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Inside

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HCFA's final rule on APCs is out: ED managers can breathe sighs of relief

The long-awaited final rule will have minimal impact on reimbursement

If you were expecting a major decline in reimbursement due to the switch to ambulatory payment classifications (APCs), you can relax. Dire predictions of a 15% decrease in payment for outpatient services won't come to pass, according to experts interviewed by *ED Management.*

The Health Care Financing Administration (HCFA) in Baltimore now projects that minimal decreases and, in some cases, increases, in the level of payment will occur as a result of APC implementation, says **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine.

The major negative effect of the regulations will be on outpatient services, says **Jeffrey Bettinger**, MD, FACEP, member of the Dallas-based American College of Emergency Physicians' (ACEP) reimbursement committee and co-chair of the Florida College of Emergency Physicians' medical economics committee. Instead

ED Management provides coverage of final hospital outpatient payment rule

This special issue of *ED Management* covers the just-published final rule on ambulatory payment classifications (APCs) for outpatient services. The regulations from the Health Care Financing Administration will have a major impact on your ED's reimbursement. Our cover story reports on key points in the final rule that will affect your bottom line. Related stories give you expert advice on how to maximize your reimbursement under APCs, list additional payments you can receive, summarize key points and dates you should know, and explain why the regulations could shut down ED observation units. Don't miss reading this special issue of *ED Management*! ■

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Executive Summary

The final rule on ambulatory payment classifications (APCs) for outpatient services from the Health Care Financing Administration (HCFA) was published in the April 7, 2000, *Federal Register,* with a July 1, 2000, implementation date.

- EDs might receive increased reimbursement for services under APCs, in sharp contrast to previous predictions of a 15% decrease in reimbursement.
- Instead of combining CPT and ICD-9-CM coding for clinic and emergency visits APCs, HCFA has assigned three APCs for the emergency department and a fourth APC for critical care.
- There is no APC for a medical screening exam, which could improve reimbursement.
- There is no separate APC for observation services, which means no additional payment will be given.
- You can continue to use your current charge structure and correlate present levels of service with the appropriate CPT visit level.
- You will have to "unbundle" visit levels to list nursing and physician procedures separately as specific line items.

of receiving a separate APC, values for observation services are bundled into the other outpatient APCs, which means that no extra payment will be given, he explains. **(For more on how that will affect ED observation services, see p. 54.)**

From a financial perspective, the final rule is very positive for EDs, Smith reports. "Simply put, HCFA put a lot more money on the table," he says. "They accomplished this primarily by removing those provisions from the proposed rule that were designed to prevent any possibility of the outpatient prospective payment system resulting in increased Medicare payments."

HCFA made those changes as the result of a congressional mandate to eliminate the planned reduction in total payments and add a four-year transitional protection of hospital costs, he explains.

Under the revised rules, the average hospital has little financial risk related to emergency services, Smith says. "Better yet, there is a definite opportunity for hospitals to generate greater payment under the new rules than they currently receive under the cost-based reimbursement."

After several delays, the regulations for HCFA's outpatient prospective payment system were published in the April 7, 2000, *Federal Register,* and there will be a July 1, 2000, implementation. **(For details on how to access the regulations, see p. 51. For more on APCs, see *ED Management*, August 1999, p. 85, January 2000, p. 9, and February 2000, p. 17.)**

The final rule is nearly 1,000 pages long and replaces the proposed rule published on Sept. 8, 1998. "Many of the concepts presented in the proposed rule have undergone major revision as a result of comments submitted and additional analysis by HCFA staff," notes Smith. **(See stories on key deadlines, p. 51, how to cope with APCs, p. 55, and key points from the final rule, p. 57.)**

Use current charge structure

Here is an outline of the regulations:

1. **Hospitals can continue to use their current charge structures.** In a major surprise to most experts, HCFA has stated that hospitals can simply "map" their present levels of service to the appropriate CPT visit level, 99281 through 99285, he says. "HCFA is permitting hospitals to continue their present charge structure."

However, it is unclear what documentation standards will be applied to the hospitals to support the level of service code (99281 through 99285) hospitals choose to apply, Smith says. "It is clear that HCFA will hold hospitals to CPT criteria for critical care."

2. **HCFA has eliminated the "hybrid" approach to designating APCs for emergency visits.** Three APC payment levels have been assigned for the ED, and a fourth APC payment level will be used for critical care, says Bettinger. "Elimination of the hybrid approach of combination of CPT and ICD-9 codes should make for more accurate assignment of APCs with less possibility to 'game' the system. The potential was great to have undue pressure placed on the emergency physician to assign a diagnosis geared to reimbursement."

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At the beginning of the inpatient prospective payment system implementation of diagnosis-related groups (DRGs), there were a multitude of courses that taught hospitals how to code for the highest level of reimbursement depending on which diagnostic category to place the patient in, Bettinger explains. "A lot of this was very subjective, especially in patients with multiple diagnoses. There was abuse which took many years to straighten out."

By eliminating the diagnostic component, there should be less "flexibility" in the system, he says. "Emergency physicians had some concerns that they may have been placed in uncomfortable positions if the diagnosis they applied for medical reasons was not the optimal for reimbursement purposes." **(See story on physician documentation and hospital coding, p. 53.)**

Because most visits to EDs are symptom-driven, it isn't unusual for the final diagnosis to be less acute than the presenting symptom, Bettinger says.

3. **There will be no screening exam APC in the ED.** No additional payment will be made for special ED screening services, says **Caral Edelberg**, CPC, CCS-P, president of Medical Management Resources, an emergency medicine coding and consulting firm in Jacksonville, FL, specializing in financial reimbursement.

"These screening services will be 'bundled' into the APC rate for the level of service," she explains. "If no actual level of service is rendered, screening is to be billed at the lowest ED level of service."

Elimination of the screening exam CPT code could be beneficial, according to Bettinger. "This APC had the potential of being utilized, retrospectively, by HCFA to downcode some ED visits. ACEP has contended that the typical screening exam done in the ED is far more intensive than the quick 'eyeball exam' that seems to be [preferred by] some third-party payers." **(See guest column on physician and hospital coding for APCs, p. 57.)**

4. **Critical care (CPT 99291) is recognized as a visit level.** Incremental critical care time will not be recognized for facility payment because it is assumed that any patient requiring more than 74 minutes of critical care time will be admitted to the hospital, Smith explains. "If admitted, payment will ultimately be based on a diagnostic-related group and not on outpatient prospective payment."

Critical care presented a challenge to HCFA in attempting to define the service in terms of facility, not physician, input, says Edelberg. "Hospitals are required to use code 99291 in place of, not in addition to, the code for the level of service in the ED."

Where to find the regulations

The new hospital outpatient prospective payment system regulations are published in the April 7, 2000, *Federal Register.* The *Federal Register* is available at many libraries. For copies, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. The cost of each copy is $8. Specify the date of the issue and enclose a check or money order payable to the superintendent of documents, or enclose your Visa or MasterCard number and expiration date. Credit card orders also may be placed by calling the order desk at (202) 512-1800 or by faxing them to (202) 512-2250.

The regulations also are available from the *Federal Register* on-line database through GPO Access, a service of the U.S. Government Printing Office. The superintendent of documents' address is www.access.gpo.gov/su_docs/aces/aces140.html.

The regulations also can be downloaded from HCFA's Web site at www.hcfa.gov. ■

Know these key deadlines

The Baltimore-based Health Care Financing Administration has established several key dates surrounding the implementation of the ambulatory payment classifications for outpatient services:

- May 30, 2000. Determine what copayment discounts, if any, the hospital elects to offer to Medicare beneficiaries for the period from July 1, 2000, to Dec. 31, 2000.
- July 1, 2000. Process claims under the outpatient prospective payment system rules for claims with a date of service on or after July 1.
- Nov. 30, 2000. Determine what copayment discounts, if any, the hospital elects to offer to Medicare beneficiaries for the period of Jan. 1, 2001, to Dec. 31, 2001. ■

5. **HCFA has not fundamentally changed the proposed rule with respect to bundled services.** Pharmacy, central services, and several other departments remain bundled into visit and procedure charges, says Smith. However, splinting and strapping have been recognized as separate procedures, with

Sample ED payments under APCs

ED visit levels have been grouped into four ambulatory payment classification (APC) levels, including critical care. Hospitals will need to define their charges as related to a visit level, using a CPT evaluation and management (E&M) code, 99281 through 99285, or 99291 if the patient requires critical care. There are a total of six valid E&M codes for the ED. The four APC payment levels correspond to those six visit levels for ED services. For example, 99291 (critical care services) will cross-reference to APC 620 (critical care). **(See chart, below.)**

ED visit levels payments APC 610, 611, and 612 do *not* include the value of specific services, such as lab tests, X-rays, and computed tomography scans. Those services can be identified separately by HCPCS codes.

APC payment levels and corresponding CPT E&M codes

APC	CPT E&M Service Visit Level	Medicare Payment*	Patient Copay*	Total Payment*
610	99281	$65	$21	$86
	99282	$65	$21	$86
611	99283	$102	$36	$139
612	99284	$155	$54	$209
	99285	$155	$54	$209
620	99291	$417	$153	$570

*Numbers are rounded.

Source: Lynx Medical Systems, Bellevue, WA.

reimbursement related to the procedure of applying the splint instead of the cost of plaster and materials, he notes.

"Wrapping the ankle will carry a national total value of $72 when the service is reported by the ED with the appropriate CPT code," he says.

6. **Visit levels will need to be "unbundled" to list nursing and physician procedures separately as specific line items.** APCs are based on the definitions used by physicians to describe and bill for their office services, Smith explains. "Medicare will pay separately for specific services that are currently bundled into ED levels of service." **(See story on additional payments under APCs, p. 56.)**

Levels of service payments have been reduced to account for the value of the payments that will be made for the unbundled services, says Smith. Here are examples of nursing services that will be reimbursed only if separately identified, he says:

- laceration repairs;
- EKG monitoring;
- joint dislocations;
- burn therapy;
- fracture treatment;
- splinting and strapping.

7. **No separate payment will be made for most drugs used in ED visits.**

HCFA's analysis of the cost of drugs commonly associated with each ED level of service has facilitated bundling of the drug component into the associated ED APC level, says Edelberg. "Hospitals will continue to itemize these drugs through their billing, however, and Medicare will bundle the payment accordingly into the ED level of service."

However, additional reimbursement will be made through the APC system for the following drugs and services associated with an ED visit: diagnostic testing, administration of infused drugs, therapeutic procedures including resuscitation, and high-cost "clotbuster" drugs, Edelberg says.

8. **There is a broad interpretation of your responsibilities under EMTALA.** The final rule affirms HCFA's previous position that the hospital and ED staff must respond to any request for emergency medical screening, notes Smith. "The scope of the area where response is required includes the entire 'campus.' This includes the parking lot, street, and other hospital properties," including urgent care centers. ■

Physicians/hospitals don't have to correlate

In the final rule on APCs, physician documentation and hospital E/M codes don't have to correlate, notes **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine. "HCFA did not require hospitals to demonstrate that physician documentation in the clinical record supports the visit level assigned."

This eliminates a concern that the hospital's level of service must match that assigned by the physicians, Smith explains. "It also leaves unanswered how Medicare reviewers will determine if a service level was 'medically necessary.' Audit criteria for medical necessity is defined for physician services that are billed using the same CPT definitions."

Hospitals select HCPCS code

The mechanism for designating the correct HCFA common procedural classification system (HCPCS) code is left up to the hospital to decide, based on intensity of service, says **Jeffrey Bettinger**, MD, FACEP, member of the Dallas-based American College of Emergency Physicians' reimbursement committee and co-chair of the Florida College of Emergency Physicians' medical economics committee. "An expert advisory panel will look further into possible methods of better identifying underlying resources utilized, especially nursing services," he says.

The hospital will assign an HCPCS code for each service rendered. Currently, the hospitals are expected to supply this code, but it will now be a requirement, says Bettinger. "The Medicare intermediary will cross-reference the HCPCS code to the corresponding APC, which will determine payment."

For basic services in the ED, there will be four APCs that correlate to six HCPCS codes, as follows:

• 99281 (problem-focused decision making) and 99282 (expanded problem-focused low medical decision making) will cross-reference to APC 610 (low-level emergency visits).

• 99283 (expanded problem-focused moderate medical decision making) will cross-reference to APC 611 (mid-level emergency visits).

• 99284 (detailed medical decision making) and 99285 (comprehensive medical decision making) will cross-reference to APC 612 (high-level emergency visits).

• 99291 (critical care services) will cross-reference to APC 620 (critical care).

The hospital can list only one of those HCPCS codes, in addition to other billable HCPCS codes that cross-reference to other APCs. HCFA expects the hospital to have an internal system of choosing HCPCS codes 99281 through 99285 and 99291 based on intensity of service, Bettinger explains. "This system need not correlate with the choice of physician service CPT codes."

The physician's choice of a CPT code might have no correlation with the HCPCS code designated by the hospital, he notes. "Overall, I am happy with the final rule, as I had concerns that hospitals would have widespread undercoding, which could potentially be used by HCFA to question the CPT coding of the corresponding physician services."

The potential existed to cross-reference the two codes and possibly downcode the physician's CPT code, Bettinger explains. "By de-linking the hospital's HCPCS code and the physician CPT code, the potential to challenge physician coding is diminished," he says.

Lack of correlation between the hospital's HCPCS coding and the physician CPT coding will diminish the importance of physician documentation, he notes. "Probably nursing time will be a major determinant, along with the amount of ancillary services utilized."

Hospitals will develop unique systems for mapping services to different visit levels, says **Caral Edelberg**, CPC, CCS-P, president of Medical Management Resources, a Jacksonville, FL, emergency medicine coding and consulting firm specializing in financial reimbursement. "Facilities will be expected to develop and comply with their own facility's unique levels, and the crosswalk of these levels to the appropriate HCPCS code[s]," she explains. "HCFA expects assurance that each facility will follow its own established criteria, and those criteria are expected to represent the intensity of service at the different levels of HCPCS codes." ■

Sources

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APCs won't pay for ED observation

Units might close, expert predicts

With the new ambulatory payment classification (APC) system for billing of outpatient services, the Baltimore-based Health Care Financing Administration (HCFA) has struck a blow to ED observation services, according to experts interviewed by *ED Management.* The just-published regulation states that observation services will not be given their own APC codes, which means no additional payment will be made for those services.

Instead of having their own APCs, the values are bundled into the other outpatient APCs, says **Jeffrey Bettinger**, MD, FACEP, a member of the Dallas-based American College of Emergency Physicians' reimbursement committee and co-chair of the Florida College of Emergency Physicians' medical economics committee.

"Lack of a separate APC for outpatient observation services may have a chilling effect on the ability of existing observation units to remain operational," Bettinger stresses.

'HCFA does not understand'

An incorrect statement appears in the HCFA regulations, asserts **David Chauvin**, DO, FACEP, chairman of compliance for Premier Health Care Services, an ED physician group in Dayton, OH. The statement reads, "We assume that chest pain patients, such as those described by the commenters, are sent to the CCU or ICU for observation. We believe that, in general, if a patient needs to be monitored in the ICU or CCU for any length of time, then that patient should be admitted as an inpatient."

Chest pain patients who are placed in observation units do not need to be in the ICU or CCU, Chauvin says. "Clearly, HCFA does not understand how a chest pain observation unit is used," he says.

The regulations will cause ED observation units to close, which will increase inpatient admissions, Bettinger predicts. "The lack of assignment of an APC value for observation services is a big mistake by HCFA," he says. "HCFA's comments showed a lack of understanding on how medical observation units function. Hopefully, this error will be rectified in future modifications."

In November 1996, HCFA issued instructions limiting payment for observation to no more than 48 hours except in exceptional circumstances, notes **Caral Edelberg**, CPC, CCS-P, president of Medical Management Resources, a Jacksonville, FL, emergency medicine coding and consulting firm specializing in financial reimbursement. HCFA will continue to monitor use of observation for future consideration of a separate APC, she says.

"Hospitals are requested to continue billing for observation services under the ED under revenue center code 762, which will allow HCFA to continue monitoring this service," she explains

The regulations caution that observation must represent some level of active monitoring by medical personnel, she warns.

Not a major cost?

Some experts insist that packaging observation services with ED level 4 and 5 will not be a major cost to hospitals. Hospitals still will be paid the ED visit APC, and all nursing services provided during observation also will paid, according to **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine.

Present ED billing practices rarely unbundle nursing services from the visit-level services, notes Smith. "To bill under APCs, EDs will need to unbundle many of the services they presently include in a single-visit service charge."

Observation services will include additional nursing services, ancillary tests, and procedures, he says. "If all these payments are added up, the net impact on the emergency department will be minimal."

Still, hospitals are likely to favor a decision to admit the patient and might elect to convert the observation unit to an inpatient service, Smith acknowledges. "But by doing this, we may be able to have the best of both worlds. When the dust settles, I believe the hospitals and physicians will find a way to make observation services work." ■

Source

For more on APCs and observation services, contact:

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Here's how to cope with APC system

Unfortunately, ED managers might have heeded advice on how to restructure ED operations in response to the switch to ambulatory payment classifications (APCs) based on outdated information, says **Caral Edelberg**, CPC, CCS-P, president of Medical Management Resources, a Jacksonville, FL, emergency medicine coding and consulting firm specializing in financial reimbursement. The long-awaited regulations have now been published by the Health Care Financing Administration (HCFA) in Baltimore. "So now you can take action based on facts, not hysteria or misinformation," she says.

Here is some advice for maximizing your reimbursement under APCs:

1. **Know which services are subject to APC payment methodology.** Types of services subject to APC payment methodology include surgical procedures, radiology (including radiation therapy), clinic visits, ED visits, diagnostic services, other diagnostic tests, partial hospitalization for the mentally ill, surgical pathology, cancer chemotherapy, surgical supplies, and preventive services for healthy persons, notes Edelberg.

"In general, services included within the APC procedure groups will be bundled for payment, including observation," she says.

Types of services excluded from APC payment methodology include antigens, splints, strapping and casts, pneumococcal vaccines, hepatitis B vaccines, influenza vaccines, blood and blood products, immunosuppressive drugs following organ transplant, and certain high-cost drugs infrequently administered, says Edelberg.

2. **Do your homework.** Careful review of the regulations is necessary, urges **Jeffrey Bettinger**, MD, FACEP, member of the Dallas-based American College of Emergency Physicians' reimbursement committee and co-chair of the Florida College of Emergency Physicians' medical economics committee.

"I would advise ED managers to study the rule closely, speak with peers and consultants, and start drafting crosswalk criteria," he recommends.

3. **Improve documentation.** Investigate how information is recorded and processed into codes and charges for billing purposes, suggests Edelberg. "Physicians, nurses, and other ED staff should be working on improving documentation of services."

These are the key documentation areas you should focus on, she says:

— Perform both random and focused audits to identify those records in which documentation is deficient and nursing progress notes don't support the level of service indicated in doctors' orders and medical decision making.

— Identify records in which notes indicate that procedures may have been performed, but the type and extent of the procedure, as well as supplies and medications ordered, were not documented appropriately.

Although Medicare may bundle certain supplies and medications into the APC, others will be separately identifiable, notes Edelberg. "And for those other payers that do not bundle supplies and medication into the visit, you will want to itemize separately for them."

4. **Develop an effective forum for communication between coders and ED staff, including physicians and nurses.** Effective communication ensures that coding can be performed appropriately to best benefit the institution, Edelberg advises. Coders should be represented at meetings to discuss documentation and coding issues, she suggests. "ED staff should be notified of coding changes that may impact how documentation is required to be performed to ensure correct coding."

The coding department might want to highlight outstanding ED staff who document well to encourage others, she says. "Peer pressure helps! Doctor-to-doctor and nurse-to-nurse is generally the most effective means of communicating. So one person should be designated from each professional area [physician, nurse, radiologist, etc.] to carry the message, while working closely with either hospital or outside coders to better understand and improve documentation and communication."

5. **Learn how payments and denials will be managed.** Study the process of how payments and denials will be managed under the new system so you can communicate any necessary information to ED staff and coders, Edelberg advises. When payments are reviewed and/or posted, you should have a system to ensure the denial is consistent with payer policy, she explains.

ED managers should ask the business office the following questions:

— When charges for more than one service or procedure are billed, how are they reimbursed?

— Is reimbursement bundled or itemized and paid separately?

6. **Don't cut staff yet.** Edelberg has been contacted by administrators who were advised by other consultants to cut full-time equivalent (FTE) positions across the board in preparation for APCs. "That is bad business, in my opinion, as we can pretty much guarantee a learning curve for medical records and the business office. That may demand additional FTEs to manage the transition properly, outsourcing to coding, or a better method of performing the billing function." ■

Here are additional payments given by APCs

Ambulatory payment classification (APC) visit-level payments assume additional payments for physician procedures and nursing services, reports **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine. "Additional payments are associated with additional procedures," he says. Here are additional payments for ED services, according to Smith:

1. Typical ED visits at levels three and higher will include multiple line items that will materially increase the payment if reported. For example, an ankle injury evaluated in the ED and treated with either an elastic bandage or a plaster splint can have at least two services reported. The visit level is reported as 99283 (APC 611), with reimbursement set at $139. Splinting the ankle is reported 29540 (APC 058), which pays $72. The total payment is $211. Additional payment also will be made for X-rays. **(See chart, below, for some of the common APC categories that apply to services routinely provided in the ED.)**

2. Most of the surgical procedures (laceration repairs, fractures, and incision and drainage of an abscess) are identified by CPT code listed under an APC group with a status of "T." The full value for the highest-value service will be paid. Additional procedures within the same or other APC groups designated as status "T" will be paid at 50% of the value listed.

3. APCs identified with an "S" (significant procedures) or an "X" (ancillary services) are not subject to discount for multiple occurrences when more than one CPT code is submitted. For example, each of three intramuscular injections will be paid at the full value.

4. For visit services, Medicare will make separate payments for IV infusion therapy, intramuscular injections, and numerous other "nursing services" in addition to the level of service. Those services are not subject to discount when multiple services are performed.

5. Two new APCs were added for splinting, strapping, and casting. Those APCs include all the CPT codes listed in the splinting and strapping section of CPT.

6. Expensive drugs, such as thrombolytics, will be paid for as "add-on" payments, even if the patient is transferred and admitted to another facility.

7. Patients who die in the ED will be treated as outpatients for the purpose of payment, unless they have been admitted to inpatient status at the time of their death. ■

APCs for common ED services

APC	APC Description	Indicator Status	Medicare Payment*	Patient Co-Pay*	Total Payment*
024	Lac repair (except complex)	T	$118	$45	$162
043	Closed fracture Tx	T	$80	$16	$105
058	Level 1 splinting	S	$53	$19	$72
094	Resuscitation and cardioversion	S	$219	$105	$324
359	Injections	X	$47	$9	$56
340	Minor ancillary procedure	X	$50	$13	$63

*Numbers are rounded. T = surgical procedures. S = significant procedures. X = ancillary services.

Source: Lynx Medical Systems, Bellevue, WA.

Know these key points of the APC system

The final rule on ambulatory payment classifications (APCs) from the Baltimore-based Health Care Financing Administration (HCFA) incorporates the following changes in hospital outpatient payments:

• The APC payment rate established for each group applies to all services within the group. Although national payment rates are established for each group, payments will be wage-adjusted to reflect geographic differences. Under the final rule, HCFA has developed separate APCs to pay for blood, other blood products, and anti-hemophilic factors.

• In addition, HCFA modified the proposed regulation to allow a smoother transition to the new fee system for providers. The APC groups were refined based on comments. The changes included requiring the use of HCFA common procedural classification system codes only for purposes of computing payments for medical visits to clinics and EDs.

• The regulation excludes ambulance services because a new fee schedule is being developed. Physical, occupational, and speech therapies, orthotic and prosthetic devices, durable medical equipment, and clinical laboratory services are excluded because they are paid under existing fee schedules.

Medicare will make additional payments for certain new medical devices and drugs for up to three years.

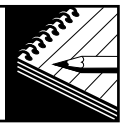
During a transition period until 2004, Medicare will pay hospitals a portion of any losses they otherwise would incur from smaller payments than under prior law. For rural hospitals with 100 or fewer beds, those losses will be replaced fully.

• Medicare will make an outlier payment for high-cost cases, with payments projected not to exceed 2.5% of total payments to hospital outpatient departments in 2000-2003. When the cost exceeds the APC payment by more than 2.5 times, HCFA will pay 75% of the cost above the 2.5 threshold.

• HCFA will review the APC groups, wages, and other adjustments annually. As part of that review, HCFA will consult with an expert panel composed of provider representatives.

Source: Health Care Financing Administration, Baltimore.

GUEST COLUMN



Know difference between APC coding systems

By **Marty Karpiel**, FACHE, FHFMA
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With the Health Care Financing Administration's (HCFA) switch to ambulatory payment classifications (APCs) for outpatient services, hospitals will need to revise their chargemasters to include all of the evaluation and management (E&M) CPT codes for emergency and clinic technical services. Physician- and hospital-generated CPT codes present different challenges.

If the hospital chooses to use the physician CPT codes, keep these points in mind: First, the physician CPT coding should never be performed on the higher-level visits without complete documentation of those higher-level visits such as 99284 or 99285. Therefore, the individual responsible for coding should wait until the dictation is transcribed before assigning an E&M CPT code.

That might delay the coding and billing function by days or weeks at some hospitals due to lengthy transcription turnaround times. Formatted clinical charts and information systems with documentation modules eliminate the need for dictation and provide a form of

Executive Summary

You'll need to revise your chargemasters to include all of the evaluation and management CPT codes for emergency and clinic technical services to prepare for the Health Care Financing Administration's switch to ambulatory payment classifications for outpatient services.

- Physician- and hospital-generated CPT codes present different challenges.
- Physician CPT coding should never be performed on the higher-level visits without complete documentation of the higher-level visits
- A descriptive patient classification system (PCS) does not accurately portray the intensity of the visit, but the quantified PCS lists specific nursing tasks and assigns a point value to each one

documentation that can be immediately available for coding. The physician relationship with the hospital will influence the physician coding. Emergency and clinic physicians usually are employed by an independent group, large physician contracting group, or the hospital. Physicians who are employees or owners in an independent or large contracting group generally have a significantly different CPT coding profile than those physicians who are hospital employees. The nonhospital employee physicians are compensated based on the services provided and the complete documentation of those services. Therefore, the nonhospital employed physician generally will optimize documentation.

Walking a fine line

Nonhospital employee physician groups tend to contract with large billing services experienced in billing, often exclusively for emergency and/or clinic visits. Those billing companies provide extensive training to their coding staff on optimum coding based on the documentation provided by the physician. Due to the recent HCFA and Office of the Inspector General fraud and abuse cases, the billing companies have learned how to walk the fine line between coding optimization and overcoding.

Hospital-employed physicians are rarely rewarded or penalized for their documentation of services provided. Therefore, their documentation may include the clinically pertinent information, but it often does not meet the CPT coding guidelines based on the chief complaint. Most commonly, their documentation may not include a complete review of systems, complete physical examination, or adequate medical decision making to support a higher CPT code, even though the clinical care would have warranted the higher CPT code assignment. The incomplete documentation is then coded by hospital coders who likewise are not incentivized to optimize the physician coding.

Using hospital CPT codes

If the hospital decides to rely on its own coding, then it faces other complex challenges. First, there are no requirements for standardization of ED and clinic visits for the technical side as there are for the professional side. Hospitals have one to 12 ED visit levels, and as many clinic levels. Only a chargemaster with five or six visit levels (critical care being the sixth) will map to the E&M CPT codes, which in turn map to the APCs for medical visits. Therefore, hospitals will need to revamp their ED and clinic chargemasters.

Secondly, how will the hospital ensure there is consistent and appropriate application of hospital visit charge level and CPT code? For physician services, the CPT coding guidelines clearly indicate which CPT code to use, based on the documentation, including the medical decision making. No such guidelines are mandated or standardized for facility visit levels. Hospital financial managers should be concerned that they develop a visit charge level system to meet HCFA compliance guidelines. While there are no specific guidelines, two types of systems should withstand a compliance audit if appropriately implemented: Those patient classification systems (PCS) are a detailed descriptive level system and a quantitative level system.

Hospital financial managers should be concerned that they develop a visit charge level system to meet HCFA guidelines.

A descriptive PCS is often based on nursing resources required to provide care to patients. Because nursing costs are the largest part of an ED's direct costs, it stands to reason that all other departmental costs will follow in the use of nursing resources. Higher acuity patients require more nursing time, spend more time in the department, and consume more supplies and other resources. The descriptive model uses broad explanatory terms to organize patients into specific groups on the basis of symptoms and/or diagnoses that use similar levels of resources. Using diagnosis exclusively does not accurately portray the intensity of the visit.

The quantified PCS model lists specific nursing tasks and other patient care activities and assigns a point value to each one. The sum of the points then determines the ED charge level. For a PCS to serve as an ideal ED information tool, it needs to allocate an average number of nursing minutes to each level of care. This system permits the PCS to not only serve as a charging system, but also as a costing and productivity measurement tool.

(Editor's note: Karpiel Consulting Group works with EDs nationwide on process improvement and financial reimbursement.) ■

Source

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JOURNAL REVIEWS

Tintinalli JE. **Analysis of insurance payment denials using the prudent layperson standard.** *Ann Emerg Med* 2000; 35:291-294.

Managed care organizations (MCOs) are denying payment for ED visits that meet the prudent layperson definition of an emergency, says this study from the University of North Carolina at Chapel Hill. The study reviewed 200 ED visits that were classified as "not a medical emergency" by two MCOs. One MCO denied 44 visits, of which 38 met the prudent layperson standard, and the other MCO denied 156 visits, of which 113 met the standard.

Part of the problem is that there is no explicit or consensus definition of the prudent layperson standard, says the researcher. The ED visits were analyzed for chief compliant and risk factors for morbidity. Any minor disorder lasting one day or more, with normal vital signs recorded, was considered not to meet the prudent layperson standard because a personal physician could have been contacted within that time frame.

The prudent layperson standard has been adopted for Medicare and Medicaid programs in most states. However, the study shows that federal and state prudent layperson legislation, although important for reimbursement of ED visits, does not ensure compliance. ICD-9-CM coding systems need to be expanded to include variables such as triage severity, chief complaint, comorbidities, and mechanism of injury to determine whether the prudent layperson standard is met, according to the study. In the future, compliance by MCOs will be affected by legislation, pressure from consumers and physicians, improvement in classification systems, and expanded chart review, says the researcher. ▼

Husni ME, Linden JA, Tibbles C. **Domestic violence and out-of-hospital providers: A potential resource to protect battered women.** *Acad Emerg Med* 2000; 7:243-248.

Out-of-hospital providers can be valuable resources to help victims of domestic violence, many of whom refuse transport to the hospital, according to this study from Beth Israel Deaconess Hospital in Boston, Boston University School of Medicine, and Hennepin County Hospital in Minneapolis.

Emergency medical services (EMS) personnel are important resources for domestic violence victims for the following reasons, say the researchers:

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• As initial responders, they have an opportunity to intervene on behalf of the victims.

• They can observe the environment in which the violence occurred. They might detect violence that could otherwise go undetected, because they are able to observe the behavior of the batterer in the home.

• In many cases, victims might refuse to be transported to the hospital for a variety of reasons, including shame, fear of retaliation, fear of legal consequences for the batterer, and child care issues. Failure to transport prevents victims from obtaining hospital-based services such as social work or referrals to hotlines and emergency shelters. Educational programs should focus on

CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management. (See *Journal Reviews.*)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *HCFA's final rule on APCs is out: ED managers can breathe sighs of relief; APCs won't pay for ED observation;* and *Here's how to cope with APCs.)*
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication.

improving recognition of abuse and competency in safety planning and documentation, the study suggests. For example, the EMS training curriculum might need to include topics not covered in current training modules, such as scene safety and evidence preservation.

Prehospital personnel should be trained to identify and document domestic violence, assess patient safety, offer timely resources, and empower victims to make choices, write the researchers. "Increased training and competence in assisting victims of domestic violence may allow earlier intervention, before the violence escalates and the woman is seriously harmed." ▼

Blank FS, Keyes M. **Thrombolytic therapy for patients with acute stroke in the ED setting.** *J Emerg Nurs* 2000; 26:24-30.

EDs should develop practice guidelines to reflect the Stroke Council of the American Heart Association's 1996 guidelines for thrombolytic therapy for acute stroke, according to this study from Baystate Medical Center in Springfield, MA. The ED implemented the guidelines, and the following challenges were noted:

• The logistics of arranging 24-hour, seven-day neurology coverage for the ED was difficult because of a paucity of neurologists in the area.

• The expertise and physical presence of a neurologist in the ED at the time of patient assessment is an essential component of the protocol for giving tissue plasminogen activator (t-PA) therapy to a person who has had an acute stroke.

• A neurologist must be present to confirm the diagnosis after the CT scan and to perform the assessment, including the National Institutes of Health Stroke Scale.

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Because of the strict inclusion criteria, the use of t-PA therapy in the ED for stroke patients is very low, the authors note. However, quickly assessing patients who meet the inclusion criteria and initiating therapy for them without delay are critical, because there is only a three-hour window of opportunity from onset of symptoms to drug administration, they add.

The authors caution that the possibility of an intracranial bleed and/or death exists as a complication with any thrombolytic therapy. "The ED should have all the professional supports in place and the resources needed to manage complications before instituting new treatment modalities such as this one." ■