2019 Reimbursement Update

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The Safety Net for Society

- Over half of the 35.4 million annual inpatient admissions in the United States begin in the ED
- 5 times as many ED visits are treated and released
- ED visits outpaced population growth since 1993
- The number of ED visits increased 14.8% from 2006 to 2014. The U.S. population grew 6.9%
- ED visits by those in the lowest quartile of income rose 23% from 2006-2014
- The rate of mental health/substance abuse-related ED visits increased 44.1 percent from 2006 to 2014

The Healthcare Cost and Utilization Project sponsored by sponsored
By The Agency for Healthcare Research and Quality (AHRQ)
National CMS Launches Comparative Billing Report (CBR) Program

Comparative Billing Report Program
7127 Ambassador Rd., Suite 150
Baltimore, MD 21244

Questions: Contact CBR Support
www.cbrinfo.net
(800) 771-4430 / M-F 9 am – 5 pm ET
cbssupport@eglobaltech.com

According to an OIG report titled Coding Trends of Evaluation and Management Services, physicians have shifted their billing of emergency department services from lower level to higher level codes over time. Per the report, from 2001 to 2010, “Physicians’ billing of the highest level code (99285) rose 21 percent, increasing from 27 to 48 percent. During the same time,

Based on the Medicare Fee-for-Service 2016 Improper Payments Report, emergency department services had a 12.4 percent improper payment error rate with a projected improper payment amount of $268 million. Emergency department services submitted with CPT® code 99285 had an improper payment rate of 6.4 percent.

Benchmarks: Total Allowed Charges, Avg. Allowed Charges per Visit, % 99285, Use of Modifier 25 vs State and National

CBR Employed Benchmarks

Metrics and National Statistics

- Percentage of Services with CPT® Code 99285
  - Nation: 55%

- Percentage of Services with Modifier 25
  - Nation: 11%

- Average Charges for All Part B Services
  - Nation: $143.74
MI Specific Benchmarks

Claims with Dates of Service: July 1, 2016 - June 30, 2017

- Modifier 25 - 13% of claims
- Average Allowable - $145.75
- Percentage of 99285 - 56%

CBR Data Comparison Format

Table 3: Percentage of Services Billed with CPT® Code 99285
Dates of Service: July 1, 2016 – June 30, 2017

<table>
<thead>
<tr>
<th>Number of Services with CPT® Code 99285</th>
<th>Total Number of Services</th>
<th>Your Percent</th>
<th>Your State’s Percent</th>
<th>Comparison with Your State</th>
<th>National Percent</th>
<th>Comparison with National Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>267</td>
<td>456</td>
<td>59%</td>
<td>50%</td>
<td>Significantly Higher</td>
<td>55%</td>
<td>Higher</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha = 0.05.
Copy Pasting Cloning

Office of Inspector General OIG

Inappropriate copy pasting could inflate claims to support billing higher service levels.

Identical notations were noted for different patients with different problems. In several instances language was exactly the same. Most of the physical exam was identical.

CMS Contractor

Cloned documentation: it would not be expected the same patient had the same exact problem, symptoms, and required the exact same documentation on every encounter.

Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Pitfall: Copy Pasting Cloning

Identical notations were noted for different patients with different problems. In several instances language was exactly the same. Most of the physical exam was identical.

Thank you for taking the time to meet with the Fraud Investigation and Prevention Unit (“FIP”) of Blue Cross and Blue Shield.

In brief, FIP has found:

1. A significant portion of the computer generated documentation submitted by you to FIP for Evaluation and Management (“E/M”) services appeared to be pre-populated or copied.

Based on the medical record review that FIP conducted, and as a result of the insufficient documentation found in your medical records and incorrect coding and billing, repayment of $________ to BCBS________ overpayments made to ________
The History and Acuity Caveats

“If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstances which precludes obtaining a history.”

CMS 1995 Documentation Guidelines

- 99285 requires:
  - Comprehensive History
  - Comprehensive Exam
  - High Level Medical Decision Making

*Emergency department visit* for the evaluation and management of a patient, which requires these three key components *within the constraints imposed by the urgency* of the patient’s clinical condition and/or mental status.

CPT 2019
**Documentation Best Practice:**
**Defending the Patient’s Acuity**

- Document a differential diagnosis:
  - Chest pain: ACS, GERD, Pneumothorax, PE

- Clearly state co-morbidities
  - IDDM, Htn, Lymphoma

- Be aware of diagnoses qualifying as high risk
  - Abrupt change in mental status
    - (seizure, TIA, weakness, numbness)

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**Auditor Downcoded to 99284:**
“lacks medical decision making”

**HPI** – 52 year old obese male presents with upper epigastric discomfort and a feeling of indigestion for the past 4 hours. He has tried TUMS and Mylanta without relief. Associated signs and symptoms include diaphoresis and nausea.

**Medical Decision Making** – CBC with differential, Chem 7, Troponin, EKG and US of gallbladder. Reviewed nurses notes

**Plan** – Admit

**Diagnosis** – Chest pain

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No documentation of:
- risk with differential dx
- co-morbidities (HTN, smoker)
- old record review (old ekg)
- discussion w/ providers (Cards and Hospitalist)

Had episode of chest pain in the ER treated with SL NTG
HPI: 68 year old with PMH of CAD, HTn, and IDDM with several days of worsening lower extremity swelling. Also reports recent productive cough and low grade fever.

PE: Breath sounds + crackles bil bases, 2+ pitting edema to knees

DDx: ACS, CHF, pulmonary edema, pneumonia

MDM: CBC, CMP, BNP, Troponin, EKG, CXR obtained. EKG interpretation by ED provider: septal infarct age undetermined, CXR interpretation by ED provider: bil. basal infiltrates, BNP elevated at 864, Troponin neg.

ED Course: Treated with Lasix 80 mg IV and MSO4 2 mg IV BS 385 (Tx SQ Insulin)

Old record reviewed with summary: Previous admission last May for Pneumonia and renal insufficiency

Case discussed with DR XXX (IM/Cardiology) for admission with continuity of care

Final Diagnosis: CHF, Pneumonia

The Defense

- 4 HPI for most presentations
- Small or large macro for ROS and PE depending on complexity
- Differential Diagnosis
- Course of care and responses to treatment
- Review of data: labs, EKG, CXR, old record
- Conversations: EMS, Family, PCP, Hospitalist
"Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work."

- Must be performed in the physical presence of a teaching physician or resident

2019 Final Rule Teaching Physician Policy

“documentation requirements for E/M services furnished by teaching physicians are burdensome and duplicative of notations that may have previously been included in the medical records by residents or other members of the medical team.”

“The teaching physician continues to be responsible for reviewing and verifying the accuracy of notations previously included by residents and members of the medical team, along with further documenting the medical record if the notations previously provided did not accurately demonstrate the teaching physician’s involvement in an E/M service.”

-CMS Documentation Guideline Reform

- CMS Sought comment on changing the current documentation guidelines
- Specifically sought comment on whether it would be appropriate to remove our documentation requirements for the history and physical exam for all E/M visits at all levels. We stated that we believed MDM and time are the more significant factors in distinguishing visit levels, and that the need for extended histories and exams is being replaced by population-based screening and intervention.
**2019 Physician Final Rule: No Change To ED Codes**

"The proposed changes only apply to office/outpatient visit codes: CPT codes 99201 – 99215. We understand there are more unique issues to consider in other settings such as emergency department care. We may address sections of the E/M code set beyond the office/outpatient codes in future years."

-2019 Physician Rule

- 2019 and 2020 No changes to any E/M codes
- 2021 office visit codes move away from the 1995 guidelines
  - Time and Medical Decision Making
- Collapsed payment level for new/established patient
  - Level 2-4 one rate and level 5 one rate

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**2019 Compressed Payment and Documentation Requirements for Office Codes**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$76</td>
<td>$130</td>
<td>$45</td>
<td>$197 (at 38 minutes)</td>
<td>$210</td>
</tr>
<tr>
<td>Level 3</td>
<td>$110</td>
<td>$170</td>
<td>$44</td>
<td>$197 (at 38 minutes)</td>
<td>$210</td>
</tr>
<tr>
<td>Level 4</td>
<td>$167</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>$211</td>
<td></td>
<td></td>
<td></td>
<td>$344 (at 90 minutes)</td>
</tr>
<tr>
<td><strong>Established Patient</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$45</td>
<td>$100</td>
<td>$45</td>
<td>$157 (at 34 minutes)</td>
<td>$170</td>
</tr>
<tr>
<td>Level 3</td>
<td>$74</td>
<td>$103</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>$109</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>$148</td>
<td></td>
<td></td>
<td></td>
<td>$281 (at 70 minutes)</td>
</tr>
</tbody>
</table>
2019 RBRVS Equation

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

\[ RVU_{\text{Total}} \times \text{Conv. Factor} = \text{Medicare Payment} \]

Medicare Payment per RVU: Conversion Factor Update

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- REPEALED SGR – no more 21% cuts
- 2016-2019 ½% increases to the conversion factor
  - 2018 ACCESS Act cut the 2019 0.5% increase to 0.25%
- PQRS, VBM, and EHR incentive programs rolled up
- Merit Based Incentive Payment System (MIPS)
  - 2018 data → 2020 payment +/- 5%
  - 2019 data → 2021 payment +/- 7%
2019 Conversion Factor

2017 $35.8887
2018 $35.9996

TABLE 92: Calculation of the Final CY 2019 PFS Conversion Factor

<table>
<thead>
<tr>
<th>CY 2018 Conversion Factor</th>
<th>35.9996</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Update Factor * MACRA</td>
<td>0.25 percent (1.0025)</td>
</tr>
<tr>
<td>CY 2019 RVU Budget Neutrality Adjustment</td>
<td>-0.14 percent (0.9986)</td>
</tr>
</tbody>
</table>

* Balanced Budget Act of 2018 reduced the 0.5% MACRA Update to 0.25%

2019 RVUs Stable

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>99281</td>
<td>0.45</td>
<td>0.45</td>
<td>0.11</td>
<td>0.11</td>
<td>0.04</td>
<td>0.04</td>
<td>0.60</td>
<td>0.60</td>
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<tr>
<td>99282</td>
<td>0.88</td>
<td>0.88</td>
<td>0.21</td>
<td>0.21</td>
<td>0.08</td>
<td>0.08</td>
<td>1.17</td>
<td>1.17</td>
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<td>99283</td>
<td>1.34</td>
<td>1.34</td>
<td>0.29</td>
<td>0.29</td>
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<td>0.12</td>
<td>1.75</td>
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<tr>
<td>99284</td>
<td>2.56</td>
<td>2.56</td>
<td>0.53</td>
<td>0.53</td>
<td>0.23</td>
<td>0.23</td>
<td>3.32</td>
<td>3.32</td>
</tr>
<tr>
<td>99285</td>
<td>3.80</td>
<td>3.80</td>
<td>0.75</td>
<td>0.74</td>
<td>0.34</td>
<td>0.35</td>
<td>4.89</td>
<td>4.89</td>
</tr>
<tr>
<td>99291</td>
<td>4.50</td>
<td>4.50</td>
<td>1.42</td>
<td><strong>1.39</strong></td>
<td>0.38</td>
<td><strong>0.39</strong></td>
<td>6.30</td>
<td><strong>6.28</strong></td>
</tr>
</tbody>
</table>
## 2019 Emergency Medicine Revenue Stable

### TABLE 94: CY 2019 PFS Estimated Impact on Total Allowed Charges by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(A) Allowed Charges (mil)</th>
<th>(B) Impact of Work RVU Changes</th>
<th>(C) Impact of PE RVU Changes</th>
<th>(D) Impact of MP RVU Changes</th>
<th>(E) Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy/Immunology</td>
<td>$239</td>
<td>0%</td>
<td>-1%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>$31,852</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Audiologist</td>
<td>$88</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>$293</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$6,016</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$7,614</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>$775</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>$728</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Colon And Rectal Surgery</td>
<td>$168</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>$342</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>$3,400</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Diagnostic Testing Facility</td>
<td>$721</td>
<td>0%</td>
<td>-5%</td>
<td>0%</td>
<td>-5%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>$3,121</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>$482</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>$5,317</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$7,754</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>General Practice</td>
<td>$428</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>$2,000</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Genomics</td>
<td>$157</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Head Surgery</td>
<td>$214</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>$3,741</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>$636</td>
<td>0%</td>
<td>2%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Infections Disease</td>
<td>$549</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>$10,766</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Comments on ED E/M code listed in the 2019 final rule include:

- Intensity, and not time, is the main determinant of code level in emergency departments
- Refocusing documentation on presenting conditions and medical decision-making
- There is no established relationship with the patient and differential diagnosis is critical to rule out many life-threatening conditions

The main issue is not that the emergency department visit codes themselves are undervalued. Rather, these commenters noted that a greater percentage of emergency department visits are at a higher acuity level, yet payers often do not pay at a higher level of care and the visit is often inappropriately down-coded based on retrospective review.
CMS Not Finalizing All Proposals -YAY!

We note that our original proposal was developed more generally to maintain overall RVUs within the codes describing office/outpatient visits, but, after consideration of public comments, we are not finalizing several elements of those proposals, including and especially the multiple procedure payment reduction. As a result, implementation with the values and policies as altered, would require off-setting reductions in overall PFS payments. Following our current methodology, these reductions, required by statute, would be applied through a budget neutrality adjustment in the PFS CF, consistent with our established methodology. As a result of such an adjustment, specialties that do not furnish office/outpatient visits generally would see overall reductions in payment of approximately 2.0 percent, as generally reflected in the Table 95.

Dodged a Bullet— for Now

As discussed in section II.H., of this final rule, based on the statements by commenters that the medical community, through the CPT process, has committed itself to considering revisions to the office/outpatient visit codes and given the history of collaboration between CMS and the medical community, we expect to consider any possible changes in CPT coding, as well as recommendations regarding valuation for services, from the RUC and other stakeholders, through our annual rulemaking process, between now and implementation for CY 2021. We note that any potential coding changes, and recommendations in overall valuation for new or existing codes, could have significant impact on the actual change in overall RVUs for office/outpatient visits relative to the rest of the PFS.
If the Proposed Rule Provisions Had Been Accepted

If the Proposed Rule Provisions Had Been Accepted

Geographic practice cost index (GPCI)

- Reflects the cost differential for providing services in different localities
  - i.e. New York City, NY vs. Madison, WS
  - (1.052, 1.180, 1.615) vs. (1.000, 0.957, 0.347)

- 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
For quite a few years there has been a GPCI floor of 1.0 to support rural hospitals and emergency departments.

Required yearly congressional fixes - not in 2018 Final Rule.


2019 GPCI Floor Update

<table>
<thead>
<tr>
<th>MAC</th>
<th>Locality Number</th>
<th>Locality Name</th>
<th>PW GPCI with 1.0 Floor</th>
<th>PE GPCI</th>
<th>MP GPCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0112</td>
<td>00</td>
<td>ALABAMA</td>
<td>1.000</td>
<td>0.250</td>
<td>0.402</td>
</tr>
<tr>
<td>02102</td>
<td>01</td>
<td>ALASKA**</td>
<td>1.500</td>
<td>1.117</td>
<td>0.708</td>
</tr>
<tr>
<td>03102</td>
<td>00</td>
<td>ARIZONA</td>
<td>1.000</td>
<td>0.971</td>
<td>0.834</td>
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<tr>
<td>07102</td>
<td>73</td>
<td>ARKANSAS</td>
<td>1.000</td>
<td>0.872</td>
<td>0.578</td>
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<tr>
<td>02202</td>
<td>01</td>
<td>DETROIT, MI</td>
<td>1.000</td>
<td>0.969</td>
<td>1.601</td>
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<tr>
<td>02292</td>
<td>99</td>
<td>REST OF MICHIGAN</td>
<td>1.000</td>
<td>0.912</td>
<td>1.018</td>
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<td>00202</td>
<td>00</td>
<td>MINNESOTA</td>
<td>1.000</td>
<td>1.011</td>
<td>0.362</td>
</tr>
<tr>
<td>03202</td>
<td>01</td>
<td>MONTANA***</td>
<td>1.000</td>
<td>1.000</td>
<td>1.631</td>
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<tr>
<td>05402</td>
<td>00</td>
<td>NEBRASKA</td>
<td>1.000</td>
<td>0.910</td>
<td>0.319</td>
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<tr>
<td>03312</td>
<td>00</td>
<td>NEVADA***</td>
<td>1.000</td>
<td>1.017</td>
<td>0.969</td>
</tr>
</tbody>
</table>

Example: 99284 Michigan Payment 2019

\[(\text{Work RVUs}) \times (\text{Work GPCI}) + \]
\[(\text{Practice Expense RVUs}) \times (\text{PE GPCI}) + \]
\[(\text{Liability Insurance RVUs}) \times (\text{PLI GPCI}) = \text{Total RVUs}\]

\[
(2.56)(1.000) \\
(0.53)(0.919) \\
+(0.23)(1.018) = 3.28 \text{ Total Adjusted RVUs}
\]

\[(\text{Total RVUs}) \times (\text{Conversion Factor}) = \text{Medicare Payment}\]
\[(3.28) \times ($36.039) = $121.68 \text{ in Non- Detroit Michigan}\]

Congressional GPCI Floor legislation.
"We agree with the majority of commenters that these services may be potentially misvalued given the increased acuity of the patient population and the heterogeneity of the sites where emergency department visits are furnished. As a result, we look forward to reviewing the RUC’s recommendations regarding the appropriate valuation of these services for our consideration in future notice and comment rulemaking.

“Additionally, regarding the commenters’ concerns about documentation guidelines for E/M services, we refer readers to section II.I for details regarding our comment solicitation on documentation for E/M guidelines more generally.”

- 2018 Physician Final Rule page 166/1250

ED E/M Work RVU Review in 2018

How Important Are Work RVUs to E Med?

E Med has the highest percentage of Work to Total RVUs of any specialty since we have limited practice expense.
2019/2020 the RUC Cycle and Next Steps

2020 Payments

Current Step

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ED E/M Code Revaluation for 2020

- Codes 99281-99285 were reviewed by the RUC in April 2018
- Look for CMS comment in the 2020 NPRM and Final Rule for the Medicare PFS
- That valuation could be impacted by the current proposal to collapse payment and documentation requirements for office based codes
- Revised Documentation Guidelines are under current consideration by a joint CPT RUC Workgroup
Status of Recent Codes Identified as Misvalued

Potentially Misvalued Services Project

- Codes under Review, 131, 6%
- Deleted, 410, 17%
- Decreased, 953, 41%
- Increased, 210, 9%
- Reaffirmed, 647, 27%

2019 CPT Update
2019 CPT Update

Effective for dates of service
January 1, 2019

- New code (172)
- Deleted code (82)
- Revised code (60)
- Contains new or revised text
- FDA approval pending
- Resequenced code
- Appendix P Telemedicine code

PICC Line Code Changes

- New preamble in CPT 19 for Peripherally Inserted Central venous Catheters (PICCs)
- Maybe placed with or without imaging
- Use codes 36568 or 36569 for PICCS w/o imaging
- Use codes 36572, 36573, 36584 for PICCs with imaging (e.g. ultrasound or fluoroscopy). When reporting a with imaging guidance you must show documentation of images, associated supervision and interpretation and final positioning of the catheter
- For ultrasound that includes real-time visualization of the needle entry into the vein
PICC Line Code Changes

- ▲ 36568: Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age
- ▲ 36569: age 5 years or older
- # 36572: Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age
- # 36573: age 5 years or older

2019 Flu Vaccine Update

- Now 18 different codes for Influenza Virus Injections
- CPT codes 99053 – 90674
- Some are Resequenced (90600, 90672, 90661)
  - 90672: Code is out of numerical sequence. See 90658-90664
  - 90673: Code is out of numerical sequence. See 90658-90664
  - 90674: Code is out of numerical sequence. See 90658-90664
- Some with FDA approval pending:
  - ✔ 90666: Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use
2019 ICD-10 Update

- ICD-10 is updated Oct. 1- already live!
- ED relevant codes added, deleted or revised
  - Mental /Behavioral
  - Cerebral Infarction
  - Appendicitis

2019 ICD-10 Update- Mental/ Behavioral

- Mental Behavioral
  - New codes for Cannabis use
    - F12.23 Cannabis dependence with withdrawal
    - F12.93 Cannabis use, unspecified with withdrawal
  - New code for Postpartum depression
    - F53.0 Postpartum depression
2019 ICD-10 Update- Cerebral Infarction

- New Cerebral infarction code
- I63.81 Other cerebral infarction due to occlusion or stenosis of small artery
- Other cerebral infarction code changed from I63.8 to I63.89

2019 ICD-10 Update- Appendicitis

- Several new appendicitis codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K3520</td>
<td>Acute appendicitis with generalized peritonitis, without abscess</td>
</tr>
<tr>
<td>K3521</td>
<td>Acute appendicitis with generalized peritonitis, with abscess</td>
</tr>
<tr>
<td>K3530</td>
<td>Acute appendicitis with localized peritonitis, without perforation or gangrene</td>
</tr>
<tr>
<td>K3531</td>
<td>Acute appendicitis with localized peritonitis and gangrene, without perforation</td>
</tr>
<tr>
<td>K3532</td>
<td>Acute appendicitis with perforation and localized peritonitis, without abscess</td>
</tr>
<tr>
<td>K3533</td>
<td>Acute appendicitis with perforation and localized peritonitis, with abscess</td>
</tr>
<tr>
<td>K35890</td>
<td>Other acute appendicitis without perforation or gangrene</td>
</tr>
<tr>
<td>K35891</td>
<td>Other acute appendicitis without perforation, with gangrene</td>
</tr>
</tbody>
</table>
Updated specificity for post procedure infections

- Examples:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T8140XA</td>
<td>Infection following a procedure, unspecified, initial encounter</td>
</tr>
<tr>
<td>T8141XA</td>
<td>Infection following a procedure, superficial incisional surgical site, initial encounter</td>
</tr>
<tr>
<td>T8144XA</td>
<td>Sepsis following a procedure, initial encounter</td>
</tr>
<tr>
<td>T8149XA</td>
<td>Infection following a procedure, other surgical site, initial encounter</td>
</tr>
</tbody>
</table>

- Codes available for other types of procedure
- Codes available for subsequent and sequela

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Summary Regulatory Update & Good News!

- March- 2018: “Students May document services in the medical record”. TP must perform the PE and MDM
  - Medicare Transmittal R3971
- May 2018: “The treating signature on a Scribe note indicates that the physician affirms the note adequately documents the care provided. “
  - Medicare transmittal 751
- 2019 “The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by a physician, resident, or nurse.”
WPS FAQ on Scribes

WPS FAQ

**Question**- If a physician or non-physician practitioner (NPP) uses a scribe to document the services he or she provides, does the scribe need to sign the medical record?

**Answer**- When a physician or NPP uses a scribe in documenting medical record entries, the scribe does not need to sign and date the documentation. The treating physician’s or NPP’s signature on a note indicates that the provider affirms the note adequately documents the care provided.

2019 Proposal to Lessen Teaching Physician Documentation Requirements

CMS Proposal: “The medical records must document that the teaching physician was present at the time the service is furnished. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by a physician, resident, or nurse.”

- 2019 Physician Proposed Rule page 376/1473
2019 Who Is a Student?

- New CMS Transmittal 4068 released May 2018 replacing Transmittal 3971 released in Feb. 2018
- Deals with E/M Documentation provided by students
- Does not restrict the new rule to just “medical students”, so a teaching physician could perhaps be able to use NP and PA student documentation
- ACEP has asked for clarification that is supportive of our educational mission. In the meantime, you are advised to check with your local payers for guidance

2019 Forecasting the Conversion Factor: RVU Budget Neutrality

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve budget neutrality which for 2018 is .10%

- Medicare Physician Final Rule, page 1149
PAMA- (Protecting Access To Medicare Act)- annual target for reductions in PFS expenditures resulting from adjustments to relative values of misvalued codes. We estimate the CY 2018 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.41 percent. Does not meet the 0.5 percent target. Payments under the fee schedule must be reduced by the target recapture amount. As a result, we estimate that the CY 2018 target recapture amount will produce a reduction to the conversion factor of -0.09%.

- Physician Final Rule page 1148