Emergency Department Update
2010 Outpatient Payment System

ED Facility Level Guidelines:  Still No National Guidelines
Triage Only Services
Critical Care Requires Documentation of 30 Minutes
Composite APCs Continue
Facility Conversion Factor Update
Hospital Outpatient Quality Measures
Technical Specifications for Quality Measures
Type A ED Visit Levels
Medicare released its 2010 Final Outpatient Prospective Payment System (OPPS) on October 30, 2009 with formal publication in the Federal Register on November 20, 2009. This update highlights the Emergency Department changes within the final rule. The full content of the final rule can be found on the LogixHealth website at www.logixhealth.com.

CMS completed an evaluation of a full year of 2008 data and has decided to maintain its prior stance regarding ED Facility Evaluation and Management (E/M) level coding guidelines; CMS determined that there was no need to institute a national set of guidelines.

“...Therefore, we did not propose to implement national visit guidelines for emergency department visits.” (OPPS 2010, p. 836)

CMS comments included that it observed that there have been several years of a stable distribution of ED visit levels.

“We continue to observe a normal and stable distribution of clinic and emergency department visit levels in hospital claims.” (OPPS 2010, p. 836)

CMS has continued to analyze the distribution of ED Facility E/M codes and has determined that hospitals are appropriately reporting E/M levels utilizing their current coding methodologies.

“As a result of our updated analyses, we are encouraging hospitals to continue to report visits during CY 2010 according to their own internal hospital guidelines.” (OPPS 2010, p.836)

CMS noted that in the absence of national Facility E/M guidelines Recovery Audit Contractors could theoretically be allowed to review a hospital’s internal guidelines, but that there is no activity in this area and that RAC issues must be approved by CMS.

“While we also would encourage RACs to review a hospital’s internal guidelines when an audit occurs, we note that currently there are no RAC activities involving visit services. RAC audits may involve CMS-approved issues only and must be posted to each RAC’s web site.” (OPPS 2010, p.839)

CMS reiterated the expectation that internal E/M guidelines comply with the principles identified in the 2008 OPPS final rule and made no significant changes related to the eleven general directives relating to Facility E/M guidelines published in the 2008 OPPS Final Rule. Those directives include:

• The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code. (65 FR 18451)
• The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources. (67 FR 66792)
• The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits. (67 FR 66792)

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• The coding guidelines should meet the HIPAA requirements. (67 FR 66792)
• The coding guidelines should only require documentation that is clinically necessary for patient care. (67 FR 66792)
• The coding guidelines should not facilitate upcoding or gaming.
• The coding guidelines should be written.
• The coding guidelines should be applied consistently across patients in the clinic or ED to which they apply.
• The coding guidelines should not change with great frequency.
• The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
• The coding guidelines should result in coding decisions that could be verified by other hospital staff as well as outside sources.

**Triage Only Services**

Hospitals sought clarification regarding the reporting of ED visits involving “triage only” services that had no direct involvement by a physician, but during which the patient was seen and evaluated solely by the hospital’s triage nurse. CMS responded that OPPS does not specify a requirement for direct physician involvement and that OPPS allows for payments to be made for services provided incident to physicians’ services.

“One commenter requested clarification regarding “triage only” visits in which a patient is seen by a nurse and triaged in the hospital emergency department but leaves prior to a physician’s examination and treatment. The commenter asked if hospitals can bill visit codes for such cases if the patient is not seen by a physician.”

Response: “As we have stated in the past (73 FR 68686), under the OPPS, unless indicated otherwise, we do not specify the type of hospital staff (for example, nurses or pharmacists) who may provide services in hospitals because the OPPS only makes payment for services provided incident to physicians’ services. Hospitals providing services incident to physicians’ services may choose a variety of staffing configurations to provide those services, taking into account other relevant factors, including State and local laws, hospital policies, and other Federal requirements such as EMTALA…” (OPPS 2010, p.832)

**Critical Care Requires Documentation of 30 Minutes**

The coding of critical care will continue to require documentation of 30 minutes of critical care time.

“Hospitals must continue to provide a minimum of 30 minutes of critical care services in order to bill CPT code 99291, according to the CPT code descriptor and CPT instructions. As we have stated in the past (72 FR 66806), the CPT instructions for reporting of critical care services with CPT code 99291 and the CPT code descriptor specify that the code can only be billed if 30 minutes or more of critical care services are provided.” (OPPS 2010, p. 830)

Previously, in March of 2007, CMS clarified that there must be at least 30 minutes of actual critical care time, and that time from multiple providers providing critical services at the same time could not be added together. Furthermore, CMS emphasized that hospitals are required to follow the CPT guidelines when reporting 99291, which in addition to meeting the threshold for 30 minutes of care speak to the issue of procedures that are bundled with critical care. CPT bundles the following codes with critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data [99090]); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilatory management (94002-94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36591, 36600).
For 2010 CMS has continued the new class of APCs defined as "composite APCs", which were created in 2008. These are actually a combination of two distinct Evaluation and Management services. The composite APCs define an extended assessment and management of a patient and advance CMS' efforts to increase the packaging of outpatient services.

CMS did not change the reporting and documentation requirements for Observation services relating to a physician order and evaluation, and a documented start and stop time originally published in the 2008 OPPS Final Rule. The timing requirements for Observation were previously defined as follows (2008 OPPS, p. 893):

1. Observation time must be documented in the medical record.
2. A beneficiary’s time in observation (and hospital billing) begins with the beneficiary’s admission to an observation bed.
3. A beneficiary’s time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient to be released or admitted as an inpatient.
4. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

For reference, a full discussion of the original formation of the Observation composite APC structure and requirements may be found in the 2008 OPPS Final Rule pages 890–907.

APC 8002 includes a level 5 clinic visit in conjunction with observation services of substantial duration and is reimbursed $381.34 for 2010.

APC 8003 includes either a level 4 or 5 Type A Emergency Department visit or critical care services or a level 5 Type B ED visit in addition to observation services and is reimbursed $705.27 for 2010.

CMS included a market basket update factor of 2.1% in the payment rates for services paid under the OPPS for 2010. The 2009 conversion factor of $66.059 increased to $67.406 for 2010. CMS reduced the conversion factor update by 2% for hospitals failing to report quality measures under the Hospital Outpatient Quality Data Reporting (HOP QDRP) program. The reduced rate includes a 2% penalty, and for 2010 will be $66.086. (2010 OPPS, p. 239)

Significant penalties for hospitals not meeting CMS quality reporting requirements:

“"To calculate the CY 2010 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2010 payment update, we...used a reduced market basket increase update factor of 0.1 percent. This resulted in a reduced market basket conversion factor for CY 2010 of $66.086 for those hospitals that fail to meet the HOP QDRP requirements."” (OPPS 2010, p. 339)

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The hospital clinical “core measure” quality program has been expanded from being exclusively based upon inpatient services, to now include outpatient measures. Several measures relating to care provided to acute MI and peri-operative patients in the outpatient ED setting were mandated for 2009 reporting. As noted, hospitals failing to report quality data will see a reduction in their annual payment update factor by 2.0 percentage points.

For the 2010 annual payment update, CMS will require HOP QDRP reporting using seven quality measures: five ED measures plus two perioperative care measures. CMS also identified four imaging measures that would be implemented in 2010 utilizing a claims submission process.

“The four imaging measures that we adopted beginning with the CY 2010 payment determination are claims-based measures that CMS will calculate using Medicare Part B claims data without imposing upon hospitals the burden of additional chart abstraction. For purposes of the CY 2010 payment determination, we will calculate these measures using Medicare administrative claims data.” (2010 OPPS, p.1140)

CMS has made clear their intent to publicly display the outpatient quality data:

“After consideration of the public comments we received, we have decided to finalize our proposal to publicly report HOP QDRP data on Hospital Compare in 2010” (OPPS 2010, p.1234)

The full list of the 11 HOP QDRP 2010 Measures

OP-1 Median Time to Fibrinolysis
OP-2 Fibrinolytic Therapy Received Within 30 Minutes
OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4 Aspirin at Arrival
OP-5 Median Time to ECG
OP-6 Timing of Antibiotic Prophylaxis
OP-7 Prophylactic Antibiotic Selection for Surgical Patients PQRI
OP-8 MRI Lumbar Spine for Low Back Pain
OP-9 Mammography Follow-up Rates
OP-10 Abdomen CT – Use of Contrast Material
OP-11 Thorax CT – Use of Contrast Material

Technical Specifications for Quality Measures

Technical specifications for each HOP QDRP measure are listed in the HOPD Specifications Manual, which is posted on the CMS QualityNet website at www.QualityNet.org. CMS has also shared a list of proposed measures for future implementation including:

• ED Throughput—Median Time from ED Arrival to ED Departure for Discharged ED Patients
• Use of Computed Tomography in Emergency Department for Headache
• Simultaneous Use of Brain Computed Tomography and Sinus Computed Tomography
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