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Emergency Department

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CMS Final Rule

On November 1, 2019, Medicare released the 2020 Physician Fee Schedule Final Rule. The final rule governs payment rates, as well as other critical reimbursement issues, for dates of service beginning on January 1, 2020. The rule, which is published in the November 15, 2019 Federal Register can be found on the LogixHealth website, www.logixhealth.com.

MACRA Legislation and the Elimination of the Sustainable Growth Rate Formula

The 2020 rule is not governed by the Sustainable Growth Rate (SGR) formula, which had mandated continuing annual cuts to physician payments, resulting in year-after-year eleventh-hour congressional rescues with short-term fixes. Instead, with the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), 2020 represents another year of a stabilized conversion factor. In addition to stabilizing the conversion factor, MACRA also provided for sweeping payment reforms combining the quality programs of PQRS, the Value Modifier process, and Meaningful Use into a single CMS quality payment program, the Merit-Based Incentive Payment System (MIPS).

2020 Conversion Factor

At the conclusion of 2019, the Medicare conversion factor (the amount Medicare pays per RVU) was set at $36.0391. MACRA previously provided for annual conversion factor payment increases of 0.5% through 2019 which have now ended and we have entered a period of 0.0% updates. The 2020 final rule, as in past years is subject to "budget neutrality" which while previously an obscure factor working in the background, is becoming increasingly impactful.

> *"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."* 2020 Physician Final Rule page 1890/2475

As a result, the 2020 final rule published a conversion factor of $36.0896, representing a roughly $0.05 increase.

2020 Final Rule Conversion Factor Calculation

January 1, 2020 through December 31, 2020 Conversion Factor		
Conversion Factor in effect in CY 2019		$36.0391
Update Factor	0.00%	
CY 2020 RVU Budget Neutrality Adjustment	0.14% (0.0014)	
CY 2020 Conversion Factor		**$36.0896**

Merit-Based Incentive Payment System (MIPS)

The Merit-Based Incentive Payment System (MIPS) represents a payment mechanism that provides for annual reimbursement adjustments related to quality program requirements impacting 2022 payments based on 2020 performance in four categories:

- Quality
- Cost
- Improvement Activities
- Promoting Interoperability- previously Meaningful Use of an Electronic Health Record (EHR) System

For the 2020 performance year (impacting 2022 payments), the four MIPS categories will be simplified for most emergency physicians. The final rule assigned the Cost category a weight of 15% for 2020 (likely increasing to 30% for 2022 as required by statute). In addition, if a provider delivers greater than 75% of their Medicare services in an emergency department, they are excused from the Performance Interoperability category (Meaningful Use of an EHR). The consolidated program is then reweighted in 2020 to 70% Quality (the old PQRS program), 15% Cost, and 15% Improvement Activities.

The MIPS quality and value program adjusts physician payments based upon performance. MIPS does not have an aggregate spending target, which is what previously created the need for annual congressional patches to prevent the mandated SGR cuts. The MIPs program started at +/-4% and has now increased to +/-9% for the 2022 payment period (based on 2020 performance).

Evolution of the Federal Quality Payment Program

<table>
<tr><th></th><th>2019</th><th>2020</th><th>2021</th><th>2022</th><th>2023</th><th>2024</th><th>2025</th><th>2026+</th></tr>
<tr><td>Base</td><td>0.25%</td><td colspan="6">Base Conversion Factor Update of 0.0% each year</td><td>0.25%</td></tr>
<tr><td>EHR</td><td rowspan="4">(+/-) 4%</td><td rowspan="4">(+/-) 5%</td><td rowspan="4">(+/-) 7%</td><td rowspan="4" colspan="4">(+/-) 9%</td></tr>
<tr><td>PQRS</td></tr>
<tr><td>VM</td></tr>
<tr><td>MIPS</td></tr>
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2020 Geographic Practice Cost Index Update

The geographic practice cost index (GPCI) is used by CMS to modify the RVU values based on regional differences relating to cost of living, malpractice, and practice cost/expense. The GPCI values allow Medicare to adjust reimbursement rates to take into account regional and practice-specific factors. Some states have a permanently fixed GPCI, including Alaska's work GPCI of 1.5 and the frontier states PE GPCI of 1.0 (Montana, Nevada, North Dakota, South Dakota, and Wyoming). Other states are subject to a work RVU GPCI that ranges from 0.6 - 1.2. However, in past years, Congress passed single-year legislation, setting a GPCI work floor of 1.0 which then expired at the end of the year. A work GPCI floor of 1.0 was put in place by the 2018 Bipartisan Budget Act which provided GPCI relief for rural areas through December 31, 2019. The 2020 work GPCIs published in the 2020 Physician Fee Schedule Final Rule reflect an expiration of the work GPCI floor of 1.0. Reinstatement of the GPCI floor of 1.0 is dependent on congressional action.

In 2018, CMS recommended that the American Medical Association's Relative Value Update Committee (RUC) survey and potentially revalue the work RVUs associated with the ED evaluation and management (E/M) CPT codes (99281-99285) citing that they are potentially undervalued.

The 2018 Physician Fee Schedule Final Rule highlights concerns that the ED E/M services may be undervalued.

"We received information suggesting that the work RVUs for emergency department visits did not appropriately reflect the full resources involved in furnishing these services. Specifically, stakeholders expressed concerns that the work RVUs for these services have been undervalued given the increased acuity of the patient population and the heterogeneity of the sites, such as freestanding and off-campus emergency departments, where emergency department visits are furnished. Therefore, we sought comment on whether CPT codes 99281-99285 (Emergency department visits for the evaluation and management of a patient) should be reviewed under the misvalued code initiative." 2018 Physician Final Rule, pages 164-165/1250

CMS accepted the recommendations to increase the work RVUs for ED E/M services.

"We agree with the majority of commenters that these 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." 2018 Physician Final Rule, page 166/1250

The American College of Emergency Physicians (ACEP) has representation on the RUC. The ACEP representatives developed robust arguments supporting the higher acuity of ED patients and the additional resources required to care for sicker patients with greater comorbidities. The RUC recognized the higher acuity of the ED patient population and recommended to CMS that the work RVUs for the ED E/M services be increased. CMS has accepted the RUC's recommendations and the 2020 Physician Fee Schedule Final Rule has published updated RVUs for the ED E/M services.

For 2020, the work RVUs for emergency medicine services have increased. The total RVUs associated with ED E/M services 99281-99285 are also going up. The CMS specialty-specific impact analysis states that emergency medicine will experience a 1% update in overall Medicare reimbursement for 2020. The published 1% increase for emergency medicine as a specialty contains moderate rounding and for many practices it may be slightly higher. In summary, the RVUs for emergency medicine codes are increasing and the conversion factor has been increased by roughly 5 cents.

2020 ED E/M RVUs 99281-99285, 99291

Code	2019 Work RVUs	2020 Work RVUs	2019 PE RVUs	2020 PE RVUs	2019 PLI RVUs	2020 PLI RVUs	2019 Total RVUs	2020 Total RVUs
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
99291	4.50	4.50	1.39	1.38	0.39	0.40	6.28	6.28

Observation services were also revalued for 2020, resulting in some small adjustments.

Same-Day Observation

CPT Code	2019 Work RVUs	2020 Work RVUs	2019 PE RVUs	2020 PE RVUs	2019 Total RVUs	2020 Total RVUs
99234	2.56	2.56	0.99	1.00	3.75	3.77
99235	3.24	3.24	1.30	1.30	4.77	4.77
99236	4.20	4.20	1.65	1.64	6.13	6.14

Multi-Day Observation Services (Initial Day)

CPT Code	2019 Work RVUs	2020 Work RVUs	2019 Total RVUs	2020 Total RVUs
99218	1.92	1.92	2.81	2.82
99219	2.60	2.60	3.83	3.83
99220	3.56	3.56	5.23	5.22

Multi-Day Observation Services (Discharge Day)

CPT Code	2019 Total RVUs	2020 Total RVUs
99217	2.06	2.05

Subsequent Observation Services

Subsequent observation services remained relatively stable from 2019-2020.

CPT Code	2019 Work RVUs	2020 Work RVUs	2019 Total RVUs	2020 Total RVUs
99224	0.76	0.76	1.12	1.12
99225	1.39	1.39	2.06	2.05
99226	2.00	2.00	2.95	2.95

Critical Care Services

Critical care services were also revalued as part of the final rule and received small changes.

CPT Code	2019 Work RVUs	2020 Work RVUs	2019 Total RVUs	2020 Total RVUs
99291	4.50	4.50	6.28	6.28
99292	2.25	2.25	3.15	3.16

CPT Changes for Emergency Medicine in 2020

There were no significant changes in the E/M code section of CPT directly impacting emergency medicine. Consistent with prior years, with the usual updating of the vaccine codes in the medicine section relating to tweaks of the dosage or composition, there is a single new influenza vaccine formulation. Additionally, there are new codes to report online digital E/M services (e.g., email communication), Remote Physiologic Monitoring as well as updates to several procedure codes. LogixHealth has published a *2020 ED Chargemaster Update* detailing 2020 CPT code changes potentially of interest to emergency medicine groups.

Emergency Medicine ICD-10 Diagnosis Update

Unlike CPT code changes which occur on the calendar year, ICD-10 code changes are updated and effective in October. ED relevant codes added, deleted or revised include atrial fibrillation, phlebitis/thrombophlebitis, cyclical vomiting, orbital fracture, and heatstroke/sunstroke.

In keeping with the times, there is an effort underway to capture illnesses associated with vaping.

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for the most up-to-date information.

Documentation Guidelines: No ED Changes Any Time Soon

For quite some time, providers, payers, and the government, have felt that the current documentation guidelines originally published in 1995 have become burdensome and don't reflect current clinical processes and work flows.

The 2019 Physician Fee Schedule Final Rule highlights the discussion that the Documentation Guidelines are simply outdated:

> *"Stakeholders have long maintained that all of the E/M documentation guidelines are administratively burdensome and outdated with respect to the practice of medicine. Stakeholders have provided CMS with examples of such outdated material (on history, exam and MDM) that can be found within all versions of the E/M guidelines (the AMA's CPT codebook, the 1995 guidelines and the 1997 guidelines)."* 2019 Physician Final Rule, page 543/2378

In 2021, office visit encounters will be scored solely based on MDM or time.

The 2019 final rule opted for a measured approach to updating the documentation guidelines. While there will be **no changes to the ED E/M code documentation requirements**, the office visit E/M codes will undergo a major restructuring in 2021. For 2020, CMS will continue the existing documentation requirements for all E/M services.

Additionally, CMS is moving away from the concept of History and Physical Exam element counting and instead in 2021 will require office visit encounters to be scored solely based on Medical Decision Making (MDM) or time. While in the past various MDM grids have been circulated by stakeholders, CMS is adopting a brand new MDM scoring process promulgated by CPT to be used for the office visit E/M codes in 2021.

> *"We are finalizing our proposal to adopt the MDM guidelines as revised by CPT and allow the use of time or MDM to select office/outpatient E/M visit level beginning January 1, 2021."* 2020 Physician Final Rule page 870/2475

Importantly, the ED codes are not part of the 2021 revision process.

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