Hospital Clinic Visits

by Cindy C. Parman, CPC, CPC-H, RCC

When a physician performs a patient visit in an office or freestanding center where the doctor owns and/or rents the space, employs and/or contracts with all staff, and bears all operating costs, payers make a single payment for this encounter. This physician payment includes *both* the professional service and the technical service (in other words, the practice expense component). When the patient visit is performed in the hospital outpatient department setting, however, the physician bills and receives reimbursement for *only* the professional service. The hospital then charges the payer for the technical services (practice expense component). A number of myths and "urban legends" exist regarding how to report codes for hospital clinic visits. Some hospitals may even miss revenue from these encounters if they are not correctly charged.

Defining a Clinic Visit

With the implementation of the Outpatient Prospective Payment System (OPPS) in August 2000, the Centers for Medicare & Medicaid Services (CMS) issued guidelines for the reporting of clinic visit codes. Hospitals were instructed to use the existing CPT® procedure codes for patient visits, but establish their own criteria to reflect facility resource consumption. CMS states that each facility is responsible for mapping the services provided during the patient encounter to the different levels of effort represented by the visit procedure code. Each facility is then held accountable for following its own written internal guidelines.

Of importance, the hospital does *not* report any consultation codes. Instead, the hospital must determine whether the visit is a new patient visit (codes 99201-99205) defined as an encounter for an individual who has not been registered as an inpatient or outpatient of the hospital within three years prior to the current visit, or an established patient visit (codes 99211-99215) for an individual who has been registered as an inpatient or outpatient within the past three years.

According to the Medicare Claims Processing Manual, Chapter 2: "The term 'encounter' means a direct personal contact in the hospital between a patient and a physician, or other person who is authorized by State law and, if applicable, by hospital staff bylaws to order or furnish services for diagnosis or treatment of the patient…When a patient has follow-up visits with a physician in the hospital following an initial encounter, each subsequent visit to the physician will be treated as a separate encounter for billing."[1]

The Office of the Inspector General (OIG) adds: "The clinic visit typically includes a history taking, examination, and a medical decision making to resolve a patient's presenting problem." And: "For the hospital to be able to charge for a clinic visit, the clinic patient needs to have had a face-to-face encounter with a physician, physician assistant, nurse practitioner, nurse-midwife, or visiting nurse, which includes a history taking, examination, and a medical decision making to resolve the patient's disease, condition, illness, injury, complaint, or other reason for encounter."[2]

Developing Internal Guidelines

Regarding the development of internal guidelines, CMS requires that hospital internal guidelines comport with the following principles:[3]

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).
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 addition, hospitals with multiple clinics may have different coding guidelines for each clinic, but these sets of guidelines must measure resource use in a relative manner. For example, a level three clinic visit in the cardiology department will use similar resource consumption as a level three clinic visit in the oncology department (even if the resources are not identical).

The American Hospital Association (AHA) and the American Health Information Management

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As indicated, the definition of the hospital technical service is not considered to be a "nurse visit."

Association (AHIMA) jointly developed a set of proposed standardized facility E/M guidelines, which address all insurance payers (public and private). These guidelines are available online at: *www.ahima.org/pdf_files/emcodingreport.pdf*. From 2004 to 2005, CMS employed a contractor to evaluate the AHIMA/AHA guidelines. The contractor found numerous problems with the guidelines, primarily involving the need for better definitions of terms. As part of the OPPS Proposed Rule for 2007, CMS posted to its website the draft AHIMA/AHA guidelines and also the agency's comments on the guidelines. Despite the problems identified by the contractor, CMS stated in the 2007 OPPS Final Rule that it believed the AHIMA/AHA guidelines were the "most appropriate and well-developed guidelines for use in the OPPS" of which the agency was aware.[4]

In the 2009 OPPS Final Rule, CMS stated that it continued to see a "normal and stable" distribution of visit codes. The agency encouraged hospitals to continue to use their internal guidelines and stated that it "will not implement national guidelines prior to CY [calendar year] 2010."[5]

Table 1. APC Calculations

Drug Administration		Clinic Visit	
250	Pharmacy	250	Pharmacy
251	Generic Drugs	251	Generic Drugs
252	Non-Generic Drugs	252	Non-Generic Drugs
257	Non-Rx Drugs	257	Non-Rx Drugs
258	IV Solutions	258	IV Solutions
259	Other Pharmacy	259	Other Pharmacy
270	Medical & Surgical Supplies	270	Medical & Surgical Supplies
271	Non-Sterile Supplies	271	Non-Sterile Supplies
272	Sterile Supplies	272	Sterile Supplies
279	Other Sterile Supplies	279	Other Sterile Supplies
630	Drugs Requiring Identification	630	Drugs Requiring Identification
631	Single Source Drug	631	Single Source Drug
632	Multiple Source Drug	632	Multiple Source Drug
633	Restrictive Rx	633	Restrictive Rx
762	Observation Room	762	Observation Room
260	IV Therapy, General	700	Cast Room
262	IV Therapy, Pharmacy Services	709	Other Cast Room
263	IV Therapy, Drug/Delivery		
264	IV Therapy Supplies		
269	Other IV Therapy		

Not a "Nurse Visit"

As indicated, the definition of the hospital technical service is not considered to be a "nurse visit." Nurses are not separately reimbursed for patient visits in *any* practice setting. In all correspondence regarding charges for clinic visits, CMS has stated that the facility should base the code assignment on *all hospital resources* used during the outpatient encounter. For example, items such as room use, nursing services, nutrition services, social work, pain management assessments, and scheduling diagnostic tests may be included in the technical patient visit service performed.

The April 7, 2000 *Federal Register* describes the transition to Ambulatory Payment Classification (APC) reimbursement under the OPPS and prohibits charging for unbundled services. Payment under any prospective payment system provides a single payment for a specific service that includes all "packaged services," such as use of the room, anesthesia, supplies, the services of nurses and other hospital personnel, equipment used, certain drugs, and various incidental services.

Table 1 is a list of revenue codes that are included in the medical visit

and revenues codes that are included in drug administration. A review of these items indicates that all services included in the prospective payment for a clinic visit are also included in a drug administration service. As a result, a medical visit would not typically be charged in addition to a drug administration service on the same date in the same department.

Billing "Incident To"

Although the clinic visit codes were designed to report the technical component of an outpatient physician visit, in limited circumstances they may be reported for "incident to" services performed by physician order in the outpatient department.

According to the CMS Manual System, Publication 100-2, Chapter 6, Section 20.4.1: "Therapeutic services which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians in the treatment of patients. Such services include clinic services and emergency room services."[6]

This document also states that the services and supplies must be furnished on a physician's order by hospital personnel and under a physician's supervision. "A hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment."[6]

CMS adds: "Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. A hospital may bill a visit code, based on the hospital's own coding guidelines, which must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented."[6]

As a result, it may not be possible to report a 99211 (low level established patient visit) code whenever the patient sees a nurse or other member of the hospital staff.

For 99211 services performed by hospital personnel and billed as an "incident to" service, the documentation is expected to demonstrate the "link" between the non-physician service and the precedent physician service to which the non-physician service is incidental. The medical record must also include the physician's order for the patient services, and documentation that demonstrates the services were provided under direct physician supervision.

Hospitals often experience a coding dilemma surrounding reporting a visit code for chemotherapy teaching or education performed by a staff member in the infusion center. According to the American Society of Clinical Oncology (ASCO): "Physician time spent on treatment planning and management is considered to be captured under the E/M codes. Chemotherapy management cannot be billed separately. Time spent by nursing staff and other health professionals on nutrition counseling, therapy management, and care coordination is also not separately billable."[7]

In general, "education" is not charged separately as an E/M clinic visit since this service is considered to be part of the initial patient visit service. The date of service is not the issue: CMS and the American Medical Association (AMA) agree that there are "post E/M" services that may be performed on the same day or a separate day, but are not separately charged. There must always be a written order for all services, but this alone may not make the education a separately billable event.

Of course, if the individual Medicare contractor or insurer provided written policy information recognizing coverage for a separate education visit, then it should be charged according to the payer's coding specification.

Using Modifier 25

As stated above, hospitals do not generally charge for a clinic visit when the patient presents for drug administration. Some patients tolerate the drug administration well and require very few, if any, additional resources. Other patients may require more nursing attention or other hospital resources to complete the drug administration. However, both the uncomplicated administration and the more complex service are reimbursed at the same Medicare APC allowance. APC reimbursement is intended to reflect a "median" prospective payment and not a fee schedule allowance for each service performed during a patient encounter.

For hospital reporting purposes, modifier 25 is appended to the patient visit code when documentation supports a significant, separately identifiable technical visit service performed on the same day as a procedure with status codes "S" or "T" (services designated as "significant procedures"). Documentation must be clear that the patient visit service provided was ordered by the physician as an incident-to service and separate and distinct from the procedure performed.

According to CMS Transmittal 785, dated December 16, 2005: "Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration services."[8] While nursing services performed prior to, during, and/or after the drug administration service are generally considered to be included in the administration charge, a visit performed in a different hospital department on the same day as drug delivery should be separately charged with modifier 25 appended to the visit code.

Understanding Multidisciplinary Visits

In certain situations, hospitals may bill HCPCS code G0175, which is defined as "scheduled interdisciplinary team conference (minimum of three exclusive of patient care nursing staff) with patient present." According to Chapter II of the OPPS Manual: "Hospitals can use HCPCS code G0175 in reporting a scheduled medical conference providing that the key requirements for this service are met:[1]

- There must be at least 3 members of the multidisciplinary staff present; and

- One of these individuals must be a physician; and
- None of these 3 individuals can be a nurse (nurses may be present in addition to the other members of the multidisciplinary team, but at least 3 team members must represent disciplines other than nursing); and
- The patient must also be present for the interdisciplinary conference.

Based upon the requirement that the patient must be physically present during the team conference, hospitals should make certain that HCPCS code G0175 is not assigned for tumor board meetings or other staff conferences that do not include the patient.

Even with a thorough understanding of how to bill for clinic services, keep in mind that in all coding scenarios, local contractor or payer guidelines take precedence and should be consulted and followed.

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References

[1] Centers for Medicare & Medicaid Services. Chapter 2: admission and registration requirements. *Medicare Claims Processing Manual* (Revision 1472, March 6, 2008.) Available online at: *http://www.cms.hhs.gov/manuals/downloads/clm104c02.pdf*. Last accessed Jan. 27, 2009.

[2] Department of Health and Human Services. Office of the Inspector General. *Review of Outpatient Clinic Services Provided by the University of Massachusetts Memorial Medical Center for Fiscal Year 1999*. Dec. 2001. Available online at: *http://oig.hhs.gov/oas/reports/region1/10100524.pdf*. Last accessed Jan. 27, 2009.

[3] Centers for Medicare & Medicaid Services. Medicare and Medicaid programs; interim and final rule. *Federal Register*. 72(227):66579–67226. Nov. 27, 2007. Available online at: *http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1392fc.pdf*. Last accessed Feb. 2, 2009.

[4] Centers for Medicare & Medicaid Services. Medicare program—revisions to hospital outpatient prospective payment system and calendar year 2007 payment rates;final rule. *Federal Register*. 71(226):67960–68401. Nov. 24, 2006. Available online at: *http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1506fc.pdf*. Last accessed Feb. 2, 1009.

[5] Centers for Medicare & Medicaid Services. Medicare program: changes to the hospital outpatient prospective payment system and CY 2009 payment rates. *Federal Register*. 73(223):68502–69380. Nov. 18, 2008. Available online at: *http://edocket.access.gpo.gov/2008/pdf/E8-26212.pdf*. Last accessed Feb. 2, 2009.

[6] Centers for Medicare & Medicaid Services. Chapter 6: hospital services covered under Part B. *Medicare Claims Processing Manual* (Revision 101, Jan. 1, 2009). Available online at: *http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf*. Last accessed Jan. 27, 2009.

[7] American Society of Clinical Oncology. *FAQs on Revised Medicare Drug Administration Codes and Cancer Care Demonstration Project* (Update April 25, 2005). Available online at: *http://www.asco.org/asco/downloads/Updated_FAQ_on_drug_admin_final.pdf*. Last accessed Jan. 27, 2009.

[8] Centers for Medicare & Medicaid Services. Transmittal 785. *CMS Manual System: Pub 100-04 Medicare Claims Processing.* Dec. 16, 2005. Available online at: *http://www.cms.hhs.gov/transmittals/downloads/R785CP.pdf*. Last accessed Jan. 27, 2009.

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