

Consideration of C.R.S. 25-37-106 (2)(c)(II)(P)

- I. Task Force is using the following process when considering P – The effect of CPT and HCPCS modifiers on edit types A – O:

Edit Committee

1. Identify modifiers in use – CPT, HCPCS.
2. Define these modifiers – using definitions from source.
3. Identify if modifiers affect payment; i.e., override an edit.
4. Take to Task Force for consensus.
5. Consensus items are referred to the Payment Rules Committee.

Payment Rules Committee

1. Utilizing the sources identified in the statute identify the “rules” – circumstances when the modifier can be used to override an edit.
2. Identify the result of the override:
 - a. Allow, adjust;
 - b. If the line item is to be adjusted, identify if there is an industry norm.
3. Determine if any specific reporting [coding] clarification is necessary for the purpose of standardizing the rules.
4. Make a recommendation to Task Force for consensus.

- II. Task Force review of Bilateral Modifier information:

- Discussion points regarding Bilateral Modifier 50
- Consensus definitions of Pricing Rule and Payment Rule Guidelines
- Determination of Payment

- III. Task Force Considerations/Discussion

What “level” of standardization will the Task Force recommend?

- First level – allow, adjust;
- Second level – if there is an industry norm and the line item is to be adjusted, recommend that the contracted rate is adjusted by that percentage.

Discussion

Discussion points regarding the Bilateral Modifier

Standard and transparent rules have the potential to eliminate the varying payer billing requirements that often times conflict even within payers claim platforms. Some payers do not provide their billing requirements to physicians, causing physicians to struggle with submitting the expected codes and modifiers that the payer will accept. The result is unnecessary delays and denials of the claims and added administrative costs, which is borne by the physician and, ultimately, the health care system. For example, a common nontransparent and inconsistent reporting requirement of the CPT codes occurs when a physician performs a procedure that is commonly performed on one side on both sides of the appendage.

Currently, the Rules Committee is solely focusing its efforts on the CPT modifier 50– bilateral procedure. The bilateral modifier not only causes immense burden for both physicians and payers, it encompasses both a coding element as well as a payment element. Discussions on the bilateral modifier are based on the guidelines that the Task Force agreed on during the September 26th call.¹

Inconsistent Coding Guidelines – Cost to the Healthcare System

Cost to system

In 2009, the AMA engaged Medical Present Value Inc. (MPV) to perform a data analysis study on claims payments. Out of 85,598 claims from 8 payers, 39% were found to have errors related to the bilateral modifier. It is estimated that if appeals were filed on the claims identified with errors related to the bilateral modifier, it would cost both physicians and payers over \$2.8 million. The cost for two appeals is over \$5.6 million.²

Current bilateral modifier reporting

The following chart outlines the various reporting methods of the bilateral modifier.

Entity	Guideline
CPT	Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code. This modifier is to be appended to the appropriate unilateral code as a single-line entry. XXXXX-50
CMS	To report a unilateral procedure performed on both sides, report a single claim line entry with the CPT modifier 50 appended . CMS guidelines support single line reporting for surgical procedures. XXXXX-50, XXXXX
Third-party payers	May require a single line appended with modifier 50 or a double claim line billing entry that is inconsistent with CPT coding guidelines.

It is the recommendation of the Rules Committee that modifier 50 be reported on one line. This is supported by both CPT and CMS. (When a bilateral procedure is reported with RT and LT, the procedure codes will be reported on two lines. These modifiers will be addressed separately.)

Listing of Status Indicators

The Medicare Fee Schedule Database (MFSDB) identifies procedure codes that are not subject to the special payment rules that apply to other bilateral procedures and may be potentially used

¹ See Attachment A: Pricing Definition and Guidelines.”

² Figures are based on the following cost estimates: \$25 for a physician to file an appeal and \$60 for a payer to process the appeal.

as a criteria that would require two line reporting.³ This database has identified five status indicators (0,1,2,3 and 9) used to outline the payment adjustment for each procedure code. The Edit Committee is looking further into the MFSDB as it relates to the bilateral concept. The Rules Committee needs to further study the MFSDB as well to determine which reporting method is appropriate based on these status indicators.

For example, the Rules Committee needs to study more closely the appropriateness of the one line reporting method that would be used for those procedure codes with as status indicator of 1. Those procedure codes with a status indicator of 3 are not subject to the special payment rules that apply to other bilateral procedures and may be reported on two lines.

Determination of payment

In order for a physician practice to understand what will be paid on a submitted claim, the following information is needed:⁴

- Underlying fee schedule (contracted rate between the physician and payer)
- The disclosure of payment and compensation terms, including code edits, pricing rules and medical payment polices, to calculate payment is required.

While the underlying fee schedule methodology is proprietary to the payer, the other components needed to determine pricing, such as percentages, can be disclosed to physicians without compromising the proprietary nature of that methodology. According to Colorado Law C.R.S. 25-37-103 Section (2)(a) "The disclosure of payment and compensation terms pursuant to subsection (I) of this section shall include information sufficient for the health care provider to determine the compensation or payment for the health care services..."

As mentioned previously, one of the components necessary to determine pricing is the disclosure of payment rules, including percentages. Standardizing the way payment rules (including percentages) are applied to negotiated fees would simply ensure that all parties understand and agree to the payer's fee schedule, thus making it dramatically easier for physicians to calculate how much the patient must pay and reconcile claims payments.

The industry standard when bilateral pricing is applied is a 50% reduction for the second procedure. The Rules Committee sees no reason for not accepting this standard.

³ The Medicare PRRRVU12 can be accessed at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU12B.html>. Once you download the data, open the file titled "PPRRVU12.xlsx. Codes not subject to the bilateral modifier payment adjustment are identified with a status indicator 3.

⁴ Refer to Attachment B: Determination of payment for more information.

Consensus Definitions of Pricing Rules and Payment Rule Guidelines

Background - RBRVS versus Medicare or other Fee Schedule

In a resource-based relative value scale (RBRVS) system, payments for services are determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance. This is merely an allocation system to fairly represent the above three components across all services performed.

- The physician work component accounts, on average, for 48 percent of the total relative value for each service.
- The practice expense component of the RBRVS accounts for an average of 48 percent of the total relative value for each service.
- Centers for Medicare and Medicaid the Services (CMS) assigned professional liability insurance component of the RBRVS accounts for an average of 4 percent of the total relative value for each service.

Payer payments are then calculated by multiplying the combined costs of a service by a conversion factor (a monetary amount that is determined by CMS). CMS has an established pool of dollars that can be spent, therefore the conversion factor is a reflection of the budget for the current year. Medicare also allows an adjustment for geographical differences in resource costs. Payments can also be adjusted for geographical differences in resource costs by using the GPCI. The conversion factor and GPCI are calculated independent of the RBRVS system.

The percentages assigned to the modifiers and the methodology and percentages assigned to the multiple procedure reduction methodology are assigned by CMS, but originally were based solely on the RBRVS and the cost of providing each service and was independent of budget restrictions or political pressures. There have been recent exceptions to that rule, which includes the CMS radiology reductions that were not based on the RBRVS system.

Visit www.ama-assn.org/go/rbrvs for more information regarding the RBRVS system.

Pricing Rule definition and Payment Rule guidelines

Pricing Rule Definition

“Pricing rules” globally are defined to mean payment rules applied by a health plan or its agent to increase or decrease the agreed fee schedule amount (but not decreased to \$0) in specified circumstances.

Pricing rules considered in scope for discussion are contained within the CO legislation (Bill HB10_1332). View the CO legislation for a listing of payment rules.

Payment Rule guidelines

- The purpose of pricing rules is to move toward a uniform, transparent practice in the marketplace.
- The Medicare pricing rules based on the RBRVS are recommended for the starting point of the discussion for the development of a Colorado payment rule standard because they are already widely used by both public and private payers and maintain the relativity of the Medicare RBRVS.
- Pricing rules should not include cost containment, political influences or benefit limitations.
- The pricing rules must not affect payers' ability to negotiate an agreed upon contracted rate with physicians and other health care providers for the performance of medical procedures and services.
- The pricing rules only standardize the way payment rules are applied to those negotiated fee-schedules.

I. Pricing rule definition and payment rule guidelines were approved as listed above.

II. Rules work group is charged with bringing forward pricing rule recommendations that meet the above stated guidelines and legislation requirements.

Determination of payment

In order for a physician practice to understand what will be paid on a submitted claim, the following information is needed.

I. Underlying fee schedule (contracted rate between the physician and payer)

The underlying fee schedule or its methodology that includes what is the source for the contracted rate for each procedure and the percentage application for the service or drug provided.

For example

CPT XXX	2012 Medicare fee schedule and conversion factor	percentage application	contracted fee schedule rate \$\$\$
CPT XXX	2012 AWP rate table	percentage application	contracted fee schedule rate \$\$\$

In the CO Clean Claims legislation, the above is proprietary between the payer and contracted physician as stated in D (III), page 7.

II. The disclosure of payment and compensation terms to calculate payment is required.

To calculate payment need fee schedule (allowed amount for a given procedure or service). See example below:

CPT XXX-50 \$\$\$
Applicable code edits
Applicable percentage of allowed amount if applicable
Applicable pricing adjustments, based on medical payment policy

CPT XXX-50 \$100 allowed amount
No code edits applied
150% of contracted fee schedule allowable when CPT modifier 50 is appended and documented appropriately
No pricing adjustments applied

Payer and patient financial responsibility \$150 subject to patient's co-payment, co-insurance and deductible requirements. This information will be provided through the eligibility verification response.