

HB 10-1332 Colorado Medical Clean Claims Transparency and Uniformity Act Task Force

Agenda

July 18, 2012, 8:00 am – 3:30 p.m.

Location: University Physicians, Inc, 13199 East Montview Blvd, Aurora

The Lilly Marks Boardroom, 1st floor

Parking lot off Victor Street

Call-in number: 1-866-740-1260, ID 8586328 #

Agenda

- 7:30 – 8:00 a.m. Coffee and Continental Breakfast
- 8:00 – 8:10 a.m. Roll call, welcoming remarks
- 8:10 – 8:20 a.m. Housekeeping
- Approve June 2012 meeting minutes (Attachment A)
 - Review Agenda
 - Thank you to NHXS for sponsoring catering
- 8:20 – 9:20 a.m. June 27th follow-up items
- Conflict of interest guidelines/form
 - **CONSENSUS ITEM:** In scope/out of scope methodology (Attachment B)
 - In scope/out of scope edits identified so far

Committee Reports

Committee Reports: introduce committee members; committee principles (if applicable); committee scope of work; report of activities to date; recommendations (draft and final); issues to be resolved or investigated; questions for the full task force; next steps.

- 9:20 – 10:30 a.m. Edit – Mark Painter/Beth Wright
- Progress report on definitions
 - Other Edit Types (Attachment B 2)
 - **CONSENSUS ITEMS** (Attachment C):
 - Add-on edit with revised comment
 - Same-day medical visit
 - Global Surgery Days with revised definition
 - Laboratory rebundling
 - Bundled services
 - New patient revised

- 10:20 – 10:45 a.m. Break
- 10:45 – noon Specialty Society – Marilyn Rissmiller
- Payment rules
 - Examples from other states
 - Task force methodology
 - New Payment Rules Committee
 - Discussion of Payment Parameters Committee timeline and charge: define the term “payment parameter;” provide examples; and develop a recommended set of payment parameters (Attachment D)
 - Discussion for Implementation Committee
- 12:00 – 12:30 p.m. Working Lunch
- Guest: Sue Birch, executive director, Colorado Department of Health Care Policy and Financing
- 12:30 – 1:30 p.m. Data Sustaining Repository (DSR) – Val Clark/Barry Keene
- Criteria for and scoring of RFI responses (Attachment E)
 - Development and distribution of RFP
- 1:30 – 2:15 p.m. Project Management – Barry Keene
- Revised public contact sheet (Attachment F)
 - Updated work plan
- 2:15 – 2:30 p.m. Finance – Barry Keene
- Meeting with foundations and stakeholders
- 2:30 – 2:40 p.m. Break
- 2:40 – 3:15 p.m. Next Steps and Other Business
- Set November/December Meeting
 - Reminder of 2012 meeting schedule (Attachment G)
 - Next face to face meeting October 24th
- 3:15-3:25 PM Public Comment
- 3:30 PM ADJOURNMENT

Attachment A - DRAFT

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Meeting Minutes

June 27, 2012

12 PM – 2 PM, MST

Call-in Number: 1-866-740-1260

Conference ID: ID 8586328

Web Login: <https://cc.readytalk.com/cc/s/showReg?udc=e7plv4cig8js>

Attendees:

- Barry Keene, CC
- Beth Wright
- Beth Provost, alternate
- Doug Moeller, MD
- Fred Tolin, MD
- Helen Campbell
- Jill Roberson
- Kim Davis
- Lori Marden
- Marilyn Rissmiller, CC
- Mark Laitos, MD
- Mark Painter
- Mark Rieger
- Michele Baran, alternate
- Nancy Steinke, alternate
- Tammy Banks, alternate
- Marie Mindeman
- Tom Darr, MD
- Valerie Clark
- Wendi Healy

Staff :

- Laura Powers

Public:

Meeting Objective (s):

Key:

- TF = Task Force
- TFM = Task Force Member
- CC = Co-Chair

Parking Lot:



	<p><i>As an employee of CIGNA and as a result of CIGNA having relationships with one or more of the vendors that will be bidding on the RFP that will be issued by the task force, a conflict of interest as defined by the Policy may exist. The above serves to disclose such potential conflict of interest.</i></p> <p>With the minutes, the amended conflict of interest statement can be sent out.</p>	<p>Laura will send this out to the task force</p>	<p>Prior to next meeting</p>
	<p>IN SCOPE AND OUT OF SCOPE EDITS</p> <p>CC asked for any comments on in scope and out of scope at this point?</p> <p>Proposed language: <i>“Edits out of scope” include the following types of edits only, as allowed for in statute: medical necessity, utilization review, and fraud. If there is a CPT code and a related edit then it is in scope.</i></p> <p>CC asked for any comments on this? Is there anyone who cannot agree to this sentence?</p> <p>TFM noted that the edit committee discussed what is out of scope. For example, how do we edit laboratory services stating that this is out of scope. This language changes what the edit committee has stated.</p> <p>Another TFM suggested deleting the 2nd sentence of the statement.</p> <p>TFM suggested going back to look at some of these others that we had determined to be out of scope.</p> <p>CC noted we never intended to address contracted payment amounts.</p> <p>A TFM suggested creating a spreadsheet for all of those we have determined to be out of scope.</p>		

	<p>CC stated that the TF is looking to answer a question about in scope and out of scope and the statute is clear for what is out of scope. Do we need a consensus or do we need a spreadsheet for what is out of scope?</p> <p>TFM noted once the lab bundling language is determined in scope then the exceptions will be easier to deal with. Let's not define out of scope before we define in scope.</p> <p>CC suggested tabling this for consensus for now until we have more knowledge of what things are out of scope aside from what the statute says.</p> <p>PROS AND CONS – DOES A PAYER HAVE TO USE ALL THE EDITS IN THE UNIFORM EDIT SET</p> <p>CC asked if perfect be the enemy of the good here? Biggest concern about not having uniformity. Secondly, are we potentially opening the door to a pitfall we can't potentially see right now? Can we see a claim rejected because of this? Consensus that no one could think of an example where if a payer didn't use an edit that it could cause it to be rejected. This may cause a question in the providers mind of why did I get paid for this as a rejection would. Whole point it to reduce administrative burden.</p> <p>TFM suggested same format that we use for exception table.</p> <p>CC noted a TFM described a scenario in which we say yes, under some conditions for a specific edit we would allow them now to use it. The payer would then need to let the providers know.</p> <p>A TFM noted concern about having to let providers know. Like giving a calling card to commit fraud.</p> <p>Another TFM commented this is a CPT guideline for the accurate reporting of guidelines. The challenge is when this is applied inappropriately. Having consistency among payers reduces need for review.</p>		
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	<p>A TFM stated that one of the concerns about new versus established patient has to do with the capability of a payer to track a patient going to a new practice. Adding that parameters created complication and cost on the payer side. Records are not at the new practice so a lot of rework will need to be done.</p> <p>TFM noted What about looking at the sub-specialty, I think we need to look at this.</p> <p>A TFM stated a lot of payers can't assign sub-specialty.</p> <p>TFMs discussed the pros and cons of this.</p> <p>A TFM asked when does rule have to be applied? Let's say you don't apply when you process the claim but apply the rule 90 days after. Can you apply the rule anytime? Up to a year later?</p> <p>TFM stated every state usually has a law about this.</p> <p>A TFM noted not sure what Colorado law is.</p> <p>TFM asked does that accomplish the goal of lessening administrative burden.</p> <p>TFM stated from CPT, this document is not a part of the CPT guidelines. This was provided at a request for further information and interpretation of the CPT guidelines.</p> <p>CC stated we set out to determine does a payer have to use all the edits we are discussing. Can we hear the providers one more time. Do you object on this particular edit, do we object if the payer does not use this particular edit?</p> <p>CC noted that how it gets administered is not in our purview.</p> <p>A TFM stated this does not reduce administrative burden which is the goal.</p> <p>A TFM noted this is a question for the payers. It appears that some payer systems do not have this capability of noting the sub-specialty. Does any payer that does not have their capability in their system and determine is this type of limitation in their system affordable. Is this sub-specialty edit a bigger issue?</p>	<p>What is Colorado law? C.R.S. 10-16-704 (4.5)</p> <p>(4.5) (a) All claims paid by a carrier shall be considered final unless adjustments are made pursuant to this subsection (4.5).</p> <p>(b) Except as otherwise provided in this subsection (4.5), adjustments to claims by the provider or the carrier shall be made within the time period set out in a contract between the provider and the carrier. Such time period shall be the same for the provider and the carrier and shall not exceed twelve months after the date of the original explanation of benefits.</p> <p>(c) Except as otherwise provided in this subsection (4.5), if there is no contract between a provider and a carrier, adjustments to claims paid to providers shall be made within twelve months after the date of the original explanation of benefits. The time period for adjustments shall be the same for the provider and the carrier.</p>	<p>Determine before next meeting</p>
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	<p>A TFM stated they cannot capture sub-specialties in our systems at Humana.</p> <p>A TFM asked how is the sub-specialty defined?</p> <p>TFM gave example of Internal doc with a subspecialty as Cardio.</p> <p>A TFM noted here is a field in the 37 for taxonomy but fewer than 10 % of claims are populating that field. Some are listing taxonomies that are not listed. Haven't provided In our rules, how is the payer going to identify how this rule can be applied.</p> <p>CC asked if most payers use how provider ID file to identify the doctor's specialty?</p> <p>TFM's noted yes.</p> <p>CC stated this may be bigger than the scope of what we are trying to deal with. Should we allow a payer to not use an edit or not include an edit that causes this kind of a problem.</p> <p>TFM asked how do we deal with providers that aren't following the rules.</p> <p>Another TFM stated the intent of statute is that no one denies a claim using an edit that is not consistent. This is not in the statute.</p> <p>CC noted we don't want a claim rejected because an edit isn't used .</p> <p>A TFM stated United Health Group originally brought this up. Is this technology or is this how you credential your providers?</p> <p>Another TFM posed the following scenario: I am not going to be able to bill a new patient for 3 years, what if you don't have the capability of pulling up records back 3 years.</p> <p>CC suggested writing report how implementation occurs. We say the complete set occurs within one or two years. There may be a cushion to state that fundamental technology needs to change in order to implement this.</p> <p>CC asked if an option should be added if they don't have the capability to implement it initially, they can add this edit later?</p>		
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	<p>A TFM noted being uncomfortable for stating that goes under fraud.</p> <p>A TFM stated there might be another edit time that a carrier has that I don't but that doesn't mean that is a fraud review.</p> <p>Another TFM disagreed with being able to do this edit post-adjudication. If this edit cannot be operationalized, should we have it in our edit set?</p> <p>A TMP pointed out the importance with front claim edits where there are technical requirements. Some of these, we owe it ourselves to discuss the syntax including the taxonomy code that we use to put in the system so that we don't allow everyone to program it differently.</p> <p>CC noted this is tabled and there are some subtopics to be discusses including operationalization. If this is problematic to operationalize, can we leave them out? If they have to be there then how long are we giving for implementation? Can do a conversation about this for the 18th of July.</p> <p>TFMs noted that some felt this was reasonable to expect payer's to implement and some felt it was not.</p> <p>A TFM stated some of payers that are not as large – you may be killing competition and raising rates.</p> <p>CC suggested that once we have defined then look at how they get implemented.</p> <p>CC suggested we begin with the DSR committee to begin a conversation about scalability. Not asking for consensus today and will contact a few of you to discuss this further. Discuss with Doug Moeller the difficulty of software updates.</p>	<p>Add this to the next agenda</p>	<p>July 18</p>
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<p>Committee Reports</p>	<p>DATA SUSTAINING REPOSITORY – MARK RIEGER AND VAL CLARK</p> <p>RFI Follow-up</p> <p>CC stated that of the dozen or so we sent out, we received 4. These dozens of re- sponses are on the password protected page. We appreciate the degree of detail that was put into this effort. One thing that was surprising was the time it would take to implement, the shortest of which was 6 months. In the RFP, we will have to be very demanding about this. No one that was involved in the proposals was involved in the analysis of the information. That was purely a budgetary determination. Suggested RFP criteria is that price is something we had to be conscious of and timing is also very important. One vendor did not quote SAAS (software as a service). Some vendors want extra funds to create a software construct. We also need to be careful about the transition. We don't want to create a great burden. I didn't see in most of these, a response that this would be a problem. It appeared that what the vendor would already have in place is important – probably unrealistic to have a vendor cre- ate it all fresh.</p> <p>A TFM noted that we learned a lot about what is should look like. There is already a platform from which we can jump rather than inventing our own wheel.</p> <p>Another TFM noted there are different ways that these could be approached. This will help us to write a reasonable RFP.</p> <p>CC asked for comments that anyone has regarding our document that we put togeth- er.</p> <p>A TFM noted the benefits of RFI step.</p> <p>CC asked why Optum didn't respond.</p> <p>TFM stated it was a question about whether this something to pursue not whether this is a bad idea.</p> <p>TFM stated that in July will be working on the parameters for the RFP. Will be creat- ing a committee for this purpose as we move further.</p>	<p>Create parameters for the RFP</p> <p>Create a committee for RFP</p>	<p>At July 18 meeting</p> <p>In July</p>
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	<p>EDIT/NCCI COMMITTEE – BETH WRIGHT/MARK PAINTER</p> <p>The definitions list progress</p> <p>TFM discussed the Global Surgery Day.</p> <p>Add-on codes with bilateral modification discussed. Not changing the definition, just moving that piece over to the comments.</p> <p>Laboratory Rebundling TFM noted that the task force was deeming that this was out of scope so we may want to hold off until we have the bigger answer of in scope and out of scope determined.</p> <p>CC stated this is both in-scope and out of scope.</p> <p>TFM noted to also look at Laboratory Rebundling and Bundled Service</p> <p>SPECIALTY SOCIETY – TAMMY BANKS/HELEN CAMPBELL</p> <p>Payment rules in other states</p> <p>CC noted a document regarding this has been posted on the private side of the website on the PSO committee page. This is just a starting point.</p> <p>A TFM commented that the specialty societies are cooperating and participating with us. In regards to Federation Outreach, we are hopeful to get a letter out to the federation soon. Will send a letter thanking CPT, ACS and American College of Radiology for their participation.</p> <p>CPT has developed “black & white” edits and will share them with the Task Force.</p> <p>PROJECT MANAGEMENT – BARRY KEENE</p> <p>Public Listing of Contact Sheet</p> <p>Has anyone that would not like information posted to please let Laura know.</p>	<p>Bring this for consensus</p> <p>Bring this to consensus</p> <p>Bring to Consensus on definition</p> <p>Members only list with all info on member side and public version without mobile numbers on the public site.</p>	<p>July 18</p> <p>July 18</p> <p>July 18</p> <p>Prior to next meeting</p>
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	<p>FINANCE – BARRY KEENE Foundations Meeting</p> <p>CC noted that the foundations do not want to facilitate technology – none of the three foundations are willing to fund the database. They are willing to pay for staff and facilitation of the task force work.</p>		
Other Business	CC: Asked for a sponsor for the July meeting.	Mark Rieger volunteered NXHS as a sponsor	July 18
Public Comment	There were no public comments.		
ADJOURNMENT	Meeting adjourned at 2:06 pm		

Attachment B

“Edits Out of Scope”

Version 2, as of 7-8-12

“Edits out of scope” include the following types of edits only, as allowed for in statute: medical necessity, utilization review, and fraud.

If there is a CPT code and a related edit then it is in scope except that the Task Force may allow for exceptions under the circumstances and using the process described below.

- If a payer does not have the provider identification data to implement an edit (e.g., _____), the Task Force may grant the payer a waiver subject to conditions set by the Task Force (e.g., length of time to come into compliance, information that must be submitted for a waiver to be considered, etc.).
- Where a payer receives a waiver for a specific edit, the payer shall not use any other edit, including a proprietary edit.
- With respect to the creation of the initial comprehensive standard edit set, the task force shall select edits in the way it thinks the edits should be, even if exceptions may need to be made under specific circumstances. The Task Force and Edits Committee shall refer to an Implementation Committee all implementation issues, including the circumstances under which a waiver may be granted. The Implementation Committee shall in turn make recommendations to the full Task Force for how the comprehensive standard edit set should be implemented.

Attachment B 2 – Other Edit Types – Working Definitions 7/18/12

EDIT TYPE	DEFINITION	SOURCES	COMMENT
Duplicate	This edits for duplicate check for Inpatient, Medicare Part A Crossover, Medicare UB04 Part B Crossover and Outpatient. These would be facility. Medicaid 0105	Colorado Medicaid Appendix R	Out of Scope - Clean Claim, Unprocessable edit
Validation of Procedure Code to Provider Type	The provider type is PT and the rendering provider is speech therapist. Checks to determine the charges are not from PT/OT which requires a modifier. Medicaid 0122	Colorado Medicaid Appendix R	Out of Scope
Validation of Category of Service to Provider Type	To verify Category of Service (COS) assigned to provider type, i.e., physician, DME, laboratory. Medicaid 0301	Colorado Medicaid Appendix R	Out of Scope
Missing Modifier	Code H0004 requires a modifier HF and the claim was submitted without a modifier. 0376	Colorado Medicaid Appendix R	Out of Scope – Clean Claim, Unprocessable edit
Pricing File Not Loaded	The procedure or revenue code is set up to reimburse using the Relative Value Scale (RVS) and does not have an associated conversion factor. Example: 33516 has an RVS base value of 68.00 and a conversion actor of 32.47 for Medicaid. If the conversion factor was not assigned or added to our system this would set the edit. 0380	Colorado Medicaid Appendix R	Out of Scope – Payment files
Pricing File Requires Manual Pricing/Split Claim	Not a facility message. Edit applies to physician, lab/x-ray, transport, etc. The procedure code has multiple pricing segments and the dates of service on the claim span a reimbursement change. Example: DOS on claim is 06/25/11 through 7/2/11. Fee Schedule was updated effective with DOS 07/01/11. Another Example: procedure code is effective 04/01/11 and From DOS 3/30/11 the edit will set. To date is 10/02/11 and the procedure code was terminated on 09/30/11. 0429	Colorado Medicaid Appendix R	Out of Scope –Payment files
Manual Pricing Required	Edit sets when one of the modifiers on line item is equal to 50 (bilateral procedure). Line item associated with 50 modifier needs to be manually priced. Applies to Medicare Part B Crossover claims.	Colorado Medicaid Appendix R	Out of Scope - Bilateral edit has been addressed; this is a Medicaid specific edit required to price the claim correctly.

	1479		
Procedure code to modifier validation	This edit identifies when a modifier is inappropriately billed with a procedure code.	CMS, Vendor	Out of Scope



HB 10-332 Colorado Medical Clean Claims Transparency & Uniformity Task Force

Subgroup Recommendation

Topic	Add-on Edit Definition - REVISION
Date	7/18/12
Subgroup, Chair & Contact Information*	Edit Committee, Beth Wright, Beth.Wright@anthem.com
Issue (1-2 sentences)	Task Force previously approved the Add-on definition, however questions were raised concerning the CPT comment that was included. The original Comment was: bilateral procedure reductions do not apply to procedure codes designated with the plus symbol (+) in the CPT manual.
RECOMMENDATION	<p>Definition: This type of edit will identify incorrect billing of a CPT/HCPCS add-on code. An add-on code describes a circumstance under which a procedure is rendered by the same physician <i>in addition</i> to a primary procedure or service. The add-on code, by definition, <i>never</i> would be reported as a stand-alone code. While not all add-on codes have a designated “parent” code, the use of a specific primary code with an add-on code is required when indicated by AMA CPT parentheticals. Add-on codes are identified by AMA CPT with the plus symbol (+), and instructions in the code description for reporting the service in addition to the primary procedure.</p> <p>Revised Comment: Multiple procedure reductions do not apply, as procedure value is based on the knowledge that they are never done alone. *Bilateral procedure reductions do apply to those codes identified on the MFSDB with the modifier 50 indicator.</p> <p>Note: This edit applies only to those procedure codes specifically designated as such with the plus symbol (+). Other procedures that follow the same “add-on” functional logic, that is they are never reported alone, but do not have the AMA designation will be handled by a separate edit [to be added to the MCCTF edit dictionary].</p>
Reason/basis for recommendation (3-5 sentences)	The Edit Committee reviewed samplings of designated procedure codes in various sections of the CPT to determine whether or not the MFSDB indicated that the procedure should be exempt from the bilateral procedure reduction.
TASK FORCE ACTION & DATE	

* Please contact chair if you have questions or concerns



**HB 10-332 Colorado Medical Clean Claims
Transparency & Uniformity Task Force**

Subgroup Recommendation

Topic	Same-day medical visit
Date	7/18/12
Subgroup, Chair & Contact Information*	Edit Committee, Beth Wright, Beth.Wright@anthem.com
Issue (1-2 sentences)	The following edit was submitted for consideration: This edit identifies when an Evaluation and Management visit is billed on the same day as a surgical procedure or substantial diagnostic or therapeutic (such as dialysis, chemotherapy and osteopathic manipulative treatment) procedure.
RECOMMENDATION	The Edit Committee did not feel a separate edit was necessary to handle this situation, rather it should be covered under the existing Global Surgery Days edit. The wording of the Global Surgery Days edit has been revised to include E&M on the same day: This type of edit will identify incorrect billing when services that are routinely considered part of the global surgery package are reported separately within the pre operative, same day* and post operative days assigned to that surgical procedure code.
Reason/basis for recommendation (3-5 sentences)	The proposed same-day edit is not necessary if the Task Force is in agreement with revising the Global Surgery Days eit.
TASK FORCE ACTION & DATE	

* Please contact chair if you have questions or concerns.



**HB 10-332 Colorado Medical Clean Claims
Transparency & Uniformity Task Force**

Subgroup Recommendation

Topic	Global Surgery Days - REVISED
Date	7/18/12
Subgroup, Chair & Contact Information*	Edit Committee, Beth Wright, Beth.Wright@anthem.com
Issue (1-2 sentences)	The current definition of Global Surgery Days does not indicate that an evaluation and management service on the day of surgery would be considered part of the global surgery package.
RECOMMENDATION	Revise the current definition to incorporate the day of surgery in the global surgery package: This type of edit will identify incorrect billing when services that are routinely considered part of the global surgery package are reported separately within the pre operative, same day* and post operative days assigned to that surgical procedure code.
Reason/basis for recommendation (3-5 sentences)	This will clarify the edit intent and eliminate the need for an edit specifically to address an evaluation and management service on the day of surgery.
TASK FORCE ACTION & DATE	

* Please contact chair if you have questions or concerns.



**HB 10-332 Colorado Medical Clean Claims
Transparency & Uniformity Task Force**

Subgroup Recommendation

Topic	Laboratory rebundling
Date	7/18/12
Subgroup, Chair & Contact Information*	Edit Committee, Beth Wright, Beth.Wright@anthem.com
Issue (1-2 sentences)	Additional edit submitted for consideration to identify when the components of a CPT comprehensive organ or disease-oriented panel are reported separately under the individual test codes rather than the one panel code.
RECOMMENDATION	<p>Definition: This edit identifies incorrect billing when components of a comprehensive multiple component blood test (i.e., organ or disease-oriented panel) are reported separately. If all components are billed separately, they will be combined into the appropriate single comprehensive code.</p> <p>Comment: We recognize that public and private payers commonly have a reimbursement maximum in place to limit the amount paid when individual components of a panel (but not all components) are billed separately. This type of payment edit is out of scope.</p>
Reason/basis for recommendation (3-5 sentences)	<p>This edit is consistent with Medicare Clinical Laboratory guidelines.</p> <p>Medicare Claims Processing Manual, Chapter 16, Section 90.2</p>
TASK FORCE ACTION & DATE	

* Please contact chair if you have questions or concerns.



**HB 10-332 Colorado Medical Clean Claims
Transparency & Uniformity Task Force**

Subgroup Recommendation

Topic	Bundled service
Date	7/18/12
Subgroup, Chair & Contact Information*	Edit Committee, Beth Wright, Beth.Wright@anthem.com
Issue (1-2 sentences)	Additional edit submitted for consideration to identify certain services and supplies that are part of another and should not be reported separately.
RECOMMENDATION	<p>Definition: This edit identifies when certain services and supplies are considered part of the overall care and should not be reported separately.</p> <p>Comment: Procedure codes are identified with a status indicator B on MFSDDB.</p>
Reason/basis for recommendation (3-5 sentences)	Consistent with Medicare guidelines.
TASK FORCE ACTION & DATE	

* Please contact chair if you have questions or concerns.



**HB 10-332 Colorado Medical Clean Claims
Transparency & Uniformity Task Force**

Subgroup Recommendation

Topic	New patient - REVISED
Date	7/18/12
Subgroup, Chair & Contact Information*	Edit Committee, Beth Wright, Beth.Wright@anthem.com
Issue (1-2 sentences)	Additional edit submitted for consideration to identify correct billing of a new patient visit.
RECOMMENDATION	Definition: This type of edit is used for a new versus established patient. Professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
Reason/basis for recommendation (3-5 sentences)	Consistent with CPT definition
TASK FORCE ACTION & DATE	

* Please contact chair if you have questions or concerns.

**Attachment D – Colorado Clean Claim Task Force Discussion Document
Payment Parameters – July 18, 2012**

The legislation directs the Task Force to develop a standardized set of payment rules and claim edits for use by health care providers and payers in the processing of medical claims. The base set of rules and edits shall be identified through existing sources:

- NCCI
- CMS directives, manuals and transmittals
- CMS National Clinical Lab Fee Schedule
- HCPCS coding system and directives
- CPT coding guidelines and conventions, and
- National specialty society coding guidelines

The legislation defines edit as, "... a practice or procedure, consistent with the standardized set of payment rules and claim edits developed pursuant to Section 25-37-106 (MCCTF), pursuant to which one or more adjustments are made regarding procedure codes, ... that results in:

- (a) Payment for some, but not all of the codes;
- (b) Payment for a different code;
- (c) A reduced payment as a result of services provided to a patient that are claimed under more than one code on the same service date;
- (d) A modified payment related to a permissible and legitimate modifier used with a procedure code... or
- (e) A reduced payment based on multiple units of the same code billed for a single date of service."

The two major components the Task Force is considering are edits and payment rules; additionally we are to consider the affect of modifiers on the edits. All three work in combination to determine how a claim will be processed by the payer.

Edit Defines intent	➔	Payment Rule Provides specificity to ensure the intent is met	➔	Modifier [Payment]* Identifies a situation that overrides all or part of the payment rule
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*There are also modifiers that payers consider "informational"

As the Task Force begins the work of defining the "rules" we should keep in mind our guiding principles – consistency, standardization, administrative simplification and transparency. Like we did for edits, the Task Force needs to begin to identify the principles that will be used to "define" the rules.

In some cases payment rules are just as varied across payers as the edits are. For example multiple surgery reductions:

Figure 3: Payer application of multiple procedure reduction logic rule

Payer	Total contracts	100%, 50%, 50%, 50%,50% MSR	100%, 50%,25%, 25%, 25% MSR	Other MSR rate
A	235	76.2%	23.0%	0.9%
B	440	95.9%	2.5%	1.6%
C	3415	82.6%	12.2%	5.2%
D	478	77.4%	22.0%	0.6%
E	324	13.9%	86.1%	0.0%
F	135	87.4%	12.6%	0.0%
G	174	45.4%	54.6%	0.0%
H	250	80.8%	17.2%	2.0%
TOTAL	5451	77.7%	18.7%	3.6%

From AMA White paper on Standardization of the Claims Process

The legislation directs us to our starting sources. NCCI does include a number of “coding principles, issues, policies” (rules) in the NCCI Policy Manual for Medicare Services. Chapter I includes general correct coding policies, Chapters II through XIII include correct coding policies specific to the procedure codes identified within each chapter. (Copy of Table of Contents attached.)

Recommendation: Use the NCCI coding principles, issues and policies as a starting point to begin to define our payment parameters. Set up a new work group to begin the job of cataloging, defining and sourcing the parameters similar to the work the Edit Committee is doing. Once the NCCI/Medicare rules have been identified and documented we can solicit other payment parameters from the full Task Force members.

TableofContents_01012012final.doc

Revision Date: 1/1/2012

(Chapter VIII - Revision Date 4/1/2012)

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FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Selected Summary Information from RFI Responses & Suggestions for Criteria to Score RFP Responses

Vendor Respondents

Vendor	Select RFI Responses			
	(months)	Phase I Price (\$)	Cost (\$)	SaaS
MCAG (Managed Care Advisory Group)	9	\$736,000	\$268,000	No
McKesson	6 -to- 12	\$1,450,000	\$125,000	Yes
NXHS	6	\$40,000	\$0	Yes
Verisk	6	\$500,000 -to- \$750,000	\$5,000	Yes

Vendors that Declined to Respond

Vendor	Comments
Colorado Health Institute	CHI doesn't feel that we are well positioned to take this project on. Thanks for forwarding, but we weren't planning on responding. - Amy Downs
Correct Coding Solutions - CCS	CCS will not be able to submit a response to the RFI at this time. However, we would appreciate you notifying us when the RFP is posted. - Niles Rosen
HIMSS	This is a topic of interest to our Business-Centered Systems group but will not be participating.
Novitas Solutions, Inc. (formerly Highmark Medicare Services Inc.)	We appreciate you providing us with the opportunity to review this RFI and to provide a response. Unfortunately, we have decided not to respond. - Jody Grier
Optum	n/a
RMCMCI	Unfortunately RMCI is not going to provide a response to the RFI. Our company has the technical wherewithal to meet technical development needs stated in the RFI, however we did not find a partner with the necessary medical knowledge to assist us in determining a method for making this venture profitable. When a formal RFP is generated for this project we would appreciate the opportunity to be invited to respond. RMCI will continue to seek a partner with the proper experience in this market.
The Lewin Group	n/a
Trailblazer Health Enterprises, LLC	n/a

Some Suggested RFP Criteria

- o Price
- o Maintenance cost

Attachment E

- o Delivery date
- o Saas
- o License fees
- o Miscellaneous fees
- o Transition viability--scalability going from Phase I to II (a lot more users); transferability
- o Experience, particularly working with a range of edits
- o Nimbleness--ability to respond quickly to task force requests for different array, analysis of edits
- o Articulated understanding of what is needed
- o Degree of architecture in place
- o Alignment of in-place architecture and goals
- o Software as a service v. buying software (unless cheaper)
- o Other

Attachment F - HB10_1332 Clean Claims Transparency Task Force Members

NAME, first	NAME, last	STAKEHOLDER GROUP	TITLE	PHONE	E-MAIL	Primary Stake	Comment	Note	Contact	State
Amy	Hodges	IV, Billing Revenue Cycle Mngt, BloodHound Technologies, a subsidiary of Verisk Health	Director of Content	919-313-1670	ahodges@veriskhealth.com	3	Contracting w/States	to implement NCCI for Medicaid	BMK	NC
Barry, Finance Committee Chair, Project Mgmt Committee Chair	Keene	Other, KEENE Research & Development	Non-medical Analyst	303-665-0180	krd@gadas.com	NA	co-author HB10_1332, non-stakeholder	Co-Chair HB10_1332 Task Force		CO
Beth, Edit Committee Co-Chair	Wright	2, Anthen Blue Cross and Blue Shield	Manager – Reimbursement Policies and Procedures	203-654-3186	Beth.Wright@anthem.com	2	FP payer		BMK	CN
Carol	Reinboldt	V.a., State of Colorado	Claims Operations Section Manager	303-866-6197	carol.reinboldt@state.co.us	2	Colorado Dept Health Care Policy & Finance	Other, Assistant to TFM	MR	CO
Catherine	Hanson	Other, Physician practices, American Medical Association	Vice-President Private Sector Advocacy	312-464-4640	Catherine.Hanson@ama-assn.org	1	ASQ work group member		MR	IL
Douglas	Moeller, MD	Other, Software, McKesson Health Solutions	Medical Director, Claims Performance Group	610-993-4333, 1080	Doug.Moeller@McKesson.com	3	Primary software vendor	internal med MD	BMK	PA
Fredrik	Tolin, MD	II, Humana	Market Vice President	312-441-5539	ftolin@humana.com	2	FP Payer		BMK	IL
Helen, PSO Committee Co-Chair	Campbell	II, United Health Group	Vice-President Interoperability and Standards Development	254-780-1076	helen_t_campbell@uhc.com	2	FP payer	ASQ work group member	BMK	TX
Jill	Roberson	I.d., Denver Health & Hospital Authority	Director of eHS-Health Information Management	303-602-8026	jill.roberson@dhha.org		Federally Qualified Health Center	largest FQHC in Colorado	MR	CO
Kathy	McCreary	1.d., University of Colorado Hospital	Managed Care and Contractor Administration	720-848-8779	Kathleen.mccreary@uch.edu	1	key contributor to legislation, contracts officer	CHA member	MR	CO
Kim	Davis	IV, Physician Billing, University Physicians, Inc.	Director of Patient Accounts	303-493-7781	kim.davis@upicolo.org	3	1,100 physicians billing	University Hospital, affiliate	BMK	CO
Lori	Marden	II, Other, Rocky Mountain Health Plans, HMO	Claims Director	970-248-8750	lori.marden@rmhp.org	2	NFP payer / HMO		BMK	CO
Marie	Mindeman	American Medical Association	Director of CPT Coding and Regulatory Affairs	312-464-4421	marie.mindeman@ama-assn.org		American Medical Association			
Marilyn	Rissmiller	Other, Physician Practices, Colorado Medical Society	Senior Director, Health Care Finance	720-858-6328	marilyn_rissmiller@cms.org	1	co-author HB10_1332	Co-Chair HB10_1332 Task Force		CO
Mark	Laitos, MD	CIGNA	Senior Medical Director	303-566-4705	mark.laitos@cigna.com	2	FP Payor	State / Regional Medical Director	BMK	CO
Mark, Edit Committee Co-Chair	Painter	IV, V.c., CEO, Relative Value Studies, Inc.	Chief Executive Officer	303-534-0574, x110	markp@prsnetwork.com	3	Will provide feedback to DOWC		MR	CO
Mark, DSR Committee Chair	Rieger	III, National Healthcare Exchange Services Inc. - NHXS	Chief Executive Officer	916-231-0431	mark@nhxs.com	3	Only Practice Management System Vendor	ASQ work group member	BMK	CA
OPEN		I.c					NO URGENT CARE CENTER APPLICANTS			
OPEN							NO AMBULATORY SURGICAL CENTERS APPLICANTS			
OPEN		V.b.					NO FEDERAL GOV'T APPLICANTS			
Robin	Weston	IV, IPA, Centura	Revenue Cycle Administrator	303-673-1000	robinweston@centura.org	3	Only IPA, 24 practices	FP hospital affiliate	BMK	CO

Attachment F - HB10_1332 Clean Claims Transparency Task Force Members

Ryshell	Schrader	I.a., Community Reach Center	Billing Manager	303-412-6091	R.Schrader@mpli.org	1	Only Community Clinic plus psyc & pediatrics	MGMA member	MR	CO
Tom	Darr, MD	Other, Software, Ingenix	Chief Medical Officer/Emergency Physician	801-982-3590	Tom.Darr@ingenix.com	3	Primary software vendor	co-author HB10_1332, ER MD	MR	UT
Valerie, DSR Committee Co-Chair	Clark	II, Other, Kaiser Permanente Colorado, HMO	Compliance Manager - Coding/Revenue Cycle	303-344-7237	valerie.s.clark@kp.org	2	NFP payer / HMO		BMK	CO
Wendi	Healy	Other, Independent Coder with CHC - Correctional Healthcare Companies	Manager Provider Contracting	720-622-8012	Wendi.Healy@correctionc	1	Coding Contractor, AAPC member	MGMA member	MR	CO
Alternates										
Dee	Cole	V.a., Department of Health Care Policy and Finance, State Gov't Representative	NCCI Analyst	303-866-2880	dee.cole@state.co.us	2	Colorado Dept Health Care Policy & Finance	alternate for Carol Reinboldt	MR	CO
Elizabeth	Provost	Cigna health Care, Cigna alternate	Clinical Code Edit Lead	815-933-0399, 815-693-0129 (m)	beth.provost@cigna.com	2	FP Payor, Clinical Code Edit Lead	alternate for Mark Laitos	BMK	IL
Michele	Baran	Other, Software, McKesson, alternate		484-557-5350	michele.baran@mckesson	3a		alternate for Doug Moeller	BMK	PA
Nancy	Steinke	II, Other, Rocky Mountain Health Care Maintenance - RMHP, HMO	RN, Clinical Policy Manager	303-967-2083, 303-981-0614 (m)	nancy.steinke@rmhp.org	2	NFP payer / HMO	alternate for Lori Marden	BMK	CO
Ray	Painter	IV, V.c., Relative Value Studies, Inc.	Consultant	303-534-0574 x108, 303-619-1988 (m)	rayp@prsnetwork.com	3	Will provide feedback to DOWC	alternate for Mark Painter	MR	CO
Rose	Laur	III, National Healthcare Exchange Services Inc. - NHXS	Director, Healthcare Solutions	916-231-0404, 916-995-2703 (m)	Rose@nhxs.com	3	Only Practice Management System Vendor	ASQ work group member, alternate for Mark Rieger	BMK	CA
Tammy, PSO Committee Co-Chair	Banks	Other, Physician practices, American Medical Association - AMA, alternate	Director of Practice Management Association	312-464-4792, 312-420-9755 (m)	tammy.banks@ama-assn.c	1a		alternate for Catherine Hanson	MR	IL
Timothy	Miller	II, Anthem Blue Cross and Blue Shield, alternate		804-354-2135, 804-212-6977 (m)	tim.j.miller@anthem.com	2a	FP payer	alternate for Beth Wright	BMK	VA
Other										
Barbara	Yondorf	Other		303-329-7912, 720-979-7912 (m)	byondorf@gmail.com	N/A	MCCTF Staff			CO
Laura	Powers	Other		303-800-4478, 303-435-9267 (m)	lauramichellepowers@gmail.com	N/A	MCCTF Staff			CO
Susan	McMillon	Kim Davis' assistant		303-493-7705	Susan.McMillon@upicolo.org	N/A				
Primary Stakeholder categories: 1 Provider, 2 Payor, 3 Indirect										

Attachment G

2012 Task Force Meeting Schedule, All Task Force Meeting Times are MST (Mountain Standard Time)

July 11, 3 – 4 pm: Edit Committee Meeting

July 12, 10 am – noon: DSR Committee Meeting

July 18, 8 am – 3:30 pm: Full Task Force Quarterly Meeting

July 25, 3 – 4 pm: Edit Committee Meeting

August 8, 3 – 4 pm: Edit Committee Meeting

August 9, 10 am – 12 pm: DSR Committee Meeting

August 22, noon – 2 pm: Full Task Force Meeting

September 5, 3 – 4 pm: Edit Committee Meeting

September 13, 10 am – noon: DSR Committee Meeting

September 19, 3 – 4 pm: Edit Committee Meeting

September 26, noon – 2 pm: Full Task Force Meeting

October 3, 3 – 4 pm: Edit Committee Meeting

October 11, 10 am – noon: DSR Committee Meeting

October 17, 3 – 4 pm: Edit Committee Meeting

October 24, 8 am – 3:30 pm: Full Task Force Quarterly Meeting

October 31, 3 – 4 pm: Edit Committee Meeting

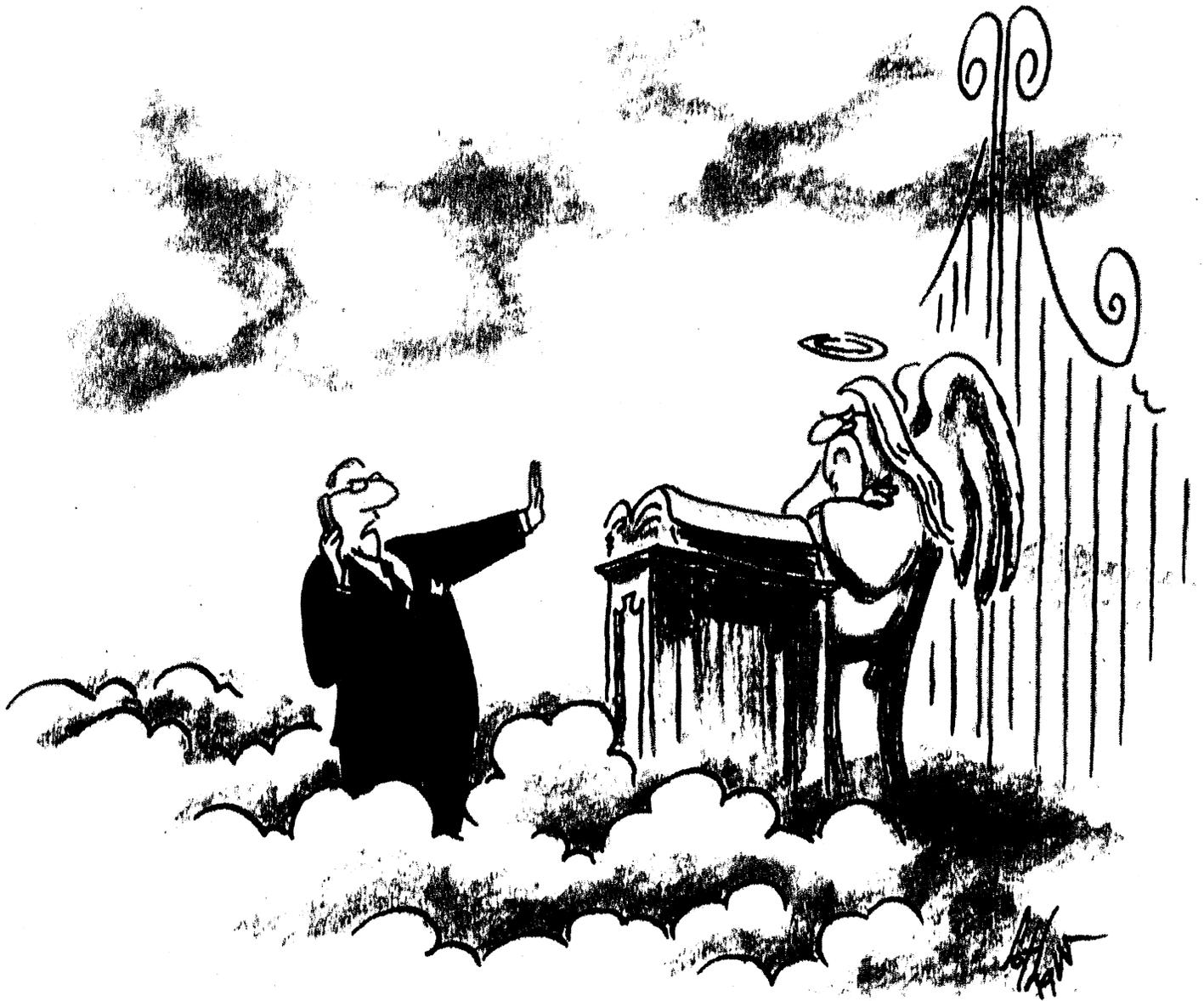
November 8, 10 am – noon: DSR Committee Meeting

November 14, 3 – 4 pm: Edit Committee Meeting

November 28, 3 – 4 pm: Edit Committee Meeting

December 12, 3 – 4 pm: Edit Committee Meeting

December 13, 10 am – noon: DSR Committee Meeting



“Quick! I need some more charitable donations!”