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 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 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 2009 book includes more than 8600 CPT codes and instructions for their use.

Changes to the codes and their descriptions are made through the CPT Editorial Panel. The panel is composed of physicians from the various specialties and representatives of government and third party payers. The AMA Department of Coding and Nomenclature also help. 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 and be paid for the services you provide.

Carriers 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.

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 the procedures commonly performed in the ED, including 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 polices 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 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 2009

Each year, ACEP 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 2009 are listed below.

- The entire pediatric section has been reformatted. Seventeen new codes have been developed to replace the previous codes.
- The current critical care codes 99291 and 99292 should be reported for the physician's attendance during the transport of critically ill or critically injured patients over 24 months of age to or from a facility or hospital.

- Codes 99466 and 99467 should be reported for physician transport services of a critically ill or critically injured patient 24 months of age or less.

- The 907XX series codes for infusion/injections were deleted and replaced with a new set of codes.

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 $36.0666 for 2009 . In the final rule released on November 1, 2008 and published on November 19, 2008, Medicare set the conversion factor at $36.0666 for 2009. In 2007 and 2008, a budget neutral adjustment was applied to the work RVUs in the formula. In 2009, CMS applied the adjustment to the conversion factor which resulted in an increase in reimbursement for some evaluation and management (E/M) services . 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.

Consider the emergency department Evaluation and Management CPT code 99284
(Work RVUs) + (Practice Expense RVUs) + (PLI RVUs) = Total RVUs

If you practiced in Arizona and used the GPCIs for that area, your payment for code 99284 would be $112.53 in 2009.

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

(2.56)(1.000) + (0.47)(0.957) + (0.14)(0.822) = 3.12

(Total RVUs) (Conversion Factor) = Medicare Payment

(3.12) ($36.0666) = $112.53

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 although we are still in a transition and refinement period for that process. The RUC formed a subcommittee, the Practice Expense Advisory Committee (PEAC), to assist in refinement of practice expense RVUs during the transition. The PLI RVUs were resource based for the first time in 2000. Those values are now based on actual claims paid data and are not considered by the RUC. The PEAC assisted the RUC for several years in order to complete the review process of practice expense inputs but no longer meets as a functioning committee. Previous members of the PEAC attend RUC meetings to provide historical information on certain codes and to assist with new codes being presented. Practice expense will be a greater focus for the RUC in the coming years.

The RUC makes recommendations to CMS based on the new and revised codes that it considers during the course of the year. Traditionally, 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 seek. 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. Natural coalitions tend to form between specialty societies that use similar groups of CPT codes, but each RUC member is charged with remaining neutral and voting for RVUs based on the evidence presented. The budget neutral adjustment to the work values was 0.8994 for 2007 and 0.8806 for 2008. As stated above, in 2009 CMS applied the budget neutral adjustment to the conversion factor rather than to the work relative value units (RVUs).

It is estimated that over 70% 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.

Compliance and the Billing Process

Medical services provided by emergency physicians are identified using the AMA Current Procedure Terminology or CPT codes. Whether it is the physicians themselves or trained coding staff that assign the CPT codes for services provided, the information to support the charges must be documented in the medical chart. 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. These 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. The 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. 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.

Elements of a Compliance Plan

A compliance plan should address program design, implementation, and enforcement. An effective compliance program needs to be "home grown" and unique to the entity. All compliance plans should have seven key elements. These are based on the seven steps outlined in the Federal Sentencing Guidelines and form the basis for all of the OIG's "model" compliance programs.

1) Compliance Standards and Procedures

An entity should develop written standards of conduct, including a clearly delineated commitment to compliance, for all medical professionals, employees, and contractors.

Written policies for risk areas such as documentation, coding and billing should also be established. Risk areas to address that are pertinent to emergency medicine, many of which will be discussed in later sections of this document, may include:

- Proper documentation of the service rendered and its medical necessity. Medical necessity is always an issue. There are a variety of methods for documenting medical necessity (e.g. ICD-9 codes, differential diagnoses, narrative descriptions, etc.) or it may be implied by the presenting symptoms or chief complaint.
- Coding and billing for utilization of mid level providers.

- Teaching physicians (i.e., attending physicians working with fellows, and/or residents).
- EMTALA regulations and Advanced Beneficiary Notices (ABNs)
- Additional items include X-ray Interpretations and critical care.

Fraudulent "upcoding," including "assumption" (presumptive) coding, pattern billing, and computer software programs that encourage coding and billing personnel to enter data in fields indicating services were provided although they are not specifically documented. Assumption coding refers to the practice of assigning a code based on the "assumption" of a higher level of service (presumed from a presenting complaint, diagnosis or disposition) as opposed to coding based on the documentation that such a service was actually provided. An example would be the assumption that a laceration was sutured although the provider did not document this procedure.

- Coding errors, including failure to properly use modifiers (e.g., teaching physician modifiers, modifiers for minor surgical procedures where the emergency physician will not render postoperative care, etc.)
- Fraudulent billing, including billing for items/services not performed or documented, unbundling (e.g., coding the individual components of a procedure separately when a single code is used to describe the service), inappropriate balance billing, duplicate claims.
- Inappropriate discounts and/or professional courtesy (including routine waiver of co-payments, co-insurance, deductibles, etc.)
- Billing company incentives that violate anti-kickback statutes or other similar Federal or State law or regulation.

More general risk areas mentioned by the OIG are appropriate management of credit balances (overpayments), maintaining the integrity of data systems (including back-up and patient confidentiality), and record retention.

2) Oversight Responsibilities

Someone in an entity must be assigned the responsibility for overseeing compliance. For example, an organization could designate a chief compliance officer who reports directly to the CEO or Board of Directors. Depending on the size of the entity, such oversight may involve one individual, a compliance committee, or both. This person or committee will oversee and monitor the implementation of the compliance program, periodically revise the program as needed, develop an educational and training program on the elements of the compliance program, and independently investigate and act on matters related to compliance.

3) Education and Training

The entity ought to develop and implement education and training programs for all affected employees and contracted providers. The program should effectively communicate standards and procedures to all individuals involved. This may include mandatory meetings or internal publications outlining policies and procedures.

4) Developing Effective Lines of Communication

The entity should create and maintain a process that facilitates submission of concerns and complaints to the relevant authorities, such as a hotline. This should include procedures that preserve, as best as is possible, the anonymity of complainants, if they so desire. In addition, complainants ought to be protected from possible retaliation.

5) Monitoring and Auditing

A compliance program should demonstrate that the entity has taken reasonable steps to achieve compliance through monitoring and auditing systems designed to detect inappropriate conduct by its employees or agents.

6) Enforcement and Discipline

The entity should have a system to consistently investigate allegations of improper or illegal activities and should take appropriate disciplinary action against persons who have violated internal compliance policies.

7) Response and Prevention

After an offense has been detected, an entity must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses. The appropriate response to an offense will depend upon the underlying cause(s). Since the determination of such cause(s) can be open to interpretation, it would be prudent to seek the advice of someone knowledgeable regarding the requirements of repaying and reporting. In general, inadvertent (which itself might be open to interpretation) errors or mistakes can be addressed by appropriate repayment.

If an entity has discovered credible evidence of *its own* "misconduct" (e.g., possible violation of criminal, civil, or administrative law) in its own activities, it must report such conduct to the appropriate government agencies. In the face of a governmental audit, prior reporting of aberrant actions in the past will generally reduce the government's penalties, since the entity recognized the problem, responded to correct it, and reported it to the government entities.

There should be good communications between the billing company as an external party and the physician entity itself. If an outside billing company discovers evidence of *provider* "misconduct", it should refrain from submitting any questionable claims and notify the provider in writing within 30 days. If a coding/billing company discovers credible evidence of a client's continued "misconduct," or discovers evidence of flagrant or abusive conduct, the coding/billing company should: 1) refrain from submitting any false or inappropriate claims; 2) terminate the client's contract; and/or 3) report such conduct to the appropriate Federal and State authorities within 60 days.

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 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 audit or 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, call ACEP at 800 798-1822, ext. 3232, or visit the ACEP Web site at www.acep.org.