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# Emergency Physician Reimbursement: Getting Shortchanged or Shrewdly Negotiating?



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0196-0644/\$-see front matter

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<https://doi.org/10.1016/j.annemergmed.2020.08.025>

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Emergency physician reimbursement by Medicare has long been the subject of debate. Emergency physicians seek reimbursement that reflects the cognitive and procedural intensity of emergency care and keeps up with health care inflation; policymakers and payers often want to reduce emergency physician payments as one way to manage increasing health care costs. The battle between these competing interests accelerated amid the coronavirus disease 2019 pandemic; federal and state budgets became strained just when emergency physicians were on the front lines of care delivery with a new threat to their patients and to them, all while their departments struggled with balance sheets devastated by rapid and severe declines in emergency department (ED) visits.

In this issue of *Annals*, Pollock et al<sup>1</sup> present an analysis of Medicare reimbursement rates for common emergency physician services during the past 2 decades. This approach provides historical context and allows a more nuanced analysis of Medicare policy. The authors report that mean reimbursements for emergency physician services decreased by 29% between 2000 and 2020, with the greatest reimbursement reduction observed for laceration repairs. Although practicing physicians may interpret this as a major financial setback to emergency physicians and advocate simply increasing reimbursement rates for minor procedures, a more detailed understanding of Medicare payment policy might offer a different interpretation of these findings in context and promote the “sustainable payment reforms” described in the authors’ conclusion.

In general, emergency physicians are paid on a fee-for-service basis in which each service is aligned with a distinct Current Procedural Terminology (CPT) code and results in a standard Medicare reimbursement. Usually, 85% of the services billed by emergency physicians are for evaluation and management services, whereas the remainder are for separately reimbursed procedures, ranging across a wide spectrum from cerumen removal to intubation. The

reimbursement provided for each service comes from multiplying a standard reimbursement rate, referred to as the conversion factor (\$36.09 in 2020), by the assigned relative value unit (RVU) for a given service. The RVU has 3 cost elements: physician work, practice expense, and liability insurance, each of which is adjusted for local geographic differences. The latter 2 have largely remained stable and are based on actuarial calculations, but the physician work component for emergency care alters over time and offers a unique insight into the evolution of payments.

The physician work RVUs come from the American Medical Association’s Relative Value Scale Update Committee (RUC), which includes one emergency physician representative. The Centers for Medicare & Medicaid Services accepts all RUC recommendations, making this deliberative body a key driver of physician payment policy and national health care spending patterns. The American Medical Association CPT and RUC process has supported physician payment since 1966; however, the current RUC approach faces criticism for several shortcomings that include implicit favor of specialists over primary care physicians and surgical over cognitive specialties,<sup>2</sup> lack of fair committee representation,<sup>3</sup> methodological limitations,<sup>4</sup> and a concern about limited transparency.<sup>5</sup>

During the past 20 years, the American College of Emergency Physicians (ACEP) has continued advocating for emergency physician reimbursements and participated in the RUC process. ACEP experts note that emergency care is constantly changing and contemporaneously at risk for payment cuts. As such, despite the average 29% decline in reimbursements for common CPT codes reported by Pollock et al, whereas the proportion of ED visits by Medicare beneficiaries has increased,<sup>6</sup> emergency physician pay increased during 15 years after adjusting for inflation,<sup>7</sup> from \$265,458 in 2004 to \$353,000 in 2019 (reported in 2019 dollars).<sup>8,9</sup> How can these discordant trends—less reward for specific care but higher physician pay—coexist?

**Table.** Relative frequency of top 20 CPT codes in emergency medicine.

CPT Code	CPT Label	Change (Pollock et al), %	NEDS (ED Discharges), %				MPUF (All Disposition), %	
			All Payer		Medicare		Medicare	
			2006	2017	2006	2017	2012	2017
12001	Single laceration up to 2.5 cm (scalp; neck; axillae; external genitalia; trunk, including hands and feet)	-67	1.1	0.9	0.8	0.8	0.1	0.1
12013	Single laceration 2.6 up to 5.0 cm (face, ears, eyelids, nose, lips, or mucous membranes)	-65	0.2	0.2	0.2	0.3	0.0	0.0
12011	Single laceration up to 2.5 cm (face, ears, eyelids, nose, lips, or mucous membranes)	-61	0.7	0.6	0.5	0.5	0.0	0.0
12002	Single laceration repair 2.6 to 7.5 cm (scalp, neck, axillae, external genitalia, trunk, hands and feet)	-61	0.6	0.6	0.6	0.6	0.0	0.0
93042	Rhythm ECG interpretation report	-49	0.1	0.0	0.2	0.0	2.8	1.3
62270	Spinal puncture—lumbar	-36	0.1	0.0	0.0	0.0	0.1	0.1
99283	Level III ED examination	-31	33.7	35.0	32.6	27.1	14.1	11.4
99285	Level V ED examination	-24	5.0	14.9	9.0	24.9	39.3	43.6
99281	Level I ED examination	-24	14.6	4.8	11.1	3.6	0.1	0.1
31500	Intubation	-20	0.0	0.0	0.1	0.1	0.4	0.3
29505	Application of long leg splint (thigh to ankle or toes)	-19	0.2	0.1	0.2	0.1	0.0	0.0
99291	Critical care first hour	-19	0.1	0.0	0.2	0.1	18.7	20.1
99284	Level IV ED examination	-18	17.2	30.4	23.9	34.5	21.9	21.3
29130	Application of finger splint	-17	0.3	0.1	0.1	0.1	0.0	0.0
23650	Treatment of shoulder dislocation	-14	0.1	0.1	0.1	0.1	0.0	0.0
29125	Application of short arm splint (forearm to hand)	-11	0.8	0.5	0.7	0.5	0.1	0.1
29515	Application of short leg splint (calf to foot)	-9	0.6	0.3	0.4	0.2	0.1	0.0
99282	Level II ED examination	-6	24.1	10.8	19.0	6.4	1.3	0.8
16020	Dressings or debridement of partial-thickness burns	-4	0.1	0.1	0.1	0.0	0.0	0.0
10060	Incision and drainage abscess simple/single	13	0.5	0.5	0.3	0.3	1.0	0.7

NEDS, Nationwide Emergency Department Sample; MPUF, Medicare Provider Utilization File.

The first column is percentage change in reimbursement, from 2000 to 2020, consumer price index adjusted, reported by Pollock et al. Each remaining column gives the proportion of claims, among the top 20 CPT codes in emergency medicine, for each code. The NEDS data are an all-payer nationally representative sample of ED visits that resulted in discharge. The MPUF is limited to Medicare fee for service and includes claims irrespective of visit disposition.

The services provided by emergency physicians changed during the past 20 years as the hospital-based ED evolved into an acute diagnostic center, the primary portal to hospital admission, and the safety net for both vulnerable populations and the community response to public health crises.<sup>10</sup> We conducted a brief analysis of multiple data sets to examine what changed (Table). We found that the 15 most common

CPT codes analyzed by Pollock et al, excluding the 5 evaluation and management codes reported on ED visits in general, comprised only 1.3% of visits resulting in discharge in the Nationwide Emergency Department Sample in 2006 and 1.0% of visits in the sample in 2017. Visits for the codes with largest absolute reimbursement, such as a level IV and level V examination, experienced the greatest relative increase in

service use among ED discharges. In addition, in an analysis of Medicare Physician and Other Supplier Public Use File data inclusive of all ED visits among Medicare fee-for-service beneficiaries (both admission and discharge), critical care services (CPT code 99291), for which Pollock et al report a 19% decrease in reimbursement, had the greatest increase in relative service use (7%). This code composed 20.1% of reimbursed codes, among the top 20, in this Medicare fee-for-service population in 2017. Conversely, those CPT codes with the greatest declines in reimbursement such as lacerations and ECG interpretation composed only 2.9% of the top 20 of reimbursement codes in 2012 and 1.4% in 2017. Between 2006 and 2017, the average consumer price index–adjusted physician fee for the top 20 codes in the Nationwide Emergency Department Sample, weighted according to the frequency of each CPT code, increased from \$95.52 to \$105.76 (10.7%). In short, although average reimbursements declined for nearly all CPT codes after adjustment for inflation, changes in emergency medicine practice with a relative increase in higher-acuity evaluation and management services resulted in increased total reimbursement. Simply put, emergency physicians are receiving steady or higher total reimbursement for harder work.

This evokes the more important question: Are emergency physician reimbursements too low or too high? Are emergency physicians over- or underpaid? Like all things in medicine and policy, it depends. On one hand, the changes observed by Pollock et al, taken in conjunction with the observed changes in patient case mix, may reflect shrewd advocacy on the part of emergency physicians in the RUC process. Although the RUC process is not a zero-sum negotiation, the allocation of Medicare payments based on RVUs recommended by the RUC functions within a neutral federal budget. As such, allocating both advocacy efforts and data collection resources including analysis of payer claims and surveys of physicians toward higher-frequency services may have helped emergency physicians avert the Medicare payment cuts cliff faced by other specialties.

Furthermore, despite this evolution, many gaps in Medicare reimbursement of emergency physicians remain. First, reimbursement for emergency medicine evaluation and management services continues to lag the work required to discharge patients with complex medical and social needs after high-intensity evaluation. Second, the conversion factors for reimbursement have lagged behind health care inflation for decades.<sup>11,12</sup> Third, the “unfunded mandate” of the Emergency Medical Treatment and Labor Act results in providing more uncompensated care, a fact that is now more salient, given the abject failure to finance emergency pandemic preparedness at the federal level. Emergency

medicine practice has rapidly evolved in the past 20 years and will change even faster in the coming decade as the population ages and arrives with increasing comorbidities and needing care 24 hours a day, 7 days a week. This care includes acute, unscheduled diagnostic and treatment modalities for common things and being ready and responding to the crises, including catastrophes such as a pandemic or mass casualty event. With all of this, the work and the coding of work will change for emergency physicians.

From a policy standpoint, the determinants of physician Medicare reimbursement rates largely remained untouched despite changes in health care financing policy through the Patient Protection and Affordable Care Act and physician payment policy in the Medicare Access and CHIP Reauthorization Act. Although the latter eliminated the maligned sustainable growth rate calculation and created the new Quality Payment Program to support physician adoption of alternative payment models, these policy changes focused on the Medicare conversion factor and end-of-year payment penalties and bonuses, neither of which affects the central role in reimbursement of RVUs. As the nation continues to face unprecedented challenges in the coming months and years, policymakers will have an opportunity to observe, adopt, and scale innovations in care delivery and physician payment that are simpler and more transparent alongside increased emergency physician accountability for care. This alignment between work and payment through value-oriented alternative payment models will be essential to meet the physician-driven Medicare mantra of “patients over paperwork.”

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*Supervising editor:* Donald M. Yealy, MD. Specific detailed information about possible conflict of interest for individual editors is available at <https://www.annemergmed.com/editors>.

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*Authorship:* All authors attest to meeting the four [ICMJE.org](http://www.icmje.org) authorship criteria: (1) Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND (2) Drafting the work or revising it critically for important intellectual content; AND (3) Final approval of the version to be published; AND (4) Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

*Funding and support:* By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see [www.icmje.org](http://www.icmje.org)). Dr. Venkatesh was

previously supported by the Yale Center for Clinical Investigation KL2 TRO00140 from the National Center for Advancing Translational Science, a component of the National Institutes of Health, and currently works under contract with the Centers for Medicare & Medicaid Services (CMS) in the development of hospital outcome and efficiency quality measures and rating systems. Dr. Venkatesh has also been supported by the American College of Emergency Physicians Emergency Quality Network for the design, implementation, and analysis of national quality improvement collaboratives and quality measures for CMS payment programs.

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## IMAGES IN EMERGENCY MEDICINE

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### DIAGNOSIS:

*COVID toes.* There has been recent discussion regarding less common clinical manifestations of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19. One such possible symptom has been labeled COVID toes. Individuals report areas of red or purple discoloration on the feet or hands, sometimes accompanied by a burning sensation, pain, or tenderness. Initial lesions are papular and may evolve during 1 week to become purpuric and flattened.<sup>1</sup> Affected patients are often in their second or third decade of life, but symptoms have also been reported in older adults. COVID toes is unique because it tends to appear in asymptomatic or mildly affected patients. Most report spontaneous resolution within 2 weeks. The exact mechanism remains unclear. Suggested causes include local vasculitis or thrombotic events. One study found all COVID-19 patients in the ICU to have acroischemia.<sup>2</sup>

Similar manifestations have been found in other diseases. However, the incidence of COVID toes has been higher than expected since the COVID-19 pandemic onset. Furthermore, a recent report found that 20% of COVID-19 patients had skin-related symptoms.<sup>3</sup> Although experts argue whether COVID toes is a symptom of COVID-19, all agree that the medical community should be aware of it as a possible symptom.

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