On March 6, short-term acute-care hospitals will find out whether CMS data shows they are outliers in their billing for resource use in the emergency department (ED) in either direction—upcoding or downcoding.

The Program for Evaluating Payment Patterns Electronic Report (PEPPER), which is a free comparative report on billing rates in certain medical necessity and coding target areas, has added one for ED evaluation and management (E/M) visits (RMC 12/11/17, p. 3)—and it will be in the next release. The compliance monitoring data is for hospital facility fees, which is tricky because there are no CMS-approved standards for selecting ED facility E/M levels of service. CMS instructed hospitals in 2000 to develop their own coding systems, and as long as hospitals apply them consistently, they should be safe. But the audits have come and gone, and now ED E/M visits are facing Targeted Probe and Educate (TPE), CMS’s medical review strategy (RMC 11/20/17, p. 1).

Kim Hrehor, project director of the TMF Health Quality Institute, which generates PEPPERs for CMS, says the E/M program integrity high beams have mostly been aimed at physicians, and adding ED E/Ms to PEPPER is a good way to bring more attention to the hospital side. She says the data bear her out.

“When we looked at the data at the hospital level, we saw a wide distribution of utilization for the highest level code. The distribution was skewed to the right, with a long tail at the high end,” she tells RMC. “This can be a concern for hospitals as well, and there is an opportunity for upcoding and undercoding.”

PEPPERs are provided quarterly to all short-term acute-care hospitals and annually to other entities, including critical-care hospitals. The data is specific to each hospital, comparing the hospital’s billing statistics for target areas to other hospitals in the nation, Medicare administrative contractor (MAC) jurisdiction and state. It’s a red flag when a hospital’s billing in a risk area is at or above the 80th national percentile, which means it bills a higher percentage for that target area than 80% of all hospitals nationally. That doesn’t necessarily mean there was an error, but it’s up to the hospitals to determine whether there’s a compliance issue or some reasonable explanation. The purpose of PEPPERs is to help hospitals point their compliance monitoring in more productive directions. Because the ED E/M target area is a coding issue, a hospital would also be identified as a low outlier if they are at or below the 20th percentile.

Also in the February 26, 2018, Issue of RMC

- Substance-Use Confidentiality Rules Bring Some Changes; Push to Align With HIPAA Continues
- With TKR Off Inpatient-Only List, Comorbidities Take Center Stage
- Sample Policy For Admission Status—Total Knee Replacement
- CMS Transmittals, Feb. 16–22
- News Briefs
**Code Has ‘Greatest Incentive For Upcoding’**

Hospitals use five CPT codes (99281 through 99285) to report ED E/M visits, with 99281 representing the lowest severity level and least reimbursement and 99285 the other extreme. “We wanted to focus on the highest code, with the greatest incentive for upcoding,” Hrehor says. The way TMF calculated this target area, the numerator is the number of visits that are coded to the highest CPT code (99285). “We are comparing that to the denominator, which is all ED E/M visits that are 99281 to 99285,” she explains. “If a hospital has a really high percentage of E/M visits to the highest level, they might want to think about whether that reflects accurately the types of patients they are seeing in their ED.” The levels of service for the visits may be appropriate, but the hospital may want to determine whether the documentation supports the code. “On the flip side, if they have a low target area percent, maybe check that. The hospital could be leaving money on the table,” Hrehor says. The ED E/M target area only summarizes data from outpatient claims.

Before 2000, hospitals couldn’t bill Medicare separately for ED E/M facility fees. With the advent of the outpatient prospective payment system, however, CMS opened the door to Medicare charges for nursing, administrative and other services provided in EDs if they weren’t wrapped into ambulatory payment classifications (APCs). CMS promised for years to produce E/M facility fee coding guidelines for EDs and clinics, but they never materialized. Hospitals were instructed to develop their own methodology for billing E/M services “with the caveat that it reasonably relate to resources consumed by the hospital, which is pretty open to interpretation,” says Amy Gendron, director of clinical and regulatory compliance at Trinity Health in Livonia, Mich., which is being audited now for ED E/M levels of service by its MAC, Wisconsin Physician Services (WPS), under TPE.

“CMS indicated time and time again that as long as we’re following our own internal guidelines and they don’t appear to game the system, we should be OK,” Gendron says. Hospital ED E/M billing is separate from physician E/M billing. Physicians bill their professional fees on their own and are governed by 1995/1997 Medicare Documentation Guidelines.

Over the years, hospitals devised their own methodology for reporting E/M levels of service or adopted versions developed by other organizations. At first, Trinity Health used various homegrown systems to assign E/M levels for ED visits. Now many of its 93 hospitals use a proprietary software called LYNX that uses an algorithm based on the patient’s chief complaint, clinical interventions performed during the ED visit, the patient’s arrival mode (e.g., walk-ins, ambulance rides) and discharge disposition, she says. Some Trinity hospitals use the (copyrighted) American College of Emergency Physicians’ (ACEP) criteria, and “a smattering” stick with their homegrown criteria.

In light of the new MAC and PEPPER focus on ED E/M billing, Gendron is wondering whether hospitals will be judged only on their adherence to their guidelines, or whether CMS intends to pull back the curtain on the coding systems. “If CMS found that various methodologies don’t relate to CPT codes, maybe they would feel these systems that have been developed by ACEP or LYNX are too aggressive or don’t relate to the intensity of CPT codes. From a volume perspective, the risk can be very great,” she says.

Is Spike Related to Two-Midnight Rule?

With all E/M levels of service, CMS has made the assumption historically that there should be a bell-shaped distribution, and the same goes for ED visits, says Cheryl Rice, vice president and chief corporate responsibility officer for Mercy Health in Cincinnati. CPT 99285 is on the far right, and 99281 is on the far left, and 99283 is typically billed most often and pays somewhere in between. “You might have a shift to the right at a tertiary trauma center that does a lot of severe cases, including critical care,” she says. “But at a run-of-the-mill suburban hospital without a lot of high trauma, it may not make sense to see a shift far to the extreme either way.”
The historic rule of thumb in government audits has been that the variance between what the doctor and the hospital charges shouldn’t be more than two levels of service, Rice says. It’s possible that will play a role in the new audits even if hospital and physician resource consumption are not supposed to necessarily correlate. But she sees other factors potentially at play.

There may be a spike in CPT 99285 on the facility side because of the two-midnight rule, Rice says. If hospitals are holding more patients in an outpatient setting when physicians don’t believe they will cross two midnights, they may keep patients longer in the ED and may be charging the higher ER rate if hospitals incorporated time spent in the ED in their scoring tool, she says.

Another possible driver of 99285 is double counting of separately billable ED services. If hospitals put lab tests, radiology and other separately billable services on the treatment sheet, which is used to score the E/M service, that essentially inflates effort because they could be counting separately billable items that shouldn’t be included in the ED E/M calculation, Rice says.

Meanwhile, physicians may face revisions to their documentation guidelines for E/M services. CMS is considering an overhaul of the Medicare Documentation Guidelines. Already it has reversed its position in one area. CMS said Feb. 2 that all documentation by medical students counts for E/M billing, according to Medicare Transmittal 3971 (RMC 2/12/18, p. 5).

Contact Hrehor at kimberly.hrehor@area-b.hcqis.org, Rice at clrice@mercy.com and Gendron at gendrona@trinity-health.org.

**Subscribing to RMC**

If you are interested in subscribing to Report on Medicare Compliance, please contact Skyler Sanderson at 888.580.8373 x 6208 or skyler.sanderson@hcca-info.org to review our very reasonable rates for bulk or site licenses that will permit weekly redistributions of entire issues to members of your team.