2020 Reimbursement Strategies

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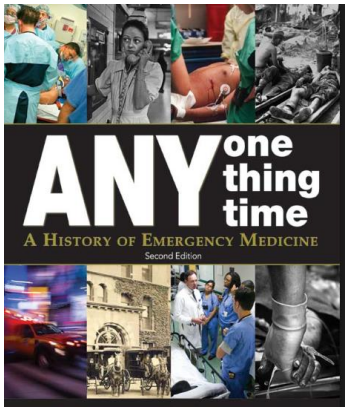
MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

1

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

2

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

3

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**

eGlobalTech

4

CBR Data Comparison Format

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

Number of Services with CPT® Code 99285	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
358	585	61%	61%	Does Not Exceed	55%	Significantly Higher

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

5

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%

6

Comparative Billing Report: Phase 2 June 2019

CBR 201906:

Emergency Department Services

Compares Your Group to State and National Average

1. 99285%
2. Modifier 25
3. Average Allowed Charges

Topic Reviewed	MI	National
Percentage of Services Billed with CPT® Code 99285	**49.51%**	46.53%
Percentage of Services Appended with Modifier 25	**12.76%**	10.44%
Avg. Allowed Charges Medicare Part B Services, per Visit	**$133.20**	$126.93

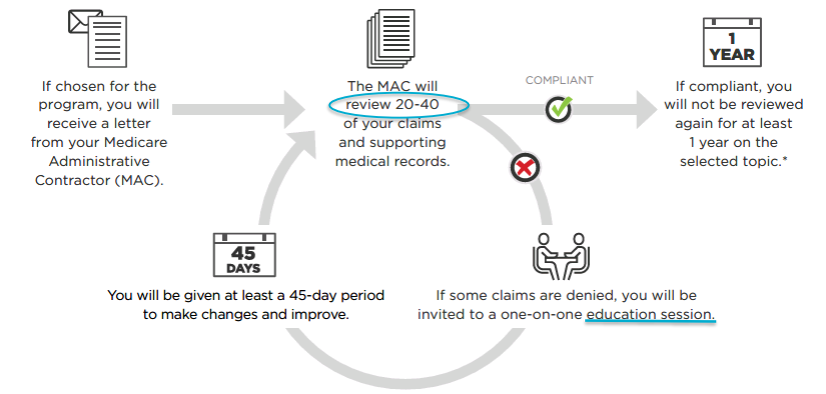
7

How To Get Your CBR

- https://cbrfile.cbrpepper.org/

8

CMS- Target Probe and Educate



Up To 3 Rounds

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

9

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

CMS CENTERS for MEDICARE & MEDICAID SERVICES

CMS CENTERS for MEDICARE & MEDICAID SERVICES

10

Pitfall: Medical Necessity

Targeted Probe and Educate

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

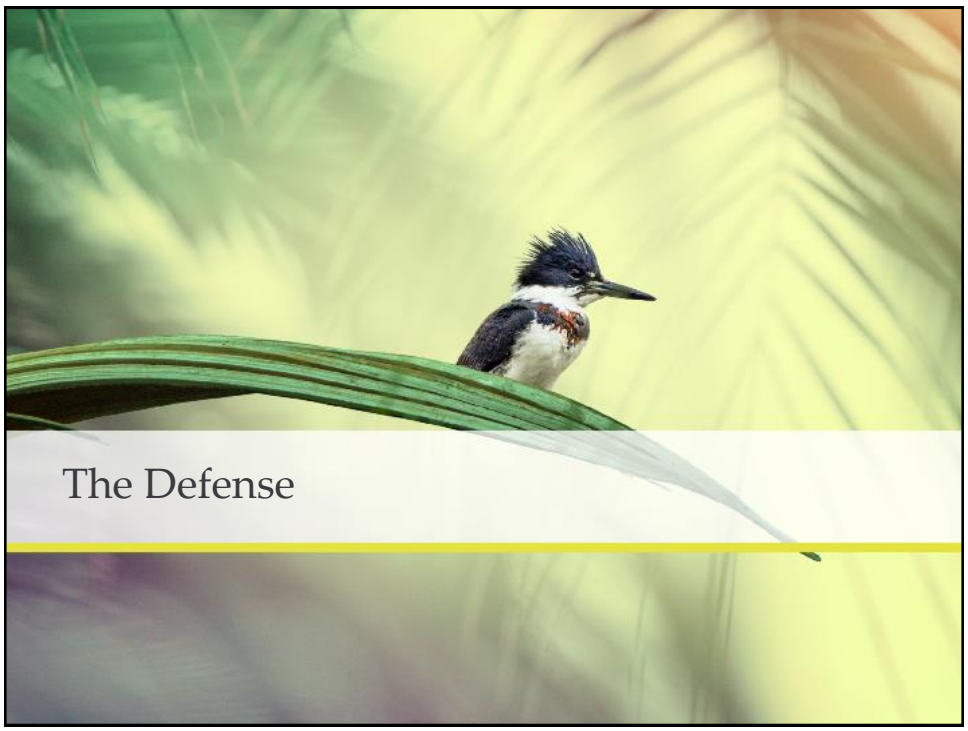
Dear Provider,

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.

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

11



12

Documentation Guidelines: Practical Application

Level	HPI	ROS	PFSHx	PE
1	1	0	0	1
2	1	1	0	2
3	1	1	0	2
4	4	2	1	5
5	4	10	2	8

13

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

14

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

15

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

16

Auditor Downcoded to 99284: "lacks medical decision making"

HPI – 47 year old female with jaw pain, dyspnea and nausea.

Medical Decision Making – CBC with differential, Chem 7, Troponin, EKG. Reviewed nurses notes.

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

17

99285 Upheld

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

PE: slightly confused, neck and Right hip pain

Extensive diff dx & high risk conditions

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

Data

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

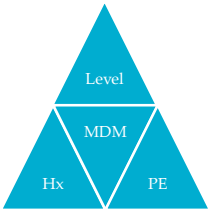
Final Diagnosis- Syncope, hip contusion, renal insufficiency.

Ongoing Additional Tx

18

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



19

Regulatory Good News!

20

Washington Is To Blame….

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.

21

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**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R808PI.pdf

22

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

23

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."

24

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4283	Date: April 26, 2019
	Change Request 11171

SUBJECT: Documentation of Evaluation and Management Services of Teaching Physicians

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 29, 2019

For purposes of payment, E/M services billed by teaching physicians require that *the medical records must demonstrate:*

- That the *teaching physician* performed the service or *was* physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

25

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

cpt Assistant

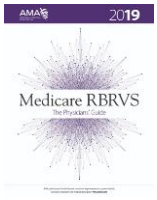
July 2019 Volume 29 Issue 7 page 10

26

2019/2020 RBRVS Equation

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

RVU_{Total} X Conv. Factor
= Medicare Payment



27

The RVUs: ED E/M Codes Felt To Be Undervalued

*"**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

28

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.

29

2020 RVUs Increasing

Code	2019 Work	2020 Work	2019 PE	2020 PE	2019 PLI	2020 PLI	2019 Total	2020 Total
99281	0.45	**0.48**	0.11	0.11	0.04	0.05	0.60	**0.64**
99282	0.88	**0.93**	0.21	0.21	0.08	0.09	1.17	**1.23**
99283	1.34	**1.42**	0.29	0.29	0.12	0.13	1.75	**1.84**
99284	2.56	**2.60**	0.53	0.51	0.23	0.27	3.32	**3.38**
99285	3.80	**3.80**	0.74	0.71	0.35	0.40	4.89	**4.91**

30

The 2020 Conversion Factor

2018 $35.9996
2019 $36.0391
2020 $36.0896

TABLE 117: Calculation of the CY 2020 PFS Conversion Factor

CY 2019 Conversion Factor		36.0391
Statutory Update Factor	0.00 percent (1.0000)	
CY 2020 RVU Budget Neutrality Adjustment	0.14 percent (1.0014)	
CY 2020 Conversion Factor		**36.0896**

31

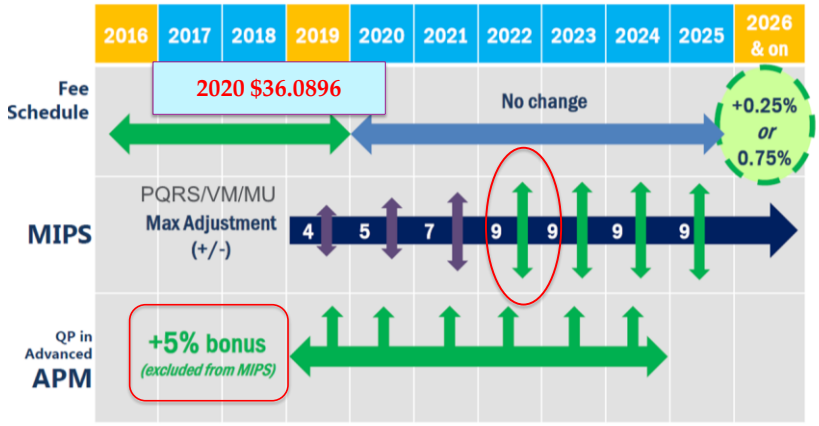
2020 Conversion Factor and RVU Increases

2020 ED E/M Payment Changes

Code	2019 Payment	2020 Payment	Change
99281	$21.62	$23.10	+1.48
99282	$42.17	$44.39	+2.22
99283	$63.07	$67.85	+4.78
99284	$119.65	$121.62	+1.97
99285	$176.23	$178.28	+2.05

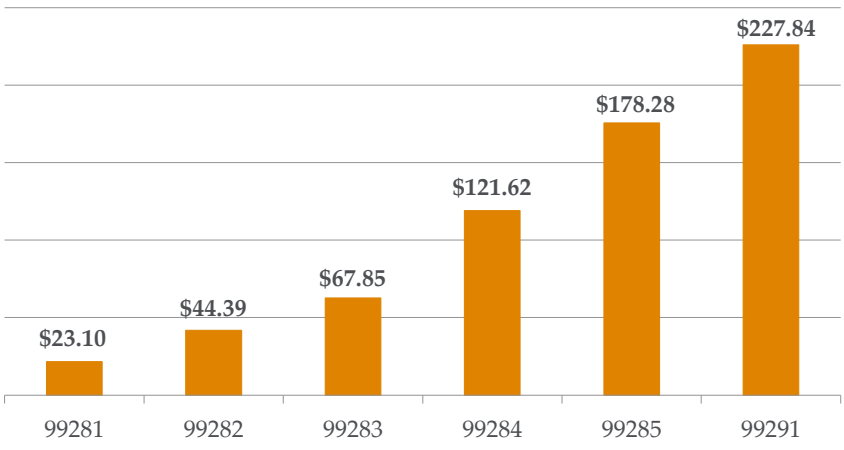
32

2020 CMS MIPS Payment Impact



33

DOCUMENTATION & CODING 2020 Increases With Each E/M Level



34

35

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

36

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 of 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**

37

The RUC Concept of Relativity

99213 reference code
revalued $75 ⟹ $90

38

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.

39

Coalition Letter

August 15, 2019

Seema Verma, 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 Verma:

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.

American College of Surgeons
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of PAs
American Academy of Physical Medicine and Rehabilitation
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Emergency Physicians ★

American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American Medical Association
American Orthopaedic Foot and Ankle Society
American Orthopaedic Society for Sports Medicine
American Pediatric Surgical Association
American Podiatric Medical Association
American Shoulder and Elbow Surgeons
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract & Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Dermatologic Surgery Association
American Society of General Surgeons
American Society of Metabolic and Bariatric Surgery
American Society of Plastic Surgeons
American Society of Retina Specialists
American Spinal Injury Association
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Heart Rhythm Society
J. Robert Gladden Orthopaedic Society
Limb Lengthening and Reconstruction Society
Musculoskeletal Infection Society
Musculoskeletal Tumor Society
North American Spine Society
Orthopaedic Rehabilitation Association
Orthopaedic Trauma Association
Pediatric Orthopaedic Society of North America
Ruth Jackson Orthopaedic Society
Scoliosis Research Society
Society for Maternal-Fetal Medicine
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)
Society of Gynecologic Oncologists
The Hip Society
The Knee Society
The Society of Thoracic Surgeons

40

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

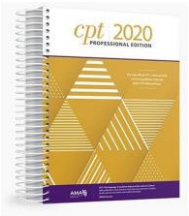
41

2020 CPT Update

42

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

43

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

44

2020 Pericardiocentesis Code Changes

- New unifying code which adds the description of **<u>including imaging guidance</u>** 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

45

Additional New Codes of Interest

<u>Flu vaccine formulation for 2020 season</u>

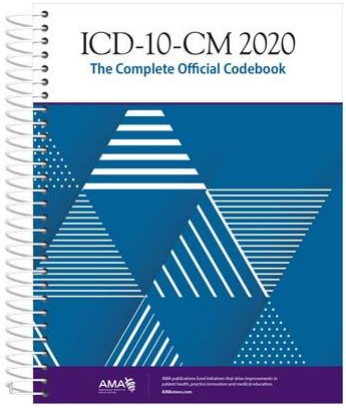
- **90694-** Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

<u>Needle insertion not requiring an injection</u>

- **20560** Needle insertion(s) without injection(s); 1 or 2 muscle(s)
- **20561** Needle insertion(s) without injection(s); 3 or more muscles

46

2019-2020 ICD 10 Update



October 1, 2019

- 273 additions,
- 30 code revisions
- 21 deletions

47

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

48

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!

49

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50

51

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

52

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

53

2020 ICD-10 Update- Phlebitis/Thrombophlebitis

- Several new phlebitis/thrombophlebitis codes to allow for more specificity:

I80.241	Phlebitis and thrombophlebitis of right peroneal vein
I80.242	Phlebitis and thrombophlebitis of left peroneal vein
I80.243	Phlebitis and thrombophlebitis of peroneal vein, bilateral
I80.249	Phlebitis and thrombophlebitis of unspecified peroneal vein
I80.251	Phlebitis and thrombophlebitis of right calf muscular vein
I80.252	Phlebitis and thrombophlebitis of left calf muscular vein
I80.253	Phlebitis and thrombophlebitis of calf muscular vein, bilateral
I80.259	Phlebitis and thrombophlebitis of unspecified calf muscular vein

54

2020 ICD-10 Update- Orbital Fracture

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

Examples

S02.122A	Fracture of orbital roof, left side, initial encounter for closed fracture
S02.831A	Fracture of medial orbital wall, right side, initial encounter for closed fracture
S02.841A	Fracture of lateral orbital wall, right side, initial encounter for closed fracture

Revised

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

55

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

56

2020 ICD-10 Update- Cyclical Vomiting

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

Revised

- G43.A0 Cyclical vomiting, **in migraine**, not intractable
- G43.A1Cyclical vomiting, **in migraine**, intractable

New

- R11.15 Cyclical vomiting syndrome unrelated to migraine

57

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.

58

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

59

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60