

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

Agenda

June 26, 2013, noon – 2 PM MDT

Call-in number: 1-866-740-1260, ID 8586314#

Web Login:

<https://cc.readytalk.com/r/37d3cyokwael&eom>

Agenda

- 12:00 PM Roll call, welcoming remarks and housekeeping
- Introduce new MCCTF staff member, Vatsala Pathy (Attachment A)
 - Approve June 2013 meeting minutes (Attachment B)
 - Next face to face meeting August 27 and 28.

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.

- 12:10 PM Committee Reports
- Project Management – Barry Keene:
 - Distribution of Public Notice
 - Sign-Up Records (Sent as separate attachment)
 - Work Plan Update (Attachment C)
 - Finance – Barry Keene
 - Edit– Beth Wright/Mark Painter:
 - Definitions (Attachment D) – **Consensus Item***
 - Bilateral Query Template (Attachment E)- Informational
 - Rules Committee – Lisa Lipinski:
 - Absence Coverage August/September
 - Specialty Society – Tammy Banks/Helen Campbell:
 - Data Sustaining Repository – Mark Rieger/Open:
 - Response to McKesson Inquiry (Attachment F)
 - RFP Final (6/27/13)

1:55 PM Public Comment

2:00 PM ADJOURNMENT

TASK FORCE MEETING SCHEDULE 2013

- July 24, noon – 2 pm: Full Task Force Meeting
- **August 27-28: Full Task Force Quarterly Meeting***
- September 25, noon – 2 pm: Full Task Force Meeting
- **October 22-23: Full Task Force Quarterly Meeting***
- November 26, noon – 2 pm: Full Task Force Meeting
- December 18, noon – 2 pm: Full Task Force Meeting

VATSALA KAPUR PATHY

3377 S. Clermont St. • Denver, Colorado 80222 • 303.512.3330 • Vatsala.pathy@rootstocksolutions.com

SENIOR NON-PROFIT CONSULTANT

A dynamic, results-driven professional with extensive experience providing strategic plans and solutions in the non-profit sector by analyzing, writing, and evaluating grant proposals and requests, executing strategic initiatives, improving processes, and delivering measurable results. Outstanding success at managing large-scale and high-impact projects from concept to completion, leading diverse teams and departments, and providing superior service. Extremely passionate and dedicated with a record of achievement that demonstrates a high level of industry expertise, business acumen, and innovative problem-solving skills. Strongly committed to maintaining organizational integrity and leadership while maximizing profitability, driving business initiatives, enhancing strategic partnerships, and exceeding goals and objectives.

- Philanthropy
 - Bilingual in Spanish
 - Health Policy & Public Affairs
 - Project Management & Operations
 - Budget & Program Management
 - Publications & Presentations
 - Organization Change Management
 - Strategic Planning & Execution
 - Team Leadership & Facilitation
-

PROFESSIONAL EXPERIENCE

ROOTSTOCK SOLUTIONS, LLC, Denver, CO

2008 – Present

Owner, Strategic Consultant & Project Manager

A consulting company with projects and clients throughout the U.S. and Canada specializing in strategic planning and project management in the non-profit and healthcare sectors. Key clients include: National Assembly on School Based Health Care; REACH Healthcare Foundation; Kaiser Foundation Health Plan of Colorado; Delta Dental Plan of Colorado; Mile High United Way; Full Circle Projects; Public Health Agency of Canada; Colorado Telehealth Network; and more.

NON-PROFIT KEY PROJECTS INCLUDE:

- **Children's Museum of Denver** -- Elected Board Chair, Head of the Board of Development Committee, and member of the Strategic Planning Committee.
- Oversaw the executive search process, as Head of the Search Committee, to hire a new CEO and create a more rigorous system of accountability for the CEO.
- Led the implementation of new HR policies, board policies and culture, and improved performance metrics.
- Negotiated with Denver Public Schools for land acquisition to expand the museum, and bolstered the \$12M capital campaign resulting in being named by *Forbes Magazine* as one of the 12 Best Children's Museums 2012.
- **Denver Public Schools** -- Provided oversight and guidance for the management and prudent expenditure of bond and mill levy dollars to support maintenance, new schools, and curriculum for the district.
- Collaborated with other community leaders and constituents on the content, scope and focus of the 2012 ballot initiative as a member of the Denver Public Schools Citizens Planning Advisory Committee.

HEALTHCARE KEY PROJECTS INCLUDE:

- **Kaiser Foundation Health Plan of Colorado** – Supported the development and implementation of a chronic disease management program for co-morbid Medicaid patients.
- Served as primary liaison between Kaiser, the State of Colorado Department of Health Care Policy and Financing, and the Center for Health Care Strategies.
- Worked across departments to ensure a smooth implementation of the project from an operational perspective.
- **REACH Healthcare Foundation** – Led the development of the Foundation's strategic plan.
- Facilitated board and staff consensus and provided guidance on best practices for program implementation and evaluation.

THE COLORADO HEALTH FOUNDATION, Denver, CO

2005 – 2007

Program Officer / Senior Program Officer

- Supervised a team of 2 program officers, and assistant, and numerous project-related consultants.
- Evaluated grant requests and made recommendations to executives and Board of Directors.
- Established the initial strategy for the Foundation's healthcare grant-making portfolio, and oversaw grants and initiative development that exceeded \$20M.

VATSALA KAPUR PATHY

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- Oversaw major initiatives including seed funding for the Colorado School of Public Health, Healthy Eating and Active Living work that led to the creation of LiveWell Colorado, and school-based health center funding.
- Developed and implemented the Foundation's first major initiative, Healthy Connections, a HIT initiative aimed to strengthen the capacity of safety net clinics that provided \$9.4M to 43 organizations over its life span.
- Served as lead applicant and steward to the Robert Wood Johnson Foundation and received funding for Partners Investing in Nursing's Future, a national initiative working closely with Colorado Center for Nursing Excellence.

THE CDC FOUNDATION, Atlanta, GA

2001 – 2003

Program Officer

- Developed, managed, and oversaw budgets totaling more than \$10M.
- Wrote reports to grant-making organizations and provided oversight to grant recipients.
- Served as liaison and managed relationships with CDC, grantees, contractors, donors, and constituents.
- Managed disbursement of endowments funds, and gained in-depth knowledge on public health issues.
- Led major projects including: Prevent Antimicrobial Resistance Campaign; National Campaign for Appropriate Antibiotic Use; Avon-CDC Foundation Mobile Access Program; and Management Academy for Public Health.

GEORGIA HEALTH POLICY CENTER, Atlanta, GA

1999 – 2000

Consultant

- Facilitated and coordinated the development of the Philanthropic Collaborative for a Healthy Georgia, a collaboration of Georgia foundations interested in healthcare grant-making activities.
- Reviewed two rounds of applications on school health and rural health as part of a panel of reviewers for the Philanthropic Collaborative for a Healthy Georgia, and developed RFPs aimed at school health programs.
- Provided technical assistance to rural communities throughout Georgia focused on building community partnerships and coordinating care for underserved populations.
- Managed survey contract for Medicaid and Children's Health Insurance Program (SCHIP) satisfaction surveys, and researched and wrote reports and issue briefs on consumer satisfaction with the Medicaid and SCHIP programs.

KAISER FOUNDATION HEALTH PLAN OF COLORADO, Denver, CO

1998 – 1999

Government Program Coordinator

- Directed School Connections, a collaborative school-based health center-HMO insurance program, including survey design, quality of care data analysis and collection, daily operations, and evaluations.
- Negotiated and implemented first contract with State of Colorado for the Child Health Plan Plus.
- Managed the fundraising, budget, and daily operations and developed strategies for the Charitable Fund.
- Served as lead with community partners in the School Connections and Child Health Plan Plus programs.

COLORADO DEPT. OF HEALTH CARE POLICY & FINANCING, Denver, CO

1996 – 1998

Health Policy Analyst

- Designed and oversaw the disbursement of \$114,000 grants programs for safety net providers.
- Co-wrote CHIP State Plan for benefits package, premium cost sharing, and marketing for Title XXI funding.
- Managed and designed initial implementation of the Consumer Assessment of Health Plans Study (CAHPS) survey for Medicaid clients, and created important components of a quality oversight system for Medicaid HMOs.
- Co-managed \$200,000 technical assistance contract with the National Committee for Quality Assurance.

EDUCATION & PROFESSIONAL DEVELOPMENT

THE UNIVERSITY OF TEXAS, Austin, TX – *M.P.Aff.*, The Lyndon Baines Johnson School of Public Affairs, GPA: 4.0

M.A., The Institute of Latin American Studies, GPA: 4.0

THE COLORADO COLLEGE, Colorado Springs, CO – *B.A.*, Major in Political Science and History, Graduated *cum laude*

UNIVERSITY OF DENVER, Denver, CO – Completed 40 Hours of Professional Mediation Training, 2012

GERMAN MARSHALL FUND OF THE UNITED STATES – Recipient of the American Marshall Memorial Fellowship, 2008

UNIVERSITY OF COLORADO DENVER, Denver, CO – Accepted into the Denver Community Leadership Forum, 2006

DRAFT

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Executive Summary of Meeting Minutes
May 21, 2013, 11:00 AM - 3:30 PM, MDT
Call-in Number: 1-866-740-1260
Conference ID: ID 8586314

Attendees:

- Tammy Banks
- Jim Borgstede, MD
- Helen Campbell
- Dee Cole
- Wendi Healy
- Amy Hodges
- Barry Keene
- Lisa Lipinski
- Kathy McCreary
- Marie Mindeman
- Doug Moeller, MD
- Mark Painter
- Elizabeth Provost
- Mark Rieger
- Nancy Steinke
- Beth Wright

Staff :

- Connor Holzkamp
- Barbara Yondorf

Public:

Marianne Fink (HUM)
Julie Painter (STS)
George Swan
Bob Jasak (ACS)

Meeting Objective (s):

See Agenda

Key:

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

Location:

University Physicians, Inc.
13199 East Montview Blvd,
Aurora, CO 80045
Lilly Marks Boardroom



May 21, 2013

DISCUSSION**ROLL CALL & WELCOME:**

There were 16 TFM in attendance. The first order of business was to approve the minutes from April. It was noted that on page 12, Beth Wright was not the TFM that asked if the “the sometimes/sometimes category could be switched to always.” The quote was changed accordingly, and the minutes were approved.

ACTION ITEM: April minutes were approved w/the noted correction on page 12.

Before the meeting continued, the Executive Committee extended their gratitude to the University of Colorado Health for covering the catering costs. The TF does not budget for the catering costs associated with the face-to-face meetings, and very much appreciates the donation.

LEGISLATIVE UPDATE:

Barry reported that SB_13166 passed all the way through the legislature with good bipartisan support. This bill gives the TF an additional year to complete its legislative charge, as well as a \$100,000 appropriation. This was great news for the TF, and a gigantic amount of credit should go to Barry, Senator Aguilar and Representative Sue Shaffer.

EDIT COMMITTEE—Beth Wright and Mark Painter

The Edit Committee brought forth the query templates for co-surgery, team surgery, age and gender to the TF as informational items. These documents can be found in the agenda (*Attachments C, D, E and F*). It was noted that these documents are meant to compliment the Rules Committee documents, and are really for use by the DSR.

Beth Wright, Co-chair of the Edit Committee explained, “Essentially we are just going to create a big file with every code in it. (Co-surgery column, team surgery column and so on). It won’t be as massive as CMS file but that is what we are aiming for.”

There was a brief discussion around the purpose of these query templates, but much of what people wanted to discuss had more to do with the ‘rule recipes’ than the query templates. The TF was encouraged to hold these comments until the Rules Committee discussion.

Perhaps the most important discussion that took place regarding the query templates was involving the age template. In the document, the Edit Committee recommended that the TF establish a standard way to report age, and decided upon ‘months’ as the easiest way to do that. However, after the TF discussed the implications of this it was decided that a better idea would be to allow age to be reported in days, months, or years. Thus, it was decided that the payer would be responsible for including either a “D” for days, “M” for months, or “Y” for years, along with a source.

ACTION ITEM: Age will be accepted in days, months, or years; payer will be responsible for reporting “D”, “M” or “Y” along with a source.

SPECIALTY SOCIETY—Tammy Banks and Helen Campbell

The Co-chair of the Specialty Society Committee, Tammy Banks, did not have anything to bring to the TF. However, it was noted that the more time the TF could give for the specialties to comment the better.

PAYMENT RULES COMMITTEE—Lisa Lipinski

The Payment Rules Committee had drafted the ‘rule recipes’ for co-surgery, team surgery, bilateral surgery and assistant surgery (*Attachments G, H, I, J*) and brought them forth to the TF seeking consensus approval.

Lisa Lipinski briefly explained the document for co-surgery, “We have context and modifier involved and definition. Then if you go to page two we have all four indicators and the coding and adjudication guidelines which follow CMS policy. On the third page you can see when a code is eligible for adjustment, and when it is not it is eligible for status code 1 and 2; 2 indicates that it applies and 1 is with documentation. As Nancy said earlier, the payer has the option to pay with review or deny. Note that it says “eligible” not that an adjustment *will* be made. Next are those which are not eligible, status indicator 0 and 9. Under that is where you can find co-

surgery indicators. After that is the rationale we used which includes the sources we used. Under that we have included some exceptions which I will get to in a second. Then we have the TF comment from previous conversations. After that we have the modifier definitions which came from the Edit Committee, and CPT® definitions as well. Then we have the exact co-surgery indicators which have been taken directly from Medicare, followed by the federation outreach we did. This gets us to the Appendix which are codes that are going to be added to the DSR using the same rationale. These exceptions were identified that might have a different indicator in the Fee Schedule, and differed from CPT®.”

The TF discussed the co-surgery document (*Attachment G*) at great length. Much of the discussion revolved around the exceptions list (located in appendix A of the document) which described specific codes which CMS allow but CPT® did not. Even though these codes were listed as exceptions, there was some disagreement as to whether or not this was really the case. The rationale outlined by the Rules Committee essentially outlines a hierarchy that would follow the guidance outlined in CPT® as a primary source. However, in recognizing the fact that the AMA does not actually publish a list, the CMS file would be used as a secondary source to pull the list. Beth Wright explained this process:

“So it sounds like we have here a two-tiered decision making process right? You’re using two different sources and the question is which do you want to look at first? It sounds like CPT® is your preference to be your first source, and then you’re supplementing with CMS right? So what I get here is that CPT® takes precedence over CMS—If that is always going to be the standard, then we say, ‘always pull the pile from CMS and cross-reference it to CPT® to see if CPT® differs, and agree to use CPT® values if it differs.’ Is this what you are really saying? . . . If that is the case, then I do not think we need this exceptions list.”

Beth’s statement was largely agreed upon by the TF, but there was some discontent around the scope of this hierarchy. It was clarified by Marilyn Rissmiller that this hierarchy would not be feasible for every rule:

“Yes, the idea is to use CPT® and national specialty’s first. But recognizing that those sources are not available for everything we are going to have to deal with, we would have to look at each rule and make a decision. We can’t do it across the board with our hierarchy.”

By the end of the discussion the TF decided that as long as the rationale is clear, the exceptions list is unnecessary. Appendix A as it was presented was essentially stricken from the document and moved to the query template. It was noted that the rationale section was too important to be tucked away in the appendix; instead, it was decided that it be moved to the front and Appendix A would contain the big list of codes that the TF would create.

The TF made several additional changes to the co-surgery document:

- There was a typo under the rationale section in the appendix (second bullet). “Bilateral” was changed to “co-surgery” and “modifier 50” was changed to “modifier 62.”
- The section that was in the appendix was changed to, “The musculoskeletal system procedure codes listed below were considered by CPT®. The following codes should not be appended with modifier 62 and are not eligible for the co-surgery adjustment. *These codes have a CCTF indicator of no.*

ACTION ITEM: The TF achieved consensus on the ‘rule recipe’ for co-surgery with the noted changes.

The TF broke for lunch at approximately 12:30 PM MDT. The meeting resumed at 12:44 PM MDT.

The next rule that the TF looked at was team surgery (*Attachment H*), which looked very similar to co-surgery. The TF decided to eliminate the exceptions exactly like they did for co-surgery.

Beth Wright pointed out that, *“Under guidelines in the second bullet it says each payer should send copy of notes to us. I cannot speak for provider community but from our perspective we have always said don’t send us anything we won’t review. That is more added administrative expense to send us something we won’t even look at.”*

The TF agreed with Beth and the sentence was removed from the document.

ACTION ITEM: The TF achieved consensus on the team surgery rule recipe with the noted changes.

Beth reminded the TF that the sentence which was just removed also appears on the co-surgery rule, and asked if they could go back and delete it. There was no one opposed.

ACTION ITEM: TF agreed to remove sentence for all rule recipes that reads: “Each should include a copy of the notes when reporting the service to the third-party payer.”

The next document the TF discussed was the bilateral surgery rule recipe.

“The Bilateral is laid out the same way,” said Lisa Lipinski, *“The difference is we put examples in here to show how these would be coded, which can be found under Coding and Adjudication Guidelines. Other than that it is similar to the one we just looked at, including the Exceptions and Appendix section that we modified in the other rule.”*

Conversation regarding the hierarchy was sparked again during this discussion. Because CPT® is largely silent on the use of modifier 50, most payers use the guidance outlined in CMS. It was noted again that the hierarchy would need to be evaluated on a case-by-case basis.

The same changes that were made to the other two rules regarding the exceptions list and the appendix were made to bilateral.

ACTION ITEM: The TF adopted the ‘rule recipe’ for bilateral procedure by means of consensus with the above mentioned modifications.

The next item on the agenda was to revisit assistant surgery. The co-chairs did not feel great about where the TF had ended the discussion on the AS rule, and wanted to insure that the group had vetted it out properly. Barry Keene provided some background information:

“We are confident that the expertise represented by this group is more than competent to make these decisions, but there remains an open comment period for each of these to change. So far we have been very good as a group on achieving consensus, but now we are starting to get into more contentious subjects. As you recall, last meeting we took a vote on assistant surgery which passed overwhelmingly. However, the source was on the short end of this vote. Marilyn and I talked in length about this and decided that it didn’t feel good to have the very entity that we cite as a source disagree with how we are using it. Now this could very well happen, and if I feel that it happens in a context that is a well informed decision then that is just the way it is. However, I would much rather achieve consensus on these very important points at the front-end of this process. That way, when we get to these contentious issues down the line when we’re applying these rules, we have some basis of trust and understanding. We feel we did a pretty good job on the bulk of this rule, but it came down to some disagreement around the

sometimes/sometimes category where people felt we didn't have enough info. So we decided that we would submit this without that and go forward to look at actual data that we have today courtesy of Doug Moeller. So what we want to do is: 1. We want to build trust. We did have a legitimate vote, but when we revisited that, the CCs were uncomfortable. Now, as a CC, I will say I will not allow this very often but in this particular instance I would like to revisit this. We would like to get consensus on this rule with the exception of the sometimes/sometimes category. We will then have a separate discussion on the sometimes/sometimes which will be a pivotal point for me to make an honest judgment on if the TF can actually do the work it was chartered to do. We will have the data in front of us, and I am curious as to how does the data help us make a decision?"

According to the bylaws, in order for the TF to revisit something that was already adopted by consensus it must be approved by the group.

ACTION ITEM: TF granted permission to revisit the sometimes/sometimes category for Assistant at Surgery.

The objective was to look at the sometimes/sometimes category of the assistant at surgery rule using frequency data provided by Doug Moeller and McKesson. Doug described where the data came from as well as how the data was cut:

"This particular sample I am about to show you is from 2012, may have some from 2013, and is from at least 15 different health plans that have given us permission to use this data in a composite. It also has some Medicare data and Medicaid data. Ultimately, it is a fairly large, multiple purpose, data repository of claims data. It is de-identified in that I could not tell you which belongs to a particular payer. This particular request asked me to identify on a code-by-code basis what the frequency of modifiers are that occur for assistant surgeon. To this end, we looked at 283 million claims comprised of 699 million claim lines with total billed amount of \$267 billion dollars. So that is database that the entire segment was pulled from. Of those 1,800,000 claims had one of these 4 modifiers, and 2.2 million lines associated with modifier AS 81 or 82. So we narrowed it down to those surgical codes that were in the sometimes category which was about 900 codes. The sometimes/sometimes category is about 2/3 of that."

The TF had a discussion around the data, specifically around how the TF uses data to arrive at a decision. Overall, the data illuminated the fact that the sometimes/sometimes category involves a very small amount of codes, but more data would be needed to understand the impact of those codes. Specifically, it was recommended that the TF look at the percentages in terms of all surgical codes (rather than entire universe of codes). Instead of spending more time analyzing data, the TF decided that the public comment period could provide them with this information. Marilyn noted that *" We do not have data that demonstrates total costs and I think this is crucial to understanding the full picture."*

After much deliberation, The TF decided that the sometimes/sometimes category be switched from never to always. This was largely due to the fact that the payers are the ones that have access to this data. By switching them to an always, the payers will presumably have more of a reason to pull their data and make a comment.

There are two main implications of switching the codes in the sometimes/sometimes bin to an always:

1. The payers have the data that can analyze the impact of this rule. By switching the codes to an always the payer presumably has more motivation to participate in public comment.
2. The ACS disagreed with the previous logic that defined the sometimes/sometimes codes as a never. By switching them to an always, the TF now has the full consent of the ACS moving forward.

Another interesting point that was made which affected this decision was said by Beth Provost of Cigna:

“At Cigna we currently deny the sometimes codes. However, we are in the process of changing our policy because of some compliance issues that have surfaced, and in the future we will be paying the sometimes as long as documentation is submitted. The designation that we are talking about for CMS says sometimes it is appropriate to have an assistant as medically necessary if clinical documentation is submitted. So CMS uses the terminology ‘medical necessity’ in that designation, and we were denying them as ‘not clinically appropriate’ without any review. The compliance concern is that when you have a designation that says sometimes it is medically necessary, it is not correct to deny it as inappropriate. To Beth’s point I was one of those who was in alignment with this decision because at the time that was our position. However, legal has asked us to rethink this and so I do not think I would stand there today.”

The general feeling by the end of the discussion was to send out the AS rule with the sometimes/sometimes codes listed as an always and see what payers bring back.

ACTION ITEM: TF achieved consensus to send out the Assistant at Surgery ‘rule recipe’ for public comment, changing the sometimes/sometimes from a never to an always.

Another subject of this discussion was regarding what criteria does the TF use to make hard decisions. The following were some of the criteria that came out of this conversation:

1. The number of claims affected;
2. Percentage that are paid;
3. Does it affect only a select group of procedures?;
4. What is current practice among payers?
5. What are specialty societies opinions?

DATA SUSTAINING REPOSITORY:

The TF was challenged to answer the question: how does the TF use data to make hard decisions? The following were some of the criteria that came out of this conversation:

1. The number of claims affected;
2. Percentage that are paid;
3. Does it affect only a select group of procedures?;
4. What is current practice among payers?
5. What are specialty societies opinions?

The TF also agreed that more data could help determine impact. Wendy suggested that it would be useful to know “how many of these are overturned on appeal.”

PUBLIC COMMENT:

George Swan, a retired hospital provider made the only comment from the public. (Please see transcript).

OTHER BUSINESS:

<none>

The meeting was adjourned at approximately 3:15 PM MDT

DRAFT

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Executive Summary of Meeting Minutes

May 22, 2013, 8 AM-2 PM, MDT

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

Conference ID: ID 8586314

Attendees:

- Tammy Banks
- Jim Borgstede, MD
- Helen Campbell
- Dee Cole
- Wendi Healy
- Amy Hodges
- Barry Keene
- Lisa Lipinski
- Kathy McCreary
- Marie Mindeman
- Doug Moeller, MD
- Mark Painter
- Mark Rieger
- Nancy Steinke
- Beth Wright

Staff :

- Connor Holzkamp
- Barbara Yondorf

Public:

Diane Hayek (ACR)
George Swan
Sharon Black
Bob Jasak (ACS)

Meeting Objective (s):

See Agenda

Key:

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

Location:

University Physicians, Inc.

13199 East Montview Blvd,
Aurora, CO 80045

Lilly Marks Boardroom



May 22, 2013

DISCUSSION

ROLL CALL & WELCOME:

There were 15 TFM in attendance.

PROJECT MANAGEMENT AND FINANCE—Barry Keene

Barry reported that SB 13166 passed with good bipartisan support. This gave the TF a year extension as well as the \$100,000 appropriation. On July 1, the TF will have access to \$100,000 from the HHS, which is a little

different from the grants in that the TF will actually have to bill the department of Health Care Policy and Finance. Barry also thanked the CHF and Colorado Medical Society for their financial support. The TF will need to find about \$69,000 over the next 18-19 months to fund the project. With that said, the TF has close to 75% of its budget accounted for and will continue to look to stakeholders to fill that gap.

Barry outlined the goals of the TF:

1. Administrative simplification
2. Uniformity
3. We are obliged to make sure we don't create an unintended consequence. An unintended consequence would be something that drives the cost of insurance up, or puts a payer out of business. There is no way this can be left out of the conversation, it is all about money in the end, but it was never about cost reduction; it was about simplification. So we need to be as neutral as we can, but this will not always be possible. We need to be open minded that when we do something that puts a benefit in someone's hand, there is a lot of tools at our disposal to deal with managing the cost of healthcare.
4. Correct coding

APPLYING THE PROCESS—CONTINUING DISCUSSION FROM 5/21/13

Barb started off the discussion, "After the discussion we had yesterday around the sometimes/sometimes category, I think the goal of today is to take what we learned yesterday and focus on how the TF makes decisions on contentious issues. We are interested in creating some sort of approach for making these decisions. Some things that came up yesterday, from a payers perspective, is you have the ability to audit claims, you can look at patterns of providers frequency data, fraud and review, contractual provisions etc. On the providers' side we said you always have the ability to appeal. We also talked about provider education. So let's look at the criteria we looked at yesterday. What are the thresholds for a decision? The ones I kept track of were: 1) Small vs. big percentage of claims. What was interesting about yesterday is that it is a very small percentage of claims but that didn't necessarily answer the question or convince anybody. 2) The percentage of claims that are actually paid on appeal. We didn't have that data but do you know what to make of it even if you did have it. 3) Another thing you did in your exercise was discuss what is the current practice of the payers?"

Helen shed some light on the overturned by appeal piece:

"We are doing a project where we are putting some up-front claim edits into our electronic processing system and we found that claims that were denied for certain coding type reasons, providers only reacted to those claims (called us, sent in claims reconsideration etc.) only 30% of the time. We thought we would be getting a huge bang on this project but we are not getting as much as we thought we would get because providers bill a certain way for various reasons. I mean sometimes they know they are going to get a denial but they're going to capture it in their system in a certain way and maybe bill differently than the payers would actually need to pay for those services. If you take that 30% and take it down to whether they were actually paid on appeal, I think most were."

Nancy responded to this:

"We have had a bit of conversation about percentages of appeals that are submitted and overturned. I would just caution that we will overturn an appeal because it was billed incorrectly the first time, but on an appeal they corrected the coding. So I think it is important to recognize whether we're overturning it because it has been corrected or because there is a valid reason to make an exception."

The TF discussed the use of a vote (which occurred for the first time in TF history during the April meeting). This was already something that has been in the bylaws and the TF agreed that it is going to be a necessary tool going forward when consensus cannot be achieved. Some of the questions that were brought up include:

1. What does the vote imply? What kind of weight does a vote carry?
2. Is the vote simple majority? Does everyone get an equal vote?

The answer to the first question can best be summed up with a direct quote from Barry:

“I want to put a little more weight to what we are putting out there. It is my impression that we have industry experts at this table having used a methodology that we have laid out for ourselves to put out a well thought out document. Now, there is always the possibility that the public could catch something that we missed, but the idea is that you all are some of the most knowledgeable people in the industry and the documents that we release should be more than just ideas. They may not be completely set in stone, but by the time we put these things out there they should be very close to final.”

The second question was not resolved completely. As of May 2013, the vote is a simple majority where each TFM gets one vote. The group decided that this process will likely have to be revisited down the line.

One of the points that was made during this discussion was the problem of taking each rule one at a time. It is understood that everybody may not like the result of every vote but hopefully everyone can be happy with the entirety of decisions as a whole. This is one of the reasons why the TF needs to develop some kind of governance; it is hard to take each one individually and accept a loss without seeing the big picture.

Ultimately, the TF agreed to the decision making process as it stands for now. The question of how the TF makes its decisions are part of a very crucial component to its success. This “governance” aspect is something that will need to be worked out as time goes by.

The TF was asked to think of what thresholds, if any, are used to make a decision. Mark Painter made an interesting comment on this:

“I do think there will eventually be the threshold of not raising premiums to consumers, but in reality what this group is concerned with is correct coding. We originally decided we would look at coding structures and intent for correct coding, and if you flip that to a threshold process based on straight money we will be moving away from this focus.”

The group agreed with Mark. Thresholds will vary from rule to rule and ultimately it is going to be very difficult to create any threshold that applies to everything.

The TF reconvened after a 15 minute break at approximately 10:00 AM MDT

APPLYING THE PROCESS CONT'D

The conversation evolved into what kind of direction to give to the public regarding how to comment on the documents. Some had envisioned the TF giving specific directions as to how to comment while others had imagined just giving the public the documents with very little direction. After weighing both sides of the argument, the TF decided that it would provide the public with some general guidelines as to how to make a comment. The following is what the TF decided upon as to these guidelines:

1. Number and Topic
2. Position—support, disagree, modification

3. Recommendation
4. Rationale in support of recommendation
5. Supporting data and sources e.g. frequency, associated costs
6. Estimated impact of proposed rule
7. Contact information
8. Organizational information

Another suggestion that was accepted by the TF is to categorize the comments as they are funneled in so that they are more manageable.

During this conversation the TF outlined the process for public comment. Theoretically the information will be posted on the website <http://www.hb101332taskforce.org> and everything will be done there. For the first rule release the TF planned to send out a letter notifying payers, health plans etc. of the release/public comment period. This letter will be a one-time document notifying those who are interested and directing them to sign up for notifications via the sign-up page on the site.

Another point of discussion was how long to give the public to comment on these items. The general consensus was that the TF should give as much time as possible for a comment period. Along these lines, the deadline for comments was extended to July 15, 2013.

ACTION ITEM: Deadline for public comment period extended 45 days to July 15, 2013
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The next thing that was tackled by the group was how to number the rules in order to easily reference them. It was suggested that you say the rule name, then add the numbers followed by a “v” (for version) and .01 for draft and .10 for final. It was also noted that the word “draft” appear along with a watermark. So the co-surgery would look like: **Draft Co-Surgery 103v.01**

The next item on the agenda was to take a look at the website regarding how the notification sign-up form is set up. Barry pulled up the TF homepage (<http://www.hb101332taskforce.org>) and went over the notice on the bottom of the page. He also demonstrated the notification sign-up form and ProjectFork (New project management piece on website for members only). While the functionality of the form was not where it needed to be, the TF was at least able to see what it looked like.

The TF continued to talk about the public comment and rule release process to make sure everything was good to go. The first four rules (team surgery, co-surgery, assistant surgery, and bilateral) were to be sent out no later than Friday, June 7. In order for this to happen Lisa had to finish updating the consensus documents from the rules committee, and Beth/Mark would be responsible for creating the query.

Barb summed it up nicely:

“Ok. So I am just going to recap that discussion for everyone: We are going to get the query on the bilateral draft out tomorrow. Mark, you’re doing the Medicare Fee Schedule Table by Wednesday. Marilyn is going to send out the recipe template by this Friday. Next Tuesday is the deadline for comment on the recipe template and the query. Also on next Tuesday, Marilyn and Barry will be meeting with Mark Rabin on the website. Next Friday is when we will send the rules out for the public.”

Barry invited public comment from George Swan who offered words of wisdom to the TF. Essentially his point was that arguing over every single piece of overhead is not wise. Sharon Black also commented, thanking the TF for the invite.

Mark Painter demonstrated to the TF a different take on the data that Doug brought forth during day one of the meeting. Mark took the data and cut it so that all that was left were the sometimes/sometimes codes. What he found out is that this category deals with even less codes than originally thought.

Beth stated a possible consequence of turning these codes to an always in that volume could go up as more people bill for an AS. In other words, providers may begin to bill an AS for everything just because it pays. However, as Mark put it, “if you turned it to “never”, the payers could make the decision to not pay. So you could change this number (\$311,000) to \$0. I just think that when you are talking about unintended consequences you must consider both sides. I mean all of our rules are only made for the 5% of cheaters out there but that is just how it goes.”

The TF broke for lunch at 11:45 AM MDT. The meeting reconvened at approximately 12:00 PM MDT.

REVIEWING TASK FORCE WORK PLAN FOR 2013-2014

After lunch the TF reviewed the work plan for the rest of the year. Barry noted that the RFP is ready to go out with the exception of the detailed query information, which the Edit Committee is close to getting done. Barry agreed to send Mark/Beth the latest of what he has for the RFP in hopes to complete it as soon as possible.

ACTION ITEM: Barry to send RFP to Beth Wright and Mark Painter

The next item of business was to decide the next wave of rules to be released. After talking it over the TF decided on *age, gender, maximum frequency, global surgery, global maternity, TCPC, add-ons, anesthesia, place of service* to be the second wave of rules.

The rest of the rules had been identified but were not yet defined/developed by the Edit Committee: *Multiple Endoscopic, Multiple Radiology, Multiple Physical Therapy, Procedure to Modifier Validation, Multiple E&M's on the Same Day, Bundled Service, Same Day Medical Visit and Medical Procedure, Rebundling*. These would be the third wave of rules to be released.

It was noted that some of these would be harder than others and more comment time would probably be needed.

The TF is becoming more and more crunched for time. Emphases was put on meeting all future deadlines. In order for the TF to successfully complete its charge the members and subcommittees will need to be working on several things at once. (Please see work plan in agenda)

ACTION ITEM: TF decided upon second wave of rules to be released: <i>Age, Gender, Maximum Frequency Per Day, Global Surgery, Global Maternity, TCPC, Add-ons, Anesthesia, Place of Service.</i>
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OTHER BUSINESS:

The executive committee ran the idea by the TF for a monthly co-chair meeting to keep everyone on the same page. The idea was not met with enthusiasm and the plan was accepted on an “as necessary” basis only.

The idea of a project manager was discussed with the TF. Barry mentioned that this person would need to have experience running projects and know the industry on some level. Barry really believes this to be necessary and asked the TF to send him any ideas regarding a potential candidate.

PUBLIC COMMENT:

George: So I understood the exceptions would be those extracted out of the Fee Schedule. I am sure there are a lot of providers where it is never allowable so they don't even submit a claim. Really if a payer decided that they

were just going to pay all claims for all services it doesn't matter because they are actually working on a lot of other business variables that would reduce the utilization. There is a famous quote by Lyndon Johnson that says, "Don't spit in the soup. We all got to eat." He means we are all responsible for the common good. There is also the dark side that could mean don't bother changing things. The dark side would be cherry picking—not including patients that have a big demand for example, or employee selection in the hiring process. So I just wanted to bring that to a more visible role in the decision making you do. Thank you

Barry: Thank you George.

Beth: Do you think we will know by the end of June if we have to expand August? Barb had mentioned that we might need more time.

Barry: Well didn't we agree we would do 2-day meetings?

Barb: Yea I did mention that but it actually looks like we might be OK. If that last group has 13 things in the list you may want to have a longer TF meeting and we would need some advanced notice, but I believe you look ok. It sounds as if that last "third" of rules is going to be the largest grouping so maybe you want to split those up?

Beth W: I think we will be Ok.

Marilyn: Yea. In August we can decide about October.

Barb: Ok. You made a slew of decisions today great job. If there is nothing else we will adjourn.

THE MEETING WAS ADJOURNED @ APPROXIMATELY 1:30 PM MDT

MEDICAL CLEAN CLAIMS TRANSPARENCY
UNIFORMITY ACT TASK FORCE, HB10-1332



Work Plan and Statutory Deadlines, April 2013 – December 2014 as of June 18, 2013

Activity	2013										2014										Deadline	Status as of 6-18-13		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov **	Dec		JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct			Nov	Dec
2013																								
Task force solicits interested parties to put their contact information on an interested parties list of insurers, vendors and others who want to be notified of solicitations for input, comments, task force hearings, etc.																							Ongoing	Ongoing
Federation and others are notified that the task force will be sending out for review and comment, three rounds of proposed edit rule recipes in May, June and July.																							June 14, 2013	DONE
Website set up to include all notices [and public comments?] Other things?]																							Ongoing	Ongoing

* In-person task force meeting.
**** May need 2-day November meeting to make deadlines.**
 *** May need to move these deadlines to November to meet other deadlines.

* In-person task force meeting. **** May need 2-day November meeting to make deadlines.** *** May need to move these deadlines to November to meet other deadlines.
 **** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013										2014										Deadline	Status as of 6-18-13				
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec			
RULES																										
<u>1st bundle</u> : Edit and Payment Rules committees work on the draft edit rule recipes for the first bundle of rules and submit to task force for approval.																									Early May	DONE
Task force reviews and approves first bundle of draft edit rule recipes.																									May 22	DONE
First bundle of draft edit rule recipes circulated for review and comment.																									May 31	DONE (Late – June 7)
Public comments due on 1 st bundle																									July 15	
Payment & Edit Committees review comments on 1 st set of recipes and make recommendations for revisions.																									Early August	
Task force finalizes and approves first bundle of recipes.																									August 27 mtg	
<u>2nd bundle</u> : Edit and Payment Rules committees work on the draft edit rule recipes for second bundle of rules & submit to TF for approval.																									Early August	
Task force reviews and approves draft second bundle of draft edit rule recipes.																									August 27 mtg	
Second bundle of draft recipes issued for 5-week**** public review and comment.																									August 29	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.

**** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013										2014										Deadline	Status as of 6-18-13			
	April	MAY	June	July	AUG*	Sept	OCT*	Nov **	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec		
Public comments due on 2 nd bundle.																							October 4		
Payment & Edit Committees review comments on 2 nd set of recipes and make recommendations for revisions.																								Early November	
After reviewing comments received on 2 nd bundle draft edit rule recipes, TF finalizes and approves 2 nd bundle.																								November 26	
<u>3rd bundle:</u> Edit and Payment Rules committees work on the draft edit rule recipes for the third bundle of claims edits and payment rules and submit to task force for approval.																								Early October	
Task force reviews and approves draft 3 rd bundle of draft edit rule recipes.																								October 22 mtg	
3 rd bundle of draft recipes circulated 5-week public review and comment period. ****																								October 25	
Public comments due on 3 rd bundle																								December 2	
Payment & Edit Committees review comments on 3 rd set of recipes and make recommendations for revisions.																								Early January	
After reviewing comments on 3 rd bundle of draft recipes, task force finalizes and approves.																								January 2014 TF mtg	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines. **** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013										2014										Deadline	Status as of 6-18-13		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec	
Update entire draft set with current codes. [Q: Who does this?] [2014]																								
FUNDING																								
Task force secures \$100,000 legislative appropriation.																							May	DONE
Task force secures grant from The Colorado Health Foundation to round out full funding for budget through Dec 2014.																							May	DONE
Additional monies raised to fully fund budget.																							December	
Task force project manager hired.																							June	DONE
DATA SUSTAINING REPOSITORY OPERATIONS																								
<p>DSR committee works on recommendations concerning data repository operations when the standardized set is finalized and ready for implementation and use by vendors, insurers and others. This includes implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including:</p> <ul style="list-style-type: none"> Who is responsible for establishing a central repository for accessing the rules and edits set and Enabling electronic access—including downloading capability—to the rules and edits set 																						End of September		

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.
**** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013									2014												Deadline	Status as of 6-18-13		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec				
<p>DSR Committee submits data repository operations recommendations to the task force and task force reviews and approves recommendations concerning the implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including:</p> <ul style="list-style-type: none"> o who is responsible for establishing a central repository for accessing the rules and edits set, and o enabling electronic access--including downloading capability--to the rules and edits set 																								Oct 22 mtg	
DATA ANALYTICS																									
Task force secures funding to hire a data analytics consultant.																									DONE (assumes original low-bid is amt needed.)
RFP for data analytics contractor issued.																								End of June	
Proposals from data analytics contractors due. Executive Committee and three unconflicted task force members review and score RFP responses.																								End of July	
Task force reviews and approves selection of an RFP contractor based on scoring.																								August 27 mtg	
Contract for data analytics contractor signed.																								Mid-September	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.
**** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013									2014									Deadline	Status as of 6-18-13			
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept			Oct	Nov	Dec
Data analytics contractor establishes system to accept & analyze edits. [Through 2014]																						Mid-March 2014	
Task force publishes notice of intent to solicit edits for inclusion in the data analytics model and specifies form in which edits should be submitted to the data analytics contractor. Notice is sent to interested parties list. [2014]																						Mid-March 2014	
Staff work on and 2nd task force progress report submitted to Health Care Policy & Financing and the General Assembly																						December 31, 2013	
2014																							
Contractor ready to accept edits from vendors, payers, others.																						March 2014	
Call for submission of edits from vendors, payers and others issued																						End of March 2014	
Deadline for edit submissions																						Mid-May 2014	
Contractor analyzes edit sets as directed to enable Edit & Payment Committees to make recommendation to the task force for a proposed standardized edit set. Appropriate committees/task force works on this & contractor refines system as necessary.																						Early July 2014	
Complete proposed standardized edit set ready for review and approval by task force.																						July 2014 TF mtg	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines. **** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013									2014									Deadline	Status as of 6-18-13			
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept			Oct	Nov	Dec
Proposed standardized edit set published for review & for interested parties to run their claims through the proposed set. Task force also solicits comments on its recommendations for DSR operations regarding who is responsible for establishing a central repository for accessing the rules & edits set & enabling electronic access—including downloading capability—to the rules & edits set.																						End of July 2014	
Comments due on proposed standardized edit set and DSR operations. Public hearing.																						Mid-Sept 2014	
TASK FORCE FINALIZES EDIT SET																							
Committees review public comments on proposed edit set and DSR operations based and develop recommendations for consideration by full task force.																						End of October 2014	
Task force reviews & approves final standardized edit set & DSR operations recommendations.																						November 2014 mtg	
Task Force submits final report to legislature & executive director of Department Health Care Policy & Financing that: <ul style="list-style-type: none"> • Recommends implementation of a set of uniform standardized payment rules & claim edits to be used by payers & providers; • Makes recommendations concerning the implementation, updating, & dissemination of the standardized set of payment rules and claim edits, including: 																					December 31, 2014		

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.

**** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013									2014									Deadline	Status as of 6-18-13			
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept			Oct	Nov	Dec
<ul style="list-style-type: none"> ○ who is responsible for establishing a central repository to access the rules & edits set, & enabling electronic access--including downloading capability--to the rules and edits set; and ● Includes a recommended schedule for commercial health plan payers to implement the standardized set. 																							
FINAL REPORT																							
Staff draft final report to legislature and HCPF.																						Early November 2014	
Task force reviews 1 st draft of final report.																						Nov ember 2014 TF mtg	
Task force approves final report.																						December 2014 TF mtg	
Final report submitted to legislature and HCPF.																						Dec 31, 2014	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.
**** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

STATUTORY DEADLINES

Activity	Deadline	Status
Task Force shall submit a progress report to the Executive Director and Colorado Senate and House Human Services Committees.	November 30, 2012	DONE
Task Force shall present its progress report to a joint meeting of the Colorado House and Senate Human Services Committees.	January 31, 2013	DONE
<p>The Task Force shall continue working to develop a complete set of uniform, standardized payment rules and claim edits to be used by payers and health care providers and shall submit a report and may recommend implementation of a set of uniform standardized payment rules and claim edits to be used by payers and health providers. As part of its recommendations, the Task Force shall:</p> <ul style="list-style-type: none"> • Make recommendations concerning the implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including: <ul style="list-style-type: none"> ○ who is responsible for establishing a central repository for accessing the rules and edits set and ○ enabling electronic access—including downloading capability—to the rules and edits set; and • Include a recommended schedule for payers that are commercial health plans to implement the standardized set. 	December 31, 2014	
Payers that are commercial plans shall implement the standardized set within their claims processing systems.	According to a schedule in Task Force rec's or Jan 1, 2016, whichever occurs first	
Payers that are domestic, nonprofit health plans shall implement the standardized set within their claims processing systems.	January 1, 2017	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.

**** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

EDIT TYPE Consensus Definitions 06/05/2013

EDIT TYPE	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
A – Unbundled (Bundled)	<p>This type of edit is also referred to as procedure to procedure edit (PTP) and will prevent inappropriate billing of services on the same calendar date when incorrect code combinations are reported. PTP edits cover a variety of situations, such as:</p> <ol style="list-style-type: none"> 1. Comprehensive/ component code pairs; 2. Code pairs differing only in complexity of the service rendered (simple/complex, superficial/deep, etc.); 3. Code pairs from the same family of CPT/HCPCS codes, which describe redundant, comprehensive or incidental services. 4. Services designated by CPT as separate procedures when carried out as an integral component of a total service; 5. Services that are typically included in the performance of a service provided at the same encounter. 6. General anesthesia services provided for multiple surgical procedures performed during the same operative session. <p>Consensus on 3/28/12</p>	<p>NCCI, CMS directives/transmittals, HCPCS, CPT/HCPCS and National Specialty Society; machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered</p>	<p>Frequency limitations spanning a period of time will be addressed separately, including MUEs.</p> <p>Appropriate modifiers as defined by CPT or HCPCS may be reported to override this type of edit.</p>
B – Mutually Exclusive	<p>This type of edit identifies incorrect billing of professional services that cannot reasonably be performed at the same anatomic site or same patient encounter, by the same physician.</p> <p>Consensus on 3/28/12</p>	<p>NCCI, CMS directives/transmittals, HCPCS, CPT and National Specialty Society; machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered</p>	<p>Appropriate modifier as defined by CPT or HCPCS may be reported to override this type of edit.</p>
C – Multiple Procedure Reduction	<p>This type of edit identifies when two or more procedures/services are performed during the same session by the same provider, not all of the procedures/services may be reimbursed at 100%.</p> <p>Consensus on 3/28/12</p>	<p>MFSDDB, CMS directives/transmittals, HCPCS, CPT and National Specialty Society; machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be</p>	<p><i>RVU for each of these procedures included pre-service, intra-service and post-service in the form of work/time practice expense and malpractice expense. The concept of multiple procedural reduction is the pre-</i></p>

		considered	<i>service and post-service once is only performed once when multiple procedures are performed at the same time.</i>
D – Age	This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of the service/procedure code or the related coding guideline implies age-specific parameters. Consensus on 3/28/12	CPT/HCPCS	Note: ICD-9/10 diagnoses edits are not within the scope of this legislation, and would be allowed with a procedure code edit.
E – Gender	This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of service/procedure code implies gender-specific parameters. Consensus on 3/28/12	CPT/HCPCS	Note: ICD-9/10 diagnoses edits are not within the scope of this legislation, and would be allowed with a procedure code edit.
F – Maximum Frequency Per Day	This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of the service/procedure code, or the related coding guidelines imply restrictions on the number of times the service/procedure can be provided on a single calendar date. Consensus on 3/28/12	CPT/HCPCS	Note: Frequency limitations spanning a period of time will be addressed separately, including MUEs
G – Global Surgery Days	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. Consensus on 3/28/12 Consensus on revised definition 7/18/12	CPT/HCPCS, MFSDDB, National Specialty Society, CMS directives/transmittals	Note: The legislative intent was not to limit the edit to just the number of days, but also to address the global surgery package.
H – Place of Service	This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptors of the service/procedure codes do not match the place service reported on the claim. Consensus on 3/28/12	CPT/HCPCS	Note: Many of the CPT/HCPCS descriptions of the evaluation and management codes include a specific place(s) of service. CPT coding guidelines in other locations may also direct site of service reporting. The CMS Inpatient Only Listing was considered, however it may not

			always be appropriate for the younger age population and was therefore not considered an appropriate source.
I – Type of Service	This type of edit is no longer used by Medicare for internal tracking; providers do not have to report when submitting claims. Not applicable Consensus on 3/28/12		
J – Assistant at Surgery	This type of edit will identify when an assistant at surgery will be considered for payment. Consensus on 5/23/12	Multiple sources, (1) ACS, if missing or indicates sometimes use (2) CMS, if it indicates Yes or No use this, (3) if CMS is sometimes then the determination would be up to the individual payer. Machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered.	CPT modifier 80, 81, 82 or HCPCS modifier AS should be appended to the surgical procedure code, according to CPT/Medicare modifier definition.
K – Co-surgery	This type of edit will identify when consideration for payment will be made to two surgeons reporting that they were the primary surgeon when performing a distinct part(s) of a single surgical procedure. Consensus on 3/28/12	MFSDDB, National Specialty Society, CMS directives, and machine-readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered Modifier 62 would be appended according to CPT definition.	Modifier 62 would be appended according to CPT definition.
L – Team Surgery	This type of edit will identify when consideration for payment will be made when a complex surgical procedure requires several physicians to act as a primary surgeon when performing a distinct part(s) of a single surgical procedure. Consensus on 3/28/12	MFSDDB, National Specialty Society, CMS directives, and machine-readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered Modifier 66 would be appended according to CPT guidelines and instructions.	Modifier 66 would be appended according to CPT guidelines and instructions.
M – Total, Professional or Technical Split	This type of edit will identify incorrect billing of a procedure code that is either not eligible for the professional, technical split, or incorrectly identifies the professional or technical component. Consensus on 3/28/12	MFSDDB will be used to identify which procedures codes are appropriate for professional/technical split. HCPCS modifier TC would be appended according to HPCS guidelines and instructions for designating the technical component. CPT modifier 26 would be appended according to CPT guidelines and instructions for	HCPCS modifier TC would be appended according to HPCS guidelines and instructions for designating the technical component. CPT modifier 26 would be appended according to CPT guidelines and instructions for designating the professional component. Note: The actual percent reimbursed is

		designating the professional component.	considered a payment issue and out of scope of the TF.
N – Bilateral Procedures	This type of edit will identify incorrect billing when the CPT/HCPCS descriptors of the service/procedure code, or the related coding guidelines imply either unilateral or bilateral restrictions. Consensus on 3/28/12	CPT/HCPCS, MFSDB Modifier 50 “Bilateral Procedure: Unless otherwise identified in the listing bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.” Bilateral services are procedures performed on both sides of the body during the same operative session or on the same day. The modifier "50" is not applicable to procedures that are bilateral by definition or in cases where the descriptor includes the terminology as "bilateral" or "unilateral". HCPCS Modifiers LT and RT can be used to indicate this circumstance	Note: As defined in the CPT, Modifier 50 “Bilateral Procedure description: Unless otherwise identified in the listing bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.” A bilateral service is one in which the same procedure is performed on both sides of the body during the same operative session or on the same day. The modifier "50" is not applicable to procedures that are bilateral by definition or whose code descriptors include the terminology of "bilateral" or "unilateral".
O – Anesthesia Services	No anesthesia specific edits were identified, they are captured under the “Unbundle” category Consensus on 3/28/12		
P – Effect of CPT & HCPCS Modifiers on these Edits			Under development
ADDITIONAL EDIT TYPES			
Add-ons	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 in addition to a primary procedure or service. The add-on code, by definition, never 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	CPT/HCPCS, MFSDB, machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered. Medicare.	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. 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

	symbol (+), and instructions in the code description for reporting the service in addition to the primary procedure. Consensus on 4/25/12 Consensus on revised definition 7/18/12		reported alone, but do not have the AMA designation will be handled by a separate edit [to be added to the MCCTF edit dictionary].
Maximum Frequency > One Day	This type of edit will identify incorrect billing when the CPT/HCPCS descriptor of the service/procedure code, or the related parenthetical coding guidelines imply restrictions on the number of times the service/procedure can be provided over a specified span of days. Consensus on 3/28/12	CPT/HCPCS	MUEs will be addressed separately
New Patient	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. Consensus 7/18/12	AMA	Note, the AMA offered this clarification, if the patient has received professional services from the same physician within the past three years, the patient is considered an established patient, even though the physician has changed medical groups or practice settings.
Laboratory rebundling	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. Ready for consensus 6/27/12	Vendor	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.
Bundled Service	This edit identifies when certain services and supplies are considered part of the overall care and should not be billed separately. Consensus 7/18/12	CMS, Vendor	For example, status indicator B on MFSDB

ADDITIONAL EDIT TYPES REVIEWED BUT NOT ACCEPTED

Same Day Medical	This edit identifies when an Evaluation and	Modifiers -25 and -57 may be appropriately	A separate edit definition is not needed, it
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Visit	<p>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.</p> <p><i>Not applicable as a separate edit type, combined with global surgery</i></p> <p><i>Consensus 7/18/12</i></p>	billed to override this edit.	<p>has been combined with revised global surgery definition.</p> <p>TF should consider whether or not a separate edit is needed for same day medical visit and medical procedure.</p>
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Other Edit Types For Review/Recommendation By Edit Committee

EDIT TYPE	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
Same Day Medical Visit and Medical Procedure	<p>This type of edit will identify incorrect billing when an evaluation and management (E&M) service is reported on the same day as a substantial diagnostic or therapeutic procedure (such as dialysis, chemotherapy and osteopathic manipulative treatment), and E&M service is routinely considered an integral part of the other service and should not be reported separately.</p> <p>Task Force discussion 7/18/12</p>	CPT/HCPCS, MFSDB, machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered.	During the TF 7/18/12 discussion of Global Surgery Days it was determined that a separate edit definition to address same day edits for non-surgical procedures may be needed.
Multiple E&Ms on the same day	<p>This edit identifies when multiple E&Ms are billed on the same day by the same provider. Only one E&M may be eligible for reimbursement.</p> <p>Refer to Payment Rules Committee</p>	Modifier -25 override may be appropriately billed to override this edit.	<p>INCLUDES:</p> <p>All services provided on the date of admission in other sites of service (eg, emergency department, office, nursing facility) (99201-99215, 99281-99285, 99304-99318, 99324-99337, 99341-99350, 99381-99397)</p> <p>Initial physician services provided to the patient in the hospital or "partial" hospital settings (99221-99223)</p> <p>Physician services provided to the patient observation status on the same date as inpatient E & M service</p>
Rebundling	<p>When two or more codes submitted together are better described by a single code or series of codes, transfer the original code combination into the more appropriate code or code combinations.</p> <p>Refer to Payment Rules Committee</p>		
Procedure code to modifier validation	<p>This edit identifies when a modifier is inappropriately billed with a procedure code.</p> <p>Refer to Payment Rules Committee</p>	CMS, Vendor	<p>1) Should we codify this or get it from the vendor?</p> <p>2) Should we just use ranges?</p> <p>3) Should we limit this to only in-scope/payment modifiers? Or include</p>

			informational modifiers?
Multiple Endoscopy Reimbursement	This edit identifies when multiple endoscopic surgical procedures within the same family are performed during the same session by the same provider, not all of the procedures/service may be reimbursed at 100%. Refer to Payment Rules Committee	CMS/MFSDB	RVU for each of these procedures includes pre-service, intra-service and post-service in the form of work/time, practice expense and malpractice expense. The concept of multiple procedural reductions is, the pre-service and post-service is only performed once when multiple endoscopies are performed at the same time. Special CMS rules.
Multiple Radiology Reduction	This type of edit identifies when multiple imaging procedures are performed during the same session by the same provider. Not all may be reimbursed at 100%. Refer to Payment Rules Committee	Medicare Multiple Procedure Percentage Reduction (MPPR)	RVU for each of these procedures includes pre-service, intra-service and post-service in the form of work/time, practice expense and malpractice expense. CMS has applied the concept of multiple procedural reductions on both the technical and professional component of imaging services. The national specialty society (ACR) has provided background information documenting how the CMS application of a flat percentage reduction to the professional component across all imaging is a flawed process. This approach does not adequately take into consideration the variation in physician work/time associated with a given procedure. The ACR does not support the inclusion of this flawed approach as part of the Task Force's recommendations.
Multiple Physical Therapy	This type of edit identifies when multiple therapy services are performed during the same session by the same provider. Not all may be reimbursed at 100%. Refer to Payment Rules Committee		



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

Edit/Payment Rule Query

Topic	Bilateral Procedures
Definition	<p>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.</p> <p>This rule is applicable for the specific situations identified for this modifier.</p> <p>There may be appropriate situations where multiple modifiers apply, however not all situations are covered in this rule.</p>
Associated CPT®¹ and HCPCS modifiers (or codes)	50 – Bilateral Procedure
Query logic	<ol style="list-style-type: none"> 1) Using the CMS MPFS schedule, identify the column labeled as Bilat Surg. 2) Any code with a value of '0', '2', '3' or '9' should be listed as No. 3) Any code with a value of '1' should be listed as Yes. 4) Change value from No to Yes for the following codes: 27215, 27216, 27217, 27218.
Rationale	Applying based on Task Force consensus on bilateral procedures recommendation. The code exceptions are documented in the Rules Committee recommendation.
DATE	May 23, 2013

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QUESTIONS FROM MCKESSON REGARDING RELEASE OF EDITS TO BE USED EXCLUSIVELY BY THE TASK FORCE

Requested parameters that need to be defined:

- Specification of rules to be released, with timetables
- Specification of edits, by source, to be released, starting with CMS and, perhaps, CPT. A better understanding of the edit review and approval process may be important before we get to the release of specialty society content, based on consideration of what is and is not intellectual property of each specialty.
- 'File Format' and media for release

McKesson Leadership would also like to better understand:

- The business model for the Common Edit Set, including maintenance of existing and updated edits
- The sustaining nature of the review process, before and during 'production' phases
- Data security safeguards for the edits to be shared, prior to the 'publication' date
- An understanding of the appeals process for edits that are rejected

Without agreeing [yet] on the total scope of edits to be released, the Leadership Team agreed that the following content, from McKesson, may be shareable, pending clarification of the questions/parameters above:

- Rules/edits, sourced to CMS [beyond publicly available edits like NCCI or MUEs; this might include edits based on the Medicare National Physician Fee Schedule, the NCCI Policy Manual (printed annually in Oct), or CMS Payment Transmittals]
- CPT-based edits
- Specialty Society edits (TBD)
- Edit Rationale statements (TBD)