Principles for Emergency Department Coding Guidelines

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by Tedi Lojewski, RHIA, CCS

Since the implementation of the Outpatient Prospective Payment System (OPPS), the Centers for Medicare and Medicaid Services (CMS) has required hospitals to report facility resources for emergency department (ED) visits using CPT evaluation and management (E/M) codes.

However, CMS recognized that CPT E/M codes do not adequately describe the intensity and range of ED services by hospitals because they reflect physician activities. Therefore, CMS instructed hospitals to develop their own internal guidelines for reporting E/M visits. This article outlines principles for hospital ED visit guidelines, as well as guidance on reporting them.

Four Basic Models

Two of the best known models for ED visit levels are the AHA/AHIMA Guidelines and the American College of Emergency Physicians ED Facility Level Coding Guidelines (ACEP Guidelines). During its consideration of various available guidelines, CMS identified four basic models in use:

- Guidelines based on the number or type of staff interventions. Both the AHA/AHIMA Guidelines and the ACEP Guidelines fall into this category. Intervention models use basic care interventions to report the lowest level of service, with higher levels assigned as complexity or number of nursing and ancillary staff interventions increases.
- Guidelines based on time spent with the patient. As time spent with the patient increases, so does the level assigned.
- Guidelines based on a point system. The time, complexity, and type of staff required determine the number of points assigned to each intervention.
- Guidelines based on patient severity. The diagnoses, level of medical decision making, and presenting complaint or medical problem are used to correlate resource consumption.

ED Visit Guiding Principles

Regardless of the model, guidelines should reflect the hospital resources used in providing the service. CMS recognizes that the E/M level reported by the hospital will not necessarily equate to the level reported by the physician for physician services provided for the same encounter. "Therefore, facilities should code a level of service based on facility resource consumption, not physician resource consumption. This includes situations where patients may see a physician only briefly, or not at all."[1]

CMS makes clear that hospital guidelines must reasonably relate the intensity of hospital resources to the levels of effort represented by the codes.

While the healthcare industry continues to operate without national guidelines, CMS expects that each hospital's internal guidelines should:

- Follow the intent of the CPT code descriptor—the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code
- Be based on hospital facility resources, not physician resources
- Be clear to facilitate accurate payments and be usable for compliance purposes and audits
- Meet HIPAA requirements
- Require only documentation that is clinically necessary for patient care
- Not facilitate upcoding or gaming
- Be written or recorded, well documented, and provide the basis for selection of a specific code
- Be applied consistently across patients in the clinic or emergency department to which they apply
- Not change with great frequency

- Be readily available for fiscal intermediary (or, if applicable, MAC) review
- Result in coding decisions that could be verified by other hospital staff, as well as outside resources

Separately Payable Procedures

In its evaluation of the available models, CMS found some systems too complex and overburdensome, susceptible to variability, and subjective in interpretation of guidelines. It also found that all proposed guidelines allow for counting of separately paid services (e.g., intravenous infusion, x-ray, EKG, and lab tests) as interventions or staff time in determining a level of service.

CMS stated that the "level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable."[2] It expressed concerns that the ACEP model allowed counting of separately payable services, which could result in double counting of hospital resources and subsequent duplicate payment.

In the 2008 OPPS final rule, CMS reconsidered this position and seems to have taken a step back, stating, "In the absence of national visit guidelines, hospitals have the flexibility to determine whether or not to include separately payable services as a proxy to measure hospital resource use that is not associated with those separately payable services."[3] Hospitals must be able to substantiate any decision to include otherwise separately payable services as a determining factor in the ED level assignment and be able to clearly articulate why those services reflect a proxy for additional hospital resource consumption.

Reporting ED Procedures and Modifier -25

Hospitals have increased their internal monitoring of modifier -25 because of the Office of Inspector General's emphasis on correct -25 assignment and increased activity by the Department of Justice to review hospital billing practices related to the modifier's use.

As defined by CPT-4, modifier -25 indicates a significant, separately identifiable E/M service by the same provider on the same day of a procedure or other service. The ED is a location where primarily unscheduled, urgent, or emergency care is provided, and modifier -25 use is legitimately higher in the ED than in other outpatient hospital settings.

CMS Transmittals A-00-40 and A-01-80 clarified the appropriate use of modifier -25 under OPPS. To append modifier -25 appropriately to an E/M code, the service provided must meet the definition of a "significant, separately identifiable E/M service" as defined by CPT. It is appropriate to append modifier -25 to ED codes 99281–99285 when these services lead to a decision to perform diagnostic or therapeutic procedures.

Transmittal A-00-40 states that Medicare requires modifier -25 "always be appended to the emergency department E/M codes when provided."[4] However, the Outpatient Code Editor only requires the use of modifier -25 when the E/M service is reported with a procedure code with a status indicator of S or T.

The transmittal further clarifies that it is acceptable to report modifier -25 in conjunction with procedures that are not status S or T, if the E/M service meets the definition of a significant and separately identifiable service. It would not be appropriate to append modifier -25 to the E/M code in cases where the E/M code is the only code on the claim.

Long Journey toward National Guidelines

The introduction of HIPAA in 1996 raised concerns that the use of E/M visit codes with varying hospital-defined reporting rules would violate HIPAA requirements for standardized code sets. Thus the journey for national guidelines began.

CMS responded in its November 1, 2002, OPPS final rule with a recommendation that an independent panel of experts be convened to make recommendations regarding standard definitions and guidelines for ED facility visit code assignment. In January 2003, AHIMA and the American Hospital Association (AHA) formed such an independent expert panel. In June 2003 the panel submitted the report "Recommendation for Standardized Hospital Evaluation and Management Coding of Emergency Department and Clinic Services" to CMS.

CMS made modifications to the recommended guidelines and contracted a pilot study to test them. The pilot was halted when it revealed that the guidelines required clearer definition.

CMS continued to review several submitted guidelines for consideration. Even after the problems encountered with the pilot study, CMS stated its belief that the AHA/AHIMA Guidelines are the "most appropriate and well-developed guidelines for use in the OPPS."[1] In the 2008 OPPS final rule, CMS recognized that the complexity of the undertaking was more challenging than it had anticipated.

In the absence of national guidelines, CMS is now regularly re-evaluating hospital outpatient visit patterns of reporting through the annual analysis of claims data to ensure that hospitals continue to bill appropriately according to their own internally developed guidelines.

Note

1. "Medicare: Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; Proposed Rule." Federal Register 71, no. 163 (August 23, 2006): 49505–977. Available online at http://edocket.access.gpo.gov/2006/06-6846.htm.

The Critical Care Controversy

In the 2008 OPPS final rule, CMS again stated that hospitals must provide a minimum of 30 minutes of critical care services in order to report CPT code 99291, Critical care evaluation and management of the critically ill or critically injured patient; first 30–74 minutes. The response to CMS frequently asked question 8809 states that hospitals must follow the CPT instructions related to CPT code 99291. Any services that CPT indicates are included in the reporting of CPT code 99291 should not be billed separately by the hospital.

CMS also addressed the policy during a hospital open door forum last winter, reiterating that CMS follows CPT-4 guidelines to the extent possible and that critical care coding rules in the CPT-4 manual apply to hospitals and physicians.

Hospitals should thus subtract from the critical care time any separately reportable procedures, such as CPR and drug administration. They should not report separately those procedures included in the CPT definition of critical care. Hospitals also should report face-to-face critical care time provided by physicians or hospital staff. If multiple staff members or physicians are providing the service simultaneously, the time involved can only be counted once.

The HIM Professional's Role

Eight years later, hospitals continue to develop their own internal guidelines for reporting ED facility visits. The challenge is daunting, and the impact on compliant billing practices is broad. CMS expects hospitals to maintain, update, and provide ongoing education to their providers regarding the internal guidelines they have developed, while following the principles delineated above.

Medical record documentation must support the services billed, based on the hospital's established internal coding guidelines. HIM professionals play a pivotal role in the development, education, and execution of their hospital's internal policies. HIM professionals must be advocates for compliant reporting of ED E/M services and act as a resource for the most accurate information under the current regulatory environment.

Notes

1. Jones, Lolita M. The Modifier Clinic: A Guide to Hospital Outpatient Challenges, second ed. Marblehead, MA: HC Pro, 2005.
2. "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2003 Payment Rates; and Changes to Payment Suspension for Unfiled Cost Reports." Federal Register 67, no. 154 (Aug. 9, 2002): 52133–240. Available online at www.cms.hhs.gov/QuarterlyProviderUpdates/Downloads/cms1206p.pdf.

3. American College of Emergency Physicians. "2008 OPPS Final Rule Executive Summary." Available online at www.acep.org/practres.aspx?id=35402.
4. Centers for Medicare and Medicaid Services. "Further Information on the Use of Modifier -25 in Reporting Hospital Outpatient Services." Transmittal A-00-40. July 20, 2000. Available online at www.cms.hhs.gov/hospitaloutpatientpps/downloads/a0040.pdf.

Resources

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CMS. "Use of Modifier -25 and Modifier -27 in the Hospital Outpatient Prospective Payment System (OPPS)." Transmittal A-01-80. June 29, 2001. Available online at www.cms.hhs.gov/Transmittals/downloads/A0180.pdf.

"Hospital Coding and Payment for Visits." *Federal Register* 72, no. 227 (Nov. 27, 2007): 379–409. Available online at www.access.gpo.gov/su_docs/fedreg/a071127c.html.

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"Update on Hospital Clinic and Emergency Department Visit Coding." AHA Coding Clinic for HCPCS 7, no. 4 (fourth quarter 2007).

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