



COLORADO HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Clean Claims Rules and Edits

Background:

During the 2010 legislative session Colorado's lawmakers passed, by a wide bipartisan margin, HB10-1332 which instructed that a Task Force of a broad based set of stakeholders be formed to develop a uniform set of claim edits that would subsequently be adopted by all payers having contracts with providers in Colorado.

To this end a group of approximately 25 experts including national representatives from many health plans, vendors of software and providers came together voluntarily to deliberate. This group is now approximately 38 months into a 4 year project. This fully transparent process has solicited input from all stake holders, works by consensus and continues to add members.

There are currently four committees that are undertaking the work of the taskforce on behalf of the full MCCTF. They are tasked with the following:

- Edit Committee: To examine the edits and associated rules, concepts and methodologies contained in national sources and national source guidelines; assessing their applicability to private health plan claims processing; and making recommendations to the task force on the claims edits to be included in the standardized set.
- Rules Committee: To develop and make recommendations to the task force concerning coding scenarios that is unique and eligible for differentiated payment.
- External Engagement Committee: To liaison between the task force and the AMA's Federation of Medicine, which includes 122 national specialty societies and 50 state medical societies in order to assess if public ode edit and payment policy libraries meet the needs of national medical societies and state medical associations by reaching out and obtaining feedback from these groups.
- Data Sustaining Repostiory Committee: To recommend to the task force how the standardized set will be maintained, updated and sustained.

All of these committees "touch" the process described below at various points. The description below describes the process for and oversight of public comments. We believe that this provides ample opportunity for public comment and for MCCTF review and vetting.

It is recommended that the process developed by the MCCTF be used to continue the work that will be required to test and maintain the data set and rules presented to under this legislation. As technology and the nomenclature required under HIPAA for health care transactions evolves the edits sets created will need to be maintained. Additional rules may be desired with changes in the system and medical technology. The following description of the processes used by the task force is intended as a template for the continued development and maintenance of this Rule set designed to simplify the payment of medical claims as directed by section 10109 of the Affordable Care Act.

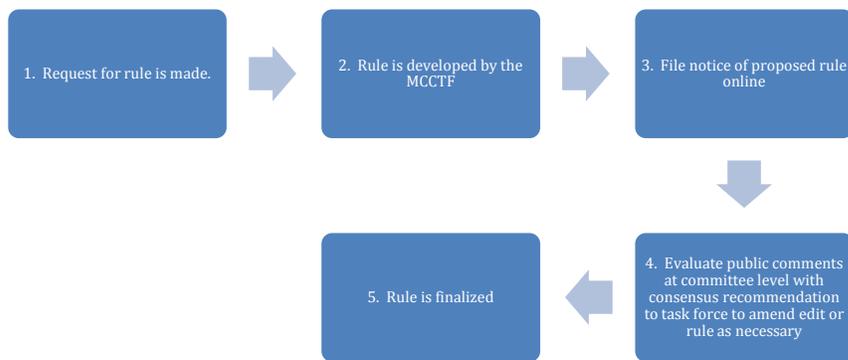
The MCCTF emphatically believes that a permanent entity similar to the existing task force representing all parties affected by the rule set function as the core decision-making body should be created with respect both rules and edits. This recommendation reflects that belief.

Definition of terms/glossary:

Please see attached Glossary of terms (Pages 8 - 10)

Development of Rules:

The MCCTF has created rules sets based on the Act to be applied to claims submitted in the state of Colorado. The rules have been initially developed with input from the members of the task force. Rules have been released for public comment in four separate bundles. Public comment has been received and responded to under the following format and guidance. It is recommended that a similar format be used to address new rule requests.



1. Rule is requested:
 - Rules may be requested by affected parties or legislation, principally health plans.
2. Proposed rule is developed and/or reviewed by the MCCTF:
 - Requests for a rule will be vetted by the MCCTF Rules Committee and either determined to be actionable or rejected for inclusion in the rule set based on the following:
 - The rule is within the scope of the legislation
 - The rule can be defined and sources are available to develop effective edits in accordance with the acceptable data sets.
 - The rule is not in conflict with or covered by existing rules.
 - If the request for the rule is determined to be actionable by the MCCTF, the MCCTF will develop the rule through attempted consensus among the members in accordance with the rules template. In lieu of consensus a simple majority vote of the members will serve as adequate for publication of the final rule.
 - No requested rule by a stakeholder may be arbitrarily rejected without due consideration if it is deemed within the scope of the Act.
3. File notice of the proposed rule online:
 - The notice will be posted on the MCCTF website and electronic notification will be sent to the interested parties alerting them.

- Initially identify “interested” parties by utilizing the communication networks of the Colorado Association of Health Plans, Colorado Medical Society, American Medical Association, and vendor organizations. Additionally notification will be sent to Health & Human Services, the Colorado Division of Insurance, Colorado Division of Workers Compensation, and Colorado Health Care Policy and Finance. Need to have an official method of notifying Payers Division of Insurance, Insurance commissioner (we have the big players on the committee but ..) in the list.
 - A sign up place will be added to the MCCTF website for interested parties to request/receive direct notification of future proposed rules.
- a. Notification should include enough information for the public to understand the proposed rule, its potential impact, and the decision making process the MCCTF used to arrive at the recommendation:
- Edit/payment rule name and definition;
 - Associated modifiers;
 - Rule logic description (including a payment rule hierarchy where there are multiple sources as well as date tracking);
 - Rationale for the rule;
 - Administrative guidelines for handling special billing situations;
 - Specialty Society comments as available;
 - Initial Edit set; and,
 - A summary of the Task Force workgroup recommendation/decision.
- b. Provide information on how to submit comments and by when:
- Take comments only by electronic submission to the MCCTF e-mail address, provide an automatic acknowledgement receipt with an indication of the next steps/timeframe.
 - Identify what format the comments should be in and the type of rationale/information necessary for a complete evaluation.
 - Commenter should provide a contact person in case more information is needed. *For the initial review process a 30-day comment period is deemed sufficient; a second review opportunity for input occurs before the final implementation date.*

4. Evaluation of comments:

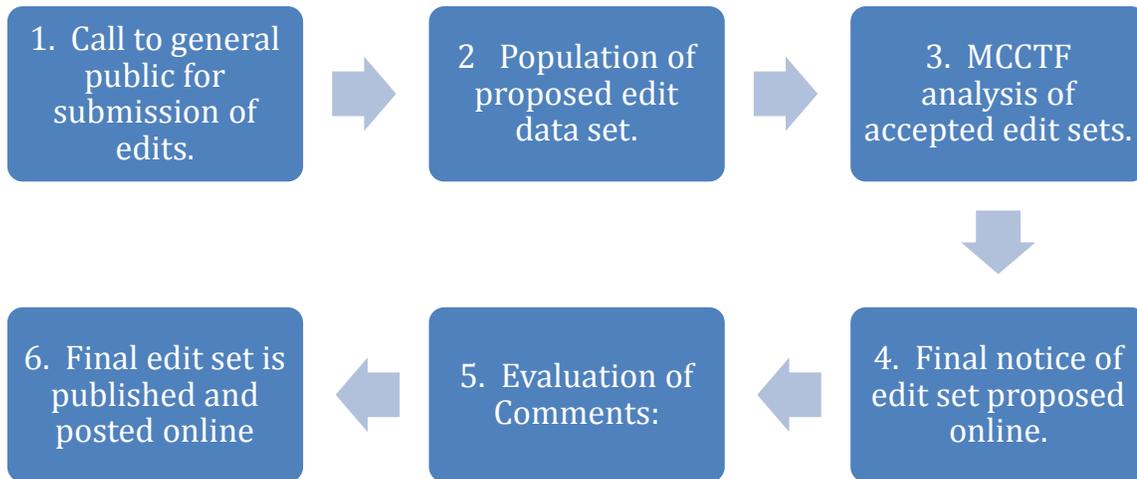
- *Initial process review by Staff, which will include a quick review of the comment for required format and supporting information within 7 days of receipt.*
- Committee co-chairs evaluate public comment cleared by staff and send to committee members for review within 14 days. *Committee members will be notified and asked to review and post their comments within 14 days*
- Committee co-chairs present member input and present to their own committee members for consensus recommendation to the whole Task Force.
- The MCCTF co-chairs will do an initial evaluation of the comments; they will include their evaluations as part of a regularly scheduled committee meeting. *To facilitate the process, the comments will be posted to the Task Force members’ site for review.*
- Task Force reaches consensus on committee recommendations regarding comments, including rationale for decision. *The Task Force will complete its review of all comments with consensus recommendations by 60 days after the close of the comment period.*

5. Rule is finalized:

- Final rule is published.
- Rule is then moved to Edit set development protocol.

Edit Set Development:

Once a rule is developed the MCCTF will initiate the development of and edit set to support the implementation of the rule. Again the process of consensus will be attempted at the edit level. The task will require that the MCCTF develop parameters for edit analysis including time frames for response and appeal of adopted edits. In lieu of consensus a simple majority vote of the members shall prevail.



1. Call to general public for submission of edits

- A database for edits is created for housing of all edits.
- An acceptable format for submission of edits will be included in the request for submission of edits for each rule or set of rules.
- A timeline for submission of edits is included in the request for submission of edits.
- Submission request includes notification that edits not submitted will not be included in the final edit set and therefore, will not be allowed in processing of claims unless specifically included in contractual agreements between payer and provider.

2. Population of proposed edit data set.

- Edits that conform to requested edit submission format will be added to the proposed edit set. Edit submission format will include the following:
 - Edit must be in electronic format in file layout specified in the submission request.
 - Edit must include a source recognized by MCCTF:
 - Existing national industry sources as identified in [House Bill 10-1332](#)
 - (I) THE NCCI;
 - (II) CMS DIRECTIVES, MANUALS, AND TRANSMITTALS;
 - (III) THE MEDICARE PHYSICIAN FEE SCHEDULE;
 - (IV) THE CMS NATIONAL CLINICAL LABORATORY FEE SCHEDULE;

- (V) THE HCPCS CODING SYSTEM AND DIRECTIVES;
- (VI) THE CPT CODING GUIDELINES AND CONVENTIONS; AND
- (VII) NATIONAL MEDICAL SPECIALTY SOCIETY CODING GUIDELINES.
- Other

3 MCCTF analysis of accepted edit sets.

- MCCTF will assign edit review to sub-committees
- Sub-committees will analyze edits for all edits in which there is conflict from sources.
- Sub-committee will analyze edits, other than those in conflict, at its discretion.
- For those edits which are analyzed, source analysis will be conducted as needed
 - Clear source notation with detailed sourcing to published data will be validated as needed with source referenced
 - Source reference which is unclear or not sourced to published reference will be checked by source contact if possible
 - If source reference does not agree with interpretation and/or can provide counter reference material initial source will be considered invalid and edit removed from data set, subject to the conflict resolution process
 - If sources referenced are determined by the MCCTF to be valid, source will be included in edit set
 - If in rare instance valid sources are in conflict. Sub-committee will attempt to resolve conflict giving higher credence to the most clinical reference available.
 - All decisions for which conflict is noted and resolved by sub-committees will be vetted with full MCCTF.
 - Upon consensus where possible and upon majority vote when needed, final edit set will be approved, from time to time, as required, by full MCCTF.

4 Final notice of edit set proposed online

- Vendor/payer/provider (VPP) who has its own rule logic takes the MCCTF edit set and compares it/conducts an internal crosswalk against their edit list.
- Vendor/payer/provider provides MCCTF with its requests to remove, retain or add edits based on analysis. VPP must provide rationale for any change recommendations. It is anticipated that comments on edits will be provided in required format similar to process required for on-going edit evaluation.

5 Evaluation of Comments:

- MCCTF Edit Committee reviews VPP recommendations during its bi-monthly meetings and arrives at consensus recommendations on what is “in” and what is “out” based on its review and analysis of the VPP recommendations. If consensus is not achievable within Edit Committee on any edit and edit committee has agreed that source information is valid, edit will be sent for review by full task force with noted lack of consensus.
- Edit Committee posts its vetted edit list for MCCTF full task force review and comment relative to any non-consensus edits. All other edits for which consensus has been obtained will be added to edit set to be posted to website for public comment. The website will have the capability to place vetted edit list for public comment with data files and a section for public comment. *Commenters will have 30 days to review the edit list.*

- Edit Committee will review public comments at the end of the public comment period and provide responses to commenters and its consensus recommendation to the Task Force. Following same process used for VPP comment review.
- Task Force reaches consensus based on committee recommendations regarding comments, including rationale for decision. *The Task Force will complete its review of all comments with consensus recommendations by 60 days after the close of the comment period.*
- *IF Full task force consensus for an edit/rule change cannot be obtained. Rule /Edit will be subject to panel arbitration as follows:*
 - a. *Arbitration panel (AP) will be elected consisting of x vendors, x payers, x providers and x others.*
 - b. *Panel will review comments from public, committees and task force.*
 - c. *Based on review a vote of the AP will be conducted. The AP can vote to include the edit or rule change, reject the edit or rule change or refer the edit or rule change back to a committee for further evaluation.*
- As the federal register and other government agencies do, the MCCTF would provide a summary of the comments it has received and their deliberations/decisions for each.

6 Final edit set, current and/or update version, is published and posted online

- This notification would be posted on the same website and notification would be sent out to the interested parties.
- The notification would provide the final determination.
- The notification would include the “effective” date or implementation date and specific statutory requirements. *Notification of the rule findings and finalization will be completed within 180 days of publication.*

New Rules and updates to edit sets:

New rules and those updates as required by changes in code and technology will be subject to the process stated above.

Dispute Resolution Processes:

In the event a person or group wishes to challenge an edit or a rule, the following three level dispute resolution process is proposed:

1. First, a dispute goes through MCCTF resolution; MCCTF resolution will consist of comparing edit and complaint to determine if either or both are correctly sourced to an accepted source by vendor or staff. If both are correctly sourced dispute would be elevated to MCCTF for resolution. If either is incorrectly sourced the correctly sourced decision would be recommended to task force for adoption of deletion, retention or addition of edit.
2. Upon resolution of edit by MCCTF decision of MCCTF can be challenged through mediated resolution. An independent ad hoc dispute resolution capability would be created which is separate from the business and content management functions. It would entail the creation of a three person panel comprised of: 1) complainant selected individual; 2) defendant selected individual; and, 3) a 3rd person that is acceptable to other two parties. Disputes would be brought before this three person panel for review and a final decision. The panel would be all-volunteer and not receive any direct compensation.

On-Going:

As the MCCTF is scheduled to be dissolved at the end of 2014 a new, permanent entity will need to be created to assume the role of the task force. It is recommended that a similar group be created. It is recommended that the new body be similar in make up consisting of 4 payer representatives, 4 provider representatives, 3 vendor representatives and 2 lay people representing the patient interests. All meetings should be open to the interested public. Further it is recommended that any sub-committee created have balanced representation to maintain the spirit of cooperation and integrity the MCCTF has been able to create. It is recommended that members of the group be technically qualified to analyze the issues presented to the group and that the membership be approved by the state. Further it is recommended that the body be made up of volunteers with compensation only for travel and expenses for required meetings of the group.

The group will carry out the charge of maintaining the Rule and Edit set in the spirit and function created by the task force with changes to the process adopted by consensus of the group.

[Draft] MCCTF GLOSSARY OF TERMS

| Term | Definition |
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| Act | As used in this report, the Medical Clean Claims Transparency and Uniformity Act (Colorado HB-10-1332). |
| Base Set | The standardized edits and rules established pursuant to the act that consist of rules and edits drawn from national industry sources listed in the act (e.g., the National Corrective Coding Initiative and Medicare physician fee schedule). |
| Claim Edits | Adjustments by payers to the procedure codes physicians use to describe and bill for services that are part of the process payers use to determine whether a particular claim for payment should be paid and at what level. (See definition of edit below.) |
| Complete Set | The base set of standardized edits and rules and edits and rules for health services involved in a medical claim that are not encompassed by the national industry sources established pursuant to the act. |
| Current Procedural Terminology (CPT®) code set | A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. CPT® is a registered trademark of the American Medical Association. Copyright 2012 American Medical Association. All rights reserved |
| Data Analytics | The process the task force will use to do data runs on and analyses of the universe of edits that companies and organizations are willing to share with the task in order to select the edits that will constitute the final recommended set. |
| Data Sustaining Repository | The place (not necessarily a physical location) where the standardized set is “housed,” updated and maintained and electronic access to the standardized set, including downloading capability. |
| Data Sustaining Repository Committee (DSR Committee) | Subcommittee of the task force; responsible for examining how the standardized set will be maintained and sustained. |
| Edit | §25-37-102(4), C.R.S., defines an edit as “a practice or procedure, consistent with the standardized set of payment rules and claim edits developed pursuant to section 27-3-106 that results in - (a) payment for some, but not all of the codes; (b) payment for a different code; (c) a reduced payment as a result of services provided to a patient that are claimed under more than one code on the same date of service; (d) modified payment related to a permissible and legitimate modifier used with a procedure code as specified in section 25-37-106(2); or (e) a reduced payment based on multiple units of the same code billed for a single date of service.” |
| Edit Committee | Subcommittee of the task force; responsible for identifying definitions and edits for the base set |
| Federation of Medicine | The term “Federation” is used by the AMA to describe the state, county and specialty medical societies (e.g., American Academy of Pediatrics, American College of Radiology, American College of Surgeons) represented in the AMA House of Delegates that work together to advance the agenda of physicians and their patients. The Federation of Medicine includes 122 national specialty societies and 50 state medical societies |

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| Healthcare Common Procedure Coding System (HCPCS) | Provide standardized coding when health care is delivered. HCPCS was developed in 1983 by the Health Care Financing Administration (now the CMS) to standardize the coding systems used to process Medicare claims on a national basis. The HCPCS is structured in 2 levels. Each of the 2 HCPCS levels is its own unique coding system. Level I is the AMA CPT® code set, which makes up the majority of the HCPCS. Most of the procedures and services performed by physicians and other qualified health care professionals are reported with CPT® codes. Level II national codes are assigned, updated, and maintained by CMS. These codes describe services and supplies not found in the CPT® code set, for example, durable medical equipment, medical/surgical supplies, drugs. |
| ICD-9/ICD-10 | ICD means International Statistical Classifications of Diseases. ICD codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to human beings. ICD-9 is the classification that has been in place since 1977. ICD-10 is the newest classification of diseases that is in the process of being implemented by all payers and providers |
| Modifiers | These are used in addition to a CPT® code to add more information on the claim. They state special circumstances that may affect the amount the physician will be reimbursed. For example, a modifier may indicate unusual circumstances that made a procedure more complicated and may warrant additional payment or that led to a procedure being discontinued, which may not warrant full payment. A modifier is appended to a five digit CPT® code and "...provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." (American Medical Association, "Appendix A", CPT® (Current Procedural Terminology) Professional Edition, 2013. P 595.) |
| National Medical Specialty Society | National medical organizations that are assigned as advisors to, or are represented on, AMA, CPT, and AMA Health Care Professionals Advisory Committee (HCPAC) that includes organizations representing limited license practitioners and other allied health professionals. |
| National Correct Coding Initiative (NCCI) | A system used to promote consistency in claims coding and to control improper coding leading to inappropriate Medicare claims payments for professional health care services. |
| Out of Scope Edits | 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 applications of variations in payment or benefits based on either the provider's or member's contract; or are Medicare or Medicaid-specific. |
| Payment Rule | Indicates how codes should be reported and which codes are eligible for a pricing adjustment. Payment rules are a statement of how a submitted procedure code, procedure code combination should be processed when an edit has been triggered. The task force agreed that its legislative mandate is to elucidate and standardize coding rules—including payment rules, but that specific amounts for pricing adjustments to specific codes are out of scope. The task force may, however, describe those coding scenarios that are unique and may be eligible for differentiated pricing. |
| Payment Rules Committee (i.e. 'Rules Committee') | Subcommittee of the task force that is responsible for developing payment (but not pricing) rule recommendations. |

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| Pricing Rule | As used in this report, refers to a rule that specifies the amount for pricing adjustments to coding. Pricing rules are out of scope. Reported codes subject to a specific payment rule would be adjusted by a payer pricing rule that would apply a payment adjustment amount to a contracted rate. For example, reported codes eligible for the bilateral adjustment would be subject to a payer pricing rule. |
| Professional Functions and Entities | Refers to rule making about the standardized set once it is established, including decisions about which edits and rules are in, out or modified over time. |
| Proprietary or Payer-Specific Edits | Edits that are specific to an Insurance company; there are millions of proprietary edits. |
| Resource-Based Relative Value Scale (RBRVS) | A schema used to determine how much money medical providers should be paid. |
| RFI (Request for information) | The task force issued (and received responses to) a request for information about potential strategies for, and the cost to design and develop, an online data repository. The purpose of the RFI, which was released May 3, 2012, was to invite input, better understand potential strategies and costs associated with the design and development of an online data repository, and solicit innovative solutions. It explained that the information gathered from the RFI would help to inform request for proposals (RFP). |
| RFP (Request for proposals) | The task force issued a request for proposals (RFP) in 2013 for [a] data analytics contractor[s] that would compile the edits that companies and organizations would like to see in the standardized set and, at the direction of the task force, analyze the edits to arrive at a recommended standardized set. |
| Rule Bundles | The task force released a number of payment rules (see <i>payment rule</i> in glossary) for a period of public review/comment. These rules were systematically organized into four separate releases – each ‘grouping’ of rules that were released is referred to as a ‘bundle’ (bundle 1, bundle 2 bundle 3 and bundle 4). |
| Source | Refers to the list of publically available national industry sources found in §(2)(b)(I--VII),C.R.S., of HB10--1332 only-(I) the NCCI; (II) CMS directives, manuals and transmittals; (III) the CMS national clinical laboratory fee schedule; (V) the HCPCS coding system and directives; (VI) the CPT coding guidelines and conventions; and (VII) national medical specialty society coding guidelines. |
| Standardized Set | The standardized set of claim edits and payment rules recommended by the task force that all payers having contracts in Colorado must use to edit claims as of the dates outlined in the act. |
| Task Force (MCCTF) | The task force created by the Medical Clean Claims Transparency and Uniformity Act, HB 10-1332. |
| Technical Functions and Entities | Refers to rule distribution, display and access to the standardized set after it has been established. |
| Voluntary National Initiative | A national collaborative effort that was overseen by the federal Department of Health and Human Services (HHS) consisting of a diverse group of stakeholders for the purpose of reaching consensus on a complete or partial set of standardized edits. The national initiative no longer exists |