AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
SCIENTIFIC ASSEMBLY
1999

Reimbursement Into the New Millennium: Coding, Compliance, and Pitfalls

Every new year brings significant changes to the world of physician reimbursement. The lecturer will review the latest changes with CPT coding guidelines and discuss other timely issues dealing with emergency physician reimbursement. The speaker will also discuss in detail many of the common reasons why emergency physicians do not receive the compensation they are due.

- Discuss changes with respect to CPT coding guidelines.
- Discuss changes in federal programs that affect emergency physicians.
- Describe ways to avoid committing common errors that have a negative impact on revenue.

WE-171
Wednesday, October 13, 1999
4:00 PM - 4:55 PM
Room # N223
Las Vegas Convention Center

**FACULTY*

**Consulting Panel Member: A Life Medical*

FACULTY

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Reimbursement into the New Millenium: Coding, Compliance, and Pitfalls

Kenneth L. DeHart, M.D.

I. Course Description

This course will assist the participants to optimize reimbursement by incorporating the latest changes in CPT.

II. Course Objectives

After attending this session, participants will be able to:

A. Discuss changes with respect to CPT coding guidelines.

B. Discuss changes in federal programs that affect emergency physicians.

C. Describe ways to avoid committing common errors that have a negative impact on revenue.

III. Course Overview

A. Contemporary CPT Developments

B. Coding Audit Methodologies

C. Reimbursement Challenges and Opportunities

IV. Contemporary CPT Developments

A. Evaluation and Management Services and Contemporaneous Procedures

New language about separately identifiable procedures. "Different diagnoses are not required for reporting of the procedure and the E/M services on the same date." No clinical vignettes except in Appendix D.

B. Prolonged Services

Excludes use with ED E/M codes. There is a list of code families for which prolonged care can be "added-on" (Use 99354 in conjunction with codes 99201-99215, 99241-99245, 99301-99350)

C. Comprehensive Metabolic Panel. 80054

Carbon dioxide (bicarbonate) was added to the panel. This test must be included to bill the panel using the 80054 code.

D. Hepatic function panel – 80058

Now requires direct bilirubin and total bilirubin.

E. Bilirubin: total or direct 82250 has been deleted

New codes for Immunization Administration for Vaccines/Toxoids
90471 – Immunization administration (includes percutaenous, intradermal subcutaneous, intramuscular and jet injections and/or intranasal or oral administration): Single or combination vaccine/toxoid.

90472 – Two or more single or combination vaccines/toxoids
Use these codes if a significant separately identifiable E/M service is performed
27 new vaccine/toxoid codes were added to CPT.

F. Modifiers

Editorial change to –25 adds the language about not requiring different diagnoses for use. Two new modifiers for 1999.
–73 discontinued outpatient hospital/ambulatory surgery center prior to administration of anesthesia.
–74……after administration of anesthesia.

CPT Applications for CPT 2000 book
Dermabond application was discussed at February CPT Editorial Panel meeting (staples and tissue adhesives)
Critical care – proposed to reduce standard to "potentially unstable"
Change to 99285 caveat within the constrains imposed by the urgency of the patient's clinical condition and/or mental status."

G. Documentation Guidelines

To be discussed again at May CPT Meeting. Proposed changes to history (brief and extended) Refinement of exam bullet requirements. MDM issues (hospitalization and prescription management) Implementation

H. Dermabond

At the February 1999 meeting, the CPT Editorial Panel accepted revisions to the Repair (Closure) guidelines to allow the use of the codes in that section to designate wound closure utilizing sutures, staples or tissue adhesives (e.g., 2-cyanoacrylate) either singly or in combination with each other, or in combination with adhesive strips.

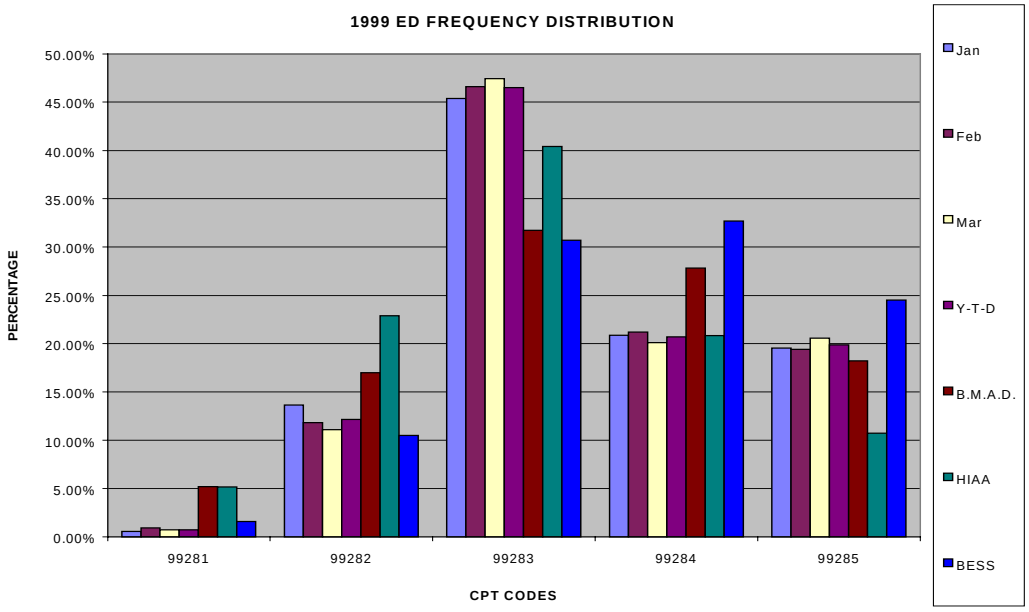
V. Coding Audit Methodologies

A. Aggregate Analysis

1. Frequency distribution Issues
   a. B-MAD Data
   b. BESS Data

B. Specific Encounters Review

C. ED Frequency Distribution



VI. Reimbursement Challenges

A. Governmental

1. The RBRVS Process

What is RBRVS? Resource Based Relative Value Scale (RBRVS) Determines Medicare and about 70% of all carrier payments. Implemented in 1992 based on resource-based costs associated with providing a CPT service. Replaced usual, customary, reasonable charge basis of payment.

2. Components of RBRVS Equation

A. Overview

1. Work RVUs) + (Practice Expense RVUs) + (PLI RVUs) = Total RVUs
2. (Total RVUs) (GAF) (Conversion Factor) = Medicare payment
3. Example 1999 Las Vegas payment for CPT Code 99283
   (Work RVUs) + (Practice Expense RVUs) + (PLI RVUs) = Total RVUs
   (1.24) + (0.49) + (0.03) = 1.76
   (Total RVUs) (GAF) (Conversion Factor) = Medicare payment
   (1.76) (1.016) (34.7315) = 62.11

B. Work Values

1. Originally based on Harvard Hsiao study data for 1992 implementation.
   New and refined codes are considered by the Relative Value Update Committee (RUC)
   Work values are recommended to HCFA with a 93% adoption rate
2. RUC meets 3-4 times a year for 3-4 days each meeting
   Budget Neutrality and Compelling Evidence Requirements
   Five Year Review 1997-2002

C. Practice Overhead Expense

1. Resourced-based for the first time in 1999
   Based on the AMA Socioeconomic Monitoring System (SMS) and CPEP data
   Top down methodology chosen over bottom up
2. Four year transition to full values
   Intended to reallocate payments to primary care practices away from surgical subspecialties

3. Facility/Non-facility Practice Expense
   Allocates higher practice expense values to services provided in office settings to cover the cost of providing equipment and other overhead costs provided by the facility
   Facility is a hospital SNF or ASC

   Non-Facility is physician's office; patient's home or an institution other than those listed above

4. Direct/Indirect Expenses
   a. Direct expenses can be attributed to a particular service, (physician time, supplies, etc.)
   b. Indirect expenses can not be easily attributed to a particular service, (rent, utilities, etc.)
   c. Emergency physician is perceived to have no substantive direct expense, and indirect expenses are extrapolated from direct expense.

5. Six Categories of Practice Expense:

administrative labor	other expenses
clinical labor	supply cost
equipment	office cost

6. Emergency Medicine Concerns

   a. "Emergency physicians are perceived to have no practice expense"
   b. Uncompensated care and stand by time not considered
      Under representation in the SMS sample
   c. Allowed $13 per physician hour of practice expense for emergency medicine
      Result was a proposed 13% drop in payments to emergency physicians

7. ACEP Arguments
   a. Uncompensated care is a real cost of emergency medicine practice
   b. EMTALA mandated services-Healthcare Safety Net 24/7 staffing and readiness creates real stand-by costs
      Reservation wage-if you don't compensate physicians for working ED shifts they won't resulting in reduced access to quality emergency care

8. Lewin Study Results
    a. ACEP commissioned an independent study by the Lewin Group in 1998. Results showed actual practice expense was $27 not $13 as in the SMS data. Uncompensated care costs boosted practice expense to $97 per hour

9. Argued for emergency medicine to receive the all physician average of $67.

10. HCFA Statement From 11/2/98 Federal Register
    a. HCFA agrees to use the "all physician" average to calculate administrative labor and other expenses cost pool for emergency medicine stating. "Though many specialties must deal with the issue of uncompensated care, we do agree that it may pose a particular problem for emergency physicians, who are obligated under law to treat any patient regardless of the patient's ability or willingness to pay for treatment. Therefore, the amount of patient care hours spent on uncompensated care could be significantly higher for emergency medicine than for any other specialty. These issues require further examination."

11. HCFA PE results for 1999
    a. Uncompensated care acknowledged for the first time
       All physician average granted for 2 of 6 PE categories (administrative labor, other expenses)
    b. Changed estimated emergency medicine decrease from 13% to 10% after 4 years
    c. Emergency medicine per hour costs went from $13 to $31.60
    d. Practice expense RVUs are "interim" during the transition period

12. Practice Expense Advisory Committee (PEAC)
    a. Similar in composition to the RUC, to which it reports
    b. Will make recommendations of practice expense RVUs for new and revised codes
    c. First meeting February 1999

13. Surgical Coalition Lawsuit

a. Suing HCFA over choice of 1998 as base year for practice expense calculations
b. Content that 1997 or 1991 data should be used as the base year
c. Several surgical subspecialties face double digit reimbursements cuts

C. Professional Liability Insurance

1. Not currently resource based, but should be by 2000

D. Conversion Factor

1. 1999 Physician fee schedule conversion factor is $34.7315
5% decrease from 1998
Conversion factor is affected by: elimination of the work adjustment factor, +/- $20 million rule, Medicare Economic Index adjustments, Sustainable Growth Rate Adjustments

B. Prudent Layperson Applications

1. Medicaid Programs

2. HMO Programs

VII. Compliance Challenges

A. Governmental Developments

1. Federal False Claims Account
a. Recent Applications

2. "Medical Necessity" Enforcement

3. HCFA Documentation Guideline Enforcement

4. Stack II Issues

5. OIG & HCFA Interactions

B. Private Sector Developments

1. "Insurance-Only" Issues

2. EMTALA Ramifications

VIII. Contemporary Compliance Program

Compliance Program – Essential Elements

A. Contents of an Emergency Services Compliance Plan

1. Compliance Policy and Procedures:

- Develop a written policy that commits the organization to accurate coding and billing for all services. Distribute the policy annually among finance, admitting and registration staff, billing personnel, physicians, medical records coders, the chargemaster review team and others involved with the billing process.

- Develop and maintain a practice coding policy manual to include policies for the following issues:

  - Use of charge documents/physician responsibility;
  - Process of obtaining accurate, updated demographic and insurance information;
  - Description of the coding check and balance process;
  - Payment processing (i.e., receipting, balancing and documenting, etc.); and
  - Coding and documentation of:
    - E/M Levels of Service
    - Interpretive Services
    - Procedural Services
    - Ancillary Service Utilization
    - Use of Modifiers
    - Medical Necessity Issues
    - Resident Supervisor
    - Observation and Critical Services
  - E.M.T.A.L.A.

2. Compliance Officer:

- Assign a high-level person with emergency medicine experience within your organization to oversee the compliance program. This person should be able to accept a great deal of additional responsibility.
- Develop specific job descriptions.

3. Training:

- Effectively communicate the compliance requirements to everyone (i.e., employees, subcontractors, agents).
- Maintain a detailed description of each employee job description in the compliance plan folder.
- Consistently provide agendas and minutes for compliance team meetings.
- Develop and document training, including:
    - How new physicians are oriented to the coding and billing rules;
    - How new staff are oriented to the coding and billing rules;
    - Training programs for physicians; and
    - Periodic training on coding accuracy for staff members.

4. Internal Audit and Resource Development:

- Make sure that compliance objectives can be achieved and that there are mechanisms in place to detect problems.
- Perform a monthly or quarterly internal audit of the physician's use of E/M, CPT and ICD-9-CM codes. The results should be documented and feedback given to the physician(s) involved.
- Develop an internal resource library and develop revenue capture tools, such as registration forms, release of information, waivers, etc. Setting up a resource library can be as easy as gathering all Medicare newsletters, bulletins and manuals in one location. Another part of this process should include reviewing publication lists from the Medical Group Managers Association (MGMA), the American Medical Association (AMA), St. Anthony Publishing, Inc., and other organizations. Select reference material that will provide a broad range of billing and coding topics. Forms design discussions and examples are available in several of the books that you will see on the reference book lists.
- Document how the coding and billing department communicates with physicians regarding pertinent coding changes and individual coding behaviors. Consider comparison reports by individual physician on a quarterly basis.

5. Action Plans:

- Establish response procedures to be followed when problems are identified.
- Develop physician coding peer review in addition to any existing peer review policies.
- Implement problem logs from the coders and payment processors, and how follow-through actions are undertaken and solutions arrived at.
- Educate all staff about proper billing procedures and document the practice's activities to ensure that all staff understand what happens when they perform their assigned tasks well, and the effects when they perform them poorly.
- Develop a form for employee's review and signature that states the practice's intent to comply with all federal rules and regulations when coding and billing professional services. The statement should encourage the employee to report any questionable coding or billing practices to a designated administrator. The employee must not be subject to repercussions when reporting such concerns, and this fact must be documented in the compliance statement.
- Have regular meetings with coding and billing staff and encourage employees to voice their concerns or questions regarding coding or billing issues.

6. Disciplinary Action:

- Consistently enforce rules and discipline those who do not follow them.

7. Outside Counsel:

- Contact outside counsel immediately if billing problems are discovered or if investigators begin to make inquiries or request records.

By developing a compliance program, you can help detect coding and billing problems and possibly reduce the penalties imposed in the event that billing problems are detected during an audit. The goal of a compliance plan is to make sure the employees understand the billing rules and feel comfortable raising questions if they think any billing problems exist. It is wise to encourage billing personnel to ask lots of questions. A compliance plan should be a user-friendly method of ensuring that employees are aware of relevant regulations.

IX. Compliance Pitfalls

A. Policy Development

1. Interpretive Services

2. Procedural Services

3. Modifier Utilization

4. Documentation Thresholds

B. Human Resources

1. Physician Issues

2. Billing Staff Issues

Bibliography:

Baker, L.C. and Baker, L.S., "Excess Cost of Emergency Department Visits for Nonurgent Care," *Health Affairs*, 1994: pp. 162-171

Capitation Strategy, The Governance Committee, Washington, DC: 1995

Dietrich, A.J. and Martin, K.I., "Does Continuous Care From a Physician Make a Difference," *The Journal of Family Practice*, 1982; Vol. 15: pp. 929-937

Effective Reimbursement Strategies, 2nd Ed,. ACEP; 1991

Epstein, A.M., "U.S. Teaching Hospitals in the Evolving Health Care System," *JAMA*, 1995:273: pp. 1203-1207

Karpiel, M., "Managed Care in Emergency Medicine," Long Beach, CA, ACEP; 1995

Kongstvedt, P., The Managed Health Care Handbook, (Gaithersburg, MD: Aspen Publishing, 1989)

Lazarus, G.P., "A View From the Future: The Challenge for Academic Medicine in Northern California," *Acad Med*, 1995:70: pp. 87-89

Lyle, J.R. and Torras, H.W., The Managed Health Care Handbook, (Los Angeles, CA: Practice Management Information Corp.)

Masters, G. and Valentine, S., "Health Care Capitation & Risk Contracting Manual'" (New York, NY: Thompson Publishing Group, 1995)

Rogers, M., et al, "Cultural and Organizational Implications of Academic Managed Care Networks," *N Eng J Med*, 1994:331: pp. 1374-1377

Ross, R. and Johns, M., "Changing Environment and the Academic Medical Center: The John Hopkins School of Medicine," *Acad Med*, 1989:64: pp. 1-6

St. Anthony's Health Care Capitation Report, (Reston, VA, St. Anthony Publishing)

Weiner, J.P., "Forecasting the Effect of Health Reform on US Physician Work Force Requirements," *JAMA*, 1994:272: pp. 222-230

Young, G. and Skiar, D., "Health Reform and Emergency Medicine," *Annls of Emergency Medicine*, 1995:25(5): pp. 666-674