ACEP
Reimbursement & Coding
WEBINAR

Tuesday, January 21, 2014

Nuts and Bolts of Reimbursement:
Reimbursement Primer and the RBRVS System

ED Groups are under escalating financial pressure. Your group’s success depends on an understanding of the way medical services are reimbursed. RVUs, CPT codes, and Diagnosis codes as well as governmental and private payer reimbursement methodologies directly determine our value and compensation.

Tuesday, January 21, 2014
1:00 – 2:00PM CST

(*) Ownership interest: President LogixHealth
The Nuts and Bolts of Physician Reimbursement

Michael A. Granovsky MD CPC FACEP
President, LogixHealth

Goals and Topics

- Demystify the ED Reimbursement Process
- Define how ED revenue is generated
- Demonstrate the components of the ED revenue chain
  - CPT Code Assignment
  - RVU Valuations
  - Special CMS Programs
Coding...What Happens?

- A series of 5 digit codes are used to describe each medical service provided
  - The Payer receives only CPT codes not a copy of the chart
- The codes are published in the CPT Manual
  - Current Procedural Terminology
  - www.amapress.com
- Maintained by the American Medical Association
- AMA CPT Advisory Committee is made up of one member from each specialty society
  - 110 panelists from Pediatrics, OB, E Med, N-Surg etc...
- Codes are updated each year effective January 1st

CPT Rules:
Evaluation & Management Codes

- Describe the cognitive work involved in taking care of the patient

- History, Physical Exam, and Medical Decision Making determine the code choice

- Emergency Medicine Codes:
  - 99281
  - 99282
  - 99283
  - 99284
  - 99285
  - 99291
Documentation Rules

- Most ED Visits Hx and PE scored using the Medicare 1995 Documentation Guidelines
- Based on:
  - HPI elements
  - Past Family Social Hx
  - Review of Systems
  - Physical Exam elements
  - Medical Decision Making

Documentation Guidelines

<table>
<thead>
<tr>
<th>Level</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSoc</th>
<th>PE</th>
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Medical Decision Making

Sets The Highest Possible Level

- Drives the ultimate code choice
- Ankle sprain - level 3
  - can’t be dressed up
- Chest Pain level 5
  - needs full Hx and PE support
- Determined by:
  - Number of Dx & Mgt Options
  - Data Reviewed/Testing
  - Risk to Patient (Complications / M&M)
  - Severity of Problem

Common Clinical Scenarios

Potential 99283
- Vaginal d/c no abd. pain
- Gastroenteritis no IVF
- Diarrhea - Tx po fluids
- Ankle sprain
- Foreign body – eye
- Rx drug management
- Systemic symptoms
  - Fever, tachycardia
- Head contusion
  - w/o neurologic changes

Potential 99285
- Acute Onset Chest Pain
- Cardiac, PE, dissection…
- Cardiac work up w/ EKG, CXR, labs and cardiac markers
- Parenteral narcotics
- Worst Headache of Life
- C.V.A. presentations
- Respiratory distress with:
  - Multiple treatments and continuous nebulizers
  - Lab, x-ray, IV therapy
RVUs and Reimbursement

The Value of Our Codes

- Based upon recommendations made by the Relative Value Update Committee to CMS
  - Made up of representatives from each specialty within the house of medicine
- The metric employed by the RUC is the RVU...Relative Value unit
  - Watt, Joule, Second, meter²
How We Get Paid

- RVU-Relative Value Unit
- 1992 RBRVS Instituted- Resource Based Relative Value Scale
- Prior to 1992 -Usual Customary Reasonable (UCR)
- 90% of all ED Physician payments are based on RVUs
  - Medicare
  - Payers using RVUs Directly
  - Payers using Medicare % (120%-220%)

RVU: Relative Value Unit

- Relative Value Unit
- The universal metric of physician reimbursement
- 1 unit of physician effort
- When System devised referenced to the work associated with a moderate level established patient office visit
RVU - The Components

- Physician Work
  - Cognitive
  - Procedural
- Practice Expense
  - Coding, Billing, Collections
  - Payroll and Support Staff
- Liability Insurance

RBRVS EQUATION

Work RVUs
Practice Expense RVUs
+ Liability Insurance RVUs
Total RVUs for a given code

RVU Total X Conversion Factor
= Medicare Payment
RVUs and Payment Simplified

1. RVUs for a given code
2. Multiplied by the Dollars payer reimburses per RVU
3. Yields physician payment amount

2014 current Payment for 99284:
3.30 RVUs $35.8228 = $118.22

Taking it To The Next Level:
The GPCI

- Geographic practice cost index (GPCI)
- Reflects the cost differential for providing services in different localities
  – i.e. New York City vs Fargo North Dakota
- Each of the 3 RVU components are adjusted based on a local cost index
- GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVUs for each component times the local GPCI for that component
99284 Arizona Payment

(Work RVUs) x (Work GPCI) +
(Practice Expense RVUs) x (PE GPCI) +
(Liability Insurance RVUs) x (PLI GPCI) = Total RVUs

(2.56)(1.000)
(0.53)(0.983)
+(0.21)(0.913) = 3.27 Total RVUs

(Total RVUs) x (Conversion Factor) = Medicare Payment
(3.27) x ($35.8228)= $117.14 in Phoenix, AZ

2013 and 2014 RVUs

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<td>0.58</td>
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<td>0.22</td>
<td>0.21</td>
<td>3.36</td>
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<td>3.80</td>
<td>0.83</td>
<td>0.76</td>
<td>0.30</td>
<td>0.29</td>
<td>4.93</td>
<td>4.85</td>
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<td>1.44</td>
<td>0.34</td>
<td>0.33</td>
<td>6.40</td>
<td>6.27</td>
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</table>
**DOCUMENTATION & CODING**

Increases With Each E/M Level

![2014 Medicare ED RVUs chart]

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**Future RVU Evolution**

- Practice Expense and Liability Insurance tweaked annually
  - Small impact on ED RVUs...typically 0% - 2%
- Work RVUs make up roughly 80% of ED Total RVUs
- Every 5 years Congress mandates a work RVU review
  - 2012 last Review...ED codes not involved...Observation
- 2014 ED work RVUs stable

- 2017 next possible E/M 5 year work review
  - No clear 9928x plans at this point
  - CMS Practice Expense and Liability tweaked....resulting in small changes 2013 to 2014
  - 99285  4.93  4.85
Breakdown: ED RVUs and Revenue

Procedures 11%

9928x E/M Services 85%

Add in Critical Care 89%

E/M Codes - Get the simple stuff right!

The Conversion Factor
Medicare’s Payment per RVU
Conversion Factor and SGR Formula

- SGR Formula (Sustainable Growth Rate)
  - Established 1997 target for expenditure on physician services
    - Comparison of GDP growth to Medicare Cost increases
  - If actual expenditures exceed SGR, physician payments cut
  - Flawed SGR Formula
    - Prescription Drug Spending
    - Budget Neutrality (PCP RVUs)
    - Deficit Spending
  - SGR formula now mandates steep cuts in physician payments by decreasing Medicare’s payment per RVU
- 15 Patches by Congressional Action 2002-2014
  - 20.1% ↓ physician payments… SGR patch through 3.31.14
  - 0.5% CF of $35.8228

2014 Cut in Medicare MD Reimbursements

<table>
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<tr>
<th>Year</th>
<th>SGR Mandated Cuts</th>
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<tr>
<td>2013</td>
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<td>2014</td>
<td>-20.10%</td>
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### 2014 Payments

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<tr>
<th>Code</th>
<th>2013 Payments</th>
<th>2014 Base Payment</th>
<th>Increase (Percent)</th>
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*CF 3.31.2014  $35.8228

### DOCUMENTATION & CODING

Increases With Each E/M Level

#### 2014 Medicare ED RVUs & Reimbursement

<table>
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<tr>
<th>Code</th>
<th>RVUs</th>
<th>Reimbursement</th>
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<td>$61.97</td>
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<td>$173.74</td>
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<td>99285</td>
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<td>$224.61</td>
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<td>99291</td>
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Now we know the system…

How to maximize your RVUs

85% of RVUs generated by Evaluation and Management codes 99281-99285

Get the simple stuff right!
Documentation Guidelines

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Procedures: Separate Payment

- Most procedures are separately billable
- Document full procedure note
  - Clearly document to ensure credit
  - Site (laceration, fracture)
  - Size (length of laceration)
  - Technique (layered, manipulated)
  - Complexity (abscess drainage)
  - Anatomic areas involved (epistaxis)
Abscess Drainage: Getting It Right

Simple or Single
- Furuncle, paronychia
- Superficial
- Single

Complex or multiple
- Probing
- Loculations
- Packing

Abscess: Medicare Reimbursement

- Simple or single 10060  2.72 RVUs/$96
- Complex or Multiple 10061
  5.07 RVUs/ $179… 86%  
  4 abscesses per day X $83 = $121,180 annually
Well Documented I&D

Fracture Manipulation: Sky High RVUs
Distal Radius Fracture
With Manipulation

EMERGENCY DEPARTMENT COURSE AND DIAGNOSTIC DATA: This is a 56-year-old female with right wrist pain, status post fall. The patient’s x-ray of the right wrist showed Colles fracture of the distal radius with ulnar styloid avulsion. There is some mild dorsal angulation and displacement of the distal fragment.

The patient’s hematoma block was performed with 10 mL of 1% lidocaine without epinephrine. The fracture displacement was reduced by me. A plaster sugar-tong splint is placed by me. Postreduction x-ray showed improvement of the dorsal angulation of the distal radius. The distal radial articular surface is now essentially perpendicular to the long axis of the radial shaft. There is no subluxation or dislocation.

- Code for all manipulations
- Robust RVUs
- Use the without anesthesia codes
- Splint is bundled
- Apply -54
- 25605 10* RVUs...$352

RVU Production

\[
\text{RVUs/Patient} \times \text{Patients/Hr} = \text{RVUs/Hr}
\]

89% E/M Level Fast/Efficient

RVUs/Hr
Common ED Service RVUs

- EKG 0.24 RVUs
- 99282 1.16 RVUs
- 99285 4.85 RVUs
- CPR 5.29 RVUs
- Finger Lac 1.29 RVUs
- Chest Tube 5.13 RVUs
- LP 1.69 RVUs
- Shldr. Disloc. 8.16 RVUs
- Facial lac 1.61 RVUs
- Epistaxis 2.29 RVUs

RVU Production

Dr. Jones sees a weak and dizzy 80 year old. He obtains extensive history from the family. The work up includes a Head CT, full cardiac evaluation with labs, and an EKG.

He speaks with the PMD and her cardiologist. The patient is admitted.

RVUs: 99285 (4.85) + EKG (.24) = 5.09

While waiting for the labs to come back he reduces a nursemaid's elbow.

RVUs: Nursmemaid (2.69) + 99282 (1.16) = 3.85

76% more productive
Patients per Hour

Average Patients/Hour

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<th>Average Patients/Hour</th>
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<tr>
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<td>K. Dixon MD</td>
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<td>C. Green PA</td>
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<tr>
<td>V. Blue PA</td>
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<td>H. Clinton MD</td>
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<td>A. Gupta MD</td>
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<td>E. Lack PA</td>
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<td>D. Stillwell MD</td>
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Efficiency Factors

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<th>RVU Enhancers</th>
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<tr>
<td>Inadeq. Support Staff</td>
<td>Adequate staff</td>
</tr>
<tr>
<td>MD answers phone</td>
<td>MD clinical focus</td>
</tr>
<tr>
<td>MD chases down labs</td>
<td>Pre-registration</td>
</tr>
<tr>
<td>Staff initiative</td>
<td>Clinical protocols</td>
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<tr>
<td>Long turn around times</td>
<td>X ray EKG UA/BHCG</td>
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<tr>
<td>CT Lab X ray</td>
<td>Benchmark TAT</td>
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<tr>
<td>Boarding patients</td>
<td>Streamline admits</td>
</tr>
<tr>
<td>Multiple admission calls</td>
<td>Use of PAs &amp; Residents</td>
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RVUs per Hour

Each year the AMA publishes the set of diagnosis codes used to report medical services
- www.amapress.com
- International Classification of Diseases 9th Revision Clinical Modification
- ICD -9- CM or ICD 9
- Diagnosis Codes
- 10.1.2014 switching to ICD 10
Diagnosis Coding Relevance

- Communicate to the payer the medical necessity for the visit
- The ICD 9 code lines up opposite the CPT code on the bill
- Tx for tonsillitis 99283…tonsillitis (463)
- Finger Lac…open wound finger (883.0)
- Chest tube…Spont. Ptx. (512.81)

Payer Diagnosis Edits

- Many payers use diagnosis edits
- Will only pay for a certain service with a given set of diagnosis
- Medicare for EKGs
  - Chest pain, syncope approved
  - Hip fracture, hypoglycemia no payment
- State Medicaids
  - Acute otitis media not acceptable
    - Fever or otalgia OK
- Private payers may use for E/M levels
  - Gastroenteritis supports no more than 99283
    - May even be denied all together
  - Dehydration, fever, chest pain may support up to 99285
Diagnoses

▪ Think Clinical and Reimbursable by Payer
▪ Protects patient from getting stuck with the bill
▪ Chief Complaint focus
  – Headache, chest pain, palpitations, dyspnea, abdominal pain, fever, dehydration
▪ Severe or trauma diagnosis first priority
▪ Never use initials

ICD-9 Clinical Examples

▪ 4 m.o. infant with fever to 103.5 has work up including CBC, BCx, IVF bolus, and IV antibiotics to evaluate & treat for sepsis.
▪ The studies are negative, the infant improves and the parents are told he has a “URI”
  – 780.6 febrile illness
  – 276.5 dehydration
  – 465.9 Upper Respiratory Infection
PQRI now PQRS
(Physician Quality Reporting System)

CMS Physician Quality Program

PQRS Basics

- Program started in 2007
- Involves physicians reporting quality measures
  - Similar to CORE measure the hospital reports
- ED specific measures
- Quality Codes go right on the claim form
- Providers currently earn a bonus for reporting the quality codes
CMS-1500 Claim Example

Common ED Physician Quality Measures

1. Aspirin at Arrival for AMI (#28)
2. Electrocardiogram Non-Traumatic CP (#54)
3. Electrocardiogram Performed for Syncope (#55)
4. Vital Signs for CAP (#56)
5. Empiric Antibiotic for CAP (#59)
2014 Physician Quality Reporting System (PQRS)

- Requires 50% reporting on 3 measures
  - To avoid a 2.0% penalty
- Significant requirements for 0.5% bonus
  - Roughly $350 per provider
- PQRS Update with publication of Physician Final Rule

- ED Measures continue: ASA for AMI, EKG for Chest Pain and Syncope, Some Pneumonia measures

PQRS Scores Populating The Physician Compare Website

- Physician Compare Currently supports searching by name, type of provider, and specialty
- Educational Background, Medicare Participation
- If you successfully participated in PQRI
- Will shortly provide detailed information regarding physician quality (PQRS) measures
  - Macro data already available

“CMS is required to implement a plan for making information on physician performance publicly available through Physician Compare.”
Physician Compare Website Is Live!

PQRS …Getting Personal
Wrap Up

- E/M Codes 99281-99285 drive 85% of our revenue
- Procedures contribute an additional 11%
- Diagnosis Codes justify the medical necessity for the visit
- The PQRS quality program determines an increasingly important component of our future reimbursement

Thanks!

Michael Granovsky MD CPC FACEP

President, LogixHealth

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781-280-1575
Appendix

Resources – Coding & Billing

- ACEP web site www.acep.org
  - Frequently Asked Questions
- ACEP News articles
- Reimbursement department: 1.800.798.1822
- ACEP courses Reimbursement and Coding
  February 2014 New Orleans
- ED Coding Alert 1.800.508.2582
- ED List Serve www.coding911.com
## Resources - PQRI

- CMS web site
  - www.cms.hhs.gov/pqri/

- AMA Resources

## Contact Information:

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781-280-1575