

## Medical Clean Claims Transparency and Uniformity Act Task Force



MCCTF MONTHLY STATUS UPDATE

July 1, 2013

### Action Items from June Meeting

- The task force achieved consensus on the following definitions from the Edit Committee: (revisions are outlined in parenthesis)
  - **Same Day Medical Visit and Medical Procedure:** (parenthetical sentence removed)
  - **Multiple E&Ms on the Same Day:** (last sentence removed)
  - **Rebundling:** (no revisions made)
  - **Procedure Code to Modifier Validation:** (add "CPT/HCPCS" before "procedure code.")
  - **Multiple Endoscopy Reimbursement:** (remove "not all may be reimbursed at 100%")
- These five edits were approved by consensus and have been referred to the Payment Rules Committee.
- The definition for **Multiple Radiology Reduction** was ultimately determined to be out of the task force's scope because it is "used by the payer to internally administer variations in the application of payment or benefit based on either the provider's or member's contract." A more detailed explanation as to why this edit is out of scope will be submitted to the task force in July as an informational document.
- The definition for **Multiple Physical Therapy** was also determined to be out of scope. The exact wording as to why this edit is out of scope will be submitted to the task force in July as an informational document.
- The second wave of rules (which was scheduled for release in August) was separated into two groups. The first of which includes seven rules and will be completed by the Payment Rules Committee in time for the July meeting.

### To-Do List for July

- Lisa Lipinski and the Payment Rules Committee to finish drafting next bundle of (seven) rules for public review. These will be brought forth as consensus items in the July agenda.
- Marilyn to draft the detailed description behind why *Multiple Radiology Reduction/Multiple Physical Therapy* fall out of scope.
- DSR Committee to review inquiry from McKesson regarding release of edits to be used exclusively by the task force.

### Upcoming Meetings and Important Dates:

- The next full task force conference call is **July 24, 2013**
- The deadline for the first public comment period is **July 15, 2013**

**Barry Keene**  
Co-Chair, MCCTF  
[krd@qadas.com](mailto:krd@qadas.com)

**Marilyn Rissmiller**  
Co-Chair, MCCTF  
[marilyn\\_rissmiller@cms.org](mailto:marilyn_rissmiller@cms.org)

**DRAFT**

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

Executive Summary of Meeting Minutes

June 26, 2013, noon-2 PM, MDT

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

Conference ID: ID 8586314

**Attendees:**

- Amy hodges
- Barry Keene, CC
- Beth wright
- Fred Tolin
- Helen Campbell
- Jim Borg
- Kim Davis
- Lisa Lipinski
- Lori Marden
- Marilyn Rissmiller, CC
- Jill Roberson
- Mark Painter
- Rysshell Shrader
- Tom Darr
- Wendi Healy

**Staff :**

- Connor Holzkamp
- Barbara Yondorf
- Vatsala Pathy

**Public:**

- Pam Kassing (ACR)
- Julie Painter (STS)
- Sherry Smith(AMA)

**Meeting Objective (s):**

See Agenda

**Key:**

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



**June 26, 2013**

**ROLL CALL & WELCOME:**

- There were 15 members in attendance.
- The minutes from May were accepted with no changes.
- It was noted that the next face-to-face meeting will be August 27 and 28, 2013.

**PROJECT MANAGEMENT COMMITTEE—Barry Keene**

**New Project Manager:**

The TF welcomed Vatsala Pathy who will become the official project manager on July 1, 2013.

### **Distribution of Public Notice:**

Barry Keene, co-chair of the TF, outlined the current process the TF has in place for the distribution of the first “bundle” of rules for public comment:

- Notification letter was sent to all health plans having contracts with providers in Colorado, and all Colorado providers about this initial release.
- The interested parties were advised to sign-up via the TF website ([www.hb101332taskforce.org](http://www.hb101332taskforce.org)) to receive email notifications regarding all future releases.
- The letter also said that any comments on the first “bundle” of rules must be submitted to the TF website by **July 15, 2013** in order to be taken into consideration.

### **Sign-Up Records:**

- The TF briefly reviewed the people/organizations that had signed up via the website as of June 26, 2013.

### **Work Plan Update:**

- The updated TF work plan was displayed. It can be viewed [HERE](#).

### **FINANCE COMMITTEE—Barry Keene**

There was nothing new to report from the Finance Committee. The TF will continue to look for contribution from stakeholders at the table to fund the project

### **EDIT COMMITTEE—Beth Wright and Mark Painter**

The Edit Committee brought forth a list of definitions for seven different edits (*Attachment D* in agenda). The task force achieved consensus on the following definitions from the Edit Committee (Revisions to *Attachment D* are outlined in parenthesis):

- **Same Day Medical Visit and Medical Procedure:** (parenthetical sentence removed)
- **Multiple E&Ms on the Same Day:** (last sentence removed)
- **Rebundling:** (no revisions made)
- **Procedure Code to Modifier Validation:** (add "CPT/HCPCS" before "procedure code.")
- **Multiple Endoscopy Reimbursement:** (remove "not all may be reimbursed at 100%")

<b>ACTION ITEM:</b> These five edits were approved by consensus and have been referred to the Payment Rules Committee.
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The meat of the discussion revolved around the definitions for **Multiple Radiology Reduction** and **Multiple Physical Therapy**.

- The definition for **Multiple Radiology Reduction** was ultimately determined to be out of the task force's purview because it is "used by the payer to internally administer variations in the application of payment or benefit based on either the provider's or member's contract." This quote was taken out of a document that had previously been approved by the TF which defined the criteria for which edits are out of the TF's scope.
- Essentially there was no one opposed to this decision. However, several TFM suggested that the rationale behind this decision be recorded in greater detail, a suggestion that was accepted unanimously. Marilyn Rissmiller, Co-Chair of the TF, volunteered to draft this document which will be brought to the task force in July for informational purposes.
- Even though Tammy Banks from the American Medical Association was reflected in the consensus, it was noted that the AMA “does not support the application of multiple procedure reduction logic on radiology codes.”

- The definition for **Multiple Physical Therapy** was also determined to be out of scope. The rationale for making this Edit out of scope is similar to that of **Multiple Radiology Reduction**.
- However, it was noted by multiple TFM that there may not even be a need for this edit because it is already handled through existing CPT® coding directions. There was some disagreement over this, but ultimately everyone was able to agree that the edit was out of scope for the TF. Because the end result is the same, the payer who disagreed was able to live with consensus.
- The exact wording as to why this edit is out of scope will also be submitted to the task force in July as an informational document courtesy of CC Marilyn Rismiller.

**ACTION ITEM:** *Multiple Physical Therapy* and *Multiple Radiology Reduction* were determined to be out of scope for the TF.

**Bilateral Query Template (Attachment E in agenda):**

- Beth Wright displayed the document for the group to see. The template was accepted as an informational item.

**PAYMENT RULES COMMITTEE—Lisa Lipinski**

Lisa Lipinski, Chair of the Payment Rules Committee, reported that she will be taking a personal leave of absence from July 17, to September 2, 2013. Helen Campbell and Tammy Banks will be picking up the slack while Lisa is out. It was noted that Tammy Banks will be taking over as the AMA’s primary representation within the Task Force.

The committee reported that it was ahead of schedule on creating the next “bundle” of rules to be released. Because of this, the second wave of rules (which was to be brought to the TF in August) was separated into two groups. The first of which includes seven rules and will be completed by the Payment Rules Committee in time for the July meeting.

**SPECIALTY SOCIETY OUTREACH COMMITTEE—Tammy Banks and Helen Campbell:**

The Specialty Society reported that the AMA recently sent out the announcement to the federations regarding the first release of rules by the TF.

**DATA SUSTAINING REPOSITORY COMMITTEE—Mark Rieger**

Barry Keene noted that the TF will be looking for someone to assist Mark Rieger with the DSR Committee, who will be looking to meet in July regarding a request from McKesson (*Attachment F* in agenda), as well as implementing the RFP (please see *RFP* from previous minutes).

Barry made a proposal to “allow a vendor that does our data analytics to monetize that in 2015,” and encouraged TFM to email him with any comments.

**PUBLIC COMMENT:**

<none>

**OTHER BUSINESS:**

<none>

**The meeting was adjourned at approximately 2:00 PM MDT**

7/17/2013

## Notification Signup

1/2

Date	Contact Name	Organization Name	Organization Address	Contact Title	Telephone	Contact Email
5/23/2013 12:21	Name:lisa lipinski		515 n state street\nChicago, Il 60647	Sr Policy Analyst	(312) 464-5349	lisa.lipinski@ama-assn.org
5/24/2013 9:49	Mike Bailie	Optum	2799 Greensborough Dr. Highlands Ranch,CO 80129	Vice President		michael.baillie@optum.com
5/30/2013 15:21	Barry Ziman	Gov.	Washington, DC			
5/30/2013 15:24	Tricia Tennant	Gov.	1350 I Street NW, Suite 590\nWashington, DC 20005	Legislative Assistant	(202) 354-7103	ptennan@cap.org
6/5/2013 9:26	Barry Keene		1309 Alexandria St\nLafayette, CO 80026	President		krd@qadas.com
6/5/2013 12:31	Marilyn Rissmiller		7351 E. Lowry Blvd.\nDenver, CO 80230	Sr. Director	(720) 858-6328	marilyn_rissmiller@cms.org
6/5/2013 14:58	Marc Reece	Colorado Health Plans	1121 Grant St #103\nDenver, CO 80203	Associate Director		mreece@colohealthplans.org
6/5/2013 14:59	Jacob Wager	Kaiser	1410 Grant Street, D-315\nDenver, CO 80203	Government Relations Specialist	(303) 832-2872	jacob.w.wager@kp.org
6/5/2013 15:05	Dianne Bricker	America's Health Insurance Plans	601 Pennsylvania Avenue, NW, Suite 500 - South Bldg\nWashington, DC 20004	Regional Director - State Affairs	(202) 861-6378	dbricker@ahip.org
6/5/2013 15:13	Stephanie Ziegler	Seechange Health Insurance	10159 Wayzata Blvd\nMinnetonka, MN 55305	VP, Strategic Development	(415) 335-2701	sziegler@seechangehealth.com
6/6/2013 8:12	Julia Hix	Assurant	501 W Michigan Street\nMilwaukee, WI 53201-3050	Vice President Regulatory Compliance	(414) 299-7830	julie.hix@assurant.com
6/6/2013 12:55	Patricia Williams	DHHA	938 Bannock St. 3rd Flr.\nDenver, CO. 80204	Claims Mgr.	(303) 602-2014	Patricia.Williams@dhha.org
6/6/2013 14:08	Michael Huotari	Rocky Mountain Health Plans (RMP)	6251 Greenwood Plaza Blvd\nsuite 250\nGreenwood Village CO\n80111	VP	(720) 320-7011	michael.huotari@rmhp.org
6/6/2013 14:11	Lori Marden		2775 Crossroads Blvd\nGrand Junction CO 81502	Director, Claims	-	lori.marden@rmhp.org
6/6/2013 14:14	Nancy Steinke	United	6251 Greenwood Plaza Blvd\nGreenwood Village CO 80111	Clinical Policy Manager	(303) 967-2083	nancy.steinke@rmhp.org
6/7/2013 17:17	Philip A. Lyons	United Healthcare of Colorado	6465 S. Greenwood Plaza Blvd. Suite 300\nCentennial, CO 80111	Associate General Counsel	(303) 267-3212	palyons17@yahoo.com
6/10/2013 7:40	Marla Mangeot	DHHA	938 Bannock Street\nDenver, CO 80204	Senior Project Manager	(303) 602-2062	marla.mangeot@dhha.org
6/10/2013 11:23	Julia Hix	Assurant	501 W Michigan \nMilwaukee, WI 53201	Vice President Reg Compliance	(414) 299-7830	julie.hix@assurant.com
6/10/2013 13:02	same	UC Denver Department of Radiology	12401 E. 17th Ave\nAurora, CO\n80045		(720) 848-6608	gerald.dodd@ucdenver.edu
6/10/2013 13:42	Chet Seward	Colorado Medical Society	7351 Lowry Blvd., Ste 110\nDenver, cO 80230	Executive Director	(720) 858-6336	chet_seward@cms.org
6/10/2013 13:48	Dennis Beck	Beacon Medical Services	10065 E Harvard Ave\nSuite 800 Denver, CO 80231	CEO	(303) 306-4560	dbeck@beacon-medical.com

6/10/2013 14:28	Michele Cameron	Retinal Alliance	8101 E Lowry Blvd \nSuite 210\nDenver, CO 80230	Practice Administrator	(303) 261-1600	mcameron@retinacolorado.com
6/10/2013 17:57	Cindy Sears	DHHA	990 Bannock St\nDenver, CO 80204	Payer Contractor Manager	(303) 602-2268	cindy.sears@dhha.org
6/10/2013 20:24	John L Bender	Miramont Family Medicine	4674 Snow Mesa Drive Suite #140\nFort Collins CO 80528	CEO		jlbender@miramont.us
6/11/2013 8:18	Julie DeSaire	Miramont Family Medicine	3850 N Grant Ave\nSuite 100\nLoveland, CO 80538	Director of Clinical Quality	(970) 225-5107	jmdesaire@miramont.us
6/11/2013 10:17	Niles Rosen	Correct Coding Solutions LLC	PO Box 907\nCarmel, IN 46082-0907	President	(317) 752-8735	niles.rosen@correctcodingsolutions.com
6/11/2013 13:24	Luana Ciccarelli	American Academy of Neurology	201 Chicago Ave\nMinneapolis, MN 55415	Program Manager, Medical Economics		lciccarelli@aan.com
6/11/2013 14:01	Madeleine Mongan	Vermont Medical Society (VTMD)	P.O. Box 1457\nMontpelier, VT 05601	Deputy EVP	(802) 223-7898	mmongan@vtmd.org
6/11/2013 14:06	Thomas Healy	American Medical Association Chicago	515 N. State St.\nChicago, IL 60654	VP, Deputy General Counsel	(312) 464-5537	thomas.healy@ama-assn.org
6/11/2013 16:20	Tammy Banks		515 North State Street\nChicago, IL 60654	Director	(312) 464-4792	tammy.banks@ama-assn.org
6/12/2013 5:55	Diane Hayek		1891 Preston White Drive\nReston, VA 20191	Director, Economics & Health Policy	(703) 648-8922	DHayek@acr.org
6/12/2013 6:54	Erin Young	American Society for Radiation Oncology	8280 Willow Oaks Corporate Drive Suite 500 Fairfax, VA 22031	Health Policy Analyst	(703) 839-7416	eriny@astro.org
6/12/2013 7:43	Natacha Graham	Endourological Society	1000 Corporate Boulevard\nLinthicum, MD 21090	Reimbursement and Regulation Coordinator	(410) 689-4071	ngraham@auanet.org
6/12/2013 7:45	Ellen Jaffe	American Psychiatric Association	1000 Wilson Blvd\nArlington, VA 22209	editor	(703) 907-8591	ejafe@psych.org
6/12/2013 10:36	michael bigby	Beth Israel Deaconess Medical Center (BIDMC)	330 Brookline Ave\nBoston Ma02215	MD	(617) 667-5205	mbigby@bidmc.harvard.edu
6/12/2013 12:57	Patty	American Association of Oral and Maxillofacial Surgeons (AAOMS)	Rosemont, IL			pserpico@aaoms.org
6/12/2013 13:21	Patti Clarke	UCLA	5767 W. Century Blvd #400\nLos Angeles, Ca. 90045	MSO1	(310) 301-8979	pclarke@mednet.ucla.edu
6/13/2013 6:43	Allison Hirschorn	American Society of Clinical Oncology (ASCO)	2318 Mill Road\n8th Floor\nAlexandria, VA 22314	Coding and Reimbursement Specialist	(571) 483-1653	allison.hirschorn@asco.org
6/13/2013 13:44	Shelley Ginsberg	International Pediatric Endosurgery Group (IPEG)	11300 W. Olymipic Blvd\nSuite 600\nLos Angeles, CA 90064			shelley@sages.org
6/13/2013 15:49	anne mcnealis	Kaiser	1 kaiser plaza\noakland CA 94612		(510) 267-4230	anne.d.mcnealis@kp.org
6/14/2013 14:42	Tim Sherman	Rocky Mountain Health Plans (RMP)	2775 Crossroads Blvd.\nGrand Junction, CO 81506	Director of Legal and Regulatory Affairs	(970) 244-7867	tim.sherman@rmhp.org
6/17/2013 9:43	Susan Moore	Medical Association of Georgia (MAG)	1849 The Exchange\nSuite 200\nAtlanta, GA 30339	Director Health Policy and TPP Advocacy	(678) 303-9275	smoore@mag.org



Activity	2013										2014										Deadline	Status as of 7-5-13					
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec				
<b>RULES</b>																											
<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
Public comments due on 1st bundle																										July 15	DONE
Payment & Edit Committees review comments on 1st 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 7-5-13				
	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 <sup>nd</sup> bundle.																						October 4		
Payment & Edit Committees review comments on 2 <sup>nd</sup> set of recipes and make recommendations for revisions.																							Early November	
After reviewing comments received on 2 <sup>nd</sup> bundle draft edit rule recipes, TF finalizes and approves 2 <sup>nd</sup> bundle.																							November 26	
<u>3<sup>rd</sup> 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 <sup>rd</sup> bundle of draft edit rule recipes.																							October 22 mtg	
3 <sup>rd</sup> bundle of draft recipes circulated 5-week public review and comment period. ****																							October 25	
Public comments due on 3 <sup>rd</sup> bundle																							December 2	
Payment & Edit Committees review comments on 3 <sup>rd</sup> set of recipes and make recommendations for revisions.																							Early January	
After reviewing comments on 3 <sup>rd</sup> 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 2<sup>nd</sup> and 3<sup>rd</sup> bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013										2014										Deadline	Status as of 7-5-13		
	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]																								
<b>FUNDING</b>																								
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
<b>DATA SUSTAINING REPOSITORY OPERATIONS</b>																								
<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"> <li>o Who is responsible for establishing a central repository for accessing the rules and edits set and</li> <li>o Enabling electronic access--including downloading capability--to the rules and edits set</li> </ul>																						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 2<sup>nd</sup> and 3<sup>rd</sup> bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013									2014									Deadline	Status as of 7-5-13					
	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"> <li>o who is responsible for establishing a central repository for accessing the rules and edits set, and</li> <li>o enabling electronic access--including downloading capability--to the rules and edits set</li> </ul>																							Oct 22 mtg		
<b>DATA ANALYTICS</b>																									
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 2<sup>nd</sup> and 3<sup>rd</sup> bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013									2014									Deadline	Status as of 7-5-13				
	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	
<b>2014</b>																								
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 2<sup>nd</sup> and 3<sup>rd</sup> bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013									2014									Deadline	Status as of 7-5-13			
	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	
<b>TASK FORCE FINALIZES EDIT SET</b>																							
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"> <li>• Recommends implementation of a set of uniform standardized payment rules &amp; claim edits to be used by payers &amp; providers;</li> <li>• Makes recommendations concerning the implementation, updating, &amp; dissemination of the standardized set of payment rules and claim edits, including:</li> </ul>																						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 2<sup>nd</sup> and 3<sup>rd</sup> bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013									2014									Deadline	Status as of 7-5-13						
	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"> <li>○ who is responsible for establishing a central repository to access the rules &amp; edits set, &amp; enabling electronic access--including downloading capability--to the rules and edits set; and</li> <li>● Includes a recommended schedule for commercial health plan payers to implement the standardized set.</li> </ul>																										
<b>FINAL REPORT</b>																										
Staff draft final report to legislature and HCPF.																									Early November 2014	
Task force reviews 1 <sup>st</sup> 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 2<sup>nd</sup> and 3<sup>rd</sup> 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"> <li>• 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"> <li>○ who is responsible for establishing a central repository for accessing the rules and edits set and</li> <li>○ enabling electronic access--including downloading capability--to the rules and edits set; and</li> </ul> </li> <li>• Include a recommended schedule for payers that are commercial health plans to implement the standardized set.</li> </ul>	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 2<sup>nd</sup> and 3<sup>rd</sup> bundles in order to have enough time for complete all tasks to meet statutory deadline.

## Other Edit Types For Review/Recommendation By Edit Committee

EDIT TYPE	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
Multiple Radiology Reduction	<p>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%.</p> <p>Refer to Payment Rules Committee</p>	Medicare Multiple Procedure Payment Reduction (MPPR)	<p>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. <b>The ACR does not support the inclusion of this flawed approach as part of the Task Force's recommendations.</b></p>
Multiple Physical Therapy	<p>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%.</p> <p>Refer to Payment Rules Committee</p>	Medicare Multiple Procedure Payment Reduction (MPPR)	

Follow up to June 26, 2013 meeting:

During the June monthly meeting of the Colorado Clean Claims Task Force the two additional edits noted above were reviewed to determine whether they should be included in the standardized set of claim edits and if they should be referred to the Payment Rules Committee for development. **The task force determined that these edits were out of scope as previously defined by the task force.** However, the task force wanted to ensure that the rationale for this

decision was documented for historical purposes. The following is taken from the Medical Clean Claims Transparency and Uniformity Act Task Force report to the Colorado General Assembly dated November 30, 2012:

*Section I. A. Key Provisions – The task force defines **out-of-scope edits** as edits that are not within the task force’s purview because they: are addressed as part of other edit types already included in the standardized set; are part of a different stage in the claims processing system; are used by the payer to internally administer variations in application of payment or benefit based on either the provider’s or member’s contract; or are Medicare or Medicaid-specific.”*

The report further defined the guidelines used in the development of standardized Payment Rules as:

*Payment rules for coding scenarios that are unique and eligible for differentiated payment should not consider implementation or budget constraints, political influences or benefit limitations. The task force understands the need for cost containment, but similar to the edit type “utilization review” that can be used to control costs by limiting the diagnoses or frequency of specific services, these fall outside of the scope of work for the task force and should not be included as part of, or influence, a standardized set of edits and payment rules.*

*The payment 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 task force is only standardizing how the coding scenarios eligible for differentiated payment are to be applied to those negotiated fee schedules.*

In recent years, Medicare has expanded the application of the Multiple Procedure Payment Reduction (MPPR) to diagnostic imaging, both the professional and technical components; the practice expense portion of certain therapy services; and most recently to the technical component of diagnostic cardiovascular and ophthalmology services. This expansion has been driven by legislative action for cost containment. The question was raised regarding whether or not a payer that currently has one of these edits in place could continue that practice once the standardized set is implemented. These edits will not be part of the Colorado Medical Clean Claims standard set of claims edits and payment rules, however, as noted above this does not preclude the payer from utilizing such an edit if it is in place to administer variations in application of payment based on the provider’s contract.

The question was raised regarding why/how these MPPR rules differ from the multiple procedure (C) and multiple endoscopy edits that have been adopted by the task force. The AMA staff explained the difference between the rules. Multiple surgery and multiple endoscopy payment adjustments have been based on resource cost and the fundamentals of the RBRVS. That is, the 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 RUC applies the concept of multiple procedural reductions, the pre-service and post-service is only performed once when multiple procedures are performed at the same time to avoid overlap, when it makes a RVU recommendation. This process has been accepted by the profession.

In 2010, Section 3134 of the Affordable Care Act (ACA) added section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. This has given rise to Medicare's expansion of the MPPR and bypasses the established CPT/RUC process. The AMA and organized medicine as a whole has expressed its objections to this approach. Their contention is that there is a process already in place through the CPT/RUC to have concerns about overlap in resource cost addressed on a case-by-case basis. Payers, providers, CMS can request that the CPT/RUC evaluate procedure codes to determine within the fundamentals of the RBRVS if there is resource overlap and make recommendations to adjust the value and/or changes to the procedure coding to address the duplication.

Regarding the physical therapy codes within the 97001-97755 range that are subject to the MPPR adjustment, the AMA pointed out that there is a specific coding instruction that modifier 51 should not be appended to these codes. The reason for this note is that when the procedures were valued the RUC recognized that these were not stand-alone procedures, they would always be done in combination, and they were valued accordingly to avoid overlap in the resource cost.

Medicare identifies those procedure codes that are subject to the special MPPR payment adjustment rules by the use of specific indicators on the Medicare Physician Fee Schedule in the column labeled MULT PROC. Indicator 4 identifies diagnostic imaging procedures, indicator 5 identifies therapy services, indicator 6 identifies diagnostic cardiovascular procedures, and indicator 7 identifies diagnostic ophthalmology procedures. The task force will not utilize these indicators in the development of its edits and/or payment rules. Furthermore, if Medicare continues to expand its application of the MPPR outside of the RUC process, as directed by the ACA, any additional services identified for adjustment will be considered **out-of-scope**.

## Add-ons

### Rules Committee Recommendation

#### Add on reporting rule

##### Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

#### Modifier Involved.

There are no Current Procedural Terminology (CPT<sup>®</sup>)<sup>1</sup> or HCPCS modifiers that apply.

#### Add-on rule

Procedures subject to the add-on rule are listed in Appendix D of the CPT codebook.

The codes identified in Appendix D are also listed in the column labeled GLOBAL DAYS of the Medicare Physician Fee Schedule (MPFS)<sup>2</sup> with an indicator of ZZZ. These codes are related to another service and are always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post-service time.)

#### Coding and adjudication guidelines

Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with the + symbol and they are listed in **Appendix D** of the CPT codebook. Add-on codes in *CPT*

<sup>1</sup> Copyright 2013. All rights reserved. American Medical Association

<sup>2</sup> References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.

2013 can be readily identified by specific descriptor nomenclature that includes phrases such as “each additional” or “(List separately in addition to primary procedure).” The add-on code concept in *CPT 2013* applies only to add-on procedures or services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure, eg, additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s). Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. All add-on codes found in the CPT codebook are exempt from the multiple procedure concept (see the modifier 51 definition in **Appendix A** of the CPT codebook).

A summary of CPT add-on codes can be found in Appendix D of the CPT codebook.

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 MPFS 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 reported alone, but do not have the CPT designation will be handled by a separate edit [to be added to the MCCTF edit dictionary].

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 CPT parentheticals. Add-on codes are identified by CPT with the plus symbol (+), and instructions in the code description for reporting the service in addition to the primary procedure. **Task Force Consensus on 4/25/12 Consensus on revised definition 7/18/12**

## **Rationale**

The following rationale was used to formulate the Rule Committee Recommendation:

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- Procedures subject to the add-on rule are listed in Appendix D of the CPT codebook were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

## **MCCTF comment**

Multiple procedure reductions do not apply, as procedure value is based on the knowledge that they are never done alone. \*Bilateral procedure reductions do apply to those codes identified on the MPFS 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 reported alone, but do not have the CPT designation will be handled by a separate edit [to be added to the MCCTF edit dictionary].

## **Modifier definitions**

No modifiers apply.

## **Payment indicator definitions**

The following is a payment indicator definition that is outlined in the column labeled GLOBAL of the MPFS for Global Surgery<sup>3</sup>.

**ZZZ** = Code related to another service is always included in the global period of the other service.

## **Federation outreach**

### **American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten for review.

### **American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

### **American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

### **American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to Anne Diamond of ACOG for review.

### **Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

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<sup>3</sup> Information taken from “<sup>3</sup> Information taken from “[How to Use the Searchable Medicare Physician Fee Schedule \(MPFS\)](#)”, Centers for Medicare & Medicaid Services”, Centers for Medicare & Medicaid Services.

Current Procedural Terminology (CPT®) Codes in Appendix D of CPT codebook (Copyright 2013. American Medical Association. All rights reserved)	MOD	DESCRIPTION	GLOB Days Indicators
0095T		Artific diskectomy addl	XXX
0098T		Rev artific disc addl	XXX
0163T		Lumb artif diskectomy addl	YYY
0164T		Remove lumb artif disc addl	YYY
0165T		Revise lumb artif disc addl	YYY
0172T		Lumbar spine process addl	XXX
0174T		Cad cxr with interp	XXX
0189T		Videoconf crit care addl 30	XXX
0190T		Place intraoc radiation src	XXX
0196T		Arthrod presac interbody eac	XXX
0054T		Bone surgery using computer	XXX
0055T		Bone surgery using computer	XXX
0079T		Endovasc visc extnsn repr	XXX
0081T		Endovasc visc extnsn s&i	XXX
0092T		Artific disc addl	XXX
01953		Anesth burn each 9 percent	XXX
01968		Anes/analg cs deliver add-on	XXX
01969		Anesth/analg cs hyst add-on	XXX
0229T		Njx tfrml epri w/us cer/thor	XXX
0231T		Njx tfrml epri w/us lumb/sac	XXX
0309T		Prescri fuse w/ instr I4/I5	XXX
20936		Sp bone agrft local add-on	XXX
22841		Insert spine fixation device	XXX
33961		External circulation assist	XXX
76814		Ob us nuchal meas add-on	XXX
81266		Str markers spec anal addl	XXX
82952		GTT-added samples	XXX
86826		Hla x-match noncytotoxc addl	XXX
87187		Microbe susceptible mlc	XXX
87503		Influenza dna amp prob addl	XXX
87904		Phenotype dna hiv w/clt add	XXX
88155		Cytopath c/v index add-on	XXX
88311		Decalcify tissue	XXX
88311	TC	Decalcify tissue	XXX
88311	26	Decalcify tissue	XXX
88332		Path consult intraop addl	XXX
88332	TC	Path consult intraop addl	XXX
88332	26	Path consult intraop addl	XXX
88334		Intraop cyto path consult 2	XXX
88334	TC	Intraop cyto path consult 2	XXX
88334	26	Intraop cyto path consult 2	XXX
88388		Tiss ex molecu study add-on	XXX

88388	TC	Tiss ex molecu study add-on	XXX
88388	26	Tiss ex molecu study add-on	XXX
90785		Psytx complex interactive	XXX
90840		Psytx crisis ea addl 30 min	XXX
90863		Pharmacologic mgmt w/psytx	XXX
94645		Cbt each addl hour	XXX
95940		Ionm in operatng room 15 min	XXX
95941		Ionm remote/>1 pt or per hr	XXX
99486		Suprv interfac trnsport addl	XXX
99602		Home infusion each addtl hr	XXX
99607		Mtms by pharm addl 15 min	XXX
0241T		Esoph motility w/stim/perf	YYY
0159T		Cad breast mri	ZZZ
0159T	TC	Cad breast mri	ZZZ
0159T	26	Cad breast mri	ZZZ
0205T		Inirs each vessel add-on	ZZZ
0214T		Njx paravert w/us cer/thor	ZZZ
0215T		Njx paravert w/us cer/thor	ZZZ
0217T		Njx paravert w/us lumb/sac	ZZZ
0218T		Njx paravert w/us lumb/sac	ZZZ
0222T		Plmt post facet implt addl	ZZZ
0289T		Laser inc for pkp/lkp donor	ZZZ
0290T		Laser inc for pkp/lkp recip	ZZZ
0291T		Iv oct for proc init vessel	ZZZ
0292T		Iv oct for proc addl vessel	ZZZ
0294T		Ins lt atrl mont pres lead	ZZZ
0300T		Esw wound healing addl wound	ZZZ
11001		Debride infected skin add-on	ZZZ
11008		Remove mesh from abd wall	ZZZ
11045		Deb subq tissue add-on	ZZZ
11046		Deb musc/fascia add-on	ZZZ
11047		Deb bone add-on	ZZZ
11101		Biopsy skin add-on	ZZZ
11201		Remove skin tags add-on	ZZZ
11732		Remove nail plate add-on	ZZZ
11922		Correct skin color ea 20.0cm	ZZZ
13102		Cmplx rpr trunk addl 5cm/<	ZZZ
13122		Cmplx rpr s/a/l addl 5 cm/>	ZZZ
13133		Cmplx rpr f/c/c/m/n/ax/g/h/f	ZZZ
13153		Cmplx rpr e/n/e/l addl 5cm/<	ZZZ
14302		Tis trnfr addl 30 sq cm/<	ZZZ
15003		Wound prep addl 100 cm	ZZZ
15005		Wnd prep f/n/hf/g addl cm	ZZZ
15101		Skin splt grft t/a/l add-on	ZZZ
15111		Epidrm autogrft t/a/l add-on	ZZZ
15116		Epidrm a-grft f/n/hf/g addl	ZZZ
15121		Skn splt a-grft f/n/hf/g add	ZZZ

15131		Derm autograft t/a/l add-on	ZZZ
15136		Derm autograft f/n/hf/g add	ZZZ
15151		Cult skin grft t/a/l addl	ZZZ
15152		Cult skin graft t/a/l +%	ZZZ
15156		Cult skin grft f/n/hfg add	ZZZ
15157		Cult epiderm grft f/n/hfg +%	ZZZ
15201		Skin full graft trunk add-on	ZZZ
15221		Skin full graft add-on	ZZZ
15241		Skin full graft add-on	ZZZ
15261		Skin full graft add-on	ZZZ
15272		Skin sub graft t/a/l add-on	ZZZ
15274		Skn sub grft t/a/l child add	ZZZ
15276		Skin sub graft f/n/hf/g addl	ZZZ
15278		Skn sub grft f/n/hf/g ch add	ZZZ
15777		Acellular derm matrix implt	ZZZ
15787		Abrasion lesions add-on	ZZZ
16036		Escharotomy addl incision	ZZZ
17003		Destruct premalg les 2-14	ZZZ
17312		Mohs addl stage	ZZZ
17314		Mohs addl stage t/a/l	ZZZ
17315		Mohs surg addl block	ZZZ
19001		Drain breast lesion add-on	ZZZ
19126		Excision addl breast lesion	ZZZ
19291		Place needle wire breast	ZZZ
19295		Place breast clip percut	ZZZ
19297		Place breast cath for rad	ZZZ
20931		Sp bone agrft struct add-on	ZZZ
20937		Sp bone agrft morsel add-on	ZZZ
20938		Sp bone agrft struct add-on	ZZZ
20985		Cptr-asst dir ms px	ZZZ
22103		Remove extra spine segment	ZZZ
22116		Remove extra spine segment	ZZZ
22208		Incis spine 3 column adl seg	ZZZ
22216		Incis addl spine segment	ZZZ
22226		Revise extra spine segment	ZZZ
22328		Treat each add spine fx	ZZZ
22522		Percut vertebroplasty addl	ZZZ
22525		Percut kyphoplasty add-on	ZZZ
22527		Idet 1 or more levels	ZZZ
22534		Lat thor/lumb addl seg	ZZZ
22552		Addl neck spine fusion	ZZZ
22585		Additional spinal fusion	ZZZ
22614		Spine fusion extra segment	ZZZ
22632		Spine fusion extra segment	ZZZ
22634		Spine fusion extra segment	ZZZ
22840		Insert spine fixation device	ZZZ
22842		Insert spine fixation device	ZZZ

22843		Insert spine fixation device	ZZZ
22844		Insert spine fixation device	ZZZ
22845		Insert spine fixation device	ZZZ
22846		Insert spine fixation device	ZZZ
22847		Insert spine fixation device	ZZZ
22848		Insert pelv fixation device	ZZZ
22851		Apply spine prosth device	ZZZ
26125		Release palm contracture	ZZZ
26861		Fusion of finger jnt add-on	ZZZ
26863		Fuse/graft added joint	ZZZ
27358		Remove femur lesion/fixation	ZZZ
27692		Revise additional leg tendon	ZZZ
29826		Shoulder arthroscopy/surgery	ZZZ
31620		Endobronchial us add-on	ZZZ
31627		Navigational bronchoscopy	ZZZ
31632		Bronchoscopy/lung bx addl	ZZZ
31633		Bronchoscopy/needle bx addl	ZZZ
31637		Bronchoscopy stent add-on	ZZZ
31649		Bronchial valve remov init	ZZZ
31651		Bronchial valve remov addl	ZZZ
32501		Repair bronchus add-on	ZZZ
32506		Wedge resect of lung add-on	ZZZ
32507		Wedge resect of lung diag	ZZZ
32667		Thoracoscopy w/w resect addl	ZZZ
32668		Thoracoscopy w/w resect diag	ZZZ
32674		Thoracoscopy lymph node exc	ZZZ
33141		Heart tmr w/other procedure	ZZZ
33225		L ventric pacing lead add-on	ZZZ
33257		Ablate atria lmted add-on	ZZZ
33258		Ablate atria x10sv add-on	ZZZ
33259		Ablate atria w/bypass add-on	ZZZ
33367		Replace aortic valve w/byp	ZZZ
33368		Replace aortic valve w/byp	ZZZ
33369		Replace aortic valve w/byp	ZZZ
33508		Endoscopic vein harvest	ZZZ
33517		Cabg artery-vein single	ZZZ
33518		Cabg artery-vein two	ZZZ
33519		Cabg artery-vein three	ZZZ
33521		Cabg artery-vein four	ZZZ
33522		Cabg artery-vein five	ZZZ
33523		Cabg art-vein six or more	ZZZ
33530		Coronary artery bypass/reop	ZZZ
33572		Open coronary endarterectomy	ZZZ
33768		Cavopulmonary shunting	ZZZ
33884		Endovasc prosth taa add-on	ZZZ
33924		Remove pulmonary shunt	ZZZ
34806		Aneurysm press sensor add-on	ZZZ

34808		Endovas iliac a device addon	ZZZ
34813		Femoral endovas graft add-on	ZZZ
34826		Endovasc exten prosth addl	ZZZ
35306		Rechanneling of artery	ZZZ
35390		Reoperation carotid add-on	ZZZ
35400		Angioscopy	ZZZ
35500		Harvest vein for bypass	ZZZ
35572		Harvest femoropopliteal vein	ZZZ
35600		Harvest art for cabg add-on	ZZZ
35681		Composite byp grft pros&vein	ZZZ
35682		Composite byp grft 2 veins	ZZZ
35683		Composite byp grft 3/> segmt	ZZZ
35685		Bypass graft patency/patch	ZZZ
35686		Bypass graft/av fist patency	ZZZ
35697		Reimplant artery each	ZZZ
35700		Reoperation bypass graft	ZZZ
36148		Access av dial grft for proc	ZZZ
36218		Place catheter in artery	ZZZ
36227		Place cath xtrnl carotid	ZZZ
36228		Place cath intracranial art	ZZZ
36248		Ins cath abd/l-ext art addl	ZZZ
36476		Endovenous rf vein add-on	ZZZ
36479		Endovenous laser vein addon	ZZZ
37185		Prim art m-thrombect add-on	ZZZ
37186		Sec art m-thrombect add-on	ZZZ
37206		Transcath iv stent/perc addl	ZZZ
37208		Transcath iv stent/open addl	ZZZ
37222		Iliac revasc add-on	ZZZ
37223		Iliac revasc w/stent add-on	ZZZ
37232		Tib/per revasc add-on	ZZZ
37233		Tibper revasc w/ather add-on	ZZZ
37234		Revasc opn/prq tib/pero stent	ZZZ
37235		Tib/per revasc stnt & ather	ZZZ
37250		Iv us first vessel add-on	ZZZ
37251		Iv us each add vessel add-on	ZZZ
38102		Removal of spleen total	ZZZ
38746		Remove thoracic lymph nodes	ZZZ
38747		Remove abdominal lymph nodes	ZZZ
38900		Io map of sent lymph node	ZZZ
43273		Endoscopic pancreatoscopy	ZZZ
43283		Lap esoph lengthening	ZZZ
43338		Esoph lengthening	ZZZ
43635		Removal of stomach partial	ZZZ
44015		Insert needle cath bowel	ZZZ
44121		Removal of small intestine	ZZZ
44128		Enterectomy cong add-on	ZZZ
44139		Mobilization of colon	ZZZ

44203		Lap resect s/intestine addl	ZZZ
44213		Lap mobil splenic fl add-on	ZZZ
44701		Intraop colon lavage add-on	ZZZ
44955		Appendectomy add-on	ZZZ
47001		Needle biopsy liver add-on	ZZZ
47550		Bile duct endoscopy add-on	ZZZ
48400		Injection intraop add-on	ZZZ
49326		Lap w/omentopexy add-on	ZZZ
49327		Lap ins device for rt	ZZZ
49412		Ins device for rt guide open	ZZZ
49435		Insert subq exten to ip cath	ZZZ
49568		Hernia repair w/mesh	ZZZ
49905		Omental flap intra-abdom	ZZZ
51797		Intraabdominal pressure test	ZZZ
51797	TC	Intraabdominal pressure test	ZZZ
51797	26	Intraabdominal pressure test	ZZZ
56606		Biopsy of vulva/perineum	ZZZ
57267		Insert mesh/pelvic flr addon	ZZZ
58110		Bx done w/colposcopy add-on	ZZZ
58611		Ligate oviduct(s) add-on	ZZZ
59525		Remove uterus after cesarean	ZZZ
60512		Autotransplant parathyroid	ZZZ
61316		Implt cran bone flap to abdo	ZZZ
61517		Implt brain chemotx add-on	ZZZ
61609		Transect artery sinus	ZZZ
61610		Transect artery sinus	ZZZ
61611		Transect artery sinus	ZZZ
61612		Transect artery sinus	ZZZ
61641		Dilate ic vasospasm add-on	ZZZ
61642		Dilate ic vasospasm add-on	ZZZ
61781		Scan proc cranial intra	ZZZ
61782		Scan proc cranial extra	ZZZ
61783		Scan proc spinal	ZZZ
61797		Srs cran les simple addl	ZZZ
61799		Srs cran les complex addl	ZZZ
61800		Apply srs headframe add-on	ZZZ
61864		Implant neuroelectrde addl	ZZZ
61868		Implant neuroelectrde addl	ZZZ
62148		Retr bone flap to fix skull	ZZZ
62160		Neuroendoscopy add-on	ZZZ
63035		Spinal disk surgery add-on	ZZZ
63043		Laminotomy addl cervical	ZZZ
63044		Laminotomy addl lumbar	ZZZ
63048		Remove spinal lamina add-on	ZZZ
63057		Decompress spine cord add-on	ZZZ
63066		Decompress spine cord add-on	ZZZ
63076		Neck spine disk surgery	ZZZ

63078		Spine disk surgery thorax	ZZZ
63082		Remove vertebral body add-on	ZZZ
63086		Remove vertebral body add-on	ZZZ
63088		Remove vertebral body add-on	ZZZ
63091		Remove vertebral body add-on	ZZZ
63103		Remove vertebral body add-on	ZZZ
63295		Repair laminectomy defect	ZZZ
63308		Remove vertebral body add-on	ZZZ
63621		Srs spinal lesion addl	ZZZ
64480		Inj foramen epidural add-on	ZZZ
64484		Inj foramen epidural add-on	ZZZ
64491		Inj paravert f jnt c/t 2 lev	ZZZ
64492		Inj paravert f jnt c/t 3 lev	ZZZ
64494		Inj paravert f jnt l/s 2 lev	ZZZ
64495		Inj paravert f jnt l/s 3 lev	ZZZ
64634		Destroy c/th facet jnt addl	ZZZ
64636		Destroy l/s facet jnt addl	ZZZ
64727		Internal nerve revision	ZZZ
64778		Digit nerve surgery add-on	ZZZ
64783		Limb nerve surgery add-on	ZZZ
64787		Implant nerve end	ZZZ
64832		Repair nerve add-on	ZZZ
64837		Repair nerve add-on	ZZZ
64859		Nerve surgery	ZZZ
64872		Subsequent repair of nerve	ZZZ
64874		Repair & revise nerve add-on	ZZZ
64876		Repair nerve/shorten bone	ZZZ
64901		Nerve graft add-on	ZZZ
64902		Nerve graft add-on	ZZZ
65757		Prep corneal endo allograft	ZZZ
66990		Ophthalmic endoscope add-on	ZZZ
67225		Eye photodynamic ther add-on	ZZZ
67320		Revise eye muscle(s) add-on	ZZZ
67331		Eye surgery follow-up add-on	ZZZ
67332		Rerevise eye muscles add-on	ZZZ
67334		Revise eye muscle w/suture	ZZZ
67335		Eye suture during surgery	ZZZ
67340		Revise eye muscle add-on	ZZZ
69990		Microsurgery add-on	ZZZ
74301		X-rays at surgery add-on	ZZZ
74301	TC	X-rays at surgery add-on	ZZZ
74301	26	X-rays at surgery add-on	ZZZ
75565		Card mri veloc flow mapping	ZZZ
75565	TC	Card mri veloc flow mapping	ZZZ
75565	26	Card mri veloc flow mapping	ZZZ
75774		Artery x-ray each vessel	ZZZ
75774	TC	Artery x-ray each vessel	ZZZ

75774	26	Artery x-ray each vessel	ZZZ
75946		Intravascular us add-on	ZZZ
75946	TC	Intravascular us add-on	ZZZ
75946	26	Intravascular us add-on	ZZZ
75964		Repair artery blockage each	ZZZ
75964	TC	Repair artery blockage each	ZZZ
75964	26	Repair artery blockage each	ZZZ
75968		Repair artery blockage each	ZZZ
75968	TC	Repair artery blockage each	ZZZ
75968	26	Repair artery blockage each	ZZZ
76125		Cine/video x-rays add-on	ZZZ
76125	TC	Cine/video x-rays add-on	ZZZ
76125	26	Cine/video x-rays add-on	ZZZ
76802		Ob us < 14 wks addl fetus	ZZZ
76802	TC	Ob us < 14 wks addl fetus	ZZZ
76802	26	Ob us < 14 wks addl fetus	ZZZ
76810		Ob us >= 14 wks addl fetus	ZZZ
76810	TC	Ob us >= 14 wks addl fetus	ZZZ
76810	26	Ob us >= 14 wks addl fetus	ZZZ
76812		Ob us detailed addl fetus	ZZZ
76812	TC	Ob us detailed addl fetus	ZZZ
76812	26	Ob us detailed addl fetus	ZZZ
76937		Us guide vascular access	ZZZ
76937	TC	Us guide vascular access	ZZZ
76937	26	Us guide vascular access	ZZZ
77001		Fluoroguide for vein device	ZZZ
77001	TC	Fluoroguide for vein device	ZZZ
77001	26	Fluoroguide for vein device	ZZZ
77051		Computer dx mammogram add-on	ZZZ
77051	TC	Computer dx mammogram add-on	ZZZ
77051	26	Computer dx mammogram add-on	ZZZ
77052		Comp screen mammogram add-on	ZZZ
77052	TC	Comp screen mammogram add-on	ZZZ
77052	26	Comp screen mammogram add-on	ZZZ
78020		Thyroid met uptake	ZZZ
78020	TC	Thyroid met uptake	ZZZ
78020	26	Thyroid met uptake	ZZZ
78496		Heart first pass add-on	ZZZ
78496	TC	Heart first pass add-on	ZZZ
78496	26	Heart first pass add-on	ZZZ
78730		Urinary bladder retention	ZZZ
78730	TC	Urinary bladder retention	ZZZ
78730	26	Urinary bladder retention	ZZZ
88177		Cytp fna eval ea addl	ZZZ
88177	TC	Cytp fna eval ea addl	ZZZ
88177	26	Cytp fna eval ea addl	ZZZ
88185		Flowcytometry/tc add-on	ZZZ

90461		Im admin each addl component	ZZZ
90472		Immunization admin each add	ZZZ
90474		Immune admin oral/nasal addl	ZZZ
90833		Psytx pt&/fam w/e&m 30 min	ZZZ
90836		Psytx pt&/fam w/e&m 45 min	ZZZ
90838		Psytx pt&/fam w/e&m 60 min	ZZZ
91013		Esophgl motil w/stim/perfus	ZZZ
91013	TC	Esophgl motil w/stim/perfus	ZZZ
91013	26	Esophgl motil w/stim/perfus	ZZZ
92547		Supplemental electrical test	ZZZ
92608		Ex for speech device rx addl	ZZZ
92618		Ex for nonspeech dev rx add	ZZZ
92621		Auditory function + 15 min	ZZZ
92627		Eval aud status rehab add-on	ZZZ
92921		Prq cardiac angio addl art	ZZZ
92925		Prq card angio/athrect addl	ZZZ
92929		Prq card stent w/angio addl	ZZZ
92934		Prq card stent/ath/angio	ZZZ
92938		Prq revasc byp graft addl	ZZZ
92944		Prq card revasc chronic addl	ZZZ
92973		Prq coronary mech thrombect	ZZZ
92974		Cath place cardio brachytx	ZZZ
92978		Intravasc us heart add-on	ZZZ
92978	TC	Intravasc us heart add-on	ZZZ
92978	26	Intravasc us heart add-on	ZZZ
92979		Intravasc us heart add-on	ZZZ
92979	TC	Intravasc us heart add-on	ZZZ
92979	26	Intravasc us heart add-on	ZZZ
92998		Pul art balloon repr percut	ZZZ
93320		Doppler echo exam heart	ZZZ
93320	TC	Doppler echo exam heart	ZZZ
93320	26	Doppler echo exam heart	ZZZ
93321		Doppler echo exam heart	ZZZ
93321	TC	Doppler echo exam heart	ZZZ
93321	26	Doppler echo exam heart	ZZZ
93325		Doppler color flow add-on	ZZZ
93325	TC	Doppler color flow add-on	ZZZ
93325	26	Doppler color flow add-on	ZZZ
93352		Admin ecg contrast agent	ZZZ
93462		L hrt cath trnsptl puncture	ZZZ
93463		Drug admin & hemodynamic meas	ZZZ
93464		Exercise w/hemodynamic meas	ZZZ
93464	TC	Exercise w/hemodynamic meas	ZZZ
93464	26	Exercise w/hemodynamic meas	ZZZ
93563		Inject congenital card cath	ZZZ
93564		Inject hrt congntl art/grft	ZZZ
93565		Inject l ventr/atrial angio	ZZZ

93566		Inject r ventr/atrial angio	ZZZ
93567		Inject supr vlv aortography	ZZZ
93568		Inject pulm art hrt cath	ZZZ
93571		Heart flow reserve measure	ZZZ
93571	TC	Heart flow reserve measure	ZZZ
93571	26	Heart flow reserve measure	ZZZ
93572		Heart flow reserve measure	ZZZ
93572	TC	Heart flow reserve measure	ZZZ
93572	26	Heart flow reserve measure	ZZZ
93609		Map tachycardia add-on	ZZZ
93609	TC	Map tachycardia add-on	ZZZ
93609	26	Map tachycardia add-on	ZZZ
93613		Electrophys map 3d add-on	ZZZ
93621		Electrophysiology evaluation	ZZZ
93621	TC	Electrophysiology evaluation	ZZZ
93621	26	Electrophysiology evaluation	ZZZ
93622		Electrophysiology evaluation	ZZZ
93622	TC	Electrophysiology evaluation	ZZZ
93622	26	Electrophysiology evaluation	ZZZ
93623		Stimulation pacing heart	ZZZ
93623	TC	Stimulation pacing heart	ZZZ
93623	26	Stimulation pacing heart	ZZZ
93655		Ablate arrhythmia add on	ZZZ
93657		Tx l/r atrial fib addl	ZZZ
93662		Intracardiac ecg (ice)	ZZZ
93662	TC	Intracardiac ecg (ice)	ZZZ
93662	26	Intracardiac ecg (ice)	ZZZ
94729		Co/membrane diffuse capacity	ZZZ
94729	TC	Co/membrane diffuse capacity	ZZZ
94729	26	Co/membrane diffuse capacity	ZZZ
94781		Car seat/bed test + 30 min	ZZZ
95079		Ingest challenge addl 60 min	ZZZ
95873		Guide nerv destr elec stim	ZZZ
95873	TC	Guide nerv destr elec stim	ZZZ
95873	26	Guide nerv destr elec stim	ZZZ
95874		Guide nerv destr needle emg	ZZZ
95874	TC	Guide nerv destr needle emg	ZZZ
95874	26	Guide nerv destr needle emg	ZZZ
95885		Musc tst done w/nerv tst lim	ZZZ
95885	TC	Musc tst done w/nerv tst lim	ZZZ
95885	26	Musc tst done w/nerv tst lim	ZZZ
95886		Musc test done w/n test comp	ZZZ
95886	TC	Musc test done w/n test comp	ZZZ
95886	26	Musc test done w/n test comp	ZZZ
95887		Musc tst done w/n tst nonext	ZZZ
95887	TC	Musc tst done w/n tst nonext	ZZZ
95887	26	Musc tst done w/n tst nonext	ZZZ

95962		Electrode stim brain add-on	ZZZ
95962	TC	Electrode stim brain add-on	ZZZ
95962	26	Electrode stim brain add-on	ZZZ
95967		Meg evoked each addl	ZZZ
95967	TC	Meg evoked each addl	ZZZ
95967	26	Meg evoked each addl	ZZZ
95973		Analyze neurostim complex	ZZZ
95975		Cranial neurostim complex	ZZZ
95979		Analyz neurostim brain addon	ZZZ
96361		Hydrate iv infusion add-on	ZZZ
96366		Ther/proph/diag iv inf addon	ZZZ
96367		Tx/proph/dg addl seq iv inf	ZZZ
96368		Ther/diag concurrent inf	ZZZ
96370		Sc ther infusion addl hr	ZZZ
96371		Sc ther infusion reset pump	ZZZ
96375		Tx/pro/dx inj new drug addon	ZZZ
96376		Tx/pro/dx inj same drug adon	ZZZ
96411		Chemo iv push addl drug	ZZZ
96415		Chemo iv infusion addl hr	ZZZ
96417		Chemo iv infus each addl seq	ZZZ
96423		Chemo ia infuse each addl hr	ZZZ
96570		Photodynmc tx 30 min add-on	ZZZ
96571		Photodynamic tx addl 15 min	ZZZ
97546		Work hardening add-on	ZZZ
97598		Rmvl devital tis addl 20cm/<	ZZZ
97811		Acupunct w/o stimul addl 15m	ZZZ
97814		Acupunct w/stimul addl 15m	ZZZ
99100		Special anesthesia service	ZZZ
99116		Anesthesia with hypothermia	ZZZ
99135		Special anesthesia procedure	ZZZ
99140		Emergency anesthesia	ZZZ
99145		Mod sedat phys/qhp ea 15 min	ZZZ
99150		Mod sed diff phys/qhp add on	ZZZ
99292		Critical care addl 30 min	ZZZ
99354		Prolonged service office	ZZZ
99355		Prolonged service office	ZZZ
99356		Prolonged service inpatient	ZZZ
99357		Prolonged service inpatient	ZZZ
99359		Prolong serv w/o contact add	ZZZ
99467		Ped crit care transport addl	ZZZ
99489		Complx chron care addl30 min	ZZZ
☐			

XXX = Global concept does not apply.

YYY = Carrier/MAC determines whether global concept applies and establishes postoperative period, if :

ZZZ = Code related to another service is always included in the global period of the other service.

## D – Age

**\*DRAFT – PLEASE DO NOT DISTRIBUTE**

### Rules Committee Recommendation

#### Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

#### Modifier Involved

63 – Procedure performed on infants less than 4 kg

Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005- 69990 code series. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine** sections.<sup>1</sup>

This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

#### Age rule definition

The descriptors or related coding guidelines of certain Current Procedural Terminology(CPT®)<sup>1</sup>/HCPCS procedure codes either specify or imply that there are age-specific parameters associated with that procedure/service.

**Note:** Edits based on the diagnosis codes, either ICD-9 or ICD-10 are not within the scope of the Medical Clean Claims Task Force legislative charge and are not covered by this rule.

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## Coding and adjudication guidelines

There are two ways to code for age-specific restrictions: by CPT code and by the use of modifier 63.

### Age-specific CPT codes

In certain circumstances the reported procedure code has an age-specific restriction associated with it. The following adjudication guidelines are offered to cover the situation where the reported procedure code does not match the reported age of the patient:

- When the reported age of the patient does not match the age-specific parameter of the CPT/HCPCS procedure code either because of the description or related coding guidelines – ACTION: Deny the line with the age-specific code.

Example                    XXXXX, younger than age 12

### Guidelines for use of modifier 63:

- Modifier should be appended only to invasive surgical procedures code range 20005-69990.
- Appropriate to report only for neonates or infants up to a present body weight of 4 kg.
- Used to identify significant increased work intensity related to:
  - Temperature control
  - Obtaining and maintaining intravenous access
  - The operation itself, which is technically more difficult with regard to maintenance of homeostasis
- Examples of appropriate modifier 63 use
  - 33820 Repair of patent ductus arteriosus; by ligation
  - 44120 Enterectomy, resection of small intestine; single resection and anastomosis
  - 44140 Colectomy, partial; with anastomosis
  - 43220 Esophagoscopy, rigid or flexible; with balloon dilation
- Refer to Appendix F in the CPT codebook for CPT codes that are exempt from modifier 63.
- Modifier should not be used with procedures for the correction of congenital abnormalities.
- Modifier should not be used with procedures that include pediatric status in descriptors.
- Modifier should not be used with Evaluation & Management services, anesthesia, radiology, pathology/laboratory or medicine procedures.

### Listing of Status Indicators

No status indicators available.

### Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT<sup>®</sup>)<sup>2</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for age and modifier 63 were selected.

### MCCTF comment

Informational modifier, could lead to a payment adjustment in recognition of the increased complexity.

### Definitions

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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

**Modifier 63 – Procedure performed on infants less than 4 kg**

Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005- 69990 code series. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine** sections.

**Payment indicator definitions**

None available

**Federation outreach**

**American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten for review.

**American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

**American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

**American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to Anne Diamond of ACOG for review.

**Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

**Appendix F – Summary of Current Procedural Terminology (CPT®) Codes Exempt from Modifier 63**

30540	43520
30545	43831
31520	44055
33401	44126
33403	44127
33470	44128
33472	46070
33502	46705
33503	46715
33505	46716
33506	46730
33610	46735
33611	46740
33619	46742
33647	46744
33670	47700
33690	47701
33694	49215
33730	49491
33732	49492
33735	49495
33736	49496
33750	49600
33755	49605
33762	49606
33778	49610
33786	49611
33922	53025
33960	54000
33961	54150
36415	54160
36420	63700
36450	63702
36460	63704
36510	63706
36660	65820
39503	99337
43313	
43314	

**Current Procedural Terminology (CPT®)<sup>1</sup> code descriptors containing  
reference to age**

0260T ( <i>will be deleted</i> <i>1/1/2014</i> )	49492	90958
0260T ( <i>will be deleted</i> <i>1/1/2014</i> )	49495	90959
0260T ( <i>will be deleted</i> <i>1/1/2014</i> )	49496	90960
0260T ( <i>will be deleted</i> <i>1/1/2014</i> )	49500	90961
320	49501	90962
326	49505	90963
561	49507	90964
562	49580	90965
834	49582	90966
836	49585	90967
31520	49587	90968
31525	54000	90969
31601	54001	90970
33822	54150	92601
33824	54160	92602
36400	54161	92603
36405	67229	92604
36406	88014	94011
36410	88029	94012
36420	90460	94013
36425	90461	95782
36440	90644	95783
36450	90655	95810
36455	90656	95811
36460	90657	99100
36510	90658	99143
36555	90696	99144
36556	90700	99145
36557	90702	99148
36558	90714	99149
36560	90715	99150
36561	90732	99170
36568	90951	99381
36569	90952	99382
36570	90953	99383
36571	90954	99384
36660	90955	99385
4014F	90956	99386
49491	90957	99387

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**Current Procedural Terminology (CPT®)<sup>1</sup> code descriptors containing  
reference to age**

99391  
99392  
99393  
99394  
99395  
99396  
99397  
99460  
99461  
99462  
99463  
99464  
99465  
99466  
99467  
99468  
99469  
99471  
99472  
99475  
99476  
99477  
99478  
99479  
99480  
99485  
99486  
99502

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## E – Gender

**\*DRAFT – PLEASE DO NOT DISTRIBUTE**

### Rules Committee Recommendation

#### Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

#### Modifier Involved

The following modifier was recommended to be added to the Gender rule as it is required to be reported by CMS when a procedure code is reported with a description specifically male or female may inappropriately trigger a gender edit.

#### HCPCS Modifier: KX

Requirements specified in the medical policy have been met<sup>1</sup>

#### Gender rule

According to National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services<sup>2</sup>, the descriptor of some Current Procedural Terminology (CPT®)<sup>3</sup>/HCPCS codes includes a gender-specific restriction on the use of the code. CPT/HCPCS codes specific for one gender should not be reported with CPT/HCPCS codes for the opposite gender.

<sup>1</sup> 2013 Alpha-Numeric HCPCS File – updated 11/14/2012

<sup>2</sup> National Correct Coding Initiative Policy Manual for Medicare Services, Chapter I, General Correct Coding Policies, Revision date: January 1, 2013.

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## Coding guidelines

In certain circumstances the reported procedure code implies a gender-specific restriction associated with it. The following adjudication guidelines are offered to cover the situation where the reported procedure code does not match the reported gender of the patient:

- When the reported gender of the patient does not match the CPT/HCPCS procedure code because the description implies a gender-specific restriction – ACTION: Deny the line with the gender-specific code.
  - Example           XXXXX, vaginal delivery  
                          Gender reported is male
- When the reported gender of the patient does not match the CPT/HCPCS procedure code because the description implies a gender-specific restriction, but the procedure is appropriately reported appended with modifier KX – ACTION: Recognize the procedure and code for processing.
  - Example           XXXXX KX, vaginal delivery  
                          Gender reported is male
- When the reported gender of the patient **does** match the CPT/HCPCS procedure code gender-specific restriction description and modifier KX is appended. Please note KX is not a required modifier. ACTION: Recognize the procedure and code for processing.

### Guidelines for use of HCPCS modifier KX

Append the KX modifier on the claim line with any appropriately performed and documented procedure code(s) that are gender specific and may trigger a gender edit. This will alert the payer that the physician or other health care professional is performing a service on a patient for whom gender specific editing may apply, and that the service should be allowed to continue with normal processing.<sup>4</sup>

### Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT®)<sup>5</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT/HCPCS procedure code descriptions implying gender were selected.
- The National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services<sup>6</sup> were reviewed.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

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<sup>4</sup> For Part B claims processing, the KX modifier shall be billed on the detail line with any procedure code(s) that are gender specific. The definition of the KX modifier is: Requirements specified in the medical policy have been met. Use of the KX modifier will alert the MAC that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, but should have such editing by-passed for the beneficiary. The CWF shall override any gender specific edits for procedure codes billed with the KX modifier and allow the service to continue normal processing.

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<sup>6</sup> National Correct Coding Initiative Policy Manual for Medicare Services, Chapter I, General Correct Coding Policies, Revision date: January 1, 2013.

### **MCCTF comment**

ICD-9/10 diagnoses edits are not within the scope of this legislation, and would be allowed with a procedure code edit.

### **Modifier definition**

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

### **HCPCS Modifier: KX**

Requirements specified in the medical policy have been met

### **Payment indicator definitions**

None available

### **Federation outreach**

#### **American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten for review.

#### **American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

#### **American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

#### **American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to Anne Diamond of ACOG for review.

#### **Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

## O - Anesthesia

### Rules Committee Recommendation

#### Anesthesia reporting rule

##### Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

#### Modifier Involved.

##### Medical Direction and Supervision HCPCS Modifiers

AA: Anesthesia services performed personally by anesthesiologist

AD: Medical supervision by a physician – more than 4 concurrent anesthesia procedures

QK: Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals

QX: CRNA service – with medical direction by a physician

QY: Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist

QZ: CRNA service – without medical direction by a physician

#### Physical Status Modifiers<sup>1</sup>

P1: A normal healthy patient

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P2: A patient with mild systemic disease

P3: A patient with severe systemic disease

P4: A patient with severe systemic disease that is a constant threat to life

P5: A moribund patient who is not expected to survive without the operation

P6: A declared brain-dead patient whose organs are being removed for donor purposes

## **22: Increased Procedural Services<sup>2</sup>**

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

## **23: Unusual Anesthesia**

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

## **47: Anesthesia by Surgeon**

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.

## **59: Distinct Procedural Service**

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

## **Anesthesia rule**

Procedures subject to the anesthesia rule are listed in the column labeled STATUS CODE of the Medicare Physician Fee Schedule (MPFS).<sup>3</sup> The anesthesia rule applies to procedure codes that are listed in the column labeled STATUS CODE of the MPFS with an indicator of J.

This type of edit identifies incorrect billing for anesthesia services provided by the anesthesiology professional, including but not limited to, general or regional anesthesia, monitored anesthesia

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<sup>2</sup> Copyright 2013. American Medical Association. All rights reserved.

<sup>3</sup> References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.

care, or other medical services delivered to achieve optimal patient care. An anesthesiology professional refers to an Anesthesiologist, a Certified Registered Nurse Anesthetist (CRNA), Anesthesiologist Assistant (AA), or other qualified individual working independently or under the medical supervision of a physician.

All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100 – 01999) with the appropriate physical status modifier appended.

All anesthesia services are reported with the appropriate modifier to indicate if the procedure was personally performed, medically directed, or medically supervised, including services performed by teaching or student anesthesiologists or CRNAs.

Other edits, such as unbundling, rebundling, or maximum frequency per day, may apply. The applicable modifier must be appended when appropriate.

### **Coding and adjudication guidelines**

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (eg, ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). Unusual forms of monitoring (eg, intra-arterial, central venous, and Swan-Ganz) are not included.

Use Modifier 47 to report regional or general anesthesia provided by a physician also performing the services for which the anesthesia is being provided.

### **Time**

Time for anesthesia procedures may be reported as is customary in the local area. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room (or in an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

### **Supplied Materials**

Supplies and materials provided (eg, sterile trays, drugs) over and above those usually included with the office visit or other services rendered may be listed separately.

### **Separate or Multiple Procedures**

When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures.

## **Rationale**

The following rationale was used to formulate the Rule Committee Recommendation:

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions and guidelines for anesthesia codes were selected.

- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual<sup>4</sup> were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

### **MCCTF comment**

No anesthesia specific edits were identified, they are captured under the “Unbundle” category Consensus on 3/28/12

### **Modifier/Edit definitions**

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*

### **Anesthesia indicator definitions**

The following are indicator definitions that are outlined in the MPFS in the column labeled STATUS CODE<sup>5</sup>.

**J = Anesthesia services.** (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)

### **Federation outreach**

#### **American Society of Anesthesiology (ASA)**

This recommendation was sent to Sharon Merrick for review.

#### **American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten for review.

#### **American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

#### **American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

#### **American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to Anne Diamond of ACOG for review.

#### **Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

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<sup>4</sup> Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

<sup>5</sup> Information taken from “[How to Use the Searchable Medicare Physician Fee Schedule \(MPFS\)](#)”, Centers for Medicare & Medicaid Services.

## B – Mutually Exclusive

### Rules Committee Recommendation

#### Mutually Exclusive reporting rule

##### Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

##### Modifiers Involved

25, 59 (see definitions below)

### Mutually Exclusive rule

The mutually exclusive edit table includes several Colorado Clean Claim Task Force rules: including gender, add-on codes, incident to-services, total, professional and technical components, and anesthesia.

The mutually exclusive edit table can be created from the publically available online tables<sup>1</sup> or from tables that can be purchased from the National Technical Information Service (NTIS)<sup>2</sup>. See Appendix A for the mutually exclusive table.

Examples: An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an initial service or a subsequent service.

<sup>1</sup> NCCI edits utilized for practitioner claims (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>); NCCI edits utilized for outpatient hospital claims in the Outpatient Code Editor (OCE) (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>) Current quarterly version update changes for NCCI edits and published MUEs ([http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version\\_Update\\_Changes.html](http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html))

<sup>2</sup> The NCCI Edits Manual may also be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) website located in the "Related Links Outside CMS" section below, or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

With the exception of drug administration services, the initial service and subsequent service cannot be reported at the same beneficiary encounter. A third example is when the descriptor of a Current Procedural Terminology (CPT®)<sup>3</sup>/HCPCS code includes a gender-specific restriction on the use of the code. For CPT/HCPCS codes specific for one gender, the HCPCS/CPT code should not be reported for the opposite gender.

### **Coding and adjudication guidelines**

Modifier 59 is used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances. This modifier should be used only if there is not a more descriptive modifier available, and the use of modifier 59 best explains the circumstances.

The mutually exclusive edit table contains edits consisting of two codes (procedures) which cannot reasonably be performed together based on the code definitions or anatomic considerations. Each edit consists of a column 1 and column 2 code. If the two codes of an edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a CCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed.

#### **Separate Procedure**

- Some of the procedures or services listed in the CPT nomenclature that are commonly carried out as an integral component of a total service or procedure have been identified by including the term “separate procedure”.
- Codes designated as separate procedures should not be reported in addition to the code for the total procedure or service of which it is considered an integral component
- Examples of CPT codes with “separate procedure” in the code description.
  - 29870—Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
  - 38780—Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)
  - 44312—Revision of ileostomy; simple (release of superficial scar) (separate procedure)

CPT codes which are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. These codes are not necessarily linked to one another with one code narrative describing a more comprehensive procedure compared to the component code, but can be identified as code pairs which should not be billed together.

#### **Assigned modifier indicators in the National Correct Coding Initiative (NCCI)**

- “0” An NCCI-associated modifier cannot be used to bypass the edit
- “1” An NCCI-associated modifier may be used to bypass the edit if it meets the criteria under appropriate circumstances
- “9” Edit deleted on the same date as when it became effective

### **Rationale**

The following rationale was used to formulate the Rule Committee Recommendation:

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- The Current Procedural Terminology (CPT®)<sup>4</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptors for modifiers 25 and 59 were selected.
- The NCCI mutually exclusive code pairs were reviewed and selected.

#### **MCCTF comment**

Appropriate modifier as defined by CPT or HCPCS may be reported to override this type of edit.

#### **Modifier/Edit definitions**

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.

*Consensus on 3/28/12*

#### **Modifier 25: Significantly, separately identifiable E/M services by the same physician on the same day of the procedure or other service**

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

#### **Modifier 59: Distinct Procedural Service**

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

#### **Mutually Exclusive indicator definitions**

The following are indicator definitions that are outlined in the NCCI edit table were used.

**0** = Not allowed.

**1** = Allowed.

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9 = Not applicable.

### **Federation outreach**

#### **American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten for review.

#### **American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

#### **American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

#### **American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to Anne Diamond of ACOG for review.

#### **Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

## G - Global Surgery Days/Package

**\*DRAFT – PLEASE DO NOT DISTRIBUTE**

**\*Some portions of this document are up for discussion at the CPT Panel meeting and may be subject to change pending discussions with CMS.**

### Rules Committee Recommendation

#### Global Surgery Days/package reporting rule

##### Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Payers and providers are encouraged to reach an agreement regarding specific additional documentation that must be submitted with a claim when the rule states documentation may be required by the payer.

##### Modifiers involved

24, 25, 54, 55, 56, 57, 58, 78, 79 (see below for definitions)

This rule is applicable for the specific situations identified for these modifiers. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

### Global Surgery rule definition

The number of days assigned to the Current Procedural Terminology (CPT®)<sup>1</sup>/HCPCS procedure codes in the column labeled GLOBAL DAYS of the Medicare Physician Fee Schedule (MPFS)<sup>2</sup> will be utilized to identify the post-operative period associated with the procedure.

<sup>1</sup> Copyright 2013 American Medical Association. All rights reserved.

<sup>2</sup> References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.

- The global surgery rule applies to procedure codes listed in the column labeled GLOBAL DAYS of the MPFS with indicators of 000, 010, 090 and sometimes YYY.
- The global surgery rule is excluded from procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of XXX.
- The global surgery rule is excluded from procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of MMM, as they are maternity codes and are excluded from the usual global surgery days/package. For more information on maternity codes, view the Global Maternity Care reporting rule.
- The global surgery rule does not apply to procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of ZZZ. These codes are related to another service and are always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post-service time.)
- **Duration of the Global Surgical Period**
  - Zero days (Typically endoscopies or minor surgeries) – There is no preoperative or postoperative period for endoscopies and minor surgeries. Visits on the same day of the procedure are generally included in the allowance for the procedure, unless a significant, separately identifiable service is also performed and reported with the appropriate modifier.
  - 10 days (Typically other minor surgeries) – There is no preoperative period for other minor surgeries and visits on the same day or 10 days after the procedure are generally not allowed as a separate service unless a significant and, separately identifiable service is also performed and reported with the appropriate modifier. The postoperative period is 10 days immediately following the day of surgery.
  - 90 days (Typically major surgeries) - The preoperative period for major surgeries is the day immediately prior to the day of the surgery, and the postoperative period is 90 days immediately following the day of surgery. Services provided on the day of surgery but prior to the surgery are considered preoperative, while services furnished on the same day but after the surgery are considered postoperative.
    - An evaluation and management service within the preoperative period that results in the decision for surgery is reportable with the appropriate modifier appended to the E/M code.
    - Significant and separately identifiable, unrelated evaluation and management work provided within the global period is reportable with the appropriate modifier appended to the E/M code.
- See Coding and adjudication guidelines below for modifiers that override the global surgery rule.
- **Surgical Package**  
The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services “included” in a given CPT surgical code, the following services are always included in addition to the operation per se:
  - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
  - Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical);

- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the postanesthesia recovery area;
- Postsurgical Pain Management by the surgeon;
- Complications directly related to the surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room, or are not related to other medical conditions of the patient;
- Typical postoperative follow-up care during the global period of the surgery that are related to recovery from the surgery;
- Supplies - Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

From a CPT coding perspective, this definition indicates that when a surgical procedure is reported with a CPT code, the items listed in that guideline are included (if performed) and are not reported separately. Since patients may have other disease(s) or injury(s) or may have undergone other diagnostic and/or therapeutic procedure(s), certain variables may impact reporting, and include: The type of procedure performed; The place where the surgery occurs; The time (during hospitalization) the surgery is performed; The insurance contract of each individual patient.

Therefore, because it is not possible to address all of these variables in each code descriptor, only the preoperative E/M service related to the procedure performed on the date immediately before the procedure (including the history and physical) is stated as inclusive of the CPT surgical package definition. It is important to note that this included E/M encounter must occur subsequent to the E/M encounter at which the decision for surgery was reached. For example, the E/M service is separately reported when a physician performs an office E/M service, and at that visit it is determined that surgery is necessary. The appropriate modifier must be appended.

## **Coding and adjudication guidelines**

In certain circumstances it is appropriate to report additional medical or surgical services provided during the global surgical period. The following modifiers appended to the procedure code are used to identify these:

- **Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period.** The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during the postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service
- **Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.** It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated

with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines in the CPT codebook for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used in conjunction with a major surgical procedure (one that has 90 days postoperative follow up) to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

- Modifier 54: Surgical Care Only. When one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure code.
- Modifier 55: Postoperative Management Only. When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure code.
- Modifier 56: Preoperative Management Only. When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure code.
- Modifier 57, Decision for Surgery, is used to indicate that an evaluation and management service resulted in the initial decision to perform the surgery. Use of this modifier is limited to procedures with 90-day global periods.
- Modifier 58: Staged or Related Procedure or Service by the same Physician or Other Qualified Health Care Professional During the Postoperative Period. The use of the modifier 58 enables the payers to appropriately pay for the procedure per se and other associated postoperative services performed by the original surgeon or provider within or subsequent to its assigned global period (eg, 0 days, 10 days, 90 days). Modifier 58 is used to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure.
- Modifier 76, Repeat Procedure or Service by Same Physician, is used to indicate that a procedure or service was repeated subsequent to the original procedure or service in a separate operative session by the same physician.
- Modifier 78, Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period. When a procedure is related to the first (but not a repeat procedure) and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.

- Modifier 79, Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period. When a procedure or service performed during the postoperative period was unrelated to the original procedure, this circumstance is communicated by appending the modifier 79 to the unrelated procedure.

Refer to the CPT Surgical Package Definition for a listing of the elements that are included in the surgical package.

Care that can be separately reported and is not a part of the surgical package includes:

- Care of the condition for which a diagnostic procedure was performed or a concomitant condition
- Complications, exacerbations recurrence, or the presence of other diseases or injuries requiring additional services.

See Chapter 12, Sections 40.1-40.3 of the Medicare Claims Processing Manual<sup>3</sup> for further instruction including:

- Carrier edits
- Billing requirements

For services not subject to the global surgical package, see the following:

- CPT code set, Follow –Up Care for Diagnostic Procedures, page 58 and Follow-Up Care for Therapeutic Surgical Procedures, page 58 of the CPT codebook.
- Medicare Claims Processing Manual, Chapter 12, 40.1, B – Services Not Included in the Global Surgical Package.

## **Rationale**

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT<sup>®</sup>)<sup>4</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for global surgery and associated modifiers were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual<sup>5</sup> were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

## **MCCTF comment**

The legislative intent was not to limit the edit to just the number of days, but also to address the global surgery package.

<sup>3</sup> Chapter 12 – Physician/Nonphysician Practitioners. *Medicare Claims Processing Manual*, Publication # 100-04

<sup>4</sup> Copyright 2013 American Medical Association. All rights reserved.

<sup>5</sup> Chapter 12 – Physician/Nonphysician Practitioners. *Medicare Claims Processing Manual*, Publication # 100-04.

### MCCTF definition

Physician may need to indicate a procedure or service was repeated subsequent to the original procedure or service

### Description

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

## **Additional definitions**

### **Intraoperative Services**

All intraoperative services that are normally included as a necessary part of a surgical procedure are included in the global package.

### **Preservice, intraservice and postservice work**

The work involved in actually providing a service or performing a procedure is termed "intraservice work." For office visits, the intraservice period is defined as patient encounter time; for hospital visits, it is the time spent on the patient's floor; and for surgical procedures, it is the period from the initial incision to the closure of the incision. (ie, "skin-to-skin" time).

Work prior to and following provision of a service, such as surgical preparation time, writing or reviewing records, or discussion with other physicians, is referred to as "pre-service and post-service work." When preservice, intra-service, and postservice work are combined, the result is referred to as the "total work" involved in the service. For surgical procedures, the total work period is the same as the global surgical period, including recovery room time, normal postoperative hospital care, and office visits after discharge, as well as preoperative and intraoperative work.

## **Payment indicator definitions**

The following are payment indicator definitions that are outlined in the column labeled GLOBAL of the MPFS for Global Surgery<sup>6</sup>. This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

**000** = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; initial evaluation and management services on the day of the procedure are payable with proper documentation showing that the evaluation and management service was necessary for the diagnosis/treatment.

**010** = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

**090** = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

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<sup>6</sup> Information taken from "How to Use the Searchable Medicare Physician Fee Schedule (MPFS)", Centers for Medicare & Medicaid Services", Centers for Medicare & Medicaid Services.

**MMM** = Maternity codes; usual global period does not apply.

**XXX** = Global concept does not apply.

**YYY** = Carrier/MAC determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

**ZZZ** = Code related to another service is always included in the global period of the other service.

## **Federation outreach**

### **American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten and Joanne Willer for review.

### **American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

### **American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

### **American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to James Scroggs and Anne Diamond of ACOG for review. ACOG responded that there are no procedures that are performed by ob-gyns that would have any deviation from the Rules Committee draft recommendation. The document reflects standard edits supported by CPT and CMS. The pre- and post-operative global periods are already defined for the procedures as listed in CPT. The document is consistent with what ACOG teaches in their Coding Workshops.

### **American Society of Anesthesiology (ASA)**

This recommendation was sent to Sharon Merrick. Sharon indicated that anesthesia is not allowed under the CMS global surgery package and had nothing to bring forward.

### **Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

# G – Global Surgery/Days/Package

\*DRAFT – PLEASE DO NOT DISTRIBUTE

## Appendix A - To be added to Data Sustaining Repository

### Rationale

The following rationale was used to formulate the Rules Committee Recommendation:

- The Current Procedural Terminology (CPT<sup>®</sup>)<sup>7</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for global surgery and the modifiers listed were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy, as identified in the Medicare Physician Fee Schedule (MPFS) and the Medicare Claims Processing Manual<sup>8</sup>, were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

### Exceptions

At the time of the initial review, the following exceptions were identified. This may not be a comprehensive listing of appropriate exceptions.

For services not subject to the global surgical package, see the following:

- CPT code set, Follow –Up Care for Diagnostic Procedures, page 58 and Follow-Up Care for Therapeutic Surgical Procedures, page 58 of CPT codebook.
- Medicare Claims Processing Manual, Chapter 12, 40.1, B – Services Not Included in the Global Surgical Package.

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<sup>8</sup> Chapter 12 – Physician/Nonphysician Practitioners, Medicare Claims Processing Manual, Publication # 100-04.

## H – Place of Service

**\*DRAFT – PLEASE DO NOT DISTRIBUTE**

### **Rules Committee Recommendation**

#### **Context**

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

#### **Modifier Involved**

No modifiers

#### **Place of Services rule**

This type of edit will identify incorrect billing of a professional service when the Current Procedural Terminology (CPT<sup>®</sup>)<sup>1</sup>/HCPCS descriptor of the service/procedure codes do not match the place service reported on the claim.  
Consensus on 3/28/12

See Appendix A: National Place of Service Definitions for the complete current National POS code set with facility and nonfacility designations noted for Medicare payment for services on the Physician Payment Schedule.<sup>2</sup>

#### **Coding and adjudication guidelines**

The appropriate Place of Service (POS) code should be added to the professional claim to indicate the setting in which a service was provided.

See Appendix A: National Place of Service Definitions for the current National POS code set with facility and nonfacility designation noted for Medicare payment for services on the Physician Payment Schedule.

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<sup>2</sup> Medicare RBRVS The Physician's Guide, 2013. American Medical Association.

Correct coding requires that an appropriate POS code be added. If not coded appropriately – ACTION: Deny the line(s), or adjudicate one line with correct POS code.

### **Rationale**

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT<sup>®</sup>)<sup>3</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CMS descriptions for POS codes were selected.
- The Centers for Medicare and Medicaid Services (CMS) National Place of Service Definitions were selected.

### **MCCTF comment**

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.

### **Definition**

This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of the service/procedure codes do not match the place service reported on the claim. Consensus on 3/28/12

### **Payment indicator definitions**

See Appendix A: National Place of Service Definitions for the current National POS code set with facility and nonfacility designation noted for Medicare payment for services on the Physician Payment Schedule.

### **Federation outreach**

#### **American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten for review.

#### **American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

#### **American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

#### **American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to Anne Diamond of ACOG for review.

#### **Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

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### National Place of Service Definitions

The following is the current National Place of Service (POS) code set with facility and nonfacility designations noted for Medicare payment for services on the Physician Payment Schedule:

POS Code/Name Description	Payment Rate Facility = F Nonfacility = NF
<b>01/Pharmacy</b> A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.	NF
02/Unassigned	—
<del>03/School</del> <del>A facility whose primary purpose is education.</del>	<del>NF</del> 
<del>04/Homeless Shelter</del> <del>A facility or location whose primary purpose is to provide temporary housing to homeless individuals (eg, emergency shelters, individual or family shelters).</del>	<del>NF</del>
<del>05/Indian Health Service Free-standing Facility</del> <del>A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.</del>	<del>Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA</del>
<del>06/Indian Health Service Provider-based Facility</del> <del>A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.</del>	<del>Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA</del>
<del>07/Tribal 638 Free-standing Facility</del> <del>A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization.</del>	<del>Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA</del>
<del>08/Tribal 638 Provider-based Facility</del> <del>A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.</del>	<del>Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA</del>
<del>09/Prison—Correctional Facility</del> <del>A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either federal, state, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.</del>	NF
10/Unassigned	—

(continued)

<p style="text-align: center;"><b>POS Code/Name</b> Description</p>	<p style="text-align: center;"><b>Payment Rate</b> Facility = F Nonfacility = NF</p>
<p><b>11/Office</b> Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.</p>	NF
<p><b>12/Home</b> Location, other than a hospital or other facility, where the patient receives care in a private residence.</p>	NF
<p><b>13/Assisted Living Facility</b> Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.</p>	NF
<p><b>14/Group Home</b> (Description Revised Effective April 1, 2004) A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (eg, medication administration).</p>	NF
<p><b>15/Mobile Unit</b> A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.</p>	NF
<p><del><b>16/Temporary Lodging</b> A short-term accommodation such as a hotel, camp ground, hostel, cruise ship, or resort where the patient receives care and which is not identified by any other POS code.</del></p>	<del>NF</del>
<p><b>17/Walk-in Retail Health Clinic</b> A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.</p>	NF
<p><b>18/Place of Employment Worksite</b> (No later than May 1, 2013) A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.</p>	NF
<p>19/Unassigned</p>	—
<p><b>20/Urgent Care Facility</b> Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.</p>	NF
<p><b>21/Inpatient Hospital</b> A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.</p>	F
<p><b>22/Outpatient Hospital</b> A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</p>	F

<p style="text-align: center;"><b>POS Code/Name</b> Description</p>	<p style="text-align: center;"><b>Payment Rate</b> Facility = F Nonfacility = NF</p>
<p><b>23/Emergency Room-Hospital</b> A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.</p>	F
<p><b>24/Ambulatory Surgical Center</b> A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.</p>	<p><b>F (Note: pay at the nonfacility rate for payable procedures not on the ASC list)</b></p>
<p><b>25/Birthing Center</b> A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.</p>	NF
<p><b>26/Military Treatment Facility</b> A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former US Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).</p>	F
<p>27-30/Unassigned</p>	—
<p><b>31/Skilled Nursing Facility</b> A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.</p>	F
<p><b>32/Nursing Facility</b> A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.</p>	NF
<p><b>33/Custodial Care Facility</b> A facility which provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.</p>	NF
<p><b>34/Hospice</b> A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.</p>	F
<p>35-40/Unassigned</p>	—
<p><b>41/Ambulance—Land</b> A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.</p>	F
<p><b>42/Ambulance—Air or Water</b> An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.</p>	F
<p>43-48/Unassigned</p>	—
<p><b>49/Independent Clinic</b> A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.</p>	NF

(continued)

<p style="text-align: center;"><b>POS Code/Name</b> Description</p>	<p style="text-align: center;"><b>Payment Rate</b> Facility = F Nonfacility = NF</p>
<p><b>50/Federally Qualified Health Center</b> A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.</p>	NF
<p><b>51/Inpatient Psychiatric Facility</b> A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.</p>	F
<p><b>52/Psychiatric Facility—Partial Hospitalization</b> A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.</p>	F
<p><b>53/Community Mental Health Center</b> A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.</p>	F
<p><b>54/Intermediate Care Facility/Mentally Retarded</b> A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.</p>	NF
<p><b>55/Residential Substance Abuse Treatment Facility</b> A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.</p>	NF
<p><b>56/Psychiatric Residential Treatment Center</b> A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.</p>	F
<p><b>57/Non-residential Substance Abuse Treatment Facility</b> A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.</p>	NF
<p>58-59/Unassigned</p>	—
<p><b>60/Mass Immunization Center</b> A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall but may include a physician office setting.</p>	NF
<p><b>61/Comprehensive Inpatient Rehabilitation Facility</b> A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.</p>	F

<p style="text-align: center;"><b>POS Code/Name</b> Description</p>	<p style="text-align: center;"><b>Payment Rate</b> Facility = F Nonfacility = NF</p>
<p><b>62/Comprehensive Outpatient Rehabilitation Facility</b> A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.</p>	NF
<p>63-64/Unassigned</p>	—
<p><b>65/End-Stage Renal Disease Treatment Facility</b> A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.</p>	NF
<p>66-70/Unassigned</p>	—
<p><b>71/State or Local Public Health Clinic</b> A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.</p>	NF
<p><b>72/Rural Health Clinic</b> A certified facility, which is located in a rural medically underserved area, that provides ambulatory primary medical care under the general direction of a physician.</p>	NF
<p>73-80/Unassigned</p>	—
<p><b>81/Independent Laboratory</b> A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.</p>	NF
<p>82-98/Unassigned</p>	—
<p><b>99/Other Place of Service</b> Other place of service not identified above.</p>	NF

## F – Maximum Frequency Per Day

**\*DRAFT – PLEASE DO NOT DISTRIBUTE**

### Rules Committee Recommendation

#### Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Payers and providers are encouraged to reach an agreement regarding specific additional documentation that must be submitted with a claim when the rule states documentation may be required by the payer.

#### Modifier Involved

Modifier 59, 76, or 91 (see definitions below)

#### Maximum Frequency Per Day rule

This type of edit will identify incorrect billing of a professional service when the Current Procedural Terminology (CPT<sup>®</sup>)<sup>1</sup>/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

The maximum frequency per day (MFD) value is the number of units that are eligible for payment on a single date of service, but may be subject to the application of other rules, as appropriate.

#### Coding and adjudication guidelines

In certain circumstances, the reported procedure code descriptor may have a maximum frequency restriction associated with it.

Therefore, the rule applies whether a physician or other health care professional submits one CPT or HCPCS code with multiple units on a single claim line or multiple claim lines with one or

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more unit(s) on each line. Regardless, when a code is reported with units that exceed the maximum frequency restriction the code will be pended or denied.

There may be situations where a physician or other healthcare professional reports units accurately and those units exceed the established MFD value. In such cases, an adjustment may be considered, if reported with an appropriate modifier such as modifier 59, 76, or 91.

### **Rationale**

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT<sup>®</sup>)<sup>2</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for maximum frequency per day were selected.

### **MCCTF comment**

Frequency limitations spanning a period of time will be addressed separately, including MUEs.

### **Modifier definition**

#### **Modifier 59 - Distinct Procedural Service**

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different size or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used.

#### **Modifier 76 - Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional**

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.

#### **Modifier 91 - Repeat Clinical Diagnostic Laboratory Test**

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

### **Payment indicator definitions**

None available

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## **Federation outreach**

### **American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten for review.

### **American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

### **American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

### **American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to Anne Diamond of ACOG for review.

### **Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

## M –Professional and Technical Component Rule

**\*DRAFT – PLEASE DO NOT DISTRIBUTE**

### Rules Committee Recommendation

#### Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

#### Modifiers Involved

26, TC (see definitions below)

#### Modifier definition

##### Modifier 26: Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.<sup>1</sup>

##### Modifier TC: Technical Component

Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure or service code.

This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

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## Professional and Technical component (PCTC) rule

Procedures subject to the Professional and Technical component rule as listed in the Medicare Physician Fee Schedule (MPFS) column labeled PCTC.<sup>2</sup>

Professional Component (26) and Technical component (TC) adjustments apply to procedure codes with an indicator of 1.

Professional Component (26) adjustments apply to procedure codes with an indicator of 6 or 8. The total procedure or TC component cannot be reported. It is inappropriate and unnecessary to append a TC.

Professional Component (26) and Technical component (TC) adjustments do not apply to procedure codes with indicators of 0, 2, 3, 4, 5, 7 or 9. It is inappropriate and unnecessary to append a PC (26) or TC.

It is inappropriate to append a Professional Component (26) or Technical component (TC) modifier to global services.

## Coding guidelines

Because Current Procedural Terminology(CPT®)<sup>3</sup> codes are intended to represent physician and other health care practitioner services, the CPT nomenclature does not contain a coding convention to designate the technical component for a procedure or service. CPT coding does provide modifier 26, Professional component for separately reporting the professional (or physician) component of a procedure or service. This is because a hospital or other entity may be reporting the technical component of the procedure. The HCPCS Level II modifier TC is used to differentiate the professional versus technical components of the service provided.

Unmodified CPT codes are intended to describe both the technical and professional components of a service. When the professional component and technical component are provided for the same patient on the same day by the same physician, the global charge would be reported. If the technical and professional components of the service are performed by the same provider, it is not appropriate or necessary to report the components of the service separately.

## Professional versus Technical Component

Certain procedures described by the CPT code set are a combination of a professional (physician) component and a technical component (ie, diagnostic tests that involve a physician's interpretation, such as cardiac stress tests, electroencephalograms, or physician pathology services).

## PCTC Indicators

The MPFS provides ten status indicators (0,1, 2, 3, 4, 5, 6, 7, 8 and 9) used to identify procedure codes for TC and PC

- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 0 are not subject to the PCTC rule.
- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 1 are subject to the PCTC rule.

<sup>2</sup> References to the Medicare Physician Fee Schedule (MPFS) made in this document refer to the MPFS Relative Value File. Visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.

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- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 2 are not subject to the PCTC rule.
- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 3 are not subject to the PCTC rule.
- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 4 are not subject to the PCTC rule.
- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 5 are not subject to the PCTC rule.
- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 6 are subject to the PCTC rule for PC adjustment only.
- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 7 are not subject to the PCTC rule.
- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 8 are subject to the PCTC rule for PC adjustment only.
- Procedure codes outlined in the column labeled PCTC of the MPFS with a status indicator of 9 are not subject to the PCTC rule.

### **Rationale**

The following rationale was used to formulate the Rule Committee Recommendation:

- The Current Procedural Terminology (CPT<sup>®</sup>)<sup>4</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for modifier 26 and Technical Component (TC) were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual<sup>5</sup> were reviewed.

### **MCCTF comment**

HCPCS modifier TC would be appended according to HCPCS 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 fee schedule for PC & TC is considered a payment issue and out of scope of the Task Force.

This type of edit will identify incorrect billing of a procedure code that are either not eligible for the professional, technical split, or incorrectly identifies the professional or technical component.  
Consensus on 3/28/12

### **Professional Component (PC)/Technical component (TC) indicator definitions**

The following are indicator definitions that are outlined in the MPFS in the column labeled PCTC for the Professional Component and the Technical Component<sup>6</sup>.

**0 = Physician service codes.** This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers -26 and TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense, and malpractice expense. There are some

<sup>4</sup> Copyright 2013 American Medical Association. All rights reserved.

<sup>5</sup> Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

<sup>6</sup> Information taken from “How to Use the Searchable Medicare Physician Fee Schedule (MPFS)”, Centers for Medicare & Medicaid Services.

codes with no work RVUs.

**1 = Diagnostic tests or radiology services.** This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers -26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

**2 = Professional component only codes.** This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers -26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

**3 = Technical component only codes.** This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers -26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

**4 = Global test only codes.** This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers -26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

**5 = Incident to codes.** This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers/MACs for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers -26 and TC cannot be used with these codes.

**6 = Laboratory physician interpretation codes.** This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician, work, practice expense, and malpractice expense.

**7 = Private practice therapist's service.** Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

**8 = Physician interpretation codes.** This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for a hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the Prospective Payment System (PPS) rate. No payment is recognized for

code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

**9 = Concept of a professional/technical component does not apply.**

### **Federation outreach**

#### **American Academy of Orthopaedic Surgeons (AAOS)**

This recommendation was sent to Matt Twetten for review.

#### **American College of Radiology (ACR)**

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

#### **American College of Surgeons (ACS)**

This recommendation was sent to Jennifer Jackson for review.

#### **American Congress of Obstetricians and Gynecologists (ACOG)**

This draft proposal was sent to Anne Diamond of ACOG for review.

#### **Federation Payment Policy Workgroup**

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

DRAFT

## 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)