COLORADO
HB10_1332 MEDICAL CLEAN CLAIMS TRANSPARENCY & UNIFORMITY ACT TASK FORCE

Presented by:

Barry Keene, Co-Chair

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http://hb101332taskforce.org

Section 1171(5) of Social Security Act (42 U.S.C. 1320D(5)))

- ***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.*

What is meant by “claim edit?”

- An edit refers to a change to the data submitted by deletion, insertion or combination.
- There is currently no industry standard definition of *edit*.
- Lexicon is a first order definitional issue in attacking this problem.
- The Colorado legislation is focused on a specific class of edits.

When do edits occur? Where are there pain points and opportunities for improvement?

- The distinction is in the *purpose* for the edit.
- They include:
  - "Unprocessable edits"
  - Fraud and abuse edits
  - Utilization review edits
- These are **not** the edits Colorado is addressing.

Colorado's Focus

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

Colorado's Focus (Cont.)

- Edits used by Medicare and private payers based on their interpretation of CPT coding guidelines and conventions. They include:
  - Multiple procedure reductions
  - Bilateral surgery
  - Assistant surgery
  - Global surgery
  - Modifiers
- Due to the separate interpretations, there can be variations in application between payers.

What are some solutions to the coding, editing, & claims burden?

- Transparency and standardization around the edits and associated payment rules would go a long way toward alleviating the administrative burden.

Observations

- A standardized set of claim edits, disclosed to the provider community in advance and in a downloadable format for inclusion in the physicians' billing system, would streamline the claims submission and processing.

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

How can the problem of "over sending" information be addressed?

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

Are other states planning to follow Colorado's initiative?

- Thematically, California, Minnesota, Texas, Vermont and Washington have previous or current work ongoing around administrative streamlining that includes uniformity efforts in claims processing where edits have been some part of the conversation.

How can Colorado's initiative be turned into a national agenda?

- A recognized national authority must step in.
- Solidify a consensus to:
  - Formalize and standardize some level of edit adoption
  - Create a transparent and credible process
  - Establish a sustaining strategy

National Initiative (Cont.)

- Sanction a “Stakeholder Consortium”
  - Constituents highly knowledgeable in edits
  - Providers across the spectrum of place of service
  - Payers; Commercial, N-F-P, Coop & Government
  - Vendors of software at all levels and markets
  - Billing and revenue cycle services
  - NCCI
  - Knowledgeable consumer(s)

Starting Point For Edits

- Selecting a base set of edits includes:
  - Communities of focus, most impact for effort
  - Decide whether to build or buy
  - Developing criteria for adoption

Details Require Cooperation

- Sustainability: Principle Building Blocks
  - Establish or adopt criteria and definitions for "nationally recognized sources"
  - Determine transparent credible use of those sources . . . . *translating adverbs into logic*
  - Establish behavior standards for nationally recognized sources

Implementation & Enforcement

- Enforce the national work group's recommendations with carrot & stick.
  - Protect participating payers from collective actions in this arena
  - Protect participating payers from 50 different state approaches
  - Require all payers participating in exchanges to adopt the uniform set of edits and payment rules
  - Require adoption for these features for quality society accreditation

But remember…!

- Payers **must** be allowed to differentiate themselves in order to compete with each other. They also bring useful cost control insight to the table that adds value for consumers.
- However, differentiation should **not** be at the expense of standardization that nurtures automation at the claims processing level.

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

- CMS should accept their role as the payer predominating providers in all 50 states and by extension their responsibility to lead an initiative to standardize edits.
- NCCI should institute a goal of alignment with private sector payer practices and create an initiative to reconcile discontinuities where they are revealed.

Don’t overlook!

- The NCCI contractor must be part of the conversation and have the authority to speak openly about their development process and protocol.

- Where CMS does not want a contractor to speak for them they must be present and speak for themselves.

Why now?

- IDC10 exponentially increases the number of codes, standardization of edits reduces the impact on coders and leverages the value of finer resolution care detail.
- The insurance exchanges compare uniform products; non-uniform edits will undermine this goal and dampen consumer trust.
- Creating an essential benefits package requires a uniform edit approach to enforce the value metric.

Collateral Observations

- Mistrust and antagonizing between industry partners is exacerbated by nontransparent non-uniform edits.
- Clearly the quality of comparability across multiple payers, of data in All Payer Claims Databases is significantly improved.
- Consumers are impacted by unanticipated out of pocket medical expense caused by inability to estimate cost at point and time of service.

Barry Keene, Co-Chair
Colorado Medical Clean Claims Task Force
303.665.0180 krd@qadas.com