



Medicare Critical Access Hospital Version

KEY CONCEPTS OUTLINE

Module 6: Outpatient Visits and Provider-Based Departments

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 services, diabetes outpatient self-management training, medical nutrition therapy and kidney disease education. This commentary applies to CAHs.

- B. Overview: In general, 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 provider-based 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 provider-based department of the hospital. <See 42 C.F.R. 410.27(a)(1)(i) and (iii); see *Medicare Benefit Policy Manual*, Chapter 6 § 20.5.2>

Provider-based departments must meet regulatory requirements found at 42 C.F.R. 413.65, which generally require the department or clinic is integrated into the operations of the hospital.

NOTE: for the duration of the COVID-19 Public Health Emergency (PHE) CMS waived the requirements of 42 C.F.R. 413.65, as well as many CoPs, to allow alternate care provision sites, including patient's homes. Hospitals must continue to comply with non-waived CoPs and other requirements for coverage.

D. Order

1. The service must be furnished on the order of a physician or NPP working within their scope of practice. <See *Medicare Benefit Policy Manual*, Chapter 6 § 20.5.2>
 - a. The CERT contractor found the majority of improper payments for hospital outpatient services was 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); see *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. <See *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. <See *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

II. Provider-Based Departments

A. 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, 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 must be immediately available and accessible as defined in 42 *C.F.R.* 410.47 and 410.49. These services may not be supervised by an NPP. <See 42 *C.F.R.* 410.27 (a)(1)(iv)(B)(1); 42 *C.F.R.* 410.47 and 410.49>
 - a. During the COVID-19 Public Health Emergency (PHE) and until the later of the end of the calendar year the PHE ends or December 31, 2023, the presence of the physician 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

B. Provider-based departments provide facility services in conjunction with a patient encounter, for which they are paid under applicable payment systems, including the OPFS, MPFS, CLFS and cost. <81 Fed. Reg. 79710>

1. Physician or NPP professional services are excluded from payment under hospital payment systems and must be submitted separately on a professional services claim (i. e., 1500 claim or UB04 under Method II billing). <81 Fed. Reg. 79710>

Tip: A separate claim for physician professional services may or may not accompany the facility's claim. Facility "incident-to" coverage does not require the physician see the patient at each encounter.

- a. When billing the professional services on the 1500 claim form, the place of service must be reported as being provided in a hospital outpatient department which decreases the MPFS payment amount.
- b. When billing under Method II, the related professional services are billed on the UB04 claim form with the facility outpatient services and the place of service is not reported.
2. A provider-based department must meet Medicare requirements found at 42 CFR 413.65, which generally require the department or clinic to be integrated into the operations of the hospital.
3. The total payment for an encounter in a provider-based department or clinic may be higher than if the clinic were operated as a freestanding physician's office. <81 Fed. Reg. 79699>Off-Campus Provider-Based Departments

C. Definition of Campus

1. A provider'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)>
 - a. 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 provider-based 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.

- b. An off-campus provider-based department may be located up to 35 miles from the hospital and must meet certain other requirements. <42 C.F.R. 413.65(a)(2), (e)(3)>
 - i. If a CAH or necessary provider CAH wants to add a new provider-based location, the CAH will continue to meet the provider-based location requirements only if the new off-campus provider-based department is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH. <Medicare Program Integrity Manual Transmittal 882>
 - ii. If the location requirement is not met, the CAH's MAC, in consultation with the CAH's Regional Office, will reject the application for the new provider-based location. <Medicare Program Integrity Manual Transmittal 882>

C. Special Rules for an Off-Campus Provider-based Department

1. Modifiers applicable for services in off-campus locations in OPPS hospitals

- a. CAH is not required to report the following modifiers for off-campus provider-based department services. The reporting of these modifiers is intended to affect the various payment methodologies and collection of data in an OPPS hospital.
 - i. 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>
 - ii. Modifier –PN (Non-excepted service provided at an off-campus outpatient, provider-based department of a hospital). <Medicare Claims Processing Manual, Chapter 4 § 20.6.12>
 - iii. Modifier –ER (Items and services furnished by a provider-based off-campus emergency department). <Medicare Claims Processing Manual Transmittal 4202>

III. Billing Clinic and Emergency Department Services

A. Outpatient Clinic Visits

- 1. Clinic visits are billed using CPT Evaluation and Management (E/M) codes and miscellaneous HCPCS Level II codes. <Medicare Claims Processing Manual, Chapter 4 § 160>

a. Outpatient visit codes in a CAH

- i. A clinic visit may be reported with New (99202-99205) and Established (99211-99215) E/M codes.

- a) An established patient is a patient who has been registered as an inpatient or outpatient of the hospital in the past three years. 73 *Fed. Reg.* 68679>

- b) The new versus established determination is made from the perspective of the billing entity. In the provider-based setting, a hospital may appropriately bill a new patient code when the physician bills an established patient code and vice versa. 71 *Fed. Reg.* 68128>

b. Outpatient visit code in an OPPOS hospital

- i. For hospitals paid under OPPOS, clinic visits are billed with a single HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient). <78 *Fed. Reg.* 75042, *Medicare Claims Processing Manual Transmittal* 2845>

- a) A CAH may use G0463 for clinic visits billed to Medicare.

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

NOTE: A CAH is required to have emergency services available 24 hours per day, 7 days per week which meets the definition of a Type A emergency department. An “urgent care” or “walk-in” clinic may meet the definition of a Type B emergency department if at least one-third of its outpatient visits are for emergency care on an urgent basis without a scheduled appointment, as well as meeting other EMTALA criteria.

3. 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 department to which they apply*

IV. 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. Definition of Critical Care

1. The CPT manual provides a definition for “critical care” in the guidelines preceding the critical care codes (located in the E/M chapter of CPT).
2. CMS has established the following criteria to be applied in addition to the CPT definition of critical care. <Medicare Claims processing Manual, Chapter 23 § 20.7.6.3.2 (C)>
 - a. Clinical condition criterion – There is a high probability of sudden, clinically significant or life-threatening deterioration in the patient’s condition which requires the highest level of physician preparedness to intervene urgently.

- b. Treatment criterion – Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis, would likely result in sudden, clinically significant or life-threatening deterioration in the patient's condition.

C. 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>

D. Time Requirements for Billing Critical Care

1. In order 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)>

Case Study 1

Facts: A Medicare patient with serious coronary artery disease was seen in the CAH 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 CAH report for the critical care services provided?
- How much will Medicare pay for the services?

E. 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>

F. Trauma Activation

1. Trauma activation may only be billed if a 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 an OPPS 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. This edit does not apply to a CAH, but a CAH should be aware of the appropriate use of trauma activation (G0390) with critical care services (99291). <IOCE Specifications, Section 6.2, 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>

CASE STUDY 2

Facts: A CAH is designated as a Level 4 trauma center. The CAH's emergency department received notification from the EMS team that they will be arriving in 10 minutes with a patient who fell from a ladder at home. Patient has a history of serious coronary artery disease and is in unstable, critical condition. Based on the documentation in the medical record, the emergency department physician, nursing, and other support staff spent 1 hour and 45 minutes attempting to stabilize the patient; however, the patient expired.

What CPT code(s) should the CAH report for the critical care services provided?

V. Proper Reporting of Modifier -25

- A. When an E/M service is provided on the same date as diagnostic (excluding pathology and laboratory services) and 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.

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 3

Facts: A Medicare patient presented to a provider-based 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 CAH 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 4

Facts: A Medicare patient was seen in a CAH 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 CAH report the services it provided in connection with this encounter?

VI. Proper Reporting of Modifier -CS

- A. Medicare deductible and coinsurance for COVID-19 testing related services is waived for medical visits that result in the ordering of a test for COVID-19. <MLN Matters Article SE20011; Families First Coronavirus Response Act, Section 6002>
- B. When the following four requirements for waiver of deductible and coinsurance are met, the COVID-19 testing related visit service is billed with modifier -CS and facilities should not charge the patient any deductible or coinsurance. <MLN Matters Article SE20011; IOCE Specifications (v21.2), Section 5.1.3 (Supplement)>
 1. A specified visit service:
 - a. Visit services with status indicator of V or J2 (Observation C-APC);
 - b. Critical care (99291); or
 - c. Hospital COVID-19 specimen collection (C9803¹). <IOCE Specifications v21.2; Section 5.1.3>
 2. The visit is provided on March 18, 2020 through the end of the COVID-19 PHE. <MLN Matters Article SE20011>
 3. The visit results in an order for or administration of a COVID-19 test. <MLN Matters Article SE20011; Families First Coronavirus Response Act, Section 6002>

Note: The MLN Matters Special Edition explaining this provision only mentions the laboratory tests U0001, U0002, and 87635. Subsequent to its original publishing, additional COVID-19 laboratory testing codes were adopted, including U0003 and U0004 for high throughput tests; and 86769 and 86328 for antibody testing. Presumably, the coinsurance and deductible waiver also applies when the visit results in the ordering of one of these additional test codes as well. Providers should confirm application of the waiver to these additional codes with their MAC.

¹ Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2)(coronavirus disease [covid-19], any specimen source

4. The visit relates to the furnishing or administration of the COVID-19 test or to the evaluation of an individual for determining the need for the COVID 19-test. <MLN Matters Article SE20011; Families First Coronavirus Response Act, Section 6002>

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CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare patient with serious coronary artery disease was seen in the CAH 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 CAH report for the critical care services provided?
- How much will Medicare pay for the services?

Analysis: The CAH should report 99291 for the first hour of critical care and 99292 for the additional half hour beyond the first hour. Assuming all documentation supports billing for both codes, Medicare will pay a CAH for both services based on reasonable costs. An OPPS hospital will only be separately paid for 99291, and payment for 99292 is packaged into payment for 99291. <71 *Fed. Reg.* 68134, *Medicare Claims Processing Manual Transmittal 1139*, OPPS Addendum B>

Case Study 2

Facts: A CAH is designated as a Level 4 trauma center. The CAH's emergency department received notification from the EMS team that they will be arriving in 10 minutes with a patient who has a history of serious coronary artery disease and is in unstable, critical condition. Based on the documentation in the medical record, the emergency department physician, nursing and other support staff spent 1 hour and 45 minutes attempting to stabilize the patient; however, the patient expired.

- What CPT code(s) should the CAH report for the critical care services provided?

Analysis: The CAH should report one unit of 99291 for the first 60 minutes of critical care and two units of 99292 for the additional 45 minutes. Critical care is reported regardless of the outcome with the patient. The CAH should also report trauma activation G0390 as a designated trauma center that received prior notification of the patient's arrival and provided critical care services to the patient.

Case Study 3

Facts: A Medicare patient presented to a provider-based 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 CAH 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>

Case Study 4

Facts: A Medicare patient was seen in a CAH 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 CAH report the services it provided in connection with this encounter?

Analysis: The CAH 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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This content is from the eCFR and is authoritative but unofficial.

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 by a doctor of medicine or a doctor of osteopathy, as specified in §§ 410.47 and 410.49, respectively. Until the later of the end of the calendar year in which the PHE as defined in § 400.200 of this subchapter ends or December 31, 2023, the presence of the physician 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, 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 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, 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]



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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 03/03/2022
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SEE UPDATED LIST ON THE FOLLOWING PAGE

Services Designated as “Sometimes Therapy” that May be Paid as Non-Therapy Services for Hospital Outpatients

HCPCS Code	Long Descriptor
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

200.10 - Billing for Cost Based Payment for Certified Registered Nurse Anesthetists (CRNA) Services Furnished by Outpatient Prospective Payment System (OPPS) Hospitals

CPT/HCPCS	Effective Date	Term Date	Change Request #	6
92520	1/1/2010		6719	✓
97597	Prior to 1/06			✓
97598	Prior to 1/06			✓
97602	Prior to 1/06			✓
97605	Prior to 1/06		4226	✓
97606	Prior to 1/06		4226	✓
97607	1/1/2015		8985	✓
97608	1/1/2015		8985	✓
97610	1/1/2014		8482	✓
G0456	1/1/2013	12/31/2014	8985	✓
G0457	1/1/2013	12/31/2014	8985	✓
0183T	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>			

Version 03/2022
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Hospital Outpatient Therapeutic Services That Have Been Evaluated for a Change in Supervision Level

For all hospital outpatient therapeutic services furnished prior to January 1, 2020 with the exception of non-surgical extended duration services (NSEDTS), Medicare required direct supervision unless CMS assigned a supervision level of either general or personal supervision for an individual service. Effective January 1, 2020, the default minimum level of supervision for hospital outpatient therapeutic services changed to general supervision for all services except for NSEDTS, pulmonary rehabilitation services, cardiac rehabilitation services, and intensive cardiac rehabilitation services. Except as described below, NSEDTS continue to have a hybrid level of supervision. See 42 CFR 410.27(a)(1)(iv)(E) for a description of NSEDTS. Similarly, except as described below, pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services continue to require direct supervision by a doctor of medicine or osteopathy. See 42 CFR 410.27(a)(1)(iv)(D).

Regarding NSEDTS and pulmonary rehabilitation services, cardiac rehabilitation services, and intensive cardiac rehabilitation services, we promulgated an interim final rule that addresses the supervision requirements for these services during the Public Health Emergency (PHE). Specifically, effective March 1, 2020, we are changing Medicare payment rules during the PHE for the COVID-19 pandemic so that outpatient hospital providers are allowed broad flexibilities to furnish services. During the PHE, the minimum level of supervision for NSEDTS has been changed to general for the duration of the entire service, including the initiation portion of the service. 42 CFR 410.27(a)(1)(iv)(E) has been revised to reflect this change in the minimum level of supervision. Also during the PHE, the direct supervision requirement for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services may be fulfilled by the virtual presence of the health care provider through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. 42 CFR 410.27(a)(1)(iv)(D) has been revised to reflect this change in the direct supervision requirements.

Since CY 2012, the Hospital Outpatient Payment (HOP) Panel has considered and advised CMS on stakeholder requests for changes in the required minimum level of supervision of individual hospital outpatient therapeutic services. For services furnished prior to January 1, 2020, the following table lists the hospital outpatient therapeutic services that were evaluated by the HOP Panel for a change from direct supervision as well as the HOP Panel evaluation dates and recommendations and the final CMS decision on the supervision levels for the services. The table also lists select codes with CMS-initiated supervision level changes.

- For HCPCS codes for which “N/A” appears in the HOP Panel Evaluation Date and HOP Panel Recommendation columns for services, CMS initiated the supervision level changes.
- For HCPCS codes with “N/A” in the HOP Panel Recommendation column, the Panel chose not to make a recommendation when it evaluated the service described by that code.
- For HCPCS codes with “N/A” in the effective date column, there is no effective date provided because CMS did not make a change in the supervision level for services described by that code that were furnished prior to January 1, 2020.

May 8, 2020

Finally, the table includes two new columns. The first new column is "Level of Supervision January 1 to February 29, 2020" which indicates the required supervision level for outpatient therapeutic services furnished during the period of January 1 to February 29, 2020, that have been evaluated by the HOP Panel or CMS in the past for a change in the required supervision level. The second new column is "Level of Supervision during the COVID-19 PHE Starting March 1, 2020. As explained above, with the exception pulmonary rehabilitation services, cardiac rehabilitation services, and intensive cardiac rehabilitation services, the required supervision level for all outpatient therapeutic services furnished during the COVID-19 PHE starting on March 1, 2020 is general supervision.

HCPCS Code	Short Descriptor	HOP Panel Evaluation Date	HOP Panel Recommendation	CMS Decision	Effective Date for Services Furnished prior to January 1, 2020	Level of Supervision January 1 to February 29, 2020	Level of Supervision during the COVID-19 PHE Starting March 1, 2020
C8957	Prolonged iv inf, req pump	N/A	N/A	NSEDTS	January 1, 2011	NSEDTS	General
11719	Trim nail(s) any number	Aug, 2012	General	General	January 1, 2013	General	General
29580	Application of paste boot	Aug, 2012	General	General	January 1, 2013	General	General
29581	Apply multilay comprs lwr leg	Aug, 2012	General	General	January 1, 2013	General	General
36000	Place needle in vein	Aug, 2012	General	General	January 1, 2013	General	General
36430	Blood transfusion service	March, 2014	General	General	July 1, 2014	General	General
36591	Draw blood off venous device	Aug, 2012	General	General	January 1, 2013	General	General
36592	Collect blood from picc	Aug, 2012	General	General	January 1, 2013	General	General
36593	Declot vascular device	March, 2014	General	General	July 1, 2014	General	General
36600	Withdrawal of arterial blood	March, 2014	General	General	July 1, 2014	General	General
51700	Irrigation of bladder	Aug, 2012	General	General	January 1, 2013	General	General
51701	Insert bladder catheter	Feb, 2012	General	General	July 1, 2012	General	General
51702	Insert temp bladder cath	Aug, 2012	General	General	January 1, 2013	General	General
51705	Change of bladder tube	Aug, 2012	General	General	January 1, 2013	General	General
51798	Us urine capacity measure	Aug, 2012	General	General	January 1, 2013	General	General
90471	Immunization admin	Feb, 2012	General	General	July 1, 2012	General	General
90472	Immunization admin each add	Feb, 2012	General	General	July 1, 2012	General	General

HCPCS Code	Short Descriptor	HOP Panel Evaluation Date	HOP Panel Recommendation	CMS Decision	Effective Date for Services Furnished prior to January 1, 2020	Level of Supervision January 1 to February 29, 2020	Level of Supervision during the COVID-19 PHE Starting March 1, 2020
90473	Immune admin oral/nasal	Feb, 2012	General	General	July 1, 2012	General	General
90474	Immune admin oral/nasal addl	Feb, 2012	General	General	July 1, 2012	General	General
90832	Psytx pt&/family 30 minutes	Feb, 2012	General	General	July 1, 2012	General	General
90834	Psytx pt&/family 45 minutes	Feb, 2012	General	General	July 1, 2012	General	General
90837	Psytx pt&/family 60 minutes	Feb, 2012	General	General	July 1, 2012	General	General
90785	Psytx complex interactive	Feb, 2012	General	General	July 1, 2012	General	General
90846	Family psytx w/o patient	Feb, 2012	General	General	July 1, 2012	General	General
90847	Family psytx w/patient	Feb, 2012	General	General	July 1, 2012	General	General
90849	Multiple family group psytx	Feb, 2012	General	General	July 1, 2012	General	General
90853	Group psychotherapy	Feb, 2012	General	General	July 1, 2012	General	General
90857	Intac group psytx	Feb, 2012	General	General	July 1, 2012	General	General
94640	Airway inhalation treatment	Feb, 2012	NSEDTS	Direct	July 1, 2012	General	General
94640	Airway inhalation treatment	March, 2014	None	Direct	N/A	General	General
94667	Chest wall manipulation	March, 2014	General	General	N/A	General	General
94668	Chest wall manipulation	March, 2014	General	General	July 1, 2014	General	General
96360	Hydration iv infusion init	Aug, 2012	General	General	January 1, 2013	General	General
96361	Hydrate iv infusion add-on	Aug, 2012	General	General	January 1, 2013	General	General
96365	Ther/proph/diag iv inf init	Aug, 2012	General	NSEDTS	N/A	NSEDTS	General
96366	Ther/proph/diag iv inf addon	Aug, 2012	General	General	January 1, 2013	General	General
96367	Tx/proph/dg addl seq iv inf	Aug, 2012	General	NSEDTS	N/A	NSEDTS	General
96368	Ther/diag concurrent inf	Aug, 2012	General	NSEDTS	N/A	NSEDTS	General
96369	Sc ther infusion up to 1 hr	March, 2014	General	NSEDTS	N/A	NSEDTS	General
96370	Sc ther infusion addl hr	March, 2014	General	General	July 1, 2014	General	General
96371	Sc ther infusion reset pump	March, 2014	General	NSEDTS	N/A	NSEDTS	General

HCPCS Code	Short Descriptor	HOP Panel Evaluation Date	HOP Panel Recommendation	CMS Decision	Effective Date for Services Furnished prior to January 1, 2020	Level of Supervision January 1 to February 29, 2020	Level of Supervision during the COVID-19 PHE Starting March 1, 2020
96372	Ther/proph/diag inj sc/im	Aug, 2012	General	General	January 1, 2013	General	General
96374	Ther/proph/diag inj iv push	Aug, 2012	General	NSEDTS	N/A	NSEDTS	General
96375	Tx/pro/dx inj new drug addon	Aug, 2012	General	NSEDTS	N/A	NSEDTS	General
96376	Tx/pro/dx inj same drug addon	Aug, 2012	General	General	January 1, 2013	General	General
96401	Chemo anti-neopl sq/im	March/August	General	Direct	N/A	General	General
96402	Chemo hormon antineopl	March/August	General	Direct	N/A	General	General
96409	Chemo iv push sngl drug	March/August	General	Direct	N/A	General	General
96411	Chemo iv push addl drug	March/August	General	Direct	N/A	General	General
96413	Chemo iv infusion 1 hr	March/August	General	Direct	N/A	General	General
96415	Chemo iv infusion addl hr	March/August	General	Direct	N/A	General	General
96416	Chemo prolong infuse w/pump	March/August	General	Direct	N/A	General	General
96417	Chemo iv infus each addl seq	March/August	General	Direct	N/A	General	General
96521	Refill/maint portable pump	Aug, 2012	General	General	January 1, 2013	General	General
96523	Irrig drug delivery device	Aug, 2012	General	General	January 1, 2013	General	General
97597	Rmvl devital tis 20 cm/<	March, 2014 March 2015	General N/A	Direct	N/A	General	General
99406	Behav chng smoking 3-10 min	Feb, 2012	General	General	July 1, 2012	General	General
99407	Behav chng smoking > 10 min	Feb, 2012	General	General	July 1, 2012	General	General
99490	Chron care mgmt srvc 20 min	N/A	N/A	General	January 1, 2015	General	General
99495	Trans care mgmt 14 day disch	N/A	N/A	General	January 1, 2015	General	General
99496	Trans care mgmt 7 day disch	N/A	N/A	General	January 1, 2015	General	General
G0008	Admin influenza virus vac	Aug, 2012	General	General	January 1, 2013	General	General
G0009	Admin pneumococcal vaccine	Aug, 2012	General	General	January 1, 2013	General	General
G0010	Admin hepatitis b vaccine	Aug, 2012	General	General	January 1, 2013	General	General

HPCS Code	Short Descriptor	HOP Panel Evaluation Date	HOP Panel Recommendation	CMS Decision	Effective Date for Services Furnished prior to January 1, 2020	Level of Supervision January 1 to February 29, 2020	Level of Supervision during the COVID-19 PHE Starting March 1, 2020
G0127	Trim nail(s)	Aug, 2012	General	General	January 1, 2013	General	General
G0176	Opps/php:activity therapy	March, 2014	General	General	July 1, 2014	General	General
G0177	Opps/php: train & educ serv	Feb, 2012	General	General	July 1, 2012	General	General
G0378	Hospital observation per hr	Aug, 2012	None	NSEDTS	N/A	NSEDTS	General
G0379	Direct refer hospital observ	Aug, 2012	General	NSEDTS	January 1, 2013	NSEDTS	General
G0410	Grp psych partial hosp 45-50	Feb, 2012	General	General	July 1, 2012	General	General
G0411	Inter active grp psych parti	Feb, 2012	General	General	July 1, 2012	General	General

Posted on the CMS Federal Advisory Committee Act website**Release Date: February 22, 2017***(Note: date of release is 2018 rather than 2017)***Release: Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access Hospitals and Small Rural Hospitals**

Beginning on March 18, 2010, the Centers for Medicare & Medicaid Services (CMS) instructed its contractors not to evaluate or enforce the supervision requirements for therapeutic services provided to outpatients in Critical Access Hospitals from January 1, 2010 through December 31, 2010. CMS extended this instruction for 2011 and expanded it to include small rural hospitals with 100 or fewer beds beginning in 2011. For purposes of this enforcement instruction, CMS defines “small rural hospitals” as hospitals with 100 or fewer beds that are geographically located in a rural area or that are paid under the hospital outpatient prospective payment system with a rural wage index. The enforcement instruction has been extended by Congress several times through 2016.

The Bipartisan Budget Act of 2018 now extends this enforcement instruction through 2017, beginning January 1, 2017 and ending on December 31, 2017. In addition, the CY 2018 OPPS/ASC final rule with comment period continues the enforcement instruction for calendar years 2018 and 2019.

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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.

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