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DOs: Physicians Treating People, Not Just Symptoms

June 27, 2019

Mr. Samuel J. Marchio
Regional Vice President, Federal Affairs
Anthem, Inc.
1001 Pennsylvania Avenue, NW, Suite 710
Washington, DC 20004

Dear Mr. Marchio:

On behalf of the Osteopathic Physicians and Surgeons of California (OPSC), I am writing to urge Anthem Blue Cross Blue Shield (Anthem) to reconsider its recent payment update related to Evaluation and Management (E/M) services appended with Current Procedural Terminology (CPT) modifier 25.

Effective March 1, 2019 for commercial claims, Anthem announced to network physicians that it "will deny the E/M service with a modifier 25 billed on the day of a related procedure when there is a recent service or procedure for the same or similar diagnosis on record for the same provider." OPSC is deeply concerned this update will cast a wider net than Anthem intends and result in unjustified claims denials for appropriately billed E/M services. In addition, we believe recent language clarification issued by Anthem addressing ambiguous terms reflected in the update ignores medical necessity and will negatively impact patient care.

Anthem's definition of appropriate use of modifier 25 is inconsistent with nationally accepted guidelines. CPT guidelines for using modifier 25 allows for separate payment for a significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. Anthem's update is inconsistent with standard coding convention and practice patterns in that reporting an E/M visit disqualifies payment for the same condition within a short period of time if the patient presents to the physician again and requires a separate and distinct E/M visit and a procedure on a particular date of service.

Anthem's update ignores medical necessity, which will negatively impact patient care. Over the past several months, multiple stakeholders – including the American Osteopathic Association (AOA) – requested that Anthem clarify several terms related to operationalizing the update. In a response to the American Medical Association (AMA) dated May 28, 2019, Anthem defined "recent" and "same/similar" for purposes of applying the update as "recent as the billing of an E/M with modifier 25 and a minor procedure occurring within approximately two months of billing another E/M for the same/similar diagnosis." Anthem then defines same/similar as "having a primary diagnosis in the same family."

It is important to recognize that many clinical scenarios require a subsequent encounter for a recently reported condition and an unrelated procedure. Delaying or disallowing a medically necessary and appropriate follow-up visit to ensure payment under Anthem's recent update will likely result in negative implications for patients and interferes with the practice of medicine. Following are two examples where follow-up encounters are medically necessary and appropriate:

- A patient presents with knee pain and self-reports the pain as 4 out of 10. The physician prescribes rest and conservative pain management modalities (E/M visit, CPT code 99213). The patient's symptoms subsequently worsen and the patient returns for re-evaluation within three weeks of the initial visit, now reporting pain as 8 out of 10. During this unplanned, follow-up visit, the patient requires an intra-articular injection (CPT code 20610) after re-evaluation of the joint. This visit would be appropriately billed as an E/M (CPT code 99213) visit appended with modifier 25, and the patient maintains the same diagnosis as the previous visit. (ICD-10 code M25.562, left knee pain)

- A patient presents with a lower left leg abscess. After evaluating the patient, the physician performs an incision and drainage (CPT code 10060) and prescribes antibiotics for the patient (E/M – CPT code 99214) and procedure reported with modifier 25). The patient returns one week later with recurrence of the abscess requiring a repeat incision and drainage (CPT code 10061, higher complexity than the 1st I&D). This visit would be appropriately billed as an E/M visit (CPT code 99214) with a repeat procedure reported with modifier 25, and the patient maintains the same diagnosis as the previous visit. (ICD-10 code L02.91, cutaneous abscess, unspecified).

Disallowing or postponing a medically necessary and appropriate repeat E/M for the same condition – regardless of whether a procedure is performed – will result in negative implications for the patient and interferes with the practice of medicine. OPSC is also concerned our members will soon face numerous and likely inappropriate claims denials for E/M services appended with modifier 25 that do not meet Anthem's new criteria as stated in the recent update.

The update will result in inappropriate denials and increased administrative burdens. OPSC is concerned this update will cast a much wider net than Anthem intends and penalize physicians who bill modifier 25 appropriately. While Anthem's notice to physicians advises that they may submit medical records and appeal in writing, this process creates unnecessary administrative burden and delays both physician payment and patient care.

Anthem has failed to provide evidence of modifier 25 misuse. In 2004, the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) reviewed modifier 25 utilization and found that two percent of claims did not meet the threshold for modifier 25, and that 31 percent of claims were denied due to improper and/or inaccurate documentation. Recognizing that an in-depth understanding of documentation standards is critical for properly reporting modifier 25, the AOA and OPSC has engaged in significant efforts to educate its members on the documentation requirements necessary to receive payment when reporting modifier 25. In addition, it is important to acknowledge that OIG has not further evaluated modifier 25 utilization in 15 years. To date, Anthem has not provided evidence of inappropriate follow-up visits or widespread misuse of modifier 25. Should Anthem suspect modifier 25 misuse or inappropriate follow-up encounters, Anthem has means to review and ensure it is only reimbursing physicians for appropriate patient care, rather than imposing across-the-board claims denials. If inaccurate coding or inappropriate encounters are occurring, OPSC is interested in understanding current trends in an effort to improve the relevant educational resources we provide to our members.

OPSC strongly encourages Anthem to reconsider its recent payment update regarding E/M services billed with CPT modifier 25 for the reasons described above. To further detail our concerns, OPSC also requests a meeting as soon as possible to include the appropriate individuals from your organization, the AOA, and OPSC leadership.

Thank you for your consideration and commitment to providing support to contracted osteopathic physicians who provide high-quality, patient-centered care to Anthem's members. I look forward to discussing this issue with you in the near future.

Sincerely,

Minh Q. Nguyen, DO, FACOEM
President, Osteopathic Physicians and Surgeons of California