



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

Response to Public Comments
October 4, 2013

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®)¹ 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>.

Professional and Technical Component Rule 207 V.01 9/4/13

Comment: A national specialty society commented that the proposed rule logic incorrectly indicates, "Professional component only codes are identified with an indicator of 2, 6 or 8. ***It is inappropriate and unnecessary to append a 26 modifier.***"

The commenter also pointed out that the proposed rule conflicts with Medicare's direction to append modifier 26 to procedure code G0452 – Molecular pathology procedure, physician interpretation and report.

Response: The task force has reviewed the Medicare Physician Fee Schedule Database (MPFSD) and agrees with the commenter. The PCTC indicator 6 does *not* preclude the use of modifier 26, and in fact the fee schedule listing for procedure codes with a PCTC indicator of 6 includes a value for only modifier 26. However, indicator 6 does state that modifier TC cannot be used with these procedure codes.

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When the final rule is written we will revise this section accordingly:

- Professional component only codes are identified with an indicator of 2, 6 or 8. For procedure codes with an indicator of 2 or 8, it is inappropriate to report modifier 26 or TC.

- Procedure codes with an indicator of 6 should be reported with a modifier 26. It is inappropriate to report modifier TC.

The above correction will allow for modifier 26 to be appended to code G0452 as it has a PCTC indicator of 6.

Comment: The national specialty society pointed out an oversight in the proposed rule concerning anatomic pathology. As in the case with Medicare and Medicaid, and under explicit Colorado State law (Chapter 41 §10-16-138, et seq.) the professional component (Modifier - 26) of anatomic pathology services (CPT 88000 series) and subcellular/molecular pathology **cannot** be billed by a physician who performs no component of the service. In addition, the technical component of the Pap test (including, cytopathology services for cervical cancer screening Pap codes 88141-8175) **cannot** be billed by a health care provider when such services are performed by an outside laboratory pursuant to state law.

To ensure compliance, some payers in Colorado have adopted edits that screen E&M codes when billed with certain anatomic pathology services. These edits are used by payers to ascertain if an ordering E&M provider has improperly billed, in violation of state law and coding conventions, for an anatomic pathology service, including technical and professional service codes, when performed by an outside laboratory. The prohibited uses and coding conventions attached to this -26 modifier were also noted by the Task Force.

Furthermore, as is the case with Medicare and Medicaid the -90 (pass-through) modifier **cannot** be used by an ordering physician to denote the performance of an anatomic pathology or subcellular/molecular pathology service unless the physician has performed the professional component of the service. The prohibited uses and coding conventions attached to this – 90 modifier were also noted by the Task Force.

Response: The omission of modifier 90 from the proposed rule was an oversight, and we agree that it should be included. The final rule will include a statement instructing that the professional component for anatomic pathology and subcellular/molecular pathology can only be billed by the qualified healthcare professional who performs the interpretation. Additionally, the rule will indicate that the technical component of the Pap test (including, cytopathology services for cervical cancer screening Pap codes 88141-8175) cannot be billed by a health care provider when such services are performed by an outside laboratory.

Comment: The commenter pointed out that the proposed rule conflicts with CPT coding conventions. According to the AMA CPT definition, “the use of modifier 26, Professional component, is required for CPT codes 80048-89356 [describing pathology and laboratory services] in those instances when the

physician is only billing for the professional component of the laboratory tests (e.g., medical direction, supervision or interpretation). This method of reporting is appropriate when the technical and professional components are reported by different providers.” Thus, the Final Rule’s logic stating that use of the 26 modifier is “inappropriate and unnecessary” is in direct conflict with the CPT coding rules for use of the 26 modifier with a pathology CPT code.

Response: Recognizing the importance of this issue to the national specialty society, the task force reviewed its original recommendation. The task force acknowledges that the CPT® coding guidelines do indicate that a modifier 26 is required when reporting professional component only for procedure codes in the pathology and laboratory services section of the codebook. The purpose of the CPT® “...terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services...” However, the CPT® also states that “Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.” Likewise, it is not within the task force’s purview to determine payment for a particular service or procedure. Rather the task force is trying to identify and standardize correct coding principles; for this reason the task force agreed that the following modification would be made when the final rule is written:

As identified in CPT® coding guidelines², “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).”

Payment of professional component for clinical laboratory services may be subject to the individual payer’s policy/contract.

Clinical laboratory services are identified on the MPFSD with a status X and a PCTC indicator of 9.

Comment: We have concern with the technical component definition listed on page one of the Task Force’s Professional and Technical Component Edit/Payment Rule. We specifically have concerns with the sentence that states that “Technical component charges are institutional charges and not billed separately by physicians.”

The Task Force should be aware that there is no federal requirement for the TC (i.e., 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.

Response: In the section of the draft rule referred to, *Associated Current Procedural Terminology (CPT®) and HCPCS modifiers*, the descriptions listed are taken directly from the source documents either CPT or HCPCS. The task force does not have the option of revising these descriptions. However, previously we did add a footnote to the TC modifier description regarding the customary and prevailing profiles. This footnote will be expanded to encompass the concerns

² CPT Assistant article dated August 2005.

raised in this comment when the final rule is written.

The task force would like to express its appreciation not only for submission of comments, but also for the engagement of the national specialty society in discussion of its recommendations.

**Multiple Procedure
Reduction
202.V01 9/4/13**

Comment: From the American Gastroenterological Association, American Society for Gastrointestinal Endoscopy and the American College of Gastroenterology asking for revisions to the section of the proposed rule that references unrelated multiple endoscopies. They suggested the following revisions:

Claims for endoscopies that are not in the same 'family' should be processed according to regular multiple surgery pricing methodology.

- 'Standard multiple surgical payment adjustment rules' are used to calculate reimbursement for endoscopic procedures in different families;
- If the endoscopic procedure is reported on the same date as another procedure, the procedures are first ranked by fee schedule amount from highest to lowest;
- The procedure with the highest fee schedule amount is reimbursed at the highest level;
- Endoscopies that are performed on the same date as other surgical procedures should be subject to the regular multiple surgery pricing methodology;
- First, pricing is determined for all codes in the endoscopic family according to the standard payment adjustment rules;
- Next, the family of endoscopic codes is considered against the other surgical procedures; and,
- The 'family' of and the other surgical procedures are ranked by fee schedule amount from highest to lowest.

Endoscopies in the same 'family' (i.e., those that share the same base procedure) are reimbursed according to the following rules:

- 'Standard multiple surgical payment adjustment rules' are used to calculate reimbursement for endoscopic procedures in the same family;
- The endoscopic procedure with the highest fee schedule amount is reimbursed at the highest level;
- If the endoscopic procedure is reported on the same date as another procedure, the procedures are first ranked by fee schedule amount from highest to lowest; and,
- If the endoscopy and its base procedure are the only endoscopies submitted, the base endoscopy will not be reimbursed separately. It is included in the other procedure.

The inconsistent application of the multiple procedure and multiple endoscopy rules creates a difficult and confusing situation for physicians, facilities and patients. A number of payers apply multiple procedure rules to endoscopic procedures. Payers that do apply multiple endoscopy rules developed by McKesson have not been consistent in their application of their payment rules for endoscopic rules, which creates confusion for patients and providers in determining whether claims were properly reimbursed. Uniform application of a

single multiple procedure reimbursement rule for all surgical procedures – including all endoscopic procedures (urology, gastroenterology, colorectal, pulmonary, orthopedic, gynecology, etc.) - will eliminate confusion and create more transparency.

It is for these reasons that we urge the CCCTF to provide a consistent recommendation for the processing of multiple endoscopic procedures, as we outline above.

Response: The specialty societies that submitted these comments and the American Urological Association worked directly with the task force on the drafting of the Multiple Endoscopy Reduction Rule that was submitted for public comment on November 4, 2013. One of the inconsistencies raised during the drafting of the Multiple Endoscopy Reduction rule relates to the fact that the percentage reduction applied to multiple endoscopies is different than the reduction applied to other multiple surgeries/procedures by some payers. As the determination of the specific percentage reduction to be applied is outside of the scope of the task force, the societies agreed that the Multiple Endoscopy Reduction rule should be addressed separately as originally discussed with reference to the application of reductions within a family of related endoscopies, and reductions for unrelated endoscopies. The cross reference in the Multiple Procedure Reduction rule will be reviewed for consistency with the final Multiple Endoscopy Reduction rule and revised if necessary prior to the final publication.

Age
203.V.01 9/4/13

Comment: From the American Academy of Pediatrics.

While appropriate to have an age edit factor into claims system logic, our concern is that in order to make a unified claims edit system, all parties must be operating under the same rules and logic.

In Current Procedural Terminology (CPT®), there are codes that are still listed with the term “child.” This term is not being uniformly defined by all payers. There are currently three codes in the CPT code set that use the term “child” but never define the age range.

Therefore, we respectfully request that any age ambiguities be fully worked out either through this edit system as a transparent rule or with changes to the CPT nomenclature so that the term “child” or any other vague term related to age is more clearly defined.

The three codes directly related to this comment are:

24640 (Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation)

73540 (Radiologic examination, pelvis and hips, infant or child, minimum of 2 views)

76010 (Radiologic examination from nose to rectum for foreign body, single view, child)

Response: While the task force completely understands the concern regarding inconsistent application of age restrictions, the edit definition that this rule is

based on is completely dependent upon the CPT® procedure description and/or and related coding guidelines. For this reason, the task force will relay the society's concern to the AMA CPT® task force member and ask that it be reviewed for consideration of nomenclature revision and/or a CPT® Assistant article.

Comment: RMHP

RMHP assigns age limits to selected procedure codes based on the AMA CPT code descriptor, but also includes limits found in published information from professional specialty societies and the Food and Drug Administration. Although related to diagnosis coding, when it is appropriate to apply to a procedure, our edits may be based on information from International Classification of Diseases, Ninth Revision Clinical Modification (ICD-9-CM), the current HCPCS Level II Expert, and the American Hospital Association (AHA) Coding Clinic. If the code descriptor does not contain a specific age or an industry source is not found to support an age assignment then a default value of 0 – 99 is indicated. In the development of the code to age edits, will CCCTF consider these sources when the age is not specific, e.g. newborn or infant?

Response: The additional edits submitted by payers and vendors during the analytic phase of the task force's work will be reviewed and evaluated for inclusion in the standard edit set. The sources of these additional edits should be clearly identified when the file is submitted for consideration.

Add-on
209.V01 9/4/13

Comment: RMHP

RMHP's edit system includes add-on codes outside of those designated with a + sign. For example, we use interpretation of CPT as a source for codes that include descriptors such as "list in addition to", however there is no + sign in front of the code. Some edits apply for definitive (+) and interpreted relationships to assign the primary code. Although the edit previously used codes with a designation of ZZZ global days, the new CMS categories of I, II, and III add-on logic includes codes that do not have the ZZZ designation. A complete list of add-on codes with identification of appropriate primary codes is needed for adequate comparison and analysis.

out the line on two separate lines with the provider's billed amount equally divided to allow for the multiple surgery adjustment to allow up to 150% for the bilateral eligible service.

Response: The task force will ask the Rules Committee to review the additional information submitted and make a recommendation concerning whether/how the draft Add-on rule may need to be revised.

Anesthesia
208.V01 9/4/13

Comment: RMHP

The Anesthesia Rule does not specify who the "anesthesiology professional" is. RMHP employs an edit that limits billing of anesthesia codes to an anesthesiology professional, including Anesthesiologist, CRNA, and Anesthetist Assistant (AA), based on ASA Sourcing under the Statement of Anesthesia Care Team documentation. Additionally, a claim for a surgical procedure that is submitted by this provider type will be edited to require the appropriate

anesthesia code. We agree with the list of codes designated by indicator J.

Response: The determination regarding the types of providers that are eligible to bill 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.

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