Critical Care Documentation and Coding in 2015: Don't Undervalue, Don't Overreach
By Ronald W. Stunz, MD, FACEP

The core competency that defines emergency medicine as a specialty field is centered in our ability to bring to bear critical interventions on patients presenting with organ or life threatening illness and injury. While we routinely handle debilitating ankle sprains, patiently help a young child through his first finger laceration as painlessly as possible, or reassure a middle-aged man that his chest pain is not from a heart attack, our ultimate value to our hospital and our community is our availability and competence in the delivery of complex, skilled intervention to those who would suffer extreme morbidity or mortality were we not present.

Our timely interventions in severe infectious, ischemic, traumatic, surgical and other emergent scenarios obviously have a direct impact on patient outcome. Not so obvious, but only slightly less important in the prevailing climate of rising and scrutinized health care costs, what we do well in the first hour of a patient’s presentation can significantly reduce downstream costs for care.

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<tr>
<th>Evaluation and Management</th>
<th>CPT E/M Code</th>
<th>RVU</th>
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<td>Limited/Problem Focused</td>
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<td>.60</td>
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Critical Care (30-74 Minutes) 99291 6.29
Critical Care (Additional 30 Minutes) 99292 3.14

It is thus not surprising that provision of critical care is the most highly compensated level of Evaluation and Management (E/M) codes for our specialty. The accompanying table shows the Relative Value Units (RVUs) for emergency medicine E/M levels. Worth remembering is the statistic that E/M coding and billing accounts for 80-85 percent of the revenue stream for a typical practice, and that critical care (99291 and 99292) is reimbursed about 25 percent higher than a comprehensive E/M code (99285) which might be coded for an uncomplicated hospital admission. The question of whether compensation for the provision of critical care is adequate and truly reflective of the skill required or the real impact on outcome and cost remains open to some debate. That question aside, it is clear that critical care represents not only the best argument for our specialty’s presence, but also, relatively speaking, our best reimbursed activity.

What remains surprising is the tendency of many emergency physicians to fail to recognize that, in many circumstances, the care they have provided constitutes critical care and their subsequent failure to submit a billing request for this level of service. Typically, these circumstances are the product of the very competence that should be rewarded: the experienced provider manages a serious and complex case with alacrity and comes to view such activity as routine. A recurrent example would be an elderly patient presenting with acute congestive heart failure whose diagnosis is often immediately apparent and whose management is often relatively predicatable and formulaic. Too often, the chart of such patients does not reflect the time spent in reassessment, discussions with the patient, family members and consultants, reviewing studies and prior patient records, and the physician does not request critical care coding and billing for the encounter. Similarly, unclaimed critical care scenarios are seen in the setting of extended ED management of asthma, otherwise healthy young adults with supraventricular tachycardia, or patients with new onset uncontrolled atrial fibrillation.

**Defining Critical Care**

Current Procedural Terminology (CPT) is relatively explicit and detailed in its descriptions of critical care services. Three components are required for codes 99291 and 99292: a critical illness, which “...impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition;” critical intervention, involving “...high complexity decision making to assess, manipulate, and support vital organ system failure;” and, time, defined as “...time spent engaged in work directly related to the individual patient’s care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.” In order for critical care services to be coded and billed, documentation to support all three components of the definition must be present in the medical record, accompanied by the physician’s attestation that critical care was provided.

Further nuances have importance for each of the three components of critical care. Critical illness may be somewhat problematic and situational in its formal definition, but, paraphrasing Supreme Court Justice Potter Stewart on another subject, “I can’t define it, but I know it when I see it.” Emergency physicians are trained and skilled in the recognition of clinical scenarios in which the patient’s potential for severe clinical deterioration is either actively evolving or imminently likely to occur. Certainly, examples cited by CPT in its guidelines, “...central nervous system failure,
circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure,” are usually readily apparent and well-defined clinical scenarios in which critical intervention is mandatory in a timely fashion. Other presentations, in which overt organ failure has not occurred, but in which a high probability of such failure is possible, and prevention of which requires active physician management, represent cases in which, situationally, the critical care services codes are justified and sustainable.

In terms of physician intervention, it is noteworthy that all three verbs used by CPT to define the care provided, “assess, manipulate and support,” are active rather than transitive. The implication is that the physician is taking an active role in the management of the case, and this should be manifested by documentation evidence of therapeutic intervention. Whether cases ending with simple assessment, in which therapeutic intervention on the part of the emergency physician is neither feasible nor indicated, meet the requirements of the CPT definition remains a question in coding and billing circles. An elderly patient presenting with transient neurologic symptoms certainly has the potential for deterioration, although such deterioration is generally not so temporally imminent as to mandate even hospital admission in many cases, and therapeutic manipulation may not be emergently prescribed in the ED. For a similar patient with evidence of an active ischemic stroke with fixed deficits for whom no pharmacologic intervention is warranted or necessary by the emergency physician, is the definition of critical care met? While such patients clearly require significant time for coordination of care and interpretation of studies, the absence of manipulative and supportive interventions may argue against the notion that critical care was actively provided. CPT states: “Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.” Thus, in the absence of active care by the physician, some ambiguity may exist in certain clinical scenarios.

To elaborate further on the common scenario of acute ischemic stroke, in the absence of pharmacologic intervention, the question becomes: in the absence of such intervention, what distinguishes the case in which critical care services are requested and billed from a similar case coded 99285, a comprehensive E/M service? For 99285 billing, CPT concludes its definition by stating: “Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.” This is certainly concordant with the presentation of acute ischemic stroke.

The Medical Decision Making documentation requirement for 99285 must attest to “high complexity,” a characterization entirely sustainable even in the absence of therapeutic intervention by the provider. It is apparent that, at least in this context, the gradation between a comprehensive level of E/M service and critical care service is ill-defined and open to interpretation both by the provider and the coder.

The time component of critical care service is inherently somewhat approximate. There is no requirement that the physician carry a stopwatch. Few critical care encounters occur uninterrupted, and in a busy emergency department, the physician is often buffeted by overlapping and conflicting obligations to a number of patients. Thus, an approximation or a range of time spent in the provision of critical care is sufficient for coding and billing purposes.

For code 99291, critical care time is defined as 30 to 74 minutes spent, including direct bedside time,
documentation time, time for discussion with other medical staff, time spent in the interpretation of laboratory or imaging studies, review of old records, and time spent discussing the care of an incompetent or unconscious patient with family members. As noted, this time need not be continuous. Frequent contributors to bedside time that often go undocumented are the recurrent physical reassessments that are regular concomitants to critical care. Brief notes covering these revisits are important not just for accurate coding and billing, but are crucial elements from a medico-legal, risk management perspective.

A number of procedures and services are incorporated into the coding and billing for critical care time and may not be separately billed. These include interpretation of chest x-rays, pulse oximetry and blood gasses, passage of a nasogastric tube, temporary pacing, ventilator management and peripheral vascular access. Procedures not specifically listed in the CPT manual as included in critical care services can and must be separately billed. The two most commonly performed, separately billable procedures performed in the setting of a critically ill patient are endotracheal intubation and the establishment of central venous access. The time spent performing these separately billable procedures must be subtracted from the total amount of critical care time claimed by the physician. Thus, for example a 60-minute total time for critical care in which intubation required five minutes and the insertion of a central line another five minutes, the time submitted would be 50 minutes.

Critical care may not be billed for patients under the physician’s care for less than 30 minutes. As an example, a patient with a coronary artery lesion who is expedited from the ED to the cardiac catheterization laboratory within 25 minutes of arrival does not qualify for critical care services, even though such care may well have been provided. Code 99291 covers minutes 30 to 74 of the patient’s ED time. Subsequent to this time, incremental intervals of 30 minutes are billed using 99292 for each additional half hour. Longer time frames require progress notes justifying the time spent in direct patient care.

Documentation of a request for critical care time by the physician should include a statement covering the nature of the illness, and a listing of those components of care requiring the provider’s time, with a notation that time spent on separately billable procedures has been subtracted from the total time claimed. Templated records, such as the T-System, contain acceptable statements covering the documentation requirements. Newer electronic records typically incorporate macros, wherein a single mouse click can generate several sentences covering the critical care services. With all templated records, whether paper or electronic, care must be taken that the documentation is patient-specific, meeting the requirements of medical necessity. The Center for Medicare and Medicaid Services (CMS) has specifically stated that it looks askance at macro-generated “cookie cutter” charts that all look alike.

Finally, in terms of documentation requirements, critical care charting is not governed by the same rules that apply to high level E/M codes. A “comprehensive” E/M service (99285) requires four elements in the HPI, 10 elements in ROS, two of three elements in past medical/family or social history, and eight areas in the physical examination. These component elements are waived for critical care services (99291).

Critical care is relatively highly compensated, and because of this audits from third-party payers should be anticipated. Such audits may focus on any of the three principal components of critical
care services: the severity of the illness itself, the care provided, or the amount of time claimed by the provider.

Audits typically are triggered by a physician’s relatively high percentage of claims. A skilled coding and billing service, by identifying records where critical care time may have been provided but was not submitted for, helps assure appropriate physician compensation, and, conversely, will help the physician in the avoidance of audits by avoiding submission of critical care codes when not clearly justified by the medical record. While well trained coders are taught to use judgment in submission of claims by the physician for critical care services, it is worth keeping in mind that coders are likely to be influenced by statements from the physician, and may be reluctant or insufficiently clinically experienced to adjudicate those records containing inappropriate requests by the physician. Furthermore, regardless of who codes the record, the provider, under fraud and abuse statutes, bears the ultimate responsibility for the codes submitted.

In conclusion, emergency physicians should, on the one hand, not undervalue their services and remember to properly submit claims for critical care in all appropriate clinical circumstances. On the other hand, overreaching for critical care services in marginal cases could potentially prove costly.

*Ronald W. Stunz, MD, FACEP, is the medical director of Zotec Partners.*
By design, high deductible health plans (HDHPs) increase cost sharing by patients, with the goal to reduce health care spending by making the financial impact of care decisions more transparent to decision makers. Theoretically, cost sharing can encourage better spending choices, or at the very least reduce unnecessary health care spending. For example, patients must now contend with the inappropriate use of medical care - like getting an MRI for a headache. And while these over-utilized services are common, patients may now think twice if these services are coming out of pocket.

With these major increases in patient cost sharing, providers are facing greater challenges in collecting outstanding balances and managing their accounts receivable. Health insurance exchange plans and HDHPs typically have high out-of-pocket payments for median income families, and in turn high out-of-pocket payments have the biggest impact on providers. However, there are strategies that hospital based physicians can employ to optimize collections from the high deductible patient population, especially where patient engagement technologies are concerned.

**Follow-up Technology**

Patient service personnel who are equipped with sophisticated technologies are likely to be more effective in the follow-up process. For instance, predictive dialers, call management and recording systems, screen capture software, and interactive voice response (IVR) can all ultimately impact collections. These technologies are often used separately in the patient collections process, but when deployed in a systematic way that provides various points of patient access, they will have far larger impact on the success of HDHP patient collections. Tactics to follow up with patients might include automated, customized calls made on an ongoing basis. Finally, secure billing portals that offer online payments as an option are critical among today’s internet-savvy patients who prefer to avoid the paper statement route.

As the credit card industry can attest, the more consumer touches there are, the more likely payments will be made – and the health care industry is certainly no different.

**Business Intelligence Technology**

Mining patient data and analyzing trends via the use of analytical tools will give practices greater insights as to how they might collect from this group of patients. For instance, real time analysis and reporting can help discover missing insurance, incomplete demographics, or other key front end data requirements enabling proactive action and reducing days in A/R vs. the traditional month-end reporting process. Effective data mining will enable practices to better identify processes and strategies that are or are not working in their collections efforts from HDHP patients. The ability to calculate patients’ out of pocket levels via real-time information is also helpful – at the time of service.

**Besides Technology**

The effective use of People, Process and Technology can help an ED practice collect on outstanding
receivables – especially where the HDHP patient population is concerned. There are several other pieces of the puzzle that a practice must consider within the revenue cycle to achieve optimum results. These include:

- **Clear Billing Statements**: Statements should clearly delineate the amount that is the patient’s responsibility, and why, as well as the payment due date, assuring clear, yet brief, language and terms.
- **Uninsured Patient Receivables**: Does your group have a self-pay accounts management strategy that combines a series of targeted phone calls with progressive statements and letters to maximize patient contact?
- **Payment Plan Monitoring**: It is important to negotiate payment terms, send monthly reminder letters, and follow-up on broken payment arrangements while being mindful of the group’s hospital’s guidelines in the process.
- **Additional Services**: Specialized services including insurance identification, verification, billing, and bankruptcy reviews will no doubt ensure greater success in the collection of patient responsibilities.

In conclusion, an ED practice that creates an HDHP patient-centered billing and follow-up process may ultimately achieve greater success in their collection efforts. While patient friendly, efficient facilities and well-organized front desk processes are an important part of the ED environment, practices must also consider the same approach in patient collections to optimize their ongoing financial health. These approaches include helping patients understand their bills, timely and effective communications and collecting on deductibles and co-payments with a structured follow-up plan.

*Patrick Holland is a director of business development with Zotec Partners.*
Independent Emergency Practices Achieve Significant Benefits from a Physician Ownership Model  
By Greg Thomson, CPA

Shifting hospital priorities and continued growth in emergency department (ED) volume have led many emergency departments to reconstitute themselves as stand-alone, independent practices.

Making the successful transition from employed physician to independent group requires a clear strategy about how best to organize and staff the enterprise. Most emergency groups today are structured around either independent contractor relationships, physician employees or owner-partner physicians.

Evaluating the benefits and drawbacks of each approach within the context of the group’s needs and circumstances is key to selecting the most appropriate business model. That said, emergency groups that follow the physician ownership path typically enjoy the widest range of advantages over the long-term.

With a properly structured physician owned group, individual physician incentives and group mission are aligned, workforce stability is maximized, and continuity in hospital relationships is enhanced. Given the complexities associated with this approach, however, many physicians elect to enlist qualified third-party practice managers and billing vendors to assist in establishing and operating the business.

The Independent Contractor Model

An independent group contracting with sole-proprietor physicians offers perhaps the simplest and fastest way to get a newly independent practice off the ground. On the plus side, contracting eliminates the need for creating payroll and benefits packages and therefore reduces administrative overhead.

Paying physicians an hourly rate on a contractual basis also gives practices the flexibility needed to quickly adjust staffing to meet changes in patient volume. In many markets, physicians can be drawn from a large pool of full- or part-time contractors. These contractors can include highly qualified general practitioners seeking to augment their practice income with periodic ED shift work.

The downside of using independent contractors is that there are no built-in incentives for motivating physicians to help optimize collections through more effective documentation and coding. This reality presents a significant and chronic impediment to improving financial performance in an increasingly difficult marketplace.

In addition, drawing from a large pool of physicians to meet various shift requirements may undermine care team continuity in the emergency department. It can also create a perception of instability among the hospital and medical staff. A "revolving door" of new or infrequently seen faces through the emergency room may undercut confidence in emergency services among hospital administrators and referring internists and specialists.

Employed Physicians
Hiring physicians as full-time group employees represents the second primary business model for emergency groups. Benefits of this approach include greater workforce stability and improved care continuity. With this model, group owners are not required to share profits and can focus on attracting and retaining the best talent through appropriate compensation and benefits packages. Employed status is attractive to many physicians because it provides a stable work environment with a steady income. It also eliminates the risks and responsibilities associated with equity ownership.

Like contractors, however, employed physicians are not necessarily incentivized to support revenue cycle optimization. And while they may be more receptive to coding and documentation education than contractors, they are nonetheless susceptible to an "hourly worker" mentality that may inhibit a shared and aggressive commitment to organizational goals.

In addition, groups that adopt the employed physician model -- unlike those who use independent contractors -- must support a range of administrative functions, including withholding, salary and benefits administration. This increases practice overhead as well as practice manager responsibilities.

**Physician Ownership Model**

The most significant benefit for emergency groups that form around a physician ownership model is that individual goals are aligned with practice goals. Physicians are more likely to sustain a commitment to optimizing collections and providing outstanding service if they are financially incentivized to do so. Likewise, enlisting physician involvement in hospital-driven initiatives like practice benchmarking becomes easier if doctors understand that they'll benefit -- directly or indirectly -- from the effort.

Because the group's survival and success ultimately depends on maintaining the hospital contract, anything that supports a commitment to improving the group's relationship with the hospital and the medical staff is a plus. With equity ownership, physicians are more inclined to take a proactive role in accomplishing this, whether through involvement in hospital committees or by leading quality assurance initiatives.

Similarly, an equity ownership structure can promote practice strength by helping foster constructive, long-term working relationships between the stable group of owner-physicians and the referring medical staff.

It should be noted that the downside of physician ownership, at least in the initial stages, is not insignificant. Creating a shareholding organization, be it a partnership, corporation or Limited Liability Corporation (LLC), is a complex task that requires considerable time and resources. A fair compensation structure that can take into account different levels of productivity must be developed. In addition, methodologies need to be established for buying in and buying out of the practice. The process also includes meeting many of the administrative responsibilities associated with the employed physician model.

**Qualified Assistance**

It is unlikely that most physicians have the skills, background or inclination needed to independently establish and maintain a physician owned organization. That’s why it is important for groups to
identify a trusted third-party provider that can assist in this process.

Beyond helping with the legal creation of the new entity and the tasks associated with that process -- establishing bylaws, setting up compensation mechanisms and benefits, shopping for insurance and the like -- a qualified consultant should be able to provide assistance in negotiating managed care and hospital contracts. In addition, outsourcing the coding and billing process to an experienced billing provider will help ensure optimal reimbursement and consistent cash flow over the long-term.

**Improved Income, Stronger Relationships**

The physician ownership business model for independent emergency practices is unquestionably more complex than the alternatives. It nonetheless provides physicians with the greatest potential for income growth and long-term independence and stability. Perhaps most importantly, it fosters an environment conducive to positive, stable hospital relations. Given the current market trends of diminishing reimbursements, increasing ED volume and growing competition from national emergency staffing firms, this arguably is the most compelling reason to pursue a physician ownership model, provided that the group can align with an experienced and qualified third-party.

Greg Thomson, CPA is the executive vice president of practice management for Zotec Partners.
ICD-10 CM and the Emergency Department

By Stacie Norris, MBA, CPC, CCS-P

October 1, 2015 is rapidly approaching and this date has special meaning in the coding and billing community. As many know, ICD-10 was delayed in 2014 as part of the Protecting Access to Medicare Act of 2014 (SGR temporary fix for 2014 was also contained in this bill) and October 1, 2015 is the current implementation date. ICD-10 has far-reaching implications for the specialty of Emergency Medicine (even more so than some of the other specialties), since Emergency Medicine providers render care to every patient that walks into the emergency department (ED). This translates in ICD-10 terms into the fact that ED providers and coders utilize every part of ICD-10 CM, and not just some specific sections.

Some of the concerns surrounding initial ICD-10 implementation include:

1. How will payers use ICD-10?
2. What should physicians/billers do to help mitigate possible revenue disruptions?

While no one can know for certain what payers will do exactly with the increased specificity of diagnostic codes provided by ICD-10 CM, there are a few reasonable assumptions. ICD-10 CM has the potential to be used as more of a payment tool for payers then ICD-9 CM does. For example, the increased specificity of ICD-10 coding could be used by payers as a either a tool for more claims denials or to pend claims, (i.e. postpone claim reimbursement) to providers.

To help mitigate potential losses/delays in revenue, billers should put processes in place to track and appeal claims affected by ICD-10 denials, and in addition, charts can be suspended and sent back to providers where appropriate for more specific documentation. Most billing experts recommend having reserves (line of credit) to cover at least three months of operating expenses available for possible cash flow disruptions. In addition, when negotiating payer contracts, ICD-10 should always be included in the discussions and language should be incorporated whenever possible to protect the physician practice from adverse claims decisions based on ICD-10.

For the ED specifically, payers must be educated as to the special environment of the ED, such as EMTALA requirements, limitations on how specific the ED provider can be for some illnesses/injuries based on the diagnostics available, etc. For example, in ICD-9 there are six possible knee sprain codes; in ICD-10 there are approximately 81. Some of the explosion in codes for the knee sprains is due to laterality distinction, but some are due to ICD-10 specificity to the exact ligament that is sprained. Unless an MRI is performed, it is not possible to get to this diagnostic granularity in the ED. Payers have to be made aware of this and the logic pointed out that it isn’t cost effective to pay for an MRI for every patient coming to the ED with a possible knee sprain.

In conclusion, Zotec Partners will be providing ED-specific ICD-10 resources to our ED Clients, such as quick reference documents, case-specific coding examples, guidance documents and a Power-Pont presentation that providers can review.
If you have additional questions Zotec Partners will be happy to discuss how ICD-10 may affect your ED practice. Please contact Stacie Norris at sanorris@zotecpartners.com with any questions that you may have.

_Stacie Norris, MBA, CPC, CCS-P is director of coding quality assurance with Zotec Partners._
Responding to Medicare RACs in 2015
By Ed Gaines, JD, CCP

After a temporary suspension of activity in 2014 (during a bid protest by one of the existing Medicare RACs), CMS announced the official restart of their (RAC) reviews with some favorable changes in response to concerns expressed to CMS in a joint ACEP/EDPMA letter and criticism by the AMA. Specifically, RACS have a shorter reporting period for findings and have more pressure to get their audits right. This article outlines some specific targets and regulatory changes for emergency department (ED) groups, and how they can respond to RAC audits in 2015.

The Final Exam for EDs

Various RACs have targeted these common ED scenarios for audit scrutiny, including:

1. Critical care billed on same day as ED E/M by same physician for same patient
2. Services or procedures billed during the 10 or 90 day global surgical period (GSP)
3. Admit and discharge same day Observation Codes (CPT® 99234-236 codes)
4. Improper payments based on improper -59 modifier application

For the Medicaid RACs, the following issues have been cited of note:

1. Services/procedures billed during the 10 or 90 GSP as noted above;
2. Credit balances and refunds in compliance with the ACA mandates.

Look for Changes in Additional Documentation Requests, Notification Timelines

In response to industry feedback, including a joint letter by ACEP and EDPMA calling for changes in the RAC program, CMS will ensure that RACs establish additional documentation request (ADR) limits based on provider compliance with Medicare rules. ED practices with low denial rates will have lower ADR limits, and practices with high denial rates will have higher ADR limits.

The fix: CMS will now adjust the ADR limits as a practice’s denial rate decreases. That will ensure that providers complying with Medicare rules have fewer RAC reviews. What this means for you is that you get rewarded for prior good audit outcomes. The previously permitted ADR limit amounted to two percent of all claims submitted for the prior calendar year, divided by eight. RACs had been allowed to send a maximum of 400 requests per 45 days to a practice; RACs can apply ADR limits incrementally to new providers under review.

But what if you don’t have an audit history? One of the complaints to CMS was that new providers were receiving requests for the maximum number of medical records allowed, causing administrative headaches and possible accounts receivable delays at their most vulnerable time. RACs should then apply ADR limits incrementally to new providers under review.

Thirty Day Notification Period of Complex Review Findings

You won’t have to wait as long to learn the findings from any RAC complex audits. In the past, ED providers waited up to 60 days before being notified of the findings of RAC complex reviews. The new 30 day deadline requires more immediate feedback to providers about the outcome of reviews.
**No RAC Payment Until After the Second Level of Appeal; RACs Must Maintain An Overturn Rate of Less Than 10% Percent**

RACS now have more incentive to get the audits right the first time. Previously, RACs were paid immediately upon denial and recoupment of claims according to the percentage of recoupment allowed in their contract, until and unless they were reversed on appeal. This created an unfair delay in provider payment while the appeals process played out, often over many months. The new rules add performance standards that can delay when the RACs get paid. CMS will require that the RACs have an overturn rate of less than 10 percent at the first level of appeal, excluding claims denied because of insufficient documentation or claims corrected during the appeals process. If a RAC fails to have a low overturn rate, CMS will place it on a corrective action plan that could include decreasing ADR limits or ceasing certain reviews. Hopefully this new rule creates incentives for RAC audit decisions to be fairly based upon Medicare statutes, coverage determinations, regulations and manuals.

**Unfavorable Audit? Don’t Think Twice About Appealing**

If you’ve taken a hit from RAC auditors, think twice before just writing a check for alleged overpayments. ED groups are an attractive target for auditors because the percentage of governmental payer patients, e.g. Medicare, Medicaid and Tricare, tends to be much larger on average than other specialties. This means when audits identify overpayments, the potential for recoupment is larger because of the volume of governmental patient claims reported by the ED group. The cost of extrapolation with these volumes can get expensive very quickly, so you should appeal any audits that seem unfair or inaccurate. Check out this scenario: An AMA survey found that the average RAC audit overpayment amount was $86 per claim. However, the average cost of a RAC audit to a medical practice is approximately $110 per claim. So doing the math, there’s a net loss of each RAC audit appeal per claim of -$24.00 ($110 cost less $86 overpayment average). Initially this appears to add additional expense and it would be cheaper to just write a check for the overpayment amount. However if you consider that CMS data shows that 60 percent of appeals are successful at Levels 1 through 4, it is in your best interests to go through the appeals process if you are confident your code assignments are correct.

The net reduction in the overpayment could offset much of the cost of the appeal process. You also are mitigating risks of Progressive Corrective Action (PCA), through statistical sampling and extrapolation.

**You Want To Avoid Extrapolation If You Can**

RAC Extrapolation is a method of forecasting the results of an audit sample to the universe of claims from which the sample was drawn. It is used to project an error rate, such as 10 percent, across all Medicare claims from that provider for a multi-year period of time, e.g. 4-5 years.

But be advised that the Medicare statute (Medicare Modernization Act of 2003) does NOT permit extrapolation unless there is “a sustained or high level payment error,” or a “documented educational intervention” has failed to correct the payment errors.

CMS has utilized one or more of the following to identify a sustained or high level payment error:
Good Reasons for Appealing Medicare Administrative Contractor (MAC) & RAC Findings

- The decision to use extrapolation cannot be challenged on Medicare appeal or in the federal courts, 42 USC 1395fff (d)(3), 42 CFR 405.926 (p) and MPIM 8.4.1.2.
- The extrapolation methodology to determine the overpayment is subject to challenge on appeal and in the courts.
- The MAC/RAC methodology is presumed valid, and burden of proof is on the provider.
- CMS Ruling 86-1. This ruling provides that CMS and the MACs may use statistical sampling to project overpayments when claims reflect a pattern of erroneous billing and case by case review is not administratively feasible.

In closing, while ED groups must look for changes to include additional documentation requests and notification timelines for the targeted areas noted above, RACs are also undergoing scrutiny to correctly audit, and within a shorter reporting period. ED groups must remember they can (and should) always appeal an unfavorable audit, though they may avoid it altogether by internal audit and QA, and heeding those specific regulatory changes and items that RACs are targeting in 2015.

Ed Gaines, JD, CCP is a chief compliance officer with Zotec Partners.
Zotec Partners' Ronald Stunz, MD, FACEP Appointed to New National ACEP Clinical Data Registry Committee

Zotec Partners announces that its Medical Director, Ronald Stunz, MD, FACEP has been appointed to the newly created National American College of Emergency Physicians (ACEP) Clinical Data Registry Committee set up to establish the ACEP Qualified Clinical Data Registry (QCDR). The QCDR will replace claims-based quality reporting and is anticipated to be functionally ready by January 1, 2016. In addition to creating and implementing the QCDR, the new Committee is charged with developing reporting measures for emergency medicine.

Stunz will serve on the QCDR Subcommittee for Data Standards, which is structured to provide input and advice to the registry vendor, Quality Measures Expert Panel and the ACEP Board regarding administrative data, claims-based, clinical and EHR data sets, data sources, data definitions and data standards.

“Quality reporting is going to assume increasing importance as governmental and other payers move toward alternative reimbursement models, and ACEP’s establishment of a Qualified Clinical Data Registry is a critical portal to capture the contributions of emergency medicine toward improved patient outcomes and cost containment,” said Ronald Stunz, MD, FACEP, medical director with Zotec Partners. “In addition, this Committee’s work in developing well thought out measures for reporting will assure that our contributions are effectively and meaningfully defined. The makeup of the Committee puts many of the best minds in the specialty into service to achieve these important objectives and I’m pleased and honored to be able to make some contribution.”

T. Scott Law, founder and CEO of Zotec Partners said, “We are thrilled that Dr. Stunz has taken this new appointment at a critical time for quality reporting in the specialty of emergency medicine. He not only has the experience and knowledge to contribute to these initiatives, but Zotec Partners also has the data and technology that will help him effectively serve on this Committee and develop reporting initiatives to shape the specialty for years to come.”

Dr. Stunz has a 25-year career as a practicing physician and currently serves as Medical Director with Zotec Partners. He served on the National ACEP Council and is a member of the ACEP Committees for Reimbursement and Coding Nomenclature Advisory (CNAC). He has served in a number of hospital administrative capacities, including Chairman of the Department of Medicine for the Bryn Mawr Hospital, and Chairman of the Department of Emergency Medicine for Main Line Health. Dr. Stunz also serves on the Coding Nomenclature Advisory Committee and Reimbursement Committee for National ACEP. He is the co-chair of PaACEP’s Reimbursement Committee; Chapter representative to the Novitas (formerly Highmark) Contractor Advisory Committee; member of the Government Affairs Committee, and co-organizer of the 2010 Chapter Reimbursement Conference. Dr. Stunz has been certified by the American Boards of Internal Medicine and Emergency Medicine, and is a graduate of Case Western Reserve University and the Université de Reims, France.
Zotec Partners' Stacie Norris Appointed as Co-Chair to the EDPMA Quality, Coding and Documentation Committee

Zotec Partners announces that its Director of Coding and Quality Assurance, Stacie Norris, MBA, CPC, CCS-P has been appointed as co-chairwoman to the Emergency Department Practice Management Association’s (EDPMA) Quality, Coding and Documentation Committee. The committee is responsible for leading issues related to quality measures, value, and performance in emergency medicine, and keeps EDPMA members apprised of ongoing coding and documentation issues affecting emergency medicine.

Ms. Norris will lead the committee in advising organizations on issues of payer use and abuse of the CMS and Marshfield E/M documentation guidelines, misinterpretation by payers of AMA/CPT guidelines, and/or how ICD-10 will affect documentation and coding. She will also continue to educate physicians about the 2015 Medicare Final Rule Physician Quality Reporting System (PQRS) and Value Modifier (VM) requirements, respectively, analyzing the measures and specifications that are specific to emergency departments and discussing strategies for effective PQRS documentation. Her knowledge and understanding of the PQRS has been instrumental for Zotec Partners, its clients and the emergency medicine industry.

Uniquely positioning Zotec Partners in the emergency medicine specialty, Norris’ appointment is the second appointment by a Zotec Partners employee to a national emergency medicine association in 2015 on issues of quality reporting; In March 2015, Ronald Stunz, MD, FACEP, medical director with Zotec Partners, was appointed to the national ACEP Clinical Data Registry Committee.

Elizabeth Mundinger, executive director of the EDPMA states, “We are thrilled that Stacie Norris has agreed to co-chair EDPMA’s new committee on Quality, Coding and Documentation. She has been a valuable resource to the association on quality issues for many years, and we are becoming even more dependent on her expertise as a growing percentage of reimbursement is impacted by quality measures. “

“This committee will assist and partner with hospital and ED administrators and physicians to go beyond traditional performance in providing quality care, and it is our goal to assist ED physicians in meeting the plethora of documentation, quality, coding and performance requirements imposed upon them, notes Ms. Norris. “In addition, this Committee’s work in quality measures and performance will affect change as it did more than a decade ago when it played a significant role in preventing the 1997 CMS Guidelines from being the only acceptable guidelines by retaining the 1995 guidelines as an alternative.”

According to T. Scott Law, founder and CEO of Zotec Partners, “This is a critical time for quality reporting and physician performance measures in the specialty of emergency medicine, and Stacie is among Zotec’s most knowledgeable professionals on CMS programs – especially with PQRS. Her research, interpretation and application of these quality reporting programs have been invaluable to Zotec’s clients as they appropriately code and document their reports for optimum reimbursement. Together with Stacie and our emergency medicine team, Zotec Partners will continue to support the EDPMA with data and technology that can add value and shape physician performance and reimbursement in the specialty.”
The Emergency Department Practice Management Association (EDPMA) is one of the nation’s largest trade associations supporting the delivery of emergency medical care to all Americans. Together, EDPMA’s members deliver (or directly support) health care for over half of the 136.3 million patients who visit U.S. emergency departments each year. Its members include physician groups, billing and coding companies, and others who support health care provided in the Emergency Department and work collectively to deliver services often unmet elsewhere. The EDPMA provides advocacy and educational resources to Emergency Department physician groups and their practice partners.