

The Fundamentals of Reimbursement: What Every Graduating Resident Should Know Before Starting Practice

ACEP Reimbursement Committee

As a recent residency graduate, you should have a thorough understanding of the basics of two important reimbursement issues: coding and billing. Both are vitally important because if you don't code your services correctly, you will not be able to bill properly. That means you may not be reimbursed appropriately for the services you provide, and worse, improper coding could result in accusations of coding abuse or even fraud.

There is so much clinical information to be learned during a physician's training period that usually little or no attention is given to practice management issues. Unfortunately, providing excellent care will not correlate with receiving appropriate reimbursement if you do not document, code and bill correctly. Understanding important issues such as documentation, coding, and billing will add value to your practice. This in turn will make you a more valued employee/partner in an increasingly competitive market place.

The following material is intended to introduce emergency medicine residency graduates to the fundamental concepts of reimbursement. Topics covered include a description of the coding system currently in place for physician services, an explanation of the use of the Resource Based Relative Value Scale, and a discussion of compliance issues for avoiding charges of fraud and abuse.

Understanding CPT

Physician services are reported using a coding system called Current Procedural Terminology – known as CPT – that was developed in 1966 by the American Medical Association.

CPT descriptive terms and identifying codes serve several functions in the field of medical nomenclature, including the reporting of physician services and claims processing. CPT's uniform language is also used for local, regional, and national utilization comparisons. Other countries have been adopting CPT and the AMA has said that it would like CPT to become the dominant coding methodology in the world. The AMA publishes a new CPT book each year with input from specialty societies

such as ACEP. The 2014 book includes more than 8600 CPT codes and instructions for their use.

AMA-authorized changes to the codes and their descriptions are made through the CPT Editorial Panel. The Panel is composed of physicians from various specialties and representatives of government and other third party payers. The AMA Department of Coding and Regulatory Services also helps with the process. ACEP and other specialty societies, appoint advisors to provide input to the panel on issues of interest to their particular specialty.

If a specialty society wants to submit an application for a new or revised code, it must complete the appropriate form and submit it to the AMA prior to the deadline for the next CPT Editorial Panel meeting. ACEP is the only emergency medicine medical specialty society with representation at the CPT meetings. When ACEP submits coding applications, the appointed representatives provide testimony in support of the request and answer questions that may arise during the presentation. The development cycle for a CPT book runs from May to February. An application must be completely through the process by February to appear in the CPT book published for the next year.

As a physician, CPT allows you to report the services you provide. Insurers use the codes to identify services provided to subscribers. They assign payment based on the codes indicated on claim forms, either through a set fee schedule or based on a contractual discount or other arrangement. However, insurers also often revise CPT service descriptions and coding policies for their beneficiaries. If a practitioner signs a participation agreement with a payer it will be important for him or her to know about such respective revisions.

Other entities use CPT codes as a tracking system to collect data on utilization of services for analysis. Health plans may use this data to predict future use and allocate resources appropriately. The Centers for Disease Control use the data to track the incidence of emergency department use across the nation. The Centers for Medicare and Medicaid Services (CMS) – which oversees the Medicare and Medicaid programs, uses the same data to determine its budget and fee schedule for each successive year.

Emergency Department Evaluation and Management Codes

Up to 80% of emergency physician reimbursement is generated from five CPT codes. They are the Emergency Department Evaluation and Management (E/M) codes 99281-99285. These codes describe the cognitive services provided to patients in the emergency department. Other codes describe other services commonly performed in the ED,

including observation, critical care, laceration repairs, diagnostic testing, fracture care, and foreign body removal.

It is important to choose the code that accurately reflects the service provided. Criteria for selection are listed in the front of the CPT book or in the preamble to a certain section or series of codes. Sometimes payers, such as CMS, develop their own policies for code use. For example, CMS created a set of Documentation Guidelines for E/M services to help choose the appropriate code based on what is documented in the chart. Elements of history, physical exam, and medical decision making are totaled and compared to a list of minimal documentation requirements for each level of service. The chart documentation for a given level must meet these documentation guidelines in order for that CPT code assignment to be considered valid.

A firm grasp of the CPT process is the first step in understanding the fundamentals of reimbursement. It is also a good way to make sure you are paid for the services you provide. As a recent graduate you should know how CPT works, and more importantly, how to use it properly.

CPT Updates for 2014

Each year, medical specialty societies works with the CPT Editorial Panel and AMA staff to produce new CPT codes, or revise existing code language as dictated by actual medical practice experience.

Some of the relevant changes for emergency physicians in 2014 are listed below.

Changes to Observation Codes:

- The initial observation codes (99218-99220) have been updated with a new listing of typical times spent at the bedside and on the patient's floor or unit. Those times now appear as 30 minutes for 99218, 50 minutes for 99219 and 70 minutes for 99220
- Likewise, typical times for observation services codes 99234-99236 are now 40, 50, and 55 minutes respectively.
- These typical time additions to the subsequent observation codes come into play with new language in the prolonged services codes.
- Code 99356 (*Prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)*) has a new parenthetical list of applicable code ranges that now include the observation codes.

(Use 99356 in conjunction with 90837, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310).

Other Items:

- Time is not a factor in ED E/M code set (99281-99285) selection. New “Coding Tips” appear in the CPT E/M section about the significance of time as a factor in the selection of certain E/M codes. This is not a new concept but provides a reminder that the inclusion of time is there to assist physicians in selecting the appropriate E/M level. However, it has been a long standing tenet within CPT that time is not a factor in selecting the appropriate ED level of service. The inclusion of the separately delineated ED “coding tip” reiterates that for CPT time is not a factor in selecting ED E/M codes “since services are provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.”
- There is a small but meaningful change in the laceration repair code preamble replacing the instruction to report wound repairs of different classification as well as those involving nerves, blood, vessels and tendon in a complex repair using modifier -59 (*Distinct procedural service*) rather than the -51 (*Multiple procedures*) as in years past. This should help to identify to the payers truly separate repairs that should be fully reimbursed rather than be subject to a significant decrease in payment.
- There are new codes 49082-83 for *Abdominal paracentesis (diagnostic or therapeutic)* with and without imaging guidance and 49084 (*Peritoneal lavage, including image guidance when performed*).
- A complete list of all the changes for 2014 can be found in Appendix B summary of Additions, Deletions and Revisions found on page 651 of the 2014 CPT book Professional Edition.

ICD-9 Diagnosis Codes for 2014

In addition to CPT codes that describe the services provided, you must also be familiar with ICD codes that identify the diagnosis or symptoms that made any furnished services medically necessary.

ICD-9, the most currently used iteration of the International Classification of Disease, has several additional codes relevant to Emergency Medicine that became available to use as of October 1, 2013.

Although everyone is anticipating the transition to ICD-10 in October of 2015 there are some useful new diagnosis codes available for ED

physicians to demonstrate medical necessity for their claims based on the latest ICD 9 updates. Consider these ICD-9 code changes for dementia which more clearly indicate how the disease impacted the care provided in the ED including inability to obtain the normal history or physical exam requirements:

New sub 294.2 Dementia, Unspecified

Excludes *mild memory disturbances, not amounting to dementia*
(310.89)

New code 294.20 Dementia, unspecified, without behavioral disturbance

New code 294.21 Dementia, unspecified, with behavioral disturbance

These new codes are an additional arrow in the quiver of proving the medical necessity for the visit to the payer.

Other ED relevant new ICD-9 codes

These new ICD-9 codes detail influenza with other specific respiratory manifestations:

488.81	Influenza due to identified novel influenza A virus with pneumonia
488.82	Influenza due to identified novel influenza A virus with other respiratory manifestations
488.89	Influenza due to identified novel influenza A virus with other manifestations

These new ICD-9 codes detail causes of anaphylactic shock and other reactions to greater specificity:

999.41	Anaphylactic reaction due to administration of blood and blood products
999.42	Anaphylactic reaction due to vaccination
999.49	Anaphylactic reaction due to other serum
999.51	Other serum reaction due to administration of blood and blood products
999.52	Other serum reaction due to vaccination
999.59	Other serum reaction

These new V codes expand the list of factors influencing health status and contact with health services that could help explain the reason for an ED visit:

V12.21	Personal history of gestational diabetes
V12.29	Personal history of other endocrine, metabolic, and immunity disorders
V12.55	Personal history of pulmonary embolism

V13.81	Personal history of anaphylaxis
V13.89	Personal history of other specified diseases
V23.42	Pregnancy with history of ectopic pregnancy
V23.87	Pregnancy with inconclusive fetal viability
V40.39	Other specified behavioral problem

Be sure to review the guide to the 2014 ICD-9 CM Updates published in the front of the diagnosis code book, which notes changes effective for 2014. A complete listing of the ICD-9 code changes for 2014 (effective 10.1.2011) is available on the CMS website at:

https://www.cms.gov/icd9providerdiagnosticcodes/07_summarytables.asp.

The RBRVS Process

Once a new or revised CPT code is approved by the CPT Editorial Panel, it is sent to the AMA Relative Value Update Committee or RUC. The RUC assigns relative value units to CPT codes for CMS consideration in the next year's Medicare Fee Schedule. This process determines what you will be paid by Medicare for any given CPT code.

The Resource Based Relative Value Scale (RBRVS) is a methodology developed to rank services relative to other services. For example 45 minutes of a family practitioner's time for an office visit may pay \$45. A thoracic surgeon may take 45 minutes to do an open chest procedure that pays \$4,500. Arguably, the surgical procedure has a higher price because the relative work, cost, and risk are higher than seeing a patient in the office for a routine examination. These assigned values are based on research done at Harvard. The RBRVS equation is composed of these three components: work values, practice expense values, and professional liability insurance (PLI). Each of these components is assigned relative value units (RVUs).

These three RVU amounts are added together to produce a total RVU figure. Total RVUs are multiplied by the annual conversion factor, which is \$35.8228 for 2014. The Protecting Access to Medicare Act of 2014 signed into law April 1, 2014 extended this conversion factor for the full year. CMS determines this conversion factor for Medicare based on several factors including budget concerns and utilization data. The CMS conversion factor is updated every year. CMS also applies a Geographic Adjustment Factor (GAF) to this dollar amount to account for cost differences in urban versus rural areas for labor and other practice expenses. Also included in the legislation passed by Congress was a freeze to the work value portion of the Geographic Practice Cost Index (GPCI) at 1.0. This cut would have a significant impact on rural departments. Although this sounds complicated, it is easier to visualize as an equation.

To understand how this works in practice, consider the emergency department Evaluation and Management CPT code 99284 applying actual CMS assigned values to the RBRVS formula of (Work RVUs) + (Practice Expense RVUs) + (PLI RVUs) = Total RVUs

Example:

If you practiced in Arizona and used the GPCIs for that area, your payment for code 99284 would be \$115.71 in 2014.

(Work RVU X Work GPCI) + (Practice Expense RVU X PE GPCI) + (PLI or Malpractice) RVU X PLI GPCI] = Total RVU X Conversion Factor = Medicare payment

$$(2.56)(0.981) + (0.53) (0.988) + (0.21) (0.944) = 3.23$$

(Total RVUs) (Conversion Factor) = Medicare Payment

$$(3.23) (\$ 35.8228) = \$115.71$$

The RUC has historically only assigned work RVUs to each CPT code, because only that component was resource based. Starting in 1999, practice expense values became resource based and is also considered by the RUC based on actual non physician clinical time, supplies and equipment used in provision of the service in question. The PLI RVUs are now based on actual claims paid data and are not considered by the RUC.

The RUC makes recommendations to CMS based on the new and revised codes that it considers during the course of the year. Historically, CMS has adopted around 95% of the RUC's recommendations. These values are used to create the fee schedule for the next year that is usually released in November of the current year.

When a medical specialty society such as ACEP brings a code before the RUC, they must provide compelling evidence to justify the RVUs they recommend. This is usually done in the form of survey data of providers who use the code. If more than one specialty provides the service, they must work together to reach a common recommendation. The Medicare budget and RUC process operate in a budget neutral environment. This means for every dollar increase produced by a given code RVU change; there is a dollar less for everyone who does not use the code. This makes the compelling evidence argument very important. Each RUC member is charged with remaining neutral and voting for RVUs based on the evidence presented rather than what might be advantageous to their own specialty.

It is estimated that over 80% of all payments for physician services are based on the RBRVS data. Even if Medicare patients are not a large part of your practice, RBRVS will impact what you are paid for a given service. Your chart documentation is critical to accurately capture the services you provided and the commensurate reimbursement you earn.

Compliance and the Billing Process

Whether it is the physicians themselves or trained coding staff who assign the CPT codes for any medical services provided, the information to support the charges must be documented in the medical chart. And regardless of who assigns the service codes, the practitioner has ultimate responsibility for the coding and billing. The AMA CPT book provides descriptors for each of the 8600 codes listed. Frequently there are additional instructions for code use in each section of the book. Unless overridden by a participating payer's policies, CPT rules should be followed when choosing the correct code to describe the service provided. This is important for two reasons. Choosing the correct code will improve the chances of proper payment for services provided. Accurate coding is also necessary to avoid charges of fraud and abuse.

Each physician, group, and hospital should have a compliance plan in place to address potential fraud and abuse issues. For example, a federal Office of the Inspector General (OIG) has developed compliance guidance for several entities. Guidance for physician practices was released in the September of 2000. ACEP's Reimbursement Committee has developed a compliance educational piece based on the OIG guidance and reviewed by a noted healthcare attorney. This information is available on the ACEP Web site in the member's only area. Some of the key points are outlined here.

In simple terms, a compliance program is a quality assurance strategy. It sets up rules for an entity to establish internal controls and monitor its conduct in order to prevent and correct inappropriate activity. Generally, there are no statutes or laws that require an organization to have a compliance program. A compliance program is meant to ensure that an entity will not inadvertently, negligently, or intentionally engage in illegal activity. Should an entity subsequently be found guilty of fraud, the existence of an otherwise effective compliance plan may decrease the penalties imposed. Essentially, a compliance program functions as a potential shield, while establishing a culture that articulates and demonstrates commitment to legal and ethical conduct. It is essential that whatever compliance plan or program is adopted be realistic and is likely to be implemented completely. The worst thing a practice can do is to adopt a compliance plan that it does not follow.

You should have a compliance plan, whether you are practicing with a small group, a large staffing company, as an academic physician, as an employee or independent contractor, or in any other coding/billing arrangement. Hospitals, as part of their compliance requirements, will usually require hospital-based physicians to have their own plan.

Documentation Issues

The potential for fraud and abuse is a continuum that begins with an initial patient encounter and continues through the documentation of such encounter in the patient's medical record. The medical record is then the source document for subsequent coding and/or billing. For emergency medical services, a compliance program requires a risk assessment and strategy to deal with each step in this continuum.

CMS states that "Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examination, tests, treatments, and outcomes." Further, CMS states that the medical record should "facilitate accurate and timely claims review and payment." The importance of accurate documentation cannot be overstated. Your compliance plan should include provider education and policies addressing documentation standards required for all billable patient encounters. Reasonable areas to address include the patient record, recording methodologies, continuing education, and communication between physicians and coding staff.

A crucial aspect of services provided during a patient encounter is the requirement for medical necessity. The concept of medical necessity is referenced frequently in all of the OIG's Compliance Guidances. The issue is whether or not the presenting complaint justifies the selected level of documented evaluation and management services, procedure(s) performed, and/or ancillaries such as lab and x-ray. Medical necessity should be addressed in the compliance plan. Tools such as random audits, pattern analysis, and review of denied claims might be useful in uncovering problems in this area. Note that undertaking these analyses will create an obligation to repay on the part of a group that discovers that there are problems.

Coding associated with the provision of professional services encompasses two basic components: identification of the specific service(s) provided and identification of the patient's malady(ies). The medical record documentation must address both of these components. The patient chart should clearly show what the physician did and why it was necessary to avoid denied claims and charges of fraud and abuse.

Other Considerations

The federal government maintains that irrespective of who performs the coding and billing functions, the provider, in whose name the claim is submitted, is ultimately accountable for the correct processing of the claim associated with the patient encounter. The OIG strongly recommends that any coding entity coordinate with its provider clients to establish clearly delineated compliance responsibilities.

The basic obligation of whatever entity does the coding and billing is to assure that its policies and procedures concerning proper coding reflect the current reimbursement principles set forth in applicable statutes, regulations, and federal, state, or private payer health care program requirements.

Although all applicable statutes and legal regulations must be followed, payer program requirements that are not statutory or based on legal regulation must be followed only if a provider has agreed in any separate contract to comply with such requirements, for example in a participation contract.

Already, a substantial number of hospitals, physicians, and physician groups, and other providers have been investigated, and the number and amount of identified overpayments and penalties have increased dramatically. In this endeavor, the federal government has powerful tools such as the False Claims Act (FCA) of 1986, the Health Insurance Portability and Accountability Act (HIPAA), and the Balanced Budget Act of 1997. There are other legal bases for enforcement including use of mail fraud, wire fraud, and conspiracy statutes, and non-health-care related statutes, and other sources of authority the government can also apply in its search for illegal activity. These tools provide increased funding for the OIG's fraud and abuse activities and a variety of enforcement means. A health care fraud investigation can potentially lead to the imposition of criminal penalties including fines and imprisonment, and civil penalties, including monetary penalties and/or exclusion from the Medicare and Medicaid programs.

Issues such as accountability for coding, billing processes, education, monitoring, and discipline, must be incorporated in any formalized compliance program developed by the group, hospital, or individual emergency physicians. Contractual relationships between emergency physicians and their employers and/or practice locations need to clearly delineate compliance responsibilities. It is evident that development and implementation of an effective and usable compliance program is rapidly becoming an industry standard. Compliance programs are a powerful tool to promote a strong ethical approach to coding and billing and might provide at least a partial mitigation of any penalties resulting from a

governmental auditor fraud investigation.

Conclusion

As a resident, you were trained to handle any number of clinical issues. The unfortunate reality of medical practice is that patient care is not your only concern. Failure to understand the business side of medicine, including the reimbursement process, can hurt your income and result in assessment of civil and even criminal penalties. ACEP will continue to provide education to its members on these important issues as well as lobby on behalf of all emergency physicians at the federal and state level.

For additional information on reimbursement issues, please call ACEP at: 800-798-1822, ext. 3232, or visit the ACEP Web site at: www.acep.org/content.aspx?id=28754 for up to date content on specific reimbursement and coding topics.