

In light of these concerns, one thing we could do is to provide increased APC payments for clinic and emergency room visits furnished by rural hospitals having 100 or fewer beds. Any adjustment to payments for these hospitals would be made under the authority granted to the Secretary under section 1833(t)(2)(E) of the Act, to establish in a budget neutral manner adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals. We invite comments on whether we should provide an adjustment, such as the one described above, for small rural hospitals.

XI. Other Policy Decisions and Proposed Changes

A. Hospital Coding for Evaluation and Management (E/M) Services

Facilities code clinic and emergency department visits using the same [Physicians'] Current Procedural Terminology (CPT) codes as physicians. For both clinic and emergency department visits, there are currently five levels of care. Because these codes were defined to reflect only the activities of physicians, they are inadequate to describe the range and mix of services provided to patients in the clinic and emergency department settings (for example, ongoing nursing care, preparation for diagnostic tests, and patient education). An example to illustrate the services that are billed using E/M codes in the hospital outpatient department follows:

An adult male patient presents to a clinic after a fall while working in his yard. As a result, he has scraped off the top layer of skin covering his entire back. The physician examines the patient, finds a dirty and possibly infected wound, which is the only injury. The physician orders the nurse to clean the wound, apply antiseptic medication, and dress the wound. In addition, the physician orders an intramuscular antibiotic and a tetanus injection.

The nurse will spend a considerable amount of time cleaning and dressing the wound with large amounts of sterile supplies (because of the large body surface area) as well as administering medications. The nurse also will give the patient discharge instructions regarding the care of the wound.

Although the physician services are captured using existing E/M codes, the additional staff and supplies integral to the outpatient department services are not. The low level E/M code that describes the physician services in the example is not reflective of the services

provided by the nurse (and any other staff that may have become involved) or of the quantity of supplies used in the treatment.

In the April 7, 2000 final rule (65 FR 18434), we stated that in order to ensure proper payment to hospitals, it was important that emergency and clinic visits be coded properly. To facilitate proper coding, we required each hospital to create an internal set of guidelines to determine what level of visit to report for each patient. In the August 24, 2001 proposed rule (66 FR 44672), we asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. Commenters recommended that we should keep the current E/M coding system until facility specific E/M codes for emergency department and clinic visits, along with national coding guidelines, were established. Commenters also recommended that we convene a panel of experts to develop codes and guidelines that are simple to understand, implement, and that are compliant with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

APC Panel Recommendations

During its January 2002 meeting, the APC Panel made the following recommendations regarding coding for evaluation and management services:

1. Propose, and make final, facility coding guidelines for E/M services for CY 2004.
2. Create a series of G codes with appropriate descriptors for facility E/M services.
3. Maintain a single set of codes, with five levels of service, for emergency department visits.
4. Develop a single set of codes, with five levels of service, for clinic visits. The Panel specifically recommended that we not differentiate among visit types (for example, new, established, and consultation visits) for the purposes of facility coding of clinic visits.
5. Adopt the American College of Emergency Physicians (ACEP) facility coding guidelines as the national guidelines for facility coding of emergency department visits.
6. Develop guidelines for clinic visits that are modeled on the ACEP guidelines but are appropriate for clinic visits.
7. Implement these guidelines as interim and continue to work with appropriate organizations and stakeholders to develop final guidelines.

After careful review and consideration of written comments, oral testimony, and the APC Panel's recommendations, we proposed the

following in the August 9, 2002 proposed rule (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services:

GXXX1—Level 1 Facility Emergency Services;
GXXX2—Level 2 Facility Emergency Services;
GXXX3—Level 3 Facility Emergency Services;
GXXX4—Level 4 Facility Emergency Services; and
GXXX5—Level 5 Facility Emergency Services.

2. To develop five G codes to describe clinic services:

GXXX6—Level 1 Facility Clinic Services;
GXXX7—Level 2 Facility Clinic Services;
GXXX8—Level 3 Facility Clinic Services;
GXXX9—Level 4 Facility Clinic Services; and
GXXX10—Level 5 Facility Clinic Services.

3. To replace CPT Visit Codes with the 10 new G codes for OPPS payment purposes.

4. To establish separate documentation guidelines for emergency visits and clinic visits.

In our November 1, 2002 final rule (67 FR 66792), we stated that the most appropriate forum for development of new code definitions and guidelines would be an independent expert panel that would make recommendations to us. We wanted to ensure that definitions and guidelines were developed using an open process involving a variety of experts in the field. We stated that it is critically important to the development, acceptance, and implementation of facility visit code definitions and guidelines that the organizations that develop the guidelines also maintain and update the guidelines and provide ongoing education to providers on use of the codes. In light of the expertise of organizations such as the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA), we felt that these organizations were particularly well equipped to make recommendations to us and to provide ongoing education to providers. Furthermore, we stated that the process should provide adequate time for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the new codes and guidelines.

On their own initiative, the AHA and the AHIMA convened an independent expert panel of individuals from various