



Medicare Hospital and Chargemaster Version LifePoint Custom

KEY CONCEPTS OUTLINE

Module 7: Hospital Outpatient Departments, including Clinics

- I. Coverage of Hospital Outpatient Therapeutic Services
 - A. Most hospital outpatient therapeutic services paid under OPPS 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 OPPS Final Rule* indicates “incident to” requirements do not apply to therapeutic services not paid under the OPPS. <76 Fed. Reg. 74369-70>

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

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

C. Location

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

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

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

a. Exceptions

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

D. Order

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

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

E. Integral, though Incidental

1. The service must be furnished as an integral, though incidental, part of the physician's or NPP's services in the course of diagnosing or treating the patient. <See 42 C.F.R. 410.27(a)(1)(ii); 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

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](#)

II. Hospital Outpatient Departments, including Clinics

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

Example: A physician sees an established patient in an on-campus hospital clinic that is consider a department of the hospital. The physician services are appropriately submitted as a level 4 office visit (99214) and the facility services are appropriately submitted as a hospital outpatient clinic visit (G0463). The allowable national payment amounts for 2023:

Claim Type	Service	Freestanding	Hospital Department	Difference
CMS-1500	Allowable for Professional Services (99214)	\$128.43	\$97.60	-\$30.83
UB-04	Allowable for Facility Services (G0463)	None	\$120.86	\$120.86
	Total Allowable	\$128.43	\$218.46	\$90.03

III. Off-Campus Hospital Outpatient Departments

- A. Off-campus department services are excluded from reimbursement under the OPSS and are reimbursed under the MPFS or another applicable fee schedule, unless the department they are provided in is defined as “excepted”. <See 42 C.F.R. 419.48; Bipartisan Budget Act of 2015, Section 603; 42 C.F.R. 419.22; 81 Fed. Reg. 79698-700>
- Handout 13 has a diagram illustrating on- and off-campus departments and modifiers used for these departments.

B. Definition of Campus

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

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

C. "Excepted" Off-Campus Departments

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

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

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

2. Remote Locations

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

3. Emergency Departments

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

4. Grandfathered Departments

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

Note: In a COVID-19 related Interim Final Rule (CMS-5531-IFC), published May 8, 2020, CMS adopted **an alternate method** for relocation of all or part of a hospital department to allow services to continue to be billed as excepted services during the PHE. The relocation may be to a patient’s home. The provider must notify the CMS Regional Office within 120 days of delivery of services at the proposed new location. For details of what to include in the notification, see the IFC.

Notification is only necessary where the provider wishes to relocate all or part of an excepted department to continue to bill services with modifier -PO. A provider may use an alternate location and treat it as a new location, billed with modifier -PN without notification to the Regional Office. This may be appropriate for services that do not receive a payment reduction when reported with modifier -PN (e.g., therapy).

c. Change of Ownership

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

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

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

E. “Nonexcepted” Off-Campus Department Services

1. “Nonexcepted” off-campus departments are off-campus departments that do not meet the requirements to be an “excepted” department.
2. All services provided at “nonexcepted” off-campus departments are coded with modifier -PN, including drugs, laboratory services, and therapy. <See *Medicare Claims Processing Manual Transmittal 3685*; 81 *Fed. Reg.* 79719>
 - a. Modifier -PN and -PO would not be reported on the same item or service but could be reported on the same claim if both “excepted” and “nonexcepted” services are billed on the claim. <See *Medicare Claims Processing Manual Transmittal 3685*>
3. Services reported with modifier -PN are paid a “site of service specific” (SoSS) rate under the MPFS calculated at 40% of the applicable OPFS rate. <82 *Fed. Reg.* 53027-28>
 - a. OPFS policies that apply to the SoSS MPFS rate:
 - i. Normal OPFS packaging logic, C-APC logic, multiple procedure reduction logic, and wage index are applied prior to application of the 60% reduction. <81 *Fed. Reg.* 79726>
 - ii. Hospital outpatient physician supervision policies continue to apply to services paid under the SoSS MPFS rate. <81 *Fed. Reg.* 79727, 82 *Fed. Reg.* 53027>
 - b. OPFS policies that do not apply to the SoSS MPFS rate:
 - i. Outlier payments do not apply to the SoSS MPFS rate. <81 *Fed. Reg.* 79727>
 - ii. The patient’s coinsurance is not capped at the inpatient deductible for services paid at the SoSS MPFS. <81 *Fed. Reg.* 79727>
 - iii. Rural SCH, cancer hospital, quality reporting, and TOPs adjustments do not apply to the SoSS MPFS. <81 *Fed. Reg.* 79727>
 - c. Exceptions:
 - i. Services with a status indicator “A” paid under the MPFS are still paid at the standard MPFS rate, rather than the SoSS MPFS rate. <81 *Fed. Reg.* 79725>
 - ii. Services with status indicator “A” or “Q4”, if not packaged, are paid under the Clinical Laboratory Fee Schedule. <81 *Fed. Reg.* 79725>

- iii. Ambulance services with status indicator “A” are paid under the ambulance fee schedule. <81 Fed. Reg. 79725>
- iv. Drugs and biologicals with status indicator “G” or “K”, coded with modifier -PN are paid under the MPFS at ASP +6%. <81 Fed. Reg. 79725>

Example: A physician sees an established patient in a “nonexcepted” hospital clinic. The physician services are appropriately submitted as a level 4 office visit (99214) and the facility services are appropriately submitted as a hospital outpatient clinic visit (G0463-PN). The allowable national payment amounts for 2023:

Claim Type	Service	Freestanding	Hospital Department	Difference
CMS-1500	Allowable for Professional Services (99214)	\$128.43	\$ 97.60	-\$30.83
UB-04	Allowable for Facility Services (G0463)	None	\$ 48.34	\$48.34
	Total Allowable	\$128.43	\$145.94	\$17.51

IV. Billing Clinic and Emergency Department Services

A. Clinic Encounters

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

B. Emergency Department Encounters

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

- b. Type B Emergency Departments are billed using HCPCS Level II codes (G0380-G0384).
- i. A “Type B” ED is a facility that meets the EMTALA definition of a “dedicated emergency department” but is not open 24 hours a day, 7 days a week. <71 Fed. Reg. 68132- 68133; Medicare Claims Processing Manual, Chapter 4 § 160>

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

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

2. Level Selection

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

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

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

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

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

B. Location of Critical Care Services

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

C. Time Requirements for Billing Critical Care

1. To bill critical care, the hospital must provide 30 minutes of critical care services. <71 *Fed. Reg.* 68134>

a. When reporting critical care, the hospital counts the time spent by the physician or hospital staff actively engaged in face-to-face critical care of the patient. <*Medicare Claims Processing Manual Transmittal 1139*>

i. If multiple staff members are in attendance, the time may only be counted once.

b. If fewer than 30 minutes of critical care is provided, the hospital should report an appropriate clinic or emergency department code, at a level consistent with their internal guidelines. <71 *Fed. Reg.* 68134, *Medicare Claims Processing Manual Transmittal 1139*>

c. If more than 74 minutes of critical is provided, the hospital may report CPT code 99292 – used to report additional increments of 30 minutes.

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

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 hospital emergency department in unstable, critical condition. The emergency department physicians and nurses spent 1 hour and 30 minutes attempting to revive the patient, however, the patient expired. What codes should the hospital report for the critical care services provided? How much will Medicare pay for the services?

D. Trauma Activation

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

E. Critical Care Composite

1. Ancillary Services Billed with Critical Care

- a. Services listed by the CPT manual as bundled to critical care for physicians, are not bundled for hospitals and should be reported separately. <75 Fed. Reg. 71988>
- b. Ancillary services¹ with status indicator Q3 assigned to the critical care composite are packaged into the payment for critical care when billed on the same claim as critical care. <75 Fed. Reg. 71988; see *IOCE Specifications*, Section 5.4.3 (Supplement)>
 - i. If these services, except pulse oximetry (94762) and arterial puncture (36600), are reported with modifier -59, -XE, -XS, -XP, or -XU they are processed with their standard status indicator and APC. <See *IOCE Specifications*, Section 5.4.3 (Supplement)>
 - ii. It is unclear if this allows payment for chest x-rays (71045, 71046) when reported with modifier -59. These codes have an initial status indicator of Q3 and APC of 5521 which has a standard status indicator of S. Typically, x-rays, including all other x-rays assigned APC 5521, have initial status indicator Q1 and would be packaged to the critical care code due to its status indicator of V. <OPPS Addendum A, OPSS Addendum B, and OPSS Addendum D1>

VI. Remote Mental Health Services

- A. Remote mental health (RMH) services provided by hospital staff to patients in their homes are billed with codes C7900 – C7902. <87 Fed. Reg. 72015; *Medicare Claims Processing Transmittal 11737*>
 1. Table 66 of the 2023 OPSS Final Rule contains the long descriptors of C7900 – C7902. Table 66 is included in the materials behind the outline.
 2. RMH services include services for the diagnosis, evaluation, or treatment of a mental health or substance use disorder. <87 Fed. Reg. 72015, Table 66>
 3. Hospital staff providing mental health services to patients in their homes do not need to be physically located in the hospital. <87 Fed. Reg. 72017>

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

B. Communication Technology

1. Hospital staff must have the capability to use an interactive telecommunications system that includes two-way, real-time, interactive audio and video communications. <87 Fed. Reg. 72018-19>
2. Real-time audio-only communication technology may be used if the beneficiary is not capable of or does not consent to two-way audio and video technology. <87 Fed. Reg. 72018-19>

C. Periodic In-Person Visit Requirements

1. There must be an in-person service within 6 months prior to the first remote mental health service. <87 Fed. Reg. 72017-18>
 - a. Beneficiaries who began receiving mental health services in their homes during the Covid Public Health Emergency (PHE) or the 151-days after the end of the PHE do not require an in-person visit 6 months prior to receiving remote mental health services. <87 Fed. Reg. 72018>

The 151-day period was designed to match requirements for hospital outpatient remote mental health services with those delivered under the physician fee schedule (PFS) and at Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) established by Congress in 2021. Subsequent to the 2023 OPPTS Final Rule being published, Congress further extended application of in-person requirements through December 31, 2024 for mental health services under the PFS, and at RHCs and FQHCs. It is unclear if CMS will adopt a similar policy for hospital outpatient mental health services.

2. There must be an in-person service within 12 months of each RMH service furnished by hospital clinical staff. <87 Fed. Reg. 72017-18>
 - a. An in-person visit is not required within 12 months of the RMH services if the hospital clinical staff and the beneficiary agree that the risks and burdens of an in-person service outweighs the benefits of the in-person visit. <87 Fed. Reg. 72017-18>
 - b. Documentation requirements for in-person exception:
 - i. A clear justification documented in the medical record, including the clinician's professional judgment that:
 - a) The patient is clinically stable; and/or

b) An in-person visit:

- 1) Has the risk of worsening the person's condition,
- 2) Creating undue hardship on the person or their family, or
- 3) Result in disengaging with care that has been effective in managing the person's illness;

- ii. The patient has a regular source of general medical care; and
- iii. The patient has the ability to obtain any needed point of care testing, including vital sign monitoring and laboratory studies. <87 Fed. Reg. 72017>

D. Remote Mental Health Services Provided with Other Mental Health Services

1. With Partial Hospitalization Programs (PHP)

- a. A PHP program is an intensive outpatient program of psychiatric services provided as an alternative to inpatient psychiatric care for individuals who have an acute mental illness and require a minimum of 20 hours per week of therapeutic services. <87 Fed. Reg. 71994, 72001-002>
 - i. All PHP services are billed individually and then grouped together by date of service and paid under a single APC depending on whether the PHP is hospital based or provided by a community mental health center (CMHC). <IOCE Specifications, Sections 5.4.2, 5.4.4 (Supplement)>
- b. RMH services are not considered PHP services because PHP services may not be provided in the patient's home by statute. <87 Fed. Reg. 72000>
- c. RMH services may be provided to a patient in PHP, if documentation continues to support the patient's eligibility for PHP, all other program requirements are met, and the physician updates the plan of care. <87 Fed. Reg. 72001-002>
 - i. The RMH services may be provided by a different entity than the PHP services (e.g., a hospital outpatient department provides the RMH services and a community mental health center provides the PHP). <87 Fed. Reg. 72001>
 - ii. When RMH services are provided along with PHP by the same hospital, the RMH service is packaged and not paid separately. <IOCE Specifications, Sections 5.4.4, 5.4.4.1 (Supplement)>

2. With Daily Mental Health Services Composite APC

- a. If multiple mental health services are provided on a single date of service and the total payment would exceed the amount payable for hospital-based PHP, payment is capped at the Mental Health Services Composite APC 8010 (equal to the hospital-based PHP). <IOCE Specifications, Section 5.4.3 (Supplement)>
 - i. The APC 8010 will be assigned to one line and all other mental health services are packaged. <IOCE Specifications, Section 5.4.3 (Supplement)>
 - ii. Mental health services included in the Daily Mental Health Composite cap have a status indicator Q3. A list of all HCPCS codes that have status indicator Q3 (i.e., codes that are part of composite APCs) is included behind the outline of the OPSS Payment module.
- b. RMH services have a status indicator S and are not counted toward the cap triggering the Mental Health Services Composite APC. <OPSS Addendum B; IOCE Specifications, Sections 5.4.3, 5.4.3.1 (Supplement)>
- c. If the Mental Health Services Composite APC is triggered, any RMH services will be packaged to the composite APC 8010 and not paid separately. <IOCE Specifications, Sections 5.4.3, 5.4.3.1 (Supplement)>

VII. 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 2

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

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

Case Study 3

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

VIII. Billing for Observation Services

A. Covered observation services are billed with two G-codes:

1. G0378 – “Hospital observation services, per hour”
2. G0379 – “Direct admission of patient for hospital observation care”
 - a. Code G0379 must be reported with G0378. <IOCE Specifications, Section 6.2, Edit 58 (Supplement)>

B. Observation services are reported with revenue code 0762 (“Observation Hours”). <Medicare Claims Processing Manual, Chapter 4 § 290.2.1>

1. Ancillary services performed while the patient is in observation status are reported using appropriate revenue codes and HCPCS codes as applicable. <Medicare Claims Processing Manual, Chapter 4 § 290.2.1>

C. Counting Observation Hours

1. Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time observation care is initiated in accordance with a physician’s order. <Medicare Claims Processing Manual, Chapter 4 §§ 290.2.2 and 290.5.1>
2. Observation time ends:
 - a. When the patient is actually discharged from the hospital or admitted as an inpatient; or
 - b. Prior to discharge, when all medically necessary services related to observation have been completed. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>
 - i. Other covered services provided after observation has ended, should be billed separately or as part of appropriate E/M visit charges. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>

Tip: Medically necessary services such as therapy, wound care, or drug administration, provided after medically necessary observation has ended but the patient remains at the hospital awaiting placement or discharge, may be billed separately and may qualify for separate payment.

- c. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. <Medicare Claims Processing Manual, Chapter 4 §§ 290.2.2, 290.5.1>
3. Accounting for actively monitored procedures
- a. Where active monitoring is part of a procedure that occurs during an observation stay, the time providing the procedure should be subtracted from the total observation time reported. The provide may:
 - i. Document the beginning and ending times of each period of observation and add the periods of observation together to get the total time; or
 - ii. Subtract an average length of time for interrupting procedures from the total time. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>
4. Observation is reported by hour, rounded to the nearest hour. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>
- a. CMS provides the example of observation from 3:03 pm to 9:45 pm reported as 7 hours of observation. <Medicare Claims Processing Manual, Chapter 4 § 290.2.2>
 - b. There is a conflict in the guidance from MACs on what rounding to the nearest hour means:
 - i. One MAC, Novitas, indicates you calculate the total time, including carving out time for services that require active monitoring, and then round to the nearest hour. Novitas provides the following example on their website: Order placed for observation at 12:20 am, order to admit as inpatient at 11:45 pm, total 11 hours and 25 minutes, 1 hour and 40 minutes for a diagnostic test carved out yields 9 hours and 45 minutes, yielding 10 hours of billed time. <“How to clock observation time”, Novitas Part A website>
 - ii. Two MACs, Noridian and Palmetto, indicate you round the start time to the nearest hour and the stop time to the nearest hour and then calculate the hours. Noridian provides the following example on their website: “observation began at 3:29 pm and ended at 9:31 pm, the total hours would be calculated using the span of 3:00 pm to 10:00 pm for a total of 7 hours”. They do not address rounding after subtracting the time for “interrupting procedures” from the total duration of observation, but presumably the time would still need to be rounded as this would

rarely equal a round number. <“ACT Questions and Answers – March 23, 2022 Revised”, Noridian Part A Website; “Observation Care”, published 01/10/2019, Palmetto GBA Part A website>

Caution: The example from the *Medicare Claims Processing Manual* would result in 7 hours as rounded under either of the contractor methodologies. Providers should seek further clarification from their MAC if they have questions on rounding and reporting observation.

D. Reporting Observation

1. All hours of observation should be reported on a single line. The line-item date of services is the date the observation services began, regardless of whether some of the services spanned the midnight hour and were provided on subsequent dates of service. <*Medicare Claims Processing Manual*, Chapter 4 § 290.2.2>

Tip: CMS has a published Medically Unlikely Edit (MUE) of 72 hours for G0378 which prevents reporting of more than 72 hours of observation. The edit may be appealed if more than 72 hours of medically necessary observation are provided. However, cases over 48 hours should be reviewed to confirm all observation care is medically necessary and identify missed inpatient admission opportunities for future improvement.

Additionally, for CAHs, the Common Working File (CWF) will edit TOB 085X and not allow the claim to be processed for payment when observation services reported with revenue code 0762 are greater than 48 hours (units). <*Medicare Claims Processing Manual Transmittal 907*>

2. All non-repetitive services occurring on the same day or in the same episode of care with the observation services, must be billed on the same claim to ensure payment logic can operate correctly. <*Medicare Claims Processing Manual*, Chapter 4 § 290.5.3>

IX. Payment for Observation Services

A. There are three ways Medicare pays for covered observation services: <Medicare Claims Processing Manual, Chapter 4 §§ 290.5.1, 290.5.2, and 290.5.3; 80 Fed. Reg. 70335-336>

1. Packaged into/paid as part of the C-APC for Comprehensive Observation Services (APC 8011);
2. Packaged into a visit APC for direct referral for observation; or
3. Packaged into/paid as part of other services on the claim.

B. Comprehensive-APC (C-APC) for Comprehensive Observation Services

1. The C-APC for Comprehensive Observation Services (C-APC 8011) makes a single payment for all services provided during an encounter that includes at least 8 hours of observation and meets other criteria. <80 Fed. Reg. 70335-336; Medicare Claim Processing Manual, Chapter 4 § 290.5.3>
2. Criteria for payment of C-APC 8011 (\$2,439.02)
 - a. An assessment visit, assigned status indicator J2, with a date of service on the day of or the day before observation services:
 - i. A clinic visit billed with G0463; or
 - ii. A Type A ED visit billed with 99281 - 99285; or
 - iii. A Type B ED (urgent care) visit billed with G0380 – G0384; or
 - iv. A critical care visit billed with 99291; or
 - v. Direct referral for observation billed with G0379. <80 Fed. Reg. 70335-336; Medicare Claim Processing Manual, Chapter 4 § 290.5.3>
 - b. At least 8 hours of observation care billed with G0378. <80 Fed. Reg. 70335-336; Medicare Claims Processing Manual, Chapter 4 § 290.5.3>
 - c. No surgical procedure assigned status indicator T or J1 reported on the same claim as the observation services. <80 Fed. Reg. 70335-336; Medicare Claims Processing Manual, Chapter 4 § 290.5.3>
3. If all criteria for C-APC 8011 are not met, the observation will be packaged into the other services on the claim and no additional payment will be made for the observation. <Medicare Claims Processing Manual, Chapter 4 § 290.5.3>

- a. Any other separately payable HCPCS (i.e., the clinic visit, ER visit, etc.) will be paid separately according to their “usual associated” APCs. <Medicare Claims Processing Manual, Chapter 4 § 290.5.3>

C. Payment for Direct Referral for Observation

1. Separate payment is available for direct referral for observation (G0379) if the following criteria are met:
 - a. The services on the claim do not qualify for payment under C-APC 8011;
 - b. No service with status indicator T, J1 or V (visit) is billed on the same claim. <IOCE Specifications, Section 5.5.7, 5.5.7.1 (Supplement), Medicare Claims Processing Manual, Chapter 4 § 290.5.2>
2. Payment is made under APC 5025 – “Level 5 Type A ED Visit.” (\$548.11) <IOCE Specifications, 5.5.7, 5.5.7.1 (Supplement), OPSS Addendum A>

D. Packaged Observation Services

1. Covered observation services that do not qualify for payment as part of the C-APC for Comprehensive Observation Services or direct referral for observation are packaged to other separately payable services. <Medicare Claims Processing Manual, Chapter 4 § 290.5.1>

Examples of packaged observation services (i.e., no additional payment for observation is made), include

- Observation services provided during an encounter with a surgical procedure (i.e., services with status indicators T or J1)
- Observation stays of less than 8 hours, unless they are the result of a direct referral for observation

Case Study 4

Facts: A Medicare patient presented to an emergency department complaining of chest pain. The ED physician evaluated the patient and called in the patient's cardiologist. At 1 am the next morning, the cardiologist assessed the patient's risks, wrote an initial note on the patient's need for observation services and wrote an order for observation. The observation nurse did an initial assessment and made the patient comfortable. The cardiologist saw the patient in observation at 3 am, wrote a progress note, and ordered various diagnostic tests. At 6 am, the cardiologist wrote an order discharging the patient to home with instructions to see her back in the office the following day. At 7 am, observation care was completed and the patient left the hospital. The hospital assigned the emergency department visit a level 4 (99284) visit code. Are the observation services covered? What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Modified Facts: The patient in the prior question continued in medically necessary observation until 10 a.m. and was discharged home. What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Modified Facts: The patient was ready for discharge at 7 a.m. but did not leave the hospital until 10 a.m. because they were waiting for transportation home. What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

X. Outpatient Physical Therapy, Occupational Therapy and Speech Therapy Language Pathology

A. Therapy services are billed with two types of CPT/HCPCS codes: timed and untimed. <Medicare Claims Processing Manual, Chapter 5 § 20.2 B, C>

1. Codes that describe a service or procedure not defined by a specific timeframe (e.g., evaluation codes) are billed with a unit of one. <Medicare Claims Processing Manual, Chapter 5 § 20.2 B>

2. When reporting services with CPT/HCPCS codes defined by time (i.e., 15 minutes), all face to face time with the patient in a single day is rounded to the closest 15 minute increment, subject to the guidelines in the *Medicare Claims Processing Manual*. <Medicare Claims Processing Manual, Chapter 5 § 20.2 B, C>:
 - a. At least 8 minutes must be provided to report one unit of service.
 - i. If less than 8 minutes is provided of more than one type of service, the provider may sum the minutes and if the sum is at least 8 minutes, the provider may report one unit of the service performed for the most minutes.
 - b. When more than one service is performed in a single day, the total number of minutes of service determines the maximum number of units billed.

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

XI. Payment for therapy services

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

1. “Sometimes” Therapy Codes

- a. CMS publishes a list of therapy codes that are “sometimes” considered therapy services. The list of “sometimes” therapy codes for CY2022 is included in the materials behind the outline. At the time of publishing the CY2023 Annual Therapy Code update has not been posted. <See *Medicare Claims Processing Manual*, Chapter 4 § 200.9>

Link: [Therapy Code List under Medicare-Related Sites - General](#)

- b. When “sometimes” therapy services are provided outside a plan of care by nursing staff they are paid under the OPFS. <See *Medicare Claims Processing Manual*, Chapter 4 §200.9>

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

Therapy Revenue Codes and Modifiers:

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

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

Example of application of the multiple procedure reduction under the MPFS

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

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

- C. Therapy Services Provided by Therapy Assistants (Modifiers CQ/CO)
 - 1. Modifier -CQ (outpatient physical therapy services furnished in whole or in part by a physical therapy assistant) or modifier -CO (outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant) must be reported on therapy codes provided at least “in part” by a therapy assistant. <86 Fed. Reg. 65169; Medicare Claims Processing Manual, Chapter 5 § 20.1>

- a. CMS adopted a “de minimis” standard that requires reporting the therapy assistant modifier if more than 10% of the service is provided by a therapy assistant. <86 Fed. Reg. 65169-177>
- b. CMS clarified that the 8 minute or “mid-point” rule continues to apply to certain situations where a therapist provides 8 minutes of therapy and would be able to report the code without taking into account the therapy provided by the assistant. <86 Fed. Reg. 65169-177>

Example:

PTA – 97110 – 22 minutes

PT – 97110 – 23 minutes

Total 45 minutes of therapy – 3 billable units

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

Explanation:

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

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

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

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

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

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

D. Modifier -KX Therapy Threshold

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

- a. When therapy exceeds the annual dollar limit or threshold, but the therapy is medically necessary and this is documented in the patient's medical records, the provider should append the –KX modifier to all applicable lines. *<Medicare Claims Processing Manual, Chapter 5 § 10.3 D, Bipartisan Budget Act of 2018, Section 50202>*
 2. For CY2023, there is one threshold or limit for physical therapy and speech-language pathology services combined (\$2,230) and a separate cap for occupational therapy services (\$2,230). *<Medicare Claims Processing Manual Transmittal 11626>*
- E. Manual Review of Therapy
1. Therapy services that exceed \$3,000 for physical therapy and speech-language pathology combined or \$3,000 for occupational therapy and meet criteria for potential for overpayments (e.g., high denial rate, aberrant billing patterns, new provider) are subject to manual review. *<Bipartisan Budget Act of 2018; 83 Fed. Reg. 59654>*

CASE STUDIES WITH ANALYSIS

Case Study 1

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

Analysis: Based on CPT guidance, the hospital should report 99291 for the first hour of critical care and 99292 for the additional half hour beyond the first hour. The payment rate for 99291 is \$767.72 and payment for 99292 is packaged into payment for 99291. Under CMS guidance to physicians in the CY2023 MPFS Final Rule, only 99291 is reportable because CMS indicated 104 minutes would be required to report the add-on code 99292 for an additional ½ hour of critical care. It is unclear if this guidance applies to hospital reporting of critical care. <71 Fed. Reg. 68134; Medicare Claims Processing Manual Transmittal 1139; OPSS Addendum B; 87 Fed. Reg. 69616>

Case Study 2

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

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

Case Study 3

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

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

Case Study 4

Facts: A Medicare patient presented to an emergency department complaining of chest pain. The ED physician evaluated the patient and called in the patient's cardiologist. At 1 am the next morning, the cardiologist assessed the patient's risks, wrote an initial note on the patient's need for observation services and wrote an order for observation. The observation nurse did an initial assessment and made the patient comfortable. The cardiologist saw the patient in observation at 3 am, wrote a progress note, and ordered various diagnostic tests. At 6 am, the cardiologist wrote an order discharging the patient to home with instructions to see her back in the office the following day. At 7 am, observation care was completed and the patient left the hospital. The hospital assigned the emergency department visit a level 4 (99284) visit code. Are the observation services covered? What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Analysis: The observation services meet the order and documentation requirements and are not excluded from coverage so they will be covered. The emergency department visit should be billed with 99284 and the observation services should be billed with G0378 with units of 6. The services do not qualify for payment of the Observation C-APC because 8 hours of observation were not provided. The hospital will be paid for the emergency department visit (99284) and the observation will be packaged into the emergency department visit. The payment rate for 99284 is \$381.61 which will be adjusted by the hospital's wage index. <Medicare Claims Processing Manual, Chapter 4 § 290, OPSS Addendum B>

Modified Facts: The patient in the prior question continued in medically necessary observation until 10 a.m. and was discharged home. What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Analysis: The emergency department visit should be billed with 99284 and the observation services should be billed with G0378 with units of 9. The services qualify for payment of the Observation C-APC, with a payment rate of \$2,439.02. <Medicare Claims Processing Manual, Chapter 4 § 290, OPSS Addendum B>

Modified Facts: The patient was ready for discharge at 7 a.m., but did not leave the hospital until 10 a.m. because they were waiting for transportation home. What HCPCS codes should be reported for the emergency department visit and observation services? How much will the hospital be paid for these services?

Analysis: The additional 3 hours of observation while the patient is waiting for a ride home is not covered and should not be billed as covered to Medicare. The hospital should only bill for 6 hours of covered observation. The hospital will be paid for the emergency department visit (\$381.61) and the observation will be packaged. <Medicare Claims Processing Manual, Chapter 4 § 290, OPPS Addendum B, Medicare Benefit Policy Manual, Chapter 6 § 20.6>

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 OPSS 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 OPPS/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

utilization of mental health services provided by hospital staff to beneficiaries in their homes through communications technology. We also sought comment on whether there are changes commenters believe CMS should make to account for shifting patterns of practice that rely on communications technology to provide mental health services to beneficiaries in their homes.

In response to our comment solicitation, we received approximately 60 comments that were predominantly in support of continuing OPPTS payment for mental health services furnished to beneficiaries in their homes by clinical staff of the hospital through the use of communications technology as a permanent policy post-PHE. These comments stated that the expansion of virtual care broadly during the PHE has been instrumental in maintaining and expanding access to mental health services during the PHE.

4. Current Crisis in Mental Health and Substance Use Disorder

During the COVID-19 pandemic, the number of adults reporting adverse behavioral health conditions has increased sharply, with higher rates of depression, substance use, and self-reported suicidal thoughts observed in racial and ethnic minority groups.¹¹⁷ According to CDC data “[d]uring August 19, 2020–February 1, 2021, the percentage of adults with symptoms of an anxiety or a depressive disorder during the past 7 days increased significantly (from 36.4% to 41.5%), as did the percentage reporting that they needed but did not receive mental health counseling or therapy during the past 4 weeks (from 9.2% to 11.7%)”.¹¹⁸

In addition to the mental health crisis exacerbated by the COVID-19 pandemic, the United States is currently in the midst of an ongoing opioid PHE, which was first declared on October 26, 2017, by former Acting Secretary Eric D. Hargan, and most recently renewed by Secretary Xavier Becerra on April 4, 2022, and is facing an overdose crisis as a result of rising polysubstance use, such as the co-use of opioids and psychostimulants (for example, methamphetamine, cocaine). Recent CDC estimates of overdose deaths now exceed 107,000 for the 12-month period ending in December 2021,¹¹⁹ with overdose death rates surging among

Black and Latino Americans.¹²⁰ While overdose deaths were already increasing in the months preceding the COVID-19 pandemic, the latest numbers suggest an acceleration of overdose deaths during the pandemic. Recent increases in overdose deaths have reached historic highs in this country.¹²¹ According to information provided to CMS by interested parties, these spikes in substance use and overdose deaths reflect a combination of increasingly deadly illicit drug supplies, as well as treatment disruptions, social isolation, and other hardships imposed by the COVID-19 pandemic; but they also reflect the longstanding inadequacy of our healthcare infrastructure when it comes to preventing and treating substance use disorders (SUD) (for example, alcohol, cannabis, stimulants and opioid SUDs). Even before the COVID-19 pandemic began, in 2019, more than 21 million Americans aged 12 or over needed treatment for a SUD in the past year, but only about 4.2 million of them received any treatment or ancillary services for it.¹²²

According to the Commonwealth Fund, the provision of behavioral health services via communications technology has a robust evidence base; and numerous studies have demonstrated its effectiveness across a range of modalities and mental health diagnoses (for example, depression, SUD). Clinicians furnishing tele-psychiatry services at Massachusetts General Hospital Department of Psychiatry during the PHE observed several advantages of the virtual format for furnishing psychiatric services, noting that patients with psychiatric pathologies that interfere with their ability to leave home (for example, immobilizing depression, anxiety, agoraphobia, and/or time consuming obsessive-compulsive rituals) were able to access care more consistently since eliminating the need to travel to a psychiatry clinic can increase privacy and therefore decrease stigma-related barriers to treatment. This flexibility

¹²⁰ Drake, J., Charles, C., Bourgeois, J.W., Daniel, E.S., & Kwende, M. (January 2020). Exploring the impact of the opioid epidemic in Black and Hispanic communities in the United States. *Drug Science, Policy and Law*. doi:10.1177/2050324520940428.

¹²¹ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

¹²² Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>.

could potentially bring care to many more patients in need, as well as enhance ease of scheduling, decrease rate of no-shows, increase understanding of family and home dynamics, and protect patients and practitioners with underlying health conditions.¹²³

5. CY 2023 OPPTS Payment for Mental Health Services Furnished Remotely by Hospital Staff

a. Designation of Mental Health Services Furnished to Beneficiaries in Their Homes as Covered OPD Services

During the PHE for COVID-19, many beneficiaries may be receiving mental health services in their homes from a clinical staff member of a hospital or CAH using communications technology under the flexibilities we adopted to permit hospitals to furnish these services. After the PHE ends, absent changes to our regulations, the beneficiary would need to physically travel to the hospital to continue receiving these outpatient hospital services from hospital clinical staff. We are concerned that this could have a negative impact on access to care in areas where beneficiaries may only be able to access mental health services provided remotely by hospital staff and, during the PHE, have become accustomed to receiving these services in their homes. We are also concerned about potential disruptions to continuity of care in instances where beneficiaries' inability to continue receiving these mental health services in their homes would lead to loss of access to a specific practitioner with whom they have established clinical relationships. We believe that, given the current mental health crisis, the consequences of loss of access could potentially be severe. We also note that beneficiaries' ability to receive mental health services in their homes may help expand access to care for beneficiaries who prefer additional privacy for the treatment of their condition. We also believe that, given the changes in payment policy for mental health services via telehealth by physicians and practitioners under the PFS and mental health visits furnished by staff of RHCs and Federally Qualified Health Centers (FQHCs), using interactive, real-time telecommunications technology, it is important to maintain consistent payment policies across settings of care so as not to create payment incentives to furnish these services in a specific setting.

¹²³ <https://www.commonwealthfund.org/blog/2020/using-telehealth-meet-mental-health-needs-during-covid-19-crisis>.

¹¹⁷ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>.

¹¹⁸ <https://www.cdc.gov/mmwr/volumes/70/wr/mm7013e2.htm>.

¹¹⁹ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

Therefore, we proposed to designate certain services provided for the purposes of diagnosis, evaluation, or treatment of a mental health disorder performed remotely by clinical staff of a hospital using communications technology to beneficiaries in their homes as hospital outpatient services that are among the “covered OPD services” designated by the Secretary as described in section 1833(t)(1)(B)(i) of the Act and for which payment is made under the OPSS. To effectuate payment for these services, we proposed to create OPSS-specific coding to describe these services. The proposed code descriptors specified that the beneficiary must be in their home and that there is no

associated professional service billed under the PFS. We noted that, consistent with the conditions of participation for hospitals at 42 CFR 482.11(c), all hospital staff performing these services must be licensed to furnish these services consistent with all applicable State laws regarding scope of practice. We also proposed that the hospital clinical staff be physically located in the hospital when furnishing services remotely using communications technology for purposes of satisfying the requirements at 42 CFR 410.27(a)(1)(iii) and (a)(1)(iv)(A), which refer to covered therapeutic outpatient hospital services incident to a physician’s or

nonphysician practitioner’s service as being “in” a hospital outpatient department. We solicited comment on whether requiring the hospital clinical staff to be located in the hospital when furnishing the mental health service remotely to the beneficiary in their home would be overly burdensome or disruptive to existing models of care delivery developed during the PHE, and whether we should revise the regulatory text in the provisions cited above to remove references to the practitioner being “in” the hospital outpatient department. Please see Table 66 for the final codes and their descriptors.



TABLE 66: C-CODE NUMBERS AND LONG DESCRIPTORS

HCPCS Code	Long Descriptor
C7900	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service
C7901	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 30-60 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service
C7902	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service (List separately in addition to code for primary service)

When beneficiaries are in their homes and not physically within the hospital, we do not believe that the hospital is accruing all the costs associated with an in-person service and as such the full OPSS rate may not accurately reflect these costs. We believe that the costs associated with hospital clinical staff remotely furnishing a mental health service to a beneficiary who is in their home using communications technology more closely resembles the PFS payment amount for similar services when performed in a facility, which reflects the time and intensity of the professional work associated with performing the mental health service but does not reflect certain practice

expense costs, such as clinical labor, equipment, or supplies.

Therefore, we proposed to assign placeholder HCPCS codes CXX78 and CXX79 to APCs based on the PFS facility payment rates for CPT codes 96159 (Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)) and 96158 (Health behavior intervention, individual, face-to-face; initial 30 minutes), respectively. We explained that we believe that the APC series that is most clinically appropriate would be the Health and Behavior Services APC series. For CY 2022, CPT code 96159 has a PFS facility payment rate of

around \$20 while CPT code 96158 has a PFS facility payment rate of around \$60. We noted that if we use these PFS payment rates to approximate the costs associated with furnishing C7900 and C7901, these codes should be placed in APC 5821 (Level 1 Health and Behavior Services) and APC 5822 (Level 2 Health and Behavior Services), respectively. As C7902 is an add-on code, payment would be packaged; and the code would not be assigned to an APC. See Table 67 for the final SI and APC assignments and payment rates for HCPCS codes C9700–C7902 (placeholder HCPCS codes CXX78–CXX80 in the proposed rule).

TABLE 67: FINAL CY 2023 SI, APC ASSIGNMENT AND GEOMETRIC MEAN COST FOR HCPCS CODE C7900-C7902

HCPCS Code	Short Descriptor	Proposed SI	Proposed Proxy Service	PFS Facility Rate	Proposed APC	APC GMC
C7900	HOPD mntl hlt, 15-29 min	S	96159	\$19.52	5821	\$30.48
C7901	HOPD mntl hlt, 30-60 min	S	95158	\$56.56	5822	\$77.67
C7902	HOPD mntl hlt, ea addl	N	N/A	N/A	N/A	N/A

We solicited comment on the designation of mental health services furnished remotely to beneficiaries in their homes as covered OPD services payable under the OPPS, and on these proposed codes, their proposed descriptors, the proposed HCPCS codes and PFS facility rates as proxies for hospital costs, and the proposed APC assignments for the proposed codes. We stated that we recognize that, while mental health services have been paid under the OPPS when furnished by hospital staff in person to beneficiaries physically located in the hospital, the ability to provide these services remotely via communications technology when the beneficiary is at home is a new model of care delivery and that we could benefit from additional information to assist us to appropriately code and pay for these services. We invited additional information from commenters on all aspects of this proposal. We stated that we will also monitor uptake of these services for any potential fraud and/or abuse. Finally, we noted this proposal would also allow these services to be billed by CAHs, even though CAHs are not paid under the OPPS.

Comment: Many commenters supported our proposal to designate mental health services furnished by hospital staff to beneficiaries in their homes through communication technology as covered OPD services. Commenters stated that this policy would permit beneficiaries to maintain access to mental health services furnished through PHE-specific flexibilities and that it has the potential to even expand access, particularly in areas where there is a shortage of in-person mental health care. A few commenters requested that CMS allow other services, such as services provided

for the treatment of immunocompromised patients, to be furnished by hospital staff to beneficiaries in their homes through the use of telecommunications technology for other types of services beyond those described by the proposed HCPCS codes.

Response: We thank commenters for their support for this proposal. We will consider any expansions to this policy for future rulemaking.

Comment: Some commenters supported the creation of Medicare-specific HCPCS codes to describe these services, while others stated that the use of C-codes was confusing because existing CPT codes described similar services and did not represent the whole range of mental health services and staff that furnish them in a HOPD. Some commenters recommended that CMS use existing CPT codes and create a modifier to identify when the service is furnished remotely to a beneficiary in their home.

Response: We thank commenters for their support. While we understand that there may be some challenges surrounding when it would be appropriate to bill a Medicare-specific C-code where there are existing CPT codes that describe a similar service, however we believe that creating new codes rather than relying on existing CPT codes will reduce confusion because the CPT codes could also be billed by the hospital to account for the costs hospitals incurred when there is an associated professional service. Furthermore, creation of Medicare-specific coding will allow CMS to monitor these services and make refinements to the coding to more accurately reflect clinical practice.

Comment: A few commenters supported the proposed payment rates,

while many others stated that the proposed rates did not accurately capture all of the costs to the hospital of providing these services. These commenters stated that, even if the beneficiary is not physically in the hospital, the hospital would still be accruing costs associated with staffing and technology and that using the facility payment rate under the PFS is inappropriate and would not account for the additional costs to the hospital of providing these services. Some commenters supported the use of the facility payment rate under the PFS to inform the APC-assignment of these services but recommended that CMS compare them to CPT codes 90832 (Psychotherapy, 30 minutes with patient) through 90838 (Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)), as the commenters believe these codes better reflect the work and costs associated with care, which are consistent across physician office and hospital settings.

Response: We continue to believe that the resources associated with hospital staff furnishing mental health services to beneficiaries in their homes through telecommunications technology is better accounted for through the facility payment rate under the PFS, and that using this payment rate to inform the APC assignment is a reasonable methodology until such time as we have claims data for these services. We acknowledge that there are likely costs to the hospital other than the time of the hospital staff providing the service, including the amount of infrastructure needed to provide the service; however, we believe these costs are likely

minimal given that the beneficiary is in their home and not in the hospital.

Regarding the alternative codes commenters suggested we use to make appropriate APC assignments for the proposed C codes, we note that we do not believe the OPSS rates for these services serve as an appropriate crosswalk for the new mental health codes because these psychotherapy codes are for services performed at the hospital, not remotely.

Comment: Most commenters recommended that CMS revise the requirements at 42 CFR 410.27(a)(1)(iii) and (a)(1)(iv)(A), which refer to covered therapeutic outpatient hospital services incident to a physician's or nonphysician practitioner's service as being "in" a hospital outpatient department to remove references to the services being "in" the hospital. These commenters stated that this would allow for maximum flexibility for practitioners and could increase access to mental health services. One commenter requested clarification as to whether the supervising physician would have to be physically located at the hospital to meet general supervision requirements.

Response: We appreciate the additional information provided by commenters. We agree that not requiring the staff providing the mental health service to the beneficiary in their home to be physically in the hospital would likely maximize flexibility, particularly in areas where there is a shortage of healthcare practitioners. Therefore, we are finalizing an amendment to 42 CFR 410.27(a)(1)(iii) to add the phrase "except for mental health services furnished to beneficiaries in their homes through the use of communication technology" and § 410.27(a)(1)(iv)(A) to add the phrase "or through the use of communication technology for mental health services." The physician supervision level for the vast majority of hospital outpatient therapeutic services is currently general supervision under § 410.27. This means a service must be furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the service.

Comment: A few commenters requested that CMS clarify that when these services are furnished by hospitals that are owned or operated by the Indian Health Service, Indian Tribes, or Tribal Organizations, they are also covered, but will be paid at the applicable OMB rate that is established and published annually by the Indian Health Service rather than under the OPSS, in accordance with 42 CFR

419.20(b) and CMS's longstanding practice.

Response: IHS facilities may be paid at the applicable all inclusive payment rate established and published annually by the Indian Health Service rather than under the OPSS, in accordance with 42 CFR 419.20(b) when billing for these services.

After consideration of the public comments we received, we are finalizing as proposed to assign HCPCS codes C7900 and C7901 to APCs based on the PFS facility payment rates for CPT codes 96159 (Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)) and 96158 (Health behavior intervention, individual, face-to-face; initial 30 minutes), respectively. We are finalizing our proposal with modification to clarify at 42 CFR 410.27(a)(1)(iii) and (a)(1)(iv)(A) that mental health services provided to beneficiaries in their homes through communication technology are exempt from the requirement that therapeutic hospital or CAH services must be furnished in a hospital or CAH or in a department of the hospital or CAH.

b. Periodic In-Person Visits

Section 123(a) of the CAA, 2021 also added a new subparagraph (B) to section 1834(m)(7) of the Act to prohibit payment for a Medicare telehealth service furnished in the patient's home for purposes of diagnosis, evaluation, or treatment of a mental health disorder unless the physician or practitioner furnishes an item or service in person, without the use of telehealth, within 6 months prior to the first time the physician or practitioner furnishes a telehealth service to the beneficiary, and thereafter, at such times as the Secretary determines appropriate. In the CY 2022 PFS final rule, we finalized that, after the first mental health telehealth service in the patient's home, there must be an in-person, non-telehealth service within 12 months of each mental health telehealth service—but also finalized a policy to allow for limited exceptions to the requirement. Specifically, if the patient and practitioner agree that the benefits of an in-person, non-telehealth service within 12 months of the mental health telehealth service are outweighed by risks and burdens associated with an in-person service, and the basis for that decision is documented in the patient's medical record, the in-person visit requirement will not apply for that 12-month period (86 FR 65059). We finalized identical in-person visit requirements for mental health visits

furnished through communications technology for RHCs and FQHCs.

In the interest of maintaining similar requirements between mental health visits furnished by RHCs and FQHCs via communications technology, mental health telehealth services under the PFS, and mental health services furnished remotely under the OPSS, we proposed to require that payment for mental health services furnished remotely to beneficiaries in their homes using telecommunications technology may only be made if the beneficiary receives an in-person service within 6 months prior to the first time the hospital clinical staff provides the mental health services remotely; and that there must be an in-person service without the use of telecommunications technology within 12 months of each mental health service furnished remotely by the hospital clinical staff. We also proposed the same exceptions policy as was finalized in the CY 2022 PFS final rule, specifically, that we would permit exceptions to the requirement that there be an in-person service without the use of communications technology within 12 months of each remotely furnished mental health service when the hospital clinical staff member and beneficiary agree that the risks and burdens of an in-person service outweigh the benefits of it. Exceptions to the in-person visit requirement should involve a clear justification documented in the beneficiary's medical record including the clinician's professional judgement that the patient is clinically stable and/or that an in-person visit has the risk of worsening the person's condition, creating undue hardship on the person or their family, or would otherwise result in disengaging with care that has been effective in managing the person's illness. Hospitals must also document that the patient has a regular source of general medical care and has the ability to obtain any needed point of care testing, including vital sign monitoring and laboratory studies.

Section 304(a) of Division P, Title III, Subtitle A of the Consolidated Appropriations Act, 2022 (Pub. L. 117-103, March 15, 2022) amended section 1834(m)(7)(B)(i) of the Act to delay the requirement that there be an in-person visit with the physician or practitioner within 6 months prior to the initial mental health telehealth service, and at subsequent intervals as determined by the Secretary, until the 152nd day after the emergency period described in section 1135(g)(1)(B) (the PHE for COVID-19) ends. In addition, Section 304 of the Consolidated Appropriations Act, 2022 (CAA, 2022), delayed until

152 days after the end of the PHE similar in-person visit requirements for remotely furnished mental health visits furnished by RHCs and FQHCs. In the interest of continuity across payment systems so as to not create incentives to furnish mental health services in a given setting due to a differential application of additional requirements, and to avoid any burden associated with immediate implementation of the proposed in-person visit requirements, we proposed that the in-person visit requirements would not apply until the 152nd day after the PHE for COVID-19 ends.

Comment: A few commenters supported requirements for in-person visits; however, most opposed the proposal, particularly to require an in-person visit within 6 months prior to the first telehealth service. Commenters stated that CMS should defer to the clinical judgement of the treating practitioner, who is in the best position to understand the individual needs of their patients. Commenters appreciated that CMS proposed to allow exceptions to the subsequent 12-month visit requirement if the patient and practitioner agree that the benefits of in-person, non-telehealth service within 12 months of the mental health telehealth service are outweighed by risks and burdens associated with an in-person service, and the basis for that decision is documented in the patient's medical record.

Response: In section II.D.1.e of the CY 2023 PFS final rule entitled "Implementation of Telehealth Provisions of the Consolidation Appropriations Acts, 2021 and 2022", CMS clarifies that for purposes of the requirement that an in-person visit required within 6 months prior to the initial mental health telehealth services, this requirement does not apply to beneficiaries who began receiving mental health telehealth services in their homes during the PHE or during the 151-day period after the end of the PHE. The requirement for an in-person visit within 6 months of the initial telehealth mental health services takes effect only for telehealth mental health services beginning after the 152nd day after the end of the PHE. For reasons stated in the proposed rule, we believe it is important to maintain similar standards for mental health services furnished to beneficiaries in their homes through the use of telecommunications systems paid under OPPS. Therefore, we are making the same clarification; however, for patients newly receiving mental health services furnished remotely post-PHE, we continue to believe that the initial in-person visit within 6 months prior to the first remote

mental health service is crucial to ensure the safety and clinical appropriateness of the following remote mental health services. We also reiterate that for both patients who began receiving mental health services in their homes during the PHE and those who began treatment post-PHE, we expect that these beneficiaries will receive an in-person, non-telehealth service every subsequent 12 months and that exceptions to this requirement will be documented in the patient's medical record.

After consideration of the public comments we received, we are finalizing as proposed, and clarifying that beneficiaries who began receiving mental health telehealth services in their homes during the PHE or the 151-day period after the end of the PHE before the in-person visit requirements take effect do not need to have an in-person, non-telehealth service within 6 months prior to receiving mental health service in their homes. Instead, the requirement to receive an in-person visit within 12 months of each remote mental health telehealth service would apply.

c. Audio-Only Communication Technology

Section 1834(m) of the Act outlines the requirements for PFS payment for Medicare telehealth services that are furnished via a "telecommunications system," and specifies that, only for purposes of Medicare telehealth services furnished through a Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term "telecommunications system" includes asynchronous, store-and-forward technologies. We further defined the term, "telecommunications system," in the regulation at § 410.78(a)(3) to mean an interactive telecommunications system, which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communications between the patient and distant site physician or practitioner.

During the PHE for COVID-19, we used waiver authority under section 1135(b)(8) of the Act to temporarily waive the requirement, for certain behavioral health and/or counseling services and for audio-only evaluation and management (E/M) visits, that telehealth services must be furnished using an interactive telecommunications system that includes video communications technology. Therefore, for certain services furnished during the PHE for COVID-19, we make payment for these telehealth services when they are furnished using audio-only

communications technology. In the CY 2022 PFS final rule, we stated that, given the generalized shortage of mental health care professionals¹²⁴ and the existence of areas and populations where there is limited access to broadband due to geographic or socioeconomic challenges, we believed beneficiaries may have come to rely upon the use of audio-only communications technology in order to receive mental health services, and that a sudden discontinuation of this flexibility at the end of the PHE could have a negative impact on access to care (86 FR 65059). Due to these concerns, we modified the definition of interactive telecommunications system in § 410.78(a)(3) for services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home to include two-way, real-time audio-only communications technology in instances where the physician or practitioner furnishing the telehealth service is technically capable to use telecommunications technology that includes audio and video, but the beneficiary is not capable of, or did not consent to, use two-way, audio/video technology. We stated that we believed that this requirement would ensure that mental health services furnished via telehealth are only conducted using audio-only communications technology in instances where the use of audio-only technology is facilitating access to care that would be unlikely to occur otherwise, given the patient's technological limitations, abilities, or preferences (86 FR 65062). We also made a conforming change for purposes of furnishing mental health visits through telecommunications technology for RHCs and FQHCs. We limited payment for audio-only services to services furnished by physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communications technology in instances where the beneficiary is not capable of, or does not wish to use, two-way, audio/video technology.

In order to maximize accessibility for mental health services, particularly for beneficiaries in areas with limited access to broadband infrastructure, and in the interest of policy continuity across payment systems so as to not create incentives to furnish mental health services in a given setting due to a differential application of additional requirements, we proposed a similar

¹²⁴ <https://bhwh.hrsa.gov/data-research/review-health-workforceresearch>.

policy for mental health services furnished remotely by hospital clinical staff to beneficiaries in their homes through communications technology. Specifically, we proposed that hospital clinical staff must have the capability to furnish two-way, audio/video services but may use audio-only communications technology given an individual patient's technological limitations, abilities, or preferences.

Comment: Commenters were very supportive of CMS's proposal to allow for audio-only communication technology in instances where the beneficiary did not have access to, or did not wish to use, two-way, audio/video communication technology. A few commenters disagreed with CMS's proposal to require the practitioner to have the capacity to furnish services via two-way, audio/video, stating that this may be problematic for practitioners in rural areas or areas without access to reliable broadband.

Response: As we stated in the CY 2022 PFS final rule, because services furnished via communication technology are generally analogous to and must include the elements of the in-person service, it is generally appropriate to continue to require the use of two-way, real-time audio/video communications technology to furnish the services (86 FR 65061–65062). Therefore, we are maintaining the requirement that hospital staff must have the technical capability to use an interactive telecommunications system that includes two-way, real-time, interactive audio and video communications at the time that an audio-only mental health service is furnished.

 After consideration of the public comments we received, we are finalizing our proposal regarding use of audio-only communications technology as proposed.

B. Comment Solicitation on Intensive Outpatient Mental Health Treatment, Including Substance Use Disorder (SUD) Treatment Furnished by Intensive Outpatient Programs (IOPs)

There are a range of services described by existing coding under the PFS and OPSS that can be billed for treatment of mental health conditions, including SUD, such as individual, group, and family psychotherapy. Over the past several years, in collaboration with interested parties and the public, we have provided additional coding and payment mechanisms for mental health care services paid under the PFS and OPSS. For example, in the CY 2020 PFS final rule (84 FR 62673), we finalized the creation of new coding and payment

describing a bundled episode of care for the treatment of Opioid Use Disorder (OUD) (HCPCS codes G2086–G2088). In the CY 2021 PFS final rule, we finalized expanding the bundled payments described by HCPCS codes G2086–G2088 to be inclusive of all SUDs (85 FR 84642 through 84643). These services are also paid under the OPSS.

Additionally, in the CY 2020 PFS final rule (84 FR 62630 through 62677), we implemented coverage requirements and established new codes describing bundled payments for episodes of care for the treatment of OUD furnished by Opioid Treatment Programs (OTPs). Medicare also covers services furnished by inpatient psychiatric facilities and partial hospitalization programs (PHP). PHP services can be furnished by a hospital outpatient department or a Medicare-certified Community Mental Health Center (CMHC). PHPs are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in section 1861(ff) of the Social Security Act (the Act). According to the Medicare Benefit Policy Manual, Chapter 6, Section 70.3, the treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program and is at a level more intense than outpatient day treatment or psychosocial rehabilitation. PHPs work best as part of a community continuum of mental health services, which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support.

We understand that, in some cases, people who do not require a level of care for mental health needs that meets the standards for PHP services nonetheless require intensive services on an outpatient basis. For example, according to SAMHSA's *Advisory on Clinical Issues in Intensive Outpatient Treatment for Substance Use Disorders*, IOP programs for substance use disorders (SUDs) offer services to clients seeking primary treatment; step-down care from inpatient, residential, and withdrawal management settings; or step-up treatment from individual or group outpatient treatment. IOP treatment includes a prearranged schedule of core services (e.g., individual counseling, group therapy, family psychoeducation, and case management) for a minimum of nine hours per week for adults or six hours per week for adolescents. SAMSHA further states that the 2019 National Survey of Substance Abuse Treatment Services reports that 46 percent of SUD

treatment facilities offer IOP treatment.¹²⁵

We solicited comment on whether these services are described by existing CPT codes paid under the OPSS, or whether there are any gaps in coding that may be limiting access to needed levels of care for treatment of mental health disorders or SUDs, for Medicare beneficiaries. We welcomed additional, detailed information about IOP services, such as the settings of care in which these programs typically furnish services, the range of services typically offered, the range of practitioner types that typically furnish those services, and any other relevant information, especially to the extent it would inform our ability to ensure that Medicare beneficiaries have access to this care.

Comment: Commenters were generally supportive of CMS providing payment for IOP services. Some commenters stated that existing HCPCS coding was adequate to describe IOP services, while other commenters stated that it was necessary for the OPSS to create Medicare-specific coding to describe these services.

Response: We thank commenters for the information provided and will consider their input for future rulemaking.

C. Direct Supervision of Certain Cardiac and Pulmonary Rehabilitation Services by Interactive Communications Technology

In the interim final rule with comment period titled "Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency," published on April 6, 2020 (the April 6th COVID-19 IFC) (85 FR 19230, 19246, 19286), we changed the regulation at 42 CFR 410.27(a)(1)(iv)(D) to provide that, during a Public Health Emergency as defined in § 400.200, the presence of the physician for purposes of the direct supervision requirement for pulmonary rehabilitation (PR), cardiac rehabilitation (CR), and intensive cardiac rehabilitation (ICR) services includes virtual presence 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. Specifically, the required direct physician supervision can be provided through virtual presence using audio/video real-time communications technology (excluding audio-only) subject to the clinical judgment of the supervising practitioner. We further amended § 410.27(a)(1)(iv)(D) in the CY

¹²⁵ https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep20-02-01-021.pdf.

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.

Excerpt from Medicare Claims Processing Manual, Chapter 4

The RHC/FQHC services remain subject to the encounter rate payment methodology and are billed using the RHC/FQHC provider number, bill type and revenue codes.

See the Medicare Benefit Policy Manual for a description of covered RHC/FQHC services.

See chapter 9, in this manual for billing instructions for provider based and independent RHC/FQHC services.

290 - Outpatient Observation Services

(Rev. 1, 10-03-03)

A3-3663, A3-3112.8.D, A-01-91

290.1 - Observation Services Overview

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

290.2 - General Billing Requirements for Observation Services

(Rev. 787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

290.2.1 - Revenue Code Reporting

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Hospitals are required to report observation charges under the following revenue codes:

Revenue Code	Subcategory
0760	General Classification category
0762	Observation Room

Other ancillary services performed while the patient receives observation services are reported using appropriate revenue codes and HCPCS codes as applicable.

290.2.2 - Reporting Hours of Observation

(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

290.3 - Reserved

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

290.4 - Billing and Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

290.4.1 - Billing and Payment for All Hospital Observation Services Furnished Between January 1, 2006 and December 31, 2007

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Since January 1, 2006, two G-codes have been used to report observation services and direct referral for observation care. For claims for dates of service January 1, 2006 through December 31, 2007, the Integrated Outpatient Code Editor (I/OCE) determines whether the observation care or direct referral services are packaged or separately payable. Thus, hospitals provide consistent coding and billing under all circumstances in which they deliver observation care.

Beginning January 1, 2006, hospitals should not report CPT codes 99217-99220 or 99234-99236 for observation services. In addition, the following HCPCS codes were discontinued as of January 1, 2006: G0244 (Observation care by facility to patient), G0263 (Direct Admission with congestive heart failure, chest pain or asthma), and G0264 (Assessment other than congestive heart failure, chest pain, or asthma).

The three discontinued G-codes and the CPT codes that were no longer recognized were replaced by two new G-codes to be used by hospitals to report all observation services, whether separately payable or packaged, and direct referral for observation care, whether separately payable or packaged:

- G0378- Hospital observation service, per hour; and
- G0379- Direct admission of patient for hospital observation care.

The I/OCE determines whether observation services billed as units of G0378 are separately payable under APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other services provided by the hospital in the same encounter. Therefore, hospitals should bill HCPCS code G0378 when observation services are ordered and provided to any patient regardless of the patient's condition. The units of service should equal the number of hours the patient receives observation services.

Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or hospital outpatient surgical procedure (status indicator T procedure) on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is referred directly for observation care after being seen by a physician in the community (see §290.4.2 below)

Some non-repetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service. See chapter 1, section 50.2.2 of this manual. It is vitally important that all of the charges that pertain to a non-repetitive, separately paid procedure or service be reported on the same claim with that procedure or service. It should also be emphasized that this relaxation of same day billing requirements for some non-repetitive services does not apply to non-repetitive services provided on the same day as either direct referral to observation care or observation services because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including diagnostic tests, lab services, hospital clinic visits, emergency department visits, critical care services, and status indicator T procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

290.4.2 - Separate and Packaged Payment for Direct Referral for Observation Services Furnished Between January 1, 2006 and December 31, 2007

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

In order to receive separate payment for a direct referral for observation care (APC 0604), the claim must show:

1. Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service;
2. That no services with a status indicator T or V or Critical care (APC 0617) were provided on the same day of service as HCPCS code G0379; and
3. The observation care does not qualify for separate payment under APC 0339.

Only a direct referral for observation services billed on a 13X bill type may be considered for a separate APC payment.

Separate payment is not allowed for HCPCS code G0379, direct admission to observation care, when billed with the same date of service as a hospital clinic visit, emergency room visit, critical care service, or “T” status procedure.

If a bill for the direct referral for observation services does not meet the three requirements listed above, then payment for the direct referral service will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.4.3 - Separate and Packaged Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Separate payment may be made for observation services provided to a patient with congestive heart failure, chest pain, or asthma. The list of ICD-9-CM diagnosis codes eligible for separate payment is reviewed annually. Any changes in applicable ICD-9-CM diagnosis codes are included in the October quarterly update of the OPSS and also published in the annual OPSS Final Rule. The list of qualifying ICD-9-CM diagnosis codes is also published on the OPSS Web page.

All of the following requirements must be met in order for a hospital to receive a separate APC payment for observation services through APC 0339:

1. Diagnosis Requirements

- a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.
- b. Qualifying ICD-9-CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field, but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

2. Observation Time

- a. Observation time must be documented in the medical record.
- b. Hospital billing for observation services begins at the clock time documented in the patient’s medical record, which coincides with the time that observation

services are initiated in accordance with a physician's order for observation services.

- c. A beneficiary's time receiving observation services (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services

- a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
 - An emergency department visit (APC 0609, 0613, 0614, 0615, 0616) or
 - A clinic visit (APC 0604, 0605, 0606, 0607, 0608); or
 - Critical care (APC 0617); or
 - Direct referral for observation care reported with HCPCS code G0379 (APC 0604); must be reported on the same date of service as the date reported for observation services.
- b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

- a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
- b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Only observation services that are billed on a 13X bill type may be considered for a separate APC payment.

Hospitals should bill all of the other services associated with the observation care, including direct referral for observation, hospital clinic visits, emergency room visits, critical care services, and T status procedures, on the same claim so that the claims

processing logic may appropriately determine the payment status (either packaged or separately payable) of HCPCS codes G0378 and G0379.

If a bill for observation care does not meet all of the requirements listed above, then payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.5 - Billing and Payment for Observation Services Furnished on or After January 1, 2008

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

290.5.1 - Billing and Payment for Observation Services Furnished Between January 1, 2008 and December 31, 2015

(Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16)

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. From January 1, 2014 through December 31, 2015, in certain circumstances when observation care was billed in conjunction with a clinic visit, high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through APC 8009 (Extended Assessment and Management Composite) when certain criteria are met. Prior to January 1, 2014, in certain circumstances when observation care was billed in conjunction with a high level clinic visit (Level 5), high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment could be made for the entire extended care encounter through one of two composite APCs (APCs 8002 and 8003) when certain criteria were met. APCs 8002 and 8003 are deleted as of January 1, 2014 and APC 8009 is deleted as of January 1, 2016. For information about payment for extended assessment and management composite APC, see §10.2.1 (Composite APCs) of this chapter.

There is no limitation on diagnosis for payment of APC 8009; however, composite APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. The I/OCE evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

1. Observation Time

- a. Observation time must be documented in the medical record.
- b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.
- c. A beneficiary's time receiving observation services (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

2. Additional Hospital Services

- a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
 - A Type A or B emergency department visit (CPT codes 99284 or 99285 or HCPCS code G0384); or
 - A clinic visit (HCPCS code G0463 beginning January 1, 2014; CPT code 99205 or 99215 prior to January 1, 2014); or
 - Critical care (CPT code 99291); or
 - Direct referral for observation care reported with HCPCS code G0379 (APC 0633) must be reported on the same date of service as the date reported for observation services.
- b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

3. Physician Evaluation

- a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration,

discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

- b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that the criteria will be met for payment of the extended encounter through extended assessment and management composite payment.

Only visits, critical care and observation services that are billed on a 13X bill type may be considered for a composite APC payment.

Non-repetitive services provided on the same day as either direct referral for observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.5.2 - Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008 (Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16)

Direct referral for observation is reported using HCPCS code G0379 (Direct referral for hospital observation care). Prior to January 1, 2010, the code descriptor for HCPCS code G0379 was (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Payment for direct referral for observation care will be made either separately as a hospital visit under APC 5013 (Level 3 Examinations & Related Services) or packaged into payment for comprehensive APC 8011 (Comprehensive Observation Services) or packaged into the payment for other separately payable services provided in the same

encounter. For information about comprehensive APCs, see §10.2.3 (Comprehensive APCs) of this chapter.

The criteria for payment of HCPCS code G0379 under either APC 5013 or APC 8011 include:

1. Both HCPCS codes G0378 (Hospital observation services, per hr.) and G0379 (Direct referral for hospital observation care) are reported with the same date of service.
2. No service with a status indicator of T or V or Critical Care (APC 5041) is provided on the same day of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

Only a direct referral for observation services billed on a 13X bill type may be considered for a comprehensive APC payment through the Comprehensive Observation Services APC (APC 8011).

290.5.3 - Billing and Payment for Observation Services Furnished Beginning January 1, 2016 (Rev. 3425, Issued: 12-18-15, Effective: 01-01-16, Implementation: 01-04-16)

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. Beginning January 1, 2016, in certain circumstances when observation services are billed in conjunction with a clinic visit, Type A emergency department visit (Level 1 through 5), Type B emergency department visit (Level 1 through 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, comprehensive payment may be made for all services on the claim including, the entire extended care encounter through comprehensive APC 8011 (Comprehensive Observation Services) when certain criteria are met. For information about comprehensive APCs, see §10.2.3 (Comprehensive APCs) of this chapter.

There is no limitation on diagnosis for payment of APC 8011; however, comprehensive APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. The I/OCE evaluates every claim received to determine if payment through a comprehensive APC is appropriate. If payment through a comprehensive APC

is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive a comprehensive APC payment through the Comprehensive Observation Services APC (APC 8011):

1. Observation Time

- a. Observation time must be documented in the medical record.
- b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.
- c. A beneficiary's time receiving observation services (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

2. Additional Hospital Services

- a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
 - A Type A or B emergency department visit (CPT codes 99281 through 99285 or HCPCS codes G0380 through G0384); or
 - A clinic visit (HCPCS code G0463); or
 - Critical care (CPT code 99291); or
 - Direct referral for observation care reported with HCPCS code G0379 (APC 5013) must be reported on the same date of service as the date reported for observation services.
- b. No procedure with a T status indicator or a J1 status indicator can be reported on the claim.

3. Physician Evaluation

- a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
- b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that the criteria will be met for payment of the extended encounter through the Comprehensive Observation Services APC (APC 8011).

Only visits, critical care and observation services that are billed on a 13X bill type may be considered for a comprehensive APC payment through the Comprehensive Observation Services APC (APC 8011).

Non-repetitive services provided on the same day as either direct referral for observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.6 - Services Not Covered as Observation Services

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Hospitals must not bill beneficiaries directly for reasonable and necessary observation services for which the OPSS packages payment for observation as part of the payment for the separately payable items and services on the claim. Hospitals should not confuse packaged payment with non-coverage or nonpayment. See the Medicare Benefit Policy Manual, Pub 100-02, chapter 6, section 20.6 for further explanation of non-covered services and notification of the beneficiary in relation to observation care.

300 - Medical Nutrition Therapy (MNT) Services

(Rev. 2127, Issued: 12-29-10, Effective: 01-01-2002, Implementation: 03-29-11)

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>			