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Making intelligence matter

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Large 2024 Financial Impact: Watch Your ED Facility Levels Closely

LOGIX TIP #117

CMS continues to package more services into the ED facility level payment. Increased bundling means that assigning the appropriate E/M level is more important than ever.

E/M Level	Approximate Payment
99283	$275
99284	$425
99285	$615

2024 OPPS Emergency Department Update

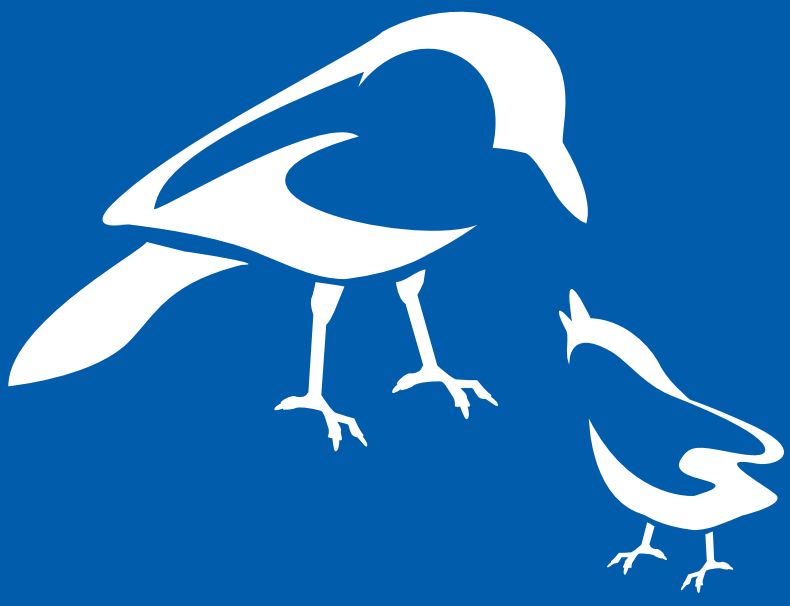
On November 2, 2023, the Centers for Medicare and Medicaid Services (CMS) published the Outpatient Prospective Payment System (OPPS) final rule. The final rule updates payment rates and policies for outpatient services furnished by hospitals that are paid under the OPPS and governs services provided on or after January 1, 2024. The final rule can be found on the LogixHealth website, www.logixhealth.com.

The Facility Conversion Factor

For 2024, CMS is updating the 2023 OPPS payment rates for hospitals that meet quality reporting requirements by 3.1%. This update is based on the projected hospital market basket increase of 3.3% which was reduced by 0.2 percentage points for the productivity adjustment. As a result for 2024, CMS is using a conversion factor of $87.382 in the calculation of the national unadjusted payment rates. CMS estimates that total payments to OPPS providers for calendar year 2024 will be approximately $88.9 billion, an increase of approximately $6.0 billion compared to 2023.

As in prior years, CMS will apply a 2% penalty for hospitals not reporting outpatient quality measures, leading to a reduced conversion factor for those hospitals not meeting the Hospital Outpatient Quality Reporting (OQR) requirements.

> *"...hospitals that fail to submit data required to be submitted on quality measures selected by the Secretary, in the form and manner and at a time specified by the Secretary, incur a reduction of 2.0 percentage points to their OPD fee schedule increase factor, that is, the annual payment update factor."* 2024 OPPS final rule, page 142/1672



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ED Facility E/M Level Guidelines

Historically, CMS has supported hospitals in developing their own internal guidelines for ED E/M reporting.

> *"Since April 7, 2000, we have instructed hospitals to report facility resources for clinic and ED hospital outpatient visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level (65 FR 18451)."*
> 2016 OPPS Final rule, page 59/1221

For 2024, there are no significant changes to the rules governing the ED facility E/M level guidelines. Per the initial description in the 2008 OPPS final rule, hospitals will be allowed to utilize their own scoring systems provided they accurately reflect facility resource utilization and are consistent with the 11 Guiding Principles published in the 2008 OPPS final rule.

While several years ago, CMS had shown intent to explore a single set of national ED facility guidelines, going back to the 2016 final rule, CMS stated that this has been a complex endeavor and that it did not have a timetable for creating national guidelines.

> *"...we have signaled in past rulemaking our intent to develop guidelines, this complex undertaking has proven challenging. Our work with interested stakeholders, such as hospital associations, along with a contractor, has confirmed that no single approach could consistently and accurately capture hospitals' relative costs. Public comments received on this issue, as well as our own knowledge of how clinics operate, have led us to conclude that it is not feasible to adopt a set of national guidelines for reporting hospital visits that can accommodate the enormous variety of patient populations and service-mix provided by hospitals of all types and sizes throughout the country."* 2016 OPPS final rule, page 593/1221

In March of 2019, MedPAC explored the possibility of national ED facility guidelines, however, CMS has been slow to pursue rule making related to this complex area.

> *"We received two public comments, one from a health system and another from a health information management association, in response to our CY 2020 proposal. Commenters suggested that CMS should adopt the recommendation of the Medicare Payment Advisory Commission (MedPAC) for the development and implementation of a set of national guidelines for coding hospital emergency department (ED) visits under the OPPS. They argued that national guidelines would provide hospitals with a clear set of rules for coding ED visits. We thank the commenters for their responses. We will consider these comments for future rulemaking."*
> 2020 OPPS final rule, page 600/1113

For 2024, CMS has demonstrated it is satisfied with the current ED Facility E/M process and there are no anticipated changes to the overall reporting process. For quite a few years CMS has simply stated it is continuing with current policies.

> *"We did not receive any comments on our proposals to continue our current ED outpatient visits and critical care payment policies for CY 2024 and are finalizing our proposals without modification."* 2024 OPPS final rule, page 631/1672

2024 Reporting of All Five ED Levels Continues

While CMS has not embraced a single set of uniform national ED coding guidelines, the issue of CMS simply collapsing the five ED facility levels into a single payment APC still requires monitoring. In 2014, CMS explored collapsing both ED and outpatient clinic visit levels into a corresponding single payment rate. The 2014 OPPS final rule finalized a collapse of the outpatient clinic levels with a resulting single payment rate under APC 0634, however, CMS maintained five distinct ED payment levels. The 2016 OPPS final rule examined the potential collapse of the current five ED facility levels and concluded that the five ED levels will remain for reporting hospital services.

> *"...we continue to believe that additional study is needed to assess the most suitable payment structure for ED visits. Therefore, in the CY 2016 OPPS/ASC proposed rule (80 FR 39288), we did not propose any change in ED visit coding. Rather, for CY 2016, we proposed to continue to use our existing methodology to recognize the existing five CPT codes for Type A ED visits as well as the five HCPCS codes that apply to Type B ED visits, and to establish the proposed CY 2016 OPPS payment rates using our established standard process. We stated that we may propose changes to the coding and APC assignments for ED visits in future rulemaking."*
> 2016 OPPS final rule, page 597/1221

Importantly, the 2024 OPPS final rule does not entertain collapsing the five ED levels into a single payment amount and the issue seems to have been stable since 2016.

> *"For a description of these (ED) policies, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70448)."*
> 2024 OPPS final rule, page 631/1672

In an effort to better align services with common resource intensity, CMS in 2016, shifted and renumbered the ED E/M APCs. The renumbered convention continues for 2024 without changes to the ED APC numbering.

See the chart below for the ED APCs and 2023/2024 payment rates.

Facility Level	APC	2023	2024
99281	5021	$75.09	$84.68
99282	5022	$139.69	$155.99
99283	5023	$245.03	$272.14
99284	5024	$381.61	$422.44
99285	5025	$548.11	$612.63
99291	5041	$767.72	$846.36

CMS Facility E/M Level Guiding Principles

- The guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate to the intensity of hospital resources to the different levels of effort represented by the code.
- The coding guidelines should be based on hospital facility resources, not physician resources.
- The guidelines should be clear to facilitate accurate payments and should be usable for compliance purposes and audits.
- They should meet HIPAA guidelines.
- They should only require documentation that is clinically necessary for the patient.
- The guidelines should not facilitate upcoding or gaming.
- These guidelines should be well documented and should provide the basis for the selection of a specific code.
- They should be applied consistently across patients in the clinic or ED to which they apply.
- These guidelines should not change with great frequency.
- They should be readily available for fiscal intermediary or, if applicable, MAC review.
- These guidelines should result in coding decisions that could be verified by other hospital staff and outside sources.

2008 OPPS final rule, page 227/647

In 2008, CMS adopted the composite APC methodology, reimbursing for ED facility and observation services in a single packaged construct. For 2024, the packaged/composite methodology continues to combine ED and observation services into a single APC.

For 2024, APC 8011 will reimburse $2,610.71. The observation APC underwent a drastic increase in payment in 2016 related to the extensive packaging associated with the Comprehensive APC construct.

Observation services have been part of the growing list of Comprehensive APCs, and for 2024, payment for observation services will be via Comprehensive APC 8011, which will require a qualifying visit along with eight units of G0378. The types of qualifying visits for observation were expanded greatly in 2016 and have remained unchanged for 2024. The prior requirements for eight units of G0378 and no T status procedure continue for 2024. As previously described in the 2016 OPPS final rule, observation may be reported for any clinic visit HCPCS code G0463, any Type A ED visit (CPT codes 99281-99285), any Type B ED visit (HCPCS codes G0380-G0384), a direct referral to observation (HCPCS code G0379) or critical care (CPT code 99291) provided by a hospital in conjunction with observation services of substantial duration (eight or more hours of observation/eight units of HCPCS code G0378), provided the observation was not furnished on the same day as surgery or post-operatively and with no status indicator T on the same claim.

In summary, payment is made for the Comprehensive APC 8011 if the following claim criteria are met:

- A minimum of eight units of G0378
- No procedure with a status indicator T
- A qualifying E/M visit is on the claim on the same date of service or one day before the date of service:
  - Type A ED visit (99281-99285)
  - Type B ED visit (G0380-G0384)
  - Critical care (99291)
  - An outpatient clinic visit (G0463)
  - A direct referral (G0379)

The reimbursement for the observation composite APC has been steadily increasing over the past several years.

Observation Services Payment Increase Trend

Year	Composite Payment
2009	$660.00
2010	$705.27
2011	$714.33
2012	$720.64
2013	$798.47
2014	$1,199.00
2015	$1,234.22
2016	$2,174.14

Year	Composite Payment
2017	$2,221.70
2018	$2,349.66
2019	$2,386.80
2020	$2,203.35
2021	$2,316.41
2022	$2,331.90
2023	$2,439.02
2024	$2,610.71

CMS developed comprehensive APCs as an evolution of extensive packaging to encourage hospital efficiency.

> *"A Comprehensive APC (C-APC) is defined as a classification for the provision of a primary service, as well as all adjunctive services provided in support of the primary service. We established C-APCs as a category broadly for OPPS payment, and implemented 25 C-APCs beginning in CY 2015."* 2016 OPPS final rule, page 124/1221

For 2024, CMS continued the Comprehensive APC concept.

> *"When such a primary service is reported on a hospital outpatient claim, taking into consideration the few exceptions that are discussed below, we make payment for all other items and services reported on the hospital outpatient claim as being integral, ancillary, supportive, dependent, and adjunctive to the primary service (hereinafter collectively referred to as "adjunctive services") and representing components of a complete comprehensive service (78 FR 74865 79 FR 66799). Payments for adjunctive services are packaged into the payments for the primary services. This results in a single prospective payment for each of the primary, comprehensive services based on the costs of all reported services at the claim level."* 2024 OPPS final rule, page 54/1672

Bundling of Observation Comprehensive APC 8011

The observation Comprehensive APC 8011 bundles the vast majority of typical ancillaries provided during an observation visit, including most:

- Labs
- CT scans
- Ultrasound studies
- Typical non-T status procedures
- IV fluids
- Infusions
- Most medications

Some separate payments continue. Services represented by status indicators F, G, H, L, and U are not bundled during an observation visit, such as:

- Self-administered drugs
- Ambulance services
- Mammography

CMS Overall Packaging Continues

CMS has continued increased packaging of services in an effort to transform the OPPS into more of a prospective payment system, and less like a fee schedule. CMS has communicated that increased packaging incentivizes efficiencies in care delivery.

> *"Because packaging encourages efficiency and is an essential component of a prospective payment system, packaging payments for items and services that are typically integral, ancillary, supportive, dependent, or adjunctive to a primary service has been a fundamental part of the OPPS since its implementation in August 2000."* 2024 OPPS final rule, page 88/1672

"We believe that the OPPS methodology, as opposed to payment based on hospitals' charges adjusted to cost, also would provide hospitals with incentives for efficiency in the provision of services to Medicare beneficiaries." 2024 OPPS final rule, page 50/1672

The 2024 final rule describes significant packaging for services. Items that will be packaged include those described by the status indicators defined below.

CMS previously retired the status indicator X, and has been expanding the use of the status indicator Q series related to conditional packaging. The status indicator Q series packaging includes:

- Status indicator QI - Packaged with status indicator S/T/V procedures
- Status indicator Q2 - Packaged with T procedures
- Status indicator Q3 - Packaged as part of a composite payment
- Status indicator Q4 - Labs packaged with status indicator JI, J2, S, T, V, QI, Q2, Q3

The OPPS final rule lists the various iterations of packaging on a code-specific level. Importantly, ED ancillaries such as hydration, injection, and infusion primary services will continue to be reported and paid separately.

For a full copy of the 2024 OPPS final rule, visit the LogixHealth website at www.logixhealth.com.

Hydration/Injection/Infusion Services Update

Each year, the OPPS final rule updates reimbursement rates for essential ED services. In particular, with the complex coding rules surrounding the high-frequency hydration, injection, and infusion codes, there is significant revenue at stake for appropriate charge capture of these services.

Significant revenue is at stake for appropriate charge capture of hydration, injection, and infusion services.

Code	Service	2023 CMS Payment	2024 CMS Payment
96360	Hydration	$206.57	$204.43
96361	Hydration+	$42.37	$45.30
96365	Infusion	$206.57	$204.43
96366	Infusion+	$42.37	$45.30
96374	IV Push	$206.57	$204.43
96375	IV Push +	$42.37	$45.30

Critical Care

In 2011, CPT updated language within the definition of 99291, allowing facilities to report some services, such as x-rays, gastric intubation, and transcutaneous pacing that are bundled under physician payment rules. Despite this change, for 2012-2024, there will not be any separate OPPS payments made outside of the APC for these additional services. Critical care will continue to be reported by facilities with code 99291, which crosswalks to APC 5041 (designated in 2016) which in 2024 will be reimbursed $846.36. The 2024 OPPS language shows that CMS is currently satisfied with the critical care reporting processes that have been in place.

> *"We also proposed to continue our payment policy for critical care services for CY 2024. For a description of this policy, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70449), and for the history of this payment policy, we refer readers to the CY 2014 OPPS/ASC final rule with comment period (78 FR 75043)."* 2024 OPPS final rule, page 631/1672

Hospital Outpatient Quality Reporting

CMS has made clear its commitment to expanding quality tracking. Hospitals failing to report quality measures will suffer a 2% reduction in their conversion factor. Each year, CMS issues an updated list of hospital measures required for meeting reporting requirements. Additionally, as the administrative and clinical realities of the quality measures become realized, some measures are subsequently postponed or suspended.

Hospital OQR Program Measure Set for the CY 2026 Payment Determination and Subsequent Years

Measure Name
MRI lumbar spine for low back pain
Abdomen CT – use of contrast material
Cardiac imaging for preoperative risk assessment for non-cardiac, low-risk surgery
Median time for discharged ED patients
Left without being seen
Head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke who received head CT or MRI scan interpretation within 45 minutes of ED arrival
Colonoscopy follow-up interval
Cataracts visual function
Facility 7-day risk-standardized hospital visit rate after outpatient colonoscopy
Admissions and emergency department (ED) visits for patients receiving outpatient chemotherapy
Hospital visits after hospital outpatient surgery
OAS CAHPS – about facilities and staff
OAS CAHPS – communication about procedure
OAS CAHPS – preparation for discharge and recovery
OAS CAHPS – overall rating of facility
OAS CAHPS – recommendation of facility
Covid-19 vaccination coverage among health care personnel
Breast cancer screening recall rates
ST-segment elevation myocardial infarction (STEMI) eCQM

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