Statement of Chris Jagmin, MD
Aetna
On Behalf of America's Health Insurance Plans
to the
National Committee on Vital and Health Statistics'
Subcommittee on Standards
Regarding the Transparency of Claims Edits
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Overview and Introduction

I am Chris Jagmin, a Medical Policy and Operations Senior Medical Director for Aetna. In this capacity I serve as Aetna's subject matter expert and educator for coding and payment policy issues.

Aetna is one of the nation's leading diversified health care benefits companies, serving approximately 36.3 million people with information and resources to help them make better informed decisions about their health care. Aetna offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, and medical management capabilities and health care management services for Medicaid plans. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

Today I'm testifying on behalf of America's Health Insurance Plans whose members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

I chair AHIP's Coding and Claims Edit Workgroup and am AHIP's representative to the AMA CPT Editorial Panel. I am pleased to provide the subcommittee with input as it discusses the requirement under section 10109 of the Affordable Care Act (ACA) that the Department of Health and Human Services seek input on "[w]hether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans." Earlier this year, AHIP convened a group of health plan experts to help thoughtfully develop these recommendations. We have focused our recommendations on coding for services to detect and deter fraud, waste and abuse on services that are billed using the CMS 1500 Health Insurance Form.

Role of Health Plan Claim Edits

The Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Sets Rule mandates that all health plans use the Current Procedural Terminology (CPT) codes for

reporting physician and other health care professional services. Claims "edits" are computer algorithms programmed into a health plan claims adjudication system related to the treatment of a specific service reported on a claim with a CPT or Healthcare Common Procedure Coding System (HCPCS) Level II code. They are designed to promote the correct coding of services performed by physicians, ensuring that we as health plans:

- Pay for services that are rendered; and
- Pay for the work associated with each service only once (as defined within the RVU of the CPT code).

It is important to note that when I refer to "claims edits," I am not including edits that may be associated with a health plan's particular benefits. Such edits are beyond the scope of my testimony.

While claims edits have been important tools to ensure correct coding and reduce fraud and abuse, it has been suggested that some of the variation in claims edits used by health insurance plans increases administrative costs for plans and providers without offsetting incremental benefits in improved coding. We have given this issue serious consideration, with a goal of identifying potential areas in which the government may be able to reduce any such unnecessary administrative costs through actions related to: (1) categories of edits applied; (2) the processes through which such edits are developed; and (3) how issues related to such edits are resolved.

The Use of NCCI Edits in the Commercial Market

Before we discuss the role of health plan-specific claims edits, it is important to provide the commercial insurance perspective on Medicare's use of claims edits. As you will hear from other testifiers today, the National Correct Coding Initiative (NCCI) establishes claims edits used by CMS to ensure that claims are coded properly according to Medicare guidelines and that the most appropriate CPT code is used for each service that is billed to Medicare. The use of NCCI was recently expanded by the ACA to Medicaid.

While commercial health insurance plans use NCCI to varying degrees, such plans have individually developed their own claims edits or utilized commercial claims editing software that is more applicable to commercial insurance populations.

It is likely that some will suggest that HHS should use the NCCI edits as the foundation of such efforts, based on its broad (Medicare) and expanding (Medicaid) application. The scope of their use makes the topic of NCCI edits a necessary part of any discussion of making the coding edit process more efficient. There are, however, several issues, both procedural and substantive, with the NCCI edits. Therefore, we suggest that any NCVHS or HHS discussion of promoting more consistent edits be informed by the NCCI edits but: (1) not be limited to NCCI edits given their limited applicability and scope and (2) not require the use of NCCI given the edits are developed for Medicare and Medicaid implementation without the input of commercial health insurers.

A key aspect of any claims edit development process is transparency. From a health plan's perspective the process used by CMS to develop claims edits, while transparent to providers and

selected national health organizations, has not been open to input from private insurers and to the public at large until the final decisions on edits are made and posted. CMS meetings related to the NCCI and mutually exclusive code (MEC) edits are not open to the public and the National Correct Coding Solutions does not provide a general means of understanding the rationale or methodology behind edits chosen. For example, there is no way to tell if a CMS decision to incorporate an edit is based on: clinical considerations, provider and specialty society feedback, the limits of the CMS adjudication system, or statistical methods showing outliers in the Medicare population.

Because of the limited information and lack of engagement from private insurers, health plans lack information necessary for interactions with regulators and providers. Unfortunately, plans can only provide the information that they have, and the lack of disclosure to health plans about the rationale for the NCCI edits can leave us unable to have a productive dialogue with providers, state regulators, and consumers about the difference between commercial and NCCI claims edits. This leads to unnecessary claim appeals and administrative costs for both providers and health plans.

Second, NCCI edits are not designed to be implemented by the commercial market. The CMS claims edit process does not allow providers to receive the logic behind specific edits before submitting a claim. Instead, providers have to individually request the logic after submitting the claim (and the logic is not available to all providers in Medicare). The NCCI contractor has indicated that education of potential users of NCCI edits, other than providers and Medicare contractors, is not in its scope of contract with CMS.

Third, the scope of the NCCI edits is based on a Medicare population. NCCI edits incorporate Medicare's policies regarding appropriateness (e.g., relating to which procedures can be done at Ambulatory Surgery Centers and what constitutes an inpatient versus an outpatient service). These edit policies may not always be applicable to a commercial population.

Most importantly, the NCCI edits are missing many code pairs that are not part of the Medicare population (e.g., OBGYN, pediatrics). While this likely will change as the NCCI edits are expanded to include Medicaid populations, long-term issues remain. NCCI edits include only incidental edits and mutually exclusive code edits and do not include many categories of edits used by private insurers:

- *Multiple Procedure Reduction*. When more than one procedure is performed on the same day by the same provider, such an edit may reduce the rate paid on the secondary procedure, while leaving the primary procedure unaffected.

- *Duplicate Edits*. Establish limits as to how many times the same procedure, on the same day, rendered to the same patient, by the same provider are allowed. Commercial insurers handle these issues through duplicate edits, while the Medicare program utilizes HCPCS codes.

- *Bundling edits*. This type of edit ensures equal treatment of codes submitted as a group or separately (e.g., submitted as part of a lab panel versus coded separately). NCCI does not

include bundling/rebundling edits when multiple codes are billed and there may be a more appropriate code that includes all of those codes (e.g., lab panels).

- *Assistant Surgeon edits*. This edit is not in NCCI, but is rather handled by Medicare practice. Medicare practice in this area differs significantly from commercial market practices, which are based on recommendations from other sources on the application of assistant surgeon edits.

We recognize the potential benefits of improving consistency of some types of edits. The NCCI edits, in their current form are both insufficient to address the full range of commercial issues and are inappropriate for mandatory, total use due to procedural and substantive issues.

Additional detail on these edits are included in an appendix to my written statement.

Alternative Approaches to NCCI

Section 10109 referenced the need for "consistent methodology and processes" used to establish claims edits used by health plans. As an alternative to the adoption of a single set of code edits, such as the NCCI, for commercial markets, it may be useful to consider whether additional governance structures and processes could be established to provide a forum for the discussion and review of the NCCI edits and address existing conflicts between other commonly used edits and coding recommendations when health plans incorporate these edits into practice.

We note that health plans must be afforded the opportunity to make their own decisions on how to incorporate the recommendations of any new processes that are developed. Today there are numerous sources of edits that are applicable to either the commercial market, government programs or both. These include:

- National Correct Coding Initiative (NCCI)
- CPT and CPT Assistant
- Specialty Society Recommendations
- Coders Desk Reference – Terminology and Definitions
- Medicare's Common Procedure Coding System (HCPCS) coding system
- Medicare Coverage Decisions (MCDs)
- DME Coding Practices

Today, health plans have processes in place to review their own claims data and make decisions about what claims edits to implement. For example, at Aetna these decisions are made with the input of health plan workgroups of staff medical directors, coding experts, and provider advisory groups, and include a process for appeals of edits based on unique circumstances.

Any work to review claim edits and their sources must be done with careful attention to antitrust and competition policy parameters, given the relationship of claims edits and payments. Such careful attention should extend both to the relevant discussions, as well as to the manner in which resulting recommendations are conveyed and utilized. Because antitrust law generally

prohibits agreements on price-related terms, an agreement among commercial plans on a set of claims edits is not a viable option. In contrast, all stakeholders, including health plans, providers, and government entities could benefit from independent, appropriately created, voluntary recommendations, for independent consideration and use as appropriate.

We propose that it would be useful to have some sort of public-private governance process to review claims edits sources and provide recommendations for potential use, on a voluntary basis, by various stakeholders. This process would need to include balanced representation, including providers, health plans, consumer representatives, employers, professional coders, and service providers in discussions around coding, claims edits, and related issues. Such a public-private governance process should be (1) open and transparent and (2) have clear parameters around the process. In addition to the obvious need for private participants to have antitrust counsel, HHS and other government stakeholders should ensure that they receive appropriate antitrust counsel from DOJ in advance of, as well as during, the process.

Potential activities could include:

- Review non-NCCI edit categories with the goal of developing best practices for potential use by commercial market and government stakeholders.

- Dialogue with CMS on ways to make the NCCI edits and the process by which they are adopted more transparent and useful to commercial stakeholders and the possibility of CMS providing the rationale behind each NCCI edit, or group each edit into general, rationale-related categories (i.e., specific to Medicare population, local carrier driven, clinical, etc.).

- Develop principles for discussing the standardization of claims edits related to clinical validity, specialty society recommendations, common administrative definitions, applicability to Medicare population, or other considerations. All edits related to benefit design would be out of scope (except in those cases where there is a state-mandated benefit).

- Establish a process for the public to provide input. While CMS may participate to provide the reasoning behind NCCI edits, it is recommended that this structure operate independently of CMS.

- Work with claims edit software vendors on ways to increase the transparency of the claims edits used by health plans for providers.

NCVHS should recommend that HHS take steps to increase the transparency of the NCCI claims edit development process to ensure broad stakeholder input and participation. We also recommend that various steps be taken to ensure that the process does not create antitrust concerns, including a dialogue between HHS and DOJ on the best ways to ensure that the process is productive while not raising such concerns.

In addition, some states are attempting to find solutions to perceived administrative inefficiencies without adequate resources, detailed knowledge base, and broad stakeholder input. A national effort would help establish a common platform for those areas where an alignment of interests is possible.

Recommendations and Conclusions

AHIP supports the following recommendations:

1. Given the potential benefits of improving consistency of some types of edits, HHS should recognize that the NCCI edits, in their current form are both insufficient to address the full range of commercial issues and are inappropriate for mandatory, total use due to the procedural and substantive issues we have described.

2. NCVHS should recommend that HHS take steps to increase the transparency of the NCCI development process to ensure broad stakeholder input and participation in the development phase.

3. NCVHS should consider recommending a public-private governance process to review claims edits sources and provide recommendations for potential use, on a voluntary basis, by various stakeholders. However, any process to seek input on claims edits must be done in a way that does not create antitrust concerns. Therefore, we recommend that NCVHS seek input from HHS and DOJ on the best ways to ensure that the process is productive while not raising such concerns.

I thank you for the opportunity to provide input to the Subcommittee's deliberations.

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Appendix
Claims Edit Types

Today NCCI Edits only include Incidental Edits and Mutually Exclusive Edits:

- *Incidental Edits* disallow a procedure that is included in another procedure. For example, in order to perform a surgical procedure, there needs to be an incision to access the area, and there need to be stitches to close the incision. The incision and the stitches may be included in the surgical procedure, which cannot be done without the incision and the stitches.

- *Mutually Exclusive Edits* address when two approaches resulting in the same outcome are billed. For example, there are two different procedures to remove a gallbladder. It can be done laparoscopically or as an open procedure (incision). If the surgeon begins the procedure as laparoscopic but must change to an open procedure in order to complete the surgery, only one gallbladder removal has been performed. Billing for both may result in one procedure being disallowed as mutually exclusive with the other.

In addition to incidental edits and mutually exclusive edits, health plans use several other types of claim edits to ensure proper and accurate coding of healthcare claims:

- *Multiple Procedure Reduction*. When more than one procedure is performed on the same day by the same provider, such an edit may reduce the rate paid on the secondary procedure, while leaving the primary procedure unaffected. These types of edits commonly used by commercial insurers are based on the concept that the provider is not required to perform the full scope of a particular procedure (including initial incision and closing) when performing multiple procedures for the same patient in the same operative session. For example, when the provider performs multiple procedures in the same abdominal area, the abdomen only needs to be opened and closed once. Therefore such edits may account for the fact there were not opening and closing components in the secondary abdominal surgery.

- *Duplicate Edits*. There may be limits as to how many times the same procedure, on the same day, rendered to the same patient, by the same provider are allowed. Commercial insurers handle these issues through duplicate edits, while the Medicare program utilizes HCPCS codes that have instructions for billing a higher level of service to include all like services for an individual on the same day rather than billing multiple services.

- *Bundling edits*. This type of edit ensures equal treatment of codes submitted as a group or separately (e.g., submitted as part of a lab panel versus coded separately). NCCI does not include bundling/rebundling edits when multiple codes are billed and there may be a more appropriate code that includes all of those codes (e.g., lab panels). For example, Medicare does not reimburse for the General Health Panel. However, if the provider separately bills each of the labs that comprise this panel, Medicare will allow those separately billed lab services because there is no edit in CCI that addresses more than two procedure codes.

- *Assistant Surgeon edits*. This edit is not in NCCI, but is rather handled by Medicare practice. Medicare practice in this area differs significantly from commercial market practices, which are based on recommendations from other sources on the application of assistant surgeon edits. Medicare bases its allowance on statistics (e.g., how many times an assistant surgeon billed for the procedure). Other sources, such as the American College of Surgeons, base their recommendations on medical necessity (e.g., was an assistant surgeon required to successfully complete the procedure).