Emergency Department EDPMA Practice Management Association

October 28, 2016

Harold L. Paz, M.D., M.S.
Executive Vice President and Chief Medical Officer
Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156

Re: Aetna OfficeLink Updates, September 2016 Volume 13, Issue 3 – ER Level of Care

Dear Dr. Paz:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn. Together, EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year. Of course, many of these visits are Aetna members all over the United States.

We are writing you today to alert you that Aetna's recent Office Link Update regarding *ER level of care* and Aetna's intent to down-code emergency services based on certain *designated minor diagnosis codes* would constitute an unfair claims settlement practice. We request that Aetna rescind this update (Exhibit 1) prior to December 1, 2016.

The Evaluation and Management (E/M) code 99285 is an AMA/CPT code with specified guidelines on the appropriate use of this code when filing a claim. E/M 99285 reflects a comprehensive history dependent upon clinical judgment and on the nature of the presenting problem(s); and a comprehensive examination also dependent on clinical judgment and on the nature of the presenting problem(s); and medical decision making of high complexity[1].

All emergency patients are "New" to the emergency provider; and therefore, the evaluation is more complex than if the patient's history, chronic conditions, medications, etc. were well known to the provider. Nothing in the prescribed AMA/CPT guidelines for determining the emergency department E/M service level refers to the final diagnosis as a factor to be considered.

[1] Pages 9-10, 22-23 Professional Edition AMA/CPT 2016

The final diagnosis is excluded from the determination because the final diagnosis does not reflect the work and risk associated with the patient's presenting problems. In fact, CPT and CMS both state that determining the level of E/M does not require a final diagnosis be determined during the encounter.

Sometimes a final diagnosis turns out to be "minor"; however, the presenting signs and symptoms and the differential diagnoses that were considered may have been complex and often pose a potential threat to life or physiologic function. As you are aware, the 1500 claim form does not allow the provider to indicate the differential diagnoses and ICD diagnosis guidelines specify that differential diagnoses evaluated at the time of the encounter are not to be reported. However, we know that many chronic diagnoses, age, sex, and vital signs often must be considered with certain minor signs or symptoms because they can also be indicative of serious and sometimes life threatening conditions. Because of the reporting limitations, the provider and usually a professional coding expert make the E/M level determination by considering all of the elements of the encounter.

One should also consider that it has also been found in various states - and CMS has agreed - that requiring "payable diagnoses" lists and/or requiring the submission of medical records based on a final diagnosis is a compliance problem and could be considered abuse. Placing such routine cumbersome requirements on providers without any evidence of coding or documentation errors has usually been considered an unfair claims settlement practice.

We are willing to review Aetna's "designated minor diagnosis codes"; however, no determination of an E/M level on a claim can be justly made based solely on a final diagnosis. With the Aetna list we can provide Aetna with specific examples of correctly coded level 99285 encounters that demonstrate that a patient required a level 5 history, exam, and Medical Decision Making, to conclude the patient was only suffering from a "minor" condition. However, if Aetna chooses to arbitrarily down-code our 99285 services based solely on the final diagnosis and require providers to appeal each such case, then relief will be sought by all means available.

It is our opinion and hope that this Aetna policy was made in error and will be revised prior to December 1, 2016. However, if after reconsideration, Aetna still plans to implement this policy, we request:

1. **Immediate notice from yourself and Aetna's Chief Compliance Officer of your intent; and**
2. **Aetna immediately forward or publish the list of Aetna "designated minor diagnosis codes".**

Sincerely,

Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors

EXHIBIT ONE

Aetna Office Link Updates SE Region
September 2016 • Volume 13, Issue 3

ER level of care

December 1, 2016

CPT code 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening, and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285.

When a hospital or physician bills a level 5 emergency room service (CPT 99285) with a designated minor diagnosis code, we will down code 99285 to a level 4 emergency room service (CPT 99284).