2021 Reimbursement Update and National Trends

Michael Granovsky MD, CPC, FACEP
President, LogixHealth

David McKenzie CAE
ACEP Director of Reimbursement

1

October 2020 COVID Statistics: Comparisons to January, 2020 Pre COVID Baseline

National Volume Data

- **ED:** Maximum decrease was ⬇48% nationwide from Jan, 2020 baseline
  - Positive trend: -20% from Jan, 2020 baseline
  - Down 16% year over year
- **Urgent Care:** Maximum decrease was ⬇76% from Jan, 2020 baseline
  - Some return towards Jan, 2020 baseline now -43%
  - Down 17% year over year
- **Peds ED:** Maximum decrease was ⬇70% from Jan, 2020 baseline
  - Stabilizing at -52% from Jan, 2020 baseline
  - Down 38% year over year
- **Testing:** Contributing to expanded access
  - ED visit, urgent care visit, Swab only visit

2

COVID Related ED Visit Trends

- Month of April: **25%-30%** of nationwide ED visits COVID related
- Month of May: **25%-30%** of nationwide ED visits COVID related
- Month of June: 17%-20% of nationwide ED visits COVID related
- Month of July: **20%-25%** of nationwide ED visits COVID related
- Month of August: 17% - 21% of nationwide ED visits COVID related

- Month of September: 15% - 19% of nationwide ED visits COVID related
- Month of October: **19% - 24%** of nationwide ED visits COVID related
- Month of November: **22% - 29%** of nationwide ED visits COVID related

3

Who Is Staying Home?
Compared with January, 2020 Baseline

4

COVID Treatment Monoclonal Antibody Bamlanivimab

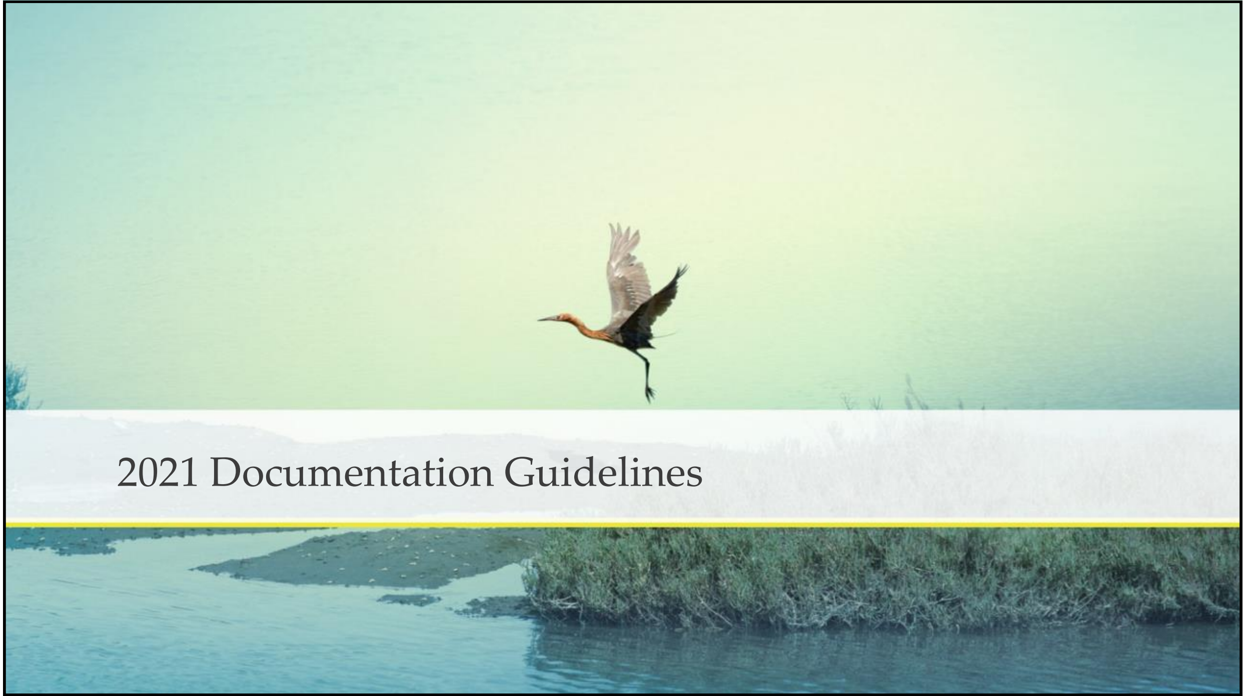
- COVID +, High Risk, only mild/moderate disease
- Runs in over 1 hour with minimum 1 hour of monitoring
  - Outpatient setting: ED, Infusion Center, Physician's Offices
- "Health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis" CMS Mab Infusion Instruction
- Hospital generally gets the drug for free – no DRUG charge
- Hospital charges to infuse drug, monitor the patient
  - M0239: Includes infusion and post administration monitoring
  - $309.60 CMS published fee schedule

5

COVID Treatment Monoclonal Antibody Bamlanivimab

- Patient identified through the course of ED 9928x encounter and qualify- Would be COVID positive, high risk, symptomatic
  - Medication requires monitoring (EUA, potential for anaphylaxis)
- Sent to ED from outside with a positive COVID test
  - High risk patient, COVID positive, with symptoms
  - Individual hospital work flows vary
  - ED patient - EMTALA considerations
  - Infusion is too short to meet the 8 hours for Obs
  - Likely not critical care as wouldn't qualify for the drug
    - Exception- complication of infusion
  - 9928X considerations- document an appropriate note

6



7

The Devil We Knew: 1995 Documentation Guidelines Going Away– For the Office Codes

25 Years Ago!

8

Office Code Changes
2021 Unified CMS AND CPT Documentation Guidelines

"2021, for office/outpatient E/M visits (CPT codes 99201-99215), we proposed generally to adopt the new coding, prefatory language, and interpretive guidance framework that has been **issued by the AMA/CPT** because we believed it would accomplish greater burden reduction."

Physician final rule page 868/2475

"Therefore, we are finalizing our proposal to adopt the MDM guidelines as revised by CPT to select office/outpatient E/M visit level beginning January 1, 2021."

Physician final rule page 868/2475

9

When Does the ED Transition to Updated Guidelines?

NO APPLICATION IN THE ED YET

"The proposed changes only apply to office codes: 99201 – 99215.

There are more unique issues to consider for the E/M code sets used in the emergency department care, such as unique clinical and legal issues.

We may address sections of the E/M code set beyond the office/outpatient codes in future years."

CMS Physician Rule page 332/1473

CPT RUC work group formed targeting 2023

10

MDM or Time Will Determine Office Code Choice

2021 Office Visit Code Scoring

"The CPT code changes allow clinicians to choose the E/M visit level based on either medical decision making or time." **2020 CMS Physician Final Rule Press Release**

1. Requires performance of history and exam only as medically appropriate

2. Allows clinicians to choose the E/M visit level:
   - Medical Decision Making ; OR
   - Time (appendix)

11

ED E/M Services and Time

Time as a Factor in the Emergency Department Setting

"Time is **not** a descriptive component for the emergency department levels of E/M services… Emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient."

CPT Coding Guidelines, Evaluation and Management 2021 CPT Professional Edition page 29

12

2021 Office Code MDM Overview

- Still uses 3 components for MDM- more concrete
- MDM is scored by the highest two of three components:
  - Number and complexity of problems addressed
    - Previously – the number of diagnoses or management options
  - Amount and/or complexity of data to be reviewed and analyzed
    - Very quantitative
  - Risk of complications and/or morbidity/mortality of patient management
    - Incorporates components of the risk table as examples

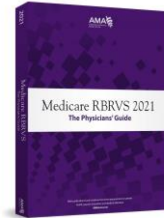
13

2021 Physician Fee Schedule

14

2021 RBRVS Equation

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



RVU_{Total} X Conv. Factor = Medicare Payment

15

2021 Work RVU Increases !

Table 25 2021 Physician Final Rule page 264

Code	2020 RVWs	2021 RVWs	% Change
99283	1.48	1.60	12.68%
99284	2.60	2.74	5.38%
99285	3.80	4.00	5.26%

16

2021 RVUs Component Detail

Code	2020 Work	2021 Work	2020 PE	2021 PE	2020 PLI	2021 PLI	2020 Total	2021 Total
99281	0.48	**0.48**	0.11	0.11	0.05	0.05	0.64	**0.64**
99282	0.93	**0.93**	0.21	0.21	0.09	0.10	1.23	**1.24**
99283	1.42	**1.60**	0.29	0.33	0.13	0.17	1.84	**2.10**
99284	2.60	**2.74**	0.51	0.54	0.27	0.29	3.38	**3.57**
99285	3.80	**4.00**	0.71	0.74	0.40	0.42	4.91	**5.16**

Typical group will see an increase of roughly 0.2 RVUs per patient

17

The 2021 Conversion Factor

"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. If this threshold is exceeded, we make adjustments to preserve budget neutrality." **- Physician Rule page 893**

2018	$35.9996
2019	$36.0391
2020	$36.0896
2021	$32.4085 (-10.2%)

TABLE 104: Calculation of the CY 2021 PFS Conversion Factor

CY 2020 Conversion Factor		36.0896
Statutory Update Factor	0.00 percent (1.0000)	
CY 2021 RVU Budget Neutrality Adjustment	-10.20 percent (0.8980)	
CY 2021 Conversion Factor		**32.4085**

18

Table 106 Impacts by Specialty (page 1660)

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
ALLERGY/IMMUNOLOGY	$247	5%	4%	0%	9%
ANESTHESIOLOGY	$2,020	-6%	-1%	0%	-8%
AUDIOLOGIST	$75	-4%	-2%	0%	-6%
CARDIAC SURGERY	$266	-5%	-2%	0%	-8%
CARDIOLOGY	$6,871	1%	0%	0%	1%
CHIROPRACTOR	$765	-7%	-3%	0%	-10%
CLINICAL PSYCHOLOGIST	$832	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	$857	0%	1%	0%	1%
COLON AND RECTAL SURGERY	$168	-4%	-1%	0%	-5%
CRITICAL CARE	$378	-6%	-1%	0%	-7%
DERMATOLOGY	$3,767	-1%	0%	0%	-1%
DIAGNOSTIC TESTING FACILITY	$748	-1%	-2%	0%	-3%
EMERGENCY MEDICINE	$3,077	-5%	-1%	0%	-6%
ENDOCRINOLOGY	$508	10%	5%	1%	16%
FAMILY PRACTICE	$6,020	8%	4%	0%	13%
GASTROENTEROLOGY	$1,757	-3%	-1%	0%	-4%
GENERAL PRACTICE	$412	5%	2%	0%	7%
GENERAL SURGERY	$2,057	-4%	-2%	0%	-6%
GERIATRICS	$192	1%	1%	0%	3%
HAND SURGERY	$246	-2%	-1%	0%	-3%
HEMATOLOGY/ONCOLOGY	$1,707	8%	5%	1%	14%

19

Potential Remedies to Proposed CF Decrease

- Conversion factor changes not under CMS or HHS; decided by Congress
- *Holding Providers Harmless From Medicare Cuts During COVID-19*
  - Rep. Ami Bera MD (D-CA), Larry Buschon MD (R-IN)
- During COVID 19- optics of a 10.2% decrease in Medicare payments
- Some possibility (small) next coronavirus relief package CF relief
- Kick the can without formal repeal- phased in over several years
- Formal budget neutrality waiver during the PHE or longer
- Advocacy effort underway
  - https://p2a.co/SeZSIvU

20

21

2021 ED 9928X Telemedicine Proposals

- CMS was proposing to **keep** ED codes **99281-99283** on the approved telehealth list for the remainder of the year after the PHE expires
  - May then be considered further

PUBLIC HEALTH EMERGENCY

- CMS was proposing to **remove 99284 and 99285** for telemedicine services when the public health emergency formally ends:

  "Higher level emergency department visits (CPT codes 99284-99285): We are concerned that the full scope of service elements of these codes cannot be met via two-way, audio/video telecommunications technology."

2021 Physician Proposed Rule page 97

22

2021 Physician Final Rule Telemedicine All 5 ED Codes Continue for Now

- New Telehealth Category 3: Will remain on the telehealth list of approved services through end of calendar year in which the PHE ends
- ED 99281-99285 (all codes not just 99281-99283)
- Critical care 99291-99292
- Subsequent observation (99224-99226) and obs discharge

- Provider and patient in the same place = regular visit

"We are, therefore, reiterating in this final rule that telehealth rules do not apply when the beneficiary and the practitioner are in the same location even if audio/video technology assists in furnishing a service"

CMS Fact Sheet 2021 Physician Final Rule

23

COVID Teaching Physician Oversight via Telehealth

- Teaching physicians may meet the supervisory requirements using telehealth during the PHE
- Does not need to be in-person

"The requirement for the presence of a teaching physician can be met, through direct supervision by interactive telecommunications technology… the teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service."

March 30th CMS IFR page *103/221*

24

Teaching Physician Telemedicine: 2021 and Into The Future

- Rural settings- TP oversight via telemedicine now permanent

  "We are finalizing a **permanent policy** to permit teaching physicians to meet the requirements to bill for their services involving residents through virtual presence, but only for services furnished in residency training sites that are located outside of an OMB-defined metropolitan statistical area (MSA)." **2021 Physician Final Rule page 309**

- Non rural settings: "We are not permanently finalizing our teaching physician virtual presence policies; however, they will remain in place for the duration of the PHE to provide flexibility for communities that may experience resurgences in COVID-19 infections." **2021 Physician Final Rule page 310**

25

Hospital Transparency

January 1, 2021, hospital required to provide clear, accessible pricing information online in two ways

1. A comprehensive machine-readable file with **all items** and services
   - Single machine-readable file containing: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges
2. A display of shoppable services in a consumer-friendly format
   - At least **300 "shoppable services**"; provide the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges
   - **70 specified** (Appendix)

26

Employed Docs vs Fee for Service

Q: Do these requirements apply to non-employed physicians and other practitioners who provide and bill for the same services at the hospital?

A: No. Services provided by physicians and non-physician practitioners who are not employed by the hospital are practitioners that are practicing independently, establish their own charges for services, and receive the payment for their services.

Q: Do these requirements apply to the services of employed practitioners whose charges are not found in the hospital chargemaster?

A: Yes. The Hospital Price Transparency Final Rule does not limit the requirements to only hospital standard charges that are found within the hospital chargemaster. Including, in the case of payer-specific negotiated charges, in contracts and rate sheets that are specific to a particular third party payer.

27

2021 MAT in the ED

- Previously no reimbursement for ED Medication Assisted Treatment (MAT)
- 2021 Finalized ED MAT code:

*"**G2213** Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services (List separately in addition to code for primary procedure.)"* **2021 Physician Final Rule page 542**

- Billed in addition to the 9928x ED E/M level
- Work RVUs1.30 Total RVUs 1.89

28

Conclusion

- ED volume is returning despite COVID – the public sees our value
- ED RVUs are increasing
- Need Congressional action for the conversion factor
- Telemedicine is growing
- The regulatory environment is complex, fluid, and rapidly changing
- Stay tuned!

29

Michael Granovsky, MD, CPC, FACEP
www.logixhealth.com
mgranovsky@logixhealth.com
781.280.1575

David McKenzie, CAE
Dmckenzie@acep.org
1.800.798.1822

30

31

CMS 70 Shoppable Services Highlights

- Psychotherapy
- New patient office visit
  - 99203-99205
- Office consultation
- Preventive medicine
- Many standard lab tests
  - CBC
  - LFTs
  - UA
- EKG
- Many radiology studies
  - Head CT
  - CT abdomen and pelvis
  - Abdominal US
  - Trans vaginal US
- Surgical Procedures
  - Major joint replacement
  - EGD
  - Cardiac cath

Hospital discretion for additional 230

32

2021 MAT In The ED Documentation Requirements

"In response to which elements are required in order to bill for this code, practitioners should furnish only those activities that are clinically appropriate for the beneficiary." **2021 Physician Final Rule page 542**

- Write a note demonstrating medical necessity

33

Michael Granovsky, MD, CPC, FACEP
www.logixhealth.com
mgranovsky@logixhealth.com
781.280.1575

David McKenzie, CAE
Dmckenzie@acep.org
1.800.798.1822

34