Coding Clinic Visits under the Outpatient Prospective Payment System

by Linda B. Gledhill, M.H.A.

Oncology programs face many challenges in today's marketplace. Because of the emphasis placed on reimbursement under the ambulatory payment classification system (APC) and the rising costs of providing quality health care, oncology programs must understand and use all available resources. One area that does not seem to be well understood is clinic visits.

Q *What is a clinic visit?*

A Clinic visits are "separate and identifiable services" provided in a clinic setting by hospital staff, in addition to physician services.

Q *Who can bill for these services?*

A Any hospital employee who meets the requirements for documenting in the patient chart, such as social workers, nutritionists, and registered nurses, can provide and bill for these services. The key words are "separate and identifiable." When a physician provides a professional service, the physician bills at the professional visit level. When chemotherapy is provided, administration codes are applicable. When a staff member provides services outside the scope of these definitions, the staff member can bill clinic visit codes.

Q *How do you code these services?*

A Clinic visit codes are technical charges (HCPCS codes) based on the intensity or combination of the service provided. These charges are submitted on a UB-92 claim form along with other technical services provided under the outpatient prospective payment system (OPPS). (Note: The codes assigned for clinic visits, 99201-99205, 99211-99215, 99241-99245, 99271-99275, 99291, are the same codes used by physicians for professional visits and should not be confused with those services.) Additionally, oncology programs often use interdisciplinary team visit codes (99361 for a 30-minute visit and 99362 for a 60-minute visit).

Q *How do you determine the level of service provided?*

A The Center for Medicare and Medicaid Services (CMS) has charged hospitals with developing an internal mapping that represents the service or combinations of services provided at each level. These services must reasonably relate to the intensity of hospital resources indicated by the level of HCPCS code.

Q *How do you know if you are billing at the correct level?*

A Each facility is accountable for following its own system when assigning different levels of HCPCS codes. Once a facility has defined the different levels of service, documentation becomes key.

Q *I am an oncology nurse and routinely review toxicity screens with my patients. Is this a billable service?*

A Reviewing toxicity screens is a separate and identifiable service provided by a nurse to patients in a medical oncology clinic. Another example would be a patient seen for a nadir visit provided by a nurse. In radiation oncology, patients typically will have three to five clinic visits per radiation course for services provided by a nurse, social worker, or nutritionist.

Q *Does a physician have to be present during these visits?*

A Although these visits do not require direct supervision by a physician, a physician order, which can be standing, should be present to justify medical necessity.

Q *What do I need to do to get the process started in my clinic?*

A Once the appropriate levels of service have been defined, you will need to work with your Finance and Billing Department to update your charge master. These service definitions apply to every outpatient department in the hospital except the emergency room, which has its own definitions and codes. Nursing encounter forms have become popular because they define the levels of service for the hospital staff that will be using them. Coordinate with several administrative departments to ensure that all those involved in billing are aware of the process.

Q *What is the outpatient prospective payment reimbursement for these services?*

A Under the OPPS, the reimbursement rates for these clinic visit codes range from $44.29 to $70.25. These rates, which can be found on CMS' web site (*www.cms.gov*), include a 20 percent co-pay by the patient. The final rule on these rates was issued on Feb. 28, 2002, under Laws and Regulations, Addendum B.

Linda B. Gledhill, M.H.A., is an associate in the Consulting Division at ELM Services, Inc., in Rockville, Md.