AAOS
American Association of Orthopaedic Surgeons

October 2, 2020

Omar Latif, MD
Vice President of Health Care Management
Anthem Blue Cross Blue Shield
220 Virginia Avenue
Indianapolis, IN 46204

Dear Dr. Latif,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we would like to make you aware of two letters we recently sent to AIM Specialty Health regarding policy changes that have negative implications for our members and their patients.

Please see attached to this cover letter the following two letters:

1. A letter from AAOS to AIM Specialty Health regarding AIM Specialty Health Musculoskeletal Program changes issued on July 1, 2020, and effective October 1, 2020. The policy pertains to four spine codes (CPT codes 22633, 22634, 63265 and 63267) and two joint codes (29871 and 29892), and new requirements for providers to substantiate medical necessity should they opt to perform these procedures in the inpatient setting.

2. A letter from AAOS to AIM Specialty Health regarding the AIM Specialty Health Clinical Appropriateness Guidelines for Joint Surgery which states that concomitant subacromial decompression/acromioplasty is not medically necessary in conjunction with rotator cuff repair procedures. This policy has led to the denial of shoulder codes (CPT codes 29824 with 29826, and 29824 with 29827) when reported together.

The urgency of this request is accelerated by the continued challenges placed on clinician practices during the COVID pandemic, and the additional burden this will place on those practices. A survey published by AAOS on May 12, 2020, focused on COVID impacts, found that 79% of individuals considered their biggest challenge to be “catch-up” in the next three to four months. Implementing these policies while practices are attempting to resume normal operations only further restricts necessary patient care.

Toward this end, the AAOS would welcome working with Anthem Blue Cross Blue Shield to explore innovative alternatives to prior authorization requirements that improve care and outcomes for patients. For the reasons expressed above, we strongly request that AIM Specialty Health permanently suspend these new site-of-care requirements. We will also be reaching out to Anthem Blue Cross Blue Shield to express our concerns with this policy and ask them to not adopt this policy.

We are open to further dialogue with AIM Specialty Health to resolve this and appreciate your time and attention to this issue. Please contact Shreyasi Deb, PhD, MBA deb@aaos.org to facilitate further discussions.

Sincerely,

Joseph A. Bosco, III, MD, FAAOS
President, AAOS

cc: Daniel K. Guy, MD, FAAOS, First Vice-President, AAOS
Felix H. Savoie, III, MD, Second Vice-President, AAOS
Thomas E. Arend, Jr., Esq., CAE, CEO, AAOS
William O. Shaffer, MD, FAAOS, Medical Director, AAOS

AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

AANA
ADVANCING THE SCOPE™

NASS
ADVANCING GLOBAL SPINE CARE

aossm
American Orthopaedic Society for Sports Medicine

October 2, 2020

Richard Valdesuso, MD, MBA, MA
Senior Medical Director, Musculoskeletal
AIM Specialty Health
8600 West Bryn Mawr Avenue
South Tower, Suite 800
Chicago, IL 60631

Dear Dr. Valdesuso,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we would like to respond to updates to the AIM Specialty Health (AIM) Musculoskeletal Program. Specifically, we are writing to request revoking the new setting determination requirements, which were issued on July 1, 2020, and will be effective October 1, 2020.

The urgency of this request is accelerated by the continued challenges placed on clinician practices during the COVID pandemic, and the additional burden this will place on those practices. A survey published by AAOS on May 12, 2020, focused on COVID impacts, found that 79% of individuals considered their biggest challenge to be "catch-up" in the next three to four months. Implementing such a policy while practices are attempting to resume normal operations only further restricts necessary patient care.

The policy pertains to new requirements for providers to substantiate medical necessity should they opt to perform procedures identified by four spine codes (CPT codes 22633, 22634, 63265 and 63267) and two joint codes (29871 and 29892) in the inpatient setting, to include one of the following:

- Current postoperative care requirements are of such an intensity and/or duration that they cannot be met in an observation or outpatient surgical setting.

- Anticipated postoperative care requirements cannot be met, even initially, in an observational surgical setting due to the complexity, duration, or extent of the planned procedure and/or substantial preoperative patient risk.

We understand that Anthem Blue Cross and Blue Shield, and several of their state subsidiary health plans have indicated that they follow the AIM Musculoskeletal Program and will be adopting this new policy. These health plans are in the following states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Nevada, New York, Ohio, Virginia, and Wisconsin.

The AAOS has concerns with these requirements for several reasons:

1) Supersedes Physician Autonomy

Requiring specific criteria for levels of care that are dictated by an outside third-party erodes the doctor-patient relationship, and the ability to make decisions that are in the best interest of the patient. Clinicians go through years of training, and patients share personal information that dictates what type of care patients seek, where, and how it is delivered. In fact, in the Centers for Medicare and Medicaid Services (CMS) 2021 Outpatient Prospective Payment System (OPPS) proposed rule, they talk about this very issue, explaining that *"the physician should use his or her clinical knowledge and judgment, together with*

consideration of the beneficiary's specific needs, to determine whether a procedure can be performed appropriately in a hospital outpatient setting or whether inpatient care is required for the beneficiary".[1]

2) Increases Administrative Burden

This policy would add significant burden for providers. For some patients it is advisable to have an inpatient admission and adjust accordingly if the patient is able to go home, or if they are able to stay for just one night of observation. The prescriptive nature of this requirement does not allow for these real-time clinical considerations in terms of adjusting a patient's course of care appropriately. There is also the increased administrative workload that would result from the additional documentation to justify an inpatient admission, and any peer-to-peer conversations where discrepancies arise. The continued issuance of these policies is untenable to daily operations, when external approval is needed for an internal decision.

3) Negative Impact on Patient Care

Perhaps, most unfortunate is the negative impact that these policies will have on patients. These site of care requirements will only delay necessary patient care, which could lead to adverse patient outcomes. For every new requirement like this provider personnel resources and efforts are redirected away from optimizing outcomes for patients and toward administrative paperwork. The answer to improving patient outcomes does not rely on intervening in the operational day-to-day work that providers have been trained to do but focusing on means to support their clinical efforts.

Toward this end, the AAOS would welcome working with AIM Specialty Health and Anthem Blue Cross Blue Shield to explore innovative alternatives to prior authorization requirements that improve care and outcomes for patients. For the reasons expressed above, we strongly request that AIM Specialty Health permanently suspend these new site-of-care requirements. We will also be reaching out to Anthem Blue Cross Blue Shield to express our concerns with this policy and ask them to not adopt this policy.

We are open to further dialogue with you to resolve this and appreciate your time and attention to this issue. Hence, please let us know your availability for a call to discuss these issues further. Please contact Shreyasi Deb, PhD, MBA deb@aaos.org to facilitate further discussions.

Sincerely,

Joseph A. Bosco, III MD, FAAOS
President, American Association of Orthopaedic Surgeons

Brian J. Cole, MD, MBA
President, Arthroscopy Association of North America

William J. Sullivan, MD
President, North American Spine Society

Michael G. Ciccotti, MD
President, American Orthopaedic Society for Sports Medicine

[1] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 85 FR 48772 (proposed August 12, 2020) (to be codified at 49 C.F.R. pts. 410, 411, 412, 414, 414 and 419).

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Senior Medical Director, Musculoskeletal
AIM Specialty Health
8600 West Bryn Mawr Avenue
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Chicago, IL 60631

Dear Dr. Valdesuso,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we would like to respond to updates to the AIM Specialty Health (AIM) Musculoskeletal Program. Specifically, we are writing in reference to a policy regarding subacromial impingement syndrome effective May 17, 2020.

Arthroscopic acromioplasty has been recognized as a medical necessary and effective treatment for certain shoulder pathologies since it was first described in 1985 by Ellman.[1] It has had Category I CPT code since the American Medical Association's Resource-Based Relative Value Scale (RBRVS) was implemented in 1992. Category I CPT codes are widely reported and recognized as effective treatment and are not considered experimental.[1]

Recent Guidelines published by AIM Specialty Health[2] state that "concomitant subacromial decompression/acromioplasty is considered not medically necessary for all rotator cuff repair procedures." The American Academy of Orthopaedic Surgeons, The Arthroscopy Association of North America (AANA), The American Shoulder and Elbow Surgeons (ASES) and the American Orthopaedic Society for Sports Medicine (AOSSM) represent the community of practicing orthopaedic surgeons in the United States. Our societies believe that determining medical necessity is the provenance of individual orthopaedic surgeons making treatment decisions in the best interest of their patients.

The publishers of the AIM guidelines share our sentiment with the following disclaimer:
"These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines."[3] The publishers also state *"The Guidelines do not address coverage, benefit or other plan specific issues"*[4] and we could not agree more. Treatment guidelines should not govern coverage and reimbursement policy.

The Guidelines published by AIM are in direct conflict with AMA CPT Guidelines which designate CPT code 29826 *(Arthroscopy, shoulder, surgical decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure))* as an add-on code. The CPT

[1] American Medical Association. Criteria for CPT® Category I and Category III codes. Accessed https://www.ama-assn.org/practice-management/cpt/criteria-cpt-category-i-and-category-iii-codes
[2] AIM Specialty Health. Clinical appropriateness guidelines. Musculoskeletal Program AIM 2020. Available at www.aimspecialtyhealth.com.
[3] Ibid
[4] Ibid

code descriptor clearly states that code 29826 should be *listed separately in addition to the code for the primary procedure*. Parenthetical instruction in CPT also states that code 29826 is to be used in conjunction with codes 29806-29825, 29827 and 29828. Furthermore, there are no existing National Correct Coding Initiative (NCCI) edits in place for these code pairs which would preclude one from reporting these codes together. The AIM guidelines have bundled these procedures which has resulted in denials of code pairs 29824/29826 and 29824/29827 when reported together.

Lastly, AAOS created the Global Service Data Guide for Orthopaedic Surgery (GSD). The guide is published yearly and contains examples of CPT codes included in and excluded from the global service package. The GSD states specifically that codes 29826 and 29827 are *excluded* from the global service package, and therefore, separately reportable. Given the overwhelming amount of guidance from the Centers for Medicare and Medicaid Services (CMS), AMA and AAOS, we strongly urge AIM to reconsider their guidelines and rescind these policies.

We welcome dialogue with AIM Specialty Health to resolve this issue and appreciate your attention to this issue. Please contact Shreyasi Deb, PhD, MBA (deb@aaos.org) to facilitate further discussions.

Sincerely,

Joseph A. Bosco, III MD, FAAOS
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Brian J. Cole, MD, MBA
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