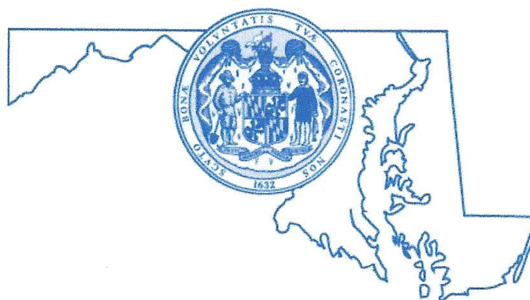
State of Maryland
Department of Health



Health Services Cost Review Commission

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Data Analytics

To: All Hospitals, Chief Financial Officers

From: William H. Hoff, Chief, Audit & Compliance

Date: June 16, 2020

RE: Clinic Evaluation & Management Relative Value Units Reset

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On June 10th, 2020, the Health Services Cost Review Commission (HSCRC) adopted revisions to the Relative Value Units (RVUs) scale for Clinic Evaluation & Management Services. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual. The revised RVUs are similar to Medicare's E&M RVUs scale and CMS national cost weights.

The RVUs scale was adopted to reflect linkages of RVUs to the Current Procedural Terminology (CPT) codes and to link national guideline for Clinic E&M Services consistent with the HSCRC plan to adopt national RVUs where possible.

The attached RVUs in the revised Appendix D for Clinic Evaluation & Management Services are to be utilized beginning July 1st, 2020. In order to ensure that the revisions are revenue neutral to the overall Global Budget Revenue (GBR), approximately $60 million in Clinic Revenue will be reallocated to other rate centers.

If you have any questions or concerns, please feel free to contact me via email at William.Hoff@maryland.gov.

Account Number 6720

OVERVIEW: REPORTING STRUCTURE FOR CLINIC SERVICES

DEFINITION OF CLINIC SERVICES

Clinic Services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services will be provided to inpatients (Examples and discussion are included later in this document.)

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Delivery, EEG, EKG, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, Speech Therapy, are to be reported in those specific rate centers.

Clinic services may include either one or both of the following two components: an evaluation and management (E/M) visit, and non-surgical procedures. To report an E/M visit and a procedure on the same day, the E/M service must be separately identifiable. The Medicare definition of separately identifiable is included in the Evaluation and Management section.

RVU ASSIGNMENT OF CLINIC VISITS

The relative value units (RVUs) for the evaluation and management portion of a clinic visit are based on a 5-point visit level scale, while the RVUs for non-surgical procedures are specified by procedure. The development of the RVU values for each component will be explained in more detail in subsequent paragraphs. Clinic procedures considered surgery are to be reported via operating room minutes. The definition of surgical procedures will be explained in more detail later in this section.

RVUs were assigned based on clinical care time (CCT), as described in the E/M section, with a rule of 5 minutes of CCT per 1 RVU. This same logic should be applied to any services that are "by report".

PART 1: EVALUATION AND MANAGEMENT (E/M) COMPONENT

CLINICAL CARE TIME

The evaluation and management portion of the clinic visit is based on a 5-point visit level scale. The amount of clinical care time provided to the patient during the E/M portion of the visit determines the visit level. Clinical care time is the combined total amount of time that each non-physician clinician spends treating the patient. The time does not necessarily have to be face-to-face with the patient, but the patient must be present in the department. The time spent by physicians, and other –physician providers, who bill professionally for their services is not included. It is possible for

multiple clinic personnel to be providing CCT to the same patient simultaneously. Therefore, in a given time interval, the hospital may record and report CCT greater than the actual clock time that as elapsed.

Both direct and indirect patient care may be included in CCT. Direct patient care will always be included in CCT. Indirect patient care may be included when the skills of a clinician are required to provide the care. Direct patient care includes tasks or procedures that involve face-to-face contact with the patient. These tasks may include: specimen retrieval, administration of medications, family support, patient teaching, and transportation of patients requiring a nurse or other clinical personnel whose cost is assigned to the Clinic. Indirect patient care includes tasks or procedures that do not involve face-to-face contact with the patient, but are related to their care. These tasks may include: arranging for admission, calling for lab results, calling a report to another unit, documentation of patient care, and reviewing prior medical records.

EXAMPLES OF SERVICES INCLUDED IN E/M COMPONENT

The following are examples of services performed by nursing and other clinical staff that may be included in CCT provided during the E/M portion of a clinic visit. The list is not all-inclusive and is only meant as a guide.

- Patient evaluation and assessment
- Patient education and skills assessment
- Patient counseling
- Patient monitoring that does not require equipment or a physician order (different from observation)
- Skin and wound assessment
- Wound cleansing and dressing changes
- Application of topical medications
- Transporting a patient, when it requires the skill of a clinician
- Coordination of care and discharge planning that requires the skill of a clinician

EXAMPLES OF SERVICES EXCLUDED FROM E/M COMPONENT

Services that do not require the skills of a clinician should be excluded from CCT. Examples of excluded activities are listed below. The list is not all-inclusive and is only meant as a guide.

- Patient waiting time
- All time spent on the phone with a payer
- Time spent securing payment authorization
- Chart set-up, room preparation
- Appointment setting
- Calling in prescriptions and entering orders and/or charges

PROFESSIONAL SERVICES ONLY VISIT

In instances where a patient sees only an *outside provider,* the hospital may only report a Level one E/M visit regardless of the amount of time a patient spends with the outside provider. An outside provider is a physician or other provider who bills professionally and is not included on the hospital's wage and salary reporting schedule. A level one E/M visit may also be reported when a patient is seen by clinic personnel and CCT totals 1-10 minutes, as per the E/M visit level guidelines below.

INTERNAL GUIDELINES

The RVUs for each visit level remain the same across every clinic. However, each clinic within a hospital is expected to develop and maintain a set of internal guidelines to standardize the amount of CCT required to perform common E/M services in the particular clinic. Hospitals are expected to conduct in-service programs to assure that new and existing clinic staff understand the guidelines and apply them fairly and consistently. The over-riding consideration is that there must be a "reasonable" relationship between the intensity of resource use and the assigned visit level.

The clinic's internal guidelines should include a typical time range for all of the commonly performed services in that clinic. The time range allows for the circumstances of the visit and judgment of the clinician, while maintaining a degree of uniformity among clinicians. The guidelines are not expected to dictate a definitive time value for every service that could be performed in a clinic. Instead their purpose is to provide an average time frame for commonly performed procedures. The format and content are at the facility's discretion. For example, taking vital signs: 5 minutes.

VISIT LEVELS

The minutes and RVUs for each of the five levels of an E/M visit are:

	New/Established	Minutes	RVUs
Level 1	99201/99211	0–10	2
Level 2	99202/99212	11–25	3
Level 3	99203/99213	26–45	4
Level 4	99204/99214	46–90	5
Level 5	99205/99215	>90	6

HCPCS code G0463 can be used for Medicare billing with the above levels assigned RUVs.

NEW VS. ESTABLISHED

The 2000 Federal Register defines a new vs. an established patient by whether or not the patient has an established medical record. Patients with a previously established medical record are considered established whether or not it is their first visit to a specific clinic.

SEPARATELY IDENTIFIABLE

To ensure uniform reporting by all Maryland hospitals, it is important to recognize when an E/M visit should be reported separately from a procedure or other E/M services. This manual is not meant to provide guidance on how to bill services or to interpret Medicare rules. Medicare discusses the term "separately identifiable" in Program Memorandum Transmittals AA-00-40 and A-01-80. Providers who want additional guidance or examples may check with their Medicare Administrative Contractor or other payor representative.

PART II: SERVICES AND NON-SURGICAL PROCEDURES

Each section includes tables with CPT codes, descriptions, and RVU values. It is prefaced with any information, coding guidelines, etc. that were used in setting the RVUs for each area. This manual is not meant to give direction or interpretation to Medicare billing or coding rules. Moreover, it is the goal of every work group that recommends revisions to RVUs that the revised system be as impervious as possible to future changes in billing rules and correct coding guidelines.

BACKGROUND INFORMATION ON DRUG ADMINISTRATION SERVICES

This manual is not meant to give direction or interpretation to Medicare billing or coding rules. However, substantial information on the current coding guidelines for injections, transfusions, and infusions is being included here because of the frequent changes and clarifications to coding guidelines for these services. The information is included to document the rules in place at the time the RVUs were developed and to provide rationale for the relative values. The Clinic RVU work group assigned RVUs to transfusions, infusions, and related drug administrations with the following information in mind.

VASCULAR ACCESS DEVICES

There are several codes related to vascular access devices, however, only 36593, "declotting-thrombolytic agent of vascular access device or catheter", is routinely and frequently performed in clinics. It was assigned an RVU value of 9. The insertion of non-tunneled central venous catheters (36555 and 36556) are performed and reported more frequently in interventional cardiology than in clinics, although a few hospitals routinely perform those procedures in clinics. After considering the options, the group decided that RVUs for the insertion of non-tunneled central venous catheters

(36555 and 36556) in the clinic would be reported via operating room minutes. (See the Surgical Procedures section of this appendix for further information.) The remaining CPT codes related to vascular access devices (36557-36620) are routinely performed in the IVC or operating room suite, and therefore, should not be assigned clinic RVUs. Any of these procedures that are performed in the clinic will be reported through the operating room cost center.

INJECTIONS

Are injections billed per injection, or per drug?

After substantial discussion, the work group agreed that injectable drugs are charged per injection when splitting a dosage is ordered and documented. The following examples were cited for further clarification.

- *If two drugs are mixed into one syringe/injection based* on nursing guidelines or standards of practice (such as Phenagran and Demerol), one unit/injection should be billed.
- *If two drugs cannot be administered together and require separate injections, two units of service may be billed, but the documentation should denote that these were separately administered based on the time injected. (Note: hospitals should avoid split drugs just for the sake of billing twice.)*
- *If an order is written as "10 mg morphine" and staff titrates it as 2 mg x 5 separate injections before the pain is relieved-the facility still can bill only one unit.*
- *If an order is written as "10 mg of morphine" and staff titrates 2 mg x 5 injections with no relief, and then the doctor orders an "additional 6 mg of morphine" and staff titrates 2 more injections of 2 mg prior to pain relief (14 mg total now administered)-two units/injections may be billed (7 actual injections performed).*
- *If an order is written as "10 mg of morphine" and staff titrates 2 mg x 5 injections with no relief, and then the doctor orders "5 mg of Torodol" and staff injects all 5 mg with pain relief-2 injections may be billed (one for each drug).*

If an order is written for an IM injection of Gentamycin, 160 mg. And a nurse administers it in a split 80 mg. IM dose, it should be billed as one unit of 90772 (IM injection). If it was ordered to be titrated in two 80 mg. doses, it could be billed as two units of 9077288. Hospitals may have specific physician-approved hospital policies that specify circumstances under which a dose is titrated. For example, "if a patient weights less than X, titrate IM injections over X mg. into multiple injections of not more than X mg." In this case, charge and bill for each IM injection.

TRANSFUSIONS

Transfusion of blood or blood components (36430) will be internally stratified by the number of hours. Stratifying by the number of units transfused was rejected because the resources consumed in the transfusion of units vary by patient diagnosis and type of product. The first hour of transfusion is weighted heavier than subsequent hours to include the staff's time preparing and assessing the patient prior to and at the conclusion of the transfusion. The timing of the transfusion begins and ends with the start and stop of the transfusion, and/or resolution of any reaction to the blood product. Any fraction of the first hour can be reported as a full hour, subsequent hours are subject to simple rounding rules i.e., must be 30 minutes or more.

INFUSIONS

Infusion coding is currently divided into chemotherapy and non-chemotherapy, and first hour and each additional hour. The first hour of infusion is weighted heavier than subsequent hours to include the staff's time preparing, educating and assessing the patient prior to and at the conclusion of the infusion. The timing of the infusion begins and ends with the start and stop of the infusion. The treatment of a reaction to a chemotherapy infusion should not be included in the timing of the infusion. A hospital that believes time resolving a reaction should be accounted for may consider whether those services are separately identifiable and warrant an E/M code. Education including discussion of the management of side effects is included in the value of chemotherapy infusions.

For further clarification, providers are encouraged to consult with their Medicare Administrative Contractor or other payor representative.

DRUG ADMINISTRATION SERVICES

IMMUNIZATIONS

36430	Transfusion, blood or blood components, first hour (0-90 min)	12
36430	Transfusion, blood or blood components, two hours (91-150 min)	18
36430	Transfusion, blood or blood components, three hours (151-210 min)	24
36430	Transfusion, blood or blood components, four hours (211-270 min)	30
36430	Transfusion, blood or blood components, five hours (271-330 min)	36
36430	Transfusion, blood or blood components, six hours (331-390 min)	42
36430	Transfusion, blood or blood components, seven hours (391-450 min)	48
36430	Transfusion, blood or blood components, eight hours (451-510 min)	54
36591	Collection of blood specimen from a completely implantable venous Access device	6
36593	Declotting by thrombolytic agent of implanted VAD or cath	9

IMMUNIZATIONS

Code	Description	Units
90465	Immuniz. <8 y/o, percut, intraderm, IM, subq, first	2
+90466	Immuniz. <8 y/o, ea. additional, per day	1
90467	Immuniz. <8 y/o, intranasal or oral, first	2
+90468	Immuniz. <8 y/o, intranasal or oral, ea. additional	1
90471	Immuniz. percut, intraderm, IM, subq, first	2
+90472	Immuniz. ea. Additional, per day	1
90473	Immuniz. intranasal or oral, first	2
+90474	Immuniz. intranasal or oral, ea. additional	1

NON-CHEMOTHERAPY INJECTIONS AND INFUSIONS

Code	Description	Units
90760	IV infusion, hydration; initial, 31 minutes to 1 hour	12
+90761	IV infusion, hydration; ea add'l hr	6
90765	IV infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hr	12
+90766	IV infusion, ea add'l hr	6
+90767	IV infusion, add'l sequential infusion up to one hour	6
+90768	IV infusion, concurrent infusion	1
90769	SubQ infusion for therapy or prophylaxis, initial, up to 1 hr, including pump set-up and establishment of subQ infusion site(s)	By Report
+90770	SubQ infusion for therapy or prophylaxis, ea add'l hr	By Report
+90771	SubQ infusion for therapy or prophylaxis, add'l pump set-up and establishment of new subQ infusion site(s)	By Report
90772	Therapeutic, prophylactic, or diagnostic injection, subQ, or IM	3
90773	Therapeutic, prophylactic, or diagnostic injection, intraarterial	By Report
90774	Therapeutic, prophylactic, or diagnostic injection, IV push, single or initial substance/drug	6
+90775	Therapeutic, prophylactic, or diagnostic injection, IV push, ea add'l IV push of a new substance/drug	3
+90776	Therapeutic, prophylactic, or diagnostic injection, ea add'l sequential IV push of the same substance/drug provided in a facility single or initial substance/drug	By Report
90779	Unlisted ther, prophyl, or dx IV or IA injection or infusion	By Report

CHEMOTHERAPY INFUSIONS

RVUs are "By Report" for several services that are performed infrequently within the state.

Code	Description	RVU
96401	Chemotherapy admin, subQ or IM, non-hormonal anti-neoplastic	6
96402	Chemotherapy admin, subQ or IM, hormonal anti-neoplastic	6
96405	Chemotherapy admin, intralesional, 1-7 lesions	By Report
96406	Chemotherapy admin, Intralesional, 8+ lesions	By Report
96409	Chemotherapy admin, IV push, single or initial substance/drug	6
+96411	Chemotherapy admin, IV push, ea add'l substance/drug	3
96413	Chemotherapy admin, IV infusion, up to one hour, single or initial	18
+96415	Chemotherapy, IV infusion, ea add'l hour	9
96416	Chemotherapy, IV infusion initiation of prolonged infusion, >8hrs, with port or implantable pump	By Report
+96417	Chemotherarpy, IV Infusion, ea add'l sequential infusion, up to 1 hr	9
96420	Chemotherapy, intra-arterial, push	By Report
96422	Chemotherapy, intra-arterial, infusion, up to 1 hr	By Report
+96423	Chemotherapy, intra-arterial infusion, ea add'l hr	By Report
96425	Chemotherapy, intra-arterial infusion, initiation of prolonged infusion,>8 hrs, with port or implantable pump	By Report
96440	Chemother into pleural cavity, w/ thoracentesis	By Report
96445	Chemo into peritoneal cavity, w peritoneocent.	By Report
96450	Chemo into CNS, intrathecal, w/ spinal puncture	By Report
96521	Refill and maintenance of portable pump	By Report
96522	Refill and maintenance of implantable pump	By Report
96523	Irrigation of implanted venous access device for drug delivery	3
96542	Chemo inject, subarach or intraventric, subq reserv.	By Report
96549	Unlisted chemotherapy procedure	By Report

PSYCHIATRY (EXCLUDES PARTIAL HOSPITALIZATION- PHP)

In instances where a patient only sees an outside provider who bills professionally, the hospital may only report two RVUs regardless of the amount of time a patient spends with the outside provider. Two RVUs corresponds to a level one E/M visit that is used to report the facility component of an E/M visit when a clinic patient is seen only by an outside provider. *(See Professional Services Only Visit under Part II: E/M Component.)* The following RVUs are to be assigned only when the service is performed by a non-physician provider who does not bill professionally for the service.

Code	Description	RVUs
90791	Psychiatric diagnostic evaluation (no medical services)	12
90792	Psychiatric diagnostic evaluation (with medical services)	18
90785	Interactive complexity (add-on code)	By Report
	Psychotherapy	
90832	Psychotherapy, 30 minutes	6
90833	Psychotherapy, 30 minutes (add-on code to E&M code)	6
90834	Psychotherapy, 45 minutes	9
90836	Psychotherapy, 45 minutes (add-on code, to E&M code)	9
90837	Psychotherapy, 60 minutes	12
90838	Psychotherapy, 60 minutes (add-on code to E&M code)	12
90839	Psychotherapy for crisis, first 60 minutes	12
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)	6
90853	Group Psychotherapy (other than that of multi-family)	3
90845	Psychoanalysis	By Report
90846	Family psychotherapy w/o patient	10
90847	Family psychotherapy w/ patient	10
90849	Multiple family group psychotherapy	By Report
90853	Group psychotherapy	3
	Other	
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes	By Report
90870	Electroconvulsive therapy (ECT), single seizure. Performed and reported in OR	
90875	Individual psychophysiolog ther-biofdbk w/ psychotherapy, 20-30 min	6
90876	Individual psychophysiolog ther-biofdbk w/ psychotherapy, 45-50 min	10
90880	Hypnotherapy	By Report
90882	Environmental intervention for med management	By Report
90885	Psychiatric eval of records, reports & tests for diagnosis	By Report
90887	Interpret of psych or med exams & data to family	By Report
90889	Prep of report of pt status, hx, tx, or progress	By Report
90899	Unlisted psychiatric service or procedure	By Report

BIOFEEDBACK TRAINING

RVUs were left as “by report” as these services are not routinely performed in the Clinic setting.

These services are also reportable via the rehabilitation rate centers.

90901	Biofeedback training, any modality	By Report
90911	Biofeedback training, perineal muscles	By Report

OPHTHALMOLOGY

COMPREHENSIVE VS. INTERMEDIATE

In deciding whether to code an ophthalmologic exam as comprehensive vs. intermediate, the direction in the most recent CPT manual should be consulted. RVUs were set with the following distinction in mind: a comprehensive visit includes treatment, whereas, an intermediate visit does not.

92002	Ophthalmol svcs, medical exam, intermed, new pt.	4
92004	Ophthalmol svcs, medical exam, comprehensive, new pt.	6
92012	Ophthalmol svcs, medical exam, intermed, estab pt.	3
92014	Ophth svcs, medical exam, comprehensive, estab pt.	4
92015	Determination of refractive state	2
92018	Ophthal exam under gen anesth, complete	By Report
92019	Ophthal exam under gen anesth, limited	By Report
92020	Gonioscopy	By Report
92060	Sensorimotor exam, interp and report	9
92065	Orthoptic &/or pleoptic training w/ med. Direction	6
92070	Fitting of contact lens, include. Lens supply	By Report
92081	Visual field exam, w/ interp & report, limited	2
92082	Visual field exam, w/ interp & report, intermed.	4
92083	Visual field exam, w/ interp & report, extended	6
92100	Serial tonometry, w/ interp & report	By Report
92120	Tonography w/ interp & report	By Report
92130	Tonography w/ water provocation	By Report
92135	Scanning computerized ophthalmic diagnostic imaging, posterior seg, w/ interp & report, unilateral	4
92136	Ophthalmic biometry, partial coherence interferometry	By Report
92140	Provocative tests for glaucoma, w/ interp & report	By Report
92225	Ophthalmoscopy, extended, interp & report, initial	By Report
92226	Ophthalmoscopy, extended, interp & report, subsequent	By Report
92230	Fluorescein angioscopy, w/ interp & report	By Report
92235	Fluorescein angiography, w/ interp & report	4
92240	Indocyanine-green angiography, w/ interp & report	2
92250	Fundus photography w/ interp & report	2
92260	Ophthalmodynamometry	By Report

92265	Needle oculoelectromyography, w/interp & repor	By Report
92270	Electro-oculomyography, w/interp & report	By Report
92275	Electro-retinography, 2/interp & report	By Report
92283	Color vision exam, extended	By Report
92284	Dark adaptation exam w/interp & report	By Report
92285	External ocular photography, w/interp & report 3	
92286	Special anterior segment photography, w/interp & report	By Report
92287	Ant. Segment photo, w/fluorescein angiography	By Report
92499	Unlisted Ophthalmological service or procedure	By Report

CARDIAC REHABILITATION

RVUs for caridac rehab were based on the principle of one RVU per five minutes of clinical care time, with the assumptions that services are usually provided in a group setting with a staff to patient ratio of 1:3, and sessions last 60-75 minutes.

93797	Physician services for cardiac rehab, without monitoring	0
93798	Physician services for cardiac rehab, continuous monitoring	5

ALLERGY TESTING/IMMUNOTHERAPY

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

95004	Percutaneous tests w/ allergenic extracts, immed type reaction, incl test interp & report by physician, specify # of tests	By Report
95010	Percutaneous tests, w/ drugs, biological, venom, immed. rxn	By Report
95015	Intracutaneous tests, w/ drugs, biologicals, venom, immed. rxn	By Report
95024	Intracutaneous/intradermal tests, w/ allergenic extracts, immed. Rxn, incl test interp & report by physician, specify # of tests	By Report
95027	Intracutaneous/intradermal tests, w/ allergenic extracts, airborne, immed. Rxn, incl test interp & report by physician, specify # of tests	By Report
95028	Intracutaneous tests, allergenic extracts, delayed rxn, + reading	By Report
95044	Patch or application tests	By Report
95052	Photo patch tests	By Report
95056	Photo tests	By Report
95060	Ophthalmic mucous membrane tests	By Report
95065	Direct nasal mucous membrane tests	By Report
95070	Inhalation bronchial challenge, w/ histamine or methacholine	By Report
95071	Inhalation bronchial challenge, w/ antigens or gases	By Report
95075	Ingestion challenge, sequential and incremental	By Report
95180	Rapid desensitization procedure, ea hour	By Report
95199	Unlisted allergy/clinical immunologic service or procedure	By Report

ENDOCRINOLOGY

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

95250	Glucose monitoring, up to 72 hours by continuous recording	By Report

PSYCHOLOGICAL TESTING

Some of the following CPTs may also be reported via the speech language pathology (STH) rate center using the RVUs defined in that rate center.

96101	Psyc Testing per hour of MD or Ph.D time, both face-to-face time to administer tests & interp & report prep time	12
96102	Psyc Testing w/ qualified health care professional interp & report, admin by tech, per hr of tech time, face-to-face	By Report
96103	Psyc Testing admin by computer, w/ qualified health care professional interp & report	By Report
96105	Assessment of aphasia12	
96110	Developmental testing	By Report
96111	Developmental testing, extended	By Report
96116	Neurobehavioral status exam	12
96118	Neropsych testing, per hr of MD or Ph.D, both face-to face time to administer tests & interp & report prep time	By Report
96119	Neuropsychological testing battery, admin. by technician, per hour	By Report
96120	Neuropsychological testing battery, admin. by computer, per hour	By Report
96125	Standardized cognitive performance testing, per hr, both Face-to-face time admin tests & interp & report prep time	By Report

PHOTODYNAMIC THERAPY/DERMATOLOGY

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

96567	Photodynamic therapy, external application of light	By Report
+96570	Photodynamic therapy, endoscopic application of light, 30 min	By Report
+96571	Photodynamic therapy, endoscopic, ea additional 15 min	By Report
96900	Actinotherapy	By Report
96902	Microscopic exam of hair–telogen and anagen counts	By Report
96910	Photochemotherapy, tar & UVB or petrolatum & UVB	By Report
96912	Photochemotherapy, psoralens & UVB	By Report
96913	Goeckerman &/or PUVA, severe, 4-8 hrs, direct superv.	By Report

96920	Laser treatment, <250 cm²	By Report
96921	Laser treatment, 250-500 cm²	By Report
96922	Laser treatment, > 500 cm²	By Report
96999	Unlisted special dermatological service or procedure	By Report

MEDICAL NUTRITION THERAPY

These services are currently not a facility benefit for Medicare purposes, but are routinely performed in the hospital clinic setting.

97802	Medical nutrition therapy, Individual, initial, ea 15 min	3
97803	Medical nutrition, Individual, re-assess, ea 15 min	3
97804	Medical nutrition, group, re-assess, ea 30 min	4
G0270	Medical nutrition therapy, Individual, ea 15 min	3
G0271	Medical nutrition therapy, group, ea 30 min	4

ACUPUNCTURE AND CHIROPRACTIC

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

97810	Acupuncture, 1 or more needles, 15 min	By Report
+97811	Acupuncture, 1 or more needles, addl 15 min	By Report
97813	Acupunct, 1 or more needle, w/elect. Stim, 15 min	By Report
+97814	Acupunct, 1 or more needle, w/ elect. Stim, addl 15 min	By Report
98925	Osteopathic manipulative trmt (OMT); 1-2 regions	By Report
98926	Osteopathic manipulative trmt (OMT); 3-4 regions	By Report
98927	Osteopathic manipulative trmt (OMT); 5-6 regions	By Report
98928	Osteopathic manipulative trmt (OMT); 7-8 regions	By Report
98929	Osteopathic manipulative trmt (OMT); 9-10 regions	By Report
98940	Chiropractic manipulation, spinal 1-2 regions	By Report
98941	Chiropractic manipulation, spinal 3-4 regions	By Report
98942	Chiropractic manipulation, spinal 5 regions	By Report
98943	Chiropractic manip, extraspinal 1 or more regions	By Report

DIABETES SELF MANAGEMENT TRAINING

G0108	Diabetes self management, Individual, 30 min.	6
G0109	Diabetes self management, group, 30 min.	3

SMOKING CESSATION

99406	Smoking/tobacco-use cessation counseling; intermediate, >3-10 min	2
99407	Smoking/tobacco-use cessation counseling; intensive, >10 min	9

ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE

99408Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 min	By Report
99409Alcohol and/or substance abuse structured screening and brief intervention services; >30 min	By Report

GASTROENTEROLOGY

All GI services (codes 91000-91299) will be reported through the operating room center. (See the Surgical Procedure section for more information.)

WOUND CARE

No new assignments were made for services performed in a wound care clinic. The following codes are not reportable in Clinic because they are already assigned in the Physical Therapy cost center: 97597, 97598, 97602, 97605, 97606, 0183T. The decision to use 1104X codes to describe excisional debridement should be made based on guidance from your Medicare Administrative Contractor or other payor representative.

PART III: SURGICAL PROCEDURES

Any surgical procedures performed in a clinic should be reported via the operating room cost center, and associated surgical costs allocated to the operating room rate center (excluding the exceptions listed in more detail below). Surgical procedures are defined as all procedures corresponding to CPT codes from 10000 to 69999 (surgery) and 91000 to 91299 (gastroenterology).

A few rate centers include a limited number of surgical procedures with CPT codes between 10000 and 69999 that have already been assigned RVUs relative to other procedures in that cost center. For the most part, the RVU values and reporting of these procedures will remain unchanged. The procedures and how they should be reported are:

- *Clinic*-Specimen Collection via VAD (CPT 36591), Declotting (CPT 36593), and Blood Transfusions (CPT 36430) have been assigned Clinic RVUs, and should be reported as clinic revenue.

  Delivery-Non-Stress Tests, amniocentesis, external versions, cervical cerclages, dilation and curettage/evacuation and curettage, hysterectomies, deliveries, etc. Continue to report via DEL by assigned RVUs.

Interventional Cardiology-certain IVC procedures have surgical CPT codes are defined in the IVC rate center with RVUs. Hospitals should continue to report using those IVC RVUs

- until instructed otherwise.

- *Laboratory*-Venipunctures/Capillary punctures. These procedures are considered to be part of the E/M component of a clinic visit. If a hospital chooses to code and report them separately in the clinic, the RVU is zero. If a phlebotomist comes to the clinic to do the procedure, the revenue and expenses are allocated to LAB.

- *Lithotripsy*-Procedures will continue to be reported in the LIT cost center as the number of procedures.

- *Occupational and Physical therapy*-Splinting, Strapping and Unna Boot application (CPT codes 29105-29590) continue to report with assigned PT/OT RVUs

- *Radiation Therapy*-Stereotactic Radiosurgery (61793). Continue to report with assigned RAT RVUs.

- *Speech Therapy*-Laryngoscopy (31579). Continue to report via STH by assigned RVUs.

- *Therapeutic apheresis*-Continue to report through LAB; RVUs are by report.

Non-physicians may perform procedures that will be reported as operating room revenue. The HSCRC acknowledged that it is appropriate for non-physicians to generate operating room minute charges as long as the clinician is providing services within the scope of his or her practice standards.

DOCUMENTING START AND STOP TIMES FOR SURGICAL PROCEDURES PERFORMED IN CLINIC

The definition of stop and start time for surgical procedures performed in clinics is the same definition as that used in the operating room Chart of Accounts that states:

> *Surgery minutes is the difference between starting time and ending time defined* as follows: *Starting time is the beginning of anesthesia administered in the operating room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating room. Ending time is the end of the anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient in the recovery room is not to be counted.*

Clinicians need to document procedure stop and start times in the medical record, unless the hospital is using average times. It is not necessary to keep a log similar to the one kept in the Operating Room (OR) to document the minutes of each procedure. Unlike in the OR, clinic staff may enter and leave the room during a procedure. This does not affect the calculation of procedure minutes. Please

reference additional information in this section regarding reporting of actual minutes (included vs. excluded minutes).

As an alternative to reporting actual minutes, hospitals may report procedures using average times that are "hard coded". To report average procedure times, hospitals should conduct time studies to find the average time it takes to perform common procedures and periodically verify these average times. Please reference additional information in this section regarding reporting of average minutes (included vs. excluded minutes).

ACTIVITIES INCLUDED IN PROCEDURE TIME

As stated above, the definition of procedure start and stop times for surgical procedures performed in the clinic is the same as the definition of procedure start and times for procedures performed in the operating room. However, for surgical procedures performed in the clinic, some activities that are integral to the procedure may not be typically thought of as included in the time of the procedure. The following lists of included and excluded activities are examples to guide the decision of which activities to include and exclude from the timing of surgical procedures performed in clinics. These lists are not all-inclusive but should be used as a guide when reporting minutes for these services.

INCLUDED ACTIVITIES

When the following activities are integral to a procedure, the time it takes to perform the activity should be included in the procedure time. These services are all above and beyond the actual performance of the surgical service, i.e. "cut to close". Many of these examples apply directly to wound care but should also be applied to all surgical procedures performed in the clinic. The overriding consideration is that the minutes associated with the procedure along with the minutes associated with clinical care time spent preparing the recovering the patient are reportable surgical minutes.

- Positioning of the patient in preparation for the procedure
- Removal of dressing/casting/Unna boot (i.e. whatever covers the wound)
- Cleansing of wound
- Wound measurement and assessment
- Applications of topical/local anesthetic
- Application of topical pharmaceuticals and dressing post procedure
- Monitored time when waiting for anesthetic to become effective
- Taking vital signs
- Monitored time when waiting for cast to dry

Monitored time post procedure when waiting for recovery from anesthetic

EXCLUDED ACTIVITIES

The time it takes to perform the following activities should not be included in the procedure time.

- Waiting time in general
- Teaching
- Non-monitored time when waiting for topical and/or local anesthetic to become effective
- Non-monitored time when waiting for cast to dry
- Non-monitored time post procedure when waiting for recovery from anesthetic

PART IV: MISCELLANEOUS INFORMATION

COUNTING CLINIC VISITS

The definition of a clinic visit follows the logic of the definition of a referred ambulatory visit. See Section 500 Reporting Instructions page 017 Schedule V2B columns 1 to 3. A patient who is seen in a clinic and receives an E/M service and/or non-surgical procedure is counted for one clinic visit. A patient who is seen in a clinic and receives a surgical procedure is counted as a surgery visit. A patient who is seen in a clinic and receives an E/M service plus a surgical procedure is counted as two visits-clinic and surgery. A patient receiving E/M services and/or non-surgical procedures in two different clinics is counted as two visits. Patients who are seen twice at the same clinic at two different times on one day for therapeutic or treatment protocol reasons are counted as having two visits. However, patients who are seen in the same clinic at two different times on one day because of scheduling difficulties would be counted as one visit. More information on counting visits is included in Part III: Surgical Procedures under the Same Day Surgery section and in Section 500 of this manual-Reporting Instructions for Schedule OVS.