American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

FACT SHEET

ACEP Responses to E/M Proposals in CY 2020 PFS and QPP Proposed Rule

Valuation of Emergency Department Evaluation and Management (E/M) Codes for CY 2020

There are a few codes that affect emergency medicine that have proposed revaluations in this year's rule—the largest of which is the set of Emergency Department (ED) E/M codes (CPT codes 99281-99285).

In the CY 2018 PFS final rule, CMS finalized a proposal to nominate CPT codes 99281- 99285 as potentially misvalued based on information suggesting that the work relative value units (RVUs) for ED visits may not appropriately reflect the full resources involved in delivering these services. CMS specifically agreed with commenters, including ACEP, that these services might be "potentially misvalued given the increased acuity of the patient population and the heterogeneity of the sites where emergency department visits are furnished."[1] In the past, ACEP has argued that there has been an increase in intensity in reported ED services as a whole, due in part to successful attempts to guide non-emergency patients to other sites of service, as well as the increasing complexity of transition or coordination of care under episode-based or accountable care organization (ACO) models. As well, practice intensity has increased in EDs because EDs are treating older and sicker Medicare beneficiaries with multiple chronic conditions, and therefore emergency physicians must utilize more sophisticated diagnosis methods to manage the problems of these more-challenged beneficiaries.[2] Therefore, we welcomed the opportunity for the American Medical Association (AMA) Relative Value Scale (RVS) Update Committee (RUC) to propose new values for the codes.

The five ED E/M codes were surveyed and reviewed for the April 2018 RUC meeting. For CY 2020, CMS is proposing the RUC-recommended work RVUs of 0.48 for CPT code 99281, a work RVU of 0.93 for CPT code 99282, a work RVU of 1.42 for 99283, a work RVU of 2.60 for 99284, and a work RVU of 3.80 for CPT code 99285.

ACEP is extremely pleased that CMS agrees with the RUC recommendations for work RVUs for the ED E/M codes. ACEP members have participated in the RUC process for many years, contributing a tremendous level of effort and commitment providing analysis and documentation supporting the need for equitable E/M codes. We conducted a thorough survey of our members and presented our findings to the RUC at the April 2018 meeting. The RUC, in turn, provided a reasonable and appropriate recommendation for the value of these codes based on our findings. **Therefore, we thank CMS for recognizing the RUC's increase in the valuation of these codes and for recognizing the increase in the intensity of the level 5**

[1] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program Proposed Rule, 82 Fed. Reg. 53018 (November 15, 2017).

[2] Gonzalez Morganti, Kristy, Sebastian Bauhoff, Janice C. Blanchard, Mahshid Abir, Neema Iyer, Alexandria Smith, Joseph Vesely, Edward N. Okeke, and Arthur L. Kellermann, The Evolving Role of Emergency Departments in the United States. Santa Monica, CA: RAND Corporation, 2013. https://www.rand.org/pubs/research_reports/RR280.html.

service over the past few years. However, as discussed in the "Payment for Office and Outpatient E/M Visits" section below, we urge CMS to finalize an additional increase in these codes in CY 2020 to maintain the relative value between the new patient office and outpatient codes proposed for CY 2021 and the ED E/M codes.

Payment for Office and Outpatient E/M .Visits

In last year's rule, CMS finalized significant changes to the office and outpatient E/M payment structure that would become effective in CY 2021. Most notably, CMS consolidated E/M visit levels 2 through 4 into one payment rate. Based on feedback from the CPT and the RUC, CMS is rescinding that major policy and instead keeping these levels separate and proposing new code values for CY 2021. In all, CMS proposes to accept the RUC-recommended work values for all new and established patient office/outpatient E/M codes (including proposing to delete the level 1 office/outpatient visit for new patients). Further, CMS is proposing to refine the two add-on codes for complexity that CMS previously finalized and consolidate those codes into one comprehensive code that both primary care providers and specialists can bill.

ACEP respects the RUC process and supports CMS' decision to accept the RUC's recommendations for these codes. However, we are extremely cognizant of the significant budget neutrality adjustment that would be triggered if CMS finalized all of the proposals as proposed in CY 2021. According to conversations with CMS, the office and outpatient E/M codes represent approximately 20 percent of billed services under the PFS. Further, the AMA estimates that the additional add-on code for complexity has a re-distributional impact of another $1 to $2 billion. Emergency physicians do not tend to bill these codes. Approximately 85 percent of their billable services are from the ED E/M codes discussed in the previous section. Therefore, because emergency physicians do not bill for the office and outpatient E/M services, the budget neutrality impact on our specialty is estimated to be extremely large. Although meant for illustrative purposes, Table 111 of the proposed rule shows a -7 percent reduction to the emergency medicine specialty if the CY 2021 proposals were implemented in CY 2020.[3] While ACEP understands that the -7 percent figure is hypothetical given that there could be other policies in CY 2021 that could shift that percentage up or down, a reduction anywhere close to that magnitude could significantly jeopardize the emergency care safety net, especially in rural areas.

Further, such a large reduction to emergency medicine in CY 2021 does not make sense from a policy perspective. In CY 2020, CMS is proposing to increase the value of the most billed services for emergency physicians (the ED E/M codes) because the agency appropriately believes that these codes are currently undervalued. If CMS finalized the CY 2021 office and outpatient E/M proposals as proposed, all of the increases in emergency physician payments from CY 2020 (if the increases recommended by the RUC are finalized) would be completely eliminated, and instead these physicians would see a significant decrease in Medicare payments. In other words, CMS would be making an appropriate valuation of emergency physician services in one year (based on an extensive RUC process), and then completely reversing course

[3] Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Proposed Rule, 84 Fed. Reg. 40886 (August 14, 2019).

the following year and decreasing overall payments for emergency physicians. In the end, the ED E/M codes and emergency physician payments would be undervalued once again. This simply does not make sense and would undermine the RUC's recommendation that the ED E/M payments should be more appropriately valued.

Given our concerns with the potential effect of the proposed increases in office and outpatient E/M codes, **we offer the following two solutions: 1) increase the value of the ED E/M codes, levels 1 through 3, to align with the corresponding levels for the office and outpatient E/M codes for new patients; AND 2) delay the implementation of the add-on code for complexity.**

Increase the Value of the ED E/M Codes, Levels 1 through 3, to Align with the Corresponding Levels for the Office and Outpatient E/M Codes for New Patients

ACEP strongly urges CMS to increase the value of the ED E/M codes, levels 1 through 3, to align with the corresponding levels for the office and outpatient E/M codes for new patients. We appreciate that CMS is accepting the RUC's recommended values for these services in CY 2020, but we believe that the CY 2021 office and outpatient E/M proposals have fundamentally altered the state of affairs from when the RUC considered the ED E/M codes in April 2018.

Our proposal is in line with previous statements from the RUC. In fact, the RUC has three times (1997, 2007, and 2018) recommended that the ED E/M codes should be the same value as the new patient Office or Other Outpatient E/M codes for levels 1 through 3. The RUC rationale, which has also been accepted by CMS historically, for the current work values of the ED codes is as follows:

"The RUC agreed that the original assumptions utilized in valuing the Emergency Department visits were flawed. In addition, the RUC's recommendations on the new patient office visits (99201 - 99205) would create a rank order problem if the Emergency Department codes were not addressed. In the first Five-Year Review of the RBRVS, the RUC had recommended that the first 3 levels of Emergency Department services should be valued equivalent to the first three levels of new patient office visits. The RUC had further recommended that Emergency Department levels 4 and 5 should be valued higher than the level 4 and 5 new patient office visits. The RUC reaffirms its previous recommendations with this submitted recommendation."

The ED E/M codes have been undervalued compared to the new patient office codes since the 2010 increase in those codes due to the Medicare elimination of the consultation code from payment. During the recent review, the RUC further reiterated its position on maintaining that relativity and the April 2018 increase was meant to bring the two code families back into alignment. Now that the new patient office codes are proposed to increase again in CY 2021, the inequities will return; perpetuating a problem even before the current fix is implemented.

We specifically request that CMS increase the ED E/M code work values to the same levels as the CY 2021 proposed new patient codes. If code 99201 is removed from the code set, then there is no direct crosswalk to 99281.

ED Code	Work RVU	New Office Code	Work RVU	Difference	Percent Difference
99281	0.48	99201	N/A	N/A	N/A
99282	0.93	99202	0.93	0.00	0.0%
99283	1.42	99203	1.60	0.18	-12.6%
99284	2.60	99204	2.60	0.00	0.0%
99285	3.80	99205	3.50	0.30	+7.9%

- We request that 99283 be raised to match the new proposed work RVU of 99203 to be **1.60**.
- We request that 99284 be raised to maintain historic relativity to 99204 by 6.9 percent to **2.74**
- To maintain historic relativity to 99205, CMS would need to raise the code by 10.41 percent to **4.20.**
    - However, although the crosswalk suggests a higher work RVU for 99285, we ask instead for **4.00**, which was the survey median in the 2018 presentation to the RUC based on those that regularly provide the service.
    - That presentation cited numerous peer-reviewed journal articles showing the intensity of 99285 had increased significantly over the past decade because of fewer admissions based on more detailed workups in the ED setting.

Rationale for Request

We are proposing a direct crosswalk between 99202 and 99203 and 99282 and 99283 as in the chart above. Further, to maintain historic relativity and avoid rank order anomalies across both families of codes, for 99284 and 99285, we propose using the relative difference between 99204's and 99205's current work values and the proposed work values, respectively, for CY 2021.

Code	Current RVUw	Proposed RVUw
99204	2.43	2.60
99284	2.56	2.60
99205	3.17	3.50
99285	3.80	3.80

For 99204 to 99284:
(2.43-2.60) / (2.43) = (6.99% X 2.56) = (0.18 +2.56) = **2.74.**

Appling the same methodology to 99205 and 99285:
(3.17/3.50) / (3.17) = (10.41% X 3.80) = (0.396 + 3.80) = **4.20**

Delay the Implementation of the Add-on Code for Complexity

To mitigate the budget neutrality adjustment that would potentially occur in CY 2021, we strongly recommend that CMS delay the implementation of the add-on code for complexity (GPC1X) until CY 2022 or later. As discussed earlier, this code within itself could have a $1 billion to $2 billion re-distributional impact. In fact, in Table 115 of the rule, CMS displays the impacts on specialties if CMS had deleted both the add-on codes for complexity that CMS had previously finalized for 2021 but accepted the

other RUC recommendations for the office and outpatient E/M codes.[4] The table, which displays these impacts as if the policies were implemented in CY 2020, shows a reduction for emergency medicine of -4 percent, much less than the reduction of -7 percent for emergency medicine displayed in Table 111. While we understand that there are multiple caveats around this estimate of -4 percent, we believe that it clearly shows that not finalizing the add-on code for complexity in CY 2021 would decrease the overall reduction to emergency medicine by a couple of percentage points.

Beyond emergency medicine, delaying the implementation of the add-on code would establish a fairer and more equitable payment structure for other specialties that do not bill office and outpatient E/M codes. Although ACEP does support an increase in payment for primary care and other office-based visits, we think that other physician specialties do not need to experience payment reductions that could be up to 10 percent for CMS to still be able to achieve its overall goal.

[4] 84 Fed. Reg. 40906 (August 14, 2019).