APPROVED

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Meeting Minutes
Wednesday, May 25, 2011
8am-4pm
Call-in Number: 1-800-406-9170
Conference ID: 3891479554#
http://coloradomedicalsociety/acrobat.com/cleanclaimswebinar/

Attendees:

- Tammy Banks*
- Michele Baran (by phone)*
- Helen Campbell (by phone)*
- Heidi Canono*
- Dee Cole
- Rebecca Craig
- Dr. Tom Darr*
- Kim Davis*
- Dr. Mark Dawson*
- Lori Harris (by phone)
- Wendy Healy*
- Barry Keene (Co-Chair) *
- Rose Laur (Mark Rieger alternate)*
- Lori Marden*
- Dr. Douglas Moeller*
- Mark Painter*
- Carol Reinboldt*
- Marilyn Rissmiller (Co-Chair)*
- Robin Weston (by phone)*
- BethAnn Wright*

Meeting Objective (s):

- Assess CCI scope of work and time table
- Identify how the pieces are fitting together
- Identify where we can apply more resources and what they are
- Identify and recommend committee next steps

Key:
-TFM = Task Force Member
-CC = Co-Chair

**Power Point presentations are available on the website.

Parking Lot:
Fee Schedule adjustments

TFM needs to keep track of insights and suggestions of changes that need to be made to the system in order to update processing.

Provider/coding education

• Kirstin Michel • Jessica Morgan (Anthem) • Kelly Shanahan-Marshall • Christine Velez • Barbara Yondorf • Kathryn Zwack Public attendee • Mark Reese • Bob Semro (Bell Policy Center) • Larry Tolle • Rebecca Tolle • Rebecca Weiss (Anthem)		

MEETING MINUTES

Topic	Discussion	Action	Due Date
Welcome and Introductions	**ROLL CALL & WELCOME:** 17 Task Force Members* in attendance	**Quorum Met**	

Housekeeping • Approve April 27, 2011 Minutes • Review of day's agenda • Meeting procedures Brief review of HB10-1332 Timeline and deliverables	**APPROVAL OF APRIL MINUTES:** Minutes approved as drafted. **REVIEW OF TODAY'S AGENDA:-** • CCI and PSO will need TFM feedback after each presentation. • Introduction of new facilitator: Barbara Yondorf • Advised TFM of the appointment of the replacement of a representative for ASCs, Rebecca Craig. However, Rebecca's schedule did not allow her to attend this meeting. **MEETING PROCEDURES:** • TFM turn tents up to be acknowledged • TFM calling in will need to speak up • Process on how to handle consensus. Facilitator suggests going through each presentation (CCI and PSO) and then circling back to questions and consensus. • The intent is to hear all information and then put together key questions. • Questions about process and clarifying questions should be asked during the presentations. Key question and discussions will happen after the presentations. • Write down the issues in your mind, so that we can have the discussion later on. **BRIEF REVIEW OF HB10 HB10-1332 TIMELINE AND DELIVERABLES:** • Kelly - Reiterate charge: HB1332 develop complete set of **uniform standardized** payment rules and claims edits. This applies to all payers having contracts with providers in Colorado.	**Minutes Approved**	

	• Review of timeline - reporting and presentation to legislature in January 2013. Present to director of HCPF in December 2012. Really need to wrap up August/September 2012 because the TF needs time to write report. • Review of list of 7 existing National Industry Sources to be considered in the base set and look at what is missing in order to reach mileposts . • Want outcome to be transparent and clean.		

Topic	Discussion	Action	Due Date
Committee Reports • Correct Coding Initiative (CCI) • Professional Society Outreach (PSO) • Data Sustaining Repository (DSR) • Project Management (PM) • Finance	**COMMITTEE REPORTS:** Scope of work, report of activities to date, recommendations, issues to be resolved or investigated, questions for the full task force, next steps.		

Topic	Discussion	Action	Due Date

CCI Committee Report	**CCI - Beth Wright****
	PRESENTATION:
	• Review of subgroup members (9 TFMs)
	• SOW: analyze NCCI concepts and methodologies to understand application and make recommendations to TF.
	• NCCI is the base set of edits. Evaluate the NCCI edits where the denied code has the higher RVU. Analyze RVU data - focused on non-facility RVU file from January 2011.
	• Currently looking at how to store files so that TFM can have access.
	• CCI group want blanket rules that can be sustainable.
	• **Current recommendation for TF consensus: If modifier override is allowed, leave NCCI edit in place. Providers should code claims using appropriate modifiers.**
	• Focus on edits where no modifier override is allowed.
	• Looking at individual edits that may be flawed
	• Next, the CCI sub-group will look at all combinations where no modifier override is allowed.
	• **Question to TF: In the case of an NCCI edit where the denied code has the higher RVU, if a payer has a policy in place allowing payment for both services, what would be the direction of this task force? Goal for discussion is to obtain consensus on whether a health plan policy can override the NCCI edit.**
	• Additional Areas of review:
	  • Specialty Society
	  • Payment modifiers - don't know which modifiers are allowed for each specific instance.
	  • Next steps:
	  ○ Continue analysis
	Obtain data and analyze where there is no modifier override when lower RVU is denied.
		Consensus reached
		
		Parking Lot	

	DISCUSSION: TFM Question: Going back to exceptions - does payer have the ability to review modifier usage for over utilization? Answer: Yes, the payer does have the right to audit. Question: Are you talking about the modifier they have to modify their edits? Modifier discussions: 1) CMS does not state what modifier can override a CCI edit 2) Future discussion on whether we need to build edits that indicate when a modifier is inappropriately billed with a specific code. The subgroup looked carefully at top 100 codes where denied code is the one with the higher RVU. Edits are based on CPT. The other procedure has part of its procedure as part of the higher RVU. Many of the code combinations include Evaluation & Management (E&M) codes. This set of edits makes sense within the larger set of edits. CPT coded guidelines: add-on codes protect the payment of the additional procedure codes. Need to keep certain types of edits. Specific example used to discuss the policy question needs to be explored from a coding perspective. Larger issue regarding policy positions is still outstanding. What are we going to include in contractual exceptions? It is important to reduce administrative burden. TFM: suggest that NCCI is not perfect but it is a reasonable approach with 2-3 dozen edits that need to be excluded. Best if TFM could come up with a mechanism to accept the bulk of the rule but identify and remove the 2-3 dozen edits that don't work. Focus is to create a sustainable rule and not select specific code edits to be removed. We also have to remember that we are charged to facilitate the legislative process.		

Topic	Discussion	Action	Due Date

Professional Society Outreach	**PSO - Tammy Banks***
	• What is a code edit? Get explanations and perceptions of approach.
	• Came up with guiding principles that have been agreed on so far.
	• Review of SOW
	• Trying hard to secure Dr. Rosen or another representative from NCCI to present at a future meeting
	• Review of PSO subcommittee activities to date
	• Existence of transparent easily accessible system
	• Current code edits are antiquated and we need to look at code edits in way that makes sense to stakeholders.
	• Questions to TF:
	  ○ Is there any other purpose the code edits should achieve?
	  ○ How to keep a public code edit library sustainable that meets the needs of all the stakeholders
	  ○ What is the computer logic for code edits and denials and the resulting work flow in the physician practice management system/payer adjudication system?
	  ○ Are there any other additional payer specific code edits that should be included in the NCCI code edit set?
	• Focus on:
	  ○ Accurate coding edits
	  ○ Benefit level determinations (health plan medical benefit to the patient) to remove ambiguity
	  ○ Fraud and abuse
	  ○ Fee schedule adjustments -*Tag for discussion later*
	• Review of criteria for data analysis
		Parking Lot	

	Question to TFM: In the development of payer edits, was thoughtful consideration given to all AMA and National Medical Specialty Societies' policy documents, clinical vignettes, comments, etc? • Specialty Societies were okay with NCCI code edits. They have an appeal and review process in place. • Some specialty societies have recommendations that some procedures have become a medical necessity. • Looked at NHXS data for the top 10 code edits where the code is not allowed and the top 10 code edits where the code is allowed. • The point is that Specialty Societies are represented in NCCI code edits. • Payers have specialty code edits other than those found in NCCI		

	PSO PRESENTATION DISCUSSION: TFM Question: Does there need to be an expedited CPT review? Getting on the CPT agenda can take several months. There is also an 18 month delay for changes to be made. How do we create a process that is expeditious? How many expedited requests would CPT take? Would they have an expedited process just for this Task Force? TFM comment: Not everyone agrees that CPT is as accurate as we would like to think nor is the process completely understood. There needs to be intrinsic changes to the CPT process. Facilitator comment: TFM needs to keep track of insights and suggestions of changes that need to be made to the system in order to update the process. TFM comment: There are limitations to the CPT process because they need to standardize procedures. Needs consensus among stakeholders on usage. TFM comment: Communication is key among all stakeholders. Comment: Process has to be transparent and open so that contract negotiations between payer and provider can be fair and honest.	**Parking Lot**	

	TFM comment: Most people are not professional coders. How do we educate providers? How do we alleviate misguided coding? Is it within the scope of work of this Task Force to get more trained providers? Answer: In that it contributes to the problem, there is no reason why some discussion of this issue cannot find its way into our report. **DISCUSSION OF CCI & PSO PRESENTATIONS:** <u>Facilitator process for discussion:</u> 1. Do we pursue the issue? 2. Is there a solution to the problem? 3. Policy issue discussion <u>Discussion</u>: CCI subgroup request for TF consensus: If a modifier override is allowed, leave NCCI edits in place. Providers should code claims using appropriate modifiers. Question: From a payer's perspective, is it correct coding to require different and distinct diagnosis code? Answer: No. TFM comment: Sees consensus question as two different questions. Answer: We are saying these edits make sense if they are not modified. We are only saying that if it is not modified, the higher RVU should be denied. CCI subgroup found that if modifier overrides are allowed, then it is something they could live with. The subgroup did not address a feedback loop to NCCI but it is a good idea that should be pursued.	**Parking Lot** **Parking Lot**	

	TFM comment: I need to bring this back to my medical board because we have criteria around billing modifiers 25 & 59. We want something identifying what is distinct about the procedure. Answer: The request for consensus is not about whether the modifier is appropriate. This is not about payment policy. We are only asking the TF to help define the scope of work for the CCI subgroup. Which modifiers are allowed with which codes is not addressed. For later discussion, does this fall within the CCI subgroup scope of work? There are 35 modifiers that can be used to override an NCCI edit. The list will be shared with the CCI subcommittee. <u>PSO Discussion</u>: 1. Specialty societies are represented in NCCI. 2. Are there other specific specialty pair edits that can be considered for inclusion in NCCI? TFM question: Are there specialties not represented? Answer: We don't know. TFM question: Is NCCI inadequate for specialties? Edits have not gotten the care, attention, and revisions necessary. Answer: Specialties feel they are adequate for same day edits. They are not adequate for global days. The NCCI process does not exclude specialties. HCPF TFMs are in agreement with observations from PSO subgroup.		

	Are there specialties missing? If yes, there is a relatively easy process for identifying that they are missing. The TFM feel comfortable that specialties are represented within the NCCI coding package. From the point of view of the specialist, they are okay with NCCI. CCI subgroup is charged with evaluating the usefulness of NCCI. PSO says Specialty Societies are represented in NCCI. To the degree where there are holes, do payers feel NCCI is complete? It is a totally differentr issue to say that specialties are represented but edits may not be robust enough. Is it fair to say that an output of this task force is to come up with NCCI-PLUS. Is it up to this task force to come up with more robust edits? Are there other edits that should be included? Is this part of our Scope of work to come up with edits for NCCI? TFM question: If NCCI is our base will the TF have to do a gap analysis? Answer: No. The statement is that we have found nothing to date that would make us exclude using NCCI as base. **National Medical Specialty Societies are represented within NCCI edits.** **There is nothing about the NCCI process that necessarily excludes any specialties.** Due to timeline constraints, can we note things in the report that need further discussion? What are the issues? Can we identify what can be resolved, e.g. what is a code edit? Do we agree that code edits are in place to help providers do correct coding?	**TF agreement** **TF agreement**	

	Purpose of code edits is to have physicians report procedures accurately. "Code edits that make sure the procedures and services performed are reported accurately and consistently with CPT." Our task is to look at unbundling, the mutually exclusive code pairs and what is allowed and not allowed. Whether or not the physician pulls the correct code out of the CPT book is not part of our scope of work. Facilitator comment: We will keep these concerns in the parking lot. CCI subgroup question to TF: What do we do if a payer has a policy in place to pay for 2 services that we have traditionally paid for but there is a disagreement in NCCI. Do we follow NCCI and disregard payment policy? TFM comment: Proportion is important. This topic needs to have a robust discussion but we need to have a notion as to the proportion and economic impact. • Is there a mechanism to look at advantages and disadvantages to providers. • Don't want to lose sight that there will be winners and losers in this process. TF question: Is this a maximum set of edits? Cannot substitute, change or edit? TF comments: This is a good conversation of standardizing edits. However, we have to understand the different pairs of edits. Understand that there will be policies and procedures that will be applied by payers.	**Parking Lot**	

	Is the point maximum edits, do we need to look at this more closely? We are establishing process guidelines for clients. We cannot reach outside to benefits. However, there is no avoiding stepping into benefits. We need to set up a baseline. Some benefits will crossover into the code edits that we come up with. We have to stay within our scope and present a reasonable baseline. NCCI is not the maximum. It is a starting point. Payment/reimbursement policies are not within our scope of work. We are coming up with edits that are within the norm. What happens if a health plan says we have additional edits. I think this is why Tammy is trying to get us to define, "What is an edit?" If a payer has an edit for which we already have an edit, what is the enforcement of that? I think we have a lot of work to do before we can make recommendations around that. A payer cannot define a more stringent edit than what we come up with. We can have more stringent and richer edits but understand that there will be contractual agreements between payer and provider. Our TF is looking at the edits that are mutually exclusive and bundling but I think the definition in the legislation is broader than that. We do have concurrent E&M for Peds and ObGyn that are excluded in NCCI. We also have edits that are not consistent with NCCI. We have over 2.5 million edits that are proprietary. I think it is good to start with the statement, "If we use NCCI, then this is what you need to know about NCCI."		
	I like the idea of a base set of edits, can we be more literal with a set of edits, is there a maximum. What kind of information can help us stay within the spirit of the law and yet helps us put our arm around the issue.		

Topic	Discussion	Action	Due Date

	The facilitator requested that the group do a roundtable and TFMs provide their opinions on NCCI, the edits and the TF scope of work. Some individuals declined to comment. • There was significant discussion around the NCCI edits and whether they were a starting point or the maximum set. • It was not the intension of the legislation that NCCI should be the maximum set of edits; NCCI is a starting place. The Task Force needs to review the industry sources identified in the legislation to determine whether or not to endorse them as part of the larger set of standard edits. • The TF will have to agree upon how to handle each one of the industry sources, accept in total, accept with certain caveats, reject, etc. The TF has started the process by analyzing NCCI. • The legislation has a broader definition of "edit" than just the 700,000+ NCCI edits. One health plan has approximately 2.5 million different edit codes; there are many that NCCI does not address. Therefore, NCCI alone is not sufficient. • The Task Force has a huge opportunity to explain the methodology behind the edits [payments]. There needs to be more transparency regarding how payments get processed. • There is an economic impact of this opportunity. • The goal of the legislation is to have a set of edits for reimbursement. There is an opportunity for NHXS to use their data to look at payor-specific edits. This is the bucket of payors and edits that does not match CCI. NHXS could perform another level of analysis: what is the variance among payors? • One TFM has genuine concerns and feels that there needs to be a healthy balance. The TF needs to be more liberal on the set of edits and come up with a consensus. • • Another TFM felt a reasonable guideline set should be presented, "the perfect is the enemy of the good."		16

	• Another TFM felt a reasonable guideline set should be presented, “the perfect is the enemy of the good.” • Outstanding questions: Does the Task Force have purview over a health plan that decides to pay edits that are not determined by this Task Force? Can a health plan policy override an NCCI edit? • Administrative simplification is one of the overall goals of the legislation. The TF needs to be aware of how its work impacts the workflow of the providers and the payers. • CMS has mandated that Medicaid agencies use CCI.		

Lunchtime Presentation and Discussion	Over lunch the Task Force heard presentations regarding the initiatives that are underway in other states. 1) Lori Marden/Laura Darst presented information on an initiative from Minnesota. The AUC was established 15 years ago. All payors licensed in Minnesota had to comply with new legislation by 2009. Providers are now required to send data electronically. In addition, a data standardization process based on Medicare codes took place with the intent of providing better information to payors. Some of the challenges faced were determining the scope between coding and reimbursement and what to do with consult codes that are no longer paid by Medicare. In addition, the initiative involved looking at other opportunities and providing recommendations to the commissioner. In addition, mandated pharmacy prior authorization legislation was passed. A question was posed regarding bringing issues to the committee. The response was that there is an operations group that has an equal balance of payors and providers. When voting, there must be a quorum. There is a technical advisory group that meets once per month. Unfortunately the issue of coding is never completed; there are always new things. The key is to have a process of checks and balances. In response to another question it was reported that there are penalties for non-compliance with the legislation, but that it is largely complaint-driven. A party would have to file a complaint in order for penalties to be assessed.		

	2) Kim Davis reported on HB 5346 was passed in the state of Washington and currently includes voluntary requirements. Link to legislation: http://www.onehealthport.com/worksmart/sb5346.php. The commissioner can mandate adoption of best practices, including enhanced eligibility guidelines, timelines for processing, browser-based tool development, reason codes for denials and adjustments, and implementation of fee schedules. It was suggested that Oregon also has new legislation as well. The TF will research and report at a future meeting. 3) Kelly Shanahan Marshall described the Colorado Innovative Benefit Design Project. This project is funded through the state Medicaid agency. The purpose is to bring comparative effectiveness research to benefit design. The University of Michigan is watching experiments with design. Typically self-funded plans are experimenting, since they are able to operate outside of the confines of legislation. The project is looking at services based on value. A tool has been created that categorizes high value services as "green" and low value services as "red" across a spectrum. Higher cost sharing barriers are being tested for red zone services. Shared decision-making is being encouraged, by engaging patients in decision-making and developing patient decision aids.		

Post-lunch Discussion	After the presentations, Barbara continued facilitating the discussions that were ongoing prior to the break. • Barry outlined the framework of legislation. Payment to providers is outside of the discussion, which should focus on developing a consistent code editing system for medical tasks and work. • TFM described the history behind why claims auditing is considered proprietary. The rules are not proprietary and payors can share information about rules. Edit codes are proprietary since different companies use edits in different ways. About five years ago, more transparency was introduced. There is still hesitation to publicize the different sets of edits. • TFM asked if providing the rules will cause physicians to change their billing behavior to meet or take advantage of the rule set. Will physicians try to beat the system? • When CCI came out it was a "black box." It is difficult to negotiate when both parties are not privy to the terms of the contract. • TFM suggested that the TF start with the NCCI edits but that additional edits may be needed for payors. What else is missing for coding/edits? • There was much discussion around the term benefit design and whether or not code editing was ever utilized to achieve correct processing in these instances. • The payer representatives felt that there is nothing code-related in benefit design, a member's benefit package has nothing to do with claim edits. Edits should be based on correct coding. Physicians should bill for the services they render.		

	• The legislation does not address edits on the billing side, it only addresses the edits on the payor side. It should have addressed both, but it does not. The insurance carrier cannot deny a claim if it contains the correct elements. • The question of which should come first was raised, when Medicare is using its own code rather than the CPT code for the same service. • TFM feels attention needs to be given to developing modeling analytics. He doesn't like the idea of winners and losers (as described by CC earlier in the discussion) and the assumption that "things will settle out" eventually. Instead, there needs to be modeling to ensure that the TF develops something that is fiscally responsible. Contract negotiations are expensive.		
	Barb facilitated the group to start discussing Next Steps ○ Rose Laur offered to obtain more information. ○ Have physicians' needs been met? How can the Task Force help to make their lives easier?	**NHXS to provide PSO Comm. with addtil. data on specialty edits**	**June 25, 2011**

	• Dr. Dawson said that they need to start with NCCI. He can understand the physicians' frustration and that indeed there are many edits above NCCI. The TF needs to go back to employers to see what they can bring to the group with respect to proprietary edits. They can start with NCCI but need to look at other edits.
	• Typically providers consider edits payor-specific if they are not NCCI or CPT.
	• Marilyn said that the Task Force should put the non-NCCI edits in buckets so that they will not be tied to specific payors and can be analyzed for the underlying source of the edits.
	• Barry Keene requested that decisions and next steps be confirmed.
	• Barbara Yondorf asked if any Task Force members could get decisions from their organizations within one month regarding providing edit codes or rules?
	  ○ Rose Laur responded "Yes"
	  ○ Dr. Dawson said that he try to obtain permission from McKesson to determine code edits that are Aetna-specific. Aetna uses McKesson's product.
	  ○ Lori Marden will try to obtain permission
	  ○ Dr. Moeller said that he could start with the rules. This has been a strong business model and how quickly he can receive a response is uncertain. Customers are not permitted to disclose large sections of the knowledge base. He will have to determine what is McKesson's requirement. However, the national physician fee schedule is public domain.
	  ○ BethAnn Wright indicated that she would like to wrap up the RVU information within NCCI by the end of June. The specialty edit piece would be the next piece. Can the group begin to meet weekly?
		Obtain decisions from organizations within one month regarding edits codes or rules	**June 25, 2011**

	○ Tammy will work with Dr. Dawson on specialties and come up with some recommendations. ○ Dr. Dawson suggested to Rose Laur that she look at the code edits that are used most commonly among payors. ○ Dr. Darr brought up the question of workload and indicated that tasks need to shared among the sub-committees		

Topic	Discussion	Action	Due Date
Data Sustaining Repository Sub-Committee Report (Rose Laur)	The sub-committee team has just been formed. They are working on setting up the first meeting and developing a Scope Of Work. The committee members are as follows: • Chair: Mark W. Rieger, NHXS • Two payor vendors: Doug Moeller (McKesson) & Tom Darr (Ingenix) • Two provider vendors: Mark Rieger & Mark Painter (Relative Value Studies) • Two payors: Mark Dawson (Aetna) & Heidi Canono (Kaiser) • Two providers: Robin Weston (Centura) & Wendy Healy (Western Nephrology)	**Set up first meeting** **Develop Scope of Work**	**ASAP** **TBD**

Topic	Discussion	Action	Due Date

Project Management Report (Barry Keene)	• All tasks from March are completed.
	• May:
	  • Web site design is completed.
	  • Rebecca Tolle is present at the meeting today. TFMs now have passcodes and the link to the web site.
	  • Additional features that will be added include: 1) a page for other state activities; 2) a system to add links to documents on other committee's home pages; and 3) develop a team logo.
	  • Outreach (Line 78): still trying to get Niles Rosen to the meeting. It is imperative that CCI be represented
	  • Refining facilitation (line 79) Facilitation will now be handled by Barbara Yondorf
	  • New goals of the Project Management team include:
	  ○ Improving the automation of the catering
	  ○ Securing ongoing use of the University Physicians Boardroom
	  ○ Improving the meeting menu
	  ○ Improving the conference phone service
	  ○ Training members to use the web site
	  ○ Recruiting additional members to the project management team to take on some of the management tasks
	  ○ The Committee Chair requested that Task Force members review the web site and provide feedback. Images on the web site are currently arbitrary.
		Create page for state activities
		Enable posting on committee home pages
		Develop a Task Force logo
		
		Improve catering and menu
		
		Secure meeting space
		
		Improve phone service
		Recruit members to PM team
		
		Review web site and provide feedback
			
			August 2011
			
			August 2011
			
			August 2011
			
			June 2011

Topic	Discussion	Action	Due Date
Finance Committee	In March, the committee updated the budget. The committee has communicated with foundations and other funders. The team will embark on outreach for additional funding sources. Rocky Mountain Health Plans has made a pledge (through Lori Marden). Molly from Bell Policy is working on a WellPoint Foundation application and negotiating additional funding. More committee members are engaging to assist with TF funding. Wendy Healy is working on some things. In May, the committee managed to have first year funding in place. Overall, the TF has a $133,000 budget. To date, $70,500 has been pledged or received. Second year funding needs to be in place by the November meeting. To date, the TF is operating under budget since expected expenses for coordination and facilitation were not incurred early on in the process. A Thank You was extended to Anthem Blue Cross Blue Shield for sponsoring lunch at today's meeting. The Finance Committee provided an impromptu report to Colorado Trust. Originally the meeting was expected to be in June. Regardless the meeting went fine. There is a report to the Colorado Health Foundation scheduled for June 2011.	**Complete report to Colorado Health Foundation**	**June 2011**

Topic	Discussion	Action	Due Date
Next Steps	The following Next Steps were agreed to by the Task Force members: 1) Coordination of additional committees: It was suggested that modeling tools be developed. Can the Data Sustaining Committee take this on to begin with? There was discussion regarding what is being modeled? A set of claims data needs to be run through a model combination of rules and edits, conducting quality assurance, and timeline for delivery. It was determined that such a model needs to be developed by the first or second quarter of next year. It is understood that payers will probably want to do their own modeling.	**Develop model**	**Q1 or Q2 of 2012**
	2) There was a question for each of the sub-committees: What is on agenda for the August in person meeting? What can each sub-committee accomplish by August? a. Professional Society Outreach (PSO) Sub-committee: Tammy Banks (Chair) indicated that they will present the process, timeline, and other initiatives for CPT. (They will know in July if they can present in August.) They will develop guiding principles. They will work with NHXS and United HealthCare to obtain a list of specialty pair-specific edit sources. They will put these in a specific format or buckets to promote sustainability. If they can analyze data from other payers, they will, but are only committing to analyze UHC at the present time. They will also attempt to connect with Dr. Rosen	**Provide agenda items for August meeting** **Develop guiding principles (PSO)** **Analyze UNC data (PSO)** **Connect with Dr. Rosen to attend future meetings (PSO)**	**July 2011**

	b. Correct Coding Initiative (CCI): BethAnn Wright (Chair) said that there is not much else to analyze for the mutually exclusive and unbundled piece. They will have that work done by August. Mark Painter suggested that they "chunk up" the work and have it completed by multiple committees to attack MFSDB. By August, there will be a new scope for the sub-committees. c. Data Sustaining Repository: Rose Laur (Alternate for Mark Rieger—Chair) indicated that frequency will not be in Medicare fee schedule. She is not aware what the sub-committee will present in August. The initial thinking is that modeling is a key component. Mark Rieger's objective for August is Line 102 on the project plan: Business model Concept Development & Report. d. Other agenda items for August meeting include reviewing the fee schedule adjustment piece from Tammy's presentation. There needs to be additional discussion about this issue. e. Anyone not on a committee? All Task Force Members are on at least one sub-committee.	**Business model Concept Development & Report (DSR)** **Review fee schedule adjustment**	**August 2011** **August 2011**

Topic	Discussion	Action	Due Date
Public Comment	There was a comment from a public observer that "nothing is coming out of this meeting that will help the public." The public has a huge interest in this process but there seems to be little public interest. The speaker hoped for a good conclusion to the process.		

Topic	Discussion	Action	Due Date
Other Business	BethAnn Wright inquired regarding expected attendance at the November meeting. All other Task Force members indicated that they planned to attend.		