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

Meeting Agenda	
Meeting Date:	November 26, 2013, noon – 2 PM MDT
Call-In Number:	1-866-740-1260; ID 8586318#
Web Link:	https://cc.readytalk.com/cc/s/registrations/new?cid=pc8tp5e9c2iq

12:00 PM WELCOMING REMARKS & ROLL CALL

- **Housekeeping Items:**
  - Approve October 2013 Meeting Minutes (Attachment A)
  - Next In-Person Meeting: January 21-22, 2014

12:10 PM COMMITTEE REPORTS:

- **Edit Committee– Beth Wright/Mark Painter**
  - Modifier Effect on Edits

  Draft Query Templates:
  - Maximum Frequency- Span of Days (To be distributed separately)
  - Same Day Medical Visit & Medical Procedure (To be distributed separately)
  - Multiple Endoscopy (To be distributed separately)
- **Rules Committee – Lisa Lipinski/Helen Campbell**

  Consensus Items:
  - Bundled Service (Attachment B)
  - Procedure to Modifier (Attachment C)
  - Rebundling (Attachment D)
  - Multiple E/Ms on the Same Day (Attachment E)
- **Data Sustaining Repository – Mark Painter/Barry Keene**
  - RFP Distributed 11/13
  - Seating/Selecting RFP Evaluation Committee
  - Long-term funding strategy Options & Recommendations
  - Division of Insurance Update
- **Specialty Society – Helen Campbell**
- **Project Management – Barry Keene/Vatsala Pathy**
  - Updated Workplan – (Attachment F)
  - Rules Tracking Sheet (Attachment G)
- **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**
December 18, 2013	**Wed:** 12:00 – 2:00 p.m.	Monthly Conference Call
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

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HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE
Meeting Minutes
October 22, 2013, 12:00–6:00 PM, MDT
Call-in Number: 1-866-740-1260
Conference ID: ID 8586318#

Attendees:
- Amy Hodges
- Barry Keene, CC
- Beth Kujawski
- Beth Wright
- Dee Cole
- Doug Moeller, MD
- James Borgstede, MD
- Jill Roberson
- Kathy McCreary
- Kim Davis
- Lisa Lipinski
- Marilyn Rissmiller, CC
- Mark Painter
- Nancy Steinke
- Robin Weston
- Tom Darr, MD
- Wendi Healy

Staff :
- Connor Holzkamp
- Vatsala Pathy

Public:
- Barry Ziman (CAP)
- Denise Gourris (AGA)
- Diane Hayek (ACR)
- George Swan
- Joel Brill ACG
- Leslie Narramore (AGA)
- Stephanie Stinchcomb (AUA)
- Susan Crews (AUA)
- Todd Klemp (CAP)

Meeting Objective (s):
See Agenda

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

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Day One: October 22, 2013

WELCOMING REMARKS & ROLL CALL:

Housekeeping Items:
- Minutes from August were accepted with one change made (to correct a typo in the date).
- The Task Force recognized and thanked Humana and Rocky Mountain Health Plans for sponsoring the catering for 10/22 and 10/23.
- Catering sign-up sheet was passed around for 2014 in-person meetings. Kathy McCreary (University of Colorado Health) and Wendi Healy (Correctional Healthcare Companies), joined co-chairs Marilyn Rissmiller (Colorado Medical Society) and Barry Keene (Keene Research and Development) as sponsors for the four in-person meetings in 2014.
- It was noted that the next regularly scheduled MCCTF conference call is Tuesday, November 26, 2013.

EDIT COMMITTEE—Beth Wright and Mark Painter

- The Edit Committee brought three 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.)
  - Global Procedure Days/Package:
    - ✓ Reference to modifier 76 added to document
  - Procedure to Procedure:
    - ✓ No revisions made
  - Professional and Technical Component:
    - ✓ No revisions made
- The Committee will work to draft the remaining query templates as the rules are drafted and adopted by consensus.
- The Committee also reported that it will be drafting the rule for item "P" on the A-P list (Procedure to modifier validation)

The TF accepted the Edit Committee's query templates as informational items. To download these query templates please click here;

SPECIALTY SOCIETY OUTREACH COMMITTEE—Helen Campbell:

- 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— Lisa Lipinski and Helen Campbell

- The Rules Committee brought the following draft rules to the Task Force for consensus:
  - Global procedure days/package**:**
    - ✓ Previously named "global surgery days" – had been revised to include same day medical visit & medical procedure.
    - ✓ Modifier 76 was included after discussion.
    - ✓ Consensus reached as defined in the MCCTF by-laws.
  - Bundled service:
    - ✓ There was discussion onwhether or not to include the status B codes. Beth sent Lisa more information on 10/25 to take back to the committee.
    - ✓ The rule was sent back to the Rules Committee for further review and will be released in next "bundle" of rules.
- The following draft rules were submitted for discussion at the on-site meeting. Because these rules were considered "discussion items," no immediate action was taken. ***Note: a brief conference call was scheduled for Wednesday, October 30, to get consensus on these rules.*
  - **Laboratory Rebundling:**
    - ✓ Adopted by consensus on 10/30/13
  - **Maximum Frequency for Span of Days:**
    - ✓ Adopted by consensus on 10/30/13
  - **Multiple Endoscopy:**
    - ✓ Adopted by consensus on 10/30/13
    - ✓ Revised to include *multiple procedure reduction*
    - ✓ The words "usual" and "standard" was omitted from rule and "Multiple Endoscopy" was capitalized so that it is distinguished from multiple procedure. It was noted that the representatives from the ASGE approved of these changes.
    - ✓ A representative from the AUA requested that language be added to explicitly inform the user that examples do not just apply to gastrointestinal endoscopy. The representative also added that the TF did a great job with the rule.
  - **Multiple E&M's Same Day:**

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- ✓ Sent back to Rules Committee for further review
- ✓ To be included in fourth bundle for public comment (to be released 12/4/13)

- **Rebundling:**
  - ✓ Sent back to Rules Committee for further review
  - ✓ To be included in fourth bundle for public comment

The TF adopted the *global procedure days/package* rule by consensus. The third bundle of rules will be released on 11/4/13 and include: *max frequency for span of days, multiple endoscopy, same day medical visit and medical procedure and laboratory rebundling*; The fourth (and final) bundle of rules will include: *unbundled, bundled service, multiple e&ms on the same day* and *procedure to modifier,* and will be release after November TF meeting.

OTHER BUSINESS

- The Task Force spent much of the afternoon reviewing the public comments that had been received on the second bundle of rules.
  - The process for evaluating comments was evaluated and it was determined that a brief meeting be called to review future comments. This meeting would be for the CC's of the subcommittee's as well as any other TF members that want to join. The TF decided to do this to ensure that each comment is thoroughly reviewed before being brought to the TF.
  - One of the commenters disagreed with the TF logic in the TCPC Rule that says "modifier 26 is unnecessary and inappropriate." because CPT© allows for the 26 to be billed with a pathology code. The group discussed several possible ways to address this:
    - ✓ The discussion evolved into adding language to the rule to say that 26 *is* appropriate and correct coding but in the real world payers do not accept it – it would have to be contractual.
    - ✓ The TF agreed to one member's opinion that, "CPT© is a valid reporting tool. However, the TF is attempting to standardize payment rules, and, after reviewing this particular rule, the TF determined that most payers have contractual provisions against the use of 26 which is out of scope for the task force"
  - Another comment that was discussed at length was on the *multiple endoscopy rule* and how the rule should be integrated with the *multiple procedure reduction*. The TF agreed with this comment and will continue to vet how this should be done.
  - The TF will look to finalize response to comments as soon as possible, ensuring that each comment is thoroughly reviewed. Official TF responses to comments can be viewed on the website under the "Public Comment" section.

PUBLIC COMMENT:
<none>

The meeting was adjourned at approximately 6:00 PM MDT

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HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE
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- Mark Painter
- Nancy Steinke
- Tom Darr, MD
- Wendi Healy

Staff :
- Connor Holzkamp
- Vatsala Pathy

Public:
- **Barry Ziman (CAP)**
- **Diane Hayek (ACR)**
- George Swan
- **Todd Klemp (CAP)**

Meeting Objective (s):
See Agenda

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Day Two: October 23, 2013

WELCOMING REMARKS & ROLL CALL:

The TF was joined by special guest Senator Irene Aguilar, MD.

The TF continued the previous day's discussion of the public comment concerning the draft technical and professional component rule and the use of modifier 26.

Three options were discussed to address this comment:
- **Option One:** No change to proposed rule - Modifier 26 cannot be used with clinical lab.
- **Option Two:** Acknowledge CPT coding convention regarding use of modifier 26 with all lab codes. Payment may be subject to individual payer/contract.

- **Option Three:** Revise rule and remove comment regarding inappropriate/unnecessary billing. Acknowledge the TF agreed to follow CMS payment rules. Providers have the right to pursue individual contract negotiations.

The TF discussed these options at length and decided to go with option two and "acknowledge CPT© coding guidelines and conventions allowing use of modifier 26 with all lab codes. Payment may be subject to individual payer/contract."

PROJECT MANAGEMENT AND FINANCE COMMITTEE – Barry Keene and Vatsala Pathy

The following documents were displayed as informational items:

- Work plan – The TF is on track to complete its remaining work for 2013.
- Rule recipe tracking sheet;
- Running action items document; and
- Frequently asked questions (for the website)

The TFM to send any comments on the draft F.A.Q's to Connor/Vatsala.

DATA SUSTAINING REPOSITORY COMMITTEE – Mark Painter and Barry Keene

- The DSR has been working to release a Request for Proposals (RFP) for the data analytics contractor and hopeful that it will be sent out before the TF meets again in November.
- Barry reported that he believed the hold-up on the RFP (with Department of Health Care Policy and Finance/Attorney General) was primarily due to a misunderstanding of its purpose. Barry and Marilyn will meet with Bob Douglas and report back to the TF.
- Barry also reported that HCPF recommended the TF move its statute from contract law to the Division of Insurance. This is because the TF needs a rule making body that can promulgate rules which is better done with DOI than HCPF. Barry has a meeting with DOI next week and will report back to the TF.

Barry will update the TF with more information in the coming weeks regarding the RFP and DOI meeting.

The DSR Committee has been working to lay out recommendations for the "business model" that will sustain the work of the TF. Mark presented the TF with a PowerPoint that highlights the work of the committee thus far. The presentation was organized into five sections: *DSR Committee scope of work, HB10_1332 relevant highlights & gaps, DSR Committee discussions, key areas for discussion & consensus* and *recommended next steps.* Detail on each section is provided below:

I. <u>DSR Committee Scope of Work:</u>

- To assess and evaluate data analytics and DSR needs.
- To learn from best practices and others' experiences.
- To evaluate options.
- To provide TF with recommendations and next steps on how to get from here to there.
- To arrive at consensus with TF at October, 2013 meeting on recommendations and next steps.

II. <u>HB10_1332 Relevant Highlights and Gaps:</u>

A. Highlights

- The work of the TF currently resides within the Department of Health Care Policy and Financing (HCPF).
- TF members are appointed by Executive Director of HCPF.
- TF to recommend format and function to sustain the data set and rules for future anticipating new legislation to address next generation of TF.
- TF sunsets 12/31/14 with no current legislative framework on how to maintain the work of the TF beyond that point.

B. Gaps

- The TF lacks official rule promulgating authority.
- The TF lacks authority to contract with vendors to maintain and update the edits during the 2015 timeframe as they are being implemented by users.

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- Legislation anticipates new law in 2015 but does not provide for update of data during end of TF and implementation of new legislation.

III. <u>DSR Committee Discussions:</u>

In order to realize the intent of the original legislation, the TF must:

- Provide consensus recommendations on how to effectively implement the work of the TF through the groundwork laid by the DSR Committee; and
- Create and support the legislative and legal framework to make that implementation possible.

IV. <u>Key Areas for Discussion & Consensus:</u>

A. Draft Governance Recommendation

- The establishment of a permanent governing body with oversight from the Division of Insurance that has the capacity to continue the rule promulgating process beginning in January, 2015.

<u>Composition:</u>

- Health Plans – 4 Representatives
- Providers – 4 Representatives
- Vendors/Regulators – 3 Representatives
- Majority Vote

<u>Organizational Documents:</u>

- Articles of Incorporation
- Mission / Vision
- Bylaws / Policy & Procedures
- Or contract with State to operate with data input from Board.

<u>Delineation of Authorities:</u>

- Operational issues (delegated to vendor or Contracting)
- Edit table load, distribution, initial dispute resolution (vendor or entity)
- Addition of new rules, review of data and dispute follow-up Board.
- A competitive bidding process to accept bids from qualified entities, to maintain the product created by the TF.

B. Draft Dispute Resolution Recommendation

- Level 1: Staff Resolution
- Level 2: Mediated Resolution
- Level 3: Legal Process through Civil Suit

C. Draft Financing Recommendation

- Fee based financing mechanism with:
  - 50% of accepted bid split equally among physicians
    * Estimated to be $44/year (Based on $2 million annual cost)
  - 50% of accepted bid assessed to health plans with fee based on the number of covered lives in Colorado.
    * Estimated to be 12 cents per insured life (Based on $2 million annual cost)
- The group discussed the options for how to collect and enforce this "50/50" financing recommendation. It was initially proposed by the committee that perhaps the DOI would have the ability to collect the fees from the payers, while the physicians end could be collected via licensure fees.
- It was noted that both the Colorado Medical Society and the American Medical Association would not be able to join consensus on any financial strategy that collects funding through license fees. Both organizations have formally adopted policies in place that strongly opposes
- The financing recommendation was discussed at length. The TF unanimously agreed that it is a top priority for the group to flesh out the long term funding strategy to sustain the work of the TF after the implementation period in 2015. The group also agreed that it would almost certainly have to be funded by some combination of the stakeholders due largely to a lack of a better available option.

Action Item: The TF reached consensus that: **1)** It is a top priority for the group to flesh out the long-term funding strategy to sustain the work of the TF afterthe taskforce sunsets; and **2)** Some combination of the stakeholder(s), payers, providers, vendors etc., will be needed to fund these operations.

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V. <u>Recommended Next Steps:</u>

1. Bring legislation forward during the 2014 legislative session to address gaps in HB10_1332 with recommendations on governance, dispute resolution and financing.
2. The DSR Committee will continue to flesh out the long-term strategies that will sustain the work of the TF in 2015 and beyond.
3. Explore what kind of data is available that will help quantify the potential impact of the task force's work. This is important as the stakeholders will be more inclined to support a user fee if the savings potential is fully understood.

Action Items: The TF accepted the DSR Committee's recommended next steps; Kim Davis will bring data for first line denials to the TF to help quantify the potential impact of the legislation.

PUBLIC COMMENT:

George Swan was present and gave the TF his thoughts on the process. Overall, he appreciates what the TF is attempting to do and supports the initiative. George submitted a comment via the TF website highlighting his opinions. His comment is appreciated and will be thoroughly reviewed by the CC's.

The meeting was adjourned at approximately 1:45 PM MDT

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Bundled

Rules Committee Recommendation

Bundled reporting rule

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.

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.

Modifier Involved.

There are no Current Procedural Terminology (CPT®)[1] or HCPC modifiers that apply.

Bundled rule

Procedures subject to the bundled rule are listed in the column labeled STATUS CODE of the Medicare Physician Fee Schedule (MPFS).[2]

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.

Coding and adjudication guidelines

Services with a status indicator of P are never paid separately as a professional service.

Services with a status indicator of T 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.

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[2] 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.

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Procedures identified with an indicator of B in the STATUS CODE column of the MPFS were considered during the development of this policy. Many of the procedures CMS has labeled as Status B are assigned the indicator to assist in the facilitation of CMS benefits. 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).

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for bundled codes were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual[3] were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Modifier/Edit definitions

This edit identifies when certain services and supplies are considered part of the overall care and should not be billed separately.
Consensus 7/18/12

Bundled indicator definitions

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 = Bundled/excluded codes. 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 service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.[4]

T = 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.

Federation outreach

- American Academy of Orthopaedic Surgeons (AAOS)
- American Academy of Otolaryngology – Head and Neck Surgery

[3] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.
[4] This is the Medicare definition and the reference covered services are specific to the MPFS

- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American Congress of Obstetricians and Gynecologists (ACOG)
- College of American Pathologists (CAP)
- The AMA Federation Payment Policy Workgroup

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Procedure to Modifier Validation

Rules Committee Recommendation

Procedure to Modifier validation rule

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.

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.

Modifier Involved.

All Current Procedural Terminology (CPT®)[1] modifiers apply. See the Appendix A of the CPT code set for definitions.

Procedure to Modifier validation rule

This edit identifies when a modifier is inappropriately reported with a procedure code.

Coding and adjudication guidelines

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. The modification to the reported service could be represented by; 1) noting an increase or decrease to what is ordinarily provided (such as noting a service that is substantially greater than usual or reduced as compared to the ordinary service); 2) explanation of a condition or special circumstance that may exist (such as provision of a service by more than one provider); 3) repeat performance of a procedure or service for a specific reason (such as the provision of an identical service to a different anatomical location [when appropriate] or the completion of the service to a lateral part of the body [bilateral performance]); deliberate or planned performance of a component of the complete service (such as performance

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of only the preoperative management of a complete surgical service or provision of the professional component of a complete service); or any other circumstances where modification of the service exists. Visit Appendix A of the CPT code set to identify the complete set of modifiers that have been developed for reporting purposes.

In reporting with the most comprehensive CPT code according to the hierarchy of complexity, modifiers may still be required.

It is equally important to recognize that as techniques in medicine and surgery have evolved, new types of services, including minimally invasive surgery, as well as endovascular, percutaneous, and endoscopic interventions have challenged the traditional distinction of Surgery vs. Medicine. Thus, the listing of a service or procedure in a specific section of the CPT code set should not be interpreted as strictly classifying the service or procedure as "surgery" or "not surgery". The placement of a given service in a specific section of the CPT code set may reflect historical or other considerations (e.g., placement of the percutaneous peripheral vascular endovascular interventions in the Surgery/ Cardiovascular System section, while the percutaneous coronary interventions appear in the Medicine/Cardiovascular section).

For this reason, the following listing may be used as a guide to identify common uses of modifiers for certain sections of the CPT code set. As stated below, this listing is not intended to be a comprehensive or exhaustive list. Modifiers listed as "*excluded from use*" are listed to identify modifier/code set combinations that are intentionally excluded from use together.

***NOTE: The following listing is only intended for use as a guide. This listing is not intended to be a comprehensive or exhaustive list.**

Category I Codes	
Evaluation & Management Section	
Intended for use (not a comprehensive list)	Modifiers 24, 25, 32, 57
Not probable for use	Modifiers 26, 47, 50, 51, 53, 54, 55, 56, 58, 62, 63, 66, 76, 77, 78, 80, 81, 82, 90, 91, 92
Excluded from use	1P, 2P, 3P, 8P
Anesthesia Section	
Intended for use (not a comprehensive list)	Modifiers 47, 53, P1-P6, AA, AD, QK,QS,QX,QY,QZ
Not probable for use	Modifiers 24, 25, 26, 47, 62, 66, 80, 81, 82, 90, 91, 92
Excluded from use	1P, 2P, 3P, 8P
Surgery Section	
Intended for use (not a comprehensive list)	Modifiers 22, , 32, 33, 50, 51, 52, 53, 54, 55, 56, 58, 59, 62, 63, 66, 76, 77, 78, 79, 80, 81, 82, FA, F1-F9, LC, LD, LM, RC, TA, T1-T9,
Not probable for use	Modifiers 24, 25, 57, 90, 91, 92
Excluded from use	1P, 2P, 3P, 8P
Radiology Section	
Intended for use (not a comprehensive list)	Modifiers 26, 32, 50, , 52, 53, 58, 57, 59, 62, 76, 77, 78, 79, 80, RT, LT, TC, FA, F1-F9, TA, T1-T9
Not probable for use	Modifiers 24, 25, 51, 54, 55, 56, , 66, 80, 81, 82, 90, 91, 92
Excluded from use	1P, 2P, 3P, 8P
Pathology and Laboratory Section	
Intended for use (not a comprehensive list)	Modifiers 26, 59, 90, 91, 92
Not probable for use	Modifiers 23, 24, 25, 47, 62, 66
Excluded from use	1P, 2P, 3P, 8P

Medicine Section	
Intended for use (not a comprehensive list)	Modifiers 26, 50, 51, 52, 53, 59, 76, 77, 78, 79
Not probable for use	Modifiers 23, 24, 25, 90, 91, 92
Excluded from use	1P, 2P, 3P, 8P

Category II	
Intended for Exclusive Use	Modifiers 1P, 2P, 3P, and 8P only
Excluded from use	All other CPT codes et modifiers

Category III	
Modifiers dependent on procedure	

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for modifiers were selected.

Modifier/Edit definitions

This edit identifies when a modifier is inappropriately reported with a procedure code.

Federation outreach

- American Academy of Orthopaedic Surgeons (AAOS)
- American Academy of Otolaryngology – Head and Neck Surgery
- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American Congress of Obstetricians and Gynecologists (ACOG)
- College of American Pathologists (CAP)
- The AMA Federation Payment Policy Workgroup

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Rebundled

Rules Committee Recommendation

Rebundled rule

Context

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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.

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.

Modifier Involved.

There are no Current Procedural Terminology (CPT®)[1] or HCPC modifiers that apply.

Rebundled rule

This edit is used to ensure accurate coding with the most comprehensive code which describes the service performed rather than reporting multiple codes to describe the service.

Coding and adjudication guidelines

A code description may define a rebundling relationship when procedure codes submitted together are described by another single procedure code or series of codes, based on the language in the descriptor.

According to CPT, “Select the name of the procedure or service that accurately identifies the service performed.”

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DRAFT

The National Correct Coding Initiative Policy Manual for Medicare Services guidelines supports this rationale stating, "A physician should not report multiple codes corresponding to component services if a single comprehensive code describes the services performed."

The appropriate modifier must be appended when services are performed as separate sessions.

Action: When procedure codes submitted together are described by another single procedure code or series of codes, deny the lines with the component codes, or transfer the component codes to the appropriate comprehensive code or series of codes, adjudicate the transfer codes and deny the component codes.

Example – Incorrect Reporting of Codes

- Use the following administrative guidelines if the above criteria are not met:
  Two component codes of a CT of the abdomen and pelvis are billed for a single encounter. No modifier is applied
  - CT Scan of the abdomen
  - CT Scan of the pelvis

Action: Deny both lines with the component codes

- CT Scan of the abdomen - Deny
- CT Scan of the pelvis - Deny

OR

Transfer the component codes to the appropriate comprehensive code or series of codes, adjudicate the transfer codes and deny the component codes.

- CT Scan of the abdomen - Deny
- CT Scan of the pelvis – Deny
- CT Scan of pelvis and abdomen – Add comprehensive code and adjudicate

Example – Correct Reporting of Codes

- Use the following administrative guidelines if the above criteria are met:
  Two component codes of a CT of the abdomen and pelvis are billed for imaging done at separate encounters on the same day. Modifier 59 is appended.
  - CT Scan of the abdomen
  - CT Scan of the pelvis - 59

Action: Adjudicate both lines

- CT Scan of the abdomen - Allow
- CT Scan of the pelvis - 59 - Allow

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for modifiers were selected.
- The National Correct Coding Initiative Policy Manual for Medicare Services guidelines were reviewed.

Modifier/Edit definitions

DRAFT

This edit identifies when certain services and supplies are considered part of the overall care and should not be billed separately.
Consensus 7/18/12

Federation outreach

- American Academy of Orthopaedic Surgeons (AAOS)
- American Academy of Otolaryngology – Head and Neck Surgery
- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American Congress of Obstetricians and Gynecologists (ACOG)
- College of American Pathologists (CAP)
- The AMA Federation Payment Policy Workgroup

DRAFT

Multiple E/Ms on the Same Day

Rules Committee Recommendation

Multiple E/Ms on the Same Day reporting rule

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.

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.

Modifier Involved

Current Procedural Terminology (CPT®)[1] or HCPCS modifiers that apply.

Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

Multiple E/Ms on the Same Day rule

This edit identifies when multiple E/M services are billed on the same day by the same provider. Except when the criteria are met and the appropriate modifier is appended, only one E/M may be eligible for reimbursement.

Additional correct coding edits for reporting E/M services exist. This rule addresses reporting multiple E/M services for the same date of service by the same provider.

[1] Copyright 2013. All rights reserved. American Medical Association

Coding and adjudication guidelines

Rules governing the reporting of more than one E/M code reported for a patient on the same date of service by the same provider are very complex and are not described in their entirety herein. However, the NCCI contains numerous edits based on several principles including, but not limited to:

1. A physician or other qualified healthcare provider may report only one “new patient” encounter on a single date of service. However, if that encounter includes more than one E/M code when significant, separately identifiable services are performed during a visit for both a preventive E/M and a problem-oriented E/M, both a new patient code for the preventive exam AND a new patient code for the problem-oriented E/M may be submitted for the same encounter when appropriate. Modifier 25 must be appended to the problem-oriented E/M code.

2. A physician or other qualified healthcare provider may report only one code from a range of codes describing an “initial” E/M service on a single date of service. Modifier override is not allowed with the exception of newborn care services in the hospital

3. A physician or other qualified healthcare provider may report only one “per diem” E/M service from a range of per diem codes on a single date of service. Modifier override is not allowed.

4. A physician or other qualified healthcare provider should not report an “initial” per diem E/M service with the same type of “subsequent” per diem service on the same date of service. Modifier override is not allowed.

5. E/M codes describing observation/inpatient care services with admission and discharge on same date should not be reported on the same date of service as initial hospital care per diem codes subsequent hospital care per diem codes or hospital discharge day management codes. Modifier override is not allowed.

Preventive medicine and problem-oriented E/M visits

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

For example, if the patient makes an appointment for a routine physical and is asymptomatic at the time of the encounter, discussion of chronic problems and medication refills are an expected part of the exam – not something extra that can be billed. If the patient is asymptomatic, there is no chief complaint to support anything beyond the well visit.

If the patient makes an appointment for a routine physical and upon presentation expresses a symptomatic problem, there is a chief complaint and a problem-oriented E/M may be reported.

Office/outpatient problem-oriented E/M visits for unrelated problems

More than one E/M visit should be reported by a physician for the same patient on the same day **ONLY** when the visits were for unrelated problems in the office or outpatient setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident). The physician must document that the visits were for unrelated problems.

Hospital admission (inpatient or observation status) following an encounter in another site

If a patient is admitted to the hospital in the course of an encounter in another site of service (e.g., emergency department, observation status changing to inpatient admission in a hospital, office, nursing facility), all E/M services provided by a physician in conjunction with the admission are considered part of the initial hospital care, when performed on the same date as the admission. A separate code for the E/M services in the other site is not reported. The initial hospital care level of service reported by the admitting physician should include the services related to the admission provided in other sites of service, as well as the E/M services the physician provided on that same date in the inpatient setting.

If a patient is admitted to a hospital after an outpatient consultation, and the patient is not seen on the unit on the date of admission, only the outpatient E/M code is reported.

Critical care services and other E/M services

When time-based critical care services are provided on a date where an inpatient hospital or office/outpatient E/M service was furnished on the same date at which time the patient did not require critical care, both the time-based critical care and the E/M services may be reported. Modifier 25 must be appended to the code with the lower RVU. Payers may require documentation to support the claims for both services. This guideline excludes global neonatal and pediatric critical care services.

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 and be paid as though each were the single physician. 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. However, 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.
If reporting the global neonatal or pediatric critical care codes, only one code may be submitted per group practice, same specialty, regardless of the number of different providers performing critical care on the same date of service.

Other circumstances

In addition to the exceptions outlined above, the following categories of services can be separately reported. The appropriate performance of these services with other E/M codes is outlined in the CPT manual. Be advised that a physician or other health care professional may need to indicate that on the day a procedure or service identified by a procedure code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual preservice and postservice care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

- **Complex Chronic Care Management**
  Specific procedure codes are reported only once per calendar month and include all non-face-to-face complex chronic care coordination services and none or one face-to-face office or other outpatient, home, or domiciliary visit. Such procedure codes may only be reported by the single physician or other qualified health care professional who assumes the care coordination role with a particular patient for the calendar month. Complex chronic care coordination can be reported in any calendar month during which the clinical staff time requirements are met. If care coordination resumes after a discharge during a new month, start a new period or report transitional care management services as appropriate. If discharge occurs in the same month, continue the reporting period or report transitional care management services.

- **Delivery/Birthing Room Attendance and Resuscitation Services**
  When a physician performs and reports either attendance at delivery or neonatal resuscitation services and subsequently admits the newborn to the hospital and assumes care, both the attendance at delivery or neonatal resuscitation services may be reported in addition to the initial care code (i.e., normal newborn, initial hospital care, intensive care or critical care) that defines the newborns level of care required.

- **Disability Exams**
  Related codes are used to report evaluations performed to establish baseline information prior to life or disability insurance certificates being issued. This service is performed in the office or other setting, and applies to both new and established patients. When using these codes, no active management of the problem(s) is undertaken during the encounter. If other evaluation and management services and/or procedures are performed on the same date, the appropriate E/M or procedure code(s) should be reported in addition to these codes.

- **Emergency Department**
  Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient. Critical care and other E/M services may be provided to the same patient on the same date by the same individual.

- **Other Emergency Services**
  In directed emergency care, advanced life support, the physician or other qualified health care professional is located in a hospital emergency or critical care department, and is in two-way voice communication with ambulance or rescue personnel outside the hospital. Direction of the performance of necessary medical procedures includes but is not limited to: telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous fluids and/or

administration of intramuscular, intratracheal or subcutaneous drugs; and/or electrical conversion of arrhythmia.

- **Newborn Care Services**
  When normal newborn services are provided by the same provider or group of providers on the same date that the newborn later becomes ill and receives additional sick, intensive or critical care services, both the normal newborn code and the appropriate code that defines the level of care required (eg, intensive care) is reported in addition with modifier 25 for these services.
- **Pediatric Critical Care Patient Transport**

Emergency department services, initial hospital care, time-based critical care, initial date neonatal intensive or global critical care may be reported in addition to pediatric critical care transport after the patient has been admitted to the emergency department, the inpatient floor, or the critical care unit of the receiving facility if the same provider performs both. If inpatient critical care services are reported in the referring facility prior to transfer to the receiving hospital, use the time-based critical care codes in addition to the pediatric critical care patient transport.

- **Preventive Medicine Services**
  If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant separately identifiable evaluation and management service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

- **Prolonged Services**
  Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes. Physicians or other qualified health care professionals who may report evaluation and management services should report their time spent in a team conference with the patient and/or family present using evaluation and management (E/M) codes (and time as the key controlling factor for code selection when counseling and/or coordination of care dominates the service).

- **Standby Services**
  A specific code(s) may be used to report physician or other qualified health care professional standby services that are requested by another individual and that involve prolonged attendance without direct (face-to-face) patient contact. Care or services may not be provided to other patients during this period. Certain codes are not used to report time spent proctoring another individual or also not used if the period of standby ends with the performance of a procedure, subject to a surgical package by the individual who was on standby.

- **Transitional Care Management**
  Specific procedure codes are used to report transitional care management services (TCM). These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest

home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual[2] were selected.

MCCTF comment

Includes all services provided on the date of admission in other sites of service (eg, emergency department, office, nursing facility) (99201-99215, 99281-99285, 99304-99318, 99324-99337, 99341-99350, 99381-99397)

Includes initial physician services provided to the patient in the hospital or "partial" hospital settings (99221-99223) Physician services provided to the patient observation status on the same date as inpatient E & M service.

Edit/Modifier definitions

This edit identifies when multiple E/Ms are billed on the same day by the same provider. Except when the above criteria are met and the appropriate modifier is appended, only one E/M may be eligible for reimbursement. However, other E/M services, as listed above can be separately reported on the same day as other procedures.

Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Additional definitions

NA

Federation outreach

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

- American Academy of Othopaedic Surgeons (AAOS)
- American Academy of Otolaryngology – Head and Neck Surgery
- American College of Emergency Physicians
- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American Congress of Obstetricians and Gynecologists (ACOG)
- College of American Pathologists (CAP)
- The AMA Federation Payment Policy Workgroup

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MEDICAL CLEAN CLAIMS TRANSPARENCY
UNIFORMITY ACT TASK FORCE, HB10-1332

Work Plan and Statutory Deadlines, April 2013 – December 2014

as of November 19, 2013

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		
2013																							
Task force solicits interested parties to put their contact information on an interested parties list of insurers, vendors and others who want to be notified of solicitations for input, comments, task force hearings, etc.																						Ongoing	Ongoing
Federation and others are notified that the task force will be sending out for review and comment, three rounds of proposed edit rule recipes in May, June and July.																						June 14, 2013	DONE
Website set up to include all notices and public comments.																						Ongoing	Ongoing
RULES																							
1st bundle: Edit and Payment Rules committees																						Early May	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		
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 1st bundle																						July 15	DONE
Payment & Edit Committees review comments on 1st set of recipes and make recommendations for revisions.																						Early August	DONE
Task force finalizes and approves first bundle of recipes.																						August 27 mtg	DONE
2nd bundle: 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 2nd 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
3rd bundle: 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 2	
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		
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.																						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 4th 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.

FUNDING																							
Task force secures $100,000 legislative appropriation.																						May	DONE
Task force secures grant from The Colorado Health Foundation to round out full funding for budget through Dec 2014.																						May	DONE
Additional monies raised to fully fund budget.																						December	DELAYED
Task force project manager hired.																						June	DONE
DATA SUSTAINING REPOSITORY OPERATIONS																							
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: o Who is responsible for establishing a central repository for accessing the rules and edits set and o Enabling electronic access--including downloading capability--to the rules and edits set																						Oct 22 mtg	DONE
DATA ANALYTICS																							
Task force secures funding to hire a data analytics consultant.																						DONE (assumes original low-bid is amt needed.)	DONE
RFP for data analytics contractor issued.																						November	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.

Proposals from data analytics contractors due. Executive Committee and three unconflicted task force members review and score RFP responses.																						December	In Process
Task force reviews and approves selection of an RFP contractor based on scoring.																						December	
Contract for data analytics contractor signed.																						January	
Data analytics contractor establishes system to accept & analyze edits. [Through 2014]																						Mid-March 2014	
Task force publishes notice of intent to solicit edits for inclusion in the data analytics model and specifies form in which edits should be submitted to the data analytics contractor. Notice is sent to interested parties list. [2014]																						Mid-March 2014	
Staff work on and 2nd task force progress report submitted to Health Care Policy & Financing and the General Assembly																						December 31, 2014	
2014																							
Contractor ready to accept edits from vendors, payers, others.																						March 2014	
Call for submission of edits from vendors, payers and others issued																						End of March 2014	
Deadline for edit submissions																						Mid-May 2014	
Contractor analyzes edit sets as directed to enable Edit & Payment Committees to make recommendation to the task force for a proposed standardized edit set. Appropriate committees/task force works on this & contractor refines system as necessary.																						Early July 2014	

* 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.

Complete proposed standardized edit set ready for review and approval by task force.																						July 2014 TF mtg	
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.																						End of July 2014	
Comments due on proposed standardized edit set and DSR operations. Public hearing.																						Mid-Sept 2014	
TASK FORCE FINALIZES EDIT SET																							
Committees review public comments on proposed edit set and DSR operations based and develop recommendations for consideration by full task force.																						End of October 2014	
Task force reviews & approves final standardized edit set & DSR operations recommendations.																						November 2014 mtg	
Task Force submits final report to legislature & executive director of Department Health Care Policy & Financing that: • Recommends implementation of a set of uniform standardized payment rules & claim edits to be used by payers & providers; • Makes recommendations concerning the implementation, updating, & dissemination of the standardized set of payment rules and claim edits, including: ○ who is responsible for establishing a central repository to access the rules & edits set, & ○ enabling electronic access--including																						December 31, 2014	

* 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.

downloading capability--to the rules and edits set; and • Includes a recommended schedule for commercial health plan payers to implement the standardized set.																							
FINAL REPORT																							
Staff draft final report to legislature and HCPF.																						Early November 2014	
Task force reviews 1st draft of final report.																						Nov ember 2014 TF mtg	
Task force approves final report.																						December 2014 TF mtg	
Final report submitted to legislature and HCPF.																						Dec 31, 2014	

* 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
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: • Make recommendations concerning the implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including ○ 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	O	I
B-Mutually Exclusive (PTP)	2	X	X	X	X	X	X	X	X	O	I
C-Multiple Procedure Reduction	2	X	X	X	X	X	X	X	X	O	I
D-Age	2	X	X	X	X	X	X	X	X	O	I
E-Gender	2	X	X	X	X	X	X	X	X	O	I
F-Maximum Frequency Per Day	2	X	X	X	X	X	X	X	X	O	I
H-Place of Service	2	X	X	X	X	X	X	X	X	O	I
M- Total/Prof./ Tech. Split	2	X	X	X	X	X	X	X	X	O	I
O-Anesthesia Services	2	X	X	X	X	X	X	X	X	O	I

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	O	I
G-Global Surgery Days (Modified to Global Procedures)	2	X	X	X	X	X	X	X	X	O	I
Global Maternity	2	X	X	X	X	X	X	X	X	O	I
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	O	I	I
Bundled Service (Status B)	4	X	X	X	I	X	X	X	O	I	I
Rebundling	4	X	X	X	I	X	X	X	O	I	I
P- Modifiers effect on edits:	4	X	X	X	I	O	O	O	I	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 Ba**r (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 0% 100%	% 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%	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)		85%	8	1	0.5	8.5
B-Mutually Exclusive		85%	8	1	0.5	8.5
C-Multiple Procedure Reduction		85%	8	1	0.5	8.5
D-Age		85%	8	1	0.5	8.5
E-Gender		85%	8	1	0.5	8.5
F-Maximum Frequency Per Day		85%	8	1	0.5	8.5
H-Place of Service		85%	8	1	0.5	8.5
M- Total/Prof./ Tech. Split		85%	8	1	0.5	8.5
O-Anesthesia Services		85%	8	1	0.5	8.5

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)]
Add-ons		85%	8	1	0.5	8.5
G-Global Surgery Days		85%	8	1	0.5	9
Global Maternity		85%	8	1	0.5	8.5
New Patient		85%	8	1	0.5	9
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		65%	6	1	0.5	6.5
Bundled Service (Status B)		65%	6	1	0.5	7
Rebundling		65%	6	1	0.5	6.5
P- Modifiers effect on edits:		45%	3	3	1.5	5
Multiple radiology		100%	7	0	0	7
Multiple phys. Therapy		100%	7	0	0	7

Rule	PROGRESS BAR 0% 100%	% 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	