

APPROVED

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Meeting Minutes

Wednesday, October 26, 2011

12PM – 2 PM MST

Call-in Number: 1-800-406-9170

Conference ID: 3891479554#

<http://coloradomedicalociety/acrobat.com/cleanclaimswebinar/>

<http://hb101332taskforce.org>

Attendees:

- Tammy Banks (alternate)
- Michele Baran (alternate)
- Helen Campbell
- Valerie Clark
- Dee Cole (alternate)
- Tom Darr
- Mark Dawson
- Wendi Healy
- Barry Keene (co-chair)
- Rose Marie Laur (alternate)
- Lori Marden
- Kathy McCreary
- Doug Moeller
- Mark Painter
- Carol Reinboldt
- Mark Rieger
- Marilyn Rissmiller (co-chair)
- Jill Roberson
- Ryshell Schrader
- Nancy Steinke
- Amy Hodges

Staff

- Ian Danielson
- Kirstin Michel
- Barbara Yondorf

Meeting Objective (s):

- New Member recognition
- Subcommittee work/progress updates
- Address task force growth (& national attention)
- Prep for November meeting

Key:

-TFM = Task Force Member

-CC = Co-Chair

Parking Lot:



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| <p>Letter to Dr. Rosen (Cont.)</p> | <p>CC question: Will the letter to Dr. Rosen alleviate the roadblocks regarding CCI?</p> <p>TFM response/question: Could we ask Dr. Rosen to clarify differences between Medicaid CCI and Medicare CCI, not just around the code pairs but will bill types be expanded for Medicaid?</p> <p>Public comment: You will need to ask those specifics at the end because it's too broad.</p> <p>The American Medical Association (AMA) coordinates the process with specialty societies and Dr. Rosen. It's done through an email process, and the specialty societies are very satisfied. Is there more information that we could provide to you about how AMA coordinates between Dr. Rosen and specialty societies?</p> <p>CC: If AMA has documents on this that we can all share, we could delete that from this question set to cut costs.</p> <p>Public: Tammy can get you a copy of the documentation for Dr. Rosen's coordination with specialty societies. I haven't seen Dr. Rosen's contract but AMA probably does have documents on that.</p> <p>Tammy confirmed that she can send the documentation from AMA regarding specialty societies.</p> <p>The co-chair will revise the letter to Dr. Rosen to not include specialty society information.</p> <p>CC question: Is anything else Dr. Rosen could do on his end that could be helpful?</p> | <p>Tammy will provide documents to co-chairs regarding AMA's coordination of Dr. Rosen's communications with specialty societies.</p> <p>Co-chair will revise letter to Dr. Rosen to not include specialty society information</p> | <p>Within the next 5 days.</p> |
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| <p>Letter to Dr. Rosen (cont.)</p> | <p>TFM: The marketplace would benefit from the rationale and expertise of specialty societies and other entities that you [Dr. Rosen] and NCCI rely upon for final edits. This information should be made transparent on a code by code basis.</p> <p>CC: We will get you a written statement to confirm that we understood that.</p> <p>TFM: The question is not how to identify Medicare edits but how we identify NCCI edits.</p> <p>CC: Thoughts from AMA? I had the impression that as AMA becomes aware of conflicts, they would work with Dr. Rosen.</p> <p>TFM question: Can we get them to identify whether an edit is for <i>payment</i> or <i>coding</i> clarification purposes?</p> <p>CC: This could be an addition to 2a, it's kind of why: clarification of reimbursement policy? I can handle this.</p> <p>TFM: Also, how can we see what the age limits are?</p> <p>CC clarification: You are asking if there is a file of age limits?</p> <p>TFM: CCI does not have age limits.</p> <p>TFM: On the professional side, if it's not part of what Dr. Rosen does, we should not ask it.</p> <p>CC: The age question is not a Dr. Rosen question but needs to be discussed in CCI group.</p> <p>TFM: <i>Some</i> changes to CCI are retroactive, but the date on which they stamp the change goes back to the beginning of the CCI edits. How do those decisions get made? We need to know how those decisions are made.</p> | <p>Co-chairs will provide Tom Darr with a written confirmation of his statement for confirmation of understanding.</p> <p>Marilyn will add to question 2a.</p> | |
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| <p>Letter to Dr. Rosen (cont.)</p> | <p>TFM: And the medically unlikely edits, it looks like they are not temporal, they just replace an old version with a new one. Can we ask Dr. Rosen if they intend to make medically unlikely edits like CCI edits where eventually they will be temporal?</p> <p>CC: How important is that to our task?</p> <p>TFM: Basis for a decision?</p> <p>CC: We should find out what his rationale is and we may have to find out if there is reasoning we can adopt.</p> <p>CC: We will draft a revised document with these considerations included and provide a time-limited chance for revision.</p> | <p>Marilyn will revise letter to Dr. Rosen to include temporal considerations and distribute to task force</p> | |
| <p>Specialty Societies</p> | <p>No new updates from the Specialty Societies</p> <p>The co-chair reminded the group that anyone can use either of the co-chairs as sounding boards for issues, such as one member has done. He asked a TFM to recount his discussion of vendor experiences with specialty societies.</p> <p>TFM: ACS published a study that says whether for each code a surgical assistant is always, sometimes, or never required. After a brief introduction, there is page after page of data – with a designation for each CPT code of whether an Assistant at Surgery (Modifier AS, actually another physician for</p> | | |

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| <p>Specialty Society</p> | <p>whether an Assistant at Surgery (Modifier AS, actually another physician for this study, although Modifiers 80, 81, 82 can be used to designate non-physicians) is utilized ‘almost always,’ ‘sometimes,’ or ‘almost never.’</p> <p>McKesson auditing logic follows ‘almost always,’ or ‘almost never’ almost exactly - payment is allowed for ‘almost always’ and denied for ‘almost never.’ However, the category of ‘sometimes’ for a computer is a serious problem. We therefore have to make some assumptions: namely, if an assistant surgeon is only present ‘sometimes’ it means that a single surgeon is ABLE to perform the procedure on most or nearly all patients without an Assistant. Therefore, it is not unreasonable to assume that the principal surgeon must provide suitable documentation for establishing the ‘medical necessity’ of the Assistant – since most health plans are not insuring for costs that are not necessary. For example, there are certain arthroscopic knee procedures in this category that do not routinely require an assistant, but when the patient is excessively large, or trauma has occurred, or bilateral procedures are being performed, or special equipment is used, that an Assistant IS medically necessary. Unfortunately, the auditing logic is set to deny this Assistant until there is a review of the medical documentation to approve this payment and medical necessity.</p> <p>If you ask the ACS (we did) about the use of Assistants at Surgery, ACS maintains, that surgeons should have the autonomy to make that decision without further review. If one looks at actual utilization data, a very different picture emerges - some surgeons use assistants all the time, and other surgeons performing the same procedure almost never. I think the conflict of interest is readily apparent.</p> <p>TFM: CMS (not Dr. Rsen) has a group that creates assistant surgery auditing logic by CMS criteria. By legislative mandate they allow</p> | | |
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| <p>Specialty Society (cont.)</p> | <p>TFM: CMS (not Dr. Rosen) has a group that creates auditing logic by CCI criteria. By legislative mandate they allow an assistant surgeon when they have seen one allowed for more than 5% of the claims. That's not a clinical criteria in the way McKesson would think about it, but that's how they developed it (with legislative oversight).</p> <p>CC: This is not meant to end debate, but it's enlightening into how these competing claims on sourcing could both be true. The better we understand why these things come up, the better positioned we are to trust each other and search for a solution that works in a standardized way. This would say that the CMS rationale is deeply flawed or legislation that led to that is deeply flawed. This is a good discussion.</p> <p>CC: The piece developed with assistance from Barb was included in the webinar.</p> | | |
| <p>Data Sustaining Repository (DSR)</p> | <p>CC: We are 10 months into the program and we have done useful things, but are not as far as I thought we would be. We have had some interesting things from DSR, and Barb Yandorf took the thoughts from those meetings and compiled them. One TFM provided a parallel piece as well that may be made a formal discussion topic for the November meeting.</p> <p>Presenter: The tasks of the DSR are 1. Governance 2. Economics, and 3. Ethics, which are described in detail in the guiding principles. We have committed to a straw man document, which is now before the full committee. This is a draft document that the DSR committee has not seen before this meeting. Another TFM offered a third model. The current draft has 2 models under consideration. One is a self sustaining model, in which each approved source would deliver a fully baked loaf to the library. Then the library would put together (pricing and medical) including pros and cons. The second model is something more formal in terms of a formal</p> | | |

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| <p>Data Sustaining Repository (cont.)</p> | <p>organization having an entity be the final decision maker of what goes into the library. There could be subset models within those, but I am not familiar enough with this yet because this is not a doc we've seen before today.</p> <p>CC Question: Could you provide a brief overview?</p> <p>Staff: This document is trying to get clarity about the attempt to separate the technical from the professional. We also worked on the first couple of pages of the guiding principles, key responsibilities, and functions. This does not stop anyone from adding options 4, 5, or 6, and we left option 3 blank to leave space for Doug Moeller's proposal. We have sent a request to see if he could distill his paper into something that might fit into this format.</p> <p>CC: Thanks, I appreciate the quality of task force you are forming. We are trying to make rules that do not ignore NCCI. If we ignore that then it will not be uniform, and our goal is to create a singular standardized set. The overarching approach is either we start with nothing in the bucket and add things in the bucket one at a time (this has taken a long time to do it this way), or we do the polar opposite, where we put everything in the bucket and decide what doesn't belong. The legislation says you can't have any proprietary edits after December 31, 2013 in Colorado, so if payers like what they have now they should put them on the table.</p> <p>TFM: It takes a substantial amount of highly trained people to put this information together. It doesn't come from specialty societies. The idea is to get edits from payers and create a place where they can put them all. If they couldn't offer sourcing it would be great to talk to those who do sourcing (organizations such as Bloodhound). We can then look at the costs and provide an opportunity to have people look at those. The task force will then be the entity that creates governance around this process, and listens to grievances. The legislation isn't supposed to think past a certain date, but before we think about that problem we need to figure this one out.</p> | | |
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| <p>Data Sustaining Repository (DSR) (cont.)</p> | <p>CC comment: This is meant to generate a conversation about which end we go at this from. Maybe we need to think about a different way than asking for individual plans. I assume that when McKesson or someone goes to a new client, they have a standard set of edits to start from, and then the client specifies to modify it. Can we approach it like that, from the vendor level rather than the payer level? If we go down that path, we need to know that the starting point is not blocked. I'm not suggesting that you just give us this for a tax deduction, but we will be doing an RFP of sorts to see what it would cost. I'd like people to think about that, I want to move our project forward, and we may need to change course, but I don't want to stop anybody's stuff that they are doing right now. Still, we need to be conscious of where the shore line is and we are a long way from it now. AMA comments?</p> <p>(No comments.)</p> <p>CC: I'll try to answer this. We start with all known edits but that puts a huge load on the provider side to go through millions. This is not meant to be a specific proposal but to show us the boundaries of where we need to go. Any comments?</p> <p>TFM: When we define what buckets A-P would be, some of these would fall in with NCCI and could be moved over to NCCI it would be helpful.</p> <p>CC: Age logic, modifier logic, that's what I would think it (buckets A-P), was.</p> <p>CC: All task force members should read through this document, we will have a discussion at the November meeting.</p> | <p>All task force members will read: Clean Claims--DSR--Possible models of operation (draft #2 with MR edits of 10-13-11).docx</p> | |
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| <p>Project Management – Barry Keene</p> | <p>CC: Barb, myself, Marilyn and two grad students recently met with Bell Policy Center to go over the budget. We have not made effective use of Ian and Kirsten, so we will start having Kirstin sit in on subcommittee meetings as much as possible. Consider them your staff for TF purposes. They can take minutes and, we will offer feedback documents to committee members. The staff will help you remember what you’ve committed to do. Any suggestions on how we should use staff are welcomed.</p> <p>I also think the task force should respond to Dr. Cross’s letter. He was present at the wedi exchange, and we were asked to attend their preconference discussions on what wedi input would be to HHS for this part of the Affordable Care Act. We talked about our work with claim edits, which is a big area in administrative simplification. We did a 10 minute introduction to a 2 hour conversation. Dr. Cross was a productive contributor. The net of that is that he has concepts that he thinks might be doable, so I told him that I would respond to his letter. I’m pulling together an informal committee to respond to Dr. Cross. Lexicon was a problem with this group initially. They thought that standardization needs to happen, payers were a little reluctant, and that whatever needs to be done has to happen nationally. Soon I will have the notes from that session, the main wedi conference will receive these and deliberate whether to provide comments to NCVHS at the national meeting developing recommendations for the Secretary of HHS. Before our next meeting, we have been invited to give testimony on Nov. 18th on this topic with a written piece of testimony. The testimony that we will be giving focuses on the necessary pieces of the pie and what have we learned throughout this process so far. We were invited to specifically address the difficulty of getting at the NCCI contractor for dialogue.</p> | <p>Barry to develop draft response to Dr. Cross’s letter.</p> | |
| <p>Finance Committee – Barry Keene</p> | <p>Presenter/CC: We are still in need of a catering sponsor for the November meeting. For those of you who know your organization has not contributed, if you could put me in contact with the right person at your organization that would be wonderful.</p> | | |

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| Process Development and Review | Presenter/CC: We are developing national visibility and have recently been approached by Humana and Cigna and others about our work. A 50 person task force is unwieldy. We need to have an open process but there are limitations, so we need to think about how to balance inclusion with unwieldiness. | | |
| Open Items | <p>CC: Dr. Rosen’s letter has been taken care of. Tammy and Helen where are you with your outreach to ACS?</p> <p>TFM: We are waiting to find out what this work group wants from ACS.</p> <p>TFM: I asked how frequently they would update the ACS, and they said every other year. He asked if they would do it every year for specific codes, even if they only do the whole list every other year.</p> <p>TFM: We still have a lot questions to figure out and prioritize, such as what are the expectations for a source, what does source mean, etc.</p> <p>CC: Tammy can you send an email to Marilyn so she can define these questions for you to ask?</p> | Marilyn will define questions for Tammy | |
| Other Business | CC: We will entertain ideas for the November meeting, everyone please send those items in to us. | Send ideas for November meeting to co-chairs | |
| Public Comment | None | | |
| Adjourn | The meeting adjourned at 2:00 PM, MST. | | |

To: Barry Keene

From: Ian Danielson

Date: November 1, 2011

Subject: MCCTF October 26th meeting assignments

Based on my notes, these are the assignments from the September task force meeting.

1. Barry Keene:

- a. Provide Tom Darr with a written version of his statement, “The marketplace would greatly benefit from the rationale and expertise of specialty societies and other entities that you and NCCI rely upon for final edits. This information should be made transparent on a code by code basis, not standards of medical practice, but codes”. This will ensure that his message was clearly received.
- b. Pull together an informal committee to respond to Dr. Cross.

2. Marilyn Rissmiller:

- a. Add clarification to reimbursement policy to question 2a in letter to Dr. Rosen.
- b. Revise letter to Dr. Rosen to include temporal considerations and distribute this revised letter to the task force.
- c. Define questions for Tammy to ask ACS/specialty societies.

3. The CCI subcommittee will provide information from CMS to see if that database is one that could be used for place of service edits, as well as discussing the “age question”.

4. Mark Painter will forward NCCI meeting minutes to co-chairs.

5. Tammy Banks will provide documents to co-chairs regarding AMA’s coordination of Dr. Rosen’s communications with specialty societies with the next 5 days.

6. The Finance Committee will attempt to find a sponsor for catering for the November meeting.

7. All – please send any ideas for the November meeting, as well as suggestions for how to use staff.

HB10_1332 MEDICAL CLEAN CLAIMS

TRANSPARENCY AND UNIFORMITY ACT TASK FORCE



October 31, 2011

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

Dear Dr. Rosen,

Pursuant to your agreement with the State of Colorado to provide consulting services to the Medical Clean Claims Task Force we are submitting the questions noted below for your consideration and response. If you should need clarification on any of these questions please let us know, our contact information is noted below.

1. Edit Sourcing:

- a. The Colorado Clean Claims Task Force looks for the rationale that supports each clinical edit that impacts provider payment. What sourcing is used in the adoption of clinical edits for NCCI?
- b. When NCCI lists "standards of medical practice" as the edit rationale, how is that determination made? Briefly describe the process and the sourcing of these edits.
- c. For these edits to work more effectively in a wider arena, there would need to be access to the rationale used in their development, including the rationale and expertise received from specialty societies on a code by code basis. Can this information be made publically available?
- d. Is there a plan for NCCI to cite the source of edits?

2. Variance among CCI edits, AMA CPT edits, and Specialty Society recommendations:

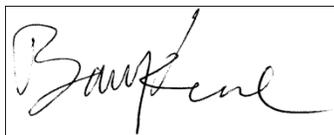
- a. How will the Colorado Clean Claims Task Force locate ALL codes and edits that are created specifically for Medicare and vary from AMA CPT edits? An example is the edit in CCI that precludes modifier override for CPT code 29877 when billed with another arthroscopic procedure, but allows payment at a lower rate for the same procedure billed with G0289.

Niles Rosen, MD
October 31, 2011
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- i. What is the basis for the variance; e.g., coding clarification, reimbursement policy?
 - ii. Is there a file that is publically available?
3. Industry standards
 - a. To what extent does the use of NCCI by nearly all payers other than CMS factor into the NCCI rule making process?
 - b. What differences are envisioned between Medicare CCI edits and those developed for Medicaid, e.g. expanded bill types?

Your timely and thoughtful responses to these questions will greatly facilitate the deliberations of our Task Force. When you submit you reply please include an invoice so we can have a check issued to you for your time.

Sincerely,



Barry Keene, Co-Chair
President
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