



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

**TESTIMONY IN SUPPORT OF H.1101 AND S.699
AN ACT RELATIVE TO FAIR AND EQUITABLE REIMBURSEMENT FOR MEDICAL
SERVICES
BEFORE THE COMMITTEE ON FINANCIAL SERVICES
SEPTEMBER 12, 2023**

The Massachusetts Medical Society (MMS) is a professional association of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. The MMS is committed to advocating on behalf of patients, to give them a better health care system, and on behalf of physicians, to help them provide the best care possible. To that end, the MMS wishes to be recorded in strong support for H.1101/S.699, *An Act Relative to Fair and Equitable Compensation for Medical Services*. This legislation would prohibit health insurers from reducing reimbursement for medical services when a modifier 25 code is employed.

Modifier 25 allows physicians to report a significant, separately identifiable Evaluation and Management service by the same physician on the same day of a procedure or other service. Being able to report and be appropriately compensated for providing both an Evaluation and Management service and procedure allows physicians to provide effective and efficient, high-quality care. In many cases this saves patients from needing to schedule a subsequent visit to address the issue, thereby eliminating unnecessary time and expense, including additional copayment and cost-sharing for patients. By addressing patient concerns in one visit, this helps patients and families avoid unnecessary trips to the physician's office and take less time out of work. This is what patient centered care is all about.

Unfortunately, in recent years many health insurers have implemented policies that create unnecessary barriers to efficient care and result in unwarranted claims denials, and which contribute to the growing administrative burdens impacting physician practices across the Commonwealth. Under such policies, when an E/M code with a modifier 25 and a procedure code are billed by the same provider for the same date of service, or when the patient had a follow up encounter within a defined period as the initial visit and the diagnosis codes overlap, the carrier will either deny reimbursement outright, or compensate the E/M service or procedure code at a reduction, typically 50% of the otherwise allowed amount. These policies contradict well-accepted coding conventions and guidelines, and as a result, inappropriately reduce reimbursement to numerous specialties including Primary Care Physicians, Dermatology, Otolaryngology, Urology, Orthopedic surgery, Podiatry, Rheumatology, Obstetrics/Gynecology, and Hematology/Oncology, among others.

To justify this payment reduction, some insurers contend that there is an overlap in expenses between E/M and procedure codes, and thus, a duplication of expense. This is not accurate and the MMS would like to clarify this misunderstanding of the code valuation process. The Relative Value Scale Update Committee (RUC) and the Centers for Medicare & Medicaid Services (CMS) already adjust reimbursement for procedure codes typically reported with E/M codes to account for any overlapping costs, including efficiencies in time, duplication of materials, and duplication of encounter components.

The RUC removes duplication of expenses through a reduction in the value of procedure codes that are commonly reported with an E/M. This reduction is aimed at removing the valuation of duplicate practice

expenses and pre- and post-service physician work. This reduction is automatic and still applies even if the procedure is performed independent of an E/M appended with modifier 25. The RUC reductions to procedure codes are explained in information contained in the AMA's RBRVS Data Manager.

CMS provides a check on the AMA RUC and further adjusts the time and expense value in a code in the CY 2018 Medicare Physician Fee Schedule Final Rule when it believes it is necessary to account for overlap. In this important update, CMS explained that it has removed pre- and post-service time and decreased valuation for particular services when it was determined that the RUC did not adequately address overlap, further explaining that, "The RUC has recognized this valuation policy and, in many cases, now addresses the overlap in time and work when a service is typically furnished on the same day as an E/M service."

In conclusion, Massachusetts physicians are committed to excellence in the diagnostic, medical and surgical aspects of their specialty, advocating for high standards in clinical practice, education, and research, and supporting and enhancing patient access to care. These detrimental health insurance policies contradict such commitment and well-accepted coding conventions and guidelines. Moreover, they are inconvenient, costly, and often harmful to patients who are at times forced to schedule a return visit, thus delaying access to care, and incurring additional co-pays or deductibles. For these reasons, the MMS urges the Committee on Financial Services to support H.1101/S.699 and to prohibit insurers from inappropriately reducing reimbursement for medical services when a modifier 25 code is employed.