

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

**Two-day meeting: Tuesday, August 27, 2013 (12:00 p.m. – 6:00 p.m. MDT) and
Wednesday, August 28, 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 number: 1-800-866-740-1260, ID 8586318#

Web Login:

DAY ONE: <https://cc.readytalk.com/r/6lcpvstd5e8a&eom>

Agenda

Day 1—Tuesday, August 27, 2013

12:00 PM Welcome & Introductions

12:00—12:25 PM Housekeeping

- Approve July 2013 meeting minutes (Attachment A)
- Review agenda
- Meeting procedures
- 2014 meeting schedule (Attachment B)
- Thanks to McKesson for sponsoring the catering
- 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

- Additional Items to be distributed separately

12:55—1:00 PM Specialty Society—Tammy Banks/Helen Campbell

1:00—1:25 PM Payment Rules Committee—Tammy Banks in for Lisa Lipinski/Helen Campbell

1:35—3:30 PM Payment Rules Committee continued – Tammy Banks/Helen Campbell

Informational Items:

- Age (Attachment D)
Age Procedure Code Table (Attachment D₂)

- Gender (Attachment E)
Gender Procedure Code Table (E₂)
- Mutually Exclusive (Attachment F)
- Anesthesia (Attachment G)
- Maximum Frequency Per Day Procedure Code Table (Attachment H)

Rules for Consensus:

- Global Maternity Care (Attachment I)
- Place of Service (Attachment J)
- TCPC (Attachment K)
- New Patient (Attachment L)
- Multiple Procedure Reduction (Attachment M)
- Unbundled-Bundled (Attachment N)

- 3:30—4:00 PM** **Task Force Response to Public Comments**
- MCCTF Response to Public Comments (Attachment O)
 - Additional Comments to Follow
- 4:00—4:30 PM** **Break/Refreshments**
- 4:30—5:50 PM** **Payment Rules Committee Discussion Continued**
- MCCTF review of revised rules
- 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, August 28, 2013 (7:30 a.m. – 2:00 p.m. MDT)

Call-in number: 1-800-866-740-1260, ID 8586318#

Web Login:

DAY TWO: <https://cc.readytalk.com/r/popnf4qdivci&eom>

Agenda

Day 2— Wednesday, August 28, 2013

- 7:30—8:00 AM** **Continental Breakfast**
- 8:00—8:15 AM** **Public Release of Second Bundle**
- Roll Call**
- 8:20—8:40 AM** **Program Management and Finance – Barry Keene/Vatsala Pathy**

- Colorado Health Foundation Update
- Review updated workplan (Attachment P)
- Recipe Tracking Sheet – (Attachment Q)
- MCCTF “Running Action Items” Document (Attachment R)

8:40—10:20 AM Data Sustaining Repository – Mark Painter/Barry Keene

- Meeting with Attorney General
- McKesson Inquiry/Response (Attachment S)

Consensus Item:

- Draft Governance Template (Attachment T)

10:20—10:35 AM Break

10:35—12:00 PM Data Sustaining Repository Continued

- Analytics RFP (Attachment?)

12:00—12:10 PM Specialty Society—Tammy Banks/Helen Campbell

12:10—12:40 PM Lunch

12:40—1:40 PM Ongoing Task Force Activities

- Public Comment Timing
- Next Release Timing
- Refresh on Notification Process

1:40—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
September 25	Wed: 12:00 pm – 2:00 p.m.	Monthly Conference Call
October 22-23	Tue: 12:00 pm–6:00 pm; Wed: 7:30 am—2:00 pm	Quarterly Meeting (face-to-face)
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

July 24, 2013, noon-2 PM, MDT

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

Conference ID: ID 8586314#

Attendees:

- Amy Hodges
- Barry Keene, CC
- Beth Wright
- Dee Cole
- Doug Moeller, MD
- Fred Tolin, MD
- Helen Campbell
- Kathy McCreary
- Kim Davis
- Lori Marden
- Marilyn Rissmiller, CC
- Mark Painter
- Nancy Steinke
- Tammy Banks
- Tom Darr, MD

Staff :

- Connor Holzkamp
- Vatsala Pathy

Public:

- Beth Kujawski (UCH, RAD)
- Catherine French (AANEM)
- Diane Hayek (ACR)
- Joseph Cody (AAOS)
- Julie Painter (STS)
- Luana Ciccarelli (AAN)
- Pam Kassing (ACR)
- Regina McNally (MSSNY)
- Sharon Merrick (ASA)
- Sherry Smith (AMA)
- Stacie Saylor (MSMS)
- Stephanie Stinchcombe (AUA)
- Susan Crews (AUA)

Meeting Objective (s):

See Agenda

Key:

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



July 24, 2013

WELCOMING REMARKS & ROLL CALL:

- There were 15 members in attendance.

Housekeeping Items:

- The minutes from June were accepted with no changes.
- The MCCTF monthly status update (attachment B to agenda) was displayed as an informational item.
- It was noted that the next face-to-face meeting will be August 27 and 28, 2013.

PROJECT MANAGEMENT COMMITTEE—Barry Keene/Vatsala Pathy

- The notification sign-up records (attachment B in agenda) of those who signed up via the TF website were displayed as an informational item. It was discovered that Nancy Steinke was mistakenly associated with Kaiser; an error was caused by an unknown technical problem with the sign-up form that the TF encountered early on in the process. This error has since been resolved and no more problems are expected.
- The updated work-plan was displayed (attachment C in agenda) as an informational item.
- Helen Campbell of United Health Care reported that United was unable to submit its comments before the July 15 deadline due to an internal legal review. Barry noted that the TF will need to be flexible for this first round of comments and will accept United's comments if they are received within a reasonable time frame.

EDIT COMMITTEE—Beth Wright and Mark Painter

- The Edit Committee has been reviewing the comments that have been received on the first bundle of rules and aim to finalize its review and copy the Rules Committee in order to provide feedback to Marilyn by the end of this month.
- The Edit Committee will work on query statements for rules that are adopted by consensus during the Rules Committee report (see below).

PAYMENT RULES COMMITTEE—Lisa Lipinski

- Per the discussion from the June TF meeting, the specific language for out-of-scope edits (Medicare Multiple Procedure Payment Reduction including: Multiple Radiology Reduction, Multiple Physical Therapy) were drafted by Marilyn Rissmiller and accepted as an informational item by the Task Force (Attachments E and F to the agenda).
- Marilyn noted that when the Rules Committee was developing the multiple procedure rules it became obvious that the TF needed to address MPPR as a whole, rather than addressing each individual type of service that Medicare is adding to their MPPR rule. Task force members agreed as additional MPPR services would follow the same rule logic and would be considered out-of-scope.
- The committee brought forth nine rules to the TF for consensus:

The Following Rules Were Accepted With No Revisions:

- *Add-ons*
- *Global Surgery Days*
- *Maximum Frequency Per Day*

The Following Rules Were Revised and Accepted (Revisions In Parenthesis):

- *Age* (Modifier 63 removed from rule and will be put into separate document)
- *Gender* (Modifier KX removed from rule and will be put into separate document)
- *Anesthesia* (Sharon Merrick of the ASA to send updated definition for HCPCS modifiers; language added to communicate that modifiers *may* be reported according to specific payer policy.)
- *Mutually Exclusive* (Language added to clarify that the NCCI mutually exclusive code pairs were reviewed and selected *for the initial set of codes applicable to the edit.*)

The Following Rules Required More Information and Referred Back to the Rules Committee:

- *TCPC*
- *Place of Service*
- Marilyn will send additional information regarding TCPC and Place of Service to TF.

SPECIALTY SOCIETY OUTREACH COMMITTEE—Tammy Banks and Helen Campbell:

- The Specialty Society had nothing to report at this time.

DATA SUSTAINING REPOSITORY COMMITTEE—Barry Keene/OPEN

- Barry reported that Mark Rieger had officially resigned from the TF. Mark Painter was chosen to take his place as the Chair of the DSR Committee.
- The DSR Committee will be continuing its discussion around McKesson’s inquiry (Attachment O to agenda) regarding the release of edits to be used exclusively by the TF.
- The DSR Committee is also attempting to figure out the details for the Analytics RFP.
- Both McKesson’s inquiry and the Analytics RFP will be agenda items for the committee over the next month.

FINANCE COMMITTEE—Barry Keene

- Barry reported that the TF does not yet have a sponsor to cover the catering for the August meeting and will be asking the stakeholders for support.
- The TF will continue to look for contribution from stakeholders at the table to fund the project moving forward.

PUBLIC COMMENT:

<none>

OTHER BUSINESS:

<none>

The meeting was adjourned at approximately 2:00 PM MDT

ATTACHMENT B

2014 Meeting Schedule, All Task Force Meeting Times are Mountain Standard Time (MST)

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

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
October 22-23, 2013		
January 21-22, 2014		
April 22-23, 2014		
August 26-27, 2014		
November 18-19, 2014		

ADDITIONAL EDIT COMMITTEE DOCUMENT

EDIT TYPE Revised Definitions 08/21/13

EDIT TYPE	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
<p>A – Unbundled (Bundled/Incidental) B – Mutually Exclusive</p>	<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 CPT/HCPCS 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. 	<p>NCCI, CMS directives/transmittals, HCPCS, CPT/HCPCS and National Specialty Society; machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered</p>	<p>Frequency limitations spanning a period of time will be addressed separately, including MUEs.</p> <p>Appropriate modifiers as defined by CPT or HCPCS may be reported to override this type of edit.</p>
<p>C – Multiple Procedure Reduction</p>	<p>This type of edit identifies when two or more procedures/services are performed during the same session by the same provider, subsequent procedures/services may be subject to a reduction.</p>	<p>MFSD, CMS directives/transmittals, HCPCS, CPT and National Specialty Society; machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered</p>	<p><i>RVU for each of these procedures included pre-service, intra-service and post-service in the form of work/time practice expense and malpractice expense. The concept of multiple procedural reduction is the pre-service and post-service once is only performed once when multiple procedures are performed at the same time.</i></p>

D – Age

***DRAFT – PLEASE DO NOT DISTRIBUTE**

Rules Committee Recommendation

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 (RAR) 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

63 – Procedure performed on infants less than 4 kg – refer to Modifier Table XXX for additional information.

Age rule definition

The descriptors or related coding guidelines of certain Current Procedural Terminology(CPT®)¹/HCPCS procedure codes either specify or imply that there are age-specific parameters associated with that procedure/service.

Note: Edits based on the diagnosis codes, either ICD-9 or ICD-10 are not within the scope of the Medical Clean Claims Task Force legislative charge and are not covered by this rule.

Coding and adjudication guidelines

Age-specific CPT codes

In certain circumstances the reported procedure code has an age-specific restriction associated with it. The following adjudication guidelines are offered to cover the situation where the reported procedure code does not match the reported age of the patient:

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- When the reported age of the patient does not match the age-specific parameter of the CPT/HCPCS procedure code either because of the description or related coding guidelines – ACTION: Deny the line with the age-specific code.

Example XXXXX, younger than age 12

Listing of Status Indicators

No status indicators available.

Rationale

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

- The Current Procedural Terminology (CPT[®])² coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- .

MCCTF comment

Informational modifier, could lead to a payment adjustment in recognition of the increased complexity.

Definitions

This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of the service/procedure code or the related coding guideline implies age-specific parameters. Consensus on 3/28/12

Payment indicator definitions

None available

Federation outreach

American Academy of Orthopaedic Surgeons (AAOS)

This recommendation was sent to Matt Twetten for review.

American College of Radiology (ACR)

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)

This recommendation was sent to Jennifer Jackson for review.

American Congress of Obstetricians and Gynecologists (ACOG)

This draft proposal was sent to Anne Diamond of ACOG for review.

Federation Payment Policy Workgroup

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

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E – Gender

***DRAFT – PLEASE DO NOT DISTRIBUTE**

Rules Committee Recommendation

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.

Gender rule

According to National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services¹, the descriptor of some Current Procedural Terminology (CPT®)²/HCPCS codes includes a gender-specific restriction on the use of the code. CPT/HCPCS codes specific for one gender should not be reported with CPT/HCPCS codes for the opposite gender.

Coding guidelines

In certain circumstances the reported procedure code implies a gender-specific restriction associated with it. The following adjudication guidelines are offered to cover the situation where the reported procedure code does not match the reported gender of the patient:

- When the reported gender of the patient does not match the CPT/HCPCS procedure code because the description implies a gender-specific restriction – ACTION: Deny the line with the gender-specific code.
 - Example XXXXX, vaginal delivery
 Gender reported is male

¹ National Correct Coding Initiative Policy Manual for Medicare Services, Chapter I, General Correct Coding Policies, Revision date: January 1, 2013.

² Copyright 2013 American Medical Association. All rights reserved.

Rationale

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

- The Current Procedural Terminology (CPT[®])³ coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT/HCPCS procedure code descriptions implying gender were selected.
- The National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services⁴ were reviewed.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

MCCTF comment

ICD-9/10 diagnoses edits are not within the scope of this legislation, and would be allowed with a procedure code edit.

Modifier definition

This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of service/procedure code implies gender-specific parameters. Consensus on 3/28/12

Payment indicator definitions

None available

Federation outreach

American Academy of Orthopaedic Surgeons (AAOS)

This recommendation was sent to Matt Twetten for review.

American College of Radiology (ACR)

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)

This recommendation was sent to Jennifer Jackson for review.

American Congress of Obstetricians and Gynecologists (ACOG)

This draft proposal was sent to Anne Diamond of ACOG for review.

Federation Payment Policy Workgroup

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

³ Copyright 2013 American Medical Association. All rights reserved.

⁴ National Correct Coding Initiative Policy Manual for Medicare Services, Chapter I, General Correct Coding Policies, Revision date: January 1, 2013.

B – Mutually Exclusive

Rules Committee Recommendation

Mutually Exclusive 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.

Modifiers Involved

25, 59 (see definitions below)

Mutually Exclusive rule

The mutually exclusive edit table includes several Colorado Clean Claim Task Force rules: including gender, add-on codes, incident to-services, total, professional and technical components, and anesthesia.

The mutually exclusive edit table can be created from the publically available online tables¹ or from tables that can be purchased from the National Technical Information Service (NTIS)². See Appendix A for the mutually exclusive table.

Examples: An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an initial service or a subsequent service.

¹ NCCI edits utilized for practitioner claims (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>); NCCI edits utilized for outpatient hospital claims in the Outpatient Code Editor (OCE) (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>) Current quarterly version update changes for NCCI edits and published MUEs (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html)

² The NCCI Edits Manual may also be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) website located in the "Related Links Outside CMS" section below, or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

With the exception of drug administration services, the initial service and subsequent service cannot be reported at the same beneficiary encounter. A third example is when the descriptor of a Current Procedural Terminology (CPT®)³/HCPCS code includes a gender-specific restriction on the use of the code. For CPT/HCPCS codes specific for one gender, the HCPCS/CPT code should not be reported for the opposite gender.

Coding and adjudication guidelines

Modifier 59 is used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances. This modifier should be used only if there is not a more descriptive modifier available, and the use of modifier 59 best explains the circumstances.

The mutually exclusive edit table contains edits consisting of two codes (procedures) which cannot reasonably be performed together based on the code definitions or anatomic considerations. Each edit consists of a column 1 and column 2 code. If the two codes of an edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a CCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed.

Separate Procedure

- Some of the procedures or services listed in the CPT nomenclature that are commonly carried out as an integral component of a total service or procedure have been identified by including the term “separate procedure”.
- Codes designated as separate procedures should not be reported in addition to the code for the total procedure or service of which it is considered an integral component
- Examples of CPT codes with “separate procedure” in the code description.
 - 29870—Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
 - 38780—Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)
 - 44312—Revision of ileostomy; simple (release of superficial scar) (separate procedure)

CPT codes which are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. These codes are not necessarily linked to one another with one code narrative describing a more comprehensive procedure compared to the component code, but can be identified as code pairs which should not be billed together.

Assigned modifier indicators in the National Correct Coding Initiative (NCCI)

- “0” An NCCI-associated modifier cannot be used to bypass the edit
- “1” An NCCI-associated modifier may be used to bypass the edit if it meets the criteria under appropriate circumstances
- “9” Edit deleted on the same date as when it became effective

Rationale

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

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- The Current Procedural Terminology (CPT®)⁴ coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptors for modifiers 25 and 59 were selected.
- The NCCI mutually exclusive code pairs were reviewed and selected for the initial set of codes applicable to the edit

MCCTF comment

Appropriate modifier as defined by CPT or HCPCS may be reported to override this type of edit.

Modifier/Edit definitions

This type of edit identifies incorrect billing of professional services that cannot reasonably be performed at the same anatomic site or same patient encounter, by the same physician.

Consensus on 3/28/12

Modifier 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.

Modifier 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 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.

Mutually Exclusive indicator definitions

The following are indicator definitions that are outlined in the NCCI edit table were used.

0 = Not allowed.

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1 = Allowed.

9 = Not applicable.

Federation outreach

American Academy of Orthopaedic Surgeons (AAOS)

This recommendation was sent to Matt Twetten for review.

American College of Radiology (ACR)

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)

This recommendation was sent to Jennifer Jackson for review.

American Congress of Obstetricians and Gynecologists (ACOG)

This draft proposal was sent to Anne Diamond of ACOG for review.

Federation Payment Policy Workgroup

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

O - Anesthesia

Rules Committee Recommendation

Anesthesia 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.

Medical Direction and Supervision HCPCS Modifiers

AA: Anesthesia services performed personally by anesthesiologist

AD: Medical supervision by a physician – more than 4 concurrent anesthesia procedures

QK: Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals

QX: Qualified non-physician anesthesiologist service – with medical direction by a physician

QY: Medical direction of one qualified non-physician anesthesiologist by an anesthesiologist

QZ: CRNA service – without medical direction by a physician

GC: This service has been performed in part by a resident under the direction of a teaching physician

Physical Status Modifiers¹

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P1: A normal healthy patient

P2: A patient with mild systemic disease

P3: A patient with severe systemic disease

P4: A patient with severe systemic disease that is a constant threat to life

P5: A moribund patient who is not expected to survive without the operation

P6: A declared brain-dead patient whose organs are being removed for donor purposes

22: Increased Procedural Services²

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

23: Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

47: Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.

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 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.

Anesthesia rule

Procedures subject to the anesthesia rule are listed in the column labeled STATUS CODE of the Medicare Physician Fee Schedule (MPFS).³ with an indicator of J.

² Copyright 2013. American Medical Association. All rights reserved.

³ 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.

This type of edit identifies incorrect billing for anesthesia services provided by the anesthesiology professional, including but not limited to, general or regional anesthesia, monitored anesthesia care, or other medical services delivered to achieve optimal patient care. An anesthesiology professional refers to an Anesthesiologist, a Certified Registered Nurse Anesthetist (CRNA), Anesthesiologist Assistant (AA), or other qualified individual working independently or under the medical supervision of a physician.

All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100 – 01999). Physical status modifiers and medical direction/supervision modifiers (listed above) may be reported according to specific payer policy. In addition, qualifying circumstances that significantly impact the anesthesia care are reported with the add-on code specific to the circumstance (codes 99100, 99116, 99135, 99140) in conjunction with the primary code that describes the anesthesia service (00100-01999).

Other edits, such as unbundling, rebundling, or maximum frequency per day, may apply. The applicable modifier must be appended when appropriate.

Coding and adjudication guidelines

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (eg, ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). Unusual forms of monitoring (eg, intra-arterial, central venous, and Swan-Ganz) are not included.

Use Modifier 47 to report regional or general anesthesia provided by a physician also performing the services for which the anesthesia is being provided.

Time

Time for anesthesia procedures may be reported as is customary in the local area. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room (or in an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

Supplied Materials

Supplies and materials provided (eg, sterile trays, drugs) over and above those usually included with the office visit or other services rendered may be listed separately.

Separate or Multiple Procedures

When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures.

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 and guidelines for anesthesia codes were selected.

- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual⁴ were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

MCCTF comment

No anesthesia specific edits were identified, they are captured under the “Unbundle” category Consensus on 3/28/12

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

Anesthesia indicator definitions

The following are indicator definitions that are outlined in the MPFS in the column labeled STATUS CODE⁵.

J = Anesthesia services. (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)

Federation outreach

American Society of Anesthesiology (ASA)

This recommendation was sent to Sharon Merrick for review.

American Academy of Orthopaedic Surgeons (AAOS)

This recommendation was sent to Matt Twetten for review.

American College of Radiology (ACR)

This recommendation has been viewed by Pam Kassing and Diane Hayek of ACR.

American College of Surgeons (ACS)

This recommendation was sent to Jennifer Jackson for review.

American Congress of Obstetricians and Gynecologists (ACOG)

This draft proposal was sent to Anne Diamond of ACOG for review.

Federation Payment Policy Workgroup

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

⁴ Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

⁵ Information taken from “[How to Use the Searchable Medicare Physician Fee Schedule \(MPFS\)](#)”, Centers for Medicare & Medicaid Services.

Global Maternity Care

***DRAFT – PLEASE DO NOT DISTRIBUTE**

Rules Committee Recommendation

Global Maternity Care 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.

Modifiers involved

Current Procedural Terminology (CPT®)¹ modifiers that apply.

22, 24, 25, 51, 57, 58, 59, 76, 77, 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 Maternity Care rule definition

Definitions

Maternity global – Services provided in uncomplicated maternity cases including antepartum care, delivery and postpartum care.

- Maternity Period—for the purposes of billing a maternity global, this is defined as beginning at the initial antepartum visit where the comprehensive pregnancy work up is performed and a obstetrics record is created and ends at the conclusion of the postpartum period.

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- Confirmation of Pregnancy—If a pregnancy is confirmed during a problem-oriented or preventive visit but no comprehensive antepartum work is performed and no obstetric record is established, this visit may be reported separately (outside the global package).

Global obstetric package - The global obstetric package as defined in CPT outlines a basic set of services that are included in an uncomplicated pregnancy. This definition, however, implicitly excludes certain services for which it is appropriate to code separately. The following are examples of services not included in the global obstetric package:

Antepartum services:

- * Treatment of complications requiring additional services or more than the usual 13 visits (eg, gestational diabetes, pre-eclampsia, hyperemesis, observation for preterm labor)
- * All medically indicated laboratory examinations except a routine chemical urine analysis (eg, obstetric panel, pregnancy test, and Pap test)
- * All medically indicated evaluation procedures (eg, ultrasound examinations, biophysical profiles, fetal non stress tests or amniocentesis)
- * Treatment for other conditions during the pregnancy (eg, vaginitis, sinusitis or urinary tract infection)

Delivery services:

- * Hospital admission services of more than 24 hours duration for a patient that is admitted and subsequently discharged from the hospital prior to delivery.
- * Hospital care that is distinct from labor or delivery and rendered up to, but not including, the day of delivery
- * Treatment for medical problems complicating the management of labor and delivery requiring additional services
- * Treatment of surgical complications of pregnancy (eg, an appendectomy or an ovarian cystectomy)

Postpartum services

- * Complications requiring other services or visits during the postpartum period.²

The global maternity care rule applies to only those procedure codes listed in the column labeled GLOBAL DAYS of the MPFS with a payment indicator of MMM.³

Note: Procedure codes assigned an indicator of 000, 010, 090 and sometimes YYY in the column labeled GLOBAL DAYS of the MPFS are addressed under the Global Surgery Days/Package Rule.

Duration of the Global Maternity Care period

The global period for maternity care starts with performing and reporting the comprehensive work of the initial antepartum visit and ends with the conclusion of postpartum care. If the pregnancy is confirmed during a problem-oriented or preventive visit but no obstetric record is established, this visit may be reported separately (outside the global package). The typical postpartum care period is 6-8 weeks. The American Congress of Obstetricians and Gynecologists does not endorse a specific number of days for postpartum care. The duration of the global maternity care period is identified in the payer's contract with the physician.

² ACOG Coding Guidance: CPT GLOBAL OBSTETRIC PACKAGE, 2010, Frequently Asked Questions in Obstetrics and Gynecology Coding, 5th Ed, 2011 and The Essential Guide to Coding in Obstetrics and Gynecology, 4th Ed. 2010

³ Access <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-to-MPFS-Booklet-ICN901344.pdf> for more information.

Global Maternity Care Package

The services provided in uncomplicated maternity cases include antepartum care, delivery and postpartum care.

- **Antepartum care** includes:
 - initial and subsequent history;
 - physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical (dipstick) urinalysis;
 - Diagnostic tests performed should be separately reported.
 - Visits
 - monthly visits up to 28 weeks gestation;
 - biweekly visits to 36 weeks gestation; and,
 - weekly visits until delivery.
 - Ten to fifteen antepartum visits are considered normal for routine obstetrical care and would be included in the global codes. The CPT definition includes 13 visits. The patient may be seen for additional visits for a pregnancy-related condition or a condition unrelated to the pregnancy.
 - Additional Visits
 - Pregnancy-related condition—

A patient is usually seen for extra visits because of a family or personal history of complications or medical problems that affect the pregnancy. Current year ICD diagnosis codes must be used to establish the medical necessity of the extra visits and any extra diagnostic tests.

 - If a patient is seen more frequently than the usual 13 visits, but no complications develop in the current pregnancy, only the global service is normally reported.
 - If the number of visits exceeds 13 because of complications, then the additional visits are reported using E/M codes, but they are not reported to the insurer until the patient delivers.
 - Examples of complications of pregnancy include: cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, preterm labor, premature rupture of membranes, trauma) and medical problems complicating labor and delivery management.
 - Condition unrelated to pregnancy-

A patient is treated for a condition unrelated to the pregnancy during the maternity period,

 - The office visit may be reported by reporting the:
 - appropriate E/M code or medical services codes; and the,
 - appropriate diagnosis code(s) for the condition, regardless of the total number of antepartum visits.
 - These visits are reported at the time of service.
 - Examples of unrelated conditions include:
upper respiratory tract infections, urinary tract infections, pneumonia, chronic hypertension⁴
 - Late Registrant Visits
Patients enrolling for antepartum care late in their pregnancy
 - More intensive management over fewer visits may be required, to the point that the level of care matches or surpasses that given to a typical obstetric patient.

⁴ (Essential Guide to Coding in Obstetrics and Gynecology, 4th Edition, 2010)

- Generally appropriate to report the global package codes for patients enrolling late for obstetric care provided by the same physician or physician group.
 - Should be considered on a case by case basis
 - When appropriate (if there is a significant reduction in service), the 52 modifier may be appended to indicate reduced services.
- **Delivery services**-include:
 - admission to the hospital
 - admission history and physical examination
 - management of uncomplicated labor (routine hospital visits following delivery in addition to hospital discharge services)
 - vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery
- **Postpartum care**- include
 - office or other outpatient visits following vaginal or cesarean delivery,
 - routine hospital visits following delivery, and
 - hospital discharge services.

Coding and adjudication guidelines

In certain circumstances one physician or qualified health care professional may not provide all of the global maternity care. The following coding guidelines are used to identify these situations:

- **Antepartum care.** If the physician or qualified health care professional provides some or all of the antepartum care, but not the delivery and postpartum care, the appropriate CPT Antepartum procedure codes (59425, 59426) should be reported based on the number of visits provided. Note: For less than four visits the appropriate evaluation and management codes should be reported.
- **Delivery only.** If the physician or qualified health care professional provides only the vaginal or cesarean delivery, the appropriate CPT delivery procedure codes should be reported. In addition the inpatient postpartum management and discharge services can be reported using the appropriate evaluation and management codes.
- **Delivery and postpartum care.** If the physician or qualified health care professional provides the delivery and postpartum care, but not the antepartum care, the appropriate CPT delivery including postpartum care procedure codes should be reported (59410, 59515, 59614, and 59622).
- **Multiple gestations.** The presence of multiple gestations creates potential complications for the pregnancy. Report multiple gestations (e.g., delivery of twins) when performed by the same physician or same physician group, according to CPT codes, guidelines and conventions⁵, as follows:

Vaginal delivery only:

Report: 59400 or 59610 for Twin A and 59409-59 or 59612-59 for Twin B. This method of coding communicates that one global maternity package is being billed along with an additional vaginal delivery (without antepartum care and without postpartum care)

Vaginal delivery in addition to a cesarean section

Report: 59510 or 59618 for Twin B and 59409-51 or 59612-51 for Twin A. This communicates that both a cesarean and a vaginal birth were performed.

⁵ American Medical Association, Principles of CPT coding

Cesarean section only

Report the appropriate cesarean code. If the cesarean delivery, was significantly more difficult, modifier 22 should be appended to the delivery code.

ACOG recommends the diagnosis code for the specific multiple gestation be linked to the procedure code reported.

- **Miscarriage.** If the patient miscarries before 20 weeks gestation, the global codes (delivery or antepartum care) would not be reported. Report the specific services provided, i.e., diagnostic tests, E/M visits etc. (Frequently Asked Questions in Obstetrics and Gynecology Coding, 5th Ed, 2011, Appendix G)
- **Postpartum Care only** If the physician or qualified health care professional provides the postpartum care, but not the antepartum care and delivery, the appropriate CPT postpartum procedure code (59430) should be reported.

Listing of procedures contained in the Medicare Definition

See Chapter 12, Sections 40.1-40.3 of the Medicare Claims Processing Manual⁶ for further instruction.

Rationale

The following rationale was used to formulate the Rule 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 maternity care and associated modifiers were selected.
- The American Congress of Obstetricians and Gynecologists was consulted.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS were selected.

MCCTF comment

No comment

Modifier 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 pre-operative, same day* and post-operative days assigned to that surgical procedure code.

Modifier 22: Increased Procedural Services

when the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

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 a postoperative period for a reason(s) unrelated

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

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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 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 51: Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D in the CPT codebook).

Modifier 57: Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Modifier 58: Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary 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. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

Modifier 59: Distinct Procedural Services

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 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.

Modifier 76: Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

Modifier 77: Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

Modifier 78: Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

Modifier 79: Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

Additional definitions

None

Payment indicator definitions

The following are payment indicator definitions that are outlined in the column labeled GLOBAL DAYS of the MPFS for Global Surgery⁸. 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.

⁸ Information taken from “[How to Use the Searchable Medicare Physician Fee Schedule \(MPFS\)](#)”, Centers for Medicare & Medicaid Services.

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.

(Note: Physician work is associated with intra-service time and in some instances the post service time.)

Federation outreach

American Congress of Obstetricians and Gynecologists (ACOG)

This recommendation has been sent to ACOG for review.

Federation Payer Payment Policy Workgroup

H – Place of Service

***DRAFT – PLEASE DO NOT DISTRIBUTE**

Rules Committee Recommendation

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

NA

Place of Services rule

This type of edit will identify incorrect billing of a professional service when the Current Procedural Terminology (CPT[®])¹/HCPCS descriptor of the service/procedure codes does not match the place service reported on the claim.
Consensus on 3/28/12

See Appendix A: National Place of Service Definitions for the complete current National POS code set with facility and non-facility designations noted for Medicare payment for services on the Physician Payment Schedule.²

With two (2) exceptions, the POS code to be used by the physician and other supplier will be assigned as the same setting in which the patient received the face to-face service. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician /practitioner will be the setting in which the patient received the Technical Component (TC) of the service.

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² Medicare RBRVS The Physician's Guide, 2013. American Medical Association.

Exceptions

The correct POS code assignment will be for that setting in which the patient is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). In other words, reporting the inpatient hospital POS code 21 or the outpatient hospital POS code 22, is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient or an outpatient of a hospital respectively. If the physician/practitioner is aware of the exact setting the patient is a registered inpatient or hospital outpatient, the more exact POS code may be reported.

NOTE: Physicians/practitioners who perform services in a hospital outpatient department will use, at a minimum, POS code 22 (Outpatient Hospital). Code 22 (or other appropriate outpatient department POS code as described above) will be used unless *the* physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65³. Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.65.⁴

Mobile Unit Settings (POS Code 15)

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a SNF. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the Mobile Unit POS code 15. The POS code 15 is considered a non-facility place of service.

Hospice POS

When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

When a patient is in an "inpatient" respite or general "inpatient" care stay, the POS code 34 (hospice) will be used. When a patient who has elected coverage under the Hospice benefit is receiving inpatient hospice care in a hospital, SNF, or hospice inpatient facility, POS code 34 (Hospice) will be used to designate the POS on the claim.

For services provided to a hospice patient in an outpatient setting, such as the physician/nonphysician practitioner's office (POS 11); the patient's home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital (POS 22)), the patient's physician or non-physician practitioner or hospice independent attending physician or nurse practitioner, will assign the POS code that represents that setting, as appropriate. There may be use of nursing homes as the hospice patient's "home," where the patient resides in the facility but is receiving a home level of care. In addition, hospices are also operating "houses" or hospice residential entities where hospice patients receive a home level of care. In these cases, physicians and non-physician practitioners, including the patient's independent attending physician or nurse practitioner, will use the appropriate POS code representing the particular setting, e.g., POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.⁵

³ 42 CFR 413.65 See link <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div5&view=text&node=42:2.0.1.2.13&idno=42#42:2.0.1.2.13.5.57.3> for more information.

⁴ 42 C/F/R/ 413.65 See link <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div5&view=text&node=42:2.0.1.2.13&idno=42#42:2.0.1.2.13.5.57.3> for more information.

⁵ MM7631 Revised, effective April 1, 2103.

Coding and adjudication guidelines

The appropriate POS code should be added to the professional claim to indicate the setting in which a service was provided.

See Appendix A: National Place of Service Definitions for the current National POS code set with facility and non-facility designation noted for Medicare payment for services on the Physician Payment Schedule.

Correct coding requires that the appropriate POS code be added. If not coded appropriately –

ACTION: Deny the line(s), or adjudicate one line with correct POS code.

Example: XXXXX incorrect POS code – subject to action

Rationale

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

- The Current Procedural Terminology (CPT[®])⁶ coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CMS descriptions for POS codes were selected.
- The Centers for Medicare and Medicaid Services (CMS) National Place of Service Definitions were selected.

MCCTF comment

Many of the CPT/HCPCS descriptions of the evaluation and management codes include a specific place(s) of service. CPT coding guidelines in other locations may also direct site of service reporting. The CMS Inpatient Only Listing was considered, however it may not always be appropriate for the younger age population and was therefore not considered an appropriate source.

Definition

This type of edit will identify incorrect billing of a professional service when the CPT/HCPCS descriptor of the service/procedure codes does not match the place service reported on the claim. Consensus on 3/28/12

Payment indicator definitions

See Appendix A: National Place of Service Definitions for the current National POS code set with facility and non-facility designation noted for Medicare payment for services on the Physician Payment Schedule.

Federation outreach

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New Patient

Rules Committee Recommendation

New Patient 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 HCPCS modifiers that apply.

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

New patient rule

According to CPT code set, a new patient is one who has not received any professional services from the physician or another physician and/or health care professional of the same group and same specialty, within the past three years.

Therefore, a physician should only bill for new patient services when the elements of the definition are met.

The new patient definition applies even if the physician saw the patient while a member of a different physician group. For example, a physician leaves group practice A to join group practice B. If a patient who received professional services while the physician was part of group A sees the physician after joining group B within the three year window, the encounter would be reported with an established patient code.

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An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician."²

"Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient."³

Coding and adjudication guidelines

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 and selected.
- The CPT descriptions were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual⁴ were reviewed.

MCCTF comment

Note, the AMA offered this clarification, if the patient has received professional services from the same physician within the past three years, the patient is considered an established patient, even though the physician has changed medical groups or practice settings.

Modifier definitions

This type of edit is used for a new versus established patient. **Professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. **Consensus 7/18/12**

² 2013 Current Procedural Terminology Book, page 30.

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

Additional definitions

NA

indicator definitions

NA

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DRAFT

C - Multiple Procedure Reduction ***DRAFT – PLEASE DO NOT DISTRIBUTE**

Rules Committee Recommendation

Multiple Procedure Reduction reporting rule

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Modifier Involved

Current Procedural Terminology (CPT®)¹ modifiers that apply.

51 – Multiple Procedures

62 - Co-surgery (cross reference K-co-surgery rule)

66 –Team Surgery (cross reference team surgery rule)

80 – Assistant at Surgeon (cross reference assistant surgery rule)

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

Multiple procedure reduction rule

When two or more procedures/services are performed during the same session by the same provider, not all of the procedures/services may be allowed at the full contracted rate. *Consensus on 3/28/12.*

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The Multiple Procedure Reduction rule may apply when two or more procedures are billed by the same physician or other qualified healthcare provider for the same patient for the same surgical/procedure session.

Procedures subject to the multiple procedure reduction adjustment are listed in the column labeled MULT PROC of the Medicare Physician Fee Schedule (MPFS).²

Multiple Procedure Reduction Indicators

The MPFS column labeled MULT PROC provides seven indicators (0, 1, 2, 3, 4, 5 and 9) used to identify procedure codes for which the payment adjustment rule for multiple procedures applies to a service. The Rules Committee has outlined the following recommendations as the indicators that relate to this rule:

- Procedure codes with an indicator of 0 are not eligible for the multiple procedure reduction adjustment.
- Procedure codes with an indicator of 1 are eligible for the multiple procedure reduction adjustment.
- Procedure codes outlined with an indicator of 2 are eligible for the multiple procedure reduction adjustment. Exception: Nuclear Medicine codes 78306, 78320, 78802, 78803, 78806, and 78807 marked with an indicator of "2" are considered out of scope for this rule, as all 70000 series radiology codes are considered out of scope for the multiple procedure adjustment.
- Procedure codes with an indicator of 3 may be eligible for the multiple procedure reduction adjustment. Refer to the payment rule on Multiple Endoscopy for additional information.
- Procedure codes with an indicator of 4 are out of scope and not eligible for the multiple procedure reduction adjustment.³
- Procedure codes outlined with an indicator of 5 are out of scope for this rule.
- Procedure codes with an indicator of 6 out of scope for this rule.
- Procedure codes with an indicator of 7 out of scope for this rule.
- Procedure codes outlined with an indicator of 9 are not recognized for reporting multiple procedures because the concept does not apply

The Multiple Procedure Reduction rule applies only when two or more procedures *with an eligible indicator (1, 2, or 3)* are billed by the same physician or other qualified healthcare provider for the same patient for the same surgical/procedure session.

Note: Procedures in the column labeled MULT PROC of the Medicare Physician Fee Schedule (MPFS) with indicators 4, 5, 6 and 7 (as of 1/1/2013), as well as Nuclear Medicine 78000 series codes designated with an indicator 2, are not included within this rule.

Coding and adjudication guidelines

The following procedures apply when billing for multiple surgeries by the same physician on the same day.

- Report the more major surgery or endoscopy procedure without the 51 modifier.
- Report additional surgeries or endoscopy procedures performed by the physician on the same day with modifier 51.

Procedures are ranked in descending order based on the appropriate facility or non-facility RVU. If two or more multiple surgeries are of equal value, rank them in descending dollar order billed and base payment adjustments as if the second procedure has a lesser RVU value.

There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries may not be appropriate. In such cases, the physician does not use modifier “-51” unless one of the surgeons individually performs multiple surgeries.

The modifier 51 does not apply to E/M codes, designated add-on codes (see Appendix D of the CPT codebook), or codes designated as modifier 51 exempt (see Appendix E of the CPT codebook). The use of the modifier 51 is not restricted to operative procedures, although it is commonly used in this context. To assist in determining the appropriate reporting, modifier 51 has four applications, namely to identify:

- Multiple medical procedures performed at the same session by the same provider;
- Multiple, related operative procedures performed at the same session by the same provider;
- Operative procedures performed in combination at the same session, by the same provider, whether through the same or another incision or involving the same or different anatomy; and
- A combination of medical and operative procedures performed at the same session by the same provider.

Multiple Procedure Reductions rule relationships

When any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure adjustment as one payment amount – apply the bilateral payment adjustment first then rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.

(Refer to Bilateral Surgery Rule for more information)

When endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures:

- Two unrelated endoscopies (e.g., 46606 and 43217): Subject to the multiple procedure reduction rule;
- Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608): Apply the multiple endoscopy reduction rules to each series (see multiple endoscopy reduction rule for more information) and then apply the multiple surgery rules. Consider the total payment for each set of endoscopies as one service;
- Two related endoscopies and a third, unrelated procedure: Apply the special endoscopic rules to the related endoscopies, and, then apply the multiple surgery rules. Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.

(Refer to Multiple Endoscopy Reduction Rule for more information)

Code IS eligible for multiple procedure reduction adjustment (indicator 1, 2, and sometimes 3)

Procedure codes listed in the column labeled MULT SURG of the MPFS with an indicator of 1, 2, or 3 are subject to the multiple procedure reduction adjustment, which may be applied ONLY

when 1) Two or more of the submitted codes have a multiple procedure indicator of 1, 2, or 3 signifying that the code is eligible for the adjustment and 2) the second or subsequent codes are reported with modifier 51; or 3) Two or more of the submitted codes have the multiple procedure indicator of 1, 2 or 3 without appropriate modifier. ACTION: Eligible for multiple procedure reduction adjustment.

Procedure codes eligible for the multiple procedure reduction adjustment, where the second or subsequent codes are reported inappropriately without the modifier 51. ACTION: Payer adjudicates the line item as if modifier 51 had been appended.

Code is NOT eligible for multiple procedure reduction adjustment (indicator 0 or 9)

Procedure codes listed in the column labeled MULT PROC of the MPFS with an indicator of 0 or 9 are not eligible for the multiple procedure reduction adjustment. ACTION: Eligible for payment without adjustment.

Procedure codes not eligible for the multiple procedure reduction adjustment, where the secondary codes are reported inappropriately with the modifier 51 (for example, an add-on code or code that is modifier 51 exempt). ACTION: Payer may choose to adjudicate the line item as if modifier 51 had NOT been appended, or may choose to deny the line item as a billing error.

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 multiple procedures and modifier 51 were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual⁴ were selected, special rules for Cardiovascular, Ophthalmology, Radiology and Physical Therapy services were determined to be out of scope for this rule

..

(Refer to out of scope rationale for radiology and physical therapy codes when finalized.)

MCCTF comment

RVU for each of these procedures included pre-service, intra-service and post-service in the form of work/time practice expense and malpractice expense. The concept of multiple procedure reduction is based on the fact that pre-service and post-service work is performed only once when multiple procedures are performed at the same time.

Modifier definitions

Modifier Definitions

51 – Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional

⁴ Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated “add-on” codes (see Appendix D in the CPT code book).⁵

62 – Co surgery (cross reference K - Cosurgery Rule)

Two Surgeons: When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 –Surgical Team (cross reference L - Team Surgery Rule)

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

80 - Assistant Surgeon (cross reference J-Assistant Surgery Rule)

Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

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.

Pre-service and post-service work

The work involved in actually providing a service or performing a procedure is termed “intra-service work.” For office visits, the intra-service 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 pre-service, intra-service, and post-service 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. (page 28)

⁵ Current Procedural Terminology (CPT®), Fourth Edition. 2013. American Medical Association.

Multiple procedure indicator definitions

The following are indicator definitions that are outlined in the MPFS in the column labeled MULT PROC for multiple procedures that apply to this rule⁶. This field provides an indicator that indicates which payment adjustment rule for multiple procedures applies to the service.

0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applied to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, Medicare ranks the procedures by fee schedule amount and the appropriate reduction to this code is applied.

2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, carriers/MACs rank the procedures by fee schedule amount and apply the appropriate reduction to this code.

3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G of the Form CMS-1500 or its electronic equivalent claim. The multiple endoscopy rules apply to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately paid. Payment for the base procedure is included in the payment for the other endoscopy. (*Refer to Multiple Endoscopic Reduction rule for more information.*)

4 = CMS Special rules for TC diagnostic imaging (effective for services on or after January 1, 2006 through June 30, 2010). Out of scope for this rule.

5 = CMS Special rules for the practice expense component for certain therapy services (effective for services January 1, 2011 and after). Out of scope for this rule.

6 – CMS Special rules for the TC of Cardiovascular services effective 1/1/13. Out of scope for this rule.

7 – CMS special rules for TC of Ophthalmology services effective 1/1/13. Out of scope for this rule.

9 = Concept does not apply.

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

A – Unbundled (Procedure to Procedure)

Rules Committee Recommendation

Unbundled/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.

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

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

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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

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 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.

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

Unbundled rule

The unbundled/bundled procedure listing is contained within the current year National Correct Coding Initiative (NCCI) "Column One/Column Two Correct Coding Edit Table". The NCCI table is an exclusive edit table that includes several Colorado Clean Claim Task Force rules: including gender, global allowance, add-on codes, incident to-services, and anesthesia.

The unbundled/bundled table can be created from the publically available online tables² or from tables that can be purchased from the National Technical Information Service (NTIS)³.

² NCCI edits utilized for practitioner claims (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>); NCCI edits utilized for outpatient hospital claims in the Outpatient Code Editor (OCE) (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>) Current quarterly version update changes for NCCI edits and published MUEs (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html)

³ The NCCI Edits Manual may also be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) website located in the "Related Links Outside CMS" section below, or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

Coding and adjudication guidelines

Modifier 59 is used to identify procedures or services that are typically bundled, but are appropriate under the circumstances. This modifier should be used only if there is not a more descriptive modifier available, and the use of modifier 59 best explains the circumstances.

Procedures should be reported with the most comprehensive CPT code that describes the services performed.

There are several general principles that can be applied to the bundled/unbundled edits as follows:

1. The component service is an accepted standard of care when performing the comprehensive service.
2. The component service is usually necessary to complete the comprehensive service
3. The component service is not a separately distinguishable procedure when performed with the comprehensive service.

Access Chapter 1 General Correct Coding Policies⁴ for specific examples of appropriately and inappropriately bundled code pairs.

- A claim that is submitted for a service or supply that is bundled and **is appropriately reported** because it is a separate site or surgical session with an appropriate modifier on the secondary procedure. Action: ACTION: Adjudicate one line with no adjustment and apply the rule to the second line.

Example: XXXXX
 XXXXX 59 – subject to action

- A claim that is submitted for a service or supply that is bundled, but **not appropriately reported** because it is a separate site or surgical session with an appropriate modifier on the secondary procedure. Action: ACTION: Adjudicate one line with no adjustment, deny other line.

Example: XXXXX
 XXXXX – subject to action

Rationale

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

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for unbundled codes were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy was reviewed.
- The NCCI was selected for the bundling/unbundling rule.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rules Committee Recommendation.

⁴See link <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> for more information.

MCCTF comment

Frequency limitations spanning a period of time will be addressed separately, including MUEs.

Appropriate modifiers as defined by CPT or HCPCS may be reported to override this type of edit.

Modifier/edit definitions

This type of edit is also referred to as a 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:

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 CPT/HCPCS 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.

Consensus on 3/28/12

NCCI Guidelines

- Modifier 59:
 - Was established for use when several procedures are performed on different anatomical sites, or at different sessions (on the same day)
 - Indicates that the procedure represents a distinct service from others reported on the same date of service
 - Is appended when distinct and separate multiple services are provided to a patient on a single date of service
 - Was developed explicitly for the purpose of identifying services not typically performed together

Unbundled modifier definitions

The following are assigned modifier indicators in the NCCI.

0 = Not allowed. An NCCI-associated modifier cannot be used to bypass the edit.

1 = Allowed. An NCCI-associated modifier may be used to bypass the edit if it meets the criteria under appropriate circumstances

9 = Not applicable. Edit deleted on the same date as when it became effective

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Revised August 15, 2013

M –Professional and Technical Component Rule

***DRAFT – PLEASE DO NOT DISTRIBUTE**

Rules Committee Recommendation

Disclosure statement

Recommended payment rules, as outlined by the Medical Clean Claims Transparency and Uniformity Act, are intended for administrative simplification purposes, with a focus on transparency of information. All health plans and providers are expected to follow these recommended payment rules. However, if a health plan deviates from the recommended payment rule(s) as agreed upon by all contracting parties, the health plan must clearly communicate the deviation to all contracted health care providers that are impacted by the deviation. The deviation must include sufficient information for the contracted health care provider to report and understand what will be paid on a procedure or service, including the underlying fee schedule and disclosure of payment and compensation terms to calculate payment. If the deviation is not disclosed in writing, it shall be disclosed in a manner that allows the health care provider to timely evaluate the payment or compensation for services under proposed contracts, contracts and amendments.

If the coding reported does not adhere to this recommendation, the payer may make a decision to deny the claim line on an electronic remittance advice 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. The payer may use a clearly defined payer adjustment code; in addition to a CARC and as appropriate a RARC, on a paper remittance advice.

Modifiers Involved

Current Procedural Terminology (CPT®)¹ modifiers that apply.

26, TC (See definitions below)

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

Modifier definition

Modifier 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.

Modifier TC: Technical Component²

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

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² This is the HCPCS definition and the reference to customary and prevailing profiles is specific to Medicare.

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.

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.

Professional and Technical Component Rule

Procedures subject to the Professional and Technical Component Rule are listed in the Medicare Physician Fee Schedule (MPFS) column labeled PCTC.³

Professional component (26) and technical component (TC) modifier identification applies to procedure codes with an indicator of 1. Modifiers 26 and TC may be appended to describe the professional and technical components respectively when appropriate.

Professional component only codes are identified with an indicator of 2, 6 or 8. Technical component (TC) only codes are identified with an indicator of 3. It is inappropriate and unnecessary to append either a 26 or TC modifier.

Professional component (26) and technical component (TC) modifier identification does not apply to procedure codes with an indicator of 0, 4, 5, 7 or 9. It is inappropriate and unnecessary to append a 26 or TC.

Note: CPT codes identified with PC/TC indicator 5 are not intended to be reported by the physician in the facility setting. These codes are typically not eligible for payment when reported with a facility place of service (POS 21, 22, 23, 26, 34, 51, 52, 56, or 61).

Note: It is inappropriate to append a 26 modifier or TC modifier to services included in the Global Surgical package.

Coding guidelines

Because CPT codes are intended to represent physician and other health care practitioner services, the CPT nomenclature does not contain a coding convention to designate the technical component for a procedure or service. CPT coding does provide modifier 26, professional component for separately reporting the professional (or physician) component of a procedure or service. This is because a hospital or other facility may be reporting the technical component of the procedure. The HCPCS Level II modifier TC is used to differentiate the professional versus technical components of the service provided.

Unmodified CPT codes are intended to describe the global service (both the technical and professional components), professional component only or technical component only of a service. If the technical and professional components of the service are performed by the same provider, it is not appropriate or necessary to report the components of the service separately.

Professional versus Technical Component

Certain procedures described by the CPT code set are a combination of a professional (physician) component and a technical component (ie, diagnostic tests that involve a physician's interpretation, such as cardiac stress tests, electroencephalograms, or physician pathology services).

³ 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.

PCTC Indicators

The MPFS provides ten status indicators (0,1, 2, 3, 4, 5, 6, 7, 8 and 9) used to identify procedure codes for TC and PC

The descriptions of the PC/TC indicators were deleted from the section as the complete Medicare definition is located on pages 4 and 5.

Place of Service (POS) instructions for the interpretation of Professional Component (PC) and the Technical Component (TC) of diagnostic tests.

With two (2) exceptions, the POS code to be used by the physician and other supplier will be assigned as the same setting in which the patient received the face-to-face requirement is obviated, such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test from a distant site, the POS code assigned by the physician /practitioner will be the setting in which the patient received the Technical Component (TC) of the service.

Exceptions

The correct POS code assignment will be for that setting in which the patient is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). In other words, reporting the inpatient hospital POS code 21 or the outpatient hospital POS code 22, is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient or an outpatient of a hospital respectively. If the physician/practitioner is aware of the exact setting the patient is a registered inpatient or hospital outpatient, the more exact POS code may be reported.

NOTE: Physicians/practitioners who perform services in a hospital outpatient department will use, at a minimum, POS code 22 (Outpatient Hospital). Code 22 (or other appropriate outpatient department POS code as described above) will be used unless *the* physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65⁴. Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.65⁵.

Rationale

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

- The Current Procedural Terminology (CPT[®])⁶ coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions for modifier 26 and Technical component (TC) were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual⁷ were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

⁴ 42 CFR 413.65. See link <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div5&view=text&node=42:2.0.1.2.13&idno=42#42:2.0.1.2.13.5.57.3> for more information.

⁵ 42 C.F.R. 413.65 See link <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div5&view=text&node=42:2.0.1.2.13&idno=42#42:2.0.1.2.13.5.57.3> for more information.

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⁷ Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

MCCTF comment

HCPCS modifier TC would be appended according to HCPCS guidelines and instructions for designating the technical component. CPT modifier 26 would be appended according to CPT guidelines and instructions for designating the professional component.

Note: The actual fee schedule for PC & TC is considered a payment issue and out of scope of the Task Force.

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.
Consensus on 3/28/12

Professional Component (PC)/Technical component (TC) indicator definitions

The following are indicator definitions that are outlined in the MPFS in the column labeled PCTC for the Professional Component and the Technical Component⁸.

0 = Physician service codes. This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers -26 and TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense, and malpractice expense. There are some codes with no work RVUs.

1 = Diagnostic tests or radiology services. This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers -26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

2 = Professional component only codes. This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers -26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 = Technical component only codes. This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers -26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

⁸ Information taken from "How to Use the Searchable Medicare Physician Fee Schedule (MPFS)", Centers for Medicare & Medicaid Services.

4 = Global test only codes. This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers -26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

5 = Incident to codes. This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers/MACs for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers -26 and TC cannot be used with these codes.

6 = Laboratory physician interpretation codes. This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician, work, practice expense, and malpractice expense.

7 = Private practice therapist's service. Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

8 = Physician interpretation codes. This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for a hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the Prospective Payment System (PPS) rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 = Concept of a professional/technical component does not apply.

Federation outreach

Federation staff payment policy workgroup

Recommend renaming Procedure to Procedure Rule, including Unbundled (Bundled/Incidental) and Mutually Exclusive

Rules Committee Recommendation

Procedure to Procedure Rule, including Unbundled (Bundled/Incidental) and Mutually Exclusive

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.

Modifiers Involved.

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

25, 59 and HCPCS separate site modifiers (see definitions below)

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

Procedure to Procedure Rule, including Unbundled (Bundled/Incidental) and Mutually Exclusive

The unbundled/bundled/mutually exclusive procedure listing is contained within the current year National Correct Coding Initiative (NCCI) "Column One/Column Two Correct Coding Edit Table". This edit table is a publically available online table⁴ or can be purchased from the National Technical Information Service (NTIS)⁵.

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This edit table is a publically available online table⁴ or can be purchased from the National Technical Information Service (NTIS)⁵.

Procedure to procedure edit definition

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:

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 CPT/HCPCS 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.

Example: An example of when this rule would apply, is the repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an initial service or a subsequent service. With the exception of drug administration services, the initial service and subsequent service cannot be reported at the same patient encounter.

Coding and adjudication guidelines

Unbundling Modifier 59 is used to identify procedures or services that are typically bundled, but are appropriate under the circumstances. This modifier should be used only if there is not a more descriptive modifier available, and the use of modifier 59 best explains the circumstances.

Procedures should be reported with the most comprehensive CPT code that describes the services performed.

There are several general principles that can be applied to the **procedure to procedure** edits as follows:

1. The component service is an accepted standard of care when performing the comprehensive service.
2. The component service is usually necessary to complete the comprehensive service

⁴ NCCI edits utilized for practitioner claims (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>); NCCI edits utilized for outpatient hospital claims in the Outpatient Code Editor (OCE) (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>) Current quarterly version update changes for NCCI edits and published MUEs (http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html)

⁵ The NCCI Edits Manual may also be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) website located in the "Related Links Outside CMS" section below, or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

- A claim that is submitted with two or more services or supplies, one of which is typically bundled, but in this instance is appropriately reported with a modifier to override the edit on the secondary procedure because it was performed on a separate site or during a separate surgical session.
ACTION: Adjudicate one line with no adjustment and if the second claim line is appended with an appropriate modifier that allows the edit to be overridden, the second line will be eligible for consideration.
Adjudicate both lines and apply other rules, when appropriate.

Example: XXXXX
YYYYY,59 – subject to action

- A claim that is submitted with two or more services or supplies, one of which is typically bundled, but in this instance is appropriately reported because it is a separate anatomic site with an appropriate modifier to override the edit on the secondary procedure. ACTION: If appended modifiers are appropriate and allowed to override the edit, adjudicate both lines and apply other rules when appropriate.

Example: XXXXX F4
XXXXX F5 – subject to action

- A claim that is submitted with two or more services or supplies, one of which is typically bundled, but in this instance is not reported appropriately with a modifier on the secondary procedure indicating that it is a separate site or surgical session.
ACTION: Adjudicate one line with no adjustment, deny other line.

Example: XXXXX
YYYYY, – subject to action

- A claim that is submitted with two or more services or supplies, one of which is typically bundled, but in this instance is not reported appropriately as the modifier on the secondary procedure is not eligible to override the edit.
ACTION: Adjudicate one line with no adjustment, deny other line.

Example: XXXXX
YYYYY – 51 subject to action,

Procedure to procedure edit consists of a column 1 and column 2 code pair. If the two codes of an edit are billed by the same provider for the same patient for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a NCCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed.

CPT codes that are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. These codes are not necessarily linked to one another with one code narrative describing a more comprehensive procedure compared to the component code, but can be identified as code pairs that should not be billed together.

Separate Procedure

- Some of the procedures or services listed in the CPT nomenclature that are commonly carried out as an integral component of a total service or procedure have been identified by including the term “separate procedure”.
- Codes designated as separate procedures should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.
- Examples of CPT codes with “separate procedure” in the code description.
 - 29870—Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
 - 38780—Retroperitoneal transabdominal lymphadenectomy, extensive, including pelvic, aortic, and renal nodes (separate procedure)
 - 44312—Revision of ileostomy; simple (release of superficial scar) (separate procedure)
- Codes designated as separate procedures can be reported if they are not being performed in addition to the code for the total procedure or service of which it is considered an integral component.

Rationale

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

- The Current Procedural Terminology (CPT®)⁷ coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptors for modifiers 25 and 59 and unbundled/mutually exclusive codes were selected.
- The NCCI unbundled and mutually exclusive code pairs were reviewed and selected.
- CPT codes were reviewed for exceptions to the CMS pricing policy but none were found to add to this rule at this time.

MCCTF comment

Unbundled

Frequency limitations spanning a period of time will be addressed separately, including MUEs.

Appropriate modifiers as defined by CPT or HCPCS may be reported to override this type of edit.

Mutually Exclusive

Appropriate modifier as defined by CPT or HCPCS may be reported to override this type of edit.

Modifier 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**

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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.

Modifier 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 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

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

Unbundled/Mutually Exclusive indicator definitions

The following are indicator definitions that are outlined in the NCCI edit table were used.

0 = Not allowed. An NCCI-associated modifier cannot be used to bypass the edit.

1 = Allowed. An NCCI-associated modifier may be used to bypass the edit if it meets the criteria under appropriate circumstances.

9 = Not applicable. Edit deleted on the same date as when it became effective.

Federation outreach

Federation Payer Payment Policy Workgroup

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



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

Response to Public Comments
August 15, 2013

Background

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit 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 task force is to identify the standardized set of rules and edits through existing national industry sources including: National Correct Coding Initiative (NCCI); Centers for Medicare & Medicaid Services (CMS) directives, manuals and transmittals; the Medicare physician fee schedule; CMS national clinical laboratory fee schedule; the Healthcare Common Procedure Coding System (HCPCS) coding system and directives; the Current Procedural Terminology (CPT®)¹ coding guidelines and conventions; and national medical specialty society coding guidelines.

The task force is not developing rules or edits that are used to identify potential fraud and abuse or utilization review. Additionally, the standardized rules and edits cannot limit contractual arrangements or terms negotiated between the contracting entity and the health care provider.

Additional information can be found at <http://hb101332taskforce.org>.

General

Several comments were submitted in general support of the approach the task force is taking in the development of a standardized set of rules and edits. Specifically they support the inclusion of a broad base of stakeholders and the use of nationally recognized sources as a starting point.

One commenter expressed concern with the implementation of another coding system that may at times be inconsistent with Medicare guidance, and felt this could be confusing for providers and their staff. The commenter felt it would be important for the task force to identify for the public what the protocol will be in cases where the Colorado standardized set of rules and edits differ from Medicare.

The commenter also noted that the procedure code table included with the public release of these rules did not include the descriptors of the procedure codes. There was a request that any procedure codes that were exceptions to Medicare be specifically identified to make the review easier. Additionally, the

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commenter asked that the task force add a column to the procedure code table that would identify what specialties most frequently bill the CPT code in order to facilitate the review process.

Response: The task force shares the commenter's concern regarding the implementation of another coding system and that is why the legislation calls for the task force to consider the existing national sources rather than develop a completely unique set. However, where a rule/edit does not exist for Medicare, due to the population it is intended to serve, or where a rule is based on a Medicare benefit limitation or federal mandate, the task force has looked to other sources for input. One of these sources for additional input has been through the American Medical Association (AMA) and their Federation partners including the national specialty societies.

The task force currently has a limited copyright license with the AMA for use and publication of the Current Procedural Terminology (CPT®). This allows us to publish the procedure codes but not the associated descriptors. When the complete set of standardized rules and edits are published there should be a new copyright license in place that will allow for the use of both the codes and descriptors.

The task force has deliberated how to publish information on which CPT codes vary from Medicare. One of the concerns is that this may not be a static listing and initially publishing specific codes could lead to confusion later as new CPT/HCPCS² codes are added to the procedure code table. It also becomes an element for consideration in the ongoing maintenance of the standardized set. The task force will re-evaluate this request, as we do want to ensure transparency.

The task force does not have access to claims history so we are unable to determine which specialties bill particular CPT codes most frequently. The procedure code table is available in an Excel format so it is hoped that this will facilitate a comparison within a practice or specialty society.

Another commenter felt that the rules (Team Surgery, Co-surgery and Bilateral Procedures) should give the providers more direction on how to report in relation to full or adjusted charges.

Response: The rules do not address specific payment adjustments, including percentages or stated monetary amounts. The charge of the task force is to elucidate and standardize coding rules and edits. Directions to specific percentages or amounts for pricing adjustments to be applied or reported are not within the scope of the task force's purview.

**Assistant at Surgery
101 V.01 5/23/13**

Comments were received requesting consistency in the terminology used throughout this rule. It was pointed out the terms assistant at surgery, assistant surgeon and assistant surgery were used interchangeably. It was suggested that

² HCPCS – As used in the task force rules refers to CMS Healthcare Common Procedure Coding System Level II alphanumeric procedure codes and modifiers.

the term *assistant at surgery* should be used as this describes the services performed without placing limitations on who is performing the service. Additionally, the commenters pointed out that under Colorado statutes, physicians are not the only qualified health care professional who can provide assistant at surgery services and recommended adding a clarification in the definition that indicates assistant at surgery services can be provided by physicians or other qualified health care professional practicing within the scope of his or her license.

Concerns were also raised relative to the CPT and HCPCS modifier descriptions, as they seemed to be restricting the types of professionals who could provide these services.

Response: The task force agrees with the comments regarding the consistent use of the term *assistant at surgery* and will include these revisions in the final rule. Additionally, given the fact that under the Colorado statutes, physicians are not the only professional qualified to provide assistant at surgery services such a clarification will be included in the final rule as part of the administrative guidance.

The task force is charged with utilizing existing national sources such as the CPT and HCPCS coding and does not have the authority to alter those descriptions. We recognize that by using the term “surgeon” in the modifier names for 80, 81 and 82 it appears that the CPT is implying a physician is providing the service. However, in the Introduction of the CPT code book it does state that the “*Current Procedural Terminology (CPT), Fourth Edition* is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals.” CPT has made a number of terminology changes recently to incorporate the phrase *and other qualified health care professionals*. We will raise this as an area for consideration of such a change in future updates.

However, modifier 82 is specific to physician residents in an academic institution, and Medicare. Because Medicare reimburses the institution for resident services they will not pay separately for assistant at surgery services unless a resident was not available. The use of modifier 82 communicates the unavailability of a resident to the Medicare contractor. Again, this is language that the task force cannot alter and was intended to address a very specific situation.

The HCPCS modifier AS was developed by Medicare to address the specific health care professionals whose services are covered under that program. The task force cannot alter the HCPCS descriptors. If the commenters feel that the HCPCS definition is no longer consistent with the program requirements, they should contact CMS to update the modifier description.

As mentioned previously, the task force agreed that a clarification regarding *physician or other qualified health care professional* would be appropriate and hopefully counter potential confusion caused by the modifier descriptions.

Comments were received in support of the approach the task force has taken from the national specialty society that develops and publishes one of the source publications used as a basis for the assistant at surgery rule rationale. Additionally, they have indicated a willingness to update the publication annually with the new CPT procedure codes and review the entire report when necessary.

Although the national specialty society understands that the task force's charge includes leveraging administrative simplification when possible, and they are in general support of the task force's proposed rule, they did express concern with the elimination of the "sometimes" category. The removal of this category necessitates that the assistant at surgery services be either initially allowed or denied and they felt that this could lead to unnecessary denials.

Response: The task force appreciates the cooperation of the specialty societies during the development of this rule. We are pleased that the society has offered to update their publication annually. An annual review should reduce the need to use an alternate source.

The task force spent a great deal of time deliberating the elimination of the "sometimes" category and the resulting action. This is an area that can be re-examined in the future if any of the stakeholders (professionals or payers) provides additional information or statistics that they feel prove a compelling argument for change.

One commenter asked that there be further clarification in the Administrative Guidance regarding how procedures that the American College of Surgeon's publication, "Physicians as Assistants at Surgery: 2011 Study" classified as "sometimes" are to be handled according the rule.

Response: Based on this comment, the task force will re-evaluate the explanation to see if the rule logic/decision hierarchy process can be further clarified.

**Team Surgery
102.V01**

Several commenters expressed support for this rule as published.

One commenter requested publication of a list of procedure codes that are eligible for team surgery consideration.

Response: The procedure code table does include a column for Team Surgery eligibility with indicators of Y (Yes) or N (No). As indicated previously, the CPT descriptors were not included on the table but are anticipated to be included in the final standardized set of rules and edits.

**Co-Surgery
103V.01**

Several commenters expressed support for this rule as published.

One commenter suggested that the clarification "different or the same specialty" be added as there are cases where a surgeon is categorized as a general surgeon in Medicare, but specializes in a particular type of general surgery.

Response: The statement regarding specialty is currently contained within the Administrative Guidance section of the rule. The task force will evaluate whether or not this same statement should be included within the definition section of the rule as well. The task force cannot add this to the modifier section as this reflects the CPT and/or HCPCS terminology.

One commenter suggested it would be helpful if the task force could provide additional clarity regarding the term “straightforward” as it is used in the rule logic section under “Code is NOT eligible for co-surgery adjustment (indicators 0 and 9).

Response: The reference to “straightforward” is taken directly from the Medicare Physician Fee Schedule Database (MPFSD)³ explanation of the indicators used on the file. Representatives of the AMA CPT sit on the task force and we will see if they can provide any assistance in providing additional administrative guidance.

**Bilateral Procedure
104.V01**

Several commenters expressed support for this rule as published and indicated that it would provide needed consistency.

One commenter felt that the rule was confusing and additional examples were needed to add clarity.

A national specialty society that supports this rule did request that the task force include a detailed explanation of the bilateral procedure rule in task force’s final educational materials. They committed to work with its members to educate them on the reporting as well.

Response: The task force realizes that there has not been consistency in the reporting or processing of bilateral procedures within the industry. The Medicare approach appeared to be the most widely known and utilized and that is why the task force adopted its principles. As with all aspects of the task force’s final set of standardized rules and edits, detailed educational materials will need to be developed and deployed to both payers and providers.

Another commenter expressed concern with the requirement to report the HCPCS modifiers RT and LT, as it could be confusing if included in the bilateral procedure rule.

Response: The reference to the RT and LT modifiers within the bilateral procedure rule is consistent with Medicare. However, these modifiers are used primarily in radiology when the procedure can be performed bilaterally but is not subject to the bilateral adjustment, and should be reported on two lines. The RT and LT modifiers can also be used in other situations for informational purposes. This explanation can be included as part of a more detailed description of all modifiers currently in development.

^{3 3} 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 task force identified that two of the procedure codes on the table included for public release contained an incorrect bilateral indicator.

Response: The task force identified that CPT procedure codes 58661 and 92132 were labeled incorrectly on the procedure code table. They should be designated as follows:

58661 = N

92132 = Y

The final procedure code table will be corrected.

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



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

Response to Public Comments
August 22, 2013

Assistant at Surgery 101 V.01 5/23/13

One commenter expressed concern with the task force recommendation to use the American College of Surgeons' eligibility list as the primary source to determine whether an assistant at surgery is eligible and the Medicare Physician Fee Schedule Database (MPFSD)¹ assistant surgeon indicators as a secondary source, indicating that this would be problematic for Medicare and Medicaid claims. The commenter supports use of the CMS MPFSD as the sole source in order to reduce administrative difficulties between Medicare, Medicaid and COB claims. The commenter further stated that the MPFSD is a nationally recognized standard by most if not all payers, whereas the ACS is not.

Response: In the development of payment rules and edits, the task force relies on existing national industry sources represented by (I) NCCI; (II) CMS directives, manuals, and transmittals; (III) the Medicare Physician Fee Schedule; (IV) 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.² The legislation also directs the task force to work with national experts to identify any rules and edits that are not encompassed by the national industry sources identified or that potentially conflict with each other. Members of the task force have agreed to give strong credence to the value of clinical input in its deliberations, and in the instance of the assistant at surgery rule, agreed that when clinical input was provided by the American College of Surgeons it would be the first source utilized to determine whether an assistant at surgery was reimbursable.

Comment: In keeping with their recommendation of only relying on the CMS MPFSD indicators, the commenter also addressed the Rule logic as outlined in the proposed rule. (1) When the ACS recommendation is "sometimes" and CMS indicates the procedure is never eligible for assistant at surgery reimbursement, they support that the CMS rules should be primary. (2) They felt that the task force recommended action concerning when the ACS recommendation is "sometimes" and the CMS indicator is a 0 (CMS only allows payment of assist at surgery when supporting documentation is submitted to establish medical necessity) to default to always eligible for reimbursement may increase the risk of paying for assistant at surgery services that are not medically necessary. Additionally, they feel this would place their government business at risk, as this is not in compliance with CMS standards.

¹ 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.

² § 25-37-106(2)©(I), C.R.S.

Response: The goals of the Act were to eliminate some of the excessive administrative costs of the current claims submission, payment and reconciliation process; reduce administrative redundancies; remove some of the ambiguity and complexity of the claims process, thus enabling the adoption of point-of-service pricing; and promote greater payment transparency across payers. The task force recognizes, however, that because of the numerous variations between payers in the payment rules and claims edits currently in place, system changes will be inevitable if we are to meet our goals. It is hoped that in the overall scope of work, that by using the national sources, the impact can be minimized.

Comment: The commenter would have administrative difficulties and incur increased health care costs if the task force rules were to be adopted. The commenter would need to reconsider the sourcing used in its Assistant Surgery Policy as they currently do not utilize the ACS eligible list nor do they permit reimbursement for assistant surgeon services with CMS indicator of 0.

Response: The standardized set of uniform payment rules and claim edits do not apply to government programs; they are only applicable in Colorado for private insurers. The task force recognizes that there may be coverage differences for assistant at surgery services based on its recommendations; however, we don't believe that this is a unique situation. There may be other instances where the private coverage varies from that of Medicare and needs to be handled differently for Medicare cross-over claims.

The task force is cognizant of the potential its work has on costs to the industry and considers this in its deliberations. That was the primary reason for eliminating the "sometimes" category that would have necessitated pending a claim for review. If the task force had chosen to make codes with a CMS indicator of 0 not eligible for assistant at surgery, claims that potentially were medically necessary could have been denied resulting in expensive re-work on the part of the provider and payer. Preliminary review of the sources available to the task force indicate that the number and frequency associated with the procedure codes that fall into this category are small. The task force spent a great deal of time in its deliberations, and this is an area that can be re-examined in the future if any of the stakeholders (professionals or payers) provides additional information or statistics that they feel prove a compelling argument for change.

**Bilateral Procedure
104.V01**

Comment: Overall the commenter supports the Task Force proposed rules to use the CMS NPFS Bilateral Indicators for determining which procedures are eligible for bilateral payment; however, we have concerns regarding restrictions on units for selected bilateral codes and restricting use of modifier 50 for indicator 3 codes.

Bilateral indicator 0 or 9 (Code is not eligible for bilateral adjustment):
Commenter concurs with the administrative guidance in the proposed rules for these codes.

Bilateral indicator 1 (Code is eligible for bilateral adjustment):

Administrative guidance from Task Force:

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.
Example: XXXXX 50

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

- 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.

Example: XXXXX 50

XXXXX 50 - subject to action

We currently require a bilateral eligible procedure to be reported on one line with a modifier 50 with one unit. However, for processing purposes, we split out the line on two separate lines with the provider's billed amount equally divided to allow for the multiple surgery adjustment to allow up to 150% for the bilateral eligible service.

This is consistent with CMS rules regarding indicator 1 codes: "If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules."

Response: The task force does not feel that the commenter's internal approach to processing bilateral procedures identified by CMS indicator 1 is in conflict with the proposed rule. The requirement that the procedure code be submitted on one line with one unit of service is the same as the proposed rule. The proposed rule also states that these procedure codes are eligible for the bilateral payment adjustment. It is not within the purview of the task force to direct how these adjustments will be administered by the payers. The second example under the administrative guidance is applicable if the provider submits the bilateral procedure that has a CMS indicator of 1 on two separate claim lines, and does not apply to the payer's internal processing requirements.

Comment: Please note that there are selected codes that are considered bilateral eligible that could potentially be reported with more than 1 unit. This is especially needed for procedures on the vertebrae. The use of appropriate anatomic modifiers or the use of modifier 59 should be allowed to accommodate for these special situations. Below is an example:

If the laminotomy is performed bilaterally, report code 63020 or 63030 with modifier 50 for the first interspace. If a laminotomy of a second interspace is performed bilaterally, use add-on codes to represent additional levels rather

than sides. In this instance, report code 63035 with modifier 50. If a laminotomy of additional interspaces (3 or more) is performed bilaterally, report code 63035 with modifiers 50 and 59 with the appropriate number of units.

It is recommended that the use of appropriate anatomic modifiers or the use of modifier 59 should be allowed to accommodate for these special situations requiring multiple units on a bilateral indicator 1 codes. This would decrease the administrative burden for providers and payers for handling bilateral eligible services which should be allowed with multiple units.

Response: The Rules Committee was asked to review these coding examples and is in agreement with the commenter, that in these specific situations it would be appropriate to allow the use of anatomic modifiers or modifier 59. The proposed rule will be revised accordingly and will incorporate examples similar to those noted above.

Comment: The commenter disagrees with the Task Force interpretation on the CMS NPFS Indicator 3. The Task Force is interpreting that CMS only allows these services to be reported with a modifier RT and LT on separate lines. Per CMS the indicator 3 is described as:

“The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for **each** side or (b) **100% of the fee schedule amount for each side**. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries”.

These procedures can be reported with a modifier 50 (or RT and LT) but per CMS should be allowed up to 200% of the fee schedule amount to pay for each side.

For processing purposes, the commenter:

- _accepts the billing of modifier RT and LT on separate lines for indicator 3 codes and allow up 100% for each side and
- _accepts the billing of modifier 50 on one line with 1 unit for indicator 3 codes. To allow 100% of each side, we split the provider’s charge on two lines to pay up to 200% for the bilateral procedure and to consider multiple procedure rules when they apply.

For the purposes of administrative simplification and alignment with CMS, the commenter supports the use of modifier 50 or the use of RT and LT on indicator 3 codes. Providers and payers should be allowed to report in either manner.

Response: The Rules Committee was asked to review the comments and make a recommendation. Another commenter also expressed concern with requiring

only the use of the RT and LT modifiers when the CMS indicator is 3. The task force is striving for standardization, however, if there are instances when it is more [just as] appropriate to use modifier 50 then the task force may need to reconsider its proposal. The bilateral procedure rule has numerous intricacies and the task force appreciates the commenter's in-depth review.

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

Activity	2013										2014										Deadline	Status as of 8-19-13					
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec				
RULES																											
<u>1st bundle</u> : Edit and Payment Rules committees work on the draft edit rule recipes for the first bundle of rules and submit to task force for approval.																										Early May	DONE
Task force reviews and approves first bundle of draft edit rule recipes.																										May 22	DONE
First bundle of draft edit rule recipes circulated for review and comment.																										May 31	DONE
Public comments due on 1st bundle																										July 15	DONE
Payment & Edit Committees review comments on 1st set of recipes and make recommendations for revisions.																										Early August	DONE
Task force finalizes and approves first bundle of recipes.																										August 27 mtg	DONE
<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	
Second bundle of draft recipes issued for 5-week**** public review and comment.																										August 29	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines. **** 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 8-19-13				
	April	MAY	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept			Oct	Nov	Dec	
Public comments due on 2 nd bundle.																						October 4		
Payment & Edit Committees review comments on 2 nd set of recipes and make recommendations for revisions.																							Early November	
After reviewing comments received on 2 nd bundle draft edit rule recipes, TF finalizes and approves 2 nd 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	
Task force reviews and approves draft 3 rd bundle of draft edit rule recipes.																							October 22 mtg	
3 rd bundle of draft recipes circulated 5-week public review and comment period. ****																							October 25	
Public comments due on 3 rd bundle																							December 2	
Payment & Edit Committees review comments on 3 rd set of recipes and make recommendations for revisions.																							Early January	
After reviewing comments on 3 rd bundle of draft recipes, task force finalizes and approves.																							January 2014 TF mtg	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines. **** 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 8-19-13		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec	
Update entire draft set with current codes. [Q: Who does this?] [2014]																								
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																								
<p>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:</p> <ul style="list-style-type: none"> o Who is responsible for establishing a central repository for accessing the rules and edits set and o Enabling electronic access--including downloading capability--to the rules and edits set 																						End of September		

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.
**** 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 8-19-13				
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept			Oct	Nov	Dec	
<p>DSR Committee submits data repository operations recommendations to the task force and task force reviews and approves recommendations concerning the implementation, updating, and dissemination of the standardized set of payment rules and claim edits, including:</p> <ul style="list-style-type: none"> o who is responsible for establishing a central repository for accessing the rules and edits set, and o enabling electronic access--including downloading capability--to the rules and edits set 																							Oct 22 mtg	
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

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.
**** 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 8-19-13			
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept			Oct	Nov	Dec
Data analytics contractor establishes system to accept & analyze edits. [Through 2014]																						Mid-March 2014	
Task force publishes notice of intent to solicit edits for inclusion in the data analytics model and specifies form in which edits should be submitted to the data analytics contractor. Notice is sent to interested parties list. [2014]																						Mid-March 2014	
Staff work on and 2nd task force progress report submitted to Health Care Policy & Financing and the General Assembly																						December 31, 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	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.

**** 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 8-19-13			
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept			Oct	Nov	Dec
Proposed standardized edit set published for review & for interested parties to run their claims through the proposed set. Task force also solicits comments on its recommendations for DSR operations regarding who is responsible for establishing a central repository for accessing the rules & edits set & enabling electronic access—including downloading capability—to the rules & edits set.																						End of July 2014	
Comments due on proposed standardized edit set and DSR operations. Public hearing.																						Mid-Sept 2014	
TASK FORCE FINALIZES EDIT SET																							
Committees review public comments on proposed edit set and DSR operations based and develop recommendations for consideration by full task force.																						End of October 2014	
Task force reviews & approves final standardized edit set & DSR operations recommendations.																						November 2014 mtg	
Task Force submits final report to legislature & executive director of Department Health Care Policy & Financing that: <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: 																					December 31, 2014		

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines. **** 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 8-19-13			
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov**	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept			Oct	Nov	Dec
<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 commercial health plan payers to implement the standardized set. 																							
FINAL REPORT																							
Staff draft final report to legislature and HCPF.																						Early November 2014	
Task force reviews 1 st draft of final report.																						Nov ember 2014 TF mtg	
Task force approves final report.																						December 2014 TF mtg	
Final report submitted to legislature and HCPF.																						Dec 31, 2014	

* In-person task force meeting. ** May need 2-day November meeting to make deadlines. *** May need to move these deadlines to November to meet other deadlines.

**** 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. ** **May need 2-day November meeting to make deadlines.** *** May need to move these deadlines to November to meet other deadlines.

**** 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.

Recipe Development Tracking Sheet

PC = Public Comment

PRC = Payment Rules Committee

TF = Task Force

KEY

X = Completed

I = Incomplete

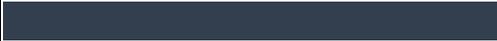
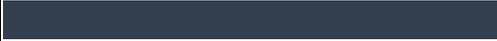
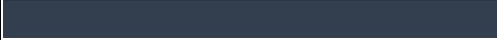
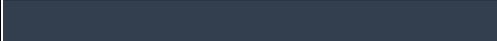
O = In Progress

Rule	Bundle	Definition From EC	Rationale	HCPS/CPT Modifiers From EC	Query Tables Drafted	Rule Logic Drafted by PRC	Administrative Guidance Drafted By PRC	Specialty Outreach	TF Approval of Rule for PC	TF Response to PC	TF Consensus on Finalized Rule
J-Asst. Surgery	1	X	X	X	X	X	X	X	X	X	I
K-Co-surgery	1	X	X	X	X	X	X	X	X	X	I
L-Team Surgery	1	X	X	X	X	X	X	X	X	X	I
N-Bilateral Procedures	1	X	X	X	X	X	X	X	X	X	I
A-Unbundle (PTP)	2	X	X	X	I	X	X	X	O	I	I
B-Mutually Exclusive	2	X	X	X	I	X	X	X	O	I	I
C-Multiple Procedure Reduction	2	X	X	X	I	X	X	X	O	I	I
D-Age	2	X	X	X	I	X	X	X	X	I	I
E-Gender	2	X	X	X	I	X	X	X	X	I	I
F-Maximum Frequency Per Day	2	X	X	X	I	X	X	X	X	I	I
G-Global Surgery Days	2	X	X	X	I	X	X	X	X	I	I
H-Place of Service	2	X	X	X	I	X	X	X	O	I	I
M- Total/Prof./ Tech. Split	2	X	X	X	I	X	X	X	O	I	I
O-Anesthesia Services	2	X	X	X	I	X	X	X	O	I	I

Add-ons	2	X	X	X	I	X	X	X	X	I	I
Global Maternity	2	X	X	X	I	X	X	X	O	I	I
P- Modifiers effect on edits:	3	X	X	X	I	I	I	I	I	I	I
Max. Frequency- Span of Days	3	X	X	X	I	I	I	I	I	I	I
New Patient	3	X	X	X	I	X	I	I	O	I	I
Bundled Service (Status B)	3	X	X	X	I	I	I	I	O	I	I
Multiple Endoscopy	3	X	X	X	I	O	I	O	I	I	I
Multiple E&M's Same Day	3	X	X	X	I	I	I	I	I	I	I
Rebundling	3	X	X	X	I	I	I	I	I	I	I
Same day med visit & med procedure	3	X	X	X	I	O	I	I	I	I	I
Multiple radiology	N/A	X	x	x	N/A	N/A	N/A	N/A	N/A	OUT OF SCOPE	
Multiple phys. Therapy	N/A	X	x	x	N/A	N/A	N/A	N/A	N/A	OUT OF SCOPE	

NOTE: The **Progress 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		90%	9	0	0	9
K-Co-surgery		90%	9	0	0	9
L-Team Surgery		90%	9	0	0	9
N-Bilateral Procedures		90%	9	0	0	9
A-Unbundle (PTP)		65%	6	1	0.5	6.5
B-Mutually Exclusive		65%	6	1	0.5	6.5
C-Multiple Procedure Reduction		65%	6	1	0.5	6.5
D-Age		70%	7	0	0	7
E-Gender		70%	7	0	0	7
F-Maximum Frequency Per Day		70%	7	0	0	7
G-Global Surgery Days		70%	7	0	0	7
H-Place of Service		65%	6	1	0.5	6.5
M- Total/Prof./ Tech. Split		65%	6	1	0.5	6.5
O-Anesthesia Services		65%	6	1	0.5	6.5

Add-ons		70%	7	0	0	7
Global Maternity		65%	6	1	0.5	6.5
P- Modifiers effect on edits:		30%	3	0	0	3
Max. Frequency- Span of Days		30%	3	0	0	3
New Patient		45%	4	1	0.5	4.5
Bundled Service (Status B)		35%	3	1	0.5	3.5
Multiple Endoscopy		40%	3	2	1	4
Multiple E&M's Same Day		30%	3	0	0	3
Rebundling		30%	3	0	0	3
Same day med visit & med procedure		35%	3	1	0.5	3.5
Multiple radiology		100%	7	0	0	7
Multiple phys. Therapy		100%	7	0	0	7

Total Phases of Rule Development	10
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[DRAFT] Categorical Summary of Task Force Action Items

Updated August 19, 2013

Category	Date	Action Item Description	Comments	Committee	Status	Status Date
Data Analytics	July, 2013	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. <u>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.</u>	DSR Committee	Ongoing	N/A
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. <u>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).</u>	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).				
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	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.	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	July, 2013	Eight draft edit rules of second bundle to be submitted to the Task Force for approval.	<i>Add on; Age; Gender; Anesthesia; Mutually Exclusive; Global Surgery; Place of Service; Maximum Frequency Per Day; TCPC</i>	Payment Rules Committee	Ongoing	N/A
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.	Executive Committee	Completed	6/6/2013
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	Multiple	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	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.		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.	N/A	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.	N/A	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

QUESTIONS FROM MCKESSON REGARDING RELEASE OF EDITS TO BE USED EXCLUSIVELY BY THE TASK FORCE

Requested parameters that need to be defined:

- Specification of rules to be released, with timetables
- Specification of edits, by source, to be released, starting with CMS and, perhaps, CPT. A better understanding of the edit review and approval process may be important before we get to the release of specialty society content, based on consideration of what is and is not intellectual property of each specialty.
- 'File Format' and media for release

McKesson Leadership would also like to better understand:

- The business model for the Common Edit Set, including maintenance of existing and updated edits
- The sustaining nature of the review process, before and during 'production' phases
- Data security safeguards for the edits to be shared, prior to the 'publication' date
- An understanding of the appeals process for edits that are rejected

Without agreeing [yet] on the total scope of edits to be released, the Leadership Team agreed that the following content, from McKesson, may be shareable, pending clarification of the questions/parameters above:

- Rules/edits, sourced to CMS [beyond publicly available edits like NCCI or MUEs; this might include edits based on the Medicare National Physician Fee Schedule, the NCCI Policy Manual (printed annually in Oct), or CMS Payment Transmittals]
- CPT-based edits
- Specialty Society edits (TBD)
- Edit Rationale statements (TBD)

**COLORADO HB10_1332 MEDICAL CLEAN CLAIMS
TRANSPARENCY AND UNIFORMITY ACT**



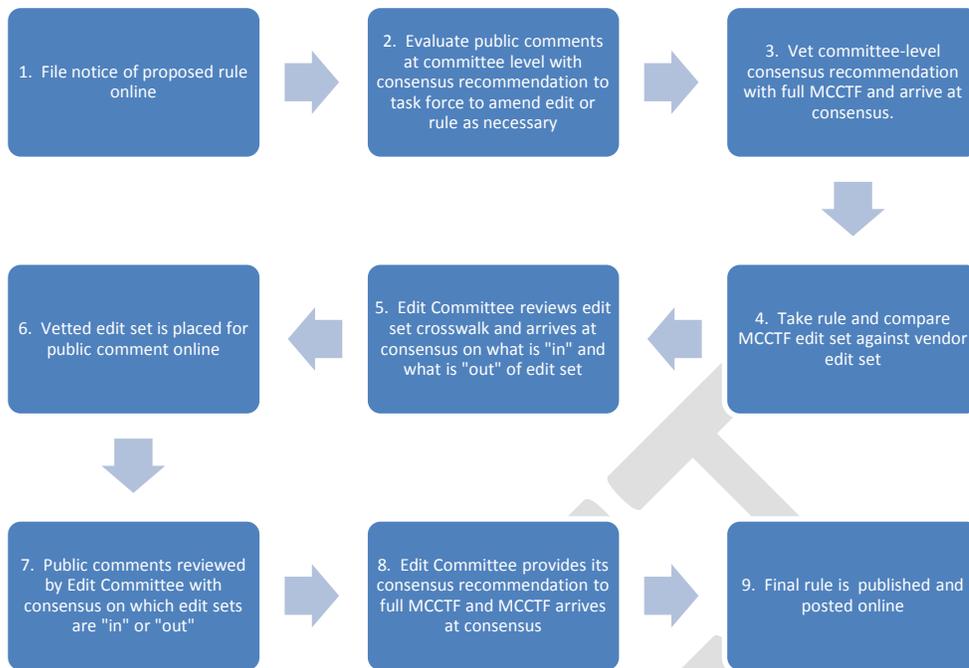
**MCCTF Governance & Public Comment Process
Draft (7/30/13)**

On March 21, 2013, MCCTF developed a “Notice of Proposed Rule Process.” This notice has been further refined below to clarify to include governance and decision making processes for the data analytics and data sustaining repository phase of work of the MCCTF (which were not in the 3/21/13 notice).

There are currently four committees that are undertaking the work of the taskforce on behalf of the full MCCTF. They are tasked with the following:

- Edit Committee: To examine the edits and associated rules, concepts and methodologies contained in national sources and national source guidelines; assessing their applicability to private health plan claims processing; and making recommendations to the task force on the claims edits to be included in the standardized set.
- Rules Committee: To develop and make recommendations to the task force concerning coding scenarios that is unique and eligible for differentiated payment.
- External Engagement Committee: To 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 ode 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.
- DSR Committee: To recommend to the task force how the standardized set will be maintained, updated and sustained.

All of these committees will “touch” the process described below at various points. The description below describes the process for and oversight of public comments. We believe that this provides ample opportunity for public comment and for MCCTF review and vetting. Below is a high level summary of the process with greater detail in the following section:



1. File notice of the proposed rule online:
 - The notice will be posted on the MCCTF website and electronic notification will be sent to the interested parties alerting them.
 - Initially identify “interested” parties by utilizing the communication networks of the Colorado Association of Health Plans, Colorado Medical Society, American Medical Association, and vendor organizations. Additionally notification will be sent to Health & Human Services, the Colorado Division of Insurance, Colorado Division of Workers Compensation, and Colorado Health Care Policy and Finance. Need to have an official method of notifying Payers Division of Insurance, Insurance commissioner (we have the big players on the committee but ..) in the list.
 - We will add a “sign up” place on the MCCTF website for interested parties to receive direct notification of future proposed rules.

2. Notification should include enough information for the public to understand the proposed rule, its potential impact, and the decision making process the MCCTF used to arrive at the recommendation. It should include the “recipe”:
 - Edit/payment rule name and definition;
 - Associated modifiers;
 - Rule logic (including a payment rule hierarchy where there are multiple sources and how to handle termed edits);
 - Rationale for the rule;
 - Administrative guidelines for handling special billing situations;
 - Specialty outreach;
 - Initial Edit set based on recipe; and,
 - A summary of the decision.

3. Provide information on how to submit comments and by when:

- Take comments only by electronic submission to the MCCTF e-mail address, provide an automatic acknowledgement receipt with an indication of the next steps/timeframe.*
- Identify what format the comments should be in and the type of rationale/information necessary for a complete evaluation. *The Co-chairs/Task Force needs to determine what information will be required for us to consider the comment actionable. AMA is to provide the format NCCI uses regarding supporting rationale, this may provide some guidance. Note: The format will need to be somewhat rule specific and can be developed through a formula based on each initial edit set. I can work with you and Connor to set this up.*
- Commenter should provide a contact person in case more information is needed. *For the initial review process a 30-day comment period should be sufficient, knowing there will be another opportunity for input before the final implementation date.*

4. Evaluation of comments:

- *Initial process review by Staff, which will include a quick review of the comment for required format and supporting information within 7 days of receipt.*
- Committee co-chairs evaluate public comment cleared by staff and send to committee members for review within 14 days. *Committee members will be notified and asked to review and post their comments within 14 days*
- Committee co-chairs present member input and present to their own committee members for consensus recommendation to the whole Task Force.
- The MCCTF co-chairs will do an initial evaluation of the comments, they will include their evaluations as part of a regularly scheduled committee meeting. *To facilitate the process, the comments will be posted to the Task Force members' site for review.*
- Task Force reaches consensus on committee recommendations regarding comments, including rationale for decision. *The Task Force will complete its review of all comments with consensus recommendations by 60 days after the close of the comment period.*

5. Final rules compared to edit list:

- Vendor/payer/provider (VPP) who has its own rule logic takes the MCCTF final rule and compares it/conducts an internal crosswalk against their edit list.
- Vendor/payer/provider provides MCCTF with recommendations on which edits are “in” and which edits are “out” based on this comparison. VPP also provides rationale for their recommendations. It is anticipated that comments on edits will be provided in required format similar to process required for on-going edit evaluation.
- MCCTF Edit Committee reviews VPP recommendations during its bi-monthly meetings and arrives at consensus recommendations on what is “in” and what is “out” based on its review and analysis of the VPP recommendations. If consensus is not achievable within Edit Committee on any edit and edit committee has agreed that source information is valid, edit will be sent for review by full task force with noted lack of consensus.
- Edit Committee posts its vetted edit list for MCCTF full task force review and comment relative to any non-consensus edits. All other edits for which consensus has been obtained will be added to edit set to be posted to website for public comment. The website will have the capability to place vetted edit list for public comment with data files and a section for public comment. *Commenters will have 30 days to review the edit list.*
- Edit Committee will review public comments at the end of the public comment period and provide responses to commenters and its consensus recommendation to the Task Force. Following same process used for VPP comment review.
- Task Force reaches consensus based on committee recommendations regarding comments, including rationale for decision. *The Task Force will complete its review of all comments with consensus recommendations by 60 days after the close of the comment period.*

- *IF Full task force consensus for an edit/rule change cannot be obtained. Rule /Edit will be subject to panel arbitration as follows:*
 - *Arbitration panel (AP) will be elected consisting of x vendors, x payers, x providers and x others.*
 - *Panel will review comments from public, committees and task force.*
 - *Based on review a vote of the AP will be conducted. The AP can vote to include the edit or rule change, reject the edit or rule change or refer the edit or rule change back to a committee for further evaluation.*

6. Notification of proposed rule findings and final rule:

- *As the federal register and other government agencies do, the MCCTF would provide a summary of the comments it has received and their deliberations/decisions for each.*
- *This notification would be posted on the same website and notification would be sent out to the interested parties.*
- *The notification would provide the final determination.*
- *The notification would include the “effective” date or implementation date and specific statutory requirements. Notification of the rule findings and finalization will be completed within 180 days of publication.*

7. Sustain the final rule and edit sets on an ongoing basis:

- *The Data Sustaining Repository is created and managed to facilitate the transfer of electronic files for final edit sets and rules and accommodate quarterly updates on an ongoing basis.*
- *It is anticipated that the MCCTF will recommend an ongoing governance process based on findings of development of the final rule set as directed by Statute.*