AMA
AMERICAN MEDICAL ASSOCIATION

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Richard Migliori, MD
Executive Vice President, Medical Affairs
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UnitedHealth Group
9900 Bren Road East
Minnetonka, MN 55343

Dear Dr. Migliori:

On behalf of the American Medical Association (AMA) and its physician and student members, I request that UnitedHealthcare (UHC) halt plans to implement two payment policies that represent unjustified reductions in physician payment. UHC recently announced that effective October 1, 2018, payments for evaluation and management (E&M) services billed with Current Procedural Terminology (CPT) modifiers 25 or 57 when reported with a procedure or surgical code will be reduced by 25 percent. In a separate policy also effective October 1, UHC will deny payment for consultation codes and will instead pay for these services with an E&M code. Many state medical associations and national medical specialty societies have voiced significant concerns about similar payment adjustments implemented by other health plans. Notably, the AMA's House of Delegates established new policies at its 2017 Interim Meeting to advocate against both payment reduction for E&M codes appropriately reported with a modifier 25 and discontinuation of payment for consultation services by commercial insurers. We urge UHC to reconsider these policies given the evidence outlined below; the significant, adverse financial impact on physician practices; and the potential disruption of the delivery of timely patient care.

Modifier 25/57

According to the CPT description, modifier 25 provides the means to report a significant, separately identifiable E&M service by the same physician on the same day of a procedure or other service. Modifier 57 is used to report an E&M service that results in the initial decision to perform surgery on either the day before or the day of a major surgery (90 day global). By facilitating the provision of unscheduled, medically necessary care, both modifiers 25 and 57 support prompt and streamlined treatment—**which in turn promotes efficient, high-quality, and patient-centric care.**

UHC's 25 percent proposed payment reduction for E&M services reported with modifiers 25 or 57 represents a substantial payment cut that will broadly impact physicians nationwide, across medical specialties and geographic regions. We recognize that this policy may reduce costs for your company and its clients in the short term. However, we urge UHC to reconsider this approach and instead consider the long-term impact on patient care. By prioritizing immediate savings through the modifier 25/57 payment reduction, UHC is creating a disincentive for physicians to provide medically appropriate, but unscheduled, services. Moreover, this approach does not support efficient, value-based care, which I know is a shared goal of our organizations.

To justify this payment reduction, UHC has cited an overlap in expenses between E&M and procedure codes. **We must stress that this reflects a misunderstanding of the code valuation process. The recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) do not include overlapping physician work or practice expense for procedures/surgeries typically billed with an E&M service on the same day.** The RUC reduces the value of procedure/surgical codes that are reported over 50 percent of the time with E&M codes to

eliminate duplicate valuation of practice expenses and pre- and post-visit physician work, and the RUC reductions to these codes are explained in publicly available information contained in the AMA's RBRVS DataManager. The Centers for Medicare & Medicaid Services (CMS) acknowledge this adjustment in the CY 2018 Medicare Physician Fee Schedule (PFS) Final Rule, noting that the RUC ". . . addresses the overlap in time and work when a service is typically furnished on the same day as an E/M service." While the valuation methodology described in the PFS does not explicitly address reduction in indirect practice expense to account for overlap when procedure codes are commonly billed with E&M visits, both physician work and direct practice expense relative value units (RVUs) are used to allocate indirect practice expense. Thus, the reductions in physician work and direct practice expense RVUs described in the PFS result in a similar downward adjustment in indirect practice expense RVUs.

Because the RUC has already adjusted code valuations to account for overlap, any policy that further reduces payments for E&M codes reported with modifiers 25 or 57 when reported with a procedure or surgical code constitutes a duplicative and unfair further reduction in physician payment for legitimate, necessary services. We note that Anthem, following several discussions with AMA physician leadership and staff who clarified RUC processes and provided examples of procedures for which valuation has been reduced to eliminate overlap, withdrew its planned policy to reduce payment for E&M codes reported with modifier 25. Blue Cross Blue Shield of Michigan and Health Net in California also recently rescinded modifier 25 policies after being presented with data confirming the lack of payment overlap. **We hope that UHC, after reviewing and considering our clarification of the code valuation process, will join these other commercial health plans in withdrawing a policy that unfairly reduces payment for E&M services.**

Consultation Services

We also strongly object to UHC's decision to deny payment for consultation services. As stated in the CPT description, a consultation is a type of E&M service provided at the request of another physician to either recommend care for a specific condition or problem, or to determine whether to assume responsibility for ongoing management of all or part of a patient's care. Consultation services involve care coordination between physicians and thus play a critical role in ensuring quality, safe treatment. Fair payment for consultation codes recognizes and ascribes the appropriate value to the additional work, expertise, and documentation involved in the communication and collaboration between consulting and referring physicians. As with the modifier 25/57 payment reduction, **we are again concerned that UHC, by creating disincentives for the provision of quality care associated with appropriate care coordination, is focusing on short-term cost savings at the expense of long-term plan expenses and patient outcomes.**

Beyond our primary concern about the impact of this policy on care coordination, we also question the specifics of UHC's implementation. In announcing this policy, UHC has referenced CMS's decision to discontinue payment for consultations in 2010 and instead pay for these services with an E&M code. At that time, the AMA, along with many state medical associations and national medical specialty societies, forcefully advocated against this change. However, we note that when CMS implemented this policy, it was done in a budget-neutral manner: CMS increased the work RVUs for new and established E&M visits to reflect the discontinuation of payment for consultation codes. **We are unclear if UHC will similarly adjust its fee schedules to increase payment for E&M codes to account for the elimination of consultation codes in contracts for all network physicians and would appreciate clarification on this point.**

We also believe that this policy has the potential to cause payment disruptions, administrative burdens, and significant confusion for physicians and their staff. Practices will need time to learn how to comply with these new coding guidelines and identify the correct crosswalks between consultation and E&M codes. To our knowledge, UHC is the only national commercial health insurer that has discontinued payment for consultation codes, meaning that this policy represents a significant coding change—particularly for those practices that do not bill Medicare and are unaccustomed to the crosswalk between consultation and E&M codes. Processing of secondary claims will be another challenge: UHC will presumably not accept consultation codes on claims forwarded by a primary insurer that does pay for these services, which will undoubtedly lead to payment delays. It also appears that the policy only applies to consultations billed by specialists, with primary care physicians still being eligible to receive payment for

consultation codes. This distinction will undoubtedly cause further confusion—particularly since specialists are more likely to bill consultation services than primary care physicians.

Targeted Education vs. Blunt Policies

We recognize that health plans often implement payment policies to address improper coding or billing practices. However, we vigorously object to blunt payment reduction policies—such as UHC's forthcoming changes related to E&M services reported with modifiers 25/57 and consultation codes—that penalize all physicians, regardless of the accuracy of their practice's coding and billing. Instead of instituting unwarranted payment reductions across all network physicians, we urge UHC to (1) supply recent, reliable data demonstrating unexpectedly high use of modifiers 25/57 and/or consultation codes across network physicians; and (2) selectively target only those practices with billing patterns significantly different from same-specialty peers for education on proper coding. The AMA strongly supports correct coding and billing practices and would welcome the opportunity to work with UHC on educational tools and resources to ensure proper use of modifiers 25 and 57 and consultation codes.

Movement to Value-Based Payment

In a recent discussion with state medical association and national medical specialty society staff, UHC suggested that these policies are part of the health care industry's movement to value-based payment. We believe that UHC's proposed changes and the resulting barriers to the delivery of necessary, unscheduled care and care coordination do not reflect alignment with true value-based care, which factors in both quality and cost. In addition, UHC is choosing to reduce physician compensation at a critical time in practices' transition to value-based care models. The AMA fully supports the shift to these new payment systems, but we must emphasize that physicians will need to invest significant resources in practice enhancements, such as care coordination, data analytics, clinical registries, and population health management, that are essential to value-based care delivery. Burdening physician practices that are already financially strapped with punitive payment policies will hinder progress towards value-based payment, particularly for smaller practices that are already challenged in acquiring the technology and tools necessary to succeed in these new care models. **While we share UHC's commitment to transitioning our health care system to value-based payment, we request that you consider the negative effect that the modifier 25/57 and consultation code policies will have on practices' ability to prepare for success in these new systems.**

Follow Up and Further Discussion

The AMA is committed to building collaborative and productive relationships between physicians and health plans. We appreciate the ongoing dialog that exists between AMA and UHC leaders and staff and look forward to continuing these candid, constructive conversations to explore ways in which our organizations can better work together to increase the quality, value, and efficiency of patient care.

To further detail our concerns about these two particular UHC policies, we request a face-to-face meeting as soon as possible to include the appropriate individuals from your organization. I have asked Robert D. Otten, Vice President, Health Policy (rob.otten@ama-assn.org or 312-464-4735), to follow up with your office to schedule a meeting with you and the appropriate members of your team to further discuss these issues.

Sincerely,

James L. Madara, MD

cc: Lewis Sandy, MD