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Ryan Howe
Acting Director
Hospital Ambulatory and Policy Group
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Director Howe:

This letter is a follow up to recent conversations between the Centers for Medicare & Medicaid Services (CMS) and American Medical Association (AMA) staff regarding National Correct Coding Initiative (NCCI) contractor responses to stakeholder input on NCCI proposed edits. We appreciated the opportunity for the dialogue regarding the previous practices of discussing potential NCCI edits with the relevant clinical specialties prior to their publication for comment.

We were disappointed to learn in an email response on Monday, May 24, that Capitol Bridge, LLC, will not use the practice employed by the previous contractor of communicating with the AMA and specialty society stakeholders on potentially questionable edits prior to publication. The rationale provided by Capitol Bridge was that the sensitive nature of payment-related information does not allow for this communication, even though this was a standard practice of the previous NCCI contractor for many years.

With previous communication practices that were employed until Capitol Bridge took over the NCCI work in March of 2019, individual responses were provided by the NCCI contractor with a level of detail to aid in ensuring that the AMA and societies could identify the specific inquiry to which the response pertained and know the specific CMS decision, which instilled confidence that the inquiry had been both received and reviewed. This 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 societies.

The previous practices also offered an avenue for the NCCI contractor and CMS to reach out and receive proactive feedback from societies, to ensure proposed edits were clinically relevant and appropriate prior to release for review and comment. This level of early engagement provides programmatic benefits and enables CMS to efficiently manage the NCCI program by receiving relevant information in advance of distribution.

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."

In some cases, detailed specialty society input can help ensure that approved NCCI edits do not inadvertently result in edits with increased, unnecessary administrative burden. An example is recent NCCI edits implemented for the IRE organ ablation code 0600T *Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous*.

The methodology used to identify these code pairs appears to be focused on codes with the word 'ablation' in their descriptor, without reference to specific clinical practice or implication. For example, edits were created pairing code 0600T with all endoscopy with ablation codes such as 45346 *Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)*, 45388 *Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)*, and 46615 *Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique*. Code 0600T was also paired with 20982, which is ablation therapy for bone tumors, and with 0581T, a procedure for percutaneous breast tumor ablation.

One would question the necessity of these edits being relevant 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.

At least one society sent input on the overly broad nature of the edit restrictions, also reaching out to the AMA with concerns regarding the additional administrative burden created: "Recently, we objected to a blanket CCI edit of the new IRE organ ablation code paired with every single CPT code that had the word ablation (e.g., IRE liver tumor ablation with all the endoscopy ablations codes or with percutaneous breast fibroma ablation). They all have an indicator of "1," but the pairings…require documentation to show modifier 59 applies."

However, the following response received from the NCCI contractor does not provide sufficient information to know if the objection was read or even considered: "Thank you for your response. We appreciate your participation in the NCCI edit process. The Centers for Medicare & Medicaid Services (CMS) owns the National Correct Coding Initiative (NCCI) and makes all decisions about its content. CMS evaluated your comments and has decided to retain the proposed NCCI Procedure to Procedure (PTP) edit. The change will be implemented in a future edit update. The update will be available for Medicare and Medicaid on the CMS website. CMS and the NCCI Program appreciate your time in making this submission."

The previous dialogue the AMA and the specialty societies have had with CMS and its contractor on NCCI edits helped to ensure that the edits were clinically accurate. In addition, the AMA and its members are aligned with CMS in being committed to patients over paperwork. The recent practices related to the creation of NCCI edits threatens the progress we have all made toward decreased administrative burden. Our belief is that the input of the AMA and medical specialties performing these services helps to improve the overall work product of the NCCI program.

The AMA has traditionally provided support for the NCCI program. This includes expedited data entry of the annual CPT code set solely for the purpose of creating files for CMS to begin their work on proposed edits that can be "fast tracked" at the beginning of each year. This is followed throughout the year with continuous updates from the AMA so that CMS always has the most accurate code set for the NCCI program. 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. In this light, we ask that Capitol Bridge utilize the previous practices employed, providing meaningful communication to ensure the quality and relevance of NCCI edits and processes.

We are hopeful that the background and examples provided will help in providing the needed direction around expectations to get these communications back on the solid, transparent, collaborative track among all parties (CMS, AMA and specialty societies) that has been so beneficial in the past.

Thank you for your consideration of this important issue. 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