AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

November 22, 2021

Carol Blackford
Director, Hospital Ambulatory and Policy Group
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Blackford:

This letter is a follow up to a June 21, 2021 correspondence sent by the American Medical Association (AMA) to the Centers for Medicare & Medicaid Services (CMS) regarding National Correct Coding Initiative (NCCI) edits and NCCI contractor practices in creating NCCI proposed edits. We appreciate the opportunity to bring to your attention additional issues regarding recent NCCI edits and the ongoing unwillingness of the current NCCI contractor to discuss potential NCCI edits with the relevant clinical specialties prior to their publication.

As discussed previously, the current NCCI contractor, Capitol Bridge, LLC, has indicated that they will not utilize the transparent practices employed by the previous contractor to communicate with the AMA and specialty society stakeholders on any edits prior to publication. The AMA is disappointed by this determination, given the questionable nature of recent edits and the undue administrative burden these edits place on physicians and qualified health care professionals in their care of Medicare patients. The lack of communication surrounding NCCI edits flies in the face of the emphasis the Biden administration has placed on transparency.

The AMA continues to be contacted by specialty societies concerned with the lack of information included in Capitol Bridge responses related to NCCI proposed edits and other matters. As stated in our June 21st correspondence, previous communication practices employed prior to Capitol Bridge assuming the role as the NCCI contractor in March 2019 involved individual responses provided by the then-NCCI contractor with a level of detail to aid in ensuring that the AMA and specialty societies could identify the specific inquiry to which the response pertained and further know the specific CMS decision. This communication practice instilled confidence that the inquiry had been both received and reviewed and incentivized the societies to take the time to prepare high quality clinical feedback for CMS' benefit, regardless of the NCCI contractor or CMS final decisions on the edits themselves – which may not have been in agreement with the AMA or specialty societies. **The AMA continues to request that CMS or Capitol Bridge provide relevant responses that clearly address the issues raised in correspondence from the AMA and specialty societies.** Recently proposed NCCI edits highlight the need for this ongoing communication and bring to light many questions and concerns regarding the methodology employed by Capitol Bridge to create these edits.

By way of background, the 2022 Current Procedural Terminology (CPT®) Professional Edition revised the introductory guidelines in the Musculoskeletal System section, part of which included clarification on

the inclusion of casts, splints or traction devices for services represented by CPT codes in the section. The concept of including initial casting with the procedure as a part of the global service is not new; it was merely called-out in 2022 with an emphasis on clarifying reporting when a cast is removed by someone other than the physician or other qualified health care professional who applied the cast. However, it is clear that the inclusion of the initial cast, strapping, or traction device with the appropriate procedure has always been included.

Further review of the recently proposed edits calls into question the clinical relevance of these edits. As currently structured (NCCI MUE Proposed Edits spreadsheet attached), the codes in question for each range (arthroscopies of the range CPT codes 29800 – 29916 for Column 1, and cast and strapping codes CPT codes 29000 – 29750 for Column 2) are simply listed in numerical order in each column, without regard for the inherent distinct nature of some codes due to the anatomy referenced (that a coder would notice), and/or for clinical considerations of truly complex cases that may arise (as a physician could clarify). The result is a series of pairings that are random and unnecessary. Of note:

- Row 50 highlights a proposed edit between CPT codes 29871, Arthroscopy, knee, surgical; for infection, lavage and drainage, and CPT code 29550, Strapping; toes. There is no inherent connection between an arthroscopy procedure on the knee and strapping of a toe; the use of a modifier in this instance is unnecessary. The code descriptors themselves differentiate between the services presented and no edit is necessary.
- Row 35 notes a proposed edit between CPT codes 29846, Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement, and CPT code 29345, Application of long leg cast (thigh to toes). Again, these would be noted as inherently distinct procedures due to the disparate anatomy involved, and no modifier or edit should be necessary.

These are merely two examples of clinically questionable proposed NCCI edits. Of additional importance is the instance where there are legitimate reasons for some of these code pairs to co-exist on a claim, such as in cases of major trauma. The addition of these proposed edits will have the effect of placing additional reporting burden in cases that already require highly complex care, and where it would be understood that treatments of this type may be needed across disparate body sites.

As with other edits noted in our June 21st correspondence, it is reasonable to question the relevance of many of these edits given that they would likely not be clinically performed for the same patient on the same day, and if they were, the code descriptors clearly define the services performed as separate and distinct work and methodologies that would be mutually exclusive, negating the need for an edit. All have a modifier indicator of "1," meaning a modifier must be used to bypass the edit; but the question is whether the edits and the subsequent reporting burden to support the use of a modifier are even necessary with procedures that are mutually exclusive based on code definitions or anatomic considerations.

It is also worth noting the confusing nature of the proposed edits in the attached spreadsheet. The full scale of the proposed edits has been obscured with this cumbersome and confusing formatting.

With the number of edits suggested, combined with the broad range of potential impact, complicated by the unusual and inefficient presentation format, there would be an expectation that some communication would occur between either Capitol Bridge or CMS and the AMA and/or specialty societies to confirm the NCCI's interpretation of the new guidelines prior to distributing such a broad list. Had such communication occurred, it would have been quickly discovered that the revisions made did not warrant a set of proposed edits at all, thereby obviating the need to publish anything.

Practices employed by the previous NCCI contractor and CMS offered an avenue for gathering *proactive* feedback from societies, to ensure proposed edits were clinically relevant and appropriate prior to release for review and comment. This level of collaborative engagement provides programmatic benefits and enables CMS to efficiently manage the NCCI program by receiving relevant information in advance of distribution.

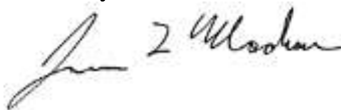
As stated in our June 21st correspondence, we note that this practice is called out in NCCI policies and procedures. Page 8 of the online Introduction of the NCCI Policy Manual states: "The CMS may also specifically seek comment from national medical/surgical societies, providers, and other NHOs before implementing many types of changes in the NCCI program." This reinforces the need to maintain strong levels of communication with the AMA and specialty societies.

This is further supported in the manual under "NCCI Edit Development and Review" which describes the specialty societies as one of the three sources for changes to the NCCI program: "(1) additions, deletions, or modifications to CPT or HCPCS Level II codes or CPT Manual instructions; (2) CMS policy Revision Date (Medicare): 1/1/2021 Intro-8 initiatives; and **(3) comments from the AMA, national or local medical/surgical societies, other NHOs, Medicare contractor medical directors and staff, providers, billing consultants, etc.**"

The AMA and specialty societies remain committed to maintaining the forward momentum realized as CMS continues to focus on reducing administrative burden. Recent proposed NCCI edits, and the practices employed to create these edits, threaten the progress we have all made on this front. The AMA strives to promote correct coding and has always worked closely with CMS to ensure a process that is fair and workable for all stakeholders. We are eager to return to the transparent, collaborative practices of the past among all parties (CMS, AMA and specialty societies) and ask that Capitol Bridge implement processes that allow for meaningful communication to ensure the quality and relevance of NCCI edits.

We thank you for your consideration and look forward to getting this issue addressed in the near future. If you have any questions, please contact Margaret Garikes, AMA's Vice President of Federal Affairs at margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD

Attachment: NCCI MUE Proposed Edits 10.29.21