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*Working collaboratively to assure patient access to
minimally invasive interventional procedures.*

February 22, 2008

Niles R. Rosen, MD
Medical Director
National Correct Coding Initiative
Correct Coding Solutions LLC
PO Box 907
Carmel, IN 46082-0907

****Submitted electronically via Email to niles.rosen@correctcodingsolutions.com
and linda.dietz@correctcodingsolutions.com****

RE: *National Correct Coding Initiative Policy Manual for Medicare Services* (Version 13.3):
Chapter 5- Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems (CPT Codes
30000-39999); example 16, page 12

Dear Dr. Rosen:

The American College of Cardiology (ACC), American College of Radiology (ACR), Society for Cardiovascular Angiography and Interventions (SCAI), Society for Vascular Surgery (SVS) and Society of Interventional Radiology (SIR) represent over 76,400 physicians [ACC 34000, ACR 32000, SCAI 3700, SVS 2400, SIR 4300] including the majority of practicing vascular interventionists in the United States. We are writing because we are concerned about the revision made to Chapter 5 of the recently released, 13.3 version of the *National Correct Coding Initiative Policy Manual for Medicare Services*. This revision establishes a guideline (example 16, page 12) that is in direct conflict with established AMA (American Medical Association) coding conventions for percutaneous endovascular therapeutic interventions, and also conflicts with the instructions provided to Medicare carriers in the *Medicare Claims Processing Manual*.

Per the recently revised *National Correct Coding Initiative Policy Manual for Medicare Services* (example 16, page 12),

If an atherectomy fails to adequately improve blood flow and is followed by an angioplasty at the same site/vessel during the same patient encounter, only the successful angioplasty may be reported. Similarly if an angioplasty fails to adequately improve blood flow and is followed by an atherectomy at the same site/vessel at the same patient encounter, only the successful atherectomy may be reported. If atherectomy and/or angioplasty fail to adequately improve blood flow and are followed by a stenting procedure at the same site/vessel during the same patient encounter, only the successful stenting procedure may be reported. These principles apply to percutaneous or open procedures.

This guideline is in direct conflict with established AMA coding conventions for correct coding of percutaneous interventional radiology therapeutic interventions. The codes used to report these services were specifically designed and valued to be reported as component codes, not as complete procedures. While we understand that CMS has a long-standing policy of only paying for the ultimate, “successful” procedure for open surgical procedures, we believe that the comparison with respect to coding of these open procedures to minimally-invasive, endovascular interventions is not correct. Most codes describing invasive surgical codes define and are valued as a complete procedure including potential attempted or intermediate steps leading to the final procedure. The codes that describe endovascular therapies, however, were defined and valued as modules; specifically designed to be used as building blocks with the expectation that more than one code might be used to describe the complete procedure.

Modular coding is used for procedures that have one or more of three traits. First, there are many instances where teams of physicians each performing either the endosurgical service(s) or the imaging guidance service(s) work together to provide the total service. Second, there are many instances in which multiple variants of the service might be performed, depending upon the patient’s specific anatomy, pathology, and other clinical circumstances. Third, there are many instances in which services might be offered in a variety of combinations and permutations in various circumstances. Modular coding for endovascular interventions has worked well to allow description of innumerable combinations of procedures with relatively few codes, rather than having thousands of codes to specifically represent all of the potential combinations. These codes were designed and valued to individually describe a portion of the total service being provided. These endovascular surgical component codes are subject to the 50% surgical reduction discount.

Component coding for percutaneous peripheral endovascular therapeutic interventions was established in 1992 with the specific and direct support of the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS- then known as HCFA). The national, established coding conventions for percutaneous interventional services clearly support reporting multiple interventions (including PTA, atherectomy, stent placement, etc.) when rendered by the same doctor, to the same patient at the same setting. These coding conventions have been detailed in numerous *AMA CPT Assistant* articles. Some examples of *CPT Assistant* articles detailing these coding conventions are, as follows (these articles have been included in their entirety as Attachments A-C):

Attachment A- “Component Coding of Interventional Radiology Services: Why and How”, *CPT Assistant*. Fall 1993

“Often diagnostic and therapeutic services are delivered in a variety of combinations and permutations as directed by the underlying disease process, the clinical evaluation of the patient, and the on-line interpretation of the diagnostic portion of the service (including physiological data and images obtained). These contingencies result in an almost infinite number of coding possibilities. If each of these possibilities were to be described by a unique code, the number of necessary codes would be enormous.”

Attachment B “Percutaneous Dialysis Declotting”, *CPT Assistant*. May 2001

This *CPT Assistant* article clearly details the correct coding using various component codes for endovascular intervention of dialysis grafts/fistulas that clearly supports reporting PTA services in conjunction with other therapeutic interventions.

Attachment C “Coding Transluminal Angioplasty”, *CPT Assistant*. 1996.

This *CPT Assistant* article presents the AMA’s coding recommendation for a PTA and stent placement of the right common iliac via the right groin. The recommendation clearly supports that correct coding entails reporting both, PTA and stent placement, as well as the corresponding radiological and supervision imaging and catheterization codes.

Quiz-How would you code the following?

3. PTA and stent placement of the right common iliac via the right groin, without diagnostic study.

Answers

3. 36200, 37205, 35473, 75960, 75962

The recently revised *National Correct Coding Initiative Policy Manual for Medicare Services* example 16 (page 12) is also in direct conflict with established Medicare claims processing instructions as presented in the *Medicare Claims Processing Manual*: Chapter 12 - Physicians/Nonphysician Practitioners (Rev. 1277, 06-29-07)(Rev. 1321, 08-24-07), which provides specific instruction for the processing of multiple interventional radiological procedures in section 40.6 - Claims for Multiple Surgeries (Rev. 1, 10-01-03) B3-4826, B3-15038, B3-15056 (example 19, page 92), as follows:

19. In cases of multiple interventional radiological procedures, both the radiology code and the primary surgical code are paid at 100 percent of the fee schedule amount. The subsequent surgical procedures are paid at the standard multiple surgical percentages (50 percent, 50 percent, 50 percent and 50 percent);

The application of the concept of “failed” procedures to complex percutaneous endovascular therapeutic interventions is not appropriate and does not recognize the fact that the most clinically successful therapeutic procedure requires a series of steps, none of which would be considered a failure. While one particular modality may not fully open the vessel, it is successful in enabling application of the next modality, and the combination in total is successful in reaching a clinically successful result. For instance, a patient with a severely ulcerated foot due to critical limb ischemia is found to have extensive dense plaque throughout most of the length of her femoral artery. Attempts to advance a stent delivery system through the diseased vessel are unsuccessful, so the decision is made to first treat the vessel with atherectomy to open a channel wide enough to allow passage of the stent delivery system. This additional step makes the difference between successful revascularization of the leg and failure to provide any amelioration of this patient’s severe problem. The atherectomy itself

was not able to open the vessel adequately to provide clinical relief, but is a successful first step in a series of steps that will ultimately result in a durable, widely patent artery.

Complex percutaneous endovascular therapeutic interventions are very intensive with respect to work and time, and also with respect to equipment and supplies required. Implementation of these new NCCI edits would result in total non-payment to physicians and facilities for services they have provided to patients, as well as lack of reimbursement for very expensive equipment and devices. It is important to understand that,

- (1) procedures which do not result in adequate blood flow often require more physician work than “successful” procedures, and
- (2) the success of the procedure often relies on a complex combination of interventions that ultimately result in restored blood flow, alleviating the patient’s symptoms, and that use of multiple interventions does not imply “failure” of any one, but all may be “enabling”, leading to the desired success and patient relief (e.g., angioplasty makes successful atherectomy possible; angioplasty and atherectomy make successful stenting possible.)

Non-payment for complex procedures such as these will result in these procedures not being available to Medicare beneficiaries. No physician or facility can afford to perform these limb-saving procedures if they are reimbursed for only one modality, since the codes which are applicable describe only one isolated portion of the procedure.

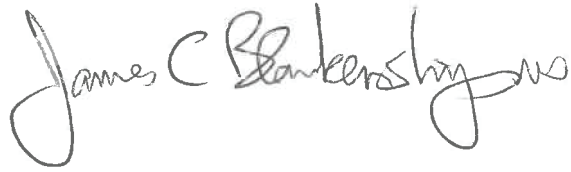
We are also concerned that this policy cannot be enforced. Aside from auditing all claims, there would be no way to ascertain which is the “final” procedure. Even the physicians performing these complex procedures are often unable to determine that one single part was the “final” treatment that resulted in success. There is also no way to determine which modalities are being applied to the same vessel versus a different vessel.

In summary, we believe the Version 13.3 edits go far beyond NCCI’s purpose of ensuring correct coding, into the realm of payment policy. We believe that it is not appropriate to use NCCI to change payment policy. We are extremely dismayed that CMS invoked this major change in policy without consulting any of the involved specialty societies beforehand. This unannounced disruption of established reporting conventions has left thousands of providers questioning how to correctly report procedures they do everyday. Finally, if CMS elects to disallow correct coding of, and payment for, various components of complex percutaneous endovascular therapeutic interventions the financial impact to providers can be described as nothing short of drastic. We believe that once the provider world is made aware of these reductions, there will be a sudden and significant loss of access to life and limb saving procedures for Medicare beneficiaries. Therefore we respectfully request that example 16 (page) 12 be revised or stricken from the *National Correct Coding Initiative Policy Manual for Medicare Services*. ACC, ACR, SCAI, SVS, and SIR representatives are ready and available for further discussion of this issue, if desired. Please feel free to contact the endorsing Societies’ staff detailed below, if you would like to arrange a conference call or meeting.

Sincerely,



Diane E. Wallis, MD, FACC
Chair, Coding and Nomenclature Committee
ACC



James C. Blankenship, MD, FACC
Chair, Cardiovascular Relative Value
Update Committee
ACC



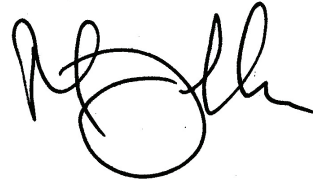
Richard Duszak, Jr., MD
Chair, Committee on Coding & Nomenclature
ACR



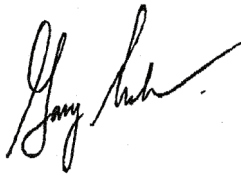
Bibb Allen, MD
Vice-Chair, Commission on Economics
ACR



Bonnie H. Weiner, MD
President
SCAI



Robert Zwolak, MD
Chair, Government Relations
SVS



Gary P. Siskin, MD
Co-chair, Economics Committee
SIR



Sean M. Tutton, MD
Co-chair, Economics Committee
SIR

CC: Linda Dietz, Correct Coding Solutions
Ken Simon, MD, CMS
Amy Bassano, CMS
Michael Beebe, AMA
Sherry Smith, AMA
Katharine L. Krol, MD, SIR
Robert L. Vogelzang, MD, SIR
Richard A. Baum, MD, SIR
Gerald Niedzwiecki, MD, SIR
Geraldine McGinty, MD, ACR
John Patti, MD, ACR
Scott Trerotola, MD, ACR
Diane Hayek, ACR
Maurine Spillman-Dennis, ACR
Angela Choe, ACR
Denise Garris, ACC
Wayne Powell, SCAI
Tricia McClenny, SIR
Deborah Ramsburg, SIR
Dawn R. Hopkins, SIR

Societies' Staff Contact Information

Denise Garris, Associate Director, Regulatory and Legal Affairs
American College of Cardiology
Phone: (202) 375-6496; Email: dgarris@acc.org

Maurine S. Dennis, Senior Director Economics and Health Policy
American College of Radiology
Phone: (703) 648-8900, ext. 4559; Email: MSDennis@acr.org

Wayne Powell, Senior Director for Advocacy and Guidelines
Society for Cardiovascular Angiography and Interventions
Phone: (202) 375-6341; Email: wpowell@scai.org

Tricia McClenny, Associate Executive Director
Society of Interventional Radiology
Phone: (703) 691-1805; Email: McClenny@SIRweb.org