October 10, 2017

Neil Patel, M.D.
Medical Director, Reimbursement Policy
UnitedHealthcare Operations
9900 Bren Road East
Minnetonka, MN 55343

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

Dear Dr. Patel,

We, the undersigned representing cognitive medical specialty societies are writing to thank UnitedHealthcare (UHC) for delaying implementation of the policy to discontinue payment for consultation services reported by CPT® codes 99241-99245 and 99251-99255. As cognitive physicians, we believe our timely services are integral to the effective treatment of patients who have severe, complex conditions. We seek to engage UHC in a discussion of these services in order to explain how consultation services best align with UHC's Triple Aim of "improving health care services, health outcomes, and overall costs of care."

Cognitive physicians obtain additional training in a specific field of medicine and primarily provide evaluation and management services to individuals with complex medical conditions that require a level of expertise the referring physician is not trained to diagnose or qualified to treat. Cognitive physicians treat a broad range of diseases such as arthritis, rheumatic diseases, diabetes, HIV and other infections, behavioral health disorders, visual disorders, neurologic disorders such as Alzheimer's disease, as well as a myriad of other complicated diseases and conditions. Frequently, cognitive physicians are able to prevent patients from having costly procedures and inpatient stays by identifying and treating patients early in an episode of care.

We understand that the policy has been delayed; however we would like to provide our perspective if UHC should ever consider reinstating the policy in the future. When providing a consult, cognitive physicians must review substantial prior documentation (detailing the prior evaluation and therapeutic attempts so as to not repeat expensive diagnostic studies or unsuccessful or poorly tolerated treatments), refine the differential diagnosis, recommend diagnostic, therapeutic, and other treatment options, educate the patient regarding diagnostic considerations, prognosis and treatment options, and coordinate next steps with the patient's other providers and their family members. We believe the cognitive care we provide is very valuable to the health and well-being of your beneficiaries which allows UHC to achieve the Triple Aim.

In the Provider Bulletin, dated June of 2017, it states that UnitedHealthcare began its own data analysis of claims containing the consultation codes. This data analysis alleges misuse of the consultation codes. We hope that UHC will begin a provider outreach program on the appropriate use of the codes in lieu of reconsidering the policy in future years.

The July 2017 Network Bulletin provided additional information related to the proposed coding change, namely that UHC is following the precedence set by CMS in 2010 and "and supports the budget neutrality strategy that resulted in the increases to the Relative Value Units (RVU) assigned for the non-consultation E/M codes." UHC should note that the policy implemented by CMS in 2010 was met with significant opposition from the physician community as it failed to recognize the difference in physician work and ultimately in valuation between the two codes sets. A close examination of the policy that CMS implemented will show that work RVUs "saved" from the consultation codes were disproportionately redistributed to outpatient E/M codes, leaving the subsequent hospital visit codes "undervalued" for the complex medical decision-making that is involved in providing this care to severely sick patients in the hospital. Failing to acknowledge the difference in work between a consultation and the relative simplicity of assuming the care of a patient with a known diagnosis is misguided, inappropriate and will predictably limit the ability of providers to consult on these complex cases.

It is also worth noting that cognitive physicians have overarching concerns regarding the entire set of evaluation and management (E/M) codes, and as such we have asked the Centers for Medicare & Medicaid Services, with congressional support, to perform a comprehensive study of this code set to ensure proper valuation and payment for all E/M services. We share a general belief that the underlying inputs within the current valuation methodology are inadequate to appropriately capture complex medical decision-making inherent in cognitive specialty care.

We appreciate your review of this matter and subsequent reconsideration of your policy. We look forward to a partnership with UHC and continuing to provide the care to your beneficiaries that you have found to be so valuable in the past. If you have questions or wish to schedule a call at a mutually convenient time please contact Kay J. Moyer, IDSA Program Officer, Clinical Affairs. kmoyer@idsociety.org or 703-299-0430

Sincerely,

American Academy of Allergy, Asthma & Immunology

American Academy of Neurology

American Psychiatric Association

American College of Rheumatology

Coalition of State Rheumatology Organizations

Endocrine Society

Infectious Diseases Society of America

North American Neuro-Ophthalmology Society