October 16, 2017

Colleen Brennan
Vice President and Chief Integrity and Compliance Officer
Florida Blue
P.O. Box 1798
Jacksonville, FL 32231-0014

Re: ER Department Billing and Reimbursement Changes" dated, August 2017, that may represent an Unfair Claims Settlement Practice and may encourage false claims by providers.

Ms. Brennan:

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.

Together, **EDPMA's members deliver (or directly support) health care for about half of the 141.4 million patients that visit U.S. emergency departments each year.** 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.

We are writing today with serious concerns regarding Florida Blue Cross and Blue Shield's (FBCBS) recent announcement concerning ER Department Billing and Reimbursement Changes, which we believe amounts to a fundamental policy change with respect to your members' ability to access emergency care.

Notwithstanding your company's pronouncement that this is not a change in policy, we believe this statement is grossly inaccurate, potentially violates state and federal law and by the fact that it virtually affects all Florida Blue products, we believe it is not only an unfair business practice but one that will undoubtedly cause serious health risks to your members.

We believe this policy change is without merit for the following reasons:

1. As referenced in FBCBS' provider manual, a member has the right to receive emergency care that a member, as prudent layperson, acting reasonably, would have believed that an

emergency medical condition existed. **Payment will not be withheld** in cases when, a member, acting reasonably, seeks emergency medical services.

2. In the referenced document FBCBS indicates, "more than 60 percent of hospital and professional ER claims are billed with the two highest level E&M codes". This may be accurate statistical reporting however, we would like to see the professional statistics for professional ER broken down by FBCBS Product. Surely we would expect for example that it is normal for the Level 4 and Level 5 codes for the Medicare products to equal 60% or more due to the known acuity of Medicare patients presenting in the Emergency Room.

3. FBCBS goes on to indicate that "These high level E&M codes are sometimes being billed with low level severity ICD-10 codes…and are not consistent with the E&M procedural code definitions".

First, please provide us with examples so that can we can establish which part of the E&M procedural code definitions you feel are inconsistent with certain ICD-10 codes. We would also like to know where your system is determining the ICD-10 code that applies to the E&M code since ICD-10 information appears in two separate places on a claim. For example, the 1500 claim field (a/k/a X12N-837) electronic format lists diagnoses in fields HI01 through HI04-2, however, this is a list of all ICD-10 diagnoses applicable to the encounter for the specific claim, but not linked to specific CPT procedure codes.

The ICD list in this field are all the ICD's pertinent to the encounter, clearly the final diagnoses might be of lower severity than the presenting signs or symptoms also in the ICD list. What matters is what ICD is principally responsible for the level of E&M along with comorbidities that may not be listed on the claim but indicated in the chart. We agree that some limitations exist with claims data making it impossible to ascertain all of the clinical factors defining the patient's acuity upon presentation to the Emergency Department and often the notes in the chart are needed to accurately determine the patient's acuity.

1500 Claim Crosswalk to Electronic Claim – ICD List

21	Diagnosis or Nature of Illness or Injury	2300	HI01-2; HI02-2;HI03-2 HI04-2	

It is very important to note that the only ICD-10(s) that apply to the E&M code listed are those in the ICD field directly associated with the E&M code. This field (24E on 1500) are "pointers" that tell the adjudication system which ICD's in the list in field 21 specifically apply to the specific corresponding CPT code. For example, you may have 4 ICD's listed in field 21, but

when the field for the E&M code is read it may have a pointer HIO1 and HI04, but does not apply HI02 and HI03 to the E&M. The first pointer indicated should be the ICD most responsible for the reason the patient came to the Emergency Room, such as acute abdominal pain, but the second pointer indicated as associated with the E&M might be gastritis. Examining the claim in isolation it is impossible to determine whether the patient has co-morbidities, abnormal labs, etc. or one which required the physician to do a full work-up only to find that the patient had gastritis.

1500 Claim Crosswalk to Electronic Claim – ICD link to specific CPT code

24E	Diagnosis Pointer	2400	SV107 (1-4)	Titled Diagnosis Code Pointer in the 837P.

On this point we would like to discuss further exactly where the ICD is located and in which position that FBCBS is searching and finding "low severity diagnosis codes" associated with the E&M levels. It seems that if a low level diagnosis code appears in any position that the FBCBS system may miss the ICD that indicates a presenting problem of High Severity and unfairly deny claims.

FBCBS indicates that, "Claims submitted with higher level ER department E&M codes 99284 (or) 99285 and one or more low severity diagnosis codes may be denied for the reason that the ER E&M level billed is inconsistent with the diagnosis reported on the claim."

Again, we want to stress that a lower severity diagnosis code may appropriately appear on a claim with a high severity diagnosis code and in such cases it would be unfair to deny the claim. We very much would like to discuss how your system will determine such denials and we would like to discuss how we might ensure that we can comply with ICD rules and FBCBS.

ICD rules are clear, with much being published in the ICD Coding Clinic explaining that one must list the principle reason for the visit and final diagnoses if one is determined. Failing to follow ICD guidelines could be considered a false claim.

The FBCBS policy may be encouraging or requiring that a provider leave off the final diagnoses if it is lower acuity than the principle diagnosis in order to avoid a denial. We are confident it is not FBCBS's intent to encourage or require false claims in order for the provider to be paid.

FBCBS in this policy statement indicates that, "[t]he intent of the denial is to direct providers to verify their billing and submit a corrected claim with the appropriate E&M code and ICD-10 diagnosis code combination. This could result in a corrected bill with a more appropriate E&M procedure code and/or updates to the diagnosis code(s) reported. If the claim is billed with a diagnosis code that is not identified as low level complexity, the claim will process as it does today."

We would like to emphasize that the level of care provided is not dependent upon the final diagnosis, but the complexity and medical decision making that is required to reach the diagnosis. That is why a higher level of care can be billed even though the final diagnosis does not appear to be severe.

Clearly, this policy encourages the provider to omit the final diagnoses when that diagnoses is of lower severity. This would not meet the compliance guidelines provided by ICD or the OIG. If FBCBS's system ignores the high acuity reason for the visit listed on the claim in order to deny the claim based on a final diagnosis this would also be inconsistent with CPT and CMS policies. Such a systematic denial process could be deemed to be a very serious unfair claims settlement practice in the State of Florida.

EDPMA encourages FBCBS to delay further implementation of the ER Department Billing and Reimbursement Changes announcement that we believe may be an unfair claims settlement practice and may result in an unfair appeals burden on providers. We respectfully request a conference call to discuss with us FBCBS' list of diagnosis codes that lead FBCBS to deny claims under this policy and we'd also like to address on the call the following questions:

- Does the policy ever allow the denial of a claim before reviewing additional medical records?
- Which diagnosis/diagnose located on the claims form, primary or otherwise, is the denial based upon?
- Can FBCBS provide and share examples of inconsistencies that resulted in this policy change?
- In what way is the new policy consistent with CPT and CMS polices?

To schedule the conference call, please contact Elizabeth Mundinger, Executive Director, EDPMA, at emundinger@edpma.org.

Sincerely,

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