

TABLE 14.—CROSSWALKS OF 2003 HCPCS CODES TO THE PROPOSED G CODES—Continued

2003 HCPCS description	2004 G code description	2003 HCPCS	2004 Proposed G codes	APC	Payment amount
Critical care	Level 4 Critical Care provided in the clinic.	99291 99292	GXXX8	0620	491.01

The independent panel convened by the AHA and AHIMA recommended these levels in anticipation of the development of national coding guidelines for emergency and clinic visits that meet the following criteria we announced in the August 9, 2002 proposed rule (67 FR 52131):

1. Coding guidelines for emergency and clinic visits should be based on emergency department or clinic facility resource use, rather than physician resource use.

2. Coding guidelines should be clear, facilitate accurate payment, be usable for compliance purposes and audits, and comply with HIPAA.

3. Coding guidelines should only require documentation that is clinically necessary for patient care. Preferably, coding guidelines should be based on current hospital documentation requirements.

4. Coding guidelines should not create incentives for inappropriate coding (for example, up-coding).

We have received recommendations for a set of coding guidelines from the independent E/M panel comprised of members of the AHA and AHIMA. We proposed to implement new evaluation and management codes only when we are also ready to implement guidelines for their use, after allowing ample opportunity for public comment, systems change, and provider education. We also proposed to use cost data from the current HCPCS codes in these APCs to determine the relative weights of these APCs until cost data from GXXX1 through GXXX8 are available to set relative weights. We note that this proposal requires discontinuing the use of all HCPCS codes in these APCs and would not allow us to collect cost data for the five levels of emergency and clinic visits that are currently described by CPT codes. We further note that we would no longer be able to distinguish among the costs for visits by new patients, established patients, consultation patients, or patients being seen for more specialized care (for example, pelvic screening exams and glaucoma screening exams).

We would be using claims data from current HCPCS codes and crosswalking those data to the new codes in the same APCs; therefore, there would be no

change in payment for any of these services as a result of these coding changes. Once cost data become available from the new HCPCS codes, we would use those data to set the relative weights, and, therefore, there should be no budgetary impact.

We are currently considering the set of proposed national coding guidelines for emergency and clinic visits recommended by the independent panel. We plan to make any proposed guidelines available to the public for comment on the OPPTS web site as soon as they are complete. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following Web site: <http://www.cms.hhs.gov/medlearn/listserv.asp> and follow the directions to the OPPTS listserve. With regard to the development of these guidelines, our primary concerns are—

1. To make appropriate payment for medically necessary care;

2. To minimize the information collection and reporting burden on facilities;

3. To minimize any incentives to provide unnecessary or low quality care;

4. To minimize the extent to which separately billable services are counted as E/M services;

5. To develop coding guidelines that are consistent with facility resource use; and

6. To develop coding guidelines that are clear, facilitate accurate payment, are useful for compliance purposes and audits, and comply with HIPAA. Before adoption and implementation of any coding changes or coding guidelines, ample time will be provided for the public to comment on our proposal and, following announcement of any final decisions, for the education of clinicians and coders and for hospitals to make the necessary changes in their systems to accommodate the codes and guidelines. In the proposed rule, we requested comments on the amount of time hospitals believe would be adequate to implement these new codes and guidelines. We stated that we remain committed to working with appropriate organizations and stakeholders in our continuing development of a standard set of codes and national guidelines for

facility coding of emergency and clinic visits.

We received comments on our proposal, which are summarized below with our responses.

Comment: Several physician societies objected to the creation of new G codes to replace existing CPT codes for facility coding of emergency and clinic visits. These commenters stated that new G codes for these services would add an unnecessary layer of complexity and confusion to the system, and that the existing CPT codes adequately and appropriately describe the services provided in the emergency and clinic settings. One physician society supported the creation of new G codes for facility coding of emergency and clinic visits, agreeing that CPT codes fail to accurately describe facility resources used to provide E/M services, but expressed concern that payers or auditors might refer to crosswalks made in establishing facility E/M code levels to determine appropriate level of coding for physician E/M services. This commenter urged CMS to clarify that the levels of visits for facility E/M services should not be used by payers or auditors to verify that physicians have billed for the appropriate level of visit.

Several commenters, including a hospital association and federation, commended CMS for proposing new G codes for facility coding of emergency and clinic visits, stating that existing CPT codes for E/M services correspond to different levels of physician effort and fail to adequately describe non-physician resources. These commenters stated that the proposed new G codes would appropriately capture facility resources, minimize confusion relative to physician versus facility E/M services, and adequately meet hospitals' need to comply with HIPAA regulations.

Response: We agree with those commenters who believe that CPT codes for E/M services describe different levels of physician effort, and therefore, fail to accurately describe facility resources used to provide E/M services. In the November 1, 2002 final rule (67 FR 66718), we explained that the development of new HCPCS codes for facility visits was necessary to address potential HIPAA compliance issues. We also agree with comments that the