



Medicare Hospital and Chargemaster Version LifePoint Custom

KEY CONCEPTS OUTLINE

Module 15: Strategies and Key Issues by Revenue Code: Other Departments

I. Respiratory Services (041x), Pulmonary Function (046x), Pulmonary Rehabilitation (0948)

A. Coverage

1. The American Association for Respiratory Care (AARC) has a website summarizing different state licensure rules. Recall that once a state defines licensure and scope of practice, the hospital needs to follow suit for the services to be covered when provided by these staff.
 - a. Note that most RN scopes of practice include respiratory services
2. The 041x respiratory therapy revenue codes are for specific therapeutic services. Pulmonary function diagnostic tests are appropriately billed under revenue code 0460.

B. Coding and edit issues

1. Introductory section to CPT® codes 94010–94799 is important to read. Several codes are defined as initial day and subsequent day. Initial day charge reflects packaged equipment/supplies and additional staff time.
2. Inhalation treatments (94640):
 - a. NCCI Policy Manual: *“CPT code 94640 shall only be reported once during an episode of care regardless of the number of treatments that are administered. ... If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care.”* <National Correct Coding Initiative Policy Manual, Chapter XI § J (8)>

- b. Episode of care is when the patient arrives at a facility and ends when the patient leaves the facility. <National Correct Coding Initiative Policy Manual, Chapter XI § J (8)>

C. Inpatient and outpatient payment concepts

1. Many commercial plans may attempt to deny respiratory therapy charges for inpatients or outpatients when performed by nursing personnel, arguing that this is part of the room rate and/or observation hours since nurses on the floor are performing the services.
 - a. The best defense is to prove scope of practice for nursing and that all other *CoP* requirements for respiratory care are met. Ensure documentation of respiratory therapy services by nursing rises to the same level on separate forms that would be documented by an RT.
2. Most payers consider pulse oximetry to be another vital sign and not separately payable. However, it should be separately coded and billed per CPT definitions for single and/or multiple determinations per date of service or via continuous overnight monitoring.

D. General ledger and finance considerations

1. Oxygen:
 - a. Oxygen may be billed as a supply, but documentation is challenging. An RT may or may not round on patients regularly and document liters of oxygen in a manner sufficient to substantiate separate charges.
 - b. Because oxygen is a gas available in the walls for any patient bed, it can be defined as a routine supply and built into the room rate for all patients or continue to be billed separately.
2. If nursing personnel perform some or part of RT services that are separately billed as ancillary RT, consider reclassifying expense to match revenue as appropriate.
3. Code Blue response:
 - a. CPR or 92950 can only be billed once per patient per episode. Typically, staff from numerous departments respond to Code Blue, but only one department should be responsible for capturing the charge. Typically, due to airway management, RT is a good choice.
4. Caution for blood gas machines that automatically produce electrolyte test results: Will results interface to the laboratory information system (LIS)? Are

machines calibrated the same as LIS machines? Will results produce a report like LIS reports? Will the blood gas machine interface for charging blood gases?

5. RT tests performed in the ED by ED staff should be billed with an ED revenue code to match expenses with revenue code.
6. Often specialized RT staff are associated with the NICU.
 - a. Determine whether they are expensed to RT or NICU. Match expenses to revenue and revenue codes.

E. Charge capture

1. RTs usually document from the inpatient or outpatient EMR with their own flow sheets. Ensure charge capture is appropriate per HCPCS definitions and units.
2. Ensure orders, documentation, and verification of physician medical decision-making from documentation are captured to substantiate charges.
3. It is ideal if a workflow based on orders, template documentation per test order, and acknowledgment by the ordering physician can be retained.

II. Physical Therapy (042x), Occupational Therapy (043x), and Speech Language Pathology (044x)

A. Coverage

1. Coverage of outpatient rehabilitation services is under its own coverage provision separate from outpatient hospital services and diagnostic and physician services. Benefits are described for PT, OT, and SLP at 42 *C.F.R.* §§ 410.60, 410.59, and 410.62, respectively.
2. Requirements for the treatment plans are found at 42 *C.F.R.* § 410.61.
 - (i) The treatment plan is supposed to be in place before treatment begins. Think about how orders are received that state "evaluate and treat."
2. Comprehensive Outpatient Rehabilitation Facilities (CORFs) provide coordinated therapy services to beneficiaries and bill facility services on UB-04/837I claims.

B. Coding and billing

1. Note that any outpatient hospital claim with therapy services must meet the therapy billing rules.
 - (i) If CPT® services in the 97xxx range are performed by staff other than therapists (e.g., nurses for sometimes therapy codes like wound care), the applicable revenue codes and therapist modifiers are not used.
2. CPT® codes for PT and OT evaluations represent low, moderate, or high complexity:
 - (i) (a) codes 97161, 97162, and 97163 for PT; and
 - (ii) (b) codes 97165, 97166, and 97167 for OT.
 - (iii) Reevaluation codes, 97164 & 97168, The CPT® code descriptors for PT and OT evaluative procedures include specific components that are required for reporting as well as the corresponding typical face-to-face times for each service.
3. Therapy services performed by a qualified therapist under a therapy plan of care are billed under specific therapy revenue codes and with specific therapy modifiers:
 - (i) Revenue code 042X, modifier -GP for physical therapy services
 - (ii) Revenue code 043X, modifier -GO for occupational therapy services
 - (iii) Revenue code 044X, modifier -GN for speech therapy and language pathology <See *Medicare Claims Processing Manual*, Chapter 4 § 200.9; *Medicare Claims Processing Manual*, Chapter 5 § 20.1>
4. 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>
 - (i) 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>

- (ii) 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.

2. 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
3. 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>
5. Therapy services are billed with two types of CPT®/HCPCS codes: timed and untimed. <*Medicare Claims Processing Manual*, Chapter 5 § 20.2 B, C>
- i. Codes that describe a service or procedure not defined by a specific time frame (e.g., evaluation codes) are billed with a unit of one. <*Medicare Claims Processing Manual*, Chapter 5 § 20.2 B>
 - ii. 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 eight minutes must be provided to report one unit of service.
 - 1) If less than eight minutes is provided of more than one type of service, the provider may sum the minutes and if the sum is at least eight 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.

C. Inpatient and outpatient payment concepts

- 1. Inpatient therapy services rendered to short-term acute hospital inpatients are paid via the DRG or other inpatient per diem or case rate.
- 2. Outpatient payment for therapy services—therapy services provided by hospitals, except critical access hospitals, are paid on the MPFS. <See *Medicare Claims Processing Manual*, Chapter 4 § 200.9>

ii. “Sometimes” Therapy Codes

- 1. CMS publishes a list of therapy codes that are “always” or “sometimes” considered therapy services. <See *Medicare Claims Processing Manual*, Chapter 4 § 200.9>
- 2. 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>
- 3. 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>
 - a. “Sometimes” therapy services provided outside a plan of care and paid under OPFS are subject to the incident to coverage requirements, including supervision, discussed in the outpatient coverage section. <77 *Fed. Reg.* 68424-425>

D. 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*>

E. Section 50202 of the Bipartisan Budget Act of 2018 (Repeal of Medicare Payment Cap for Therapy Services; Limitation to Ensure Appropriate Therapy)— requires:

1. Medicare claims are no longer subject to the therapy caps (one for occupational therapy services and another for physical therapy and speech-language pathology combined);
2. Claims for therapy services above a certain amount of incurred expenses (therapy thresholds), \$2,150 for 2022, must include the -KX modifier indicating that such services are medically necessary as justified by appropriate medical record documentation; and <86 FR 64996>
3. Claims for therapy services above certain threshold levels of incurred expenses will be subject to targeted medical review. The medical review thresholds for therapy services in a year before 2028 are \$3,000.

D. General ledger and finance considerations

1. Typically, each specialty has its own expense and revenue center. At times, the inpatient therapy departments are also separated from the outpatient therapy departments.
2. For the untimed codes, pricing tiers can be defined to better represent acuity/cost of evaluations and reevaluations.
3. When therapy teams are treating patients, it is best if each specialty is represented and develops its own report regarding assessment and treatment recommendations. Each specialty would bill separately and only for the time they performed separate services or divide the time.

*Therapists, or therapy assistants, working together as a "team" to treat one or more patients **cannot** each bill separately for the same or different service provided at the same time to the same patient. CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. <11 Part B Billing Scenarios for PTs and OTs>*

E. Coding and edit issues

1. Documentation of time per therapy is critical and now documentation of the portion of time the assistant is involved in the patient service will also be important.

F. Charge capture

1. Beware of time grids for documentation/charge capture that are completed separate from clinical medical record documentation.
2. Documentation in an EMR should allow therapists to complete their notes at the point of service while also capturing the correct billing codes in the process.

III. Emergency Room (045x); Trauma Response (068x); Cast Room (070x); Clinics (051x); Special Services (0760, 0761)

A. Coverage:

1. The EMTALA (Emergency Medical Treatment and Labor Act) definition of a "dedicated emergency department":
 - a. Under EMTALA, a dedicated emergency department is a facility that meets one of the following requirements:
 - (i) Licensed by the state as an emergency department
 - (ii) Held out to the public as a location for emergency care on an urgent basis without a scheduled appointment
 - (iii) During the prior calendar year, provided at least one-third of its outpatient visits for emergency care on an urgent basis without a scheduled appointment <71 *Fed. Reg.* 68129–68133; *Medicare Claims Processing Manual*, Chapter 4 § 160>
 - (iv) Modifier ER is to be added to off-campus DEDs.

B. Coding and edit issues:

1. Type A EDs that meet the CPT® definition of "an organized hospital-based facility for the provision of unscheduled episode services to patients who present for immediate medical attention. The facility must be available 24 hours a day" use the 99281–99285 or critical care 99291/99292 when the definition of critical care has been met.
2. Type B EDs that do not meet the definition of ED per CPT use outpatient visit codes for commercial payers or CMS Type B HCPCS codes G0380–G0384.

- a. Hospitals must assess any “fast-track” areas to determine whether to bill Type A or Type B codes for the visits performed in those areas.
 - b. See Handout 19 for a diagram for Assessing ER to Determine Applicability of Type B ED Codes.
3. Outpatient hospital departments bill CPT visit codes 99202–99205/99211–99215 and CMS requires HCPCS Level II code G0463 for all outpatient hospital visits.
4. Level selection:
- a. CMS permits hospitals to develop their own internal systems for assigning E/M levels for ED encounters and the respective prices. CMS has provided the following general principles for hospitals to use during guideline development:
 - (i) The guidelines should follow the intent of the codes by reasonably relating the intensity of hospital resources to the different levels of effort represented by the codes. <See 72 Fed. Reg. 66805>
 - (a) The guidelines should be based on hospital facility resources, not physician resources. <See 72 Fed. Reg. 66805>
 - (ii) The guidelines should not require documentation that is not clinically necessary for patient care purposes. <72 Fed. Reg. 66805>
 - (iii) The guidelines should be applied consistently across patients in the department to which they apply. <See 72 Fed. Reg. 66805>
 - (a) Hospitals may develop separate guidelines for different specialties, but they should ensure the guidelines reflect comparable resources for the same code. <See 72 Fed. Reg. 66805>
 - b. LWBS (Left Without Being Seen) after nurse triage:
 - (i) CMS answered the question of whether a visit is billable, although the answer is no longer on its FAQ website. The response is based on the visit not meeting the “incident to” coverage requirements. It is recommended that you check your MAC website for any other coverage and billing instructions.
 - (ii) What about billing diagnostic services ordered via protocol at triage and LWBS?

- (a) Since most diagnostic services require an order from a treating physician or practitioner, there is no coverage for the diagnostic services ordered via protocol when a physician or practitioner did not assess or “treat” the patient.
5. 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>
 - c. When the ED visit level is critical care and there is a 068x charge, CMS instructs hospitals to add G0390 to the 068x charge line. However, when the ED visit level is not critical care, the 068x charge should be billed without a CPT® or HCPCS code.
 - d. Revenue code 068x must be used with FL 14 type of visit 5 for trauma center; however, patient type 5 can be used on trauma patients for whom pre-hospital notification was not used.
 - i. *Note:* The Trauma Care Association of America (TCAA) publishes a trauma charge report and other billing and coding resources.
 - ii. A claim edit to remove G0390 from the outpatient claim is recommended if ED level under 0450 is not critical care 99291. Note that HCPCS codes are not required for 068x charges.
 - iii. For trauma activations post-ED arrival, it is recommended that activation charges be set up under 0450 and sum with the ED visit level charge so that the unit of service for 99285 or 99291 is 1 but the billed charge includes the price for the visit plus the price for the applicable post-ED arrival activation.
 - e. See Handout 20 for Sample Trauma Services Charges.
6. Freestanding clinics (052x)—used for RHCs, FQHCs, and other freestanding clinics owned and operated by a hospital.

- a. For Medicare, services are required to be billed on a 1500/837P with POS 11.
7. Provider-based clinics—because commercial insurances and Medicaid accept all five levels of E/M codes, it is best to maintain visit guidelines and charge all five levels and convert the codes to the G0463 for Medicare or to Medicaid local codes if required for Medicaid.
 8. Ambulances (054x)—coverage and billing rules for ambulance services, whether on a UB/837I or 1500/837P, are beyond the scope of this course.
- C. Inpatient and outpatient payment concepts:
1. Outpatient hospital visit codes can only be billed if the location is licensed as a department of the hospital and considered provider-based for CMS' purposes.
 2. If community physicians schedule patients to the ED for follow-up, consider charging non-ED E/M visit codes for those visits.
- D. General ledger and finance considerations:
1. Lab tests should be set up with CLIA waiver modifier -QW when appropriate.
- E. Charge capture:
1. Many EMR ED applications use a point system that associates individual nursing interventions in the ED with points, and when nurses document, it attributes the associated points and then sums them for an encounter to determine the ED visit level. This is optimal for charge capture.
 2. Trauma activation charges and critical care charges do not lend themselves to this point-based methodology. Best practice is to have charges accumulate in a pre-post work queue where they are validated by trained staff before posting to the account.
 3. Drug administration documentation and coding is critical.
 4. It is ideal to include supplies in the ED procedure charges. Who selected the ED procedure charges: HIM? Trained staff? ED nursing with HIM review?
 5. Date of service: < *Medicare Claims Processing Manual*, Chapter 4, § 180.6 >
 - a. Emergency department services provided by hospital outpatient departments (OPPS & non-OPPS) should be billed in the following manner:

- (i) The line-item date of service for the ED encounter is the date the patient entered the ED even if the patient's encounter spans multiple service dates.
- (ii) For all other services related to the ED encounter (i.e., lab, radiology, etc.), the line-item date of service reported is the date the service was actually rendered.

IV. Cardiology (048x); EKG/ECG (073x), EEG (074x), and Cardiac Rehabilitation (0943)

- A. Coverage—most cardiology services are covered including diagnostic and therapeutic as long as coding and coverage policies are met.
- B. Inpatient and outpatient payment concepts
 - 1. Several cardiac cath procedures require device HCPCS codes to be billed in addition to the CPT®/HCPCS codes for procedures.
 - 2. Due to costly devices, inpatient and outpatient cardiac procedures often have carve-out provisions in commercial contracts.
- C. General ledger and finance considerations
 - 1. Caution is needed for pacemaker clinics where pacemaker vendors send their staff to the clinics. For the vendor staff services to meet "incident to" requirements for coverage, contracts may be required. No separate payment should be made because the cost is usually included in the pacemaker device implant cost. Also, a hospital employee such as a nurse should perform patient history and vitals and ensure all documentation is in the medical record, including documentation from the vendor staff.
- D. Coding and edit issues.
 - 1. Use of modifiers for cardiac vessels are required (-LC, -RD, etc.).
- E. Charge capture
 - 1. Cardiac catheterization and other interventional radiology procedures are challenging to code because they require a detailed knowledge of the arterial and venous systems, and these are not the same on each side of the body. HIM staff did not traditionally code outside the surgical CPT range of 1xxxx–6xxx9, and these codes often require a combination of surgical and cardiology codes.

- a. Codes are typically hard-coded in the CDM. Surgical codes typically use CPT® range 0361, although revenue code 0481 is allowed and cardiology CPT® codes are typically billed under revenue code 0481.
- b. Final coding review can be performed by trained technologists. Giving performing techs feedback about errors will improve accuracy. Coding errors identified by HIM should be reported to the performing department.

V. Labor/Delivery (072x)

A. Coverage

1. By CMS definition, labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse midwife, or other qualified medical person acting within their scope of practice as defined in hospital medical staff bylaws and state law certifies that, after a reasonable time of observation, the woman is in false labor. It is very common for patients experiencing contractions to be directed from the ED to the maternity floor. Aside from ensuring hospital policies exist to address this circumstance, it is equally important to document the services provided and ensure the option exists for the hospital to appropriately bill for the services performed.
2. Often patients are routed to the maternity floor where nurses perform the non-stress test (NST) and other assessments, but there is not an order for these services. This prevents them from being covered.
 - a. Consider protocol orders based on presenting signs/symptoms.
 - b. Consider advance orders for each woman once she chooses the hospital for delivery. OB can do advance orders based on when the patient presents to the hospital for the assessment and NST. Once the patient presents, the order set can be activated.
3. Note that many payers now consider circumcision elective (similar to a cosmetic procedure) and not medically necessary. Waivers should be signed and cost estimates provided prior to performing.
4. Sterilization during C-section is often performed, but not covered by Medicaid without notification. Determine whether the hospital will choose to write off any separate charges or move to non-covered column and report ICD codes in remarks filed and not on claims to avoid denials.

B. Inpatient and outpatient payment concepts

1. Observation for labor monitoring

- a. Because a full-term woman needs to be assessed to determine when to admit as an inpatient, the services do not meet the true definition of observation; rather, they are outpatient services.
- b. Once the determination of active labor toward delivery has been verified, the inpatient admission order should be written. Caution: Many hospitals wait until actual delivery before admitting as an inpatient, and this results in lost days of care.
- c. Lactation services—mandated under ACA, services are often billed on the infant’s account, but diagnoses are due to breast issues. Payers may deny them. Services should be billed on either the mother’s or infant’s account depending on the medically necessary reason.
 - (i) If billed on the infant’s account, the order may need to come from the pediatrician rather than the OB.
 - (ii) If billed on the mother’s account, the order should be from the OB, not the pediatrician.
 - (iii) Pumps/supplies for lactation support post-discharge may require prescription and supply by the supplier as opposed to the hospital.

C. General ledger and finance considerations

1. Bililight treatments

- a. The bililight is a piece of capital equipment that may be reused for several patients. As such, it is not separately billable. Any perceived charge for the bililight should be included in the room rate for patients in the nursery.

2. Combined mother-baby accounts versus separate accounts

3. Review for any point-of-care lab tests, including the fern test, which is a PPM

D. Coding and edit issues.

1. Stress tests and fetal monitoring:

- a. 59020 contraction stress test (i.e., oxytocin challenge test [OCT])—the physician evaluates fetal response to induced contractions in the mother. The physician applies external fetal monitors to the maternal abdominal wall. Pitocin is given intravenously to the mother to cause uterine

contractions. The fetal heart rate and uterine contractions are monitored and recorded for 20 minutes to determine the effect of contractions on the fetus. This procedure is usually performed during the third trimester.

- b. 59025 non-stress test—the qualified provider evaluates fetal heart rate response to its own activity. The provider reports fetal movements as an external monitor records fetal heart rate changes. The procedure is noninvasive and takes 20–40 minutes to perform. If the fetus is not active, an acoustic device may be used to stimulate activity. Note that the testing may exceed the typical time frames due to inactivity of the fetus or other circumstances. In such instances, it is not appropriate to charge for two NSTs or to routinely assess observation time.
 - c. Both of the above tests must be ordered by the physician or other qualified healthcare professional. They must be medically necessary.
2. It is necessary to establish visit levels or G0463 for assessments where the patient is discharged based on the determination she is not in active labor. The visit code can be attached to the labor check charge. This can be charged separately from the hourly labor charge. Note, however, that HCPCS codes are not required for revenue code 0720. Hourly labor charges by low, intermediate, and high risk can be charged up until the time of admission.

Tip: Many hospitals send pregnant women presenting to the ED to the obstetrics floor for their evaluation.

Consider using a Type B ED visit code for these unscheduled visits referred from the ED.

The assessment of whether the patient is in active labor can be billed as an outpatient visit code; each hour of labor monitoring can be billed with revenue code 0720 and no HCPCS codes. The non-stress test can be billed with 0720 or 0929 revenue code.

3. Several procedures can be performed in L&D, including amniocentesis, version, and others. Each of these should be separate charges.

E. Pricing considerations

1. OB delivery package rates can be established for uncomplicated vaginal and/or C-section deliveries. Patients can pay copayments in advance to prevent the bulk of financial liability occurring after delivery. Ensure that the qualifications of complication versus uncomplicated are well understood.

F. See Handout 21 for a Sample of Labor & Delivery Chargemaster.

G. Charge capture

1. Consider defining nursing flow sheets such that their documentation is directly associated with each charge—routine vaginal delivery, complex vaginal delivery, amniocentesis, etc.
2. Ensure NST strips are maintained in the record to support the NST tests.

VI. Audiology (047x)

A. Coverage

1. Audiology services are diagnostic tests and must be furnished under the appropriate level of physician supervision; however, they are excepted from physician supervision when personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable state laws.
2. Audiological diagnostic testing refers to tests of the audiological and vestibular systems (e.g., hearing, balance, auditory processing, tinnitus, and diagnostic programming of certain prosthetic devices performed by qualified audiologists).

B. Inpatient and outpatient payment concepts

1. Hearing screening is a state-mandated requirement for newborns.
2. Most hearing screening tests are done prior to discharge from the hospital or birthing clinics.
3. Prior to discharge, each newborn has his or her hearing tested. If, for some reason, the newborn does not pass the screen, a rescreen is usually done. If the infant does not pass the second hearing test, they are referred to a specialist for further testing.
4. Several of the audiology codes have -TC/-26 modifiers in the relative value file, indicating that a formal report of interpretation must be performed and retained in the medical record.

C. General ledger/finance considerations

1. Newborn hearing screening test expense is usually part of the nursery.

2. If there is a clinic with audiologists and technicians who perform tests on adults and follow-up tests on infants and other pediatric patients, then this is usually a separate expense and revenue center.
3. Audiology is its own cost center (3040) on the Medicare cost report.

D. Coding and edits

1. It is recommended that the CPT® codes for these services be hard-coded in the chargemaster.
2. 92558 (OAE screening code)—evoked otoacoustic emissions, screening (DPOAE or TEOAE), automated analysis. When performing an automated pass/fail screen, with a fixed or limited number of frequencies at a single intensity level, note that most OAE newborn screenings will fall in this category.
3. 92587 (OAE limited diagnostic code)—distortion product evoked otoacoustic emissions, limited evaluation (to confirm the presence or absence of a hearing disorder, 3–6 frequencies), or transient evoked otoacoustic emissions, with interpretation and report. When 3–6 frequencies are tested bilaterally, include the interpretation of the test with reporting of the results in the patient’s medical record.

E. Charge capture

1. Charge capture for these tests should be via charge ticket or EMR.

VII. Other Diagnostic Services (092x)

A. Coverage

1. As long as the diagnostic test is required for the beneficiary to support the physician’s medical decision-making for a sign or symptom (i.e., not for screening purposes and there are no statutory restrictions, NCD, or LCD limiting coverage), the test is covered.
2. Neurophysiological and sleep tests are examples of diagnostic tests that may be billed under this revenue code. Correct levels of supervision must be followed.

B. Inpatient and outpatient payment concepts

1. Most non-lab diagnostic tests require a formal report of interpretation that is retained with the order and the actual test results. When the interpretation is

made by a physician, such as a radiologist, then the interpretation can be coded if the final impression supports a diagnosis.

C. General ledger and finance considerations

1. Ensure each separate type of test has a unique expense and revenue general ledger. CMS makes the subcategories in 092x to different cost centers.

D. Coding and edits

1. It is recommended that the CPT[®] codes for these services be hard-coded in the chargemaster.

E. Charge capture

1. Charge capture for these tests should be via charge ticket or EMR.

VIII. Other Therapeutic Services (094x–095x)

A. Coverage

1. If the services are medically necessary, provided “incident to” a physician service in the hospital setting, and there are no specific statutory benefit restrictions, NCDs, or LCDs limiting coverage, the services should be covered.
2. Other payers may exclude or have limited coverage, and pre-authorization is recommended.
3. Once Congress determines a benefit category for a therapeutic service, it limits coverage (e.g., nutrition therapy).
 - a. Medicare Part B coverage of medical nutrition therapy services (MNT) for certain beneficiaries who have diabetes or a renal disease was established by statute on January 1, 2002. Regulations for MNT were established at 42 *C.F.R.* §§ 410.130–410.134. This NCD establishes the duration and frequency limits for the MNT benefit; coordinates MNT and diabetes outpatient self-management training (DSMT) as a national coverage determination; and limits coverage to the freestanding setting. After this time, MACs stopped covering nutrition therapy provided “incident to” to a hospital outpatient beneficiary despite documentation of medical necessity because the statutory benefit was limited to diabetes and renal disease.

B. Inpatient and outpatient payment concepts

1. Several of these revenue codes are limited to partial hospitalization programs or outpatient behavioral health services.

2. Medicaid programs often associate substance abuse services with mental health service limitations and may have limited managed care coverage that must be billed to a different TPA than medical services.

C. General ledger and finance considerations

1. Review the revenue code to cost center crosswalk and determine the best cost centers in the cost report to aggregate these services.
2. Services in support of Partial Hospitalization Programs or outpatient behavioral health should be expensed to those departments.

D. Coding and edits

1. Claims for any activity therapies and other recreational therapy services may only be accepted on claims with mental health diagnoses.
2. These services may be appropriate for developmentally delayed pediatric patients, so negotiation and education with payers may be required.

E. Charge capture

1. Charge capture for these tests should be via charge ticket or EMR.

IX. Pre-Hospice/Palliative Care Services (069x)

A. Coverage

1. These services should be covered as medically necessary hospital and clinician services to address palliative care needs prior to hospice.

B. Inpatient and outpatient payment concepts—should follow inpatient and outpatient payment methods

C. General ledger and finance considerations

1. Due to advance care planning (ACP) services, pre-hospice election, and the increasing importance of palliative care (not hospice care), a separate cost center with a palliative care expert and certified staff, including physicians and practitioners, may be beneficial.
2. Tracking these expenses compared to patients who elect hospice after palliative care, or do not elect hospice but who have better outcomes, may be important for population health and other bundled payment initiatives.

D. Coding and edits

1. ACP codes—CMS finalized separate payment for advance care planning services under OPSS. When they are the only service rendered at an encounter, CPT® 99497 is paid and the add-on code 99498 is packaged. When ACP services are provided on the same day as other OPSS services, payment for 99497 is packaged. Note that the services must be initiated at each encounter by a physician or practitioner, and then other team members such as RNs and licensed clinical social workers (LCSW) can complete the visit for coverage.
2. On institutional claims, non-terminal condition services are coded with condition code 07, "Treatment of Non-Terminal Condition for Hospice." A/B MACs (A) and (B) process services coded with the -GW modifier or condition code 07 in the normal manner for coverage and payment determinations.

E. Charge capture

1. Charge capture for these tests should be via charge ticket or EMR.

X. Inpatient Renal Dialysis (080x); Hemodialysis (082x); Peritoneal Dialysis (083x); CAPD (084X); CCPD (085x); Miscellaneous Dialysis (088x)

A. Coverage

1. Outpatient renal dialysis is covered for ESRD patients in a covered ESRD facility.
 - a. See the link "ESRD Prospective Payment Overview" for more information.
2. EPO has specific coverage requirements for ESRD vs. cancer and other patients.
 - a. See the link "Erythropoietin Stimulating Agent Policies" for more information.
3. There is coverage of emergency dialysis for an ESRD patient in the hospital.

B. Inpatient and outpatient payment concepts

1. Inpatient dialysis is paid via the MS-DRG payment or other IPPS payment.
2. Managed care may wish to use these revenue codes for an inpatient and/or outpatient carve-out provision.
3. A separate cost center for these services is recommended.

C. General ledger and finance considerations

1. In many hospitals, inpatient and emergency dialysis is performed on patients via an "under arrangement" agreement with the local dialysis company that provides trained staff, equipment, and supplies. If the dialysis company provides solutions, determine whether these are appropriate to bill as supplies or drugs.

D. Coding and edits

1. In certain medical situations in which ESRD outpatients cannot obtain their regularly scheduled dialysis treatment at a certified ESRD facility, OPSS allows payment for non-routine dialysis treatments (which are not covered under the ESRD benefit) furnished to ESRD outpatients in the outpatient department of a hospital. Payment for unscheduled dialysis furnished to ESRD outpatients and paid under the OPSS is limited to the following circumstances:
 - a. Dialysis performed following or in connection with a dialysis-related procedure such as vascular access procedure or blood transfusions
 - b. Dialysis performed following treatment for an unrelated medical emergency (e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, CMS allows the hospital to provide and bill Medicare for the dialysis treatment)
 - c. Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients for the hospital to receive payment
2. In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using the HCPCS code G0257 (unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility).

E. CMS has revised Section 200.2 of Chapter 4 of the *Medicare Claims Processing Manual* to clarify that HCPCS code 90935 (hemodialysis procedure with single physician evaluation) may be reported and paid only if one of the following two conditions is met:

1. The patient is a hospital inpatient with or without ESRD and has no coverage under Part A but has Part B coverage. The charge for hemodialysis is a charge for the use of a prosthetic device. See the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 120. A. The service must be reported on a type of bill 12X or type of bill 85X. See the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 6, Section 10 (Medical and Other Health Services Furnished to Inpatients of Participating Hospitals) for the criteria that must be met for services to be paid when a hospital inpatient has Part B coverage but not Part A coverage.

2. A hospital outpatient does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a type of bill 13X or 85X. <CR 7762, *Transmittal 2455*, April 26, 2012>

F. Charge capture—through nursing flow sheets or other specialized module

Case Study

Facts: A Medicare ESRD patient is admitted as an outpatient for an ambulatory surgery procedure. The patient does not meet post-surgical discharge criteria on the day of the procedure and is sent to a floor for continued recovery monitoring. The next day is a scheduled dialysis day for the patient, but their condition is worsening due to the interaction of post-surgery with the need for dialysis. The physician orders dialysis after consulting with the patient's ESRD physician. The hospital arranges for outpatient dialysis at the hospital, and the patient is discharged home late after dialysis and successfully meeting post-surgery discharge criteria.

Analysis: The outpatient dialysis constitutes unscheduled/emergency dialysis for the outpatient hospital provider. The hospital bills the surgical procedure and G0257 on the two-day outpatient claim.

XI. Acquisition of Body Components (081x)

A. Coverage

1. Coverage of organ acquisition is defined in the *Organ Procurement Benefit Manual*.
2. Bone marrow transplantation (BMT) is excluded from organ procurement. Section 110.8.1 of the *National Coverage Determination Manual* lists those instances in which autologous or allogeneic stem cell transplantation are nationally covered, nationally noncovered, or left to contractor discretion.
 - a. Bone marrow and peripheral blood stem cell transplantation is a process that includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high-dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow or peripheral blood stem cell transplantation is non-covered, none of the steps are covered.

- b. Revenue code 0815 is to be used exclusively for allogeneic donor search and cell acquisition costs. CMS also established cost center 77 for allogeneic donor search and cell acquisition costs. Effective for cost reporting periods beginning on or after October 1, 2020, allogeneic donor search and cell acquisition costs are to be cost reimbursed per Section 108 of the Further Consolidation Appropriations Act of 2020.

B. Inpatient and outpatient payment concepts

1. Organ procurement is managed by separate providers called organ procurement agencies (OPA). A hospital's cost of maintaining a patient for purposes of organ procedures is billable to the OPA.
2. The following resources are available regarding Medicare's organ acquisition and donation payment policy:
 - a. *PRM Transmittal 471*—CMS Pub. 15-1, Chapter 31
 - b. *PRM*—CMS Pub. 15-2, chapters 33 and 40
 - c. *Medicare Claims Processing Manual*—CMS Pub. 100-04
 - d. *Medicare Benefit Policy Manual*—CMS Pub. 100-02
3. BMT donor costs are included on the recipient's claim and paid via the BMT payment rate—either the MS-DRG or C-APC.
 - a. Outpatient BMT is billed with CPT® 38240 and CMS will edit claims with 38240 for the presence of revenue code 0815 with charges and vice versa.
 - b. CMS is also dedicating cost center 77 on the cost reports for donor search and acquisition expense and revenue.

C. General ledger and finance considerations

1. A separate patient account needs to be created to bill the OPA for costs determined after the time of death but before discharge and OPA services are ended.
 - a. Consider putting a hold on the account and having nurse auditors move charges to the new OPA account after discharge so that the record can be audited.
2. A separate general ledger account should be maintained for any organ acquisition costs that are specific.

3. Another separate general ledger should be maintained for invoice expense from the NMDP or other BMT acquisition or processing source.
 - a. Costs associated with autologous BMT are accumulated in the different treating/performing departments. CMS has not issued guidance on how to aggregate these costs.
4. For BMT, the transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether the itemized statement is for a patient that is either a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report. The hospital shows charges for the transplant itself in revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

D. Coding and edits

1. *Medicare Claims Processing Manual*, Chapter 3, § 90 addresses billing for transplantation.
 - a. Section 90.3 addresses both coverage and billing requirements for stem cell transplantation even though it is not an organ transplant service.
 - i. The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, Chapter 4, § 231.11 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the outpatient setting.
 - ii. When the allogeneic stem cell transplant occurs in the inpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately by using revenue code 0819 (other organ acquisition). Revenue code 0819 (0815 beginning January 1, 2017) charges should include all services required to acquire stem cells from a donor, as defined above. On the recipient's transplant bill, the hospital reports the acquisition charges, cost report days, and utilization days for the donor's hospital stay (if applicable) and/or charges for other encounters in which the stem cells were obtained from the donor. The donor is covered for medically

necessary inpatient hospital days of care or outpatient care provided to acquire cells for the allogeneic stem cell transplant.

E. Charge capture

1. Charge capture may be challenging if there are not clear guidance to nursing, patient access, and finance for any direct invoiced costs, such as those for NMDP.
2. Charge capture for these tests should be via charge ticket or EMR.

XII. Behavioral Health (090x–091x)

A. Coverage

1. Inpatient behavioral health services are covered in two ways:
 - a. General acute care hospitals with or without separately licensed inpatient psychiatric beds that are not distinct part units
 - b. Inpatient psychiatric facilities (IPF) that are either specialty psychiatric hospitals or distinct part units licensed by the state; if the IPF is a distinct part unit, it has a separate provider number and agreement for the distinct part unit

B. Both inpatient and outpatient behavioral health services require physician certification and care plans for coverage.

C. Outpatient hospital or community mental health center (CMHC) partial hospitalization program (PHP) services represent a distinct and organized intensive ambulatory psychiatric treatment program that offers less than 24-hour daily care to patients who either:

1. Have been discharged from inpatient hospital treatment, and the PHP is in lieu of continued inpatient treatment; or
2. Would be at reasonable risk of requiring inpatient hospitalization in the absence of partial hospitalization

D. Inpatient and outpatient payment concepts:

1. Payment is under the MS-DRG that the case is assigned via the ICD-10 codes for psychiatric admissions to general, short-term acute hospitals.
2. Payment is under the IPF methodology if the case is discharged from an IPF or distinct part unit.

- a. Patients who are treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness with a 60-day lifetime reserve and for 190 days of care (total in a lifetime) in freestanding psychiatric hospitals.
- b. Caution: Medicaid managed care often tries to apply distinct part unit rules to short-term acute hospital licensed units that are not distinct part units and would not meet the Medicaid definition of a Severely Mentally Disabled facility.

E. General ledger and finance considerations

1. Professionals that otherwise are not covered as independent practitioners are recognized for behavioral health services such as clinical psychologists and licensed clinical social workers.
 - a. If employed by the hospital for behavioral health services, these professionals should reassign their benefits to the hospital, and the hospital should assist the professionals in enrolling in Medicare for NPIs.
 - b. Professional billing should occur for their individual and covered services to beneficiaries when provided in the correct setting in addition to the provider billing under IPPS or OPSS, as appropriate.
2. Prior authorization needs to ensure both the professional and provider (facility) components are covered.
3. Be careful billing facility/provider charges if no staff other than the professional is involved with the patient. Medically necessary staff services that are documented separately from the professional's service should be performed and documented.

F. Coding and edits

1. Psychiatric codes that include "with E/M" in the description are add-on codes to be billed with a visit code both on the facility and professional claims.

G. Charge capture

1. Charge capture should be via charge ticket or EMR.

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Title 42 - Public Health

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

Subchapter B - Medicare Program

Part 410 - Supplementary Medical Insurance (SMI) Benefits

Subpart B - Medical and Other Health Services

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

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

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

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

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

physician or nonphysician practitioner must be present in the room when the procedure is performed. For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished 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 OPSS, 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 OPSS/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 OPSS, 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 OPSS 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 OPSS/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 OPSS/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 OPSS/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://bhw.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.

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>			

Inhalation Treatment for Acute Airway Obstruction

Post Teleconference Question and Answer

Q. We understand that CPT code 94640 is reported only one time per episode of care. What date of service should the provider report on the claim when that episode of care spans more than one day? For example, when a patient is in observation and inhalation treatments were provided on different dates of the episode of care. Is it the first date that an inhalation treatment was provided or the date the last inhalation treatment was provided?

- A: CPT code 94640 can only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. Inhaled medication can be reported separately. The date of service would be the date the patient received the first treatment.

Q: Is it correct that since providers are to report only one unit of 94640 per episode of care, providers should also charge for only one unit regardless of the number of inhalation treatments provided during the episode of care? If that is correct, please provide the authoritative citation for charging as if only one treatment had been provided. The cost to provide multiple inhalation treatments during an episode of care is not the same as the cost to provide one inhalation treatment.

- A: The actual charge for the line would be the cost for all the services provided. For example, if you provide 5 treatments and each is \$25 the total billed would be \$125, but the units are 1. The method of reimbursement is set per CMS.

Q: I just want to confirm that we should only be billing one 94640 on outpatient claims and swing bed and inpatient claims do not have to follow this policy? If we are only to bill one 94640 for an outpatient encounter and the patient is here for 48 hours and has multiple treatments, how should we capture the cost involved with all the treatments since every patient does not get the same number of treatments?

- A: Inpatient claims are not subject to NCCI editing. Report all charges associated with this service

Q: It was made clear that CPT 94640 may only be reported once per patient encounter regardless of how many times the patient received respiratory treatments. During an outpatient encounter a patient may have multiple treatments. What is the rationale behind only allowing one unit to be charged per encounter when the service is provided multiple times?

- A: CMS has given guidance on this in NCCI policy manuals and states:
 - *CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. If CPT code 94640 is used for treatment of acute airway*

obstruction, spirometry measurements before and/or after the treatment(s) shall not be reported separately. It is a misuse of CPT code 94060 to report it in addition to CPT code 94640. The inhaled medication may be reported separately.

- *An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care.*
- *If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640.*
- *If inhalation drugs are administered in a continuous treatment or a series of “back-to-back” continuous treatments exceeding one hour, CPT codes 94644 (continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) and 94645 (...; each additional hour) may be reported instead of CPT code 94640.*
- Please see the [NCCI webpage](#) on the CMS website

Q: Medicare coverage analysis (MCA) has always said we should charge for all that we do yet the Medically Unlikely Edits (MUE) do not let us. I asked about using the quantity of 1 with the charge combined and was told this is not acceptable. Is there a MCA regulation that states this is inappropriate? I believe that this helps us charge all payers the same and we have been told by consultants that correcting the quantity and adding the charges is correct for this type of MUE.

- A: All charges should be associated with this service.

Q: Please clarify how to bill for each of the following scenarios:

- Scenario One: Patient was in the ED and received 2 inhalation treatments of duo nebulizer for diagnosis of acute exacerbation of asthma. Do we bill CPT code 94640 with a unit of 1 and NOT add in the charge for the second duo neb?
 - A: CPT code 94640 can only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered; however inhaled medication can be reported separately per the NCCI Policy Manual
- Scenario Two: Patient was admitted to acute inpatient and received 2 duo nebulizer inhalation treatment on days 1, 2, and 3. Do we bill 94640 once for each date of service, or on DOS day 1, day 2, and day 3? Diagnosis is acute exacerbation of COPD.
 - A: Inpatient claims are not subject to NCCI edits.

Q: Scenario: Patient is in observation status and has 4 treatments of 94640 in 2 days. The medication is charged separately. I understand that 94640 should be 1-line item with a quantity of 1. Can we roll up the charge for the 4 services and apply to the quantity of 1? I thought I heard on the webinar that this was not allowed based on CMS guidance. If I heard that correctly, where can I find that guidance? National Correct Coding Initiative (NCCI) edits provide billing rules, not charging conventions. I thought Medicare wants us to accurately report our costs regardless of the number of units reported.

- A: All associated charges are added together and added to the single line.

Q: We are in a provider based rural health clinic (RHC). If a breathing treatment is given, it is given by a clinic nurse. Do we still key the 94640 AND the medicine separately?

- A: If the nurse is under the supervision of a physician, then yes. RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code.

Q: When criteria for condition code (CC) 44 is met and the patient status is flipped from an inpatient (IP) to observation (OBS), what charging mechanism do you suggest since hospitals can charge 94640 to an inpatient per treatment but only once for an observation?

- A: you will need to follow the outpatient encounter rules for billing.

Q: I fully understand the policy is to charge for only one CPT 94640 per encounter under OPSS. What I would like to know is, what is the rationale behind this determination? There are many repetitive services for which hospitals/facilities hospitals can charge and get reimbursed. Why did Medicare adopt the policy to pay for only one inhalation treatment per encounter when it is often necessary to give multiple treatments to stabilize a patient before discharge?

- A: CMS issued the instructions on this determination. Please consult CMS for the rationale.

Q: Do you bill the medication used with the treatment or is it included in the treatment?

- A: The medication used during the inhalation treatment is billed separately. CPT code 96460 can only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. Inhaled medication can be reported separately.

Q: Nebulizer supplies are an expense to the providers. Are they separately reimbursed like the medication is? I am referring to A7015 or A7016.

- A: The medication used during the inhalation treatment is billed separately and A7015 is billed separately when an aerosol mask is used with nebulizer solution. CPT code 96460 can only be

reported once during an episode of care regardless of the number of separate inhalation treatments that are administered.

Q: Does exacerbation of a chronic condition such as COPD meet the definition of acute airway obstruction?

- A: We would need additional information regarding the exacerbation. Documentation would need to support that the exacerbation caused an acute episode of the chronic condition.

Q: For a critical access hospital (CAH) patient encounter, is an emergency room (ER) admission through an observation stay considered a singular episode of care so that only one treatment would be separately reportable for reimbursement? OR is the ER admission and the observation stay each considered a separate episode?

- A: This would be considered one episode of care per the NCCI policy manual:
 - An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care.
 - If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640.

Q: If a respiratory therapist who is employed by a critical access hospital (CAH) is asked to provide a nebulizer treatment at the rural health clinic (RHC) on campus, is the treatment separately reportable for reimbursement or is it included in the level of office visit?

- A: A rural health clinic (RHC) can submit a claim for a patient encounter with the physician or practitioner. Services by other personnel are considered incident to and not submitted separately, but instead are part of the cost report. Since the Respiratory Therapist is employed by a CAH, rather than the RHC, the RHC would not submit any charges. For the RHC to include the charges for the service either a part of the encounter or the cost report, the therapist would have to meet the definition of an employee. This would include a W2 employee, leased employee, or independent contractor. If requested, the employee relationship would need to be supplied. Since the patient is not a patient of the CAH, the CAH would not have charges to submit.

Q: If the treatment is administered by a Respiratory Therapist (RT) it is the expectation that the Respiratory Therapist will be present at bedside for the entire treatment and if they are not, is the medication considered a self-administered drug?

- A: Yes, the Respiratory Therapist needs to remain at the bedside to monitor the physiological changes in response to the medication administration.

Q: If by policy a facility substitutes all meter dose inhaler (MDI) home medications with nebulized medications is this considered a self-administered drug even if provided by a Respiratory Therapist?

- A: It is not considered self-administered. However, the important question to ask is whether the nebulizer is medically necessary as defined by Medicare not your facility policy.

Q: A provider documented in the physical exam: "status post (S/P) Duo-neb: Complete clearing of the wheezing". This is obviously not enough documentation to bill for this service. Can you give examples of appropriate documentation and any guidelines for billing this procedure?

- A: Follow the CMS documentation guidelines for an exam. They need to describe the medical necessity and the CPT code that reflects this. Once the physical exam is performed from an E/M stand point, and the appropriate CPT code is billed, the 94640 will bundle payment per NCCI.

Q: Do you bill the medication used with the treatment or is it included in the treatment?

- A: The medication used during the inhalation treatment is billed separately. CPT code 96460 can only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered.

Q: I am hoping you will clarify the documentation requirements when this is done during an outpatient visit please

- A: We would need additional information regarding this question. Is the patient coming into the outpatient setting with an acute episode? If so, documentation would need to include E/M guidelines and explain in the documentation why this medication was needed, what symptoms the patient presented in the outpatient setting with, record of vitals, review of systems, etc.

Q: If a patient is admitted to the hospital stays for multiple days before discharge, how are we to capture the pricing for all the inhalation treatments we report with 94640? The way I am reading the NCCI Policy Manual we are only able to report 94640 once during this patient stay even if they stay for 10 days. So, if we do 5 treatments the first day and 4 the next day, how are we to capture all that we do? We don't perform the same number of treatments on all patients.

- A: The NCCI/OCE edits are applied to outpatient claims, so they would not apply to inpatient admissions.

Q: Per NCCI guidance, since CPT code 94640 should only be reported once during an episode of care, regardless of the number of separate inhalation treatments that are administered, and when treatments are not "back to back" treatments; in a scenario when multiple inhalation treatments are administered during one episode of care, would it be appropriate to report on the claim the total dollar amount charged for all of the inhalation treatments on one line with a quantity of one?

- A: Medicare will only reimburse one per episode of care, but it is appropriate to report the total dollar amount charged on the claim. The medication used during the inhalation treatment is billed separately. CPT code 96460 can only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered.

Q: Does this apply to both outpatient and inpatient claims and both outpatient prospective payment system (OPPS) and critical access hospitals (CAH) hospitals?

- A: Yes, the NCCI edits apply to both OPPS and CAH outpatient claims for TOB 13X, 14X, and 85X. I will share a document after all questions have been reviewed and share with all the attendees. In that I will include a link to CMS website and "How to use the NCCI Tools"

Q: What is considered an "episode" for an inpatient regarding CPT code 94640? Is it per day, per admission, per face to face encounter with the patient?

- A: An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care, however; the NCCI edits do not apply to inpatient claims.