2020 Reimbursement Strategies

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The Is Who We Are!
The Safety Net

140 million visits, 39 million related to injury, >60% of hospital admissions, 4% of the work force - >50% of the care for Medicaid and CHIP
National CMS Comparative Billing Report (CBR) Program

RELI Group
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
cbrsupport@eglobaltech.com
Write to the return address above

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with eGlobalTech, a professional services firm, to develop Comparative Billing Reports (CBRs).

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

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
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>
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<tbody>
<tr>
<td>358</td>
<td>585</td>
<td>61%</td>
<td>61%</td>
<td>Does Not Exceed</td>
<td>55%</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

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

MI Specific Benchmarks Phase 1

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

- Modifier 25- 13% of claims
- Average Allowable- $145.75
- Percentage of 99285- 56%
Comparative Billing Report:
Phase 2 June 2019

Compares Your Group to State and National Average
1. 99285%
2. Modifier 25
3. Average Allowed Charges

<table>
<thead>
<tr>
<th>Topic Reviewed</th>
<th>MI</th>
<th>National</th>
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<tbody>
<tr>
<td>Percentage of Services Billed with CPT® Code 99285</td>
<td>49.51%</td>
<td>46.53%</td>
</tr>
<tr>
<td>Percentage of Services Appended with Modifier 25</td>
<td>12.76%</td>
<td>10.44%</td>
</tr>
<tr>
<td>Avg. Allowed Charges Medicare Part B Services, per Visit</td>
<td>$133.20</td>
<td>$126.93</td>
</tr>
</tbody>
</table>

How To Get Your CBR

- https://cbrfile.cbrpepper.org/
CMS - Target Probe and Educate

If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).

The MAC will review 20-40 of your claims and supporting medical records.

If compliant, you will not be reviewed again for at least 1 year on the selected topic.*

You will be given at least a 45-day period to make changes and improve.

If some claims are denied, you will be invited to a one-on-one education session.

Up To 3 Rounds

*MACs may conduct additional review if significant changes in provider billing are detected.

TPE Error Rate Consequences

- After three rounds of review and continued high denial rates CMS may instruct the MAC for additional action which could include:
  - Extrapolation
  - Referral to the Zone Program Integrity Contractor or Unified Program Integrity Contractor
  - Referral to the Recovery Audit Contractor
  - 100% prepay review
Pitfall: Medical Necessity

Targeted Probe and Educate

Dear Provider,

You are receiving this letter for educational purposes. Your claim was medically reviewed via an Additional Documentation Request (ADR) and denied because of the errors listed below for Part B services for Edit ID 2284.

The Granular Error Denial table details the reason for denial. The Granular Error Education table provides additional information.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Date of Service</th>
<th>Granular Error Denial</th>
<th>Denial Code and Description</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Documentation received lacks high complexity decision making to support vital system function to prevent further life threatening deterioration.</td>
<td>[NOTMN] - Documentation does not support Medical Necessity (no LCD used)</td>
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</table>

The Defense
**Documentation Guidelines: Practical Application**

<table>
<thead>
<tr>
<th>Level</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSHx</th>
<th>PE</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>5</td>
<td>4</td>
<td>10</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

**Defense Tools: CMS & CPT Documentation**

“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 2020
Medical Decision Making Contributors

- Differential diagnosis
- Course of care and responses to treatment
- Conversations: EMS, Family, PCP, Hospitalist
- Severity of presentation
  - Abnormal vitals
  - Patient discomfort

Medical Decision Making Area To Focus: Amount or Complexity of Data

- Review and Summarization of old records 2 POINTS
  - Last ED Visit, Old EKG, Old x-ray Reports
  - DC Summary...write a brief summary
  - 9.3.2019 admit for Cheat Pain, Stress test negative

- Obtaining history from someone else or discussion of case with another health provider 2 POINTS
  - Admitting physician
  - Family (meds, allergies, course of illness)
  - PMD (meds and Past Hx)
  - NH notes- summarize
  - EMS run sheets- vitals, “call went out for...” and interventions
HPI – 47 year old female with jaw pain, dyspnea and nausea.


Plan – Admit

Diagnosis –
Jaw pain, Dyspnea, Nausea

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 pressure and diaphoresis in the ER treated with SL NTG

92 year old with PMH of SAH, HTN and cardiac arrhythmia. Presented after possible syncopal episode and fall.

PE: slightly confused, neck and Right hip pain

DDx: ICH, Cardiac event, PE, Hip fracture

MDM: CT Head, neck and pelvis eval. For bleed and Fx. CBC, CMP, BNP, Troponin, EKG, CXR obtained. EKG interpretation by ED provider. ED Course: Creatinine 1.9. (compared to baseline 1.2). Mental status back to baseline. CTs negative. Plan admission with tele monitoring and rehydration.

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

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

Final Diagnosis: Syncope, hip contusion, renal insufficiency.
Documentation Best Practices

- 4 HPI for most presentations
- Small or large macro for ROS and PE depending on complexity
- Completed Past Medical and Social Hx
  - Family Hx as relevant
- Recognize Hx and acuity caveat opportunities
- Robust medical decision making
  - Combined with Hx/PE = LEVEL

Regulatory Good News!
A Letter to Doctors
CMS Administrator Seema Verma

Dear Doctor,

Washington is to blame for many of the frustrations with the current system, as policies that have been put forth as solutions either have not worked or have moved us in the opposite direction. Electronic Health Records were supposed to make it easier for you to record notes, and the government spent $30 billion to encourage their uptake. The increasing requirements for information that must be documented – has turned this tool into a serious distraction from patient care.

Student Documentation Now Acceptable

“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 duplicative of notations that may have previously been included 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.”

-2019 Physician Final Rule page 638/2378

April e mail with CMS for clarity

April CMS Inquiry and Response

(1) If a teaching physician saw the patient, reviewed and verified notations by the resident, do they still have to write a personal attestation to support a Medicare part B service or is this now optional?

- In the absence of national policy, we defer to the local Medicare Administrative Contractors (MACs). Providers may wish to contact their local MAC for guidance related to their specific situations.

 ― We are working to update the Medicare Claims Processing Manual consistent with the regulatory changes made as part of the CY 2019 PFS Final Rule.”
July CPT Assistant Update: Observation and Mental Health

Resources Follow Revenue

- Historically No clear direction re coding multi day mental health “borders” or “psych holds”
- CPT Behavioral Health Vignette:
  - No Beds and has a 3 day ED stay
- Asked CPT how to report a 3 day “psych hold”

**Official Answer**
- Obs day 1 99218-99220
- Middle days 99224-99226
- Final day 99217

- 5 day stay 4.89 RVUs ➔ 13.47 RVUs
We agree with the majority of commenters that ED 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.

- Physician Final Rule page 166/1250
The Room Where It Happens

ACEP RUC team made robust arguments related to the increased acuity of our patients.

The RUC accepted our survey data and recommended an RVU increase.

CMS has accepted the RUC’s recommendation.

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<td>0.48</td>
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<tr>
<td>99285</td>
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<td>3.80</td>
<td>0.74</td>
<td>0.71</td>
<td>0.35</td>
<td>0.40</td>
<td>4.89</td>
<td>4.91</td>
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The 2020 Conversion Factor

2018 $35.9996
2019 $36.0391
2020 $36.0896

TABLE 117: Calculation of the CY 2020 PFS Conversion Factor

<table>
<thead>
<tr>
<th>CY 2019 Conversion Factor</th>
<th>36.0896</th>
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<tbody>
<tr>
<td>Summary Update Factor</td>
<td>0.00%</td>
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<tr>
<td>CY 2020 RVU Budget Neutral Adjustment</td>
<td>0.14%</td>
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<tr>
<td>CY 2020 Conversion Factor</td>
<td></td>
</tr>
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</table>

2020 Conversion Factor and RVU Increases

2020 ED E/M Payment Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>2019 Payment</th>
<th>2020 Payment</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>$21.62</td>
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<td>99285</td>
<td>$176.23</td>
<td>$178.28</td>
<td>+2.05</td>
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2020 CMS MIPS Payment Impact

Fee Schedule

2020 $36.0896

No change

+0.25%
or 0.75%

MIPS

PQRS/VM/MU
Max Adjustment
(+/-)

QP in Advanced APM

+5% bonus
(excluded from MIPS)

DOCUMENTATION & CODING
2020 Increases With Each E/M Level

99281
99282
99283
99284
99285
99291

$23.10
$44.39
$67.85
$121.62
$178.28
$227.84
The Future of The Conversion Factor

Forecasting the Future 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...

- Medicare Physician Final Rule
2021 Office Visit Code Are Increasing: Ramifications?

- Office visit codes represent 20% of total Medicare physician expenditures
- “The AMA RUC-recommended values will increase payment for office/outpatient E/M visits in 2021.” Physician Final Rule page 888/2475
- Budget neutrality triggered with a decrease in the conversion factor
- Those not billing the office visits codes will be negatively impacted.
- “Many commenters expressed concerns about the redistributive impact of revaluing the office/outpatient E/M visit code set, particularly for practitioners who do not routinely bill office/outpatient E/M visits.” Physician Final Rule page 888/2475

The RUC Concept of Relativity

99213 reference code revalued $75 → $90
Relativity Strategy

Proposal: CMS proposed to increase the value of the ED E/M codes, consistent with recommendations made by the American Medical Association (AMA) Relative Value Scale (RVS) Update Committee (RUC).

ACEP Response:

- We thanked CMS for recognizing the RUC’s recommended increase in the valuation of these codes.
- But as discussed in the “Payment for Office and Outpatient E/M Visits” section below, we urged CMS to finalize an additional increase in the ED E/M codes to maintain the relative value between the new patient office and outpatient codes proposed for CY 2021 and the ED E/M codes.

Coalition Letter

August 15, 2019

Sonja Verna, MPH
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1715-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Policies for CY 2021 for Office/Outpatient E/M Visits in the CY 2020 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Verna:

On behalf of 53 organizations we write to express our strong opposition to the CMS proposal not to incorporate the adjusted values of the office E/M services for other E/M services and procedures.
Future Direction and Approach

“These revised codes and values do not take effect until 2021. We believe it would be premature to finalize a strategy in this final rule as these values would not be effective until 2021. However, we intend to consider these concerns and address them in future rulemaking.”  

Physician Final Rule page 888/2475

“We are considering updating other E/M visits to maintain relativity with the revalued office/outpatient E/M code set as part of CY 2021 PFS rulemaking”  

Physician Final Rule page 889/2475

2020 CPT Update
2020 CPT Update

Effective for dates of service January 1, 2020

- New code (248)
- Deleted code (71)
- Revised code (75)
- Contains new or revised text
- FDA approval pending
- Resequenced code
- Appendix P Telemedicine code

2020 Revision of Nerve Injection Codes

- **Revised:** 64400-64450 Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (i.e., ophthalmic, maxillary, mandibular)

All remaining nerve injections (CPT 64400-64450) have addition of “and/or steroid” to code descriptor.

Example:

- 64450- Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve branch
2020 Pericardiocentesis Code Changes

- New unifying code which adds the description of including imaging guidance and deletion of 4 codes

New Code:
- **33016** Pericardiocentesis, including imaging guidance, when performed

Deleted codes:
- **33010** Pericardiocentesis: initial
- **33011** Pericardiocentesis: subsequent
- **33015** Tube pericardiostomy
- **76930** Ultrasound guidance for pericardiocentesis

Additional New Codes of Interest

Flu vaccine formulation for 2020 season
- **90694** - Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

Needle insertion not requiring an injection
- **20560** Needle insertion(s) without injection(s); 1 or 2 muscle(s)
- **20561** Needle insertion(s) without injection(s); 3 or more muscles
2019-2020 ICD 10 Update

October 1, 2019

- 273 additions,
- 30 code revisions
- 21 deletions

2020 ICD-10 Update

- ICD-10 is updated Oct. 1 - already live!

  ED relevant codes added, deleted or revised

- Atrial fibrillation
- Phlebitis/thrombophlebitis
- Cyclical vomiting
- Orbital Fracture
- Heatstroke/sunstroke
- Vaping Considerations
Conclusions

- Document Medical Decision Making
  - Will be increasingly important!
- ED RVUs are increasing
- The 2020 Conversion factor is Increasing
- 2021 Office Visit code changes will have a big impact
- Stay Tuned!

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781.280.1575
Educational Appendix

2020 Lumbar Puncture Code Changes

- New codes for Lumbar Puncture that include fluoroscopic or CT guidance

New codes:
- 62328 - Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance
- 62329 - Spinal puncture, lumbar, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter; with fluoroscopic or CT guidance
2020 ICD-10 Update- Atrial fibrillation

- New classifications for persistent and chronic atrial fibrillation
  - Persistent Atrial Fibrillation
    • I48.11 Longstanding persistent atrial fibrillation
    • I48.19 Other persistent atrial fibrillation
    Former single code:
    I48.1 Persistent Atrial Fibrillation
  - Chronic Atrial Fibrillation
    • I48.20 Chronic atrial fibrillation, unspecified
    • I48.21 Permanent atrial fibrillation
    Former single code:
    I48.2 Chronic atrial fibrillation

2020 ICD-10 Update- Phlebitis/Thrombophlebitis

- Several new phlebitis/thrombophlebitis codes to allow for more specificity:
  - Phlebitis and thrombophlebitis of right peroneal vein
  - Phlebitis and thrombophlebitis of left peroneal vein
  - Phlebitis and thrombophlebitis of peroneal vein, bilateral
  - Phlebitis and thrombophlebitis of unspecified peroneal vein
  - Phlebitis and thrombophlebitis of right calf muscular vein
  - Phlebitis and thrombophlebitis of left calf muscular vein
  - Phlebitis and thrombophlebitis of calf muscular vein, bilateral
  - Phlebitis and thrombophlebitis of unspecified calf muscular vein
2020 ICD-10 Update- Orbital Fracture

- Several new codes added for orbital fractures
- Anatomical specificity:
  - roof
  - medial wall
  - lateral wall

Examples

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S02.122A</td>
<td>Fracture of orbital roof, left side, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.831A</td>
<td>Fracture of medial orbital wall, right side, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S02.841A</td>
<td>Fracture of lateral orbital wall, right side, initial encounter for closed fracture</td>
</tr>
</tbody>
</table>

Revised

S02.8xxx Fracture of other specified skull and facial bones

2020 ICD-10 Update- Heatstroke/Sunstroke

- Revised previous code of T67.0XXA Heatstroke and sunstroke
  - New: T67.01XA Heatstroke and sunstroke, initial encounter
- New classifications
  - Exertional
    T67.02XA Exertional heatstroke, initial encounter
  - Other
    T67.09XA Other heatstroke and sunstroke, initial encounter

Note: additional codes for subsequent encounter and sequela
2020 ICD-10 Update- Cyclical Vomiting

- New and Revised Cyclical Vomiting codes to differentiate presence or absence of migraine

Revised
- G43.A0 Cyclical vomiting, in migraine, not intractable
- G43.A1 Cyclical vomiting, in migraine, intractable

New
- R11.15 Cyclical vomiting syndrome unrelated to migraine

Vaping- Diagnosis Considerations

- Currently there are no specific ICD-10 codes for reporting vaping
- Considerations for reporting range from nicotine dependence to adverse events as well as injuries
- ICD-10 committee is continuing to look into changes for more specified diagnosis codes.
Vaping- Diagnosis Considerations

Diagnosis codes to consider for presentations related to vaping

- F17.290 Nicotine dependence, other tobacco products, uncomplicated
- T65.9x Toxic effect of unspecified substance
- T50.915x Adverse effects of multiple unspecified drugs, medicaments and biological substances
- F12.188 Cannabis abuse with other cannabis-induced disorder
- T40.7X5x Adverse effect of cannabis (derivatives)
- T20.00XA Burn of unspecified degree of head, face, and neck, unspecified site, initial encounter
- J69.1 Pneumonitis due to inhalation of oils or essences