

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

### Agenda

August 22, 2012, noon – 2 pm MST

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

Web Login: <https://cc.readytalk.com/r/q4hnu6ecat3g>

### **Agenda**

- 12:00 PM Roll call, welcoming remarks and housekeeping
- Approve July 2012 meeting minutes (Attachment A)
  - 2012 meeting schedule update (Attachment B)
  - Next face to face meeting October 23-24
  - In scope/Out of Scope language (Attachment C)

### **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.***

- 12:30 PM Committee Reports
- Data Sustaining Repository – Mark Rieger/Val Clark
    - Discussion of DSR Long Term Business Model
  - Edit– Beth Wright/Mark Painter
    - Other Edit Types (Attachment D)
  - Rules Committee – Lisa Lipinski
  - Specialty Society – Tammy Banks/Helen Campbell
  - Project Management – Barry Keene
  - Finance – Barry Keene/Foundations Meeting
- 1:50 PM Other Business
- 1:55 PM Public Comment
- 2:00 PM ADJOURNMENT

# Attachment A - DRAFT

## HB10\_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Meeting Minutes

July 18, 2012

8 PM – 3:30 PM, MST

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

Conference ID: ID 8586328

### Attendees:

- Amy Hodges
- Barry Keene, CC
- Beth Wright
- Beth Provost, alternate
- Dee Cole, alternate
- Doug Moeller, MD
- Helen Campbell
- Jill Roberson
- Kim Davis
- Mark Painter
- Mark Rieger
- Nancy Steinke, alternate
- Robin Weston
- Tammy Banks, alternate
- Tom Darr, MD
- Wendi Healy

### Staff :

- Laura Powers
- Barbara Yondorf

### Public:

**Lisa Lipinski from AMA**  
**Ms. Montenegro**

### Meeting Objective (s):

#### Key:

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

#### Parking Lot:



<b>TOPIC</b>	<b>DISCUSSION</b>	<b>ACTION ITEM</b>	<b>DUE DATE</b>
<p><b>Welcome &amp; Roll Call &amp; Housekeeping</b></p>	<p><b>ROLL CALL &amp; WELCOME:</b> 16 Task force Members in attendance, quorum met</p> <p>Barry: Welcome to Marie Mindeman from CPT, she has officially joined the committee. Also speaking with Lisa Lipinski who is not officially on the task force but will be helping us with our work.</p> <p>Sue Birch – from the Colorado Department of Healthcare and Finance will be joining us for lunch.</p> <p>The Radiology society will be joining us and the Urology Society will also be helping us with our work.</p> <p>Dept of Health and Human Services will be helping us with the Affordable Care Act--Lorraine Doo writing a recommendation for our part of section 10109.</p>		
<p><b>Follow-up from June 27 meeting</b></p>	<p><b>Approve June 2012 meeting minutes</b> CC asked for additions or corrections to the June meeting minutes. There were no comments or corrections and the minutes were approved. Doug Moeller moved for approval and Mark Rieger seconded approval.</p> <p>Barry: Marilyn will not be attending due to her husband's surgery today.</p> <p><b>Thank you to NHXS for catering – second time they have sponsored.</b></p> <p><b>Review Agenda</b> Barb: There are 7 consensus items and a discussion item from the specialty work group. This is on a very important issue regarding payment rules. Sue Birch the Executive Director of the Colorado Department of Healthcare Policy and Finance, and also the person who appointed most of you to the committee, will be meeting with us. We'll discuss the RFP next steps then discussion about finance and wrap up with discussion about the next meeting.</p> <p><b>CONFLICT OF INTEREST FORMS</b> Barb: There are still several forms that are due from task force members and alternates. If those have not been turned in, please do so as soon as possible.</p>		

**IN SCOPE/OUT-OF-SCOPE (Attachment B of agenda)**

Barb: Here is the proposed language listed in attachment B:

*“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.*

There was some concern in particular regarding the issue of new patients. The feeling really was that this was an implementation issue about doing this in our systems. There may be a separate implementation committee that could address these challenges and provide wavers.

Barry: Just introduced the idea of separating implementation from the edit development committee. We will talk more in the DSR committee about the implementation committee.

Mark Rieger: Technical question regarding the CPT. Surely we are going to have edits in here that are not CPT and perhaps use the broader language for HCPCS.

Barb: The suggestion is to switch CPT with HCPCS are there any other suggestions?

Nancy: Suggests adding Subspecialty in the blank.

Barb: Any other suggestions?

Nancy: What are the ramifications if you don't submit this?

Barry: They would be not be following the statute.

Mark: Concern about compliance--what happens when an entity is not able to comply with rules. What about unintentional compliance issues. What are the differences between a known and unknown compliance issues. People don't know what they don't know yet.

Barb: This becomes an example, it would be as they cropped up. I would note the understanding is the Edit Committee came up with this. The suggestion was flag it, refer to the implementation committee which will give some comfort level with recognizing those that are problematic. The committee recognizes the challenge and they will be dealing with a way to waiver it.

Barry: This particular topic, the feedback we got from the payers is that we weren't in a position to do this at all. Some payers didn't have the infrastructure to manage this. We needed a way to look at these issues and collect information on how we do some of these things.

Tammy: Originally thought a definition about why these are in or out-of-scope but this has gone further to look at how often these things occur. This is something that has to be researched. This has gone farther.

Barb: Can you send alternative language?

Tammy: I am sure we can find some general language that would be helpful.

Mark P: One of the challenges for the Edit Committee was, if it was difficult to implement an edit should we make that out-of-scope? Perhaps we should be listing only specific items are out-of-scope. If we have a definition then is compliance at the first level of adjudication or is there a certain timeline for adjudication? We are mixing apples and oranges in this definition of edits that are out-of-scope but the Edit Committee needs direction.

**AMA to provide wording suggestions**

Barb: It isn't that they are out-of-scope, it is that there is an implementation issue.

Nancy: I agree with separating these issues. I think this is too narrow. I would strike first bullet. I would strike second bullet.

Beth W: Nancy, you would strike the first bullet?

Nancy: Yes

Beth W: This waiver idea is new to me – how would that work?

Barry: This is given as an example for how to handle a case in which an edit could not be implemented for whatever reason. There would have to be a real reason for this that would have to be addressed.

Mark R: It seems to me that as this conversation is evolving and that these are separate consensus items. Make attachment B the first edits out-of-scope consensus documents. That medical necessity, utilization review, and fraud are out-of-scope and leave it alone. Don't commingle with compliance.

Second recommendation would be to create attachment C which is the Edit committee should build edits that are technically feasible, not whether current payers are able to implement. They should build edits that meet the feasibility requirements: has to be within the X12 claim including a temporal view, or if the information is included in more than one claim in more than one encounters. I would suggest something close to it. I think we can come up with a technical requirement. If it is contained in X12 and it is a mandated standard, whether payers have the ability to implement should not be the issue of the Edit Committee.

Barb: Suggested language: "The edit committee shall build edits that are feasible, unencumbered by the technical limitations of the payer."

Mark R: 3<sup>rd</sup> piece of this attachment D, non-compliance with edits document. There is not a lot of heartburn if the benefit accrues for the provider so that is the starting place for making an appeal for an exception. We need to be careful here because if you create an exception policy, it will be abused. It is not in the interest of the market place to spend time standardizing and then make exceptions. Much better to deal with non-compliance rather than starting with exceptions. There will be non-compliance on both sides.

No technical difference between a provider incorrectly coding and a payer not using the correct edit. It is very helpful to tell us how we are going to be challenged if we don't do this right.

Barb: We don't have that third piece worked out, but you are saying the Edit Committee should figure out how to deal with non-compliance.

Barry: I am hearing that you are saying something else.

Mark R: Yes I flip-flopped. My recommendation would be not to create any consensus about how non-compliance will be dealt with.

Barry: Talking about litigation, a provider can sue payer for non-compliance.

Mark R: Remember we're saying if they don't apply edit then we are going to provide an exception. If you take away the value equation, there is no difference between overpaying and underpaying.

Barry: Construct with new patient, is that in CPT guidelines. Talking way too much about enforcement. We need to have an edit committee come up with the edit and then we need an implementation committee to discuss all of these.

Barb: Need wording for point 3.

Beth Wright: I don't know where I weigh in on this. We can create the definition and look at how you could build this. This could have a huge financial impact and where this is looked at is up for discussion. We do not want to be impacting administrative costs and therefore cost of care. I do agree with the importance of looking at cost of care. While we are saying the statute lists those types of edits as out-of-scope, we have to think about what is out-of-scope. Talking a lot about new patient visit but we are trying to come up with something that works for everything.

Mark P: There is a certain amount of practicality as we have looked at the definitions. There is at least some degree of implementation to consider. Having something in terms of parameters for helping us making a definition would be helpful. Is taxonomy of specialty in X12?

Mark R: Yes it is.

Mark P: If taxonomy was in X12 then we need to be able to consider that in the piece of the data that is available.

Tammy: Can we do the first and second?

Barb: Let's hold onto that thought.

Mark R: Do we have language for that for attachment B. To create the consensus, take the first sentence of the second bullet. Say for new bullet 3:

*Part2: With respect to the creation of the initial comprehensive standard edit set, the task force shall oversee the development of an edit set that shall meet feasibility requirements based on syntactical compliance with X12 and publicly available data.*

Nancy: Beth had commented about 3<sup>rd</sup> sentence that the things we had defined as out-of-scope already don't fit into those three pieces.

Barb: What she is going to propose that these be other types of edits aside from not out-of-scope rather than out-of-scope having lots of commas or provisos after it. That is Marilyn's proposal to deal with it.

Mark P: The fact that a duplicate for a duplicate Medicare crossover is a HCPCS level edit. [In the end it is out-of-scope.]

Nancy: I agree, some of these are definitely not in the scope for these others but they are not one of the three defined as out-of-scope. No one would object to getting to the place where we need to be.

Barb: We don't want out-of-scope because this endless terminology.

Mark R: We could bridge that gap by saying other types of rules that are not in scope. We are trying to define out before we have defined in. This list is only going to grow. The payers early on in this process made clear that there are a lot of big ones they don't want in but there are going to be a lot of little ones as well.

Ultimately when in scope is in, everything else is out.

Nancy: Maybe we need to look at in scope first rather than out-of-scope first.

Mark R: We need to create a perpetual out-of-scope document, we don't need to lock ourselves in now.

Beth: Difficulty with in scope and if not in scope then out-of-scope is that we need ability to review as we go.

Barbara: Hearing the following suggestion: *"Edits out-of-scope include the edits in statute (medical necessity, utilization review and fraud) and others as excluded by the statute."*

Nancy: we should take out only.

Barry: Read the language of the statute.

Barb: Proposed language: *"With respect to the creation of the initial comprehensive standard edit set, the task force shall select edits in the way they think edits should be. The edits shall meet feasibility requirements based on syntactical compliance with X12 and other publicly available data."*

Asking for consensus.

Nancy: Not strong on technical so do we want to include something to make sure it is current.

Barb: add current to X 12 so that it reads:  
*With respect to the creation of the initial comprehensive standard edit set, the task force shall select edits in the way they think edits should be. The edits shall meet feasibility requirements based on syntactical compliance with current X 12 and OTHER publicly available data.*

Kathy: Find first bullet awkward.

Barb: I agree it is a little awkward but I think people get a sense of it.

Marie: In terms of publicly available data just add other.

Beth: Way this sentence is written, it is has to meet x 12 and other publicly available data but we need to test out some of these and see if they can meet this. Using new patient – we are not going to get 3 years of history in X 12.

Barb: Maybe, so we can move forward, we can move this forward as a tentative consensus so that we can test this with our data.

Beth: Yes or we put to consensus and then revise it.

Barb: Try to push this to tentative consensus or get consensus and then revise. Can we live with this for now and can revisit consensus later.

Kathy: The task force shall select the initial edits.

Nancy: add in accordance with the statute.

Mark R: Irrespective of the technical implementation. We can stick to the rules. If for emphasis, we can include irrespective of the technical implementation.

Kathy: Maybe include not just technical implementation but include outside influences.

Mark: and operational limitations.

Barb: So let's stop there. Basic wording of 1<sup>st</sup> and wording 2<sup>nd</sup> and then. Either have consensus or not and if you want to have proviso then we can do that

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→ **CONSENSUS:**

- 1) *Edits out-of-scope shall include those contemplated by the statute, including medical necessity, utilization review and fraud and others the task force agrees are out-of-scope.*
- 2) *With respect to the creation of the initial comprehensive standard edit set, the task force shall select edits in accordance with the statute and irrespective of operational limitations. The development of an edit shall meet the feasibility requirement based on syntactical compliance with current X 12 and other supporting publicly available data.*

Barb: These are the two we have gotten so far, is there anyone who is not along for consensus? Hearing no objection, consensus is reached.

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→ **CONSENSUS: REVISED BULLETS ONE AND TWO AS LISTED ABOVE**

In regard to third bullet shall we try to quickly come up with this third one?

Mark R: Already administrative burden. If payers cannot implement then let's not recommend this.

Beth: If we don't recommend it then what if a payer already has it in place, they would not be able to keep it? Some folks to have this and it is a mixed bag so does that mean that if a payer has it today then we have to get rid of it?

Mark P: There is an allowance in the statute that would allow the payers to put in their contract that they will not be implementing what is in the clean claims edit set. Is it more costly to allow a waiver or should everybody either comply or not comply?

Beth: Amending a contract is expensive. Why am I going to go through a 3<sup>rd</sup> party vendor to do this?

Barb: I do not see that we have consensus on this. I am going to suggest that we come back to this at the next meeting.

Tammy: It sounds like we need to do an ROI study. Was the investment in their system worth it. It is not saying whether someone should use and edit but getting the facts beforehand.

Kim: I think the most correct edit includes subspecialty. Eventually minimizing administrative burden.

Beth: I don't know that there is more that we can revisit. We need the framework from this group about when we are doing out-of-scope. We need the structure about what we are doing.

Mark R: I thought we reached consensus that the edit committee can develop edits without considering implementation as long as they meet the requirements of X 12. It is not necessary for the edit committee to solve the subspecialty issue.

**IMPORTANT POINT** Barb: What we are saying is we have not reached consensus but we agree that this is still an issue. That doesn't mean that this group isn't going to address it. It does mean that we are keeping a running list of what we already know may cause a compliance issue and this group has not agreed with how to handle these. We will come back at the next meeting and see if we can come up with a 3<sup>rd</sup> statement that is comfortable for people.

Wendi: What is the correct coding of the rule that you are going to put out there? What is the correct way to do it?

Tammy: Trying to reduce burden on the Edit Committee – we can't have the Edit Committee keep chewing on this. It should be sent to the implementation committee at this point.

Committee determined that the third bullet will be revisited at a later date.

**OTHER EDIT TYPES (Attachment B2 of agenda)**

The Committee Moved on to Discuss Other Edit Types, Attachment B2

Mark P: Discussed these did not apply. If any of these seem in scope please let us know.

The committee reviewed the definition column.

Tammy: I think HCPF (Health Care Policy and Financing--Medicaid) has a unique situation.

Doug: With HCPF, some of these may apply only to Medicaid. If there is payer line specificity, then this brings up challenges at the modifier level. Some of these things may be in scope but when it comes to implementing these there are some challenges.

Mark P: What we are saying is out-of-scope that behavioral health for 15 minutes is not only used to treat substance abuse.

Tammy: But what we are looking at correct coding. If there is a code for behavioral health, then why are we going to allow one state-based program to do it differently. All we are looking at is correct coding, not benefit design.

Tom: there are two ways to look at this, one is looking at a correct code and one is looking at a modifier. Why we said this is out-of-scope is quite clear because Medicaid is saying you have to use this code with this modifier. That is a benefit issue. Correct coding says these go together but we are not going to require all providers to use this because it is a benefits issue.

Beth: Tom is right, this is benefits issue, we should write more in the document so people understand where this is coming from.

Barb: Would be helpful to include the reason why here on the bottom of the page or elsewhere?

Mark and Beth: Yes we can clean up the comments.

Mark R: Suggested removing procedure code to modifier validation.

Mark P: There are two different issues, one of saying this is allowed and another is of validating the procedure to modifier combination.

Barb: Can we go ahead with the other ones on the list and we will revisit the last item later. All others on attachment B, minus procedure code to modifier validation. We are looking at the definition column specifically.

Kathy: Could reverse the columns so the definition is the first column?

Dee: Note Medicaid doesn't do bilateral on one line. We can't process the regular way because we have to look at it just for crossover claims in Medicare.

Tammy: When we change to one line this won't be.

Mark R: If you determine that the standard is bilateral is on one line then we are not agreeing that bilateral can be one or more line.

Mark P: We do not want to include an edit that says you have to manually price a modifier 50.

Tammy: I think we need to reword this for manual re price based on carrier deficiencies is at the carrier discretion.

Mark P: All we are asking is that we cannot adopt an edit which requires manual pricing. It is just not our job to tell people to manually process a modifier.

Barb: The point is we are not requiring edits to be manually re-priced. That is out-of-scope.

Beth: We asked people to supply edits we have and we are looking at them to say if this is in the purview.

Switch the columns so the definition column is first

Next full task force meeting August 22

<p><b>Committee Reports</b></p>	<p>Barb: Going to suggest not voting on last two in the list in the table on Attachment C (MANUAL PRICING REQUIRED and PROCEDURE CODE TO MODIFIER VALIDATION) Manual pricing might be included with more details on why.</p> <p>Mark P: Adopted a payer’s definition of an edit as they are defining, not as we are defining it.</p> <p>Wendi: This would be simple remove last option. Keep manual pricing.</p> <p><b>IMPORTANT POINT</b>--Mark and Beth: Will save manual pricing for rewrite and re-explore procedure code to modifier validation.</p> <p>Barb: Any disagreement on consensus items aside from last two?</p> <p>Only amendment would be to clean up missing modifier language.</p> <p><b>→ CONSENSUS: DEFINITIONS FOR: DUPLICATE, VALIDATION OF PROCEDURE CODE TO PROVIDER TYPE, VALIDATION OF CATEGORY SERVICE TO PROVIDER TYPE, MISSING MODIFIER (WITH CLEANED UP LANGUAGE), PRICING FILE NOT LOADED, PRICING FILE REQUIRES MANUAL PRICING/SPLIT CLAIM IN TABLE IN ATTACHMENT B2</b></p> <p><b>EDIT COMMITTEE – BETH WRIGHT/MARK PAINTER</b></p> <p>Barb: Any comments or changes on laboratory rebundling? Asking for consensus.</p> <p><b>→ CONSENSUS: LABORATORY REBUNDLING IN TABLE IN ATTACHMENT C</b></p> <p>Barb: Bundled Service: Comments or issues on this.</p> <p>Nancy: Definition sounds like it rolls in incidental services for supplies.</p> <p>Mark R: Other mutually exclusive or inclusive are covered in other places. I read this to mean that if it is on the Medicare fee schedule with indicator B then it is acceptable.</p> <p>Mark: This is the definition that we now go back and apply to actual data sets. The intention was really for the status B.</p> <p>Barb: Asking for consensus – any objections?</p>	<p>Clean up language on last two and missing modifier language. Will revisit them in edit committee and bring back for consensus</p>	<p>August 22</p>
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None given.

→ **CONSENSUS: BUNDLED SERVICE IN TABLE IN ATTACHMENT C**

Barb: New Patient Revised - any objections?

None given.

→ **CONSENSUS: NEW PATIENT REVISED IN TABLE OF ATTACHMENT C**

Mark P: Same Day Medical Visit is the next one.

Tammy: Wanted to add language about the modifiers but Marilyn indicated adding modifiers in a different column.

Marie: In the part of the statement that talks about global surgery package that they are part of the surgery package.

Beth: remove the word global?

Marie: Yes

Beth: Don't need a separate edit for same day and combining with global surgery.

Kim: The surgical package is not a decision for surgery correct?

Dee: Yes

Barb: Calling for Consensus

→ **CONSENSUS: SAME DAY MEDICAL VISIT IN TABLE IN ATTACHMENT C**

Mark P: Global Surgery Days – we are simply adding the word same day to the definition previously agreed upon. We have not yet fully defined the rules surrounding the global. This is the general definition is all we are looking at with the addition to same day.

Barb: may need a footnote that this is definition only, not definition and not modifiers.

	<p>Mark P: Only thing we are doing is adding same-day.</p> <p>Nancy: Is adding package to same day language.</p> <p>Marie: Suggested removing Global.</p> <p>Tammy: Pretty adamant about modifiers, nervous about including this. Doesn't like "Would be considered" language.</p> <p>Mark P: If we change to <i>would</i> to <i>could</i>, it would be more comfortable.</p> <p>Tammy: do we need this at all? We are only doing the definition.</p> <p>Barb: Just removing the Issue on this consensus item.</p> <p>Kathy: removing the word global?</p> <p>Barb: no because this is a statue issue. Asking for consensus on this minus Issue.</p> <p>Beth P: A part of this overlap with surgery but not every part is addressed.</p> <p>Nancy: recommend that we limit this discussion to add same day and then send other issues back to the Edit Committee.</p> <p>Mark: Edit Committee is going to struggle with the mechanics of the edit and the scope. There is a temporal component to this which is very powerful. It might be helpful when presenting the rules.</p> <p>Barb: Just take out the Issue. Proviso: The Edit Committee may come back on same-day edits for non-surgical. (put where asterisk is).</p> <p><b>→ CONSENSUS: GLOBAL SURGERY DAY REVISED DEFINITION SEE COMMENTS ABOVE REGARDING NON SURGICAL APPLICATION AND REMOVING ISSUE SENTENCE.</b></p> <p>Barb: Add-on edit being discussed. Does everyone understand?</p> <p>Mark R: does not understand this. If bilateral are somewhere else why do we need them in add-on?</p> <p>TFM: This seems like two edits crammed into one.</p>	<p>Edit committee to look at same-day edits for non-surgical</p>	<p>August 22<sup>nd</sup> meeting</p> <p>15</p>
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	<p>Nancy: Under modifier 50, you would look for a specific callout.</p> <p>Doug: I think we are running two together. Add-on codes that are used multiple times. We can report that as many times as you want to. The bilateral is just one sub-type of multiple procedure.</p> <p>Mark: I think we should strike revised comment part altogether.</p> <p>Barb: No comment on revised comment.</p> <p>Beth: It belongs on other definitions.</p> <p>Kathy: Getting rid of revised comment and original.</p> <p>Mark: Does the add-on coding have to preserve your anatomical requirements.</p> <p><b>→ CONSENSUS: ADD-ON EDIT REVISION</b></p> <p><b>SPECIALTY SOCIETY – TAMMY BANKS/HELEN CAMPBELL</b></p> <p><b>Payment Rules</b></p> <p>Barb: Payment Parameters rather than Payment rules is terminology we'd like to use.</p> <p>Barry: Payment Parameters Committee is a new committee just like Specialty Society Committee. The committee will help to have starting place for the discussion and then they will be bringing consensus much like the Edit Committee does. Any comments about this?</p> <p>None given.</p> <p>Barb: Any strong interest in serving on this group, please talk to Marilyn or Barry. Please do participate in at least one committee.</p> <p>Barb: If there are any items for discussion by this committee, please send to Marilyn and cc Barry.</p> <p>Barry: May need to wait to discuss and implement after the implementation committee.</p> <p>[NOTE: Co-chairs decided to call this new committee the Rules Committee.]</p>	<p><b>Send topics for consideration by this committee to Marilyn and Barry</b></p>	<p><b>ASAP</b></p> <p>16</p>
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**DSR COMMITTEE – BARRY KEENE/VAL CLARK**

**RFI Responses and Development of an RFP**

Barry: Looking at attachment E of the agenda for the discussion of the RFI responses and RFP. Estimated that this would cost about \$1-2 million a year to run were pretty good estimates from the DSR committee. We also learned that this might take longer than we thought. Concurrently we have developed a conversation with our funders and learned that our funders do not want to pay for the database. Phase 2 is a self-sustaining model so this is just for phase 1. We are extremely cost-sensitive.

We also learned that some wanted to sell us software and others wanted to maintain software for us (SAAS – software as a service) and it became clear that the latter is what we would prefer. We need to ensure that the format is compatible for us in the long term. We don't have the funding to manage the RFP outside of our group so we need to do this in house. We will need a draft RFP next month and then look at that with a select committee to see to it that we have covered all the bases.

In my opinion, we have to focus on two key things. On this point an RFP is not going out to anyone we don't know is eminently qualified. The timeliness to work with us on the timeline and the cost are the paramount. If there are points that are critical to be part of the RFP then I will stop for comments.

Barry: Kathy has suggested a funding option so I want to thank her for that.

Barb: How those will be measured is on 2<sup>nd</sup> page of attachment E.

Barry: We intend to ask those who are familiar with this process to submit.

Tammy: What is your ask?

Barry: We are looking for contributions in funding.

Doug: McKesson was one of the applicants but not one of the evaluators. Need a description of what we want so that those who are receiving the RFP. Getting clarity about the design features for short and long term needs to be considered. Perhaps go back to DSR about this?

Barry: The RFI was a panoply of responses and the McKesson approach was a very high end approach and there were some responses that were involving a lot of development. One thing we came to understand is that we need a vendor that understands what we are doing in addition to what we would be doing downstream. We need to know how data would be imported, what the rules are, etc.

Kim: It was clear after the RFI that based on working with certain vendors we would be starting at a higher point than for others.

Mark P: To a degree, most people did put software as a service as a way to go. Most people in the industry had tools that were already developed that could simply be modified however we were all surprised that the timelines were longer than we expected. They are putting us out 6-9 months before we even get the database back.

Doug: It turns out that date sensitivity is a big deal to have start and stop dates. CPT has 6 columns for various purposes. We have clarity with how we integrate that and we have 11 platforms. This would not be a unique build for us but it would be a modification of something we already have. 6 months goes by really quickly. It sounds like there are 12 basic rules types and each of these data formats would each require a developer to look at them. How do we score this is something we are still looking at.

Conversation tabled due to Sue Birch's arrival.

**SUE BIRCH – Executive DIRECTOR OF COLORADO'S DEPARTMENT OF HEALTHCARE POLICY AND FINANCING**

Barry: She has approved appointments and was appointed herself by Governor Hickenlooper.

Barry : Introduced the task force members.

Sue: HCPF is changing very quickly but it does a lot of rapid response and changes in our schedule. I know this is very important work and we are really being watched at the national level. I thank you all for your work with this and it will be very useful, particularly as the All Payer Claims Database gets up and running. As we completely rebuild MMIS, I encourage you to look at other states to look at how pieces and parts of this make sense because things are changing so quickly. We are doing a lot of progressive work under regional care collaboratives.

Barb: Can you say a little about what Health Care Policy and Financing does and span of authority?

Sue: HCPF drives about 27 percent of state budget. We oversee Medicaid, and Medicare and we certify the CHIP (Colorado Indigent Care Program). We have about 800,000 people under our watch and a budget of \$5.1 billion and work closely with the Colorado Health Benefits Exchange. We run this state agency with about 320 FTEs which is only 4% administrative cost. Working to rebuild our benefits enrollment system. We are working on care coordinated environments. We hope by end of year to have about 200,000 Medicaid clients moved into care coordinated scenarios.

Lastly we are under new exciting executive order to redesign and we are under dual eligibles program to better service the dual eligibles. Doing a lot of proactive work with AAA's the area offices on aging.

We are looking towards moving towards a culture of coverage. We are pushing for a culture of coordination. Other say we are pushing for de-medicalization but we are looking at less costly chronic disease management. New office of community living is also a driving force. Population and GIS mapping is really being looked at. We are also working on public/private partnerships.

Dee: EHR trying to share information in the state.

Sue: Office of information and Technology so will see more data repositories but we are looking at how might we create health information authority information of guidance.

Barry: The 1.2 million number in Medicaid, is the 133 % out of the Affordable Care Act increase or is that due to growth in population?

Sue: CHIP goes way above 133 % so state will not take an official position yet on the expansion. These are our projections but it is not a hard number.

Doug: Any questions for us?

Sue: curious about all payer claims database and how this work ties in or comes alongside.

Doug: To the extent that healthcare hasn't standardized and to the extent that this happens before the all payer claims database. If we look at sister states that are on the same track across the board. We can manage disease management systems more efficiently. Our work feeds into better data and then we are a cog to standardizing data inputs is a part to the whole equation.

Sue Birch: I'm a nurse by background. Our billing data on immunizations doesn't match the clinical data, etc. It will be great to have the APCD part of it. How can we be more accountable, reduce waste and look at fraud and abuse issues. What are thoughts about encounter data versus episodic.

Tammy: Total culture change. This is a whole new shift and it is going to take baby steps. Challenge in Colorado is we have great rules but forget that they need to be operationalized. We do so many things manually today which is ridiculous in this day and age. We keep getting side-tracked by performance improvement.

Doug: Some electronic data elements are starting to capture what we are looking at. State of Iowa to watch is the getting the whole state to walk a mile. Hope to get their wellness scores from number 26 to number 1 and many other states are working on this. We are going to get our mind around teenage smoking – we don't have to solve world hunger, you do one thing. One thing that gets us into trouble that we just get bewildered. If we prioritize, the low hanging fruit of getting started. We are doing a little.

Sue: I will remind you that Medicaid folks are a unique group that have unique coding issues. I encourage you to think about just like Iowa and looking at wellness coding. This is a demedicalization in different ways. About 25 percent of our patients take 75% of the cost. That coding piece is going to go beyond with some of these social determinants.

Barb: the people in this room understand why this is so valuable and we go to the private sector and we look at all kinds of different ways. At the same time payers have a history of why they do what they do. If they have cost data that looks like apples to apples but really they are not the same medical visit versus medical visit. Outside of this circle, we have a sales issue to explain that this is very important and that Colorado is the leader in the country to make process. Do you have any advice on how we get more financial support.

Sue: Coming from northwest Colorado which is still outlaw country. I say to Governor – if we can get our people on board for standardization then that will be a great thing. We like to use carrots instead of sticks and work in partnerships. I do think it is going to take work and this is a long journey and is going to take a lot of redundant messaging and have a lot of more simple messages for some of these reporting entities. We may have to include more regulatory options if we can't get people on board that way.

Barry: In the Affordable Care Act sec 10109 there is a portion that deals with what we are working on. We have suggested that they make us a pilot and they have been noncommittal. Can you help us with that?

Sue: I do see we will seek state transformation resources that will be available within the next 4-6 months. With OIT taking a stronger HIT realm and looking at the balance with the lead information and the post information. If we are going to compete with these transformation funds. Colorado is seen within the top 5 states to watch.

Barry: thanked Sue for coming and speaking to the task force.

**DSR Committee Conversation CONTINUED**

Barry: Looking at the possibility of a Beta version. Mark would you like to add?

Mark R: Can you add anything more about the timeline? You mentioned about the person helping you with the RFP.

Barry: Yes it is a vendor who did not submit to the RFP and we would like to submit a draft for the next meeting to review. They were sent the RFI and decided not to respond. He will share the draft with members of the task force. Doing that for cost containment purposes.

Barb: This may be critical to the process – can you clarify that a portion of what we could have prior to 6 months?

Doug: We are moving to a 2 week sprint timeline so that we are delivering something every two weeks. This will help us getting something to you sooner.

Barb: So the work of this group could continue before the 6 months?

Doug: We are looking at the rule level not the edit level is not the determining step this minute. The edit committee has a lot to work. The IT solution would still not be the limiting step. Creating a timeline and creating a roadmap is something we need and something to include in the RFP. If you need online support along the way then we would need to know that. Mark P: The modifiers are the next piece.

Beth: Even before the data there are some rules like how many lines are used.

Mark P: I thought that we agreed the implementation committee would be determining this.

Beth: Would like to volunteer for the payment committee.

Barry: You input is valued and you can sit on whatever committee you like.

Nancy: Not completely clear on where the work of the edit committee ends and the payment committee starts.

Barry: Clearly there will be a lot of collaboration and overlap between these two.

Beth: I think we have started to look at some payment rules in the edit committee already so I think that is where there needs to be some clarification.

Beth: I have a lot of notes to share with whoever is working on this because we have gone into discussion about payment on a lot of these already.

Wendi: We can delineate what was done and how it was paid. Edit Committee can say this is the correct coding and the payment committee can take it from a different perspective.

Marie: Would it be helpful to discuss the difference between coding and payment. For example with modifier 50 and that modifier 25 would include all the necessary key components that were included. As I look through the CCI step for Niles Rosen and I had a feeling that a lot of services with E & M visits that are appropriate, however if the whole industry were to shift on that then we would have to go back to them.

Barb: It sounds like it would be helpful if we can more clearly define the difference and parameters of each committee.





Wendi: Suggesting using a blog to share information between task force members between meetings.

Nancy: I don't know that I would want information out there publicly, would this be public?

Barry: Part of the sunshine act is that is public knowledge.

Wendi: Your name would not necessarily need to be listed.

Barry: Will check with webmaster to see about the possibility.

**FINANCE**

**Meeting with Foundations and Stakeholders**

Barry: Developed a proposed budget which includes budget for a project manager. The foundations felt that there had not been enough stakeholder buy-in for this. They felt that they had been supportive in an in-kind way and to date we have produced only 40% of the budget had come from the private sector. Marilyn and Barry made formal presentation and their thinking is that they like what we are doing and they recognize it as a very important thing that needs to be done. They don't want to not support it but they object to funding the database. They want us to fund the database independently. They do support funding the staff. They stated there are billion dollar companies represented and they suggest that the companies that are help with the funding. Many companies represented here can afford to give \$5,000. I have not fundraised as much as I wanted to for various reasons. The kind of money we are asking for here is a 1/3 of what we are asking the foundations for. Not asking for the individuals here to ask, just asking to be connecting with the right person to ask. Only funded right now through the end of September.

Mark P: Is this a quid pro quo? Have the foundations said their funding will not be there if this funding is not acquired?

Barry: No it is not quid pro quo and yes and I have found it counterproductive to argue with them.

Mark P: Is this a conflict of interest to be a committee member and donate?

Barry: No

	<p>Barb: They really didn't understand that this funding is really for the analysis and not the software itself which is phase 2.</p> <p>Wendi: Also hit a wall in terms of how of those who understand this topic. The national physician groups tend to wait for national initiative before they invest their money.</p> <p>Barry: We recognize that the national initiative is a big part of those.</p> <p>Tom: We have talked a lot about this business model. Maybe instead of getting donations, we look for investors. Maybe a small fee on each claim as a possibility and less money would be spent overall by everyone because there would be less back and forth.</p> <p>Barry: We do need to move that conversation on and that is in the purview of the DSR committee and Barb needs to have something in terms of business model to include in the report.</p> <p>Tom: You might get an investor to provide the immediate need with the possibility of future payoff.</p> <p>Doug: Need to be careful with pay to play idea. He can connect to the right person at McKesson. Our organization has gone forward a couple of times in whether this is even worth bidding.</p> <p>Mark R: To the point that you solve the long term budget, the short term budget is resolved but I understand that you have some short term budget constraints that are real.</p> <p>Doug: We just really need to be careful with perception for those who don't understand this situation.</p> <p>Barry: thanked the committee for their work.</p>		
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<b>Public Comment ADJOURNMENT</b>	Barb: Any public comment?  None given.  Meeting adjourned at 3:12 pm		
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## Attachment B

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

**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 23, from noon- 6pm and October 24, 8 am – 3 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 14, noon – 2 pm: Full Task Force 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

December 19, noon – 2 pm: Full Task Force Meeting

## **Attachment C**

### **“Edits Out of Scope”**

Version 2, as of 8-14-12

- Out-of-scope edits shall include those contemplated by the statute, including medical necessity, utilization review and fraud and others the task force agrees are out-of-scope.
- With respect to the creation of the initial comprehensive standard edit set, the task force shall select edits in accordance with the statute and irrespective of operational limitations. The development of an edit shall meet the feasibility requirement based on syntactical compliance with current X 12 and other supporting publicly available data.

*For discussion 8/22/12*

Attachment D

**Other Out of Scope Edit Types – Working Definitions 8/14/12**

TYPE OF EDIT	EXAMPLES	REQUESTOR	OUT-OF-SCOPE RATIONALE
Duplicate	This edit checks for duplicate for inpatient, Medicare Part A Crossover claims, Medicare UB04 Part B Crossover and Outpatient claims.	Colorado Medicaid Appendix R/0105	Edits used to check for duplicate claims/services are <a href="#">Administrative</a> and intended to ensure processing of “clean claims”
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.	Colorado Medicaid Appendix R/0122	This edit identifies a mismatch between the combination of the procedure code & modifier submitted to that expected to be billed by the provider, based on the way the payer’s provider file is set up or the scope of the provider’s license/certification. This is another example of an <a href="#">Administrative</a> edit.
Validation of Category of Service to Provider Type	To verify Category of Service (COS) assigned to provider type, i.e., physician, DME, laboratory.	Colorado Medicaid Appendix R/0301	This edit matches the category of service billed to that expected to be billed by the provider, based on the way the payer’s provider file is set up. This is another example of an <a href="#">Administrative</a> edit.
Missing Modifier	Code H0004 requires a modifier HF and the claim was submitted without a modifier.	Colorado Medicaid Appendix R/0376	There are multiple benefit programs under Medicaid and they use specific modifiers to identify what type of coverage the Medicaid recipient is entitled to. This is a <a href="#">Benefit</a> 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.	Colorado Medicaid Appendix R/0380	This edit would cause a claim to pend for manual pricing, and is another example of an <a href="#">Administrative</a> edit.
Pricing File Requires	Not a facility message. Edit applies to physician,	Colorado Medicaid	This edit would cause a claim to

Manual Pricing/Split Claim	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.	Appendix R/0429	pend for manual pricing, and is another example of an <a href="#">Administrative</a> edit.
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/1479	Bilateral edit has been addressed; this is a Medicaid specific edit required to price the claim correctly and therefor <a href="#">Administrative</a> in nature.

\*May add other examples of manual pricing as they are identified.