Medical Clean Claims Transparency and Uniformity Act Task Force

Report to:

SUE BIRCH, EXECUTIVE DIRECTOR
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

MEMBERS OF THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE
COLORADO GENERAL ASSEMBLY

MEMBERS OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
COLORADO GENERAL ASSEMBLY

In accordance with § 25-37-106(2)(d)(I), C.R.S. of the Medical Clean Claims Uniformity and Transparency Act

November 30, 2012

Medical Clean Claims Transparency and
Uniformity Act Task Force

November 28, 2012

TO: Members of the Colorado General Assembly Health & Human Services Committees

Sue Birch, executive director, Colorado Department of Health Care Policy & Financing

On behalf of the Medical Clean Claims Transparency and Uniformity Act task force, we are pleased to submit this report pursuant to § 25-37-106 (2)(d)(I), C.R.S. The statute requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing by November 30, 2012, a report and recommendations concerning a set of uniform, standardized payment rules and claim edits to be used by all payers to process claims in Colorado. A second report will be submitted by December 31, 2013.

The task force appreciates the opportunity to be a model for the country in establishing a standardized set of payment rules and claims edits. This is a critical element of the State's strategy to reduce health care administrative costs. If you have questions, please contact us.

Sincerely,

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EXECUTIVE SUMMARY: 2012 REPORT

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 required the task force to submit to the General Assembly and Department of Health Care Policy & Financing by November 30, 2012, an interim report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers to process Colorado claims. A second report is due by December 31, 2013.

The main problem the act addresses is the widely different edits and rules that payers use to process the same claim, which adds to health care costs. By establishing a standard way to edit claims, the Medical Clean Claims Transparency and Uniformity Act seeks to:

- Eliminate excessive current claims submission, payment and reconciliation costs;
- Reduce administrative redundancies;
- Remove an element of the ambiguity and complexity of the claims process;
- Make it easier for patients to determine their financial obligations;
- Promote greater payment transparency across payers; and
- Save Coloradans an estimated $80 million annually in costs related to claims processing.

Task Force Progress

Over the past two years, the task force has reached a number of milestones. Highlights include:

- Developed guiding principles that focus on administrative simplicity--consistency, transparency, standardization and improved system efficiency;
- Conducted an analysis of, and made a determination that, the Medicare edit set, which is an important source of edits for the standardized set, *does* include edits to support commercial claims;
- Confirmed that, for the most part, the national medical specialty societies are comfortable with how Medicare develops its edits;
- Reached consensus on definitions for most of the types of edits the act requires the task force to consider--definitions that will drive selection of the edits in the standardized set;

- Worked through a number of challenging issues, including whether specific pricing adjustment amounts are part of the task force's charge (the task force decided they were not);
- Compiled definitions and associated payment rules from several different sources for 32 payment rule modifiers and began working through the difficult process of finding consensus on which rules to use;
- Put together a detailed list of data sustaining repository responsibilities and essential functionalities;
- Issued and received responses to a request for information about potential strategies for, and the cost to design and develop, an online data repository;
- Drafted a request for proposals and approved criteria to select a contractor to compile the universe of existing edits and conduct analyses to inform development of the standardized set; and
- Identified alternative procedures for updating and making other changes to the standardized set after it has been implemented.

Recommendations

1. The task force recommends continuing its work, as provided for in statute, to develop a standardized set.

2. The task force recommends amending the act to extend by one year the deadline for the task force's final report and the effective dates for payer implementation of the standardized set.

   The task force has laid the groundwork for creating a standardized set of edits and rules and a central repository to access them. The work has taken longer than expected due to unanticipated challenges and national developments discussed in the report. Despite coming to the table with different concerns and perspectives, task force members have demonstrated their commitment to finding consensus on a standardized set and are well along the road to fulfilling their legislative charge but need more time to finish the job.

3. The task force recommends that the General Assembly's health and human services committees and executive director of HCPF write to the Secretary of the Department of Health and Human Services to request public access to the rationales for Medicare's edits as they relate to specific codes and/or code pairs.

   The work of the task force has been made more difficult because it has been unable to determine the rationales for all of Medicare's edits—a major source of edits for the

standardized set. The rationales are not publically available although the task force is not aware of any compelling reasons for this policy.

Conclusion

Colorado leads the nation in efforts to standardize claim edits and payment rules across private payers. It has had more success getting and keeping key stakeholders at the table and achieving consensus on difficult issues than any other state or national initiative. According to Walter Suarez, co-chair of the National Commission on Vital Health Statistics' committee on administrative simplification and health reform, "Colorado's [effort] remains the only significant work in this area."

By creating uniform medical claim edits and payment rules to be shared among all payers in Colorado, both payers and providers will be unburdened of tens of millions of dollars of administrative redundancy and outright waste, which can be redirected toward reducing the actual cost of care.

Barry Keene, task force co-chair

INTRODUCTION

Colorado enacted House Bill 1332, the Medical Clean Claims Transparency and Uniformity Act ("**the act**") in 2010. (See Appendix A for a copy of the act.) The legislation, which had broad bipartisan support, required the executive director of the Department of Health Care Policy and Financing (HCPF) to convene a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules ("**standardized set**") to process medical claims. All payers having contracts in Colorado must use the standardized set and only the standardized set to edit claims starting January 1, 2015, for commercial health plans and January 1, 2016, for domestic nonprofit plans. The legislation did not provide state funding, instead it authorized the task force is to accept grants, donations and gifts.

The act established the Medical Clean Claims Transparency and Uniformity Act Task Force ("**the task force**") and directed it to "submit a report and recommendations concerning the set of uniform, standardized payment rules and claim edits to the executive director of HCPF and the health and human services committees of the senate and house of representatives [of the Colorado General Assembly], or their successor committees, by November 30, 2012."[1] A second report is due at the end of 2013.[2]

The report reviews the task force's accomplishments and presents recommendations concerning the following, as prescribed by the act:

- Development of a base and complete standardized set of edits and payment rules;
- Establishment and operation of a central repository for accessing the rules and edits; and
- A schedule for commercial plans to implement the standardized set.[3]

The report has five parts. The first outlines the act's major provisions and reviews the problems addressed by, and goals of, the act. The second describes the task force, including its membership, the process it has used to address its charge, funding and staffing, and coordination with related efforts. The third reviews the progress the task force has made on development of the base and complete set of standardized claim edits and payment rules. The fourth discusses the groundwork the task force has laid concerning establishment and operation of a central repository of edits and rules. The final part presents the task force's recommendations.

[1] § 25-37-106 (2)(d)(I), C.R.S.
[2] § 25-37-106 (2)(d)(III)(b), C.R.S.
[3] § 25-37-106 (2)(d)(I), (III), (IV) and V(A), C.R.S.

Key terms are defined when first used and are included in the glossary in Appendix B. The first time a term is used and defined, it is shown in boldface.

Acknowledgements

Thank you to task force contract staff **Laura Powers** and **Kirsten Michel**; survey researcher and original task force organizer **Kelly Shanahan-Marshall**, Engaged Public; facilitator and senior consulting adviser, **Barbara Yondorf, Yondorf & Associates**; and consultant **Joan Henneberry**, Health Management Associates, who helped draft the task force's request for information.

Thanks also to the **Board of The Bell Policy Center** for agreeing to serve as fiscal sponsor and Bell Policy Center staff **Bob Semro** and **Molly Cross Leone** for administering the task force budget.

Special thanks to **The Colorado Health Foundation** and **The Colorado Trust** for grants to support the work of the task force.

The task force also appreciates funding received from the following organizations and companies: the **American Medical Association, Anthem Blue Cross and Blue Shield, Bloodhound Technologies (Verisk Analytics), CIGNA, Colorado Medical Group Management Association, Colorado Hospital Association, Colorado Medical Society, Community Reach Center, Gateway EDI, KEENE Research and Development, NHXS, Rocky Mountain Health Plans, RT Wellter & Associates, University Physicians, UnitedHealth Group, Wellpoint and Western Nephrology.**

The report was drafted by Barbara Yondorf at the direction of the task force**.**

I. THE MEDICAL CLEAN CLAIMS UNIFORMITY AND TRANSPARENCY ACT

The Medical Clean Claims Uniformity and Transparency Act is an important component of Colorado's blueprint for health care for all Coloradans. It is part of the effort to make health insurance more transparent and affordable. It promises to reduce unnecessary administrative costs by simplifying the health care billing, payment and claims reconciliation process.

A. Key Provisions

The act (see Appendix A) calls for development of a standardized set of claim edits and payment rules to process claims for care delivered in Colorado. **Claim edits** are payment adjustments by payers to the procedure codes physicians and other health care providers use to describe and bill for services.[4] **Payment rules** indicate how codes should be reported and which are eligible for pricing adjustment.[5] They are part of the process payers use to determine whether a particular claim for payment should be paid and at what level. Figure 1 describes the process and highlights the stage in the process that is the focus of the act.

The act does not apply to adjustments based on fraud or abuse or a finding that a procedure is not medically necessary or not covered by the patient's health benefit plan. In addition, it does not limit contractual arrangements or terms negotiated between providers and payers, including fee schedules. The Medical Clean Claims Uniformity and Transparency Task Force, described in Part II, also has agreed that the act does not apply to **pricing rules**,[6] although it reserves the right to describe scenarios that are eligible for differentiated pricing.

The act distinguishes between two types of rules and edits: a base set and a complete set. The **base set** consists 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). The **complete set** includes the base set plus edits and rules for health services involved in a medical claim that are not encompassed by the national industry sources.[7]

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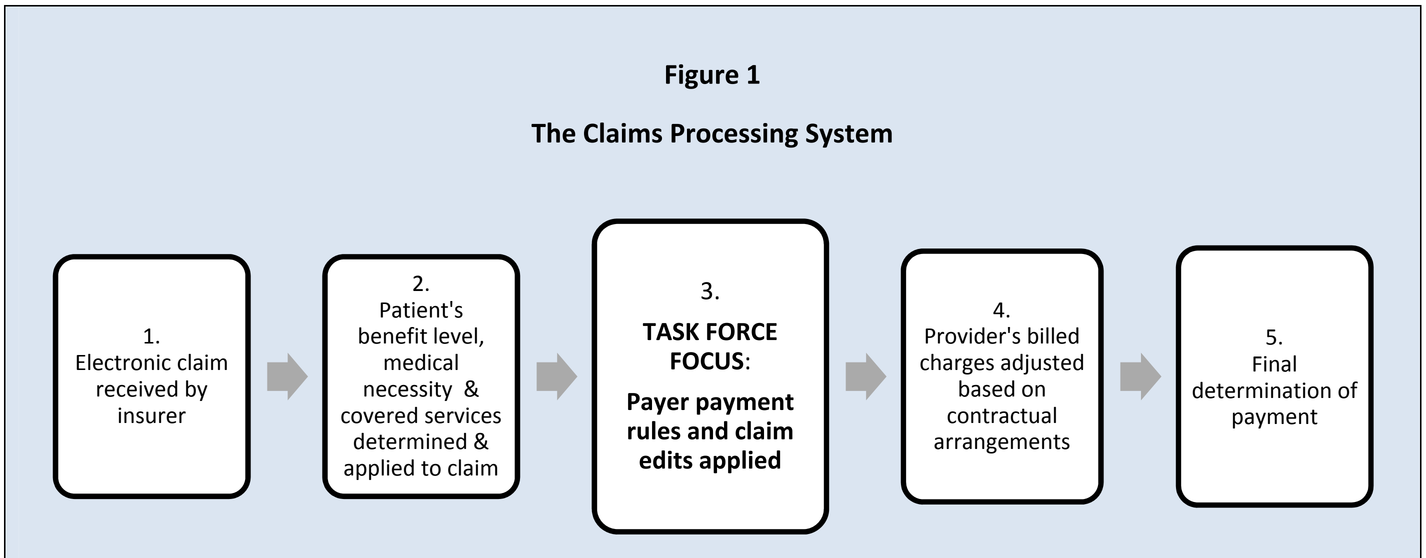
[4] See Glossary for the statutory definition "edit."

[5] Payment rules are a statement of how a submitted 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.

[6] Pricing rules are out of scope. (For a fuller description and discussion, see Glossary.)

[7] §25-37-106(2)(c)(I), C.R.S.



The act establishes a task force appointed by the executive director of HCPF that is responsible for establishing the standardized set and making recommendations concerning how the set will be implemented, updated and disseminated. Part II describes the task force and its duties.

The act requires any person or entity that contracts with a health care provider in Colorado to comply with the act and include the provisions required by the act in the contract. This includes not only commercial health plans but also third-party administrators of self-insured health plans that have contracts with providers in Colorado.[8] Enforcement of the act is by private right of action.

The act does not apply to Medicaid and Medicare. These programs use their own set of rules and edits that are the same for both government programs, with a few state-specific exceptions. The rules and edits are defined by the Centers for Medicare and Medicaid Services (CMS). While the act does not apply to Medicaid and Medicare, it does direct the task force to look to the same rules and edits used by these programs as a main source for creation of the standardized set. It also requires a representative from the Colorado Medicaid program to sit on the task force.

Once the standardized set is established and implemented, no other rules or edits can be applied to modify payment of claims, except as provided in the act.

The act requires the task force to submit reports and recommendations, and payers to come into compliance with the act, by certain dates (see Table 1). It provides for the deadlines to be delayed a year if a national collaborative effort overseen by the federal Department of Health and Human Services (HHS) and consisting of a diverse group of stakeholders has not reached consensus on a

[8] The act defines **payers** as "persons or entities that pay for health care services" § 25-37-106(2)(a)(I)(B),C.R.S.

complete or partial set of standardized edits before November 30, 2012. This report refers to the collaborative effort as the **voluntary national initiative**.

Table 1. Statutory Deadlines

Activity	Deadline
If, at the time the Task Force submits its report, the voluntary national initiative has reached consensus on a complete or partial set of standardized payment rules and claims edits (it did not):	
• The task force shall submit a report and recommendations concerning the standardized set to HCPF and the Legislature's health and human services committees. The report shall: – Make recommendations concerning the implementation, updating, and dissemination of the standardized set, including who is responsible for establishing a central repository for accessing the rules and edits set and enabling electronic access, including downloading capability, to the set; and – Include a recommended schedule for payers that are commercial health plans to implement the standardized set.	Nov. 30, 2012
• The task force shall present its report and recommendations to a joint meeting of the Colorado House and Senate Human Services Committees.	Jan. 31, 2013
• Commercial plans shall implement the standardized set within their claims processing systems.	Jan. 1, 2014
• Domestic, nonprofit health plans shall implement the standardized set within their claims processing systems.	Jan. 1, 2015
If, at the time the Task Force submits its report, the voluntary national initiative has not reached consensus on a complete or partial set of standardized payment rules and claims edits (it did not):	
• The Task Force shall continue working to develop a complete set of standardized edits and shall submit a report and may recommend implementation of a standardized set to be used by all payers and health providers.	Dec. 31, 2013
• Payers that are commercial plans shall implement the standardized set within their claims processing systems.	Jan. 1, 2015
• Payers that are domestic, nonprofit health plans shall implement the standardized set within their claims processing systems.	Jan. 1, 2016

B. Problem Addressed by the Act

The main problem the act addresses is the widely different edits and rules used by payers to process the same claim, which adds to health care costs. The example below illustrates the problem.

> *Bill, Tom and Mary have the same doctor but different insurance companies. Their doctor gave each of them an annual physical exam, cleaned their ears, and billed their companies for services rendered. Bill's carrier said ear wax cleaning was just part of the annual checkup and denied the charge for the ear cleaning. Tom's company said the ear procedure should have been under a separate visit and did not recognize the procedure as part of an annual exam. Mary's company said the cleaning was done as part of an annual physical and paid for the procedure at a reduced rate. Each company is employing different edits to process a claim for the same services.*

Insurance companies use millions of claim edits that are specific to them, known as **proprietary or payer-specific edits**. The American Medical Association (AMA) estimates that there are more than two million proprietary edits currently being used by payers to deny physicians' claims.[9] Most physicians have contracts with more than 20 payers, many with multiple products.[10] Physician billing requires tracking the specific rules of each. The plethora of different payer processing rules increases the potential for provider and payer claims processing errors, resulting in additional appeal process costs. One study estimated that the claims payment system costs physicians an estimated 10 percent to 14 percent of revenue just to get paid.[11]

Processing the same claim differently has implications for the degree to which a particular plan is adequate to meet an individual's needs and makes it difficult to compare the value of different plans. It may result in higher out-of-pocket costs under one plan than another, something not captured in descriptions of patient co-pays, co-insurance, etc. Thus coverage may not be as adequate on a particular plan as what the patient thought. Standardized claims processing rules address this problem.

The AMA summarized the problems created by lack of standardization of claim edits (the subject of this report) and pricing rules in a white paper on standardization of a code editing system:

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[9] American Medical Association Advocacy Resource Center, *Discussion Paper: State Health Insurance Exchanges"* (Chicago: AMA, 2011); http://www.ama-assn.org/resources/doc/arc/exchange-issue-brief.pdf

[10] American Medical Association, *Standardization of the Claims Process: Administrative Simplification White Paper* (Chicago: AMA, June 22, 2009); www.ama-assn.org/resources/doc/psa/admin-simp-wp.pdf.

[11] James G. Kahn et al., "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians and Hospitals, *Health Affairs:* 24 no. 6 (2005), 1629-1639; http://content.healthaffairs.org/content/24/6/1629..

The complexity and variation results in confusion for all stakeholders:

- *Physicians cannot predict what they will be paid;*
- *Consumers cannot predict what services will cost or understand the explanation of benefits (EOBs) they receive [both as a result of differences in benefit design and lack of a standardized set of claim edits and payment rules used by all payers];*
- *Practice management systems cannot automatically reconcile and post payments;*
- *Payers incur the cost of handling unnecessary appeals; and*
- *Confusion and trust issues between the trading partners [e.g., payers and providers] have undermined the ability of parties to collaborate effectively on quality improvement activities."*[12]

Evidence exists for the value of a uniform, transparent, standardized set of payment rules and edits. Medicare found that use of a standardized set for Medicare claims reduced payment errors. A United Healthcare pilot found that real-time claims adjudication, which allows a claim to be submitted to an insurer and settled before a patient leaves the office, reduced accounts receivable by 13 percent and decreased the average time to collect insurer and patient payment from 45 days to six at one practice—substantially reducing claims payment administrative costs.[13] This is possible only with a standardized edit set.

C. <u>Goals of the Act</u>

By establishing a uniform, standardized way to edit claims that must be used by all entities paying claims in Colorado, the act seeks to:

- Eliminate the excessive costs of the current claims submission, payment and reconciliation process;
- Reduce administrative redundancies;
- Remove an element of the ambiguity and complexity of the claims process, thus facilitating adoption of point-of-service pricing;
- Make it easier for all stakeholders (including patients with high-deductible plans) to determine their financial obligations both pre- and post-service;

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[12] American Medical Association, *Standardization of a Code-Editing System White Paper* (Chicago: AMA, Nov. 2011; http://www.ama-assn.org/resources/doc/psa/standardization-code-editing-whitepaper.pdf.

[13] Elliott, Victoria Staff, "Practices See Slow Progress in Instant Claims Adjudication," *amednews.com*, August 17, 2009; http://www.ama-assn.org/amednews/2009/08/17/bil20817.htm.

- Promote greater payment transparency across payers; and
- Save Coloradans an estimated $80 million annually in costs related to claims processing.[14]

Barry Keene, co-chair of the task force, says of the act,

> *By creating uniform medical claim edits and payment rules to be shared among all payers in Colorado, both payers and providers will be unburdened of tens of millions of dollars of administrative redundancy and outright waste, which can be redirected toward reducing the actual cost of care.*

[14] Estimate calculated as follows: 1) More than $1.86 billion in claims are denied annually by payers due to proprietary edits. 2) Colorado's estimated share, based on Colorado's population, is $31 million. 3) Estimated 86% of denied claims are paid on appeal. 4) AMA estimates each appeal costs providers $25 and costs payers $60. 5) AMA estimates claims processing accounts for 10% - 14% of all practice revenue. 6) Estimated $800 million spent in Colorado. 7) If 10% claims cycle cost eliminated, savings is $80 million per year.

II. THE MEDICAL CLEAN CLAIMS UNIFORMITY AND TRANSPARENCY ACT TASK FORCE

A. Members

The task force has 23 members appointed by the executive director of HCPF (see Appendix C for a list of members and alternates, titles and affiliations). The act requires the task force to include representatives from all industry segments directly affected by the act (see Table 2).[15]

Table 2

Task Force Members by Category of Appointment

I. Health care providers or employees thereof from a diverse group of settings

- *James Borgstede, MD, Colorado Radiological Society*
- *Kathy McCreary, Univ. of Colorado Hospital*
- *Jill Roberson, Denver Health & Hosp. Authority*
- *Ryshell Schrader, Community Reach Center*

II. Persons or entities that pay for health care services ("payers")

- *Helen Campbell, United Health Group*
- *Valerie Clark, Kaiser Permanente*
- *Mark Laitos, MD, CIGNA*
- *Lori Marden, Rocky Mountain Health Plans*
- *Frederick Tolin, MD, Humana*
- *Beth Wright, Anthem Blue Cross Blue Shield (WellPoint)*

III. Practice management system vendors

- *Mark Rieger, Gateway EDI*

IV. Billing and revenue cycle management service companies

- *Kim Davis, University Physicians, Inc.*
- *Amy Hodges, BloodHound Technologies*
- *Mark Painter, Relative Value Studies, Inc.*
- *Robin Weston, Centura*

V/VI. Government payers

- *Carol Reinboldt, Health Care Policy & Financing*

Other persons with expertise

- *Tom Darr, MD, Optuminsight*
- *Catherine Hanson, AMA*
- *Barry Keene, KEENE Research & Dev.*
- *Marie Mindeman, AMA*
- *Douglas Moeller, MD, McKesson Health Solutions*
- *Marilyn Rissmiller, Colorado Medical Society*
- *Wendi Healy, Correctional Healthcare Companies/CMGMA member*

[15] § 25-37-106 (2)(a),C.R.S.

B. Process

The task force held 25 meetings between December 2, 2010 and November 14, 2012. Agendas and minutes for all meetings are on the task force website, http://www.hb101332taskforce.org. At its first meeting, the task force agreed to a consensus decision making process. Early on, the task force developed a set of guiding principles (see Table 3). At its core is administrative simplicity—

Table 3.

Task Force Guiding Principles

Goal: Administrative Simplification

- Improved system efficiency
  - Appropriate system savings
  - Reduced administrative burden
- Transparency
  - Access to all edits in a machine-readable format
  - Access to the source and rationale for every edit
- Standardization and consistency

Task Force Process: Fair and Open

- Act responsibly on behalf of stakeholders
  - Consider costs
  - Consider business model implications for stakeholder organizations
  - Understand impact and potential harm
  - Report identified risk to stakeholders
- Value added—clarity about benefit of a changed edit, selection of one versus another
- Use sustainable sources of edits for the final edit set
- Transparent sources—use nationally recognized sources, don't create new edits
- Stay cognizant of scope parameters
  - Scope of charge does not include medical necessity, fraud, abuse or utilization review edits; government programs; or pricing rules .[1]

[1] The task force agreed that its legislative mandate is to elucidate and standardize coding rules, and that pricing rules are not in the purview of its mandate; specific amounts for pricing adjustments to coding are out of scope. The task force may, however, describe those coding scenarios that are unique and eligible for differentiated pricing.

Source: Minutes of January 25-26, 2011 task force meeting

consistency, transparency, standardization and improved system efficiency. The task force also committed to a fair and open process that, among other things, tries to accommodate the top concerns of stakeholders at the table (see Table 4).

The task force has accomplished most of its work through four committees that have met by conference call. Some committees include additional non-task force members with relevant expertise. The Edit Committee is responsible for identifying definitions and edits for the base set. It has met once every two to three weeks for the past two years. The External Engagement and Professional Medical Society Outreach Committee serves as a liaison between the task force and health professional societies and associations. It has met as needed, reaching out to the professional societies to collect information, solicit advice, and alert them to the task force's work. The Payment Rules Committee is responsible for developing payment (but not pricing) rule recommendations. Since it was formed in July 2012, the Payment Rules Committee has met every other week. The Data Sustaining Repository Committee is responsible for examining how the standardized set will be maintained and sustained . It has met monthly since early 2011.

Table 4

Top Stakeholder Concerns

- **Providers**
  Reduce providers' administrative costs by developing a uniform, standardized set of edits used by all payers to ensure correct coding of procedures and services that are machine-readable for loading into a provider practice management system.

- **Payers**
  Implement the act in such a way that it does not increase the cost of members' care.

- **Vendors**
  Maintain ability to work with provider and payer clients to meet their needs and protect vendors' intellectual property.

- **Consumers**
  Facilitate point-of-service pricing, reduce the amount of premium going for claims processing, and not increase premiums.

Source: Minutes of December 28, 2011, task force meeting

C. Funding and Staffing

Funding for the task force comes from monetary and in-kind gifts, grants and donations, as authorized by the act. The task force receives no state funds. The Bell Policy Center was designated as the custodian of funds for the task force. Between November 2010 and October 2012 the task force raised more than $92,000 in grants, gifts and donations from the following organizations: the AMA, 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 Wellter & Associates, The Colorado Health Foundation, The Colorado Trust , University Physicians, UnitedHealth Group, Wellpoint and Western Nephrology.

The task force is soliciting funding for 2013. It has had conversations with several Colorado foundations and federal health agencies and continues to pursue contributions from stakeholder groups. Funding for the task force's data analytics (see part IV) is included in Colorado's State Innovation Model Grant proposal to the Centers for Medicare and Medicaid Services (CMS). The purpose of these grants is to improve health care system performance. The grants are competitive; award announcements will be made in December 2012.

Most of the task force's work has been conducted by the members themselves. In addition to participating in an average of two to three task force and committee meetings each month, members have provided data, conducted data analyses, supplied materials for task force consideration, solicited grants and donations, and consulted with, reached out to and briefed other interested parties. Part-time, contract staff has been engaged to organize committee and task force meetings and take minutes; facilitate task force meetings and draft reports; and write a request for information.[16]

D. Coordination with Other Efforts

The task force has kept abreast of, and coordinated its efforts with, other national and state groups working on similar issues. Barry Keene made a presentation to the national Workgroup on Electronic Data Interchange (WEDI) in October 2011 and the National Committee for Vital Statistics (NCVHS) in November 2011. Both groups are exploring claim edit development, transparency and uniformity. The presentations were well received and generated a great deal of discussion. Colorado's work continues to attract national attention. The task force has received briefings on initiatives in

[16] See part IV for a description of the request for information.

Vermont and Washington and a representative from the Minnesota Administrative Uniformity Committee has participated by phone on several task force meetings.[17]

The task force also has coordinated its efforts with other cost containment and payment reform programs in Colorado. An important related program is Colorado's recently launched All-Payer Claims Database (APCD).[18] The ability to make meaningful cost comparisons across multiple payers based on claims data submitted to the APCD would be greatly enhanced if all payers used the same claim edit set and payment rules. Another program is the Colorado Health Benefits Exchange. A primary purpose of the exchange is to allow consumers to compare supposedly equivalent products and capture a value proposition based upon actuarial value (a summary measure of a health plan's generosity) versus premium. But without a uniform set of edits and payment rules being applied to claims, it cannot present a complete picture. Non-uniform edit and payment rules affect the direct comparability of values.

E. Summary: Launching the Task Force

The task force:

- Adopted guiding principles that emphasize transparency, improved system efficiency, standardization and consistency, and a fair and open process for developing and updating the standardized set;
- Secured funding for the first two years of operations;
- Identified major stakeholder concerns;
- Formed four working committees, each of which includes payers, providers, vendors, billing cycle management services companies and other experts, which cumulatively held more than 200 hours of meetings in 2011 and 2012; and
- Established relationships with other national, state and local groups working on administrative simplification and confirmed that, with respect to creating a standardized set for processing all commercial claims, Colorado is the leader.

[17] The Minnesota Administrative Uniformity Committee (AUC) is a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. It works to standardize, streamline, and simplify health care administrative processes.
[18] For more information about Colorado's All-Payer Claims Database, go to the APCD's website, http://www.civhc.org/CIVHC-Initiatives/Data-and-Transparency/All-Payer-Claims-Database.aspx/.

III. TASK FORCE ACCOMPLISHMENTS—BASE AND COMPLETE STANDARDIZED SET

The task force is responsible for developing a standardized set of payment rules and claim edits that must be used by all private sector payers. The act requires the base set to be identified through existing national industry sources. It specifies 16 edits (e.g., unbundle, mutually exclusive, global surgery days, bilateral procedures) the task force should consider standardizing. For health care services that are not encompassed by the base set, the act directs the task force to participate in the voluntary national initiative or work with national experts. The sections below describe the progress the task force has made responding to these directives. It also reviews challenges and developments over the past two years that have affected the workload of, and timeline for, completing the task force's work.

A. Progress Report

Over the course of several meetings, the task force worked out a process for developing the standardized set (see Table 5). Among other things, the process emphasizes transparent rationales and reliance on existing edits, consistent with industry trends, as noted in a 2006 white paper by Ingenix,[19] an information and technology-enabled health services business:

> *In the past, claims processing vendors competed on proprietary edits based on their interpretation of coding and billing regulations. But with the growing demand for standards and accountability, today's best practice is to base edits on industry-recognized third-party sources, and to clearly document the sources and explain edits in language that providers and patients can understand.*[20]

As discussed in part II, the task force established four committees to conduct the bulk of its work and make recommendations to the task force. Three of the committees are involved in different aspects of developing the standardized set, which is the subject of this part III. They are the Edit, Payment Rules, and External Engagement and Professional Medical Society Outreach Committees.

[19] Ingenix is now Optuminsight, part of Optum.

[20] Ingenix, *Six Best Practices of Claims Editing,* White Paper (Eden Prairie, MN: Ingenix, 2006); http://www.optuminsight.com/~/media/Ingenix/Resources/Downloads/0711027ClaimsEditingProfessionalWP.pdf

Table 5

Task Force Process for Developing a Standardized Set of Claims Edits and Payment Rules

The task force adopted the following decision rule for selecting, adding, deleting, modifying and reconciling conflicting edits:

The Context

The task force is responsible for developing a standardized set of payment rules and claim edits to be used by all payers. In developing the standardized set, the task force shall consider standardizing a list of types of edits listed in the act. The base set of rules and edits shall be identified through existing national industry sources.

Creating an Initial Draft of the Complete Edit Set

a. For the types of edits listed in the act, develop definitions, including purpose, rationale and guiding principles.

b. Use national sources and third-party vendor edits that: are in a machine-readable format to be determined; are not benefit-related (e.g., Medicare G codes): and comes from national sources or are sourced to a national source.

c. For a given edit, if there is only one national industry source with a definitive edit that fits the definition/rationale, use that edit.

d. If there are multiple national sources (e.g., HCPCS and a national medical specialty society (NMSS)) for the same definitive edit (e.g., age), and if all are consistent with the definition/rationale for the edit under consideration, and if the edit is not benefit-related, then establish and use a hierarchy agreed upon by the Task Force for each edit (e.g., CPT®, then NMSS, HCPCS, then NCCI, etc.).

e. For a given edit, if there is no definitive national source edit and if there is only one third-party that has done sourcing for that edit and if the third party edit fits the definition/rationale, then include the edit in the initial draft of the complete set.

f. For all other edits , where there is multiple sourcing for the same edit, select edits to get to the initial draft of the complete set using the national hierarchy approach described above to select among edits developed through third-party sourcing (e.g., for edits developed through sourcing, start with edits based on CPT® materials, then NMSS, etc.)

continued

Table 5 (continued)
Public Comment on, Review and Refinement of, and Finalizing the Initial, Complete Edit Set
a. Make the draft initial set available for testing, review and comment by vendors, payers, providers and others. Make it possible for interested parties, including the task force itself, to run various scenarios against the initial draft complete edit set. b. Require recommendations from the public (including national medical specialty societies) for additions, deletions, and modifications to the initial draft complete set to be based on one of the following; the change better fits the definition/rationale; an edit does not work for a commercial population; the original source for an edit objects to how sourcing by a third party was done; or an edit is altogether missing from, but does not duplicate an edit, in the set. c. After considering comments and recommendations from the public and weighing the results of the task force's own modeling and testing, finalize the initial complete edit set. *Source: January 24, 2012, Task Force meeting*

1. Edit Committee

The Edit Committee is tasked with examining the edits and associated rules, concepts and methodologies contained in national sources and national source guidelines; assessing their applicability to private health plan claims processing; and making recommendations to the task force on the claim edits to be included in the standardized set. Beth Wright, Anthem Blue Cross and Blue Shield, and Mark Painter, Relative Value Studies, Inc., co-chair the committee.

One of the committee's first tasks was to look at the system of edits Medicare uses—the National Correct Coding Initiative—to determine if it is robust enough to use for private sector claims processing. The **National Correct Coding Initiative (NCCI)** is a system used to promote consistency in claims coding and to control improper coding leading to inappropriate Medicare claims payments for professional services. (See Appendix D for a discussion of what codes are, examples of how coding is done and how coding affects what providers are paid and how much a patient will have to pay for services rendered.) The Edit Committee, with input from the External Engagement and Professional Medical Society Outreach Committee, also wanted to find out if the specialty societies were comfortable with the process NCCI uses to develop and update its edits and rules set. It concluded that the NCCI *does* include edits to support commercial claims (e.g., it includes pediatric and ob/gyn edits and rules despite being designed primarily for a Medicare population). The

External Engagement Committee found that the specialty societies are comfortable with how the edits are developed, with a few exceptions.

The Edit Committee has nearly completed the difficult process of developing consensus definitions for the types of edits listed in the act. It also has begun to identify and define edits that are not mentioned in the act but that are in use by the industry. The definitions will drive decisions about which edits for the same procedure will be included in the standardized set and thus their exact wording is important. The AMA, as well as other major stakeholders, has been active in reviewing and commenting on the definitions as they have been drafted. Appendix E shows the edit types listed in the act along with the definitions recommended by the Edit Committee and approved by the task force.

The committee solicited and has defined additional types of edits that need to be considered and defined to arrive at a complete standardized set. Appendix F describes the additional edit types and definitions the committee has considered, including those that have been approved by the task force.

The committee is developing a list of out-of-scope edits. 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.[21] The out-of-scope edits identified by the committee to date are shown in Appendix G. These edits are in addition to edits for medical necessity, fraud and abuse, which the act specifically identified as not part of the set of edits to be standardized.

In the course of its work, the Edit Committee has identified several payment rule issues and referred them to the Payment Rules Committee.

The Edit Committee has been working through a number of challenging issues. Several of the most difficult are listed below by way of example.

- Issue: Should the task force include in the standardized set an edit that would say sometimes pay, as opposed to always or never pay?

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[21] Administrative edit types were not contemplated by the legislation as many of them are in place at the "front-end" or early in the claims processing to ensure that all of the information required to process the claim has been provided, or to identify a claim that has already been processed. Pricing file or provider file related edit types are used to direct the claims processing to specific payment amounts for certain services. These are usually related to either scope of licensure or pricing differential based on the provider's credentials.

Resolution: In general, no. Part of the task force's charge is administrative simplification. In the automated claims processing world, "sometimes" would require manual intervention. However, each issue should be evaluated individually taking into consideration the impact on all stakeholders in terms of administrative burden, costs and variation from existing processes.

- Issue: Should the task force use national sources that are not updated regularly?

  Resolution: It should consider them but work with the sources to encourage them to update their guidelines on a regular basis (i.e., at least once every year or two).

- Issue: Can a payer decide not to use an edit in the standardized set and simply process the claim as is, which could be more beneficial to the provider?

  Resolution: No. As one task force member remarked, "If we don't take this opportunity to push for uniformity and standardization, we miss the real chance to reduce administrative costs associated with filing and processing claims." He went on to say, "To just have a repository of approved edits with the choice being left up to the health plans to use or not use them does nothing to reduce the variation, which is where the expense lies for a practicing physician."

2. Payment Rules Committee

The Payment Rules Committee is responsible for developing and making recommendations to the task force concerning coding scenarios that are unique and eligible for differentiated payment. While the task force's charge is to elucidate and standardize coding rules, specific amounts for pricing adjustments applied to reported medical services ("**pricing rules**") are out-of-scope. Lisa Lipinski, senior policy analyst, AMA, chairs the committee.

The task force established the following guidelines for the committee's work:

- Payment rules will be indentified that are unique and eligible for differentiated payment to move toward uniform, transparent reporting and processing in the marketplace.

- The Medicare pricing rules based on the RBRVS are recommended for the starting point of the discussion for the development of a Colorado payment rule standard because they are already widely used by both public and private payers and maintain the relativity of the Medicare RBRVS.

- 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.

The committee is examining the effect of modifiers in the **Current Procedural Terminology (CPT®)** and **Healthcare Common Procedure Coding System (HCPCS)** on the types of edits listed in the act (e.g., bilateral surgery, assistant at surgery).[22] **Modifiers** are used in addition to a CPT® code to add more information on the claim.[23] They state special circumstances that may affect the amount the physician will be paid. 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.

The committee is using the following process to develop a recommended set of payment rules: 1) compile CPT® and HCPCS modifier definitions and guidelines; 2) examine the definitions and how they fit with the work of the Edit Committee and requirements of the act; 3) select payment rules, beginning with but not limited to the Medicare Fee Schedule Database, that are consistent with the Committee's guidelines for payment rules and explain the rationale for the recommended rules; and 4) translate the rules so they can be implemented in a computerized medical claims processing system (this last step is to be done by a contractor).

As of August 29, 2012, the Payment Rules Committee had compiled a table of 32 CPT®/HCPCS modifiers and modifier definitions showing Edit Committee recommendations, Medicare (CMS) guidelines, and Payment Rules Committee comments for each one (see Appendix H). The Edit Committee is using the list of modifiers to identify and define the HCPCS modifiers.

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[22] The **Current Procedural Terminology (CPT®)** code set is 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. The **Healthcare Common Procedure Coding System** (HCPCS) provides 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. In 2000, the HCPCS and CPT® code sets were designated by the Department of Health and Human Services as the national coding standard for physicians and other health care professionals and procedures under the Health Insurance Portability and Accountability Act (HIPAA).

[23] More specifically, 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.)

3. External Engagement and Professional Medical Society Outreach Committee

The External Engagement and Professional Medical Society Outreach Committee ("External Engagement Committee") serves as a liaison between the task force and the AMA's **Federation of Medicine**, which includes 122 national specialty societies and 50 state medical societies.[24] The committee is responsible for assessing if public code edit and payment policy libraries meet the needs of national medical specialty societies and state medical associations by reaching out to and obtaining feedback from these groups. Tammy Banks, AMA, and Helen Campbell, United Health Group, co-chair the committee.

Keeping medical societies informed about the task force's work and soliciting their input is critical to the success of the task force. Physicians want to be sure that the standard edit system is transparent, uniform, reduces unnecessary administrative costs and results in fair reimbursement.

One of the committee's first activities was to raise the awareness about the work of the task force with AMA representatives on relevant national committees, who are well versed in coding and payment issues (i.e., the AMA CPT® and AMA RUC representatives). Attendees at the AMA CPT® and AMA/Specialty Society RVU Update Committee initial yearly meetings heard presentations about the work of the task force. Follow-up correspondence was sent to the representatives that highlighted the effort and encouraged participation.

In April 2011, the committee reached out to the American Academy of Pediatrics, American Academy of Family Physicians and American Congress of Obstetricians and Gynecologists regarding the task force's NCCI correct coding edits review. The groups reviewed the NCCI edits and concluded they fairly represented the correct coding for their respective specialties. The specialties requested that any additions to the standardized set include a Federation of Medicine feedback loop.

In May 2011, the American College of Surgeons was asked and agreed to participate in the Edit Committee's assistant at surgery discussions, which led to an Edit Committee recommendation to combine the assistant at surgery list from the American College of Surgeons and CMS.

In November 2011, the committee reached out to the Federation of Medicine that included a call to action as well as general principles for a code-editing system to provoke a discussion and interest in the task force effort.

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[24] The term "Federation of Medicine" is used 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. (Source: AMA web page: http://www.ama-assn.org/ama/pub/about-ama/our-people/the-federation-medicine.page.)

In January 2012, the External Engagement Committee confirmed with the American Society of Anesthesiologists that the Edit Committee's recommendation mirrored its correct coding guidelines.

In May 2012, the committee reached out to the American College of Radiology (ACR) as discussions regarding payment logic specific to radiology were being discussed in the Edit Committee. As a result of this activity, ACR has become an active participant in the newly formed Payment Rules Committee and task force.

In August 2012, the committee sent a letter to the Federation of Medicine providing a task force update, encouraging medical societies to become involved in the task force's work and making available to all interested parties a data file containing CPT® Code Edits, which are consistent with guidelines and conventions established by the CPT® Editorial Panel, to promote correct coding.

In October 2012, the Colorado Medical Society sent letters to the local specialty society representatives advising them of the task force's activities and soliciting their involvement through the External Engagement Committee. The committee now includes a Colorado practicing physician who is available to speak directly with other physicians about the task force and its needs. The letter was also shared with the Federation of Medicine.

The External Engagement Committee continues to raise awareness of the task force at the national level through presentations, updates to the Federation of Medicine and other stakeholders as appropriate. It will continue to facilitate discussions between the professional societies and the Edit and Payment Rules committees on issues specific to their specialties or practice. As specific requirements for submission of edits or payment rules are developed by the Data Sustaining Repository Committee, they will be communicated to the professional societies. Once the complete standardized set has been drafted, the committee will notify the professional societies of the opportunity for review and comment and encourage their input.

B. Unanticipated Challenges and Developments

Several unanticipated challenges and developments added to the task force's workload over the past two years and slowed progress. Three of the most significant are discussed below.

1. The task force determined that the base and complete set needed to be developed concurrently, not sequentially.

The act directs the task force to develop the base set by December 2012 and have a complete set ready by December 2013. This directive was based on two assumptions: 1) that the base set could be dealt with first, separate from work on the final complete set; and 2) that the voluntary national

initiative would be working concurrently on the more comprehensive set. With respect to the first assumption, the task force found that development of the base set is inextricably linked to producing the complete set and it is inefficient to try to separate the two tasks. After a year of study, testing and deliberation, the task force concluded that the best way to develop the standardized set is to do them concurrently, rather than developing a base set first and then adding to it to get to a complete set. The task force found many co-dependencies in the definitions of the edits. It decided it was not appropriate to limit thinking to the base set only when developing definitions for such things as sources, as they would have to be amended later when considering the more comprehensive set. Consequently, the more difficult issues surrounding the comprehensive set of edits must be considered up front. While it is accepted among task force members that this is the right decision, it does involve a larger task scope than was initially planned. With respect to the second assumption, the voluntary national initiative folded, as discussed next.

2. The original voluntary national initiative folded.

The act makes several references to the voluntary national initiative. At the time the legislation was drafted, a group of national stakeholders that included providers and payers of note had begun discussions that looked promising. In time, however, after Colorado's task force was formed, the Initiative dissolved.[25] The problem created by the dissolution of the national initiative is that without a complete or partial set of national initiative edits to serve as the starting point for its work, the task force has had to spend more time developing a set of edits supported by all stakeholders.

It should be noted that Colorado's initiative is on much more solid ground than the national initiative was and continues to make significant progress. It benefits from the following features: the task force and requirement to use the standardized set are in state statute; the act requires all stakeholders to be represented on the task force; the focus of the act is specific and limited; the act delineates specific goals, has a clarity of purpose, and includes reporting and implementation deadlines; and the people at the table are technical experts not generalists.

Many of the people who were at the voluntary national initiative table have been appointed to the Medical Clean Claims Uniformity and Transparency Act task force. By default, the task force has become the national initiative, if not in name then in membership.

3. The standardized set could not be developed manually.

The task force originally envisioned, and the timelines in the act assumed, that the base set could be developed manually or perhaps supplemented with simple spreadsheets and human operation from task force members. However, after investing a significant amount of time and effort, the task force

[25] However, the Association of Health Insurance Plans is continuing to examine the issue.

concluded this approach was not workable. It determined that it needed to begin with the entire universe of edits currently used by payers, which requires an electronic repository to compile the different edits currently being used. This will allow the task force to make queries to select among the edits to establish the uniform edit set. The task force refers to this as **data analytics**.

4. Some of the edits in the Medicare NCCI edit set—the primary national industry source of edits--turned out to be based on benefit design features and policies specific to Medicare.

The task force wanted to gain a better understanding of the magnitude of these aberrancies without having to undertake an extensive manual review of thousands of NCCI edits. It took longer than expected to gain access to the architect of the Medicare NCCI because of HHS administrative requirements. Once the task force gained access it asked how it could locate all the codes and edits created specifically for Medicare. It was told that "identifying which edits are based on CMS payment policy . . . would be a tedious task. It could be done, but would take a great deal of work."[26] The task force also asked for access to the rationales used to develop the NCCI edits and was told it could not: "[Although each edit] is assigned a policy statement/rationale/edit criterion . . . [that] is available to claims processing contractors, it is not publically available."

5. The need to use an electronic data analytics system to help develop the standardized set has meant the need for a larger budget.

The original task force budget was designed to cover basic expenses but did not anticipate the need for sophisticated electronic tools, in part because the task force thought the voluntary national initiative would be addressing many of the same issues. Part IV describes the data analytics tool and functionalities the tool needs to have for the task force to complete the process of developing the standardized set. The need to contract for data analytics work has required the task force to spend additional time fundraising.

C. Summary of Major Accomplishments Concerning Development of the Standardized Set

- After extensive examination of the NCCI system and feedback from several national specialty societies where the task force wanted to make sure that the system was sufficient to meet their needs, the task force determined that NCCI *does* include edits to support commercial claims and, for the most part, the specialty societies are comfortable with how the edits are developed and their ability to review the edits prior to publication. This, however, does not mean the task force will adopt all the edits as there are other problems with some of them. Also, additional edits will be needed to meet the needs of private health payers and providers.

[26] Correspondence from Niles Rosen, MD, medical director, National Correct Coding Initiative, to Barry Keene, co-chair, Medical Clean Claims Uniformity and Transparency Act Task Force, October 31, 2011.

- Based on a thorough analysis of alternative options and debate on the wording of definitions of edits types, the task force has reached consensus on most of the types of edits in the act. These definitions will drive selection of the edits in the data analytics phase of the task force's work.

- The task force has solicited and begun to define additional types of edits that need to be considered to arrive at a complete standardized set.

- A list of out-of-scope edits and rules that is consistent with the exemptions permitted by the act is under development.

- The Edit Committee has worked through a number of challenging issues, such as use of sometimes/always/never edits, use of national sources that do not update their guidelines regularly, and required use of all edits and rules in the standardized set.

- The Payment Rules Committee has compiled a list of 32 payment rule modifiers, definitions and any associated payment rules from several different sources and is working through the difficult process of finding consensus on which rules to use.

- A formal request for involvement by the Federation of Medicine has been made on behalf of the External Engagement Committee. The committee is ready to receive and facilitate input from these important stakeholders. Additionally, the committee will continue to reach out to key specialties as directed by either the Edit Committee or Payment Rules Committee to assist in their deliberations.

- The External Engagement Committee has committed to communicating to medical societies any specific requirements for submission of edits or payment rules they would like included in the standardized set. It also will notify the medical societies of the opportunity to review and comment on the draft standardized set during the public comment period.

IV. TASK FORCE ACCOMPLISHMENTS—CENTRAL REPOSITORY FOR ACCESSING THE RULES AND EDITS (DATA SUSTAINING REPOSITORY)

The task force is responsible for making recommendations concerning a central **data sustaining repository** for accessing the standardized rules and edits. The act directs the task force's recommendations to address implementation, updating, dissemination, and electronic access to the standardized set, including downloading capability. The task force has identified the following groups as the main data sustaining repository users:

- Practicing providers and medical health care specialties;
- Health plan personnel who provide health care coverage and claims payment in Colorado;
- Third party vendors who use repository information to provide their products and services;
- Repository administrative staff; and
- Individuals, with any other purpose, as permitted or required by Colorado law.

The task force formed a Data Sustaining Repository Committee early in 2011. Its charge is to recommend to the task force how the standardized set will be maintained, updated and sustained. Mark Rieger, NHXS, and Valerie Clark, Kaiser Permanente, co-chair the committee. The following sections describe the committee's work, review challenges and unanticipated developments, and summarize the committee's major accomplishments.

A. Progress Report

The Data Sustaining Repository has worked on eight major tasks over the past two years.

First, it developed a set of guiding principles concerning the economics, governance and maintenance and distribution of the standardized set in the data system repository (see Table 6). With respect to economics, the task force believes that a standardized edit set should significantly simplify code set development and administration for providers, payers, and vendors immediately and over time. For vendors and payers, standardizing the update process for the standard edit set itself across all payers and vendors should reduce development, implementation and administrative costs. Vendor access to, and participation in, the edit set update process should simplify updating costs at the vendor level. For providers, a standard edit set should reduce provider billing costs by simplifying business office training, improving the rate of clean claims processing across all payers,

Table 6

Data Sustaining Repository Guiding Principles

Economics

- Simplify code set development and administration for providers, payers and vendors, immediately and over time.
- Take costs out of, not add to, total health care system costs
- Use monies to create quality rules for public consumption
- Consider licensing fees as a principal revenue source

Governance

- Open process where stakeholders can have a fair hearing
- Balance of stakeholders on the board
- Accountability: consider state oversight to ensure public interests are met

Maintenance

- Expertise already exists
- Development and maintenance should be influenced by production requirements
- Seamless handoff from data analytics operator to data sustaining repository operator
- Decentralized development and maintenance
- Allow for professional (rule making) and technical (rule distribution) components to be separate entities

Distribution

- Centralized
- Format of rules should support most efficient distribution
- Distribution should be electronic
- Distribution capability phased in

and significantly reducing the number of appeals created by current differences in claims payment policies across payers for the affected edits.

It should be noted that the standardized edit set will still require ongoing updates due to changes in CPT®, HCPCS, and **ICD-9/ICD-10 code sets**.[27] Also, health plans will still employ automated auditing logic in conjunction with claims payment systems in order to detect incorrect coding practices, prevent payment for non-covered services, and enforce other contracted service requirements. New strategies involving analytics and new software modules are emerging to prevent fraud, waste, and abuse, without relying on claims auditing systems to detect such problems at the single claim level. Finally, quantifying the effect of standardization on transaction costs has proven to be quite difficult, but should be measurable over time. Payers may continue to use a variety of analytical strategies against submitted claims to prevent new sources of overpayment involving the claims process.

Second, the committee debated and agreed on a list of major data sustaining repository responsibilities and functions (see Table 7). It decided that the technical and professional functions described in the table could be performed by repository staff or advisory committees, or one or both functions could be contracted out. **Technical functions and entities** refer to rule distribution, display and access to the standardized set. **Professional functions and entities** refer to rule making, including decisions about which edits and rules are in, out or modified over time.

Third, the committee developed a detailed list of essential functionalities for the data sustaining repository (see Appendix I). The functionalities fall into four categories: production, database service level performance, input/output and provider/user access.

Fourth, the committee took the lead in drafting a request for information (RFI). (A copy of the RFI is posted on the task force website, http://hb101332taskforce.org/images/rfi_050412_final.pdf.) The purpose of the RFI, which was released May 3, 2012, was to invite input, better understand potential strategies and costs associated with the design and development of an online data repository, and solicit innovative solutions. The committee included language in the RFI indicating that the task force, recognizing that no current organization or initiative includes the whole universe of existing edits, has a particular interest in creative solutions that take advantage of or blend current efforts and products. The RFI invited comments and suggestions concerning design solutions (both proprietary and commercial off-the-shelf); implementation strategies and incentives; program costs (design, development, implementation and ongoing); and administration and management services. The RFI explained that the information gathered from the RFI would help to inform a

[27] **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.

Table 7

Data Sustaining Repository Responsibilities and Functions

Functions

- Accountability—To the legislature, stakeholders (e.g., consumers, providers, payers), general public, etc.
- Transparency—Ensuring that sources and rationales for edits are available as part of the library and included with the distribution and operation of the data sustaining repository and that RFPs, mission, bylaws, etc. are transparent.
- Library maintenance---After initial standardized set has been established, developing and implementing policies and procedures for approving new edits, modifications and deletions as necessary, and resolving conflicts between approved sources. Reviewing and making decisions in response to requests for additions, modifications, and deletions to the existing edit set.
- Library distribution—Providing public access to the edit registry.
- Fee collection—Collecting fees and revenue from other sources to pay for repository operations, including contracted services.*
- Contracting—Issuing RFPs and contracting for services.
- Management and fiduciary responsibility.
- Industry dialogue —Establishing and maintaining a method for receiving, logging, and responding to key stakeholder feedback , including complaints

Board, Technical Staff/Contractor, and Professional Staff/Contractor Responsibilities

- Repository board—accountability, transparency, contracting, hiring the executive director, budget, industry dialogue
- Technical—library distribution, display, access
- Professional—decisions about which edits are in, out or modified over time

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**If the fee is collected by a third party, it would turn the money over to the data sustaining repository or the money would be put into a fund for appropriation by the legislature to the repository.*

request for proposals (RFP) the task force planned to issue later in the summer or fall. The RFP would be for a data analytics contractor that would compile the edits that companies and organizations would like to see in the standardized set and, at the direction of the task force, analyze the edits to arrive at a recommended standardized set. Four groups responded to the RFI. The RFI responses are posted on the task force website, http://www.hb101332taskforce.org.

Fifth, the committee recommended criteria for reviewing proposals submitted in response to the RFP. The criteria, which were approved by the task force, are shown in Table 8.

Table 8

Criteria for Selection of a Data Analytics Contractor

• Price • Maintenance cost • Delivery date • Licensing and other contractor fees • Transition viability and scalability to permanent data sustaining repository • Nimbleness—ability to respond quickly to requests for different arrays, analyses of edits	• Articulated understanding of what is needed • Degree of architecture in place • Alignment of in-place architecture and goals • Software as a service rather than buying, unless buy is cheaper than rent • Meet minimum technical specifications

Sixth, the committee and task force began to discuss what the governance of the data sustaining repository would look like. They agreed that the repository board should include representatives of all the major stakeholders. Among other things, the board would oversee appeals, requests for changes to the edit set and the review and approval process. It would decide what is appealable and to what body, ensure transparency, determine what is reviewable, decide whether there should be an exceptions process (e.g., under special circumstances a payer would not have to use an edit in the edit set) and if so how the process would work, establish a complaints process, oversee contracting and the collection of fees, and hire the director of the organization.

Seventh, the committee identified alternative procedures for making changes to the initial standardized set after it is implemented. Three options it is exploring in more depth are shown below; all assume a data repository board would oversee the program.

- The board or a professional group established by the board would review and approve any changes to the initial standardized set that may need to be made when a change has been

made by the source of the edit (e.g., NCCI or a national medical specialty society). The board would consider requests from payers, providers and others for additions, deletions or modifications to the standardized set.

- Changes to the initial standardized set would be made only if updates were made by the source of an edit or rule. Stakeholders wanting other changes to the standardized set would have to go to the source and request changes to their edits, which would then become part of Colorado's set.
- Repository staff or the contractor maintaining the standardized set would inform the board when edits or rules are updated or modified based on actions at the source and ask if there are any objections. If there are no objections, the standardized set would be updated or modified accordingly. The contractor could suggest other changes not in the standardized set for board consideration. The board could also direct the contractor to make changes.

Finally, the committee has started to explore ways to ensure data sustaining repository sustainability. The task force plans to contract with a sustainability consultant to help identify viable options for financing repository operations over the long term, provided it can secure funding for this activity. One of its assumptions is that it is unlikely that General Funds will be available to fund the repository. Another is that, while federal or foundation grants could be an important source of funding, particularly for establishing the repository, they are not a sustainable funding source over the long term.

As of October 23, 2012, the Data Sustaining Repository Committee had identified four business models options for the repository:

- The board would contract with a single professional entity that would maintain and update the standardized set and would fund its operations by licensing data to companies that specialize in the development of claims payment systems and services. The professional and technical entity could be the same. The technical entity(ies) would bear the economic risk and set its own price for access to the repository. Payers, providers and claims software developers would not be required to use the vendor.

- The data sustaining repository would have the same features as the first model but the state or repository board would regulate pricing. Additional regulation would be required to mandate licensing of the set for claims processing.

- The repository would be set up as a co-operative and membership dues would be the major source of funding. Under this model, the board would be elected or selected from among the members of the co-operative.

- The repository would look to foundation grants and the federal government as major funding sources.

Any business model for the repository will take into account protecting the copyright in proprietary code sets such as CPT® and address licensing and royalty requirements of the owners of such code sets. The committee is developing and assessing the pros and cons of the options listed above and additional options.

B. Unanticipated Challenges and Developments

1. Based on responses to the request for information, the task force determined that the data analytics phase will take longer than expected

It is likely to be six to nine months after a data analytics contractor has been selected before the task force can begin using the complete universe of claims edits to begin analyzing the data to arrive at the standardized set. The task force originally expected this would take about three months.

2. The task force spent a significant amount of time coming to consensus regarding whether it was necessary or desirable to allow proprietary edits and rules to be submitted to the task force confidentially.

The task force weighed the risks and benefits of allowing proprietary edits to be submitted confidentially. On the one hand, it is more likely that companies and organizations will be willing to submit their edits if they are not made public. On the other hand, the task force has a commitment to transparency and expressed concern that if proprietary edits submitted to the task force were accidentally made public, there might be some liability. The fiscal sponsor was particularly concerned about this latter issue. In the end, the task force agreed that all edits submitted for consideration would be make public but that the names of those submitting edits would not.

3. Some task force members were initially uncomfortable with the degree to which they could discuss claims edit and payment rules with their competitors. Over time, however, this issue was resolved.

C. Summary of Major Accomplishments Concerning the Data Sustaining Repository

- The task force adopted guiding principles for creation and operation of the data sustaining repository.

- The task force approved a list of data sustaining repository responsibilities and functions and delineated the repository's essential functionalities.

- The task force issued an RFI concerning potential strategies and costs associated with the design and development of an online data repository to be used initially to develop a standardized set and subsequently to maintain the set and make it electronically accessible.

- An RFP has been drafted for a data analytics contractor to compile the universe of existing edits and conduct data analyses to assist the task force in developing the standardized set.

- The task force approved criteria for selecting a data analytics contractor.

- The Data Sustaining Repository Committee identified, and is examining the costs and benefits of, alternative procedures for updating and making other changes to the standardized set after it has been implemented.

- The Data Sustaining Repository Committee is exploring ways to ensure the repository's sustainability.

V. RECOMMENDATIONS

The task force has made steady progress since it was formed two years ago. Task force members have devoted hundreds of hours to the effort and have established the framework for comprehensive data analytics that will allow it to develop and test a proposed standardized set and, following a public comment period, recommend a final set. The task force's interim report recommendations are presented below.

Recommendation 1: The task force recommends continuing its work, as provided for in the statute, to develop a standardized set.

The act requires the task force to present a report and recommendations concerning a set of uniform, standardized payment rules by November 30, 2012. However, it also provides that, if at the time of the report the voluntary national initiative has not reached consensus on a complete or partial set of rules and claim edits, the task force shall "continue working to develop a complete set of uniform, standardized payment rules and claim edits and, by December 31, 2013, shall submit a report and may recommend implementation of a [standardized set] to be used by payers and health care providers."[28] As discussed in part III, the voluntary national initiative disbanded. This meant the task force did not have, as a starting point for its work, any rules and edits to process claims that stakeholders had already agreed to.

The task force recommends continuing its work on both the base set and complete standardized set. Part III reviewed the reasons the task force concluded the base and complete sets need to be developed concurrently as one uniform set rather than sequentially as originally conceived in the act. Work will continue as funding from grants, gifts and donations allows.

Recommendation 2: The task force recommends amending the act to extend by one year the deadline for the task force's final report and the effective dates for payer implementation of the standardized set.

Table 9 shows the deadlines for the task force's final report and recommendations and the deadlines for payer and provider compliance with the standardized set. It also shows the task force's recommended revised deadlines, which would require a statutory change. While significant progress has been made, the task force needs additional time to complete its work. It has already

[28] § 25-37-106(2)(d)(III),C.R.S.

Table 9

Medical Clean Claims Transparency and Uniformity Act
Statutory and Recommended Revised Deadlines

Activity	Current Statutory Deadline[1]	Recommended Revised Deadline
Task Force		
• Submit final report and recommendations concerning the standardized set and establishment and operation of a central repository for accessing the rules and edits.	December 31, 2013	December 31, 2014
Payers		
• Commercial health plans—implement the standardized set.	January 1, 2015	January 1, 2016
• Domestic nonprofit health plans—implement the standardized set.	January 1, 2016	January 1, 2017

[1] *These are the deadlines in the act if, at the time the task force submits its November 30, 2012, report to HCPF, the voluntary national Initiative has not reached consensus on a complete or partial standardized set of payment rules and claim edits, which is the case.*

tackled a number of difficult issues, including developing a common lexicon, agreeing on a process to arrive at the standardized set, establishing the basic functionalities for a central repository for accessing the rules and edits, issuing a request for information and agreeing on the elements of a request for proposals for a data analytics system that will allow it to create the standardized set. There is, however, much work still to be done.

The task force has laid the groundwork for a standardized set of edits and rules and creation of a central repository for accessing them. The work has taken longer than expected as a result of unanticipated challenges and national developments discussed in parts III and IV. If the task force is not given an additional year to complete its work, it will be unable to finalize and recommend to the legislature and HCPF a standardized set by the December 31, 2013, statutory deadline. It will not have sufficient time to publish the proposed standardized set for public comment and allow payers, vendors, provider billing systems and other interested parties to test and comment on the proposed set. With an additional year, the task force will be able to complete its work and submit a final

report and recommendations for a standardized set. In order for payers to have sufficient time to integrate the standardized set into their claims processing systems, the task force also recommends amending the act to allow them an additional year to come into compliance.

The recommended extension assumes the task force is able to secure sufficient additional grants, gifts and donations to fund its work through 2014. If it is unable to do so, the task force will submit a report to the legislature detailing the progress, findings, decisions and recommendations the task force is prepared to make at such time as funding has been exhausted. Also, if the legislature does not amend the act as recommended, the task force will submit a similar final progress report by the current deadline of December 31, 2013.

The task force wants to finish the job.

Despite coming to the table with different concerns and perspectives, task force members have demonstrated their commitment to finding consensus on a standardized set and are well along the road to fulfilling their legislative charge.

Colorado leads the nation in efforts to standardize claim edits and payment rules across private payers. It has had more success getting and keeping key stakeholders at the table and achieving consensus on difficult issues than any other state or national initiative. No other group, at the state or national level, has accomplished as much as the Colorado task force has. According to Walter Suarez, co-chair of the National Commission on Vital Health Statistics' committee on administrative simplification and health reform, "Colorado's [effort] remains the only significant work in this area."

Recommendation 3: The task force recommends that the General Assembly's health and human services committees and executive director of HCPF write to the Secretary of HHS requesting public access to the rationales for the NCCI edits.

As discussed in part III, the work of the task force has been made more difficult because it has not been able to determine the rationales for all of the NCCI edits. In particular, several edits appear to be based on benefit design elements or cost containment concerns that are specific to Medicare and not applicable to commercial health plans. As our name indicates, the Medical Clean Claims Transparency and Uniformity Act task force is committed to transparency. Transparency applies to the task force's deliberations about, process for selecting, rationales for and publication and access to the standardized set of claims edits and payment rules. Unfortunately, the NCCI process is not as transparent. The rationales for the NCCI set are not publically available despite the fact that we are

not aware of any compelling reasons for this policy. A request from the General Assembly and HCPF to the Secretary of HHS to allow public access to the NCCI edit rationales would significantly increase the likelihood that the Secretary would change the department's policy. The task force is making a similar request of the Colorado Congressional delegation.

Appendix A

MEDICAL CLEAN CLAIMS TRANSPARENCY & UNIFORMITY ACT

NOTE: This bill has been prepared for the signature of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

An Act

HOUSE BILL 10-1332

BY REPRESENTATIVE(S) Miklosi, Apuan, Gagliardi, Kefalas, Primavera, Tyler, Court, Fischer, Kagan, Todd, Frangas, Labuda, Soper; also SENATOR(S) Romer, Bacon, Boyd, Foster, Heath, Hodge, Newell, Steadman, Tochtrop.

CONCERNING THE CREATION OF THE "MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT".

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 37 of title 25, Colorado Revised Statutes, is amended, WITH THE RELOCATION OF PROVISIONS, to read:

25-37-101. [Formerly 25-37-101 (1)] Applicability of article. ~~(1) Effective January 1, 2008~~ EXCEPT AS PROVIDED IN SECTION 25-37-106, a person or entity that contracts with a health care provider shall comply with this article and shall include the provisions required by this article in the contract. ~~A contract in existence prior to January 1, 2008, that is renewed or renews by its terms shall comply with this article no later than December 31, 2008.~~

25-37-102. [Formerly 25-37-101 (2)] Definitions. ~~(2)~~ As used in this article, unless the context otherwise requires:

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

~~(a)~~ (1) "Category of coverage" means one of the following types of coverage offered by a person or entity:

~~(I)~~ (a) Health maintenance organization plans;

~~(II)~~ (b) Any other commercial plan or contract that is not a health maintenance organization plan;

~~(III)~~ (c) Medicare;

~~(IV)~~ (d) Medicaid; or

~~(V)~~ (e) Workers' compensation.

(2) "CMS" MEANS THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES IN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(3) "CPT CODE SET" MEANS THE CURRENT PROCEDURAL TERMINOLOGY CODE, OR ITS SUCCESSOR CODE, AS DEVELOPED AND COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION, OR ITS SUCCESSOR ENTITY, AND ADOPTED BY THE CMS AS A HIPAA CODE SET.

~~(b)~~ (4) "Edit" means a practice or procedure, CONSISTENT WITH THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS DEVELOPED PURSUANT TO SECTION 25-37-106, pursuant to which one or more adjustments are made regarding procedure codes, including the ~~American medical association's current procedural terminology code, also known as a "CPT code",~~ CPT CODE SETS and the ~~centers for medicare and medicaid services health care common procedure coding system, also known as "HCPCS"~~ HCPCS, that results in:

~~(I)~~ (a) Payment for some, but not all, of the codes;

~~(II)~~ (b) Payment for a different code;

~~(III)~~ (c) A reduced payment as a result of services provided to a patient that are claimed under more than one code on the same service date;

~~(IV)~~ (d) A ~~reduced~~ MODIFIED payment related to a PERMISSIBLE AND LEGITIMATE modifier used with a procedure code, AS SPECIFIED IN SECTION 25-37-106 (2); or

~~(V)~~ (e) A reduced payment based on multiple units of the same code billed for a single date of service.

(5) "HCPCS" MEANS THE HEALTH CARE COMMON PROCEDURE CODING SYSTEM DEVELOPED BY THE CMS FOR IDENTIFYING HEALTH CARE SERVICES IN A CONSISTENT AND STANDARDIZED MANNER.

~~(c)~~ (6) "Health care contract" or "contract" means a contract entered into or renewed between a person or entity and a health care provider for the delivery of health care services to others.

~~(d)~~ (7) "Health care provider" means a person licensed or certified in this state to practice medicine, pharmacy, chiropractic, nursing, physical therapy, podiatry, dentistry, optometry, occupational therapy, or other healing arts. "Health care provider" also means an ambulatory surgical center, a licensed pharmacy or provider of pharmacy services, and a professional corporation or other corporate entity consisting of licensed health care providers as permitted by the laws of this state.

(8) "HIPAA CODE SET" MEANS ANY SET OF CODES USED TO ENCODE ELEMENTS, SUCH AS TABLES OF TERMS, MEDICAL CONCEPTS, MEDICAL DIAGNOSTIC CODES, OR MEDICAL PROCEDURE CODES, THAT HAVE BEEN ADOPTED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", AS AMENDED. "HIPAA CODE SET" INCLUDES THE CODES AND THE DESCRIPTORS OF THE CODES.

~~(e)~~ ~~(I)~~ (a) "Material change" means a change to a contract that decreases the health care provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, replaces the maximum allowable cost list used with a new and different maximum allowable cost list by a person or entity for reimbursement of generic prescription drug claims, or adds a new category of coverage. ~~A~~

(b) "Material change" does not include:

~~(A)~~ (I) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract;

~~(B)~~ (II) A decrease in payment or compensation resulting from a change in the fee schedule specified in a contract for pharmacy services such as a change in a fee schedule based on average wholesale price or maximum allowable cost;

~~(C)~~ (III) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;

~~(D)~~ (IV) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;

~~(E)~~ (V) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense; or

~~(F)~~ (VI) Changes to an edit program or to specific edits; however, THE PERSON OR ENTITY SHALL PROVIDE NOTICE OF THE CHANGES TO the health care provider ~~shall be provided notice of the changes pursuant to subparagraph (II) of this paragraph (c)~~ IN ACCORDANCE WITH PARAGRAPH (c) OF THIS SUBSECTION (9), and the notice shall include information sufficient for the health care provider to determine the effect of the change.

~~(II)~~ (c) If a change to the contract is administrative only and is not a material change, the change shall be effective upon at least fifteen days' notice to the health care provider. All other notices shall be provided pursuant to the contract.

(10) "NATIONAL CORRECT CODING INITIATIVE" OR "NCCI" MEANS THE SYSTEM DEVELOPED BY THE CMS TO PROMOTE CONSISTENCY IN NATIONAL CORRECT CODING METHODOLOGIES AND TO CONTROL IMPROPER CODING LEADING TO INAPPROPRIATE PAYMENT IN MEDICARE PART B CLAIMS

FOR PROFESSIONAL SERVICES.

(11) "NATIONAL INITIATIVE" MEANS A COLLABORATIVE EFFORT LED BY OR OCCURRING UNDER THE DIRECTION OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, WHICH INCLUDES A DIVERSE GROUP OF STAKEHOLDERS, TO CREATE A LEVEL OF UNDERSTANDING OF THE IMPACT OF CODING EDITS ON THE INDUSTRY AND A UNIFORM, STANDARDIZED SET OF CLAIM EDITS THAT MEETS THE NEEDS OF THE STAKEHOLDERS IN THE INDUSTRY.

~~(f)~~ (12) "Person or entity" means a person or entity that has a primary business purpose of contracting with health care providers for the delivery of health care services.

25-37-103. [Formerly 25-37-101 (3), (4), (6), (9), and (19)] Health care contracts - required provisions - permissible provision. ~~(3)~~ (1) (a) A PERSON OR ENTITY SHALL PROVIDE, WITH each HEALTH CARE contract, ~~shall have provided with it~~ a summary disclosure form disclosing, in plain language, the following:

(I) The terms governing compensation and payment;

(II) Any category of coverage for which the health care provider is to provide service;

(III) The duration of the contract and how the contract may be terminated;

(IV) The identity of the person or entity responsible for the processing of the health care provider's claims for compensation or payment;

(V) Any internal mechanism required by the person or entity to resolve disputes that arise under the terms or conditions of the contract; and

(VI) The subject and order of addenda, if any, to the contract.

(b) The summary disclosure form required by paragraph (a) of this subsection ~~(3)~~ (1) shall be for informational purposes only and shall not be a term or condition of the contract; however, such disclosure shall

reasonably summarize the applicable contract provisions.

(c) If the contract provides for termination for cause by either party, the contract shall state the reasons that may be used for termination for cause, which terms shall not be unreasonable, and the contract shall state the time by which notice of termination for cause shall be provided and to whom the notice shall be given.

(d) The person or entity shall identify any utilization review or management, quality improvement, or similar program the person or entity uses to review, monitor, evaluate, or assess the services provided pursuant to a contract. The policies, procedures, or guidelines of such program applicable to a provider shall be disclosed upon request of the health care provider within fourteen days after the date of the request.

~~(4)~~ (2) (a) The disclosure of payment and compensation terms pursuant to subsection ~~(3)~~ (1) of this section shall include information sufficient for the health care provider to determine the compensation or payment for the health care services and shall include the following:

(I) The manner of payment, such as fee-for-service, capitation, or risk sharing;

(II) (A) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor, percentage of medicare payment system, or percentage of billed charges. As applicable, the methodology disclosure shall include the name of any relative value system; its version, edition, or publication date; any applicable conversion or geographic factor; and any date by which compensation or fee schedules may be changed by such methodology if allowed for in the contract.

(B) The fee schedule for codes reasonably expected to be billed by the health care provider for services provided pursuant to the contract, and, upon request, the fee schedule for other codes used by or which may be used by the health care provider. Such fee schedule shall include, as may be applicable, service or procedure codes such as current procedural terminology (CPT) codes or health care common procedure coding system (HCPCS) codes and the associated payment or compensation for each service code.

(C) The fee schedule required in sub-subparagraph (B) of this subparagraph (II) may be provided electronically.

(D) A fee schedule for the codes described by sub-subparagraph (B) of this subparagraph (II) shall be provided when a material change related to payment or compensation occurs. Additionally, a health care provider may request that a written fee schedule be provided up to twice per year, and the person or entity must provide such fee schedule promptly.

(III) The person or entity shall state the effect of edits, if any, on payment or compensation. A person or entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as through a web site, that allows a health care provider to determine the effect of edits on payment or compensation before service is provided or a claim is submitted.

(b) Notwithstanding any provision of this subsection ~~(4)~~ (2) to the contrary, disclosure of a fee schedule or the methodology used to calculate a fee schedule is not required:

(I) From a person or entity if the fee schedule is for a plan for dental services, its providers include licensed dentists, the fee schedule is based upon fees filed with the person or entity by dental providers, and the fee schedule is revised from time to time based upon such filings. Specific numerical parameters are not required to be disclosed.

(II) If the fee schedule is for pharmacy services or drugs such as a fee schedule based on use of national drug codes.

~~(6)~~ (3) When a proposed contract is presented by a person or entity for consideration by a health care provider, the person or entity shall provide in writing or make reasonably available the information required in subsections ~~(3)~~ (1) and ~~(4)~~ (2) of this section. If the information is not disclosed in writing, it shall be disclosed in a manner that allows the health care provider to timely evaluate the payment or compensation for services under the proposed contract. The disclosure obligations in this article shall not prevent a person or entity from requiring a reasonable confidentiality agreement regarding the terms of a proposed contract.

~~(9)~~ (4) Nothing in this article shall be construed to require the

renegotiation of a contract in existence before the applicable compliance date in this article, and any disclosure required by this article for such contracts may be by notice to the health care provider.

~~(19)~~ (5) A contract subject to this article may include an agreement for binding arbitration.

25-37-104. [Formerly 25-37-101 (7)] Material change in health care contract - written advance notice. ~~(7) (a)~~ (1) A material change to a contract shall occur only if the person or entity provides in writing to the health care provider the proposed change and gives ninety days' notice before the effective date of the change. The writing shall be conspicuously entitled "notice of material change to contract".

~~(b)~~ (2) If the health care provider objects in writing to the material change within fifteen days and there is no resolution of the objection, either party may terminate the contract upon written notice of termination provided to the other party not later than sixty days before the effective date of the material change.

~~(c)~~ (3) If the health care provider does not object to the material change pursuant to ~~paragraph (b) of this subsection (7)~~ SUBSECTION (2) OF THIS SECTION, the change shall be effective as specified in the notice of material change to the contract.

~~(d)~~ (4) If a material change is the addition of a new category of coverage and the health care provider objects, the addition shall not be effective as to the health care provider, and the objection shall not be a basis upon which the person or entity may terminate the contract.

25-37-105. [Formerly 25-37-101 (8)] Contract modification by operation of law. ~~(8)~~ Notwithstanding ~~subsection (6) of this section~~ SECTION 25-37-103 (3), a contract may be modified by operation of law as required by any applicable state or federal law or regulation, and the person or entity may disclose this change by any reasonable means.

25-37-106. Clean claims - development of standardized payment rules and code edits - task force to develop - legislative recommendations - short title - applicability - repeal. (1) THIS SECTION SHALL BE KNOWN AND MAY BE CITED AS THE "MEDICAL CLEAN CLAIMS

TRANSPARENCY AND UNIFORMITY ACT".

(2) (a) (I) FOR PURPOSES OF FACILITATING THE DEVELOPMENT OF A STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS FOR USE BY HEALTH CARE PROVIDERS AND PAYERS IN THE PROCESSING OF MEDICAL CLAIMS, THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL ESTABLISH A TASK FORCE BY NOVEMBER 30, 2010, CONSISTING OF REPRESENTATIVES OF ALL INDUSTRY SEGMENTS DIRECTLY AFFECTED BY THIS SECTION, INCLUDING:

(A) HEALTH CARE PROVIDERS OR EMPLOYEES THEREOF FROM A DIVERSE GROUP OF SETTINGS, WHICH SHALL INCLUDE PROVIDERS FROM HEALTH CARE COMMUNITY CLINICS, AMBULATORY SURGICAL CENTERS, URGENT CARE CENTERS, AND HOSPITALS;

(B) PERSONS OR ENTITIES THAT PAY FOR HEALTH CARE SERVICES, REFERRED TO IN THIS SECTION AS "PAYERS";

(C) PRACTICE MANAGEMENT SYSTEM VENDORS;

(D) BILLING AND REVENUE CYCLE MANAGEMENT SERVICE COMPANIES; AND

(E) STATE AND FEDERAL GOVERNMENT ENTITIES AND AGENCIES THAT PAY FOR OR ARE OTHERWISE INVOLVED IN THE PAYMENT OR PROVISION OF HEALTH CARE SERVICES.

(II) THE TASK FORCE SHOULD BE COMPRISED OF INDIVIDUALS WITH EXPERTISE IN THE AREAS OF PAYMENT RULES AND CLAIM EDITS AND THEIR IMPACT ON THE SUBMISSION AND PAYMENT OF HEALTH INSURANCE CLAIMS.

(III) THE TASK FORCE SHALL WORK TO DEVELOP A STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS AS REQUIRED BY THIS SUBSECTION (2) AND, WHILE FULFILLING ITS DUTIES, SHALL MONITOR AND STAY INFORMED OF THE NATIONAL INITIATIVE SO AS TO AVOID DUPLICATION OR CREATION OF COMPETING OR CONFLICTING PAYMENT RULES AND CLAIM EDITS.

(b) WITHIN TWO YEARS AFTER THE TASK FORCE IS ESTABLISHED, THE TASK FORCE SHALL DEVELOP A BASE SET OF STANDARDIZED PAYMENT RULES

AND CLAIM EDITS TO BE USED BY PAYERS AND HEALTH CARE PROVIDERS IN THE PROCESSING OF MEDICAL CLAIMS THAT CAN BE IMPLEMENTED INTO COMPUTERIZED MEDICAL CLAIMS PROCESSING SYSTEMS. THE BASE SET OF RULES AND EDITS SHALL BE IDENTIFIED THROUGH EXISTING NATIONAL INDUSTRY SOURCES THAT ARE REPRESENTED BY THE FOLLOWING:

(I) THE NCCI;

(II) CMS DIRECTIVES, MANUALS, AND TRANSMITTALS;

(III) THE MEDICARE PHYSICIAN FEE SCHEDULE;

(IV) THE CMS NATIONAL CLINICAL LABORATORY FEE SCHEDULE;

(V) THE HCPCS CODING SYSTEM AND DIRECTIVES;

(VI) THE CPT CODING GUIDELINES AND CONVENTIONS; AND

(VII) NATIONAL MEDICAL SPECIALTY SOCIETY CODING GUIDELINES.

(c) (I) AS THE BASE SET OF RULES AND EDITS DEVELOPED PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (2) MAY NOT ADDRESS EVERY TYPE OF HEALTH CARE SERVICE INVOLVED IN A MEDICAL CLAIM, THE TASK FORCE SHALL WORK TO DEVELOP A COMPLETE SET OF UNIFORM, STANDARDIZED PAYMENT RULES AND CLAIM EDITS TO COVER ALL TYPES OF PROFESSIONAL SERVICES. IN WORKING TO DEVELOP A COMPLETE SET OF RULES AND EDITS, THE TASK FORCE SHALL REQUEST TO PARTICIPATE IN THE NATIONAL INITIATIVE OR WORK WITH NATIONAL EXPERTS TO IDENTIFY ANY RULES AND EDITS THAT ARE NOT ENCOMPASSED BY THE NATIONAL INDUSTRY SOURCES IDENTIFIED IN PARAGRAPH (b) OF THIS SUBSECTION (2) OR THAT POTENTIALLY CONFLICT WITH EACH OTHER. ADDITIONALLY, THE TASK FORCE SHALL CONSIDER THE CMS MEDICALLY UNLIKELY EDITS AND COMMERCIAL CLAIMS EDITING SYSTEMS THAT SOURCE THEIR EDITS TO NATIONAL INDUSTRY SOURCES ON A CODE AND CODE EDIT PAIR LEVEL IN ORDER TO CREATE A COMPLETE SET OF PAYMENT RULES AND CLAIM EDITS.

(II) IN DEVELOPING A COMPLETE SET OF UNIFORM, STANDARDIZED PAYMENT RULES AND CLAIM EDITS, THE TASK FORCE SHALL CONSIDER STANDARDIZING THE FOLLOWING TYPES OF EDITS, WITHOUT LIMITATION:

(A) UNBUNDLE;

(B) MUTUALLY EXCLUSIVE;

(C) MULTIPLE PROCEDURE REDUCTION;

(D) AGE;

(E) GENDER;

(F) MAXIMUM FREQUENCY PER DAY;

(G) GLOBAL SURGERY DAYS;

(H) PLACE OF SERVICE;

(I) TYPE OF SERVICE;

(J) ASSISTANT AT SURGERY;

(K) CO-SURGEON;

(L) TEAM SURGEONS;

(M) TOTAL, PROFESSIONAL, OR TECHNICAL SPLITS;

(N) BILATERAL PROCEDURES;

(O) ANESTHESIA SERVICES; AND

(P) THE EFFECT OF CPT AND HCPCS MODIFIERS ON THESE EDITS AS APPLICABLE.

(d) (I) THE TASK FORCE SHALL SUBMIT A REPORT AND RECOMMENDATIONS CONCERNING THE SET OF UNIFORM, STANDARDIZED PAYMENT RULES AND CLAIM EDITS TO THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE SENATE AND HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES, BY NOVEMBER 30, 2012, AND SHALL PRESENT ITS REPORT AND RECOMMENDATIONS TO A JOINT

MEETING OF THE SAID HEALTH AND HUMAN SERVICES COMMITTEES BY JANUARY 31, 2013.

(II) IF, AT THE TIME THE TASK FORCE SUBMITS ITS REPORT, THE NATIONAL INITIATIVE HAS REACHED CONSENSUS ON A COMPLETE OR PARTIAL SET OF STANDARDIZED PAYMENT RULES AND CLAIM EDITS THAT THE TASK FORCE DETERMINES TO BE IN THE BEST INTERESTS OF COLORADO, THE TASK FORCE SHALL RECOMMEND THAT STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS FOR USE BY ALL PAYERS DOING BUSINESS IN COLORADO, WHICH SHALL BE IMPLEMENTED BY PAYERS AS FOLLOWS:

(A) PAYERS THAT ARE COMMERCIAL HEALTH PLANS SHALL IMPLEMENT THESE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS WITHIN THEIR CLAIMS PROCESSING SYSTEMS ACCORDING TO A SCHEDULE OUTLINED UNDER THE NATIONAL INITIATIVE OR BY JANUARY 1, 2014, WHICHEVER OCCURS FIRST; AND

(B) PAYERS THAT ARE DOMESTIC, NONPROFIT HEALTH PLANS SHALL IMPLEMENT THESE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS WITHIN THEIR CLAIMS PROCESSING SYSTEMS BY JANUARY 1, 2015.

(III) IF, AT THE TIME THE TASK FORCE SUBMITS ITS REPORT, THE NATIONAL INITIATIVE WORK GROUP HAS NOT REACHED CONSENSUS ON A COMPLETE OR PARTIAL SET OF STANDARDIZED PAYMENT RULES AND CLAIM EDITS:

(A) THE BASE SET OF STANDARDIZED PAYMENT RULES AND CLAIM EDITS DEVELOPED PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (2) SHALL BECOME THE STANDARDS USED IN COLORADO BY PAYERS AND HEALTH CARE PROVIDERS; AND

(B) THE TASK FORCE SHALL CONTINUE WORKING TO DEVELOP A COMPLETE SET OF UNIFORM, STANDARDIZED PAYMENT RULES AND CLAIM EDITS AND, BY DECEMBER 31, 2013, 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 CARE PROVIDERS.

(IV) AS PART OF ITS RECOMMENDATIONS PURSUANT TO THIS PARAGRAPH (d), THE TASK FORCE SHALL MAKE RECOMMENDATIONS

CONCERNING THE IMPLEMENTATION, UPDATING, AND DISSEMINATION OF THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS, INCLUDING IDENTIFYING WHO IS RESPONSIBLE FOR ESTABLISHING A CENTRAL REPOSITORY FOR ACCESSING THE RULES AND EDITS SET AND ENABLING ELECTRONIC ACCESS, INCLUDING DOWNLOADING CAPABILITY, TO THE RULES AND EDITS SET.

(V) THE STANDARDIZED PAYMENT RULES AND CLAIM EDITS DEVELOPED PURSUANT TO SUBPARAGRAPH (III) OF THIS PARAGRAPH (d) SHALL BE IMPLEMENTED BY PAYERS AS FOLLOWS:

(A) PAYERS THAT ARE COMMERCIAL HEALTH PLANS SHALL IMPLEMENT THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS WITHIN THEIR CLAIMS PROCESSING SYSTEMS ACCORDING TO A SCHEDULE OUTLINED IN THE TASK FORCE RECOMMENDATIONS OR BY JANUARY 1, 2015, WHICHEVER OCCURS FIRST; AND

(B) PAYERS THAT ARE DOMESTIC, NONPROFIT HEALTH PLANS SHALL IMPLEMENT THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS WITHIN THEIR CLAIMS PROCESSING SYSTEMS BY JANUARY 1, 2016.

(3) ONCE THE STANDARDIZED SET OF PAYMENT RULES AND CLAIM EDITS IS ESTABLISHED AND IMPLEMENTED, NO OTHER PROPRIETARY OR OTHER CLAIMS EDITS, OTHER THAN THOSE EDITS DESCRIBED IN PARAGRAPH (c) OF SUBSECTION (4) OF THIS SECTION, SHALL BE APPLIED TO MODIFY THE PAYMENT OF CHARGES FOR COVERED SERVICES; EXCEPT THAT, IF NATIONAL STANDARDS ARE LATER IDENTIFIED FOR STANDARDIZED PAYMENT RULES AND CLAIM EDITS, COLORADO PAYERS SHALL COMPLY WITH THE NATIONAL STANDARDS ACCORDING TO THE IMPLEMENTATION SCHEDULE REQUIRED BY FEDERAL LAW.

(4) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO:

(a) INTERFERE WITH OR MODIFY THE ACTUAL CONTRACTED RATE THAT IS REIMBURSED BY A CONTRACTING PERSON OR ENTITY TO A HEALTH CARE PROVIDER FOR ANY PROCEDURE OR GROUPING OF PROCEDURES;

(b) LIMIT CONTRACTUAL ARRANGEMENTS OR TERMS NEGOTIATED BETWEEN THE CONTRACTING PERSON OR ENTITY AND THE HEALTH CARE PROVIDER; OR

(c) LIMIT THE ABILITY OF THE CONTRACTING PERSON OR ENTITY TO APPLY PROPRIETARY OR OTHER CLAIMS EDITS USED TO DETERMINE WHETHER OR NOT A COVERED SERVICE IS REASONABLE AND NECESSARY FOR THE PATIENT'S CONDITION OR TREATMENT. THE EDITS PERMISSIBLE PURSUANT TO THIS PARAGRAPH (c) ARE THOSE USED IN UTILIZATION REVIEW OR MONITORING FOR SUSPECTED CASES OF ABUSE OR FRAUD, AND THE EDITS MAY LIMIT COVERAGE BASED ON THE DIAGNOSIS OR FREQUENCY REPORTED ON THE CLAIM. INFORMATION PERTAINING TO THESE EDITS SHALL BE DISCLOSED WITHIN FOURTEEN DAYS AFTER THE REQUEST OF THE HEALTH CARE PROVIDER IN ACCORDANCE WITH SECTION 25-37-103 (1) (d).

(5) NOTHING IN THIS SECTION REQUIRES THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO PROVIDE ADMINISTRATIVE OR RESEARCH SUPPORT OR ASSISTANCE TO THE TASK FORCE IN CARRYING OUT ITS DUTIES UNDER THIS SECTION.

(6) (a) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL DESIGNATE A NONPROFIT OR PRIVATE ORGANIZATION AS THE CUSTODIAL OF FUNDS FOR THE TASK FORCE. THE DESIGNATED ORGANIZATION IS AUTHORIZED TO ACCEPT AND EXPEND FUNDS AS NECESSARY FOR THE OPERATION OF THE TASK FORCE AND MAY SOLICIT AND ACCEPT MONETARY AND IN-KIND GIFTS, GRANTS, AND DONATIONS FOR USE IN FURTHERANCE OF THE TASK FORCE'S DUTIES AND RESPONSIBILITIES. ANY MONEYS DONATED OR AWARDED TO THE DESIGNATED ORGANIZATION FOR THE BENEFIT OF THE TASK FORCE ARE NOT SUBJECT TO APPROPRIATION BY THE GENERAL ASSEMBLY, AND ANY SUCH MONEYS THAT ARE UNEXPENDED OR UNENCUMBERED AT THE TIME THE TASK FORCE IS DISSOLVED OR THIS SECTION REPEALS PURSUANT TO SUBSECTION (7) OF THIS SECTION SHALL BE RETURNED TO THE DONORS OR GRANTORS ON A PRO RATA BASIS, AS DETERMINED BY THE DESIGNATED ORGANIZATION.

(b) THE DESIGNATED ORGANIZATION, ON BEHALF OF THE TASK FORCE, MAY ACCEPT IN-KIND STAFF SUPPORT FROM NONPROFIT AGENCIES OR PRIVATE GROUPS OR MAY CONTRACT WITH NONPROFIT AGENCIES OR PRIVATE GROUPS FOR THE PURPOSE OF PROVIDING STAFF SUPPORT TO ASSIST THE TASK FORCE IN CONDUCTING ITS DUTIES AND RESPONSIBILITIES UNDER THIS SECTION. ANY STAFF SUPPORT PROVIDED BY A NONPROFIT AGENCY OR PRIVATE GROUP, WETHER DONATED OR ENGAGED THROUGH A CONTRACT, SHALL NOT BE CONSIDERED EMPLOYEES OF THE TASK FORCE OR THE DESIGNATED ORGANIZATION.

(c) THE DESIGNATED ORGANIZATION SHALL PREPARE AN OPERATING BUDGET FOR THE TASK FORCE. PRIOR TO EXPENDING ANY MONEYS IT RECEIVES, THE DESIGNATED ORGANIZATION, ON BEHALF OF THE TASK FORCE, SHALL TRANSMIT A COPY OF THE BUDGET TO THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND SHALL CERTIFY TO THE EXECUTIVE DIRECTOR THAT THE DESIGNATED ORGANIZATION HAS RECEIVED OR HAS AVAILABLE ADEQUATE FUNDING TO COVER THE EXPENSES OF THE TASK FORCE AS IDENTIFIED IN THE BUDGET.

(7) THIS SECTION IS REPEALED, EFFECTIVE JUNE 30, 2012, UNLESS THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING NOTIFIES THE REVISOR OF STATUTES, IN WRITING, THAT THE ORGANIZATION DESIGNATED PURSUANT TO SUBSECTION (6) OF THIS SECTION HAS CERTIFIED THAT, AS OF JUNE 30, 2012, IT HAS RECEIVED OR HAS AVAILABLE SUFFICIENT MONEYS TO IMPLEMENT THIS SECTION.

25-37-107. [Formerly 25-37-101 (5)] Claim adjudication information - balance owing. ~~(5)~~ Upon completion of processing of a claim, the person or entity shall provide information to the health care provider stating how the claim was adjudicated and the responsibility for any outstanding balance of any party other than the person or entity.

25-37-108. [Formerly 25-37-101 (10)] Assignment of rights - requirements. ~~(10)~~ (1) A person or entity shall not assign, allow access to, sell, rent, or give the person's or entity's rights to the health care provider's services pursuant to the person's or entity's contract unless ~~he or she~~ THE PERSON OR ENTITY complies with ~~paragraph (a), (b), or (c) of this subsection (10) and also complies with paragraphs (d) and (e) of this subsection (10) as follows:~~ THE REQUIREMENTS OF THIS SECTION.

(2) A PERSON OR ENTITY MAY ASSIGN, ALLOW ACCESS TO, SELL, RENT, OR GIVE HIS, HER, OR ITS RIGHTS TO THE HEALTH CARE PROVIDER'S SERVICES PURSUANT TO THE PERSON'S OR ENTITY'S CONTRACT IF ONE OF THE FOLLOWING SITUATIONS EXISTS:

(a) The third party accessing the health care provider's services under the contract is an employer or other entity providing coverage for health care services to its employees or members and such employer or entity has, with the person or entity contracting with the health care provider, a contract for the administration or processing of claims for

payment or service provided pursuant to the contract with the health care provider;

(b) The third party accessing the health care provider's services under the contract is an affiliate of, subsidiary of, or is under common ownership or control with the person or entity; or, is providing or receiving administrative services from the person or entity or an affiliate of, or subsidiary of, or is under common ownership or control with the person or entity; OR

(c) The health care contract specifically provides that it applies to network rental arrangements and states that it is for the purpose of assigning, allowing access to, selling, renting, or giving the person's or entity's rights to the health care provider's services.

(3) IN ADDITION TO SATISFYING THE REQUIREMENTS OF SUBSECTION (2) OF THIS SECTION, A PERSON OR ENTITY MAY ASSIGN, ALLOW ACCESS TO, SELL, RENT, OR GIVE HIS, HER, OR ITS RIGHTS UNDER THE CONTRACT TO THE SERVICES OF THE HEALTH CARE PROVIDER ONLY IF:

~~(d)~~ (a) The individuals receiving services under the health care provider's contract are provided with appropriate identification stating where claims should be sent and where inquiries should be directed; and

~~(e)~~ (b) The third party accessing the health care provider's services through the health care provider's contract is obligated to comply with all applicable terms and conditions of the contract; except that a self-funded plan receiving administrative services from the person or entity or its affiliates shall be solely responsible for payment to the provider.

25-37-109. [Formerly 25-37-101 (11)] Waiver of rights prohibited. ~~(11)~~ Except as permitted by this article, a person or entity shall not require, as a condition of contracting, that a health care provider waive or forego any right or benefit to which the health care provider may be entitled under state or federal law, RULE, or regulation that provides legal protections to a person solely based on the person's status as a health care provider providing services in this state.

25-37-110. [Formerly 25-37-101 (12)] Provider declining service to new patients - notice - definition. ~~(12)~~ (1) Upon sixty days' notice, a

health care provider may decline to provide service pursuant to a contract to new patients covered by the person or entity. The notice shall state the reason or reasons for this action.

(2) ~~For the purposes of this subsection (12)~~ AS USED IN THIS SECTION, "new patients" means those patients who have not received services from the health care provider in the immediately preceding three years. A patient shall not become a "new patient" solely by changing coverage from one person or entity to another person or entity.

25-37-111. [Formerly 25-37-101 (13), (15), and (17)] Termination of contract - effect on payment terms - right to terminate - termination of pharmacy contracts. ~~(13)~~ (1) A term for compensation or payment shall not survive the termination of a contract, except for a continuation of coverage required by law or with the agreement of the health care provider.

~~(15)~~ (2) In addition to the ~~provisions of paragraph (e) of subsection (2) of this section~~ RIGHT TO TERMINATE A CONTRACT IN ACCORDANCE WITH SECTION 25-37-104 (2) BASED ON A MATERIAL CHANGE TO THE CONTRACT, a contract with a duration of less than two years shall provide to each party a right to terminate the contract without cause, which termination shall occur with at least ninety days' written notice. For contracts with a duration of two or more years, termination without cause may be as specified in the contract.

~~(17)~~ (3) A contract between a pharmacist or a pharmacy and a pharmacy benefit manager, such as a pharmacy benefit management firm as defined in section 10-16-102, C.R.S., shall be terminated if the federal drug enforcement agency or other federal law enforcement agency ceases the operations of the pharmacist or pharmacy due to alleged or actual criminal activity.

25-37-112. [Formerly 25-37-101 (14)] Disclosure to third parties - confidentiality. ~~(14)~~ A contract shall not preclude its use or disclosure to a third party for the purpose of enforcing the provisions of this article or enforcing other state or federal law. The third party shall be bound by the confidentiality requirements set forth in the contract or otherwise.

25-37-113. [Formerly 25-37-101 (16) and (18)] Article

inapplicable - when. ~~(16)~~ (1) This article shall not apply to:

(a) An exclusive contract with a single medical group in a specific geographic area to provide or arrange for health care services; however, this article shall apply to contracts for health care services between the medical group and other medical groups;

(b) A contract or agreement for the employment of a health care provider or a contract or agreement between health care providers;

(c) A contract or arrangement entered into by a hospital or health care facility that is licensed or certified pursuant to section 25-3-101;

(d) A contract between a health care provider and the state or federal government or their agencies for health care services provided through a program for workers' compensation, medicaid, medicare, the children's basic health plan provided for in article 8 of title 25.5, C.R.S., or the Colorado indigent care program created in part 1 of article 3 of title 25.5, C.R.S.;

(e) Contracts for pharmacy benefit management, such as with a pharmacy benefit management firm as defined in section 10-16-102, C.R.S.; except that this exclusion shall not apply to a contract for health care services between a person or entity and a pharmacy, ~~a~~ pharmacist, or ~~a~~ professional corporation or corporate entity consisting of pharmacies or pharmacists as permitted by the laws of this state; or

(f) A contract or arrangement entered into by a hospital or health care facility that is licensed or certified pursuant to section 25-3-101, or any outpatient service provider that has entered into a joint venture with the hospital or is owned by the hospital or health care facility.

~~(18) Notwithstanding the applicable compliance date requirement in subsection (1) of this section, a domestic nonprofit health plan shall comply with this article within twelve months after the applicable compliance date.~~

25-37-114. [Formerly 25-37-101 (20)] Enforcement. ~~(20) (a)~~ (1) With respect to the enforcement of this article, including arbitration, there shall be available:

~~(I)~~ (a) Private rights of action at law and in equity;

~~(II)~~ (b) Equitable relief, including injunctive relief;

~~(III)~~ (c) Reasonable attorney fees when the health care provider is the prevailing party in an action to enforce this article, except to the extent that the violation of this article consisted of a mere failure to make payment pursuant to a contract;

~~(IV)~~ (d) The option to introduce as persuasive authority prior arbitration awards regarding a violation of this article.

~~(b)~~ (2) Arbitration awards related to the enforcement of this article may be disclosed to those who have a bona fide interest in the arbitration.

25-37-115. [Formerly 25-37-101 (21)] Providers obligated to comply with law. ~~(21)~~ No provision of this article shall be used to justify any act or omission by a health care provider that is prohibited by any applicable professional code of ethics or state or federal law prohibiting discrimination against any person.

25-37-116. Copyrights protected. NOTHING IN THIS ARTICLE, INCLUDING THE DESIGNATION OF STANDARDS, CODE SETS, RULES, EDITS, OR RELATED SPECIFICATIONS, DIVESTS COPYRIGHT HOLDERS OF THEIR COPYRIGHTS IN ANY WORK REFERENCED IN THIS ARTICLE.

SECTION 2. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

____________________________ ____________________________

Terrance D. Carroll	Brandon C. Shaffer
SPEAKER OF THE HOUSE	PRESIDENT OF
OF REPRESENTATIVES	THE SENATE

____________________________ ____________________________

Marilyn Eddins	Karen Goldman
CHIEF CLERK OF THE HOUSE	SECRETARY OF
OF REPRESENTATIVES	THE SENATE

APPROVED____

____

Bill Ritter, Jr.
GOVERNOR OF THE STATE OF COLORADO

Appendix B

GLOSSARY OF TERMS AND ACRONYMS

Glossary

- **Act**—as used in this report, the Medical Clean Claims Transparency and Uniformity Act (Colorado HB-10-1332).
- **Base set**—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).
- **Claim edits--** 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 **edit** below.)
- C**omplete set--**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.
- **Current Procedural Terminology (CPT®) code set**--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
- **Data analytics**---as used in this report, 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.
- **Data sustaining repository**—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.
- **Edit**—§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."
- **Federation of Medicine**--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

- **Healthcare Common Procedure Coding System (HCPCS**)-- 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.

- **ICD-9/ICD-10--**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.

- **Modifiers--**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.)

- **National Correct Coding Initiative (NCCI)--** 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.

- **Out of scope edits**-- 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.

- **Payment rule**-- 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.

- **Pricing rule**—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.

- **Professional functions and entities**--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.

- **Proprietary or payer-specific edits**—edits that are specific to an Insurance company; there are millions of proprietary edits.

- **Resource-based relative value scale (RBRVS)**--a schema used to determine how much money medical providers should be paid.

- **Standardized set**—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.

- **Task force**—the task force created by the Medical Clean Claims Transparency and Uniformity Act, HB 10-1332.

- **Technical functions and entities**--refers to rule distribution, display and access to the standardized set after it has been established.

- **Voluntary national initiative--**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.

Acronyms

- **AMA**—American Medical Association.

- **CPT®**—Current Procedural Terminology

- **HCPCS** (pronounced "hick-picks)—Healthcare Common Procedure Coding System

- **HCPF**—Colorado Department of Health Care Policy and Financing.
- **HHS**—federal Department of Health and Human Services.
- **MFSDB**—Medicare Fee Schedule Data Base.
- **NCCI**- National Correct Coding Initiative.
- **RBRVS**-- Resource-based relative value scale.

Appendix C

TASK FORCE MEMBERS

James Borgstede, MD
Diagnostic Radiologist
Colorado Radiological Society, CO

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Beth Wright, co-chair, Edit Committee
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Alternate: Tim Miller

Appendix D

CODES AND MODIFIERS: EXPLANATION AND EXAMPLES

"Claim Modifiers: What Are They and How Do They Affect Me"

Breaking the Code: How CPT® Codes and Modifiers Affect Your Costs

FH Consumer Cost website,
http://www.fairhealthconsumer.org/reimbursementseries/claim_modifiers.aspx

Medical care is complicated, and sometimes it can be hard to describe exactly what services you received. So, providers and insurers use a standardized set of codes to help them communicate clearly. These Current Procedural Terminology, or "CPT," codes are developed and updated by the American Medical Association (AMA), and used by most providers around the country.

There are thousands of CPT codes. Each one represents a specific service, and helps insurers to understand what care was provided. Providers include these codes when they submit claims to your insurer. Then, your insurer generally uses the code to determine how much to pay.

For instance, if your primary care doctor spends 10 minutes examining you, he will use a certain CPT code - in this case, 99201. If he spends 20 minutes examining you, he will use a different code, 99202. Your insurer knows what each of these codes mean. Generally, the longer the visit or more complicated the service, the more your insurer will pay.

HCPCS Codes
Some medical supplies and equipment, like prosthetics and orthotics, don't have CPT codes. Instead, they are assigned a different kind of code called HCPCS (it stands for Healthcare Common Procedure Coding System). You can tell the difference because HCPCS codes start with a letter instead of a number.

Modifiers
What happens if your procedure doesn't fit a specific code? What if it takes more time than usual or your doctor has to run two lab tests instead of one? For those situations, providers add on a two-digit "modifier" to the CPT or HCPCS code. This modifier gives your plan those additional details. Then, your plan may use this information to adjust their payment. Modifiers might also be used for some diagnostic tests, like X-rays, CT scans, or lab services that have two pieces: the service that your doctor provides, and the technical equipment and staff that they use. The modifier "26" is used to describe the professional service. The modifier "TC" is used to describe the technical equipment.

What Are Some Common Modifiers?

These are some common modifiers you may see on your provider's claim form:

- 22: The procedure was unusually complicated and took more time than the general CPT code allows.
- 51: Your surgeon performed more than one surgical procedure during the same operation.
- 76: Your doctor performed the same procedure more than once during your visit. For example, you may have had multiple X-rays on the same day.
- 91: Your doctor repeated the same diagnostic test, usually on the same day. This might happen if, for example, your first test result is abnormal. Then your doctor might want to re-run the test later in the day.

Why Does it Matter?

If you go out-of-network, your plan may have certain limits on what it will pay for and modifiers can be used to help identify those limits. For instance:

- Suppose you get two surgeries during the same operation. Some plans may agree to pay 100% of their **allowed amount** for the first procedure, but only a portion of the allowed amount for the second one. Your plan will know what to pay because your provider will include modifier 51 to indicate you had multiple procedures.
- Suppose you have an X-ray at a hospital instead of a radiology facility. Some health plans may only pay your radiologist the professional portion of the fee (modifier 26), and not the technical portion (modifier TC) – even if the radiologist owns the equipment.

Modifiers in Action: Some Examples

Let's say you fracture your wrist and need surgery. Then suppose you develop carpal tunnel syndrome, so when your surgeon fixes your wrist, she also performs a carpal tunnel release.

That's two procedures. So, your surgeon will bill for:

- Wrist Fracture repair (CPT Code 25607)
- Carpal Tunnel release (CPT Code 64721, with modifier 51 to show it's a secondary procedure)

In-Network
If you go to an in-network provider, your plan will pay its contracted rate for your first procedure. So, your wrist fracture repair is covered (after you pay your **deductible** and **co-insurance**).

Suppose, however, that for the secondary procedures, your plan only pays 50% of the rate. So, it will cover half the contracted rate for the carpal tunnel release. Your network provider has already agreed to accept your plan's payment as payment in full, so you will not have to pay the difference.

Out-of-Network
Let's say your plan pays 80% of its **allowed amount** for out-of-network procedures. In this case, that means they will pay 80% of that amount for your wrist fracture repair. But again, for the secondary procedure, your plan only pays 50% of the allowed amount.

Remember, the allowed amount is not necessarily the same as the amount your provider charges. Your provider's charge may be higher, and you could be responsible for the difference.

So in this case, you might owe:

	Wrist fracture repair	**Carpal tunnel release**
Your surgeon's charge	$2,000	$1,000
Your plan's allowed amount	$1,000	$600
Your plan pays	80% of $1,000 = $800	50% of $600 = $300
You pay	$2,000 - $800 = **$1,200**	$1,000 - $300 = **$700**

Remember, these are only examples. Your plan's actual provisions may be different. Be sure to check your plan booklet, your insurer's website, or call your insurer so you can be sure you understand how your plan works.

Appendix E

EDIT TYPES LISTED IN THE ACT AND RECOMMENDED DEFINTIONS

TASK FORCECONSENSUS DEFINTIONS AS OF 10/23/12

EDIT TYPE[1]	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
A – Unbundled (Bundled)	This type of edit is also referred to as procedure to procedure edit (PTP) and will prevent inappropriate billing of services on the same calendar date when incorrect code combinations are reported. PTP edits cover a variety of situations, such as: 1. Comprehensive/ component code pairs; 2. Code pairs differing only in complexity of the service rendered (simple/complex, superficial/deep, etc.); 3. Code pairs from the same family of CPT®/HCPCS codes, which describe redundant, comprehensive or incidental services. 4. Services designated by CPT® as separate procedures when carried out as an integral component of a total service; 5. Services that are typically included in the performance of a service provided at the same encounter. 6. General anesthesia services provided for multiple surgical procedures performed during the same operative session. ***Consensus on 3/28/12***	NCCI, CMS directives/transmittals, HCPCS, CPT®/HCPCS and National Specialty Society; machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered. *[CPT® is a registered trademark of the American Medical Association. Copyright 2012 American Medical Association. All rights reserved.]*	Frequency limitations spanning a period of time will be addressed separately, including MUEs. Appropriate modifiers as defined by CPT® or HCPCS may be reported to override this type of edit.
B – Mutually Exclusive	This type of edit identifies incorrect billing of professional services that cannot reasonably be performed at the same anatomic site or same patient encounter, by the same physician. ***Consensus on 3/28/12***	NCCI, CMS directives/transmittals, HCPCS, CPT® and National Specialty Society; machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be	Appropriate modifier as defined by CPT® or HCPCS may be reported to override this type of edit.

[1] The letters in this column, A through P, refer to § 25-37-106 (2)(c)(II)(A)–(P).

EDIT TYPE[1]	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
		considered	
C – Multiple Procedure Reduction	This type of edit identifies when two or more procedures/services are performed during the same session by the same provider, not all of the procedures/services may be reimbursed at 100%. ***Consensus on 3/28/12***	MFSDB, CMS directives/transmittals, HCPCS, CPT® and National Specialty Society; machine readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered. *[MFSDB is the acronym for Medicare Fee Schedule Data Base.]*	*RVU for each of these procedures included pre-service, intra-service and post-service in the form of work/time practice expense and malpractice expense. The concept of multiple procedural reductions is the pre-service and post-service once is only performed once when multiple procedures are performed at the same time.*
D – Age	This type of edit will identify incorrect billing of a professional service when the CPT®/HCPCS descriptor of the service/procedure code or the related coding guideline implies age-specific parameters. ***Consensus on 3/28/12***	CPT®/HCPCS	**Note:** ICD-9/10 diagnoses edits are not within the scope of this legislation, and would be allowed with a procedure code edit.
E – Gender	This type of edit will identify incorrect billing of a professional service when the CPT®/HCPCS descriptor of service/procedure code implies gender-specific parameters. ***Consensus on 3/28/12***	CPT®/HCPCS	**Note:** ICD-9/10 diagnoses edits are not within the scope of this legislation, and would be allowed with a procedure code edit.
F – Maximum Frequency Per Day	This type of edit will identify incorrect billing of a professional service when the CPT®/HCPCS descriptor of the service/procedure code, or the related coding guidelines imply restrictions on the number of times the service/procedure can be provided on a single calendar date. ***Consensus on 3/28/12***	CPT®/HCPCS	**Note:** Frequency limitations spanning a period of time will be addressed separately, including MUEs
G – Global Surgery Days	This type of edit will identify incorrect billing when services that are routinely considered part of the global surgery package are reported separately within the pre operative, same day and post	CPT®/HCPCS, MFSDB, National Specialty Society, CMS directives/transmittals	**Note**: The legislative intent was not to limit the edit to just the number of days, but also to address the global surgery

EDIT TYPE[1]	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
	operative days assigned to that surgical procedure code. ***Consensus on 3/28/12*** ***Consensus on revised definition 7/18/12***		package.
H – Place of Service	This type of edit will identify incorrect billing of a professional service when the CPT®/HCPCS descriptors of the service/procedure codes do not match the place service reported on the claim. ***Consensus on 3/28/12***	CPT®/HCPCS	**Note:** Many of the CPT®/HCPCS descriptions of the evaluation and management codes include a specific place(s) of service. CPT® coding guidelines in other locations may also direct site of service reporting. The CMS Inpatient Only Listing was considered, however it may not always be appropriate for the younger age population and was therefore not considered an appropriate source.
I – Type of Service	Medicare no longer uses this type of edit for internal tracking; providers do not have to report when submitting claims. **Not applicable** ***Consensus on 3/28/12***		
J – Assistant at Surgery	This type of edit will identify when an assistant at surgery will be considered for payment. ***Consensus on 5/23/12***	Multiple sources, (1) ACS, if missing or indicates sometimes use (2) CMS, if it indicates Yes or No use this, (3) if CMS is sometimes then the determination would be up to the individual payer. Machine-readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered.	CPT® modifier 80, 81, 82 or HCPCS modifier AS should be appended to the surgical procedure code, according to CPT®/Medicare modifier definition.
K – Co-surgery	This type of edit will identify when consideration for payment will be made to two surgeons reporting that they were the primary surgeon when performing a distinct part(s) of a single surgical procedure. ***Consensus on 3/28/12***	MFSDB, National Specialty Society, CMS directives, and machine-readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered Modifier 62 would be appended according to CPT® definition.	Modifier 62 would be appended according to CPT® definition.
L – Team Surgery	This type of edit will identify when consideration for	MFSDB, National Specialty Society, CMS	Modifier 66 would be appended

EDIT TYPE[1]	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
	payment will be made when a complex surgical procedure requires several physicians to act as a primary surgeon when performing a distinct part(s) of a single surgical procedure. ***Consensus on 3/28/12***	directives, and machine-readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered Modifier 66 would be appended according to CPT® guidelines and instructions.	according to CPT® guidelines and instructions.
M – Total, Professional or Technical Split	This type of edit will identify incorrect billing of a procedure code that is either not eligible for the professional, technical split, or incorrectly identifies the professional or technical component. ***Consensus on 3/28/12***	MFSDB will be used to identify which procedures codes are appropriate for professional/technical split. HCPCS modifier TC would be appended according to HPCS guidelines and instructions for designating the technical component. CPT® modifier 26 would be appended according to CPT® guidelines and instructions for designating the professional component.	HCPCS modifier TC would be appended according to HPCS guidelines and instructions for designating the technical component. CPT® modifier 26 would be appended according to CPT® guidelines and instructions for designating the professional component. **Note:** The actual percent reimbursed is considered a payment issue and out of scope of the TF.
N – Bilateral Procedures	This type of edit will identify incorrect billing when the CPT®/HCPCS descriptors of the service/procedure code, or the related coding guidelines imply either unilateral or bilateral restrictions. ***Consensus on 3/28/12***	CPT®/HCPCS, MFSDB Modifier 50 "Bilateral Procedure: Unless otherwise identified in the listing bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code." Bilateral services are procedures performed on both sides of the body during the same operative session or on the same day. The modifier "50" is not applicable to procedures that are bilateral by definition or in cases where the descriptor includes the terminology as "bilateral" or "unilateral". HCPCS Modifiers LT and RT can be used to indicate this circumstance	**Note:** As defined in the CPT®, Modifier 50 "Bilateral Procedure description: Unless otherwise identified in the listing bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code." A bilateral service is one in which the same procedure is performed on both sides of the body during the same operative session or on the same day. The modifier "50" is not applicable to procedures that are bilateral by definition or whose code descriptors include

EDIT TYPE[1]	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
			the terminology of "bilateral" or "unilateral".
O – Anesthesia Services	No anesthesia specific edits were identified, they are captured under the "Unbundle" category ***Consensus on 3/28/12***		
P – Effect of CPT® & HCPCS Modifiers on these Edits			Under development .

Appendix F

ADDITIONAL EDIT TYPES CONSIDERED BY THE TASK FORCE AND RECOMMENDED DEFINITIONS

ADDITIONAL EDIT TYPES	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
Add-ons	This type of edit will identify incorrect billing of a CPT®/HCPCS add-on code. An add-on code describes a circumstance under which a procedure is rendered by the same physician ***in addition*** to a primary procedure or service. The add-on code, by definition, ***never*** would be reported as a stand-alone code. While not all add-on codes have a designated "parent" code, the use of a specific primary code with an add-on code is required when indicated by AMA CPT® parentheticals. Add-on codes are identified by AMA CPT® with the plus symbol (+), and instructions in the code description for reporting the service in addition to the primary procedure. *[CPT® is a registered trademark of the American Medical Association. Copyright 2012 American Medical Association. All rights reserved.]* ***Consensus on 4/25/12*** ***Consensus on revised definition 7/18/12***	CPT®/HCPCS, MFSDB, machine-readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered. Medicare.	Multiple procedure reductions do not apply, as procedure value is based on the knowledge that they are never done alone. *Bilateral procedure reductions do apply to those codes identified on the MFSDB with the modifier 50 indicator. **Note:** This edit applies only to those procedure codes specifically designated as such with the plus symbol (+). Other procedures that follow the same "add-on" functional logic, that is they are never reported alone, but do not have the AMA designation will be handled by a separate edit [to be added to the MCCTF edit dictionary].
Maximum Frequency > One Day	This type of edit will identify incorrect billing when the CPT®/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. ***Consensus on 3/28/12***	CPT®/HCPCS	MUEs will be addressed separately
New Patient	This type of edit is used for a new versus	AMA	Note, the AMA offered this clarification,

ADDITIONAL EDIT TYPES	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
	established patient. **Professional services** are those face-to-face services rendered by a physician and reported by a specific CPT® code(s). A new patient is one who has not received any professional services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. ***Consensus 7/18/12***		if the patient has received professional services from the same physician within the past three years, the patient is considered an established patient, even though the physician has changed medical groups or practice settings.
Laboratory rebundling	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. ***Ready for consensus 6/27/12***	Vendor	We recognize 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.
Bundled Service	This edit identifies when certain services and supplies are considered part of the overall care and should not be billed separately. ***Consensus 7/18/12***	CMS, Vendor	For example, status indicator B on MFSDB

Continued on next page

ADDITIONAL EDIT TYPES REVIEWED BUT NOT ACCEPTED	COLORADO MCCTF DEFINITION	POTENTIAL SOURCES	COMMENT
Same Day Medical Visit	This edit identifies when an Evaluation and Management visit is billed on the same day as a surgical procedure or substantial diagnostic or therapeutic (such as dialysis, chemotherapy and osteopathic manipulative treatment) procedure. ***Not applicable as a separate edit type, combined with global surgery*** ***Consensus 7/18/12***	Modifiers -25 and -57 may be appropriately billed to override this edit.	A separate edit definition is not needed; it has been combined with revised global surgery definition. TF should consider whether or not a separate edit is needed for same day medical visit and medical procedure.
Same Day Medical Visit and Medical Procedure	This type of edit will identify incorrect billing when an evaluation and management (E&M) service is reported on the same day as a substantial diagnostic or therapeutic procedure (such as dialysis, chemotherapy and osteopathic manipulative treatment), and E&M service is routinely considered an integral part of the other service and should not be reported separately. Task Force discussion 7/18/12	CPT®/HCPCS, MFSDB, machine-readable edits from a third-party (e.g., vendor, health plan) that are sourced to one of these will be considered.	During the TF 7/18/12 discussion of Global Surgery Days it was determined that a separate edit definition to address same day edits for non-surgical procedures may be needed.
Multiple Endoscopy Reimbursement	This edit identifies when multiple endoscopic surgical procedures within the same family are performed during the same session by the same provider, not all of the procedures/service may be reimbursed at 100%.	CMS/MFSDB	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 concept of multiple procedural reductions is, the pre-service and post-service is only performed once when multiple endoscopies are performed at the same time. Special CMS rules.
Multiple Radiology Reduction	This type of edit identifies when multiple imaging procedures are performed during the same session	Medicare Multiple Procedure Percentage Reduction (MPPR)	RVU for each of these procedures includes pre-service, intra-service and

	by the same provider. Not all may be reimbursed at 100%.		post-service in the form of work/time, practice expense and malpractice expense. CMS has applied the concept of multiple procedural reductions on both the technical and professional component of imaging services. The national specialty society (ACR) has provided background information documenting how the CMS application of a flat percentage reduction to the professional component across all imaging is a flawed process. This approach does not adequately take into consideration the variation in physician work/time associated with a given procedure. The ACR does not support the inclusion of this flawed approach as part of the Task Force's recommendations.
Multiple E&Ms on the same day	This edit identifies when multiple E&Ms are billed on the same day by the same provider. Only one E&M may be eligible for reimbursement.	Modifier -25 override may be appropriately billed to override this edit.	
Multiple Physical Therapy	This type of edit identifies when multiple therapy services are performed during the same session by the same provider. Not all may be reimbursed at 100%.	Medicare	
Rebundling	When two or more codes submitted together are better described by a single code or series of codes, transfer the original code combination into the more appropriate code or code combinations.		
Procedure code to modifier validation	This edit identifies when a modifier is inappropriately billed with a procedure code.	CMS, Vendor	

Appendix G

Edit Types that Are Out-of-Scope – Working Definitions 7/18/12

EDIT TYPES THAT THE MEDICAL CLEAN CLAIMS TRANSPARENCY & UNIFORMITY DEFINES AS OUT OF SCOPE: The act explicitly identifies edits that are not part covered by the act, including adjustments based on fraud or abuse; a finding that a procedure is not medically necessary or not covered by the patient's health benefit plan; and contractual arrangements or terms negotiated between providers and payers, including fee schedules.

PRICING RULES ARE OUT OF SCOPE: The task force has determined that specific amounts for pricing adjustments applied to reported medical services are out-of-scope.

In the course of its work, the task force identified several other edits that are out of scope and listed below.

OTHER EDIT TYPES THAT ARE OUT OF SCOPE	DEFINITION	SOURCES	COMMENT
Duplicate	This edits for duplicate check for Inpatient, Medicare Part A Crossover, Medicare UB04 Part B Crossover and Outpatient. These would be facility. Medicaid 0105	Colorado Medicaid Appendix R	Out of Scope - Clean Claim, Unprocessable edit
Validation of Procedure Code to Provider Type	The provider type is PT and the rendering provider is speech therapist. Checks to determine the charges are not from PT/OT which requires a modifier. Medicaid 0122	Colorado Medicaid Appendix R	Out of Scope
Validation of Category of Service to Provider Type	To verify Category of Service (COS) assigned to provider type, i.e., physician, DME, laboratory. Medicaid 0301	Colorado Medicaid Appendix R	Out of Scope
Missing Modifier	Code H0004 requires a modifier HF and the claim was submitted without a modifier. 0376	Colorado Medicaid Appendix R	Out of Scope – Clean Claim, Unprocessable edit
Pricing File Not Loaded	The procedure or revenue code is set up to reimburse using the Relative Value Scale (RVS) and does not have an associated conversion factor. Example: 33516 has an RVS base value of 68.00 and a conversion actor of 32.47 for Medicaid. If the conversion factor was not assigned or added to our system this would set the edit. 0380	Colorado Medicaid Appendix R	Out of Scope – Payment files
Pricing File Requires Manual Pricing/Split Claim	Not a facility message. Edit applies to physician, lab/x-ray, transport, etc. The procedure code has multiple pricing segments and the dates of service on the claim span a	Colorado Medicaid Appendix R	Out of Scope –Payment files

OTHER EDIT TYPES THAT ARE OUT OF SCOPE	DEFINITION	SOURCES	COMMENT
	reimbursement change. Example: DOS on claim is 06/25/11 through 7/2/11. Fee Schedule was updated effective with DOS 07/01/11. Another Example: procedure code is effective 04/01/11 and From DOS 3/30/11 the edit will set. To date is 10/02/11 and the procedure code was terminated on 09/30/11. 0429		
Manual Pricing Required	Edit sets when one of the modifiers on line item is equal to 50 (bilateral procedure). Line item associated with 50 modifier needs to be manually priced. Applies to Medicare Part B Crossover claims. 1479	Colorado Medicaid Appendix R	Out of Scope - Bilateral edit has been addressed; this is a Medicaid specific edit required to price the claim correctly.
Procedure code to modifier validation	This edit identifies when a modifier is inappropriately billed with a procedure code.	CMS, Vendor	Out of Scope

Appendix H

CPT®[1] MODIFIER REVIEW, as of 10/23/12

Modifier	Modifier Definition	Comments
Modifier 22: Increased Procedural Services	**Description**: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.	**Payment** modifier Doesn't override edits Documentation required – claim pended; reviewed to determine if additional payment allowed; some payers pay a flat %; some carriers don't consider it a clean claim if it isn't submitted; others just consider the claim as if -22 weren't submitted **Modifier rules to be handled by Payment Rules Committee**
Modifier 23: Unusual Anesthesia	**Description:** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.	**Payment** modifier Doesn't override edits **Modifier rules to be handled by Payment Rules Committee**
Modifier 24: Unrelated Evaluation and Management Service by the Same Physician	**Description**: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding	**Payment** modifier Can override an edit --- 'G' global surgery days

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Modifier	Modifier Definition	Comments
During a Postoperative Period	modifier 24 to the appropriate level of E/M service.	
Modifier 25: Significant Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service	**Description**: 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.	**Payment** modifier Can override an edit: • A=Unbundle (NCCI) • B =Mutually exclusive edit o Inc. 2 E&Ms • F=Frequency (2 E&Ms) • G=Global Surgery days
Modifier 26: Professional Component	**Description**: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number	**Payment** modifier Can override edits: • F – Frequency edits Important to total/26/TC (M) editing When billed appropriately
Modifier 32: Mandated Services	**Description** Services related to *mandated* consultation and/or related services (eg, third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier	Considered **informational** (has been recommended to be used when translator services were required)

Modifier	Modifier Definition	Comments
	32 to the basic procedure.	
Modifier 33: Preventive Services	**Description:** When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.	**Payment** modifier Doesn't override edit Used for benefit Could be considered for procedure to modifier editing
Modifier 47: Anesthesia by Surgeon	**Description:** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.	**Informational** – Not a payment modifier Doesn't override edit Not really used by payers – Most don't allow anesthesia by surgeons
Modifier 50: Bilateral Procedure	**Description:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.	**Payment** modifier Critical to editing – N- Bilateral procedures **Refer to Payment Rules Committee for rules about how to bill.**
Modifier 51: Multiple Procedures	**Description:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D).	**Informational** WellPoint and Rocky Mtn -don't use to drive MPR Humana will check Amy – some large clients use it in payment process --- provider not required to use CMS – informational
Modifier 52: Reduced Services	**Description:** Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of	**Payment** modifier Doesn't override edits Most apply a percentage without review (P)

Modifier	Modifier Definition	Comments
	reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).	
Modifier 53: Discontinued Procedure	**Description:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use). .	**Payment** modifier Doesn't override edits Most apply a percentage without review (P)
Modifier 54: Surgical Care Only	**Description:** When 1 physician 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 number.	**Payment** modifier It is important in editing – important to recognize the components of the surgical package Most apply a percentage without review (G) - Global
Modifier 55: Postoperative	**Description:** When 1 physician performed the postoperative management	**Payment** modifier It is important in editing – important to recognize the

Modifier	Modifier Definition	Comments
Management Only	and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.	components of the surgical package Most apply a percentage without review (G) - Global
Modifier 56: Preoperative Management Only	**Description:** When 1 physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.	**Payment** modifier It is important in editing – important to recognize the components of the surgical package Most apply a percentage without review (G) - Global
Modifier 57: Decision for Surgery	**Description:** An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.**:**	**Payment** modifier Overrides an edit (G) – Global surgery
Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	**Description:** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.	**Payment** modifier Overrides an edit (G) – Global surgery
Modifier 59: Distinct Procedural Service	**Description:** 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	**Payment** modifier Overrides edits (A) Unbundle (B) Mutually exclusive (F) Frequency

Modifier	Modifier Definition	Comments
	extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.	
Modifier 62: Two Surgeons	**Description:** When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.	**Payment** modifier Doesn't override edits Most apply percentage without review Tied to (K) Co-Surgeons
Modifier 63: Procedure Performed on Infants Less Than 4 kg	**Description:** Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005- 69990 code series. Modifier 63 should not be appended to any CPT codes listed in	**Informational** modifier Could lead to higher percentage reimbursement – need to verify who does this

Modifier	Modifier Definition	Comments
	the **Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine** sections.	
Modifier 66: Surgical Team	**Description:** 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.	**Payment or Informational?** Doesn't override edit Some review them and some let them go- Some are reviewed need to verify Tied to (L) Team Surgery
Modifier 76: Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	**Description:** It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.	**Payment** modifier Overrides edits (F) Frequency (G) – Global surgery?
Modifier 77: Repeat Procedure by Another Physician or Other Qualified Health Care Professional	**Description:** It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.	**Payment** modifier Overrides edits (F) Frequency
Modifier 78: Unplanned Return to the Operating/Procedure Room by	**Description:** It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure).	**Payment** modifier Override edits (F) Frequency (G) Global surgery

Modifier	Modifier Definition	Comments
the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)	
Modifier 79: Unrelated Procedure or Service by the Same Physician During the Postoperative Period	**Description:** 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.)	**Payment** modifier Override edits (F) Frequency (G) Global surgery?
Modifier 80: Assistant Surgeon	**Description:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).	**Payment** modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim
Modifier 81: Minimum Assistant Surgeon	**Description:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.	**Payment** modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim
Modifier 82: Assistant Surgeon (When Qualified Resident Surgeon Not Available)	**Description:** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).	**Payment** modifier Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim
Modifier 90: Reference (Outside) Laboratory	**Description:** When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.	**Informational?** **verify**

Modifier	Modifier Definition	Comments
Modifier 91: Repeat Clinical Diagnostic Test	**Description:** 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. **Note:** 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 (e.g., 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. .	**Payment** Overrides edits (F) Frequency (A) Unbundle (Lab rebundling)
Modifier 92: Alternative Laboratory Platform Testing	**Description:** When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703, and 87389). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.	**Informational** (P)
Modifier 99: Multiple Modifiers	**Description:** Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.	**Informational** Some pend these for review-due to system limitations
Modifier AA: ANESTH SVC PERFORMED PERSONAL		Anesthesia modifier – group with other anesthesia modifiers (P1-P5)

Modifier	Modifier Definition	Comments
Modifier AB: 12/99 END Reimburse<5 Employee		**Delete – no longer valid**
Modifier AC: 12/99 END Reimburse<5 Individual		**Delete – no longer valid**
Modifier AD: REIMB ANESTH > 4 PROC		Anesthesia modifier – group with other anesthesia modifiers (P1-P5)
Modifier AE: Registered dietician		**Out of scope** – not dealing with provider type edits
Modifier AF: Specialty physician		**Out of scope** – not dealing with provider type edits
Modifier AG: Primary physician		**Out of scope** – not dealing with provider type edits
Modifier AH: Clinical Psychologist		**Out of scope** – not dealing with provider type edits
Modifier AI: Principle physician of record		**Informational**
Modifier AJ: Clinical Social Worker		**Out of scope** – not dealing with provider type edits
Modifier AK: Non participating physician		**Out of scope** – not dealing with provider type edits
Modifier AL: NURS PRACT/TEAM NO RURAL (END)		**Delete** – no longer valid
Modifier AM: PHYS TEAM MEMBER SVC		**Informational**
Modifier AN: PA SVC, NOT TEAM MEM (END)		**Delete** – no longer valid
Modifier AP: REFRACT STATE NOT DETERMINED		**Informational**
Modifier AQ By phys in unlisted HPSA		**Informational**
Modifier AR : Physician serv scarce area		**Informational**

Modifier	Modifier Definition	Comments
Modifier AS: PA, NP, asst at surgery		**Payment modifier** Tied to (J) Assistant surgery (F) Frequency – when primary and assistant bill on same claim
Modifier AT: Acute Treatment		**Informational**
Modifier AU: FURN W/ UROL, OSTOMY, TRACH SU		**Informational**
Modifier AV: FURN W/ PROSTH OR ORTHOTIC		**Informational**
Modifier AW: FURN W/ SURG DRESSING		**Informational**
Modifier AX: FURN W/ DIALYSIS SVC		**Informational** l
Modifier AY : Item not for treatment of ESRD		**Informational**
Modifier AZ : Dental shortage area EHR pymt		**Informational** l
Modifier A1 : DRESSING FOR ONE WOUND		**Informational**
Modifier A2 : DRESSING FOR TWO WOUNDS		**Informational**
Modifier A3 : DRESSING FOR THREE WOUNDS		**Informational**
Modifier A4 : DRESSING FOR FOUR WOUNDS		**Informational**
Modifier A5 : DRESSING FOR FIVE WOUNDS		**Informational**
Modifier A6 : DRESSING FOR SIX WOUNDS		**Informational**
Modifier A7 : DRESSING FOR SEVEN WOUNDS		**Informational**
Modifier A8 : DRESSING		**Informational**

Modifier	Modifier Definition	Comments
FOR EIGHT WOUNDS		
Modifier A9 : DRESSING FOR 9 OR MORE WOUNDS		**Informational**
Modifier BA : FURN W/ PEN SVCS		**Informational**
Modifier BL : Special acquisition of blood		**Informational**
Modifier BO : ORAL FORMULA		**Out of scope** – derives benefit or fee schedule payment
Modifier BP : Purchase Option Beneficiary De		**Informational**
Modifier BR : Purchase Option Ben to Rent		**Informational** l
Modifier BU : Purchase Option Did Not Respon		**Informational**
Modifier CA : PROC PAYABLE INPATIENT		**Out of scope** – **fee schedule payment related** to ASCs potentially
Modifier CB : ESRD BENE PART A SNF-SEP PAY		**Informational**
Modifier CC : Procedure Code Change		**Informational**
Modifier CD : AMCC test for ESRD or MCP MD		**Informational**
Modifier CE : Med neces AMCC tst sep reimb		**Informational**
Modifier CF : AMCC tst not composite rate		**Informational**
Modifier CG : Policy criteria applied		**Informational**
Modifier CR : Catastrophe/Disaster Related		**Informational**

Modifier	Modifier Definition	Comments
Modifier CS : Related to 2010 gulf oil spill		**Informational**
Modifier DA : Oral assess other than dentist		**Informational** – not dealing with provider type edits
Modifier DD : Diag Site - Diagnostic Site		**Delete** – no longer valid
Modifier DE : Diag Site - Custodial Facility		**Delete** – no longer valid
Modifier DG : Diag Site - Hosp-based Dialysi		Delete – no longer valid
Modifier DH : Diag Site - Hospital		**Delete** – no longer valid
Modifier DI : Diag Site - Transfer Site		**Delete** – no longer valid
Modifier DJ : Diag Site - Non-hosp-base Dial		**Delete** – no longer valid
Modifier DN : Diag Site - Skilled Nursing Fa		**Delete** – no longer valid
Modifier DP : Diag Site - Physician Office		**Delete** – no longer valid
Modifier DR : Diag Site - Residence		**Delete** – no longer valid
Modifier DU : Diag Facility to Unclassified		**Delete** – no longer valid
Modifier DX : Diag Site - Phys Off then Hosp		**Delete** – no longer valid
Modifier EA : ESA, Anemia, Chemo-Induced		**Informational**
Modifier EB : ESA, Anemia, Radio-Induced		**Informational**
Modifier EC : ESA, Anemia, Non-Chemo/Radio		**Informational**
Modifier ED : HCT>39%		**Informational**

Modifier	Modifier Definition	Comments
or HGB>13g>=3 Cycle		
Modifier EE : HCT>39% or HGB>13g<3 Cycle		**Informational**
Modifier EG : Custod Facil - Hosp-based Dial		**Delete** –no longer valid
Modifier EH : Custod Facil - Hospital		**Delete** –no longer valid
Modifier EI : Custod Facil - Transfer Site		**Delete** –no longer valid
Modifier EJ : SUBS CLAIMS/SOD HYALURONATE		**Informational**
Modifier EM : ER Supply, Alpha-EPO Inj only		**Informational**
Modifier EN : Custod Facil - Skilled Nursing		**Delete** –no longer valid
Modifier EP : PART OF EPSDT PROGRAM		**Informational**
Modifier ER : Custod Facil - Residence		**Delete** – no longer valid
Modifier ET : EMERGENCY SERVICES		**Informational**
Modifier EU : Extended Care to Unclassified		**Delete** – no longer valid
Modifier EX : Custod Facil - PhysO then Hosp		**Delete** – no longer valid
Modifier EY : NO PRACTIONER ORDER FOR SVC		Rocky – requiring that all claim lines on claim have EY – otherwise require claim split- Medicare only - should be denied WLP – will be using in future Can’t create an edit to support **Out of scope – benefit related and administrative related**

Modifier	Modifier Definition	Comments
Modifier E1 : Upper Left, Eyelid		**Payment modifier** (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier E2 : Lower Left, Eyelid		**Payment modifier** (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier E3 : Upper Right, Eyelid		**Payment modifier** (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier E4 : Lower Right, Eyelid		**Payment modifier** (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier FA : Left Hand, Thumb		**Payment modifier** (F) Frequency (A) Unbundling (B) Mutually Exclusive
Modifier FB : Item provided without cost		**Out of scope** – fee schedule related
Modifier FC : Part Credit, Replaced Device		**Out of scope** – fee schedule related
Modifier FP : Service part of Fam Plng Prog		**Out of scope** – benefit related
Modifier F1 : Left Hand, Second Digit		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**
Modifier F2 : Left Hand, Third Digit		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**

Modifier	Modifier Definition	Comments
Modifier F3 : Left Hand, Fourth Digit		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**
Modifier F4 : Left Hand, Fifth Digit		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**
Modifier F5 : Right Hand, Thumb		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**
Modifier F6 : Right Hand, Second Digit		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**
Modifier F7 : Right Hand, Third Digit		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**
Modifier F8 : Right Hand, Fourth Digit		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**
Modifier F9 : Right Hand, Fifth Digit		**Payment modifier** **(F) Frequency** **(A) Unbundling** **(B) Mutually Exclusive**
Modifier GA : Waiver of Liabil Stmt on File		**Out of scope** – benefit related & provider contractual
Modifier GB : NOT COV BY GLOBAL PMT DEMO		**Informational**
Modifier GC : Svc Perf by Resident under Phy		**Informational** - potentially contractual – don't pay for residents

Modifier	Modifier Definition	Comments
Modifier GD : Unit of Service > MUE Value		**Payment modifier** Rocky – use to over MUE WLP – don't use? Humana – doesn't use (F) Frequency
Modifier GE : Svc Perf by Resident w/o Phys		**Informational** - potentially contractual – don't pay for residents
Modifier GF : NON-PHYS SERV C A HOSP		**Out of scope** – not dealing with provider type edits
Modifier GG : Screening mammo on same day		**Informational** – CMS only
Modifier GH : DX MAMMO/SCREEN MAMMO SAME DAY		**Informational** – CMS only
Modifier GI : Hosp-based Dialysis--Transfer		**Delete** – no longer valid
Modifier GJ : OPT OUT PRACT EMERG SVC		**Informational** - CMS only
Modifier GK : Actual Item/Service Ordered		**Out of scope** – benefit related & provider contractual
Modifier GL : Upgraded Item, No Charge		**Informational** – CMS only
Modifier GM : MULT PATIENTS, ONE AMB TRIP		**Informational**
Modifier GN : SVC BY SPEECH/LANG PATH		**Out of scope** – benefit related
Modifier GO : SVC BY OCC THERAPIST		**Out of scope** – benefit related
Modifier GP : SVC BY PHYSICAL THERAPIST		**Out of scope** – benefit related
Modifier GQ : VIA TELECOM SYSTEM		

Modifier	Modifier Definition	Comments
Modifier GR : Svc by resident(per VA policy)		
Modifier GS : DOSAGE REDUCED DUE TO HCT/HGB		
Modifier GT : VIA INTERACT AUDIO/VIDEO SYST		
Modifier GU : Waiver of liability, routine		
Modifier GV : PHYS NOT PAID BY HOSPICE PROV		
Modifier GW : SVC NOT RELATE TO HOSP PT COND		
Modifier GX : Notice of liability, voluntary		
Modifier GY : Statutorily Excluded		
Modifier GZ : NOT REASONABLE OR NECESSARY		**Out of sco**pe – benefit related & provider contractual

Appendix I

DATA SUSTAINING REPOSITORY: ESSENTIAL FUNCTIONALITIES

Data Model / Data Architecture (see figure)

1. Affirm interactive database model that supports multiple data tables (rule types) with a total capacity of 2,000,000 plus individual edits (records). The Phase I Common Edit Set ('edit library') in the diagram below will be the core of the repository; all other components are proposed for Phase II.
2. Consider alternatives for interactive database engine & reporting
3. Network link options for health plans / vendors

Feature/Function - Production:

1. Create an identification schema for derivate tables eligible for production.
2. Perform error checking on production tables including missing data, invalid data, non-mutually exclusive data.
3. Maintain secure interface to download production tables by authorized users.
4. Maintain logging of user, date, rule type, count.
5. Create summary reports of user download activity.

Database Service Level Performance:

1. Provide commercially reasonable uptime (99.9%).
2. Provide commercially reasonable backup protocols / disaster recovery.
3. Provide sub second response time when users are querying the data repository.
4. This project will be broken into two phases. The Phase I will have a small number of concurrent users.

Phase II will expand the number of users considerably

Input / Output - Data Contributors:

1. Create a secure file transfer interface (i.e. SFTP or secure Web) to receive data from multiple suppliers.
2. Provide real time file control messages to suppliers that include acknowledgement, error checking, logging, file transfer history, and pass/fail status.
3. Receive data in a form and format established by the CCTF. [(See Appendix C: Example of National Correct Coding Initiative (NCCI) data format].
4. Provide technical and syntactical consultation to the Task Force for the form and format of data submission.
5. Provide at least a 1.5Mb bandwidth for file transfer ("T1").
6. Allow multiple simultaneous data transfer of files up to 50Mb.
7. Create identification schema for each data supplier and each rule type submitted.
8. Enforce Supplier / Rule type limitations as defined by the CCTF.
9. Receive updates to previously submitted data as replace or append.
10. Maintain and provide access to prior versions of replaced data.
11. Assign data to the appropriate rule type as defined by the Task Force (e.g. Unbundle; Mutually Exclusive; Multiple Procedure Reduction).
12. Perform data integrity analysis (e.g. missing required data, invalid data, non-mutually exclusive data) for each rule type as defined by the Task Force.
13. Provide technical support to data suppliers to assist with data format, file transfer errors, data integrity.
14. Allow data suppliers to submit data on an X times per X basis.
15. Valid data is maintained and never deleted.

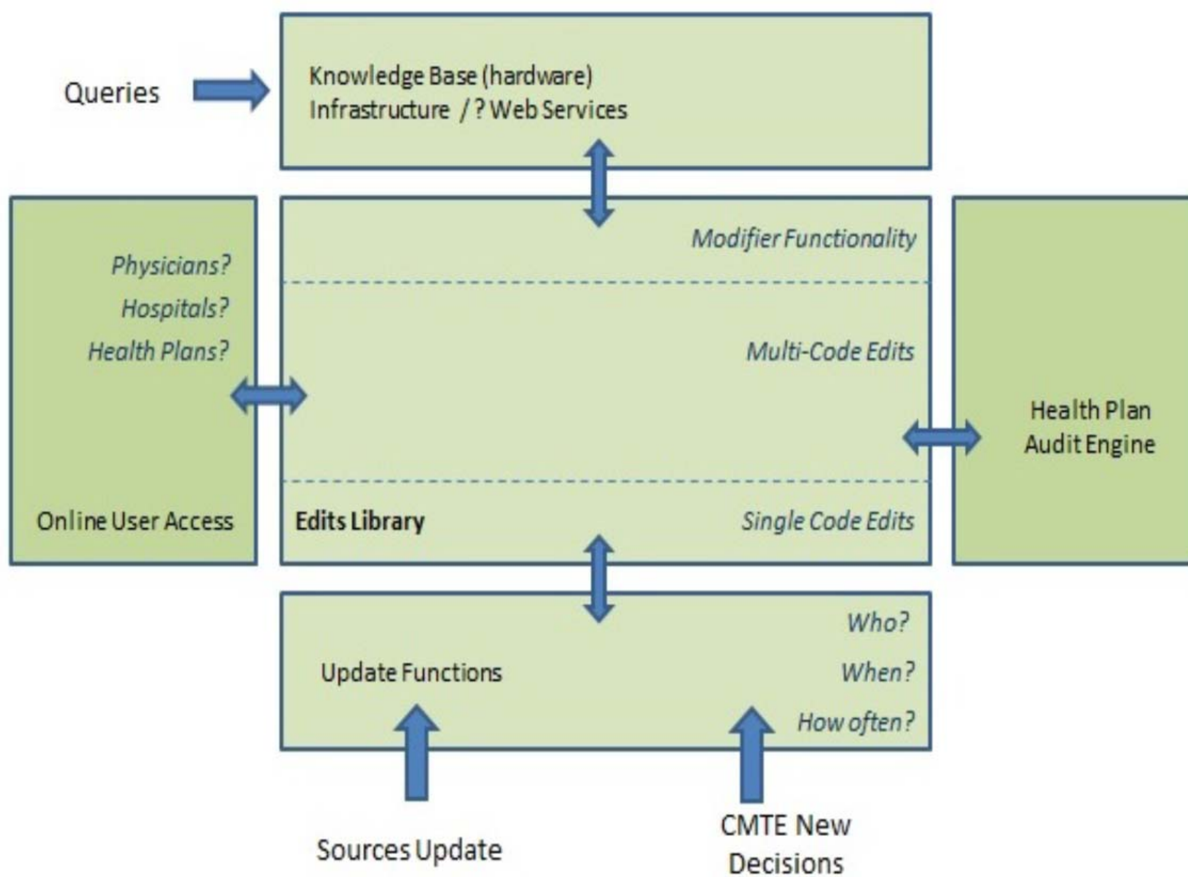
Provider/User Access (Professional) services:

1. Make all valid, active data provided by data suppliers available to authorized users.
2. Create a secure web based interface for the purpose of quantifying, comparing, filtering, and creating derivative tables from supplier data.
3. Create login based security levels for read, read-write authorization.

4. Create data source reports for each rule type with 1) Rule type, 2) Supplier ID 3) Total row count 4) Total active rows.
5. Create filters for data by 1) Rule type, 2) Supplier ID, 3) Effective date, 4) End date 5) Procedure Code(s) 6) Version ID 7) Production ID.
6. Create grouping for data source reports by 1) Rule type, 2) Supplier ID 3) Procedure code.
7. Support drill down reporting from summary level to table row level.
8. Create reports that show similarities and differences between different supplier data for the same rule type.
9. Create reports that show similarities and differences between versions of a rule type from the same supplier.
10. Apply rule type specific business rules, as defined by the Task Force, to multiple sources for the same rule type to derive a new table made up of one or more sources.
11. Implement hierarchical logic between sources within a rule type (See Appendix D: Case Example - Use Case # 1).
12. Establish an identification schema for each derivative table that includes rule type, version ID, and version date.
13. Create reports that compare versions of a rule type 1) row count, 2) same 3) different 4) different type (e.g. new row, different effective date).
14. Allow users to manually select rows from one or more rule sources to derive a new table or modify an existing derivative.
15. Repair loss of essential functionality within 15 days of notice.
16. Provide password reset in real time.
17. Provide enhancements on a time and materials basis.
18. Disable users on demand by the Task Force.
19. Track of the number of users in the system and provide reports to the AMA or any other groups that require royalty or licensing payments.

Optional Services:

1. Accept representative sample of claim data for Colorado.
2. Apply multiple versions of production rules to claim data.
3. Provide summary analysis of impact of multiple versions of production rules.
4. Summary report should include at a minimum 1) Rule type, 2) Frequency, 3) Value.
5. Allow drill down to claim level analysis of rule impact.


Queries
Knowledge Base (hardware)
Infrastructure / ? Web Services
Physicians?
Hospitals?
Health Plans?
Online User Access
Modifier Functionality
Multi-Code Edits
Edits Library
Single Code Edits
Health Plan
Audit Engine
Who?
Update Functions
When?
How often?
Sources Update
CMTE New
Decisions