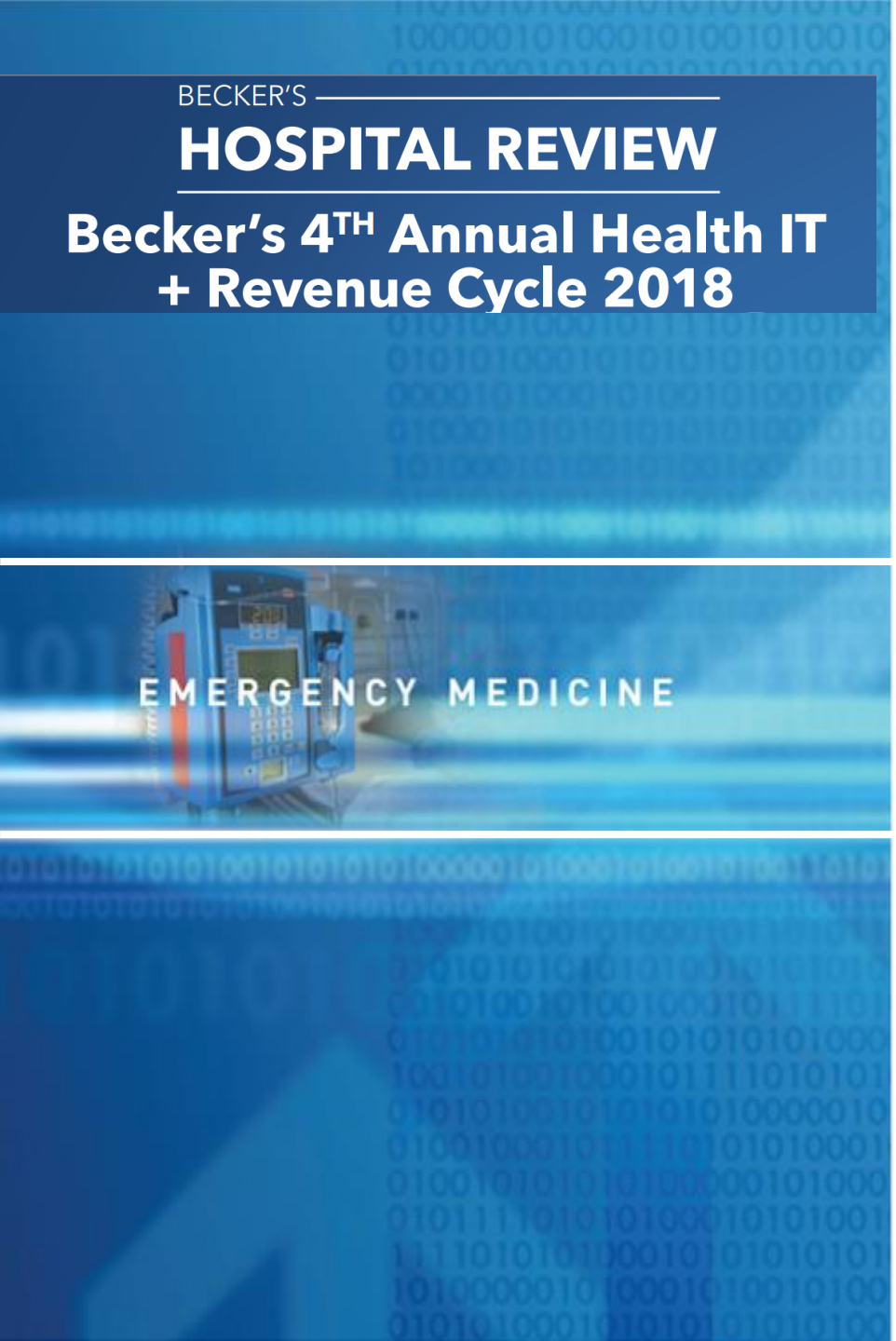

#InsuranceFail: What are the surprise coverage gaps and strategies to address it.

Sept. 20, 2018

Ed Gaines, JD, CCP
Chief Compliance Officer
Emergency Medicine Division
Zotec Partners, LLC
egaines@zotecpartners.com
Greensboro, NC
877-271-2506

Objectives and Outline for discussions:

- Review of regulatory background—prudent lay person and ACA.
- Current payor challenges & tactics:
  - Health plans invented the term “surprise bills”
  - Clinicians & hospitals should use “surprise coverage gaps”
- Solutions & approaches + case studies.
- Q&A throughout

Prudent Lay Person (PLP) Primer:

- **Federal statute: Balanced Budget Act of 1997 (BBA '97):**
  1. Applicable to Medicaid MCOs Oct. 1997 & Medicare May 1998.
  2. Prior authorization for ED svs cannot be required**
  3. Defines the "emergency medical condition" (EMC)—
     a. EMTALA EMC is different—stable for discharge.
     b. "Severe pain" is key—health plans fought us.
     c. "reasonably expect the absence of immediate medical attention"
     d. could lead to "serious impairment or dysfunction of a bodily organ or part."
     e. Section 1852(d) and 1932(b) of Social Sec. Act
  4. Then HCFA (now CMS) Letters interpreting PLP—1998, 1999 and 2000.
  5. **So what? No prior authorization concept enacted in ACA.

Applicability to payors:

- **Federal Employees Health Benefit Plan (FEHBP): 1998 Executive Order /s/ by Pres. Clinton.**
- **VA: Vet. Millennium Health Care and Benefits Act of 1999—and 38 CFR 17.1002 (b) & (c)**
- **ACA: Section 2719A extended PLP to enrollees in ACA exchange plans, 42 CFR 2590.715-2719A.**
- **ERISA plans: 29 CFR 2560.503-1.**
- **SCHIP: 42 CFR 457.10**
- **State laws: generally cover commercial health plans licensed in that state, and may apply to PPOs and TPAs**

Case study: Anthem's "non-emergent" diag. lists

EMERGENCY PHYSICIANS MONTHLY

HOME CURRENT ISSUE TOPICS COLUMNS BLOGS GET THE MAGAZINE ADVERTISE

YOU ARE AT: Home » Politics & Policy » Insurers Begin Denying Payment for "Unnecessary" ED Care

Insurers Begin Denying Payment for "Unnecessary" ED Care

By JESSE PINES, MD ON JULY 7, 2017

1 COMMENT

New coverage policies by Blue Cross Blue Shield of Georgia and others could bankrupt patients – or worse.

In May 2017, Blue Cross Blue Shield (BCBS) of Georgia announced it will no longer cover "unnecessary" emergency department (ED) care, starting July 1. According to BCBS Georgia President Jeff Fusile, "...we have got to find a better way to do some of this stuff, taking some unnecessary spending out of the system." Fusile would rather patients use urgent care, retail clinics, and their online app, instead of costly EDs for conditions treatable in those settings. The BCBS policy follows

RELATED ARTICLES

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- **Prudent Lay Person (PLP)**
- **BBA '97—federal law**
- **48 states**
- **The ACA regulations made PLP applicable to all health plans except grandfathered plans.**

Bad Payor Case Study 2.0—imitation is not the sincerest form of flattery--BCBSTX

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Texas allows Blue Cross Blue Shield to deny payments for some out-of-network ER visit

Jenny Deam | Aug. 6, 2018 | Updated: Aug. 6, 2018 10:01 a.m.

- **Parent company of BCBSTX is HCSC,**
- **HCSC has BCBS plans in IL, MT, NM & OK**

https://www.houstonchronicle.com/news/houston-texas/houston/article/blue-cross-insurance-texas-emergency-room-ER-deny-13133778.php

Bad Payor Issue 1: narrow networks, high deductible health plans (HDHPs) & surprise coverage gaps: Concerning behaviors & Solutions/Strategies

RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 36, NO. 9: MARKET CONCENTRATION

Narrow Networks On The Health Insurance Marketplaces: Prevalence, Pricing, And The Cost Of Network Breadth

Leemore S. Dafny[1], Igal Hendel[2], Victoria Marone[3], and Christopher Ody[4]

AFFILIATIONS

PUBLISHED: SEPTEMBER 2017 No Access https://doi.org/10.1377/hlthaff.2016.1669

ABSTRACT

Anecdotal reports and systematic research highlight the prevalence of narrow-network plans on the Affordable Care Act's health insurance Marketplaces. At the same time, Marketplace premiums in the period 2014–16 were much lower than projected by the Congressional Budget Office in 2009. Using detailed data on the breadth of both hospital and physician networks, we studied the prevalence of narrow networks and quantified the association between network breadth and premiums. Controlling for many potentially confounding factors, we found that a plan with narrow physician and hospital networks was 16 percent cheaper than a plan with broad networks for both, and that narrowing the breadth of just one type of network was associated with a 6–9 percent decrease in premiums. Narrow-network plans also have a sizable impact on federal outlays, as they depress the premium of the second-lowest-price silver plan, to which subsidy amounts are linked. Holding all else constant, we estimate that federal subsidies would have been 10.8 percent higher in 2014 had Marketplaces required all plans to offer broad provider networks. Narrow networks are a promising source of potential savings for other segments of the commercial insurance market.

History

Published online 1 September 2017

Information

Project HOPE—The People-to-People Health Foundation, Inc.

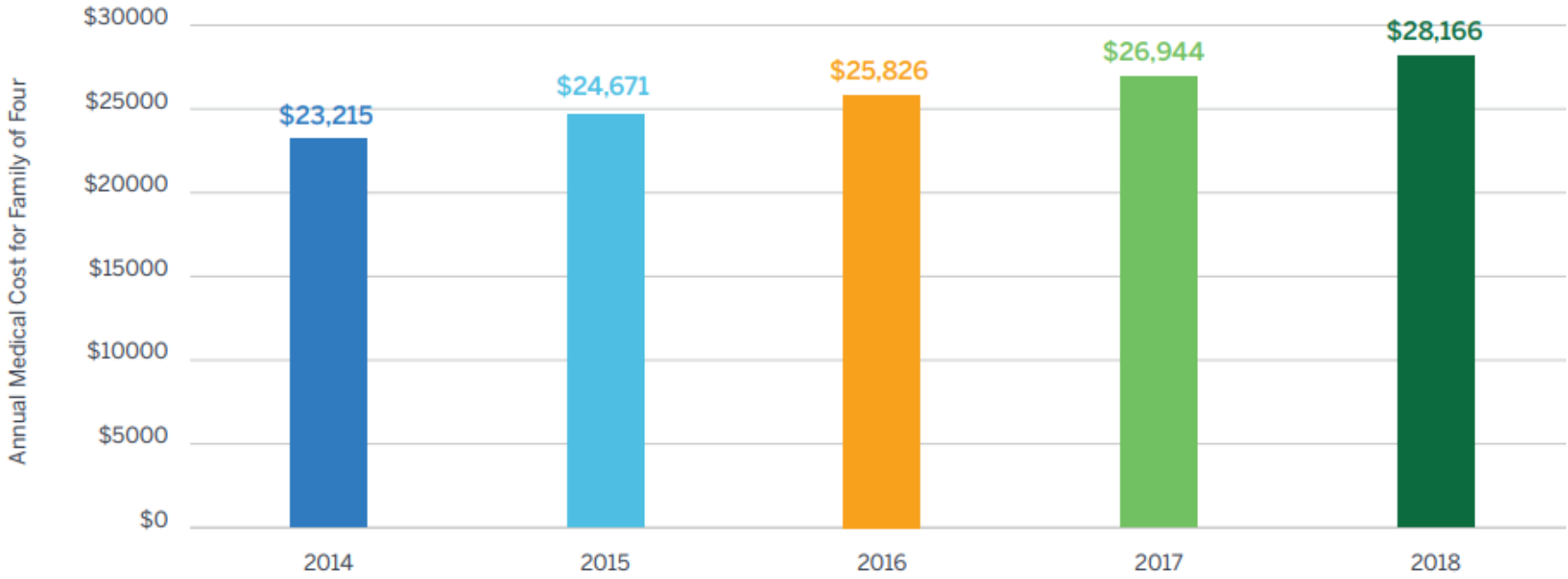
ACKNOWLEDGMENTS

The authors thank Roger Feldman, Nathan Wilson, and Jonathan Bor for valuable feedback. Mariano Irace, David Benson, Lola Segura, Chris Rose, and Edwin Wu provided excellent research assistance. An earlier version of this article was presented at the American Society of Health Economists Conference in Philadelphia, Pennsylvania, June 14, 2016.

https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1669

The Patient (Pt.) as the largest payor—over 20% YOY increase in medical cost, 5yrs.

FIGURE 1: MILLIMAN MEDICAL INDEX (MMI)



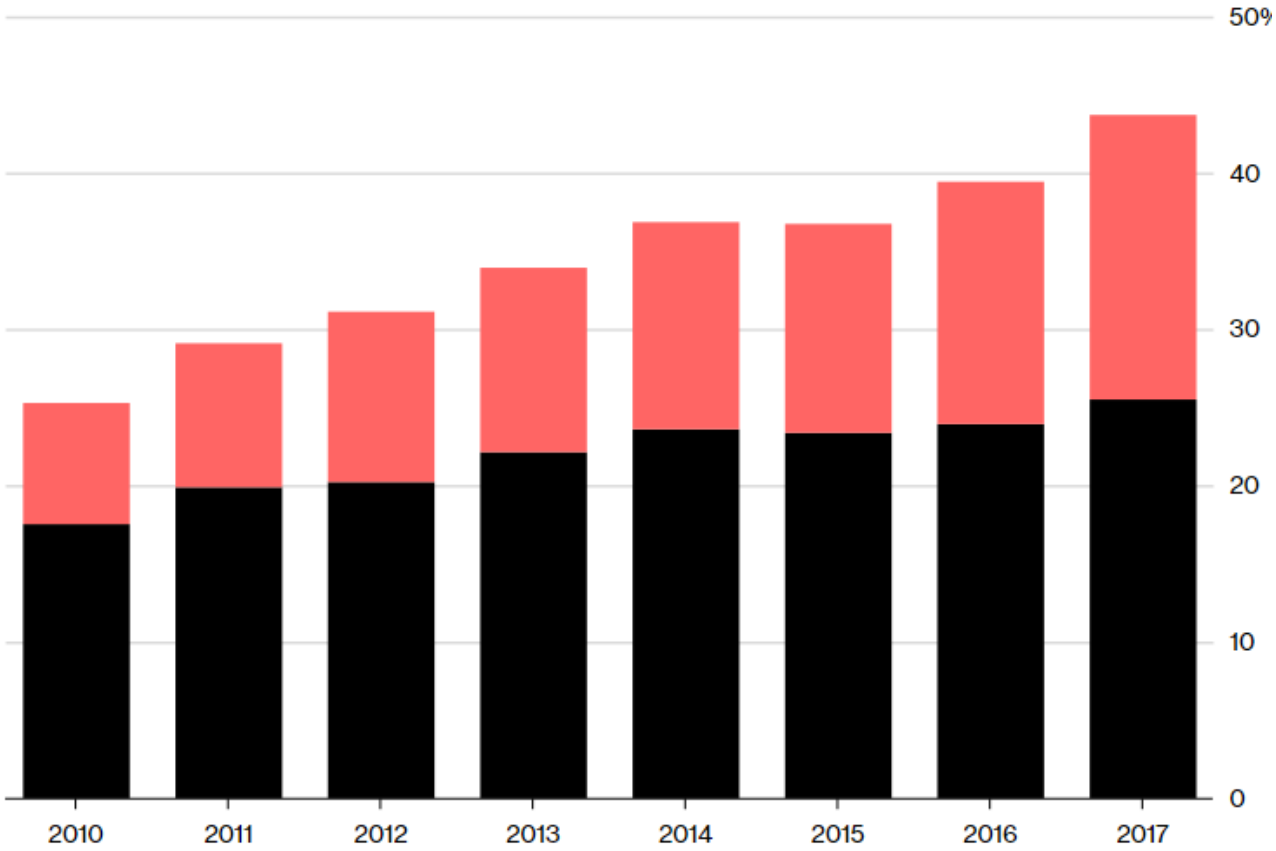
http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/2018-milliman-medical-index.pdf?mod=article_inline

Bloomberg

routine care or skipped medication to save money. That can mean illnesses that might hav
been caught early can go undiagnosed, becoming potentially life-threatening and enormously costly for the medical system.

Patients Exposed

The share of Americans under 65 enrolled in high deductible plans is rising

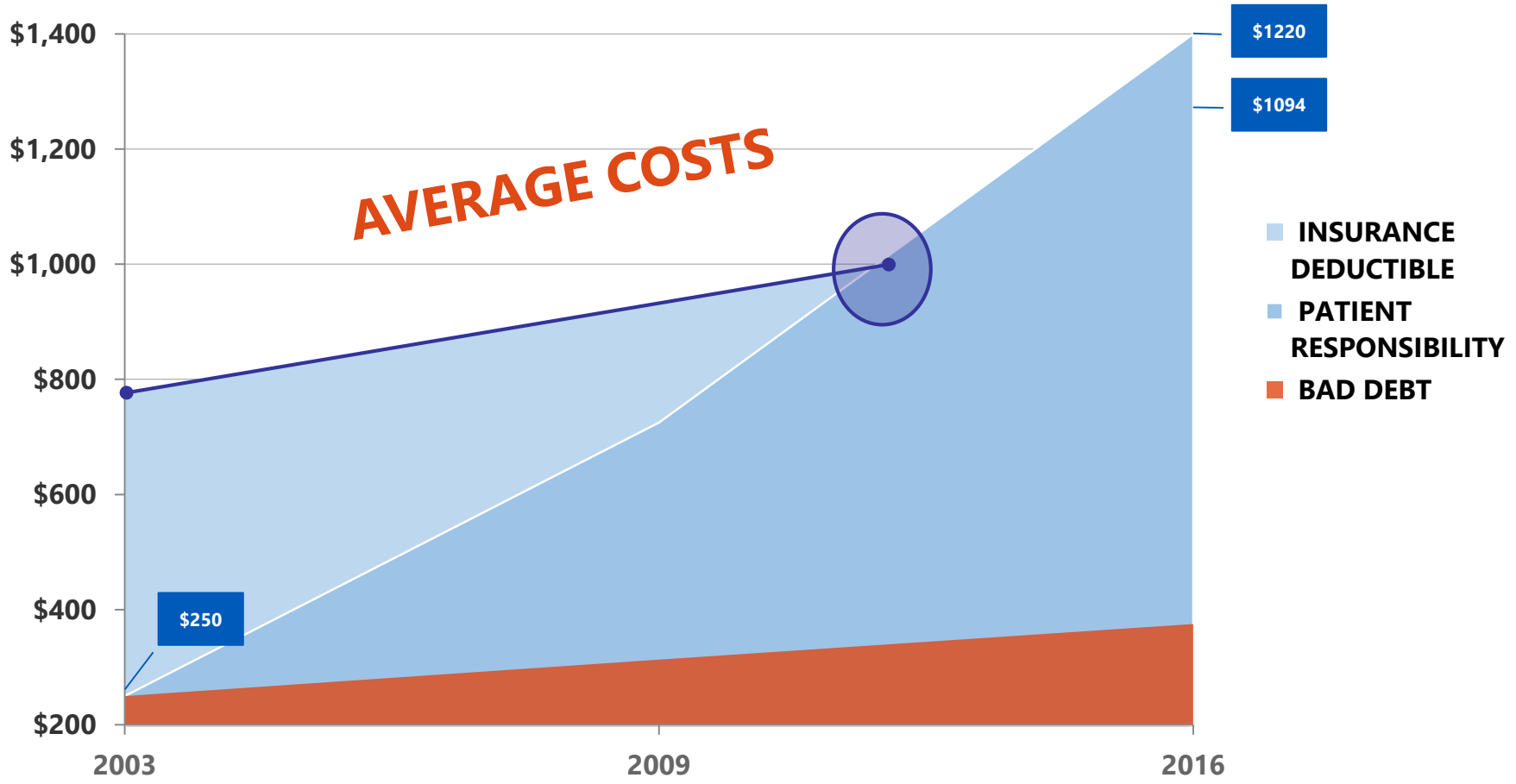


Source: National Health Interview Survey

Nearly 40% of large employers offer only a HDHP

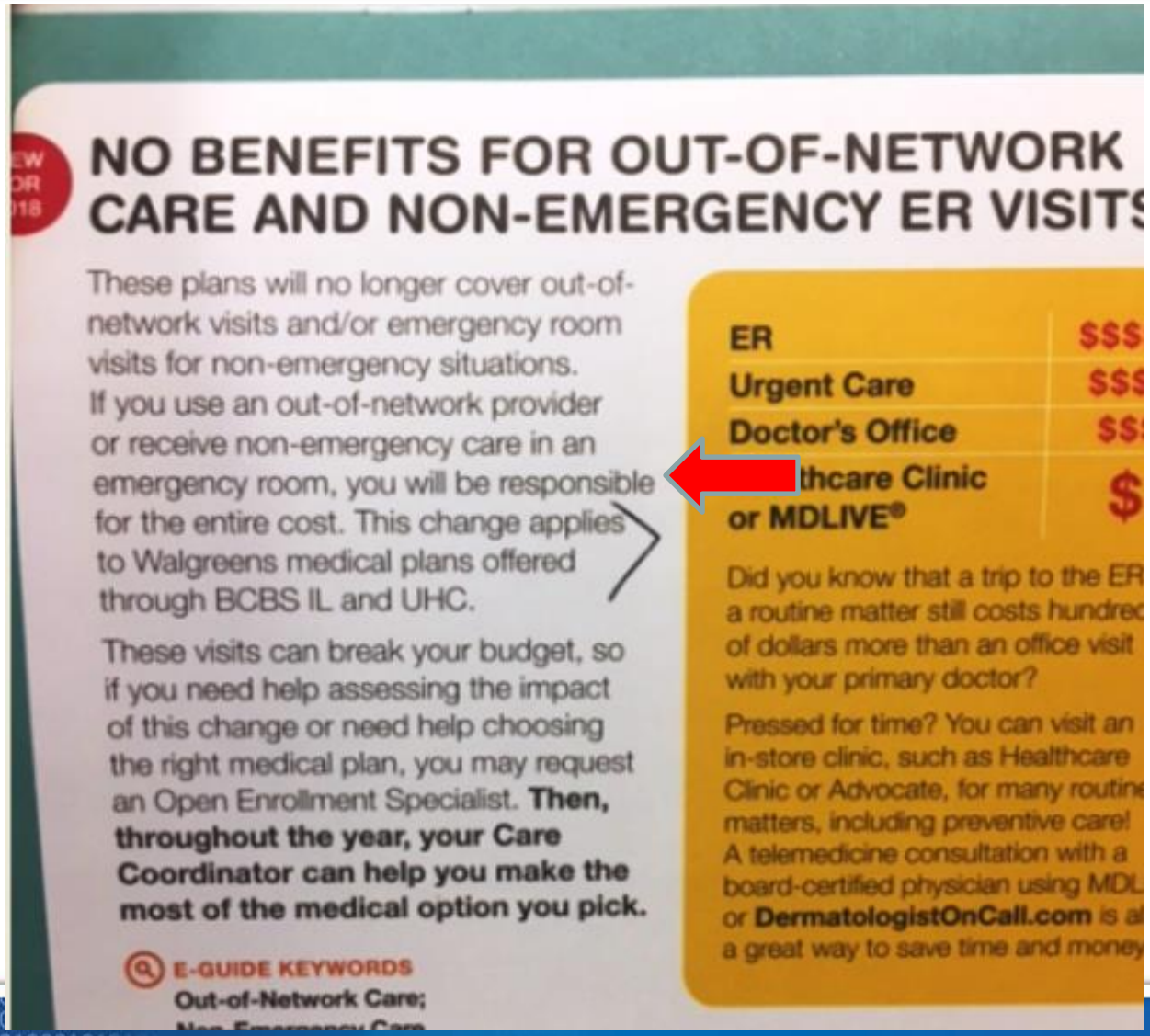
https://www.beckershospitalreview.com/payer-issues/analysis-high-deductible-health-plans-broke-the-us-health-insurance-system.html

The average Pt healthcare spend is less than the average deductible and those lines are never reversing.



Source: Kaiser Family Foundation

Walgreen plans sent this notice to benies effective 1/1/18: for plans offered via BCBSIL & UHC



NO BENEFITS FOR OUT-OF-NETWORK CARE AND NON-EMERGENCY ER VISITS

These plans will no longer cover out-of-network visits and/or emergency room visits for non-emergency situations. If you use an out-of-network provider or receive non-emergency care in an emergency room, you will be responsible for the entire cost. This change applies to Walgreens medical plans offered through BCBS IL and UHC.

These visits can break your budget, so if you need help assessing the impact of this change or need help choosing the right medical plan, you may request an Open Enrollment Specialist. **Then, throughout the year, your Care Coordinator can help you make the most of the medical option you pick.**

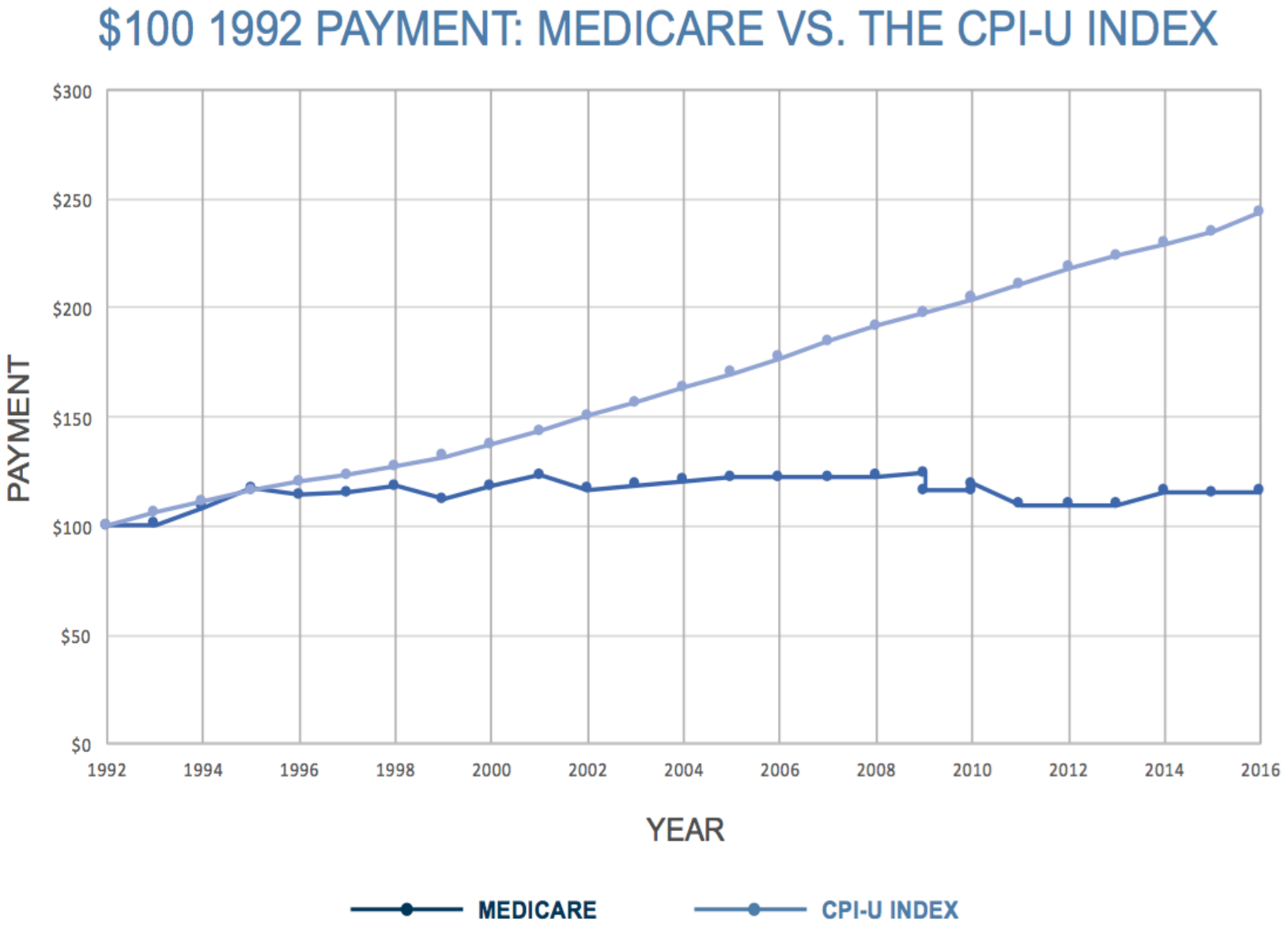
E-GUIDE KEYWORDS
Out-of-Network Care;

ER	$$$
Urgent Care	$$$
Doctor's Office	$$
thcare Clinic or MDLIVE®	$

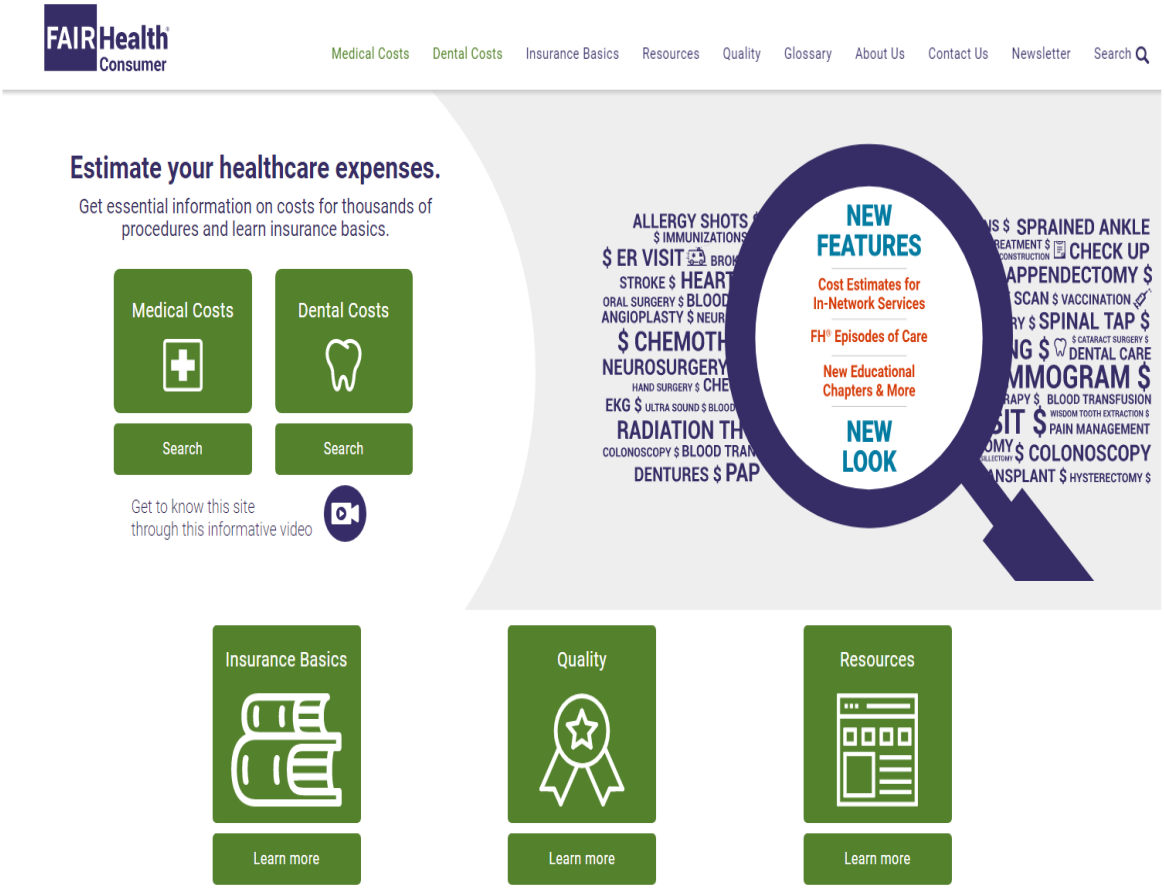
Did you know that a trip to the ER a routine matter still costs hundred of dollars more than an office visit with your primary doctor?

Pressed for time? You can visit an in-store clinic, such as Healthcare Clinic or Advocate, for many routine matters, including preventive care! A telemedicine consultation with a board-certified physician using MDL or **DermatologistOnCall.com** is a a great way to save time and money

Causes--what do the health plans want & why?

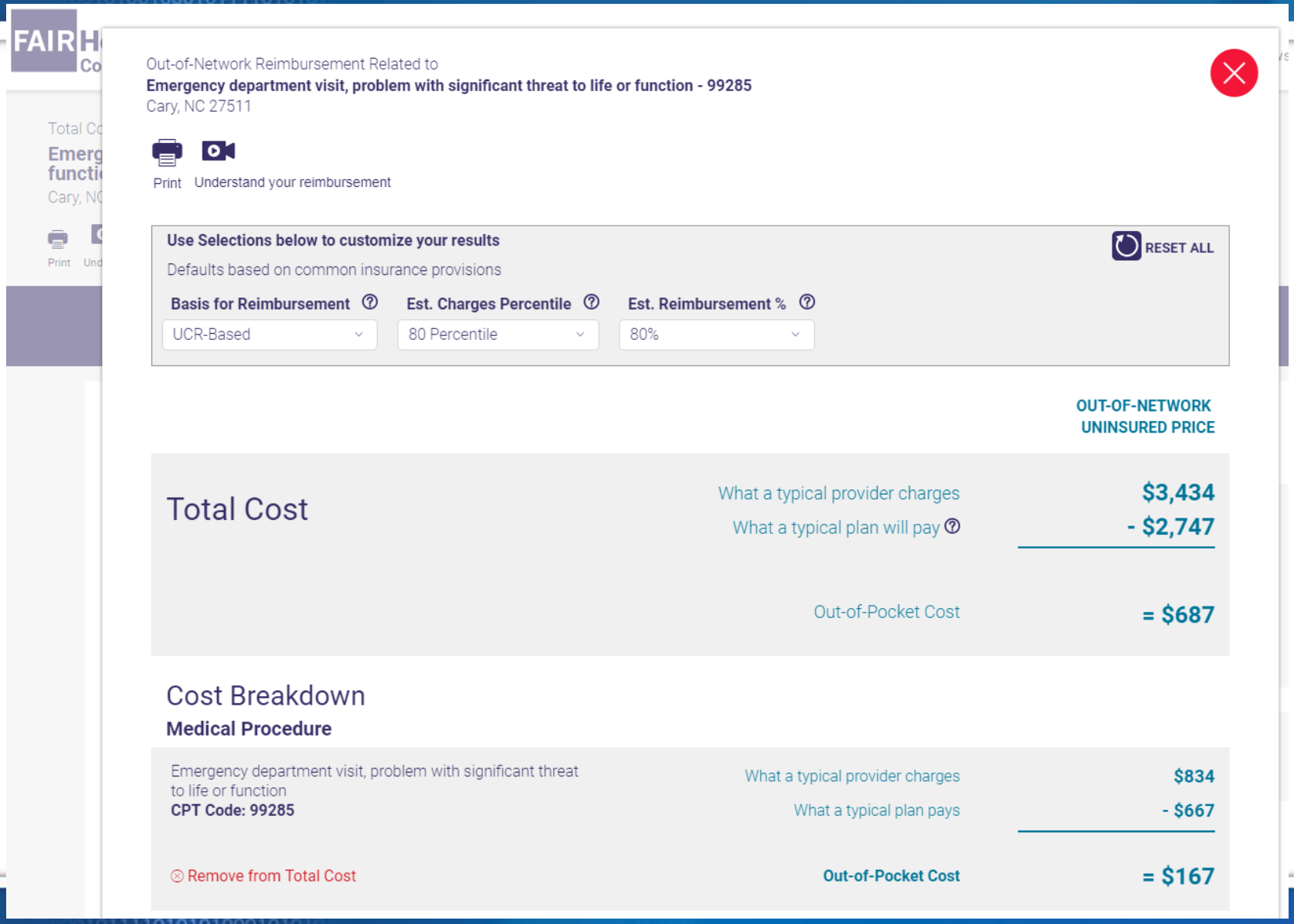


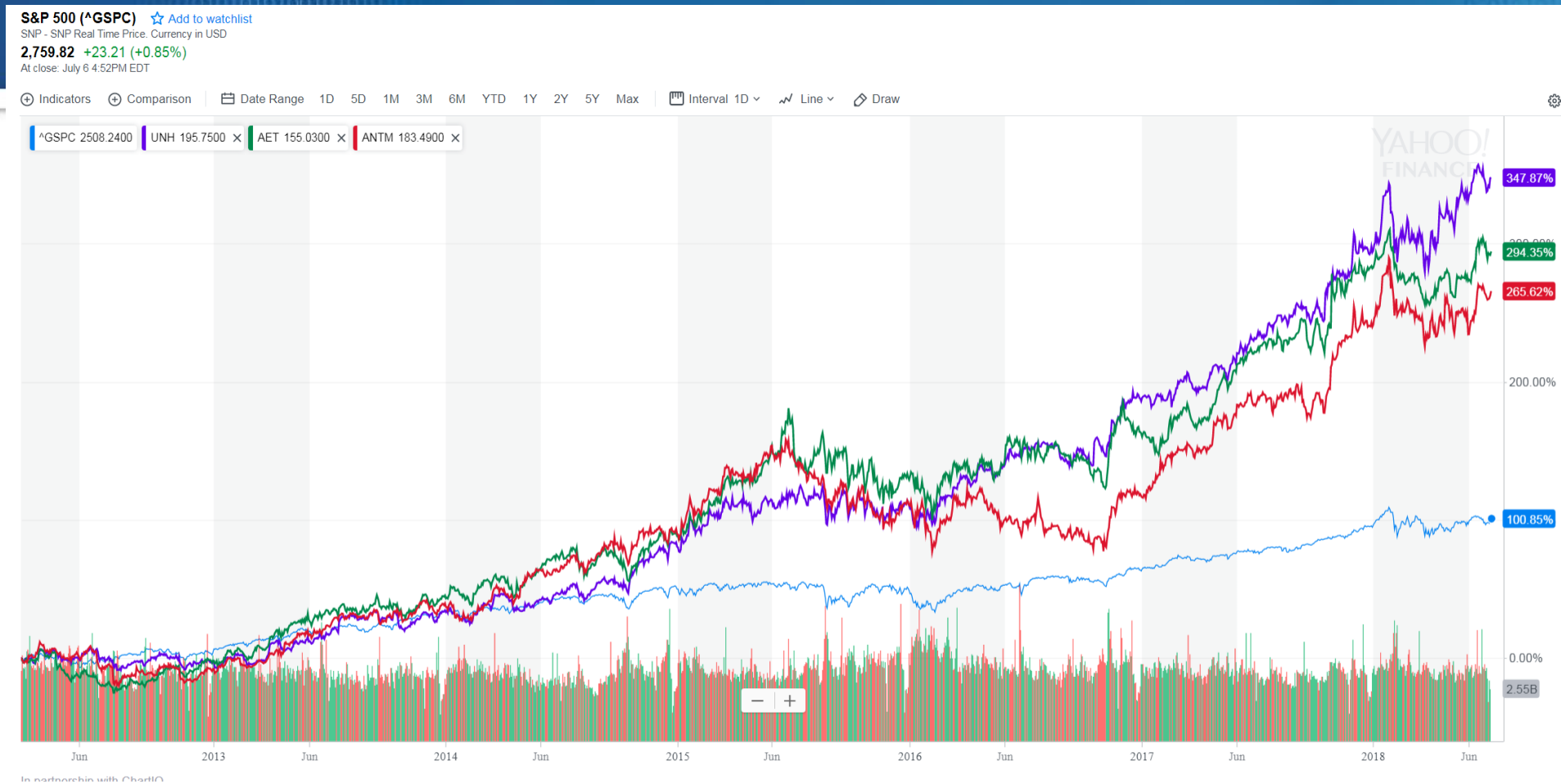
What is Fair Health & how is FH important to a solution?



https://www.fairhealthconsumer.org/

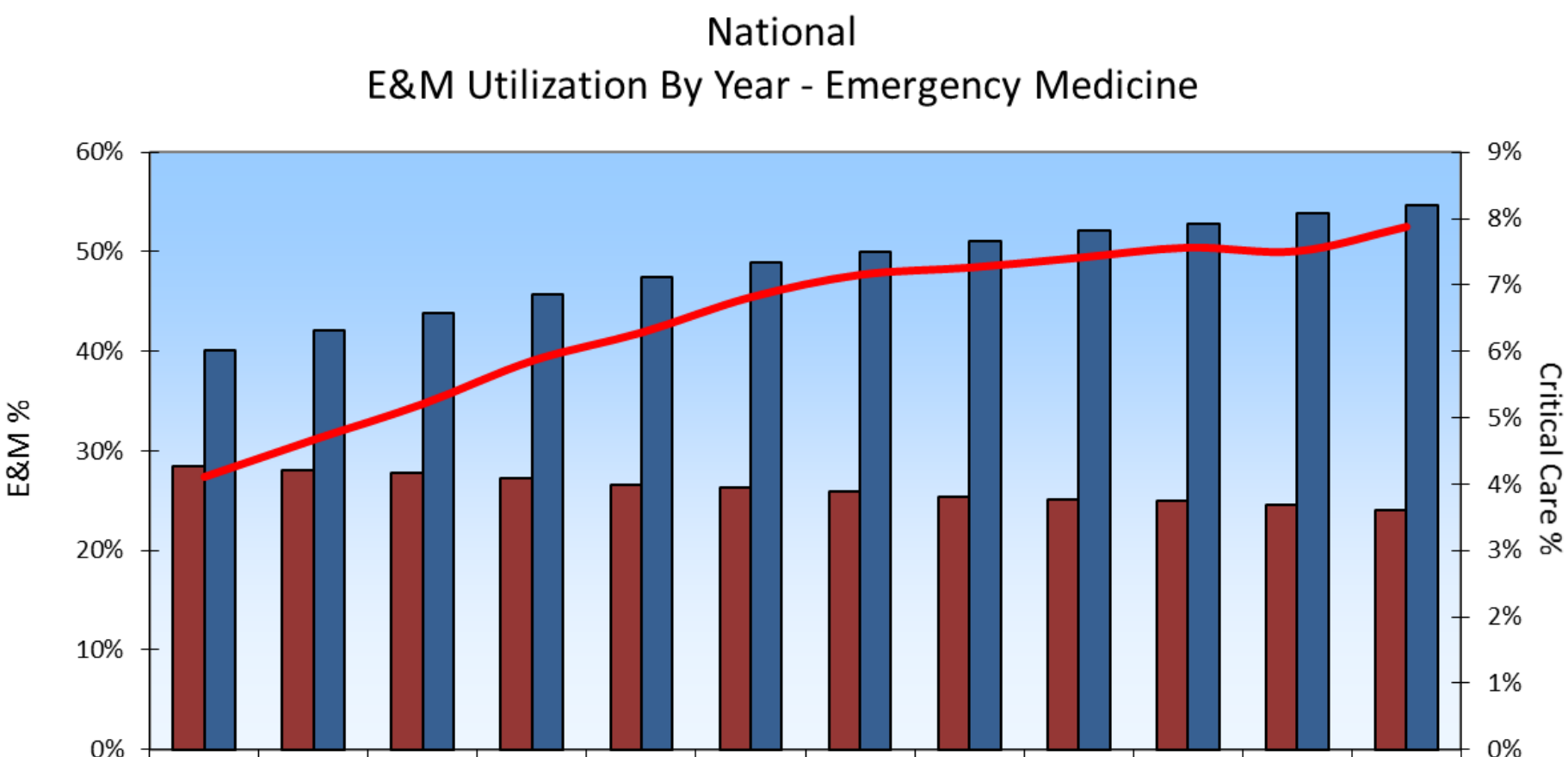
What do clinicians want and why?





Why EM & the “House of Medicine” need to continue to advocate for fair coverage

Issue 2:
ED Coding Acuity Levels Denials--Concerning behavior & Solutions/Strategies.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
99284	28.5%	28.1%	27.7%	27.2%	26.5%	26.3%	25.9%	25.4%	25.2%	25.0%	24.5%	24.1%
99285	40.1%	42.1%	43.8%	45.7%	47.5%	48.9%	50.0%	51.1%	52.2%	52.8%	53.9%	54.7%
99291	4.1%	4.7%	5.2%	5.9%	6.3%	6.8%	7.2%	7.3%	7.4%	7.6%	7.5%	7.9%

CMS' Part B National Summary Data File for Specialty 93 (EM docs): FP, IM & Peds. are not in these figures

E-GlobalTech Comparative Billing Report (CBR)

- **7/1/16 thru 6/30/17 DOS**

3 categories of review:

1. **% of 99285s**
2. **% of E/Ms w/ -25 mod.**
3. **Ave. allowed charges for Part B svs.**

- **"Peers" are all clinicians billing ED E/Ms, e.g. > 130,000 clinicians with allowed charges included in this study.**

- **https://www.cbrinfo.net/cbr201709**

Case example: Comparative Billing Reports (CBRs) CPT 99285 and -25 modifier cases

Comparative Billing Report

eGlobalTech

Comparative Billing Report Program
7127 Ambassador Rd., Suite 150
Baltimore, MD 21244

November 6, 2017

CBR#: CBR201709
Topic: Emergency Department Services

Fax#:

Questions: Contact CBR Support
www.cbrinfo.net
(800) 771-4430 / M-F 9 am – 5 pm ET
cbrsupport@eglobaltech.com
Write to the return address above

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with eGlobalTech, a professional services firm, to develop Comparative Billing Reports (CBRs).

What is a CBR?

- A CBR is an educational tool that reflects your billing patterns compared to peer patterns for the same services in your state and nationwide.

Why did I get a CBR?

- You received this CBR because your billing patterns differ from your peers in your state or across the nation. Receiving this CBR is not an indication or precursor to an audit.

What should I do with this CBR?

- Read the report in its entirety. We hope the report assists you in identifying opportunities for improvement, or helps you validate your current billing patterns.
- Contact your Medicare Administrative Contractor for specific billing or coding questions, and to ensure you are meeting Medicare standards for your jurisdiction.

Do I need to reply to explain my utilization?

- No reply is necessary, as this report is for educational purposes.

REMINDER: If you have changed your mailing address or contact information, please take time to review and update the appropriate Medicare provider enrollment system.

Sincerely,

Frank Gorton
CBR-Program Director
eGlobalTech

- **Your CBR differs from your "peers".**
- **"We're from the Gov't & we're here to educate you."**

CBR letters

There are over 130,000 providers nationwide with allowed charges for the CPT® codes included in this study. Those who received the CBR were significantly higher than one of their peer groups on at least one of the measurements studied, and also were near or above the 80th percentile in allowed charges ($50,000), with at least 200 beneficiaries during this one-year period.

Metrics were calculated from your utilization and for each of the following peer groups:

- The **state** peer group is defined as all rendering Medicare providers practicing in the individual provider's state with allowed charges for the procedure codes included in this study
- The **national** peer group is defined as all rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study

Your metrics were compared to your state and the nation using statistical analysis. There are four possible outcomes for the comparisons between the provider and the peer groups:

- Significantly Higher - Provider's value is higher than the peer value and the statistical test confirms significance
- Higher - Provider's value is higher than the peer value, but the statistical test does not confirm significance
- Does Not Exceed - Provider's value is not higher than the peer value
- N/A - Provider does not have sufficient data for comparison

It is important to note that significance is based on the total number of charges, services, visits, or beneficiaries, and the variability of those values.

Percentage of Services Billed with CPT® Code 99285

The percentage of services billed with CPT® code 99285 is calculated as follows:

$$\left(\frac{\text{Number of Services with CPT® Code 99285}}{\text{Total Number of Services}} \right) \times 100$$

Table 3 provides a statistical analysis of the percentage of emergency department services billed with CPT® code 99285. Your percentage is compared to that of your state and the nation.

- **Multiple factual & potentially analytical issues w/ CBRs.**
- **Issues:**
  - **# of ED clinicians?**
  - **Definition of "peer group"**
  - **CBRs leading to Medicare MAC TPE audits?**
  - **TPE audits may become full stat. sample extrapolation audits or pre-payment reviews.**

Strategies: How to respond to CBRs or TPE audits—ACEP Reimbursement Comm. White Paper

Emergency Medicine Evaluation and Management Code Acuity Shift:

Why have we seen a coding shift over the last decade?

- **In the past decade a nationwide increase in the acuity of ED Medicare patients has been realized, resulting in higher levels of ED Evaluation and Management services.**
  - According to the AHA, the average severity of illness for Medicare beneficiaries treated in the ED increased by 9% (from 2006 - 2010).
  - A recent RAND report suggests that more patients who previously would have been admitted to the hospital by their office-based physicians are being sent to the emergency department, leading to a 20% rise in non-elective admissions through the ED, as well as a 24% decrease in admits directly from outpatient settings.
  - Given their older age and higher prevalence of co-morbid conditions, Medicare beneficiaries are 3.4 times more likely to require admission following a visit to an emergency department.
  - The modest growth rates in Medicare admissions through EDs appears to be the product of rising numbers of beneficiaries, rather than higher rates of admission.

- **Dual-Eligible Medicare ED patients who are covered by both Medicare and Medicaid are often sicker and require more complex workups than most other Medicare patients. Dual-eligible patients are increasingly presenting to the ED for treatment, resulting in a higher shift in ED Evaluation and Management services.**
  - Dual-eligible patients now account for more than 40 % of all Medicare FFS ED visits.
  - These patients represent the sickest and poorest Medicare beneficiaries, and are three times more likely to be disabled. They also have higher rates of diabetes, pulmonary disease, stroke, behavioral health disorders, and Alzheimer's disease.

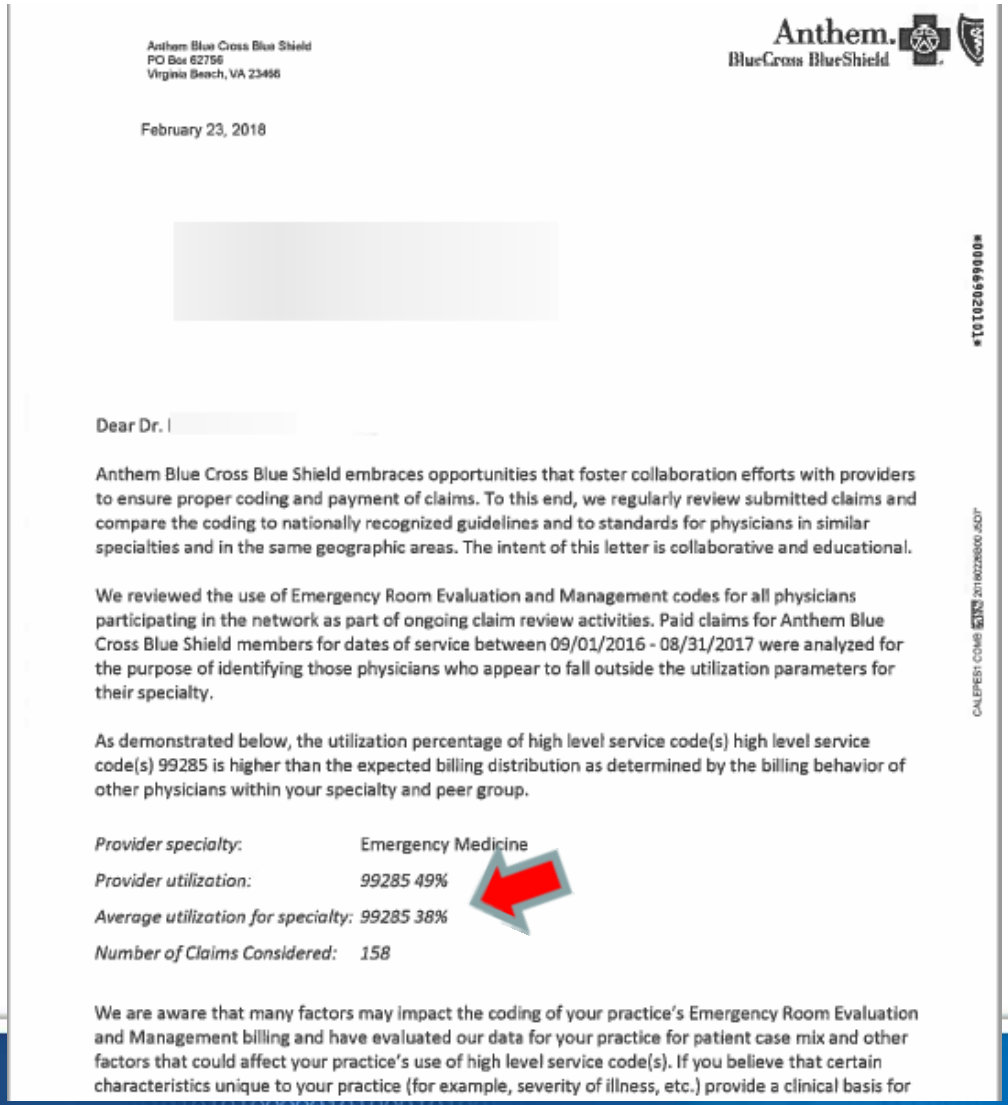
ww.acep.org/reimbursement/#sm.0001hlvieuqt1cwcyzc2ix6oj5095

Strategies: How to respond to CBRs or TPE audits—the 42 reasons

	42 Reasons E/M Distributions may vary between providers or hospitals.	Annotation
	Items listed are alphabetical not in order of significance	
1	Additional Work-up Planned defined as services referred after encounter	Will Skew Acuity Left
2	Admission criteria (protocols and admit rate)	Protocols can increase level 4 admits; usually as admits go up so do level 5's
3	Age/Sex distribution of patient population in catchment area	High dist. Males 50-70 or Females of child bearing age skew right
4	Chart Type: Structured vs EMR vs Dictation	EMR or structured Chart with prompts can skew right
5	Children's hospital in catchment area	taking critical peds out of your E.D. skews remainder left
6	Clinical Protocols (evidence based)	Documentation prompts can skew coding to the right
7	Comfortable Patient waiting area with TV	Patients willing to wait with less urgent condition skew left
8	County Hospital (or Charity Hospital)	Poor patients don't get preventive care, don't use meds appropriately, skew right
9	Disproportionate number of High Deductible Patients	Tend to avoid seeking care till acuity is very high; skews right
10	EDPs incentive compensation based on RVUs	Tend to be better documenters, more accurate charting, skew right
11	Efficient Diagnostic Study Departments	Facility with fast TAT for Labs, X-rays, CT's, MRI's tend to order more; skew right
12	ER Board Certified Providers Only	Tend to do more procedures, seek harder cases, skew right
13	Fast Track (Triage system)	Drs that only work Fast Track skew left, Drs that only work Main skew right
14	High/Low Volume of pts seen by PMD in E.D.	Hi volume of pts seen by PMD can skew EDP stats Left if only screened by EDP
15	HMO penetration in E.D. catchment area	Hi HMO penetration with high share of cost can skew EDP stats right
16	Hospital HIM department provides professional fee coding	E.D. Professional Services coding is different than Hospital OP coding; skews left

- **EDPMA Quality, Coding & Documentation (QCD) co-chair Mark E. Owen's "42 reasons" for E/M coding variety—see the appendix for an explanation & link to the Excel file.**
- **https://mcscodes.com/blog**
- **Strategy: make the case for why EDPs would skew right—it really can work when the comparative data set is "all clinicians" billing the 9928X codes & all hospitals, i.e. critical access or community vs. Level I trauma centers.**

Anthem BCBS: ED coding acuity is "too high"



Anthem Blue Cross Blue Shield
PO Box 62756
Virginia Beach, VA 23466

Anthem. BlueCross BlueShield

February 23, 2018

Dear Dr. [redacted]

Anthem Blue Cross Blue Shield embraces opportunities that foster collaboration efforts with providers to ensure proper coding and payment of claims. To this end, we regularly review submitted claims and compare the coding to nationally recognized guidelines and to standards for physicians in similar specialties and in the same geographic areas. The intent of this letter is collaborative and educational.

We reviewed the use of Emergency Room Evaluation and Management codes for all physicians participating in the network as part of ongoing claim review activities. Paid claims for Anthem Blue Cross Blue Shield members for dates of service between 09/01/2016 - 08/31/2017 were analyzed for the purpose of identifying those physicians who appear to fall outside the utilization parameters for their specialty.

As demonstrated below, the utilization percentage of high level service code(s) high level service code(s) 99285 is higher than the expected billing distribution as determined by the billing behavior of other physicians within your specialty and peer group.

Provider specialty:	Emergency Medicine
Provider utilization:	*99285 49%*
Average utilization for specialty:	*99285 38%*
Number of Claims Considered:	*158*

We are aware that many factors may impact the coding of your practice's Emergency Room Evaluation and Management billing and have evaluated our data for your practice for patient case mix and other factors that could affect your practice's use of high level service code(s). If you believe that certain characteristics unique to your practice (for example, severity of illness, etc.) provide a clinical basis for your increased use of the above-referenced service code(s), please provide us with that information for our review by April 11, 2018. Our goal is to help providers ensure that the documentation and reporting guidelines are followed and that their documentation supports the level of care billed for each service.

We will be reviewing your use of the above-referenced service code(s) over the next 6 months to determine if there is an improper use of such codes. If, after the expiration of this review period, we observe a continued high utilization of the above mentioned code(s) without a corresponding response depicting characteristics that are, in fact, unique to your practice, we may reduce the applicable reimbursement level for such code(s).

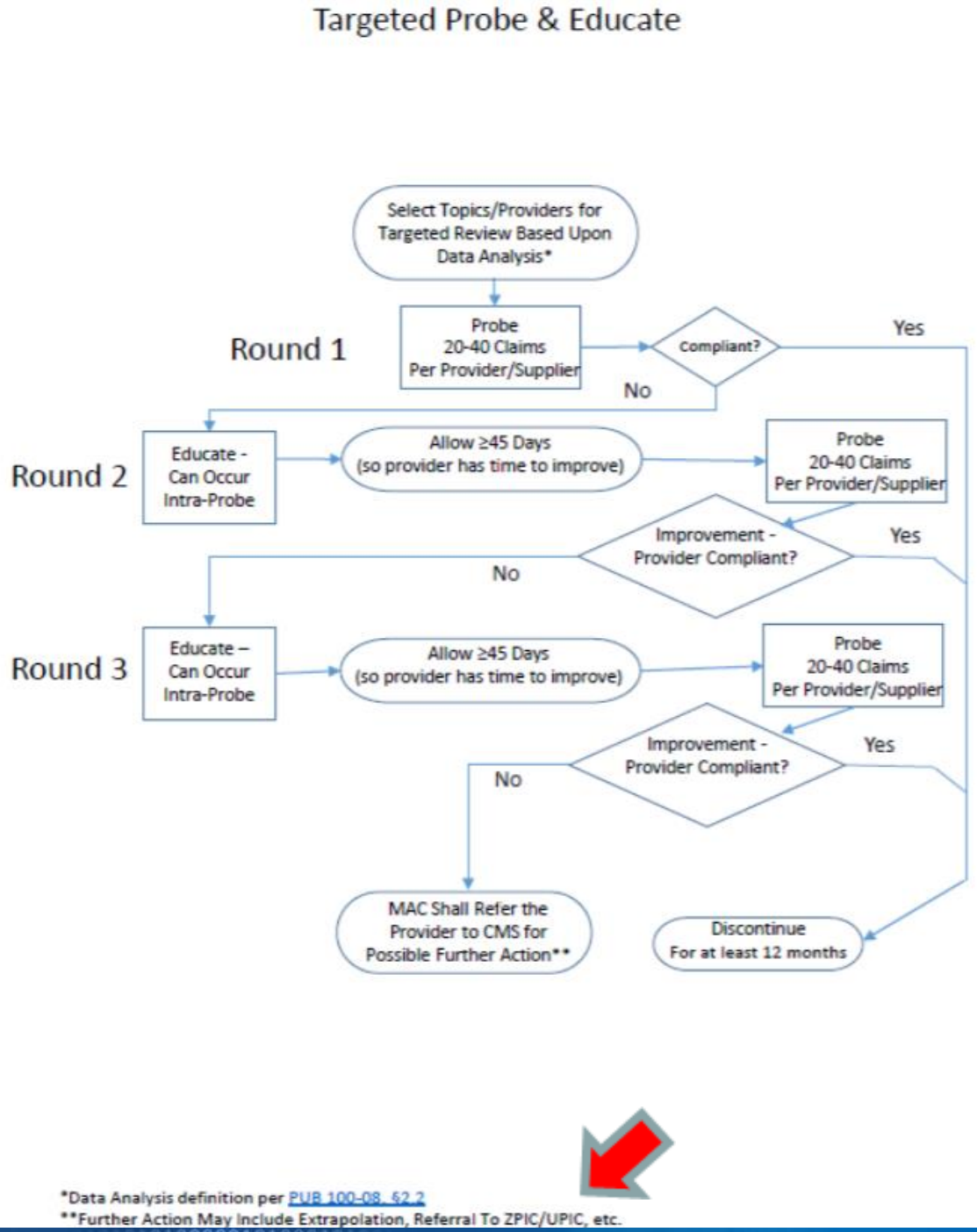
If you have questions regarding this review, please contact the Reimbursement Policy Management Team at the contact information below.

Anthem Blue Cross Blue Shield
Attn: Reimbursement Policy Management/EPE Team
PO Box 62756
Virginia Beach, VA 23466
Fax: 1-855-844-1508
Email: PEducationZ3@Anthem.com
Direct Hotline Phone: 1-844-405-4293

If you have questions regarding the possible reimbursement level reduction, please contact your contracting representative.

Sincerely,

Anthem Blue Cross Blue Shield
Reimbursement Policy Management/EPE Team



TPE Strategies:

- Educate auditors on ED E/M coding.
- Listen to education
- Change your policy if appropriate
- If UPIC referral consider counsel & consultants to assist
- If extrapolation, statistical expert is highly recommended.
- Appeal

Part I Summary:

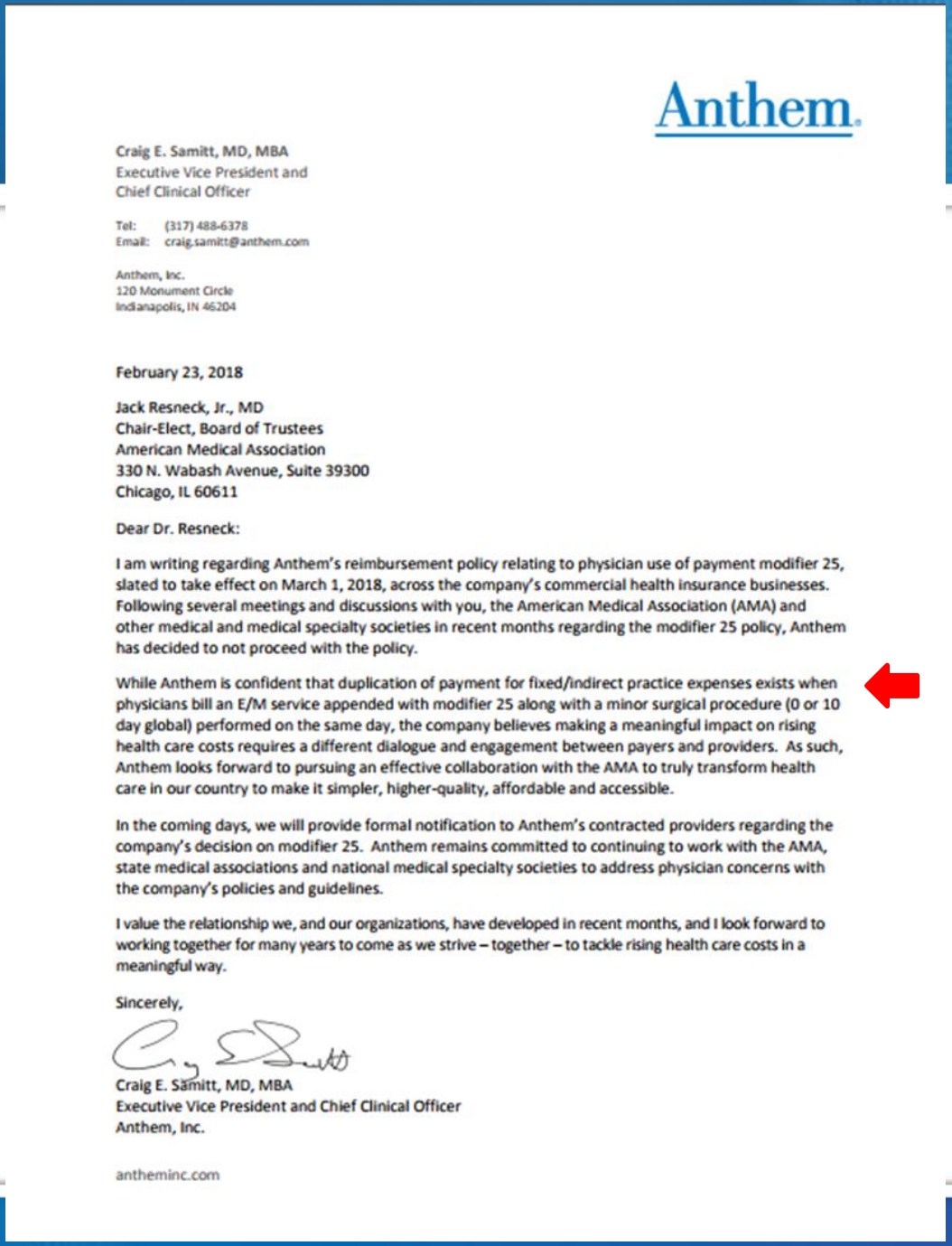
- **Analyze the PLP related issues to determine if regulators should be involved, e.g. CCIIO or state DOI.**
- **Understanding & knowledge of "acuity analysis" and probe audits can go a long way to assist in successful resolution.**
  - **Run do not walk to get experts in coding, RCM, legal and accounting if needed, e.g. ALJ.**
- **Get involved, advocate, coordinate and communicate with fellow stakeholders—the payor onslaught is not ceasing, its increasing but we can and have won many times.**

Issue 3:

ED coding levels down coded & arbitrary reducing reimbursements per a diagnosis list for Medicaid plans:

concerning behavior &

strategies/solutions.



Anthem

Craig E. Samitt, MD, MBA
Executive Vice President and
Chief Clinical Officer

Tel: (317) 488-6378
Email: craig.samitt@anthem.com

Anthem, Inc.
120 Monument Circle
Indianapolis, IN 46204

February 23, 2018

Jack Resneck, Jr., MD
Chair-Elect, Board of Trustees
American Medical Association
330 N. Wabash Avenue, Suite 39300
Chicago, IL 60611

Dear Dr. Resneck:

I am writing regarding Anthem's reimbursement policy relating to physician use of payment modifier 25, slated to take effect on March 1, 2018, across the company's commercial health insurance businesses. Following several meetings and discussions with you, the American Medical Association (AMA) and other medical and medical specialty societies in recent months regarding the modifier 25 policy, Anthem has decided to not proceed with the policy.

While Anthem is confident that duplication of payment for fixed/indirect practice expenses exists when physicians bill an E/M service appended with modifier 25 along with a minor surgical procedure (0 or 10 day global) performed on the same day, the company believes making a meaningful impact on rising health care costs requires a different dialogue and engagement between payers and providers. As such, Anthem looks forward to pursuing an effective collaboration with the AMA to truly transform health care in our country to make it simpler, higher-quality, affordable and accessible.

In the coming days, we will provide formal notification to Anthem's contracted providers regarding the company's decision on modifier 25. Anthem remains committed to continuing to work with the AMA, state medical associations and national medical specialty societies to address physician concerns with the company's policies and guidelines.

I value the relationship we, and our organizations, have developed in recent months, and I look forward to working together for many years to come as we strive – together – to tackle rising health care costs in a meaningful way.

Sincerely,

Craig E. Samitt, MD, MBA
Executive Vice President and Chief Clinical Officer
Anthem, Inc.

antheminc.com

Case study--Centene=largest Medicaid MCE in US

CENTENE® Corporation

Payment Policy: Leveling of Emergency Room Services

Reference Number: CC.PP.053
Product Types: ALL
Effective Date: 10/01/2017
Last Review Date:

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
To encourage providers to direct patients to more appropriate care settings, the health plan has adopted a payment strategy that will provide lower levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.

The purpose of this policy is to define payment criteria for emergency room services to be used in making payment decisions and administering benefits.

CENTENE® Corporation

PAYMENT POLICY
LEVELING OF EMERGENCY ROOM SERVICES

Reimbursement
The Center for Medicaid and Medicare Services (CMS) affords states the flexibility to independently develop reimbursement methodologies for the use of emergency department services for lower levels of complexity or severity.

When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, the health plan will reimburse the provider at a level 3 (99283) reimbursement rate.

Utilization
The health plan's claims processing system will use a coding algorithm strategy to automatically adjudicate emergency department claims based on the applicable ED claim category in accordance with the diagnosis code appearing on the claim.

If the diagnosis code classification falls into a categorization indicating a lower level of complexity or severity, the claim will be reimbursed at the Level 3 emergency department reimbursement level.

MEDICAID STATES

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- SOUTH CAROLINA
- TEXAS
- WASHINGTON
- WISCONSIN

Case study--Illinicare claims that their policies follow "CMS/Nat'l CCI guidelines"—also Centene plan

illinicare health

999 Oakmont Plaza Drive
Suite 400
Westmont, IL 60559

September 8, 2017

Dear Provider,

Thank you for your partnership with IlliniCare Health. We appreciate your help in achieving our shared goal of delivering quality, accessible, and affordable healthcare to our members.

In order to improve affordability for our members, encourage appropriate utilization of resources, and encourage the highest quality treatment, we are implementing new policies and practices across all lines of business. These policies should be familiar, as they follow CMS/National Correct Coding Initiative (NCCI) guidelines and have already been put in place by other payers. Most will impact only a small segment of providers who may be coding outside of standard practice.

Additional information is available by accessing our payment policies. Below is a matrix outlining which policies will apply to our various products and provides a more robust description of the policies and practice.

Please don't hesitate to reach out to your Provider Relations representative with any questions you may have.

Sincerely,

Mary D. Strasser
Vice President, Network Development & Contracting

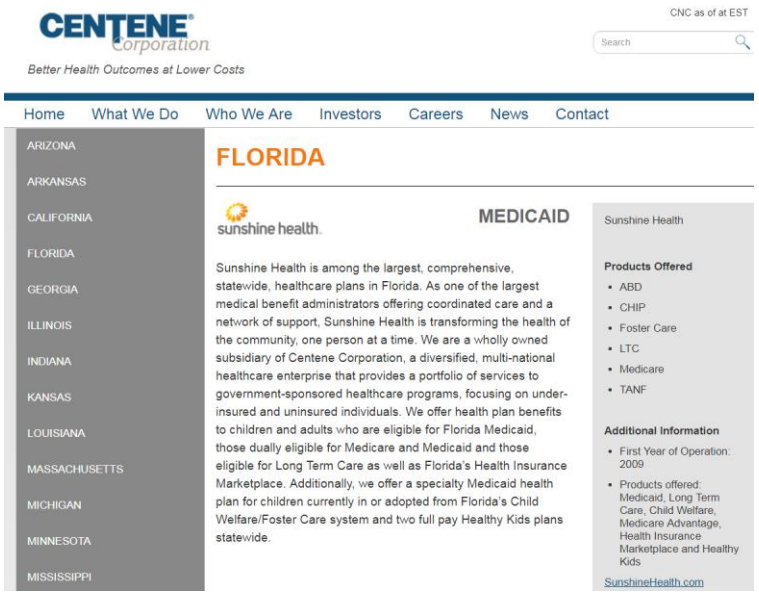
Angela R. Perry, M.D.
Chief Medical Director

These policies are developed based on medical literature and research, industry standards and guidelines as published and defined by the American Medical Association's Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), and public domain specialty society guidance.

Visit **https://www.illinicare.com/providers/resources/clinical-payment-policies.html** to find these policies. The effective date for the below policies is **October 8, 2017**.

Number	Policy Name	Policy Description	Product
CC.PP.053	Non-Emergent ER Services	The purpose of this policy is to define payment criteria for non-emergent emergency room services to be used in making payment decisions and administering benefits. When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a non-emergent diagnosis, IlliniCare Health will reimburse the provider at a level 3 (99283) contracted reimbursement rate.	Medicaid Medicare Ambetter
CP.PP.052	Problem Oriented Visits with Surgical Procedures	The purpose of this policy is to define payment criteria for problem-oriented visits when billed on the same day as a surgical procedure to be used in making payment decisions and administering benefits. Under modifier-25 correct coding principles, a patient may be seen by the physician for a problem-oriented evaluation and management (E&M) service on the same day of a procedure with a 0-, 10- or 90- day global surgical period. Providers do not incur duplicate indirect expenses with the problem-oriented E&M service when there is a surgical procedure on the same date of service. For example, obtaining vital signs, scheduling the visits, staffing, lighting, and supplying the examination room costs are not incurred twice by the provider. IlliniCare Health will reimburse the surgical procedure plus 50 percent of the problem-oriented E&M code.	Medicaid Medicare Ambetter

Case study: Centene's "Sunshine Health" & inappropriate bundling:


CENTENE Corporation

Better Health Outcomes at Lower Costs

CNC as of at EST

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MISSISSIPPI

FLORIDA

sunshine health

MEDICAID

Sunshine Health is among the largest, comprehensive, statewide, healthcare plans in Florida. As one of the largest medical benefit administrators offering coordinated care and a network of support, Sunshine Health is transforming the health of the community, one person at a time. We are a wholly owned subsidiary of Centene Corporation, a diversified, multi-national healthcare enterprise that provides a portfolio of services to government-sponsored healthcare programs, focusing on under-insured and uninsured individuals. We offer health plan benefits to children and adults who are eligible for Florida Medicaid, those dually eligible for Medicare and Medicaid and those eligible for Long Term Care as well as Florida's Health Insurance Marketplace. Additionally, we offer a specialty Medicaid health plan for children currently in or adopted from Florida's Child Welfare/Foster Care system and two full pay Healthy Kids plans statewide.

Sunshine Health

Products Offered

- ABD
- CHIP
- Foster Care
- LTC
- Medicare
- TANF

Additional Information

- First Year of Operation: 2009
- Products offered: Medicaid, Long Term Care, Child Welfare, Medicare Advantage, Health Insurance Marketplace and Healthy Kids

SunshineHealth.com

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

CPT/HCPCS Code	Descriptor
99201-99285	Outpatient, inpatient and consultation E/M services
99291-99359	Nursing home and other domiciliary and home E/M services
99363-99412	Case management, care plan oversight, and preventative medicine E/M services
99441-99498	Other special E/M services, newborn care, care management services

CPT Codes for physician services ordinarily bundled in to E/M services.

CPT/HCPCS Code	Descriptor
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
94760	Noninvasive ear or pulse oximetry

AMA
AMERICAN
MEDICAL
ASSOCIATION

September 9, 2009

David McKenzie
Reimbursement Department Director
American College of Emergency Physicians
1125 Executive Circle
Irving, TX 75038

Dear Mr. McKenzie:

Thank you for forwarding this inquiry to the American Medical Association for verification that the electrocardiogram (ECG) interpretation and report (93010 or 93042) are appropriately reported for performance in the emergency department in the same visit in the ED by the same provider of the ED Evaluation and Management services codes (99281-99285).

Assuming all the appropriate documentation is contained in the patient record, it would be appropriate to report the interpretation and report of an electrocardiogram (ECG) with codes 93010 or 93042 in the emergency department by the same provider of the ED Evaluation and Management services codes (99281-99285).

From a CPT coding perspective, code 93010, *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only*, is **not** considered to be part of a given level of E/M service. When reporting this code, the physician interprets the results of the electrocardiogram and prepares a separate, distinctly identifiable signed written report based on the interpretation of the results. The emergency department E/M services codes may be reported in conjunction with code 93010, if the physician performed an emergency department visit, including a history, examination, and medical decision making based upon the urgency of the patient's clinical condition.

From a CPT coding perspective, code 93042 *Rhythm ECG, 1-3 leads; interpretation and report only*, is **not** considered to be part of a given level of E/M service. In the instance in which a 1-3 lead rhythm electrocardiogram is performed by the ED physician, then code 93042 should be used to report the ED physician's interpretation and report. When reporting this code, the physician interprets the results of the electrocardiogram and prepares a separate, distinctly identifiable signed written report based on the interpretation of the results. The emergency department E/M services codes may be reported in conjunction with code 93010, if the physician performed an emergency department visit, including a history, examination, and medical decision making based upon the urgency of the patient's clinical condition. It is important to note that, according to the CPT guidelines, "Codes 93040-93042 are appropriate when an order for the test is triggered by an event, the rhythm strip is used to help diagnose the presence or absence of an arrhythmia, and a report is generated. There must be a specific order for an electrocardiogram or rhythm strip followed by a separate, signed, written, and retrievable report. It is not appropriate to use these codes for reviewing the telemetry monitor strips taken from a monitoring system. The need for an electrocardiogram or rhythm strip should be supported by documentation in the patient medical record."

I hope this information is of assistance
Sincerely,

Marie L. Mindeman

Marie Mindeman
Director CPT Coding and Regulatory Affairs
American Medical Association

Health Net (became part of Centene March 2016) extends down-payment of CPT 99284s & 5s to 99283 for Medicare & Medicaid Service lines.

PROVIDER*Update*

Health Net®

CONTRACTUAL | MARCH 14, 2018 | UPDATE 18-183 | 4 PAGES

Health Net Implements New Payment Integrity Policies

In order to improve affordability for our members and to encourage appropriate utilization of resources and the highest quality of treatment, Health Net of California, Inc. and Health Net Community Solutions, Inc. (Health Net) are implementing four new policies for the Medicare and Medi-Cal lines of business, effective May 16, 2018. These policies follow the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) guidelines and will impact providers who are coding outside of fair and appropriate use.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

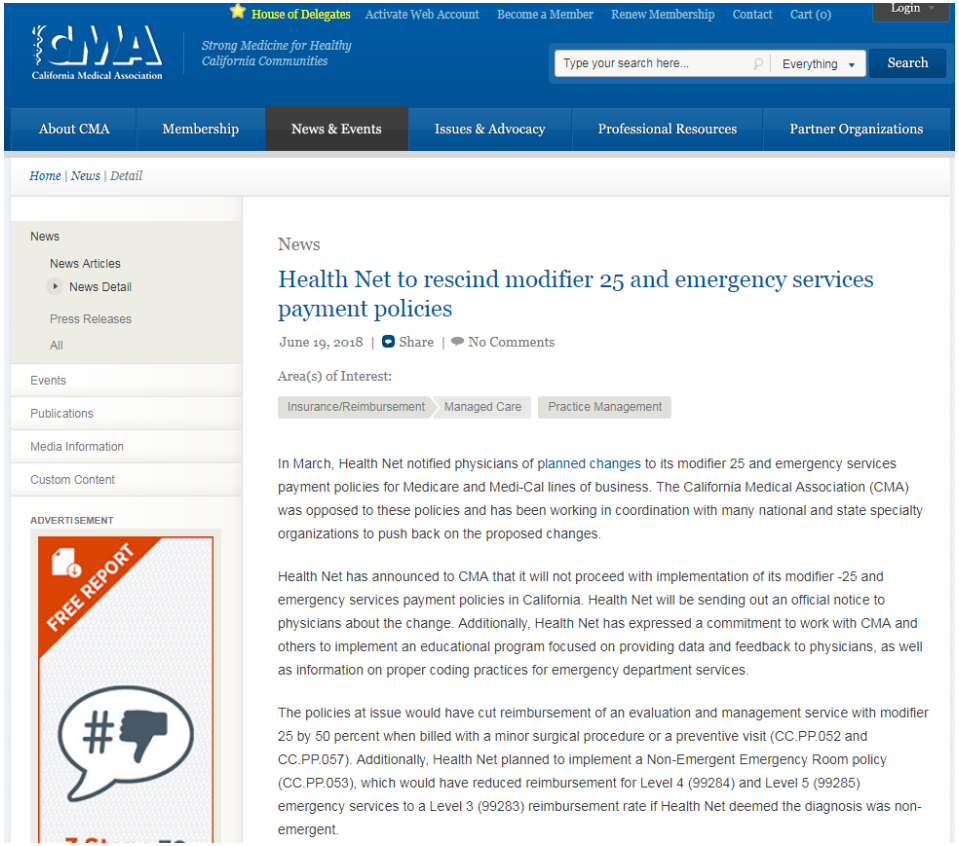
- HMO/POS/HSP
- PPO
- EPO

PAYMENT INTEGRITY POLICIES

Policy Number	Policy Name	Line of Business	Description
CC.PP.053	Non-Emergent Emergency Room Services	Medi-Cal, Medicare, Cal MediConnect	The purpose of this policy is to define payment criteria for non-emergent emergency room services. When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service with a non-emergent diagnosis, Health Net will reimburse the provider at a level 3 (99283) contracted reimbursement rate.

Macro strategies--Can't fight & win against "the Man"? ACEP & EDPMA did with Centene in CA & IN

http://www.cmanet.org/news/detail/?article=health-net-to-rescind-modifier-25-and



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News

Health Net to rescind modifier 25 and emergency services payment policies

June 19, 2018 | Share | No Comments

Area(s) of Interest:

Insurance/Reimbursement | Managed Care | Practice Management

In March, Health Net notified physicians of planned changes to its modifier 25 and emergency services payment policies for Medicare and Medi-Cal lines of business. The California Medical Association (CMA) was opposed to these policies and has been working in coordination with many national and state specialty organizations to push back on the proposed changes.

Health Net has announced to CMA that it will not proceed with implementation of its modifier -25 and emergency services payment policies in California. Health Net will be sending out an official notice to physicians about the change. Additionally, Health Net has expressed a commitment to work with CMA and others to implement an educational program focused on providing data and feedback to physicians, as well as information on proper coding practices for emergency department services.

The policies at issue would have cut reimbursement of an evaluation and management service with modifier 25 by 50 percent when billed with a minor surgical procedure or a preventive visit (CC.PP.052 and CC.PP.057). Additionally, Health Net planned to implement a Non-Emergent Emergency Room policy (CC.PP.053), which would have reduced reimbursement for Level 4 (99284) and Level 5 (99285) emergency services to a Level 3 (99283) reimbursement rate if Health Net deemed the diagnosis was non-emergent.

http://www.edpma.org/downloads/MHS_EDPolicy.pdf

mhs™

News

PAYMENT POLICY UPDATE: EMERGENCY ROOM PROFESSIONAL SERVICES

Date: 06/05/18

On February 1, 2018, MHS implemented a policy established to provide reimbursement rates consistent with the complexity or severity of services rendered in the emergency room. This may have resulted in a lower level of reimbursement for conditions charged at Level 4/Level 5 procedure codes.

After further review, MHS has decided to suspend this policy, effective June 1, 2018.

We anticipate a modified policy will be effective at a future date.

We appreciate your understanding as we work to continually improve our policies. Please contact your Provider Relations representative with any questions.

Thank you for being our partner in care.

Micro Strategies for Downcoding

- **Clinicians:**
  - **Document a high quality differential diagnosis**
    - **This allows justification of the MDM and severity of the patient when medical record is submitted.**
  - **Be as specific as possible with the final impression**
    - **Better to avoid unspecified ICD-10 codes – but sometimes can't.**
- **Coders:**
  - **Proper sequencing of the diagnosis may be important for some payors.**
  - **Coders with hospital background may overly rely on "final diagnosis" vs. NOPP**

Summary of strategies for down coding

- **Appeals**
  - **Use a coder or clinician to assist w/ narrative description that links the NOPP to work up, vital signs & final diagnosis**
  - **“paint the picture”**
- **Advocacy**
  - **State & federal levels**
  - **FCEP, ACEP, EDPMA & JTF;**
- **Possible litigation or threats thereof—**
  - **double check that “par” status is in fact supported by an agreement w/ health plan.**

Issue 4: Limiting ED access for Medicaid Pts or arbitrarily reducing MCD reimbursements

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

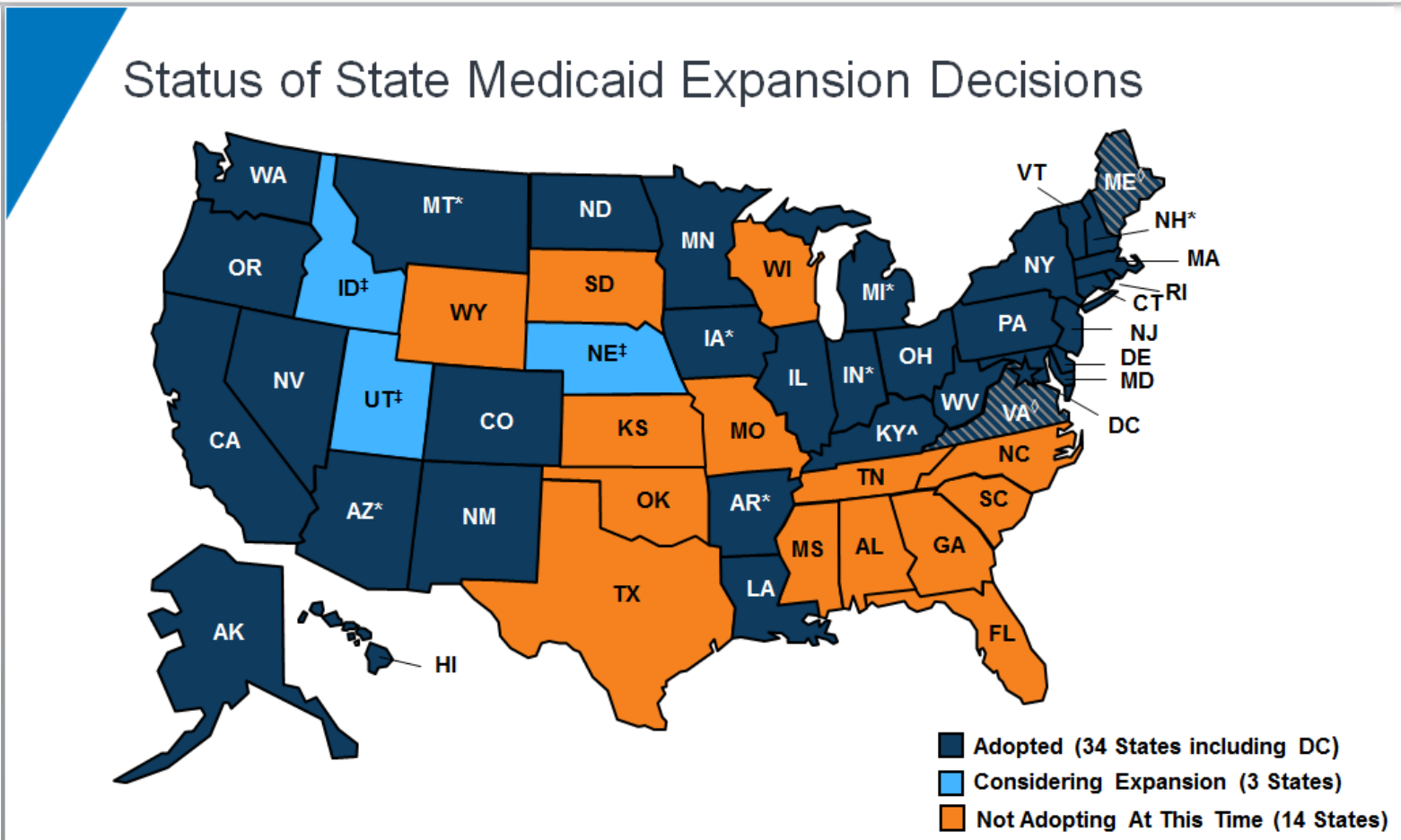
Dear Governor:

We write to you to affirm our partnership in improving Medicaid and the lives of those it serves. Medicaid is a safety net program that provides life-saving medical care to millions of Americans facing some of the most challenging health circumstances. In addressing the diversity and complexity of Medicaid recipients, we have a duty to ensure the highest level of quality, accessibility, and choices for Americans who rely on the program. We also have an obligation to taxpayers to make sure Medicaid operates in a way that best serves the most vulnerable populations.

Today, there are significant impediments that stand in the way of achieving these goals. Rigid and outdated implementation and interpretation of federal rules and requirements hinder states from focusing on their most important job: ensuring Medicaid achieves positive health outcomes for vulnerable individuals and families. The federal framework for Medicaid has not kept pace with emerging evidence around the factors that drive improvements in health outcomes. It often fails to properly account for demographic and geographic considerations, as well as health system variables, which vary in degree from one state to the next. Despite the significant investment by states and the federal government, the results should be better.

The expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program. Moreover, by providing a much higher federal reimbursement rate for the expansion population, the ACA provided states with an incentive to deprioritize the most vulnerable populations. The enhanced rate also puts upward pressure on both state and federal spending. We are going to work with both expansion and non-expansion states on a solution that

The state of Medicaid expansion in 2018:



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers. ^On June 29, 2018, the DC federal district court invalidated the Kentucky HEALTH expansion waiver approval and sent it back to HHS to reconsider the waiver program. ‡UT passed a law directing the state to seek CMS approval to partially expand Medicaid to 100% FPL using the ACA enhanced match, and UT also has a measure on the ballot in November to fully expand to 138% FPL. Initiatives to place expansion on November ballots are also underway in ID and NE. ◊Expansion is adopted but not yet implemented in VA and ME. (See the link below for more detailed state-specific notes.)
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated July 3, 2018.
https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

KFF
HENRY J KAISER FAMILY FOUNDATION

Common Themes : State Medicaid waiver applications pending approval

- ED Co-Pays: IN, KY, ME, UT

- Increased Premiums: AR, MI, ME, NM, WI
  - Disenrollment: AZ, Iowa, MT
  - Disenrollment and lockout: IN, KY,

Common themes for Sec. 1115(b) MCD waivers.

- **Work Requirement Approved: AZ & OH (part of expansion waiver) and AR, IN & NH.**
  - **AZ, KS, KY, ME, MS, NC, UT, & WI are pending CMS approval.**
- **US District Ct in KY struck down the KY MCD work requirement 6/29/18—case expected to be decided by SCOTUS.**
- **Waiver of Non-Emergent Medical Transport Benefit: AR, IN, IO, KY, & MA**

"We must continue to balance financial mechanisms to create greater enrollee accountability without discouraging appropriate use and access to emergency care for all Medicaid beneficiaries."

- **Initial waiver application ED copays $8 first visit, $25 subsequent in calendar year (no non-emerg distinction)**

- **Final application $8 ED copay all visits**

2 new MCD tactics—mandatory contracting & "just cut it"

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POLITICAL FIX

Missouri hospitals fear fallout from changes to Medicaid

By Samantha Liss St. Louis Post-Dispatch Jul 2, 2018 (4)

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Centene's finalizes nearly $4 billion purchase of Fidelis Care

The deal, which was first announced in September, adds New York, the country's second largest managed care state by membership, to the Clayton-based health insurer giant's health plan portfolio.

Toby + Olive
Top 5 Waterfalls in America

Read Now

Missouri is changing the terms for how health care providers are paid after caring for certain Medicaid recipients, a move some rural hospitals warn could lead to financial losses.

If providers do not come in-network with the three insurance companies contracted by the state to provide coverage to certain Medicaid recipients, providers will be paid 10 percent less than they're used to. The change went into effect Sunday.

Providers sounded off at a public hearing last week in Jefferson City. The public meeting was held by the Department of Social Services, which oversees the state's Medicaid program.

"We're truly in a situation where every dollar matters," Mat Reidhead, a board member of Hermann Area District Hospital, said at the hearing.

Tim Wolters, director of reimbursement for Citizens Memorial Hospital, a rural facility north of Springfield, told the Post-Dispatch the decision could create a potentially dire financial situation for hospitals.

"Medicaid overall is a huge payer for us, and if we lost 10 percent that would probably be $1 million dollars off our bottom line, and our bottom line is about $1.6 million," Wolters said.

Financial issues are among the stresses on rural hospitals. More than 120 rural hospitals have closed nationwide since 2005, according to the North Carolina Rural Health Research and Policy Analysis Center at the University of North Carolina at Chapel Hill.

RECOMMENDED

NATION
Kentucky cuts vision, dental care for 460,000 people

NATIONAL POLITICS
Nebraska Medicaid ballot org says it has met signature goal

HEALTH
Podcast: KHN's 'What The Health?' Whither Work Requirements?

HEALTH
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https://www.stltoday.com/news/local/govt-and-politics/missouri-hospitals-fear-fallout-from-changes-to-medicaid/article_396ae802-3631-5a1b-9952-bf04e38fa825.html?utm_medium=social&utm_source=twitter&utm_campaign=user-share

2 new MCD tactics—mandatory contracting & "just cut it"

BECKER'S
Hospital CFO Report

Financial Management

NJ bill caps Medicaid payments at $140 for nonemergent ER visits

Written by Morgan Haefner | June 25, 2018 | Print | Email

The New Jersey legislature passed a bill June 21 that would limit how much the state's Medicaid program pays hospitals for treating low-acuity beneficiaries in the emergency room, according to *nj.com*.

The bill, introduced and approved in committee June 18, would cap payments for N.J. FamilyCare members at $140 for nonemergent use of a hospital's ER. On average, treating low-acuity Medicaid beneficiaries in the ER costs $600, according to Wardell Sanders, president of the New Jersey Association of Health Plans.

According to the bill, the New Jersey Department of Human Services would determine what visits are low acuity.

In a statement to *nj.com*, Mr. Sanders said, "New Jersey needs to move away from a payment model that gives financial incentives to deliver primary care in the most expensive care setting."

However, hospitals largely disagree with the bill. Neil Eicher, vice president of government relations and policy at the New Jersey Hospital Association, told the publication, "Hospitals should not be penalized for doing the right thing by providing quality care to patients who show up at our doors because insurance companies have failed to provide a network of providers available to these patients."

https://www.beckershospitalreview.com/finance/nj-bill-caps-medicaid-payments-at-140-for-nonemergent-er-visits.html

CMS reiterates the federal PLP std as recently as March ’18 to EDPMA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAR 15 2018

Administrator
Washington, DC 20201

Andrea Brault, M.D.
Chair of the Board
Emergency Department Practice Management Association
8400 Westpark Drive, 2nd Floor
McLean, VA 22102

Dear Dr. Brault:

Thank you for your letter to former Acting Secretary Eric Hargan, Chief Medical Officer Vanila Singh and myself regarding enforcement of the prudent layperson standard to prevent unreasonable denials of emergency care for Medicaid beneficiaries and the use of 1115(a) demonstration authority to waive the prudent layperson standard. They have asked that I respond to you directly on their behalf.

be based on all pertinent documentation, must be focused on the presenting symptoms (and not on the final diagnosis), and must 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: https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html.

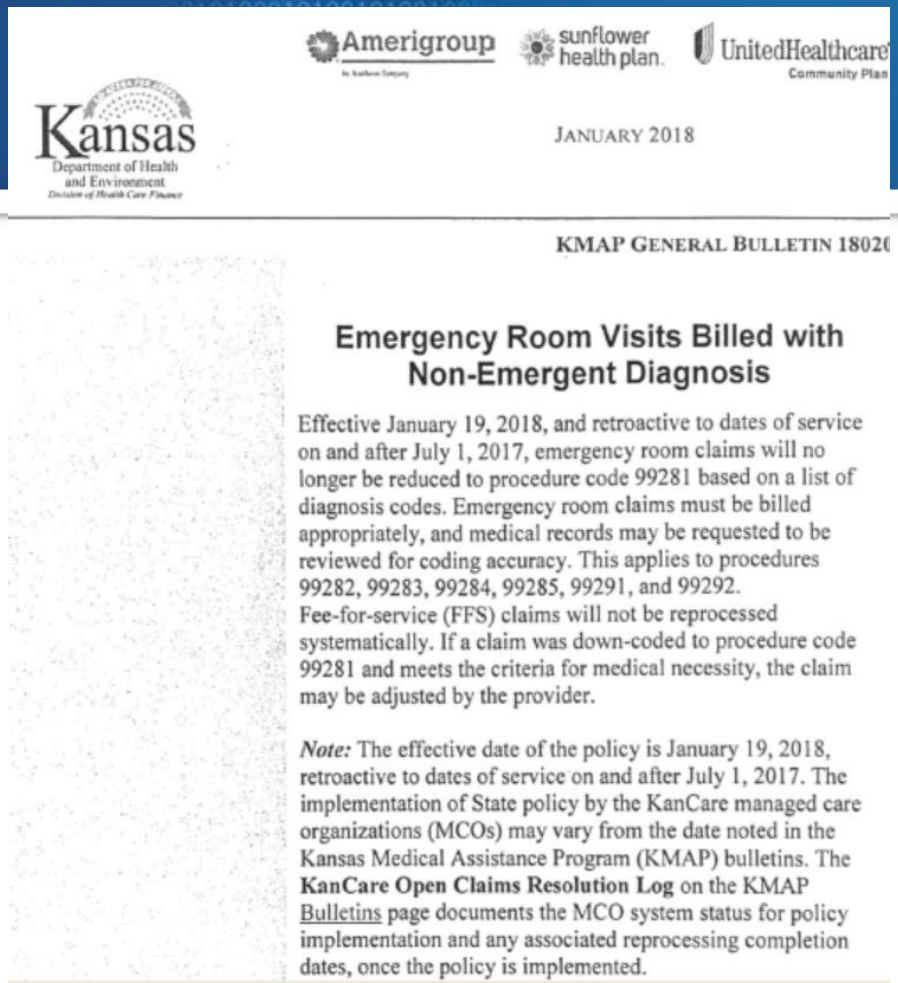
We contacted KanCare regarding your assertion that KanCare MCOs have been down-coding emergency department claims based on a list of diagnosis codes. KanCare officials advised us that they have developed a policy that prohibits down-coding of emergency room claims and that all three MCOs were scheduled to implement this policy on January 19, 2018, retroactive to July 1, 2017, dates of service.

We hope the information provided in this letter is helpful. Should you have any questions, please contact Juliet Kuhn, Division of Managed Care Plans, at 410-786-2480. I also will provide this response to Janice Wachtler.

Sincerely,

Seema Verma

Case study: Victory in KS!



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Kansas Department of Health and Environment

JANUARY 2018

KMAP GENERAL BULLETIN 18020

Emergency Room Visits Billed with Non-Emergent Diagnosis

Effective January 19, 2018, and retroactive to dates of service on and after July 1, 2017, emergency room claims will no longer be reduced to procedure code 99281 based on a list of diagnosis codes. Emergency room claims must be billed appropriately, and medical records may be requested to be reviewed for coding accuracy. This applies to procedures 99282, 99283, 99284, 99285, 99291, and 99292. Fee-for-service (FFS) claims will not be reprocessed systematically. If a claim was down-coded to procedure code 99281 and meets the criteria for medical necessity, the claim may be adjusted by the provider.

Note: The effective date of the policy is January 19, 2018, retroactive to dates of service on and after July 1, 2017. The implementation of State policy by the KanCare managed care organizations (MCOs) may vary from the date noted in the Kansas Medical Assistance Program (KMAP) bulletins. The **KanCare Open Claims Resolution Log** on the KMAP Bulletins page documents the MCO system status for policy implementation and any associated reprocessing completion dates, once the policy is implemented.

- **July 2017: KS Medicaid implements ED diag. list.**
- **Claims w/ CPT 9928X codes that hit the diag. list were down-coded to 99281.**
- **ACEP/EDPMA Joint Task Force (JTF) KS-ACEP, KS Med. Society & coalition engaged w/ in joint advocacy.**
- **Result: full reversal of prior policies.**
- **Retro-active application of new policy for down-coded claims to 7/1/17.**

Contact information:

Ed Gaines, JD, CCP

Chief Compliance Officer,

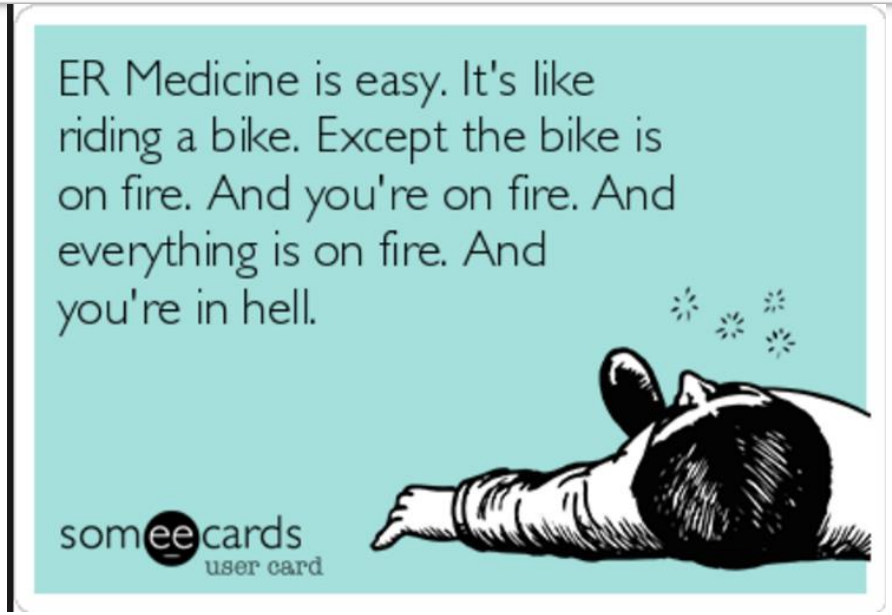
Emergency Medicine Div.

Zotec Partners

Greensboro, NC

egaines@zotecpartners.com

919-641-4927



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http://twitter.com/EdGainesIII