



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

Meeting Agenda

Meeting Date:	December 18, 2013, noon – 2 PM MDT
Call-In Number:	1-866-740-1260; ID 8586318#
Web Link:	https://cc.readytalk.com/r/fi0cksa2z3o3&eom

12:00 PM WELCOMING REMARKS & ROLL CALL

- **Housekeeping Items:**
 - Approve November 2013 meeting minutes (Attachment A)
 - Next in-person meeting: January 21-22, 2014

12:10 PM COMMITTEE REPORTS:

- **Edit Committee– Beth Wright/Mark Painter**
 - Overview of next steps for Committee
- **Rules Committee – Nancy Steinke/ . . . ?**
 - Draft rules completed
 - Overview of remaining work in 2014
- **Public Comments on Third Bundle**
 - Co-chairs to meet 12/20 to review
- **Data Sustaining Repository – Mark Painter/Barry Keene**
 - Update on RFP distributed 11/13
 - RFP Evaluation Committee
 - Long-term funding strategy options & recommendations/2014 Bill (Attachment B)
- **Specialty Society – AMA?**
- **Project Management – Barry Keene/Vatsala Pathy**
 - Workplan/Looking forward to 2014 (Attachment C)
 - Rules tracking sheet (Attachment D)
 - 2014 meeting schedule (Attachment E)
- **Finance – Barry Keene**
 - Funding the work of the Task Force
- **Other Business**

1:55 PM PUBLIC COMMENT

2:00 PM ADJOURNMENT

UPCOMING TASK FORCE MEETINGS

DATE(S)	TIME (MDT)	MEETING TYPE
January 21-22, 2014	Tue: 12:00 p.m. – 6:00 p.m.; Wed: 7:30 a.m. – 2:00 p.m.	In-Person Quarterly Meeting
February 26, 2014	Wed: 12:00 p.m. – 2:00 p.m.	Monthly Conference Call
March 26, 2014	Wed: 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
November 26, 2013, 12:00–2:00 PM, MDT
Call-in Number: 1-866-740-1260
Conference ID: ID 8586318#

Attendees:

- Barry Keene, CC
Beth Kujawski
Beth Wright
Beth Provost
Dee Cole
James Borgstede, MD
Jill Roberson
Kathy McCreary
Lisa Lipinski
Marilyn Rissmiller, CC
Marianne Finke
Mark Painter
Nancy Steinke
Robin Weston
Tom Darr, MD
Wendi Healy

Staff :

- Connor Holzkamp
Vatsala Pathy

Public:

- Becky Dolan (AAP)
Diane Hayek (ACR)
Diane Hammond (United)
David McKenzie (ASAP)
Katie Shepard (AAN)
Lou Terranova (AAP)
Luana Ciccarelli (AAN)
Todd Klomp (CAP)

Meeting Objective (s):
See Agenda

Key:

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



November 26, 2013

WELCOMING REMARKS & ROLL CALL:

Housekeeping Items:

- Minutes from October were accepted with no changes.
It was noted that the next regularly scheduled MCCTF conference call is Wednesday, December 18, 2013.

EDIT COMMITTEE—Beth Wright and Mark Painter

- The Edit Committee presented the TF with the modifiers grid (item “P” on the A-P list)
This document (along with all other rules in fourth bundle) can be downloaded by clicking here.
This document identifies modifiers that the committee considered to be important in the overall adjudication of claims from a commercial payer perspective.

- Modifiers that are *not* included in this grid may have been intentionally left off for one of several reasons:
 - ✓ Deemed to be informational in nature;
 - ✓ Used solely for the purpose of Government programs (i.e. Medicare/Medicaid)
 - ✓ Considered out of scope for the TF
- The Committee asked the group to look through the document to see if it makes sense/nothing is left out.

Action item: The TF accepted the modifiers grid as an informational item that will be released with the fourth bundle of rules. Beth and Marilyn will listen to the recording of the Rules Committee meeting from 11/14 to ensure all comments are incorporated into the document regarding Modifiers GD, GG and GH.

SPECIALTY SOCIETY OUTREACH COMMITTEE:

- The Specialty Society continues its charge to act as the “liaison between the TF 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— Lisa Lipinski and Dee Cole

- The Rules Committee brought the following draft rules to the TF for consensus:
 - **Bundled Service**
 - ✓ There was a question from the expert public as to why “Status B” codes were not included – The response was that the TF deemed it to be benefit related and considered out-of-scope for the TF.
 - ✓ A member of the expert public commented on the status indicator of “P” stating that it should be similar to “T” codes in that they are services that may be considered for payment if they are *the only service* that is reported. After discussing this, the group decided to go with the change and clarify that “*Services with a status indicator of T or P may only be considered for payment if it is the only service and is not considered incident to a physician service on the same patient during the same session by the same physician.*”

Action item: Language regarding the P and T status indicators was combined to add clarity – Consensus achieved on rule with revisions.

- **Procedure to Modifier**
 - ✓ Nancy reported that the comments added in the previous Rules Committee meeting regarding HCPC procedure codes were missing
 - ✓ The table was amended to include HCPCS modifiers
 - ✓ The “rationale” section was also amended to reference HCPC codes
 - ✓ In the definitions section, in the sentence that starts, “This rule is used to identify . . .” the word “procedure” was removed.

Action item: Language added that was already vetted by the Rules Committee to clarify rule and reference HCPCS codes and table was updated accordingly – Consensus was achieved on rule with revisions

- **Rebundling**
 - ✓ It was noted that committee had added the examples on page two since last time the TF saw the rule.
 - ✓ There was some discussion on whether the rule needed to specifically reference HCPCS codes under “Rationale” section – This revision was made to add clarity and consensus achieved on rule with revisions.

Action item: Rebundled rule was revised to specifically reference HCPC codes in the “Rationale” section, and the section titled “Preventive Medicine Services” on page five was removed – Consensus achieved on rule with revisions.

- **Multiple E/Ms on the Same Day**
 - ✓ Consensus achieved on rule as it was presented with one minor formatting change and the deletion of a duplicative paragraph on preventive care.

Action item: The Multiple E&M's rule was adopted by consensus with two minor formatting changes.

- It was noted that these four rules, in addition to the modifier grid from the Edit Committee, will be distributed for public comment on Monday, December 2, 2013. Marilyn has sent the revised rules to co-chairs to ensure all changes that were made during the meeting are accurately reflected in the final draft documents.
- To download these draft rules (with revisions) please copy and paste the following link into your web browser: http://www.hb101332taskforce.org/phocadownload/draft_rules_112613.zip

DSR COMMITTEE – Mark Painter and Barry Keene

- The Committee reported that the RFP was distributed by the TF on 11/13/13. The RFP can also be downloaded using the BIDS system on the HCPF website.
 - The deadline for bids on the RFP is December 17, 2013
- The DSR Committee has been working to pull together an evaluation team to score the responses to the RFP. As of 11/26 the following people had committed to this team:
 - Beth Wright – TFM, Anthem Blue Cross and Blue Shield;
 - Kathy McCreary – TFM, University of Colorado Hospital;
 - Alicia Goroski – Representative from Center for Improving Value in Health Care (CIVHC);
 - Marianne Finke – TFM, Humana;
 - Barry Keene – MCCTF Co-Chair, KEENE Research & Development;
 - Dee Cole agreed during the meeting to join evaluation team – TFM, Department of Health Care Policy & Finance;
 - Jo Donlin – Division of Insurance representative
 - ✓ Jo had not been confirmed as of 11/26/13, and the group will continue to pursue communications with her.
- The DSR Committee has also been working to brainstorm all possible options to fund the long-term sustaining function of the TF.
 - The group iterated that it is becoming increasingly important to lay out a clear path for how to fund the work of the TF beyond 2014. This includes:
 - ✓ Who the money comes from;
 - ✓ Mechanism for collecting the money;
 - The Committee had created a draft document that outlines/ranks each possible model (“option”) that the group could think of and includes both pros/cons for each. These options (in order of DSR ranking) are as follows:
 1. Subscriber/User Fee’s:
 - Software vendors would assess fees to their clients -- e.g. plans (Each company would register and would require pre-registration and then calculate fees based on covered lives)
 2. 50-50 split (payers/providers) collected through licensing fee’s/cost per life:
 - 50% provider licensing fee and 50% health plan fee (*It has been noted that both AMA and CMS have policies in place that would prevent them from supporting any “option” that is collected through physician licensing fees.*)
 3. Legislation:
 - Fee assessed by state at its discretion
 4. Practice Management Systems:
 - Fee per click or per subscriber assessed to users of PMS (onus on payers to collect with claims relative to members/subscribers)
 - [This draft document in its entirety can be downloaded by clicking here.](#) Note: Working documents subject to change
- There was some confusion from a member of the expert public as to what exactly the DSR is working on as it relates to the long-term funding options.
 - Barry gave out his phone number and invited the individual to call him so that he could explain in further detail what this funding is intended to do/why it is needed in order for the TF to succeed.

- Barry reported that the TF is currently in the process of moving the TF under the umbrella of the Division of Insurance; more will be reported on this during the December TF meeting.

PROJECT MANAGEMENT/FINANCE COMMITTEE – Vatsala Pathy/Barry Keene

- The work plan was presented and it was noted that the document has been updated to reflect the fourth bundle of rules that were added as well as the work of the DSR Committee.
 - [To download the work plan please click here.](#)
- The rules tracking sheet had been updated to reflect the current status of all draft rules. After the fourth bundle is released on December 2, 2013 the TF will be done drafting the payment rules.
- It was noted that the staff is working with the CC's to secure funding for the 2014 time period.
 - Proposals have been submitted to both Robert Wood Johnson Foundation & The Commonwealth Fund;
 - The Committee reported that the TF will need stakeholder contributions in order to fund its work through 2014.

OTHER BUSINESS

- The TF spent some time reviewing the response to public comments on the second bundle of rules.
 - It was noted that the Add On rule had undergone some re-work based on the comments:
- Comments asked TF to include reference The Centers for Medicare and Medicaid Services (CMS) Type I, Type II and Type III Add-on Code Edit listing.
 - ✓ This adds a table that identifies the primary codes for the Add On rule.
 - ✓ It was noted that the following language had been added to the "Rule Logic" section: *"The CMS Type I, II and III add-on code edit listings will be used to determine the acceptable primary codes that are required to be reported with the associated add-on codes. The primary procedure codes listed are not defined specifically within the CPT® codebook for add-on codes identified as Type II. However, where a specialty society has identified primary procedure codes they have been included in the listing. CPT® has only identified some, but not all, of the specific primary codes for the add-on codes identified on the Type III listing."*
 - ✓ Additionally, the following language was added in the section titled Administrative Guidance: *"There is one exception to the stipulation that an add-on code may not be the only procedure reported by the practitioner. That is in the case of critical care services provided by physicians in group practice. Physicians in the same group practice who have the same specialty may not each report the critical care codes on the same calendar date, but must bill as though each were the single physician. If a physician or other qualified healthcare provider within a group provides "staff coverage" or "follow-up" for each other after the first hour and fourteen minutes of critical care services was provided on the same calendar date by the previous group clinician, the visits by the "covering" physician or other qualified healthcare provider in the group will be reported using the CPT add-on code for the time spent in provision of critical care services. However, two or more physicians of the same group practice who have different specialties and who provide critical care services may each report the critical care codes on the same date when the care rendered is unique to each specialty."*
- It was reported that Lisa Lipinski will not remain as the AMA representative on the TF after 2013.
 - Lisa will communicate with the AMA and determine if there are plans to replace her as AMA's representative.
 - It was also noted that the TF will need someone from the AMA to assist with the Specialty Society.
- Helen Campbell has moved from United Health Care to Optum
 - Helen will remain on TF (not necessarily as the official rep for Optum)
 - Diane Hammond was present from United and reported that she will be submitting an application to join the TF as United's representative.

PUBLIC COMMENT:

<none>

The meeting was adjourned at approximately 2:00 PM MDT

Colorado Medical Clean Claims Taskforce DSR Committee
12/3/13

Option	Type of Fee (What)	Process for Administration	Mechanism for Administering Fee (How)	Pros	Cons	DSR Comments	DSR Committee Ranking
Subscriber/User Fee's	Claims Software vendors would assess fees to their clients -- e.g. plans (Each company would register and would require pre-registration and then calculate fees based on covered lives)	Sustaining Repository Contractor collects fees directly	Claims Software Vendor Systems	Streamlines the process and is the common way software and/or databases are transacted. The administrator for the contract (DOI, etc) can limit the allowable fee by contract.	Places onus on claims software vendors and plans disproportionately Reliant on the honesty of the individual How do you create a seat-based subscriber fee for a large vendor operating in multiple states?	50/50 split between plans and providers; you have to have a way to break down covered lives based on the entity asking for the license	1
50-50 split (payers/providers) collected through licensing fees/cost per insured life.	50% provider licensing fee and 50% health plan fee	State collects fee through its administrative processes	50% of fees collected from provider licensing process and 50% collected from health plans based on a per covered life fee	It creates a sense of fair play because beneficiaries are paying for the value added Simple to administer and collect (identifiable and quantifiable)	Colorado Medical Society/AMA have formal policy against tacking expenses on to physicians licensing fees and would not support this option.	Should covered lives in ERISA plans administered by Colorado payers be counted?	2
State-levied fee	Fee assessed by state at its discretion	State collects fee through its administrative processes	Department of Regulatory Affairs and/or State Division of Insurance	Integrated standardized function of state government therefore it is transparent and easily regulated Gives DORA / DOI control over cash flow; costs may be more easily managed; Adjustments in the design readily aligned with state practices DORA / DOI could decide how much of the function to have in-house or contracted	May not be well received well by legislature Government bodies can develop a legacy around software products that may not be as efficient as the open market.	The relationship between the MCCTF - DSR recommended "Governance Body" and the State Dept. would have to be carefully crafted to maintain credibility with stakeholders while being manageable.	3
Practice management systems	Fee per click or per subscriber assessed to users of PMS (onus on payers to collect with claims relative to members/subscribers)*	PMS Vendors assess fee through their contracts with providers	Practice Management System Vendors	Fee doesn't contradict AMA/CMS policy For every electronic claim submitted, you collect a fee	Fee unevenly assessed in cases where providers don't have PMS How do you identify PMS systems serving Colorado clients? Could only collect on electronic transactions	Who collects fee? 50/50 split between plans and providers Per click on provider side would be very difficult to administer	4

*A transaction-based fee (whether a fixed amount, like \$0.10/transaction, or a percentage, like 0.5% of total transaction amount) is a common retail practice between a seller and a buyer. (Sales tax in most states is one version of a percentage charge of this type). This is more complex when a third party, such as an infrastructure vendor, becomes involved in electronic transactions between an insurance plan and a healthcare provider when multiple transactions, back and forth, may be required to create a single claim payment. All three parties must agree on the metric to be counted, the process, and a payment schema, where the payer periodically transfers the cumulative transaction fee to the network vendor. Additional challenges regarding the 'fairness' of this approach occur if not all providers (e.g. physicians, et al) do not use the same system, and not all health plans require the same transactions. Also, transactions for non-Colorado residents may need to be treated differently when processed thru clearinghouses for out of state patients (being treated in Colorado) or for out of state plans with patients in Colorado).

Activity	2013										2014										Deadline	Status as of 11-19-13				
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec			
work on the draft edit rule recipes for the first bundle of rules and submit to task force for approval.																										
Task force reviews and approves first bundle of draft edit rule recipes.																									May 22	DONE
First bundle of draft edit rule recipes circulated for review and comment.																									May 31	DONE
Public comments due on 1 st bundle																									July 15	DONE
Payment & Edit Committees review comments on 1 st set of recipes and make recommendations for revisions.																									Early August	DONE
Task force finalizes and approves first bundle of recipes.																									August 27 mtg	DONE
<u>2nd bundle</u> : Edit and Payment Rules committees work on the draft edit rule recipes for second bundle of rules & submit to TF for approval.																									Early August	DONE
Task force reviews and approves draft second bundle of draft edit rule recipes.																									August 27 mtg	DONE
Second bundle of draft recipes issued for 5-week public review and comment.																									Sept 4	DONE
Public comments due on 2 nd bundle.																									October 4	DONE

* In-person task force meeting.

** Only 30 days allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013										2014										Deadline	Status as of 11-19-13		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec	
Payment & Edit Committees review comments on 2nd set of recipes and make recommendations for revisions.																							Early November	DONE
After reviewing comments received on 2nd bundle draft edit rule recipes, 2nd bundle approved.																							November 26	DONE
<u>3rd bundle:</u> Edit and Payment Rules committees work on the draft edit rule recipes for the third bundle of claims edits and payment rules and submit to task force for approval.																							Early October	DONE
Task force reviews and approves draft 3rd bundle of draft edit rules.																							October 22 mtg	DONE
3rd bundle of draft recipes circulated 5-week public review and comment period. **																							October 25	DONE
Public comments due on 3rd bundle																							December 4	
Payment & Edit Committees review comments on 3rd set of recipes and make recommendations for revisions.																							Early January	
After reviewing comments on 3rd bundle of draft recipes, task force finalizes and approves.																							January 2014 TF mtg	

* In-person task force meeting.

** Only 30 days allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

Activity	2013										2014										Deadline	Status as of 11-19-13		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec	
4 th 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.																							Early November	DONE
Task force reviews and approves draft fourth bundle of draft edit rules.																							November 26	
Fourth bundle of draft recipes circulated 30-day public review and comment period. **																							December 2	
Public comments due on 4th bundle																							January 6	
Payment & Edit Committees review comments on 4 th set of recipes and make recommendations for revisions.																							Late January 2014	
After reviewing comments on fourth bundle of draft recipes, task force finalizes and approves.																							January 2014	
Update entire draft set with current codes. [2014]																								
Glossary developed with final set																							Ongoing	Ongoing

* In-person task force meeting.

** Only 30 days allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

STATUTORY DEADLINES

Activity	Deadline	Status
Task Force shall submit a progress report to the Executive Director and Colorado Senate and House Human Services Committees.	November 30, 2012	DONE
Task Force shall present its progress report to a joint meeting of the Colorado House and Senate Human Services Committees.	January 31, 2013	DONE
<p>The Task Force shall continue working to develop a complete set of uniform, standardized payment rules and claim edits to be used by payers and health care providers and shall submit a report and may recommend implementation of a set of uniform standardized payment rules and claim edits to be used by payers and health providers. As part of its recommendations, the Task Force shall:</p> <ul style="list-style-type: none"> • Make recommendations concerning the implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including <ul style="list-style-type: none"> ○ who is responsible for establishing a central repository for accessing the rules and edits set and ○ enabling electronic access--including downloading capability--to the rules and edits set; and • Include a recommended schedule for payers that are commercial health plans to implement the standardized set. 	December 31, 2014	
Payers that are commercial plans shall implement the standardized set within their claims processing systems.	According to a schedule in Task Force rec's or Jan 1, 2016, whichever occurs first	
Payers that are domestic, nonprofit health plans shall implement the standardized set within their claims processing systems.	January 1, 2017	

* In-person task force meeting.

** Only 30 days allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

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	X
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	O	I
Max. Frequency- Span of Days	3	X	X	X	O	X	X	X	X	O	I
Same day med visit & med procedure	3	X	X	X	O	X	X	X	X	O	I
Multiple Endoscopy (Modified to include multiple procedure reduction)	3	X	X	X	O	X	X	X	X	O	I
Multiple E&M's Same Day	4	X	X	X	I	X	X	X	X	I	I
Bundled Service (Status B)	4	X	X	X	I	X	X	X	X	I	I
Rebundling	4	X	X	X	I	X	X	X	X	I	I
P- Modifiers effect on edits:	4	X	X	X	I	X	X	X	X	I	I
Multiple radiology	N/A	X	X	X	N/A	N/A	N/A	N/A	N/A	OUT OF SCOPE	
Multiple phys. Therapy	N/A	X	X	X	N/A	N/A	N/A	N/A	N/A	OUT OF SCOPE	

NOTE: The **Progress Bar** (below) is a visual representation of the data to the left (*Recipe Development Tracking Sheet*). While this tool can be useful to quickly view the overall progress of a rule, it is important to note that the percentages displayed are not precise measurements of how close a rule is to completion. The progress bar, which is a direct representation of the data in the "% Done" column, is calculated using the following formula:

$$\frac{[\# \text{ of "X's" in Row}] + [(\# \text{ of "O's" in row})(0.5)]}{[\text{Total \# of Columns}]}$$

Progress						
Rule	PROGRESS BAR	% Done	Number of "X's"	Number of "O's"	Number of O's Multiplied by (.5)	[# of "X's" in Row] + [(# of "O's" in row)(0.5)]
J-Asst. Surgery	100%	100%	10	0	0	10
K-Co-surgery		100%	10	0	0	10
L-Team Surgery		100%	10	0	0	10
N-Bilateral Procedures		100%	10	0	0	10
A-Unbundle (PTP)		100%	10	0	0	10
B-Mutually Exclusive		100%	10	0	0	10
C-Multiple Procedure Reduction		100%	10	0	0	10
D-Age		100%	10	0	0	10
E-Gender		100%	10	0	0	10
F-Maximum Frequency Per Day		100%	10	0	0	10
H-Place of Service		100%	10	0	0	10
M- Total/Prof./ Tech. Split		100%	10	0	0	10
O-Anesthesia Services		100%	10	0	0	10

Rule	PROGRESS BAR	% Done	Number of "X's"	Number of "O's"	Number of O's Multiplied by (.5)	[# of "X's" in Row] + [(# of "O's" in row)(0.5)]
Add-ons		100%	10	0	0	10
G-Global Surgery Days		100%	10	0	0	10
Global Maternity		100%	10	0	0	10
New Patient		85%	8	1	0.5	8.5
Max. Frequency- Span of Days		80%	7	2	1	8
Same day med visit & med procedure		70%	6	2	1	7
Multiple Endoscopy		80%	7	2	1	8
Multiple E&M's Same Day		70%	7	0	0	7
Bundled Service (Status B)		70%	7	0	0	7
Rebundling		70%	7	0	0	7
P- Modifiers effect on edits:		70%	7	0	0	7
Multiple radiology		100%	7	0	0	7
Multiple phys. Therapy		100%	7	0	0	7

Rule	PROGRESS BAR 100%	0%	% Done	Number of "X's"	Number of "O's"	Number of O's Multiplied by (.5)	[# of "X's" in Row] + [(# of "O's" in row)(0.5)]
Total Phases of Rule Development						10	

COLORADO HB10_1332 MEDICAL CLEAN CLAIMS
TRANSPARENCY AND UNIFORMITY ACT TASK FORCE



MCCTF 2014 Meeting Schedule

* Note: All Meeting Times are Mountain Standard Time (MST)

* All in-person meetings are shown in red

<u>Meeting Type</u>	<u>Date</u>	<u>Time</u>
In-Person Meeting	1/21-1/22	1/21: 12-6; 1/22: 7:30-2
Teleconference	2/26	12-2
Teleconference	3/26	12-2
In-Person Meeting	4/22 - 4/23	4/22: 12-6; 4/23: 7:30-2
Teleconference	5/28	12-2
Teleconference	6/25	12-2
Teleconference	7/23	12-2
In-Person Meeting	8/26-8/27	8/26: 12-6; 8/27: 7:30-2
Teleconference	9/24	12-2
Teleconference	10/22	12-2
In-Person Meeting	11/18 - 11/19	11/18: 12-6; 11/19: 7:30-2
Teleconference	12/17	12-2