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Focus on facility evaluation and management leveling

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The New York American College of Emergency Physicians (New York ACEP) posted information in late 2017 relaying to its membership that a large commercial insurance company was expected to implement a revised policy regarding Emergency Department (ED) facility evaluation and management (E/M) coding[1] affecting reimbursement practices. The new policy was to focus on ED claims reporting Level 4 or 5. The new logic would not include reviewing medical record documentation; rather, the E/M code assigned would be validated based upon the other reported codes.

You may be asking, why the change? We've seen changes in E/M leveling for the facility outpatient hospital clinics in 2014. The Centers for Medicare & Medicaid Services (CMS) removed the levels in all areas of the hospital, with the exception of the ED. The reason for this change, cited by the commercial insurance companies, is their national experience with inconsistencies in coding accuracy and on the E/M coding principles.[2] The previous facility leveling for clinics is still seen in the ED. CMS has not published standards or criteria for the facility E/M levels; rather, it indicated each facility should develop their own.

So, is the change warranted? The answer is not as straightforward as you may think. Many hospitals do have E/M leveling systems that result in a code most reflective of the intensity of hospital resources expended. However, depending on how the leveling system is designed, there is a possibility of artificially skewing an E/M code to a higher level than might be warranted. An example of this could be a leveling system that assigns an E/M Level 4 to the following scenario:

A female patient presents with a chief complaint of diarrhea for the past few hours. The chief complaint or presenting problem is automatically assigned a Level 3 E/M prior to any intervention or workup. The provider, as part of the workup, orders a complete blood count (CBC) and X-ray of the abdomen. The CBC and X-ray are normal. The patient is diagnosed with gastroenteritis and instructed to drink plenty of fluids to avoid dehydration. She is given oral medications to control the diarrhea and sent home.

In the above example, the emphasis is on the presenting problem, which results in an immediate assignment of an E/M Level 3 without any intervention. The presenting problem, along with the addition of the CBC and X-ray of the abdomen, results in an E/M Level 4. But does this scenario "reasonably relate the intensity of hospital resources to the level assigned"[3] as indicated by CMS? The E/M code descriptor 99284 indicates the presenting problem(s) are of high severity and require urgent evaluation by the physician.

Commercial carrier review

According to the article by the New York ACEP, the commercial carrier will begin using a proprietary tool to analyze claim data to ensure the level assigned by the facility reasonably relates to the intensity of resource utilization. This does reflect CMS's 2008 guidance, which indicates that facilities should relate the intensity of

the resources used to the different levels of codes.[4] In theory, this sounds like a great way to ensure claims are reported with the most accurate level.

For the scenario described above, when analyzed by the tool, an E/M Level 3 was identified. The Level 3 code descriptor for E/M code 99283 indicates the presenting problem(s) are of moderate severity. Based upon the claim information alone, one could argue that an E/M Level 3 is the most appropriate. However, there can be drawbacks to using only claims data to validate coding, rather than considering the specific information supported in the medical record.

For our example, let us speculate that the patient has a history of anxiety, and when she arrives in the ED she is so anxious, she requires oral Ativan and frequent monitoring by the nursing staff. Even with the addition of the code for anxiety, the example review tool still calculates a Level 3 E/M, even though more resources have now been expended to require frequent monitoring of the patient.

Or consider the patient who has chronic kidney disease and is monitored every 15 minutes by nursing staff to ensure the patient does not develop dehydration, which could affect kidney function. If the code for the chronic kidney disease is accidentally omitted from the claim, there would be no way to know there is an additional condition that affects patient care. This added element requires more than expected resources, warranting a higher E/M level.

Facilities may experience claims adjustments or denials based upon the reimbursement structure within their agreements; however, they will have the opportunity to submit reconsideration or appeal requests.[5] Facilities will not be notified of the change or the reason. Therefore, all facilities must be aware and develop a plan for addressing any policy changes. This means more than just ensuring billing staff are aware and reviewing the remittances carefully. Facilities will have to work with their Chargemaster staff to ensure it matches what the commercial carrier is seeking. This will place additional burdens on the facility in terms of time, money, and IT resources. Facilities are responsible for the submission of appropriate claims. Without a review of the documentation, claims could be denied or downcoded when the level is appropriate. This will result in facilities having to decide if they should appeal or accept the determination, either of which will result in a decrease in reimbursement or an increase in staffing time and costs.