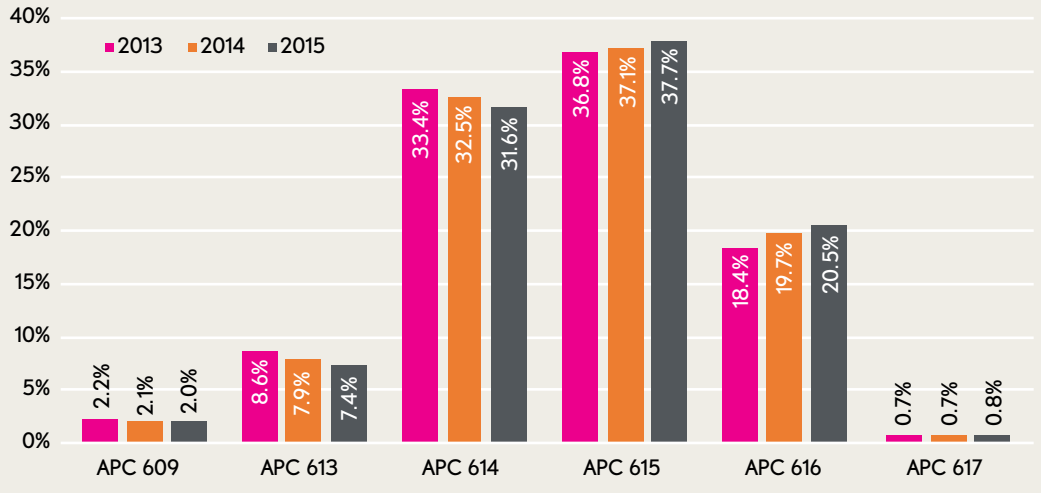
E&M coding levels for hospital EDs, 2013-15

Hospitals use evaluation and management (E&M) ambulatory payment classification (APC) codes to bill for emergency department (ED) services. Each of the six APC codes defined for this purpose signifies a different level of intensity for the care provided. Because they are quite commonly used, health plans often investigate these codes looking for instances of erroneous or improper coding.

By analyzing coding patterns involving these APCs within their organizations and comparing them with national coding trends, hospital finance executives can gain a perspective on their organization's use of these codes relative to industry norms. A basic analysis of the distribution of these codes can indicate patterns of undercoding or overcoding for ED encounters. Undercoding can result in lower payment levels, while overcoding can present a compliance issue that requires correction. Health plan investigations and audits invariably focus on the latter.

For this study, we examined national Medicare outpatient prospective payment system (OPPS) claims data covering the calendar years of 2013 through 2015. These data contain only Medicare fee-for-service outpatient claims. The information does not include claims for patients admitted through the ED, for managed care beneficiaries, and for services delivered by critical access hospitals.

PERCENTAGE OF TOTAL EMERGENCY DEPARTMENT CLAIMS



The APC codes CMS uses to pay E&M claims and the Medicare OPPS base payment rates in effect for each year studied are shown in the exhibit at right.

The exhibit on page 58 displays the portion of all ED claims represented by each APC code for the years studied. It shows the same trend we observed in a similar analysis of this information performed in 2013 covering claims from 2007 to 2010.[a] Both studies indicate a steady decline in the percentage of lower level claims and increases at the more intense levels.

It is intriguing to compare these results with those from the prior analysis with any eye to how much the percentages have changed over time. Hospitals should conduct regular reviews of their own claims compared with data for peer facilities and investigate unexpected variations. Such an analysis also should prove useful when discussing E&M utilization with health plans. ■

a. "E&M Coding Levels for Hospital EDs, 2007-10," Data Trends, *hfm*, March 2013.

MEDICARE APC DEFINITIONS AND PAYMENT RATES BY E&M LEVEL

APC	Definition	Medicare OPPS Payment Rate		
		2013	2014	2015
609	Level 1 Type A Emergency Visits	$51.82	$60.49	$60.49
613	Level 2 Type A Emergency Visits	$92.16	$112.79	$112.79
614	Level 3 Type A Emergency Visits	$143.36	$198.39	$198.39
615	Level 4 Type A Emergency Visits	$229.37	$333.80	$333.80
616	Level 5 Type A Emergency Visits	$344.71	$492.69	$492.69
617	Critical Care	$535.86	$656.94	$656.94

This analysis was performed by American Hospital Directory, Inc., Louisville, Ky. For more information, contact William Shoemaker at wshoemaker@ahd.com.