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Compliance Today - December 2021
OIG focusing on emergency department physician evaluation and management services

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The U.S. Department of Health & Human Services Office of Inspector General (OIG) conducts audits every year to ensure proper federal healthcare program payments are made. OIG remains at the forefront of the nation's efforts to fight fraud in federal healthcare programs and hold wrongdoers accountable for fraud, waste, and abuse.[1] The audits are conducted based on risk areas identified by the OIG, which are put into a work plan. OIG has released its work plan for fiscal year 2022, which includes an audit of Medicare emergency department (ED) evaluation and management (E/M) services. In fiscal year 2020, OIG audits identified $566 million in expected recoveries and $920 million in potential savings for the Department of Health & Human Services programs.[2]

Performing audits that parallel the OIG work plan is imperative for healthcare organizations, as audits will identify areas of potential risks, avoid potential legal trouble or federal fines for noncompliance, and help promote the integrity of the organization's compliance program. OIG repeatedly emphasizes in its guidance documents the importance of auditing and monitoring activities for an effective healthcare compliance program.

Routine audits should be conducted at least once annually, according to the OIG Hospital Guidance (and, of course, for-cause audits should be conducted as concerns are identified). A common method of assessing compliance program effectiveness is measuring various outcomes indicators (e.g., billing and coding error rates, identified overpayments, and audit results). Hence, organizations should develop detailed annual audit plans tailored to reduce risks associated with improper claims and billing practices.[3]

Coding for physician and NPP services in an ED setting

When coding for services in an ED setting, physicians, nonphysician practitioners (NPPs), and facilities use the same codes to report E/M services. Surgical procedures or other services performed in the ED setting are also to be reported. The codes used to report E/M services in the ED setting are 99281–99285. Criteria for determining the correct level of service, however, differs between the two providers. This article discusses the criteria for professional fee billing for services provided in the ED setting.

General principles of E/M documentation

Physicians and other NPPs are responsible for accurately, completely, and legibly documenting all services performed. Regardless of the type of services (medical and surgical) and the place of service, these principles apply:

- The medical record should be complete and legible.
- Documentation for each encounter should include:
    - Reason for the encounter, relevant history, physical exam findings, and prior diagnostic test results;
    - Assessment, clinical impression, or diagnosis;
    - Medical plan of care;
    - Date and identity of the observer; and
    - The rationale for ordering diagnostic and other ancillary services (if not documented, it should be easily inferred).
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record.

Documentation requirements for E/M services

There are several factors to consider when selecting a code for professional services: the patient type (new vs. established), setting of service (office or other outpatient setting, hospital inpatient, emergency department, or nursing facility), and the level of service performed. There are three key components to consider when selecting the appropriate level of E/M service: history, examination, and medical decision-making. For encounters that are dominated by counseling and/or coordination of care, time is the key or controlling factor used to determine a level of service.[4]

ED E/M codes 99281–99285

The ED E/M code set comprises five levels of service based on the nature of the presenting problem. There are four components to be considered when a physician/NPP chooses a level of service: the amount of history obtained, the physical exam performed, diagnostic testing required, and the complexity of medical decision-making. In the ED, there is no distinction made between a new patient and an established patient service. Additionally, the ED code set does not have typical times assigned as E/M services in other settings (e.g., office, outpatient clinics, inpatient settings). When diagnostic medical, surgical, and/or therapeutic procedures are performed in the ED setting, physicians/NPPs are instructed to append modifier -25 to the E/M service to alert a payer that a significant and separately identifiable E/M service has also been provided. Commonly performed procedures in the ED include, but are not limited to, laceration repair, intubation, insertion of central lines, lumbar punctures, and paracentesis, along with fracture care and other orthopedic procedures. These services, of course, should be properly documented in the medical record in addition to the E/M service.

Documentation requirements for ED codes 99281–99285

- **99281**: Requires documentation of the following three key components: a problem-focused history, a problem-focused examination, and straightforward medical decision-making. Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies needs to be consistent with the nature of the problem(s) and the patient's and/or family's needs.
- **99282**: Requires documentation of the following three key components: an expanded problem-focused history, an expanded problem-focused examination, and medical decision-making of low complexity. Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
- **99283**: Requires documentation of the following three key components: an expanded problem-focused history, expanded problem-focused examination, and medical decision-making of moderate complexity. Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
- **99284**: Requires documentation of the following three key components: a detailed history, a detailed examination, and medical decision-making of moderate complexity. Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
- **99285**: Requires documentation of the following three key components: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Hospital ED facility coding: How is it different than practitioner coding?

Hospitals, like physicians, code for both procedures and for E/M services (E/M levels) provided in the ED using CPT codes 99281–99285. However, in contrast to physician/NPP coding requirements, facility visit level codes reflect the resources used by the facility to provide patient care rather than the work performed by the provider. To date, the Centers for Medicare & Medicaid Services has not developed national ED facility level guidelines but acknowledges that CPT E/M codes were designed to reflect the activities of physicians. It poorly describes the range and mix of services provided by hospitals during clinic and ED patient visits. *Medicare Claims Processing Manual* states, "While awaiting the development of a national set of facility-specific codes and guidelines, providers should continue to apply their current internal guidelines to the existing CPT codes. Each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes."[5]

Hospital EDs should develop guidelines that are reproducible, consistently applied, and accurately reflective of the hospital resources used to avoid audit scrutiny. One common solution is to develop a scorecard, listing services typically performed in the ED. Services are assigned points that are weighted according to intensity and use of resources. Visit levels are then determined by the number of points calculated. Documentation should support items and services used to determine the level of service billed.

Telehealth for emergency departments

In response to the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services has allowed

temporary coverage for ED services provided via telehealth.[6] This includes E/M services (99281–99285), critical care (99291, 99292), observation services (99217–99220, 99224—99226), and remote patient monitoring (99453, 99454, 99457, 99458, 99091). As with other telehealth services, the provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient. Services provided while the provider and patient are in the same location but in different rooms are not billed as telehealth. Facilities across the country have responded to the expanded coverage by developing novel digital approaches to provide acute emergency and intensive care, including platforms allowing multiple participants to engage a patient simultaneously. While this expanded access has reduced healthcare risk and mitigated exposure, increased use may lead to greater audit scrutiny. It remains crucial to document services with coding requirements and medical necessity in mind.

Takeaways

- Conducting routine audits or reviews will help identify risk and prevent potential monetary penalties.
- Regardless of the type and place of service, providers are responsible for accurately coding services.
- The code set for emergency department services is CPT 99281–99285.
- There are three key components that are considered when selecting an evaluation and management level of service: history, exam, and medical decision-making.
- Emergency department evaluation services billed by facilities must accurately reflect the intensity of services provided and the use of resources.

1 "Audit of Medicare Emergency Department Evaluation and Management Services," Office of Inspector General, U.S. Department of Health & Human Services, August 2021, https://www.oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000612.asp.
2 U.S. Department of Health & Human Services, Office of Inspector General, *Semiannual Report to Congress October 1, 2020–March 31, 2021*, Spring 2021, https://oig.hhs.gov/reports-and-publications/archives/semiannual/2021/2021-spring-sar.pdf.
3 OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4,858, 4,875 (January 31, 2005) , https://www.oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf.
4 Centers for Medicare & Medicaid Services, *Evaluation and Management Services Guide*, MLN906764, February 2021, https://go.cms.gov/3dVY0Wz.
5 Centers for Medicare & Medicaid Services, "Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)," § 160, *Medicare Claims Processing Manual*, Pub. 100-04, revised July 1, 2016, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.
6 "Billing for Telehealth in Emergency Departments," Telehealth.HHS.gov, accessed September 14, 2021, https://telehealth.hhs.gov/providers/telehealth-for-emergency-departments/billing/.