June 14, 2021

Ms. Erin Sutton and Ms. Rogelyn McLean
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7501 Wisconsin Ave
Bethesda, MD 20814

Dear Ms. Sutton and Ms. McLean:

During a meeting between the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA) and the Center for Consumer Information and Oversight (CCIIO) on June 2, 2021, you raised some questions about "medical necessity" and "downcoding" and how these issues are addressed in the claims processing, appeals, and adjudication processes that are currently in place.

ACEP and EDPMA have therefore produced a diagram (attached) that lays out various rationales that health plans provide for asserting a denial of payment (including due to the apparent lack of medical necessity) or attempting to downcode a service, and how these claims are typically handled. We have also attached some examples of payor policies that have led to payment denials and downcoding.

Here we articulate the distinction between medical necessity and downcoding, particularly in the context of emergency medicine.

Medical Necessity*:* Medical necessity is defined in Medicare as "health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine." Although there are currently protocols and standards in place to appropriately document medical necessity in the emergency department (ED), ACEP and EDPMA assert that care delivered in the ED is ***inherently medically necessary***—specifically due to existing and long-standing federal laws pertaining to emergency care that require the delivery of diagnostic services and stabilizing care. Two such laws are EMTALA and the Prudent Layperson standard, explained below. These patient protections were further strengthened in the Affordable Care Act (ACA), which required emergency care to be an essential health benefit.

EMTALA: As emergency physicians, we appreciate our essential role in strengthening the health care safety net for our communities. We treat all patients who come through our doors, regardless of their insurance status or ability to pay. Over the years, certain laws have been put into place to help enforce and protect patients and the emergency healthcare safety net, including the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to provide a medical screening examination to every individual who "comes to the emergency department"

seeking examination or treatment. The patient protections and federally required standard of evaluation and stabilization in the ED fundamentally establishes medical necessity. In fact, failure to meet this standard is a violation of this federal law, which has been in place since 1987.

Prudent Layperson Standard: The "prudent layperson" (PLP) standard, first established under the Balanced Budget Act of 1997, is another such law which allows people who reasonably think they are having an emergency to come to the ED without worrying about whether the services they receive will be covered by their insurance. This law states that payers must cover any 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: 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part." The PLP originally applied to all of Medicare and to Medicaid managed care plans, and then was extended under the Affordable Care Act (ACA) to all insurance plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) and qualified health plans in the state Exchanges. Furthermore, 48 states (all except Mississippi and Wyoming) have passed their own laws making some kind of PLP standard mandatory in their state.

Under the PLP, payors cannot deny reimbursement to providers based on the patient's final diagnosis. An "emergency" versus a "non-emergency" must be determined on a case-by-case basis based on whether the patient's symptoms and complaints reasonably represented to them as a prudent layperson a potential emergency condition. **In all, if the PLP standard applies (which happens almost all the time), ACEP and EDPMA assert that the care provided to patients meets the requirements of medical necessity and therefore, should be covered by insurers.**

Unfortunately, ED claims are denied by insurers due to a "lack of medical necessity" after seeing a final diagnosis. **Again, we strongly believe that such a denial represents a fundamental violation of the PLP standard**. Patients with symptoms consistent with a possible emergency health condition should not be expected to self-diagnose before making a decision as to whether to come to the ED. Even as experienced emergency physicians, we cannot determine a patient's final diagnosis (or whether they have an emergency or non-emergent medical condition) based on the patient's symptoms when they first present to the ED. Many conditions share very similar symptoms, and a full work-up and examination is frequently required (sometimes with additional diagnostic tests) before it becomes clear what the ultimate diagnosis is. In fact, a 2013 peer-reviewed study published in JAMA of over 34,000 ED visits found that for those discharge diagnoses which could be considered primary care–treatable, the chief complaints reported for these visits were identical to those reported for 88.7 percent of all of the studied ED visits, many of which ended up requiring admission to the hospital, triaged at the highest/most urgent level, or went directly to the operating room. As the authors of the JAMA paper note:

"For example, a 65-year-old patient with diabetes may be discharged with the nonemergency diagnosis of gastroesophageal reflux after presenting with a chief complaint of chest pain; however, that patient still required an emergency evaluation to rule out acute coronary syndrome."

The extremely limited concordance between presenting complaints and ED discharge diagnoses in this study demonstrates that using lists of diagnostic categories as a means for making coverage determinations is a flawed and inaccurate practice. It is medically necessary to apply appropriate diagnostic and treatment methods for patients' presenting symptoms. Failure to do so would not meet accepted standards of care and pose serious risk for patients.

Downcoding: Distinct from "medical necessity" is the issue of payor downcoding. If claims are downcoded by payors, the services are still covered by the payors (rather than denied), but the level of service on the claim is changed. Emergency physicians typically bill the ED evaluation and management (E/M) codes (Current Procedural Terminology [CPT] codes 99281-99285). An example of a claim downcoded by a payor is the scenario where an emergency physician bills a CPT code 99285 (a level 5 service), but the payor adjusts the code on the claim to a CPT code 99284 (a level 4 service).

Unfortunately, the practice of payor downcoding is routine among some insurers, and it has become a major issue in emergency medicine. Payors have instituted algorithms to automatically down code certain claims without a medical chart review—again based on the final diagnosis and thus in violation of the PLP standard.

It is important to note that both the Obama and Trump Administrations have clearly stated that the PLP standard prevents plans from modifying payment of (downcoding) – emergency claims based on diagnosis. In 2016, the Obama Administration issued the Medicaid Managed Care Rule which states "*The final determination of coverage **and payment** must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that **providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens**" (emphasis added).* In a March 15, 2018, letter to EDPMA, former CMS Administrator Seema Verma reiterated that "Whenever a payer… denies coverage **or modifies a claim for payment**, the determination of whether the prudent layperson standard has been met must be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must make take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional)" (emphasis added).

ACEP and EDPMA have strongly pushed back against downcoding policies, arguing that there are clear documentation standards and guidelines that dictate what level of service should be included on the claim. Professional services are described in claims using the universally accepted CPT and the supplementary Healthcare Common Procedure Coding System (HCPCS) codes. Decades ago, HHS named CPT and HCPCS codes as the sole code sets for describing physician services, among other services, tests, and procedures. In addition to published detailed descriptions of services named by these codes, the CPT Editorial Panel releases updated and detailed guidelines regarding the elements of services that must be present to meet requirements for assignment of a particular code to a service. Strict adherence to the above-mentioned coding guidelines is ensured by front-end quality assurance processes and on the back-end by thorough auditing processes with financial and legal implications.

First, most claims billed by emergency physicians are actually coded by professional coders who have a significant amount of training, expertise, and ongoing education. With respect to training and ongoing education, there is a standard practice in place for coders to have certification, including from the American Health Information Management Association or the American Association of Procedural Coding. There is also maintenance of certification including continuing education from CPT or the Centers for Medicare & Medicaid Services (CMS). Finally, coders receive and are responsible for education from regional Medicare Administrative Contractors (MACs).

Billing companies also undergo annual internal audits of all processes, including coding practices, as recommended by the Office of the Inspector General (OIG) within the U.S. Department of Health and Human Services (HHS). In addition, they do voluntary audits of their coding team by external parties as well. Standard practice among billing companies is to accept no less than 95% accuracy proven by these internal and external coding audits.

Moreover, all providers, both those that use professional coders and the minority that do not, are subject to strict oversight by CMS via contracted services performed by the MACs, Recovery Audit Contractors (RACs), and Zone Program Integrity Contractors (ZPICs). These contractors review claims data, analyze for variance in CPT submission, and gather additional data to determine if there are patterns of overpayment or underpayment. In response to the audit findings, providers can be subject to more intense global claim review, withholding of future payments based upon claim-by-claim review, recoupment of fees already paid to providers, and civil or even criminal charges brought by the OIG. Relatedly, private payors oftentimes also perform their own global audits of submitted claims and may refer providers for additional education or regulatory action as deemed appropriate. Lastly, patients can trigger an audit as well by contacting the above parties about any concerns they have with services billed for by providers.

Thus, overall, ACEP and EDPMA strongly oppose the unilateral, payor-driven practice of downcoding and believe that there are strong standards and enforcement mechanisms already in place to ensure accurate and appropriate coding by clinicians.

As the *No Surprises Act* is implemented, ACEP and EDPMA urge CCIIO to monitor these issues. While the Act already requires the Secretaries of the HHS, Treasury, and Labor to issue an interim and then final report on whether any insurer has a pattern or practice of routine denial, low payment, or downcoding of claims during the "90-day cooling off period" in the independent dispute resolution (IDR) process, **we believe that the Departments should track denials and downcoding more broadly**. We also believe that CCIIO should track how IDR entities rule with respect to medical complexity (which is a factor the IDR entity shall consider in disputes). If they overwhelmingly rule in the providers' favor, this again would demonstrate that coding practices for professional ED claims are accurate and appropriate.

Thank you for the opportunity to follow-up on our June 2nd meeting. If you have any questions, please reach out to our point-of-contact from the meeting, Jeffrey Davis, ACEP's Director of Regulatory Affairs, at jdavis@acep.org.

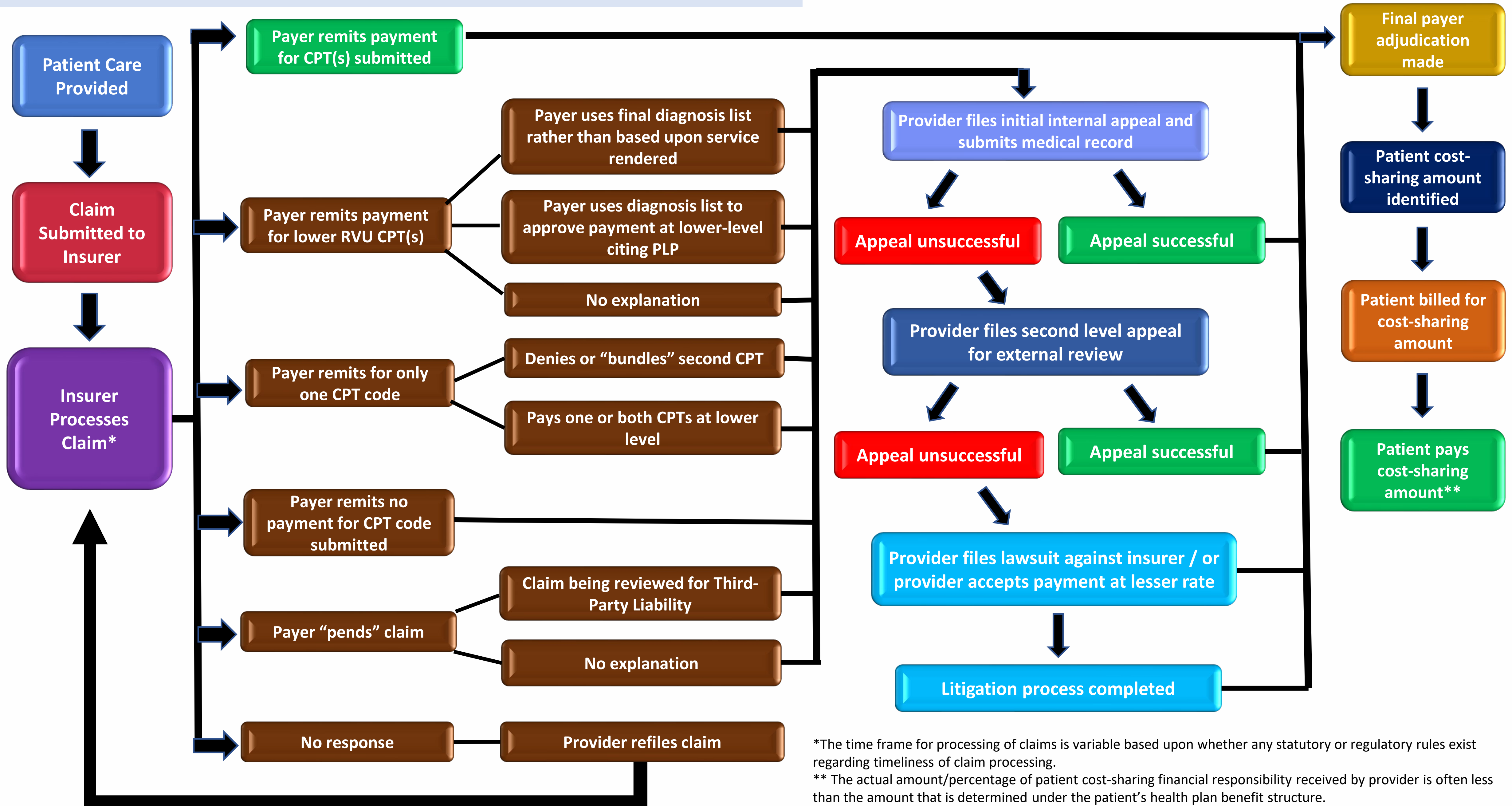
Sincerely,

Mark S. Rosenberg, DO, MBA, FACEP
ACEP President

Bing Pao, MD, FACEP
Chair of the Board, EDPMA

Attachment 1

Emergency Department – Pre-NSA Revenue Cycle Process



*The time frame for processing of claims is variable based upon whether any statutory or regulatory rules exist regarding timeliness of claim processing.

** The actual amount/percentage of patient cost-sharing financial responsibility received by provider is often less than the amount that is determined under the patient’s health plan benefit structure.

Attachment 2

Emergency Department
EDPMA
Practice Management Association

Examples of Payor Policies that Have Led to Payment Denials and Downcoding

Commercial Policies that Violate the Prudent Layperson Standard

1. **UHC emergency department (ED) Facility Fee Policy 2021**: This policy denies certain emergency claims before reviewing the presenting symptoms in the medical record. The policy was delayed until the end of the COVID-19 public health emergency.
2. **UHC ED Professional Fee Policy 2020 and 2021**: https://www.edpma.org/downloads/UHC_April1Policy.pdf. This UHC policy down codes level 5 emergency claims based on an E/M protocol which bases reimbursement on diagnosis. This policy was delayed in 2020, rescheduled in 2021, and delayed again in 2021.
3. **Moda 2021**: 5/5/21 EDPMA/ACEP Letter to Moda Health re: Policy that Violates PLP. This Moda policy proposes to routinely downcode Level 4 and Level 5 emergency visits based on diagnosis.
4. **Anthem 2021**: https://www.edpma.org/downloads/Bulletin_ERBilling.PDF further described in 2/25/21 Anthem Response to EDPMA's 2/22/21 letter on E/M Policy. This Anthem policy allows Anthem to deny, pend, or down code level 4 and 5 emergency claims from some providers based on diagnoses.
5. **Paramount 2019**: https://edpma.org/wp-content/uploads/2021/02/pg0396_emergency_room_professional_services.pdf . This Paramount policy bases emergency reimbursement on diagnoses.
6. **MS BCBS ED Policy 2018**: December 12, 2018 Professional Emergency Room Policy. This policy aligns ED E/M visit code level 1-5 with final diagnosis.
7. **FL BCBS ED E/M Policy 2017**: August 2017 Florida Blue Bulletin with Update. This policy denies and down codes level 4 and 5 emergency claims based on diagnosis code.
8. **Aetna ER Policy 2016**: https://www.edpma.org/downloads/AetnaPolicy_Level5.pdf . This Aetna policy down coded level 5 emergency claims to a level 4 based on diagnosis. The policy was replaced in 2017.

Medicaid Policies that Violate the Prudent Layperson Standard

1. **Centene National Policy** 2017 (https://edpma.org/wp-content/uploads/2021/02/2017-Centene-ER-Leveling-Policy.pdf) Centene has Medicaid MCO plans in 30 states and the policy down codes level 5's and 4's to a 3 based on diagnosis.
2. **Medicaid Kansas**- In January 2018, Kansas Medicaid released a bulletin retroactively reversing its policy of reducing emergency reimbursement using diagnosis lists (after CMS weighed in).
3. **Medicaid Virginia—July 2020:** VAMA Policy
4. **Medicaid Indiana—April 2020:** INMA Policy
5. **Medicaid Iowa—August 2018:** IAMA Policy

C. **PLP quotes from CMS under various administrations**: Key CMS PLP Quotes