

OPPS Visit Codes Frequently Asked Questions

Q1: Under the OPSS, which HCPCS codes are used by provider-based outpatient hospitals to report Type A and Type B hospital emergency department visits? Which HCPCS codes are used for reporting hospital outpatient clinic visits?

A1: Under the OPSS, hospitals report Type A emergency department visits using HCPCS codes 99281-99285. Hospitals report Type B emergency department visits using HCPCS codes G0380-G0384. Hospitals report hospital outpatient clinic visits using HCPCS codes 99201-99215 and 99241-99245.

Q2: Under the OPSS, what are the definitions of Type A and Type B hospital emergency departments that apply to determine what HCPCS codes provider-based hospitals should use for reporting emergency department visits?

A2: 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.

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 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 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.

Q3: Under the OPSS, an area of a provider-based hospital provides emergency outpatient visits and closes at 10 P.M. each evening. Would that area be considered a Type A emergency department or a Type B emergency department?

A3: Under the OPSS, each provider-based hospital must be evaluated individually and must make a decision specific to each area of the hospital to determine which codes would be appropriate. When a hospital maintains a separately identifiable area or part of a facility which does not operate on the same schedule (that is, 24 hours per day, 7 days a week) as its emergency department, that area or facility would not be considered an integral part of the emergency department that operates 24 hours per day, 7 days a week for purposes of determining its emergency department type for reporting emergency visit services. Instead, the facility or area would be evaluated separately to determine whether it is a Type A emergency department, Type B emergency department, or clinic. We would expect the hospital providing services in such facilities or areas to evaluate the status of those areas and bill accordingly. It may be appropriate

OPPS Visit Codes Frequently Asked Questions

for a Type A emergency department to “carve out” portions of the emergency department that are not available 24 hours a day, where visits would be more appropriately billed with Type B emergency department codes.

It may be necessary for a hospital to consult with its fiscal intermediary to determine which areas of its emergency department are considered Type A and which are considered Type B.

Q4: One “Fast Track” area of the provider-based emergency department is closed at 10 P.M., but is integrated into the larger emergency department for the rest of the night. Under the OPSS, would that “Fast Track” area be considered a Type A or Type B emergency department?

A4: When a provider-based hospital maintains a separately identifiable area or part of a facility which does not operate on the same schedule (that is, 24 hours per day, 7 days a week) as its emergency department, that area or facility would not be considered an integral part of the emergency department that operates 24 hours per day, 7 days a week for purposes of determining its emergency department type for reporting emergency visit services under the OPSS. However, assuming the area meets the other requirements for Type A emergency departments, if that area is available, fully staffed, and integrated into the larger emergency department after 10 P.M., and continues to remain available and staffed 24 hours a day, 7 days a week, that area would be considered a Type A emergency department.

It may be necessary for a hospital to consult with its fiscal intermediary to determine which areas of its emergency department are considered Type A and which are considered Type B.

Some provider-based emergency departments may have certain areas that are designated as “Fast Track” areas during certain times of the day, but are regularly and customarily fully staffed and available 24 hours a day, 7 days a week. Under the OPSS, the Type A versus Type B distinction applies to hours of operation of an area of the hospital, not to the process used to triage and treat patients.

Q5: There is a separately identifiable area or part of a provider-based emergency department that closes at 10 P.M. every evening, but is not integrated into the larger emergency department for the rest of the night. Under the OPSS, is the entire emergency department treated as a Type B emergency department, or just the section that closes at 10 P.M.?

A5: Under the OPSS, it may be appropriate for a Type A emergency department to “carve out” portions of the emergency department that are not available 24 hours a day, where visits would be more appropriately billed with Type B emergency department codes. In that case, the “carved out” portion of the emergency department would bill Type B emergency department codes, while the other parts of the emergency department would bill Type A emergency department codes.

It may be necessary for a hospital to consult with its fiscal intermediary to determine which areas of its emergency department are considered Type A and which are considered Type B.

OPPS Visit Codes Frequently Asked Questions

Q6: The OPSS 2007 Final Rule states that “where a hospital maintains a separately identifiable area or part of a facility which does not operate on the same schedule (that is, 24 hours per day, 7 days a week) as its emergency department, that area or facility would not be considered an integral part of the emergency department that operates 24 hours a day, 7 days a week, ...” Under the OPSS, does a separately identifiable area refer to a physically separately identifiable area, or an area that is separately identifiable because of the process used to triage and/or treat patients?

A6: A separately identifiable area or part of a facility refers purely to physical location, rather than process used to triage and treat patients.

It may be necessary for a hospital to consult with its fiscal intermediary to determine which areas of its emergency department are considered Type A and which are considered Type B.

Q7: One separately identifiable area or part of a provider-based emergency department is closed at 10 P.M., and only available for use after hours when occasional overcrowding occurs in the larger emergency department. Under the OPSS, would the area be considered a Type A or Type B emergency department?

A7: Where a provider-based hospital maintains a separately identifiable area or part of a facility which does not operate on the same schedule (that is, 24 hours per day, 7 days a week) as its emergency department, that area or facility would not be considered an integral part of the emergency department that operates 24 hours a day, 7 days a week for purposes of determining its emergency department type for reporting emergency visit services.

If a separately identifiable area of the hospital usually closes at 10 P.M., but is available for use for overflow of ED patients in unusual or extreme circumstances, that area would be considered a Type B emergency department, assuming the area meets the other requirements for Type B emergency departments.

It may be necessary for a hospital to consult with its fiscal intermediary to determine which areas of its emergency department are considered Type A and which are considered Type B.

Q8: A separately identifiable area or part of the provider-based emergency department has a special triage system in place during the morning and evening hours, but reverts to the standard triage system at all other hours. Under the OPSS, would the emergency department be considered Type A or Type B?

A8: Under the OPSS, the distinction between Type A and Type B emergency departments is determined based on hours of operation, rather than the process used to triage and treat patients. If that area of the hospital meets all the requirements of a Type A emergency department, including being regularly and customarily staffed and available 24 hours a day, 7 days a week, that area is considered a Type A emergency department.

It may be necessary for a hospital to consult with its fiscal intermediary to determine which areas of its emergency department are considered Type A and which are considered Type B.

OPPS Visit Codes Frequently Asked Questions

Q9: Under the OPSS, does the distinction between Type A and Type B emergency departments apply only to off-site provider-based satellite emergency departments, or does it also apply to emergency departments which are located on the same campus as the hospital?

A9: The distinction between Type A and Type B emergency departments applies to both off-site provider-based satellite emergency departments and provider-based emergency departments which are located on the same campus as the hospital. Hospitals must determine which areas of on campus and off-site emergency departments are considered Type A and which are considered Type B.

Q10: Is it appropriate for a hospital to bill an emergency department visit code for scheduled or anticipated care provided to a beneficiary in the hospital emergency department?

A10: In order to bill a Type A or Type B emergency department visit code based on the hospital's own coding guidelines, the patient must be a registered outpatient being treated in a Type A or Type B emergency department. The hospital's own coding guidelines must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented.

We note that we do not expect that scheduled or anticipated care would generally be provided in the emergency department. Type A and Type B emergency departments are dedicated emergency departments that treat emergency medical conditions. An emergency medical condition is defined under 42 CFR 489.24 as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Therefore, we would expect it to be uncommon for a hospital to bill for scheduled or anticipated care in the emergency department.

Q11: Under the OPSS, how does CMS pay for critical care services?

A11: When a minimum of 30 minutes of critical care services are provided in a hospital outpatient setting, the hospital must report CPT code 99291, Critical care evaluation and management of the critically ill or critically injured patient; first 30-74 minutes. We provide packaged payment for CPT code 99292, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes, for those periods of critical care services extending beyond 74 minutes, so hospitals do not have the ongoing administrative burden of precisely reporting the time for the complete period of critical care services provided. When at least 30 minutes of critical care is provided, the hospital will bill CPT code 99291 (and 99292, if appropriate), and receive payment for APC 0617, Critical Care. As the CPT guidelines

OPPS Visit Codes Frequently Asked Questions

indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines.

Q12: Under the OPSS, how do you determine the length of time that the hospital provided critical care services?

A12: Under the OPSS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.

Q13: Under the OPSS, how do outpatient provider-based hospitals determine when to report revenue code series 68x, trauma response? How does CMS pay for revenue code series 68x?

A13: To determine whether trauma activation occurs, providers are to follow the National Uniform Billing Committee (NUBC) guidelines related to the reporting of the trauma revenue codes in the 68x series. The guidelines are listed in the Medicare Claims Processing Manual, Pub 100-04, Chapter 25, §75.4. In summary, revenue code series 68x can be used only by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons. Different subcategory revenue codes are reported by designated Level 1-4 hospital trauma centers. Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response can be billed a trauma activation charge.

When revenue code series 68x, trauma response, is billed in association with services other than critical care, payment for trauma activation is bundled into the other services provided on that day.

Q14: Beginning in CY 2007, how do OPSS hospitals report critical care services associated with trauma activation? How does CMS pay for critical care services that are associated with trauma activation?

A14: Beginning in CY 2007, CMS began paying differentially when critical care services were associated with trauma activation, identified by the inclusion of revenue code series 68x on the claim, on the same date of service as the critical care services. When trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 68x and the hospital provides at least 30 minutes of critical care so that CPT code 99291 is appropriately reported, the hospital may also bill one unit of HCPCS code G0390, Trauma response team activation associated with hospital critical care service, reported with revenue code 68x on the same date of service as CPT code 99291, and the hospital will receive an additional payment under APC 0618. Hospitals that provide less than 30 minutes of critical care when trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under revenue code 68x, may report a charge under 68x, but

OPPS Visit Codes Frequently Asked Questions

they may not report HCPCS code G0390. In this case, payment for the trauma response is packaged into payment for the other services provided to the patient in the encounter, including the visit that is reported.

Q15: What services are included in CPT code 99291 (critical care, first 30-74 minutes) and should therefore not be billed separately?

A15: Hospitals must follow the CPT instructions related to CPT code 99291. Any services that CPT indicates are included in the reporting of CPT code 99291 should not be billed separately by the hospital.

Q16: Is it appropriate for a hospital to bill a visit code under the OPPS for care provided to a registered outpatient if the patient was not seen by a physician?

A16: Under the OPPS, unless indicated otherwise, we do not specify the type of hospital staff (for example, nurses, pharmacists, etc.) who may provide services in hospitals because the OPPS only makes payments for services provided incident to physicians' services. Hospitals providing services incident to physicians' services may choose a variety of staffing configurations to provide those services, taking into account other relevant factors such as State and local laws and hospital policies.

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.

Q17: How is the new or established patient classification determined under the OPPS? For example, is a clinic patient considered new or established if he was treated in an off-site clinic of the hospital or the hospital's emergency department within the past 3 years?

A17: As stated in the April 7, 2000 OPPS Final Rule (65 FR 18451), under the OPPS, the meanings of "new" and "established" pertain to whether or not the patient already has a medical record number. If a patient has a medical record that was created within the past 3 years, the patient is considered an established patient to the hospital. The same patient could be "new" to the physician but "established" to the hospital. The opposite could be true if the physician has a

OPPS Visit Codes Frequently Asked Questions

longstanding relationship with the patient, in which case the patient would be an “established” patient with respect to the physician and a “new” patient with respect to the hospital.

If a patient was seen in the hospital’s off-site clinic or emergency department within the past 3 years, that patient would be an “established” patient to the hospital if the off-site clinic or emergency department is a provider-based entity of the hospital. Similarly, if a patient was seen in an off-site clinic without provider-based status, that encounter would not contribute to classifying the patient as an “established patient.”