

October 16, 2002

John W. Rowe, MD
Chairman and Chief Executive Officer
Aetna, Inc.
151 Farmington Avenue
Hartford, CT 06156

Dear Dr. Rowe:

The undersigned medical organizations are deeply concerned about Aetna, Inc.'s 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 Aetna's misapplication of CPT codes, guidelines and conventions resulting in inappropriately denied payments to physicians and non-physician health care professionals 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 organizations oppose arbitrary and unilateral code-collapsing and recoding practices that result in unfair payment. We encourage third parties to accept physician and non-physician health care professional 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 and non-physician health care professionals 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, Aetna's 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 and non-physician health care professionals regarding Aetna's payment rates for certain services.

Aetna's Business Practices

Aetna's business practices are viewed by many physicians and non-physician health care professionals 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 Aetna.

A. Modifier -25 has been denied for the purpose of bundling. Examples include:

- preventive medicine services with problem-oriented E&M services;
- dipstick urinalysis with E&M services;
- colonoscopy with E&M services; and
- immunization administration with E&M services.

Instead of rewarding physicians and non-physician health care professionals for providing necessary patient care efficiently during the same visit, Aetna is penalizing physicians and non-physician health care professionals for providing quality, efficient care to patients that is consistent with current medical guidelines and standards. Having a patient come back for a subsequent visit for necessary care when this treatment could have been provided during the original visit jeopardizes quality patient care and safety, and threatens the patient-physician relationship.

B. Aetna has also repeatedly downcoded various CPT codes. Examples include:

- CPT code 10121 – which is a *complicated* incision and removal of foreign body or subcutaneous tissues; downcoded to CPT code 10120 – which is a *simple* incision and removal of foreign body or subcutaneous tissues;

- CPT code 53675 – which is catheterization, urethra; *complicated* (may include difficult removal of balloon catheter); downcoded to CPT code 53670 – which is catheterization, *simple*; and
 - CPT code 16025 – which is dressings and/or debridement, initial or subsequent, without anesthesia, *medium*; downcoded to CPT code 16020 – which is dressings and/or debridement, initial or subsequent, without anesthesia, office or hospital, *small*.
- C. There has been a lack of recognition or improper assignment of CPT modifier –59, which was developed for the Medicare National Correct Coding Initiative explicitly for the purpose of identifying services not typically performed together.
- D. In addition to the modifiers mentioned above, it has been brought to the AMA’s attention that there has also been a lack of recognition or improper assignment of the following CPT modifiers:
- CPT modifier –21, which is appended when additional time is needed and the service(s) provided is prolonged or otherwise greater than that usually required for the highest level of E&M service within a given category;
 - CPT modifier –22, which is appended when an unusual procedure is needed and the service provided is greater than that usually required;
 - CPT modifier –50, which is appended when performing bilateral procedures. Aetna appears to entirely deny the claim when this modifier is used, suggesting that the claim is a duplicate;
 - CPT modifier –51, which is appended when multiple procedures, other than E&M services, are performed at the same session by the same provider. For example, Aetna routinely denies endoscopic services performed on the same day;
 - CPT modifier –52, which is appended when a service or procedure is partially reduced or eliminated at the physician’s discretion;
 - CPT modifier –80, which is appended when identifying assistant surgeons.
- E. Aetna has denied entire claims when a modifier was appended to a CPT code, instead of processing the claim and requesting additional information on the service with the modifier appended.

2. Failure to recognize add-on codes by Aetna.

The “add-on” code concept in CPT applies only to add-on procedures/services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure. Add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code. All add-on codes found in CPT are exempt from the multiple procedure concept.

As an example, Aetna has failed to recognize add-on codes for myocardial perfusion imaging. We are concerned about Aetna’s current policy which only acknowledges wall motion study (CPT code 78478) or ejection fraction study (CPT code 78480), which may be submitted in addition to the perfusion studies (CPT codes 78460 – 78465). Furthermore, we have recently received reports that Aetna no longer acknowledges or accepts *either* the wall motion study or the ejection fraction study when performed with the perfusion study. The myocardial perfusion study, along with the ejection fraction and wall motion studies, are a quantitative assessment of left ventricular function which is exceedingly useful in the management of patients with known or suspected coronary disease in whom the nuclear studies are being conducted. The studies require additional images to be obtained, additional measurements and calculations to be made, and additional time for the physician to interpret and verify the calculations performed. There is significant practice expense in respect to clinical labor, time, medical supplies, and equipment when performing these studies. This additional practice expense is clearly recognized by Centers for Medicare and Medicaid Services (CMS) policy through its assignment of Relative Value Units (RVUs) as separate and distinct services.

There is absolutely no reason why Aetna should be refusing to acknowledge or accept these medically necessary services. The CPT book clearly and articulately identifies these services as separate and distinct and specifies that they are to be coded separately from the other nuclear codes and not bundled. Unlike Aetna’s current practice, all other major health plans of which we are aware, including Medicare carriers, acknowledge and accept these services.

3. Aetna’s multiple surgery reduction policy is not consistent with Medicare policy.

The AMA has received complaints that Aetna’s policy for multiple surgical procedures is inconsistent with Medicare payment policy. Medicare’s standard multiple surgery rule allows 100% of the global payment schedule for the highest valued procedure and 50% of the global payment schedule for the second through fifth procedures. The undersigned organizations strongly oppose any efforts by third-party payors and other public programs to redefine the CMS Medicare multiple surgery reduction policy.

4. Failure by Aetna to recognize and adopt policies for the submission of CPT codes.

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

- vertebral body, embolization or injection;
- routine venipuncture for collection of specimens;
- simple urethra catheterization;
- radiological supervision and interpretation;
- testing of the cognitive function of the central nervous system;
- screening test of visual acuity;
- office consultations for new and established patients; and
- care provided in the office after-hours, on weekends, and on holidays.

Basis and Function of CPT Codes, Guidelines, and Conventions

Aetna's failure to recognize and/or appropriately incorporate policies based on CPT codes, guidelines and conventions has resulted in physicians and non-physician health care professionals 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 from 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. Also, coding conventions, such as add-on codes, are explained in the guidelines. 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 *CPT Assistant* 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.

Due to the multiple complaints we have received, it appears Aetna does not fully recognize the importance of CPT add-on codes in further identifying and providing clarity to the actual provision of care provided to patients. Many procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes. Further, add-on codes do not need to be identified by CPT modifier –51, or reduced under multiple surgery reduction policy, since the work included is only the extra necessary intra-service work.

Conclusion

Based on the information provided above, we trust that Aetna will immediately change its practices of bundling and downcoding CPT codes and/or rejecting accurately coded physician and non-physician health care professional claims when the appropriately designated CPT modifiers and add-on codes are appended.

Similarly, the AMA requests that Aetna discontinue its current practice of referencing CPT codes, guidelines or conventions as justification for denying compensation for the care provided given Aetna's apparent misunderstanding of common CPT usage. Aetna's practice of reassigning and rebundling CPT codes potentially puts physicians and non-physician healthcare professionals in the position of being held accountable for Aetna's erroneous coding and billing practices.

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 Aetna 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 organizations recognize that Aetna, as with 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 Aetna) 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.

John W. Rowe, MD
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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 Dermatology Association
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Otolaryngology – Head and Neck Surgery, Inc.
American Academy of Pediatrics
American College of Cardiology
American College of Emergency Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Medical Association
American Podiatric Medical Association
American Society for Gastrointestinal Endoscopy
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Urological Association
College of American Pathologists
North American Spine Society
Society of American Gastrointestinal Endoscopic Surgeons
Medical Association of Georgia

Enclosures