REPORT 07 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Reporting Multiple Services Performed During a Single Patient Encounter
(Resolution 824-I-22)

EXECUTIVE SUMMARY

At the 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22, which asked the American Medical Association to recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter.

"Multiple services" can refer to two evaluation and management (E/M) services, a procedure plus an E/M service, or two or more procedures provided by the same physician during a single patient encounter, all of which can be appropriately reported with the existing Current Procedural Terminology (CPT®) nomenclature. CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. While CPT includes several modifiers, the one most commonly reported for multiple services is modifier 25, which is appended to an E/M service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service. Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient's condition to be appropriately reported and, therefore, appropriately paid.

Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of providing, documenting, reporting, and paying for multiple services. This can be confounded further by use of electronic health records (EHR), which can make it difficult to ensure accurate data if codes and medical terms are not used consistently. Therefore, it becomes imperative that both physicians and payers are well educated on the appropriate way to report multiple services as well as the circumstances that justify such reporting. It is also important that the CPT guidelines used to recognize the validity of claims for multiple services are consistently applied, which may be facilitated by the development of EHR tools.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 07-A-23

Subject: Reporting Multiple Services Performed During a Single Patient Encounter (Resolution 824-I-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

At the November 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22, which was sponsored by the Private Practice Physicians Section. Resolution 824-I-22 asked the American Medical Association (AMA) to recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter. Testimony at the November 2022 Interim Meeting regarding the resolution was mixed, with some speakers offering vignettes to support the need for Resolution 824-I-22 and others questioning the need for it given recent revisions to Current Procedural Terminology (CPT®) Evaluation and Management (E/M) codes that allow physicians to report encounters involving multiple services during a single patient encounter. This report focuses on the need for education of physicians and payers on appropriate reporting of multiple services using CPT nomenclature, provides a snapshot of strategies insurers use to deny claims, highlights AMA advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

As outlined in Resolution 824-I-22, “multiple services” can refer to two E/M services, a procedure plus an E/M service, or two or more procedures provided by the same physician during a single patient encounter. CPT is the most widely accepted US medical nomenclature for reporting singular or multiple medical services and procedures under public and private health insurance programs. In addition to being the code set adopted under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) for outpatient services and procedures[1], CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. The use of modifiers provides supplementary information for payer policy requirements.

While CPT provides a valid way to report multiple services, the resulting claims can result in high rates of denials. Payers may flag all multiple services claims for prepayment claim validation prior to payment or require submission of documentation with the claim, both of which create unjustifiable administrative burden for physicians, an incumbrance exacerbated in rural communities and other areas with limited health care resources. Addressing rural health inequities is a cornerstone of the Centers for Medicare & Medicaid Services’ (CMS) effort to improve health

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equity,[2] a goal that can be achieved by consistent application of CPT across all payers given its ability to promote health equity.[3]

Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of providing, documenting, reporting, and paying for multiple services. This can be confounded further by use of electronic health records (EHR), which can make it difficult to ensure accurate data if codes and medical terms are not used consistently. Therefore, it becomes imperative that both physicians and payers are well educated on the appropriate way to report multiple services as well as the circumstances that justify such reporting. It is also important that the CPT guidelines used to recognize the validity of claims for multiple services are consistently applied, which may be facilitated by the development of EHR tools.

MODIFIER 25

CPT modifier 25 is appended to an E/M service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service.[4] Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient's condition to be appropriately reported and, therefore, appropriately paid. The CPT Professional Edition also states that 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.[5] While CPT does not outline required documentation for modifier 25, its use indicates that documentation is available in the patient's record to support the reported E/M service as distinct and separately identifiable. Further, 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.

There are two scenarios where modifier 25 is typically used:

1) A Preventive Medicine E/M service provided with a problem-oriented Office or Other Outpatient E/M service:

   This is a common scenario in pre- or non-verbal patients. For example, a 2-year-old is seen for their well child visit and the physician finds otitis media during the physical examination. When a significant problem is encountered while performing a Preventive Medicine E/M service, requiring additional work to perform the key components of the E/M service, the appropriate Office or Other Outpatient E/M code also should be reported for that service with modifier 25 appended. Modifier 25 allows separate payment for these visits without requiring documentation with the claim form.

2) A minor surgical procedure provided with a problem-oriented Office or Other Outpatient E/M service:

   CPT codes for minor surgical procedures include preoperative evaluation services (i.e., assessing the site or problem, explaining the procedure, risks, and benefits, and obtaining consent). Therefore, the E/M service has to involve work "above and beyond" the preoperative evaluation services. For example, when a patient presents with a head laceration, and the physician also performs a neurological examination before repairing the laceration, the neurological exam would merit a separate E/M service reported with modifier 25.

The CPT Professional 2023 codebook definition of a significant, separately identifiable service relies on satisfying the relevant criteria for determining the correct level of E/M service to be reported. The following questions can be used to determine whether an E/M service justifies use of modifier 25 according to CPT guidelines:

- Did the physician perform and document the level of medical decision making or total time necessary to report a problem-oriented Office or Other Outpatient E/M service for the complaint or problem?
- Could the work to address the complaint or problem stand alone as a billable service?
- Did the physician perform extra work that went above and beyond the typical pre- or postoperative work associated with the procedure code?

If all answers are "yes," then use of modifier 25 is consistent with CPT guidelines.

CMS requires that modifier 25 be used:

- Only on claims for E/M services and
- Only when the E/M service is provided by the same physician on the same day as another procedure or service.

While these two requirements are consistent with CPT guidelines, Medicare policy is more restrictive in that it will not pay for more than one E/M service provided by the same physician on the same day unless the visits are for unrelated problems and could not be provided during the same patient encounter. For example, Medicare will not pay separately when a patient is seen for their annual preventive checkup and the physician finds otitis media during the physical examination – even with the use of modifier 25. However, Medicare will pay for a patient who presents for blood pressure medication evaluation and then returns five hours later that same day for evaluation of leg pain following an accident – if modifier 25 is used.

Under certain circumstances, Medicare will allow use of modifier 25 when an E/M service is reported with a global procedure. Global procedures include visits and other physician services provided within 24 hours prior to the service, provision of the service, and visits and other physician services for a specified number of days after the service is provided.

CMS defines global surgical packages based on the number of postoperative days it assigns to the service:

- XXX: Global period does not apply
- 0-day global period: Includes procedure and visit on day of procedure
- 10-day global period: Includes procedure, visit on day of procedure, and visits 10 days immediately following the day of the procedure
- 90-day global period: Includes procedure, visit on day of procedure, and visits 90 days immediately following the day of the procedure

Modifier 25 may be appended to E/M services reported with minor surgical procedures (i.e., 0-day and 10-day global periods) or procedures not covered by a global period (i.e., XXX). Since minor surgical procedures and XXX-global procedures include pre-service, intra-service, and post-service work inherent in the procedure, the physician cannot report an E/M service for this work in most circumstances when the minor surgical procedure or XXX-global is the primary procedure. Furthermore, Medicare policy prevents the reporting of a separate E/M service for the work associated with the decision to perform a minor surgical procedure.

All E/M services provided on the same day as a procedure are considered part of the procedure and Medicare only makes separate payment if an exception applies. Modifier 25 is used to provide

1 justification for a visit that is "generally not payable," as Medicare payment is made only if the
2 physician indicates that the service is for a significant, separately identifiable E/M service that is
3 above and beyond the usual pre-service and post-service work required on the day of the
4 procedure. Modifier 25 may be used in the rare circumstance of an E/M service the day before a
5 procedure which represents a significant, separately identifiable service; it typically is linked to a
6 different diagnosis than the underlying reason for the procedure (e.g., evaluation of a cough that
7 might contraindicate surgery).[6] Medicare requires that the physician appropriately and sufficiently
8 document both the medically necessary E/M service and the procedure in the patient's medical
9 record to support the claim for these services, even though the documentation is not required to
10 submit with the claim.[7]
11
12 CMS has focused on the potential misuse of modifier 25 since 2005, when the Office of the
13 Inspector General (OIG) published an analysis indicating that 35 percent of Medicare claims
14 involving modifier 25 did not meet CMS requirements.[8] Since that time, both Medicare and private
15 payers have increased their scrutiny of claims submitted with modifier 25, which has led to
16 substantial recoupment of physician payments. The OIG continues to maintain modifier 25 as a
17 target of its work plan and is expected to release a report of modifier 25 use in dermatology in late
18 2023.
19
20 OTHER CPT MODIFIERS USED FOR REPORTING MULTIPLE SERVICES
21
22 In addition to modifier 25, CPT includes other modifiers to allow the reporting of multiple
23 services:[9]
24
25 - Modifier 24: Unrelated E/M service provided by the same physician or other qualified
26 health care professional during a postoperative period
27 - Modifier 51: Multiple procedures, non-E/M procedures provided by the same individual at
28 the same session
29 - Modifier 57: Decision for surgery, an E/M service that resulted in the initial decision to
30 perform surgery
31 - Modifier 58: Staged or related procedure or service by the same physician or other
32 qualified health care professional during the postoperative period
33 - Modifier 59: Distinct procedural service, an independent non-E/M service performed on
34 the same day Modifier 59 is used to identify non-E/M procedures/services that are not
35 normally reported together but are appropriate under the circumstances. Documentation
36 must support a different session, different procedure or surgery, different site or organ
37 system, separate incision/excision, separate lesion, or separate injury (or area of injury in
38 extensive injuries) not ordinarily encountered or performed on the same day by the same
39 individual. Modifier 59 should only be used if no more descriptive modifier is available,
40 and the use of modifier 59 best explains the circumstances.
41 - Modifier 78: Unplanned return to the operating/procedure room by the same physician or
42 other qualified health care professional following initial procedure for a related procedure
43 during the postoperative period
44 - Modifier 79: Unrelated procedure or service performed by the same physician or other
45 qualified health care professional during the postoperative period

CPT CODES AND GUIDELINES THAT FACILITATE THE REPORTING OF MULTIPLE SERVICES

Prolonged Service

There are Prolonged Service CPT codes that permit the reporting of time spent beyond the highest time in the range of total time of the primary E/M service. Prolonged Service CPT codes are reported in 15 minute increments, allowing physicians to be paid for providing extended services during a single patient encounter (even if the time on that date is not continuous) that contribute toward the total time of the visit.

The AMA is currently advocating to align CMS's interpretation of the Prolonged Service codes with the CPT definition as described above. Medicare, however, requires that the physician surpass the maximum time of the highest E/M level by 15 minutes. Until such time that CPT and CMS interpretations are reconciled, Medicare requires reporting of Healthcare Common Procedure Coding System Level II codes in lieu of CPT codes for reporting prolonged services.

Care Management

Care Management CPT codes are E/M codes reported monthly for physician oversight and management of clinical staff in the development and implementation of the care plan and care coordination in patients with one or more complex chronic conditions. Care Management codes can be reported in addition to other E/M codes (e.g., Office or Other Outpatient Services). Time that is spent providing services within the scope of the Care Management service on the same day as an E/M visit can be counted towards Care Management codes, as long as the time is not counted towards the other reported E/M code(s).

Total Visit Time Versus Medical Decision Making

E/M codes are selected based on either the total time spent or medical decision making (MDM) required. The decision of which component to use in selecting the appropriate E/M code is determined by the reporting physician or qualified health care professional based on the available criteria.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. There are three elements to MDM:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Time is based on the total time spent on the date of the encounter. It includes both face-to-face time with the patient and non-face-to-face time spent on things such as care coordination, consulting with other health care professionals, and ordering medications, tests, and procedures.

Caring for a patient with multiple issues is likely to increase the total time of the encounter, which may allow the physician to report a single, higher level E/M code rather than two lower level E/M codes appended with modifier 25.

RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS)

CMS considers recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC) process to determine relative value units (RVUs) for the RBRVS. The RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services and is intended to improve and stabilize the payment system while providing physicians an avenue to continuously improve it. Determining RVUs through the RUC ensures that potential overlap is eliminated from the physician work, practice expense, and professional liability insurance (PLI) for services that are frequently provided together. The physician work component accounts for an average of 51 percent of the total RVU for each service while practice expense accounts for 45 percent. PLI accounts for the remaining four percent. The factors used to determine physician work include the time it takes to perform the service, the technical skill and physical effort, the required mental effort and judgment, and stress due to the potential risk to the patient. The practice expense components include clinical staff time, medical supplies, and medical equipment.

The process of valuing CPT codes on the RBRVS contributes to determining whether use of modifier 25 is warranted. Global procedure CPT codes are valued to include pre-service (e.g., evaluation time, patient positioning, scrub/dress/wait time), intra-service (e.g., performing the procedure, also known as "skin-to-skin" time), and post-service (e.g., patient stabilization, communicating with the patient and other professionals) work.

For example, Medicare payment for CPT code 64635 (*Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint*), includes 28 minutes pre-service time. Reporting a problem-oriented Office or Other Outpatient E/M code in addition to CPT code 64635 when evaluation is limited to assessing the specific problem is essentially double billing for the pre-service evaluation. Therefore, use of modifier 25 would not be appropriate in this situation.

However, when a patient presents for their annual skin examination and a suspicious lesion is discovered, it is appropriate for the physician to proceed with a diagnostic or therapeutic procedure at the same visit after obtaining the patient's medical history, completing a review of systems, and conducting a clinical examination. This situation would warrant the use of modifier 25. The ability to assess and intervene during the same visit is optimal for patients who subsequently may require fewer follow-up visits and experience more immediate relief from their symptoms.

MULTIPLE PROCEDURE PAYMENT REDUCTIONS

In addition to two E/M services or a procedure plus an E/M service, "multiple services" can refer to two or more procedures provided by the same physician during a single patient encounter. Payers may utilize the CMS Multiple Procedure Payment Reduction (MPPR) policy to adjudicate claims involving more than one procedure.

Under the MPPR, Medicare makes full payment for the professional component (PC) and technical component (TC) of the highest priced procedure. Payment is made at 95 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day.[10]

The rationale behind CMS' MPPR policy is similar to that of its global surgical package definitions in that "most medical and surgical procedures include pre-procedure, intra-procedure, and post-

procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work."[11]

CLAIMS ADJUDICATION AND COMPLIANCE

Policies on payment for multiple services during a single patient encounter are typically communicated via claims adjudication with the use of coding edits. Most private payers utilize customizable, propriety claims edit systems, while Medicare and Medicaid use the coordinated National Correct Coding Initiative (NCCI).

NCCI reinforces Medicare policies, and since it is common for private payers to adopt NCCI as part of their customizable claims editing systems, allowing physicians the opportunity to comment on NCCI takes on increased importance. Through a process coordinated by CMS and the AMA, national medical specialty societies are able to review and comment on proposed NCCI updates on a quarterly basis. In recent years, however, the NCCI review process has become less transparent and the AMA has continued to advocate toward a return to the "solid, transparent, collaborative track among all parties (CMS, AMA and specialty societies) that has been so beneficial in the past." (June 2021 letter, November 2021 letter)

Edits on code pairs may be overridden by appending the appropriate modifier on one of the codes. For example, NCCI includes an edit on the codes for vision screening (CPT code 99173) and a level 3 established patient Office or Other Outpatient visit (CPT code 99213) – but allows override of the edit with use of the appropriate modifier (i.e., modifier 25 appended to 99213). Payers' increased use of claims edits has resulted in a commensurate increase in physicians' use of modifiers in an effort to override restrictive payment polices. However, that strategy may backfire as some payers' code auditing processes will flag all claims billed with modifier 25 for prepayment claim validation prior to payment. Once a claim is validated, it is either released for payment or denied for incorrect use of the modifier. 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. If claim history or assigned diagnosis codes do not indicate that significant, separately identifiable services were performed, payers typically cover the primary procedure or other service and deny the secondary E/M billed with modifier 25.

Some payers have instituted policies where use of modifier 25 triggers an automatic reduction in payment for the second code to account for what they perceive to be "overlap" between the two codes (e.g., a Preventive Medicine Service E/M code reported with an Office or Other Outpatient Service E/M code appended with modifier 25 allows payment of the Preventive Medicine Service code at 100 percent and the Office or Other Outpatient code at 50 percent). While the work associated with performing the history, physical examination, and MDM for the problem-oriented E/M service may include some overlap with those performed as part of the comprehensive preventive medicine E/M service, the physician's use of modifier 25 signals that they performed a significant, separately identifiable problem-oriented E/M service. An insignificant or trivial problem or abnormality is not reported separately from the preventive medicine E/M service.

Reporting both preventive and problem-oriented E/M services during a single patient encounter can produce inconsistent results in terms of claims payment across payers. While some payers will pay the full allowable amount for both the problem-oriented E/M code and the preventive medicine services E/M code, some will assess a co-pay for each service, some will carve out the payment for the problem-oriented E/M service from the payment for the preventive medicine E/M service (which results in a total charge that does not exceed that of a comprehensive preventive

examination alone), and some will reject the claim on the basis that they do not accept coding for both a preventive and problem-oriented service on the same date regardless of the amount of the charge due to the perception of overlap between the two services. In response, physicians may decide to report only one of the services, depending on which of the two is the primary focus of the visit and requires the most amount of physician time and work; however, this is not a tenable solution as it fails to recognize the value of services provided. Alternatively, the physician may ask the patient to return for another visit to address the management of the problem or the preventive care; however, many physicians are hesitant to do this as it places significant burden on patients, particularly those with limited resources, and may risk deterioration of the patient's condition until another appointment can be scheduled.

Certain payers have considered requiring documentation for all modifier 25 claims. Most recently, Cigna proposed a policy requiring practices to send documentation with "a cover sheet indicating the office notes support the use of modifier 25 appended to the E/M code."[12] While advocacy by the California Medical Association and the AMA was initially able to delay implementation, Cigna has re-released the policy, which was scheduled to become effective in May 2023. At the time this report was written, the AMA was preparing a sign-on letter to allow state medical associations and national medical specialty societies to join in opposition against Cigna's policy. Previous AMA advocacy efforts opposing proposed modifier 25 payment reductions by Anthem (November 2017) and UnitedHealthcare (July 2018) have proven successful.

Misunderstanding and/or misuse of modifier 25 has made it a top billing compliance risk area. It has been the focus several False Claims Act and civil monetary penalty settlements,[13] as well as CMS comparative billing reports (CBR). The CMS CBR program is an educational tool intended to encourage accurate reporting and support physicians' internal compliance activities. A CBR tracks a given physician's billing patterns as compared to their peers' patterns within a Medicare service area. Since CBRs are private and shared only with the physician, CMS is able to maintain that "receiving a CBR is not an indication of or precursor to an audit, and it requires no response on a provider's part."[14]

Compliance is impacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which only allows extrapolation of overpayments based on statistical sampling when there's "a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error."[15] If an audit does not use a random sample of claims, MMA dictates that extrapolation of that sample invalidates any claim of overpayment.

AMA POLICY

The AMA has robust policy to guide advocacy for appropriate payment for multiple services performed during a single patient encounter.

Among the most relevant policies are those that:

- Focus on recognition of modifier 25 by:
    - Advocating for the acceptance of CPT modifiers, particularly modifier 25, and the appropriate alteration of payment based on CPT modifiers (Policy D-70.971);
    - Aggressively and immediately advocating through any legal means possible to ensure that when an E/M code is reported with modifier 25, that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate (Policy D-385.956);

  - Supporting insurance company payment for E/M services and procedures performed on the same day (Policy H-385.944); and
  - Advocating that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure (Policy D-70.959).

- Preserve discrete E/M code levels by:
  - Communicating to CMS and private payers that the current levels of E/M services should be maintained and not compressed, with appropriate payment for each level (Policy D-70.979) and
  - Opposing any health insurance code collapsing policies that result in unfair payment practices (Policy H-70.995).

- Combat bundling and downcoding by:
  - Opposing the bundling of procedure and laboratory services within the E/M services (Policy H-70.985);
  - Opposing the use of time elements to deny or downgrade services submitted based on a cumulative time (Policy H-70.976);
  - Advocating to ensure that public and private payers do not bundle services inappropriately by encompassing individually coded services under other separately coded services (Policy H-70.949);
  - Vigorously opposing the practice of unilateral, arbitrary recoding and/or bundling by all payers (Policy H-70.937);
  - Introducing or supporting legislation that would require managed care plans to be monitored and prohibited from the arbitrary and inappropriate bundling of services to reduce payment (Policy H-70.962); and
  - Working with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies (Policy
  - H-70.980).

AMA policy targets payer policies that deviate from CPT guidelines, such as those that:

- Oppose inappropriate bundling of medical services by third party payers (Policy D-70.983);
- Support the recognition and payment for all CPT codes by all third party payers (Policy H-70.974);
- Seek legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers (Policy H-70.954);
- Intensify efforts to ensure uniform application of coding principles (Policy H-70.986);
- Assure that CMS and local carriers appropriately reimburse all E/M services (Policy H-385.952);
- Develop national (state) standards and model legislation that require full disclosure in plain English of multiple procedure reimbursement policies (Policy H-285.946);
- Step up ongoing review of the proper use of CPT codes in medical billing claims payments by the US Health Insurance Industry (Policy D-385.949);
- Support the elimination of Medicare arbitrary visit frequency parameters (Policy H-280-974); and
- Pursue proper use of CPT codes, guidelines, and modifiers by software claims editing vendors and their customers (Policy H-70.927).

Given that CPT is copyrighted by the AMA, there are many policies that support the development, updating, and maintenance of clinically valid codes in order to accurately reflect current clinical practice and innovation in medicine, including those that:

- Work with CMS to continue to refine E/M coding (Policy H-70.961);
- Advocate that the Department of Health and Human Services designate CPT guidelines and instructions as contained in the CPT codebook and approved by the CPT Editorial Panel as the national implementation standards for CPT codes (Policy D-70.987); and
- Limit future efforts to substantially revise E/M codes to the CPT Editorial Panel (Policy H-70.921) to appropriately allow the accurate reporting of E/M services provided by all physicians (Policy H-70.982).

AMA policy advocates that payer policies must align with CPT guidelines and reduce the burden of documentation for E/M services (Policy H-70.952), including opposition to the requirement that all Level 4 or Level 5 E/M codes require submission of medical record documentation (Policy D-70.991). Furthermore, AMA policy indicates that payer audit tools must be based on the factors for arriving at complexity as defined in the CPT codebook (Policy H-70.918).

The AMA is invested in ensuring that CPT codes are appropriately valued on the RBRVS via the RUC process. AMA policy advocates that annually updated and rigorously validated RBRVS values should provide a basis for physician payment schedules, opposes CMS' policy that reduces payment for additional surgical procedures after the first procedure by more than 50 percent, and encourages third party payers and other public programs to utilize the most current CPT codes, modifiers, and RBRVS relative values (Policy D-400.999). CMS is urged to adopt RUC recommendations for new and revised CPT codes (Policy H-400.969).

AMA policy supports development of CPT educational programs for physicians and health insurance carriers (Policy H-70.993) and working with national medical specialty societies to educate their members concerning CPT coding issues (Policy H-70.973). Policy H-400.972 states that the AMA will take all necessary legal, legislative, and other action to assure that all modifiers are well publicized and include adequate descriptors.

In addition to advocating for compliance with CPT modifier 25 guidelines, AMA policy has addressed other relevant issues:

- Recognition of modifiers 54, 55, and 56 for postoperative care of surgical patients (Policy D-70.955) and modifier 26 to report the professional component separate from the technical component for the interpretation of laboratory tests (Policy D-70.957);
- Appropriate payment for office-based procedures (Policy H-330.925), emergency care (Policy H-130.978), telephone consultations (Policy H-390.889), counseling of serious medical problems (Policy H-385.977), diagnostic and laboratory panel tests (Policy H-390.923 and Policy H-70.950), vaccine administration (Policy D-440.937), consultations (Policy D-70.953 and Policy H-70.939), care plan oversight services (Policy H-70.960), and after hours services (Policy H-385.940);
- Delineation of the physician role and responsibility in supervising patient care in non-office ambulatory settings, including fair and equitable payment for those services (Policy H-70.991);
- Insurer recognition of CPT codes that allow primary care physicians to report and receive payment for physical and behavioral health care services provided on the same date of service (Policy H-385.915);

- Development of coding for non-physician services (Policy H-70.994); and
- Appropriate payment for the additional work and expenses required in treating patients during the COVID-19 pandemic (Policy D-390.947).

DISCUSSION

There is currently robust infrastructure to allow the reporting of multiple services during a single patient encounter. However, there may be a need to ensure that key stakeholders are well educated on the various reporting options. It is essential that both physicians and payers understand the nuanced concepts involved, such as existing CPT nomenclature, how the RUC process eliminates overlap of physician work and practice expense between services and procedures, and how appropriate reporting and payment for multiple services can lead to greater value to the patient, improved access to care, increased patient satisfaction, and improved overall patient care.

With the ongoing development of coding resources, it is imperative that CMS align with CPT guidelines in order to reduce potential confusion. For example, CPT and CMS do not presently agree on the interpretation of the Prolonged Service CPT codes, which have a direct bearing on physicians' ability to accurately report multiple services during a single patient encounter. This has resulted in many payers challenging physicians' use of the Prolonged Service codes or denying them all together. As such, the AMA is strongly advocating for alignment of CMS's interpretation of the Prolonged Service codes with the CPT definition. This approach is consistent with past AMA advocacy initiatives, most of which have been successful in reducing the gaps between CMS and CPT.

A comprehensive education on the appropriate reporting of multiple services should start early in physicians' careers, possibly during residency. A curriculum could focus on concepts such as how to use total visit time to report a higher-level E/M service rather than two E/M codes plus modifier 25, allowing them to bypass the administrative rigor imposed by payers who routinely flag modifier 25 claims. It would be ideal if a similar curriculum could be shared with, and undertaken by, the payer community, possibly through organizations such as America's Health Insurance Plans. With these potential resolutions, both "sides" would be cognizant of the guidelines, fostering full transparency between claims submission and claims adjudication.

As of 2021, 78 percent of office-based physicians used certified EHR systems.[16] Most EHRs include software tools to help physicians determine the appropriate E/M codes for patient encounters and when used correctly, they support accurate coding. However, these EHR-based computer-assisted E/M coding (CAEMC) tools are generally associated with higher levels of E/M coding due to factors such as "cloning" of documentation from the previous visit, which may contribute to restrictive payer policies that require burdensome documentation in order to justify payment. OIG is concerned about EHRs "aiding" providers with coding and documentation decisions, but there has been limited testing of how EHRs capture and use information to recommend E/M codes.

EHR CAEMC tools are limited in their ability to assist physicians in documenting and reporting multiple services. As such, it may be beneficial for EHR CAEMC tools to be developed to facilitate the appropriate reporting of modifier 25. Such tools might include an algorithm to ascertain the potential areas of perceived overlap between two services, which could then be synchronized to the documentation provided for each service.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 824-I-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support mechanisms to report modifiers appropriately with the least administrative burden possible, including the development of electronic health record tools to facilitate the reporting of multiple, medically necessary services supported by modifier 25. (New HOD Policy)

2. That our AMA support comprehensive education for physicians and insurers on the appropriate use of modifier 25. (New HOD Policy)

3. That our AMA reaffirm Policy D-70.971, which advocates for the acceptance of Current Procedural Technology (CPT®) modifiers, particularly modifier 25, and the appropriate alteration of payment based on CPT modifiers. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-385.956, which directs the AMA to aggressively and immediately advocate through any legal means possible to ensure that when an evaluation and management (E/M) code is reported with modifier 25, that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-385.944, which supports insurance company payment for E/M services and procedures performed on the same day. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-70.959, which advocates that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Centers for Medicare & Medicaid Services. Administration Simplification Code Set Basics. Available at: https://www.cms.gov/files/document/code-sets.pdf.
[2] Centers for Medicare & Medicaid Services. CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities; November 2022. Available at: https://www.cms.gov/files/document/cms-geographic-framework.pdf.
[3] American Medical Association. How the CPT code set can be used to help advance health equity; February 20, 2023. Available at: https://www.ama-assn.org/practice-management/cpt/how-cpt-code-set-can-be-used-help-advance-health-equity?&utm_source=BulletinHealthCare&utm_medium=email&utm_term=022123&utm_content=NON-MEMBER&utm_campaign=article_alert-morning_rounds_daily&utm_uid=&utm_effort=.
[4] American Medical Association. CPT 2023 Professional Edition; ISSN: 0276-8283.
[5] Ibid.
[6] Centers for Medicare & Medicaid Services. Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.
[7] Ibid.
[8] Department of Health & Human Services, Office of the 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.
[9] American Medical Association. CPT 2023 Professional Edition; ISSN: 0276-8283.
[10] Centers for Medicare & Medicaid Services. CMS Manual System; Pub 100-04 Medicare Claims Processing; Transmittal 3578; August 5, 2016. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3578CP.pdf.
[11] Centers for Medicare & Medicaid Services. Medicare National Correct Coding Initiative Manual; Chapter 1 General Correct Coding Policies. Available at: https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf.
[12] Cigna Reimbursement Policy. Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service; August 13, 2022. Available at: https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/Notifications/Modifier_25_Significant_Separately_Identifiable_Evaluation_and_Management.pdf.
[13] Nina Youngstrom, "Health System Pays $6.4M to Settle Case On Pre-Surgery H&Ps; The CoP Is Not Billable," Report on Medicare Compliance 28, no. 41 (November 18, 2019); https://compliancecosmos.org/health-system-pays-64m-settle-case-pre-surgery-hps-cop-not-billable.
[14] Centers for Medicare & Medicaid Services. Comparative Billing Reports. Available at: https://cbr.cbrpepper.org/Home.
[15] Centers for Medicare & Medicaid Services. "Chapter 8 – Administrative Actions and Sanctions and Statistical Sampling for Overpayment Estimation," Medicare Program Integrity Manual, Pub. 100-08, revised October 9, 2020. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c08.pdf.
[16] Office of the National Coordinator for Health Information Technology. Adoption of Electronic Health Records by Hospital Service Type 2019-2021, Health IT Quick Stat #60. April 2022. Available at: https://www.healthit.gov/data/quickstats/adoption-electronic-health-records-hospital-service-type-2019-2021.