OFFICERS
President
Barbara L. Bass, MD, FACS
Houston, TX
Immediate Past-President
Courtney M. Townsend, Jr., MD, FACS
Galveston, TX
President-Elect
Ronald V. Maier, MD, FACS
Seattle, WA
First Vice-President
Charles D. Mabry, MD, FACS
Pine Bluff, AR
First Vice-President-Elect
Mark C. Weissler, MD, FACS
Chapel Hill, NC
Second Vice-President
Basil A. Pruitt, Jr., MD, FACS, FCCM, MCCM
San Antonio, TX
Second Vice-President-Elect
Philip R. Caropreso, MD, FACS
Keokuk, IA
Secretary
Edward E. Cornwell III, MD, FACS, FCCM
Washington, DC
Treasurer
William G. Cioffi, Jr., MD, FACS
Providence, RI
Executive Director
David B. Hoyt, MD, FACS
Chicago, IL
Chief Financial Officer
Gay L. Vincent, CPA
Chicago, IL

BOARD OF REGENTS
Chair
Leigh A. Neumayer, MD, FACS
Tuscon, AZ
Vice-Chair
Marshall Z. Schwartz, MD, FACS
Bryn Mawr, PA
Anthony Atala, MD, FACS
Winston-Salem, NC
John L. D. Atkinson, MD, FACS
Rochester, MN
James C. Denneny III, MD, FACS
Alexandria, VA
Margaret M. Dunn, MD, FACS
Fairborn, OH
Timothy J. Eberlein, MD, FACS
Saint Louis, MO
James K. Elsey, MD, FACS
Atlanta, GA
Henri R. Ford, MD, FACS
Los Angeles, CA
Gerald M. Fried, MD, FACS, FRCSC
Montreal, QC
James W. Gigantelli, MD, FACS
Omaha, NE
B.J. Hancock, MD, FACS, FRCSC
Winnipeg, MB
Enrique Hernandez, MD, FACS
Philadelphia, PA
Lenworth M. Jacobs, Jr., MD, FACS
Hartford, CT
L. Scott Levin, MD, FACS
Philadelphia, PA
Fabrizio Michelassi, MD, FACS
New York, NY
Linda G. Phillips, MD, FACS
Galveston, TX
Anton N. Sidawy, MD, FACS
Washington, DC
Beth H. Sutton, MD, FACS
Wichita Falls, TX
Gary L. Timmerman, MD, FACS
Sioux Falls, SD
Steven D. Wexner, MD, FACS
Weston, FL
Douglas E. Wood, MD, FACS
Seattle, WA
Michael J. Zinner, MD, FACS
Miami, FL

BOARD OF GOVERNORS
Chair
Diana L. Farmer, MD, FACS
Sacramento, CA
Vice-Chair
Steven C. Stain, MD, FACS
Albany, NY
Secretary
Daniel L. Dent, MD, FACS
San Antonio, TX

100+years

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org

Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

February 14, 2018

Gail K. Boudreaux	Craig Samitt, MD
President &	Executive Vice President &
Chief Executive Officer	Chief Clinical Officer
Anthem, Inc.	Anthem, Inc.
120 Monument Circle	120 Monument Circle
Indianapolis, IN 46204-4903	Indianapolis, IN 46204-4903

Dear Ms. Boudreaux and Dr. Samitt:

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), I write to state our concerns with several forthcoming or recently implemented Anthem Blue Cross Blue Shield (Anthem) policies that could jeopardize access to, and the quality of, essential health care services for the surgical patient. Specifically, the ACS strongly opposes four policies that inappropriately modify coverage or physician reimbursement guidelines for care provided in the emergency room (ER), application of modifier 25 to certain evaluation and management (E/M) services, outpatient procedures and endoscopic services, and advanced radiologic imaging. We believe that these policies, described in detail below, are cost-cutting measures intended to save money, rather than to meet the needs of patients and physicians participating in the payor's networks. **The ACS urges Anthem to suspend the enforcement of these misguided policies given the negative effect on the welfare of Anthem members and the potential adverse financial impact on physician practices.**

"NON-EMERGENT" SERVICES ADMINISTERED IN THE ER

"Save the ER for emergencies – or you'll be responsible for the cost," states a letter sent by Anthem to its members affected by the payor's new policy to refuse payment for hospital ER care that Anthem decides was not an emergency.[1]

[1] Anthem, Inc. (2017). Save the ER for emergencies – Or you'll be responsible for the cost [letter to members]. *Anthem Blue Cross Blue Shield.* Retrieved from http://mediad.publicbroadcasting.net/p/kwmu/files/mo_er_member_letter_2017.pdf

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913
The American College of Surgeons Is an Equal Opportunity/Affirmative Action Employer

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

100+*years*

Between 2017 and 2018, Anthem modified guidelines in its Georgia, Indiana, Kentucky, Missouri, New Hampshire, and Ohio markets to deny coverage for services provided in the ER for conditions that the payor deems inappropriate for that setting. Per this policy, members who seek ER care are responsible for the charges incurred during the visit when the patient's final diagnosis – rather than the symptoms the patient presented with – is retrospectively determined not to have required emergency treatment.

The College does not believe that patients should be expected to self-diagnose their conditions or second guess their feeling that emergency care is needed. ACS Fellows know that patients and their caregivers already face serious challenges in determining if an acute symptom is serious enough to warrant an ER visit, and through this policy, Anthem is forcing its members to act as experienced diagnosticians during a medical event when time could be of the essence. **The ACS wishes to remind Anthem that patients do not have the expertise to accurately differentiate an emergent from a non-emergent situation before any professional clinical evaluation.** As such, coverage determinations should be made based on the symptoms that led a patient to seek care in an ER, rather than the final diagnosis. A 2013 analysis of the National Hospital Ambulatory Medical Care Survey (NHAMCS) found that patients who are diagnosed in the ER with a non-emergent condition (6 percent) presented with the identical chief complaints reported for 89 percent of all ER visits, including patients with critical illnesses.[2] This review indicates that it is not possible to prospectively classify and redirect patients with low-acuity conditions from the ER, as patients presenting with the same chief complaints are discharged with different diagnoses, some of which may be emergent and some non-urgent.

Even if patients with non-emergent conditions could be properly identified and diverted from the ER, **Anthem's attempt to cut costs by denying coverage and forcing such patients who seek ER care to pay for the associated expenses is unlikely to achieve significant savings for the payor.** A Western Journal of Emergency Medicine study of NHAMCS data found that non-urgent patients who presented at the ER had a high rate of post-visit ancillary testing and treatments, demonstrating that diverting patients from the ER does not produce savings, but

[2] Raven, M., Lowe, R., Maselli, J., et al. (2013). Comparison of presenting complaint vs discharge diagnosis for identifying "nonemergency" emergency department visits. *JAMA, 309*(11), 1145-1153.

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

100+years

simply shifts costs to other sites of care.[3] Collaborative efforts between physicians and hospitals throughout the country suggest that, rather than focusing on the relatively low savings that could be gained by redirecting patients with non-emergent conditions from the ER, more substantial savings could be achieved by improving care coordination to avoid hospital admissions and increasing access to alternative sites of care for frequent ER users.[4,5] When patients learn that they might be held responsible for the cost of ER services, even though they have insurance, we fear that they will delay or forgo seeking essential, life-saving care to treat potentially serious conditions. **The ACS is concerned that Anthem's efforts to deter ER visits will jeopardize the health and safety of Anthem members.**

In addition to the negative clinical effects of this coverage guideline, the College believes that Anthem's policy may violate patient protection laws, specifically the "prudent layperson" standard, because the payor does not conduct transparent medical record reviews. Federal statute requires health insurers covering any care in the ER to provide such coverage without prior authorization for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based on the patient's symptoms, not final diagnosis.[6] If Anthem does not conduct medical record reviews before denying a claim, it is evident that the basis for such a denial is a patient's diagnosis rather than symptoms and medical history. In addition, this policy may violate state laws, including those in Georgia, Indiana, Kentucky, Missouri, which contain patient protections equal to, or greater than, federal requirements.[7] **The ACS considers Anthem's retrospective judgment for coverage of emergency services to potentially be in conflict not only with federal and state laws, but with physicians' duty to treat patients – no matter their coverage – who appear to be in need of immediate care.**

In order to better understand Anthem's rationale to deny coverage for ER care for "non-emergent conditions", and how its policy complies with federal and state

---

[3] Honigman, L., Wiler, J., Rooks, S., et al. (2013). National study of non-urgent emergency department visits and associated resource utilization. *Western Journal of Emergency Medicine, 14*(6), 623-630.
[4] Morganti, K., Bauhoff, S., Blanchard, J., et al. (2013). *The evolving role of emergency departments in the United States.* Santa Monica, CA: RAND Corporation.
[5] Washington State Health Care Authority. (2014). *Emergency department utilization: Update on assumed savings from best practices implementation.* Olympia, WA: Office of the Chief Medical Officer.
[6] 29 C.F.R. § 2590.715–2719A(b)
[7] O.C.G.A. 33-20A-9; R.S.M.O. 376.1367(1); I.C. 27-13-36-9; K.R.S. 304.17A-580; and R.S.M.O. 376.1350(12)

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

100+years

patient protection laws, **we ask that the payor provide a complete description of the process by which a claim is reviewed, denied, and appealed, as well as evidence relating to Anthem's compliance with the prudent layperson standard.**

E/M SERVICES AND RELATED MODIFIER 25

Anthem Commercial Professional Reimbursement Policy #0026 specifies that, beginning March 1, 2018, payment will be reduced by 25 percent for E/M services billed with Current Procedural Terminology (CPT) modifier 25 when reported with a minor surgical procedure code ("0" or "10" day global period) during a same day medical visit.[8] The current March 2018 implementation date and 25 percent payment reduction are revised provisions of Anthem's original policy, under which the payor intended to cut reimbursement for E/M services billed with modifier 25 by 50 percent beginning January 1, 2018. **Despite these revisions, the ACS does not support the implementation of Anthem's policy and believes that the payor should rescind this unjustified change to reimbursement guidelines effective in the California, Connecticut, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, and Wisconsin markets.**

According to CPT coding guidelines, modifier 25 may be used to report a significant, separately identifiable E/M service by the same physician on the same day of a procedure or other service.[9] **The inclusion of modifier 25 on a claim indicates that a physician rendered two distinct, individual services during a single patient visit, and therefore should receive payment in full for both.** Modifier 25 represents physician work that is no less than what would be performed if a patient were to be evaluated during a separate encounter; for example, a patient who has been treated for gastroesophageal reflux disease (GERD) and is scheduled to have an upper endoscopy presents with complaints of exacerbation of known irritable bowel syndrome (IBS) and asks that their physician review the medications for this condition. The physician performs the upper endoscopy for the workup of GERD as scheduled and adjusts the medications for IBS. The work associated with the E/M related to IBS would be

---

[8] Anthem, Inc. (2018). *Commercial professional reimbursement policy #0026: Evaluation and management services and related modifiers -25 & -57.* Retrieved from https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g325157.pdf?refer=ahpmedprovider&state=mo

[9] American Medical Association. Appendix A – Modifiers. *Current Procedural Terminology (CPT).* Chicago: AMA Press.

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

reported with an E/M code and modifier 25 appended to indicate that this service is separate from the GERD-related upper endoscopy. As such, it is unreasonable to arbitrarily reduce the value of the E/M for IBS when it is rendered on the same day as the endoscopy procedure. Separate services performed during the same patient visit should be reimbursed appropriately and in accordance with established coding rules and conventions.

While the modifier 25 CPT guidelines are broadly accepted by both the physician community and health care insurers, Anthem has rejected these common standards of reimbursement for same-day E/M and minor surgical services and instead has developed a strategy to erroneously cut payments for physicians across multiple medical specialties. The payor asserts that the value of an E/M is already included within the global reimbursement for a procedure, and that such a payment reduction is warranted to mitigate overlapping practice expenses between minor surgery and E/M services. Anthem's policy reflects a clear disregard for the CPT code valuation process executed by the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) and the Centers for Medicare & Medicaid Services (CMS), which already decrease the value of procedure codes commonly reported with E/M services to account for overlapping costs.[10] This decrease means that physician reimbursement is automatically reduced for such procedure codes, even when they are not reported with an E/M and modifier 25. **Based on this code valuation process, the ACS believes that Anthem's policy applies unwarranted and duplicative payment cuts for medically necessary services because the payor does not have an accurate understanding of how practice expenses are managed by the RUC and CMS.**

We are also concerned that Anthem's policy will inappropriately shift costs onto patients and delay the provision of necessary care. The payor's unjustified reduction in reimbursement makes it more difficult for physicians to perform unscheduled services, and may require patients to visit their physician multiple times, with additional co-payments, to receive needed treatment. By streamlining the provision of unanticipated, medically necessary services, modifier 25 facilitates timely diagnosis and treatment, which in turn supports efficient, patient-centered care.

[10] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018, 42 CFR § 405, 410, 414, 424, 425 (2017).

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

As Policy #0026 prioritizes short-term savings over patient costs and timely care, contradicts RUC/CMS code valuations, and unfairly reduces physician payment, the ACS urges Anthem to cease implementation of, rather than continue to revise, these reimbursement guidelines. We encourage Anthem to provide payment in full for both procedures and E/M services when appropriately reported with modifier 25. The ACS asks that, if Anthem chooses to maintain this policy, the payor provide rationale that justifies a 25 percent reduction for unrelated E/M services when reported on the same day as a minor surgical procedure.

LEVEL OF CARE: HOPD AMBULATORY SURGICAL PROCEDURES AND ENDOSCOPIC SERVICES

Anthem Clinical Utilization Management Guideline #CG-SURG-52 specifies medical necessity criteria that must be met for a surgical procedure, including endoscopic services, to be covered when furnished in a hospital outpatient department (HOPD).[11] Per these criteria, Anthem will **deny payment** for a procedure performed in an HOPD when the procedure does not require the general supervision of a licensed clinician, enhanced monitoring, and immediate access to services specific to the hospital setting, or when there are no other geographically accessible sites that offer the procedure outside of the HOPD. Procedures that do not meet these criteria must be performed in the physician office or ambulatory surgical center (ASC) setting to be eligible for reimbursement.

In order to develop this payment policy, Anthem created its own selection criteria for procedures performed in HOPDs versus office or ASC settings. These selection criteria rely on the American Society of Anesthesiologists (ASA) Physical Status (PS) Classification System as the key indicator of perioperative risk, and cited the ACS Guideline on Optimal Ambulatory Surgical Care and Office-based Surgery to justify the use of ASA PS to determine the medical necessity of – and payment denial guidelines for – HOPD-based procedures.

While the ACS does believe a patient's ASA PS to be an important factor when considering the appropriateness of a procedure in a particular setting, **ASA PS is**

[11] Anthem, Inc. (2017). *Clinical utilization management guideline # CG-SURG-52: Level of care: Hospital-based ambulatory surgical procedures and endoscopic services.* Retrieved from https://www11.anthem.com/ca/medicalpolicies/guidelines/gl_pw_c185539.htm

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

just *one* of the College's *ten* core principles for office-based procedures. The College's full list of core principles for optimal ambulatory surgical care and office-based surgery include:

Core Principle #1: Guidelines or regulations should be developed by states for office-based surgery according to levels of anesthesia defined by the ASA's "Continuum of Depth of Sedation" statement dated October 13, 1999, excluding local anesthesia or minimal sedation.

Core Principle #2: Physicians should select patients by criteria including the ASA patient selection PS Classification System and so document.

Core Principle #3: Physicians who perform office-based surgery should have their facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, American Osteopathic Association (AOA), or by a state recognized entity such as the Institute for Medical Quality, or be state licensed and/or Medicare-certified.

Core Principle #4: Physicians performing office-based surgery must have admitting privileges at a nearby hospital, a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent.

Core Principle #6: States should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement.

Core Principle #7: Physicians performing office-based surgery must obtain and maintain board certification from one of the boards recognized by the American Board of Medical Specialties, AOA, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

Core Principle #8: Physicians performing office-based surgery may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

Core Principle #9: At least one physician, who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (Advanced Trauma Life Support®, Advanced Cardiac Life Support, or Pediatric Advanced Life Support), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in basic life support.

Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/ analgesia, or general anesthesia should have appropriate education and training.[12]

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

The ACS does not support Anthem's use of ASA PS as the key standard for office- or ASC-based procedures, and urges the payor to incorporate all ten of the College's core principles into Clinical Utilization Management Guideline #CG-SURG-52. We believe that Anthem is unfairly selecting standards that will undoubtedly enable the payor to deny reimbursement for a large number of procedures performed in HOPDs without regard to patient safety or clinical workflow, and do not approve of Anthem's reference to ACS principles unless the payor adopts the College's entire guideline – rather than cherry-picking standards that most restrict care and justify non-payment – for optimal ambulatory and office-based surgery.

In addition, the ACS believes that this policy is riddled with inaccurate clinical assumptions and fails to address a number of other underlying implementation issues, such as:

- *Applicable services and appeals*. Anthem does not specify how payment determinations will be made for procedures performed in an HOPD. While the payor does indicate that "this guideline will be used for the evaluation of a subset of ambulatory procedures that will be determined and posted by individual lines of business," it remains unclear which services will be selected for evaluation, how and when such an evaluation will be performed, and how physicians will be informed about which services are deemed unnecessary in the HOPD facility setting.[13] Further, Anthem does not provide any information about physicians' appeals rights in the event that a payment denial is made for a procedure performed in an HOPD due to a perceived lack of medical necessity. **The College encourages Anthem to provide clear guidance on the selection and evaluation of applicable services, expectations for establishing medical necessity in patient records, and the appeals process.**

  The ACS also asks that Anthem publish a list of services that may be impacted by this policy. The College remains concerned that Anthem does not have a full realization of the inherent risks of certain procedures,

[12] American College of Surgeons. Statement on patient safety principles for office-based surgery utilizing moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia. *Bulletin of the American College of Surgeons, 89*(4).
[13] Anthem, Inc. (2017). *Clinical utilization management guideline # CG-SURG-52: Level of care: Hospital-based ambulatory surgical procedures and endoscopic services.* Retrieved from https://www11.anthem.com/ca/medicalpolicies/guidelines/gl_pw_c185539.htm

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

many of which still pose a threat to even the healthiest of patients. Additionally, while it may be possible for certain procedures to be safely performed in an ASC or physician office, the resources needed to support such procedures are so costly that it is unreasonable for them to be regularly furnished in the ambulatory or office environment. We believe that Anthem would greatly benefit from coordinating with the surgical community to identify which procedures can safely and reasonably be furnished in an ASC or physician office.

- *Site of service and quality of care*. This policy presents a number of challenges for physicians and patients and is likely to disrupt the clinical workflow of many surgical practices. While a procedure or individual's medical status may not meet Anthem's HOPD criteria for medical necessity, it is misguided to assume that it is thus inappropriate to perform such a procedure or treat such an individual in the HOPD setting. High-quality surgical care involves much more than providing services at the lowest possible cost; for example, performing all ordered tests and procedures for a patient in the same HOPD, rather than transporting the patient to various settings in order to satisfy arbitrary medical necessity guidelines, may both reduce spending and improve patient satisfaction. An outpatient surgery in an HOPD should also be considered medically necessary when the hospital charges a lower technical fee than neighboring alternative sites. **Anthem should not use non-payment to threaten physicians to plan a course of treatment, which often seems daunting to patients even if they are able to receive all services in the same setting, based solely on sending patients to the lowest cost site of care.**

- *Physician privileges and patient accessibility*. Despite Anthem's efforts to shift surgical care out of the HOPD setting and into the ambulatory environment, the payor has not addressed the patient access and physician privileging issues associated with this transition. Anthem indicated that an outpatient surgery performed in an HOPD will be considered medically necessary when there are no other geographically accessible appropriate alternative sites for the member to undergo the procedure. However, the payor does not provide any description of a geographically accessible appropriate facility, nor details about how geographic accessibility is

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+*years*

determined. Anthem also has not specified coverage policies for a scenario in which there is one appropriate alternative site located in proximity to a patient, but the only physicians with privileges at that facility are out-of-network for the patient. **The ACS urges Anthem to clarify what distance parameters are used to determine geographic accessibility, as well as to explain how procedures will be covered when none of the ambulatory facilities accessible to a patient employ in-network physicians. Per this policy, it appears that Anthem has not taken steps to protect patients from possibly incurring more out-of-pocket costs when they are forced by their insurer to undergo a procedure at an out-of-network facility by an out-of-network physician.**

In addition, to avoid a payment denial, an HOPD-based surgeon who does not have privileges at an office or ASC facility must send a patient in need of a "non-medically necessary" procedure to an office or ASC-based physician who is not familiar with the patient's case. This referral process may delay the provision of care, as the furnishing physician often must perform their own evaluation of a patient to familiarize themselves with the patient's condition. Anthem's policy also denies patients the ability to select their treating physician and may lead to extra out-of-pocket costs incurred during the transition of care between facilities. **The College asks that Anthem take responsibility for any costs unfairly shifted onto patients when care transitions from an HOPD to a physician office or ASC due to the payor's medical necessity criteria.**

- *Patient safety*. The ACS is concerned that Anthem's policy will make it challenging for HOPD-based surgeons to perform procedures essential to the diagnosis or treatment of emergent conditions, which can lead to life-threatening health problems if such conditions are not promptly treated. This policy may also lead patients to seek care in an office or ASC for a condition that requires access to services specific to an HOPD because they fear that they will incur out-of-pocket costs. Patients who undergo a procedure in an ambulatory setting are at risk for complications that require transfer to a hospital facility, whether due to an unexpected change in the patient's health status or because the ambulatory facility ultimately did not have the capacity to safely and appropriately treat the patient (e.g., the patient was prepped for a colonoscopy at an ASC, and after the

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

100+years

procedure had begun, the surgeon recognized that the colonoscopy cannot be completed because a pediatric scope – which is only available at the HOPD – is needed). **The ACS believes that this policy may delay certain courses of necessary treatment as physicians and patients attempt to comply with Anthem's unreasonable medical necessity criteria, and urges Anthem to rescind these HOPD ambulatory surgical procedures and endoscopic services guidelines.**

LEVEL OF CARE: ADVANCED RADIOLOGIC IMAGING

Anthem Clinical Utilization Management Guideline #CG-MED-55 specifies medical necessity criteria that must be met for an advanced radiologic imaging service to be covered when furnished in an HOPD.[14] Per these criteria, Anthem will **deny payment** for advanced imaging performed in an HOPD when such services are available and geographically accessible outside of the hospital setting; when such services do not precede an HOPD procedure; when the performance of such services outside the HOPD would not be expected to adversely impact care; or when the patient is 10 years or older, does not require obstetrical or perinatology care, does not have a known contrast allergy, or does not have a known chronic disease that requires imaging at multiple time points.

This policy removes advanced imaging, which is a tool essential to the diagnosis and management of innumerable conditions, from the continuum of care. This results in a disruption to patients' course of treatment and limits their ability to select an imaging site, which range in quality and accessibility, that best meets their needs and preferences. In addition, eliminating HOPDs as a site of service for advanced imaging creates significant diagnostic challenges for HOPD-based physicians, whose patients typically present with an acute illness and sudden onset. Unlike office-based physicians, who often have extensive background information on a patient's condition and therefore do not have an immediate need for imaging studies during the average office visit, HOPD-based physicians must employ various tests to avoid missing a diagnosis, to plan an operation, or to decide to admit a patient for observation in the hospital. If physicians do not have access to the full range of diagnostic tools in HOPDs, they may not be able to appropriately identify serious illnesses – such as acute vascular disease, acute

[14] Anthem, Inc. (2017). *Clinical utilization management guideline (#CG-MED-55): Level of care: Advanced radiologic imaging.* Retrieved from https://www11.anthem.com/ca/medicalpolicies/guidelines/gl_pw_c191757.htm

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

100+years

viral infections, or trauma – which can result in disability or death unless properly treated. By limiting physicians' abilities to order advanced imaging in a care setting that is often utilized by patients with acute conditions, Anthem is greatly increasing malpractice risk for its network physicians and endangering patients seeking treatment in HOPDs. **The ACS believes that this policy may make it difficult for physicians to order necessary imaging tests, even though such services are often critical in determining whether a patient has an emergent condition, and urges Anthem to rescind these advanced radiologic imaging guidelines.**

The ACS is committed to collaborating with all stakeholders, including Anthem, to address health care costs and improve patient outcomes. We support policies that increase the efficiency of the clinical workflow and ensure access to timely, high-quality care. However, the College stands against payor policies that inappropriately reduce physician payment, shift costs onto patients, and discourage members from seeking necessary treatment. **We reiterate that uncompensated or restricted care resulting from Anthem's policies may be devastating for patients, their physicians, and health care facilities. By implementing the aforementioned coverage and reimbursement guidelines without input from patient groups or practicing physicians, the payor's actions have created numerous clinical and financial problems for its members.** The College believes that Anthem's policies are contrary to patient choice, fair physician reimbursement, and the continued viability of health care facilities, and we urge the payor to coordinate with medical specialty societies to discuss cost transparency, patient safety, and other factors related to the provision of medical services.

We welcome the opportunity to work with Anthem to identify solutions for the numerous policy implications outlined above, and request a meeting of our respective organizations to discuss alternatives to these coverage and reimbursement guidelines. Should you have additional questions or would like to initiate dialogue with the ACS about these policies, please contact Lauren Foe, Regulatory Associate, at lfoe@facs.org. Thank you for your prompt attention to these matters.

Sincerely,

David B. Hoyt, MD, FACS
Executive Director

Chicago Headquarters
633 N. Saint Clair Street
Chicago, IL 60611-3211
Voice: 312-202-5000
Fax: 312-202-5001
E-mail: postmaster@facs.org
Washington Office
20 F Street, NW Suite 1000
Washington, DC 20001
Voice: 202-337-2701
Fax: 202-337-4271
E-mail: ahp@facs.org
facs.org