Standardization of a code-editing system white paper

Prepared by the American Medical Association
Private Sector Advocacy

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The American Medical Association (AMA) is committed to eliminating administrative waste in the health care delivery system. Cost estimates of inefficient health care claims processing, payment and reconciliation are between $21 billion and $210 billion. In the physician practice, the claims management revenue cycle consumes an unsustainable 10–14 percent of practice revenue. The complexity and lack of transparency in the current system are becoming increasingly problematic for patients who are being asked to shoulder more and more financial responsibility for health care services. Today it is difficult—if not impossible—for patients to anticipate the specific, potentially significant financial obligation they may incur in conjunction with the health care services they obtain.

The current health care payment system must be replaced by one in which health insurer claims payment and other administrative processes are transparent, simple and unambiguous, thus allowing for automated, real-time health care transactions and the ultimate elimination of manual processing by all the trading partners. The AMA is committed to addressing and advocating for solutions to the ongoing problems in the claims management revenue cycle that contribute to unnecessary complexity and expense.

Toward that end, the AMA is now several years into its "Heal the Claims Process"™ campaign and published its fourth annual National Health Insurer Report Card (NHIRC) on the claims processing and claim edit activities of the nation's largest health insurers in June 2011. The AMA has identified standardization of code edit pairs and payment rules as an important aspect of the administrative simplification effort necessary to permit the real-time adjudication of claims that is needed to reduce unnecessary administrative burdens for patients, physicians and payers.

Historical perspective

Broadly speaking, payer business rules used to adjudicate a health care claim fall into two categories: payment rules and benefit level rules. Benefit level rules determine whether a health plan will pay at all for a particular service provided to a specific patient, based on the patient's specific benefit plan. Payment rules, coupled with the specific fee schedule, determine the specific amount of payment the health plan will pay for those services that are indeed covered benefits. For purposes of this discussion, claim edits and pricing rules are the two subsets of the payment rules.

A claim edit (i.e., code pair, code edit) is a rule built in to a payer's claims adjudication system that causes a service billed on a health care claim to become ineligible for payment. One such rule would be "procedure – gender conflict," wherein the service is not consistent with the patient's stated gender. Another rule would be "add-on codes," wherein instructions described in the AMA CPT® guidelines indicate that a supplemental service should always be billed with the primary service. There are currently numerous such rules in use, with millions of code pairs subject to these rules.

As opposed to claim edits that disallow the service, pricing rules reduce the payment for an allowed service. For instance, if a physician performs multiple surgical procedures during the same operative

* Visit www.ama-assn.org/go/simplify for more information on the AMA's administrative simplification recommendations.

event, the second, third and subsequent services are paid at a reduced rate. This white paper will focus solely on code edits, and a separate white paper will focus on payment rules.

Although most commercial payers use the publicly available code edits, including the hundreds of thousands of claim edits published pursuant to the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), these payers also use a host of proprietary payer-specific edits. It is time to reexamine the value of multiple code edit systems specific to each payer. Many things have occurred over the past several years that we believe require the move to a standard set of code edits that would be applied industry wide.

Since the first code-editing software was implemented in the early 1990s, a host of things have changed. CMS' NCCI has developed a robust catalogue of nearly 1 million edits that all trading partners can access and download into their practice management systems or administrative systems without charge. Ambiguities or other concerns regarding CPT codes and definitions that were previously resolved by code edits can now be brought by any of the trading partners to the CPT Editorial Panel, where code change proposals are considered in an open process and where the Centers for Medicare and Medicaid Services (CMS), America's Health Insurance Plans (AHIP), and the Blue Cross Blue Shield Association (BCBSA) all have official representatives. Auditing for outliers is increasingly addressed through sophisticated data analytic programs, such as FAIR ISAAC uses for credit card fraud. And last—but certainly not least—the patient's financial responsibility for health care services has increased dramatically. This shift toward patient responsibility has placed an increased urgency for real-time adjudication of claims, both to ensure that patients can manage their bills and that physicians and other health care professionals can keep the cost of collections to manageable levels by billing at the time of service. The variation in claim edits across payers makes little sense in this environment and indeed is adding complexity and cost that is counterproductive.

The AMA's 2011 NHIRC includes a metric that reports the total number of available claim edits disclosed by each payer (Figure 1). While there is tremendous consistency across the industry in the use of the publicly developed edits, the huge variation among payer-specific rules engines continues to be a source of complexity and cost. As Figure 1 demonstrates, just the disclosed rules amount to more than a million code pairs for a single payer, and there are millions of unique code pairs across the many payers with which a physician has contracted.

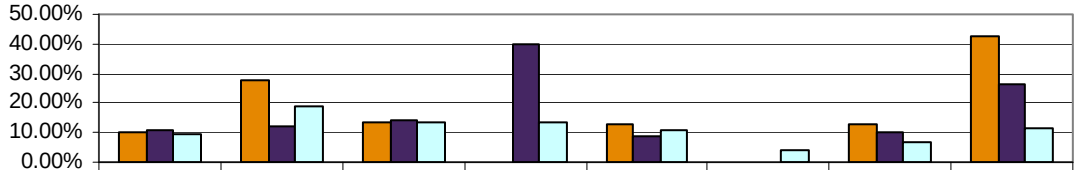
Figure 1

	Aetna	Anthem	CIGNA	HCSC	Humana	Regence	UHC	Medicare
CPT	20,167	20,454	19,953	20,454	20,454	20,454	20,358	20,454
ASA	1,070	1,070	1,070	1,070	1,070	1,070	1,070	1,070
NCCI	841,833	841,904	841,904	841,904	841,904	841,904	841,904	841,904
CMS	54,853	55,345	55,339	55,345	55,345	55,345	41,458	55,345
Payer-specific	223,985	170,027	6,795	199,610	10,534	10,490	253,462	2,224,145

Moreover, with the exception of Medicare, the complete size and scope of a payer's edit library is often unknown to the physicians. As is evident in Figure 2, metric 10B of the 2011 NHIRC, anywhere from nearly 4 to over 18% of the claim edits that result in $0 payments are based on undisclosed edits.

Figure 2

Metric 10B - Percentage of edited claim lines reduced to $0 by undisclosed edits



	Aetna	Anthem	CIGNA	HCSC	Humana	Regence	UHC	Medicare
2009	10.40%	28.00%	13.80%		12.90%		12.70%	42.90%
2010	10.80%	11.90%	13.90%	39.70%	8.90%		9.90%	26.30%
2011	9.41%	18.87%	13.33%	13.33%	10.81%	3.81%	7.04%	11.54%

Technology is an enabler in the development, maintenance and implementation of large edit rule libraries. As the number of claims submitted electronically to payers increases, increasing numbers of claims can be processed automatically. While this lowers the barrier to expansion of already large business rule libraries by payers, it concomitantly increases the burden on their trading partners to implement these rules.

This multiplicity of claim edits has created conflict between physicians and payers. Physicians typically do not know what edits will be applied by each payer, and they do not believe many of the edits which are applied are valid. As a result, it is nearly impossible for physicians or their patients to be able to price claims at the point of service. Moreover, the inevitable appeals generated by this conflict creates enormous manual work for payers as well as physicians.

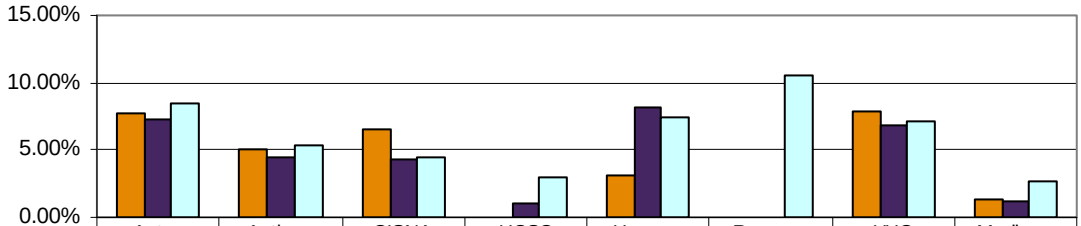
To better understand the frequency of the application of a code edit by a commercial payer, 2011 NHIRC metric 10A (Figure 3) combines both the disclosed and undisclosed edits used by the payers to give a percentage of the total claim lines where a payer applied an edit to a claim line during the study period of Feb. 1 through Mar. 31, 2011.

The NHIRC is based on data extracted from fields in the standard electronic transactions mandated by the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The technical references for these transactions are electronic claim submission (HIPAA ASC X12N 837 Health Care Claim—professional transactions) and electronic remittance advice (ERA) (HIPAA ASC X12N 835 Health Care Claim Payment/Advice Transaction), which the payer submits to a physician in response to the receipt of an electronic claim submission. For the purposes of the NHIRC, a claim edit is said to have occurred when the actual and expected allowed amount fields in the X12 835 standard transaction are equal to zero. For instance, as shown in the chart below, in 2011 CIGNA applied

a claim edit to eliminate payment for 4.50 percent of claim lines. Each claim line represents a service that the physician provided a patient.

Figure 3

Metric 10A - Percentage of total claim lines reduced to $0 by disclosed and undisclosed claim edits



	Aetna	Anthem	CIGNA	HCSC	Humana	Regence	UHC	Medicare
2009	7.70%	5.00%	6.50%		3.10%		7.90%	1.40%
2010	7.35%	4.47%	4.29%	1.07%	8.22%		6.90%	1.26%
2011	8.50%	5.30%	4.50%	3.00%	7.40%	10.50%	7.10%	2.60%

As this chart demonstrates, the application of code edits on claim lines varies greatly between commercial payers from 3 percent to more than 10 percent. [1] This variation within and among payers and plan types requires physician practices to maintain a separate billing process for each payer and plan type if they want to maintain any possibility of predicting how a claim line will be adjudicated.[2]

This 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
- Practice management systems cannot automatically reconcile and post payments
- Payers incur the cost of handling unnecessary appeals
- Confusion and trust issues between the trading partners have undermined the ability of the parties to collaborate effectively on quality improvement activities

[1] **Note:** The NHIRC includes edits where the mutually exclusive codes were not billed on the same day.

[2] Some physician practices have been able to negotiate in their contracts with payers the requirement that only code edits consistent with CPT codes, guidelines and conventions will be accepted. Such a contract provision allows the physician practice to appeal all code edits that are inconsistent with CPT codes, guidelines and conventions regardless of payer or plan type.

As a first step to eliminating this confusion and angst, the AMA has advocated that all payers fully disclose their claim edits and pricing rules. As you can see from the NHIRC results in Figures 1 and 3, we are making headway on the transparency front. However, we believe that the remaining variation is also very problematic and that more uniformity would greatly benefit the entire health care industry.

Therefore, the AMA is advocating for a standard code-editing system that is consistently applied across payers. A transparent and standardized code-editing system would create the following benefits:

- Ability to create a universal, correct coding electronic scrubber that could be used by all the trading partners (physicians, practice management system vendors, clearinghouses and payers) to eliminate all the rework associated with "unclean" claims submissions and false-positive code edit appeals and ensure that all academic studies based on claims data are indeed comparing apples to apples
- Ability for physician practices to automatically reconcile and post more claims
- Ability to price more claims accurately at the time of service
- Elimination of distrust and appeals generated by the use of current payer-specific edits

A standard code-editing system would not dictate any payer fee schedules, medical management rules, claim review processes, or product benefit levels or designs. It would, however, increase the likelihood that all relevant health care administrative information is made available clearly and concisely to patients, physicians and other health care professionals before, at the time of service and upon claim payment by every payer.

Current initiatives moving towards a standard code editing system

Current initiatives which could further this vision include expansion of the NCCI into Medicaid, the Colorado Clean Claim Task Force initiatives and other state efforts.

NCCI

Section 6507 of the Patient Protection and Affordable Care Act (ACA) requires each state Medicaid program to implement NCCI-compatible methodologies to promote correct coding and control improper coding that leads to inappropriate payment. CMS recently awarded a long-term contract to the vendor that has long handled Medicare NCCI edits to also handle the Medicaid edits.

The NCCI edit system has been in effect for years in Medicare, and the AMA has played an integral role in not only coordinating the distribution of NCCI edits but also encouraging the review by the CPT HCPCS/Advisory Committee, which is composed of representatives from the national medical specialty societies. These medical societies provide comments on the appropriateness of the proposed edits that the NCCI edit system proposes.

The expansion of the NCCI edit catalogue to state Medicaid programs will greatly reduce the administrative cost physicians face in dealing with those Medicaid programs that use proprietary edits, both by eliminating the need to manage a separate, Medicaid-specific billing process and by eliminating the need to establish a separate Medicaid-specific payment reconciliation process.

Colorado Clean Claims Task Force

The Colorado Medical Society was instrumental in passing a bill (HB 1332) that mandates the creation of a standard set of claims edits and payment rules that would govern all third-party payers in Colorado. To accomplish this, the Colorado Clean Claims Task Force has been meeting since the end of 2010 and is currently performing its phase 1 work as described in its "Framework for standard set of claims and payment rules initiative" document below.

Framework for standard set of claims and payment rules initiative

Phase I – Development of base set 12/2/10 – 11/30/12

(2)(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 professionals 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.

Additionally, Vermont has passed a law directing investigation of the value of such standardization, and the AMA is supporting the Vermont Medical Society in its efforts.

Where do we go from here?

Section 10109 of the ACA calls on the Secretary of the Department of Health and Human Services (HHS) to solicit input from stakeholders on administrative simplification opportunities, including improving the claim edits process. For all the reasons set forth in this white paper, among the recommendations AMA will make to the Secretary of HHS will be the adoption of a standard code-editing system.

Focused on these initiatives moving forward, the stakeholders need to consider the changes that have occurred to the health care delivery environment over the 20 years since code editing software was introduced, the costs to the health care delivery system of the plethora of different code-editing systems in place today and the role code-editing systems should play in the future.

What role does the health care industry see code-editing systems playing in the future?

Rather than continue an unduly complex, antiquated code-editing system, a new system should be established which better meets the needs of the 21st century:

- to provide for the consistent and accurate reporting of procedures and services performed;
- to provide a standard way for payers to report benefit denials; and
- to provide a standard way to indicate when a claim was denied or pended because of potential fraud or abuse concerns.

With the exception of the "never allowed" edit which will be discussed below, we are unaware of any purpose for which code edits are used today other than the three set forth above, but we encourage payers to review their payer-specific code edits to determine whether they currently use code edits (that is, a payment rule that allows $0 and pays zero $0 on a claim line) for any other purpose so we can ensure that all code edit uses are accounted for.

In order to move to a standard claim-edit system, we must also determine how a public code edit library would be sustained. The following discusses both the functionalities used by payers that must be supported and potential strategies for the sustainability of that system.

The four categories of functionality used by payers include: (1) accurate coding edits, (2) benefit level determinations, (3) fraud and abuse identification, and (4) "never allowed" fee schedule adjustments as discussed in more detail below. There must be a standard, electronic solution for each of these functionalities that can be incorporated into an automated work flow in the practice management system or payer administrative system. These four categories of functionality, as well as a potential process for sustaining a public code edit system, are further discussed below.

1) **Correct coding edits:** These edits are designed to ensure that the procedures and services performed are reported accurately and consistently by all physicians and other health care professionals, consistent with the CPT and HCPCS code sets. We believe there is no dispute in the industry that correct coding should occur prior to the submission of the claim.

   The edits in Figure 4 represent a small sample of the thousands of edits used by payers in the claim adjudication process to ensure correct coding according to CPT codes, guidelines and conventions.

Figure 4: Claim edits

Valid CPT/HCPCS code	Procedure code/gender conflict
Date of services before date of birth	Separate procedure
Procedure code/place of service conflict	Mutually exclusive
Valid modifier	Procedure code/units conflict
Add-on codes	Procedure code/age conflict
Future date of service	Is only allowed with

Source: National Healthcare Exchange Service, Inc. (NHXS)

Potential sustainability of a new standard claim-edit system: All stakeholders with concerns regarding the accuracy of CPT descriptions, or interpretations regarding the appropriate reporting of codes together, are encouraged to contact AMA/CPT staff for resolution through the CPT process or CPT Assistant Editorial Board. Similarly, concerns related to edits sourced to the NCCI should be addressed through Correct Coding Solutions, LLC.

2) **Benefit level determinations**: These are edits that are functioning as payer-specific benefit level determinations. We do not believe code edits are the appropriate mechanism for the application of benefit level determinations. Rather, those types of edits should be handled as a denial (reported with the applicable claims adjustment reason code [CARC] and remittance advice remark code [RARC] to trigger the appropriate work flow in the physician practice).

   For purposes of this discussion, no one questions the right of health insurers to set the scope of their benefit plans, whether by limiting the number or duration of services, establishing conditions precedent for their coverage, or eliminating coverage for particular services entirely. However, there needs to be a standard, programmable way through the reporting on the remittance advice to automate the reconciliation of benefit limitations. Because the response to a benefit denial is more disruptive to the physician work flow than the response to an "accurate coding" edit, we do not believe the code edit mechanism is appropriate for this function. Rather, we believe benefit level determinations should be conveyed as "denials" (allowed billed charge, paid $0), appended with the appropriate CARC and RARC codes. To automate the claims revenue cycle, each separate functionality must use a consistent mechanism. When a claim line is not paid because the service is not covered by the patient's benefit plan, the commonly used mechanism is the "denial."

Potential sustainability of a new standard claim-edit system: The payer would make benefit level determinations based on a patient's benefit plan and report them as "denials." The CARC and RARC code sets must be maintained to provide the level of specificity required for automation of the denial response process, and payers or those handling the claims administration process on their behalf must use the most specific codes available.

3) **Fraud and abuse:** Payers typically apply these edits to screen out bills that may reflect fraudulent or abusive billing practices, such as medically unlikely edits (MUEs), for example. Again, it is not clear that the code edit mechanism is optimal for this purpose. From a physician practice work flow perspective, it would be preferable if claims or claim lines subject to further review due to fraud and abuse concerns were either (1) pended with a request for more information challenging the submitter to prove the reported frequency is appropriate or (2) denied with the appropriate CARC/RARC code. In either case, the physician practice would be able to follow up with additional justification of the appropriateness of the claim when the facts warrant. From the standpoint of automating the system, we need a standard mechanism for indicating that a MUE edit is indeed a denial due to the fact that the covered benefit amount has been exceeded so physician practices can automate the appropriate response, which, as indicated above, is different from the response to an "accurate coding" edit, which is to correct and resubmit the claim. An MUE denial can be appealed and corrected with a resubmission of the claim. The error could have been clerical or an outlier, in which case modifiers may be used to resubmit the service on separate line entries in order to bypass the MUE limit on one claim line.

   Potential sustainability of a new standard claim-edit system: The claim-edit system would not affect current payer business practices. Each payer would continue to use its own fraud and abuse system and continue to use the standard indicator(s) (CARC/RARC codes) to indicate that a claim line has been pended for review due to fraud and abuse concerns. Stakeholders can utilize the internal and external review process if a conflict arises.

4) **"Never allowed"—fee schedule adjustment:** These are edits functioning to reduce the fee schedule amount to $0. If a health insurer has a covered procedure or service that they simply do not pay for (that is, the patient is entitled to receive the service under the benefit plan, but the physician is not entitled to get paid for providing the service), the health insurer should report in the fee schedule that it pays $0 for that service. It is misleading to indicate in the physician's fee schedule that a service has a value greater than $0 if in fact the payer never pays the fee schedule amount. In turn, the health insurer should report a claim paid $0 per the fee schedule adjustment CARC 45.

   Potential sustainability of a new standard claim-edit system: The payer would continue to determine the fee schedule directly with each physician or other health care professional.

NCCI code edits and process as the potential basis of a standard code-editing system

NCCI edits are publicly available code edits applied by Medicare and more recently Medicaid programs. As noted above, the majority of NCCI edits are included within the commercial payer code edit libraries. NCCI edits are discussed in more detail in the AMA's "Standardization of the claims process" white paper that can be accessed at www.ama-assn.org/go/simplify along with related materials. Additional NCCI question and answers can be found in Appendix A.

A common criticism of NCCI is that the code edits do not include populations that are not covered by the Medicare program. Therefore, the AMA commissioned a study by National Healthcare Exchange Services (NHXS) to assist us in examining the NCCI code edits to determine the extent to which NCCI contains edits relating to pediatrics or OB-GYN specialties. NHXS performed a data analysis that compared the frequency and type of NCCI edits in the general physician population to pediatric and OB-GYN specialties. Appendix B contains the complete results of this analysis. The claim "date of service" range for the study was the fourth quarter of 2010.

- Pediatric claims were defined as patients under 18.
- OB-GYN claims were defined as rendering physician or other health care professional registered in the NPI database with at least one of the following taxonomy codes: 207VB0002X, 207VC0200X, 207VE0102X, 207VG0400X, 207VH0002X, 207VM0101X, 207VX0000X, 207VX0201X and 207V00000X.
- The data only included claim lines to which **disclosed** payer claim edits were applied.

The NHXS analysis revealed that the most frequently occurring NCCI code edits in the pediatric and OB-GYN claim sets appear to be consistently applied in those specialties. The types of code edits applied were different from the overall claim population. This is counter to anecdotal comments that because NCCI is a work product of CMS that the code edits contained within NCCI does not address the pediatric and OB-GYN population.

The AMA has also concluded:

- The NCCI code edit library contains edits that are specific to pediatrics, OB-GYN and family physicians.
- Payers have code edits other than those found in NCCI that directly target procedures and services performed by pediatrics, OB-GYN or family physicians.

- Development of edits by entities must give thoughtful consideration to all AMA and national medical specialty society policy documents, clinical vignettes, comments, etc.

- Meaningful participation by the AMA, national medical specialty societies, payers and other entities in the development of code edit libraries by an entity free from influence by special interests, is essential to the development of a standard code edit system.

NCCI, assuming it continues to be developed with its engagement and communication with AMA and national medical specialty societies, may be the right vehicle to create the comprehensive edit library.

Payers are encouraged to review their existing payer-specific code edit libraries to determine whether they should be considered for inclusion in the NCCI edit set.

Payer-specific code edits

Further study is required to determine the basis for the remaining payer-specific code edits that cannot be sourced to CPT, ASA, NCCI or CMS so that the chosen standardized code edit development and maintenance process will provide a way to address these issues appropriately. The CPT Editorial Panel always looks for input on issues before confusion ensues, and cannot stress enough to payers the Editorial Panel's interest in addressing the concerns of all stakeholders in correct coding—physicians, other health care professionals, payers and others from the health care industry at large.

When examining why payer-specific code edits may be created in today's code-editing system and, in turn, examining how to address these types of issues in a future standard code-editing system, the following rationales and recommendations were raised for discussion.

When a CPT code descriptor may not be descriptive enough, it allows for variation in reporting.

CPT code descriptors are by nature succinct. Much education is done by CPT to educate users on the intent of the codes. When it becomes evident that there are variations in the service reported by a single code, CPT encourages communication and suggestions for resolution via code change applications. All stakeholders can bring an issue to the CPT Editorial Panel, describing the ambiguity and the suggested revision through the CPT application process. See Appendix C for more information on the specific process.

When a payer disagrees with the CPT instructions or interpretations for reporting one or more procedures or services, how should the payer be advised to address the concern?

Prior to publications, the *CPT Assistant* Editorial Board process requires the review of published interpretations by its specialty society and payer representative members. The Board commonly addresses questions regarding interpretations of CPT codes, discussing and publishing clarifications of these types of issues in *CPT Assistant* or where justified, referring these issues for potential resolution through a code change application and revision by the CPT Editorial Panel. If we are to eliminate administrative waste, payers and others in the health care industry who disagree with a CPT instruction need to bring those disputes to the CPT Editorial Panel and CPT Assistant Editorial Board. At the end of the day, all the trading partners need to use the same dictionary, with the same definitions; it is extremely wasteful for the physician community to provide services and report them consistently with CPT codes, guidelines and conventions, only to have various payers differing and denying these claims.

When a payer combined code pair detects duplication of physician work.

We would recommend stakeholder concerns regarding potential duplication of effort in codes reported for the same patient on the same day be brought to the CPT Editorial Panel for discussion. Again, when appropriate, parenthetical instructions can often be created to eliminate the inappropriate reporting of duplicate services.

When payers detect patterns in reporting of procedures or services that appear to be based on inappropriate vendor coding advice for their proprietary products/services.

All stakeholders are strongly encouraged to request that these issues be addressed by the *CPT Assistant* Editorial Board to request publication of warnings and/or education to refute any currently circulating inappropriate coding advice. Collaboration among all stakeholders to develop better mechanisms for mass circulation to share this education with all stakeholders may be advisable.

Call to action

Billions of dollars of cost savings for physicians, payers and the health care industry as a whole can be realized with a standard code-edit set and a standardized computer program that enables the elimination of "unclean" claims and unnecessary appeals as well as the move to real-time adjudication of claims.

Therefore, the AMA calls on all stakeholders to stand behind the development of a standard code-editing system. **The AMA appreciates that development of a national code-edit set will require a clear vision of the benefits and collaboration by all stakeholders.**

To better achieve this important goal, the AMA and the national medical specialty societies recommend the following guiding principles be adopted by the Colorado Clean Claim Task Force and any other group working toward a standard code-edit set. These guiding principles were developed by the AMA and the national medical specialty societies based on the NHIRC and other studies discussed above; AMA policy, which can be found in Appendix D; and the most protective state laws, which can be found in Appendix E.

Guiding principles for a standard code-editing system:

- Define the term "claim edit" to mean a payment rule applied by a health plan or its agent to decrease the agreed fee schedule amount to $0 whenever a claim line is not billed correctly. Technical definition: "Claim edit" means the application of an adjudication rule to a claim line where the Actual Allowed Amount (X12 835: AMT02) and the Line Item Provider Payment Amount (X12 835: SVC03) field in the X12 835 electronic remittance advice standard transaction are both equal to $0.

- Define the purpose of edits as a system to create uniform, correct coding practice in the marketplace and to provide transparency and simplicity for point-of-service pricing.

- Require that all edits be consistent with CPT codes, guidelines and conventions, adopted after thoughtful consideration has been given to all AMA and national medical specialty society policy documents, clinical vignettes, comments, etc.

- Require the retention of the NCCI review process as it is currently managed, which provides for review, comment and appeal by the AMA and national medical specialty societies.

- Ensure that health plan benefit coverage or payment policies are not commingled with claim edits.

- Encourage payers to review and submit recommended payer specific code-edits to the National Correct Coding Initiative for consideration and potential incorporation into a future release as well as become more involved in the CPT Editorial Panel Process.

- Encourage all stakeholders to avail themselves of the process for addressing concerns regarding CPT descriptions and disputes through CPT applications, appropriate code pair reporting or duplicate physician work to be addressed by the CPT Editorial Panel.

As stated above, a standard code-editing system, similar to NCCI, would not affect payers' ability to adopt different benefit designs for each of their products, conduct appropriate medical reviews of claim submissions, or respond to fraud and abuse. Sophisticated software now exists to analyze claims submissions in almost limitless ways and to identify anomalies and outliers. Indeed, many payers have implemented systems based on these tools, allowing them to better focus their efforts on those few unscrupulous individuals who improperly take advantage of the system rather than unfairly and counterproductively treating the entire medical profession as though it were untrustworthy. Some payers have also used their data to help educate physicians about practice variation and to proactively engage the medical profession in quality improvement efforts.

The routine receipt of accurate, understandable payment in response to the initial bill is required to build the trust necessary to support future partnerships focused on improving the quality and efficiency of health care delivery that have led to positive change in the delivery of care. It is time to more acutely focus resources on the practice of medicine and keeping patients well. For more information on the AMA's administrative simplification agenda, as well as other associated AMA efforts, visit www.ama-assn.org/go/simplify to access the AMA's "Administrative simplification" white paper and "Standardization of the claims process: Administrative simplification" white paper.

Appendix A: Frequently asked NCCI questions and answers

NCCI editing system Q&As

1. What kind of rules engine is presently running?

Answer: It depends. That is, states have their own IT infrastructure and corresponding rules engine(s). The current NCCI file formats are ASCII.TXT, Excel 2007 (.xlsx) and tab-delimited text (.txt) with column headings.

Each of the five NCCI methodologies implemented by both the Medicare and the Medicaid programs consists of the following four components:

- a set of edits;
- definitions of types of claims subject to the edits;
- a set of claims adjudication rules for applying the edits; and
- a set of rules for addressing physician and other health care professional/supplier appeals of denied payments for services based on the edits.

The NCCI edits are defined as edits applied to services performed by the same physician or other health care professional for the same beneficiary on the same date of service. They consist of two types of edits:

1) NCCI edits, or procedure-to-procedure edits, that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons; and

2) MUEs, or units-of-service edits, that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g., claims for excision of more than one gallbladder).

2. What technology platform is used for the current system?

Answer: The NCCI files are provided by CMS in three file formats: ASCII.TXT, Excel 2007 (.xlsx) and tab-delimited text (.txt) with column headings.

3. What kind of system is Medicare (and state Medicaid) running?

Answer: State systems for processing Medicaid claims (Medicaid Management Information Systems [MMISs]) vary widely. Each state's MMIS is unique to that state.

4. Did CCS, LLC build the current system, or was it transitioned from the previous vendor?

Answer: The process of the development and maintenance of the NCCI edits and systems are owned by CMS. Any systems and contracted work under a previous contract were transitioned from the incumbent contractor.

5. Where do the CCI files currently reside?

Answer: After the NCCI contractor finalizes both the CCI and MUE final files, all files are located on the CMS mainframe to download for CMS contractors only.

6. Why are we replacing edits quarterly when codes change annually?

Answer: The process for the development and implementation of the NCCI edits is a very time-consuming process with a large number of codes that must be reviewed and researched, and the appropriate and most rational decision has to be made on each code. Each code has to be researched, and each proposed edit has to be forwarded to CMS' constituents (AMA, NHO, national medical specialty societies, etc.) who have an interest in the NCCI program for their comments regarding CMS' proposed edits decision. This commenting period occurs during the period prior to each quarter. Therefore, due to the extensive amount of codes and the multi-faceted edit development process, new codes are phased in throughout that year.

Medicare NCCI website: www.cms.gov/NationalCorrectCodInitEd/

Medicaid NCCI website: www.cms.gov/MedicaidNCCICoding/

Appendix B: NHXS study results: Examination of the NCCI code edits to determine the extent to which NCCI contains edits relating to pediatrics or OB-GYN specialties

The following supports that NCCI edits applied to Pediatric and Obgyn specialties are as well represented as all other specialties.

Source	Type	All Specialties	Pediatric	Obgyn
ASA	Exceeds procedure frequency	0.0%	Na	na
ASA	Is Only Allowed With	0.0%	0.0%	na
CCI	Is Only Allowed With	4.7%	1.5%	4%
CCI	Is Not Allowed With	2.5%	2.3%	2%
CMS	Is Not Allowed	23.3%	26.1%	30%
CMS	Is Not Allowed With	4.1%	5.2%	0%
CMS	Global Day	4.0%	1.8%	8%
CMS	Is Only Allowed With	1.6%	0.8%	9%
CMS	Exceeds procedure frequency	0.9%	0.5%	0%
CMS	Diagnosis Age	0.8%	4.7%	0%
CMS	New patient E&M not allowed	0.4%	0.4%	1%
CMS	Diagnosis Gender	0.3%	0.1%	1%
CMS	Modifier Procedure	0.1%	0.1%	0%
CMS	State supplied vaccine	0.1%	22.4%	0%
CMS	Procedure age	0.1%	Na	0%
CMS	Diagnosis Invalid	0.0%	0.0%	0%
CMS	Modifier POS conflict	0.0%	0.0%	0%
CMS	Invalid procedure code	0.0%	2.2%	1%
CMS	Procedure place of service conflict	0.0%	0.0%	0%
CPT	Bundling	1.2%	0.3%	1%
CPT	Is Only Allowed With	1.1%	12.3%	2%
CPT	Is Not Allowed With	1.0%	0.1%	na
CPT	Procedure age	0.2%	1.3%	1%
CPT	Procedure gender conflict	0.1%	0.3%	1%
CPT	Invalid modifier code	0.0%	0.2%	0%
CPT	Exceeds procedure frequency	0.0%	Na	na
Payor	Diagnosis Procedure	24.0%	0.3%	3%

Payor	Is Not Allowed With		18.0%		8.1%		17%
Payor	Is Not Allowed		8.2%		5.3%		14%
Payor	Is Only Allowed With		1.9%		0.8%		2%
Payor	Bundling		0.8%		0.1%		0%
Payor	Global Day		0.4%		0.3%		1%
Payor	Max occurrence of procedure reached		0.2%		0.3%		0%
Payor	Date of Service before Date of Injury		0.1%		0.0%		0%
Payor	Modifier Procedure		0.0%		0.7%		0%
Payor	Diagnosis Supporting		0.0%		0.0%		0%
Payor	Exceeds procedure frequency		0.0%		0.1%		0%
Payor	Exceeds daily frequency		0.0%		0.0%	na	
Payor	Procedure place of service conflict		0.0%		0.5%		0%
Payor	Procedure age		0.0%		0.1%		0%
Payor	Diagnosis Age		0.0%		0.0%		0%
Payor	Lower allowed not allowed		0.0%	Na		na	
Payor	Invalid procedure code	na			0.8%	na	
Payor	Modifier POS conflict	na			0.2%	na	
Payor	Invalid modifier code	na			0.0%	na	
Payor	Procedure gender conflict	na		Na			0%
			100.0%		100.0%		100%

The following denied codes demonstrates that Pediatric and Obgyn specialty-specific code edits are included in NCCI.

ALL SPECIALTIES

Source	Type	HCPC	Line count	Short description
ASA	Is only allowed with	99135	1	SPECIAL ANESTHESIA PROCEDURE
		99116	1	ANESTHESIA WITH HYPOTHERMIA
CCI	Is not allowed with	81015	3610	MICROSCOPIC EXAM OF URINE
		99211	1629	OFFICE/OUTPATIENT VISIT EST
		69990	719	MICROSURGERY ADD-ON

		90473	479	IMMUNE ADMIN ORAL/NASAL
		29877	396	KNEE ARTHROSCOPY/SURGERY
		G0102	395	PROS CANCER SCR; DIGTL RECTAL EXAM
		85007	375	BL SMEAR W/DIFF WBC COUNT
		84479	344	ASSAY OF THYROID (T3 OR T4)
		84436	312	ASSAY OF TOTAL THYROXINE
		85008	297	BL SMEAR W/O DIFF WBC COUNT
	Is only allowed with	83721	3522	ASSAY OF BLOOD LIPOPROTEIN
		93010	2417	ELECTROCARDIOGRAM REPORT
		99213	1797	OFFICE/OUTPATIENT VISIT EST
		96372	1664	THER/PROPH/DIAG INJ SC/IM
		99214	1297	OFFICE/OUTPATIENT VISIT EST
		93000	927	ELECTROCARDIOGRAM COMPLETE
		71010	827	CHEST X-RAY
		J2001	570	INJECTION LIDO HCL IV INFUS 10 MG
		99212	521	OFFICE/OUTPATIENT VISIT EST
		97140	517	MANUAL THERAPY
CMS	Is not allowed with	94760	24132	MEASURE BLOOD OXYGEN LEVEL
		94761	1169	MEASURE BLOOD OXYGEN LEVEL
		99213	132	OFFICE/OUTPATIENT VISIT EST
		36591	106	DRAW BLOOD OFF VENOUS DEVICE
		36598	51	INJ W/FLUOR EVAL CV DEVICE
		99214	42	OFFICE/OUTPATIENT VISIT EST
		96523	41	IRRIG DRUG DELIVERY DEVICE
		99238	38	HOSPITAL DISCHARGE DAY
		36592	23	COLLECT BLOOD FROM PICC
		99215	14	OFFICE/OUTPATIENT VISIT EST
	Is only allowed	Q0091	5223	SCR PAP SMER; OBTAIN PREP&CONVY-LAB

	with			
		G0101	725	CERV/VAG CANCR SCR;PELV&CLN BRST EX
		99213	620	OFFICE/OUTPATIENT VISIT EST
		99214	516	OFFICE/OUTPATIENT VISIT EST
		99232	433	SUBSEQUENT HOSPITAL CARE
		99212	193	OFFICE/OUTPATIENT VISIT EST
		99244	178	OFFICE CONSULTATION
		99231	177	SUBSEQUENT HOSPITAL CARE
		99243	160	OFFICE CONSULTATION
		99223	139	INITIAL HOSPITAL CARE
CPT	Is not allowed with	77003	5684	FLUOROGUIDE FOR SPINE INJECT
		76376	147	3D RENDER W/O POSTPROCESS
		93307	110	TTE W/O DOPPLER COMPLETE
		76377	86	3D RENDERING W/POSTPROCESS
		99091	51	COLLECT/REVIEW DATA FROM PT
		69990	48	MICROSURGERY ADD-ON
		99144	30	MOD CS BY SAME PHYS 5 YRS +
		75676	23	ARTERY X-RAYS NECK
		75665	19	ARTERY X-RAYS HEAD & NECK
		36478	19	ENDOVENOUS LASER 1ST VEIN
	Is only allowed with	90471	2906	IMMUNIZATION ADMIN
		90472	1040	IMMUNIZATION ADMIN EACH ADD
		17003	389	DESTRUCT PREMALG LES 2-14
		69990	343	MICROSURGERY ADD-ON
		90465	270	IMMUNIZATION ADMIN
		90468	168	IMMUNIZATION ADMIN
		93320	140	DOPPLER ECHO EXAM HEART
		76937	131	US GUIDE VASCULAR ACCESS

		90466	100	IMMUNIZATION ADMIN
		93325	92	DOPPLER COLOR FLOW ADD-ON
Payer	Is not allowed with	36415	78006	ROUTINE VENIPUNCTURE
		94760	10292	MEASURE BLOOD OXYGEN LEVEL
		99000	7632	SPECIMEN HANDLING
		99173	2920	VISUAL ACUITY SCREEN
		76856	2393	US EXAM PELVIC COMPLETE
		36416	2360	CAPILLARY BLOOD DRAW
		Q0091	2127	SCR PAP SMER; OBTAIN PREP&CONVY-LAB
		81002	1068	URINALYSIS NONAUTO W/O SCOPE
		99051	934	MED SERV EVE/WKEND/HOLIDAY
		94150	861	VITAL CAPACITY TEST
	Is only allowed with	81002	3968	URINALYSIS NONAUTO W/O SCOPE
		83721	2338	ASSAY OF BLOOD LIPOPROTEIN
		36415	1302	ROUTINE VENIPUNCTURE
		81003	1054	URINALYSIS AUTO W/O SCOPE
		A4550	789	SURGICAL TRAYS
		94760	744	MEASURE BLOOD OXYGEN LEVEL
		G0009	259	ADMINISTRATION PNEUMOCOCCAL VACC
		99213	200	OFFICE/OUTPATIENT VISIT EST
		99144	130	MOD CS BY SAME PHYS 5 YRS +
		Q0091	126	SCR PAP SMER; OBTAIN PREP&CONVY-LAB

PEDIATRICS

Source	Type	Proc.	Line count	Proc. description
ASA	Is only allowed with	99140	2	EMERGENCY ANESTHESIA

CCI	Is not allowed with	90473	573	IMMUNE ADMIN ORAL/NASAL
		99211	329	OFFICE/OUTPATIENT VISIT EST
		90660	240	FLU VACCINE NASAL
		64425	135	N BLOCK INJ ILIO-ING/HYPOGI
		64450	110	N BLOCK OTHER PERIPHERAL
		90658	91	FLU VACCINE 3 YRS & > IM
		69210	82	REMOVE IMPACTED EAR WAX
		85007	82	BL SMEAR W/DIFF WBC COUNT
		90471	69	IMMUNIZATION ADMIN
		90467	51	IMMUNIZATION ADMIN
	Is only allowed with	99213	156	OFFICE/OUTPATIENT VISIT EST
		94664	121	EVALUATE PT USE OF INHALER
		99214	69	OFFICE/OUTPATIENT VISIT EST
		87880	63	STREP A ASSAY W/OPTIC
		87070	47	CULTURE BACTERIA OTHER
		74000	39	X-RAY EXAM OF ABDOMEN
		96372	36	THER/PROPH/DIAG INJ SC/IM
		71010	35	CHEST X-RAY
		G0008	35	ADMINISTRATION INFLUENZA VIRUS VACC
		51703	34	INSERT BLADDER CATH COMPLEX
CMS	Is not allowed with	94760	5097	MEASURE BLOOD OXYGEN LEVEL
		94761	329	MEASURE BLOOD OXYGEN LEVEL
		99238	4	HOSPITAL DISCHARGE DAY
		36591	3	DRAW BLOOD OFF VENOUS DEVICE
		36598	1	INJ W/FLUOR EVAL CV DEVICE
	Is only allowed with	99499	344	UNLISTED E&M SERVICE
		99213	118	OFFICE/OUTPATIENT VISIT EST

		99392	56	PREV VISIT EST AGE 1-4
		99393	51	PREV VISIT EST AGE 5-11
		99212	28	OFFICE/OUTPATIENT VISIT EST
		Q0091	21	SCR PAP SMER; OBTAIN PREP&CONVY-LAB
		99203	17	OFFICE/OUTPATIENT VISIT NEW
		99214	16	OFFICE/OUTPATIENT VISIT EST
		99394	13	PREV VISIT EST AGE 12-17
		99420	12	HEALTH RISK ASSESSMENT TEST
CPT	Is not allowed with	77003	80	FLUOROGUIDE FOR SPINE INJECT
		93307	26	TTE W/O DOPPLER COMPLETE
		76376	6	3D RENDER W/O POSTPROCESS
		36410	2	NON-ROUTINE BL DRAW > 3 YRS
		G0008	2	ADMINISTRATION INFLUENZA VIRUS VACC
		62270	1	SPINAL FLUID TAP DIAGNOSTIC
		73615	1	CONTRAST X-RAY OF ANKLE
		93351	1	STRESS TTE COMPLETE
		94762	1	MEASURE BLOOD OXYGEN LEVEL
		99091	1	COLLECT/REVIEW DATA FROM PT
	Is only allowed with	90471	6788	IMMUNIZATION ADMIN
		90472	1973	IMMUNIZATION ADMIN EACH ADD
		90473	1690	IMMUNE ADMIN ORAL/NASAL
		90465	846	IMMUNIZATION ADMIN
		90467	466	IMMUNIZATION ADMIN
		90468	430	IMMUNIZATION ADMIN
		90466	317	IMMUNIZATION ADMIN
		90474	208	IMMUNE ADMIN ORAL/NASAL ADDL
		99053	32	MED SERV 10PM-8AM 24 HR FAC
		93325	26	DOPPLER COLOR FLOW ADD-ON

Payer	Is not allowed with	99173	2304	VISUAL ACUITY SCREEN
		36415	2260	ROUTINE VENIPUNCTURE
		99000	947	SPECIMEN HANDLING
		94760	628	MEASURE BLOOD OXYGEN LEVEL
		36416	507	CAPILLARY BLOOD DRAW
		99213	330	OFFICE/OUTPATIENT VISIT EST
		81002	272	URINALYSIS NONAUTO W/O SCOPE
		81001	119	URINALYSIS AUTO W/SCOPE
		99051	116	MED SERV EVE/WKEND/HOLIDAY
		99214	108	OFFICE/OUTPATIENT VISIT EST
	Is only allowed with	81002	252	URINALYSIS NONAUTO W/O SCOPE
		81003	125	URINALYSIS AUTO W/O SCOPE
		94640	106	AIRWAY INHALATION TREATMENT
		36415	86	ROUTINE VENIPUNCTURE
		94760	85	MEASURE BLOOD OXYGEN LEVEL
		99213	51	OFFICE/OUTPATIENT VISIT EST
		99212	23	OFFICE/OUTPATIENT VISIT EST
		99145	8	MOD CS BY SAME PHYS ADD-ON
		99214	8	OFFICE/OUTPATIENT VISIT EST
		90471	7	IMMUNIZATION ADMIN

OB-GYN

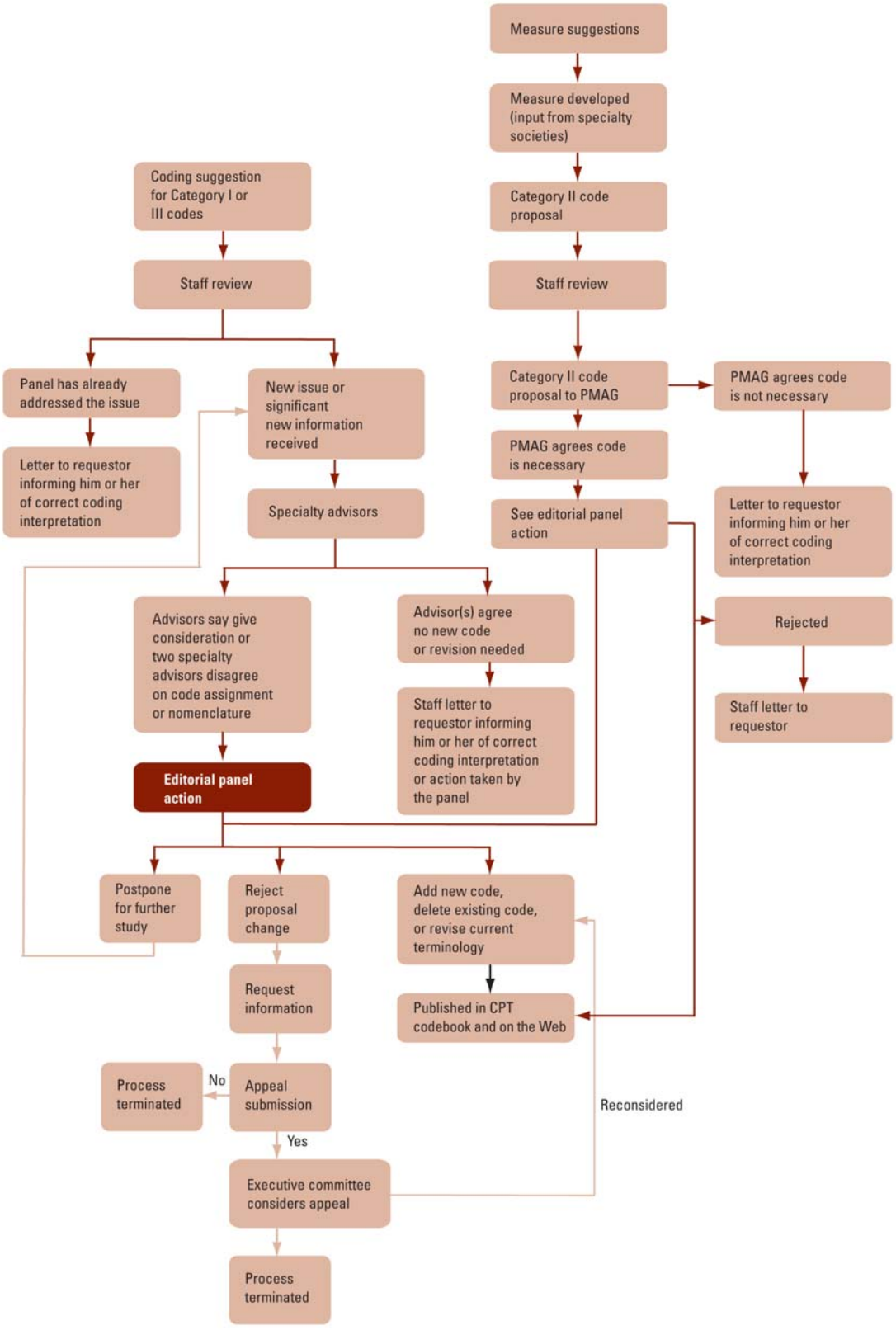
Source	Type	Proc.	Line count	Proc. description
ASA	Is only allowed with			
		None reported		
CCI	Is not allowed with	64435	91	N BLOCK INJ PARACERVICAL
		99211	81	OFFICE/OUTPATIENT VISIT EST

		51726	49	COMPLEX CYSTOMETROGRAM
		58100	22	BIOPSY OF UTERUS LINING
		57500	22	BIOPSY OF CERVIX
		57452	17	EXAM OF CERVIX W/SCOPE
		81002	17	URINALYSIS NONAUTO W/O SCOPE
		57505	17	ENDOCERVICAL CURETTAGE
		44180	16	LAP ENTEROLYSIS
		76830	12	TRANSVAGINAL US NON-OB
	Is only allowed with	59025	321	FETAL NON-STRESS TEST
		99213	288	OFFICE/OUTPATIENT VISIT EST
		96372	144	THER/PROPH/DIAG INJ SC/IM
		99212	109	OFFICE/OUTPATIENT VISIT EST
		99214	97	OFFICE/OUTPATIENT VISIT EST
		99203	77	OFFICE/OUTPATIENT VISIT NEW
		99202	48	OFFICE/OUTPATIENT VISIT NEW
		87070	27	CULTURE BACTERIA OTHER
		58350	20	REOPEN FALLOPIAN TUBE
		99204	18	OFFICE/OUTPATIENT VISIT NEW
CMS	Is not allowed with	94760	53	MEASURE BLOOD OXYGEN LEVEL
		94761	7	MEASURE BLOOD OXYGEN LEVEL
		99238	5	HOSPITAL DISCHARGE DAY
		Q0091	2081	SCR PAP SMER; OBTAIN PREP&CONVY-LAB
		G0101	431	CERV/VAG CANCR SCR;PELV&CLN BRST EX
		99213	31	OFFICE/OUTPATIENT VISIT EST
		99212	17	OFFICE/OUTPATIENT VISIT EST
		99203	14	OFFICE/OUTPATIENT VISIT NEW
		99396	12	PREV VISIT EST AGE 40-64
		99395	10	PREV VISIT EST AGE 18-39
	Is only allowed with	99214	8	OFFICE/OUTPATIENT VISIT EST

		99202	5	OFFICE/OUTPATIENT VISIT NEW
		99397	4	PER PM REEVAL EST PAT 65+ YR
CPT	Is not allowed with			
		None reported		
	Is only allowed with	90471	587	IMMUNIZATION ADMIN
		90472	32	IMMUNIZATION ADMIN EACH ADD
		51797	15	INTRAABDOMINAL PRESSURE TEST
		56606	7	BIOPSY OF VULVA/PERINEUM
		57267	6	INSERT MESH/PELVIC FLR ADDON
		96415	6	CHEMO IV INFUSION ADDL HR
		76802	5	OB US < 14 WKS ADDL FETUS
		76810	4	OB US >/= 14 WKS ADDL FETUS
		77052	3	COMP SCREEN MAMMOGRAM ADD-ON
		58611	3	LIGATE OVIDUCT(S) ADD-ON
Payer	Is not allowed with	Q0091	2620	SCR PAP SMER; OBTAIN PREP&CONVY-LAB
		36415	984	ROUTINE VENIPUNCTURE
		81002	559	URINALYSIS NONAUTO W/O SCOPE
		99000	273	SPECIMEN HANDLING
		81001	103	URINALYSIS AUTO W/SCOPE
		76856	50	US EXAM PELVIC COMPLETE
		A4550	44	SURGICAL TRAYS
		G0101	42	CERV/VAG CANCR SCR;PELV&CLN BRST EX
		99001	14	SPECIMEN HANDLING
		81003	14	URINALYSIS AUTO W/O SCOPE
	Is only allowed with	81002	313	URINALYSIS NONAUTO W/O SCOPE
		81003	97	URINALYSIS AUTO W/O SCOPE
		59410	23	OBSTETRICAL CARE

G0101	21	CERV/VAG CANCR SCR;PELV&CLN BRST EX
A4550	20	SURGICAL TRAYS
99213	17	OFFICE/OUTPATIENT VISIT EST
99212	12	OFFICE/OUTPATIENT VISIT EST
G0008	11	ADMINISTRATION INFLUENZA VIRUS VACC
59515	8	CESAREAN DELIVERY
76801	7	OB US < 14 WKS SINGLE FETUS

Appendix C: AMA CPT process



Appendix D: AMA policy

American Medical Association policies relating to the standardization of the health care billing and payment process

AMA policy regarding CPT bundling and code edits

H-70.927 Prevention of Misuse of Current Procedural Terminology (CPT)
Our AMA: (1) in order to avoid harm to physicians and patients, shall continue to pursue proper use of CPT codes, guidelines and modifiers by software claims editing vendors and their customers; and (2) will explore additional ways to work with state medical associations to provide coding advocacy for members. (Sub. Res. 819, A-00)

H-70.937 Bundling and Downcoding of CPT Codes
Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers; (2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards; (3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and (4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers. (Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01)

H-70.941 CMS Implementation of Commercial Off-the-Shelf Edits of CPT Codes
Our AMA: (1) continues to support the activities of its Correct Coding Policy Committee (CCPC) and urges the Centers for Medicare & Medicaid Services to accept CCPC recommendations relating to coding edits, whether from both the Correct Coding Initiative or the commercial off-the-shelf edits; (2) utilizes appropriate and vigorous advocacy efforts to ensure that any Medicare payment or coding policies, including the proprietary edits implemented on October 1, 1998, be made available to the public; and (3) continues to use advocacy tools and opportunities in both the public and private sectors to promote the appropriate use of CPT codes, guidelines, and modifiers; ensure that patients receive all needed services and the benefits to which they are entitled; protect the integrity of CPT; ensure accurate reporting of physicians' services; and ensure accurate payments for services provided. (BOT Rep. 35 , I-98; Reaffirmed: Res. 813, A-99)

H-70.940 AMA Program to Readily Retrieve Billing Code Data by Payee within a Practice
Our AMA promotes the development of a software communications standard for medical coding and billing software programs, similar in purpose to the HL-7 and DICOM standards. (Res. 805, I-98)

H-70.954 Improper Use of AMA-CPT by Carriers/Software Programs
Our AMA: (1) continues to seek endorsement of Current Procedural Terminology (CPT) as the national coding standard for physician services; in collaboration with state and specialty societies, will urge the Secretary of HHS and CMS and all other payers to adopt CPT as the single uniform coding standard for physician services in all practice settings; and will oppose the incorrect use of CPT by insurers and others, taking necessary actions to insure compliance with licensing agreements, which include provisions for termination of the agreement; (2) will work with the American Academy of Pediatrics and other specialty societies to support state and federal legislation requiring insurers to follow the coding as defined in the Current Procedural Terminology Manual and interpreted by the CPT Assistant for all contracts in both the public and private sectors, as long as the CPT process is simple, user friendly, and does not undergo frequent changes; and (3) seeks legislation and/or regulation to ensure that all insurance companies and

group payors recognize all published CPT codes including modifiers. (Sub. Res. 801, A-97; Appended: Res. 806, A-98; Appended: Res. 814, I-99; Reaffirmed: BOT Rep. 8, I-00)

H-70.963 CMS Implementation of Correct Coding Initiative
The AMA advocates that if the "Correct Coding Initiative" is implemented, distribution of the voluminous coding edits associated with this program be made available to physicians and their organizations on a no-cost or low-cost basis, in contrast to current distribution policies. (Res. 119, I-95; Reaffirmed by Ref. Cmt. H, A-96)

D-70.983 Inappropriate Bundling of Medical Services by Third Party Payers
Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices; (2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment; (3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate; (4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician; (5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and(6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its Web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue. (CMS Rep. 6, I-01)

H-190.970 Status Report on the National Uniform Claim Committee and Electronic Data Interchange
The AMA advocates the following principles to improve the accuracy of claims and encounter-based measurement systems: (1) the development and implementation of uniform core data content standards (e.g., National Uniform Claim Committee (NUCC) data set); (2) the use of standards that are continually modified and uniformly implemented; (3) the development of measures and techniques that are universal and applied to the entire health care system; (4) the use of standardized terminology and code sets (e.g., CPT) for the collection of data for administrative, clinical, and research purposes; and (5) the development and integration of strategies for collecting and blending claims data with other data sources (e.g., measuring the performance of physicians on a variety of parameters in a way that permits comparison with a peer group). (CMS Rep. 2, I-97)

Appendix E: Best state laws in the United States regarding transparency of physician fee-schedules and payment policies

Managed care organizations (MCOs) are required to provide physicians and other health care providers all information necessary for them to determine whether they have been paid correctly. The information must contain detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the amount the MCO will pay for covered services. MCOs must describe their payment and reimbursement methodologies in terms a reasonable layperson could be expected to understand. (CA, TX)

The information that Managed Care Organization (MCO) is obligated to provide must, at a minimum, include:

(i) a complete fee schedule upon which compensation will be calculated and paid and, if applicable, CPT, HCPCS, ASA, CDT and ICD-9-CM codes, and any applicable modifiers (CA, TX);

(ii) a detailed description and copy of coding guidelines, policies, methodologies, and processes (whether standard or nonstandard), including, but not limited to, any bundling, recoding, or downcoding guidelines, policies, methodologies, and processes that MCO reasonably expects to apply on a routine basis to the claims contracted physicians and other health care providers will submit. (CA, TX);

(iii) a description of any other applicable policies or procedures MCO may use that affects the payment of specific claims submitted by physicians and other health care providers, including but not limited to, policies or procedures affecting recoupment, copayments, coinsurance, deductibles, risk sharing arrangements, and the liability of third parties (CA, TX, KY);

(iv) information that will enable the physician or other health care provider to determine the effect of edits on compensation before the physician or other health care provider provides a service or submits a claim (CO);

(v) the manner of payment, e.g. a fee-for-service or risk-sharing basis. (OR); and

(vi) information about the methodology the MCO will use to reduce or increase the level of reimbursement, e.g. by providing a bonus or other incentive based compensation. (MD)

Specific payment rules and edits

MCO will disclose in an electronic format its Payment Policies, including, but not limited to:

(i) consolidation of multiple services or charges (CA, NC);

(ii) payment adjustments due to coding changes (CA, NC);

(iii) reimbursement for multiple procedures (CA, NC);

(iv) reimbursement for assistant surgeons (CA, NC);

(v) reimbursement for the administration of immunizations and injectable medications (CA, NC);

(vi) recognition or nonrecognition of CPT code modifiers (CA, NC);

(vii) definition of global surgery periods (NC); and

(viii) payment based on the relationship of procedure code to diagnosis code (NC).

Claims editing software information

MCO must disclose to its contracted physicians and other health care providers publisher, product name, edition, and model version of the software MCO uses to edit claims. (TX) Disclosure will be made on MCO's provider Web site and in its provider newsletters, and to its contracted physicians and other health care providers specifically upon request. (NY)