July 27, 2017

Niel Patel, M.D.
Medical Director, Reimbursement Policy
UnitedHealthcare Operations
9900 Bren Road East
Minnetonka, MN 55343
Sent via email and certified mail.

Re: UnitedHealthcare Commercial Reimbursement Policies
Revision to the Consultation Services Reimbursement Policy

Dear Dr. Patel:

The undersigned medical and specialty societies are writing to express concerns regarding United Healthcare's (UHC) announcement in its June 2017 Network Bulletin regarding its decision to no longer pay for consultation codes effective October 1, 2017. There are widespread changes afoot for the United States healthcare system; some of these changes are already creating barriers to care for patients. It is our utmost concern that UHC's proposed policy will only create another barrier, preventing patients from receiving specialty care. While some of our concerns were addressed during a Federation conference call with UHC on July 17, 2017, we would like to restate them formally and in writing.

Coordination of Care

UHC cited alignment with CMS policy among the reasons for this policy change. UHC may recall that the 2010 CMS fee schedule rule was met with much opposition from the medical community, in part due to CMS' failure to recognize the expertise and additional collaboration that is reflected in the use of consultation codes. We echo the concerns raised by the medical community, when CMS decided to remove consultation codes, including coordination of care, due to the nature of consultations and their resulting reports back to the referring physician. Removal of consultation codes could result in dissuading the usual coordination of care, because the level of work involved would not be properly recognized. It is important that UHC continue to recognize the additional work that goes into providing a consultation and coordinating care amongst other treating physicians.

Education

Much of the opposition to CMS' policy change was related to CMS' refusal to allow physicians enough time to be educated on how to comply with the new coding guidelines. In the Federation call, Dr. Patel indicated that UHC would consider how to address education concerns, especially for those physicians who do not bill Medicare and are unaccustomed to the crosswalk between codes. We hope that if UHC moves forward with this policy change that it will provide its network providers with the education necessary to properly code claims in order to avoid payment disruptions.

Payment

UHC mentioned in its notice that this will be a "budget neutral experience" due to Relative Value Unit (RVU) changes made to evaluation and management (E&M) codes in recent years. Does UHC rely on the RVUs established by CMS? If so, did UHC adjust physician fee schedules to account for the changes made to the E&M code RVUs, when CMS eliminated consultation codes in 2010? If not, does UHC plan on doing so with this policy change or will it otherwise raise E&M

code payments to make up for the difference? We are concerned that, under this new policy, UHC may not be providing appropriate compensation to specialists for the level of expertise they provide. If UHC does not pay for E&M codes at an amount comparable to consultation codes, it will result in a financial burden to practices that provide consultations. Our hope is that UHC will continue to pay these practices for consultations at the level they are accustomed, so that their practices and ultimately patient care does not suffer.

Data on Coding Abuses

UHC also referenced data analysis that lead to this policy change. We ask that UHC provide us with the data supporting the removal of consultation codes. We are troubled that UHC is reporting abuse of these codes. We have regular interactions with UHC staff and this is the first time we have heard about potential abuse. If abuse was occurring, we believe that UHC should address it with the physician(s) involved and not implement a broad policy that penalizes physicians who bill and document these codes correctly. We continue to be willing to work with UHC on a coding education and outreach initiative. We believe this would be more beneficial and less disruptive than no longer accepting consultation codes. Dr. Patel also indicated on the Federation call that UHC would consider whether to release de-identified data to the societies as a means towards provider education.

Confusing Payer Policies

Effective July 1, 2017, Oxford implemented a policy for its commercial products to require identification of the requesting provider on consultation claims. In the July 2017 Oxford Policy Update Bulletin, Oxford announced that it too would do away with consult codes effective October 1, 2017. It is very confusing that UHC and Oxford would announce this policy change at different times. It is made even more confusing by Oxford's recent announcement and implementation of a policy that requires physicians to report more data on consultation claims. UHC is the only commercial payer that we know of that will no longer pay for consultation codes; it will be very difficult for practices to implement coding practices that are different for only one commercial payer; not to mention the time and attention necessary to review and implement coding crosswalks between the consultation and E&M codes to avoid payment delays and denials. There will also be billing and payment issues for those patients who have secondary coverage with UHC. If the patient's primary health plan accepts consultation codes, then any claims that are submitted to UHC for processing will be denied. There will be an administrative burden on practices to change secondary UHC claims, plus concerns that UHC will not honor the primary plan's EOB, since it will contain a different CPT code.

Future Audits

If this policy is implemented, specialists will start billing E&M codes which will be completely different from their billing patterns prior to this policy. For instance, physicians may appropriately bill more E&M codes for initial hospital care in place of billing inpatient CPT consultation codes. In the past Optum has conducted extensive audits of physicians, when there is a sudden increase in billing of any E&M code. Also, for many of the consultation codes there is no one to one match. An example of this is CPT inpatient consultation codes of 99251 or 99252, which are the lowest-level of the inpatient consultation codes. They don't meet the minimum key component work and/or medical necessity requirements for the initial hospital care codes. How does UHC plan to handle consultation codes that do not have a clear crosswalk to an E&M code? Will UHC provide guidance to physicians on appropriate E&M codes to replace the consultation codes they are accustomed to billing? Based on past audits by UHC and Optum, we are concerned that this policy

will open affected practices up to audit. We ask that UHC provide guidance and assurance that specialists will not suddenly see an increase in audits due to a change in their billing practices.

We ask that UHC reconsider this policy and at the very least delay implementation until physicians have been adequately educated on how to properly code under the new policy.

Thank you for your attention to this matter.

Sincerely,

Medical Society of New Jersey
American Association of Clinical Endocrinologists
American College of Rheumatology
California Medical Association
Connecticut Orthopaedic Society
Connecticut State Medical Society
Idaho Medical Association
Medical Association of Georgia
Massachusetts Orthopaedic Association
Mississippi State Medical Association
Infectious Diseases Society of New Jersey
New Jersey Academy of Otolaryngology Head & Neck Surgery
New Jersey Association of Osteopathic Physicians and Surgeons
New Jersey Chapter, American College of Surgeons
New Jersey Chapter, American Society for Metabolic and Bariatric Surgery
New Jersey Neurosurgical Society
New Jersey Society of Interventional Pain Physicians
New Jersey Society of Thoracic Surgery
Medical Society of the State of New York
Carolinas Chapter of the American Association of Clinical Endocrinologists
North Carolina Chapter of the American College of Physicians
North Carolina Dermatology Association
North Carolina Medical Society
North Carolina Neurological Society
North Carolina Obstetrical and Gynecological Society
North Carolina Orthopaedic Association
North Carolina Society of Eye Physicians and Surgeons
North Carolina Society of Otolaryngology and Head and Neck Surgery
North Carolina Spine Society
Ohio State Medical Association
Pennsylvania Medical Society
Physicians Advocacy Institute
South Carolina Medical Association
Tennessee Medical Association
Texas Medical Association
Washington State Medical Association
Wisconsin Medical Society

Copy: Ashley D. Bieck, MPA, Director, Provider Communications & Advocacy