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Dear Dr. Milavetz:

This letter serves as a follow-up to our initial correspondence dated July 11, 2024, to which the AOA has yet to receive a complete response. The information outlined in the original letter remains pertinent, and the AOA respectfully requests a meeting with Regence BlueCross BlueShield Leadership to reach an amicable solution to this matter within 30 days.

This letter is sent on behalf of the osteopathic physician and student members of the American Osteopathic Association (AOA), Idaho Osteopathic Physicians Association (IOPA), Osteopathic Physicians & Surgeons of Oregon (OPSO), Utah Osteopathic Medical Association (UOMA), Washington Osteopathic Medical Association (WOMA), American Academy of Osteopathy (AAO) and the American College of Osteopathic Family Physicians (ACOFP). We emphatically request that Regence BlueCross BlueShield (BCBS) immediately halt plans to update their Global Days & Modifier: 25; Significant, Separately Identifiable Service policies. The amended policies will reduce reimbursement by 50% for evaluation and management (E/M) services appended with modifier 25 when submitted on the same date of service as a minor procedure code, by the same physician or other qualified health care provider. This amended policy fails to recognize the distinct costs of providing separately identifiable E/M services. We strongly urge Regence to reconsider this policy to (1) avoid potential negative effects on patients, and (2) to ensure physician practices are fairly paid for their services in a manner that accurately reflects work and practice expense inputs.

The AOA represents more than 197,000 osteopathic physicians (DOs) and osteopathic medical students nationwide. This includes more than 7,700 members represented by IOPA, OPSO, UOMA and WOMA, over 7,000 members by AAO as well as 26,000 members represented by ACOFP. DOs bring a unique, patient-centered approach to medicine, with approximately 57% of practicing DOs specializing in primary care specialties. Regence's 50% payment reduction policy will result in a substantial reduction in pay that will broadly impact physicians nationwide, across all medical specialties. We are concerned that Regence BCBS may shortsightedly be prioritizing immediate savings over long-term plan costs and patient outcomes. Regence's amended policies will make it impractical for physicians to provide unscheduled services, as they would have to absorb the cost for rendering them, placing unnecessary financial strain on their practices. This may force patients to schedule multiple visits (with additional co-payments) to receive necessary treatment.

While Regence's new policy is likely to increase costs and disrupt patient care for a broad range of minor procedures and surgical services, we want to highlight the impact this payment reduction will have on the delivery of osteopathic manipulative treatment (OMT). AOA's OMT guidelines, which reflect CPT billing and current clinical practice guidelines, state that an osteopathic physician should report an E/M service along with the OMT procedure on initial office visits as well as subsequent visits if a new problem occurs or if original symptoms have changed. The decision to utilize OMT as part of the overall health care of patients is made on a visit-by-visit basis. As such, it is typical that on the initial and subsequent encounters a pertinent history and physical examination is performed. Based on the history and findings of the physical examination, the physician may decide to use OMT as part of the overall management of the patient on that date.

Regence BCBS justified the payment reduction by claiming it no longer reimburses the practice expense (PE) component twice, once for the E/M service and again for the global day code. However, this rationale reflects a misunderstanding of code valuation which includes the CPT process, RUC methodology, and CMS methodology for valuing physician services which relies on a combination of RUC recommendations, public comments, and other data sources. Under the Resource-Based Relative Value Scale (RBRVS), both E/M and procedure codes are appropriately valued, ensuring there is no duplication in payment when billed correctly.

The claim that professional practice expenses are reimbursed twice is inaccurate. The PE component of the relative value units (RVUs) accounts for the actual cost of providing a service and is comprised of direct practice expense (e.g., clinical staff time, equipment, supplies) and indirect practice expense (e.g. administrative overhead, non-clinical labor and staff time, health IT). When E/M and procedure codes are billed together, the expenses are not reimbursed twice; each service has its own allocated practice expense based on the resources required. If the codes are distinct and meet the criteria for billing separately, they are reimbursed appropriately, without duplication. The CPT and RUC process is designed to clearly define distinct services, value the work of such services, and establish guidelines on appropriate coding.

For services to receive unique CPT codes, they must not be duplicated by other codes within the code set through which they could be reported. Once codes are created or revised, they are reviewed by the RUC which makes recommendations to the Centers for Medicare and Medicaid Services' (CMS) on work relative values and direct practice expense components. This process ensures that RVUs reflect the distinct resources and time involved in each service to avoid overpayment. CMS then relies on these recommendations as it develops final work and PE RVUs.

While the RUC makes recommendations to CMS on work RVUs and direct PE inputs, CMS separately calculates total PE RVUs. In determining values for new codes and reviewing potentially misvalued codes, both CMS and the RUC consider how frequently particular codes are reported with E/M codes to account for potential overlap in resources. Because CMS expressly accounts for this potential duplication, it is unclear how Regence has determined that E/M services reported with minor procedures have duplicative inputs.

The separate reporting of an E/M service and OMT service on the same date is an industry accepted practice and is further supported by the guidelines set forth by the CPT Editorial Panel, CMS, the RUC, and the National Correct Coding Initiative (NCCI) edits.

When specifically addressing OMT codes, multiple reviews of these codes have ensured that duplication in work and PE is avoided in RUC recommended values and CMS fee schedule values. In 2002, the AMA's RVS Update Committee (RUC) reviewed the practice expense RVUs for OMT codes (98925–98929). The committee recommended that only the practice expenses directly associated with the OMT procedure be included, excluding overlapping E/M services, which are billed separately when appropriate. CMS adopted these recommendations in 2003, and this principle remains in effect today.

As noted previously, when the RUC reviews codes to make valuation recommendations, the committee assesses codes that are commonly billed together to ensure that work and practice expense components are not duplicated. During the revaluation of OMT codes in February 2011, the RUC recommended removing duplicate direct practice expense inputs for CPT codes 98925-98929; medical supplies SB022 gloves non-sterile, SB026 gown patient and SB037 pillowcase, as these supplies are included in the Evaluation and Management service. However, other practice expense components were still deemed distinct to the OMT service.

Such payment reduction risks undermining the fair valuation of physician work and practice resources and may not align with standard reimbursement methodologies. Regence BCBS' policy change warrants further review to ensure compliance with established valuation frameworks and equitable provider reimbursement.

For example, comparing the non-facility PE values of CPT codes 99213 (E/M) at 1.33 and 98926 (OMT) at 0.60 shows the OMT value is 0.73 less than the E/M. If the E/M service were included in the OMT, we would expect the OMT PE to be greater, but it is not. This discrepancy further confirms that there is no E/M component included in the OMT.

The AOA shares insurers' concerns with the rising cost of healthcare and recognizes the importance of payers' fraud, waste and abuse preventions and detection processes. We are committed to providing the osteopathic profession with the most up-to-date information related to coding, billing, and documentation compliance. However, we are deeply concerned that Regence's updated policies will threaten the ability of osteopathic physicians to provide accessible care to patients and obtain appropriate reimbursement that accurately reflects service input costs. Such financial pressure will threaten the existence of many osteopathic physician practices and access to care in the communities that they serve.

Based on the information provided, we strongly encourage Regence BlueCross BlueShield to reconsider a full withdrawal of its proposed 50% payment reduction policy.

Thank you for your consideration and commitment to providing support to contracted osteopathic physicians who provide high-quality, patient-centered care to Regence BlueCross BlueShield's members. AOA respectfully requests a meeting with Regence BlueCross BlueShield Leadership to reach an amicable solution to this matter within 30 days.

If you have any questions or need any additional information do not hesitate to contact AOA Physician Services via phone (312) 202-8194 or e-mail at physicianservices@osteopathic.org.

Sincerely,

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Sources of Information

American Medical Association Practice Expense Component https://www.ama-assn.org/system/files/practice-expense-component.pdf
American Osteopathic Association Policy H635-A-20 American Osteopathic Association OMT Coverage Determination Guidance (2024)
American Osteopathic Association Guide to Coding & Documentation: Osteopathic Manipulative Treatment Second Edition (2023)
American Medical Association (AMA) Current Procedural Terminology (CPT©) 2024 Manual
American Medical Association (AMA) Relative Value Update Committee (RUC) Database
Centers for Medicare & Medicaid Services PFS Relative Value Files (April 2024)
Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFP 410, 414, 485 https://www.federalregister.gov/documents/2002/12/31/02-32503/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-for-calendar-year
Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Part 414, Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule, https://www.federalregister.gov/d/2011-13052 (June 6, 2011)