August 31, 2021

Mr. Tim Wentworth, Chief Executive Officer
Cigna
900 Cottage Grove Road
Bloomfield, CT 06002

RE: Down Coding Emergency Claims Based on Diagnosis

Dear Mr. Wentworth:

The Emergency Department Practice Management Association (EDPMA), representing half of the 146 million patient visits to U.S. emergency departments and he American College of Emergency Physicians (ACEP), representing 40,000 emergency physicians, are writing to express concerns regarding Cigna's "8/14/2021 Notification: for policy effective date of 11/14/2021. Emergency room E/M CPT codes 99284 and 99285 will be reimbursed consistent with the appropriate CPT code 99283 when a single noncomplex diagnosis code is used." As this letter explains, not only does this proposed policy violate coding guidelines, it is also a clear violation of longstanding legal requirements related to emergency department EMTALA obligations and the related prudent layperson standard. We ask that you rescind this new policy before it takes effect. If not, we ask that you meet with us to discuss this further.

Background:

Emergency Departments remain the "safety net" for patients in the US healthcare system with over 146 million visits annually. Patients presenting to the ED are now often as a population sicker and more complicated in their medical needs than in the past, as the "less sick" are now more likely to visit urgent care centers due to the explosion in their availability. As a direct result, the acuity of patients presenting to the ED has increased in severity, thus requiring more elaborate workups and treatments. Consequently, there is a measurable percentage increase in 99284 and 99285 visits to EDs nationwide. Despite the increase in acuity, patients continue to receive exceptional care in the EDs across the nation.

Against that background, Cigna proposes to routinely down code Level 4 and Level 5 visits (99284 and 99285) "when a single noncomplex diagnosis code is used." While emergency physicians will continue to provide our patients with appropriate medical care, it is important to note that you are in essence incentivizing an approach that would compromise the safety of your beneficiaries. Furthermore, it violates the federal and state prudent layperson laws. To provide a rather obvious example for purposes of illustration, when a patient presents with chest pain and other symptoms

suggesting a possible cardiac event, the physician does not begin his or her work up by assuming that the patient might just have a case of indigestion. That approach could lead to delays in diagnosis that would be life threatening for the patient. Yet, a policy of reimbursing based on the diagnosis that can only occur after the patient has been evaluated seems to assume such a course.

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, including Oregon, 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. ERISA plans were made applicable to PLP by CMS rule in 29 CFR Section 2560.503-1. **The Affordable Care Act (ACA) extended the federal prudent layperson standard to ERISA plans and all individual and group health plans, except those that are grandfathered from the ACA.** These laws provide important assurance to patients regarding access to emergency care at the time of their greatest vulnerability.

Despite the multiple layers of federal and state protection, these assurances for patients and their physicians have been undermined by government and private healthcare insurers who seem intent on ignoring the clear requirements of the law. While PLP was enacted to protect patients who seek emergency care and provides hospitals and emergency clinicians the assurance of payment for services provided, proposals by payers continue to violate the law by using the final diagnosis to determine E/M code choice.

For the reasons cited herein, the policy Cigna has proposed violates federal and state prudent lay-person laws (PLP) and regulations and should not be implemented.

Violation of the Prudent Layperson Standard

Cigna is proposing to down code claims that are properly coded at E/M levels 99284 and 99285 and pay them at a lower rate based on diagnosis. This action violates the federal prudent layperson standard. CMS has already established that the payment level cannot be denied **or modified (down coded)** based on diagnosis. In the 2016 Medicaid Managed Care Rule, CMS stated

> "*"we prohibit the use of codes (either symptoms or final diagnosis) for denying claims because we believe there is no way a list can capture every scenario that could indicate an emergency medical condition under the BBA provisions. …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 to point out that both denials **and down coding** based on diagnosis is a violation of the federal prudent layperson standard).

CMS Reiterates Policy in 2018: CMS Administrator Seema Verma sent a letter to EDPMA on March 15, 2018 reiterating 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).*

This State Medicaid Director letter is still in effect and can be found at: http://www.medicaid.gov/federal-policy-guidance/federal-policy- guidance.html " (emphasis added to point out that both denials **and down coding** based on diagnosis violates the federal prudent layperson standard). (*3/15/18 CMS Response Letter*)

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

With regard 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. 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 workups, 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 ruled 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. The final diagnosis for a condition does not in and of itself determine the complexity or risk as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of a lower severity may in the aggregate create higher risk due to interaction 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 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.
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.
    b. 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.

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 after 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.

Cigna Reliance on Only the 1997 CMS Documentation Guidelines Rather Than Also Considering the 1995 Original Documentation Guidelines

Imposing sole use of the 1997 documentation guidelines puts an undue burden on emergency physicians by forcing them to perform and document unnecessary and often clinically irrelevant physical exam components. This seems to be in direct contrast to the AMA and CMS *Patients Over Paperwork* initiative intended to reduce the administrative burden physicians experience trying to comply with complex and often confusing documentation requirements. The primary changes in the 1997 Documentation Guidelines are related to physical exam, an element which both CPT and CMS are moving away from as driver of E/M code choice in favor or MDM. As such, it seems like a strange requirement.

This is from the AMA 2021 Documentation Guideline page:

"For decades, the physician community has struggled with burdensome reporting guidelines for reporting office visits and other E/M codes. With the proliferation of electronic health records (EHRs) into physician practices, documentation requirements for office visits have moved towards increased "note bloat" within the patient record due to the largely check-box nature of meeting the current documentation requirements."

https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

Similarly, CMS has long held the policy that auditors must use either the CMS' 1995 guidelines or their 1997 guidelines, whichever most benefits the physician.

We strongly urge Cigna to adjust their policy to conform to the industry standard of using the 1995 or 1997 documentation guidelines for selecting an E/M code.

Unrecognized CPT Code Level Examples in the Cigna Policy

The table on pages three through five of the August 14th policy includes a column of "CPT code level examples". This are not consistent with the CPT examples in Appendix P. Where did Cigna obtain this CPT list? This list includes final diagnosis rather than presenting symptoms as opposed to the examples found in CPT Appendix C.

We urge you to use the actual CPT examples from Appendix C in your policy.

Conclusions:

Down-coded reimbursement for emergency department services based on noncomplex diagnosis is in direct opposition to federal and state laws that protect patients and providers.

EDPMA is committed to promoting the provision of quality health care to our patients that is also cost effective. To that end, we ask that you rescind your proposed policy, and we stand ready to work with you on ways of reducing system costs that do not compromise patient care.

If you have any questions, please contact Elizabeth Mundinger, EDPMA's Executive Director at emundinger@edpma.org of David McKenzie, ACEP's Reimbursement director.

Sincerely,

Dr. Bing Pao

Chair of the Board, Emergency Department Practice Management Association

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