CALIFORNIA MEDICAL ASSOCIATION

June 16, 2022

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Via email to Peter.welch@cigna.com and Eugene.rapisardi@cigna.com

RE: Cigna Modifier -25 Reimbursement policy update

Dear Mr. Welch and Rapisardi:

On behalf of the California Medical Association (CMA), representing nearly 50,000 physician and medical student members, we are writing to share our significant concerns with Cigna's recent reimbursement policy change regarding evaluation and management (E/M) services billed with modifier -25 and a minor procedure code. The policy change notice advises physicians that Cigna will begin requiring submission of medical records via fax for all claims billed with CPT codes 99212-99215 with modifier -25 and a minor procedure code effective August 13, 2022, and failure to submit records will result in a denial of the E/M service.

Cigna's policy change will result in significant, unnecessary administrative burden and compliance cost to physician practices, will disincentivize physicians from providing unscheduled services, is inconsistent with industry standards and CMS guidance, will create duplicate requests thus a waste of health care dollars, lacks clarity on product types impacted, and appears to violate California law.

Policy will create a significant, unnecessary administrative burden and cost to practices

The new Cigna policy is overly broad, requiring all physicians billing for office visit codes 99212-99215 with modifier -25 and a minor procedure code to submit medical records as a precondition for payment. This creates yet another unnecessary administrative burden on physicians that are using the modifier appropriately.

Additionally, based on physician practice feedback, this policy will impose an estimated cost of $3.29/per claim to produce the record and fax to Cigna, which will result in a net payment reduction. Again, this an unnecessary cost imposed even on physicians using the modifier appropriately.

This is valuable time that would be better spent scheduling and caring for patients and wastes scarce health care dollars, particularly when Cigna has not provided any basis or rationale for the policy change.

Disincentive for physicians to provide unscheduled services

This change effectively penalizes physicians for providing efficient, unscheduled care to Cigna enrollees. Many physicians hold appointment blocks open in their schedules to accommodate the 20 to 30 percent of patients that require same day procedures. This policy will change the way these physicians practice and will likely push physicians to no longer set aside this additional time in their schedules, instead requiring patients to return for another, separate visit to address the needed procedure and/or preventive visit, which will result in delays in care.

Inconsistent with professional society recommendations, CMS guidance and industry standards

According to Cigna's notice of policy change, when it reviews coverage, reimbursement, and administrative policies, it takes into consideration things such as evidence-based medicine, professional society recommendations, Centers for Medicare & Medicaid Services (CMS) guidance, industry standards and its other existing policies. However, CMA is not aware of any professional society recommendations to require records be submitted with all claims with an E/M service with modifier -25 and a minor procedure. CMA also is not aware of either CMS or other payers imposing this requirement, demonstrating this policy is not in line with industry standards. As such, it is unclear which criteria Cigna considered before making the policy change.

It does not appear that Cigna made any outreach to medical, specialty or other professional societies for feedback prior to implementation nor does the policy notice provide any basis or rationale for the policy change. Had Cigna followed its stated process and made outreach to these entities proactively, it would have allowed for a dialogue regarding the impacts of the policy prior to implementation.

Inconsistent with California law

This policy change appears to be inconsistent with Insurance Code section 10133.66(d)(2)(A) and Knox-Keene Regulation 28 C.C.R. section 1300.71(o)(2)(A) which require payment policies and rules used to adjudicate claims be consistent with "…standards accepted by nationally recognized medical societies and organizations" and "federal regulatory bodies…" CMA is not aware of any nationally recognized medical societies or organizations or federal regulatory

body (e.g., CMS) that recommend or otherwise supports the requirement to submit medical record as a condition of payment for all E/M services billed with modifier -25 and a minor procedure code.

Additionally, CMA is concerned the policy may violate the reasonably relevant information standard under Insurance Code section 10123.47(c) and Knox-Keene regulation 28 C.C.R. section 1300.71(a)(10). California law allows plans and insurers to request **reasonably relevant information** in support of a claim for reimbursement. Reasonably relevant information is defined under 28 C.C.R. section 1300.71(a)(10) as the minimum amount of material information necessary to determine liability and to comply with governmental information requirements. Additionally, a requirement in a provider contract that the provider submit medical records that are not reasonably relevant on three or more occasions over the course of any three-month period is deemed a demonstrable and unjust payment pattern (28 C.C.R § 1300.71(a)(8)(G).

Absent additional information from Cigna on the basis or rationale for the policy change, requiring records on all claims subject to the Cigna policy would appear to violate the standard of "reasonably relevant information" under California law.

Policy change notice lacks clarity of product types impacted

Nowhere in the notice does Cigna indicate which product types are impacted. CMA reached out to Cigna representatives and were recently advised it applies to all products, however that information has not been communicated to physician practices.

Policy will result in duplicate requests for records or improper denials

The policy change notification advises practices that medical records must be submitted to Cigna via fax, but that claims should continue to be submitted electronically and must have the attachment indicator selected.

The requirement to submit records **separately** from the claim forms will most certainly result in mismatched and lost records, which will either generate duplicate requests for medical records or improper denials if Cigna is unable to match the faxed attachment up to the electronically submitted claim form.

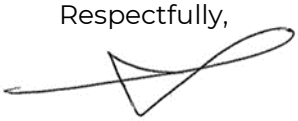
Besides the delay in payment, the process to resubmit the claim packet on paper, which includes printing a paper claim, printing or copying the record and submitting via mail, to ensure the record is properly matched with the claim, will cost physician practices $7.62/claim. If the claim is denied because of lost records, it will cost practices at least an additional $7.62/claim to print the claim form, create an appeal, attach the records and mail to Cigna to ensure the claims are paid, resulting in an additional net payment reduction.

This is a complete waste of health care dollars and practice time that would be better spent providing care to patients.

CMA has heard from several other physician organizations concerned with Cigna's modifier -25 policy, many of which have either contacted Cigna directly or are in the process of doing so to highlight the concerns and request the policy be rescinded. CMA stands ready with these organizations to discuss further with Cigna ways to address inappropriate use of the modifier through other means.

Accordingly, CMA urges Cigna to rescind the policy before it becomes effective. We believe a more collaborative approach to identify alternative methodologies for cost containment, including provider education on proper coding practices that do not bluntly penalize physicians using the modifier appropriately, will prove more effective and less costly in the long term. With the shift to value-based care, this is a time where plans and physicians should be identifying ways to work together. CMA welcomes that opportunity. If you have any questions or want to discuss this issue in more detail, please do not hesitate to contact CMA staff, including Jodi Black at 916-551-2863 or Mark Lane at 916-551-2865.

Respectfully,



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