

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

**Two-day meeting: Tuesday, January 21, 2014 (12:00 p.m. – 6:00 p.m. MDT) and  
Wednesday, January 22, 2014 (7:30 a.m. – 2:00 p.m. MDT)**

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

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

**Web Login (day one only): <https://cc.readytalk.com/r/9g5ct1iylchp&eom>**

**Agenda**

**Day 1— Tuesday, January 21, 2014**

**12:00 PM Welcome & Introductions**

**12:00—12:25 PM Housekeeping**

- Approve December 2013 meeting minutes (**Attachment A**)
- Review agenda
- Meeting procedures
- Thanks to Kathy McCreary and University of Colorado Health for catering
- Welcome Terrance Cunningham & Anita Shabazz
- 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—12:30 PM Specialty Society — Alice Bynum-Gardner (Presented by Terrance Cunningham)**

**12:30—1:30 PM Edit Committee—Beth Wright and Mark Painter**

- New Meeting Schedule 2014 (**Attachment B**)
- Draft Query Templates:
- Max. Frequency- Span of Days (**Attachment C**)
- ~~Same day med visit & med procedure (**Attachment D**)~~ – **Removed from packet**
- Multiple Endoscopy (**Attachment E**)
- Multiple E&M's Same Day (**Attachment F**)
- Bundled Service (Status B) (**Attachment G**)
- Rebundling (**Attachment H**)

**1:30—3:00 PM**

**Payment Rules Committee — Nancy Steinke/. . .?**

Final Consensus on Revised Rules:

- Highlighted Responses (**Attachment I**)
- Global Days/Package (**Attachment J**)
- Multiple Endoscopy (**Attachment K**)
- Maximum Frequency > 1 Day (**Attachment L**)
- Modifier Effect on Edits-P (**Attachment M**)

Other Items:

- Frequency Rule (**Attachment sent 1/20 via email**)
- New meeting schedule for 2014
- Co-chair for Rules Committee

**3:00—4:00 PM**

**Task Force Response to Public Comments – Third Bundle**

- MCCTF Response to Public Comments (**Attachment N**)

**– Libations –**

**4:00—5:00 PM**

**Task Force Response to Public Comments – Fourth Bundle**

- MCCTF Response to Public Comments (**Attachment O - to be distributed at meeting**)

**5:50—6:00 PM**

**Public Comment**

**6:00 PM**

**Adjourn for the Day**

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

**Wednesday, January 22, 2014 (7:30 a.m. – 2:00 p.m. MDT)**

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

**Web Login (day two only): <https://cc.readytalk.com/r/54ruuxiszawd&eom>**

**Agenda**

**Day 2— Wednesday, January 22, 2014**

- 7:30—8:00 AM**      **Continental Breakfast**
- Roll Call**
- 8:00—9:00 AM**      **Program Management and Finance – Barry Keene/Vatsala Pathy**
- Review Updated Workplan (**Attachment P**)
  - Recipe Tracking Sheet (**Attachment Q**)
  - Funding Task Force Operations through 2014
    - Fiscal Contributions (**Attachment R**)
  - Glossary of Terms (**Attachment S**)
- 9:00—10:45 AM**      **Data Sustaining Repository – Mark Painter/Barry Keene**
- Consensus item:
- **RFP Evaluation Committee Recommendations on Data Analytics Vendor**
    - **Supplementary attachment sent 1/20 via email**
- Initial Edit Library
- McKesson & CPT© Edits
- 2014 Legislation/2015 Planning
- DOI Update
  - 2014 Bill
  - Long-Term Funding Options (**Attachment T**)
- 10:45—11:00 AM**      **Break**
- 11:00—12:00 PM**      **DSR Discussion Continued**
- 12:15—12:45 PM**      **Lunch**
- 12:45—1:45 PM**      **Other Business**
- Out of Scope Edits (**Attachment U**)
- 1:45—2:00 PM**      **Public Comment**
- 2:00 PM**                **ADJOURNMENT**

**FULL TASK FORCE MEETING SCHEDULE 2014**

<b>DATE(S)</b>	<b>TIME (MDT)</b>	<b>MEETING TYPE</b>
February 26	<b>Wed:</b> 12:00 pm – 2:00 pm	Monthly Conference Call
March 26	<b>Wed:</b> 12:00 pm – 2:00 pm	Monthly Conference Call
<b>April 22-23</b>	<b>Apr 22:</b> 12:00 pm – 6:00 pm; <b>Apr 23:</b> 7:30 am – 2:00 pm	Quarterly In-Person Meeting

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

## Meeting Minutes

December 18, 2013, 12:00–2:00 PM, MDT

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

Conference ID: ID 8586318#

**Attendees:**

- Alice Bynum-Gardner
- Amy Hodges
- Barry Keene
- Beth Wright
- Douglas Moeller, MD
- James Borgstede
- Jill Roberson
- Kathy McCreary
- Kim Davis
- Lisa Lipinski
- Marianne Finke
- Marilyn Rissmiller
- Mark Painter
- Ryshell Schrader
- Beth Kujawski
- Dee Cole
- Nancy Steinke
- Terrance Cunningham

**Staff :**

- Connor Holzkamp
- Vatsala Pathy

**Public:**

- David McKenzie (ASAP)
- Diane Hayek (ACR)
- Diane Hammond (UHG)
- Julie Painter (STS)
- Lisa Lipinski (AMA)
- Todd Klemp (CAP)
- Stephanie Stinchcomb (AUA)

**Meeting Objective (s):**

See Agenda

**Key:**

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

**December 18, 2013****WELCOMING REMARKS & ROLL CALL:****Housekeeping Items:**

- Minutes from November were accepted with no changes.
- It was noted that the next regularly scheduled MCCTF meeting is a two-day, face-to-face meeting on January 21-22, 2014.
- It was announced that there were two new members of the Task Force in attendance. The following people have been officially seated per the application process/approval from the director of HCPF:
  - Alice Bynum-Gardner, the American Medical Association
  - Terrance Cunningham, the American Medical Association (Alternate for Alice)

### **EDIT COMMITTEE—Beth Wright and Mark Painter**

- The Edit Committee reported that it will be working to finish the query templates in January, and will begin working on the edit set for the data analytics contractor .

### **SPECIALTY SOCIETY OUTREACH COMMITTEE – Alice Bynum-Gardner:**

- Newly appointed Alice Bynum-Gardner (AMA) agreed to maintain the AMA’s role in leading the Specialty Society Committee for 2014.
- The Specialty Society continues its charge to act as the “liaison between the TF and the AMA’s Federation of Medicine, which includes 122 national specialty societies and 50 state medical societies in order to assess if public code edit and payment policy libraries meet the needs of national medical societies and state medical associations by reaching out and obtaining feedback from these groups.”

### **PAYMENT RULES COMMITTEE— Nancy Steinke/Open**

- The Rules Committee report was led by Nancy Steinke (RMHP), the new co-chair of the committee.
  - The former co-chair, Lisa Lipinski (AMA), will be taking up a different position at the AMA and will not be able to continue her work as a TFM. Lisa was recognized for her dedicated work in leading the Rules Committee through an incredibly productive year. Task Force greatly appreciates both Lisa and Nancy for their involvement with the committee and look forward to another productive year in 2014.
- The committee confirmed that the last of the draft rules were sent out for public comment in early December.
  - The deadline for public comment on this last “bundle” of rules is January 6, 2014.

### **DSR COMMITTEE – Mark Painter and Barry Keene**

#### **RFP Update:**

- The committee reported that the RFP was distributed by the TF on 11/13/13. The RFP can also be downloaded using the BIDS system on the HCPF website.
  - It was reported that the deadline for bids on the RFP was moved from 12/17/13 to 12/23/13.
    - ✓ It was noted that the committee anticipates at least two responses.
- The DSR Committee had pulled together an evaluation team to score the responses to the RFP. This group includes:
  - Alicia Goroski – Representative from Center for Improving Value in Health Care (CIVHC);
  - Beth Wright – TFM, Anthem Blue Cross and Blue Shield;
  - Barry Keene – MCCTF Co-Chair, KEENE Research & Development;
  - Dee Cole – TFM, HCPF;
  - Kathy McCreary – TFM, University of Colorado Hospital;
  - Marianne Finke – TFM, Humana;
  - Mark Painter – CC of DSR Committee, Relative Value Studies, Inc.,
  - Terrance Williams – American Medical Association
- The RFP Evaluation Committee will be meeting on 12/23 to finalize the scoring instrument that will be used to evaluate the responses. The committee will look to bring recommendations to Task Force in January in order to get approval on a data analytics contractor to begin constructing the means for maintaining the final edit set by March.

#### **Long-Term Funding Options**

- Barry Keene reported that he (along with several other TFM) met with Senator Aguilar, as well as representatives from the Attorney General’s office, DOI, HCPF and the insurance industry to present the long-term funding options and address holes in the legislation.
  - Barry noted that the reaction from the DOI representatives was positive.
- The Committee will continue to flesh out the long-term funding options to sustain the work of the Task Force.

### **PROJECT MANAGEMENT/FINANCE COMMITTEE – Vatsala Pathy/Barry Keene**

- The work plan was presented and it was noted that at the January meeting the third and fourth bundle of rules will be up for final approval and all draft rule recipes will be complete.

- It was noted that the staff is working with the CC's to secure funding for the 2014 time period.
  - The Robert Wood Johnson Foundation reviewed the proposal from the Task Force and did not find it to align with current funding priorities
  - The Committee reported that the TF will need stakeholder contributions in order to fund its work through 2014.

#### **OTHER BUSINESS**

- Diane Hammond (UHG) reported that United is working to find a replacement for Helen Campbell as UHG's representative on the Task Force.
- The co-chairs are scheduled to meet on 12/20/13 to review the Public Comments received on the third bundle of rules. The Task Force will look to post a response to these comments in early January.

#### **PUBLIC COMMENT:**

- Stephanie Stinchcomb from the AUA expressed her support and appreciation for the progress the Task Force has made and thanked everyone for the opportunity to participate in such an innovative and important project.

**The meeting was adjourned at approximately 12:55 PM MDT**

DRAFT

## Edit Committee Meeting Schedule Through 2014

*\* Note: This schedule is subject to change; meetings may be added/removed as necessary.*

<b>Date</b>	<b>Time (MST)</b>	<b>Call-in Information</b>
2/12/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
2/26/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
3/12/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
3/26/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
4/9/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
4/23/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
5/14/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
5/28/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
6/11/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
6/25/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
7/9/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
7/23/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
8/13/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
8/27/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
9/10/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
9/24/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
10/8/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
10/22/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
11/12/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
11/26/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
12/10/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186
12/24/2014	3:00 - 4:00 PM	<b>Call in number:</b> (866) 340-8725 <b>Code:</b> 203 654 3186



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

### Edit/Payment Rule Query

<b>Topic</b>	<b>Maximum Frequency &gt; 1 Day</b>
<b>Definition</b>	This type of edit will identify incorrect billing when the CPT <sup>®1</sup> / Health Care Common Procedure Coding System (HCPCS) descriptor of the service/procedure code, or the related parenthetical coding guidelines imply restrictions on the number of times the service/procedure can be provided over a specified span of days.
<b>Associated CPT<sup>®</sup> and HCPCS<sup>2</sup> modifiers (or codes)</b>	There are no modifiers associated with this rule.
<b>Query logic</b>	<ol style="list-style-type: none"> <li>1) No public source.</li> <li>2) Use vendor submissions</li> <li>3) File includes the code, description, frequency restriction (unit plus time span – i.e. 3 in 30 days), effective date, end date, source, comments</li> </ol>
<b>Rationale</b>	Applying based on Task Force consensus on maximum frequency > 1 day recommendation. There are no code exceptions at this time.
<b>DATE</b>	<b>January 15, 2014</b>

<sup>1</sup> Current Procedural Terminology (CPT<sup>®</sup>), Fourth Edition. 2013. Copyright 2013. All rights reserved

<sup>2</sup> Copyright 2013 American Medical Association. All rights reserved.



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

### Edit/Payment Rule Query

<b>Topic</b>	<b>Multiple Endoscopy Reduction</b>
<b>Definition</b>	This type of edit identifies when two or more endoscopic procedures within the same family are performed by the same physician or other qualified healthcare provider for the same patient for the same surgical/procedure session, subsequent procedures within the same family may be subject to a reduction.
<b>Associated CPT®<sup>1</sup> and HCPCS<sup>2</sup> modifiers (or codes)</b>	<p>-51 Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., 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). <b>Note:</b> This modifier should not be appended to designated “add-on” codes (see Appendix D in the CPT® code book).</p> <p>-59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify 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. <b>Note:</b> 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.</p> <p>There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.</p>
<b>Query logic</b>	<ol style="list-style-type: none"> <li>1) Use the CMS MPFS file – column labeled MULT PROC – to identify the codes with an indicator of ‘3’.</li> <li>2) Compare the CMS file to the vendor submission to identify differences.</li> <li>3) File should have a column for code, description, Mult Endo - Y or N?, base code, effective date, end date, source, comments</li> </ol>
<b>Rationale</b>	Applying based on Task Force consensus on multiple endoscopy reduction recommendation. There are no code exceptions at this time.
<b>DATE</b>	<b>January 15, 2014</b>

<sup>1</sup> Copyright 2013 American Medical Association. All rights reserved.



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

### Edit/Payment Rule Query

<b>Topic</b>	<b>Multiple E/Ms on the Same Day</b>
<b>Definition</b>	<p>This edit identifies when multiple E/M services are billed on the same day by the same provider. Except when the criteria noted below are met and the appropriate modifier is appended, only one E/M may be eligible.</p> <p>Note: Additional correct coding edits for reporting E/M services exist. This rule is intended to address reporting multiple E/M services for the same date of service by the same provider.</p>
<b>Associated CPT®<sup>1</sup> and HCPCS<sup>2</sup> modifiers (or codes)</b>	<p><b>-25</b> Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.</p> <p>There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.</p>
<b>Query logic</b>	<p>There is no public source available to build this rule. The rule is basically a billing guideline for billing multiple E&amp;M services.</p> <p>1) Vendors could submit code pair combinations (columns with paid code &amp; description, denied code &amp; description, effective and end dates, modifier override capability indicate Y or N, source, comments)</p>
<b>Rationale</b>	Applying based on Task Force consensus on multiple E/Ms on the same day recommendation. There are no code exceptions at this time.
<b>DATE</b>	<b>January 15, 2014</b>

<sup>1</sup> Copyright 2013 American Medical Association. All rights reserved.



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

**Edit/Payment Rule Query**

<b>Topic</b>	<b>Bundled</b>
<b>Definition</b>	This edit identifies when certain services and supplies are considered part of the overall care and should not be billed separately.
<b>Associated CPT®<sup>1</sup> and HCPCS<sup>2</sup> modifiers (or codes)</b>	There are no CPT® or Healthcare Common Procedure Coding System (HCPCS) modifiers that apply.
<b>Query logic</b>	<ol style="list-style-type: none"><li>1. Use CMS MPFS file column labeled Status code to pull codes listed with a status indicator of 'P' or 'T'.</li><li>2. Compare CMS codes to vendor submissions for bundled services.</li><li>3. List should include code, description, effective date, end date, status code from CMS, source, comments.</li></ol>
<b>Rationale</b>	Applying based on Task Force consensus on Bundled recommendation. There are no code exceptions at this time.
<b>DATE</b>	<b>January 15, 2014</b>

<sup>1</sup> <sup>1</sup> Copyright 2013 American Medical Association. All rights reserved.



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

### Edit/Payment Rule Query

<b>Topic</b>	<b>Laboratory Rebundling</b>
<b>Definition</b>	<p>This edit identifies incorrect billing when components of a comprehensive multiple component blood test (i.e., organ or disease-oriented panel) are reported separately. If all components are billed separately, they will be combined into the appropriate single comprehensive code.</p> <p>The task force recognizes that public and private payers commonly have a reimbursement maximum in place to limit the amount paid when individual components of a panel (but not all components) are billed separately. This type of payment edit is out of scope.</p>
<b>Associated CPT®<sup>1</sup> and HCPCS<sup>2</sup> modifiers (or codes)</b>	<p>-91 Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. <b>Note:</b> This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.</p> <p>There may be appropriate situations where multiple modifiers apply, however they are not covered in this rule.</p>
<b>Query logic</b>	<ol style="list-style-type: none"> <li>1) No public source available - create an excel spreadsheet from CPT PDF file with paid panel code and the individual components</li> <li>2) Use Vendor submission to compare to CPT file</li> <li>3) File should include the paid code and the individual components of the paid code, source, comments, effective and end date.</li> </ol>
	<p>Applying based on Task Force consensus on laboratory rebundling recommendation.</p> <p>CPT® codes that were exceptions to the CMS policy were identified and included in the recommendation.</p>
<b>DATE</b>	<b>January 15, 2014</b>

<sup>1</sup> Copyright 2013 American Medical Association. All rights reserved.



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

Response to Public Comments  
December 4, 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 a report to the General Assembly and Department of Health Care Policy & Financing with 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®)<sup>1</sup> 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

Comment: The American Urological Association (AUA) submitted a letter in support of the task force's activities, and agrees with the third bundle of payment rules including Global Procedure Days, Laboratory Rebundling, Maximum Frequency Greater Than One Day and Multiple Endoscopy.

Response: The task force appreciates the AUA's support and looks forward to their continued participation and input.

Comment: The American Osteopathic Association (AOA) submitted a letter in support of the third bundle of payment rules including Global Procedure Days, Laboratory Rebundling, Maximum Frequency Greater Than One Day and Multiple Endoscopy. Additionally, the AOA recommended inclusion of a reference to the National Correct Coding Initiative (NCCI) Edits found on the Centers for Medicare and Medicaid Services (CMS) website. As this information has been helpful to physicians when addressing billing challenges or denials they felt the inclusion of the NCCI reference would strengthen the guidance provided by the task force.

<sup>1</sup> Copyright 2013 American Medical Association. All Rights Reserved.

Response: The task force appreciates the AOA's support. The NCCI is one of the nationally published sources the task force has relied on during the development of payment rules. We agree that it should be referenced and will include it as part of the Rationale section of applicable rules when they are published for final comment.

As noted in the Procedure to Procedure rule that was previously published for comment, as a starting point, the current year National Correct Coding Initiative (NCCI) "Column One/Column Two Correct Coding Edit Table" is being considered. The actual code pairs will be analyzed and the final Colorado set of standardized edits may or may not include all of them.

**Global Procedure  
Days/Package  
301.V01 11/4/13**

Comment: One national insurance carrier submitted comments in support of the rule with modifications.

The carrier's Global Days Policy concurs with the Colorado Draft Policy that the codes assigned a global value of ZZZ within the *National Physician Fee Schedule (NPFS) Relative Value File (RVF)*, are not subject to the global surgery days/package concept and does not apply the global surgery rules to those codes.

However, to be comprehensive on what services are subject to the global day concept, the carrier's policy assigns values to codes assigned a global value of MMM within the *NPFS RVF*. Codes which represent delivery plus postpartum services are assigned a 42-day postoperative period. For these 42-day codes, Evaluation and Management services on the day of the delivery and during the 42-day post-delivery period are not separately reimbursable except as noted within this policy. The carrier follows ACOG guidelines, considering a six week postpartum period (42 days) after delivery and felt their policy is more lenient than the Colorado rule and we would recommend that the ACOG guidelines referenced below are followed.

Response: The task force would refer the commenter to the previously published rule on Global Maternity 211 V.01 9/04/13, which does address the number of follow up days assigned to the typical postpartum care, as well as the components, included in the package. The American Congress of Obstetricians and Gynecologists (ACOG) took part in the task force's deliberations during the development of this rule. ACOG indicated that the typical postpartum period is 6 to 8 weeks but they do not endorse a specific number of days. They understood the task force's need to define the follow up period in terms of a specific number of days and felt that the 45 day follow up period the task force decided upon would cover most cases.

Comment: The insurance carrier submitted the following comment on the procedure codes with an indicator of YYY: The Colorado draft policy states that the global procedure rule sometimes applies to procedures codes listed in the column labeled Global Days of the MPFS with an indicator of YYY. According to CMS, it is up to the CMS carrier to determine whether the global concept applies and to establish the postoperative period, if appropriate, for codes assigned an indicator of YYY. The carrier supports allowing payer discretion for determining the global day period for codes assigned an indicator of YYY.

Response: As drafted in the rule, *sometimes* gives carriers the discretion to determine whether or not follow up days should be applied to a procedure code with an indicator of YYY, and if so what number of days would be appropriate.

Comment: Carrier utilizes a separate Split Surgical Package Reimbursement Policy to address modifiers 54, 55 and 56 and identifies the percentage of reimbursement for each modifier. However, the rule should address that the global package concept still applies to procedures reported with a global day period and reported with these modifiers.

Response: The task force agrees that a note should be added to the Administrative Guidance section of the rule indicating that the use of modifiers 54, 55 and 56 does not preclude the procedure code(s) from the application of the global procedure days/package concept.

Comment: Carrier recommends removing reference to modifier 76 (Repeat Procedure or Service by Same Physician) from the modifier section of the proposed Global Procedure Days/Package Rule. Use of modifier 76 has no relevance in determining whether the global surgery package does or does not apply. The carrier's policy is aligned with the **Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners** which does not include modifier 76 within the Global Surgery guidelines.

Response: The task force agrees that procedure codes reported with a modifier 76 would not be included as part of the global surgery package related to the prior procedure. Under Administrative guidance on page 4, the draft indicates that in certain circumstances it is appropriate to report additional services provided during the global period. The list of circumstances includes a reference to modifier 76, this information will remain. However, the task force understands that modifier 76 is considered primarily an informational modifier, and it will be removed from section on Associated CPT and HCPCS modifiers on the first page. The information at the end of this section will be revised as follows: "There may be appropriate situations where multiple modifiers or modifiers not listed apply, however they are not covered in this document."

The rule concerning Modifier Effect on Edits (P) will be revised to indicate that 76 is used as an informational modifier does not result in a payment adjustment. Modifier 76 appended to a code alerts the payer that the claim is not a duplicate.

Comment: Carrier recommends that the Colorado Global Rule indicates a new global period will **not** be assigned for a procedure meeting the requirements for reporting modifier 78, (Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period) and multiple procedure reductions will not be applied. The current draft rule is silent on this. Our recommendation is based on the Medicare Claims Processing Manual.

Response: The task force agrees that a note should be added to the Administrative Guidance section of the rule indicating that a new global period will

not be assigned for procedure codes reported with a modifier 78.

Comment: Carrier recommends that additional procedure(s) (with a global surgery period) reported with modifiers 58, 78, or 79 should not be subject to the surgical package concept when reported within the postoperative period of a prior procedure(s). The current draft rule is silent on this. Our recommendation is based on the Medicare Claims Processing Manual.

Response: The draft rule is not silent on whether or not the surgical package concept is applicable when modifiers 58, 78 or 79 are reported. Under Administrative Guidance, on page 4 of the draft the first paragraph indicates:

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

It goes on to list the specific modifiers and their definitions and includes 58, 78 and 79.

The task force appreciates the in-depth review of the third bundle of rules by this insurance carrier, and would like to be sure they are aware that the Medicare Claims Processing Manual is one of the publically available sources that is used in the development of the draft rules, however the final payment rules may or may not strictly follow Medicare as other industry sources are also are part of the consideration process.

**Laboratory  
Rebundling  
302.V.01 11/4/13**

Comment: One national insurance carrier submitted comments indicating that the rule needed modification.

Under the Administrative guidance section, the draft rule references automated multi-channel tests and states “(e.g., codes 80002 – 80019).” We recommend deleting this parenthetical as CPT® deleted these codes many years ago and these codes are no longer in use.

Response: The task force acknowledges that it was in error in including the outdated reference to procedure codes 80002-80019. This note will be deleted from the Administrative guidance section.

Comment: The Task Force supports combining separate laboratory component codes into a more comprehensive laboratory panel code, aligning with CPT which requires all components to be present prior to reporting the panel code. Carrier uses CPT® coding guidelines to define the components of each panel.

Carrier also considers the number of individual component codes submitted before the services would be considered included in the more comprehensive Panel Code when reported on the same date of service by the Same Individual Physician or Other Health Care Professional. The Professional Edition of the CPT® book, Organ or Disease-Oriented Panel section states: "Do not report two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of

tests to fulfill the code definition and report the remaining tests using individual test codes."

For reimbursement purposes, Carrier differs from the *CPT*<sup>®</sup> book's inclusion of the specific number of Component Codes within an Organ or Disease-Oriented Panel. Carrier will bundle the individual Component Codes into the more comprehensive Panel Code when the combined reimbursement for the individual Panel Code(s) exceeds the reimbursement amount of the Panel Code **or** when the designated number of Component Codes identified within a Panel Code are submitted for *CPT*<sup>®</sup> codes 80047, 80048, 80050, 80051, 80053, 80061, 80069, 80074 and 80076

For reimbursement purposes, we follow CMS guidelines for bundling of the panel component codes into the comprehensive panel code. This decision was made following an analysis by our National Ancillary Services Committee, which determined the number of individual components that would need to be billed before the sum of the individual components would exceed the total allowance for the corresponding panel code according to CMS's National Clinical Laboratory Fee schedule. CMS methodology differs from the AMA *CPT*<sup>®</sup> which states all the individual components must be included before it is considered a panel for coding purposes.

Although the CMS methodology is considered "out of scope" by the Task Force, Carrier believes the rule should allow payers to give consideration to when the number of component codes would exceed the total allowance for the panel code.

Response: The task force acknowledged the carrier's concern relative to payment for panel codes in the draft rule under the Definition section:

"The task force recognizes that public and private payers commonly have a reimbursement maximum in place to limit the amount paid when individual components of a panel (but not all components) are billed separately. This type of payment edit is out of scope."

Edits that are out of scope for the task force will not be included in the final set of medical claims edits, for example such edit types include contractual and/or reimbursement edits, fraud and abuse edits or utilization review/frequency edits. The exclusion of these edit types does not mean that a carrier cannot utilize such edits in their systems, however, they should be clearly communicated to their provider community to ensure appropriate reporting.

We will revise the Summary section of the draft to match that of the definition.

Comment: We support the Task Force's position relating to modifier 91 to allow a repeat (duplicate) clinical laboratory test to be reimbursed on the same day. We also allow modifier 59 to signify that a repeat clinical laboratory test be considered a distinct and separate service, allowing a repeat (duplicate) clinical laboratory test if modifier 90 is not present on the claim. We would recommend that the Task Force consider this in addition to modifier 91, as information from both CMS and AMA indicate modifier 59 is appropriate for use on laboratory component codes.

Response: The task force agrees that modifier 59 is appropriate for use with some of the laboratory codes. Modifier 59 will be added to the draft rule with an example of when it might be used appropriately.

Comment: The proposed rule is silent on the use of modifier 90, Reference (Outside) Laboratory. Carrier's participation agreements generally prohibit reimbursement of laboratory services that are performed by a party other than the treating or reporting physician. Carrier requests clarification that this rule would not prohibit a payer, if it chose to do so, from denying laboratory services reported with modifier 90 as it signifies that the provider did not personally perform the service.

Response: Edits related to contracting/participation agreements and any related reimbursement are outside of the scope of the task force and as identified previously can be utilized by a carrier. They should be clearly communicated to the provider community.

**Maximum  
Frequency > 1 Day  
303.V01 11/4/13**

Comment: One national insurance carrier submitted comments indicating that the rule needed modification.

Carrier has a similar policy; however, we refer to it as the "From – To Date Policy."

The Rationale should also reference the National Uniform Claim Committee (NUCC) which develops and oversees the NUCC Data Set (NUCC-DS). The NUCC Data Set is a standardized data set for use in an electronic environment, but applicable to and consistent with evolving paper claim form standards. The *NUCC 1500 Health Insurance Claim Form Reference Instruction Manual For Form Version 08/05* provides instruction for the completion of the 1500 Health Insurance Claim form. This manual includes the following instruction for entering the dates of service:

"If one date of service only, enter that date under 'From.' Leave 'To' blank or re-enter 'From' date."

"If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G 'Days or Units' field."

The Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual Chapter 26, also states: "When 'from' and 'to' dates are shown for a series of identical services, enter the number of days or units in column G." CMS returns a claim as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

An example of a claim form submission where the service dates cannot be determined and therefore the claim cannot be processed:

Code	Modifier	Units	From Date	To Date
99213		3	2/10/2009	3/19/2009

The claim should be submitted as follows:

Code	Modifier	Units	From Date	To Date
99213		1	2/10/2009	2/10/2009
99213		1	2/25/2009	2/25/2009
99213		1	3/19/2009	3/19/2009

The Administrative Guide section should be more specific and provide the guidance consistent with NUCC and CMS. The Task Force should only consider reimbursement for claim lines, with a 'from' and 'to' date span greater than one day, when the units entered correspond or are equally divisible to the number of days indicated. Claim lines for which the 'from' and 'to' dates and units do not correspond, or are not equally divisible to the number of days indicated, will not be processed. The services will need to be resubmitted on separate claim form lines with the units matching the corresponding from and to dates.

The Administrative Guide section should consider providing guidance on how to correctly report services for which the CPT® or HCPCS code description specifies a time period for which it should be reported; i.e., weekly, monthly, or once for a specified time period.

Example II in the current rule indicates to report with one date of service and one unit of service for Cardiac monitoring greater than 24 hours and up to 30 days. For codes that cover a time span, Carrier strongly encourages the Task Force to provide guidance that it is appropriate to report 1 unit with the From and Thru Dates describing the beginning and ending dates for the time span the service were rendered.

Carrier recognizes there are exceptions to this Rule based on the uniqueness of some CPT® and HCPCS codes reported for services rendered. The following types of services Carrier would propose be exempt from this policy:

Certain CPT® and HCPCS codes, based on their description, are not intended to be reported on consecutive dates of service, but may be appropriate to report with a 'from' and 'to' date. For example, codes whose descriptions say per week, per month, per course of treatment would be considered exceptions to this policy. Refer to Carrier's "Time Span Codes Policy" for additional information. Codes that represent drugs or contrast and radiopharmaceutical imaging materials.

Global Maternity Codes. Refer to Carrier's "Obstetrical Policy."  
Time based Anesthesia codes. Refer to Carrier's "Anesthesia Policy."  
Unlisted codes.

Finally, Carrier would recommend including provisions that home care or DME providers are exempt from this rule. Their services are typically reported on a monthly basis and cover different dates within that same period. Their services may be reported with units that may not be equally divisible between the from and to dates reported on the claim. For example, a DME item that is rented for one month is reported with 1 unit with the from and thru dates indicating the monthly rental period.

Response: The Rules Committee discussed the commenter's concerns during a conference call and agreed to include additional coding examples that would address correct coding when the services reported were less than or greater than those identified in the procedure code description. Additionally the Rules Committee will submit a proposal to the task force to combine the two Maximum Frequency rules into one combined rule titled Frequency. They felt this would alleviate some of the confusion and provide for expansion if the task force addresses any of the MUEs in the future.

**Multiple Endoscopy  
Reduction  
304.V01 11/4/13**

Comment: One national insurance carrier submitted comments indicating that the rule needed modification.

The proposal differs from CMS guidelines by applying multiple endoscopy reductions to services reported by the same individual physician or other health care professional, while CMS applies multiple procedure and endoscopy reductions to all reducible procedure reported by physicians and other health care professionals reporting under the same group practice, regardless of specialty. Please refer to the CMS sourcing.

Response: The task force did not adopt the complete Medicare definition of multiple surgery/endoscopy. Specifically, the task force did not discuss the application of the multiple procedure/endoscopy reduction when another physician or health care professional reporting under the same group practice provides services to the same patient during the same surgical session. The Rules Committee reviewed the definition again and recommends that the rule not be revised. If a payer defines "same" physician or other healthcare professional to mean any provider under the same tax ID number, this can be included as part of their contractual agreement.

Comment: Use of the modifier 51 is not a factor used by CMS to determine if an endoscopy reduction should apply. Use of the modifier 51 is intended to provide billing instructions, not adjudication guidelines per the Medicare Claim Processing Manual, Chapter 12, Section 40.6 B. Carrier recommends that the rule be modified to reflect that although the use of the modifier 51 is in accordance with billing guidance, the absence of a modifier 51 will not prohibit a payer from applying an endoscopic adjustment when two or more procedures with the MULT POC indicator 3 are billed the same physician or physicians in the same group on the same day for the same patient.

Response: The task force agrees with the commenter and will add the following note to the Administrative guidance section of the rule:

"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."

Comment: Although the need for assistant and co-surgeon services are rare for endoscopy services, Carrier recommends provisions be included in the rule that when assistant surgeon and co-surgeon modifiers are reported, the endoscopic

reduction is determined ranking these services separately as described below:

- The services of primary surgeons are not ranked against the services reported by assistant surgeons, even if both primary and assistant surgeons are reporting under the same group practice.
- Co-surgeon services are subject to reduction if multiple endoscopic procedures reported with modifiers 62 are reported on the same date of service and by the same physician.

This is consistent with CMS.

Response: The task force agrees with the commenter and will add the following note to the Administrative guidance section of the rule:

“Assistant at surgery, co-surgery or team surgery multiple endoscopy procedures are not grouped with the primary surgeon’s. They are considered separately when determining the ranking.”

Comment: Carrier recommends that the Multiple Endoscopy rule address modifier 78. In alignment with CMS, reducible procedure codes, including endoscopic codes, reported with a modifier 78 will not be subject to the multiple procedure reductions. Refer to the CMS sourcing.

Response: The Rules Committee reviewed whether or not modifier 78 should be addressed in this rule and agreed that there should be an additional comment in the Administrative guidance section of the rule. When a payer applies a reduction based on the use of modifier 78 it is not appropriate to apply another reduction based on the Multiple Endoscopy Reduction rule.

The Rules Committee also recommends that the same Administrative guidance be added to the Multiple Procedure Reduction rule when it is finalized.

Comment: Not all payers have the ability to apply endoscopy reductions in the same method as described by CMS. Some payers may apply multiple procedure reductions to endoscopic codes by applying a 50% reduction rather than a reduction based on the value of the base endoscopic code within the same family. Often this method of reduction is more favorable to the physician than the endoscopic reduction. Publication of this rule may cause significant hardship to develop the system technology to administer endoscopic reductions in the same manner as CMS. Therefore, it is recommended that sufficient time be given to payers to accommodate the administration of this rule.

Response: The task force, as well as the national specialty societies, recognizes that not all payers utilize the CMS methodology for calculating multiple endoscopic reductions. For this reason the draft policy does not refer to any specific reduction percentages or amounts, and it does not reference the Medicare method of subtracting the base value from subsequent procedures within the same family as a means of arriving at the reduction. Rather it only references the Medicare fee schedule indicator of ENDO BASE as a means to further identify the endoscopic families of related procedures for ranking purposes.

In hopes of making this a little clearer within the rule itself, the final rule will include the following parenthetical remark:

“(The specific payment reduction is out of scope, see Context section below.)”

**Professional and  
Technical  
Component Rule  
207 V.01 9/4/13**

Comment: The College of American Pathologists (CAP) submitted additional comments concerning the technical component definition listed on page one of the Task Force’s Professional and Technical Component Edit/Payment Rule. This letter elaborates upon our previously recommended edits concerning the definition of the Technical Component (TC) modifier. On page one, under the heading of “Associated Current Procedural Terminology (CPT®), (the definition as listed in CMS’ most recent HCPCs terminology file) is listed below:

-TC Technical Component:<sup>[1]</sup> Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

Although this language is directly taken from CMS’ most recent HCPCs terminology file, the CAP disagrees with the contextual use of this language in the Colorado proposed coding edit guidance. Specifically, the CAP disagrees with the second sentence that states that TC “charges are institutional charges and not billed separately by physicians.” Absent conjunctive clarification, this language is inaccurate for pathology services. The plain fact is that pathologists, under Medicare and for private payers, are, in many cases, directly paid for TC services on the physician fee schedule. Thus, the current language proposed for the edit is taken out of proper context and would result in confusion and gross misapplication of the rule as applied to the TC of pathology services.

In support of our position, we would like to point your attention to CMS’ May 24, 2013 Change Request 8013, page 7. This paragraph includes the language of concern, but then further clarifies that payment for the TC of pathology services outside the institutional setting is made on the physician fee schedule directly to the provider. Without inclusion of this clarification, the prior statement, regarding facility based payment, is a substantial misrepresentation of facts. The below paragraph was extracted from this document and is shown below.

*B. Payment for Technical Component (TC) Services*

*1. General Rule*

*Payment is not made under the physician fee schedule for TC services furnished in institutional settings where the TC service is bundled into the facility payment, e.g., hospital inpatient and*

*outpatient settings. Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment, e.g., an ambulatory surgery center (ASC). Payment may be made under the physician fee schedule for the TC of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The physician fee schedule*

*identifies physician laboratory or physician pathology services that have a TC service.*

The CAP believes the above clarification should be incorporated into the MCCTF's Final Professional and Technical Edit/Payment File on page one, under the heading of "Associated Current Procedural Terminology (CPT). The CAP proposes the following alternative language that replaces the sentence in question with the above language from CMS' Change Request 8013:

-TC Technical Component: Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. ~~Technical component charges are institutional charges and not billed separately by physicians. Payment is not made under the physician fee schedule for TC services furnished in institutional settings where the TC service is bundled into the facility payment, e.g., hospital inpatient and outpatient settings. Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment, e.g., an ambulatory surgery center (ASC). Payment may be made under the physician fee schedule for the TC of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The physician fee schedule identifies physician laboratory or physician pathology services that have a TC service.~~ 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.

Response: As we indicated in our previous response, in the section of the draft rule referred to, *Associated Current Procedural Terminology (CPT®) and HCPCS modifiers*, the descriptions listed are taken directly from the source documents either CPT® or HCPCS. The task force does not have the option of revising these descriptions.

The task force can appreciate the concern that the definitions may be taken out of context and in response to the commenter's initial concern the task force expanded the footnote to the TC modifier description. It will now be revised to include a reference the Medicare Change Request as identified by the commenter.

<sup>2</sup> This is the Healthcare Common Procedure Coding System (HCPCS) definition and the reference to customary and prevailing profiles is specific to Medicare. Additionally as identified by the College of American Pathologists, the statement that "Technical component charges are institutional charges and not billed separately by physicians." is specific to Medicare. CMS clarified this explanation in Medicare Claims Processing Manual Transmittal 2714 dated May 24, 2013, Change Request 8013. Payment is not made under the physician fee schedule for TC services furnished in institutional settings where the TC service is bundled into the facility payment, e.g., hospital inpatient and outpatient settings. Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment, e.g., an ambulatory surgery center (ASC). Payment may be made under the physician fee schedule for the TC of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The physician fee schedule identifies physician laboratory or physician pathology

services that have a TC service.

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



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

### Edit/Payment Rule

<p><b>Number: Draft Global Procedure Days/Package Rule 301 V.02 1/21/14</b></p>	<p><b>Statutory reference: C.R.S. 25-37-106</b></p>
<p><b>Topic</b></p>	<p><b>Global Procedure Days/Package</b></p>
<p><b>Definition</b></p>	<p>This type of edit will identify incorrect billing when services that are routinely considered part of the global package are reported separately within the pre-operative, same day and post-operative days assigned to that procedure code.</p> <p>Note: The legislative intent was not to limit the edit to just the number of days, but also to address the global package.</p>
<p><b>Associated Current Procedural Terminology (CPT®)<sup>1</sup> and HCPCS modifiers</b></p>	<p>-24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period: The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during the postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service</p> <p>-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.</p> <p style="padding-left: 40px;">Note: This modifier is not used in conjunction with a major surgical procedure (one that has 90 days postoperative follow up) to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.</p> <p>-54 Surgical Care Only: When one physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure code.</p>

<sup>1</sup> Current Procedural Terminology (CPT®), Fourth Edition. 2013. Copyright 2013. All rights reserved.

	<p>-55 Postoperative Management Only: When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure code.</p> <p>-56 Preoperative Management Only: When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure code.</p> <p>-57 Decision for Surgery: Is used to indicate that an evaluation and management service resulted in the initial decision to perform the surgery. Use of this modifier is limited to procedures with 90-day global periods.</p> <p>-58 Staged or Related Procedure or Service by the same Physician or Other Qualified Health Care Professional During the Postoperative Period: The use of the modifier 58 enables the payers to appropriately pay for the procedure per se and other associated postoperative services performed by the original surgeon or provider within or subsequent to its assigned global period (e.g., 0 days, 10 days, 90 days). Modifier 58 is used to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure.</p> <p><del>-76 Repeat Procedure or Service by Same Physician: Is used to indicate that a procedure or service was repeated subsequent to the original procedure or service in a separate operative session by the same physician.</del></p> <p>-78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: When a procedure is related to the first (but not a repeat procedure) and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.</p> <p>-79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: When a procedure or service performed during the postoperative period was unrelated to the original procedure, this circumstance is communicated by appending the modifier 79 to the unrelated procedure.</p> <p>There may be situations where multiple modifiers or modifiers not listed apply, however they are not covered in this document.”</p>
<b>Rationale</b>	<p>The following rationale was used to formulate the Global Procedure Days/Package rule recommendation:</p> <ul style="list-style-type: none"> <li>• The CPT® coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.</li> <li>• The CPT® descriptions for global surgery and associated modifiers were selected.</li> <li>• The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual<sup>2</sup> were selected,</li> <li>• CPT® codes that were exceptions to the CMS pricing policy were identified and included in the recommendation.</li> </ul>
<b>Rule logic</b>	<p>The number of days assigned to the Current Procedural Terminology (CPT®)<sup>3</sup>/HCPCS procedure codes in the column labeled GLOBAL DAYS of the Medicare Physician Fee</p>

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

<sup>3</sup> Copyright 2013 American Medical Association. All rights reserved.

Schedule (MPFS)<sup>4</sup> will be utilized to identify the post-operative period associated with the procedure.

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

#### **Surgical Package**

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

<sup>4</sup> 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.

	<ul style="list-style-type: none"> <li>○ Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia</li> <li>○ Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical);</li> <li>○ Intra-operative services that are normally a usual and necessary part of a surgical procedure;</li> <li>○ Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;</li> <li>○ Writing orders;</li> <li>○ Evaluating the patient in the post-anesthesia recovery area;</li> <li>○ Postsurgical Pain Management by the surgeon;</li> <li>○ Complications directly related to the surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room, or are not related to other medical conditions of the patient;</li> <li>○ Typical postoperative follow-up care during the global period of the surgery that are related to recovery from the surgery;</li> <li>○ Supplies - Except for those identified as exclusions; and</li> <li>○ Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.</li> </ul> <p>From a CPT® coding perspective, this definition indicates that when a surgical procedure is reported with a CPT® code, the items listed in that guideline are included (if performed) and are not reported separately. Since patients may have other disease(s) or injury(s) or may have undergone other diagnostic and/or therapeutic procedure(s), certain variables may impact reporting, and include: The type of procedure performed; The place where the surgery occurs; The time (during hospitalization) the surgery is performed; The insurance contract of each individual patient.</p> <p>Therefore, because it is not possible to address all of these variables in each code descriptor, only the preoperative E/M service related to the procedure performed on the date immediately before the procedure (including the history and physical) is stated as inclusive of the CPT® surgical package definition. It is important to note that this included E/M encounter must occur subsequent to the E/M encounter at which the decision for surgery was reached. For example, the E/M service is separately reported when a physician performs an office E/M service, and at that visit it is determined that surgery is necessary. The appropriate modifier must be appended.</p>
<p><b>Administrative guidance</b></p>	<p><b>Coding and adjudication guidelines</b></p> <p>In certain circumstances it is appropriate to report additional medical or surgical services provided during the global period. The following modifiers appended to the procedure code are used to identify these circumstances:</p> <ul style="list-style-type: none"> <li>● Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period.</li> <li>● 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.</li> <li>● Modifier 54: Surgical Care Only.</li> <li>● Modifier 55: Postoperative Management Only.</li> </ul>

- Modifier 56: Preoperative Management Only.
- Modifier 57, Decision for Surgery
- Modifier 58: Staged or Related Procedure or Service by the same Physician or Other Qualified Health Care Professional During the Postoperative Period.
- Modifier 76, Repeat Procedure or Service by Same Physician
- Modifier 78, Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period.
- Modifier 79, Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period.

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

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

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

#### **Same Day Medical Visit and Medical Procedure**

“Any specifically identifiable procedure (i.e., identified with a specific CPT® code) performed on or subsequent to the date of initial or subsequent E/M services should be reported separately. The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT® codes are available may be reported separately, in addition to the appropriate E/M code. The physician’s interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT® code with modifier 26 appended. The physician may need to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient’s condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual pre-service and post-service care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.”

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

#### **Surgical procedure guidance**

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

The E/M service and minor surgical procedure do not require different diagnoses. If a

	<p>minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure. Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E/M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E/M service may be separately reportable.</p> <p>Unrelated E/M services by the same physician during a postoperative period</p> <p>When a physician provides a surgical service related to one problem and then, during the period of follow-up care for the surgery, provides an E/M services unrelated to the problem requiring the surgery a modifier 24 would be appended to the appropriate level of E/M services provided.</p> <p>For services not subject to the global package, see the following:</p> <ul style="list-style-type: none"> <li>• CPT® code set, Follow –Up Care for Diagnostic Procedures, page 58 and Follow-Up Care for Therapeutic Surgical Procedures, page 58 of the CPT® codebook.</li> <li>• Medicare Claims Processing Manual, Chapter 12, 40.1, B – Services Not Included in the Global Surgical Package.</li> </ul>
<p><b>Specialty Society outreach</b></p>	<p>The AMA Federation Payment Policy Workgroup was consulted.</p>
<p><b>Summary DATE</b></p>	<p><b>The task force will utilize the number of days assigned to the Current Procedural Terminology (CPT®)<sup>5</sup>/HCPCS procedure codes in the column labeled GLOBAL DAYS of the Medicare Physician Fee Schedule (MPFS)<sup>6</sup> to identify the post-operative period associated with the procedure.</b></p> <p><b>January 21, 2014</b></p>

**Context**

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

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

**Comments**

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

<sup>5</sup> Copyright 2013 American Medical Association. All rights reserved.

<sup>6</sup> 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.

Comments regarding the global procedure days/package rule should be submitted online to the Colorado Medical Clean Claims Task Force at [www.hb101332taskforce.org](http://www.hb101332taskforce.org) by December 4, 2013. The following information should be included:

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

Draft



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

### Edit/Payment Rule

<b>Number: Draft Multiple Endoscopy Reduction Rule 304 V.02 1/21/14</b>	<b>Statutory reference: C.R.S. 25-37-106</b>
<b>Topic</b>	<b>Multiple Endoscopy Reduction</b>
<b>Definition</b>	<p>This type of edit identifies when two or more endoscopic procedures within the same family are performed by the same physician or other qualified healthcare provider for the same patient for the same surgical/procedure session. Subsequent procedures within the same family may be subject to a reduction.</p>
<b>Associated Current Procedural Terminology (CPT®)<sup>1</sup> and HCPCS modifiers</b>	<p>-51 Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., 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). <b>Note:</b> This modifier should not be appended to designated “add-on” codes (see Appendix D in the CPT® code book).</p> <p>-59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify 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. <b>Note:</b> 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.</p> <p>There may be situations where multiple modifiers or modifiers not listed apply, however they are not covered in this document.</p>
<b>Rationale</b>	<p>The following rationale was used to formulate the Multiple Procedure Reduction rule recommendation:</p> <ul style="list-style-type: none"> <li>• The CPT® coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.</li> <li>• The CPT® descriptions for multiple procedures and modifier 51 were selected.</li> </ul>
<b>Rule logic</b>	<p>The Multiple Endoscopy Reduction rule may apply when two or more endoscopic procedures within the same family are performed by the same physician or other qualified healthcare provider for the same patient for the same surgical/procedure session.</p>

<sup>1</sup> Current Procedural Terminology (CPT®), Fourth Edition. 2013. Copyright 2013. All rights reserved.

	<p><b>Multiple Endoscopy Reduction Indicators</b></p> <p>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 Multiple Endoscopy reduction rule applies only when two or more procedures <i>with the eligible indicator (3)</i> are billed by the same physician or other qualified healthcare provider for the same patient for the same surgical/procedure session.</p> <p>For those procedure codes with an indicator of 3, the MPFS column labeled ENDO BASE identifies the applicable base endoscopy procedure code/family. An endoscopic family within the CPT® code set, consists of the base procedure and all of the indented procedure codes that follow when they are performed at the same time as the base endoscopy procedure; i.e. they share the same ENDO BASE procedure code.</p> <p>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 endoscopy 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.</p>
<p><b>Administrative guidance</b></p>	<p><b>Coding and adjudication guidelines</b></p> <p>The following procedures apply when billing for multiple endoscopic surgeries by the same physician or other qualified healthcare professional on the same day.</p> <ul style="list-style-type: none"> <li>• Report the more major endoscopic procedure without the 51 modifier.</li> <li>• Report additional endoscopic procedures performed by the physician or other qualified healthcare professional on the same day with modifier 51.</li> </ul> <p>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 adjustments as if the second procedure has a lesser RVU value.</p> <p>There may be instances in which two or more physicians or other qualified healthcare professionals each perform distinctly different, unrelated endoscopic 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.</p> <p><b>Multiple Endoscopy Reduction</b></p> <p>Multiple Endoscopic reduction adjustment rules are used to calculate reimbursement for endoscopic procedures within the same family.</p> <ul style="list-style-type: none"> <li>• Endoscopic procedures are ranked in descending order based on the appropriate facility or non-facility RVU. If two or more procedures 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.</li> <li>• If the endoscopy and its base procedure are the only endoscopies submitted, the base endoscopy will not be reimbursed separately. It is included in the other procedure. In the MPFS these procedures are identified in the multiple procedure field with an indicator 3 and the base procedure code is located in the endo base column. Examples of procedures with a multiple procedure indicator 3 are colonoscopies, arthroscopies, and cystoscopies.</li> </ul>

Multiple Endoscopy Example (Same Family)

Determine the highest valued endoscopic procedure (not subject to the multiple endoscopy rule)

For the other endoscopic procedures in the same family, apply the Multiple Endoscopic reduction.

**EXAMPLE**

In the course of performing a fiber optic colonoscopy (Current Procedural Terminology (CPT®)<sup>2</sup> code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. When multiple procedures 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).

In this example, 45385 is reported without a modifier 51 and is not subject to an adjustment, code 45380 is subject to adjustment. Append modifier 59 to 45380 to indicate that the polyp removal and lesion removal were at separate site and both should be considered.

45385

45380 – 51 - 59            Subject to adjustment

NOTE: If an endoscopic procedure with an indicator of “3” is billed with the “-51” modifier with other procedures that are not endoscopies (procedures with an indicator of “1”), the Multiple Procedure reduction rules apply. ***(Refer to the Multiple Procedure reduction rule for more information)***

Apply the following rules when multiple endoscopy procedures in different families or in combination with other procedures with MPFS indicators of 2 or 3 are performed on the same day:

Procedure Performed	Rules Applied
Two unrelated endoscopies (e.g., 46606 and 43217)	Apply the Multiple Procedure reduction rules.
Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608)	1. Apply the Multiple Endoscopy reduction rules to each series, then 2. Apply the Multiple Procedure reduction rules. (Consider the total payment for each set of endoscopies as one service. Set the primary/secondary order based on the corresponding adjustment to the RVUs for the combined procedures.)
Two unrelated endoscopies and a third, unrelated procedure	Apply the Multiple Procedure reduction rules.
Two related endoscopies and a third, unrelated	1. Apply the Multiple Endoscopic reduction rules to the related endoscopies, then 2. Apply the Multiple Procedure reduction rules. (Consider the total payment for the related endoscopies as one

<sup>2</sup> Copyright 2013. All rights reserved. American Medical Association

	procedure	service and the unrelated endoscopy as another service.)
	<b>Note:</b> When modifier 78 is reported to identify an unplanned return to the operating room by the same physician, it is not appropriate to apply an additional payment adjustment based on the Multiple Endoscopy Reduction Rule if the payer applies a reduction for the use of modifier 78.	
<b>Specialty Society outreach</b>	American College of Gastroenterology (ACG) American Gastroenterological Association (AGA) American Society for Gastrointestinal Endoscopy (ASGE) American Academy of Otolaryngology – head and Neck Surgery American Academy of Orthopaedic Surgeons (AAOS) American College of Radiology (ACR) American College of Surgeons (ACS) American Congress of Obstetricians and Gynecologists (ACOG) College of American Pathologists (CAP) The AMA Federation Payment Policy Workgroup	
<b>Summary DATE</b>	<b>The task force will utilize the indicators listed in the column labeled MULT PROC of the MPFS with an indicator of 3<sup>3</sup> to identify two or more procedure codes that may be subject to this rule when they are performed by the same physician or other qualified healthcare provider for the same patient for the same surgical/procedure session.</b>  <b>January 21, 2014</b>	

### 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.

### Comments

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

Comments regarding the multiple endoscopy reduction rule should be submitted online to the Colorado Medical Clean Claims Task Force at [www.hb101332taskforce.org](http://www.hb101332taskforce.org) by December 4, 2013. The following information should be included:

1. Number and topic
2. Position – support, disagree, modification
3. Recommendation

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

4. Rationale in support of recommendation
5. Supporting data and sources, e.g., frequency, associated costs
6. Estimated impact of the proposed rule
7. Contact information
8. Organization affiliation

Draft



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

### Edit/Payment Rule

<p><b>Number: Draft Maximum Frequency &gt; 1 Day Rule 303 V.02 1/21/14</b></p>	<p><b>Statutory reference: C.R.S. 25-37-106</b></p>
<p><b>Topic</b></p>	<p><b>Maximum Frequency &gt; 1 Day</b></p>
<p><b>Definition</b></p>	<p>This type of edit will identify incorrect billing when the CPT<sup>®1</sup>/ Health Care Common Procedure Coding System (HCPCS) descriptor of the service/procedure code, or the related parenthetical coding guidelines imply restrictions on the number of times the service/procedure can be provided over a specified span of days.</p>
<p><b>Associated Current Procedural Terminology (CPT<sup>®</sup>)<sup>2</sup> and HCPCS modifiers</b></p>	<p>There are no modifiers associated with this rule.</p>
<p><b>Rationale</b></p>	<p>The following rationale was used to formulate the Maximum Frequency &gt; 1 Day rule recommendation:</p> <ul style="list-style-type: none"> <li>• The CPT<sup>®</sup> coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.</li> <li>• The CPT<sup>®</sup> descriptions were selected.</li> <li>• The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual<sup>3</sup> were selected.</li> </ul>
<p><b>Rule logic</b></p>	<p>The CPT<sup>®</sup>/HCPCS descriptor of the service/procedure code, or the related parenthetical coding guidelines imply restrictions on the number of times the service/procedure can be provided over a specified span of days.</p>
<p><b>Administrative guidance</b></p>	<p><b>Coding and adjudication guidelines</b></p> <p>The descriptor of some CPT<sup>®</sup>/HCPCS service/procedure codes, or the related coding guidelines imply restrictions on the number of times the service/procedure can be provided over a span of days by the same physician or other qualified health care professional.</p> <p>Therefore, the rule applies whether a physician or other qualified health care professional submits one CPT<sup>®</sup>/HCPCS code with multiple units on a single claim line, a single claim with multiple claim lines with one or more unit(s) on each line, or separate claims for multiple dates of service that fall within the specified limits.</p> <p>It is incorrect to report a code with units that exceed the maximum frequency</p>

<sup>1</sup> Current Procedural Terminology (CPT<sup>®</sup>), Fourth Edition. 2013. Copyright 2013. All rights reserved

<sup>2</sup> Current Procedural Terminology (CPT<sup>®</sup>), Fourth Edition. 2013. Copyright 2013. All rights reserved

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

restriction. The code will be pended or denied.

**Example I – ESRD services**

Correct Coding

Report with one date of service and one unit of service  
ESRD services., with 2-3 visits per calendar month

Incorrect coding

Report with multiple dates of service and multiple units  
ESRD services., with 2-3 visits per calendar month

One date of service = 3 units of service

OR

Within the specified time period:

One date of service = 1 unit of service

One date of service = 1 unit of service

One date of service = 1 unit of service

**Example II - Cardiac monitoring greater than 24 hours and up to 30 days**

Correct Coding

Report with one date of service and one unit of service (regardless of the  
number of transmission or number of days that the monitor is on)

Incorrect Coding

One date of service = 3 units of service

OR

Within the specified time period:

One date of service = 1 unit of service

One date of service = 1 unit of service

One date of service = 1 unit of service

When the services rendered are less than the parameters described in the procedure code description, append the appropriate modifier (52) or select a more appropriate code as instructed in the CPT code book.

**Example I – Cardiac monitoring less than 48 hours**

External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage....

Correct coding

For less than 12 hours of continuous recording, use modifier 52

For greater than 48 hours of monitoring, see Category III codes nnnnT-zzzzT

**Example II - Sleep medicine testing less than 6 hours**

Report with modifier 52 if less than 6 hours of recording or in other cases of

	reduced services as appropriate
<b>Specialty Society outreach</b>	College of American Pathologists (CAP) American Congress of Obstetricians and Gynecologists (ACOG) American Academy of Othopaedic Surgeons (AAOS) American Academy of Otolaryngology – Head and Neck Surgery American College of Radiology (ACR) American College of Surgeons (ACS) The AMA Federation Payment Policy Workgroup
<b>Summary DATE</b>	<b>The task force will utilize the CPT® descriptors or related coding guidelines to identify those procedure codes subject to the Maximum Frequency &gt; 1 Day rule.</b>  <b>January 21, 2014</b>

### 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.

### Comments

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

Comments regarding the laboratory rebundling rule should be submitted online to the Colorado Medical Clean Claims Task Force at [www.hb101332taskforce.org](http://www.hb101332taskforce.org) by December 4, 2013. The following information should be included:

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

Attachment - Effect of Current Procedural Terminology (CPT®)<sup>1</sup> & Healthcare Common Procedure Coding System (HCPCS) Modifiers on Edits

<b>Modifier 62:</b> Two Surgeons	<b>Description:</b> 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. <b>Note:</b> 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.	This modifier can be located in the following rule(s): <ul style="list-style-type: none"> <li>• Co-Surgery</li> <li>• Multiple Procedure Reduction</li> <li>• Procedure to Modifier Validation</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier is not used to override an edit.</li> <li>• Health Plans may apply a payment adjustment based on the modifier.</li> </ul>
<b>Modifier 66:</b> Surgical Team	<b>Description:</b> Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, 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 physician with the addition of modifier 66 to the basic procedure number used for reporting services.	This modifier can be located in the following rule(s): <ul style="list-style-type: none"> <li>• Team Surgery</li> <li>• Multiple Procedure Reduction</li> <li>• Procedure to Modifier Validation</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier is not used to override an edit.</li> <li>• Health Plans may apply a payment adjustment based on the modifier</li> </ul>
<b>Modifier 76:</b> Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	<b>Description:</b> 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. <b>Note:</b> This modifier should not be appended to an E/M service.	This modifier can be located in the following rule(s): <ul style="list-style-type: none"> <li>• Global Procedure Days/Package</li> <li>• Maximum Frequency Per Day</li> <li>• Global Maternity</li> <li>• Procedure to Modifier Validation</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier is primarily an informational modifier. When used alone it alerts the payer that the claim is not a duplicate. When used in combination with another modifier, such as 58 or 78 it can override a payment edit.</li> </ul>
<b>Modifier 77:</b> Repeat Procedure by Another Physician or Other Qualified Health Care Professional	<b>Description:</b> 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. <b>Note:</b> This modifier should not be appended to an E/M service.	This modifier can be located in the following rule(s): <ul style="list-style-type: none"> <li>• Global Maternity</li> <li>• Global Procedure Days/Package</li> <li>• Procedure to Modifier Validation</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier can be used to override an edit.</li> </ul>

**Attachment - Effect of Current Procedural Terminology (CPT®)<sup>1</sup> & Healthcare Common Procedure Coding System (HCPCS) Modifiers on Edits**

<p><b>Modifier 78:</b> 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</p>	<p><b>Description:</b> 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.)</p>	<p>This modifier can be located in the following rule(s):</p> <ul style="list-style-type: none"> <li>• Global Procedure Days/Package</li> <li>• Global Maternity</li> <li>• Procedure to Modifier Validation</li> <li>• Multiple Procedure Reduction</li> <li>• Multiple Endoscopy Reduction</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier can be used to override an edit.</li> <li>• Health Plans may make an adjustment based on the use of this modifier. <ul style="list-style-type: none"> <li>○ If the Health Plan has a reimbursement policy that reduces the procedure allowance when modifier 78 is reported, it is not appropriate to apply an additional payment adjustment for the Multiple Procedure Reduction Rule or the Multiple Endoscopy Reduction rule.</li> </ul> </li> </ul>
<p><b>Modifier 79:</b> Unrelated Procedure or Service by the Same Physician During the Postoperative Period</p>	<p><b>Description:</b> The physician 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.)</p>	<p>This modifier can be located in the following rule(s):</p> <ul style="list-style-type: none"> <li>• Global Procedure Days/Package</li> <li>• Global Maternity</li> <li>• Procedure to Modifier Validation</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier can be used to override an edit.</li> </ul>
<p><b>Modifier 80:</b> Assistant Surgeon</p>	<p><b>Description:</b> Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).</p>	<p>This modifier can be located in the following rule(s):</p> <ul style="list-style-type: none"> <li>• Assistant at Surgery</li> <li>• Multiple Procedure Reduction</li> <li>• Procedure to Modifier Validation</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier is not used to override an edit.</li> <li>• Health Plans may apply a payment adjustment based on the modifier</li> </ul>
<p><b>Modifier 81:</b> Minimum Assistant Surgeon</p>	<p><b>Description:</b> Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.</p>	<p>This modifier can be located in the following rule(s):</p> <ul style="list-style-type: none"> <li>• Assistant at Surgery</li> <li>• Procedure to Modifier Validation</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier is not used to override an edit.</li> <li>• Health Plans may apply a payment adjustment based on the modifier</li> </ul>
<p><b>Modifier 82:</b> Assistant Surgeon (When Qualified Resident Surgeon Not Available)</p>	<p><b>Description:</b> The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).</p>	<p>This modifier can be located in the following rule(s):</p> <ul style="list-style-type: none"> <li>• Assistant at Surgery</li> <li>• Procedure to Modifier Validation</li> </ul>	<ul style="list-style-type: none"> <li>• This modifier is not used to override an edit.</li> <li>• Health Plans may apply a payment adjustment based on the modifier</li> </ul>



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

Response to Public Comments  
December 4, 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 a report to the General Assembly and Department of Health Care Policy & Financing with 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®)<sup>1</sup> 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

Comment: The American Urological Association (AUA) submitted a letter in support of the task force's activities, and agrees with the third bundle of payment rules including Global Procedure Days, Laboratory Rebundling, Maximum Frequency Greater Than One Day and Multiple Endoscopy.

Response: The task force appreciates the AUA's support and looks forward to their continued participation and input.

Comment: The American Osteopathic Association (AOA) submitted a letter in support of the third bundle of payment rules including Global Procedure Days, Laboratory Rebundling, Maximum Frequency Greater Than One Day and Multiple Endoscopy. Additionally, the AOA recommended inclusion of a reference to the National Correct Coding Initiative (NCCI) Edits found on the Centers for Medicare and Medicaid Services (CMS) website. As this information has been helpful to physicians when addressing billing challenges or denials they felt the inclusion of the NCCI reference would strengthen the guidance provided by the task force.

<sup>1</sup> Copyright 2013 American Medical Association. All Rights Reserved.

Response: The task force appreciates the AOA's support. The NCCI is one of the nationally published sources the task force has relied on during the development of payment rules. We agree that it should be referenced and will include it as part of the Rationale section of applicable rules when they are published for final comment.

As noted in the Procedure to Procedure rule that was previously published for comment, as a starting point, the current year National Correct Coding Initiative (NCCI) "Column One/Column Two Correct Coding Edit Table" is being considered. The actual code pairs will be analyzed and the final Colorado set of standardized edits may or may not include all of them.

**Global Procedure  
Days/Package  
301.V01 11/4/13**

Comment: One national insurance carrier submitted comments in support of the rule with modifications.

The carrier's Global Days Policy concurs with the Colorado Draft Policy that the codes assigned a global value of ZZZ within the *National Physician Fee Schedule (NPFS) Relative Value File (RVF)*, are not subject to the global surgery days/package concept and does not apply the global surgery rules to those codes.

However, to be comprehensive on what services are subject to the global day concept, the carrier's policy assigns values to codes assigned a global value of MMM within the *NPFS RVF*. Codes which represent delivery plus postpartum services are assigned a 42-day postoperative period. For these 42-day codes, Evaluation and Management services on the day of the delivery and during the 42-day post-delivery period are not separately reimbursable except as noted within this policy. The carrier follows ACOG guidelines, considering a six week postpartum period (42 days) after delivery and felt their policy is more lenient than the Colorado rule and we would recommend that the ACOG guidelines referenced below are followed.

Response: The task force would refer the commenter to the previously published rule on Global Maternity 211 V.01 9/04/13, which does address the number of follow up days assigned to the typical postpartum care, as well as the components, included in the package. The American Congress of Obstetricians and Gynecologists (ACOG) took part in the task force's deliberations during the development of this rule. ACOG indicated that the typical postpartum period is 6 to 8 weeks but they do not endorse a specific number of days. They understood the task force's need to define the follow up period in terms of a specific number of days and felt that the 45 day follow up period the task force decided upon would cover most cases.

Comment: The insurance carrier submitted the following comment on the procedure codes with an indicator of YYY: The Colorado draft policy states that the global procedure rule sometimes applies to procedures codes listed in the column labeled Global Days of the MPFS with an indicator of YYY. According to CMS, it is up to the CMS carrier to determine whether the global concept applies and to establish the postoperative period, if appropriate, for codes assigned an indicator of YYY. The carrier supports allowing payer discretion for determining the global day period for codes assigned an indicator of YYY.

Response: As drafted in the rule, *sometimes* gives carriers the discretion to determine whether or not follow up days should be applied to a procedure code with an indicator of YYY, and if so what number of days would be appropriate.

Comment: Carrier utilizes a separate Split Surgical Package Reimbursement Policy to address modifiers 54, 55 and 56 and identifies the percentage of reimbursement for each modifier. However, the rule should address that the global package concept still applies to procedures reported with a global day period and reported with these modifiers.

Response: The task force agrees that a note should be added to the Administrative Guidance section of the rule indicating that the use of modifiers 54, 55 and 56 does not preclude the procedure code(s) from the application of the global procedure days/package concept.

Comment: Carrier recommends removing reference to modifier 76 (Repeat Procedure or Service by Same Physician) from the modifier section of the proposed Global Procedure Days/Package Rule. Use of modifier 76 has no relevance in determining whether the global surgery package does or does not apply. The carrier's policy is aligned with the **Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners** which does not include modifier 76 within the Global Surgery guidelines.

Response: The task force agrees that procedure codes reported with a modifier 76 would not be included as part of the global surgery package related to the prior procedure. Under Administrative guidance on page 4, the draft indicates that in certain circumstances it is appropriate to report additional services provided during the global period. The list of circumstances includes a reference to modifier 76, this information will remain. However, the task force understands that modifier 76 is considered primarily an informational modifier, and it will be removed from section on Associated CPT and HCPCS modifiers on the first page. The information at the end of this section will be revised as follows: "There may be appropriate situations where multiple modifiers or modifiers not listed apply, however they are not covered in this document."

The rule concerning Modifier Effect on Edits (P) will be revised to indicate that 76 is used as an informational modifier does not result in a payment adjustment. Modifier 76 appended to a code alerts the payer that the claim is not a duplicate.

Comment: Carrier recommends that the Colorado Global Rule indicates a new global period will **not** be assigned for a procedure meeting the requirements for reporting modifier 78, (Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period) and multiple procedure reductions will not be applied. The current draft rule is silent on this. Our recommendation is based on the Medicare Claims Processing Manual.

Response: The task force agrees that a note should be added to the Administrative Guidance section of the rule indicating that a new global period will

not be assigned for procedure codes reported with a modifier 78.

Comment: Carrier recommends that additional procedure(s) (with a global surgery period) reported with modifiers 58, 78, or 79 should not be subject to the surgical package concept when reported within the postoperative period of a prior procedure(s). The current draft rule is silent on this. Our recommendation is based on the Medicare Claims Processing Manual.

Response: The draft rule is not silent on whether or not the surgical package concept is applicable when modifiers 58, 78 or 79 are reported. Under Administrative Guidance, on page 4 of the draft the first paragraph indicates:

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

It goes on to list the specific modifiers and their definitions and includes 58, 78 and 79.

The task force appreciates the in-depth review of the third bundle of rules by this insurance carrier, and would like to be sure they are aware that the Medicare Claims Processing Manual is one of the publically available sources that is used in the development of the draft rules, however the final payment rules may or may not strictly follow Medicare as other industry sources are also are part of the consideration process.

**Laboratory  
Rebundling  
302.V.01 11/4/13**

Comment: One national insurance carrier submitted comments indicating that the rule needed modification.

Under the Administrative guidance section, the draft rule references automated multi-channel tests and states “(e.g., codes 80002 – 80019).” We recommend deleting this parenthetical as CPT® deleted these codes many years ago and these codes are no longer in use.

Response: The task force acknowledges that it was in error in including the outdated reference to procedure codes 80002-80019. This note will be deleted from the Administrative guidance section.

Comment: The Task Force supports combining separate laboratory component codes into a more comprehensive laboratory panel code, aligning with CPT which requires all components to be present prior to reporting the panel code. Carrier uses CPT® coding guidelines to define the components of each panel.

Carrier also considers the number of individual component codes submitted before the services would be considered included in the more comprehensive Panel Code when reported on the same date of service by the Same Individual Physician or Other Health Care Professional. The Professional Edition of the CPT® book, Organ or Disease-Oriented Panel section states: "Do not report two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of

tests to fulfill the code definition and report the remaining tests using individual test codes."

For reimbursement purposes, Carrier differs from the *CPT*<sup>®</sup> book's inclusion of the specific number of Component Codes within an Organ or Disease-Oriented Panel. Carrier will bundle the individual Component Codes into the more comprehensive Panel Code when the combined reimbursement for the individual Panel Code(s) exceeds the reimbursement amount of the Panel Code **or** when the designated number of Component Codes identified within a Panel Code are submitted for *CPT*<sup>®</sup> codes 80047, 80048, 80050, 80051, 80053, 80061, 80069, 80074 and 80076

For reimbursement purposes, we follow CMS guidelines for bundling of the panel component codes into the comprehensive panel code. This decision was made following an analysis by our National Ancillary Services Committee, which determined the number of individual components that would need to be billed before the sum of the individual components would exceed the total allowance for the corresponding panel code according to CMS's National Clinical Laboratory Fee schedule. CMS methodology differs from the AMA *CPT*<sup>®</sup> which states all the individual components must be included before it is considered a panel for coding purposes.

Although the CMS methodology is considered "out of scope" by the Task Force, Carrier believes the rule should allow payers to give consideration to when the number of component codes would exceed the total allowance for the panel code.

Response: The task force acknowledged the carrier's concern relative to payment for panel codes in the draft rule under the Definition section:

"The task force recognizes that public and private payers commonly have a reimbursement maximum in place to limit the amount paid when individual components of a panel (but not all components) are billed separately. This type of payment edit is out of scope."

Edits that are out of scope for the task force will not be included in the final set of medical claims edits, for example such edit types include contractual and/or reimbursement edits, fraud and abuse edits or utilization review/frequency edits. The exclusion of these edit types does not mean that a carrier cannot utilize such edits in their systems, however, they should be clearly communicated to their provider community to ensure appropriate reporting.

We will revise the Summary section of the draft to match that of the definition.

Comment: We support the Task Force's position relating to modifier 91 to allow a repeat (duplicate) clinical laboratory test to be reimbursed on the same day. We also allow modifier 59 to signify that a repeat clinical laboratory test be considered a distinct and separate service, allowing a repeat (duplicate) clinical laboratory test if modifier 90 is not present on the claim. We would recommend that the Task Force consider this in addition to modifier 91, as information from both CMS and AMA indicate modifier 59 is appropriate for use on laboratory component codes.

Response: The task force agrees that modifier 59 is appropriate for use with some of the laboratory codes. Modifier 59 will be added to the draft rule with an example of when it might be used appropriately.

Comment: The proposed rule is silent on the use of modifier 90, Reference (Outside) Laboratory. Carrier's participation agreements generally prohibit reimbursement of laboratory services that are performed by a party other than the treating or reporting physician. Carrier requests clarification that this rule would not prohibit a payer, if it chose to do so, from denying laboratory services reported with modifier 90 as it signifies that the provider did not personally perform the service.

Response: Edits related to contracting/participation agreements and any related reimbursement are outside of the scope of the task force and as identified previously can be utilized by a carrier. They should be clearly communicated to the provider community.

**Maximum  
Frequency > 1 Day  
303.V01 11/4/13**

Comment: One national insurance carrier submitted comments indicating that the rule needed modification.

Carrier has a similar policy; however, we refer to it as the "From – To Date Policy."

The Rationale should also reference the National Uniform Claim Committee (NUCC) which develops and oversees the NUCC Data Set (NUCC-DS). The NUCC Data Set is a standardized data set for use in an electronic environment, but applicable to and consistent with evolving paper claim form standards. The *NUCC 1500 Health Insurance Claim Form Reference Instruction Manual For Form Version 08/05* provides instruction for the completion of the 1500 Health Insurance Claim form. This manual includes the following instruction for entering the dates of service:

"If one date of service only, enter that date under 'From.' Leave 'To' blank or re-enter 'From' date."

"If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G 'Days or Units' field."

The Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual Chapter 26, also states: "When 'from' and 'to' dates are shown for a series of identical services, enter the number of days or units in column G." CMS returns a claim as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

An example of a claim form submission where the service dates cannot be determined and therefore the claim cannot be processed:

Code	Modifier	Units	From Date	To Date
99213		3	2/10/2009	3/19/2009

The claim should be submitted as follows:

Code	Modifier	Units	From Date	To Date
99213		1	2/10/2009	2/10/2009
99213		1	2/25/2009	2/25/2009
99213		1	3/19/2009	3/19/2009

The Administrative Guide section should be more specific and provide the guidance consistent with NUCC and CMS. The Task Force should only consider reimbursement for claim lines, with a 'from' and 'to' date span greater than one day, when the units entered correspond or are equally divisible to the number of days indicated. Claim lines for which the 'from' and 'to' dates and units do not correspond, or are not equally divisible to the number of days indicated, will not be processed. The services will need to be resubmitted on separate claim form lines with the units matching the corresponding from and to dates.

The Administrative Guide section should consider providing guidance on how to correctly report services for which the CPT® or HCPCS code description specifies a time period for which it should be reported; i.e., weekly, monthly, or once for a specified time period.

Example II in the current rule indicates to report with one date of service and one unit of service for Cardiac monitoring greater than 24 hours and up to 30 days. For codes that cover a time span, Carrier strongly encourages the Task Force to provide guidance that it is appropriate to report 1 unit with the From and Thru Dates describing the beginning and ending dates for the time span the service were rendered.

Carrier recognizes there are exceptions to this Rule based on the uniqueness of some CPT® and HCPCS codes reported for services rendered. The following types of services Carrier would propose be exempt from this policy:

Certain CPT® and HCPCS codes, based on their description, are not intended to be reported on consecutive dates of service, but may be appropriate to report with a 'from' and 'to' date. For example, codes whose descriptions say per week, per month, per course of treatment would be considered exceptions to this policy. Refer to Carrier's "Time Span Codes Policy" for additional information. Codes that represent drugs or contrast and radiopharmaceutical imaging materials.

Global Maternity Codes. Refer to Carrier's "Obstetrical Policy."  
Time based Anesthesia codes. Refer to Carrier's "Anesthesia Policy."  
Unlisted codes.

Finally, Carrier would recommend including provisions that home care or DME providers are exempt from this rule. Their services are typically reported on a monthly basis and cover different dates within that same period. Their services may be reported with units that may not be equally divisible between the from and to dates reported on the claim. For example, a DME item that is rented for one month is reported with 1 unit with the from and thru dates indicating the monthly rental period.

Response: The Rules Committee discussed the commenter’s concerns during a conference call and agreed to include additional coding examples that would address correct coding when the services reported were less than or greater than those identified in the procedure code description. Additionally the Rules Committee will submit a proposal to the task force to combine the two Maximum Frequency rules into one combined rule titled Frequency. They felt this would alleviate some of the confusion and provide for expansion if the task force addresses any of the MUEs in the future.

**Multiple Endoscopy  
Reduction  
304.V01 11/4/13**

Comment: One national insurance carrier submitted comments indicating that the rule needed modification.

The proposal differs from CMS guidelines by applying multiple endoscopy reductions to services reported by the same individual physician or other health care professional, while CMS applies multiple procedure and endoscopy reductions to all reducible procedure reported by physicians and other health care professionals reporting under the same group practice, regardless of specialty. Please refer to the CMS sourcing.

Response: The task force did not adopt the complete Medicare definition of multiple surgery/endoscopy. Specifically, the task force did not discuss the application of the multiple procedure/endoscopy reduction when another physician or health care professional reporting under the same group practice provides services to the same patient during the same surgical session. The Rules Committee reviewed the definition again and recommends that the rule not be revised. If a payer defines “same” physician or other healthcare professional to mean any provider under the same tax ID number, this can be included as part of their contractual agreement.

Comment: Use of the modifier 51 is not a factor used by CMS to determine if an endoscopy reduction should apply. Use of the modifier 51 is intended to provide billing instructions, not adjudication guidelines per the Medicare Claim Processing Manual, Chapter 12, Section 40.6 B. Carrier recommends that the rule be modified to reflect that although the use of the modifier 51 is in accordance with billing guidance, the absence of a modifier 51 will not prohibit a payer from applying an endoscopic adjustment when two or more procedures with the MULT POC indicator 3 are billed the same physician or physicians in the same group on the same day for the same patient.

Response: The task force agrees with the commenter and will add the following note to the Administrative guidance section of the rule:

“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.”

Comment: Although the need for assistant and co-surgeon services are rare for endoscopy services, Carrier recommends provisions be included in the rule that when assistant surgeon and co-surgeon modifiers are reported, the endoscopic

reduction is determined ranking these services separately as described below:

- The services of primary surgeons are not ranked against the services reported by assistant surgeons, even if both primary and assistant surgeons are reporting under the same group practice.
- Co-surgeon services are subject to reduction if multiple endoscopic procedures reported with modifiers 62 are reported on the same date of service and by the same physician.

This is consistent with CMS.

Response: The task force agrees with the commenter and will add the following note to the Administrative guidance section of the rule:

“Assistant at surgery, co-surgery or team surgery multiple endoscopy procedures are not grouped with the primary surgeon’s. They are considered separately when determining the ranking.”

Comment: Carrier recommends that the Multiple Endoscopy rule address modifier 78. In alignment with CMS, reducible procedure codes, including endoscopic codes, reported with a modifier 78 will not be subject to the multiple procedure reductions. Refer to the CMS sourcing.

Response: The Rules Committee reviewed whether or not modifier 78 should be addressed in this rule and agreed that there should be an additional comment in the Administrative guidance section of the rule. When a payer applies a reduction based on the use of modifier 78 it is not appropriate to apply another reduction based on the Multiple Endoscopy Reduction rule.

The Rules Committee also recommends that the same Administrative guidance be added to the Multiple Procedure Reduction rule when it is finalized.

Comment: Not all payers have the ability to apply endoscopy reductions in the same method as described by CMS. Some payers may apply multiple procedure reductions to endoscopic codes by applying a 50% reduction rather than a reduction based on the value of the base endoscopic code within the same family. Often this method of reduction is more favorable to the physician than the endoscopic reduction. Publication of this rule may cause significant hardship to develop the system technology to administer endoscopic reductions in the same manner as CMS. Therefore, it is recommended that sufficient time be given to payers to accommodate the administration of this rule.

Response: The task force, as well as the national specialty societies, recognizes that not all payers utilize the CMS methodology for calculating multiple endoscopic reductions. For this reason the draft policy does not refer to any specific reduction percentages or amounts, and it does not reference the Medicare method of subtracting the base value from subsequent procedures within the same family as a means of arriving at the reduction. Rather it only references the Medicare fee schedule indicator of ENDO BASE as a means to further identify the endoscopic families of related procedures for ranking purposes.

In hopes of making this a little clearer within the rule itself, the final rule will include the following parenthetical remark:

“(The specific payment reduction is out of scope, see Context section below.)”

**Professional and  
Technical  
Component Rule  
207 V.01 9/4/13**

Comment: The College of American Pathologists (CAP) submitted additional comments concerning the technical component definition listed on page one of the Task Force’s Professional and Technical Component Edit/Payment Rule. This letter elaborates upon our previously recommended edits concerning the definition of the Technical Component (TC) modifier. On page one, under the heading of “Associated Current Procedural Terminology (CPT®), (the definition as listed in CMS’ most recent HCPCs terminology file) is listed below:

-TC Technical Component:<sup>[1]</sup> Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. The charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

Although this language is directly taken from CMS’ most recent HCPCs terminology file, the CAP disagrees with the contextual use of this language in the Colorado proposed coding edit guidance. Specifically, the CAP disagrees with the second sentence that states that TC “charges are institutional charges and not billed separately by physicians.” Absent conjunctive clarification, this language is inaccurate for pathology services. The plain fact is that pathologists, under Medicare and for private payers, are, in many cases, directly paid for TC services on the physician fee schedule. Thus, the current language proposed for the edit is taken out of proper context and would result in confusion and gross misapplication of the rule as applied to the TC of pathology services.

In support of our position, we would like to point your attention to CMS’ May 24, 2013 Change Request 8013, page 7. This paragraph includes the language of concern, but then further clarifies that payment for the TC of pathology services outside the institutional setting is made on the physician fee schedule directly to the provider. Without inclusion of this clarification, the prior statement, regarding facility based payment, is a substantial misrepresentation of facts. The below paragraph was extracted from this document and is shown below.

*B. Payment for Technical Component (TC) Services*

*1. General Rule*

*Payment is not made under the physician fee schedule for TC services furnished in institutional settings where the TC service is bundled into the facility payment, e.g., hospital inpatient and*

*outpatient settings. Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment, e.g., an ambulatory surgery center (ASC). Payment may be made under the physician fee schedule for the TC of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The physician fee schedule*

*identifies physician laboratory or physician pathology services that have a TC service.*

The CAP believes the above clarification should be incorporated into the MCCTF's Final Professional and Technical Edit/Payment File on page one, under the heading of "Associated Current Procedural Terminology (CPT). The CAP proposes the following alternative language that replaces the sentence in question with the above language from CMS' Change Request 8013:

-TC Technical Component: Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'TC' to the usual procedure number. ~~Technical component charges are institutional charges and not billed separately by physicians. Payment is not made under the physician fee schedule for TC services furnished in institutional settings where the TC service is bundled into the facility payment, e.g., hospital inpatient and outpatient settings. Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment, e.g., an ambulatory surgery center (ASC). Payment may be made under the physician fee schedule for the TC of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The physician fee schedule identifies physician laboratory or physician pathology services that have a TC service.~~ 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.

Response: As we indicated in our previous response, in the section of the draft rule referred to, *Associated Current Procedural Terminology (CPT®) and HCPCS modifiers*, the descriptions listed are taken directly from the source documents either CPT® or HCPCS. The task force does not have the option of revising these descriptions.

The task force can appreciate the concern that the definitions may be taken out of context and in response to the commenter's initial concern the task force expanded the footnote to the TC modifier description. It will now be revised to include a reference the Medicare Change Request as identified by the commenter.

<sup>2</sup> This is the Healthcare Common Procedure Coding System (HCPCS) definition and the reference to customary and prevailing profiles is specific to Medicare. Additionally as identified by the College of American Pathologists, the statement that "Technical component charges are institutional charges and not billed separately by physicians." is specific to Medicare. CMS clarified this explanation in Medicare Claims Processing Manual Transmittal 2714 dated May 24, 2013, Change Request 8013. Payment is not made under the physician fee schedule for TC services furnished in institutional settings where the TC service is bundled into the facility payment, e.g., hospital inpatient and outpatient settings. Payment is made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment, e.g., an ambulatory surgery center (ASC). Payment may be made under the physician fee schedule for the TC of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The physician fee schedule identifies physician laboratory or physician pathology

services that have a TC service.

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



Activity	2013										2014										Deadline	Status as of 01-14-14					
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec				
work on the draft edit rule recipes for the first bundle of rules and submit to task force for approval.																											
Task force reviews and approves first bundle of draft edit rule recipes.																									May 22	DONE	
First bundle of draft edit rule recipes circulated for review and comment.																									May 31	DONE	
Public comments due on 1 <sup>st</sup> bundle																									July 15	DONE	
Payment & Edit Committees review comments on 1 <sup>st</sup> 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>2<sup>nd</sup> bundle</u> : Edit and Payment Rules committees work on the draft edit rule recipes for second bundle of rules & submit to TF for approval.																										Early August	DONE
Task force reviews and approves draft second bundle of draft edit rule recipes.																										August 27 mtg	DONE
Second bundle of draft recipes issued for 5-week public review and comment.																										Sept 4	DONE
Public comments due on 2 <sup>nd</sup> bundle.																										October 4	DONE

\* In-person task force meeting.

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

Activity	2013										2014										Deadline	Status as of 01-14-14		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec	
Payment & Edit Committees review comments on 2nd set of recipes and make recommendations for revisions.																							Early November	DONE
After reviewing comments received on 2nd bundle draft edit rule recipes, 2nd bundle approved.																							November 26	DONE
<u>3rd bundle:</u> Edit and Payment Rules committees work on the draft edit rule recipes for the third bundle of claims edits and payment rules and submit to task force for approval.																							Early October	DONE
Task force reviews and approves draft 3rd bundle of draft edit rules.																							October 22 mtg	DONE
3rd bundle of draft recipes circulated 5-week public review and comment period. **																							October 25	DONE
Public comments due on 3rd bundle																							December 2	DONE
Payment & Edit Committees review comments on 3rd set of recipes and make recommendations for revisions.																							Early January	DONE
After reviewing comments on 3rd bundle of draft recipes, task force finalizes and approves.																							January 2014 TF mtg	

\* In-person task force meeting.

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

Activity	2013										2014										Deadline	Status as of 01-14-14		
	April	MAY*	June	July	AUG*	Sept	OCT*	Nov	Dec	JAN*	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov			Dec	
4 <sup>th</sup> bundle: Edit and Payment Rules committees work on the draft edit rule recipes for the fourth bundle of claims edits and payment rules and submit to task force for approval.																							Early November	DONE
Task force reviews and approves draft fourth bundle of draft edit rules.																							November 26	DONE
Fourth bundle of draft recipes circulated 30-day public review and comment period. **																							December 2	DONE
Public comments due on 4th bundle																							January 6	DONE
Payment & Edit Committees review comments on 4 <sup>th</sup> set of recipes and make recommendations for revisions.																							Late January 2014	DONE
After reviewing comments on fourth bundle of draft recipes, task force finalizes and approves.																							January 2014	
Update entire draft set with current codes. [2014]																								
Glossary developed with final set																							Ongoing	Ongoing

\* In-person task force meeting.

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



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

\* In-person task force meeting.

\*\* Only 30 days allowed for comments on 2<sup>nd</sup> and 3<sup>rd</sup> 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"> <li>• 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"> <li>○ who is responsible for establishing a central repository for accessing the rules and edits set and</li> <li>○ enabling electronic access--including downloading capability--to the rules and edits set; and</li> </ul> </li> <li>• Include a recommended schedule for payers that are commercial health plans to implement the standardized set.</li> </ul>	December 31, 2014	
Payers that are commercial plans shall implement the standardized set within their claims processing systems.	According to a schedule in Task Force rec's or Jan 1, 2016, whichever occurs first	
Payers that are domestic, nonprofit health plans shall implement the standardized set within their claims processing systems.	January 1, 2017	

\* In-person task force meeting.

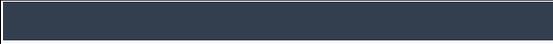
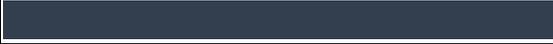
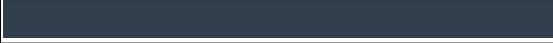
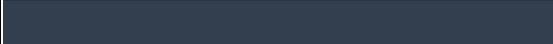
\*\* Only 30 days allowed for comments on 2<sup>nd</sup> and 3<sup>rd</sup> bundles in order to have enough time for complete all tasks to meet statutory deadline.



Rule	Bundle	Definition From EC	Rationale	HCPS/CPT Modifiers From EC	Query Tables Drafted	Rule Logic Drafted by PRC	Administrative Guidance Drafted By PRC	Specialty Outreach	TF Approval of Rule for PC	TF Response to PC	TF Consensus on Finalized Rule
Add-ons	2	X	X	X	X	X	X	X	X	X	X
G-Global Surgery Days (Modified to Global Procedures)	2	X	X	X	X	X	X	X	X	X	X
Global Maternity	2	X	X	X	X	X	X	X	X	X	X
New Patient	3	X	X	X	X	X	X	X	X	X	O
Max. Frequency- Span of Days	3	X	X	X	O	X	X	X	X	X	O
Same day med visit & med procedure	3	X	X	X	O	X	X	X	X	X	O
Multiple Endoscopy (Modified to include multiple procedure reduction)	3	X	X	X	O	X	X	X	X	X	O
Multiple E&M's Same Day	4	X	X	X	O	X	X	X	X	O	I
Bundled Service (Status B)	4	X	X	X	O	X	X	X	X	O	I
Rebundling	4	X	X	X	O	X	X	X	X	O	I
P- Modifiers effect on edits:	4	X	X	X	O	X	X	X	X	O	I
<b>Multiple radiology</b>	<b>N/A</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>OUT OF SCOPE</b>	
<b>Multiple phys. Therapy</b>	<b>N/A</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>OUT OF SCOPE</b>	

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

Rule	PROGRESS BAR	% Done	Number of "X's"	Number of "O's"	Number of O's Multiplied by (.5)	[# of "X's" in Row] + [(# of "O's" in row )(0.5)]
Add-ons		100%	10	0	0	10
G-Global Surgery Days		100%	10	0	0	10
Global Maternity		100%	10	0	0	10
New Patient		95%	9	1	0.5	9.5
Max. Frequency- Span of Days		90%	8	2	1	9
Same day med visit & med procedure		70%	6	2	1	7
Multiple Endoscopy		90%	8	2	1	9
Multiple E&M's Same Day		80%	7	2	1	8
Bundled Service (Status B)		80%	7	2	1	8
Rebundling		80%	7	2	1	8
P- Modifiers effect on edits:		80%	7	2	1	8
<b>Multiple radiology</b>		100%	7	0	0	7
<b>Multiple phys. Therapy</b>		100%	7	0	0	7

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

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

American Medical Association

Anthem Blue Cross and Blue Shield

Bloodhound Technologies (Verisk Analytics)

Colorado Medical Group Management Association

Colorado Hospital Association

Colorado Medical Society

Community Reach Center

KEENE Research and Development

NHXS

Rocky Mountain Health Plans

RT Welter & Associates

University Physicians

United Health Group

Western Nephrology

The Colorado Health Foundation

The Colorado Trust

The State of Colorado

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

Date: January 1, 2014

**[Draft] MCCTF GLOSSARY OF TERMS - 1/14/14**

<b>Term</b>	<b>Definition</b>
<b>Act</b>	As used in this report, the Medical Clean Claims Transparency and Uniformity Act (Colorado HB-10-1332).
<b>Base Set</b>	The standardized edits and rules established pursuant to the act that consist of rules and edits drawn from national industry sources listed in the act (e.g., the National Corrective Coding Initiative and Medicare physician fee schedule).
<b>Claim Edits</b>	Adjustments by payers to the procedure codes physicians use to describe and bill for services that are part of the process payers use to determine whether a particular claim for payment should be paid and at what level. (See definition of <b>edit</b> below.)
<b>Complete Set</b>	The base set of standardized edits and rules and edits and rules for health services involved in a medical claim that are not encompassed by the national industry sources established pursuant to the act.
<b>Current Procedural Terminology (CPT®) code set</b>	A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. CPT® is a registered trademark of the American Medical Association. Copyright 2012 American Medical Association. All rights reserved
<b>Data Analytics</b>	The process the task force will use to do data runs on and analyses of the universe of edits that companies and organizations are willing to share with the task in order to select the edits that will constitute the final recommended set.
<b>Data Sustaining Repository</b>	The place (not necessarily a physical location) where the standardized set is “housed,” updated and maintained and electronic access to the standardized set, including downloading capability.
<b>Data Sustaining Repository Committee (DSR Committee)</b>	Subcommittee of the task force; responsible for examining how the standardized set will be maintained and sustained.
<b>Edit</b>	§25-37-102(4), C.R.S., defines an edit as “a practice or procedure, consistent with the standardized set of payment rules and claim edits developed pursuant to section 27-3-106 that results in - (a) payment for some, but not all of the codes; (b) payment for a different code; (c) a reduced payment as a result of services provided to a patient that are claimed under more than one code on the same date of service; (d) modified payment related to a permissible and legitimate modifier used with a procedure code as specified in section 25-37-106(2); or (e) a reduced payment based on multiple units of the same code billed for a single date of service.”
<b>Edit Committee</b>	Subcommittee of the task force; responsible for identifying definitions and edits for the base set
<b>Federation of Medicine</b>	The term “Federation” is used by the AMA to describe the state, county and specialty medical societies (e.g., American Academy of Pediatrics, American College of Radiology, American College of Surgeons) represented in the AMA House of Delegates that work together to advance the agenda of physicians and their patients. The Federation of Medicine includes 122 national specialty societies and 50 state medical societies

<b>Healthcare Common Procedure Coding System (HCPCS)</b>	Provide standardized coding when health care is delivered. HCPCS was developed in 1983 by the Health Care Financing Administration (now the CMS) to standardize the coding systems used to process Medicare claims on a national basis. The HCPCS is structured in 2 levels. Each of the 2 HCPCS levels is its own unique coding system. Level I is the AMA CPT® code set, which makes up the majority of the HCPCS. Most of the procedures and services performed by physicians and other qualified health care professionals are reported with CPT® codes. Level II national codes are assigned, updated, and maintained by CMS. These codes describe services and supplies not found in the CPT® code set, for example, durable medical equipment, medical/surgical supplies, drugs.
<b>ICD-9/ICD-10</b>	ICD means International Statistical Classifications of Diseases. ICD codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to human beings. ICD-9 is the classification that has been in place since 1977. ICD-10 is the newest classification of diseases that is in the process of being implemented by all payers and providers
<b>Modifiers</b>	These are used in addition to a CPT® code to add more information on the claim. They state special circumstances that may affect the amount the physician will be reimbursed. For example, a modifier may indicate unusual circumstances that made a procedure more complicated and may warrant additional payment or that led to a procedure being discontinued, which may not warrant full payment. A modifier is appended to a five digit CPT® code and "...provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code." (American Medical Association, "Appendix A", CPT® (Current Procedural Terminology) Professional Edition, 2013. P 595.)
<b>National Medical Specialty Society</b>	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.
<b>National Correct Coding Initiative (NCCI)</b>	A system used to promote consistency in claims coding and to control improper coding leading to inappropriate Medicare claims payments for professional health care services.
<b>Out of Scope Edits</b>	Edits that are not within the task force's purview because they are addressed as part of other edit types already included in the standardized set; are part of a different stage in the claims processing system; are used by the payer to internally administer applications of variations in payment or benefits based on either the provider's or member's contract; or are Medicare or Medicaid-specific.
<b>Payment Rule</b>	Indicates how codes should be reported and which codes are eligible for a pricing adjustment. Payment rules are a statement of how a submitted procedure code, procedure code combination should be processed when an edit has been triggered. The task force agreed that its legislative mandate is to elucidate and standardize coding rules—including payment rules, but that specific amounts for pricing adjustments to specific codes are out of scope. The task force may, however, describe those coding scenarios that are unique and may be eligible for differentiated pricing.
<b>Payment Rules Committee (i.e. 'Rules Committee')</b>	Subcommittee of the task force that is responsible for developing payment (but not pricing) rule recommendations.

<b>Pricing Rule</b>	As used in this report, refers to a rule that specifies the amount for pricing adjustments to coding. Pricing rules are out of scope. Reported codes subject to a specific payment rule would be adjusted by a payer pricing rule that would apply a payment adjustment amount to a contracted rate. For example, reported codes eligible for the bilateral adjustment would be subject to a payer pricing rule.
<b>Professional Functions and Entities</b>	Refers to rule making about the standardized set once it is established, including decisions about which edits and rules are in, out or modified over time.
<b>Proprietary or Payer-Specific Edits</b>	Edits that are specific to an Insurance company; there are millions of proprietary edits.
<b>Resource-Based Relative Value Scale (RBRVS)</b>	A schema used to determine how much money medical providers should be paid.
<b>RFI (Request for information)</b>	The task force issued (and received responses to) a request for information about potential strategies for, and the cost to design and develop, an online data repository. The purpose of the RFI, which was released May 3, 2012, was to invite input, better understand potential strategies and costs associated with the design and development of an online data repository, and solicit innovative solutions. It explained that the information gathered from the RFI would help to inform request for proposals (RFP).
<b>RFP (Request for proposals)</b>	The task force issued a request for proposals (RFP) in 2013 for [a] data analytics contractor[s] that would compile the edits that companies and organizations would like to see in the standardized set and, at the direction of the task force, analyze the edits to arrive at a recommended standardized set.
<b>Rule Bundles</b>	The task force released a number of payment rules (see <i>payment rule</i> in glossary) for a period of public review/comment. These rules were systematically organized into four separate releases – each ‘grouping’ of rules that were released is referred to as a ‘bundle’ (bundle 1, bundle 2 bundle 3 and bundle 4).
<b>Source</b>	Refers to the list of publically available 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.
<b>Standardized Set</b>	The standardized set of claim edits and payment rules recommended by the task force that all payers having contracts in Colorado must use to edit claims as of the dates outlined in the act.
<b>Task Force (MCCTF)</b>	The task force created by the Medical Clean Claims Transparency and Uniformity Act, HB 10-1332.
<b>Technical Functions and Entities</b>	Refers to rule distribution, display and access to the standardized set after it has been established.
<b>Voluntary National Initiative</b>	A national collaborative effort that was overseen by the federal Department of Health and Human Services (HHS) consisting of a diverse group of stakeholders for the purpose of reaching consensus on a complete or partial set of standardized edits. The national initiative no longer exists

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

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

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



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

### Edits outside of the scope of this act (Out-of-Scope Edits)

#### 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 a report to the General Assembly and Department of Health Care Policy & Financing with 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®)<sup>1</sup> coding guidelines and conventions; and national medical specialty society coding guidelines.

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

#### Out-of-Scope

The Medical Clean Claims Transparency and Uniformity Act explicitly identifies certain types of edits that are not to be included in the standard set of payment rules and medical claim edits. Those include:

- Adjustments based on fraud or abuse,
- A finding that a procedure is not medically necessary not covered by the patient's health benefit plan,
- Contractual arrangements or terms negotiated between providers and payers, including fee schedules.

Additionally, the task force has defined out-of-scope edits as edits that are not within the task force's purview because they:

- Are addressed as part of other edit types already included in the standardized set,
- Are part of a different stage in the claims processing system,
- Are used by the payer to internally administer variations in application of payment or benefit, or
- Are Medicare or Medicaid specific.

As part of its work, the task force also addressed a number of payment rules commonly used by payers in the processing of claims and as with the edit types found that certain payment rules that it considered out-of-scope. The task force is only standardizing how the coding scenarios eligible for differentiated

<sup>1</sup> Copyright 2013 American Medical Association. All Rights Reserved.

payment are to be applied to those negotiated fee schedules. They should not consider:

- Implementation or budget constraints,
- Political influences,
- Or benefit limitations.

The task force understands the need for cost containment, but similar to the edit type “utilization review” that can be used to control costs by limiting the diagnoses or frequency of specific services, these fall outside of the scope of work for the task force and should not be included as part of, or influence, a standardized set of edits and payment rules. The payment rules must not affect payers’ ability to negotiate an agreed upon contracted rate with physicians and other health care providers for the performance of medical procedures and services.

Specific examples of out-of-scope edits identified by the task force are defined below. The exclusion of these from the standard set of payment rules and claim edits does not necessarily preclude a payer from utilizing them, for example, if they are clearly communicated to the provider in the case of administrative requirements, and/or agreed to if part of a contractual relationship.

<b>Duplicate</b>	Edits used to check for duplicate claims/services are Administrative and intended to ensure processing of “clean claims.” For example Medicaid utilizes this edit to check for duplicate for inpatient, Medicare Part A Crossover claims, Medicare UB04 Part B Crossover and Outpatient claims.
<b>Validation of Procedure Code to Provider Type</b>	This edit identifies a mismatch between the combination of the procedure code & modifier submitted to that expected to be billed by the provider, based on the way the payer’s provider file is set up or the scope of the provider’s license/certification. For example, the procedure code is PT and the rendering provider is a speech therapist. This is another example of an Administrative edit.
<b>Validation of Category of Service to Provider Type</b>	This edit matches the category of service billed to that expected to be billed by the provider, based on the way the payer’s provider file is set up. The Medicaid program utilizes this Administrative edit.
<b>Missing Modifier</b>	There are multiple benefit programs under Medicaid and they use specific modifiers to identify what type of coverage the Medicaid recipient is entitled to. This is a Benefit edit.
<b>Pricing File Not Loaded</b>	This edit would cause a claim to pend for manual pricing, and is another example of an Administrative edit.
<b>Pricing File Requires Manual Pricing/Split Claim</b>	This edit would cause a claim to pend for manual pricing, and is another example of an Administrative edit.
<b>Manual Pricing Required</b>	This edit is a payer specific and may be required in order to price the claim correctly. It is Administrative in nature.
<b>Multiple Procedure Percentage Reduction (MPPR)</b>	This type of edit was specifically developed by Medicare and has been applied to multiple imaging procedures and multiple therapy services. As part of the Affordable Care Act, Medicare was directed to potentially expand its use to other types of procedures. The task force has determined that these types of edits are out-of-scope. As the MPPR is the result of legislative and regulatory direction given to the Medicare program the task force wanted to ensure that

the rationale for this decision is documented. The following is taken from the Medical Clean Claims Transparency and Uniformity Act Task Force report to the Colorado General Assembly dated November 30, 2012:

Section I. A. Key Provisions – The task force defines out-of-scope edits as edits that are not within the task force’s purview because they: are addressed as part of other edit types already included in the standardized set; are part of a different stage in the claims processing system; are used by the payer to internally administer variations in application of payment or benefit based on either the provider’s or member’s contract; or are Medicare or Medicaid-specific.”

The report further defined the guidelines used in the development of standardized Payment Rules as:

Payment rules for coding scenarios that are unique and eligible for differentiated payment should not consider implementation or budget constraints, political influences or benefit limitations. The task force understands the need for cost containment, but similar to the edit type “utilization review” that can be used to control costs by limiting the diagnoses or frequency of specific services, these fall outside of the scope of work for the task force and should not be included as part of, or influence, a standardized set of edits and payment rules.

The payment rules must not affect payers’ ability to negotiate an agreed upon contracted rate with physicians and other health care providers for the performance of medical procedures and services. The task force is only standardizing how the coding scenarios eligible for differentiated payment are to be applied to those negotiated fee schedules.

In recent years, Medicare has expanded the application of the Multiple Procedure Payment Reduction (MPPR) to diagnostic imaging, both the professional and technical components; the practice expense portion of certain therapy services; and most recently to the technical component of diagnostic cardiovascular and ophthalmology services. This expansion has been driven by legislative action for cost containment. The question was raised regarding whether or not a payer that currently has one of these edits in place could continue that practice once the standardized set is implemented. These edits will not be part of the Colorado Medical Clean Claims standard set of claims edits and payment rules, however, as noted above this does not preclude the payer from utilizing such an edit if it is in place to administer variations in application of payment based on the provider’s contract.

The question was raised regarding why/how these MPPR rules differ from the multiple procedure (C) and multiple endoscopy edits that have been adopted by the task force. The AMA staff explained the difference between the rules. Multiple surgery and multiple endoscopy payment adjustments have been based on resource cost and the fundamentals of the RBRVS. That is, the RVU for each of these procedures includes pre-service, intra-service and post-service in the form of work/time, practice expense and malpractice expense. The RUC

applies the concept of multiple procedural reductions, the pre-service and post-service is only performed once when multiple procedures are performed at the same time to avoid overlap, when it makes a RVU recommendation. This process has been accepted by the profession.

In 2010, Section 3134 of the Affordable Care Act (ACA) added section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. This has given rise to Medicare's expansion of the MPPR and bypasses the established CPT/RUC process. The AMA and organized medicine as a whole has expressed its objections to this approach. Their contention is that there is a process already in place through the CPT/RUC to have concerns about overlap in resource cost addressed on a case-by-case basis. Payers, providers, CMS can request that the CPT/RUC evaluate procedure codes to determine within the fundamentals of the RBRVS if there is resource overlap and make recommendations to adjust the value and/or changes to the procedure coding to address the duplication.

Regarding the physical therapy codes within the 97001-97755 range that are subject to the MPPR adjustment, the AMA pointed out that there is a specific coding instruction that modifier 51 should not be appended to these codes. The reason for this note is that when the procedures were valued the RUC recognized that these were not stand-alone procedures, they would always be done in combination, and they were valued accordingly to avoid overlap in the resource cost.

Medicare identifies those procedure codes that are subject to the special MPPR payment adjustment rules by the use of specific indicators on the Medicare Physician Fee Schedule in the column labeled MULT PROC. Indicator 4 identifies diagnostic imaging procedures, indicator 5 identifies therapy services, indicator 6 identifies diagnostic cardiovascular procedures, and indicator 7 identifies diagnostic ophthalmology procedures. The task force will not utilize these indicators in the development of its edits and/or payment rules. Furthermore, if Medicare continues to expand its application of the MPPR outside of the RUC process, as directed by the ACA, any additional services identified for adjustment will be considered out-of-scope.