

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

**Two-day meeting: Tuesday, October 22, 2013 (12:00 p.m. – 6:00 p.m. MDT) and
Wednesday, October 23, 2013 (7:30 a.m. – 2:00 p.m. MDT)**

**Location: University Physicians, Inc., 13199 East Montview Blvd., Aurora
The Lilly Marks Boardroom, 1st floor
Parking lot off Victor Street**

Call-In Numbers: 1-866-740-1260, ID 8586318#

Web Login (day one only): <https://cc.readytalk.com/r/9s1oetd435kp&eom>

Agenda

Day 1—Tuesday, October 22, 2013

12:00 PM Welcome & Introductions

12:00—12:25 PM Housekeeping

- Approve September 2013 meeting minutes (**Attachment A**)
- Review agenda
- Meeting procedures
- Thanks to Humana and Rocky Mountain Health Plans for sponsoring the catering
- Catering Sponsors (**Attachment B**)
- Catering sign-up sheet (**Attachment C**)
- Roll Call

Working Lunch

Committee Reports

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

12:25—12:55 PM Edit Committee—Beth Wright and Mark Painter

Draft Query Templates:

- Procedure to Procedure (**Attachment D**)
- Global Surgery (*to be distributed prior to meeting*)
- Technical – Professional Component (**Attachment E**)

12:55—1:05 PM Specialty Society — Helen Campbell

1:05—4:30 PM Payment Rules Committee — Lisa Lipinski/Helen Campbell

Informational Items:

- Bilateral Rule (**Attachment F**)

Draft Rules for Consensus:

- Bundled Service (**Attachment G**)
- Global Surgery/Procedure – Revised to include Same Day Medical Visit & Medical Procedure (**Attachment H**)

Draft Rules for Discussion *(To be distributed prior to meeting.)*

- Laboratory Rebundling
- Maximum Frequency for Span of Days
- Multiple Endoscopy
- Multiple E&M's Same Day
- Rebundling

Brief conference call will be held on Wednesday, October 30, 12:00 PM (MDT) to get consensus on the rules listed above.

- Revisit Edit/Rules Definitions

4:30—5:00 PM

Break/Refreshments

5:00—5:50 PM

Task Force Response to Public Comments – Second Bundle

- MCCTF Response to Public Comments *(to be distributed prior to meeting)*

5:50—6:00 PM

Public Comment

6:00 PM

Adjourn for the Day

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

Wednesday, October 23, 2013 (7:30 a.m. – 2:00 p.m. MDT)

Call-In Numbers: 1-866-740-1260, ID 8586318#

Web Login (day two only): <https://cc.readytalk.com/r/b83vqkteh55a&eom>

Agenda

Day 2— Wednesday, October 23, 2013

- 7:30—8:00 AM** **Continental Breakfast**
- Roll Call**
- 8:00—8:45 AM** **Program Management and Finance – Barry Keene/Vatsala Pathy**
- Recap of Third Bundle of Draft Rules:
 - Review Updated Work-plan (**Attachment I**)
 - Recipe Tracking Sheet (**Attachment J**)
 - Funding
 - Frequently Asked Questions for Website (**Attachment K**)
 - MCCTF “Running Action Items” Document (**Attachment L**)
- 8:45—11:00 AM** **Data Sustaining Repository – Mark Painter/Barry Keene**
- Status of RFP
 - 2014 Legislation/2015 Planning
 - Senator Aguilar Joining Discussion
 - A.G. Opinion
 - **Consensus Item:**
 - **DSR Long-Term Governance Proposal (**Attachment M**)**
- 11:00—11:15 AM** **Break**
- 11:15—11:30 AM** **Ongoing Task Force Activities**
- Public Comment Timing
- 11:30—12:00 PM** **Lunch**
- 12:00 – 1:50 PM** **Other Business**
- 1:50 – 2:00 PM** **Public Comment**
- 2:00 PM** **ADJOURNMENT**

FULL TASK FORCE MEETING SCHEDULE 2013

DATE(S)	TIME (MDT)	MEETING TYPE
November 26	Tue: 12:00 pm – 2:00 p.m.	Monthly Conference Call
December 18	Wed: 12:00 pm – 2:00 p.m.	Monthly Conference Call

DRAFT

HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

Meeting Minutes

September 25, 2013, 12:00–2:00 PM, MDT

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

Conference ID: ID 8586314#

Attendees:

- Barry Keene, CC
- Beth Kujawski
- Beth Wright
- Dee Cole
- Doug Moeller, MD
- Jill Roberson
- Kathy McCreary
- Kim Davis
- Lisa Lipinski
- Marilyn Rissmiller, CC
- Mark Painter
- Nancy Steinke
- Robin Weston

Staff :

- Connor Holzkamp
- Vatsala Pathy

Public:

- Alice Bynum-Gardner (AMA)
- Diane Hayek (ACR)
- Jenny Jackson (ACS)
- Julie Painter (STS)
- Luana Ciccarelli (AAN)
- Leslie Narramore (AGA)
- Pam Kassing (ACR)
- Stephanie Stinchcomb (AUA)
- Susan Crews (AUA)
- Tammy Banks (UHC)
- Todd Klemp (CAP)

Meeting Objective (s):

See Agenda

Key:

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



September 25, 2013

WELCOMING REMARKS & ROLL CALL:
Housekeeping Items:

- The minutes from August were accepted with no changes.
- It was noted that the next in-person meeting is October 22-23, 2013 at University Physicians Inc.

EDIT COMMITTEE—Beth Wright and Mark Painter

- The Edit Committee brought seven query templates to the TF for review (*anesthesia, new patient, add-on, place of service, maximum frequency per day, global maternity, and multiple procedure reduction*). These queries are considered informational items and do not require consensus. To download these query templates please click [here](#).
- The following queries were accepted as informational items by the TF (with revisions in parenthesis):
 - **Anesthesia:** (No revisions made)
Query Logic:
 1. Identify all anesthesia procedures by column labeled STATUS CODE of the Medicare Physician Fee Schedule (MPFS) 4 with an indicator of J.
 2. Compare to vendor submission.
 - **New Patient:** (No revisions made)
Query Logic:
 1. The rule is billing guidelines. No list to be generated. Await Vendor submission. Vendor submit - - code, whether new patient indicator applies, effective date, end date, source.
 - **Add-On** (No revisions made)
Query Logic:
 1. Use the CMS MPFS file to identify codes with a ZZZ value in the Global Days column. ***Note: Todd Klemp from the American College of Pathologists to send the Rules Committee examples of add-on codes that have a value of XXX in the Global Days column for review.***
 2. No public published electronic format available to obtain the parent code in the add-on relationship. Would expect vendors to submit for consideration. ***Note: Nancy stated that there is a CMS file that can be used to obtain the parent code for the add-on relationship and that she would send Marilyn the link after the meeting.***
 3. Vendor submission needs to include one line each for every parent/add-on code relationship. Include separate columns for Add-on code, parent code, effective date, end date and source.
 - **Place of Service:** (No revisions made)
 1. Assess the MPFS facility vs. non-facility indicators following the practice expense columns.
 2. Vendor submission needs to include one line every relationship. Include separate columns for CPT or HCPC code, modifier, code description, use CMS place of service value for denied POS, effective date, end date and source.
Note: Todd Klemp stated that there are some exceptions that his organization would like to see written into the POS rule. He will send these to the TF through public comment.
 - **Maximum Frequency Per Day:** (Typo in *rational* section: “add-on” changed to “maximum frequency per day”)
 1. Use the file from the AMA for the 24 hour/per diem list.
 2. For rest of code list – await vendor list.
 3. Vendor submission needs to include one line each code limit. Include separate columns CPT/HCPC code, Frequency limit, effective date, end date and source.
 - **Global Maternity:** (No revisions made)
 1. Identify by column labeled GLOBAL DAYS of the MPFS with a payment indicator of MMM
 2. The actual day count will come from the vendor. Vendor submission – code, # of days, effective and end date, source.
 - **Multiple Procedure Reduction:** (No revisions made)
 1. Identify through column labeled MULT PROC of the Medicare Physician Fee Schedule (MPFS) with a value of 1, 2, or 3. Exclude: Nuclear Medicine codes 78306, 78320, 78802, 78803, 78806, and 78807 marked with an indicator of “2”
 2. Vendor submission – code, modifier, indicator, description, effective and end date and source.

The TF accepted the Edit Committee’s query templates as informational items. To download these query templates please click [here](#); Todd Klemp to send Rules Committee examples of add-on codes that have a value of XXX in the Global Days column for review.

PAYMENT RULES COMMITTEE— Lisa Lipinski and Helen Campbell

- Lisa Lipinski reported that she will be moving to a new position at the AMA, but will continue her work with the TF until the end of the year.
- Lisa introduced Alice Bynum-Gardner, whom will be applying for a seat on the TF once Lisa is gone.

The Rules Committee is working to finalize the following draft rules for the third bundle: *multiple endoscopy, procedure to modifier validation, multiple E&M’s on the same day, rebundling, maximum frequency greater-than one day and bundled*. The completed drafts will be brought for consensus to the full TF in October.

DATA SUSTAINING REPOSITORY COMMITTEE—Mark Painter/Barry Keene

- Barry reported that the Attorney General’s (AG) office has been reviewing the TF’s request regarding the possibility of allowing the data analytics contractor to monetize the services outlined in the RFP for the 2015 timeframe. The AG has also been reviewing the work of the TF in greater detail to examine things like legislative intent, details of implementation, transparency of the TF’s work etc. More information to come after meeting with AG (9/26/13)
- Mark P reported that the DSR Committee decided the “draft governance document” needed more work at the committee level and will be brought for next meeting in October. An important part of this document that the DSR is trying to flesh out is the business model to sustain the work of the TF after its sun has set.
- Mark P reported that the RFP is essentially done (pending review from the AG and HCPF) and will be sent out as soon as possible.

Barry, Marilyn, Mark P, Vatsala and some members of the DSR Committee will attend a meeting with the AG (9/26/13) and report back to the TF in October; The DSR Committee will continue to flesh out the “draft governance document” and bring it to the TF in October; The committee will vet the RFP using the information from the AG meeting and send it out as soon as possible.

SPECIALTY SOCIETY OUTREACH COMMITTEE—Helen Campbell:

- The Specialty Society reported that they are working hand-in-hand with the Rules Committee and have reached out to the federations regarding the October 4 deadline for public comment on the second bundle of rules.
- The American Medical Association (AMA) is a central part of the Specialty Society Outreach Committee and Barry asked Lisa if she would look into replacing Tammy Banks (formerly with the AMA) as the CC of the committee.
- The committee will continue 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.”

Staff to work with Marilyn to create a list of all the entities that the TF has reached out to; Lisa to look into who will replace Tammy Banks as the representative for the AMA in the Specialty Society Outreach Committee.

PROJECT MANAGEMENT COMMITTEE—Barry Keene and Vatsala Pathy

- Several documents that had been updated from the previous month were displayed as informational items for the TF:
 - Workplan
 - Rules tracking sheet

- Running summary of action items
- MCCTF Roster
- It was noted that the deadline for public comment on the second bundle of rules is October 4, 2013.
- The third bundle of rules is scheduled to be released October 25, 2013.

FINANCE —Barry Keene

- The TF will continue to look for contributions from the stakeholders at the table additional sources to fund TF operations.
- Barry reported that he had reached out to Dr. Borgstede to inquire about sponsoring the catering for the October in-person meeting and is awaiting his response.

OTHER BUSINESS:

<none>

PUBLIC COMMENT:

<none>

The meeting was adjourned at approximately 1:20 PM MDT

DRAFT

The Colorado Medical Clean Claims Task Force would like to extend its gratitude to the following people/organizations for their generous donations. The Task Force has been working relentlessly to complete its charge and we thank you for making all of that work possible.

Note: Those who have sponsored the catering more than once are **written in bold type.*

Catering Sponsors For In-Person Meetings

Adams County Community Outreach Center, Ryshell Shrader

Anthem Blue Cross & Blue Shield of Colorado

Colorado Hospital Association

Humana

KEENE Research & Development, Barry Keene

McKesson, Doug Moeller

NHXS, Mark Reiger

The Colorado Medical Society, Marilyn Rissmiller

United Health Group, Helen Campbell

University of Colorado Hospital, Kathy McCreary

Rocky Mountain Health Plans

Western Nephrology, Wendi Healy's Original Employer

**Please note that this list may be subject to change. If you have been mistakenly left off this list please let us know and we will make sure you are recognized for your contributions. If you would like to sponsor the catering for an upcoming meeting and/or make a donation please email Vatsala Pathy at vatsala.pathy@rootstocksolutions.com*

Date: September 25, 2013

MCCTF Catering Sign-up for Face-to-Face Meetings

*Catering involves providing meals, snacks and refreshments for meeting participants. Typically this has been around \$800 for the full two-day meeting.

Meeting Date	Name and Organization	Email
January 21-22, 2014		
April 22-23, 2014		
August 26-27, 2014	Marilyn Rissmiller <i>Colorado Medical Society</i>	marilyn_rissmiller@cms.org
November 18-19, 2014	Barry Keene <i>Keene Research and Development</i>	krd@qadas.com



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

Edit/Payment Rule Query

Topic	Procedure to Procedure A-Unbundled (Bundled) and B-Mutually Exclusive
Definition	<p>This type of edit is also referred to as procedure to procedure edit (PTP) and will prevent inappropriate billing of services on the same calendar date when incorrect code combinations are reported. PTP edits cover a variety of situations, such as:</p> <ol style="list-style-type: none"> 1. Comprehensive/ component code pairs; 2. Code pairs differing only in complexity of the service rendered (simple/complex, superficial/deep, etc.); 3. Code pairs from the same family of Current Procedural Terminology (CPT®)¹/Health care Procedure Coding System (HCPCS)² codes, which describe redundant, comprehensive or incidental services. 4. Services designated by CPT® as separate procedures when carried out as an integral component of a total service; 5. Services that are typically included in the performance of a service provided at the same encounter. 6. General anesthesia services provided for multiple surgical procedures performed during the same operative session. 7. Services that cannot reasonably be performed at the same anatomic site or same patient encounter, by the same physician.
Associated CPT®¹ and HCPCS² modifiers (or codes)	<p>CPT Modifiers:</p> <p>-25 Significantly, separately identifiable E/M services by the same physician 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.</p> <p>-59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify</p>

¹ Copyright 2013 American Medical Association. All rights reserved.

² This is the Healthcare Common Procedure Coding System (HCPCS) definition and the reference to customary and prevailing profiles is specific to Medicare.

procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

HCPCS Modifiers:

- E1 Upper left, eyelid
- E2 Lower left, eyelid
- E3 Upper right, eyelid
- E4 Lower right, eyelid
- F1 Left hand, second digit
- F2 Left hand, third digit
- F3 Left hand, fourth digit
- F4 Left hand, fifth digit
- F5 Right hand, thumb
- F6 Right hand, second digit
- F7 Right hand, third digit
- F8 Right hand, fourth digit
- F9 Right hand, fifth digit
- FA Left hand, thumb
- GG Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
- GH Diagnostic mammogram converted from screening mammogram on same day
- LC Left circumflex coronary artery
- LD Left anterior descending coronary artery
- LM Left main coronary artery
- LT Left side (used to identify procedures performed on the left side of the body)
- RC Right coronary artery
- RI Ramus intermedius coronary artery
- RT Right side (used to identify procedures performed on the right side of the body)
- T1 Left foot, second digit
- T2 Left foot, third digit
- T3 Left foot, fourth digit
- T4 Left foot, fifth digit
- T5 Right foot, great toe
- T6 Right foot, second digit
- T7 Right foot, third digit
- T8 Right foot, fourth digit
- T9 Right foot, fifth digit
- TA Left foot, great toe

Appropriate modifiers may override the edit.

There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.

¹ Copyright 2013 American Medical Association. All rights reserved.

² This is the Healthcare Common Procedure Coding System (HCPCS) definition and the reference to customary and prevailing profiles is specific to Medicare.

Query logic	<ol style="list-style-type: none"> 1) Extract NCCI files from CMS website – Column A, Column B file – current year 2) Vendor submission – line for code pair --- Column for denied code, column for allowed code, modifier override capability (Y or N), type of edit (mutually exclusive, incidental), effective date and end date of code relationship, source, comment field
Rationale	<p>Applying based on Task Force consensus on procedure to procedure recommendation. There are no code exceptions at this time.</p>
DATE	September 16, 2013

DRAFT

¹ Copyright 2013 American Medical Association. All rights reserved.

² This is the Healthcare Common Procedure Coding System (HCPCS) definition and the reference to customary and prevailing profiles is specific to Medicare.



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

Edit/Payment Rule Query

Topic	Professional and Technical Component
Definition	This type of edit will identify incorrect billing of a procedure code that is either not eligible for the professional/technical split, or incorrectly identifies the professional or technical component.
Associated CPT®¹ and HCPCS² modifiers (or codes)	<p>-26 Professional Component: Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.</p> <p>-TC Technical Component:² Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.</p> <p>This rule is applicable for the specific situations identified for these modifiers. There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.</p>
Query logic	<ol style="list-style-type: none"> 1) Create a list - Use CMS MPFS file– column labeled PC/TC – extract codes with an indicator of 1 2) Vendor submission – CPT/HCPC code, 26 modifier (Y or N), TC modifier (Y or N), effective date, end date, source
Rationale	Applying based on Task Force consensus on professional and technical component recommendation. There are no code exceptions at this time.
DATE	September 16, 2013

¹ Copyright 2013 American Medical Association. All rights reserved.

² This is the Healthcare Common Procedure Coding System (HCPCS) definition and the reference to customary and prevailing profiles is specific to Medicare.



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

Edit/Payment Rule

<p>Number: Draft Bilateral Procedure 104 V.01 5/23/13</p>	<p>Statutory reference: C.R.S. 25-37-106</p>
<p>Topic</p>	<p>Bilateral Procedure</p>
<p>Definition</p>	<p>As defined in CPT, Modifier 50 “Bilateral procedure description: Unless otherwise identified in the listing, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.” ¹Medicare further defines bilateral as follows: A bilateral service is one in which the same procedure is performed on both sides of the body during the same operative session or on the same day.²</p>
<p>Associated Current Procedural Terminology (CPT®)³ and HCPCS modifiers</p>	<p>-50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.⁴ -LT Left side (used to identify procedures performed on the left side of the body) -RT Right side (used to identify procedures performed on the right side of the body)</p> <p>This rule is applicable for the specific situations identified for this modifier. There may be appropriate situations where multiple modifiers apply such as anatomic or surgical modifiers, however not all situations are covered in this rule.</p>
<p>Rationale</p>	<p>The following rationale was used to formulate the Bilateral Procedure rule:</p> <ul style="list-style-type: none"> • The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed. • The CPT descriptions for bilateral service and modifier 50 were selected. • The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the Medicare Physician Fee Schedule (MPFS).⁵ and the Medicare Claims Processing Manual⁶ were selected. • CPT codes that were exceptions to the CMS pricing policy were identified and included in the Bilateral Procedure Rule.
<p>Rule logic</p>	<p>Procedure codes subject to the Bilateral Procedure rule were developed by reviewing the BILT SURG indicators on the most recent MPFS file and applying the rule logic noted below. The MPFS uses five indicators (0, 1, 2, 3 and 9) to identify if the procedure code is eligible for the bilateral adjustment.</p> <ul style="list-style-type: none"> • Code is eligible for bilateral adjustment (indicator 1) Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 1 are eligible for the bilateral payment adjustment and should be

¹ Copyright 2013 American Medical Association. All Rights Reserved.

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

³ Copyright 2013 American Medical Association. All Rights Reserved.

⁴ Copyright 2013 American Medical Association. All Rights Reserved.

⁵ 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.

⁶ Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

	<p>reported on one line appended with modifier 50, with 1 in the units box. When the same bilateral procedure is performed multiple times by the same physician or healthcare provider, report second and subsequent procedures with modifier 50 and 59 appended and reported on one line with one unit for each bilateral procedure performed.</p> <p>If bilateral procedures are performed with other procedures for the same patient during the same session by the same physician, apply the bilateral payment adjustment rule first, then apply any other applicable payment adjustment. (e.g. multiple surgery).</p> <ul style="list-style-type: none"> • Code is NOT eligible for bilateral adjustment (indicators 0, 2, 3 and 9) <ul style="list-style-type: none"> ○ Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 0 are not eligible for bilateral payment adjustment. Either the procedure cannot be performed bilaterally due to anatomical constraints or there is a code that more adequately describes the bilateral procedure. ○ Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 2 are not eligible for the bilateral payment adjustment. These procedure codes are already bilateral. ○ Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 3 are not eligible for bilateral payment adjustment. Report these codes on two lines with RT and LT. There is one payment per line. Indicator 3 codes are eligible for 1 unit per line. Please note that indicator 3 codes are primarily diagnostic radiology and other diagnostic medicine procedures. Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 9 are not eligible for the bilateral payment adjustment because the concept does not apply.
<p>Administrative guidance</p>	<p>Code is eligible for bilateral adjustment (bilateral indicator 1)</p> <p>A bilateral payment adjustment may be made ONLY when 1) The bilateral indicator is 1, signifying that the code is eligible for the adjustment; 2) the code is billed with modifier 50; 3) the code is billed on one line; and 4) the units are 1.</p> <p style="padding-left: 40px;">Example: XXXXX 50</p> <p>Use the following administrative guidelines if the above criteria are not met:</p> <ul style="list-style-type: none"> • Code is billed on two or more lines, each with 1 or more units, and one or more lines has modifier 50 - ACTION: Deny the lines or adjudicate one line using bilateral payment adjustment, deny other lines with the same procedure code if no additional modifier is appropriately appended. <p style="padding-left: 40px;">Example: XXXXX 50 XXXXX 50 - subject to action</p> • Code is billed on two or more lines, each with 1 or more units, and no modifiers – ACTION: Deny the lines or adjudicate one line with no bilateral payment adjustment, deny other lines with same procedure code. <p style="padding-left: 40px;">Example: XXXXX – subject to action XXXXX – subject to action</p> <p>Code is NOT eligible for bilateral adjustment (bilateral indicator 0 or 9)</p> <p>Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 0 or 9 should be billed on one line. Either the procedure cannot be performed bilaterally</p>

due to anatomical constraints, there is a code that more adequately describes the bilateral procedure, or the concept does not apply.

Example: XXXXX

Use the following administrative guidelines if the above criteria are not met:

- Code is billed with modifier 50 appended – ACTION: Deny the line or adjudicate as if 1 unit had been billed without modifier 50 appended.

Example: XXXXX 50 – subject to action

Code is inherently bilateral - NOT eligible for bilateral adjustment (bilateral indicator 2)

Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 2 should be billed on one line with 1 unit. Use of modifier 50 is inappropriate and it should not be appended.

Example: XXXXX

Use the following administrative guidelines if the above criteria are not met:

- If a procedure code with an indicator of 2 is billed on one line with modifier 50 appended or more than 1 unit – ACTION: Deny the line or adjudicate 1 unit.

Example: XXXXX 50 – subject to action

- If procedure codes with an indicator of 2 are billed on two or more lines without an appropriate modifier – ACTION: Deny the line(s) or adjudicate one line with no bilateral payment adjustment, deny other line(s) with same procedure code and no appropriate modifier.

Example: XXXXX
XXXXX – subject to action

Procedure is performed bilaterally and no bilateral adjustment is applied (bilateral indicator 3)

Procedure codes listed in the column labeled BILT SURG of the MPFS with an indicator of 3 should be billed on two lines, each line with 1 unit and one line with RT and one line with LT modifiers appended.

Example: XXXXX RT
XXXXX LT

Use the following administrative guidelines if the above criteria are not met:

- If procedure codes with an indicator of 3 are billed on one line with RT and LT modifiers, and 1 or more units – ACTION: Deny the line or adjudicate one line with unilateral pricing.

Example: XXXXX RT, LT – subject to action

- If procedure codes with an indicator of 3 are billed on more than two lines with at least one line with RT and one line with LT and 1 or more units on these lines – ACTION: Adjudicate the combination of one RT line and one LT line with no bilateral payment adjustment. Deny other line(s) for same procedure code with RT/LT modifier and no other appropriate modifier.

Example: XXXXX RT
XXXXX LT
XXXXX RT – subject to action
XXXXX LT, additional modifier

service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

Comments

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

Comments regarding the bilateral procedures rule should be submitted online to the Colorado Medical Clean Claims Task Force at www.hb101332taskforce.org by July 15, 2013. The following information should be included:

1. Number and topic
2. Position – support, disagree, modification
3. Recommendation
4. Rationale in support of recommendation
5. Supporting data and sources, e.g., frequency, associated costs
6. Estimated impact of the proposed rule
7. Contact information
8. Organization affiliation

Draft

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.

¹ Copyright 2013. All rights reserved. American Medical Association

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.

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 Manual³ 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
- 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

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

G - Global Procedure Days/Package

***Some portions of this document are up for discussion at the CPT Panel meeting and may be subject to change pending discussions with CMS.**

Rules Committee Recommendation

Global Procedure Days/package 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.

Payers and providers are encouraged to reach an agreement regarding specific additional documentation that must be submitted with a claim when the rule states documentation may be required by the payer.

Modifiers involved

24, 25, 54, 55, 56, 57, 58, 78, 79 (see below for definitions)

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

Global Procedure rule definition

The number of days assigned to the Current Procedural Terminology (CPT[®])/HCPCS procedure codes in the column labeled GLOBAL DAYS of the Medicare Physician Fee Schedule (MPFS)² will be utilized to identify the post-operative period associated with the procedure.

¹ Copyright 2013 American Medical Association. All rights reserved.

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.

- The global procedure rule applies to procedure codes listed in the column labeled GLOBAL DAYS of the MPFS with indicators of 000, 010, 090 and sometimes YYY.
- The global procedure rule does not apply to procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of XXX.
- The global procedure rule does not apply to procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of MMM, as they are maternity codes and are excluded from the usual global surgery days/package. For more information on maternity codes, view the Global Maternity Care reporting rule.
- The global procedure rule does not apply to procedure codes outlined in the column labeled GLOBAL DAYS of the MPFS with an indicator of ZZZ. These codes are related to another service and are always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post-service time.)
- **Duration of the Global Period**
 - Zero days (Typically endoscopies or minor surgeries) – There is no preoperative or postoperative period for endoscopies and minor surgeries. Visits on the same day of the procedure are generally included in the allowance for the procedure, unless a significant, separately identifiable service is also performed and reported with the appropriate modifier.
 - 10 days (Typically other minor surgeries) – There is no preoperative period for other minor surgeries and visits on the same day or 10 days after the procedure are generally not allowed as a separate service unless a significant and, separately identifiable service is also performed and reported with the appropriate modifier. The postoperative period is 10 days immediately following the day of surgery.
 - 90 days (Typically major surgeries) - The preoperative period for major surgeries is the day immediately prior to the day of the surgery, and the postoperative period is 90 days immediately following the day of surgery. Services provided on the day of surgery but prior to the surgery are considered preoperative, while services furnished on the same day but after the surgery are considered postoperative.
 - An evaluation and management service within the preoperative period that results in the decision for surgery is reportable with the appropriate modifier appended to the E/M code.
 - Significant and separately identifiable, unrelated evaluation and management work provided within the global period is reportable with the appropriate modifier appended to the E/M code.
- See Coding and adjudication guidelines below for modifiers that override the global procedure rule.
- **Surgical Package**

The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services “included” in a given CPT surgical code, the following services are always included in addition to the operation per se:

 - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
 - Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical);

- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the postanesthesia recovery area;
- Postsurgical Pain Management by the surgeon;
- Complications directly related to the surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room, or are not related to other medical conditions of the patient;
- Typical postoperative follow-up care during the global period of the surgery that are related to recovery from the surgery;
- Supplies - Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

From a CPT coding perspective, this definition indicates that when a surgical procedure is reported with a CPT code, the items listed in that guideline are included (if performed) and are not reported separately. Since patients may have other disease(s) or injury(s) or may have undergone other diagnostic and/or therapeutic procedure(s), certain variables may impact reporting, and include: The type of procedure performed; The place where the surgery occurs; The time (during hospitalization) the surgery is performed; The insurance contract of each individual patient.

Therefore, because it is not possible to address all of these variables in each code descriptor, only the preoperative E/M service related to the procedure performed on the date immediately before the procedure (including the history and physical) is stated as inclusive of the CPT surgical package definition. It is important to note that this included E/M encounter must occur subsequent to the E/M encounter at which the decision for surgery was reached. For example, the E/M service is separately reported when a physician performs an office E/M service, and at that visit it is determined that surgery is necessary. The appropriate modifier must be appended.

Coding and adjudication guidelines

In certain circumstances it is appropriate to report additional medical or surgical services provided during the global period. The following modifiers appended to the procedure code are used to identify these:

- Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period.
- 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.
- Modifier 54: Surgical Care Only.
- Modifier 55: Postoperative Management Only.
- Modifier 56: Preoperative Management Only.

- Modifier 57, Decision for Surgery
- Modifier 58: Staged or Related Procedure or Service by the same Physician or Other Qualified Health Care Professional During the Postoperative Period.
- Modifier 76, Repeat Procedure or Service by Same Physician
- Modifier 78, Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period.
- Modifier 79, Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period.

Refer to the CPT Surgical Package Definition for a listing of the elements that are included in the surgical package.

Care that can be separately reported and is not a part of the surgical package includes:

- Care of the condition for which a diagnostic procedure was performed or a concomitant condition
- Complications, exacerbations recurrence, or the presence of other diseases or injuries requiring additional services.

See Chapter 12, Sections 40.1-40.3 of the Medicare Claims Processing Manual³ for further instruction including:

- Carrier edits
- Billing requirements

Same Day Medical Visit and Medical Procedure

“Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequent to the date of initial or subsequent E/M services should be reported separately. The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician’s interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with modifier 26 appended. The physician may need 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 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.”

“The E/M service may be caused or prompted by the same symptoms or condition for which the CMT service was provided.”

³ Chapter 12 – Physician/Nonphysician Practitioners, Medicare Claims Processing Manual, Publication # 100-04

Surgical procedure guidance

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. E/M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.

The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure. Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E/M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E/M service may be separately reportable.

Unrelated E/M services by the same physician during a postoperative period

When a physician provides a surgical service related to one problem and then, during the period of follow-up care for the surgery, provides an E/M services unrelated to the problem requiring the surgery a modifier 24 would be appended to the appropriate level of E/M services provided.

For services not subject to the global package, see the following:

- CPT code set, Follow –Up Care for Diagnostic Procedures, page 58 and Follow-Up Care for Therapeutic Surgical Procedures, page 58 of the CPT codebook.
- Medicare Claims Processing Manual, Chapter 12, 40.1, B – Services Not Included in the Global Surgical Package.

Rationale

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

- The Current Procedural Terminology (CPT[®])⁴ coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for global surgery and associated modifiers were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual⁵ were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

MCCTF comment

The legislative intent was not to limit the edit to just the number of days, but also to address the global package.

⁴ Copyright 2013 American Medical Association. All rights reserved.

⁵ Chapter 12 – Physician/Nonphysician Practitioners, Medicare Claims Processing Manual, Publication # 100-04.

Modifier/edit definitions

This type of edit will identify incorrect billing when services that are routinely considered part of the global surgery package are reported separately within the preoperative, same day and post-operative days assigned to that surgical procedure code. Consensus on 3/18/12. Consensus on revised definition 7/18/12.

This type of edit will identify incorrect billing when an evaluation and management (E&M) service is reported on the same day as a substantial diagnostic or therapeutic procedure (such as diagnostic or therapeutic) procedure. Not applicable as separate edit type, combined with global surgery Consensus 7/18/12.

- **Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period.** The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during the postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service
- **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 in the CPT codebook 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 in conjunction with a major surgical procedure (one that has 90 days postoperative follow up) 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.

- **Modifier 54: Surgical Care Only.** When one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure code.
- **Modifier 55: Postoperative Management Only.** When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure code.
- **Modifier 56: Preoperative Management Only.** When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure code.

- Modifier 57, Decision for Surgery, is used to indicate that an evaluation and management service resulted in the initial decision to perform the surgery. Use of this modifier is limited to procedures with 90-day global periods.
- Modifier 58: Staged or Related Procedure or Service by the same Physician or Other Qualified Health Care Professional During the Postoperative Period. The use of the modifier 58 enables the payers to appropriately pay for the procedure per se and other associated postoperative services performed by the original surgeon or provider within or subsequent to its assigned global period (eg, 0 days, 10 days, 90 days). Modifier 58 is used to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure.
- Modifier 76, Repeat Procedure or Service by Same Physician, is used to indicate that a procedure or service was repeated subsequent to the original procedure or service in a separate operative session by the same physician.
- Modifier 78, Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period. When a procedure is related to the first (but not a repeat procedure) and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.
- Modifier 79, Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period. When a procedure or service performed during the postoperative period was unrelated to the original procedure, this circumstance is communicated by appending the modifier 79 to the unrelated procedure.

Additional definitions

Intraoperative Services

All intraoperative services that are normally included as a necessary part of a surgical procedure are included in the global package.

Preservice, intraservice and postservice work

The work involved in actually providing a service or performing a procedure is termed "intraservice work." For office visits, the intraservice period is defined as patient encounter time; for hospital visits, it is the time spent on the patient's floor; and for surgical procedures, it is the period from the initial incision to the closure of the incision. (ie, "skin-to-skin" time).

Work prior to and following provision of a service, such as surgical preparation time, writing or reviewing records, or discussion with other physicians, is referred to as "pre-service and post-service work." When preservice, intra-service, and postservice work are combined, the result is referred to as the "total work" involved in the service. For surgical procedures, the total work period is the same as the global surgical period, including recovery room time, normal postoperative hospital care, and office visits after discharge, as well as preoperative and intraoperative work.

Payment indicator definitions

The following are payment indicator definitions that are outlined in the column labeled GLOBAL of

the MPFS for Global Surgery⁶. This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; initial evaluation and management services on the day of the procedure are payable with proper documentation showing that the evaluation and management service was necessary for the diagnosis/treatment.

010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

MMM = Maternity codes; usual global period does not apply.

XXX = Global concept does not apply.

YYY = Carrier/MAC determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ = Code related to another service is always included in the global period of the other service.

Federation outreach

Federation Payment Policy Workgroup

This recommendation has been sent to the Federation Payment Policy Workgroup for review.

⁶ Information taken from “[How to Use the Searchable Medicare Physician Fee Schedule \(MPFS\)](#)”, Centers for Medicare & Medicaid Services”, Centers for Medicare & Medicaid Services.

G – Global Procedure Days/Package

*DRAFT – PLEASE DO NOT DISTRIBUTE

Appendix A - To be added to Data Sustaining Repository

Rationale

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

- The Current Procedural Terminology (CPT[®])⁷ coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for global surgery and the modifiers listed were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy, as identified in the Medicare Physician Fee Schedule (MPFS) and the Medicare Claims Processing Manual⁸, were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

Exceptions

At the time of the initial review, the following exceptions were identified. This may not be a comprehensive listing of appropriate exceptions.

For services not subject to the global surgical package, see the following:

- CPT code set, Follow –Up Care for Diagnostic Procedures, page 58 and Follow-Up Care for Therapeutic Surgical Procedures, page 58 of CPT codebook.
- Medicare Claims Processing Manual, Chapter 12, 40.1, B – Services Not Included in the Global Surgical Package.

⁷ Copyright 2013 American Medical Association. All rights reserved.

⁸ Chapter 12 – Physician/Nonphysician Practitioners, Medicare Claims Processing Manual, Publication # 100-04.

Activity	2013										2014										Deadline	Status as of 10-15-13				
	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 5 weeks 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 10-15-13		
	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	In Process
After reviewing comments received on 2nd bundle draft edit rule recipes, TF finalizes and approves 2nd bundle.																							November 26	
<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	In Process
Task force reviews and approves draft 3rd bundle of draft edit rules.																							October 22 mtg	DONE PENDING 10/30/13 CONFERENCE CALL
3rd bundle of draft recipes circulated 5-week public review and comment period. **																							October 25	Delayed
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	

* In-person task force meeting.

** Only 5 weeks 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 10-15-13		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	APR*	May	June	July	AUG*	Sept	Oct	NOV*			Dec	
After reviewing comments on 3rd bundle of draft recipes, task force finalizes and approves.																							January 2014 TF mtg	
Update entire draft set with current codes. [2014]																								
Glossary developed with final set																							Ongoing	
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	
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: <ul style="list-style-type: none"> Who is responsible for establishing a central repository for accessing the rules and edits set 																							Oct 22 mtg	In Process

* In-person task force meeting.

** Only 5 weeks 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 10-15-13				
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	APR*	May	June	July	AUG*	Sept	Oct	NOV*			Dec			
and o Enabling electronic access—including downloading capability—to the rules and edits set																										
DATA ANALYTICS																										
Task force secures funding to hire a data analytics consultant.																										DONE (assumes original low-bid is amt needed.)
RFP for data analytics contractor issued.																										End of June DELAYED
Proposals from data analytics contractors due. Executive Committee and three unconflicted task force members review and score RFP responses.																										End of July DELAYED
Task force reviews and approves selection of an RFP contractor based on scoring.																										August 27 mtg DELAYED
Contract for data analytics contractor signed.																										Mid-September DELAYED
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

* In-person task force meeting.

** Only 5 weeks 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 10-15-13		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	APR*	May	June	July	AUG*	Sept	Oct	NOV*			Dec	
Staff work on and 2nd task force progress report submitted to Health Care Policy & Financing and the General Assembly																							December 31, 2013	
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	
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																							End of July 2014	

* In-person task force meeting.

** Only 5 weeks 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 10-15-13			
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	APR*	May	June	July	AUG*	Sept	Oct	NOV*			Dec		
capability--to the rules & edits set.																									
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
<p>Task Force submits final report to legislature & executive director of Department Health Care Policy & Financing that:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ who is responsible for establishing a central repository to access the rules & edits set, & ○ enabling electronic access--including downloading capability--to the rules and edits set; and • Includes a recommended schedule for 																									December 31, 2014

* In-person task force meeting.

** Only 5 weeks 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	

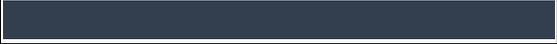
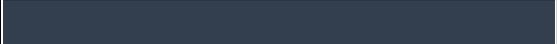
* In-person task force meeting.

** Only 5 weeks allowed for comments on 2nd and 3rd bundles in order to have enough time for complete all tasks to meet statutory deadline.

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
O-Anesthesia Services	2	X	X	X	X	X	X	X	X	O	I
Add-ons	2	X	X	X	X	X	X	X	X	O	I
Global Maternity	2	X	X	X	X	X	X	X	X	O	I
P- Modifiers effect on edits:	3	X	X	X	I	O	O	O	I	I	I
Max. Frequency- Span of Days	3	X	X	X	I	O	O	O	I	I	I
New Patient	3	X	X	X	X	X	X	X	X	I	I
Bundled Service (Status B)	3	X	X	X	I	X	X	X	O	I	I
Multiple Endoscopy	3	X	X	X	I	O	O	O	I	I	I
Multiple E&M's Same Day	3	X	X	X	I	O	O	O	I	I	I
Rebundling	3	X	X	X	I	O	O	O	I	I	I
Same day med visit & med procedure	3	X	X	X	I	X	X	X	O	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%	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)		90%	9	0	0	9
B-Mutually Exclusive		90%	9	0	0	9
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
G-Global Surgery Days		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

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)]
	100%	0%				
O-Anesthesia Services		85%	8	1	0.5	8.5
Add-ons		85%	8	1	0.5	8.5
Global Maternity		85%	8	1	0.5	8.5
P- Modifiers effect on edits:		45%	3	3	1.5	4.5
Max. Frequency- Span of Days		45%	3	3	1.5	4.5
New Patient		80%	8	0	0	8
Bundled Service (Status B)		65%	6	1	0.5	6.5
Multiple Endoscopy		45%	3	3	1.5	4.5
Multiple E&M's Same Day		45%	3	3	1.5	4.5
Rebundling		45%	3	3	1.5	4.5
Same day med visit & med procedure		65%	6	1	0.5	6.5
Multiple radiology		100%	7	0	0	7
Multiple phys. Therapy		100%	7	0	0	7

Total Phases of Rule Development	10
----------------------------------	----

Frequently Asked Questions:

General Questions

What is the purpose and intent of the Task Force?

The “Medical Clean Claims Transparency and Uniformity Act” is designed to save` Coloradans millions of dollars a year by adopting uniform medical claim edits and payment rules to be shared among all payers in Colorado. The Task Force work plan has the following core principles: **Consistency, Standardization, Transparency, and Appropriate Savings to the System.** More information can be found in the [2012 report to the legislature](#) or the [bill](#).

What is the scope of the Task Force’s work?

The task force agreed that its legislative mandate is to elucidate and standardize coding rules. The following items are out of scope: medical necessity, fraud, abuse or utilization review edits; government programs and pricing rules. The task force may, however, describe those coding scenarios that are unique and eligible for differentiated pricing. The Task Force has created a list of edits that are considered out of scope [which can be viewed by clicking here](#).

What is the scope and composition of the Task Force’s committees?

The task force has accomplished most of its work through four committees. Some committees include additional non-task force members with relevant expertise. A brief summary of each committee’s scope is below:

- **Edit Committee:** Responsible for identifying definitions and edits for the base set.
- **External Engagement and Professional Medical Society Outreach Committee:** Responsible for liaising 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:** Responsible for developing payment (but not pricing) rule recommendations.
- **Data Sustaining Repository Committee:** Responsible for examining how the standardized set will be maintained and sustained.

What is the timeframe for completion of the edits?

All timeframes can be found by viewing the [MCCTF Work-plan](#).

How were Task Force members selected?

All Task Force members have been selected through an application process, and appointed by the Executive Director of the Department of Health Care Policy and Financing. The Task Force is made up of 28 industry experts representing a wide variety of stakeholders including: health care providers or employees thereof from a diverse group of settings; persons or entities that pay for health care services (“payers”); practice management system vendors; billing and revenue cycle management service companies; and, government payers.

Who is on the Task Force?

The Task Force includes 28 industry experts from a variety of stakeholders. To view the current roster for the Task Force please click [here](#).

Who can I contact if I have questions about the Task Force?

Please direct all questions to Connor Holzkamp at connor.holzkamp@rootstocksolutions.com

Where can I access reports to the legislature?

The act directed the Medical Clean Claims Transparency and Uniformity Act Task Force to “submit a report and recommendations concerning the set of uniform, standardized payment rules and claim edits to the executive director of HCPF and the health and human services committees of the senate and house of representatives [of the Colorado

General Assembly], or their successor committees, by November 30, 2012.” This report is archived on the website and can be viewed in the section titled “archives”, or by clicking [here](#).

Public Comment Process

How do I sign up for automatic notification?

If you would like to receive automatic email notifications from the Task Force regarding the public comment process, please click [here](#).

Where can I download the documents that are currently accepting public comment?

The Task Force periodically releases documents for a period of public review. To download the documents that are currently accepting comments, please click [here](#).

How can I ensure that the Task Force reviews my comment?

The public review process is an integral part of the Task Force’s effort to create a standardized set of payment rules and claim edits for payers and providers in Colorado. All comments that are submitted properly will be reviewed. To ensure that your comment is received, please follow the directions located in the [public comment section of the website](#).

Who can submit a comment?

The Task Force does not have any requirements regarding who may provide comment. Any member of the general public may submit a comment.

What kind of information do I need to include when submitting a comment?

The public review process is explained in the [public comment section of the website](#) and includes the following:

- Contact information: Name, title, phone number, and email address.
- Organization information (if applicable): Organization name and street address.
- Comment: You may either type your comment directly into the provided form, or upload a .pdf file.

How is my comment reviewed and processed?

Task Force staff will retrieve all comments that are received through the website and direct them to the appropriate sub-committee. The committee will review the comment and make a recommendation to the full Task Force. After the comment is reviewed by the full Task Force, the official response will be posted on the website. [To view the Task Force’s response to public comments please click this link](#).

Analytics & DSR

Was there an RFI for the data analytics contractor?

The purpose of the RFI, which was released May 3, 2012, was to invite input; better understand potential strategies and costs associated with the design and development of an online data repository; and solicit innovative solutions. The committee included language in the RFI indicating that the task force, recognizing that no current organization or initiative includes the whole universe of existing edits, has a particular interest in creative solutions that take advantage of or blend current efforts and products. The RFI invited comments and suggestions concerning design solutions (both proprietary and commercial off-the-shelf); implementation strategies/incentives; program costs (design, development, implementation and ongoing); and administration/management services. [Please click here to view the RFI](#).

Can I see a copy of the RFP for the data analytics contractor?

Yes - A link will be placed here as soon as it becomes available in the archives.

Note: The RFP (Request for Proposals) is for a data analytics contractor that would compile the edits that companies and organizations would like to see in the standardized set and, at the direction of the task force, analyze the edits to arrive at a recommended standardized set.

[DRAFT] Categorical Summary of Task Force Action Items

Updated August 19, 2013

Category	Start Date	Action Item Description	Comments	Committee	Status	End Date
Data Analytics	N/A	Analytics RFP	The Possibility of perhaps "allowing a vendor that does our data analytics to monetize that in 2015" was put on the table. The DSR Committee will explore this further to determine if this can be done. <i>Update: The TF met with the Attorney General's office in July of 2013; the idea was neither accepted or rejected to allow some sort of monetization for 2015. The TF is hopeful that it will be able to issue the RFP soliciting the service priced from two different perspectives: 1) Stand-alone price, and, 2) Priced as though there were an opportunity to monetize it in 2015; Update: The DSR Committee has completed the draft RFP and will send out as soon as it is cleared with HCPF procurement office.</i>	DSR Committee	Completed	September, 2013
Data Analytics	February, 2013	Task force does a trial data analytics exercise for an edit category (assistant at surgery) to see how the Process for Developing a Standardized Set of Claims Edits and Payment Rules works and modify the process as necessary.	*Note: After the February, 2013 meeting, the Edit Committee revised the rule logic (which was used to pull the data in the exercise). The Task Force then took the revised document and re-ran the data analytics prototype in March, 2013.	Full Task Force	Completed	2/26/2013
Data Analytics	May 2013	McKesson Inquiry	McKesson informed the Task Force that it would make available a large database of edits, providing that the TF answer a number of questions in a satisfactory manner. <i>Update: The DSR Committee has been working to answer these questions. The committee revised a draft document that attempts to answer a number of these (8/1/13).</i>	DSR Committee	Ongoing	N/A
Edit	June, 2013	Definitions for five edits were approved by consensus and have been referred to the Payment Rules Committee.	<i>Same Day Medical Visit and Medical Procedure; Multiple E&Ms on the Same Day; Rebundling; Procedure Code to Modifier Validation; Multiple Endoscopy Reimbursement.</i>	Edit Committee	Completed	6/26/2013
Edit	May, 2013	The Task Force adopts standard way to report age.	Age will be accepted in days, months, or years; payer will be responsible for reporting "D", "M" or "Y" along with a source.	Edit Committee	Completed	5/21/2013
Edit	February, 2013	The Task Force achieved consensus on modifier grid for both CPT and HCPCS. (Attachment B-1 and B-2 in the February agenda)	The committee drafted the document by going through each modifier, and assessing whether or not they were important to the adjudication of the claim.	Edit Committee	Completed	2/26/2013

Edit	January, 2013	The Task Force concluded that the NCCI does include edits to support commercial claims (e.g., it includes pediatric and ob/gyn edits and rules despite being designed primarily for a Medicare population).		N/A	Completed	January, 2013
Edit	January, 2011	The Task Force reached consensus on the definition for three edits: age, gender, and maximum frequency per day		Edit Committee	Completed	1/24/2011
Finance	May, 2013	Barry Keene reported that about 75% of budget is accounted for as of 5/22/13.	The Task Force will look to stakeholders and alternative options to raise additional \$69,000.	Finance Committee	Ongoing	N/A
Finance	January, 2013	Barry Keene presents Task Force report to legislature and testifies on SB 13-166.	SB 13-166 passed with good bipartisan support. The Task Force was granted a one year extension on its deadlines as well as a \$100,000 appropriation.	Executive Committee	Completed	5/1/2013
Language	April, 2013	Proposed language change accepted regarding the term "reimbursement" when creating the edit rules.	The Task Force will use "eligible/not eligible", and "subject to/not subject to AAS restrictions." Proposed language was suggested by Tammy Banks, CC of the PSO Committee.	N/A	Completed	4/24/2013
Language	December, 2011	The Task Force adopted the following definition: "Sources" means the list of national industry sources found in §(2)(b)(I--VII), C.R.S., of HB10--1332 only: (I) the NCCI; (II) CMS directives, manuals and transmittals; (III) the CMS national clinical laboratory fee schedule; (V) the HCPCS coding system and directives; (VI) the CPT coding guidelines and conventions; and (VII) national medical specialty society coding guidelines.		N/A	Completed	12/28/2011
Language	December, 2011	The Task Force adopted the following definition of "national medical specialty society:" national medical organizations that are assigned as advisors to, or are represented on, AMA, CPT, and AMA Health Care Professionals Advisory Committee (HCPAC) that includes organizations representing limited license practitioners and other allied health professionals.		N/A	Completed	12/28/2011
Process	August, 2013	F.A.Q section to be added to Task Force website.	This FAQ section will be drafted before Oct meeting.	N/A	Ongoing	August, 2013
Process	August, 2013	The current date is to be put on every draft document to aid in version control.	The Task Force decided to add the date on the bottom of all documents in light of the discussion that took place at the meeting in August, 2013. This was put in place in order to ensure outdated copies are not distributed.	N/A	Completed	8/26/2013

Process	August, 2013	"Do not distribute" language to be taken off of all draft documents moving forward. (Current date to be added instead)	The "do not distribute" language was initially intended to aid in version control -- The Task Force produces several drafts of each document, and the group wanted to ensure that an outdated copy was not distributed to the expert public.	N/A	Completed	8/26/2013
Process	May, 2013	Deadline for comments regarding first bundle of rules extended.	The Task Force accepted Co-chair Barry Keene's recommendation to push back deadline from June 30, 2013 to July 15, 2013; allowing for 15 additional days of public review. Future bundles to be kept at 30 day time frame	N/A	Completed	5/22/2013
Process	March, 2013	The Task Force established process for public review period.	The process includes: 1) The notification of proposed rules; 2) The information required to provide comment; 3) How comments are evaluated by the Task Force; and 4) Notification of proposed rule findings and final rule. For more information, please see Notice of Proposed Rules Process (Attachment B to April Agenda).	Executive Committee	Completed	4/24/2013
Process	February, 2013	The Task Force achieved consensus on revised document concerning the edit/rule development and adoption process.	The Executive and Data Sustaining Repository Committee(s) revised existing process. For more detail, please see document entitled: <i>Task Force Process for Developing a Standardized Set of Claims Edits and Payment Rules</i> (Attachment D to February Agenda).	DSR Committee	Completed	2/26/2013
Process	July, 2012	Payment Rules Committee Created	Payment Rules Committee is responsible for creating payment (not pricing) recommendations.	Payment Rules Committee	Completed	7/1/2012
Process	May, 2011	Data Sustaining Repository Committee created.	The Data Sustaining Repository Committee is responsible for examining how the standardized set will be maintained and sustained.	DSR Committee	Completed	5/19/2011
Process	January, 2011	Edit Committee, The External Engagement and Professional Medical Society Outreach Committee, Finance Committee, Project Management Committee created.	The Edit Committee is responsible for identifying definitions and edits for the base set; The External Engagement and Professional Medical Society Outreach Committee serves as a liaison between the Task Force and health professional societies and associations; The Finance Committee handles the budget, and the Project Management Committee is to keep the Task Force on track and moving towards its goals.	N/A	Completed	1/1/2011
Rules	August, 2013	The Edit Committee determined that the Unbundled and Mutually Exclusive rules need to be combined into one.	<i>Mutually Exclusive and Unbundled</i> combined into one rule titled " <i>Procedure to Procedure</i> " due to the CMS table which has combined them.	Edit Committee	Completed	August, 2013

Rules	July, 2013	11 draft edit rules included in second bundle released for public comment.	<i>Add on; Age; Gender; Anesthesia; Mutually Exclusive; Global Surgery; Place of Service; Maximum Frequency Per Day; TCPC</i> - Update: The above mentioned rules were agreed to by consensus in Aug of 2013. Mutually Exclusive was combined with Unbundled to create Procedure to Procedure rule. The following rules were also adopted by consensus: <i>Global Maternity, New Patient, Multiple Procedure Reduction, Procedure to Procedure</i> . Second bundle of rules released for public comment. (9/5/13).	Payment Rules Committee	Completed	9/5/2013
Rules	June, 2013	First bundle of draft edit rule recipes circulated for review and comment.	Notification letter sent to interested parties explaining process for public review period; Documents uploaded to hb101332taskforce.org for download. Update: Task Force responded to comments on first bundle of rules and amended rules as needed for clarity. (9/1/13).	Executive Committee	Completed	August, 2013
Rules	May, 2013	The Task Force reviews and approves first bundle of draft edit rule recipes.	<i>Co-Surgery; Team Surgery; Bilateral Surgery; Assistant at Surgery;</i>	Payment Rules Committee	Completed	5/21/2013
Rules	March, 2013	Task force splits rules into three "bundles" to be released sequentially.		Full Task Force	Completed	3/27/2013
Rules	February, 2013	Task force approves a template for the claims edit and rules recipe ("edit rules recipe").	Recipe's include: The edit/payment rule name and definition; modifiers involved; the rule logic itself (including a payment rule hierarchy where there are multiple sources and how to handle termed edits) and specs that enable the data analytics; rationale for the rule; specialty outreach; rule logic (specs) that enables the data analytics operator to use apply the rule logic; administrative guidelines for special billing situations	<u>Multiple</u>	Completed	2/26/2013
Rules	July 2013	Task force approves the following language for rule/rule templates: "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."	This statement gives the payer the option to pay or deny as long as they communicate the rationale for the action.	Payment Rules Committee	Completed	7/1/2013

Rules	August 2012	Payment Rules Committee compiled a table of 32 CPT®/HCPCS modifiers and modifier definitions showing Edit Committee recommendations, Medicare (CMS) guidelines, and Payment Rules Committee comments for each one (see Appendix H in report)		Payment Rules Committee		8/29/2012
Rules	May 2013	The following statement was added to the "Context" section of each rule: "Payers and providers are encouraged to reach an agreement regarding any specific documentation that must be submitted with a claim when the rule states documentation may be required by the payer."	This statement addresses the issue of when a CMS indicator specifies that additional documentation is required to establish medical necessity.	Payment Rules Committee	Completed	5/10/2013
Task Force Members/Staff	September, 2013	Beth Kujawski (UCH) officially seated on the Task Force as the alternate for Dr. Jim Borgstede.	Beth is formally granted a seat on the Task Force as an alternate by HCPF executive director, Sue Birch.	Executive Committee	Completed	9/17/2013
Task Force Members/Staff	September, 2013	Marianne Finke (Humana) officially seated on the Task Force replacing Dr. Fred Tolin.	Marianne is formally granted a seat on the Task Force by HCPF Executive Director, Sue Birch.	Executive Committee	Completed	9/1/2013
Task Force Members/Staff	August, 2013	Tammy Banks (formally w/AMA) leaves Task Force	Tammy left the AMA to take on a new position and was no longer able to continue her work with the Task Force.	Executive Committee	Completed	8/28/2013
Task Force Members/Staff	August, 2013	Dr. Fred Tolin (formally w/Humana) leaves Task Force	Dr. Tolin left to take a new position outside of Humana and was unable to continue his duties with the Task Force.	Executive Committee	Completed	August, 2013
Task Force Members/Staff	July, 2013	Mark Painter replaces Mark Rieger as new Chair of the DSR Committee.	Mark Rieger no longer with the Task Force.	DSR Committee	Completed	7/18/2013
Task Force Members/Staff	July, 2013	Task force hires project manager, Vatsala Pathy.	Vatsala Pathy (owner of RootStock Solutions LLC) was hired as the project manager for the Task Force.	Project Management Committee	Completed	7/1/2013
Task Force Members/Staff	January, 2013	Catherine Hanson leaves Task Force.	Catherine Hanson left to take a new position and was unable to continue her duties with the Task Force.	Executive Committee	Completed	1/23/2013
Task Force Members/Staff	January, 2013	Lisa Lipinski (AMA) becomes formally seated Task Force member.	Lisa was formally seated by Director Birch of Health Care Policy and Finance.	Executive Committee	Completed	1/23/2013
Task Force Scope, Purpose and Bylaws	June, 2013	Multiple Radiology Reduction and Multiple Physical Therapy deemed to be out of scope for the Task Force.	Marilyn to draft specific language that reflects the Task Force's rationale.	Edit Committee	Completed	7/17/2013
Task Force Scope, Purpose and Bylaws	January, 2011	The Task Force created a document outlining guiding principles.	These include: administrative simplification, consistency, transparency, standardization and improved system efficiency. The Task Force also committed to a fair and open process that, among other things, tries to accommodate the top concerns of stakeholders at the table	Full Task Force	Completed	3/23/2011

Task Force Scope, Purpose and Bylaws	January, 2011	The Task Force set basic guidelines for scope of work as it pertains to pricing rules.	The Task Force agreed that its legislative mandate is to elucidate and standardize coding rules, and that pricing rules are not in the purview of its mandate; specific amounts for pricing adjustments to coding are out of scope. The Task Force may, however, describe those coding scenarios that are unique and eligible for differentiated pricing.	N/A	Completed	1/26/2011
Task Force Scope, Purpose and Bylaws	January, 2011	Identified major stakeholder concerns	Documented major concerns for payers, providers, vendors, and consumers.	N/A	Completed	1/1/2011
Task Force Scope, Purpose and Bylaws	December 2010	Medical Necessity and Procedure Diagnosis were deemed to be beyond the scope of the Task Force. It is applied on top of edits.		N/A	Completed	12/2/2010
Task Force Scope, Purpose and Bylaws	December, 2010	The Task Force agreed to a consensus decision making process.	The Task Force agreed that a consensus decision making process allows for more effective negotiations and the true consideration of minority opinions.	N/A	Completed	12/2/2010

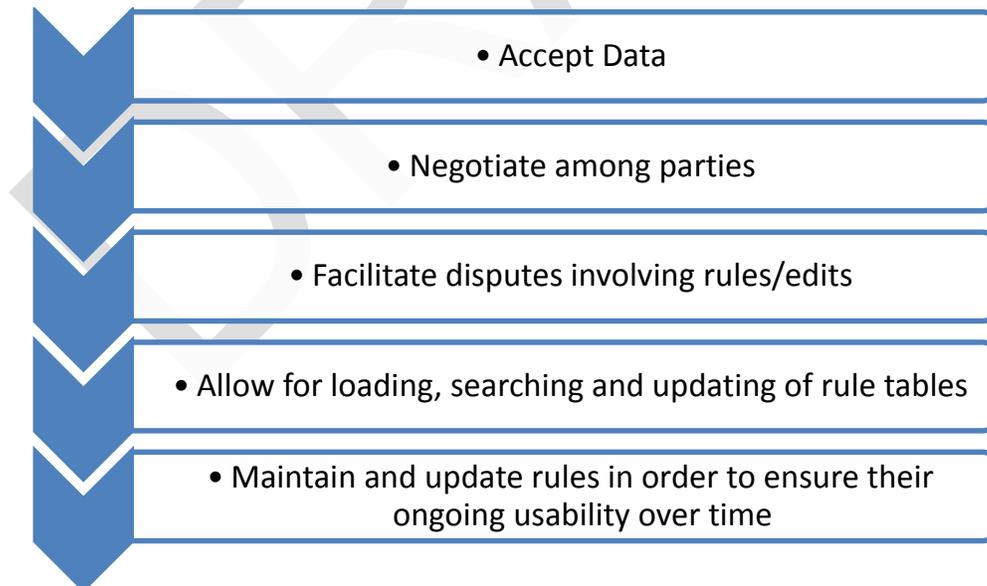
TO: COLORADO CLEAN CLAIMS TASK FORCE
FROM: DSR COMMITTEE
SUBJECT: DSR COMMITTEE UPDATE & RECOMMENDATIONS
DATE: OCTOBER 14, 2013

Background

***Why do the DSR operations matter to the CCTF?** Because edits and rules tables in the fee-for-service environment are dynamic (as a result of constant innovations and changes in practice in the healthcare delivery sector).*

In order for the CCTF's recommendations to become actionable and useful for the long term, the recommendations borne out of the CCTF must form the foundation but are not static. Therefore, a system for accepting recommendations, updating, revising and addressing disagreements related to those edits and rules must be built in order to manage the process over time. Systems already exist at the national level to develop and operationalize edits and rules; however, these systems are developed for different populations and motivations and are inconsistent and confusing to many providers. In accordance with the Clean Claims Act (2010), the state of Colorado has assigned the CCTF with the task of developing a method of standardizing a common rule and edit set for all payers within the State which can be maintained and distributed to affected parties in the State. Hence the recommendations below welcome the input of other stakeholders and rely on the expertise and systems of those in the marketplace to improve upon those efforts to help Colorado become a leader in administrative simplification.

Role of DSR



DSR Committee Process

The DSR Committee met four times since the Task Force's last in-person meeting. In addition to vetting the RFP, the committee undertook the following:

1. To assess and evaluate the data analytics and DSR needs of the project in 2015 and beyond.
2. To better understand what others in this space have done and how they have structured and managed edits over the long run. This conversation focused at length on the dispute resolution function.
 - a. The committee reviewed the processes of the AMA's Specialty Society Relative Value Scale Update Committee (RUC) and the CPT Editorial Panel.
 - b. The committee gained a stronger understanding about the ACA's language on administrative simplification.
3. To evaluate a variety of options related both to form and function addressing the gap created by the current legislation after the Task Force sunsets and prior to the implementation of new legislation for the update and distribution of the data and rules. The committee discussed the core functionality needed as well as 3-4 structures or forms that might support that functionality.
4. To provide the Task Force with recommendations based on its evaluation of options. Based on discussion with the Task Force, arrive at a recommendation to the State Legislature and relevant state agency.

DSR Committee Discussion & Recommendations

Organizational Structure:

1. While there was general consensus on the required functionality of the future entity, there was a great deal of discussion among committee members on its potential form. In particular, the committee discussed at length on the pros and cons of operations and governance being undertaken by: 1) a nonprofit entity in the community; 2) a state agency; 3) a for-profit entity. A related discussion focused on the need to "create" an entity versus simply contracting out the required functionality to a winning bidder (e.g. NCCI). The following options were evaluated:
 - a. **Option 1.** Create a free standing entity that is either associated with a state agency or is an independent 501c3 (i.e. non-profit corporation).
 - i. Should it be associated with a state agency, a board could be created at the request of the agency head that advises the state agency. The Board of Directors would also have accountability to the Colorado state government with respect to compliance with the Clean Claims Act, as well as Policy & Procedures, budget review, and any other oversight processes that may be appropriate. The biggest challenge with this approach is balancing the size of a representative Board of Directors with the ability to effectively and efficiently operate this business.
 - ii. Should it be a free standing 501c3 agency, a governing board would be created that has accountability to key constituencies and the general public.

- b. **Option 2.** Contract core content management and business functions to a private company through a contractual arrangement with a state agency (e.g. the relationship between CMS and Correct Coding Solutions). In this scenario, the state agency would ensure contract compliance and would require the private company to execute on all its contractual obligations. This contract would go out to bid periodically on a timetable to be determined by the state agency. Nevertheless, an Advisory Board of Stakeholders, comparable to the entity described above would still be essential to maintaining a broad-based sensitivity to market requirements.
- c. **Option 3.** In some states, legislative compliance is managed within existing government structures as accountable departments.

Conclusion of DSR Committee: Recommend legislation that would require the State of Colorado to contract services to support the ongoing work of the Committee to an entity that maintains and distributes the required edit logic and data for the state of Colorado under the oversight of the Division of Insurance.

Functional Requirements:

Two functional areas are proposed as fundamental operations of this entity:

1. **Data Inputs: Acquisition of auditing rules and logic.** Health Plans (or their agents) presumably want as much auditing logic as is possible to ensure correct and accurate claims for payment for insured (covered) medical services, supplies, devices, or other benefits. Other industry stakeholders (e.g. government, coding entities, industry professional associations, and others) may also wish to provide inputs into the creation and maintenance of the Common Edit Set.
2. **Data Outputs: Publication/Distribution of the Common Edit Set to Medical Provider communities and Health Plans.** Public access for examining/reviewing the Common Edit Set is a core requirement. The format for providing this access was not stipulated in the Act. Two stages are therefore proposed for public access:
 - a. **Stage 1:** On a rule-by-rule basis, all edits will be published to the Common Edit Set website in a flat file (e.g. PDF or comparable format) that may be easily viewed with simple character string search capabilities. It must also be determined whether hard-copy publications might be required to supplement electronic access to this data.
 - b. **Stage 2:** At a future date, it can be determined whether an interactive online database might better serve this need.

In addition, electronic data file formats will likely be requested by health plans for configuring their automated auditing processes for compliance with the Common Edit Set.

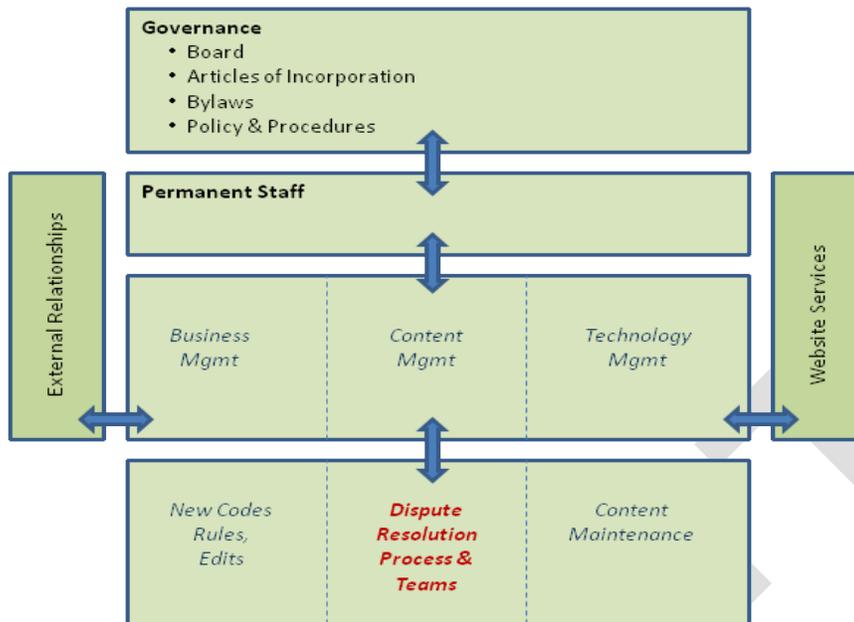


Figure 1: Functional Competencies of Proposed Business Model

Essential Information Technology Functions: A document format like CMS uses to present National Correct Coding Initiative (NCCI) edits with character-based ‘string search’ capability may be a simpler, more economical format for initial deployment. In this approach, each rule (with associated edits) would be supported with individual documents that could be updated as often as required. Even so, an interactive development database, preferably open source software, will be essential for the staff that manages the data elements required.

1. **Development Database:** Assuming that the Common Edit Set may contain as many as 20-30 rules and more than 1 million edits at the ‘go live’ date, a flexible database with a moderately rich set of data management and query tools seems fundamental. Analysts with significant healthcare coding and/or analytics experience round out this core competency.
2. **Data Imports:** New edits, based on new and revised codes, will be requested at recurring intervals. It is not clear whether these edits will be reviewed/accepted upon request or developed independently (by this Entity) and added to the Common Edit Set. The former approach, where the Entity processes Common Edit Set enhancement requests seems much the preferable option. A standard input format for each rule should be made available to any party wishing to propose new edits. Review and data management protocols are currently being developed by Task Force Workgroups.
3. **Data Exports:** Flat file formats (e.g. PDF tables) may be the simplest approach to publishing edits to an Entity website. Such formats are searchable, intuitive, and easy to use. Additional electronic file formats, similar or identical to import formats can be defined for export to payers and vendors for their system update requirements.

Dispute Resolution Process:

Although the task force has developed a process among the relevant stake holders to analyze discuss and finally adopt a process that is clearly representative of the data available, it is anticipated that disagreements will arise. In anticipation of these disagreements a Dispute resolution process must be developed. After consideration of many options the following three tiered approach is recommended.

1. **Level 1: Staff Resolution.** Health plans who have proposed edits that have not been accepted into the Common Edit Set or providers who wish to contest edits that have been included in the Common Edit Set shall submit a written statement of the issue with a rationale to the Entity. Staff shall review the submission and solicit rebuttal responses from suitable parties that would be affected by a change. For example, an orthopedic surgery group (or their professional society, as a designated agent) may object to specified edits pertaining to arthroscopic knee surgery. With staff facilitation of this interaction, one or both parties may agree to changes that resolve the issue; such changes as may be required shall be communicated, by Staff, thru a defined Common Edit Set Notification process.
2. **Level 2: Mediated Resolution.** If Entity staff fail to resolve the matter, a binding or non-binding mediation process (at the election of the parties), may be undertaken next. Each party is required to nominate a representative (e.g. provider or payer) to nominate an informed representative. Once named, the two representatives select a 3rd mutually agreed upon person to create an ad hoc, three member panel to consider the merits of the issue. This panel shall create a written recommendation of the majority opinion of the panel for consideration by the parties; if the recommendation is accepted by both parties, the recommendations are implemented. If not accepted, the parties may elect to continue to Level 3. The reasonable expense of this action, involving time and effort by the panel members, may be supported by an upfront fee from both parties that is high enough to discourage frivolous actions and cover actual costs, but not so high as to discourage reasonable actions unduly. Since multiple parties may be involved and/or benefit from a particular action, some additional consideration for fairly assessing this fee may be required. A fund for such purposes will be collected and administered by the Vendor selected to operate as a contracted entity to the state of Colorado.
3. **Level 3: Legal Process thru Civil Suit.** Since the Clean Claims Act is included in the ‘contracts’ section of the Colorado Code, compliance with the provisions of the Entity or its policies shall be subject to resolution through an appropriate legal or civil court action.

Governance:

Primary operations listed above will be contracted to a private company through a bid process overseen by a state agency (e.g. the relationship between CMS and Correct Coding Solutions). In this scenario, the state agency would ensure contract compliance and would require the private company to execute on all its contractual obligations. This contract would go out to bid periodically on a timetable to be determined by the state agency.

This entity would report to the state in two ways. First the State would have control over the cost of the program as the financial budget would be developed through proposal and awarded through a competitive bidding process. In addition, an Advisory Board of Stakeholders would be essential to maintaining a broad-based sensitivity to market requirements. This Advisory Board would be appointed by the state agency mandated to oversee the effort on an ongoing basis and would consist of key stakeholders from the provider community and health plans. The make-up of the Advisory Board would be similar to that of the current CCCTF. The Board would have rule promulgating authority. The work of the board and the associated

travel and meeting expenses would be paid for by the Vendor selected which would have been included in the bid accepted by the State.

Financing & Sustainability: A fee would be levied to cover the cost of start-up and maintenance of the project. The total fee would be based on the accepted bid from the entity(s) providing the function of the project on an annual basis as outlined in the statute. The total fee would be developed by accessing the following: 1) 50% of the accepted bid would be split equally among physicians registered with the Vendor for provision of service in Colorado; and, 2) 50% of the accepted bid would be accessed to health plans fee based on the number of covered lives in Colorado.

It is recommended that the final annual cost of the Vendor contract be split equally among the health plans and the providers using the formula outlined. Collection of the fees would be the responsibility of the Vendor. Bid oversight and approval and Advisory Board appointment would reside within the Division of Insurance. It is anticipated that after the fees accessed to both providers and payers would be off set, by a reduction in administrative costs currently expended by each provider and payer.

Enforcement of the assessment of fees could be governed by Statute for some entities and by contractual relationship for groups like ERISA plans. General enforcement would require licensed physicians and payers in the state to register with the DSR provider. Each provider/payer registered would then be provided with the cost for the upcoming year, once paid the provider/payer would then be allowed to access the data set developed by the CCCTF and maintained by the DSR entity.

As currently written the legislation requires the provider and payer to self enforce the use of the standard edit set under current contract law within the state. Revised policy could include enforcement in any or all of the following methodology:

1. State retains the ability through the Division of Insurance to suspend the license of any Insurance company not registered and paid with the Vendor. Providers would also be required to register and pay the Vendor. License suspension requests would be provided to the appropriate state agency by the DSR entity after soft collection procedures have been attempted.
2. Enforcement of the program is governed the marketplace. As the statute is currently written payers and providers are required to provide clear language in the contract specifying and agreeing to any deviation from the standard edit set. Under current contracts providers and payers would use the legal system to enforce compliance with the Statute.

With this fee structure, the total fees collected to administer the project would be based on the bid accepted by the state.

Hypothetical Example:

<p>Payer share of costs: $\\$500,000 / 4,234,046 = \mathbf{\\$.12 \text{ per covered life}}$ Physician share of costs: $\\$500,000 / 11,361 = \mathbf{\\$44.00 \text{ per practicing physician}}$</p>

- ✚ Estimated Cost of Operations based on hypothetical bid - \$1,000,000
- ✚ Total Number of Practicing Physicians in Colorado: 11,361¹
- ✚ Total Number of Covered Lives in Colorado: 4,234,046²

¹ As of 2011, there were 11,361 practicing physicians in Colorado (<http://www.coloradohealthinstitute.org/data-repository/detail/practicing-physicians-by-county>).

Recommendations to the Legislature

DSR Committee recommends that the State of Colorado adopts legislation requiring the following:

1. A competitive bidding process to accept bids from qualified entities, to maintain the work of the CCCTF (see Appendix A). This bidding process would be open and follow current Colorado bidding parameters and the recommendations herein.
2. The establishment of an advisory board similar to that which currently exists as the CCCTF, with Division of Insurance oversight.
3. A process by which the fees associated with the work of the Vendor selected can be collected from stakeholders as described below.
4. A clear and pursuable path to identify and mediate disputes anticipated in the implementation process, even though the CCCTF process has been inclusive and democratic in scope and in deed.
5. A requirement that all payers and providers abide by the rules and edit sets developed under the CCCTF and its subsequent formations or clearly delineate within contractual language any derivation from the rules and edit sets.
6. Enforcement of the program should be governed by statute with legal options to be pursued by the stakeholders in accordance with the legislation and not enforced or policed

² According to 2010 data, there are 4,234,046 covered lives in Colorado (<http://www.coloradohealthinstitute.org/data-repository/detail/uninsured-number-and-rate-by-age-and-by-county>).

Appendix A: Vendor Contract Parameters

Should the Task Force and the legislature approve the DSR Committee's recommendations, the contract requirements for a vendor are important to outline in order to better understand the scope and nature of a vendor's contractual obligations. Below are key vendor contract parameters:

Content Management & Maintenance:

1. To create all data tables in a manner that supports the rules, can accept formats currently used by others and disseminate the data to affected parties.
2. To create a Specified User interface for Users this is accessible to Users through an online application 24 hours per day, 7 days per week, through appropriate security protocol.
3. To allow for Specified Users to access the data repository and run queries for information.
4. To allow for access to active data allowing for the creation of at least 4 classes (Public Class, Task Force Query Class, Change Data Class, and Administrative Class) of users with access to specified active data in formats that are useful in the market
5. To allow for at least 25 Specified Users to access the data repository with up to 15 simultaneous Users accessing the repository at any one time.
6. To allow Specified Users to create summary reports that contain at a minimum: Rule Type, Supplier/ID, Source, Total Row Count, and Total Active Rows.
7. To allow Specified Users to create detail data reports that contain all data for each row in the rule table.
8. To allow Specified Users to filter data in the data repository by one or more of the following categories: Rule type, Supplier ID, Source, Effective Date of Edit, End Date of Edit, Procedure Code or Codes, Version ID, Production ID & Value.
9. To allow Specified Users to group data reports by the following categories: Rule type, Supplier ID, Source, Procedure code or codes, End Date of Edit, Effective Date of Edit, Version ID, Production ID, & Value.
10. To allow Specified Users to drill down into any data from the summary level to the table row level of information.
11. To create reports for Specified Users that allow those Users to see similarities and differences between Supplier/or Source data for the same Rule type for a specific version of the Rule and Edit Table.
12. To create reports for Specified Users that allow those Users to see similarities and differences between versions of a Rule Type based on version for each Supplier/or Source.
13. To create reports for Specified Users that compare version of a Rule Type, showing all the following information: change in row count between versions; data points that are the same between versions; data points that are different from one version to another; which categories are different from one version to another.
14. To allow Specified Users to apply Rule Type specific business rules to multiple sources from the same rule type to derive a new table made up of one or more sources. This functionality shall allow users to toggle between the effects of different sources of the same edit.
15. To allow specified users to manually select specific rows/CPT codes in the data repository, regardless of Rule Type or Source, and create a derivative table containing only the selected data or modify an existing derivative table to include the selected data. Downloads should be made available in common formats for use in other electronic systems.
16. To create an identification schema for each derivative table that includes all of the following: rule type, version ID, and version date.
17. To allow for the following: loading data, searching, validation of rule tables, modification and updating of rule tables, and retention of all valid data indefinitely.

18. To have a real time file control message feature in the data.

Business Management:

1. Either have in house or subcontracted, the skills necessary to carry out the content management functions described above.
2. Entity will obtain new license agreements as identified including but not limited to agreement with the AMA for the use of CPT© codes in the production data repository and may obtain edits from other entities to populate the development data repository.
3. Ensure data integrity analysis for the data.
4. Interact with state agencies as required by statute.
5. Collect user fees to support the business management, technology management, content management and dispute resolution as required by Statute

Technology Management:

1. To have a minimum of 1.5Mbps of bandwidth for data transfers and 50 Mb worth of files for simultaneous transfer.
2. To support all major web browsers.
3. To conduct system backups.
4. To provide technical support and assistance.
5. To use open source system, not proprietary software.
6. To provide a delivery of the data and rules information required for implementation of the final recommendations.
7. To provide updates for future versions of the dataset.