HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY AND UNIFORMITY ACT TASK FORCE

November 18, 2011

Testimony to the National Committee on Vital and Health Statistics Subcommittee on Standards

CLAIM EDIT TRANSPARENCY: *NCVHS to investigate whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5))). It is believed that uniform edits could improve the quality of comparability across multiple payers in an all payer claims data base, and simplify claim submission compliance for providers….*

- **What is meant by "claim edit?" At what stage of a transaction do edits occur and where are there pain points and opportunities for improvement?**

1. In general terms, edit refers to a change to the data submitted by deletion, insertion or combination. There is currently no industry standard definition of *edit*. This has added to the lack of clarity and makes discussions around standardization challenging.

2. The Colorado statute defines an edit as, "a practice or procedure pursuant to which one or more adjustments are made regarding procedure codes…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 service date; (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) A reduced payment based on multiple units of the same code billed for a single date of service."

3. The real distinction, however, is in the *purpose* for the edit. These are numerous; some we have identified are listed below.

Edits that the Colorado Task Force is NOT addressing

1. Front-end edits, used to ensure claims contain the information needed to even enter into the payer's processing system; e.g., insured name, patient name, ID number, birth date, a diagnosis code, a procedure code, etc. These are generally not contentious.Medicare refers

to these as “unprocessable edits” while private payers, and state legislative or regulatory bodies may refer to them as “clean claim” edits.

   a. Information on what the front-end edits are is shared with the provider community. This has allowed many practice management systems, billing systems and clearinghouses to program these requirements into their software thus preventing the submission of erroneous or incomplete claims. The transparency and basic uniformity of this type of edit increases the efficiencies of all in the claims process, and should be a model for all types of edits.

2. Edits that validate the accuracy of the information submitted on the claim form; such as, whether or not the diagnosis or procedure code is current and/or a valid number; is the date of service or birth date accurate; is the patient/subscriber name accurate; does the patient have coverage on the date of service, etc. These edits happen early in the process, once the claim enters the payers system. Many of these edits help to identify clerical errors and are not in themselves a pain point for the providers.

3. Fraud and abuse edits, are used to investigate potential cases of fraud or abuse and are triggered during the claim adjudication process.

   a. Fraud and abuse edits are not openly disclosed to providers, however the Office of the Inspector General (OIG) and the Recovery Audit Contractor (RACs) do publish a listing of the Medicare and Medicaid issues they will be investigating.

4. Utilization review edits are used to investigate questions related to the medical necessity of the procedure/service itself, the frequency of the service or the diagnosis reported in connection with the procedure/service.

   a. Utilization review edits are disclosed by many of the payers, both government and commercial. The Medicare Contractors have an open process for the development and publication of LCDs. (Local Contractor Determination policies which serve the purpose of monitoring for the appropriateness of the frequency, diagnosis, etc.) Many private payers have posted their medical policies dealing with utilization review issues on their secure provider websites.

The topic of utilization review and more specifically medical necessity review has come up in our Task Force discussions and is a concern for the providers; however these types of edits were specifically excluded from consideration by the Colorado legislation.

<u>Edits that the Colorado Task Force IS addressing</u>

1. Medicare (and now Medicaid) use the edits developed for the National Correct Coding Initiative (NCCI). There are two types of edits within NCCI:

a. Comprehensive edits identify code pairs where one is considered part of the other; that is, when both procedure codes are performed on the same patient on the same date of service by the same physician only one will be paid (the comprehensive procedure).

b. Mutually Exclusive edits identify code pairs that represent services that cannot reasonably be performed in the same session, only one will be paid.

NCCI edits are disclosed and available in a downloadable file. This allows for predictability and the possibility of programming this same editing logic into the physician's practice management system. Most commercial editing software utilizes the majority of the NCCI edits.

2. In addition there are a number of other edits that are used by payers in the claims adjudication process to identify the application of different payment rules. These include such things as:

    a. Multiple procedure reductions, when more than one procedure is performed on the same patient during the same session by the same physician, but they are distinct procedures and eligible for separate payment but at a reduced amount for the secondary, tertiary, etc. procedures.

    b. Bilateral surgery, these can either be identified by appending modifier 50 to the procedure code or by submission of a code that has "bilateral" within its description.

    c. Assistant surgery edits identify if the procedure code is eligible for payment, and if so applies the assistant surgery payment rule.

    d. Global surgery edits identify the follow up days for surgical procedures. Follow up medical visits within the global period are not paid separately.

    Medicare and most commercial payers publish their payment rules, but they are not in a format that can be downloaded. The pain point for providers (and payers alike) is that there is inconsistency among payers that can lead to unnecessary re-work.

3. There are edits that Medicare and private payers utilize based on their interpretation of CPT coding guidelines and conventions. The CPT coding guidelines and conventions offer instructions on when it is or is not appropriate to bill for a specific code, code combination and/or code and modifier combination. For example:

    a. Modifier 25 identifies an instance when it is appropriate to report a patient visit procedure code and a minor surgical procedure (one with 10 follow up days) on the same day for the same patient by the same physician.

b. Modifier 24 identifies an instance when it is appropriate to report a patient visit procedure code within the follow up period of a major surgical procedure on the same patient by the same physician.

c. There are CPT notes that identify procedure codes that should not be reported together, or if done in combination should be reported under one more inclusive procedure code.

These edits are generally not disclosed and therefore add to the complexity and unpredictability of the claims processing.

The Colorado legislation recognized that NCCI was only one subset that could and should be used to develop a complete set of standardized edits.

- **Each insurer requires different codes and/or information to adjudicate a claim, and responds back with a different set of codes and edits – often to the same information – but it differs by plan. This is an administrative nightmare to providers. What are some solutions?**

1. There are currently millions of edits in use by payers, and multiple variations on how they are applied. Because of the lack of transparency and inconsistency in the application of the many edits there is no predictability concerning the accuracy of the claims processing. This leads to distrust and unnecessary costs.

2. A standardized set of claim edits that is disclosed to the provider community in advance, and is in a downloadable format for inclusion in the physicians' billing system would streamline the claims submission and processing. This would be a necessary step toward the automation of the entire healthcare transaction process and significant reduction in the overall administrative expense for everyone involved.

3. As noted above the variations among payers in edits and their application are numerous. In some instances this can even lead to variations in how the services should be reported. Physicians are generally contracted with multiple payers (average of 20 contracts), necessitating them or their staff to determine (uncover) the specific rules of each. Transparency and standardization around the edits and associated payment rules would go a long way toward alleviating this administrative burden.

4. As a high level observation / goal; correct coding edits need to be separated from other "value added" functions such as, fraud detection, utilization and benefit determination.

- **Physicians "over send" information because requests are nebulous or they want to cover their bases. How can this be mitigated?**

1. The information providers currently receive is generally very cryptic and does not always explain either what action was taken on the claim or what specific information is needed to finalize the claim processing. This can lead to the provider "over sending" information.

2. Standardization of the interpretation and application of the Claim Adjustment Reason Codes (CARC) and the Remittance Advice Remark Codes (RARCs) for reporting on the Remittance Advice could advise the physician why specific actions were taken on the claim and would clarify what next step or additional information is required.

3. Consistent use of CARC and RARC codes would facilitate automation of the payment reconciliation process within the physician's billing system, eliminating even more of the current administrative expense.

- **Are other states planning to follow the Colorado initiative (http://hb101332taskforce.org)? How can the initiative, if valued, but turned into a national agenda?**

1. Minnesota Vermont and Washington have initiatives working to simplify elements of the claims process.Both MN & VT are monitoring the Colorado process actively.Earlier California and Texas both embarked upon limited simplifications around edits with respect to HMOs.This paper does not address specifically how those states activities compare with Colorado's.

2. To solidify a national initiative,an existing entity like Colorado's Task Force might be considered or a sub-group of an existing organization like the Workgroup on Electronic Data Interchange (wedi) could provide a starting platform. A national work group would need to be sanctioned by a recognized authority that could make its output enforceable. It would be useful to contract a neutral 3rd party facilitator to conduct discussions.

3. The group's basic charter should be consensus around the following:
    a. Toformalize lines of communication for adopting edits.
    b. Determine a transparent credible process to accept input from a broad spectrum of stakeholders.
    c. Establish a sustaining strategy including:
        i. Update process
        ii. Funding
        iii. Governance

4. Sanction a "Stakeholder Consortium": Sec 10109 outlines parameters of an entity that would be authorized to make recommendations to the Secretary of Health and Human Services (H &

HS) regarding administrative simplification. The Colorado legislation HB10_1332, using this baseline template created a detailed entity known as the Clean Claims Transparency & Uniformity Act Task Force, as described below, paraphrased and refined from statute:

a. To have a functional representation of the stakeholders in the industry members should have expertise in the areas of coding, payment rules and claim edits, and have hands-on experience with the impact they have on payment of professional health insurance claims.
b. Such expertise includes a technical understanding of the logic surrounding: unbundling, mutually exclusive, multiple procedure reduction, global surgery days, place and type of service, assistant surgery, co-surgery, team surgery, total/professional/technical splits, bilateral procedures, anesthesia services, and the effect of CPT and HCPCS modifiers.

c. A representative cross section of stakeholders should have all industry segments directly affected, including:

    i. Health care providers or employees thereof from a diverse group of settings, which should include community clinics including FQHCs, ambulatory surgical centers, urgent care centers, physician practices and hospitals billing for providers
    ii. Persons or entities that pay for health care services "payers" including commercial and not-for-profit organizations as well as cooperatives
    iii. Primary software developers as well as 3rd party practice management system vendors
    iv. Billing and revenue cycle management service companies
    v. State and federal government entities and agencies that pay for or are otherwise involved in the payment or provision of health care services
    vi. Professional societies such as AMA and their CPT subgroup
    vii. NCCI and/or their code edit development vendor
    viii. Knowledgeable consumer(s)

5. Select a base set of edits: This requires a high level decision at the outset as to whether to begin with an empty bucket and add to it until all needs are satisfied –or- begin with a full bucket and eliminate redundant and low value added components until an efficient set remains. From a middle ground one might observe that many already full buckets exist,consequentlyit may be productive to acquire a set from a private sector vendor.

    a. Perhaps as a starting point H&HS could sponsor procurement of a base set for the sanctioned consortium to begin from. This path may greatly reduce the time and contentiousness ofarriving at a base set of edits that are generally agreed upon by the predominance of stakeholders and need only refinement. This may also alleviate license and anti-trust conflicts which erupt across commercial terrain.

6. Sustainability: Principle building blocks that are necessary are being revealed by the Colorado work and include:

    a. Establish or adopt criteria & definitions for "nationally recognized sources".
    b. Determine credible use of nationally recognized sources, including:
        i. What is the feedback mechanism between providers & payers?
        ii. How are conflicts arbitrated to resolution?
        iii. What should the update frequency be?
        iv. Develop a uniform method for converting adverbs to machine language; logic
            1. Perhaps establish definitions of frequency to be adopted across "national sources"
        v. Resolve conflicting contributors where more than one "nationally recognized source" is available.
        vi. Establish behavior standards for nationally recognized sources dealing with:
            1. Are they responsive to payer inquiry?
            2. Do they have capability of annual updates?
            3. What is the source's degree of detail?
                a. Ambiguity predictably leads to varying interpretations; example: "sometimes" is not uniformly translatable
            4. Do they want to participate?

7. Enforce the national work group's recommendations:
    a. Protection from class action regarding edits for adopters
    b. Protection from other edit sets adopted by individual states
    c. Requirement to participate in exchanges
    d. Requirement for quality society accreditation

8. At some level payers must be allowed to differentiate themselves to provide for a useful perception of unique value added to compete with each other. Additionally, payers bring a unique perspective and set of tools to the table for cost control. This must be allowed to continue to add value for the consumer. However, this should not be at the expense of standardization at the claims processing level which supports automation and administrative simplification and the cost reductions realizable from them.

• What is the role and opportunity for the Medicare and Medicaid National Correct Coding Initiative?

1. CMS should acknowledge and accept their default role as the payer predominating providers in all 50 states and as such their responsibility to lead an initiative to standardize edits. To this end NCCI should institute a goal of alignment with private sector payer practices and create an initiative to reconcile discontinuities where they are revealed. A high level observation is that providers should not have to contend with one set of rules from the government and another from the private sector.

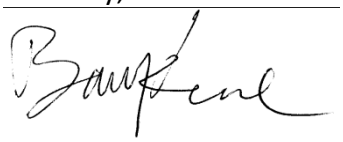
2. The NCCI contractor must be part of the conversation and have authority to speak openly about their development process and protocol. The example arrangement for this made with Colorado (1)is too restrictive and leaves results vulnerable to CMS override after the fact. Where CMS does not want the contractor to speak for them they must be present and speak for themselves. CMS and/or their contractor should be at the table as peers with all other entities. The sanctioned consortium should not have to pay a fee to acquire input from the CCI creator(s).

3. This dissertation has largely focused on the provider / payer relationship. However, a growing concern surfacing in state legislatures is that consumers are often impacted by unanticipated out of pocket medical expense because of the inability of providers to reasonably estimate their out of pocket exposure at the time and place of service.

4. Why now?

    a. IDC10 exponentially increases number of codes, standardization of edits reduces the impact on coders and leverages the value of higher resolution of care detail.
    b. The insurance exchanges demand a uniform product; non-uniform edits will undermine this goal and dampen consumer trust.
    c. Creating an essential benefits package requires a uniform edit approach for truly comparable value metrics.
    d. Clearly the quality of comparability across multiple payers in All Payer Claims Databases (ACPD) is enhanced by uniform edits.

Sincerely,



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Appendix 1

1 RESTRICTIONS IMPOSED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

1.1 The Contractor does not represent CMS in the completion of any responsibilities contained in this Statement of Work.

1.2 The Contractor shall not disclose any non-public or confidential information about CMS or the NCCI in performance of any consulting for the department of MCCTF.

1.3 The Contractor shall not violate any of the conflict of interest (COI) rules that relate to the contract that the Contractor has with CMS for the NCCI.

1.4 The Contractor shall not be required to attend any meeting of the Department, the MCCTF or any of the MCCTF's subcommittees if that meeting is scheduled at a time that conflicts with any CMS Medicare or Medicaid NCCI program meeting