

November 9, 2005

Mr. Edward H. Hanway
Chairman and Chief Executive Officer
CIGNA Corporation
One Liberty Place
Philadelphia, PA 19192-1550

Re: Adoption of Current Procedural Terminology (CPT) guidelines, rules,
and conventions:
Preventive and problem-oriented Evaluation and Management
(E/M) visits

Dear Mr. Hanway,

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 94,000 physicians and medical students nationwide, I am writing to ask that **CIGNA** follow the use of CPT as published by the American Medical Association (AMA). In particular, the intent of this letter is to focus on the inappropriate bundling of a preventive medicine and problem-oriented E/M service on the same date of service.

CPT is very clear on this point. In the guidelines preceding the Preventive Medicine Services codes, CPT states:

If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, **then the appropriate Office/Outpatient code 99201-99215 should also be reported.** Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. **The appropriate preventive medicine service is additionally reported.**

The intent of CPT in this regard is reinforced in an article describing the change to the descriptor for modifier 25 is important, which appeared in the *CPT Assistant* Winter 1994 edition. It states:

“In the past, coders asked how to report a preventive medicine visit when a problem or abnormal finding was encountered and addressed at the same visit. In CPT® 1995, the revised guidelines give instructions as to how both these services are reported when provided as part of the same visit.

You will note that the problem or abnormality that is encountered must require additional work and the performance of the key components of a problem-oriented E/M service in order for the two E/M services (preventive medicine and problem-oriented visit) to be reported on the same day.

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: The physician may need 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 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. This circumstance may be reported by adding the modifier '-25' to the appropriate level E/M service, or the separate five digit modifier 09925 may be used.

The description associated with modifier -25 has been revised to accommodate the reporting of two E/M services on the same day: “... by the same Physician on the Same Day of the Procedure or other service...” and “... separately identifiable E/M service above and beyond the other service provided or beyond...”

Thus, there is no question what the intent of CPT is in the appropriate use of modifier 25 when treating a patient for a problem-oriented E/M and a preventive service on the same date.

We are aware that many private payers use the proprietary code editing logic software supplied by McKesson Solutions and that this software otherwise bundles a preventive and problem-oriented E/M service provided by the same physician to the same patient on the same date. Some payers argue that if this bundling logic is removed, physicians will try to take financial advantage of them by always finding a medical problem during a routine physical, annual gynecological exam, or preventive visit.

We believe it is false to assume that physicians are motivated by reimbursement when treating a patient's condition that is unrelated and separately identifiable to a preventive visit. In fact, the motivation of many physicians in this situation is to not inconvenience your members [patients] when seeking care for preventive services by asking them to return on another date to discuss a problem/acute condition. Typically, physicians in this situation perform both E/M services, await the explanation of benefits statement that indicates the problem E/M is being bundled or “incidental to” the preventive service. They subsequently, write-off of the cost of providing the second, problem-oriented office visit, since physicians are usually prohibited under contract to balance bill the member. From our perspective, this is an unfair business practice amounting to nothing more than your members [patients] receiving free care. Both appropriately documented and billed services deserve to be paid either directly by the patient and/or health plan.

We are cognizant that the work involved addressing the problem-oriented visit must be significant in order to be considered reportable. The AAFP expends tremendous time and energy educating members on proper coding through in-person trainings and articles in its *Journal of Family Practice Management*. In addition, members can contact our coding department for specific questions.

The best and easiest solution is for payers to follow the CPT guidelines and conventions, including modifiers, and update their payment policy to allow for the payment of a preventive and a problem-oriented E/M service on the same date of service. It is

understandable that if patients' health benefit plan does not include a preventive service benefit, s/he will be financially responsible for this service, but the bundling logic must be removed to allow the physician to directly bill the patient for the medical care delivered.

If, after the removal of the code edit, a payer remains concerned about potential abuse, it could perform an audit of physicians who have billed an extraordinarily high percentage of claims with two E/M codes on the same date of service when compared to peers within the same specialty and marketplace. Payers could send notification as such to outlier physicians.

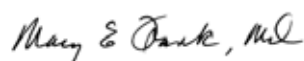
Inaction on this issue is unacceptable. The physician-patient and employer-employee relationships are strained as a result. In the current environment, physicians, who want to practice efficient, high-quality care, ask the patient who presents a health issue during a scheduled preventive service visit to make a second appointment for either the preventive or problem-oriented service. This causes fragmentation of care and increases the patient's need for time away from work, which leads to lower productivity for the employer. In addition, it causes another claim to be filed to the payer, which is an additional administrative expense.

Aetna has stepped forward in accepting feedback from the physician community and is changing its payment policy, effective February 2006, to allow for two E/M codes on the same date of service. When Aetna's Chief Medical Officer, William C. Popik, M.D., was asked by Decision Health why Aetna was changing its payment policy to allow payment for a preventive and problem-oriented service on the same date of service, he simply responded because, "it's the right thing to do."

We ask CIGNA to do "the right thing" too by adopting the CPT guidelines and conventions including modifiers and by updating CIGNA's code editing remarks accordingly to allow for the payment of preventive and a problem-oriented E/M service on the same date of service. This issue has existed unnecessarily for far too long, to the disadvantage of both physicians and patients.

Thank you for your time and consideration of this request. We look forward to you rectifying this issue and to working with you on other claims editing logic that varies from CPT. If you have any questions about this matter, please contact Mr. Trevor Stone, the AAFP's Private Sector Advocacy Manager, at 1-800-274-2237, extension 4178, or at tstone@aafp.org

Sincerely,



Mary Frank, M.D., FAAFP
Board Chair