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Defending emergency department reimbursement amid increased payer scrutiny

The challenge: The gulf between payer and provider

The friction between payers and providers regarding emergency department (ED) facility visit levels stems from their different perspectives on ED care and supporting resources.

Every day, an ED must have on standby everything necessary to address a patient's possible needs – technology, equipment and supplies, plus nursing, ancillary and provider staff needed to care for a patient. Through the course of care, the actual resources used are a fraction of those available, but that doesn't change the potential for higher acuity.

Payers, on the other hand, have limited visibility into these clinical possibilities:

- What could be wrong with the patient?
- What resources and equipment may be necessary to bring about a positive clinical outcome?

Payers see only what is actually submitted on the patient claim. They have only the diagnosis and procedure codes to tell the clinical care story. The claim often doesn't include the reasons that justify higher acuity at patient presentation and the services provided.

This difference in perspective creates friction. As a result, payers push back on ED facility visit levels and issue downgrades, denials and delays in payment.

For providers, this adds to administrative cost, which is already a massive contributor to intense margin pressure. Over the past 40 years, administrative costs have increased more than 3,000%.* During that same period, spending on physicians that provide care has increased only a fraction.

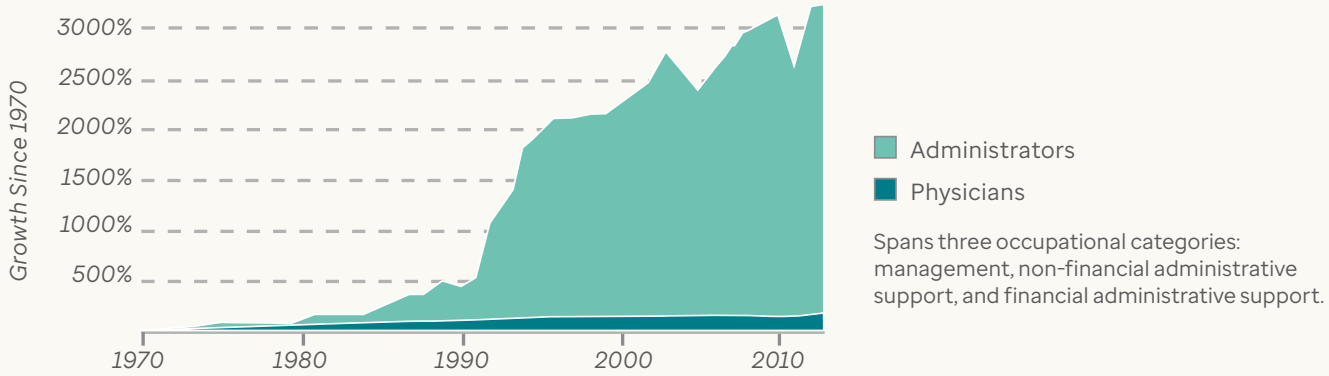
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* Woolhandler S, Himmelstein, D. "The National Health Program Slide-Show Guide." Center for National Health Program Studies, Cambridge, MA, 2014. And also, Health Care Advisory Board interviews and analysis.

More than ever, hospitals must protect their reimbursement without adding additional cost. In order to counter this payer pushback on ED facility visit levels, hospitals must defend their ED reimbursement by accurately reflecting patient severity and resources delivered during patient care.

Growth of Physicians and Administrators,* 1970–2013



Creating a foundation for success

Accurate and defensible ED reimbursement depends on three prerequisites: an effective ED facility visit level tool, accurate coding, and complete and accurate claim submission. Each presents unique challenges and potential problems hospitals need to avoid.

1. Effective ED visit level tool

Hospitals need a tool that accurately assigns the appropriate ED facility visit level based on the severity of patient needs and the resources required. An effective tool must adhere to the 11 OPPS guidelines and must produce ED facility visit levels that accurately represent the facility resource utilization required to care for each patient. This is more challenging than it first appears.

Many EMR systems include a rudimentary tool to assign an ED visit level. These EMR-based tools can inadvertently over-value the resource utilization when determining an ED facility visit level. Prior to EMR adoption, documentation was, on average, around eight pages per patient. With the advent of EMRs, ED visit records are now 30 to 40 pages long. A less sophisticated ED facility visit level methodology could be impacted by the quantityof documentation.

More charting should not be the driver for an increase in facility visit levels in the ED; the details within the documentation are far more important. Increased clinical documentation quantity does not necessarily meet the minimum documentation quality requirements to support an assigned facility visit level. The kind of quantitative analysis EMR-based tools rely upon could explain much of the shift from lower-acuity to higher-acuity ED facility visit levels and could result in over-assignment of facility visit levels 99284 and 99285.

A tool to determine ED facility visit levels can save time and maintain a common standard only if it reviews the quality of the documentation. An effective tool should review both the clinical and coding/charging details in order to determine if clinical resource utilization will be appropriately represented in the claim.

2. Accurate coding

Second, hospitals must ensure that their coding is an accurate translation of the services provided. Coding should reflect both the patient acuity and the care given. While coding teams regularly review coding accuracy, they should also review correlations between coding and ED visit level downcoding.

The key to success lies with the coding fields used on the encounter claim. ICD-10 diagnosis coding is broken into three categories: reason for visit (FL-70), external cause of injury (FL-72), and final and additional diagnosis (FL-66). While hospitals regularly apply the last one, judicious use of the first two may improve the defensibility of their ED facility visit levels.

Reason for visit often offers the largest coding improvement opportunity. It's so critical that ICD-10 allows each patient claim to include up to three. Reason for visit includes all factors that explain why the patient presented in the ED, including what the physician sees, feels or hears, and all complaints and symptoms documented by the facility and professional staff members.

Coders should base reason for visit codes on all documentation in the clinical record. Support for patient acuity and resource utilization may reside in the chief complaint, the HPI, or the nursing documentation.

Similarly, claims can also have up to three external-cause-of-injury codes. These codes tell the story of an accident, incident or injury. Some popular codes provide no defensibility of ED visit levels, such as "visit for the evaluation of other." While using it isn't wrong, it does not support an ED facility visit level assignment.

Payers are scrutinizing all claim information to determine whether the ED visit level is justified. The claim must be as complete, accurate and specific as possible.

3. Complete claims upon submission

The third key to defensible ED reimbursement is complete and accurate claim submission. While this may sound obvious, the reality is slightly more complex.

Hospitals should review the information that is actually sent to payers, not just what was coded by HIM or selected from coding platforms. By regularly reviewing 837 claim data, hospitals can confirm that all of their ICD-10 and CPT® codes are being delivered to their payers. They can validate not only the diagnosis codes, but also the procedures that were done for the patient.

The technology a hospital employs for claim submission should provide visibility into both the clinical evaluation of a patient encounter and the coding/charging of that same patient encounter.

Three phases for diagnosing and defending your ED visit levels

While hospitals may acknowledge challenges in defending their ED facility visit levels, accurately diagnosing and correcting them can be daunting. Hospitals can follow a three-phase process to analyze their visit levels.

Phase 1

- Reviewing visit level tool for accuracy and consistent use
- Evaluating critical documentation
- Identifying trends in clinical presentation and care provided

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Prerequisites for defensible ED visit level determinations

ED visit level tool

- EMR tools may inappropriately inflate visit levels
- Reflect the quality of documentation, not quantity

Accurate coding

- Maximize assignment of “reason fo visit” codes
- Maximize assignment of “external cause of injury” codes
- Complete assignment of all CPT® and HCPCS procedure codes

Complete claims

- Watch for data being stripped from claim at submission
- Review 837 feed to validate all data is being sent

Hospitals should first confirm that the tool is correctly valuing the quality and critical elements in clinical documentation, and not simply the quantity. Also important is confirmation that the visit level tool is being applied consistently to all ED visits. In some cases, rules governing when the tool is applied may be at fault for inconsistencies.

During this review:

- Look carefully at the content of documentation.
- Are certain sections of the clinical record consistently missing?
- This kind of review can identify these more obvious issues before diving into a deeper analysis.
- After confirming the tool is operating correctly and the clinical documentation is complete, look for trends in clinical presentation or care provided.
- Is your facility struggling with chest pain patients, pediatric patient populations or observation patients?
- Understanding these trends may identify areas requiring immediate attention. This information will also support the next two phases.

Phase 2

Evaluating the content of your claims

The second phase involves evaluating how well your claims represent the actual care provided. In many cases, the coding is accurate, but could be improved.

- In this phase, you’re not concerned with correcting coding errors, but rather identifying ways to provide more complete coding.
- Do your reason for visit codes accurately and completely represent all of the concerns and complaints revealed during the patient’s encounter?
- The reason for visit codes should convey not only the patient’s presenting complaint, but anything in the clinical record that supports patient acuityand resource utilization.
- How well do the external-cause-of-injury codes reflect what happened to your patient? Often, a single code isn’t sufficient to explain the uniqueness of the ED encounter.

Phase 3

- Initiating scheduled reviews of key data
- Participating in discussions with partners

Phases 1 and 2 will identify areas to target for improvement. Regular interdepartmental reviews will allow you to take action on them. These reviews should include a cross-functional team involving your partners in finance, the ED, HIM, coding, and compliance. Ask larger questions during these meetings: Do you need a better ED visit level tool? Would coding or clinical documentation changes help with visit level defensibility?

During these meetings, discuss your PEPPER (Program for Evaluating Payment Patterns Electronic Report). CMS provides your facility with this report quarterly. It benchmarks your facility against your peers on a range of payment trends, including high-acuity ED facility visit level assignment of Medicare encounters. The PEPPER can reveal shifting patterns and insights about issues affecting your ED visit levels.

Finally, consider scheduling conversations with your MAC and high-volume payer about ED facility visit levels. While this may be an uncomfortable thought, these partners can guide you based on what they see in their particular patient population or from national data sets. They can also provide guidance, policies, or documentation that explains their rationale for downcodes. They are typically very receptive to providing this help to providers, since fewer downcodes and disagreements reduce administrative work for everyone.

Payers are adapting ... are you?

Amid increased scrutiny surrounding ED visit levels causing denials and downcodes, hospitals must optimize their technology and operations to defend their ED level determinations. EMR-based tools may not be sufficient to address the current payer environment. Fortunately, hospitals can take steps to ensure that they have the right tools to accurately convey the complete patient story in their coding.

Discover our proven solution for appropriate ED visit level assignment.

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