Emergency Department EDPMA Practice Management Association

September 29, 2016

Richard Migliori, M.D.
Executive Vice President, Medical Affairs and Chief Medical Officer
UnitedHealth Group
P.O. Box 1459
Minneapolis, MN 55440-1459

Marianne D. Short
Office of the Chief Executive
Executive Vice President and Chief Legal Officer
Responsible for overseeing legal, regulatory and compliance matters across the enterprise
UnitedHealth Group

Re: UnitedHealthcare Employer & Individual Policy Number: 2016R5007
Evaluation and Management (E/M) Reimbursement Policy
Annual Approval Date: April 21, 2016
Approved By: Payment Policy Oversight Committee

Dear Dr. Migliori and Ms. Short:

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 136 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 to express our concern about recent UHC policy positions (EXHIBIT ONE attached) published in the policy referenced above. We believe that UHC should:

1. Immediately suspend the policies;
2. Convene a meeting of the affected parties; and
3. Engage experts from EDPMA, ACEP, AHIMA, and AAPC to determine whether these policies:
    a. Are consistent with federal guidelines;
    b. Are consistent with industry standard coding guidelines as required by HIPAA;
    c. May result in unfair claims settlement practices by UHC; and/or
    d. May jeopardize the quality of emergency care in the United States.

The below policies, as written, apply to "UHC Employer and Individual Policies" yet the policies below are based on the 1995 HCFA Medicare Documentation Guidelines (DGs). It is important to recognize that HIPAA regulations stipulate that Providers are to use and Payers are to accept claims based on the AMA CPT guidelines and the ICD-10-CM guidelines. The DGs UHC cites are Medicare specific guidelines applicable to claims filed for care rendered to Medicare Beneficiaries. We look forward to the opportunity to explain in detail why the DGs are not appropriate in coding and filing claims for non-governmental beneficiaries. As a quick summary:

1. If the Medicare Documentation Guidelines were appropriate to apply to UHC Employer and Individual claims the UHC policies below are still inconsistent with the DGs as written;
2. UHC policies below conflict with the appropriate AMA Current Procedural Terminology Guidelines that should be used to code such claims; and
3. UHC policies below (EXHIBIT ONE) are not consistent with accepted coding standards as represented by the industry, accepted medical coding professional associations, AHIMA and AAPC.

First, the UHC policy below regarding "additional workup planned" is not part of the 1995 Documentation Guidelines as implied below. The UHC policy conflates the DGs with a modified version of the Marshfield Clinic Guidelines that were never adopted by HCFA or CMS and are not part of the AMA CPT coding guidelines. The DGs are also not specifically coding guidelines. The Documentation Guidelines were designed to give Medicare contracted Carriers general guidance on how providers should document the medical record indicating various levels of patient history, exam, acuity and medical decisionmaking when treating a Medicare patient. The DGs were guidance to Medicare Carriers to use when auditing Provider Documentation. The AMA CPT guidelines as mentioned by HCFA in the presentation of the original guidelines are the actual coding guidelines. To summarize:

1. The Marshfield Clinic tool and subsequent variations were never adopted by HCFA, CMS, or AMA CPT as coding guidelines;
2. The Marshfield Clinic scoring tool was designed for use in a clinic or office practice not an emergency department;
3. UHC is arbitrarily defining elements of the Marsfield Clinic tool and the definitions UHC suggests are not consistent with the DGs or AMA CPT guidelines; and
4. The AMA CPT coding guidelines mandated for use and acceptance by providers and payers alike do not incorporate the 1995 DGs or the Marshfield Clinic Tool.

Second, The UHC policy below regarding "additional workup planned (AWP)" characterizes AWP as an element of the 1995 Documentation Guidelines yet it is not part of the AMA CPT coding guidelines. AWP was a construct of the Marshfield Clinic tool that was never adopted by HCFA, CMS, or AMA CPT. Furthermore, Marshfield Clinic never defined AWP and the Marshfield Clinic Tool was designed for primary care and limited specialties, not emergency medicine. Conflating "an element" of the Marshfield Cllinic tool as if it were part of the DGs and then inventing a definition of AWP that never existed as if it were part of the tool is wrong, unfair, arbitrary and capricious. Applying this UHC policy invention to emergency medicine is unfair, non-compliant with proper coding, and in violation of HIPAA guidance. It also seems to be a maneuver to reduce provider reimbursement solely to increase UHC revenue.

Third, UHC is suggesting that AWP is the prescribed method to determine the "Number of Diagnoses or Management Options" when calculating the complexity of Medical Decision Making and further

implying that the DGs support their conclusion. In fact, AWP is never specifically mentioned in the DGs other than to say, "The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses." It is also very important to note that the DGs indicate that the possible Number of Diagnoses and/or Management Options determine the complexity; meaning the more pertinent diagnoses and management options considered by the provider, the higher the complexity. The DGs go on to offer examples of Management Options as, "*…management options including patient instructions, nursing instructions, therapies, and medications"*. The 1995 Documentation Guidelines regarding Number of Diagnoses or Management Options (DMO) are available in EXHIBIT 2 attached.

Finally, the AMA CPT coding guidelines state (AMA CPT 2016 Professional Addition Pg. 10), "Medical decisionn making refers to the compexity of establishing a diagnosis and/or selecting a management option as measured by: The number of possible diagnoses and/or the number of management options that must be considered".

The complexity levels of DMO listed in AMA CPT are: "*Minimal*, *Limited*, *Multiple*, and *Extensive"*.

It is reasonable and common practice under AMA CPT guidelines to consider a single pertinent diagnosis or management option would be Minimal; two pertinent diagnoses and/or management options would be Limited; three pertinent diagnoses and/or management options would be Multiple; and four or more pertinent diagnoses and/or management options would be Extensive.

The UHC policy below may only apply to UHC participating providers; however, we urge UHC to suspend this policy immediately. We believe that because the UHC policy is not compliant with mandated coding regulations and policies that it is unenforceable and may subject UHC to unfair claims settlement charges.

The other UHC policy we wish to discuss is in the Q&A section of the UHC policies below. UHC states: "Any specifically identified procedure reported separately from the E/M service should not be considered in the selection of E/M level reported". This policy is not supported by AMA CPT coding guidelines either. The determination of the level of complexity of the provider's medical decision making is clearly provided in the AMA CPT guidelines and does not preclude consideration of separately identified and reported procedures, interpretation services or other medical services. Since UHC invoked the DGs in their E/M policy discussion it should be noted that the DGs encourage consideration of all services regardless of payment issues. Let's consider an example, a 50-year-old male presents with chest pain, hypertension, and also has diabetes. The physician, among other things, orders an Ekg. The Emergency Physician interprets the Ekg and documents the interpretation in the record. The Ekg is clearly part of the "Amount and/or Complexity of Data to be Reviewed" regardless of whether the interpretation of the Ekg is listed separately on the claim. The reimbursement of the Ekg interpretation is strictly for the interpretation and does not consider the complexity of the patient's illness, merely that it was medically necessary. The value for work just to perform the interpretation is mutually exclusive from the work involved in the assessment of the patient's acuity, condition, treatment options, diagnostic tests considered and ordered, and the risk of morbidity or mortality.

Again, as with the AWP policy we urge UHC to suspend the policy of excluding the consideration of procedures independently reported as this too is not consistent or compliant with current medical coding standards.

We hope that UHC will immediately suspend or rescind the actions described in these policies referenced herein. If upon suspending or rescinding these policies UHC would like to discuss these issues or other coding issues further, we suggest a conference with EDPMA, ACEP, AHIMA, and AAPC experts.

Sincerely,

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

EXHIBIT ONE

REIMBURSEMENT POLICY
CMS-1500

Evaluation and Management (E/M) Reimbursement Policy					
Policy Number	2016R5007A	**Annual Approval Date**	4/21/2016	**Approved By**	Payment Policy Oversight Committee

Encounters for purposes of scoring.

An example of Additional Work-up Planned, is if the physician schedules testing him/herself or communicates directly with the patient's primary physician or representative the need for testing *which is to be done after discharge from the ED*, and the appropriate documentation has been recorded. Credit for "Additional Work-up" Planned is granted (4 points assigned). Credit is not given for the work up if it occurs during the ER Encounter. This interpretation is consistent with the level 5 code description that "…Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function…". Patients admitted to the hospital under the care of a physician other than the ER physician may have testing done as part of the admitting physician's care for that patient. The ER physician will not receive credit for the Additional Work-up Planned done under the care of the admitting physician.

Definitions	
Additional Work-up Planned	Any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making.
Encounter	Interaction between a covered member and a health care provider for which evaluation and management service or other service(s) are rendered and results in a claim submission

E/M Services Performed in an Emergency Department (ER/ED) Place of Service

CPT codes 99281-99285 are used to report E/M services rendered in an ER/ED place of service. Evaluating for level of care appropriateness for these codes in an ER/ED place of service includes a review of the tests and management options that are available to be performed during the initial visit.

The 1995 CMS Documentation Guidelines state that the number of diagnoses and management options that must be considered "...is based on the number and types of problems addressed during the Encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician." Additional Work-up Planned is an element of review which includes a number of diagnoses and management options. The Additional Work-up Planned" element contributes to indicating the complexity of a patient based on the clinician's utilization of diagnostic tests. UnitedHealthcare utilizes the industry standard guidelines to determine the appropriate level of care is as follows:

A. Number of Diagnoses and Management Options	Points Assigned
Self-Limiting or minor Problems (stable, improved or worsening) Max of 2 points can be given	1
Established Problem – stable improved	1
Established Problem – Worsening	2
New Problem – No Additional Work-up Planned. Max of 1 point can be given	3
New Problem – Additional Work-up planned	4

A provider receives 3 points for "New Problem, No Additional Work-Up Planned," and 4 points for "New Problem, Additional Work-Up Planned". This one-point difference can affect whether a level 4 or level 5 code is appropriate. Please note that all Encounters with ED patients are considered "New Problem"

Questions and Answers	
1	**Q:** When a separate written report for diagnostic tests/studies is prepared by the same individual performing the E/M service, should this be considered as a factor in the E/M code selection? **A:** No. Any specifically identifiable procedure reported separately from the E/M service should not be considered in the selection of E/M service level reported.
2	**Q:** Will UnitedHealthcare require medical records for all reported E/M services? **A:** No. There may be occasions where UnitedHealthcare could request medical records to determine the appropriate level of E/M service has been reported.

EXHIBIT TWO

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS (1995 HCFA DGs)

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

•DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

· For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.

· For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible", "probable", or "rule out" (R/O) diagnoses.

•DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.

•DG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.