AMA
AMERICAN MEDICAL ASSOCIATION

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Trent Haywood, MD, JD
Chief Medical Officer
Blue Cross Blue Shield Association
225 North Michigan Ave.
Chicago, IL 60601

Dear Dr. Haywood:

On behalf of the American Medical Association (AMA) and its physician and student members, we urge Blue Cross Blue Shield Association (BCBSA) to encourage its members to halt implementation of policies that reduce payments for evaluation and management (E&M) services billed with Current Procedural Terminology (CPT) modifier 25 when reported with a minor surgical procedure code. Many state medical associations and national medical specialty societies have voiced significant concerns about this issue, and the AMA's House of Delegates established policy at its 2017 Interim Meeting to advocate against payment reduction for E&M codes appropriately reported with a modifier 25. Several BCBSA member plans have instituted modifier 25 payment reductions, and others have announced plans to implement such policies in the near future. These policies represent unwarranted reductions in physician payment that have a significant, adverse financial impact on practices, as well as the potential to interfere with the delivery of timely patient care.

Background
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. By facilitating the provision of unscheduled, medically necessary care, modifier 25 supports prompt diagnosis and streamlined treatment—which in turn promotes efficient, high-quality, and patient-centric care. Reducing payment for E&M services reported with modifier 25 represents a harmful, baseless pay cut to physicians across medical specialties. We recognize that these policies may have the potential to reduce costs for health plans and their clients in the short term. However, we urge your members to reconsider this approach and instead consider the impact on long-term plan and patient costs. By prioritizing immediate savings, plans instituting modifier 25 payment reductions create a disincentive for physicians to provide additional, unscheduled services and may force patients to schedule multiple visits (with extra co-payments) to receive necessary treatment.

Unjustified Payment Reductions
Beyond the obvious near-term cost savings, health plans have cited various rationales to justify their modifier 25 payment reductions. **We object to the following arguments that plans have presented when implementing reductions for E&M codes reported with modifier 25 and urge BCBSA to share the following information with your member plans:**

1. *Overlap in payment:* Several health plans have cited overlap in payment between E&M and procedure codes as the rationale for modifier 25 policies. **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 typically billed with an E&M service on the same day.** The RUC reduces the value of procedure 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. The Centers for Medicare & Medicaid Services 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."[1] 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 modifier 25 when reported with a procedure code constitutes a duplicative and unjustified further reduction in physician payment for legitimate, necessary services. **We note that Anthem, following several discussions with AMA staff who clarified RUC processes and provided examples of procedures for which valuation has been reduced to eliminate overlap, announced earlier this year that it would not proceed with its planned policy to reduce payment for E&M codes reported with modifier 25.** The RUC reductions to procedure codes are explained in publicly available information contained in the AMA's RBRVS DataManager.

2. *Overuse/abuse of modifier 25*: Another common explanation for health plans' modifier 25 policies is the purported overuse or abuse of this modifier in billing E&M services with same-day procedures. Yet health plans implementing these payment reductions rarely supply data establishing that: (a) network physicians' use of the modifier differs consistently and significantly from national norms and (b) any documented high utilization is inappropriate. Several plans cite the 2005 Department of Health and Human Services Office of Inspector General report on use of modifier 25, which showed that 35 percent of Medicare claims reporting modifier 25 did not meet program requirements, as evidence of widespread abuse of the modifier.[2] However, this report is not current and is in fact based on 2002 data. The report's findings are also more suggestive of a lack of appropriate documentation than true misuse of modifier 25. **Any health plans considering modifier 25 policies should first share recent, reliable data demonstrating unexpectedly high use of the modifier across network physicians and offer an adequate opportunity for practices to respond.** Plans should also recognize that high utilization of the modifier does not necessarily equate with misuse; documentation review is necessary to determine the appropriateness of billing an E&M code with modifier 25 in addition to a same-day procedure.

   The AMA supports **correct** use of modifier 25 and has educated physicians and their staff numerous times through various CPT educational publications that the modifier should only be reported for significant, separately identifiable E&M services on the same day of a procedure. **While we recognize that there may be instances where the modifier is misreported, we vigorously object to health plans' blunt payment reduction policies that penalize all physicians—regardless of whether or not they are appropriately applying the modifier—instead of selectively targeting practices with billing patterns significantly different from same-specialty peers for education on proper coding.** The AMA would welcome the opportunity to work with any of your interested member plans on educational tools and resources to ensure proper use of modifier 25.

3. *Value-based payment*: Some health plans have suggested that the movement towards value-based payment means that policies based on fee-for-service (FFS) billing will minimally impact physician practices. While the AMA supports the shift toward value-based payment models, we strongly disagree

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. 42 CFR Parts 405, 410, 414, 424, and 425 [CMS–1676–F] RIN 0938–AT02 Medicare Program. Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program. Available at: https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf. Accessed April 23, 2018.

[2] Department of Health and Human Services, Office of Inspector General. Use of Modifier 25. November 2005. OEI-07-03-00470. Available at: https://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf.

with the assumption that FFS-related policies will not significantly affect physician practices. Adoption of newer payment models has been modest at best: according to findings from the AMA's Benchmark Survey, an average of 70.8 percent of practice revenue was still received through FFS in 2016, with more than 80 percent of physicians working in practices that received at least some revenue from FFS.[3] Physician practices that are already financially strapped will need to make significant technology investments in data access and reporting to ensure success under many value-based payment models. Progress toward these new payment systems is incremental, and it may be years before smaller practices realize a meaningful shift in payment methodology. **With the large majority of practices just beginning to engage in value-based payment models, health plans must support fair FFS payments and avoid punitive policies, such as modifier 25 adjustments, that result in a significant, unjustified reduction in physician payment for rendered patient care.**

Further Discussion, Education, and Collaboration

The AMA is committed to building more collaborative and productive relationships between physicians and health plans. We welcome the opportunity to further clarify any of the points above about modifier 25 payment reductions or RUC processes with your staff or member plans. Moreover, we would be happy to partner with you or your members in educational efforts to ensure proper coding practices related to modifier 25 and strategize on alternative mechanisms that would support correct use of the modifier without bluntly penalizing all physicians and harming the financial health of so many practices. **We urge you to share this correspondence with BCBSA members and encourage them to follow up with the AMA, should they wish to discuss this issue.**

More broadly, we believe that our physicians and your member plans can find far more effective ways to increase the quality, value, and efficiency of patient care by shifting the focus to long-term health outcomes and value instead of short-term savings. We are always ready to engage with your members to identify opportunities to positively change our health care system and improve the health of our nation.

If you have any questions, please contact Robert D. Otten, Vice President, Health Policy, at 312-464-4735 or rob.otten@ama-assn.org.

Sincerely,

James L. Madara, MD

[3] Rama A. *Policy Research Perspectives: Payment and Delivery in 2016: The Prevalence of Medical Homes, Accountable Care Organizations, and Payment Methods Reported by Physicians*. Available at: https://www.ama-assn.org/sites/default/files/media-browser/public/health-policy/prp-medical-home-aco-payment.pdf. Accessed April 23, 2018.