



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

## Meeting Agenda

<b>Meeting Date:</b>	February 26, 2014, noon – 2 PM MDT
<b>Call-In Number:</b>	1-866-740-1260; ID 8586318#
<b>Web Link:</b>	<a href="https://cc.readytalk.com/r/9z79b9z77cu2&amp;eom">https://cc.readytalk.com/r/9z79b9z77cu2&amp;eom</a>

### 12:00 PM WELCOMING REMARKS & ROLL CALL

**I. Housekeeping Items:**

- a. Approve January 2014 meeting minutes (Attachment A)
- b. Next in-person meeting: April 22-23, 2014

### 12:10 PM COMMITTEE REPORTS & OTHER DISCUSSION ITEMS:

**II. Edit Committee- Beth Wright/Wendi Healy?**

- a. Query templates completed?

**III. Rules Committee – Nancy Steinke/Beth Kujawski**

- a. New Co-Chair Beth Kujawski
- b. Review TF Response to Public Comments:
  - 1. Fourth Bundle (Attachment B)
- c. Revisit Rules:
  - 1. Professional and Technical Component **(Attachment C) – CONSENSUS ITEM**
  - 2. Discussion of Bundled rule (Attachment D)
- d. Out of scope edits (Attachment E)

**IV. Specialty Society – Alice Bynum-Gardner**

**V. Continuing Enabling Legislation – Barry Keene, Legislative Liaison**

- a. Continuing discussions with DOI/Senator Aguilar
  - 1. DOI Memo (Attachment F – to be distributed prior to meeting)
  - 2. Response to DOI Memo (Attachment G – to be distributed prior to meeting)
  - 3. Proposal to HHS (Attachment H – to be distributed prior to meeting)

**VI. Data Sustaining Repository – Mark Painter/Barry Keene**

- a. Data analytics vendor update
- b. “Vendor” Committee
- c. Governance document (Attachment I – to be distributed prior to meeting)
  - 1. Reorganization of subcommittees

**VII. Project Management – Vatsala Pathy**

- a. Project workplan new format (Attachment J)
- b. Rules tracking sheet (Attachment K)

**VIII. Finance – Barry Keene/Vatsala Pathy**

- a. 2014 funding – (Attachment L)

**IX. Other Business**

### 1:55 PM PUBLIC COMMENT

### 2:00 PM ADJOURNMENT

## UPCOMING TASK FORCE MEETINGS

DATE(S)	TIME (MDT)	MEETING TYPE
March 26, 2014	<b>Wed:</b> 12:00 p.m. – 2:00 p.m.	Monthly Conference Call
April 22-23, 2014	<b>Tue:</b> 12:00 p.m. – 6:00 p.m.; <b>Wed:</b> 7:30 a.m. – 2:00 p.m.	In-Person Quarterly Meeting
May 28, 2014	<b>Wed:</b> 12:00 p.m. – 2:00 p.m.	Monthly Conference Call

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

Meeting Minutes

January 21, 2014, 12:00–6:00 PM, MDT

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

Conference ID: ID 8586318#

**Attendees:**

- Amy Hodges
- Anita Shabazz
- Barry Keene, CC
- Beth Kujawski
- Beth Provost
- Beth Wright
- Dee Cole
- James Borgstede, MD
- Kim Davis
- Lori Marden
- Marianne Finke
- Marilyn Rissmiller, CC
- Mark Painter
- Nancy Steinke
- Ryshell Schrader
- Terrence Cunningham
- Wendi Healy

**Staff :**

- Connor Holzkamp
- Vatsala Pathy

**Public:**

- Diane Hammond (UHC)
- Diane Hayek (ACR)
- Jennifer Wiler, MD (ACEP)
- Pam Kassing (ACR)

**Meeting Objective (s):**

See Agenda

**Key:**

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

**Day One: January 21, 2014****WELCOMING REMARKS & ROLL CALL:****Housekeeping Items:**

- Minutes from December were accepted with no changes made.
- The Task Force recognized and thanked Kathy McCreary and the University of Colorado Health for sponsoring the catering for both days.
- The Task Force welcomed Anita Shabazz (Denver Health and Hospital Authority) to the table as an official TFM.
  - Anita officially took the seat that was formerly held by Jill Roberson.
- It was noted that the next regularly scheduled MCCTF conference call is Wednesday February 26, 2013.

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

- **The Edit Committee brought five query templates to the TF for review. These queries are considered informational items and do not require consensus. [To download these query templates please click here.](#)**
  - **Max. Frequency- Span of Days:**
    - ✓ ‘Frequency restriction’ split into three columns: 1) number of units, 2) period of time & 3) type of time period
    - ✓ It was noted that the TF will be looking for the vendors/payers to submit a list of codes because there is no publically available list of time frames that is in a useable (electronic) format.
    - ✓ One TFM stated their concern with the scope of the edit set the TF is working to build, and noted that the group must be careful when determining the parameters for allowing an edit into the standardized set.

- Multiple Endoscopy:
  - ✓ Revise base code to CMS base code
- Multiple E&M's Same Day:
  - ✓ Add two columns – Y' modifier override; N' modifier override;
  - ✓ Column for the modifiers separated by a comma [i.e. 25,59,LT];
- Bundled Service (Status B):
  - ✓ No revisions
- Laboratory Rebundling:
  - ✓ No revisions
- There was a discussion regarding the term “vendor submission” (which appears on many of the query templates) and it was determined that the phrase would be changed to “submitter” – This is to ensure the public does not think that only vendors are permitted to submit information.
- The Committee will work to draft the remaining query templates:
  - Same Day Medical Visit & Medical Procedure; and
  - Procedure to Modifier Validation (item “P” on the A-P list)

**ACTION ITEMS:** The TF accepted the Edit Committee’s query templates (above) as informational items. To download these query templates please click [here](#); The Task Force came to the conclusion that the phrase “vendor submission” is misleading and should be changed to “submitter” on every query template.

#### **SPECIALTY SOCIETY OUTREACH COMMITTEE—Alice Bynum-Gardner**

- The Specialty Society continues its charge to act as the “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 code 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.”

#### **PAYMENT RULES COMMITTEE— Nancy Steinke**

- It was announced that Beth Kujawski had volunteered to join Nancy Steinke as the co-chair of the Rules Committee.
- The Task Force reviewed the draft response to the public comments on the third bundle concurrently with the rules.
  - [To view all formal responses in detail please click here.](#) *It is recommended to cross-reference the TF response to the third bundle of rules with the following summary of this discussion.*
- **The following draft rules from the third bundle were brought back for discussion/final consensus based on the comments received by the public:**
  - Global Procedure Package: *(Consensus reached)*
    - ✓ The task force agreed with the commenter that additional clarification should be added to the final rule to address how some specific modifiers affect the global procedure/package rule.
    - ✓ A note was added to the “Administrative Guidance” section, indicating that the use of modifier 54, 55 and 56 does not preclude the procedure from the application of the global procedure days/package concept.
    - ✓ The task force agreed with the commenter to remove a reference to modifier 76 from this rule.
    - ✓ The modifier grid was updated accordingly to indicate that modifier 76 is primarily used as an informational modifier; when used alone it alerts the payer that it is not a duplicate, and when used in combination with another modifier (such as 58 or 78) it *can* override a payment edit.

- Laboratory Rebundling: (*Consensus reached*)
  - ✓ The task force agreed to correct the reference to the panel codes as noted in the rule and provide additional clarification regarding the fact that the use of a reimbursement policy combining panel codes for payment purposes is outside of the scope of the task force.
  - ✓ Additionally, the Task Force agreed with the commenter that the task force should include the use of modifier 59 as it is appropriate in some instances (Examples to be added to rule to clarify this point).
- Maximum Frequency > 1 Day: (*Consensus reached*)
  - ✓ Revised to include additional coding examples that would address correct coding when the services reported were less than or greater than those identified in the procedure code description.
- Multiple Endoscopy Reduction: (*Consensus reached*)
  - ✓ The Task Force agreed with the commenter that an explanation should be added to the rule to clarify how modifier 78 should be handled. That is, if the payer applies a reduction based on the use of modifier 78, it is not appropriate to apply another reduction based on the multiple endoscopy rule.
- Professional and Technical Component: (*Sent back to Rules Committee*)
  - ✓ The commenter outlined their concerns regarding the definition of the Technical Component (TC) modifier: Specifically, the commenter cited a disagreement with the second sentence that states that TC *“Charges are institutional charges and not billed separately by physicians.”* The commenter points out that, *“Absent conjunctive clarification, this language is inaccurate for pathology services. The plain fact is that pathologists, under Medicare and for private payers, are, in many cases, directly paid for TC services on the physician fee schedule. Thus, the current language proposed for the edit is taken out of proper context and would result in confusion and gross misapplication of the rule as applied to the TC of pathology services.”*
  - ✓ One member of the expert public (payer) stated that they agree with the commenter, but are very concerned with publishing a rule where TC charges are institutional, which they believe to be incorrect. *“We have cases where physicians own radiology equipment in their office and will perform the technical component but do not do the interpretations. This is acceptable and they would get paid for the technical component.”*
  - ✓ One TFM (payer) recommended that the definition should not be changed as this opens the door for every specialty society/payer/vendor to refute other definitions. Instead, a note could be added that explains that *“whoever is rendering a technical component – regardless of where the place of service is – if it is illegible for TC reimbursement, it should be paid, and it is only eligible for one technical component.*
  - ✓ General consensus amongst the payers at the table agreed with the commenter in principle. However, the Task Force decided that changing the definition could open the door for all other definitions to be changed and is not the proper way to address this comment.
  - ✓ Language will be added to clarify that this modifier definition is specific to Medicare;
  - ✓ *“Refer to administrative guidance for more information”* added under the definition.
- The committee reported that the Maximum Frequency rules had been combined to avoid confusion over the titles of the two rules. The suggestion was understood/agreed to by the Task Force.

**ACTION ITEMS:** Beth Kujawski assumes co-chair role with Nancy Steinke; The TF agreed to the changes mentioned above, which are based on the public comments received on the third bundle; The TF agreed with the committee’s recommendation to combine the two frequency rules.

- The Task Force concluded the day by reviewing the comments on the fourth bundle of rules. [To view all formal responses in detail please click here.](#)
- The Rules Committee will finalize the draft response and bring for Task Force review in February.

**PUBLIC COMMENT:**

<none>

**The meeting was adjourned at approximately 6:00 PM MDT.**

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

Meeting Minutes

January 22, 2014, 12:00–6:00 PM, MDT

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

Conference ID: ID 8586318#

## Attendees:

- Amy Hodges
- Anita Shabazz
- Barry Keene, CC
- Beth Kujawski
- Beth Wright
- Dee Cole
- Doug Moeller, MD
- James Borgstede, MD
- Kim Davis
- Marianne Finke
- Marie Mindeman
- Marilyn Rissmiller, CC
- Mark Painter
- Nancy Steinke
- Terrence Cunningham
- Wendi Healy

## Staff :

- Connor Holzkamp
- Vatsala Pathy

## Public:

- Diane Hammond (UHC)
- Diane Hayek (ACR)
- Jennifer Wiler, MD (ACEP)
- Pam Kassing (ACR)

## Meeting Objective (s):

See Agenda

## Key:

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



## Day Two: January 22, 2014

### WELCOMING REMARKS & ROLL CALL:

- Roll call confirmed that a quorum was reached.

### PROJECT MANAGEMENT AND FINANCE COMMITTEE – Barry Keene and Vatsala Pathy

- It was formally announced that Mark Painter will be stepping in for Barry Keene as co-chair of the Task Force. Barry will continue his role as the Co-chair of the Finance Committee, as well as the primary legislative liaison for the Task Force.
- The following documents were displayed as informational items: (Click on item to view in web browser)
  - [Work plan](#) – The TF is still on track to complete its work in 2014 but do not have as much time as was originally anticipated to build the data analytics database.
  - [Rule recipe tracking sheet](#): All Rules have been drafted by the TF and reviewed by the public.
  - [“Glossary of Terms”](#) – Put together by staff and reviewed by Co-chairs – TFM were asked to review this document and send comments to Connor/Vatsala.
- Vatsala reported that staff will continue to explore avenues of funding and currently has a proposal in with the Commonwealth Fund and is expecting a response within the next month.
- Task Force will continue to look for funding from stakeholders at the table to fund the work through 2014.

**The TFM to send any comments on the draft “Glossary of Terms” to Connor/Vatsala.**

## DATA SUSTAINING REPOSITORY COMMITTEE – Mark Painter and Barry Keene

- The DSR reported that the RFP Evaluation Committee had completed its review of the responses to the RFP and has selected Bishop Enterprises to build/maintain the data analytics database that will sustain the work of the Task Force.
  - There were two responses to the RFP – Both responses were thoroughly evaluated and scored objectively by the RFP Evaluation Committee and Bishop was ultimately chosen to carry-out the process as defined in the RFP.
  - For more information on how the responses to the RFP were scored please contact MCCTF staff at: [connor.holzcamp@rootstocksolutions.com](mailto:connor.holzcamp@rootstocksolutions.com)
- The Committee recommended to the Task Force that a subcommittee (tentatively called the “Vendor Committee”) be formed in order to fully engage Bishop as the analytics database is built.
  - This Committee includes all of the co-chairs of the Task Force as well as other industry experts.
  - The “Vendor” Committee will work closely with Bishop during the initial phases of the development process and serve as the official correspondence between the Task Force and the contractor (Bishop).
- The DSR Committee has been working to lay out recommendations regarding the “business model” that will sustain the work of the TF. A key component of this “business model” is to determine the governance and decision making processes for the data analytics and data sustaining repository phase of the project. The Task Force spent a large portion of time discussing this governance model.

**The following questions/considerations were pulled directly from this discussion and were turned into a document that will help the DSR Committee as it works to lay out the:**

- **Could an edit be included in set without a validated source path?**
  - This is not likely due to the language in the statute; an edit must have a validated source path.
- **What is going to be referenced as a *national source*?**
  - Legislation outlines these sources, is there any room for interpretation?
  - Specialties may not agree with an NCCI edit, do we take this into consideration?
- **What is the process by which we certify a validated source path?**
  - If every payer has the edit, should that be the sole reason for inclusion?
    - ✓ On the flip side, do specialties have straight veto power? – Balance must be reached
  - Sheer volume of edits may provide challenges for a truly collaborative approach.
  - An all-encompassing hierarchy may not be ideal, the suggestion was made to work on a case-by-case basis.
- **The DSR will need to discuss optimization of edits when there is a dispute between two sources.**
- **DSR must lay down front-end recommendations on what happens to an edit after it is included/excluded from the edit set.**
  - Even if edit goes through one round, there must be a process in place to go back and review those edits that may initially slip through unnoticed.
- **Consider the scenario where we go out to a source and say, “Here is <edit> we got this from <source>, do you agree?”**
  - If we do not get response in <X> amount of time, is this edit included?
    - ✓ 60 days was suggested for “X”
  - What if they respond “No”?
    - ✓ Vote by “governance board”:
      - Board composition ideally set up in a way that payers could not out-vote providers, and vice versa.
      - Mediator? (Un-biased third-party)
      - Fee-based dispute resolution system?
    - ✓ DSR must lay down process to revisit these edits.
- The Committee will work to incorporate the discussion into a draft document for the Task Force to review in February.

- The Committee has also been working on fleshing out the [long-term funding strategy](#) which will fund the work of the Task Force after it sunsets. These “options” may or may not be used depending on what happens with the legislation, however, the group must be prepared to have a strategy in place that is acceptable by all stakeholders.

**ACTION ITEMS:** It is a top priority for the group to flesh out the long-term governance model that will maintain the work of the Task Force. The Committee will work hard to incorporate the considerations that were established during the discussion and bring a draft to the full Task Force in February; Committee will also work to finalize the “Vendor” Committee that will work with Bishop during the early stages of development.

- Barry noted that TF is still working to move its statute from contract law to the Division of Insurance.
  - Barry reported that he had received a draft from Senator Aguilar of the proposed legislation, and shared some of his concerns. One of which is that “it remains unclear to me how obliged the DOI is to accept our recommendations.”
  - After reading the draft legislation it was noted that establishing the governance model is critical in order to bring credibility to the work the Task Force has been doing.
- Barry is closely monitoring the situation and will update the Task Force as soon as more information becomes available.

**OTHER BUSINESS:**

- Marilyn presented the Task Force with what has been coined as the “Out-of-Scope” document. [To view this document in a web browser please click here.](#)
  - This document outlines the edit types that have been determined by the Task Force to be out-of-scope. It gives a detailed explanation as to why these determinations were made and is supplementary to the payment rules.

**ACTION ITEM:** The Task Force to send Marilyn any revisions/comments on the out-of-scope document via email.

**PUBLIC COMMENT:**

<none>

**The meeting was adjourned at approximately 1:40 PM MDT.**



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

Response to Public Comments  
January 6, 2014

### Background

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 a report to the General Assembly and Department of Health Care Policy & Financing with recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The task force is to identify the standardized set of rules and edits through existing national industry sources including: National Correct Coding Initiative (NCCI); Centers for Medicare & Medicaid Services (CMS) directives, manuals and transmittals; the Medicare physician fee schedule; CMS national clinical laboratory fee schedule; the Healthcare Common Procedure Coding System (HCPCS) coding system and directives; the Current Procedural Terminology (CPT®)<sup>1</sup> coding guidelines and conventions; and national medical specialty society coding guidelines.

The task force is not developing rules or edits that are used to identify potential fraud and abuse or utilization review. Additionally, the standardized rules and edits cannot limit contractual arrangements or terms negotiated between the contracting entity and the health care provider.

Additional information can be found at <http://hb101332taskforce.org>.

### Bundled Rule 401 V.01 12/2/13

Comment: One national insurance carrier submitted comments in support of the rule with modifications.

Due to benefit related agreements, carrier considers separate reimbursement for P status HCPCS code "V2520", whether billed alone or with other services. Carrier recommends adding verbiage to the Administrative Guidance section that permits separate reimbursement for a P status code when there is a benefit provision to support this. Please refer to the similar statement in the Administrative guidance section where the MCCTF agreed "that many of the Status B procedures may be for a service/procedure that is out of scope of the Task Force to consider (i.e. benefit related, contractual agreements with providers)."

Response: The Rules Committee recommends that the exclusion/definition of status B procedure codes be revisited by the task force.

<sup>1</sup> Copyright 2013 American Medical Association. All Rights Reserved.

Comment: Carrier recommends adding administrative guidance that when a P Status code is the sole service provided, it should not be reported on a CMS-1500 claim form by any physician or other qualified healthcare professional in the following facility settings: POS 21 (inpatient hospital), 22(outpatient hospital), 23 (emergency room), and 24(ambulatory surgical center).

Rationale: CMS follows a Prospective Payment System (PPS) where Medicare payment is based on a predetermined, fixed amount payable to a facility for inpatient or outpatient hospital services. In addition, CMS reimburses ambulatory surgery centers under an Ambulatory Payment Classification (APC) payment methodology. With these fixed rates all costs associated with drugs and supplies are also considered inclusive in the global payment to the facility and not considered separately reimbursable when reported on a CMS-1500 claim form by a physician or other qualified healthcare professional.

Response: The task force will add the following remark to the Administrative guidance section of the final rule:

A procedure code identified with a status indicator of P should not be reported by a physician or other healthcare professional in the following facility settings: POS 21 (inpatient hospital), 22(outpatient hospital), 23 (emergency room), and 24 (ambulatory surgical center), as it would be considered included in the payment to the facility.

**Multiple E/Ms on  
the Same Day  
402.V01 12/02/13**

Comment: One national insurance carrier recommended modifications to the rule as noted below.

Carrier recommends that, consistent with Medicare, the Colorado Multiple E/Ms on the Same Day Rule specifically apply to services reported by physicians and other health care professionals of the same specialty in the same group. We recommend clarifying this in the Definition, Rule Logic, and Administrative guidance sections of draft rule.

The Medicare Claims Processing Manual states:

"Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group."

Response: The task force has deliberated the general concerns related to services provided by more than one physician or qualified healthcare provider from the same practice on several occasions. Recognizing that there may be system limitations for some payers in automatically adjudicating this addition to the rule, the task force has determined to approach the commenter's

recommendation as an instruction under the Administrative guidance section. The reference would be on the appropriate way to report multiple E/M visits on the same day, to the same patient, by more than one physician or qualified healthcare provider from the same group practice. The guidance would also indicate that the payer may choose to audit these cases post-payment.

The rule definition will be revised to be consistent with the New Patient rule that also references professionals from the same group. The revised definition would read:

“This edit identifies when multiple E/M services are billed on the same day by the same physician/qualified healthcare professional or another physician/qualified healthcare professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice. Except when the criteria noted below are met and the appropriate modifier is appended, only one E/M may be eligible.”

Comment: In the Definition and/or the Administrative guidance sections, Carrier proposes the addition of the following language from the 2014 CPT® code book, page 4:

“In the instance where a physician/qualified healthcare professional is on call for or covering for another physician/qualified health care professional, the patient’s encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advance practice nurses and physician assistants are working with physicians (*under the same TIN*), they are considered as working in the exact same specialty and exact same subspecialties as the physician.”

Response: The task force agrees with the premise of the comment, however is concerned with quoting specific page numbers as a reference. Rather the task force will add a general instruction to follow CPT guidelines regarding on call coverage in the Administrative guidance section.

Comment: CPT guidance instructs that E/M (CPT codes 99201-99499) should only be reported by Physicians or other qualified health care professionals. In accordance with Centers for Medicare and Medicaid Services (CMS) guidelines, the only qualified health care professionals that may report E/M services are nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse midwives (CNM) and physician assistants (PA). Carrier recommends the Rule follow the CMS policy on which healthcare professionals may not report E/M services.

There are a wide variety of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that specifically and accurately identify and describe the services and procedures performed by non physician health care professionals other than NP, CNS, CNM, and PA’s. For example, coding guidelines of CMS and the American Medical Association (AMA) support denying reimbursement to speech-language therapists/pathologists for evaluation and management services represented by CPT codes 99201-99499, as both the AMA and CMS provides guidance on other codes these professionals may use.

Response:

The task force responded to a similar question related to the Anesthesia rule, our response was: The determination regarding the types of providers that are eligible to for any specific procedure code or type of service is outside of the

scope of the task force. Edits related to provider eligibility were determined to be outside of our legislative purview.

Comment: As a result of these findings described in the bullets below, Carrier recommends that the Task Force add verbiage in the Administrative guidance section stating that these services may be subject to other payment rules, and therefore separate reimbursement when reported with an E/M service on the same day by physician(s) or other health care professionals in the same group.

- Complex Chronic Care Management: Codes 99487, 99488 and add-on code 99489 are B Bundle codes according to the Medicare Physician Fee Schedule (MPFS) and payment for these covered services are always bundled into payment for other services provided on the same date. As such, the Task Force should denote in the Administrative Guide section that these services may be subject to reimbursement based on a payer's adoption of CMS's B Bundle status indicators.
- Disability Exams: Carrier recommends that the Task Force recognize that coverage for disability exams depends on whether those services are included in certificates of coverage and therefore is considered a benefit issue.
- Other Emergency Services: The services described meet the definition for CPT 99288. In accordance with CMS, CPT 99288 is considered by CMS to have a B Bundle status and is not separately reimbursable whether billed alone or in conjunction with other services on the same date. As such, the Task Force should denote in the Administrative Guide section that these services may be subject to reimbursement based on a payer's adoption of CMS's B Bundle status indicators.
- Standby Services: In accordance with CMS, Standby Services (99360) are considered by CMS to have a B Bundle status and are not separately reimbursable, whether billed alone or in conjunction with other services on the same date. As such, the Task Force should denote in the Administrative Guide section that these services may be subject to reimbursement based on a payer's adoption of CMS's B Bundle status indicators.

Response: The examples cited are identified as status B codes by Medicare. Status B codes as addressed in the Bundle Rule need to be revisited by the task force before a response can be provided.

**Procedure to  
Modifier Validation  
403.V.01 12/02/13**

Comment: One national insurance carrier supports the Task Force's development of a rule that validates the appropriate usage of CPT and HCPCS codes and modifiers when reported together, however they recommended modifications to the rule as noted below.

**Associated Current Procedural Terminology and HCPCS modifiers:**

- This section references Appendix A for CPT. Carrier recommends including a reference to the HCPCS Appendix for Modifiers. As different publishers for HCPCS codes sets may vary in naming the Appendix number or alpha character, it is recommended to not list the alpha or

numeric character for the Appendix for modifiers in the HCPCS code book.

- The proposed rule references HCPCS Level II National Modifiers. By definition, Level II Modifiers are national modifiers; therefore, Carrier proposes removing the “National” reference as this is redundant. Rationale: Level III, Local, modifiers are no longer allowed under HIPAA. Anyone referencing a HCPCS code book would not find the reference listed as “National” Modifiers, only a reference for Modifiers.

**Response:** The task force agrees with the clarification and will remove the reference to a specific appendix as well as redundant reference to “National”.

**Comment:**

**Rationale:**

- Although we agree with the current rationale, Carrier proposes that it also references the following sources used to formulate this rule:
  - *Current Procedural Terminology* book (*CPT*) from the American Medical Association (AMA);
  - CMS National Correct Coding Initiative (CCI) edits; and
  - CMS Policy Manuals.
- We recommend that the Rationale section also be more specific on which national medical specialty society coding guidelines were reviewed. Based on the Specialty Society outreach, Carrier advocates also including the American College of Cardiology (ACC), and Society of Cardiovascular Interventional Radiology (SCIR)).

**Response:** The legislative framework identifies the sources that are to be used as a starting point in development of the standardized claim edits and payment rules. However, not all of these sources are applicable to every rule. Only those sources that are used as a basis for the specific rule are included in the Rationale statement. Likewise, only those national specialty societies that provide input during the development are referenced.

**Comment:**

**Rule Logic:**

The Task Force recognizes that vendors and payers may have developed their own edit tables, since a table of this nature is not available that is recognized industry-wide. Since the Task Force recognizes that there is no industry-wide standard for edit tables, it is recommended that the Task Force consider this a guideline versus a rule, by renaming it as such, as some modifiers may be appropriately allowed for use in certain circumstances. It may also be impossible to address all possible modifier situations due to variances in payer guidelines as well as different uses and acceptance of S and T HCPCS codes.

**Response:** One of the overall goals of the work the task force is doing is to eliminate as much variation as possible and move toward standardization. Once the procedure to modifier table has been developed it will be released for public comment.

**Comment:**

**Administrative guidance:**

- The last sentence in the first paragraph states “Visit Appendix A of the CPT code set to identify the complete set of modifiers that have been developed for reporting purposes.” Please reference the Modifier Appendix in the HCPCS code set as well.
- Although the note preceding the grid explains that this is only intended for use as a guide, Carrier proposes additional verbiage to allow provisions that a payer may reject a claim when a procedure code/modifier combination is inappropriate.
- Carrier also proposes that any further guidance for this rule clearly state that any code/modifier combination rules must be sourced to an industry standard source.
- There is no clear distinction within the rule explaining the differences between the two classifications of “Not probable for use,” and “Excluded from use.” Carrier asks for an explanation of these two terms. It is not clear why the Task Force states that 1P, 2P, 3P, 8P can clearly be listed as “Excluded from use” whereas, the modifiers listed in each section for “Not probable for use” could not be considered “Excluded from use” as well. We also recommend clarifying that nothing prohibits a payer from rejecting a claim reported with a modifier classified as “Not probable for use.”
- Within the Pathology and Laboratory Section, Carrier proposes addition of modifiers 76 and 77 for Not Probable for Use. This is supported by CMS. Refer to the Medicare sourcing.
- Finally, Carrier proposes that a payer should have the right to exempt certain modifiers from this guideline when they conflict with contractual or benefit coverage obligations.

**Response:**

- We will remove the reference to a specific appendix, rather just refer the reader to the CPT and HCPCS modifiers.
- Once the procedure to modifier table has been developed and released the task force will evaluate the public comments and determine if additional administrative guidance is needed.
- Again, an overarching premise of the work of the task force is to be able to source its work to a national standard.
- CPT provided the initial work for this rule including the terms Not Probable for Use and Excluded from Use and we will ask for a clarification.
- The task force will share the Medicare information with CPT concerning the use of modifier 76 and 77 and ask for their review of this addition.
- Contractual agreements or member benefit obligations are outside of the scope of the task force. This is addressed in the out of scope “rule” and will also be included in a high level implementation document once the standardized set has been finalized.

**Rebundled  
404.V01 12/02/13**

**Comment:** One national insurance carrier recommended modifications to the rule as noted below.

- The “Rule Logic” section of the draft rule could be mis-interpreted to only

apply to NCCI edits, while the rest of the draft rule sections indicate that broader sources are meant to be applied for rebundling. We recommend clarifying in the “Rule Logic” section that the rule also applies sourcing from other guidelines such as:

- *Current Procedural Terminology* book (CPT) from the American Medical Association (AMA);
  - CMS National Correct Coding Initiative (CCI) edits;
  - CMS Policy; and
  - Physician specialty societies (e.g., American Academy of Orthopaedic Surgeons (AAOS), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), and Society of Cardiovascular Interventional Radiology (SCIR)).
- The draft rule does not include any modifiers in the Associated Current Procedural Terminology (CPT) and HCPCS modifiers section.. However, the Administrative Guidance section cites coding scenarios where one of the separate codes is reported with Modifier 59. The Administrative Guidance section should clarify that it is not advocating a type of “universal acceptance” of modifier 59 in a transfer situation for all circumstances as a way for providers to circumvent the rebundling rule, but rather that the example is merely a situation in which the rebundling would not apply because the procedures were performed at separate encounters.
  - It appears that the rule may be silent on the use of appropriate modifiers. Carrier recommends that the rule include the appropriate modifiers which may be considered in overriding a code pair edit and allowing both services separately. In addition, the rule should further specify that 1) the medical record documentation clearly substantiate the use of the modifier when reported; and 2) the use of one of the modifiers is not a guarantee that the code pair rebundling edit will be overridden. Please note that the NCCI file includes specifications when a modifier overrides the code pair edit.

We support the Task Force’s use of edit sourcing from these multiple third parties.

**Response:** The task force will revise the Rule logic section to indicate that national industry sources indicate that a physician, or other qualified healthcare professional should not report multiple codes corresponding to component services if a single comprehensive code describes the services performed.

The Associated Current Procedural Terminology (CPT) and HCPCS modifiers section will be revised to include modifier 59 and its definition as it appears in CPT. We will also add the statement that “There may be appropriate situations where multiple modifiers apply, however they are not covered in this document.” Where modifier 59 is referenced in the Administrative guidance, we will add a note that the 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, the guidance is provided for correct reporting and not as an audit tool.

The Table attached to the Modifier Effect on Edits rule indicates which modifiers can override a particular edit. In the high level implementation manual we will address a number of the principles that apply to the entire standardized set, one of those is ensuring that the reporting of services is appropriate and substantiated in the patient's record.

**The task force appreciates the continued public interest and participation in the comment period.**



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

### Edit/Payment Rule

<p><b>Number: Draft Professional and Technical Component Rule</b> <b>207 V.03 2/4/14</b></p>	<p><b>Statutory reference: C.R.S. 25-37-106</b></p>
<p><b>Topic</b></p>	<p><b>Professional and Technical Component</b></p>
<p><b>Definition</b></p>	<p>This type of edit will identify incorrect billing of a procedure code that is either not eligible for the professional/technical split, or incorrectly identifies the professional or technical component.</p>
<p><b>Associated Current Procedural Terminology (CPT®)<sup>1</sup> and HCPCS modifiers</b></p>	<p>-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.</p> <p>-90 Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.</p> <p>-TC Technical Component:<sup>2</sup> 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 number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.</p> <p><b>Note: Professional providers in certain circumstances can bill for the technical components, refer to the Administrative guidance for more information.</b></p> <p>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.</p>
<p><b>Rationale</b></p>	<p>The following rationale was used to formulate the Professional and Technical Component rule:</p> <ul style="list-style-type: none"> <li>• The CPT® coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.</li> </ul>

<sup>1</sup> Current Procedural Terminology (CPT®), Fourth Edition. 2013. Copyright 2013. All rights reserved,

<sup>2</sup> This is the Healthcare Common Procedure Coding System (HCPCS) definition and the reference to customary and prevailing profiles is specific to Medicare. Additionally as identified by the College of American Pathologists, the statement that "Technical component charges are institutional charges and not billed separately by physicians." is specific to Medicare as well as, there is no federal requirement for the TC (ie, histology slide preparation) to be performed in a Clinical Laboratory Improvement Amendments (CLIA) laboratory facility. Many TC services are, in fact, not performed in CLIA laboratories and therefore the term "institutional" is not an applicable term for the performance of the TC for anatomic pathology services.

	<ul style="list-style-type: none"> <li>• The CPT® descriptor for modifier 26 and HCPCS modifier TC were selected.</li> <li>• The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual<sup>3</sup> were selected.</li> <li>• Any CPT® codes that were exceptions to the CMS pricing policy were identified and if applicable included in the Professional and Technical Component Rule.</li> </ul>
<p><b>Rule logic</b></p>	<p>Procedures subject to the Professional and Technical Component Rule are listed in the Medicare Physician Fee Schedule (MPFS) column labeled PCTC.<sup>4</sup></p> <p>Professional component (26) and technical component (TC) modifier identification applies to procedure codes with an indicator of 1. Modifiers 26 and TC may be appended to describe the professional and technical components respectively when appropriate.</p> <p>Professional component only codes are identified with an indicator of 2, 6 or 8.</p> <ul style="list-style-type: none"> <li>- For procedure codes with an indicator of 2 or 8 it is inappropriate to report modifier 26 or TC.</li> <li>- Procedure codes with an indicator of 6 should be reported with a modifier 26. It is inappropriate to report modifier TC.</li> </ul> <p>Technical component (TC) only codes are identified with an indicator of 3. It is inappropriate and unnecessary to append a TC modifier.</p> <p>Professional component (26) and technical component (TC) modifier identification does not apply to procedure codes with an indicator of 0, 4, 5, 7 or 9. It is inappropriate and unnecessary to append a 26 or TC.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>- CPT® codes identified with PC/TC indicator 5 are not intended to be reported by the physician in the facility setting. These codes are typically not eligible for payment when reported with a facility place of service (POS 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61)<sup>5</sup>.</li> <li>- It is inappropriate to append a 26 modifier, or TC modifier to services included in the Global Service; these codes are identified with a PC/TC indicator of 4.</li> <li>- As identified in CPT® coding guidelines<sup>6</sup>, “The use of modifier 26, Professional component, is required for CPT codes 80048-89356 in those instances when the physician is only billing for the professional component of the laboratory tests (e.g., medical direction, supervision or interpretation).”</li> </ul> <p>Payment of professional component for clinical laboratory services may be subject to the individual payer’s policy/contract.</p> <p>Clinical laboratory services are identified on the MPFS with a status X and a PCTC indicator of 9.</p>
<p><b>Administrative guidance</b></p>	<p><b>Coding and adjudication guidelines</b></p> <p>Because CPT® 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, other facility, or other qualified healthcare professional may be reporting the technical component of</p>

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

<sup>4</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.

<sup>5</sup> Department for Health and Human Services Centers for Medicare and Medicaid Services MLN Matters 7631 Revised. Visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf> to access this document.

<sup>6</sup> CPT Assistant article dated August 2005.

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 the global service (both the technical and professional components), professional component only or technical component only of a service. 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 (i.e., 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 PC and TC.

The complete Medicare description of the TC modifier is located on page 10 of this rule; it indicates, "technical component charges are institutional charges..." This is not always the case and in fact Medicare acknowledged this in the Medicare Change Request 8013, Transmittal 2714 dated May 24, 2013. The Transmittal states that, "Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment... Payment may be made under the physician fee schedule for the TC of a physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients..."

There may be other instances when it is appropriate for a physician or other qualified healthcare professional to submit a procedure code with the modifier TC appended. Some examples are noted below. However, it is not appropriate to report more than one professional and one technical component charge, or one global charge for the same procedure when rendered to the same patient during the same encounter. Such charges would be considered duplicative.

**Example 1: Chest x-ray 1 view frontal performed by physician A, interpreted by physician B, place of service – office**

#### **Correct coding**

Physician A – XXXXX TC  
Physician B – XXXXX 26

#### **Incorrect coding**

Physician A – XXXXX (no modifier)  
Physician B – XXXXX 26

**Example 2: Intraoperative neurophysiological monitoring in a facility place of service**

#### **Correct coding**

Assumes that the facility does not provide the technical component. An independent neurophysiological monitoring technician provides the equipment and supplies. A neurologist performs the professional component.

Technician – YYYYY TC  
Neurologist – YYYYY 26  
Facility – No charge or payment for this service

	<p>Incorrect coding Assumes that the facility does not provide the technical component. An independent neurophysiological monitoring technician provides the equipment and supplies. A neurologist performs the professional component.</p> <p>Technician – YYYYY (no modifier) Neurologist – YYYYY 26 Facility – No charge or payment for this service</p> <p>Refer to the H- Place of Service rule for the Place of Service (POS) instructions for the interpretation of Professional Component (PC) and the Technical component (TC) of diagnostic tests.</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>- As in the case with Medicare and Medicaid, under Colorado Revised Statutes (Chapter 41 §10-16-138, et seq.) the professional component of anatomic pathology services (CPT 88000 series) and subcellular/molecular pathology <b>cannot</b> be billed by a physician or other health care professional who performs no component of the service. In addition, the technical component of the Pap test (including, cytopathology services for cervical cancer screening codes 88141-8175) <b>cannot</b> be billed by a health care professional when such services are performed by an outside laboratory pursuant to state law.</li> <li>- Modifier 90 (outside laboratory) <b>cannot</b> be used by an ordering physician or other qualified health care professional to denote the performance of an anatomic pathology or subcellular/molecular pathology service unless the physician or other qualified health care professional has performed the professional component of the service.</li> </ul>
<p><b>Specialty Society outreach</b></p>	<p>The AMA Federation Payment Policy Workgroup was consulted. The College of American Pathologists</p>
<p><b>Summary DATE</b></p>	<p>The task force will utilize the indicators listed in the PCTC column of the MPFS to identify the correct Professional Component, modifier 26, and Technical Component, modifier TC reporting as outlined in this rule. This information is included in the MPFS Relative Value file and can be accessed at <a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html</a>.</p> <p><b>Revised February 4, 2014</b></p>

**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.

**Comments**

The Task Force is working within the legislative framework of Colorado Revised Statutes Section 25-37-106 which outlines the sources to be used in the development of a standardized set of claims edits and payment rules. These parameters should be taken into consideration when providing comments. (Information on the Task Force and legislation can be found on at [www.hb101332taskforce.org](http://www.hb101332taskforce.org)).

Draft



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

### Edit/Payment Rule

<b>Number: Draft Bundled Rule 401 V.02 2/18/14</b>	<b>Statutory reference: C.R.S. 25-37-106</b>
<b>Topic</b>	<b>Bundled</b>
<b>Definition</b>	This edit identifies when certain services and supplies are considered part of the overall care and should not be billed separately.
<b>Associated Current Procedural Terminology (CPT®)<sup>1</sup> and HCPCS modifiers</b>	There are no CPT® or Healthcare Common Procedure Coding System (HCPCS) modifiers that apply.
<b>Rationale</b>	<p>The following rationale was used to formulate the Bundled rule recommendation:</p> <ul style="list-style-type: none"> <li>• The CPT® coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.</li> <li>• The CPT® descriptions were selected.</li> <li>• The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual<sup>2</sup> were selected.</li> <li>• CPT® codes that were exceptions to the CMS pricing policy were identified and included in the recommendation.</li> </ul>
<b>Rule logic</b>	<p>Procedures subject to the bundled rule are listed in the column labeled STATUS CODE of the Medicare Physician Fee Schedule (MPFS).<sup>3</sup></p> <p>The bundled rule applies to procedure codes that are listed in the column labeled STATUS CODE of the MPFS with an indicator of P or T.</p> <p><b>Bundled indicator definitions</b></p> <p>The following are indicator definitions that are outlined in the MPFS in the column labeled STATUS CODE. This field provides an indicator for services that may be bundled.</p> <p><b>P = Bundled/excluded codes.</b> There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician</p>

<sup>1</sup> Current Procedural Terminology (CPT®), Fourth Edition. 2013. Copyright 2013. All rights reserved.

<sup>2</sup> Chapter 12 – Physician/Nonphysician Practitioners. *Medicare Claims Processing Manual*, Publication # 100-04.

<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/Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html> to access the MPFS Relative Value file.

	<p>service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.<sup>4</sup></p> <p><b>T = Injections.</b> There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. <b>(NOTE: This is a 2013 change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)</b></p>
<b>Administrative guidance</b>	<p><b>Coding and adjudication guidelines</b></p> <p>Services with a status indicator of P or T may only be considered for payment if it is the only service and is not considered incident to a physician service for the same patient during the same session by the same physician.</p> <p>Procedures identified with an indicator of B in the STATUS CODE column of the MPFS were considered during the development of this rule. <b>The MCCTF has determined that the point of an edit or rule is to prevent incorrect reporting of a service(s) on the same day or over a period of days. Medicare has described status B codes as Never separately payable. This is a Medicare reimbursement policy and for that reason was determined not to be within the MCCTF definition of a rule or edit and therefore status B codes will not be included in the final edit set.</b></p>
<b>Specialty Society outreach</b>	<p>American Academy of Orthopaedic Surgeons (AAOS)  American Academy of Otolaryngology – Head and Neck Surgery  American College of Radiology (ACR)  American College of Surgeons (ACS)</p>
<b>Summary DATE</b>	<p><b>The task force will utilize the indicators listed in the column labeled STATUS CODE of the MPFS with an indicator of P or T<sup>5</sup> to identify procedure codes subject to this rule. This rule does not apply to procedure codes assigned an indicator of B.</b></p> <p><b>February 18, 2014</b></p>

### 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.

### Comments

The Task Force is working within the legislative framework of Colorado Revised Statutes Section 25-37-106 which outlines the sources to be used in the development of a standardized set of claims edits and payment rules. These

<sup>4</sup> This is the Medicare definition and the reference covered services are specific to the MPFS

<sup>5</sup> Access <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-to-MPFS-Booklet-ICN901344.pdf> for more information.

parameters should be taken into consideration when providing comments. (Information on the Task Force and legislation can be found on at [www.hb101332taskforce.org](http://www.hb101332taskforce.org).)

Draft



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

### Edits outside of the scope of this act (Out-of-Scope Edits)

#### Background

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 a report to the General Assembly and Department of Health Care Policy & Financing with recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The task force is to identify the standardized set of rules and edits through existing national industry sources including: National Correct Coding Initiative (NCCI); Centers for Medicare & Medicaid Services (CMS) directives, manuals and transmittals; the Medicare physician fee schedule; CMS national clinical laboratory fee schedule; the Healthcare Common Procedure Coding System (HCPCS) coding system and directives; the Current Procedural Terminology (CPT®)<sup>1</sup> coding guidelines and conventions; and national medical specialty society coding guidelines.

Additional information can be found at <http://hb101332taskforce.org>.

#### Out-of-Scope

The Medical Clean Claims Transparency and Uniformity Act explicitly identifies certain types of edits that are not to be included in the standard set of payment rules and medical claim edits. Those include:

- Adjustments based on fraud or abuse,
- A finding that a procedure is not medically necessary not covered by the patient's health benefit plan,
- Contractual arrangements or terms negotiated between providers and payers, including fee schedules.

Additionally, the task force has defined 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, or
- Are Medicare or Medicaid specific.

As part of its work, the task force also addressed a number of payment rules commonly used by payers in the processing of claims and as with the edit types found that certain payment rules that it considered out-of-scope. The task force is only standardizing how the coding scenarios eligible for differentiated

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payment are to be applied to those negotiated fee schedules. They 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.

Specific examples of out-of-scope edits identified by the task force are defined below. The exclusion of these from the standard set of payment rules and claim edits does not necessarily preclude a payer from utilizing them, for example, if they are clearly communicated to the provider in the case of administrative requirements, and/or agreed to if part of a contractual relationship.

**EXAMPLES:**

<b>Duplicate</b>	Edits used to check for duplicate claims/services are Administrative and intended to ensure processing of “clean claims.” For example Medicaid utilizes this edit to check for duplicate for inpatient, Medicare Part A Crossover claims, Medicare UB04 Part B Crossover and Outpatient claims.
<b>Validation of Procedure Code to Provider Type</b>	This edit identifies a mismatch between the combination of the procedure code & modifier submitted to that expected to be billed by the provider, based on the way the payer’s provider file is set up or the scope of the provider’s license/certification. For example, the procedure code is PT and the rendering provider is a speech therapist. This is another example of an Administrative edit.
<b>Validation of Category of Service to Provider Type</b>	This edit matches the category of service billed to that expected to be billed by the provider, based on the way the payer’s provider file is set up. The Medicaid program utilizes this Administrative edit.
<b>Missing Modifier</b>	There are multiple benefit programs under Medicaid and they use specific modifiers to identify what type of coverage the Medicaid recipient is entitled to. This is a Benefit edit.
<b>Pricing File Not Loaded</b>	This edit would cause a claim to pend for manual pricing, and is another example of an Administrative edit.
<b>Pricing File Requires Manual Pricing/Split Claim</b>	This edit would cause a claim to pend for manual pricing, and is another example of an Administrative edit.
<b>Manual Pricing Required</b>	This edit is a payer specific and may be required in order to price the claim correctly. It is Administrative in nature.
<b>Multiple Procedure Percentage Reduction (MPPR)</b>	This type of edit was specifically developed by Medicare and has been applied to multiple imaging procedures and multiple therapy services. As part of the Affordable Care Act, Medicare was directed to potentially expand its use to other types of procedures. The task force has determined that these types of

edits are out-of-scope. As the MPPR is the result of legislative and regulatory direction given to the Medicare program the task force wanted to ensure that the rationale for this decision is documented. 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.



Activity	2013									2014										Deadline/Status			
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct		Nov	Dec	
Website set up to include all notices and public comments.																							Ongoing
Update entire draft set with current codes. [2014]																							Ongoing
Glossary developed with final set																							Ongoing
Finalize governance process for: - Legislature - Edit process and review - Division of Insurance																							Ongoing
Task force secures \$100,000 legislative appropriation.		X																					May 1, 2013



Activity	2013										2014										Deadline/Status	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov		Dec
Task force project manager hired.			X																			June 1, 2013
Federation and others are notified that the task force will be sending out for review and comment, four rounds of proposed edit rule recipes in May, June and July.		X																				June 14, 2013
Public comments due on 1st bundle			X																			July 15, 2013
Payment & Edit Committees review comments on 1st set of recipes and make recommendations for revisions.					X																	August 4, 2013
2nd bundle: Edit and Payment Rules committees work on the draft edit rule recipes for second bundle of rules & submit to TF for approval.					X																	August 15, 2013

Activity	2013									2014										Deadline/Status		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct		Nov	Dec
Task force finalizes and approves first bundle of recipes.					X																	August 27, 2013
Task force reviews and approves draft second bundle of draft edit rule recipes.					X																	August 27, 2013
Second bundle of draft recipes issued for 5-week public review and comment.						X																September 4, 2013
Public comments due on 2nd bundle.						X																October 4, 2013
<b>3rd Bundle:</b> 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.							X															October 15, 2013

Activity	2013										2014										Deadline/Status	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov		Dec
Task force reviews and approves draft 3rd bundle of draft edit rules.							X															October 22, 2013
<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;</li> <li>o Enabling electronic access--including downloading capability--to the rules and edits set</li> </ul>							X															October 22, 2013

Activity	2013										2014										Deadline/Status	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov		Dec
3rd bundle of draft recipes circulated 5- week public review and comment period **								X														October 25, 2013
Payment & Edit Committees review comments on 2nd set of recipes and make recommendations for revisions.								X														November 15, 2013
4th bundle: Edit and Payment Rules committees work on the draft edit rule recipes for the fourth bundle of claims edits and payment rules and submit to task force for approval.								X														November 19, 2013
RFP for data analytics contractor issued.								X														November 24, 2013
After reviewing comments received on 2nd bundle draft edit rule recipes, 2nd bundle approved.								X														November 26, 2013

Activity	2013										2014										Deadline/Status	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov		Dec
Task force reviews and approves draft fourth bundle of draft edit rules.								X														November 26, 2013
Public comments due on 3rd bundle								X														December 4, 2013
Fourth bundle of draft recipes circulated 30-day public review and comment period. **									X													December 4, 2013
Additional monies raised to fully fund budget.									X													December 15, 2013
Proposals from data analytics contractors due. Executive Committee and three unconflicted task force members review and score RFP responses.									X													December 31, 2013

Activity	2013										2014										Deadline/Status	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov		Dec
Payment & Edit Committees review comments on 3rd set of recipes and make recommendations for revisions.										X												January 6, 2014
Public comments due on 4th bundle										X												January 6, 2014
Task force reviews and approves selection of an RFP contractor based on scoring.										X												January 8, 2014
After reviewing comments on 3rd bundle of draft recipes, task force finalizes and approves.										X												January 21, 2014
Payment & Edit Committees review comments on 4th set of recipes and make recommendations for revisions.												!										February 6, 2014

Activity	2013										2014										Deadline/Status		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov		Dec	
Contract for data analytics contractor (Bishop) signed.												X											February 18, 2014
After reviewing comments on fourth bundle of draft recipes, task force finalizes and approves.												!											February 15, 2014
Letter for specialty societies re data analytics to be distributed through AMA (Connor/Vatsala/Marilyn)												!	!										March 15, 2014
Coordinate with AMA to get list of coding committees												!	!										March 1, 2014
Contractor ready to accept edits from vendors, payers, others.													!										March 1, 2014







Activity	2013										2014										Deadline/Status	
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov		Dec
Initial edits installed														!!	!!							June 15, 2014
Operational Beta Test															!!	!						July 15, 2014
Complete proposed standardized edit set ready for review and approval by task force.																!						July 24, 2014

Activity	2013									2014									Deadline/Status			
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	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.																!						July 31, 2014
Production data analytics database																!	!					August 15, 2014
Comments due on proposed standardized edit set and DSR operations. Public hearing.																		!				September 15, 2014

Activity	2013									2014										Deadline/Status		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct		Nov	Dec
Committees review public comments on proposed edit set and DSR operations based and develop recommendations for consideration by full task force.																		!	!			October 25, 2014
Staff draft final report to legislature and HCPF.																				!		November 7, 2014
Task force reviews 1st draft of final report.																				!		November 18, 2014
Task force reviews & approves final standardized edit set & DSR operations recommendations.																				!		November 23, 2014
Task force approves final report.																					!	December 17, 2014

Activity	2013										2014										Deadline/Status			
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov		Dec		
Final report to the Colorado Health Foundation																						!	December 20, 2014	
Write implementation Manual																							!	December 31, 2014
Final report submitted to legislature and HCPF.																							!	Dec 31, 2014

## Recipe Development Tracking Sheet

**PC** = Public Comment

**PRC** = Payment Rules Committee

**TF** = Task Force

### KEY

X = Completed

I = Incomplete

O = In Progress

Rule	Bundle	Definition From EC	Rationale	HCPS/CPT Modifiers From EC	Query Tables Drafted	Rule Logic Drafted by PRC	Administrative Guidance Drafted By PRC	Specialty Outreach	TF Approval of Rule for PC	TF Response to PC	TF Consensus on Finalized Rule
J-Asst. Surgery	1	X	X	X	X	X	X	X	X	X	X
K-Co-surgery	1	X	X	X	X	X	X	X	X	X	X
L-Team Surgery	1	X	X	X	X	X	X	X	X	X	X
N-Bilateral Procedures	1	X	X	X	X	X	X	X	X	X	X
A-Unbundle (PTP)	2	X	X	X	X	X	X	X	X	X	X
B-Mutually Exclusive (PTP)	2	X	X	X	X	X	X	X	X	X	X
C-Multiple Procedure Reduction	2	X	X	X	X	X	X	X	X	X	X
D-Age	2	X	X	X	X	X	X	X	X	X	X
E-Gender	2	X	X	X	X	X	X	X	X	X	X
F-Maximum Frequency Per Day	2	X	X	X	X	X	X	X	X	X	X
H-Place of Service	2	X	X	X	X	X	X	X	X	X	X
M- Total/Prof./ Tech. Split	2	X	X	X	X	X	X	X	X	X	O
O-Anesthesia Services	2	X	X	X	X	X	X	X	X	X	X

Rule	Bundle	Definition From EC	Rationale	HCPS/CPT Modifiers From EC	Query Tables Drafted	Rule Logic Drafted by PRC	Administrative Guidance Drafted By PRC	Specialty Outreach	TF Approval of Rule for PC	TF Response to PC	TF Consensus on Finalized Rule
Add-ons	2	X	X	X	X	X	X	X	X	X	X
G-Global Surgery Days (Modified to Global Procedures)	2	X	X	X	X	X	X	X	X	X	X
Global Maternity	2	X	X	X	X	X	X	X	X	X	X
New Patient	3	X	X	X	X	X	X	X	X	X	X
Max. Frequency- Span of Days	3	X	X	X	X	X	X	X	X	X	X
Same day med visit & med procedure	3	X	X	X	X	X	X	X	X	X	X
Multiple Endoscopy (Modified to include multiple procedure reduction)	3	X	X	X	X	X	X	X	X	X	X
Multiple E&M's Same Day	4	X	X	X	X	X	X	X	X	X	X
Bundled Service (Status B)	4	X	X	X	X	X	X	X	X	X	O
Rebundling	4	X	X	X	X	X	X	X	X	X	X
P- Modifiers effect on edits:	4	X	X	X	O	X	X	X	X	X	X
<b>Multiple radiology</b>	<b>N/A</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>OUT OF SCOPE</b>	
<b>Multiple phys. Therapy</b>	<b>N/A</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>OUT OF SCOPE</b>	

## MCCTF BUDGET 1/18/14

## The Medical Clean Claims Transparency and Uniformity Act Task Force (HB10-1332)

	2013 Grants		2014 Rollover Funds & New Grants	
<b>INCOME</b>				
State of Colorado	\$	100,000.00	\$	47,349.75
Colorado Health Foundation	\$	60,166.00	\$	60,166.00
Other (General Donations)*	\$	15,259.84	\$	1,792.09
Other (Meals)**	\$	2,489.87	\$	-
AMA	\$	-	\$	5,000.00
<b>TOTAL</b>	<b>\$</b>	<b>177,915.71</b>	<b>\$</b>	<b>114,307.84</b>
<b>EXPENSE</b>				
<b>Line Item</b>			<b>Budget</b>	
Data Analytics Vendor			\$	50,000.00
Professional Fees				
Project Management			\$	66,000.00
Administrative Support			\$	24,000.00
Program Expense				
Supplies/Materials			\$	-
Meeting Expense*			\$	-
Contingency (12%)			\$	10,800.00
Administration				
Fiscal Sponsor			\$	-
<b>TOTAL EXPENSE</b>			<b>\$</b>	<b>150,800.00</b>
<b>2014 Unfulfilled Budget Obligations</b>			<b>\$</b>	<b>36,492.16</b>

\* In 2013, General donations came from: CMS, KEENE R & D, AMA, and Bell Policy Center

\*\*In 2013, meals covered by: CMS, Anthem, University of Colorado, Rocky Mountain Health Plans, and Humana