



HB 1332 Colorado Clean Claims Task Force

September 28, 2011, 12:00-2:00 pm MST

Call-in information: 1-800-406-9170, meeting ID 3891479554#
<http://coloradomedicalsociety.acrobat.com/cleanclaimswebinar/>

AGENDA

- 12:00 Roll Call & Welcoming Remarks
- New member recognition
- Housekeeping
- Approve August minutes
 - Future meeting schedule
 - 4th Wednesday of the month
 - Type of meeting is dependent on the month; Task Force members will be advised one month ahead of time
 - Next face-to-face meeting will on November 30th in Denver
- Discussion of August member task list
- 12:25 Committee Reports
- Sustaining/Repository – Mark Rieger
 - 9/8/11 Minute review
 - Guiding principles
 - Specialty Society – Tammy Banks
 - Update
 - NCCI Overview – Beth Wright
 - Questions for Correct Coding Solutions
 - Project Management – Barry Keene
 - Discussion of Barbara Yondorf's work plan
 - Finance – Barry Keene
- 1:25 Process Development Review
- White paper on code edit development – Tom Darr, MD
 - Other open items from August task list
- 1:50 Other Business
- Documents for discussion at the September 28th meeting should be sent by committee chairs to Barry Keene in .pdf or Power Point format no later than COB 9/26/11.
- 1:55 Public Comment
- 2:00 Adjourn

To: Task Force Members

From: Co-Chairs

Date: September 7, 2011

Subject: MCCTF August 24th meeting assignments

Based on our notes and the minutes, these are the assignments volunteered by TFMs at the August 24th meeting.

1. **Barry Keene** will determine the cost of Dr. Rosen's contract with CMS and notify the task force on or before the September meeting.
2. **The DSR subcommittee** will bring their guiding principles for adoption to the full committee at the September meeting.
3. **Tom Darr:**
 - a. To draft something for distribution to the full task force regarding the process for developing edits. (Due ASAP)
 - b. Offered to re-craft the principles set forth in the AMA white paper from the perspective of HB10-1332 for the full task force. (No due date mentioned.)
4. **Barbara Yondorf :**
 - a. To draft something for the full task force to clarify the issue of determining the initial set of edits versus the issue of sustainability. *This followed the task force's discussion regarding legislative intent and acceptable sources of edits. (p. 10 of legislation.)*
 - b. Update the early draft of the work plan
5. **Mark Rieger** will write a description of library.
6. **Doug Moeller** said he would write up what he envisioned as the process for submitting, considering and deciding on adding/revising edits. *Notes sketchy on this, apologies if loaded unduly.*
7. **The full task force (but in particular the subcommittee chairs)**
 - a. Was asked to submit their questions for Dr. Rosen directly to Marilyn and also to share with the full task force. (No due date mentioned but early Sept or by Sept. meeting preferable for initial set.)
 - b. To provide Barry with names of individuals who may have an interest in the task force's work and who also have the capacity to provide funding.
8. **The subcommittee and the subcommittee chairs** were asked to provide feedback on the dates and the work plan in general no later than September 19.

Colorado Clean Claims Task Force

Data Sustaining Repository (DSR) subcommittee

DRAFT
20110908

I. Project time line:

38 Collect Committee Members Wed 3/23/11
39 Produce Guiding Principles Statement Wed 3/23/11

71 Preliminary Assessment of Task Force modeling resources Wed 5/25/11
72 Investigation & Report on Possible Business Models Wed 5/25/11

102 Business model Concept Development & Report Wed 8/24/11

132 Develop RFP Wed 11/30/11

II. Membership

Chair – Mark W. Rieger, NHXS

2 from payer vendors (Doug Moeller, McKesson & Tom Darr, Ingenix)

2 from provider vendors (Mark Rieger & Mark Painter, Relative Value Studies)

2 from payers (Mark Dawson, Aetna & Valerie Clark, Kaiser)

3 from providers (Robin Weston, Centura & Wendi Healy, Western Nephology, Jill Roberson, Denver Health and Hospital Authority)

III. Accountability

The DSR Chair reports to the Co-Chairs of the Colorado Clean Claims Task Force and will be expected to provide updates at the plenary sessions.

The DSR Subcommittee shall be made up of members of the Colorado Clean Claims Task Force.

All decisions made by the DSR Subcommittee are a matter of public record.

IV. Background

HB-1332

SECTION 1. Article 37 of title 25

25-37-104(2)(d)(IV) AS PART OF ITS RECOMMENDATIONS PURSUANT TO THIS PARAGRAPH (d), THE TASK FORCE SHALL MAKE RECOMMENDATIONS CONCERNING THE IMPLEMENTATION, UPDATING, AND DISSEMINATION OF THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS, INCLUDING IDENTIFYING WHO IS RESPONSIBLE FOR ESTABLISHING A CENTRAL REPOSITORY FOR ACCESSING THE RULES AND EDITS SET AND ENABLING ELECTRONIC ACCESS, INCLUDING DOWNLOADING CAPABILITY, TO THE RULES AND EDITS SET.

V. Purpose statement:

The DSR shall recommend to the task force a sustainable solution that addresses the economics, governance, maintenance, and distribution of the payment rules and claim edits.

VI. Guiding principles:

Economics:

- No new monies be required
- Reduce costs or at least no net increase in transaction costs
- Monies are used to create quality rules for public consumption
- Principal revenue source from licensing fees

Governance:

- Open process
- Free from influence of special interests
- Accountability TBD

Maintenance:

- Expertise already exists
- Development and maintenance should be influenced by production requirements
- There will be a handoff from the CCTF to the sustainability solution
- Decentralized development and maintenance
- Allow for professional (rule making) and technical (rule distribution) components to be separate entities

Distribution:

- Centralized
- Format of rules should support most efficient distribution
- Distribution should be electronic
- Distribution capability phased in. 1) Library only, 2) Claim scenario, 3) Batch claim processing

The NCCI sub-group was only able to meet once in August. We met on Friday September 23. We created the following list of questions for Dr. Rosen. Some of these questions were discussed at the August Meeting. I'm sure as we dig more into the A-P list we may come up with more questions.

- 1) Mark Reiger is going to write a question for Dr. Rosen inquiring about Dr. Rosen's interest in the use of his edits by others. Mark can write it much more eloquently than I can.
- 2) Is there an intent to establish more robust rationale for each edit in NCCI? We believe the current rationale references standards of medical practice. Would there be rationale that describes why a specific procedure may be integral to another procedure?
- 3) Is there a plan to start citing the source for the edit? (such as CPT, Medical Society, etc.)
- 4) Is NCCI creating Medicaid specific edits? Or is the plan for Medicaid to use the CMS edits in the current state?
- 5) How can we identify when an edit has been created in NCCI that was developed to support Medicare benefits or pricing methodology or needed for Medicare reporting? An example would be the denial of arthroscopic services when the provider is required to bill a "G" HCPCS code for the arthroscopy.
- 6) We believe there are examples where an age limit from CMS does not adhere to the CPT coding guidelines. Are you familiar with this? And if so, is there a reason why they are different?
- 7) How many code pairs have been changed due to specialty societies input?
- 8) How many request by specialty societies have been rejected?
- 9) What is the criteria to accept/reject a request?
- 10) Recently - there were 32 changes pertaining to modifier overrides. All but three of the 32 changed to not allow a modifier override. What criteria makes up those decisions?
- 11) What are the primary drivers for changing edits including modifier usage? (i.e. - data, inquiries, appeals, etc.)
- 12) How are the assistant surgeon designations decided? What criteria goes into making the designation? Have specialty societies weighed in on the list?
- 13) We believe there are non-surgical codes on the assistant surgeon list. If so, can you please explain why?

Rest of the Committee report -

The remainder of the meeting was discussing the Assistant Surgery policy.

- Reviewed a comparison file produced by Mark Reiger that compares the American College of Surgeons (ACS) list vs. the CMS list.
- Data identified the following key points -
 - 5440 codes are shared between ACS and CMS - does not mean they have same designation.
 - 46 codes are on the ACS list and not on CMS
 - 1983 codes are on the CMS list and not on the ACS list
- Further analysis drilled down on the codes that differ between the two. The largest volume with CMS is designated with a 'sometimes' designation. We spent time discussing the 'sometimes' category and the impact on the payors and physician practices to require medical records for review. We feel this needs to be discussed further.
- The sub-group is leaning toward a recommendation that uses multiple sources - ACS, CMS, and maybe the sustainability group? No recommendation was made. We want to hear more from Dr. Rosen.

- The multiple source proposal considers that ACS is a specialty society that should have their work valued but they do not update the source frequently.
- Open question - will we producing a Colorado printed policy on the payment rules?

Next Steps:

- 1) Obtain Dr. Rosen input
- 2) Talk with Tammy and Helen - to reach out to the American College of Surgeons to determine whether they will be providing more frequent updates to their list. We would recommend the list be updated at least annually.
- 3) We will be reviewing payor policy on assistant surgeons and their current designations.
- 4) Future discussion about who can act as an assistant surgeon and how the modifiers 80, 81, 82 and AS are used.

I hope this is sufficient. Let me know if you need more.

Beth Wright, CPC

Manager, Reimbursement Policies and Procedures Department (CT/ME/NH/CO/NY)

**Medical Clean Claims Transparency and Uniformity Act
Schedule of Key Task Force Activities and Deadlines, 2011-2012**

Status Report as of _____

Task	Deadline	Status as of _____
1. Statutory Task Force Deadlines		
<p>25-37-106(2)(b), C.R.S. "Within two years after the task force [TF] is established, the TF <u>shall develop a base set of standardized payment rules and claim edits</u> to be used by payers and health care providers in the processing of medical claims and that can be implemented into a computerized medical claims processing systems."</p> <ul style="list-style-type: none"> • 25-37-106(2)(b), C.R.S. BASE SET DEFINITION: "The base set of rules and edits shall be identified through existing national industry sources that are represented by the following: the NCCI; CMS directives, manuals and transmittals; the Medicare physician fee schedule; the CMS national clinical laboratory fee schedule; the HCPCS coding system and directives; the CPT coding guidelines and conventions; and national medical specialty society coding guidelines." • 25-37-106(2)(c)(I), C.R.S. COMPLETE SET OF UNIFORM, STANDARDIZED PAYMENT RULES AND CLAIM EDITS DEFINITION: "As the base set of rules and edits developed pursuant to paragraph (b) ... may not address every type of health care service involved in a medical claim, the TF shall work to develop a complete set of uniform, standardized payment rules and claim edits to cover all types of professional services." 	Nov 30, 2012	
<p>25-37-106(2)(d)(I), C.R.S. "The TF <u>shall submit a report and recommendations concerning the set of uniform, standardized payment rules and claim edits</u> to the executive director of the Department of Health Care Policy and Financing {HCPF} and the health and human services committees of the senate and house of representatives by November 30, 2012.</p> <ul style="list-style-type: none"> • 25-37-106(d)(IV) The report "shall" include "<u>recommendations concerning</u> the implementation, updating and dissemination of the standardized set of payment rules and claim edits, including identifying who is responsible for establishing a <u>central repository</u> for accessing the rules and edits set and enabling electronic access, including downloading capability, to the rules and edits set." • 25-37-106(d)(IV)(A), C.R.S. The TF <u>recommendations shall include a "schedule" for payers to follow to "implement the standardized set</u> of payment rules and claims edits within their claim processing systems." 	Nov 30, 2012	
<p>25-37-106(7), C.R.S. No later than June 30, 2012, the TF needs to supply the executive director of HCPF with the information she needs to certify that that <u>sufficient funds have been received or are available to implement</u> the provisions of the Medical Clean Claims Transparency and Uniformity Act.</p>	Jan 30, 2012	

	25-37-106(2)(d)(I), C.R.S. (continued) The TF “ <u>shall present its report and recommendations</u> to a joint meeting of the said health and human services committees by January 31, 2013.”	Jan 31, 2013	
	25-37-106(d)(III), C.R.S. If, at the time the TF submits its report, the national initiative work group has not reached consensus on a complete or partial set of standardized payment rules and claim edits: ... (B) the TF shall <u>continue working to develop a complete set of uniform, standardized payment rules and claim edits</u> and, by December 31, 2013, shall submit a report and may recommend implementation of a set of uniform, standardized payment rules and claim edits to be used by payers and health care providers.”	Dec 31, 2013	

Task	Lead	Interdependency	Deadline	Status
2. Establish Base Set: Base set shall be identified through existing national industry sources defined and specified in statute.	CCI			
In developing a complete set of rules and edits, TF shall consider standardizing payment rules and claim edits for following types of edits(2)(c)(II):				
(A) Unbundle	CCI		Early Sept 2011	On hold because _____. Expect to resolve by _____.
(B) Mutually exclusive	CCI		Early Sept 2011	ON hold because_____. Expect to resolve by _____.
(C) Multiple procedure reduction	CCI		Late Nov 2011	
(D) Age	CCI		End Sept 2011	
(E) Gender	CCI		End Sept 2011	
(F) Maximum frequency per day	CCI		Mid Dec 2011	
(G) Global surgery days	CCI		Mid Dec 2011	
(H) Place of service	CCI		End Jan	

Task		Lead	Interdependency	Deadline	Status
				2012	
	(I) Type of service	CCI		End Jan 2012	
	(J) Assistant at surgery	CCI		Mid Sept 2011	In process.
	(K) Co-surgeon	CCI		Mid Oct 2011	
	(L) Team surgeons	CCI		Mid Nov 2011	
	(M) Total, professional or technical splits	CCI		Late Mar 2012	
	(N) Bilateral procedures	CCI		Late Mar 2012	
	(O) Anesthesia services	CCI		Mid Apr 2012	
	(P) The effect of CPT and HCPCS modifiers on these edits as applicable	CCI		Mid Apr 2012	
	TF approves base set.			Late Apr 2012 [IS THIS TOO LATE?]	
3. Professional Society Outreach					
	Determine adequacy of pediatric and ob/gyn codes and edits in NCCI	PSO		May 2011	DONE
	Reach out to specialty societies to determine what's missing, what's not working in terms of CPT codes and NCCI edits	PSO		Dec 2011	
	[ADD OTHER TASKS]				
4. Make Recommendations Regarding Data System Repository					
	Agree on guiding principles [DOES TF NEED TO APPROVE THESE?]	DSR			DONE
	Conduct a preliminary assessment of TF modeling resources. [MODELING WHAT?]	DSR		Mid Sept 2011	

Task			Lead	Interdependency	Deadline	Status
	Investigate and report on possible business models		DSR		Mid Sept 2011	
	Define exactly what is meant by a "central repository." What are/are not its functions?		DSR		Mid Sept 2011	
	Identify <u>who</u> is responsible for establishing a central repository for accessing the rules and edits set and enabling access, including downloading capability, to the rules and edits set (2)(d)(IV).		DSR		Late Sept 2011	
	TF approval of who is responsible for establishing, operating central repository.		TF		Late Oct 2011	
	Determine process for accessing the rules and edits set, and enabling access, including downloading capability.		DSR		Early Oct 2011	
		TF approval of process for accessing rules and edits.	TF		Mid Oct 2011	
	Determine process for updating rules and edits. Make recommendation.		DSR		Early Oct 2011	
	Address issue of whether all rules and edits must come from a national industry source unless, as provided for in statute, the base set of rules does not address some types of health care services. Examine statutory provisions		DSR		Early Oct 2011	
	Discuss process for including new or different edits and rationales. Also who/how is this decided?		DSR		Early Oct 2011	
	TF approval of updating process.		TF		Late Oct 2011	
	Develop RFP to [DO WHAT?]		DSR		Late Nov 2011	
	TF approval and issuance of RFP		TF		Mid Dec 2011	
	Selection of contractor [?] to [DO WHAT? WHEN DOES THEIR WORK BEGIN, END? WHAT DO WITH RESULTS?]		TF		Mid Jan 2012	
	Research organizational and personnel support and budget needed. Also identify possible financing sources for the central repository.		DSR		Mid Nov 2011	
	Complete draft recommendations concerning the implementation, updating and dissemination of the standardized set of payment rules and claims edits.		DSR		Early Dec 2011	
	TF adoption of recommendations		TF		Mid Dec 2011	

Task				Lead	Interdependency	Deadline	Status
5. Establish Complete Uniform Standardized Set of Payment Rules and Claims Edits						Nov 30, 2012 (or Dec 31, 2013)	
	With respect to situations where the base, sourced set of edits does not address every type of health care service involved in a medical claim, work to develop a complete standardized set that covers all types of professional services (2)(c)(1).			CCI		Nov 30, 2012 (or Dec 31, 2013)	
		Identify rules and edits that potentially conflict with one another		CCI		Mid Jan 2012	
		Develop recommendation for resolution of this issue.		CCI		Late June 2012	
		Identify instances where base set does not address every type of health care service involved in a claim. Consider the CMS medically unlikely edits and commercial claims editing systems that source their edits to national industry sources on a code and code edit pair level in order to create a complete set of payment rules and claims edits.		CCI		Mid Jan 2012	
		Develop recommendations to address such instances.		CCI		Mid June 2012	
		Develop complete set of uniform standardized payment rules and claims edits		CCI		Mid Apr 2012	
		TF approval of recommendation for a complete set of rules and edits (except as provided in 25-37-106(2)(d)(III)).		TF		Mid Aug 2012	
		Submit a report, and recommend implementation of, standardized payment rules and claim edits to be used by payers and health care providers (except as provided in 25-37-106(2)(d)(III)).		TF		Nov 30, 2012	
		25-37-106(d)(III), C.R.S. If, at the time the TF submits its report, the national initiative work group has not reached consensus on a complete or partial set of standardized payment rules and claim edits: ... (B) the TF shall <u>continue working to develop a complete set of uniform, standardized payment rules and claim edits</u> and, by December 31, 2013, shall submit a report and may recommend implementation of a set of uniform, standardized payment rules and claim edits to be used by payers and health care providers."		TF		Dec 31, 2013	

6. National Initiative							
			Monitor and stay informed of the national initiative to avoid duplication or creation of competing or conflicting payment rules and claim edits (2)(a)(III)	TF		Quarterly	
7. Funding							
			1 st year funding for TF committed (need \$___)	FC		End May 2011	
			2 nd year funding for TF committed	FC		End Nov 2011	
			Submit to HCPF executive director proof that TF has received or has available sufficient moneys to complete the TF's charge, as described in statute.	TF		Early June 2012	
			HCPF executive director certifies that as of June 30, 2012, the TF has received or has available sufficient funds to complete the TF's charge.	HCPF exec dir		June 30, 2012	
8. Project Management							
			Website online	PM		End May 2011	DONE
			Submit courtesy progress report to HCPF executive director	PM		End Dec 2011	
9. Final Report							
			"Staff" writes 1 st draft of final report	Staff		Early Nov 2012	
			TF reviews 1 st draft of final report	TF		Mid Nov 2012	
			TF reviews 2 nd draft of final report	TF		Early Dec 2012	
			Report finalized, printed, submitted to _____ and publicly distributed.	TF, staff		Dec 31, 2012	

Questions:

- Some kind of testing of the base set? Standardized complete, uniform set?
- Period to refine the sets based on testing?
- Other missing major activities?

To: Colorado Medical Clean Claims Transparency and Uniformity Task Force

From: Tom Darr, MD

Subject: Guiding Principles for a Standard Code Editing System

The following is my attempt to re-state the seven bullet points from the AMA White Paper on the Standardization of a Code-editing System presented to the Task Force on 8/24/2011

- A claim edit is defined as logic that denies a procedure code submitted by a provider for a patient on a given date of service. This denial can be based on any one or more different types of logic depending on the edit type.
 - An Unbundle Edit denies an integral component of a more comprehensive procedure. A Mutually Exclusive edit denies a procedure that normally would not be performed for the same patient on the same date of service by the same provider.
 - A Multiple Procedure Reduction edit decreases the percentage paid for the second, third, fourth, etc. procedures performed on the same date of service based on the concept that the relative values for each of those multiple procedures include pre-service, intra-service, and post-service work/time, practice expense, and malpractice expense that was only incurred by the provider once not multiple times.
 - An Age Edit denies a procedure that is normally not performed for a person of the given patient's age
 - A Gender Edit denies a procedure based on gender. An hysterectomy is not performed on a male.
 - Maximum Frequency Per Day edits deny procedure codes submitted by the provider in a greater number than is allowed for a given patient for a given date of service. An easy example is the removal of a gall bladder; it cannot be removed more than once in a day. There are approximately 1300 CPT codes that fall into this category where anatomy or the CPT code description itself define the MFD for a procedure. A more difficult example would be RAST testing where there is not a clinical nor anatomic limit to the MFD, but a payor may have a reimbursement policy that limits the maximum number it will pay a provider for on a given day for a single patient.
 - Global Surgery Day edits will deny Evaluation and Management Services submitted for a patient within a certain number of days after a procedure was performed. The concept here is that the relative value (work/time, practice expense, malpractice expense) of the original procedure includes the evaluation and management services required to care for the patient after the procedure.
 - Place of Service edits will deny a procedure based on the place where the Provider submitted that they performed the service. Coronary Artery Bypass Surgery would not be performed in an office setting.
 - Type of Service edits will deny a procedure based on its nature.

- Assistant at Surgery edits will deny a procedure when billed by the assistant surgeon if that procedure has been deemed to not require an assistant surgeon. This logic may also define how much an assistant surgeon will be paid when an assistant surgeon is allowed
- Co-surgeon edits will deny a procedure when billed by a co-surgeon if that procedure is deemed to not require a co-surgeon. This logic may also define how much a co-surgeon will be paid when a co-surgeon is allowed.
- Team Surgeons edits will deny a procedure when billed by a team surgeon if that procedure is deemed to not require a team surgeon. This logic may also define how much a team surgeon will be paid when a team surgeon is allowed.
- Total, Professional Split, and Technical Split edits will deny a procedure submitted with a professional service modifier when the procedure has been designated as 100% technical and vice versa. This logic may also include what percentage of a total procedure's work/time, practice expense, and malpractice expense (relative value) is deemed to be the professional component and the technical component. Procedures that have professional/technical splits are identified as such when the work/time, practice expense, malpractice expense (relative value) of the procedure can be divided into distinct portions that are each made up of the technical service (a chest xray is performed) and a professional service (the chest xray is read by the provider and shows an infiltrate consistent with right middle lobe pneumonia) and the possibility exists that different providers may perform the technical and professional components.
- Bilateral procedure edits are designed to remove the ambiguity that exists in the coding methodology around how procedure codes should be submitted when the same procedure is performed on the same structure(s) on opposite sides of the body.
- Although anesthesia services are called out as a separate group of edits in the CMCCTAUTF legislation, in general they are comprised of the same edit types listed above for CPT and HCPCS Anesthesia codes.
- Modifiers have been developed in both the CPT and HCPCS classification systems to affect how a procedure code or procedure code pair is to be further defined and therefore understood. For example:
 - The 59 modifier appended to a code for what would normally be understood as an integral component of a more comprehensive procedure and therefore denied, was actually performed on a different body part during the same surgical session, or on the same body part at a different surgical session on the same date of service and therefore should not be denied.
 - A 25 modifier on an evaluation and management code, that we will call Code B, submitted by the provider on the same date of service as another procedure or service, that we will call Code A, that has evaluation and management services included in at least a portion of its work/time, practice expense, and malpractice expense (relative value), defines that the evaluation and management services in Code B

were for additional evaluation and management services than those that were included in Code A's relative value, and therefore Code B should not be denied.

- The CMCCTAUTF legislation's intent is to decrease administrative burden and therefore remove wasted expense from money spent on healthcare by creating a uniform set of code edits to be used in Colorado based on the code edit types explained above. Providers will benefit from a clear understanding of how given clinical scenarios are to be coded and by decreased denials based on code edits as defined above. Payers will benefit from decreased cost of repeated adjudication of claims based on code edits as defined above. Providers, payers and the marketplace in general will benefit when this standardization of code editing is trusted to be consistent and accurate to the extent that services can be paid for at the time they are provided.
- The CMCCTAUTF legislation calls for the edits that are included in the uniform code edit set to be sourced to national industry sources and provides a representative, but not necessarily all inclusive, list of those sources that is reproduced below. The legislation also calls for documentation that is easily accessible to all constituents of the marketplace that explains any given code edit. This documentation must also explain why a given source prevailed when the various sources disagree. The sources are as follows:
 - The National Correct Coding Initiative of the Centers for Medicare and Medicaid Services (CMS)
 - CMS directives, manuals and transmittals
 - The Medicare Physician Fee Schedule
 - The CMS Clinical Laboratory Fee Schedule
 - The CMS Healthcare Procedural Coding System (HCPCS) and directives
 - The AMA's Current Procedural Terminology codes, guidelines and conventions, and
 - National Medical Specialty Society coding guidelines
- Although the CMCCTAUTF has no direct control over the National Correct Coding Initiative review process, the Task Force strongly recommends to the NCCI that it further open the process to a more comprehensive representation of the healthcare marketplace stakeholders. Understanding that changes like this take time, the CMCCTAUTF encourages payers to submit to the NCCI for review and inclusion those code edits that they currently have that are not included in the NCCI.
- The CMCCTAUTF also encourages the American Medical Association to further open its CPT processes to encourage a more comprehensive representation of payers and of the healthcare marketplace stakeholders in general to participate. The Task Force recommends that these processes be streamlined to decrease the time necessary for CPT to include new and adapt existing codes given the rapid rate of change of medical knowledge and related technologies. Again, understanding that changes like this take time, the Task Force recommends that all stakeholders avail themselves of the current CPT processes for addressing their CPT concerns.
- The CMCCTAUTF legislation is part of contract law in Colorado. It specifically states that this legislation is not intended to interfere with the contract negotiations between providers and payers. What the legislation is intended to do is to make those

negotiations more straightforward by making the code edits involved public and consistent. Therefore, it is a requirement that health plan benefit coverage and payment policies not be comingled with the uniform code edit set.

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Assignment: Clarify the Issue of Determining the Initial Set of Edits Versus the Issue of Sustainability: Clean Claims Act Analysis

Barbara Yondorf, facilitator; September 13, 2011

Task Force Charge

25-37-106 (2)(a)(1)

Sets forth the purpose of the Medical Clean Claims Act: “facilitating the development of a standardized set of payment rules and claims edits for use by health care providers and payers in the processing medical claims.”

Initial Set of Edits

25-37-106(2)(b)

“The base set of rules and edits shall be identified through existing national industry sources that are represented by the following: (I) the NCCI; (II) CMS directives, manuals and transmittals ... and (VII) national medical specialty society coding guidelines.”

[BY comment: This appears to specifically define the term “national industry sources” for the purposes of the act as only those sources listed in (I) through (VII).]

25-37-106 (2)(c)(I)

Describes possible problem with base set of rules developed according to existing national industry sources that task force is to address as: “The base set of rules and edits ... may not address every type of health care service involved in a medical claim.”

[BY comment: This appears to say that the only instances where other edits may be considered are where the existing national industry sources identified by the task force for the base set do not address every type of health care service involved in a medical claim. Thus, one can only go outside the national industry sources if a health care service involved in a medical claim is not addressed by one of the existing national industry sources.]

“As the base set “may not address every type of health care service, the task force shall work to develop a complete set of uniform, standardized payment rules and claim edits to cover all types of professional services.”

- In so doing, “The task force shall request to participate in the national initiative or work with national experts to identify any rule and edits that:
 - “Are not encompassed by the national industry sources identified in 25-37-106(2)(b), or
 - “That potentially conflict with one another.”
- “Additionally, the task force shall consider the CMS medically unlikely edits and commercial claims editing systems that source their edits to national industry sources on a code and code edit pair level in order to create a complete set of payment rules and claim edits.”

Sustaining

25-37-106(3)

“Once the standardized set of payment rules and claim edits is established and implemented no other proprietary or other claims edits, other than those edits described in paragraph (c) of subsection (4) [medical necessity], shall be applied to modify the payment of charges for covered services; except that, if national standards are later identified for standardized payment rules and claim edits, Colorado payers shall comply with the national standards according to the implementation schedule required by federal law.”

25-37-106 (2)(c)(IV)

“The Task Force shall make recommendations concerning the implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including identifying who is responsible for establishing a central repository for accessing the rules and edits sets and enabling electronic access, including downloading capability, to the rules and edits set.”

[BY comment: Taken together, the two paragraphs appear to say that once the standardized set has been established and implemented, it can only be changed as a result of updating. The last paragraph appears to say that the task force shall make a recommendation to the legislature regarding the type of entity (likely including governance) that should be responsible for establishing and operating the central repository.]

To: Task Force Members

From: Co-Chairs

Date: September 7, 2011

Subject: MCCTF August 24th meeting assignments

Based on our notes and the minutes, these are the assignments volunteered by TFMs at the August 24th meeting.

1. **Barry Keene** will determine the cost of Dr. Rosen's contract with CMS and notify the task force on or before the September meeting.
2. **The DSR subcommittee** will bring their guiding principles for adoption to the full committee at the September meeting.
3. **Tom Darr:**
 - a. To draft something for distribution to the full task force regarding the process for developing edits. (Due ASAP)
 - b. Offered to re-craft the principles set forth in the AMA white paper from the perspective of HB10-1332 for the full task force. (No due date mentioned.)
4. **Barbara Yondorf :**
 - a. To draft something for the full task force to clarify the issue of determining the initial set of edits versus the issue of sustainability. *This followed the task force's discussion regarding legislative intent and acceptable sources of edits. (p. 10 of legislation.)*
 - b. Update the early draft of the work plan
5. **Mark Rieger** will write a description of library.
6. **Doug Moeller** said he would write up what he envisioned as the process for submitting, considering and deciding on adding/revising edits. *Notes sketchy on this, apologies if loaded unduly.*
7. **The full task force (but in particular the subcommittee chairs)**
 - a. Was asked to submit their questions for Dr. Rosen directly to Marilyn and also to share with the full task force. (No due date mentioned but early Sept or by Sept. meeting preferable for initial set.)
 - b. To provide Barry with names of individuals who may have an interest in the task force's work and who also have the capacity to provide funding.
8. **The subcommittee and the subcommittee chairs** were asked to provide feedback on the dates and the work plan in general no later than September 19.