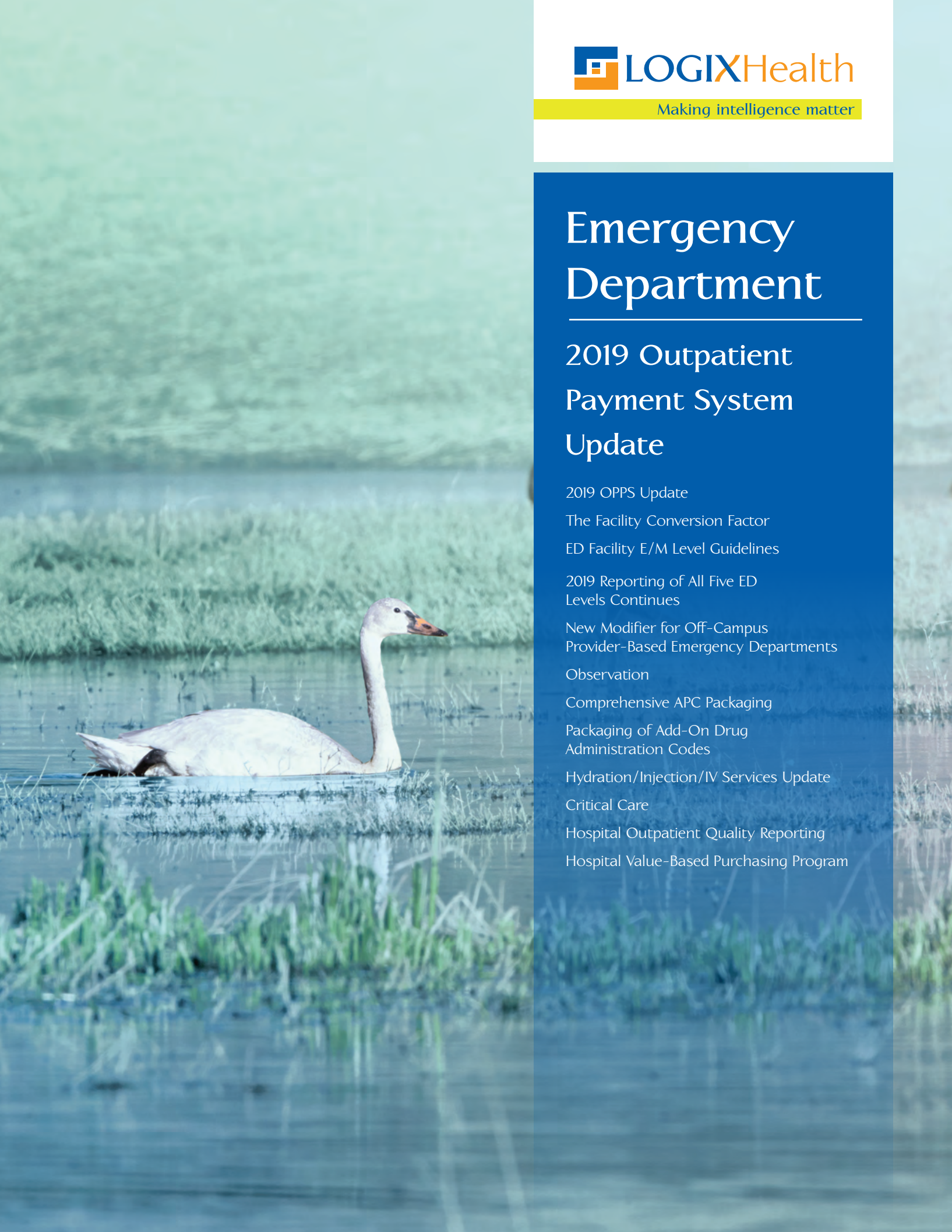

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# Emergency Department

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# Large 2019 Financial Impact: Watch Your ED Facility Levels Closely

## LOGIXTIP#116

CMS continues to package more services into the ED facility level payment. Increased bundling means that assigning the appropriate E/M level is more important than ever.

| E/M Level | Approximate Payment |
|---|---|
| 99283 | $230 |
| 99284 | $360 |
| 99285 | $530 |

## 2019 OPPS Update

On November 2, 2018, the Centers for Medicare and Medicaid Services published the 2019 Outpatient Prospective Payment System (OPPS) final rule. The final rule had a brief comment period which closed on December 3, 2018. The final rule finalizes payment rates and policies for outpatient services furnished by hospitals that are paid under the OPPS, and as written, now governs services provided on or after January 1, 2019. The final rule can be found on the LogixHealth website, www.logixhealth.com.

## The Facility Conversion Factor

For 2019, CMS is updating OPPS rates by 1.35%. The change is based on the projected hospital market basket increase of 2.9% minus both a 0.8 percentage point adjustment for multi-factor productivity (MFP) and a 0.75 percentage point adjustment required by the Affordable Care Act. The unadjusted conversion factor under OPPS will increase from the 2018 OPPS conversion factor of $78.636 to $79.490. After considering all other policy changes finalized under the OPPS, including estimated spending for pass-through payments, CMS estimates that total payments to OPPS providers will increase by approximately $360 million over CY 2018 (excluding changes in enrollment, utilization, and case-mix).

> *"We estimate that total OPPS payments for CY 2019, including beneficiary cost-sharing, to the approximately 3,840 facilities paid under the OPPS (including general acute care hospitals, children's hospitals, cancer hospitals, and CMHCs) will increase by approximately $360 million compared to CY 2018 payments, excluding our estimated changes in enrollment, utilization, and case-mix."* 2019 OPPS final rule, page 29/1182

As in prior years, CMS will apply a 2% penalty for hospitals not reporting outpatient quality measures, leading to a reduced conversion factor for those hospitals not meeting the Hospital Outpatient Quality Reporting (OQR) requirements.

> *"We are continuing to implement the statutory 2.0 percentage point reduction in payments for hospitals failing to meet the hospital outpatient quality reporting requirements, by applying a reporting factor of 0.980 to the OPPS payments and copayments for all applicable services."* 2019 OPPS final rule, page 20/1182

> *"Hospitals that fail to meet the Hospital OQR Program reporting requirements are subject to an additional reduction of 2.0 percentage points from the OPD fee schedule that would be used to calculate the OPPS payment rates for their services."* 2019 OPPS final rule, page 143/1182

## ED Facility E/M Level Guidelines

Historically CMS has supported hospitals developing their own internal guidelines for ED E/M reporting.

> *"Since April 7, 2000, we have instructed hospitals to report facility resources for clinic and ED hospital outpatient visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level (65 FR 18451)."*
> 2016 OPPS final rule, page 59/1221

For 2019, there are no significant changes to the rules governing ED facility E/M level guidelines. Per the initial description in the 2008 OPPS final rule, hospitals will be allowed to utilize their own scoring systems provided they accurately reflect facility resource utilization and are consistent with the 11 Guiding Principles published in the 2008 OPPS final rule.

While several years ago CMS had shown intent to explore a single set of national ED facility guidelines, going back to the 2016 final rule, CMS stated that this had been a complex endeavor and that it did not have a time table for creating national guidelines.

> *"...we have signaled in past rulemaking our intent to develop guidelines, this complex undertaking has proven challenging. Our work with interested stakeholders, such as hospital associations, along with a contractor, has confirmed that no single approach could consistently and accurately capture hospitals' relative costs. Public comments received on this issue, as well as our own knowledge of how clinics operate, have led us to conclude that it is not feasible to adopt a set of national guidelines for reporting hospital visits that can accommodate the enormous variety of patient populations and service-mix provided by hospitals of all types and sizes throughout the country."* 2016 OPPS final rule, page 593/1221

Furthermore, in 2017 there was limited commentary on the part of providers requesting national guidelines.

> *"In the CY 2017 OPPS/ASC proposed rule (81 FR 45667), for CY 2017, we proposed to continue with and did not propose any changes to our current clinic and emergency department (ED) hospital outpatient visits payment policies. We did not receive any public comments on this proposal. Therefore we are finalizing our CY 2017 proposal, without modification, to continue our current clinic and ED hospital outpatient visits and critical care services payment policies."* 2017 OPPS final rule, page 482/1378

Finally, in the 2019 OPPS final rule, CMS demonstrates they continue to be less and less interested in imposing national ED facility level guidelines, stating:

> *"In the CY 2019 OPPS proposed rule, we proposed to continue with our current emergency department hospital outpatient visits payment policies. We sought public comments on any changes to these codes. We did not receive any public comments on our proposals to continue our current ED hospital outpatient visits payment policies. Therefore, we are adopting these proposals as final without modification."* 2019 OPPS final rule, page 520/1182

## 2019 Reporting of All Five ED Levels Continues

While CMS has moved away from exploring a single set of uniform national ED coding guidelines, the issue of CMS simply collapsing the five ED facility levels into a single payment APC still requires monitoring. In 2014, CMS explored collapsing both ED and outpatient clinic visit levels into a corresponding single payment rate. The 2014 final rule finalized a collapse of the outpatient clinic levels with a resulting single payment rate under APC 0634, however, CMS maintained five distinct ED payment levels. The 2016 final rule examined the potential collapse of the current five ED facility levels and concluded that the five ED levels will remain for reporting hospital services.

> *"...we continue to believe that additional study is needed to assess the most suitable payment structure for ED visits. Therefore, in the CY 2016 OPPS/ASC proposed rule (80 FR 39288), we did not propose any change in ED visit coding. Rather, for CY 2016, we proposed to continue to use our existing methodology to recognize the existing five CPT codes for Type A ED visits as well as the five HCPCS codes that apply to Type B ED visits, and to establish the proposed CY 2016 OPPS payment rates using our established standard process. We stated that we may propose changes to the coding and APC assignments for ED visits in future rulemaking."* 2016 OPPS final rule, page 597/1221

Importantly, the 2019 OPPS final rule does not entertain collapsing the five ED levels into a single payment amount, but instead references the detail of the 2016 discussion.

> *"For a description of the current clinic and ED hospital outpatient visits policies, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70448)."* 2019 OPPS final rule, page 520/1182

In an effort to greater align services with common resource intensity, CMS in 2016 shifted and renumbered the ED E/M APCs. The renumbered convention continues for 2019.

See the chart below for the 2019 APCs and payment rates.

| Facility Level | APC | 2018 | 2019 | Change |
|---|---|---|---|---|
| 99281 | 5021 | $68.66 | $69.73 | +1.56% |
| 99282 | 5022 | $124.65 | $127.96 | +2.66% |
| 99283 | 5023 | $219.10 | $222.99 | +1.78% |
| 99284 | 5024 | $355.50 | $360.37 | +1.37% |
| 99285 | 5025 | $520.81 | $525.30 | +0.86% |
| 99291 | 5041 | $733.58 | $740.02 | +0.88% |

### CMS Facility E/M Level Guiding Principles

- The guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate to the intensity of hospital resources to the different levels of effort represented by the code.
- The coding guidelines should be based on hospital facility resources, not physician resources.
- The guidelines should be clear to facilitate accurate payments and should be usable for compliance purposes and audits.
- They should meet HIPAA guidelines.
- They should only require documentation that is clinically necessary for the patient.
- The guidelines should not facilitate upcoding or gaming.
- These guidelines should be well documented and should provide the basis for the selection of a specific code.
- They should be applied consistently across patients in the clinic or ED to which they apply.
- These guidelines should not change with great frequency.
- They should be readily available for fiscal intermediary or, if applicable, MAC review.
- These guidelines should result in coding decisions that could be verified by other hospital staff and outside sources.

2008 OPPS final rule, page 227/647

## New Modifier for Off-Campus Provider-Based Emergency Departments

To further gather data and analyze services being provided at off-campus provider-based emergency departments, CMS stated its plan to implement a new modifier ("ER") to be used on each claim line for outpatient hospital services furnished in an off-campus, provider-based emergency department. Additional information regarding the HCPCS modifier will likely be provided through a subregulatory process and it has an effective date of January 1, 2019.

*"We stated in the proposed rule that we will create a HCPCS modifier ("ER"— Items and services furnished by a provider-based off-campus emergency department) that is to be reported with every claim line for outpatient hospital services furnished in an off-campus provider-based emergency department. We specified in the proposed rule that the modifier would be reported on the UB– 04 form for hospital outpatient services. We stated that critical access hospitals (CAHs) would not be required to report this modifier."* 2019 OPPS final rule, page 588/1182

In 2008, CMS adopted the composite APC methodology, reimbursing for ED facility and observation services in a single packaged construct. For 2019, the packaged/composite methodology continues to combine ED and observation services into a single APC.

For 2019, APC 8011 will reimburse $2,386.80, which represents a 1.6% increase over the 2018 reimbursement. The observation APC underwent a drastic increase in payment in 2016 related to the extensive packaging associated with the Comprehensive APC construct.

Observation services have been added to the growing list of Comprehensive APCs, and for 2019, payment for observation services will be via Comprehensive APC 8011, which will require a qualifying visit along with eight units of G0378. The types of qualifying visits for observation were expanded greatly in 2016. The prior requirements for eight units of G0378 and no T status procedure continue for 2019. As previously described in the 2016 OPPS final rule, observation may be reported for any clinic visit HCPCS code G0463, any Type A ED visit (CPT codes 99281-99285), any Type B ED visit (HCPCS codes G0380-G0384), a direct referral to observation (HCPCS code G0379) or critical care (CPT code 99291) provided by a hospital in conjunction with observation services of substantial duration (eight or more hours of observation/eight units of HCPCS code G0378), provided the observation was not furnished on the same day as surgery or post-operatively and with no status indicator T on the same claim.

In summary, payment is made for the Comprehensive APC 8011 if the following claim criteria are met:

- A minimum of eight units of G0378
- No procedure with a status indicator T is on the claim for the date of service or one day prior
- A qualifying E/M visit is on the claim, such as:
  - Type A ED visit (99281-99285)
  - Type B ED visit (G0380-G0384)
  - Critical care (99291)
  - An outpatient clinic visit (G0463)
  - A direct referral (G0379)

The reimbursement for the observation composite APC has been steadily increasing over the past several years.

## Observation Services Payment Increase Trend Continues

| Year | Composite Payment |
|---|---|
| 2009 | $660.00 |
| 2010 | $705.27 |
| 2011 | $714.33 |
| 2012 | $720.64 |
| 2013 | $798.47 |
| 2014 | $1,199.00 |
| 2015 | $1,234.22 |
| 2016 | $2,174.14 |
| 2017 | $2,221.70 |
| 2018 | $2,349.66 |
| 2019 | $2,386.80 |

*"A Comprehensive APC (C-APC) is defined as a classification for the provision of a primary service, as well as all adjunctive services provided in support of the primary service. We established C-APCs as a category broadly for OPPS payment, and implemented 25C-APCs beginning in CY 2015."* 2016 OPPS final rule, page 124/1221

*"For CY 2017, we are not making extensive changes to the already established methodology used for C-APCs. However, we are creating 25 new C-APCs that meet the previously established criteria, which, when combined with the existing 37 C-APCs, will bring the total number to 62 C-APCs as of January 1, 2017."* 2017 OPPS final rule, page 50/1378

*"Comprehensive APCs: For CY 2019, we are creating three new comprehensive APCs (C-APCs). These new C-APCs include ears, nose, and throat (ENT) and vascular procedures. This increases the total number of C-APCs to 65."* 2019 OPPS final rule, page 20/1182

## Increased Bundling

The observation Comprehensive APC 8011 bundles the vast majority of typical ancillaries provided during an observation visit, including most:

- Labs
- CT scans
- Ultrasound studies
- Typical non-T status procedures
- IV fluids
- Infusions
- Most medications

Some separate payments continue. Services represented by status indicators F, G, H, L, and U are not bundled during an observation visit, such as:

- Services excluded from Comprehensive APC packaging
- Brachytherapy sources
- Pass-through drugs
- Influenza and pneumococcal pneumonia vaccine services
- Ambulance services
- Mammography

## CMS Overall Packaging Continues

CMS has finalized continued increased packaging of services in an effort to transform the OPPS into more of a prospective payment system, and less like a fee schedule.

CMS has communicated that increased packaging not only incentivizes efficiencies in care delivery, but also simplifies the payment methodology and the need to value multiple smaller subcomponent services at the CPT line item level.

> *"Finally, packaging may reduce the importance of refining service-specific payment because packaged payments include costs associated with higher cost cases requiring many ancillary items and services and lower cost cases requiring fewer ancillary items and services."* 2019 OPPS final rule, page 112/1182

The 2019 final rule describes significant packaging for services. Items that will be packaged include those described by the status indicators defined below.

CMS previously retired the status indicator X, and has been expanding the use of the status indicator Q series related to conditional packaging. The status indicator Q series packaging includes:

- Status indicator Q1 - Packaged with status indicator S/T/V procedures
- Status indicator Q2 - Packaged with T procedures
- Status indicator Q3 - Packaged as part of a composite payment
- Status indicator Q4 - Labs packaged with status indicator J1, J2, S, T, V, Q1, Q2, Q3

The OPPS final rule lists the various iterations of packaging on a code-specific level. Importantly, ED hydration, injection, and infusion primary services will continue to be reported and paid separately.

For a full copy of the 2019 OPPS final rule, visit the LogixHealth website at www.logixhealth.com.

## Packaging of Add-On Drug Administration Codes

Beginning in 2014, CMS implemented a policy to package ancillary services assigned to APCs with a geometric mean cost of $100 or less, with some exceptions, including drug administration services. However, beginning in 2018, CMS removed the previous exception for certain drug administration services. Several drug administration add-on services assigned to APCs 5691 and 5692 will be packaged with the ED E/M service.

*"Given the low geometric mean costs of drug administration services in APC 5691 and APC 5692, we stated in the CY 2018 OPPS/ASC proposed rule that we believe that when these services are performed with another separately payable service, they should be packaged, but that they should be separately paid when performed alone. We are finalizing our proposal to conditionally package low-cost drug administration services assigned to APC 5691 and APC 5692, effective January 1, 2018."*
2018 OPPS final rule, page 151/1133

### 2019 Packaged Services

| CPT Code | Description | APC |
|---|---|---|
| 96361 | Hydrate IV Infusion Add-on | 5691 |
| 96366 | Ther/Prof/Diag IV Infusion Add-on | 5691 |
| 96375 | Ther/Prof/Diag IV Infusion Add-on | 5691 |

CMS is continuing the vision of further packaging services and ultimately moving towards creating a more prospective system for outpatient care similar to the DRG system.

*"Our packaging policies are designed to support our strategic goal of using larger payment bundles in the OPPS to maximize hospitals' incentives to provide care in the most efficient manner."* 2019 OPPS final rule, page 11/1182

## Hydration/Injection/IV Services Update

Each year, the OPPS final rule updates reimbursement rates for essential ED services. In particular, with the complex coding rules surrounding the high-frequency hydration, injection, and infusion codes, there is significant revenue at stake for these procedures.

**Big dollars are at stake for correct coding of infusion services.**

| Code | Service | 2018 CMS Payment | 2019 CMS Payment | Variance |
|---|---|---|---|---|
| 96360 | Hydration | $191.08 | $187.18 | -2.04% |
| 96361 | Hydration+ | $37.03 | $37.88 | +2.30% |
| 96365 | Infusion | $191.08 | $187.18 | -2.04% |
| 96366 | Infusion+ | $37.03 | $37.88 | +2.30% |
| 96374 | Injection | $191.08 | $187.18 | -2.04% |
| 96375 | Injection+ | $37.03 | $37.88 | +2.30% |

## Critical Care

In 2011, CPT updated language within the definition of 99291, allowing facilities to report some services, such as x-rays, gastric intubation, and transcutaneous pacing that are bundled under physician payment rules. Despite this change, for 2012-2018, and now 2019, there will not be any separate OPPS payments made outside of the APC for these additional services. Critical care will continue to be reported by facilities with code 99291, which crosswalks to APC 5041 (designated in 2016) and reimburses $740.02. The 2019 OPPS language shows that CMS is currently satisfied with the critical care reporting processes that have been in place.

*"We also....did not propose any change to our payment policy for critical care services for CY 2019. For a description of the current payment policy for critical care services, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70449). In the CY 2019 OPPS/ASC proposed rule, we sought public comments on any changes to these codes that we should consider for future rulemaking cycles. We continue to encourage commenters to provide the data and analysis necessary to justify any suggested changes."* 2019 OPPS final rule, page 520/1182

## Hospital Outpatient Quality Reporting

CMS has made clear its commitment to expanding quality tracking. Hospitals failing to report quality measures will suffer a 2% reduction in their conversion factor. Each year, CMS issues an updated list of hospital measures required for meeting reporting requirements. Additionally, as the administrative and clinical realities of the quality measures become realized, some measures are subsequently postponed or suspended.

In the CY 2019 OPPS/ASC final rule, CMS continues its process of updating measures in the Hospital Outpatient Quality Reporting (OQR) Program. For 2019, the below ED relevant measure is slated to be deleted:

- **OP-5 Median Time to ECG**
  This chart-abstracted measure assesses the median number of minutes before outpatients with heart attack (or chest pain that suggests a possible heart attack) received an electrocardiograph (ECG) test to help diagnose heart attack. CMS feels the costs associated with the measure outweigh the benefit.

*"The costs of collection and submission of chart-abstracted measure data is burdensome for facilities. Based on our analysis of data submitted by 1,995 hospitals from Quarter 3 in 2016 through Quarter 2 in 2017 the variation in average measure performance between hospitals is minimal."* 2019 OPPS final rule, page 865/1182

## Differences in Performance for OP-5: Median Wait Time to ECG

| Period | Number of Hospitals | 25th Percentile | 75th Percentile | 90th Percentile |
|---|---|---|---|---|
| 2016 Q3 - 2017 Q2 | 1,995 | 11.0 minutes | 5.5 minutes | 3.8 minutes |

2019 OPPS final rule, page 865/1182

The OQR measure set determining payment for CY 2021 (2019 data collection) is shown below.

## Hospital OQR Program Measure Set for the CY 2021 Payment Determination and Subsequent Years

| Measure ID | Measure Name |
|---|---|
| OP-2 | Fibrinolytic therapy received within 30 minutes of ED arrival |
| OP-3 | Median time to transfer to another facility for acute coronary intervention |
| OP-8 | MRI lumbar spine for low back pain |
| OP-10 | Abdomen CT – use of contrast material |
| OP-13 | Cardiac imaging for preoperative risk assessment for non-cardiac, low-risk surgery |
| OP-18 | Median time from ED arrival to ED departure for discharged ED patients |
| OP-22 | Left without being seen |
| OP-23 | Head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke who received head CT or MRI scan interpretation within 45 minutes of ED arrival |
| OP-29 | Appropriate follow-up interval for normal colonoscopy in average risk patients |
| OP-31 | Cataracts: improvement in patient's visual function within 90 days following cataract surgery |
| OP-32 | Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy |
| OP-33 | External beam radiotherapy for bone metastases |
| OP-35 | Admissions and emergency department (ED) visits for patients receiving outpatient chemotherapy |
| OP-36 | Hospital visits after hospital outpatient surgery |
| OP-37a | OAS CAHPS – about facilities and staff |
| OP-37b | OAS CAHPS – communication about procedure |
| OP-37c | OAS CAHPS – preparation for discharge and recovery |
| OP-37d | OAS CAHPS – overall rating of facility |
| OP-37e | OAS CAHPS – recommendation of facility |

## Hospital Value-Based Purchasing Program

CMS continues to provide further guidance relating to the vision for expansion of the Hospital Value-Based Purchasing Program (HVBP). The HVBP has been funded by an annually increasing reduction from participating hospitals' base operating diagnosis related group (DRG) payments which for 2019 will be 2%. Hospitals then earn back a portion of the withhold based on relative scoring for both CORE measures and the CMS HCAHPS satisfaction survey.

### 2019 HVBP Domains

- Patient and Caregiver-Centered Experience of Care/Care Coordination (25%)
- Safety (25%)
- Clinical Care (25%)
- Efficiency and Cost Reduction (25%)

## Hospital VBP Program Measures for FY 2019

| Measure ID | Measure Description | Domain |
|---|---|---|
| CAUTI | Catheter-Associated Urinary Tract Infection | Safety |
| CLABSI | Central Line-Associated Blood Stream Infection | Safety |
| CDI | Clostridium difficile Infection (C. difficile) | Safety |
| MRSA | Methicillin-Resistant Staphylococcus aureus Bacteremia | Safety |
| PC-01 | Elective Delivery Prior to 39 Completed Weeks Gestation | Safety |
| SSI | Surgical Site Infection:<br>• Colon<br>• Abdominal Hysterectomy | Safety |
| MORT-30-AMI | Acute Myocardial Infarction (AMI) 30-Day Mortality Rate | Clinical Care |
| MORT-30-HF | Heart Failure (HF) 30-Day Mortality Rate | Clinical Care |
| MORT-30-PN | Pneumonia (PN) 30-Day Mortality Rate | Clinical Care |
| THA/TKA | Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) | Clinical Care |
| MSPB | Medicare Spending per Beneficiary (MSPB) | Efficiency and Cost Reduction |
| HCAHPS Survey | • Communication with Nurses<br>• Communication with Doctors<br>• Responsiveness of Hospital Staff<br>• Communication about Medicines<br>• Hospital Cleanliness and Quietness<br>• Discharge Information<br>• 3-Item Care Transition<br>• Overall Rating of Hospital | Experience of Care |


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