

February 28, 2003

Mr. Raymond F. McCaskey  
President and Chief Executive Officer  
Health Care Service Corporation  
300 E. Randolph  
Chicago, IL 60601-5099

Dear Mr. McCaskey:

The undersigned medical associations are deeply concerned about Health Care Service Corporation's (HCSC), proper understanding, interpretation and use of the Current Procedural Terminology (CPT®) work of medical nomenclature published by the American Medical Association (AMA). The undersigned organizations have received numerous complaints about HCSC health plans' misapplication of CPT codes, guidelines and conventions resulting in inappropriately denied payments to physicians for the provision of health care services. This letter is intended to educate you about these concerns.

#### The Proper Use of CPT Codes

The undersigned medical associations oppose arbitrary and unilateral code-collapsing and recoding practices that result in unfair payment. We encourage third-parties to accept physician claims that have been accurately reported using applicable CPT codes and to report back to physicians and patients using the same codes or terminology, regardless of reimbursement methodology and levels. Procedural descriptions should not be modified without appropriate professional medical consultation. Use of inappropriately modified data does not provide a proper basis for reimbursement, measuring practice patterns, peer reviews or utilization reviews, or other related uses.

The AMA has as one of its priorities to encourage consistency in the use of CPT codes, guidelines and conventions, as well as to advocate the adoption of these standards. The undersigned organizations object when health plans seek to arbitrarily and unilaterally recode or inappropriately bundle codes and services. We feel compelled to identify specific CPT code bundling problems and seek to educate health plans and other payors in dealing with these problems.

Instructions for use are clearly presented in the introduction of the CPT Book. Physicians are to select the procedure or service that "accurately identifies" the service performed. A CPT code that merely approximates the service provided is not to be selected. Additional procedures performed or pertinent special services are also to be listed. When necessary, any modifying or extenuating circumstances are to be added. Similarly, we strongly urge all third-party payors that use code-editing software (along with vendors of claims editing software) to ensure that CPT codes, guidelines and conventions contained in the annually revised CPT publications are followed on a consistent basis. Diligent

adherence to these guidelines preserves the integrity of CPT coding and maintains the efficiency of health care delivery that all patients deserve.

Acceptance of CPT codes, guidelines and conventions does not imply standardized payment for documented and reported services. CPT coding guidelines only aid users in applying the CPT codes correctly and do not dictate the circumstances for payment or the amount of the payment. However, HCSC health plans' apparent arbitrary and unilateral (and potentially inconsistent) application of CPT codes, guidelines and conventions has created confusion and uncertainty and, based upon the complaints we have received, has led to misunderstandings by physicians regarding HCSC health plans' payment rates for certain services.

### HCSC Health Plans' Business Practices

HCSC health plans' business practices are viewed by many physicians as barriers to care and obstacles to the development and maintenance of the patient-physician relationship.

We bring the following specific items to your attention so that you can promptly address the concerns noted:

#### **1. Downcoding, bundling and lack of recognition of CPT modifiers by HCSC health plans.**

- A. Modifier –25 has been denied for the purpose of bundling. Modifier –25 is appended to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management (E&M) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. Examples include:
- CPT code 69210 - *removal impacted cerumen (separate procedure), one or both ears*; with E&M services; and
  - CPT code 81007 - *urinalysis; bacteriuria screen, except by culture or dipstick*; with E&M services.

Instead of rewarding physicians for providing necessary patient care efficiently during the same visit, HCSC health plans are penalizing physicians for providing quality, efficient care to patients that is consistent with current medical guidelines and standards. The undersigned organizations are opposed to health plan payment policy that requires a patient to come back for a subsequent visit for necessary care when this treatment could have been provided during the original visit as this practice jeopardizes quality patient care and safety, and threatens the patient-physician relationship.

- B. There has been a lack of recognition or improper assignment of Modifier –59 which was developed for the Medicare National Correct Coding Initiative explicitly for the purpose of identifying services not typically performed together. Modifier –59 is

appended to indicate that under certain circumstances the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.

C. In addition to the modifier –25 mentioned above, it has been brought to the AMA's attention by the undersigned medical associations that there has been a lack of recognition or improper assignment of the following CPT modifiers:

- CPT modifier –51, which is appended when multiple procedures, other than E&M services, are performed on the same day or at the same session by the same provider; and
- CPT modifier –76, which is appended when the physician may need to indicate that a basic procedure performed by the same physician had to be repeated; specifically HCSC health plans require modifier –76 when billing for multiple units of the same pathology code. From a CPT coding perspective, modifier –76 is intended to describe a "reoperation," rather than the performance of the same procedure at multiple sites.

D. HCSC health plans have also repeatedly downcoded or recoded various CPT codes. Examples include:

- CPT code 29126 - *application of short arm splint (forearm to hand); dynamic*; recoded to CPT code 29125 - *application of short arm splint (forearm to hand); static*;
- CPT code 31255 - *nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)*; recoded to CPT code 30130 - *excision turbinate, partial or complete any method*;
- CPT code 43247 - *upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with removal of foreign body*; recoded to CPT code 43239 - *upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple*;
- CPT code 43262 - *endoscopic retrograde cholangio pancreatography (ERCP); with sphincterotomy/papillotomy*; recoded to CPT code 43261 - *endoscopic retrograde cholangio pancreatography (ERCP); with biopsy, single or multiple*;
- CPT code 43268 - *endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct*; recoded to CPT code 43261 - *endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple*;

- CPT code 45385 - *colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique*; recoded to CPT code 45384 - *colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery*;
- CPT code 64721 - *neuroplasty and/or transposition; median nerve at carpal tunnel*; recoded to CPT code 64719 - *neuroplasty and/or transposition; ulnar nerve at wrist*; and
- CPT code 92569 - *acoustic reflex decay test*; recoded to CPT code 92568 - *acoustic reflex testing*.

**2. Failure by HCSC to compensate physicians for the provision of health care services as documented by certain CPT codes.**

HCSC health plans have failed to recognize and adopt policies for the submission of several CPT codes. This has resulted in the provision of uncompensated care. Examples include:

- CPT code 32002 - *thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax) (separate procedure)*;
- CPT code 32405 - *biopsy, lung or mediastinum, percutaneous needle*;
- CPT code 70010 - *myelography, posterior fossa, radiological supervision and interpretation*; and
- CPT code 79999 - *unlisted radiopharmaceutical therapeutic procedure*.

Basis and Function of CPT Codes, Guidelines and Conventions

HCSC health plans' failure to recognize and/or appropriately incorporate policies based on CPT codes, guidelines and conventions has resulted in physicians not being compensated for care to patients. Such a result is entirely inconsistent with the purpose of CPT coding and the Resource-Based Relative Value Scale (RBRVS) system for physician payment.

In 1992, when Medicare implemented the RBRVS, new modifiers were established within the CPT codes to describe special circumstances related to the performance of multiple services or procedures on the same date. The CPT Editorial Panel, which includes representatives of the Blue Cross and Blue Shield Association and the Health Insurance Association of America, agreed with the Health Care Financing Administration, the predecessor agency of the Centers for Medicare and Medicaid Services, that these modifiers were crucial in establishing a formalized structure and linkage between CPT coding and this new payment methodology.

The same rigorous editorial process applies not only to development of CPT codes but also to the development of modifiers, instructions and guidelines contained in the CPT Book. The CPT Editorial Panel and the CPT Advisory Committee consider CPT section guidelines, specific code level instructions and definitions, and the application of modifiers at the same time the language for CPT code descriptors is developed. Thus, proper use of CPT codes must be based on all the associated material contained in the CPT Book. For example, “simple, intermediate, and complex repair” are defined in the CPT Book prior to the actual repair codes so that users understand the circumstances for reporting each. The use of codes and descriptors apart from this information limits the functionality of CPT coding and its uniform application and contributes to improper coding interpretations, which is counter to the purpose of having national standard code sets.

CPT coding incorporates modifiers as an integral part of its structure. The use of modifiers allows CPT codes to be adapted for different situations without unduly expanding the code set or making it overly complex. Modifiers provide a means to demonstrate that a service or procedure was altered by specific circumstances, but not changed in its definition or code. The service or procedure remains the same, but the circumstances of its delivery were altered. Modifiers are explained in detail in the CPT Book and other CPT related coding products published by the AMA such as *CPTAssistant* and *Principles of CPT Coding*. The ability of all users to recognize and accept CPT modifiers is important for the implementation of the CPT coding system. While acceptance of CPT modifiers is important, the subsequent step involving interpretation of modifiers in a manner that is consistent with established CPT guidelines is also critical.

### Conclusion

Based on the information provided above, we trust that HCSC health plans will immediately change their practices of bundling and downcoding CPT codes and/or rejecting accurately coded physician claims when the appropriately designated CPT modifiers are appended.

Similarly, the AMA requests that HCSC health plans discontinue their current practice of referencing CPT codes, guidelines or conventions as justification for denying compensation for the care provided given HCSC health plans’ apparent misunderstanding of common CPT usage. HCSC health plans’ practice of reassigning and rebundling CPT codes potentially puts physicians in the position of being held accountable for HCSC’s erroneous coding and claims processing.

Enclosed for your information and education are the current version of the CPT Book, *Principles of CPT Coding*, *CPT Changes*, and the CPT Process booklet. These items provide HCSC health plans with comprehensive information about the entire CPT process, as well as provide specific guidance for the appropriate uniform use of CPT codes, guidelines and conventions.

While the undersigned medical associations recognize that HCSC health plans, as do all payors, institutes its own payment system based upon its own policies, procedures and administrative guidelines, denials for payment using CPT coding as justification (when misapplied by HCSC health plans) are entirely inappropriate. We will continue to monitor complaints and actively confront the misapplication of CPT codes, guidelines and conventions by health plans and other entities by seeking to educate those who misapply such codes, guidelines and conventions.

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Should you have questions related to this correspondence, please call the office of Michael D. Maves, MD, MBA, Executive Vice President and Chief Executive Officer, AMA, at 312-464-5000.

Sincerely,

American Academy of Otolaryngology – Head and Neck Surgery  
American College of Physicians - American Society of Internal Medicine  
American College of Radiology  
American Medical Association  
American Society for Gastrointestinal Endoscopy  
American Society for Surgery of the Hand  
College of American Pathologists

Enclosures