

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

### Agenda

April 24, 2013, noon – 2 PM MST  
Call-in number: 1-866-740-1260, ID **8586314#**  
Web Login:  
<https://cc.readytalk.com/r/jjumabm122su>

### **Agenda**

- 12:00 PM Roll call, welcoming remarks and housekeeping
- Approve March meeting minutes (Attachment A)
  - Next face to face meeting May 21<sup>th</sup> 11:00 AM to 3:00 PM MST & May 22<sup>th</sup> 7:30 AM to 2:00 PM MST

### **Committee Reports**

***Committee Reports: introduce committee members; committee principles (if applicable); committee scope of work; report of activities to date; recommendations (draft and final); issues to be resolved or investigated; questions for the full task force; next steps.***

- 12:10 PM Committee Reports
- Edit– Beth Wright/Mark Painter
  - Rules Committee – Lisa Lipinski  
Bilateral procedure payment rule will be distributed later for discussion.
  - Specialty Society – Tammy Banks/Helen Campbell
  - Data Sustaining Repository – Mark Rieger/Val Clark
    1. Rerun the assistant surgery analytics with additional specifications from the Edit Committee
    2. Notice of proposed rules process (Attachment B)  
***Recipe template for consensus (Attachment C)***  
***Note: The Assistant Surgery rule was used as an example to demonstrate how it would appear when completed. However, if the results of the data rerun support the task force’s original recommendations we will also ask for a consensus vote on the Assistant Surgery rule as presented.***
  - Project Management – Barry Keene
    1. Review of MCCTF rule development tracking document (will follow)
  - Finance – Barry Keene
- 1:55 PM Public Comment
- 2:00 PM ADJOURNMENT

# Attachment A

## DRAFT

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

Executive Summary of Meeting Minutes

March 27, 2013, noon-2 PM, MST

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

Conference ID: ID 8586314

#### Attendees:

- Beth Wright
- Lisa Lipinski
- Barry Keene, CC
- Kathy McCreary
- Lori Marden
- Marilyn Rissmiller, CC
- Kim Davis
- Wendi Healy
- Marie Mindman
- Diane Hayek
- Deb McFedan (in place of Helen Campbell)
- Mark Rieger
- Mark Painter
- Doug Moeller, MD

#### Staff :

- Connor Holzkamp
- Barbara Yondorf

#### Public:

Marianne Fink (HUM)  
Pam Kassing (ACR)  
Julie Painter (STS)

#### Meeting Objective (s):

See Agenda

#### Key:

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



## March 27, 2013

### DISCUSSION

#### ROLL CALL & WELCOME:

At the start of the meeting, there were 6 Task force Members in attendance

Barry started off the meeting at 12:07 PM MDT. The following TFM were present:

- Beth Wright

- Lisa Lipinski
- Barry Keene
- Kath McCreary
- Lori Marden
- Marilyn Rissmiller

In light of the attendance, Barry recommended that the TF move on to a couple of things before asking for another roll call to see if quorum is reached.

Barry briefly updated the TF on the legislation which did pass through the Senate HHS Committee and went on to appropriations. The Colorado legislature has been very busy with other items and the Appropriations Committee has not met regarding the bill yet.

#### **EDIT COMMITTEE: Beth Wright/Mark Painter**

The Edit Committee did not have anything for consensus, and reported that it is waiting on information from Mark Rieger regarding the Assistant Surgery rule.

Mark Painter stated that “we’ve asked Mark to re-run everything, and we are looking for the information to come back with a data layout on the assistant at surgery setup because we need to take a look at some of the anomalies that turned up when we were all face to face. We need to go through these in order to come up with a generalized rule to bring to the TF. So we do not have that ready yet, but should by next month.”

Barry was under the impression that this was going to be happening today, and Beth agreed. However, the work of the Edit Committee was at a stand-still until it Mark Rieger could get back to them. In the meantime Beth stated that she would send Barry the document she has been working on regarding the query questions.

#### **ACTION ITEM: Beth will send the documents to Barry**

At approximately 12:25 PM MDT, roll call was taken again. The following people had joined the call:

- Kim Davis
- Wendi Healy
- Marie Mindman
- Diane Hayek
- Mariane Finke
- Julie Painter
- Deb McFedan (in place of Helen Campbell)
- Pam Kassing (ACR)

As of the second call for attendance, a quorum had not been reached. Barry recommended that the TF ask for one more roll call to take place a little bit later on in the call. Barry asked Beth if the Edit Committee had anything else to bring to the TF.

Beth responded, “We do not. Unfortunately our committee did not meet—mostly because I was not ready to have anything to share. Once we actually take a look at the comments on assistant surgery and we get the format done, then I think we can roll with the rest of the other four topics. I didn’t start the other four because I want to have direction on where we are going with the format.”

Barry stated that this made sense to him, and asked if the Edit Committee could offer some sort of timeline.

Beth said that if Mark R could get back to them by the end of the week then the Committee should be able to have the Assistant Surgery rule done by the next meeting in April. Mark P agreed, stating that the Committee just needs the data from Mark R.

#### **PAYMENT RULES COMMITTEE: Lisa Lipinski**

Lisa and the Rules Committee had a draft for the Bilateral Procedures Rule to bring to the table for discussion. Lisa noted that she was looking for the TF to really look at the layout of the document and recommend any adjustments.

Barb jumped in and said, “I just wanted to mention as a footnote the importance of trying to format these things consistently with each other.”

Beth wanted to know what this document is going to be used for.

The following discussion took place:

Lisa: That wasn't necessarily meant to be the template, this document on bilateral is what we had for a template.

Beth: So maybe I should send you the document that I sent Marilyn. I sort of took the list out of the process document and created a visual policy look.

Lisa: Absolutely—this document I have is just a straight-forward word document. It has the information we wanted to put on every rule, and making sure that everyone could understand our rationale, coding guidelines, and things of that nature. So yeah, we can definitely work on the actual layout of all this.

Beth: Yea. I am used to publishing for our provider community, and I think you need to have something that reads one way, and then you have to have some kind of literature in the background for us to internally review that not everyone has to see. Like I said I wasn't sure where to put everything so I put it all on to this document that I am going to send you (Lisa).

Lisa: Right and we can work on the layout of all this stuff.

Barry then asked Lisa to lead the TF through the document (Draft for the Bilateral Procedures Rule)

Lisa: So we started with a disclosure statement, which we put at the top of every single rule. Underneath that we have the modifier, or modifiers depending on the rule—for the bilateral there is only the one. We added that this rule is applicable for the specific situations identified for this modifier. There might be other appropriate situations where multiple modifiers apply. The next thing that we did was specify that we were using the Medicare Fee Schedule, and we have a link to that so somebody could identify what procedures were going to be subject to this rule. The next thing that we have on here are the status indicators and coding guidelines—so we have first the recommendation of the Rules Committee. Following that, we put in some guidelines for if the above criteria are not met, and some of the actions that can be taken if something is billed with a modifier that is different from what is listed. We also say that we are using the status indicators as outlined in the Medicare Fee Schedule so that people understand which procedure codes are applicable. Then towards bottom of page two we have the listing of the status indicators and which ones would/would not apply. Moving on to page three, the next section is the rationale—how we formulated this recommendation. It specifies that we looked at CPT©, then it says we took CPT© descriptions, and modifier 50 definition. We looked over CMS pricing policy and the Medicare Claims Processing Manual, and we looked at exceptions as well, which are in a different appendix towards the bottom so we can add to that as more exceptions come up. The next section we put in was *MCCTF Comments*. Below that we have the *Modifier Definition*, as well as the *Status Indicator Definitions* which are

clearly spelled out for everybody. Going on to page five, the last part is *Federation Outreach* so everyone can see who was contacted and what their response was.

Beth wanted to know how the exceptions are identified, which sparked the following discussion:

Lisa: Nancy actually identified these orthopedic surgery exceptions, and we verified them with the Orthopedic Surgeons Association. And then if you go on to page seven, the *CPT© Codes Category III*, our CPT© folks identified those for us.

Beth: So they are a status *one* for Medicare?

Lisa: I'm sorry that is an "I"—there are those that have letters and those that have numbers in the CMS database. I guess we should make that a little easier to read.

Beth: So I have a couple questions. One of them is it seems to me that this is a recommendation for surgical and radiology?

Lisa: For bilateral, yes.

Beth: Ok. So I know for WellPoint that will be different—I don't know about other payers.

Marie: As far as honoring the 50 on radiology? Is that what you mean?

Beth: I mean requiring them to bill on one line, and have a unit of one with the 50. We see a lot with the radiology and we didn't really make a change to that because we don't apply the 150. So they get RT on one line LT on another—we see the mixed bag on everything for radiology.

Marie: Likewise, yeah.

Beth: So this recommendation is one that requires radiology to be billed on one line—did the radiology society agree on that?

Lisa: Dr. Borgstede, Diane Hayek and Pam Kassing were on the call when we agreed to this.

Diane: It was our opinion that it should be billed on two lines; one with an RT and one with an LT.

Wendi: We did lay that out that way in the status indicator portion starting on the bottom of page four.

Beth: Ok, so on the first page where you have your *Coding Guideline Recommendation*, I think you need to modify that opening statement. It says *it is the recommendation of the Rules Committee that the only time a bilateral may be made is when. . .*

Lisa: Well right above there it states that *this rule applies to those with the status indicator of one*. So those radiology codes would be a status indicator of three, right Diane?

Diane: That is correct—the 70,000 series codes.

Beth: Right, so the *Coding Guideline* is regarding the Medicare rule? I'm not sure that if a provider were to read this that they would understand.

Wendi: I think our intention was to say that this bill on one line with the 50 modifier is only applicable to those with status indicator one, don't look at other status indicators for this rule. I can see where you are going though Beth. . .

Lisa: Yea and I see the confusion there as well.

**ACTION ITEM: Document will be revised in order to clarify the radiology piece of the document**

Lori had a question from a payer perspective, “So there are two components from the payer perspective: The first is to *pay* the claim appropriately and accurately and the second is to have it *billed* appropriately and accurately. So as I read through this disclosure statement it seems to me that all it is addressing is what the payer expectations are, so what about the billing (provider) expectations? Why is this addressed only from the payer perspective?”

This question started the discussion below:

Wendi: We actually do have this on there under the *Coding Guidelines* at the end of page one. It states *adjudicate one line using bilateral pricing adjustment, deny other lines with the same procedure code if no additional modifier is appropriately appended*. So it does address what would happen to the physicians—their claim would be denied for incorrect billing. We have gone back and forth on whether this is appropriate, but it is on there.

Lori: It’s addressed, but it still allows them to bill correctly.

Wendi: They just don’t get paid.

Lori: But they do get paid.

Wendi: Only for one of the two sides.

Lori: It says use bilateral pricing for the one. Adjudicate one line using bilateral pricing.

Wendi: Right but if I bill on two lines I only get paid for one. So let’s say that I am billing \$200 for bilateral procedure, I put \$100 on one line and \$100 on the other line—I am getting paid \$100, not \$150. It forces the provider to bill appropriately because otherwise they won’t get paid the full amount.

Lori: Right. But our system would allow it at 150% of. . .

Wendi: Ok so I get what you are saying, but the payment rules in your system would have to be appropriately set up in order to apply this rule, which, all of your rules are going to have to be right?

Lori: Right but it wouldn’t price correctly if it wasn’t billed correctly.

Wendi: Yet you are going to have to adjust the payer system on all of these rules if they are not functioning the way that the rules state, isn’t that correct?

Lori: Well I just need to say that’s a huge, huge setback.

Wendi: I think we have already addressed that in numerous other issues on what happens on the payer side, including what the costs are of changing their payment systems.

Lori: I do not support the recommendations, and I don’t know that internally our higher-ups would either.

Barry: Ok. Lori, did you attend the meeting where this rule, this document was developed?

Lori: No. Not to my knowledge.

Barry: Ok. Was Nancy?

Wendi: Yes she was.

Lisa: Yes, Nancy has been a part of this from the beginning.

Barry: Ok. My recommendation is that before we take this further with the full TF, you counsel with Nancy about this and then come back to Lisa's team with recommended different language. However, I will say it has been understood from the beginning that there will be some re-programming at the payer level.

Lori: I will do that. And I think we all understood from a payer perspective that there would be configuration changes with the new rule sets, but I just didn't think we would move to support incorrect coding.

Marilyn jumped in and said, "I think this is part of the discussion we had at the on-site where Tom Darr had brought up that we need to try to give some direction as far as what happens if it is not billed correctly. Tom's point was that we want to try and think of all the possibilities, and, like Wendi said you can't really deal with all the creative coding, but for the most part you can probably try to identify when something happens do this."

**ACTION ITEM: Lori will bring her concerns to Nancy to work out suggested language**

Lisa thanked the TF for its comments, and concluded her report on the Payment Rules Committee:

Lisa: We are also in the process of developing the co, team, and global surgery rules, and also looking at age and gender, which we hope to have ready by the May on-site TF meeting.

Barry thanked the Committee and asked that role be taken once more to see if a quorum had been reached. The following people had joined the call.

- Mark Rieger

Quorum was reached as 12 TFM were present, and Barry made a motion to approve the February minutes.

Beth seconded the motion.

**ACTION ITEM: February minutes approved with no changes**

**DSR COMMITTEE: Mark Rieger**

Mark Rieger and the DSR Committee did not have anything to bring to the TF. Mark R noted that he had received the information from Beth but had not had a chance to re-run the data yet. He mentioned that this should be done by the next meeting, and he would try to make the Edit Committee's conference call this month.

The next item for the TF on the agenda was to go over *Attachment A* in the Agenda. Barb noted that the timeline for this document should be compared with the timeline documented in the *Work Plan*.

*Attachment A* is the *Notice of Proposed Rules* Process and was drafted by Marilyn after a meeting with all of the Co-chairs. During the meeting, the CC were trying to work through and get consensus around the strategy for providing notification of the rules. It was noted that *Attachment A* was not up for consensus today.

Marilyn summarized the document: "This is just for the TF to start really trying to see if this is what we want. We talked about using the recipes because whatever the final format is needs to provide as much information as we can so that people can understand what the TF is doing and understand the impact of the rule on their organization. So we were thinking that it would be an online process rather than accept a lot of correspondence. We also need to identify how we go about sending out the notification electronically, probably using the AMA Federation. We will need to add a sign-up place on our website so that once this gets going people can sign-up to receive the proposed rule recipes directly. In part three of the document we get into the process. We need to

provide a way for people to submit comments back to us. We would like this to be electronic via email to the TF, and looked at by the Co-chairs. The other thing we need to do is provide the format, type of information that is required to submit to us for consideration. They need to provide us with a contact so that if we have questions we can go to them—If there is substance to the comment it would get funneled into the appropriate committee(s) for review, and eventually from the committees into the full TF with recommendations to accept/not accept.

According to Marilyn, one of the problems that CC's ran into was "we really don't know what the volume of comments will be and I would guess that we will get more comments as we go along and people become more aware of what we are doing.

Wendi noted that she had reached out to CMGMA and they had mentioned that they would be happy to send blasts out to their membership either on the rules or for signing up on the website to get the rules.

Doug thought that this document/process was a great place to start. Beth did as well, adding that many of these comments might end up being similar to each other.

**ACTION ITEM: Connor to add "sign-up" function on the MCCTF website.**

#### **PROJECT MANAGEMENT: Barry Keene**

Barry briefly reviewed timeline for TF (attachment B). "As an engineer my experience is that you are late at the beginning, not late at end. I am very pleased with the way I see this coming together." Barry noted that he is pleased with the cross section of participation thus far.

#### **FINANCE: Barry Keene**

Barry mentioned that the grant reports for both The Colorado Trust and Colorado Health Foundation is due Friday March 29<sup>th</sup>, and that is coming along well. "Our original grant was 25,000, and that number was matched by our stakeholders. Of the remaining 2 years constructed budget of around \$240,000, a significant chunk of that is for the data analytics as well as a project manager. We are asking for \$98,000 from CHF that will coincide with another \$100,000 from the SB 166 appropriation, so we should only have to raise an additional 20% from stakeholders." At this point, Barry went back for a moment to touch on the face-to-face in May. "It appears that Lilly marks boardroom is our best set-up, but we would have to be out by 3:30 PM on Tuesday. Wednesday is no problem, but Tuesday has a meeting coming in at 4:00. With that said, I recommend moving the starting time up just a little bit. Would there be objections if we propose to start at 11:00? No objections were made.

**ACTION ITEM: Meeting Time moved up to 11:00 AM on Tuesday, May 21.**

#### **PUBLIC COMMENT:**

There was no additional public comment.

#### **OTHER BUSINESS:**

TF will make effort to keep second day of face-to-face to 2 PM instead of 3:30 PM.

**The meeting was adjourned at approximately 1:45 PM MDT**

# Attachment B



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

April 16, 2013

Subject: Pending release of standardized medical claims edits and payment rules

The purpose of this notice is to formally advise you of the initiative undertaken in the state of Colorado to develop a uniform set of “claim edits”. 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.

To this end a group of approximately 25 experts including national representatives from many health plans, vendors of software and providers came together voluntarily to deliberate the uniform edit set. This is fully transparent process that works by consensus, and has solicited input from all stakeholders during the development process.

The Colorado Task Force is over two years into the project and now preparing to release its first set of rules for public comment. The purpose of this letter is to advise you that the release will occur the second quarter of 2013. The information will be posted on the task force website at [www.hb101332taskforce.org](http://www.hb101332taskforce.org). More information on the task force background and legislation can be found at this website.

Please let us know if you have any questions or would like to receive notification of the release directly from the task force.

Respectfully,

Barry Keene, Co-Chair MCCTF

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# Attachment C



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

### Payment Rule

<b>Topic</b>	<b>Assistant at surgery</b>
<b>Definition</b>	In the performance of a surgical procedure, an assistant to the surgeon may be required to successfully complete the procedure. Assistants at surgery represent their services by appending the modifiers listed below to the surgical procedure code.
<b>Associated CPT®<sup>1</sup> and HCPCS modifiers</b>	<p>-80 Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).</p> <p>-81 Minimum assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.</p> <p>-82 Assistant Surgeon (when qualified resident surgeon not available). The unavailability of a qualified resident surgeon is a prerequisite for the use of modifier 82 appended to the usual procedure code number(s).</p> <p>-AS Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery.</p>
<b>Rationale</b>	<p>In order to develop the assistant surgery definition to be used as part of the standard edit set, the Edit Committee has reviewed the publically available listings that identify which CPT procedure codes are eligible for an assistant at surgery. Two such lists are published, one by the American College of Surgeons (ACS) and the other by the Centers for Medicare and Medicaid Services (CMS). The lists are not identical. Members of the Clean Claim Colorado Task Force gave strong credence to the value of clinical input in determining whether an assistant surgeon would be eligible for reimbursement. The American College of Surgeons (ACS) published their recommendation in a publication called “Physicians as Assistants at Surgery: 2011 Study”. The committee agreed that when clinical input was provided by the American College of Surgeons it would be the first source utilized to determine whether an assistant at surgery was reimbursable. However, given the frequency of the publication, the committee also agreed that an alternate source would be needed to supplement the list. The Centers for Medicare and Medicaid Services (CMS) was chosen as the alternate source.</p> <p>Additionally, Members of the Task Force focused on the administrative expense associate with reviewing claims. The committee recommended the assistant surgery eligibility list would have either an approved or not eligible status to provide for automated adjudication. There was a concern that changing the SOMETIMES to an automatic ALWAYS could have an adverse financial impact on the payers and compromise the acceptability of the Task Force’s standardized edit set by the industry. Therefore the procedure codes identified through the rule logic noted below as SOMETIMES will be defaulted to NEVER.</p> <p>Further recognition was given to the fact that every clinical situation can be different. Surgical services that are not eligible for assistant surgery reimbursement can be appealed to the health plan for reconsideration with the appropriate supporting medical records.</p>

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<p><b>Rule logic</b></p>	<p>The Assistant Surgeon list was developed by reviewing the most current publication from the American College of Surgeons (ACS).</p> <ul style="list-style-type: none"> <li>• A recommendation of Almost Always from ACS was agreed to be considered an Always reimburse.</li> <li>• A recommendation of Almost Never was agreed to be considered as Not Eligible for reimbursement.</li> <li>• When the ACS recommendation was Sometimes or the ACS did not make a recommendation on a surgical code (i.e. the code was effective after the date of the most recent publication), then the Centers for Medicare and Medicaid Services (CMS) National Physician Fee schedule was reviewed.</li> <li>• The Assistant Surgeon column was reviewed. <ul style="list-style-type: none"> <li>○ If the CMS indicator is a 2 (Always), then the recommendation would be accepted as Always reimburse.</li> <li>○ If the CMS indicator is a 1 (Never), then the recommendation would be accepted as Not Eligible for reimbursement.</li> <li>○ If the CMS indicator is a 0 (Sometimes), then they will be recommended as Not Eligible for reimbursement.</li> </ul> </li> </ul> <p>Only CPT® and HCPCS surgical procedure codes were considered as part of this rule as an assistant is not generally medically necessary for non-surgical procedures.</p>
<p><b>Administrative guidance</b></p>	<p>As part of the promise of HB 10-1332 was administrative simplification, the Edit Sub-Committee recommends that the assistant surgery decision should initially always be a yes or no, rather than indicating that the SOMETIMES indicators of the source listings be PENDED for review of the medical necessity in our data set.</p> <p>If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line, this will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.</p>
<p><b>Specialty Society outreach</b></p>	<p>Specialty society outreach was conducted. The American College of Orthopaedic Surgeons (AAOS) and the American College of Surgeons (ACS) were both consulted.</p>
<p><b>Summary DATE</b></p>	<p><b>The task force will publish a list of the procedure codes for surgical services that are eligible/not eligible for assistant surgery reimbursement. The list may be updated quarterly when new codes are developed or the source information changed. The rule logic identified in this document will be utilized when considering new codes.</b></p> <p><b>April 17, 2013</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.