**AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY**

**RESPONSE TO PRIVATE PAYER POLICY REIMBURSING 50% of E/M SERVICES PERFORMED WITH CONCURRENT PROCEDURE**

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Recently the American Academy of Otolaryngology-Head and Neck Surgery (the Academy) learned of a private payer's policy to reimburse evaluation and management (E/M) services at a 50% rate when a significant, separately identifiable E/M service (appended with the 25 modifier) and surgery / diagnostic procedural services are performed on the same day. The Academy strongly believes that this policy is inconsistent with Centers for Medicare and Medicaid Services' (CMS) reporting rules and AMA Current Procedural Terminology (CPT) codes, guidelines and conventions. The Academy realizes payers develop their own reimbursement policies but those that adopt the resource-based relative value scale (RBRVS) methodology should adhere to those relative values, global surgical periods, use of modifiers, and the National Correct Coding Initiatives (NCCI) edits. Otherwise, physicians are not being reimbursed fairly for the procedures and services they perform. Otolaryngologists must be fully reimbursed for evaluation and management services given the fact they frequently perform such services, especially for new patients, with procedures on the same date of service. Performing both an E/M service along with an endoscopy, flexible laryngoscopy, excision of lesion, biopsy, removal of a foreign body, or control of epistaxis are medically necessary and should be reimbursed accordingly.

As the **Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.6** Reads:

> *CPT Modifier "-25" –Significant Evaluation and Management Service by Same Physician on Date of Global Procedure*
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> *Medicare requires that Current Procedural Terminology (CPT) modifier -25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. Carriers pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier -25 is added to the E/M code on the claim.*
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> *Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified non-physician practitioner in the patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.*

Further, the 2012 AMA CPT Manual states:

> ***"Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service:*** *It may be necessary to indicate that on the day a procedure or service indentified by a CPT code was performed, the patient's condition required a significant, separately identifiable 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. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining the level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in the decision to perform surgery."* (Appendix A, page 567)

Finally as an example of our expectation, a Medicare Administrative Contractor (MAC), TrailBlazer Health Enterprises (TrailBlazer) clarifies in its Evaluation and Management Services manual (published in November of 2011) under primary considerations for modifier 25 usages:

> "*Why is the physician seeing the patient?*
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> *"If the patient exhibits symptoms from which the physician diagnoses the condition and begins treatment by performing a minor procedure or an* ***endoscopy*** *on that same day, modifier 25 should be added to the correct level of E/M service*."

Notably, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) in developing its valuation database for various procedures **does not include work that overlaps with an evaluation and management service.** Traditionally, the RUC's deliberations minimize overlapping work and practice expense when determining value for various procedures. Thus, private payers that use this resource-based relative value scale (RBRVS) system for reimbursement should fully pay for the E&M services as well as the primary procedure since there is minimal, if any, overlapping work; certainly, a 50% cut of the E&M service is inconsistent with this methodology.

We believe the AMA, CMS and TrailBlazer wrote these guidelines in effort to give the patient more convenient treatment options after an evaluation and management service is performed. As such, the Academy and its members expect that private payers will follow the intent of the CPT codes and the RVU system by incorporating reimbursement policies that are consistent with these AMA and CMS policies and always fully reimburse, across all specialties, for all E/M services rendered with a concurrent procedure and billed with the 25 modifier. To fail to do so would not be consistent with the RVU values.