April 18, 2023

David Cordani
Chairman and Chief Executive Officer
The Cigna Group
900 Cottage Grove Road
Bloomfield, CT 06002

Dear Mr. Cordani:

On behalf of the undersigned organizations representing physicians and health care professionals across the country, we request that Cigna immediately rescind its policy requiring submission of office notes with all claims including evaluation and management (E/M) Current Procedural Terminology (CPT®) codes 99212, 99213, 99214, and 99215 and modifier 25 when a minor procedure is billed. Cigna recently notified network providers that payment will be denied for E/M services reported with modifier 25 if records documenting a significant and separately identifiable service are not submitted with the claim. We share Cigna's belief that appropriate use of modifier 25 should be paid in full for both the E/M service and procedure, while inappropriate use of modifier 25 should be prevented. **We urge Cigna to reconsider this policy due to its negative impact on practice administrative costs and burdens across medical specialties and geographic regions, as well as its potential negative effect on patients, and instead partner with our organizations on a collaborative educational initiative to ensure correct use of modifier 25.**

Strong clinical basis for correct use of modifier 25

While the stated intent of this policy is to reduce inappropriate use of modifier 25, Cigna has not offered data demonstrating unexpectedly high use of the modifier or details of the underlying rationale, other than indicating it resulted from a review of "coverage, reimbursement, and administrative policies for potential updates" and in consideration of "evidence-based medicine, professional society recommendations, Centers for Medicare & Medicaid Services (CMS) guidance, industry standards, and/[or] . . . other existing policies." We question what standards or guidelines Cigna consulted in initiating this policy change, as the CPT description clearly states that modifier 25 enables reporting of a significant, separately identifiable E/M service by the same physician or other health care professional on the same day of a procedure or other service. The clinical vignettes included in a March 2023 CPT Assistant article[1] illustrate the strong clinical basis for use of modifier 25 to support effective and efficient care**. Indeed, by facilitating the provision of unscheduled, medically necessary care, modifier 25 supports prompt diagnosis and streamlined treatment—which in turn promotes high-value, high-quality, and patient-centric care.** In contrast, Cigna's policy creates a *disincentive* for physicians and other health care professionals to provide unscheduled services, which may force patients to schedule multiple visits (with additional co-payments) to receive necessary treatment.

We also object to language in Cigna's policy suggesting that appropriate use of modifier 25 requires that the E&M service address a "new" problem. ("The separate E/M service must be significant enough to require a separate service, i.e., address a new or distinct problem.") This conflicts with CMS guidelines *quoted in the Cigna policy* stating that, "The E/M service and minor surgical procedure do not require different diagnoses." **We request that Cigna remove this inaccurate statement from the policy, as it contradicts both CMS**

[1] American Medical Association. Reporting CPT Modifier 25. CPT®Assistant (Online). 2023;33(11):1-12. Available at: https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf.

and CPT guidelines indicating that an E/M service reported with modifier 25 does not need a different diagnosis than what was reported for the concurrent procedure.

Administrative Burden and Waste

Our organizations are alarmed by the significant administrative burdens and costs for health care professionals— and Cigna—that will result from implementation of this policy. By bluntly requiring clinical documentation for all claims for an E/M service reported with modifier 25, physicians and other providers will be forced to submit an enormous number of office notes, and Cigna will be deluged with medical records. Indeed, Cigna previously advised medical societies that only a small percentage (i.e., 10 percent) of submitted documentation would be reviewed under this program. This troubling admission demonstrates Cigna's awareness of the unmanageable volume of records in question and, more importantly, highlights the pointless administrative waste created by the policy.

Cigna's proposed data submission methods exacerbate these issues. The first option—a dedicated fax number—relies on paper-based, time-consuming technology that will involve major manual burdens for health care professionals and their staff. The alternative is an email address created for this program, use of which could jeopardize patients' privacy and health care professionals' compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements if the documentation is sent via unsecure email. **Of note, Cigna's policy notification to network providers makes no mention of the need to secure protected health information, placing both parties (health care professionals and Cigna) at risk of HIPAA noncompliance.** Implementing and maintaining a secure email system to comply with this documentation requirement would be costly and burdensome for physician practices and other providers. For email to be considered a valid option for sending records, Cigna should cover the implementation and maintenance costs associated with secure messaging to protect patients' privacy and ensure compliance with federal and state law.

The suboptimal data submission methods proposed by Cigna reflect the current lack of an electronic standard for clinical record exchange. Although CMS recently issued a proposed rule addressing electronic attachment transaction standards for claims,[2] timing for finalization of this rule is highly uncertain. In the meantime, the industry faces costly, manual data exchange methods that are divorced from the electronic claim—leading to inevitable reassociation problems, lost information, time-consuming data resubmission, and delayed claim payments. **All of these concerns underscore that Cigna's policy is extremely ill-timed and will further hamper health care professionals already grappling with clinician burnout, workforce shortages, recovery from the COVID-19 public health emergency, and rising practice expenses due to inflation.**

Opportunities for collaboration and education

Without clear justification for this policy or data suggesting inappropriate use of modifier 25 by network providers, we cannot specifically respond to Cigna's concerns leading to this program change. However, our organizations support correct use of modifier 25 and stand ready to collaborate with Cigna on a more rational (and far less burdensome) approach to ensure appropriate coding. We welcome the opportunity to partner with Cigna on a modifier 25 initiative that would entail:

[2] Administrative Simplification: Adoption of Standards for Health Care Attachments Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Transaction Standard. Available at: https://www.federalregister.gov/documents/2022/12/21/2022-27437/administrative-simplification-adoption-ofstandards-for-health-care-attachments-transactions-and.

1. **Targeted outreach:** While we appreciate Cigna's stated goal of paying in full for correct use of modifier 25 and support efforts to advance correct coding and documentation, we vigorously object to health plans penalizing all health care professionals—regardless of whether or not they code correctly—with blunt modifier 25 policies. Instead, we urge Cigna to selectively engage network providers with unexpected coding patterns in follow-up education and dialog.
2. **Education on correct coding:** Many of our organizations offer educational resources to our members on correct use of modifier 25, including a recently published CPT Assistant article.[3] We would be happy to work with Cigna on dissemination of these materials and/or collaborate on training activities.
3. **Limited documentation:** If Cigna persists with documentation requirements for E&M services reported with modifier 25, only network providers with consistent patterns of miscoding should be targeted.

Conclusion

We welcome the chance to collaborate with Cigna on alternative approaches to ensuring correct usage of modifier 25 that do not unfairly punish the majority of physicians and other health care professionals that appropriately code, as well as tax Cigna's administrative systems. If you would like to discuss this issue further, please contact Robert D. Otten, Vice President, Health Policy, American Medical Association, at 312-464-4735 or rob.otten@ama-assn.org.

Sincerely,

American Medical Association
American Academy of Allergy, Asthma & Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Pediatrics
American Academy of Sleep Medicine
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Oral and Maxillofacial Surgeons
American Association of Orthopaedic Surgeons
American Chiropractic Association
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Lifestyle Medicine
American College of Medical Genetics and Genomics

[3] American Medical Association. Reporting CPT Modifier 25. CPT®Assistant (Online). 2023;33(11):1-12. Available at: https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf.

American College of Obstetricians and Gynecologists
American College of Physicians
American College of Rheumatology
American College of Surgeons
American Epilepsy Society
American Gastroenterological Association
American Geriatrics Society
American Nurses Association
American Optometric Association
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Podiatric Medical Association
American Psychiatric Association
American Rhinologic Society
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Dermatopathology
American Society of Echocardiography
American Society of Interventional Pain Physicians
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Regional Anesthesia and Pain Medicine
American Society of Retina Specialists
American Thoracic Society
American Urological Association
American Venous Forum
Association for Clinical Oncology
Congress of Neurological Surgeons
Medical Group Management Association
North American Neuromodulation Society
North American Spine Society
Outpatient Endovascular and Interventional Society
Renal Physicians Association
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Cardiovascular Computed Tomography
Society of Interventional Radiology
Society of Thoracic Surgeons
Spine Intervention Society

Medical Association of the State of Alabama
Arizona Medical Association
Arkansas Medical Society

California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Nebraska Medical Association
Medical Society of New Jersey
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
Wisconsin Medical Society
Wyoming Medical Society