American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Emergency Department EDPMA Practice Management Association

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RE: UHC Clinical Claim Reviews

The American College of Emergency Physicians (ACEP), representing 40,000 emergency physicians, and the Emergency Department Practice Management Association (EDPMA), representing about half of the 146 million patient visits to U.S. emergency departments, have serious concerns regarding UnitedHealthcare's (UHC) Emergency Department Clinical Claim Reviews and offer the following comments.

Executive Summary:

Emergency Departments remain the "safety net" for patients in the US healthcare system with well over 155 million visits annually. Patients presenting to the ED are now often sicker and much more complicated as the "less sick" have been visiting urgent cares by enticing deductibles/copays and their explosion in availability. As a direct result, the acuity of patients presenting to the ED has increased in severity requiring more elaborate workups and treatments. Consequently, there is a measurable increase in 99284 and 99285 visits to EDs nationwide. Despite the increase in acuity, patients continue to receive exceptional ED care in the EDs across the Nation.

Over the past year, ED physician groups in FL, GA, MO, OH, NC and TX have reported that UHC is conducting ED coding, documentation, and claim reviews for ED services in areas throughout the U.S. via its subsidiary or affiliate Optum Payment Integrity (Optum). In performing these audits, Optum first assigns both ED procedure codes and an Evaluation and a Management (E/M) service code to a claim, and then constructs an accompanying "case review" summary that includes Optum's findings and conclusions. In certain instances, Optum has determined, and UHC has subsequently agreed, that reimbursement for certain ED services provided to the patient will not be reimbursed. Multiple examples of services that have been denied have been reported to ACEP

and EDPMA, including:

- Interpretations of 12 lead ECGs (CPT 93010);
- E/M services requiring urgent evaluation (CPT code 99284);
- and/or cases that pose significant threat to life or physiologic function (CPT code 99285).

Following receipt of a denied claim, the denials process dictates that ED clinicians submit a written appeal that provides support for the originally billed code(s). These appeals are almost unilaterally denied by UHC, with UHC upholding its original decision not to reimburse for the denied services, and refusing to pay, even at a reduced level of service reimbursement.

State and Federal Programs and PLP:

In 1993, the Maryland General Assembly became the first state legislature to pass the prudent layperson standard for emergency department visits. Since then, forty-seven (47) states have codified their own versions of PLP that apply to state regulated health plans. (For additional information visit: http://newsroom.acep.org/2017-06-09-prudent-layperson-standard)

Success at the federal level was realized in 1997 with the passage of the federal Balanced Budget Act (BBA), after which PLP was enacted by Executive Order for the Federal Employee Health Benefits Program (FEHBP). The VA then made PLP the standard of care in the Veterans Millennium Health Care and Benefits Act of 1999 and 38 CFR Sections 17.1002 (b) and (c). CMS established PLP for the SCHIP program in 2001 in 42 CFR Section 457.10. In 2010, the ACA enacted PLP in Section 2719A and in 42 CFR Section 2590.715-2719A. Finally, ERISA plans were made applicable to PLP by CMS rule in 29 CFR Section 2560.503-1.

Despite the multiple layers of federal and state protection, patients and providers have been under increasing attack by government and private health care insurers including UHC. While PLP was enacted to protect patients who seek emergency care and provides hospitals and emergency clinicians the assurance of payment for services provided. Optum and UHC continue to violate the law by using the final diagnosis to determine E/M code choice, or to deem that services should be "bundled", or that services "are integral" to another service and not separately reimbursable as a result.

For the reasons cited herein, ACEP and EDPMA believe that the UHC and Optum documentation and claims review practice violates federal and state prudent lay-person laws (PLP) and regulations and may constitute unfair and deceptive trade practices that should immediately cease and desist. ACEP and EDPMA are advising their members that all necessary and appropriate legal action should be considered, up to, and including, litigation addressing non-payment for services rendered. The appropriate federal and state officials will be advised of these practices by copy of this letter. U.S. Senators and Representatives will also be notified of these practices. Several of the substantive areas cited above are addressed in the remainder of this letter.

Interpretation of ECG Denials:

UHC is denying ECG interpretations based on the position that these interpretations are not separately reimbursable; it is UHC's opinion that ECG interpretation is included in Evaluation and Management services. In the enclosed examples, the documentation supporting the interpretation of ECGs was confirmed in the appeals packages, yet the claims were denied by UHC in these instances for the following reasons:

- the ECG was bundled into another service;
- the documentation did not support the diagnostic test; or
- the documentation did not support the interpretation and report.

The AMA's *2019 Current Procedure Terminology (CPT) Manual* includes definitions and instructions related to the section on Results, Testing, Interpretation and Reports, and how they should be coded. Specifically, the Evaluation and Management (E/M) documentation guidelines in the CPT manual states the following:

> *"The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with modifier 26 appended."*

In denying payment for properly interpreted ECGs by claiming that the ECG was bundled into other services, UHC is in direct violation of industry guidelines as summarized above. In addition, ACEP and EDPMA believe that UHC is in violation of federal law (see below) and AMA/CPT's interpretation of the 93010 code.

In the December 1995 CMS final rule, CMS (then HCFA) said the following regarding reimbursement of EKGs by Medicare:

"Comment: W [HCFA] received relatively few comments from physicians and other entities specializing in cardiology procedures. Their comments focused on the cardiologists' greater qualifications to interpret EKGs based on their training and experience.

Response: The discussion above about the qualifications of the interpreting radiologist would also apply here. The situation with EKGs is somewhat different than with x-rays because section 13514 of OBRA 1993, Public Law 103–66, enacted August 10, 1993, requires us to make separate payment for EKG interpretations and to exclude the RVUs for EKG interpretations from the RVUs for visits and consultations, making the EKG portion of the current policy as set forth in section 2020G of the Medicare Carriers Manual obsolete."

The legal citation used by HCFA supports that ECGs must be separately reimbursed by Medicare and that the relative values for ECGs are not included in the E/M visit codes:

"SEC. 13514. SEPARATE PAYMENT FOR INTERPRETATION OF ELECTROCARDIOGRAMS.

(a) IN GENERAL- Paragraph (3) of section 1848(b) (42 U.S.C. 1395w-4(b)) is amended to read as follows:

` (3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS- The Secretary--

`(A) shall make separate payment under this section for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

`(B) shall adjust the relative values established for visits and consultations under subsection (c) so as not to include relative value units for interpretations of electrocardiograms in the relative value for visits and consultations."

Not only does federal law and Medicare policy mandate reimbursements for ECGs, AMA/CPT has mandated that ECGs are to be separately reimbursed by non-Medicare plans. The HIPAA transaction and code set (TCS) regulations require that any party sending or receiving electronic healthcare transactions must use AMA/CPT codes and (then) ICD-9 (now ICD-10). Since the AMA is legal owner of the codes, the AMA's opinion on the codes is by extension binding on the parties that are mandated to use the codes in healthcare transactions. In Sept. 2009 due to health plans alleging that the 12 lead ECG was "bundled" into the E/M service and not separately reimbursable, the AMA stated as follows:

"Assuming all appropriate documentation is contained in the patient record, it would be appropriate to report the interpretation and report of an electrocardiogram (ECG) with codes 93010 or 93042 in the emergency department by the same provider of the ED evaluation and management service codes (99281-99285)."

"From a CPT coding perspective. Code 93010, *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only,* is **not** considered part of a given level of E/M service. When reporting this code, the physician interprets the results of the electrocardiogram and prepares a separate, distinctly identifiable signed written report based on the interpretation of the results. The emergency department E/M services code may be reported in conjunction with code 93010, if the physicians performed an emergency department visit, including a history, examination and medical decision making based upon the urgency of the patient's clinical condition."

Emergency physicians routinely provide their own interpretations of ECG contemporaneous to the care of the patient's medical condition without reference to interpretations that might be provided later by another specialist. CPT has offered ample guidance for reporting EKG interpretations.

CPT specifically addresses separate reporting of diagnostic interpretive services in the prologue, "Instructions for Use of CPT" and "E/M Guidelines". Medicare follows these CPT rules regarding reporting of E/M and procedures. Payment for associated interpretive work can only occur if the CPT code related to that specific service is reported separately.

CPT, 2015 p. 6: "Select the name of the procedure or service that accurately identifies the service performed…In surgery, it may be an operation; in medicine, a diagnostic or therapeutic procedure, in radiology a radiograph…

"Any specifically identifiable procedure (i.e., identified with a specific CPT code) performed on or subsequent to the date of initial or subsequent E/M services should be reported separately."

"Interpreting" a test/study is not the same as "evaluating" or "analyzing" a test/study result. CPT visit codes are for "evaluation" and do not include interpretive services. When a written

statement of interpretive results exists, it is to be reported as an “interpretation.”

“The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code.”

Per CPT, Medical Decision Making includes "diagnostic tests, and/or other information that must be obtained, reviewed and analyzed", but not “interpreted”.

Thus, UHC’s purported denials of ECGs on the grounds that they are not separately payable services has no basis in federal law, Medicare reimbursement policy and is not compliant with the AMA/CPT interpretation of the 93010 code, and, therefore, we believe that such denials are illegal.

CPT Codes 99284 and 99285 Denials:

UHC is also denying claims that are properly coded at E/M levels 99284 and 99285. In the enclosed examples, the documentation supported these code choices, yet the claims were denied in these instances for the following reasons:

- lack of documentation;
- the position that payment for these codes is included in other procedure codes; and/or
- the position that the documentation does not support the complexity of the E/M codes submitted.

It is our belief that the 99284 and 99285 denials are the result of Optum’s reliance on software applications containing algorithms that first assess the clinician’s final diagnosis to determine E/M code choice. Such practices are either intrinsically, or, as applied here, violations of the federal and state prudent layperson (PLP) laws and regulations, as these programs rely on results of ancillary studies and therapeutic interventions provided during the emergency department (ED) visit instead of the patient’s presenting problems and chief complaints. To be precise, it is a patient’s presenting problems and chief complaints that generate a list of working differential diagnoses that must be ruled out by the treating clinician via the order of ancillary studies that are dictated by the standard of emergency care that is practiced throughout the country.

The following is one example of the type of case that is regularly denied any payment despite proper clinician documentation of the patient encounter:

A 54-year-old male patient presents to the ED at 2 am complaining of chest pain. The physician performs and documents a comprehensive history and physical exam, and orders ancillary studies intended to rule out conditions that pose a significant threat to patient morbidity and patient mortality including an acute myocardial infarction, pneumonia, pneumothorax, or a pulmonary embolus. Therapy is instituted with aspirin (ASA), IV Morphine, and Zofran. The provider orders multiple lab studies intended to rule out the conditions listed above as etiology of the patient’s chest pain including an EKG, cardiac enzymes (Troponin), a CBC, a CMP, and a CTA of the chest. The ancillary studies reveal normal and/or negative results, and the patient is subsequently diagnosed with acute gastritis, and discharged home with the appropriate prescriptions.

Patient encounters like this one are continually denied any payment, though submission of properly documented medical records has been confirmed for these denied claims. Based on the pattern of denials, we believe that diagnosis lists are being used to determine E/M levels, when a comprehensive history and exam intermixed with Medical Decision Making of high complexity should direct proper choice of a final E/M code.

Federal and State Prudent Lay Person (PLP) Laws:

The Balanced Budget Act of 1997 (BBA) established the "prudent layperson" standard, which was implemented by Medicaid in October 1997. The same standard became effective for Medicare in May 1998. Under the BBA, the prudent layperson definition of an "emergency medical condition" is:

> *"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."*

Medicare, Medicaid, and the PLP:

A Special Advisory Notice from the Department of Health and Human Services (HHS), the Office of Inspector General (OIG), and the Health Care Financing Administration (HCFA) states that:

> *"There are special requirements for managed care plans that contract with Medicare and Medicaid to provide services to beneficiaries of those programs. Congress has specified that Medicare and Medicaid managed care plans may not require prior authorization for emergency services, and must pay for such services, without regard to whether the hospital providing such services has a contractual relationship with the plan. Under statutory amendments recently enacted in the Balanced Budget Act (BBA) of 1997 (Public Law 105–33)1, Medicare and Medicaid managed care plans are prohibited from requiring prior authorization for emergency services, including those that ''are needed to evaluate or stabilize an emergency medical condition.'' Moreover, Medicare and Medicaid managed care plans are required to pay for emergency services provided to their enrollees. The obligation to pay for emergency services under Medicare managed care contracts is based on a ''prudent layperson'' standard, which means that the need for emergency services should be determined from a reasonable patient's perspective at the time of presentation of the symptoms." (emphasis added)*

Why isn't a Final Diagnosis the Appropriate Standard for ED E/M Code Choice?

With regards to the practice of emergency medicine, several factors render use of a patient's final diagnosis as the factor that drives E/M code choice inaccurate and not reflective of the work performed by the treating clinician.

1. ACEP and EDPMA strongly object to the use of any final diagnosis for a coder or auditor's choice of any emergency department (ED) Evaluation and Management (E/M) code (i.e., CPT codes 99281 to 99285). Use of final diagnoses for code choice creates significant error that leads to incorrect E/M code choice. This is especially true for those patients who receive extensive ancillary study work-ups, and/or therapeutic intervention during the emergency department visit, but are ultimately discharged following normal or negative ancillary study results, and the provision of successful therapy in the ED.
2. There are multiple symptoms that would prompt a prudent layperson to visit an ED for treatment, as the symptoms would be sufficiently severe "to reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy." Following order of ancillary studies by the ED provider, determination of these studies to be negative and/or within normal limits, and the provision of any therapy in the ED, a patient may be diagnosed with a condition that is not severe, but that in no way invalidates the medical decision making that was required to rule out the symptoms as etiology of a more serious condition. Examples include, but are not limited to:
    - chest pain that a patient felt was brought on by a heart attack but was ultimately diagnosed as acid reflux;
    - a severe headache that a patient thought was a brain bleed, but was ultimately diagnosed as a sinus infection; and
    - abdominal pain that a patient thought was appendicitis but was ultimately diagnosed as menstrual cramps.
3. The documented or implied differential diagnoses list is created by the emergency physician after he or she reviews the patient's presenting complaints and vital signs and performs a History and a Physical Exam on the patient. This list of differential diagnoses is used to determine those ancillary studies and therapies that are ordered and provided during the ED encounter. Furthermore, the differential diagnoses list is typically refined as conditions are rule out or confirmed given test results and administration of successful therapy in the ED.
4. Final diagnoses represent results of a provider's thought process and integrates the History and Physical Exam that a provider performs on a patient, as well as the results of all ancillary studies, the order and administration of therapeutic intervention(s), and the effect of those therapies on the patient. Final diagnoses do not routinely indicate the Medical Decision Making (MDM) that a provider performed in order to rule out certain conditions as etiology of a patient's presenting complaint(s). Using final diagnoses to determine E/M code choice is usually not consistent with coding guidelines or industry standard practices published by the AMA and CMS. Only a fully documented medical record that includes all details of the evaluation and management provided to a patient and/or the documented or implied differential diagnoses that the provider must rule out given a patient's complaints shed light on this effort.

Medical Decision Making and the Practice of Emergency Medicine:

Determination of the proper E/M code for emergency medicine encounters requires a combination of three key components:

- History at one of four levels (i.e., problem focused, extended problem focused, detailed, or comprehensive);
- Physical Exam at one of four levels (i.e., problem focused, extended problem focused, detailed, or comprehensive);

- and Medical Decision Making at one of four levels (i.e., straightforward, low, moderate and high complexity).

The level of each of these three key components should only be based on the MDM definitions published in the AMA's *Current Procedural Terminology* (CPT Manual) and the CMS *1995 Documentation Guidelines for Evaluation and Management Services* (DGs). Page 12 of the *AMA Current Procedural Terminology Manual*, and page 10 of the 1995 DGs both define MDM as follows:

> *"Medical Decision Making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:*
>
> 1. *The number of possible diagnoses and/or the number of management options that must be considered;*
> 2. *The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and*
> 3. *The risk or significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options."*
>
> *To qualify for a given level of decision making, two of the three above elements …. must be met or exceeded."*

Given these facts and the uniqueness of the practice of emergency medicine, the following summaries and conclusions can be reached regarding the three sub-sections of the MDM definition:

1. **MDM Definition - Subsection One: "*The number of possible diagnoses and/or the number of management options that must be considered"***
   a. The complexity of attempting to establish a diagnosis relies in part on ancillary studies such as laboratory, x-rays, and/or Special Studies (CT scans, MRIs, and Ultrasounds ordered**).** These studies are ordered by the emergency clinician to investigate the potential presence of any plausible diagnoses from the "working differential diagnoses" (written or implied) the provider considers while obtaining the patient's history and/or performing the physical exam and/or updated as the patient's evaluation continues.
   b. There is no mention of a required minimum number of ancillary studies that must be considered or ordered in order to establish a diagnosis. The ancillary studies that the clinician orders represent the standard of care in the community, the clinical training and experience of the emergency medicine provider and of course the nature of the presenting problems (presenting symptoms) and physical exam findings.
   c. Planned ancillary studies can certainly be performed during the emergency medical visit and not await the conclusion of the patient encounter in the emergency department. Every phrase in these references verifies the application of MDM level to the patient visit in its entirety and does not include timeframes following this visit such as a referral to other clinicians after the emergency visit disposition has been made. The ability to obtain necessary diagnostic results during the patient encounter is both effective and efficient patient care and is different from office-based practice where diagnostic testing is decided at the time of the initial visit; samples are obtained in the office or the patient

is referred to another location for testing; and the patient is scheduled for a follow-up office visit at which time the results will be addressed.

2. **MDM Definition - Subsection Two: "The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed"**
    a. Review of medical records, communications with persons other than the patient or other healthcare providers, and visualization and interpretation of various studies are also included in this area of MDM.

3. **MDM Definition – Subsection Three:** ***The risk or significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options"***
    a. This subsection focuses on the potential for increasing morbidity, co-morbidity, and mortality of the patient's medical condition(s).
    b. This subsection also directly relates to those procedures that were performed, and the management options that were ordered to treat or further evaluate any presenting problem(s).
    c. Management options in the emergency department generally include many of the following:
        - Oral, rectal, topical, sublingual, nasal, eye or ear medications.
        - IM, subcutaneous or IV medications.
        - Nebulizer or inhaler treatments.
        - BiPap or CPAP.
        - Laceration repair or incision and drainage of various abscesses.
        - Endotracheal intubation, non-tunneled catheter insertion or other procedures such as spinal taps or thoracostomy tube insertion.
        - Determining the patient's final dispositions including discharge, admission to hospital, placement in observation, and transfer to another facility or pronouncement of death.
        - Determining where the patient should be admitted to including the ICU, CCU, and SICU, regular bed or telemetry.

All three of the MDM components refer to the differential diagnoses considered <u>after</u> the provider performs a History and Physical Exam, as the History and Physical Exam serve to help the provider determine the lists of differential diagnoses that must be ruled out via ancillary studies, as well as any therapeutic interventions that are required to treat the patient. None of the MDM components speak to the final diagnosis(es) as the final diagnosis(es) can only be determined following review and evaluation of the ancillary study results, and the patient's response to any therapy administered in the ED. A patient's final diagnoses then, are not the driving factor behind the level of MDM required to treat a patient, or final E/M code choice.

<u>Conclusions:</u>

Full denial or down-coded reimbursement for emergency department services by UHC and Optum is in direct opposition to federal and state regulatory language that mandates the provision of medical screening exams to all patients, including the beneficiaries or covered individuals of

UHC and Optum. This regulatory language also provides for appropriate reimbursement to the hospitals and emergency physicians who provide these services.

Denials and reduced E/M code choice by UHC and Optum are totally aberrant when compared to other Medicare, Medicaid, or Commercial managed care or non-managed care organizations who also have their constituents receive care in the ED and then follow with correct, timely, and appropriate payment for emergency services provided.

Denial of payment for the interpretation of an ECG is inappropriate and directly opposed to language as presented in the present and prior CMS/AMA CPT Manuals that are used by all commercial payers. Medicaid and Medicare also reimburse the interpretation of ECGs as this service is recognized as being separate from the Evaluation and Management services provided to the patient.

Denial of emergency services with non-payment, reduction of code choice with concomitant reduction in payment for services, and non-payment for interpretation of ECGs should immediately cease by UHC and Optum. For the reasons cited herein, ACEP and EDPMA believe that the UHC and Optum documentation and claims review practice violates federal and state prudent lay-person laws (PLP) and regulations and may constitute unfair and deceptive trade practices that should immediately cease and desist. ACEP and EDPMA are advising their members that all necessary and appropriate legal action should be considered, up to, and including, litigation addressing non-payment for services rendered. The appropriate federal and state officials will be advised of these practices by copy of this letter. U.S. Senators and Representatives will also be notified of these practices.

Sincerely,





Vidor Friedman, MD, FACEP, President
American College of Emergency Physicians

Bing Pao, MD, FACEP, Chair of Board
Emergency Department Practice Management Association (EDPMA)

cc: U.S. Senator Benjamin L. Cardin
U.S. Senator Bill Cassidy
U.S. Senator Charles E. Grassley
U.S. Senator Maggie Hassan
U.S. Representative Larry Bucshon
U.S. Representative Diana DeGette
U.S. Representative Raul Ruiz

Resources

State PLP laws that apply to state regulated health plans. (For additional information visit: http://newsroom.acep.org/2017-06-09-prudent-layperson-standard)

CMS letter from April 2000 clarifying the definition of PLP in the BBA of 1997: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd040500.pdf

Federal Register Nov. 10, 1999 (Vol 64, No. 217) page 166 link