to another hospital (i.e., changes ownership). <See 42 C.F.R. 419.48(a)(2)>
- ii. If the main provider who owns the off-campus department is transferred in its entirety, including assumption of the provider agreement by the new owner, the off-campus department retains its "excepted" status. <81 Fed. Reg. 79708-9>

D. Application of Modifier -PO to "Excepted" Off-Campus Services

1. Services provided at grandfathered off-campus departments are reported with modifier -PO ("Excepted service provided at an off-campus, outpatient, provider-based department of a hospital"). <Medicare Claims Processing Manual, Chapter 4 § 20.6.11>
  - a. Modifier -PO is not reported on services provided at "excepted" off-campus emergency departments, remote locations or excepted departments within 250 yards of a remote location. <Medicare Claims Processing Manual Transmittal 3685>.
2. Effective January 1, 2020, clinic visit services reported with G0463 and modifier -PO are paid 40% of the applicable OPPS rate, similar to non-excepted department services, discussed below. <84 Fed. Reg. 61369; Medicare Claims Processing Manual, Chapter 4 § 20.6.11>

E. "Nonexcepted" Off-Campus Department Services

1. "Nonexcepted" off-campus departments are off-campus departments that do not meet the requirements to be an "excepted" department.
2. All services provided at "nonexcepted" off-campus departments are coded with modifier -PN, including drugs, laboratory services, and therapy. <See Medicare Claims Processing Manual Transmittal 3685; 81 Fed. Reg. 79719>

- a. Modifier -PN and -PO would not be reported on the same item or service but could be reported on the same claim if both “excepted” and “nonexcepted” services are billed on the claim. <See *Medicare Claims Processing Manual Transmittal 3685*>
- 3. Services reported with modifier -PN are paid a “site of service specific” (SoSS) rate under the MPFS calculated at 40% of the applicable OPPS rate. <82 *Fed. Reg.* 53027-28>
  - a. OPPS policies that apply to the SoSS MPFS rate:
    - i. Normal OPPS packaging logic, C-APC logic, multiple procedure reduction logic, and wage index are applied prior to application of the 60% reduction. <81 *Fed. Reg.* 79726>
    - ii. Hospital outpatient physician supervision policies continue to apply to services paid under the SoSS MPFS rate. <81 *Fed. Reg.* 79727, 82 *Fed. Reg.* 53027>
  - b. OPPS policies that do not apply to the SoSS MPFS rate:
    - i. Outlier payments do not apply to the SoSS MPFS rate. <81 *Fed. Reg.* 79727>
    - ii. The patient’s coinsurance is not capped at the inpatient deductible for services paid at the SoSS MPFS. <81 *Fed. Reg.* 79727>
    - iii. Rural SCH, cancer hospital, quality reporting, and TOPs adjustments do not apply to the SoSS MPFS. <81 *Fed. Reg.* 79727>
  - c. Exceptions:
    - i. Services with a status indicator “A” paid under the MPFS are still paid at the standard MPFS rate, rather than the SoSS MPFS rate. <81 *Fed. Reg.* 79725>
    - ii. Services with status indicator “A” or “Q4”, if not packaged, are paid under the Clinical Laboratory Fee Schedule. <81 *Fed. Reg.* 79725>
    - iii. Ambulance services with status indicator “A” are paid under the ambulance fee schedule. <81 *Fed. Reg.* 79725>
    - iv. Drugs and biologicals with status indicator “G” or “K”, coded with modifier -PN are paid under the MPFS at ASP +6%. <81 *Fed. Reg.* 79725>

Example: A physician sees an established patient in a “nonexcepted” hospital clinic. The physician services are appropriately submitted as a level 4 office visit (99214) and the facility services are appropriately submitted as a hospital outpatient clinic visit (G0463-PN). The allowable national payment amounts for 2024:

Claim Type	Service	Freestanding	Hospital Department	Difference
CMS-1500	Allowable for Professional Services (99214)	\$126.07	\$ 94.63	-\$31.44
UB-04	Allowable for Facility Services (G0463)	None	\$ 50.38	\$50.38
	Total Allowable	\$126.07	\$145.01	\$18.94

#### IV. Billing Clinic and Emergency Department Services

##### A. Clinic Encounters

1. Clinic encounters are billed with HCPCS code G0463 (“Hospital outpatient clinic visit for assessment and management of a patient”). <78 Fed. Reg. 75042, *Medicare Claims Processing Manual*, Transmittal 2845>

##### B. Emergency Department Encounters

1. Emergency department encounters are billed using CPT E/M codes or certain HCPCS Level II codes. <*Medicare Claims Processing Manual*, Chapter 4 § 160>
  - a. Type A Emergency Departments are billed using CPT Emergency Department Visit Codes (99281-99285).
    - i. A “Type A” ED is a facility that meets the EMTALA definition of a “dedicated emergency department” and is open 24 hours a day, 7 days a week. <71 Fed. Reg. 68129 – 68133; *Medicare Claims Processing Manual*, Chapter 4 § 160>
  - b. Type B Emergency Departments are billed using HCPCS Level II codes (G0380-G0384).

- i. A “Type B” ED is a facility that meets the EMTALA definition of a “dedicated emergency department” but is not open 24 hours a day, 7 days a week. <71 Fed. Reg. 68132- 68133; Medicare Claims Processing Manual, Chapter 4 § 160>

The EMTALA definition of a “dedicated emergency department” (DED)

- Licensed by the state as an emergency department
- Held out to the public as a location for emergency care on an urgent basis without a scheduled appointment
- During the prior calendar year, at least one-third of its outpatient visits were provided for emergency care on an urgent basis without a scheduled appointment.

## 2. Level Selection

- a. CMS permits hospitals to develop their own internal systems for assigning E/M levels for ED encounters. <72 Fed. Reg. 66805>

CMS has provided the following general principles for hospitals to use in developing and evaluating their internal guidelines:

- They should follow the intent of the codes by reasonably relating the intensity of hospital resources to the code level
- They should be based on hospital facility resources and not based on physician resources.
- They should be clear, result in code selection that can be verified, and be readily available to auditors to facilitate their use in audits
- They should be written or recorded, well documented and provide the basis for selection of a specific code
- They should not facilitate upcoding or gaming or change frequently
- They should not require documentation that is not clinically necessary for patient care purposes
- They should be applied consistently across patients in the

## V. Billing and Payment for Critical Care Services and Trauma Activation

- A. Hospitals should report 99291 in lieu of a clinic or emergency department visit code whenever qualifying critical care services are furnished for an outpatient. <65 Fed. Reg. 18451>

### B. Location of Critical Care Services

1. Critical care services should be reported regardless of the location within the hospital where the services were provided. <65 Fed. Reg. 18451>

### C. Time Requirements for Billing Critical Care

1. To bill critical care, the hospital must provide 30 minutes of critical care services. <71 Fed. Reg. 68134>
  - a. When reporting critical care, the hospital counts the time spent by the physician or hospital staff actively engaged in face-to-face critical care of the patient. <Medicare Claims Processing Manual Transmittal 1139>
    - i. If multiple staff members are in attendance, the time may only be counted once.
  - b. If fewer than 30 minutes of critical care is provided, the hospital should report an appropriate clinic or emergency department code, at a level consistent with their internal guidelines. <71 Fed. Reg. 68134, Medicare Claims Processing Manual Transmittal 1139>
  - c. If more than 74 minutes of critical is provided, the hospital may report CPT code 99292 – used to report additional increments of 30 minutes.
    - i. Code 99292 is packaged for payment purposes under the OPPS. <OPPS Addendum B (Supplement)>

In the 2023 MPFS Final Rule guidance on reporting of critical care split/shared visits, CMS adopted a policy of reporting 99292 after 104 minutes of critical care, rather than 74 minutes as specified in CPT guidance. It's unclear if this policy applies to reporting of hospital critical care services. <87 Fed. Reg. 69616>

### Case Study 1

**Facts:** A Medicare patient with serious coronary artery disease was seen in the hospital emergency department in unstable, critical condition. The emergency department physicians and nurses spent 1 hour and 30 minutes attempting to revive the patient, however, the patient expired. What codes should the hospital report for the critical care services provided? How much will Medicare pay for the services?

#### D. Trauma Activation

1. Trauma activation may only be billed if the hospital meets the following requirements for reporting under revenue center 068X. *<Medicare Claims Processing Manual Transmittal 1139>*
  - a. The hospital must be licensed or designated as a Level I-IV Trauma Center. *<Medicare Claims Processing Manual, Chapter 25 § 75.4>*
  - b. Trauma activation requires “Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient’s arrival”. *<Medicare Claims Processing Manual, Chapter 25 § 75.4>*
    - i. Patients who arrive without pre-notification do not qualify for trauma activation. *<Medicare Claims Processing Manual, Chapter 25 § 75.4>*
2. Trauma activation is reported with code G0390 when it is provided in conjunction with critical care services (CPT Code 99291). *<Medicare Claims Processing Manual Transmittal 1139>*
  - a. If a hospital reports G0390 without reporting the critical care code 99291 on the same claim, the IOCE will trigger edit 76 causing a line item rejection. *<IOCE Specifications, Section 8.2, Edit 76 (Supplement)>*
  - b. If a hospital provides less than 30 minutes of critical care, and therefore must bill an emergency department visit code rather than the critical care code, trauma activation may not be billed with code G0390. *<Medicare Claims Processing Manual Transmittal 1139>*
    - i. If the hospital provides trauma activation, but does not meet the requirements of reporting G0390, the hospital may still report a charge for trauma activation without reporting G0390. *<Medicare Claims Processing Manual Transmittal 1139>*

#### E. Critical Care Composite

1. Ancillary Services Billed with Critical Care
  - a. Services listed by the CPT manual as bundled to critical care for physicians, are not bundled for hospitals and should be reported separately. *<75 Fed. Reg. 71988>*

- b. Ancillary services<sup>1</sup> with status indicator Q3 assigned to the critical care composite are packaged into the payment for critical care when billed on the same claim as critical care. <75 Fed. Reg. 71988; see *IOCE Specifications*, Section 6.4.3 (Supplement)>
  - i. If these services, except pulse oximetry (94762) and arterial puncture (36600), are reported with modifier -59, -XE, -XS, -XP, or -XU they are processed with their standard status indicator and APC. <See *IOCE Specifications*, Section 6.4.3 (Supplement)>
  - ii. It is unclear if this allows payment for chest x-rays (71045, 71046) when reported with modifier -59. These codes have an initial status indicator of Q3 and APC of 5521 which has a standard status indicator of S. Typically, x-rays, including all other x-rays assigned APC 5521, have initial status indicator Q1 and would be packaged to the critical care code due to its status indicator of V. <OPPS Addendum A, OPPS Addendum B, and OPPS Addendum D1>

## 2. Payment for Critical Care Composite

- a. Critical care reported without trauma activation is paid under APC 5041 (Critical Care) (\$845.48) and critical care reported with trauma activation is paid under APC 5042 (Trauma Response with Critical Care) (\$1,304.47). <*Medicare Claims Processing Manual*, Chapter 4 § 160.1; OPPS Addendum A>

## VI. Proper Reporting of Modifier -25

- A. When an E/M service is provided on the same date as diagnostic (excluding pathology and laboratory services) or therapeutic services, the E/M service is only reported separately if it is “significant” and “separately identifiable.” <See *Program Memoranda A-00-40* page 1; Frequently Asked Question 2029>

According to the CPT definition of modifier -25, the E/M service must be above and beyond the “usual pre-operative and post-operative care” for the service.

<sup>1</sup> Ancillary services packaged to critical care composite: chest x-rays (71045, 71046), pulse oximetry by overnight monitoring (94762), temporary transcutaneous pacing (92953), and ventilatory management (94002, 94003, 94662). <OPPS Addendum M>

1. The following services are not significant enough to warrant separate reporting:  
<See *Program Memorandum A-00-40* pages 1, 3>
  - a. Taking the patient's blood pressure and temperature;
  - b. Asking the patient how he/she feels; and
  - c. Getting the consent form signed.

### Case Study 2

**Facts:** A Medicare patient presented to a hospital clinic for repair of a minor laceration on her hand (12001). A clinic RN asked the patient how she felt, took her blood pressure and temperature, and had her sign a consent form. There was no documentation of any other services being furnished by any non-physician clinic personnel. A clinic physician repaired the laceration and discharged the patient to home. Should the hospital report a clinic visit code (G0463) in connection with this clinic visit (in addition to the laceration repair code)?

- B. If the E/M service is significant and separately identifiable, modifier -25 is reported on the E/M service. <See *Program Memorandum A-00-40* page 1; *A-01-80* page 1>
  1. Modifier -57 (E/M service resulting in a decision for surgery) does not apply in the hospital setting – use modifier -25. <See *Program Memorandum A-00-40* page 3>
  2. Modifier -25 is only required when an E/M service is furnished with status indicator S or T services. <*Program Memorandum A-01-80* page 1>
- C. A separate diagnosis for the E/M service is not required in order to report modifier -25. <See *Program Memorandum A-00-40* page 3>
- D. The clinical documentation must support the position that the services were significant and separately identifiable. <See *Program Memorandum A-00-40* page 2; *Program Memorandum A-01-80* page 2>

### Case Study 3

**Facts:** A Medicare patient was seen in a hospital emergency department complaining of right foot pain of unknown origin. The emergency department RN took a detailed history, examined the site of the pain and recorded the patient's vital signs, including elevated blood pressure. The emergency department physician reviewed the history with the patient and performed a detailed exam, finding the patient had a simple foot abscess on the right foot. The physician performed an incision and drainage of the abscess (10060). The emergency department RN assisted the physician with the simple foot abscess and also continued to monitor the patient's elevated blood pressure. Based on nursing resources required, the hospital assigned the encounter a level three emergency department code (99283). Assuming full documentation of all services provided, how should the hospital report the services it provided in connection with this encounter?

#### VIII. Outpatient Physical Therapy, Occupational Therapy and Speech Therapy Language Pathology

- A. Therapy services are billed with two types of CPT/HCPCS codes: timed and untimed. <Medicare Claims Processing Manual, Chapter 5 § 20.2 B, C>
  1. Codes that describe a service or procedure not defined by a specific timeframe (e.g., evaluation codes) are billed with a unit of one. <Medicare Claims Processing Manual, Chapter 5 § 20.2 B>
  2. When reporting services with CPT/HCPCS codes defined by time (i.e., 15 minutes), all face to face time with the patient in a single day is rounded to the closest 15 minute increment, subject to the guidelines in the *Medicare Claims Processing Manual*. <Medicare Claims Processing Manual, Chapter 5 § 20.2 B, C>:
    - a. At least 8 minutes must be provided to report one unit of service.
      - i. If less than 8 minutes is provided of more than one type of service, the provider may sum the minutes and if the sum is at least 8 minutes, the provider may report one unit of the service performed for the most minutes.

- b. When more than one service is performed in a single day, the total number of minutes of service determines the maximum number of units billed.

For example, if one service is provided for 24 minutes, the provider may round to 30 minutes and report 2 units. If a second service is performed on the same day for 24 minutes, the provider may not report an additional 2 units because the total treatment time was 48 minutes which would round to 45 minutes or 3 units. Therefore, the provider must only report 3 units of service, reporting two units for the services with the most minutes (or in this case selecting either code).

## VIII. Payment for therapy services

- A. Therapy services provided by hospitals, except CAHs, are paid on the Medicare Physician Fee Schedule (MPFS). <Medicare Claims Processing Manual, Chapter 4 § 200.9>

### 1. “Sometimes Therapy” Codes

- a. CMS publishes a list of therapy codes that are “sometimes” considered therapy services. The list of “sometimes therapy” codes for CY2024 is included in the materials behind the outline. <Medicare Claims Processing Manual, Chapter 4 § 200.9>

Link: Therapy Code List under Medicare-Related Sites - General

- b. When “sometimes therapy” services are provided outside a plan of care by nursing staff they are paid under the OPFS. <Medicare Claims Processing Manual, Chapter 4 § 200.9>
- i. “Sometimes therapy” services provided outside a plan of care and paid under OPFS are subject to the incident to coverage requirements, including supervision. <77 Fed. Reg. 68424-425>
- c. When “sometimes therapy” services are provided under a therapy plan of care, indicated by a therapy revenue code and a therapy modifier, they are paid under the MPFS similar to other therapy services. <Medicare Claims Processing Manual, Chapter 4 § 200.9; Medicare Claims Processing Manual, Chapter 5 § 20.1>

#### Therapy Revenue Codes and Modifiers:

- Physical Therapy – 042X, -GP
- Occupational Therapy – 043X, -GO
- Speech Therapy and Language Pathology – 044X, -GN

B. Therapy services paid to hospitals under the MPFS are subject to a multiple procedure reduction when more than one therapy service or multiple units of the same therapy service are billed on the same date of service. <One Time Notice Transmittal 1194>

C. Therapy Services Provided by Therapy Assistants (Modifiers CQ/CO)

1. Modifier -CQ (outpatient physical therapy services furnished in whole or in part by a physical therapy assistant) or modifier -CO (outpatient occupational therapy services furnished in whole or in part by an occupational therapy

Example of application of the multiple procedure reduction under the MPFS

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Payment Amount
Work	\$7.00	\$7.00	\$11.00	\$25.00
Practice Expense	\$10.00	\$10 X .5 = \$5.00	\$8 X .5=\$4	\$10 + \$5 (\$10 X .5) + \$4 (\$8 X.5) = \$19
Malpractice	\$1.00	\$1.00	\$1.00	\$3.00
TOTAL	\$18.00	\$13.00	\$16.00	\$47

MPFS payment is made up of three relative value units (RVUs): work, malpractice and practice expense. The multiple procedure reduction does not apply to the work and malpractice RVUs.

assistant) must be reported on therapy codes provided at least “in part” by a therapy assistant. <86 Fed. Reg. 65169; Medicare Claims Processing Manual, Chapter 5 § 20.1>

- a. CMS adopted a “de minimis” standard that requires reporting the therapy assistant modifier if more than 10% of the service is provided by a therapy assistant. <86 Fed. Reg. 65169-177>

- b. CMS clarified that the 8 minute or “mid-point” rule continues to apply to certain situations where a therapist provides 8 minutes of therapy and would be able to report the code without taking into account the therapy provided by the assistant. <86 *Fed. Reg.* 65169-177>

Example:

PTA – 97110 – 22 minutes

PT – 97110 – 23 minutes

Total 45 minutes of therapy – 3 billable units

Billable codes: 1 unit 97110-CQ modifier, 2 units 97110

Explanation:

1 unit with CQ because PTA provided 15 minutes (22-15=7 minutes remaining)

1 unit without CQ because PT provide 15 minutes (23-15=8 minutes remaining)

Apply 8-minute rounding rule, or “midpoint rule” to remaining 15 minutes, and because PT provided at least 8 minutes, report 1 unit without CQ.

- c. CMS has provided additional examples in the CY2022 Medicare Physician Fee Schedule Final Rule at 86 *Fed. Reg.* 65169, and on the CMS website “Billing Examples Using CQ/CO Modifiers for Services Furnished In Whole or In Part By PTAs and OTAs”.

Link: Therapy Modifiers CQ/CO – Billing Examples under Medicare-Related Sites - General

2. A 15% reduction will be applied to therapy provided at least in part by a therapy assistant and reported with modifiers -CQ or -CO. <86 *Fed. Reg.* 65169; 85 *Fed. Reg.* 84954>

#### D. Modifier -KX Therapy Threshold

1. Therapy services are subject to an annual dollar limitation unless the provider includes the -KX modifier denoting the therapy is medically necessary as appropriately documented in the medical record. <*Medicare Claims Processing Manual*, Chapter 5 § 10.3 B, *Bipartisan Budget Act of 2018*, Section 50202; 83 *Fed. Reg.* 59654>

- a. When therapy exceeds the annual dollar limit or threshold, but the therapy is medically necessary and this is documented in the patient's medical records, the provider should append the –KX modifier to all applicable lines. *<Medicare Claims Processing Manual, Chapter 5 § 10.3 D, Bipartisan Budget Act of 2018, Section 50202>*
2. For CY2024, there is one threshold or limit for physical therapy and speech-language pathology services combined (\$2,330) and a separate cap for occupational therapy services (\$2,330). *<88 Fed. Reg. 78993>*

E. Manual Review of Therapy

1. Therapy services that exceed \$3,000 for physical therapy and speech-language pathology combined or \$3,000 for occupational therapy and meet criteria for potential for overpayments (e.g., high denial rate, aberrant billing patterns, new provider) are subject to manual review. *<Bipartisan Budget Act of 2018; 88 Fed. Reg. 78993>*

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## CASE STUDIES WITH ANALYSIS

### Case Study 1

**Facts:** A Medicare patient with serious coronary artery disease was seen in the hospital emergency department in unstable, critical condition. The emergency department physicians and nurses spent 1 hour and 30 minutes attempting to revive the patient, however, the patient expired. What codes should the hospital report for the critical care services provided? How much will Medicare pay for the services?

**Analysis:** Based on CPT guidance, the hospital should report 99291 for the first hour of critical care and 99292 for the additional half hour beyond the first hour. The payment rate for 99291 is \$845.48 and payment for 99292 is packaged into payment for 99291. Under CMS guidance to physicians in the CY2023 MPFS Final Rule, only 99291 is reportable because CMS indicated 104 minutes would be required to report the add-on code 99292 for an additional ½ hour of critical care. It is unclear if this guidance applies to hospital reporting of critical care. <71 Fed. Reg. 68134; *Medicare Claims Processing Manual Transmittal 1139*; OPPS Addendum B; 87 Fed. Reg. 69616>

**Case Study 2**

**Facts:** A Medicare patient presented to a hospital clinic for repair of a minor laceration on her hand (12001). A clinic RN asked the patient how she felt, took her blood pressure and temperature and had her sign a consent form. There was no documentation of any other services being furnished by any non-physician clinic personnel. A clinic physician repaired the laceration and discharged the patient to home. Should the hospital report a clinic visit code (G0463) in connection with this clinic visit (in addition to the laceration repair code)?

**Analysis:** No, the clinic visit is not “significant and separately identifiable” from the laceration repair. <Program Memorandum A-00-40, pages 1 and 3>

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### Case Study 3

**Facts:** A Medicare patient was seen in a hospital emergency department complaining of right foot pain of unknown origin. The emergency department RN took a detailed history, examined the site of the pain and recorded the patient's vital signs, including elevated blood pressure. The emergency department physician reviewed the history with the patient and performed a detailed exam, finding the patient had a simple foot abscess on the right foot. The physician performed an incision and drainage of the abscess (10060). The emergency department RN assisted the physician with the simple foot abscess and also continued to monitor the patient's elevated blood pressure. Based on nursing resources required, the hospital assigned the encounter a level three emergency department code (99283). Assuming full documentation of all services provided, how should the hospital report the services it provided in connection with this encounter?

**Analysis:** The hospital should report 10060 for the procedure and 99283-25 for the visit services. Monitoring the patient's elevated blood pressure is beyond the usual pre- and post-operative work for the foot abscess and would be considered significant and separately identifiable from the incision and drainage. <Program Memorandum A-00-40, pages 1 and 3>

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## Title 42 — Public Health

### Chapter IV — Centers for Medicare & Medicaid Services, Department of Health and Human Services

#### Subchapter B — Medicare Program

#### Part 410 — Supplementary Medical Insurance (SMI) Benefits

#### Subpart B — Medical and Other Health Services

**Authority:** 42 U.S.C. 1302, 1395m, 1395hh, 1395rr, and 1395ddd.

**Source:** 51 FR 41339, Nov. 14, 1986, unless otherwise noted.

**Editorial Note:** Nomenclature changes to part 410 appear at 62 FR 46037, Aug. 29, 1997.

#### § 410.27 Therapeutic outpatient hospital or CAH services and supplies incident to a physician's or nonphysician practitioner's service: Conditions.

- (a) Medicare Part B pays for therapeutic hospital or CAH services and supplies furnished incident to a physician's or nonphysician practitioner's service, which are defined as all services and supplies furnished to hospital or CAH outpatients that are not diagnostic services and that aid the physician or nonphysician practitioner in the treatment of the patient, including drugs and biologicals which are not usually self-administered, if—
- (1) They are furnished—
- (i) By or under arrangements made by the participating hospital or CAH, except in the case of a SNF resident as provided in § 411.15(p) of this subchapter;
  - (ii) As an integral although incidental part of a physician's or nonphysician practitioner's services;
  - (iii) In the hospital or CAH or in a department of the hospital or CAH, as defined in § 413.65 of this subchapter, except for mental health services furnished to beneficiaries in their homes through the use of communication technology;
  - (iv) Under the general supervision (or other level of supervision as specified by CMS for the particular service) of a physician or a nonphysician practitioner as specified in paragraph (g) of this section, subject to the following requirements:
    - (A) For services furnished in the hospital or CAH, or in an outpatient department of the hospital or CAH, both on and off-campus, as defined in § 413.65 of this subchapter, or through the use of communication technology for mental health services, general supervision means the procedure is furnished under the physician's or nonphysician practitioner's overall direction and control, but the physician's or nonphysician practitioner's presence is not required during the performance of the procedure.
    - (B) Certain therapeutic services and supplies may be assigned either direct supervision or personal supervision.
      - (1) For purposes of this section, direct supervision means that the physician or nonphysician practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the

physician or nonphysician practitioner must be present in the room when the procedure is performed. For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished as specified in §§ 410.47 and 410.49, respectively. Through December 31, 2024, the presence of the physician or nonphysician practitioner for the purpose of the supervision of pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services includes virtual presence through audio/video real-time communications technology (excluding audio-only); and

(2) Personal supervision means the physician or nonphysician practitioner must be in attendance in the room during the performance of the procedure.

(C) Nonphysician practitioners may provide the required supervision of services that they may personally furnish in accordance with State law and all additional requirements, including those specified in §§ 410.71, 410.73, 410.74, 410.75, 410.76, and 410.77; and

(v) In accordance with applicable State law.

(2) In the case of partial hospitalization services or intensive outpatient services, also meet the conditions of paragraph (e) of this section.

(b) Drugs and biologicals are also subject to the limitations specified in § 410.129.

(c) Rules on emergency services furnished to outpatients by nonparticipating hospitals are specified in subpart G of Part 424 of this chapter.

(d) Rules on emergency services furnished to outpatients in a foreign country are specified in subpart H of Part 424 of this chapter.

(e) Medicare Part B pays for partial hospitalization services and intensive outpatient services if they are—

(1) Prescribed by a physician who certifies and recertifies the need for the services in accordance with subpart B of part 424 of this chapter; and

(2) Furnished under a plan of treatment as required under subpart B of part 424 of this chapter.

(f) Services furnished by an entity other than the hospital are subject to the limitations specified in § 410.42(a).

(g) For purposes of this section, *nonphysician practitioner* means a clinical psychologist, licensed clinical social worker, marriage and family therapist, mental health counselor, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse-midwife.

[76 FR 74580, Nov. 30, 2011, as amended at 78 FR 75196, Dec. 10, 2013; 84 FR 61490, Nov. 12, 2019; 85 FR 8476, Feb. 14, 2020; 85 FR 19285, Apr. 6, 2020; 85 FR 86299, Dec. 29, 2020; 87 FR 72284, Nov. 23, 2022; 88 FR 82177, Nov. 22, 2023]



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**Can hospitals bill Medicare for the lowest level ER visit for patients who check into the ER and are "triaged" through a limited evaluation by a nurse but leave the ER before seeing a physician?**

No. The limited service provided to such patients is not within a Medicare benefit category because it is not provided incident to a physician's service. Hospital outpatient therapeutic services and supplies (including visits) must be furnished incident to a physician's service and under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law. Therapeutic services provided by a nurse in response to a standing order do not satisfy this requirement. (FAQ2297)

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## Title 42 — Public Health

### Chapter IV — Centers for Medicare & Medicaid Services, Department of Health and Human Services

#### Subchapter B — Medicare Program

#### Part 419 — Prospective Payment Systems for Hospital Outpatient Department Services

#### Subpart D — Payments to Hospitals

**Authority:** 42 U.S.C. 1302, 1395l(t), and 1395hh.

**Source:** 65 FR 18542, Apr. 7, 2000, unless otherwise noted.

#### § 419.48 Definition of excepted items and services.

- (a) Excepted items and services are items or services that are furnished on or after January 1, 2017—
  - (1) By a dedicated emergency department (as defined at § 489.24(b) of this chapter); or
  - (2) By an excepted off-campus provider-based department defined in paragraph (b) of this section that has not impermissibly relocated or changed ownership.
- (b) For the purpose of this section, “excepted off-campus provider-based department” means a “department of a provider” (as defined at § 413.65(a)(2) of this chapter) that is located on the campus (as defined in § 413.65(a)(2) of this chapter) or within the distance described in such definition from a “remote location of a hospital” (as defined in § 413.65(a)(2) of this chapter) that meets the requirements for provider-based status under § 413.65 of this chapter. This definition also includes an off-campus department of a provider that was furnishing services prior to November 2, 2015 that were billed under the OPPTS in accordance with timely filing limits.
- (c) Payment for items and services that do not meet the definition in paragraph (a) of this section will generally be made under the Medicare Physician Fee Schedule on or after January 1, 2017.

[81 FR 79880, Nov. 14, 2016; 82 FR 36, Jan. 3, 2017]

## Off-Campus Provider Based Department “PO” Modifier Frequently Asked Questions

### 1. What is the PO Modifier and when did it become effective?

A: In the CY 2015 Outpatient Prospective Payment System Final Rule (79 FR 66910-66914) we created a HCPCS modifier for hospital claims that is to be reported with every code for outpatient hospital items and services furnished in an off-campus provider-based department (PBD) of a hospital. This 2-digit modifier was added to the HCPCS annual file as of January 1, 2015, with the label “PO.” Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning on January 1, 2016.

### 2: Should off-campus provider based departments (PBDs) of Critical Access Hospitals (CAHs) apply the PO modifier?

A: No, the PO modifier does not apply to CAHs because CAHs are not paid through the Outpatient Prospective Payment System (OPPS).

### 3: Should the PO modifier be applied for drugs or laboratory services?

A: The determinative factor is whether or not the item or service is being paid through the OPPS. If an item or service is being provided by an applicable provider and is being paid through the OPPS, then the PO modifier should be applied.

For instance, a drug with an OPPS status indicator of “K” or a laboratory test that is packaged into an OPPS service should have the PO modifier applied. If a service is not paid through the OPPS, such as a laboratory test paid separately through the Clinical Laboratory Fee Schedule, it should not have the PO modifier applied.

Note that the Medicare Claims Processing Manual Chapter 4 20.6.11 was updated in July 2015 to read: “This modifier is to be reported with every HCPCS code for **all** outpatient hospital **items and** services furnished in an off-campus provider-based department a hospital.”

### 4: Can the same hospital outpatient claim have both a HCPCS with the PO modifier and a HCPCS without the PO modifier?

A: Yes, a single hospital outpatient claim (Type of Bill 13X) could have HCPCS with the PO modifier and HCPCS without the PO modifier (e.g., a patient is treated at an off-campus PBD and the on-campus hospital on the same day).

### 5: Should the PO modifier be applied for off-campus therapy services that are paid under the Physician Fee Schedule (PFS)?

A: No, the PO modifier only applies to services paid under the OPPS. Accordingly, therapy services that are billed under the PFS and have an OPPS status indicator of “A” do not require the PO modifier.

**6: Should the PO modifier be applied if the facility does not meet the definition of provider-based?**

A: The PO modifier does not apply to any facility that does not meet the definition of provider-based.

**7: Should the PO modifier be applied to services provided at off-campus dialysis facilities?**

A: No, services provided at off-campus dialysis facilities are billed under the ESRD PPS and, therefore, do not require the PO modifier.

**8: Should the PO modifier be applied to off-campus PBDs that are provider-based to a main hospital, if they are located in, or on the campus, of a remote location of the main hospital?**

A: The modifier does not apply to services physically provided at remote hospital locations of the applicable main hospital or on the campus of a remote location of the applicable main hospital.

**9: Should the PO modifier be applied to services provided in Type B Emergency Departments?**

A: No, the PO modifier does not apply to items or services provided in either Type A or Type B Emergency Departments.

**10: Have the PO modifier requirements changed with passage of Sec. 603 (Treatment of Off-Campus Outpatient Departments of a Provider) of the Bipartisan Budget Act of 2015?**

A: No, at this time, Section 603 of the Bipartisan Budget Act of 2015 does not impact the PO modifier requirements. Please note that this legislation will be implemented through notice and comment rulemaking in 2016.

**11: Should the PO modifier be applied to services provided through Medicare Advantage?**

A: No, the PO modifier does not apply to services provided through Medicare Advantage.

**12: Where does the PO modifier fall in the claims processing hierarchy for modifiers?**

A: The PO modifier is processed after all modifiers that affect payment have been applied.

**13: Is the January 1, 2016 requirement based on date-of-service or date of claim submission?**

A: The PO modifier is required for applicable claims based on date-of-service beginning January 1, 2016.

## 9. CT Modifier (“Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard”)

In accordance with Section 1834(p) of the Act we established modifier “CT” effective January 1, 2016 to identify computed tomography (CT) scans that are furnished on equipment that does not meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled “Standard Attributes on CT Equipment Related to Dose Optimization and Management.” Hospitals are required to use this modifier on claims for computed tomography (CT) scans described by applicable HCPCS codes that are furnished on non-NEMA Standard XR-29-2013-compliant equipment. The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).

Effective January 1, 2017, the use of this modifier will result in a payment reduction of 15 percent for the applicable computed tomography (CT) services when the service is paid separately. The 15 percent payment reduction will also be applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy. This includes procedures assigned to the two APCs (8005 and 8006) in the computed tomography (CT) and computed tomographic angiography (CTA) imaging family.

## 10. Billing for Items and Services Furnished at Off-Campus Hospital Outpatient Departments

In accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), we have established a new modifier “PN” (*Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital*) to identify and pay nonexcepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line for non-excepted items and services. The use of modifier “PN” will trigger a payment rate under the Medicare Physician Fee Schedule. We expect the PN modifier to be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services,

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier “PO” (*Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments*) for all excepted items and services furnished. Use of the off-campus PBD modifier became mandatory beginning January 1, 2016.

We would not expect off-campus provider-based departments to report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- A dedicated emergency department as defined in existing regulations at 42 CFR 489.24(b);
- A PBD that is “on the campus,” or within 250 yards, of the hospital or a remote location of the hospital as defined under 42 CFR 413.65.

## 11. Partial Hospitalization Program

### a. Update to PHP Per Diem Costs

The CY 2017 OPPTS/ASC final rule with comment period replaces the existing two-tiered APC structure for PHPs with a single APC by provider type for providing three or more services per day. Specifically, we are

emergency department visit distributions for urban and rural hospitals also closely resembled the national distribution of emergency department visits. Rural hospitals in the aggregate reported slightly higher proportions of Level 2 and 3 emergency department visits than the national average, and slightly fewer Level 4 and 5 visits. When subdividing rural hospitals into groupings based on size, the distribution for small, medium, and large rural hospitals closely mirrored the national average distribution. Large rural hospitals tended to report higher level emergency department visits than smaller rural hospitals. All of these observations regarding the patterns of reporting for rural hospitals were consistent with our expectations for care delivery at those hospitals.

Overall, both the clinic and emergency department visit distributions indicated that hospitals were billing consistently over time and in a manner that distinguished between visit levels, resulting in relatively normal distributions nationally for the OPPTS, as well as for smaller classes of hospitals. These proposed rule analyses were generally consistent with our understanding of the clinical and resource characteristics of different levels of hospital outpatient clinic and emergency department visits.

In the CY 2008 OPPTS/ASC proposed rule, we specifically invited public comment as to whether a pressing need for national guidelines continued at this point in the maturation of the OPPTS, or if the current system where hospitals create and apply their own internal guidelines to report visits was currently more practical and appropriately flexible for hospitals. We explained that although we have reiterated our goal since CY 2000 to create national guidelines, this complex undertaking for these important and common hospital services was proving more challenging than we initially thought as we received new and expanded information from the public on current hospital reporting practices that led to appropriate payment for the hospital resources associated with clinic and emergency department visits. We believed that many hospitals had worked diligently and carefully to develop and implement their own internal guidelines that reflected the scope and types of services they provided throughout the hospital outpatient system. Based on public comments, as well as our own knowledge of how clinics operate, it seemed unlikely that one set of straightforward national guidelines could apply to the reporting of visits in all hospitals and specialty clinics. In

addition, the stable distribution of clinic and emergency department visits reported under the OPPTS over the past several years indicated that hospitals, both nationally in the aggregate and grouped by specific hospital classes, were generally billing in an appropriate and consistent manner as we would expect in a system that accurately distinguished among different levels of service based on the associated hospital resources.

Therefore, while we explained in the CY 2008 OPPTS/ASC proposed rule that we would continue to evaluate the information and input we had received from the public during CY 2007, as well as comments on the CY 2008 OPPTS/ASC proposed rule, regarding the necessity and feasibility of implementing different types of national guidelines, we did not propose to implement national visit guidelines for clinic or emergency department visits for CY 2008. Instead, hospitals would continue to report visits during CY 2008 according to their own internal hospital guidelines.

In the absence of national guidelines, we will continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continued to bill appropriately and differentially for these services. In addition, we note our expectation that hospitals' internal guidelines would comport with the principles listed below.

(1) The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code (65 FR 18451).

(2) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources (67 FR 66792).

(3) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits (67 FR 66792).

(4) The coding guidelines should meet the HIPAA requirements (67 FR 66792).

(5) The coding guidelines should only require documentation that is clinically necessary for patient care (67 FR 66792).

(6) The coding guidelines should not facilitate upcoding or gaming (67 FR 66792).

We also proposed the following five additional principles for application to hospital-specific guidelines, based on our evolving understanding of the important issues addressed by many hospitals in developing their internal guidelines that now have been used for a number of years. We believed that it

was reasonable to elaborate upon the standards for hospitals' internal guidelines that we proposed to apply in CY 2008, based on our knowledge of hospitals' experiences to date with guidelines for visits.

(7) The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.

(8) The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.

(9) The coding guidelines should not change with great frequency.

(10) The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.

(11) The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

In the CY 2008 OPPTS/ASC proposed rule, we invited public comment on these principles, specifically, whether hospitals' guidelines currently met these principles, how difficult it would be for hospitals' guidelines to meet these principles if they did not meet them already, and whether hospitals believed that certain standards should be added or removed. We considered stating that a hospital must use one set of emergency department visit guidelines for all emergency departments in the hospital but thought that some departments that might be considered emergency departments, such as the obstetrics department, might find it more practical and appropriate to use a different set of guidelines than the general emergency department. Similarly, we believed that it was possible that various specialty clinics in a hospital could have their own set of guidelines, specific to the services offered in those specialty clinics. However, if different guidelines were implemented for different clinics, we stated that hospitals should ensure that these guidelines reflected comparable resource use at each level to the other clinic guidelines that the hospital might apply.

*Comment:* A number of commenters were divided as to whether there is a need for national guidelines. The majority of the commenters requested that CMS continue work on national guidelines to ensure consistent reporting of hospital visits. Some of the commenters requested that the guidelines be implemented as soon as possible, ensuring 6 to 12 months of advance notice. Other commenters suggested that guidelines would be helpful, but that it was preferable to invest significant time reviewing and

**Program Memorandum****Intermediaries**

**Department of Health and  
Human Services (DHHS)  
HEALTH CARE FINANCING  
ADMINISTRATION (HCFA)**

**Transmittal A-00-40**

**Date: JULY 20, 2000**

**CHANGE REQUEST 1250****SUBJECT: Further Information on the Use of Modifier -25 in Reporting Hospital Outpatient Services**

Due to numerous questions raised about the correct usage of modifier -25 under the Hospital Outpatient Prospective Payment System (OPPS), this Program Memorandum (PM) provides additional clarifying information. Modifier -25 was effective June 5, 2000 for hospital use. Refer to PM A-00-07 (CR 1079), dated February 2000.

**NOTE:** The effective date and the implementation date for use of modifiers has not changed.

Background

Payment for a diagnostic (with the exception of pathology and laboratory) and/or therapeutic procedure(s) (code ranges 10040-69990, 70010-79999 and 90281-99140) includes taking the patient's blood pressure, temperature, asking the patient how he/she feels and getting the consent form signed. Since payment for these types of services is already included in the payment for the procedure, it is not appropriate to bill for an Evaluation and Management (E/M) service separately.

However, there are circumstances when it is appropriate to report an E/M service code in addition to the procedures provided on the same date, provided the key components (i.e. history, examination and medical decision making) are met.

The Current Procedural Terminology (CPT-4) manual gives the definition of modifier -25 as follows:

(From CPT-4, copyright American Medical Association)

“Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.”

Further explanation of the modifier is given as follows:

“The physician may need to indicate that on the day of a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier ‘ -25’ to the appropriate level of E/M service...”

**HCFA Pub. 60A**

## Guidelines



1. Should a separately identifiable E/M service be provided on the same date that a diagnostic and/or therapeutic procedure(s) is performed, information substantiating the E/M service must be clearly documented in the patient's medical record, to justify use of the modifier –25.
2. Modifier –25 may be appended only to E/M service codes and then only for those within the range of 99201-99499. For outpatient services paid under OPPS, the relevant code ranges are:

99201-99215	(Office or Outpatient Services)
99281-99285	(Emergency Department Services)
99291	(Critical Care Services)
99241-99245	(Office or Other Outpatient Consultations)

**NOTE:** For the reporting of services provided by hospital outpatient departments, off-site provider departments, and provider-based entities, all references in the code descriptors to “physician” are to be disregarded.

*Example:* A patient reports for pulmonary function testing in the morning and then attends the hypertension clinic in the afternoon.

The pulmonary function tests are reported without an E/M service code. However, an E/M service code with the modifier –25 appended should be reported to indicate that the afternoon hypertension clinic visit was not related to the pulmonary function testing.

3. Medicare requires that modifier –25 **always be appended to the emergency department (ED) E/M code (99281-99285)** when provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).

*Example #1:* A patient is seen in the ED with complaint of a rapid heartbeat. A 12-lead ECG is performed.

In this case, the appropriate code(s) from the following code ranges can be reported:

99281-99285	(Emergency Department Services) with a modifier –25
93005	(Twelve lead ECG)

*Example #2:* A patient is seen in the ED after a fall. Lacerations sustained from the fall are repaired and radiological x-rays are performed.

In this case, the appropriate code(s) from the following code ranges can be reported:


99281-99285	(Emergency Department Services) with a modifier –25
12001-13160	(Repair/Closure of the Laceration)
70010-79900	(Radiological X-ray)



*Example #3:* A patient is seen in the ED after a fall, complaining of shoulder pain. Radiological x-rays are performed.

In this case, the appropriate code(s) from the following code ranges can be reported:



99281-99285	(Emergency Department Services) with a modifier –25
70010-79900	(Radiological X-ray)

**NOTE:** Using example #3 above, if a subsequent ED visit is made on the same date, but no further procedures are performed, appending modifier –25 to

 that subsequent ED E/M code is NOT appropriate. However, in this instance, since there are two ED E/M visits to the same revenue center (45X), condition code G0 (zero) must be reported in form locator 24 or the corresponding electronic version of the UB92.

-  4. Since payment for taking the patient's blood pressure, temperature, asking the patient how he/she feels, and obtaining written consent is included in the payment for the diagnostic and/or therapeutic procedure, it is not appropriate to report a separate E/M code for these types of service.
-  5. When the reporting of an E/M service with modifier -25 is appropriate (that is, the documentation of the service meets the requirements of the specific E/M service code), it is not necessary that the diagnosis code for which the E/M service was rendered be different than the diagnosis code for which the diagnostic medical/ surgical and/or therapeutic medical/surgical procedure(s) was performed

#### Summary for Use of Modifier -25 in Association with Hospital Outpatient Services

- Modifier -25 applies only to E/M service codes and then only when an E/M service was provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s). In other words, modifier -25 does not apply when no diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) is performed.
-  • It is not necessary that the procedure and the E/M service be provided by the same physician/practitioner for the modifier -25 to apply in the facility setting. It is appropriate to append modifier -25 to the qualifying E/M service code whether or not the E/M and procedure were provided by the same professional.
- The diagnosis associated with the E/M service does not need to be different than that for which the diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) was provided.
-  • It is appropriate to append modifier -25 to ED codes 99281-99285 when these services lead to a decision to perform diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).

**Modifier -25 was effective and implemented for hospital use on June 5, 2000 (see PM A-00-07). This PM provides additional informational only in understanding how this modifier should be used; therefore, this PM does not change the original effective and implementation dates.**

**These instructions should be implemented within your current operating budget.**

**This PM may be discarded after July 1, 2001.**

**Providers are to contact their appropriate fiscal intermediary only.**

# Program Memorandum Intermediaries

Department of Health and  
Human Services (DHHS)  
HEALTH CARE FINANCING  
ADMINISTRATION (HCFA)

Transmittal A-01-80

Date: JUNE 29, 2001

## CHANGE REQUEST 1725

**SUBJECT: Use of Modifier –25 and Modifier –27 in the Hospital Outpatient Prospective Payment System (OPPS)**

This Program Memorandum (PM) provides clarification on reporting modifier –25 and modifier –27 under the hospital OPPS.

The Current Procedural Terminology (CPT) defines modifier –25 as “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.” Modifier –25 was approved for hospital outpatient use effective June 5, 2000.

The CPT defines modifier –27 as “multiple outpatient hospital evaluation and management encounters on the same date.” HCFA will recognize and accept the use of modifier –27 on hospital OPPS claims effective for services on or after October 1, 2001. Although HCFA will accept modifier –27 for OPPS claims, this modifier will not replace condition code G0. The reporting requirements for condition code G0 have not changed. Continue to report condition code G0 for multiple medical visits that occur on the same day in the same revenue centers.

For further clarification on both modifiers, refer to the CPT 2001 Edition. Below are general guidelines in reporting modifiers –25 and –27 under the hospital OPPS.

### **General Guidelines for Modifier –25**

- A. Modifier –25 should be appended only to evaluation and management (E/M) service codes within the range of 92002-92014, 99201-99499, and with HCPCS codes G0101 and G0175.
- B. To append modifier –25 appropriately to an E/M code, the service provided must meet the definition of “significant, separately identifiable E/M service” as defined by CPT.
- C. Although we stated in Transmittal A-00-40 that Medicare requires that modifier –25 “always be appended to the Emergency Department E/M codes when provided . . .” the Outpatient Code Editor (OCE) only requires the use of modifier –25 on an E/M code when it is reported with a procedure code that has a status indicator of “S” or “T.” Nevertheless, such an edit does not preclude the reporting of modifier –25 on E/M codes that are reported with procedure codes that are assigned to other than “S” or “T” status indicators, if the procedure meets the definition of “significant, separately identifiable E/M service.”

Note the OCE will continue to process claims for those procedure codes that are assigned to other than “S” or “T” status indicators if it is reported with an E/M code and a modifier –25.

**General Guidelines for Modifier –27**

- A. Modifier –27 should be appended only to E/M service codes within the range of 92002-92014, 99201-99499, and with HCPCS codes G0101 and G0175.
- B. Hospitals may append modifier –27 to the second and subsequent E/M code when more than one E/M service is provided to indicate that the E/M service is “separate and distinct E/M encounter” from the service previously provided that same day in the same or different hospital outpatient setting.
- C. When reporting modifier –27, report with condition code G0 when multiple medical visits occur on the same day in the same revenue centers.

As is true for any modifier, the use of modifiers –25 and –27 must be substantiated in the patient’s medical record.

Fiscal Intermediaries should forward this PM electronically to providers and place on their web site. This PM should also be distributed with your next regularly scheduled bulletin.

**The *effective date* for this PM is October 1, 2001.**

**The *implementation date* for this PM is October 1, 2001.**

**These instructions should be implemented within your current operating budget.**

**This PM may be discarded after October 1, 2002.**

**If you have any questions, contact your regional coordinator.**

Version 01/29/2024  
Check for Updates

CPT/HCPCS		Effective Date	Term Date	Change Request #	6
92520	Laryngeal function studies	1/1/2010		6719	✓
97597	Dbrdmt opn wnd 1st 20 cm/<	Prior to 1/06			✓
97598	Dbrdmt opn wnd addl 20cm/<	Prior to 1/06			✓
97602	Wound(s) care non-selective	Prior to 1/06			✓
97605	Neg prs wnd ther dme<=50sqcm	Prior to 1/06		4226	✓
97606	Neg prs wnd ther dme>50 sqcm	Prior to 1/06		4226	✓
97607	Neg prs wnd thr ndme<=50sqcm	1/1/2015		8985	✓
97608	Neg prs wnd ther ndme>50sqcm	1/1/2015		8985	✓
97610	Low frequency non-thermal us	1/1/2014		8482	✓
G0456	TERMINATED CODE	1/1/2013	12/31/2014	8985	✓
G0457	TERMINATED CODE	1/1/2013	12/31/2014	8985	✓
0183T	TERMINATED CODE	1/1/2009	12/31/2013	8482	✓
6	<p>If billed by a hospital or a CAH, these OPPS-designated "sometimes therapy" HCPCS/CPT codes may be paid as non-therapy services for hospital or CAH outpatients. When these "sometimes therapy" codes are furnished by a qualified therapist under a therapy plan of care, the requirements for the MPFS-designated "sometimes therapy" codes, described in disposition '7', apply.</p>				

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