Facility Fee E/M Coding and Billing

March 2023

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Introduction

Facility outpatient departments may charge evaluation and management visit fees for medically necessary services that are separate and distinct from other billable procedures. This paper concisely addresses the following questions:

- When should hospitals charge for an outpatient E/M visit?
- How does a hospital decide whether to report a "new" vs. "established" patient E/M code?
- Which E/M visit level should be assigned for the facility fee?
- When is it appropriate for the hospital to append modifier -25 (significant, separately identifiable evaluation and management service) or modifier -27 (multiple outpatient hospital evaluation & management encounters on the same date) to an E/M HCPCS?

The professional fee Guidelines for Evaluation and Management codes from the AMA CPT® book are available on the PARA Data Editor Calculator tab:

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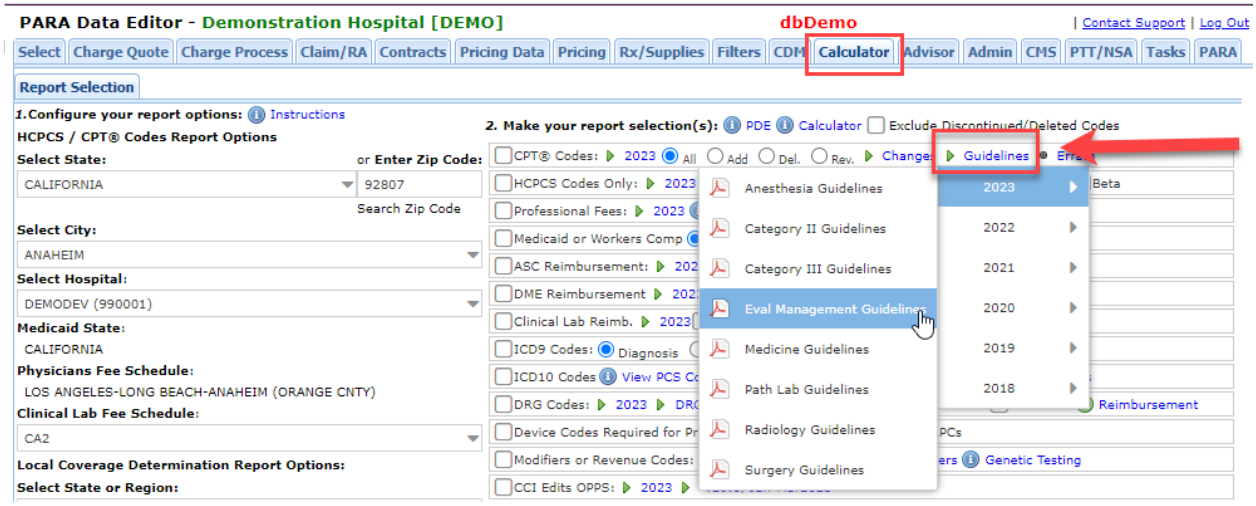

In addition, CCI edits may be researched for billing an E/M code with another procedure:

E/M codes typically used in a non-emergency hospital outpatient department setting include the CPT® codes 99202 through 99215 and G0463 in lieu of 99202-99215 for Medicare claims:

99202 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 15-29 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99203 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 30-44 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99204 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 45-59 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99205 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 60-74 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99211 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

99212 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 10-19 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 20-29 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99214 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 30-39 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
99215 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING. WHEN USING TIME FOR CODE SELECTION, 40-54 MINUTES OF TOTAL TIME IS SPENT ON THE DATE OF THE ENCOUNTER.
G0463 - HOSPITAL OUTPATIENT CLINIC VISIT FOR ASSESSMENT AND MANAGEMENT OF A PATIENT Berenson-Eggers Type of Service: M1B - OFFICE VISITS - ESTABLISHED

Medicare developed HCPCS G0463 to be reported for facility fee clinic visits in lieu of 99202-99215 in 2014. A summary of the rationale for the HCPCS was provided in the 2016 OPPS Final Rule:

> DEPARTMENT OF HEALTH AND HUMAN SERVICES
> Centers for Medicare & Medicaid Services
>
> VII. OPPS Payment for Hospital Outpatient Visits
>
> A. Payment for Hospital Outpatient Clinic and Emergency Department Visits
>
> "Since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department (ED) hospital outpatient visits using the CPT® E/M payment rates for HCPCS code G0463 based on the total geometric mean cost of the levels one through five CPT® E/M codes for clinic visits (five levels for new patient clinic visits and five levels for established patient clinic visits) previously recognized under the OPPS (CPT® codes 99201 through 99205 and 99211 through 99215). In addition, we finalized a policy to no longer recognize a distinction between new and established patient clinic visits.
>
> ...
>
> HCPCS code G0463 (for hospital use only) will represent any and all clinic visits under the OPPS.

As part of our broader initiative to restructure APCs across the OPPS to collectively group services that are clinically similar and have similar resource costs within the same APC, we proposed to reassign HCPCS code G0463 from existing APC 0634 to renumbered APC 5012 (Level 2 Examinations and Related Services), formerly APC 0632. Renumbered APC 5012 includes other services that are clinically similar with similar resource costs to HCPCS code G0463, such as HCPCS code G0402 (Initial preventive physical examination). We proposed to use CY 2014 claims data to develop the CY 2016 OPPS payment rate for HCPCS code G0463 based on the total geometric mean cost of HCPCS code G0463, as CY 2014 is the first year for which claims data are available for this code. Finally, as we established in the CY 2014 OPPS/ASC final rule with comment period (78 FR 75042), there is no longer a policy to recognize a distinction between new and established patient clinic visits."

Type A Emergency departments use the 99281-99292 E/M code set. A Type A provider-based emergency department must meet at least one of the following requirements:

> (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department and be open 24 hours a day, 7 days a week; or
> (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment and be open 24 hours a day, 7 days a week.

99281 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
99282 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND STRAIGHTFORWARD MEDICAL DECISION MAKING
99283 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND LOW LEVEL OF MEDICAL DECISION MAKING
99284 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND MODERATE LEVEL OF MEDICAL DECISION MAKING
99285 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES A MEDICALLY APPROPRIATE HISTORY AND/OR EXAMINATION AND HIGH LEVEL OF MEDICAL DECISION MAKING
99291 - CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE CRITICALLY ILL OR CRITICALLY INJURED PATIENT; FIRST 30-74 MINUTES
99292 - CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE CRITICALLY ILL OR CRITICALLY INJURED PATIENT; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)

Type B Emergency Departments report HCPCS G0380 – G0384 for E/M services. A Type B provider-based emergency department must meet at least one of the following requirements:

> (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department and is open less than 24 hours a day, 7 days a week; or
>
> (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment and is open less than 24 hours a day, 7 days a week; or
>
> (3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, regardless of its hours of operation.

G0380 - LEVEL 1 HOSPITAL EMERGENCY DEPARTMENT VISIT PROVIDED IN A TYPE B EMERGENCY DEPARTMENT; (THE ED MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE STATE LAW AS AN EMERGENCY ROOM OR EMERGENCY DEPARTMENT; (2) IT IS HELD OUT TO THE PUBLIC (BY NAME, POSTED SIGNS, ADVERTISING, OR OTHER MEANS) AS A PLACE THAT PROVIDES CARE FOR EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT; OR (3) DURING THE CALENDAR YEAR IMMEDIATELY PRECEDING THE CALENDAR YEAR IN WHICH A DETERMINATION UNDER 42 CFR 489.24 IS BEING MADE, BASED ON A REPRESENTATIVE SAMPLE OF PATIENT VISITS THAT OCCURRED DURING THAT CALENDAR YEAR, IT PROVIDES AT LEAST ONE-THIRD OF ALL OF ITS OUTPATIENT VISITS FOR THE TREATMENT OF EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT) Berenson-Eggers Type of Service: M3 - EMERGENCY ROOM VISIT
G0381 - LEVEL 2 HOSPITAL EMERGENCY DEPARTMENT VISIT PROVIDED IN A TYPE B EMERGENCY DEPARTMENT; (THE ED MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE STATE LAW AS AN EMERGENCY ROOM OR EMERGENCY DEPARTMENT; (2) IT IS HELD OUT TO THE PUBLIC (BY NAME, POSTED SIGNS, ADVERTISING, OR OTHER MEANS) AS A PLACE THAT PROVIDES CARE FOR EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT; OR (3) DURING THE CALENDAR YEAR IMMEDIATELY PRECEDING THE CALENDAR YEAR IN WHICH A DETERMINATION UNDER 42 CFR 489.24 IS BEING MADE, BASED ON A REPRESENTATIVE SAMPLE OF PATIENT VISITS THAT OCCURRED DURING THAT CALENDAR YEAR, IT PROVIDES AT LEAST ONE-THIRD OF ALL OF ITS OUTPATIENT VISITS FOR THE TREATMENT OF EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT) Berenson-Eggers Type of Service: M3 - EMERGENCY ROOM VISIT

G0382 - LEVEL 3 HOSPITAL EMERGENCY DEPARTMENT VISIT PROVIDED IN A TYPE B EMERGENCY DEPARTMENT; (THE ED MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE STATE LAW AS AN EMERGENCY ROOM OR EMERGENCY DEPARTMENT; (2) IT IS HELD OUT TO THE PUBLIC (BY NAME, POSTED SIGNS, ADVERTISING, OR OTHER MEANS) AS A PLACE THAT PROVIDES CARE FOR EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT; OR (3) DURING THE CALENDAR YEAR IMMEDIATELY PRECEDING THE CALENDAR YEAR IN WHICH A DETERMINATION UNDER 42 CFR 489.24 IS BEING MADE, BASED ON A REPRESENTATIVE SAMPLE OF PATIENT VISITS THAT OCCURRED DURING THAT CALENDAR YEAR, IT PROVIDES AT LEAST ONE-THIRD OF ALL OF ITS OUTPATIENT VISITS FOR THE TREATMENT OF EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT)
Berenson-Eggers Type of Service: M3 - EMERGENCY ROOM VISIT

G0383 - LEVEL 4 HOSPITAL EMERGENCY DEPARTMENT VISIT PROVIDED IN A TYPE B EMERGENCY DEPARTMENT; (THE ED MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE STATE LAW AS AN EMERGENCY ROOM OR EMERGENCY DEPARTMENT; (2) IT IS HELD OUT TO THE PUBLIC (BY NAME, POSTED SIGNS, ADVERTISING, OR OTHER MEANS) AS A PLACE THAT PROVIDES CARE FOR EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT; OR (3) DURING THE CALENDAR YEAR IMMEDIATELY PRECEDING THE CALENDAR YEAR IN WHICH A DETERMINATION UNDER 42 CFR 489.24 IS BEING MADE, BASED ON A REPRESENTATIVE SAMPLE OF PATIENT VISITS THAT OCCURRED DURING THAT CALENDAR YEAR, IT PROVIDES AT LEAST ONE-THIRD OF ALL OF ITS OUTPATIENT VISITS FOR THE TREATMENT OF EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT)
Berenson-Eggers Type of Service: M3 - EMERGENCY ROOM VISIT

G0384 - LEVEL 5 HOSPITAL EMERGENCY DEPARTMENT VISIT PROVIDED IN A TYPE B EMERGENCY DEPARTMENT; (THE ED MUST MEET AT LEAST ONE OF THE FOLLOWING REQUIREMENTS: (1) IT IS LICENSED BY THE STATE IN WHICH IT IS LOCATED UNDER APPLICABLE STATE LAW AS AN EMERGENCY ROOM OR EMERGENCY DEPARTMENT; (2) IT IS HELD OUT TO THE PUBLIC (BY NAME, POSTED SIGNS, ADVERTISING, OR OTHER MEANS) AS A PLACE THAT PROVIDES CARE FOR EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT; OR (3) DURING THE CALENDAR YEAR IMMEDIATELY PRECEDING THE CALENDAR YEAR IN WHICH A DETERMINATION UNDER 42 CFR 489.24 IS BEING MADE, BASED ON A REPRESENTATIVE SAMPLE OF PATIENT VISITS THAT OCCURRED DURING THAT CALENDAR YEAR, IT PROVIDES AT LEAST ONE-THIRD OF ALL OF ITS OUTPATIENT VISITS FOR THE TREATMENT OF EMERGENCY MEDICAL CONDITIONS ON AN URGENT BASIS WITHOUT REQUIRING A PREVIOUSLY SCHEDULED APPOINTMENT)
Berenson-Eggers Type of Service: M3 - EMERGENCY ROOM VISIT

When to Charge

Medicare requires that any service billed to the program is medically necessary and appropriate, and is supported by medical documentation. Not all evaluation and management visits may be medically necessary or appropriate, and the facility should not bill a visit fee if the medical documentation supporting the visit charge is insufficient.

Additionally, it is not always appropriate to bill an E/M service in conjunction with another procedure or service (see the section on Modifier -25 below).

Hospitals should bill an E/M code when the following conditions are met:

- The patient is referred to the facility for evaluation on the order of a physician (including, for example, emergency physician referrals of a pregnant woman to Labor & Delivery for evaluation); and
- The evaluation is medically necessary and appropriate; and
- The patient encounter consumes a minimum of 10 minutes of staff time and/or resources to deliver direct patient care; and
- The evaluation and management service is not "integral to" another procedure which is the primary purpose of the visit.

In a Frequently Asked Questions record dated January 2008, Medicare provides illuminating advice on whether an outpatient visit code should be charged for medication management:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/Downloads/OPPS_QandA.pdf

"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.

"For example, CPT® code 85610 (Prothrombin time) is a code that describes performance of the prothrombin time test. If the only service provided is a venipuncture and lab test to determine the prothrombin time, then this is all that should be billed. If a hospital provides a distinct, separately identifiable service in addition to the test, the hospital is responsible for billing the code that most closely describes the service provided. 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. Providers should work with their local FIs regarding the medical necessity for these visits."

New Versus Established Patient Coding

When billing non-Medicare payers for an evaluation and management visit, the facility must determine whether to report a new patient visit code (99202-99205), or an established patient visit code (99211-99215). The determination of new or established must be made from the perspective of the hospital as the billing entity, not the attending physician. In fact, the hospital may appropriately bill a new patient code when the physician bills an established patient code, and vice versa.

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For facility fee claims (837i or UB04), use the following guidelines in selecting new versus established patient E/M codes:

- A **"new patient"** means a patient has not received any face-to-face services, i.e., E/M service or surgical procedure, from the facility within the previous 3 years.
- An **"established patient"** has been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit.

The determination of "new" vs. "established" should be made by an individual who has access to registration information for the past 3 years; any face-to-face patient service by the same hospital would qualify a patient as "established."

Facility Fee E/M Level Assignment

Medicare has acknowledged that the CPT® Evaluation and Management (E/M) codes do not necessarily describe the range and mix of services provided by hospitals. Instead, CMS has instructed providers to develop internal guidelines or policies for the assignment of E/M codes. Since facilities must report G0463 to Medicare for all levels of office visits, level assignment is irrelevant to that code. However, level assignment criteria should be established by facilities for the emergency department Type A and Type B evaluation and management codes.

Since CPT® descriptions require some interpretation to crosswalk to an appropriate code for facility fees, CMS instructs each facility to develop internal guidelines for assigning the E/M level to a visit.

In the Federal Register (11/27/2007) notice of Medicare program changes, Medicare offers guidance:

> https://www.federalregister.gov/articles/2007/11/27/07-5507/medicare-program-changes-to-thehospital-outpatient-prospective-payment-system-and-cy-2008-payment
>
> "…CPT® E/M codes were defined to reflect the activities of physicians and do not necessarily fully describe the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters…"

CMS instructs that facility E/M coding policies should follow the original intent of the CPT® codes by reasonably relating the intensity of hospital resources to the different levels of effort represented by the codes. The following principles were set forth by CMS in its August 2002 proposed rule (67 FR 52131):

- Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, not physician resource use;
- Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and meet HIPAA requirements;
- Coding guidelines should only require documentation that is clinically necessary for patient care;
- Preferably coding guidelines should be based on current hospital documentation requirements, and
- Coding guidelines should not facilitate up-coding or gaming.

CorroHealth Recommendation

Since the record of staff time in delivering face-to-face patient care is one of the most objective measures of hospital facility resources, hospitals often use direct patient care time as the basic driver of E/M code level assignment. That said, facilities should be careful not to include the resources consumed in separately billable services toward the E/M level.

Documentation of time spent in caring directly for a patient is particularly important when determining whether to report the Critical Care E/M code 99291 - CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE CRITICALLY ILL OR CRITICALLY INJURED PATIENT; FIRST 30-74 MINUTES. For hospital facility fee billing, the time required may be measured by both physician and nursing staff time in delivering face-to-face patient care. Time may be continuous, intermittent, and aggregated, but the facility must count any single period of time only once, even if more than one physician or staff is providing care.

CPT® Assistant cautions providers not to count time spent performing other billable procedures in the time spent in critical care.

"The time spent performing CPR is subtracted from the total critical care time of 2 hours since CPR was provided during the 2 hours of critical care services. Documentation in the patient's record should indicate that the 90 minutes of critical care time does not include the time spent performing CPR (30 minutes)."

Modifier -25

Hospitals should exercise caution when appending modifier -25 (*significant, separately identifiable evaluation and management service*) to an outpatient E/M code billed with another procedure or DME HCPCS code. The modifier represents that the E/M care is not "integral to" another billable service. When Medicare pays for an E/M code with modifier -25 appended, the

hospital is at risk of overpayment if the E/M should have been considered reimbursed in the procedure performed at the same visit.

The Medicare Claims Processing Manual provides the following advice and example when billing an E/M level with a DME code (Chapter 4 - Part B Hospital, 20 - Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS), Section 201):

> http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
>
> "When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient's use of the item, the hospital should not bill a visit or procedure HCPCS code to report the charges associated with the fitting, adjustment, or other related services. Instead, the HCPCS code for the device already includes the fitting, adjustment or other similar services. For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment."

Modifier -27

Medicare allows hospitals to bill multiple outpatient hospital evaluation & management encounters on the same date, provided that the two visits are separate and distinct, medically necessary, and supported by documentation. The requirements are available in a Program Memorandum dated June 29, 2001:

> https://www.cms.gov/files/document/a0180.pdf

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 content of this memorandum, which is available on the PARA Data Editor, includes the following:

> "…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.
>
> "When reporting modifier 27, report with condition code G0 when multiple medical visits occur on the same day in the same revenue centers."

The UB Editor documentation of Condition code G0 is available on the PARA Data Editor Calculator tab:

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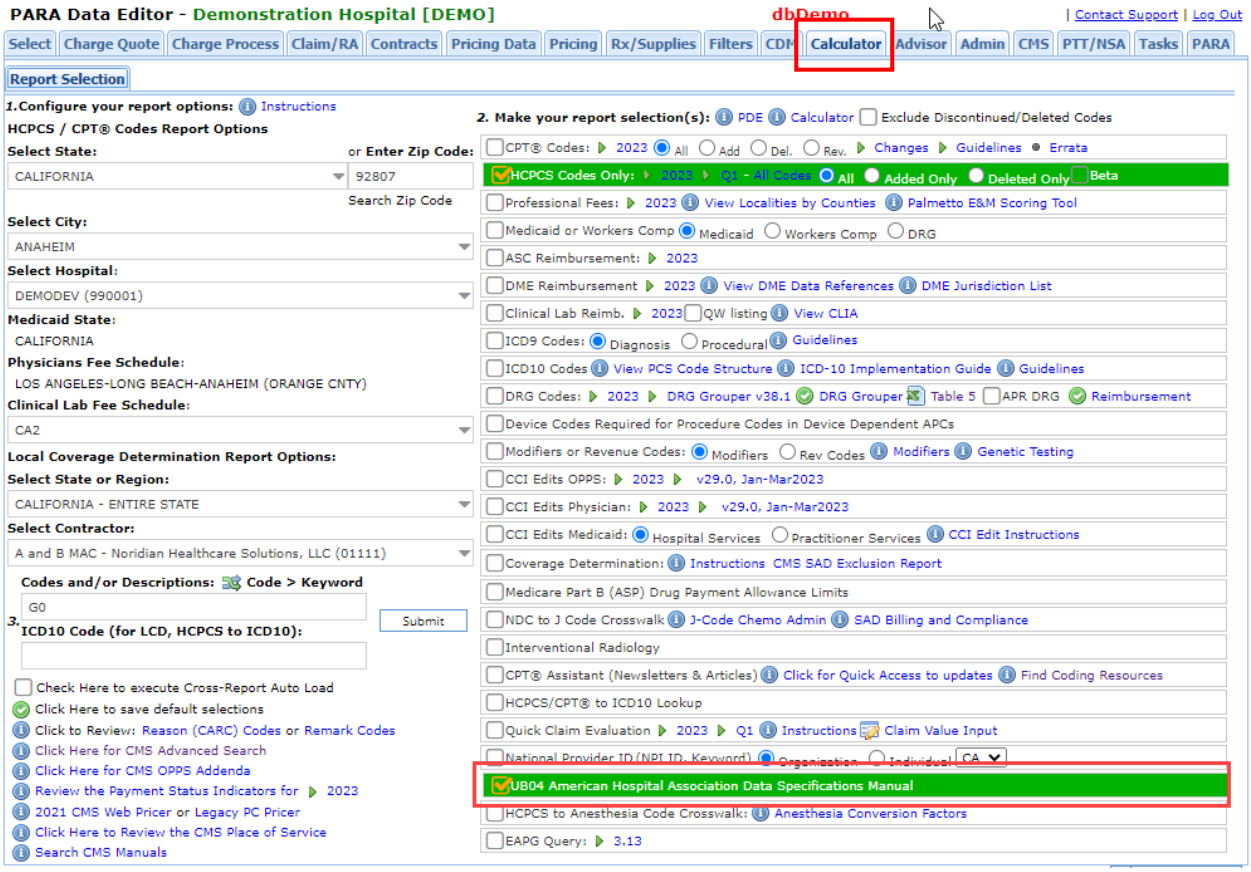

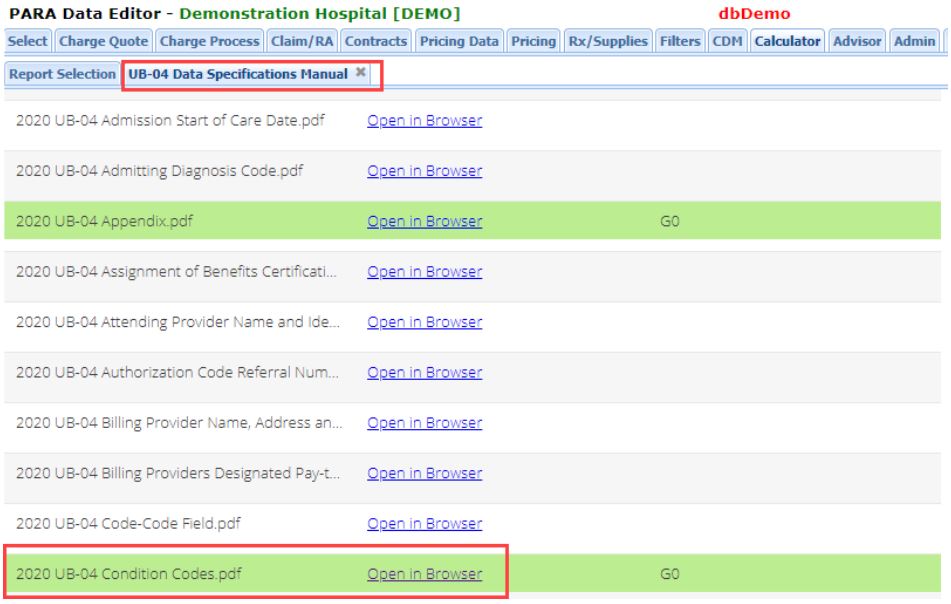

Effective Date: January 1, 2009, January 1, 2011
Meeting Date: 5/21/08, 8/12/10

Form Locators 18-28
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D8	Change to Make Medicare the Primary Payer	Change to make Medicare the primary payer.
D9	Any Other Change	Any other change.
DA-DQ	*RESERVED*	Reserved for assignment by the NUBC.
DR	Disaster Related	Used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.
DS-DZ	*RESERVED*	Reserved for assignment by the NUBC.
E0	Change in Patient Status	Change in patient status.
E1-FZ	*RESERVED*	Reserved for assignment by the NUBC.
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain.

Medicare Administrative Contractor Palmetto GBA (NC, SC, VA, WV) restates this instruction on the use of Condition Code G0 when billing multiple outpatient Evaluation and Management visits on the same date of service. The article is dated January 10, 2019. The Palmetto document reads as follows:

https://www.palmettogba.com/palmetto/jma.nsf/DIDC/8YRGAJ8515~Facilities%20and%20Organizations~Hospitals

"Hospitals, subject to Outpatient Prospective Payment System (OPPS), report condition code G0 when multiple medical visits occurred on the same day in the same revenue center (0450, 0761, 0510) but the visits were distinct and constituted independent visits

An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain.

Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim.

Appropriate reporting of condition code G0 allows for accurate payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of condition code G0."

"Proper Reporting of condition code G0 (Zero)

Hospitals should report condition code G0 on FLs 24-30 when multiple medical visits occurred on the same day in the same revenue center but were distinct and constituted independent visits. An example of such a situation would be a patient going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain.

Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim.

Claims with condition code G0 should not be automatically rejected as a duplicate claim.

In this situation, proper reporting of condition code G0 allows for proper payment under OPPS. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without condition code G0."

However, in a CPT® Assistant article from March 2004, hospitals are advised not to bill both Critical Care and another emergency department visit:

> "There is a single APC for critical care services (99291), as hospitals are required to use CPT® code 99291 to report outpatient encounters in which critical care services are furnished. The hospital is required to use CPT® code 99291 in place of, but not in addition to, a code for a medical visit or for an emergency department service. CMS proposes to implement new evaluation and management (E/M) codes only when it is also ready to implement guidelines for their use, after allowing ample opportunity for public comment, systems change, and provider education."

For additional information on E/M coding and billing, please see the following resources available in the Advisor tab of the PARA Data Editor:

2023 Coding Update – Professional Evaluation and Management Codes

AMA CPT® Evaluation and Management Code and Guideline Changes 2023

Prolonged Non-Face-to-Face E/M Services in 2023

Q&A – Observation Pro Fees 99222 and 99238