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Visit and Procedure Charges under HCFA Rules

by Mary Lou Bowers, M.B.A., L.C.S.W.

Q: Can a visit and major procedure on the same day be charged in the hospital oncology outpatient setting?

A: Yes, in all cases. The Health Care Financing Administration issued a Program Memorandum, Transmittal A-00-40, to Intermediaries on July 20, 2000, to clarify use of modifier 25 (a code that can be added to certain HCPCS and CPT codes to further define the service being billed). In that memo, HCFA states that modifier 25 applies only to Evaluation and Management. (Under APCs, E/M codes are used to bill visits in the hospital outpatient department.) In addition, modifier 25 applies only when the visit is provided on the same date as a major diagnostic or therapeutic procedure. The HCFA memo further states that the visit and procedure do not need to be provided by the same practitioner and that the diagnosis (ICD-9CM) can be the same for the visit and the procedure.

Q: Is a separate visit code always appropriate?

A: No. A separate code for a visit that is provided on the same date as a major procedure is not always appropriate. To clarify, HCFA states, "Since payment for taking the patient's blood pressure, temperature, asking the patient how he or 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." When the reporting of a visit is appropriate (that is, a separate service has been provided in addition to the procedure) a visit code with modifier 25 would be the proper billing procedure.

Q: What is required to bill a visit and a procedure?

A: Two distinct services, one a procedure and one a visit, are required. For example, if you provide either a service incorporating the history and medical decision-making components for an E/M visit or if you provide a service incorporating counseling (E/M using time as the critical element) in conjunction with a major procedure, then you can bill both a visit and a major procedure. Each service requires adequate documentation. An assessment visit could be documented by the nurse recording a HPI (history of present illness), the reason for the visit and a chronology of the patient's illness since the last visit, and a ROS (review of systems) with detail such as toxicity grading. The medical decision making is documented by the physician order, the assessment of the patient, and the communication with the physician (or documentation following the physician protocol). Counseling visits are documented by HPI, documentation of the main counseling points, and communication with the physician with all points relevant for treatment planning.

You should not charge a visit if your services only include blood pressure, temperature, and consent-type service.

Q: Can the visit services be used for radiation and medical oncology visits?

A: Yes. For example, if a medical oncology patient receives services that meet the specifics for a visit and also receives a major service such as administration of chemotherapy or blood, the bill would include the E/M visit code with modifier 25 along with the HCPCS code for the procedure. Or, if a radiation therapy patient has a similar visit (more than blood pressure, temperature, and consent) on the same date as he or she receives a radiation treatment, the visit code would require the 25 modifier. Here is a list of common major procedures for the cancer center that would require a modifier on a visit code if provided together:

- Chemotherapy administration
- IV administration
- Blood administration
- Bone marrow aspiration
- Bone marrow biopsy
- Paracentesis
- Thoracentesis
- Radiation treatment delivery
- Brachytherapy
- Stereotactic radiation therapy.

Q: What services would not require a modifier on a visit code?

A: A visit code would not need the 25 modifier if provided on the same date with only ancillary services. So, if a patient had a visit on the same date as he or she had an injection, or on the same date with port films, there would be no need for the modifier. Here is a list of ancillary services that would not create the need for the 25 modifier on same day visit code:

- Injections
- Vaccine administration
- Port films
- Dosimetry
- Physics
- Devices construction
- Phlebotomy
- Drugs or seeds.

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