

ACT 21 of 2011, Section 18

Edit Standards Workgroup Report

January 1, 2012

To

House Committee on Health Care

Senate Committee on Health and Welfare

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Executive Summary

Section 30 of Act 61 of 2009 and Section 18 of Act 21 of 2011 required MVP to convene a workgroup consisting of health plans, health care practitioners, state agencies, and other interested parties to study the explicit edit standards set forth in Act 61, as well as the edit standards found in national class action settlements and any other edit transparency standards established by other states. The prescribed goal of the workgroup is to ensure health care practitioners can reasonably access relevant information about the edit standards applicable to the health care services they provide. The workgroup was instructed to report its findings and recommendations (including recommendations for legislative change to existing language in Act 61) to the House Health Care Committee and the Senate Health and Welfare Committee by January 1, 2011, which was done (a copy of the text of the report is attached as Appendix A). The workgroup then obtained a statutory amendment to continue its work in 2011, and a second legislative report is to be filed with the House Health Care Committee and the Senate Health and Welfare Committee by January 1, 2012. This is that report.

The workgroup held four meetings between June 2011 and December 2011, with a claims edit sub-workgroup meeting seven times between August 2011 and December 2011. Meeting materials, agendas and minutes were distributed via email to seventy-six stakeholders throughout the State, of which, approximately twenty people regularly attended the meetings.

The focus of the 2011 workgroup was limited in scope to evaluation of the Most Common Primary Care Edit Issues List ("Edit Issues List") comprising the most common edit issues identified by provider and billing representatives in the group. The three commercial payers (Blue Cross and Blue Shield of Vermont, CIGNA and MVP) and Medicaid evaluated the list with providers in the group to determine if commonality in edit standards could be achieved. Due to the need to evaluate and discuss individual edit practices among the payers, the workgroup sought and obtained language in Act 21 for state action antitrust immunity with oversight by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). BISHCA attended and actively supervised every meeting both of the workgroup and sub-workgroup.

The workgroup made progress throughout 2011 opening up dialogue between payers and providers highlighting the intent of all parties to eliminate administrative burdens throughout the health care system. While progress occurred, more work needs to be done to evaluate specific editing differences between the payers and the effect of implementing potential edit changes to providers and payers. This work is continuing with the intent that the workgroup will address the already identified claim edit issues and discuss new issues identified in the open forum. The workgroup will meet on a quarterly basis to address any new concerns regarding edit standards and work to resolve the issues already identified. With the agreement of the workgroup, Blue Cross and Blue Shield of Vermont and the Vermont Medical Society are willing to convene and staff the workgroup going forward.

The workgroup also agreed to move forward with an amendment to 18 VSA § 9418a (b) in the 2012 legislative session as follows:

18 V.S.A. § 9418a. Processing claims, downcoding, and adherence to coding rules is amended as follows:

(a) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for Prescription Drug Programs coding; or other appropriate nationally-recognized standards, guidelines, or conventions approved by the commissioner.

(b) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to the following edit standards, except as provided in subsection (c) of this section:

(1) The CPT, HCPCS, and NCCI;

(2) National specialty society edit standards; or

(3) Other appropriate nationally-recognized edit standards, guidelines, or conventions approved by the commissioner.

(c) Adherence to the edit standards in subdivision (b)(1) through (3) of this section is not required:

(1) When necessary to comply with state or federal laws, rules, regulations, or coverage mandates; or

(2) For edits that the payer determines are more favorable to providers than the edit standards in subdivisions (b)(1) through (b)(3), or to address new codes not yet incorporated by a payer's edit management software, provided the edit standards are developed with input from the relevant Vermont provider community and national provider organizations, and provided the edits are available to providers, on the plans' websites and in their newsletters.

(k) Blue Cross and Blue Shield of Vermont and the Vermont Medical Society shall continue to convene a work group consisting of health plans, health care providers, state agencies, and other interested parties to study the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards established by other states to determine the most appropriate way to ensure that health care providers can access information about the edit standards applicable to the health care services they provide. The work group shall provide an annual progress report to the House Committee on Health Care and the Senate Committee on Health and Welfare.

Statutory Charge and Language

18 VSA § 9418a. Processing claims, downcoding, and adherence to coding rules

(a) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for Prescription Drug Programs coding; or other appropriate standards, guidelines, or conventions approved by the commissioner.

(b) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to edit standards that are no more restrictive than the following, except as provided in subsection (c) of this section:

- (1) The CPT, HCPCS, and NCCI;
- (2) National specialty society edit standards; or
- (3) Other appropriate edit standards, guidelines, or conventions approved by the commissioner.

(c) Adherence to the edit standards in subdivision (b)(1) or (2) of this section is not required:

- (1) When necessary to comply with state or federal laws, rules, regulations, or coverage mandates; or
- (2) For services not addressed by NCCI standards or national specialty society edit standards.

(d) Nothing in this section shall preclude a health plan, contracting entity, covered entity, or payer from determining that any such claim is not eligible for payment in full or in part, based on a determination that:

- (1) The claim is contested as defined in subdivision 9418(a)(2) of this title;
- (2) The service provided is not a covered benefit under the contract, including a determination that such service is not medically necessary or is experimental or investigational;
- (3) The insured did not obtain a referral, prior authorization, or precertification, or satisfy any other condition precedent to receiving covered benefits from the health care provider;
- (4) The covered benefit exceeds the benefit limits of the contract;
- (5) The person is not eligible for coverage or is otherwise not compliant with the terms and conditions of his or her coverage agreement;

(6) The health plan has a reasonable belief that fraud or other intentional misconduct has occurred; or

(7) The health plan, contracting entity, covered entity, or payer determines through coordination of benefits that another entity is liable for the claim.

(e) Nothing in this section shall be deemed to require a health plan, contracting entity, covered entity, or payer to pay or reimburse a claim, in full or in part, or to dictate the amount of a claim to be paid by a health plan, contracting entity, covered entity, or payer to a health care provider.

(f) No health plan, contracting entity, covered entity, or payer shall automatically reassign or reduce the code level of evaluation and management codes billed for covered services (downcoding), except that a health plan, contracting entity, covered entity, or payer may reassign a new patient visit code to an established patient visit code based solely on CPT codes, CPT guidelines, and CPT conventions.

(g) Notwithstanding the provisions of subsection (d) of this section, and other than the edits contained in the conventions in subsections (a) and (b) of this section, health plans, contracting entities, covered entities, and payers shall continue to have the right to deny, pend, or adjust claims for services on other bases and shall have the right to reassign or reduce the code level for selected claims for services based on a review of the clinical information provided at the time the service was rendered for the particular claim or a review of the information derived from a health plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

(h) Every health plan, contracting entity, covered entity, and payer shall publish on its provider website and in its provider newsletter if applicable:

(1) The name of any commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer utilizes;

(2) The standard or standards, pursuant to subsection (b) of this section, that the entity uses for claim edits;

(3) The payment percentages for modifiers; and

(4) Any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product after the effective date of this section, which are made at the request of the health plan, contracting entity, covered entity, or payer.

(i) Upon written request, the health plan, contracting entity, covered entity, or payer shall also directly provide the information in subsection (h) of this section to a health care provider who is a participating member in the health plan's, contracting entity's, covered entity's, or payer's provider network.

(j) For purposes of this section, "health plan" includes a workers' compensation policy of a casualty payer licensed to do business in Vermont.

(k) Prior to the effective date of subsections (b) and (c) of this section, MVP Healthcare is requested to convene a work group consisting of health plans, health care providers, state agencies, and other interested parties to study the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards established by other states to determine the most appropriate way to ensure that health care providers can access information about the edit standards applicable to the health care services they provide. No later than January 1, 2012 the work group is requested to report its findings and recommendations, including any recommendations for legislative changes to subsections (b) and (c) of this section, to the house committee on health care and the senate committee on health and welfare.

(l) With respect to the work group established under subsection (k) of this section and to the extent required to avoid violations of federal antitrust laws, the department shall facilitate and supervise the participation of members of the work group.

Workgroup Process

As directed by Section 18 of Act 21 of 2011, MVP continued to convene a workgroup consisting of health plans, health care practitioners, state agencies including BISHCA and DVHA, and other interested parties to study the edit standards set forth in Act 61 (the edit standards in national class action settlements; and edit standards and edit transparency standards established by other states) to determine the most appropriate way to ensure that health care providers can access information about the edit standards applicable to health care services they provide. The workgroup met formally four times from June of 2011 through December of 2011, and a sub-workgroup met seven times between August 2011 and December 2011. Materials, agendas and minutes were distributed to an email list of approximately 76 people, representing a wide array of stakeholders of which approximately 20 people attended the general meetings in person and by phone. Minutes of the meetings are attached in Appendix B. The email list is attached as Appendix C.

The work of the group was a continuation of the work conducted during the 2010 workgroup sessions focusing specifically on the Edit Issues List comprising the most common edit issues identified provider and billing representatives in the group (attached as Appendix D), and attempts by the three major commercial payers (Blue Cross and Blue Shield of Vermont, CIGNA and MVP) and Medicaid to see if commonality in these edit codes could be achieved. The codes associated with the claims scenarios outlined in the Edit Issues List reflect those that provider offices identify as having a "high hassle factor". The volumes of claims and the amount of time primary care provider offices spend on resolving edit issues were the two main factors to identify scenarios that were put on the Edit Issues List. A sub-workgroup was formed to perform granular analysis of the specific edit issues identified reporting back to the larger group. Due to the need to evaluate and discuss individual edit practices among the payers, the workgroup sought and obtained language in Act 21 for state action antitrust immunity with oversight by the BISHCA. BISHCA attorneys attended and actively supervised every meeting of both the workgroup and sub-workgroup over this past year. This work is continuing with the intent that the workgroup will address the already identified claim edit issues and discuss new issues identified in the open forum. The workgroup will meet on a quarterly basis to address any new concerns regarding edit standards and work to resolve the issues already identified. With the agreement of the workgroup, Blue Cross and Blue Shield of Vermont and the Vermont Medical Society are willing to convene and staff the workgroup going forward.

The bulk of the 2011 workgroup and sub-workgroup analysis focused on a grid of code/edit issues developed based on the Edit Issues List identifying how each of the three commercial payers, Medicaid and Medicare edited the codes for reimbursement. The sub-workgroup, which included the payers noted above, provider and billing representatives, methodically went through each edit standard to determine where there was commonality or differences among the payers. The Edit Issues List attached as Appendix D identifies the instances of commonality and differences between the payers identified to date. While the sub-workgroup found there was moderate alignment among the three major payers, at least one of the issues on the Edit Issues List resulted from claims treatment by an out-of-state payer covering only a small number of lives in Vermont. Therefore, while the three major payers may be able to voluntarily reach

commonality and limit administrative burdens for all involved, there is still the issue of out-of-state payers that cannot be resolved in this forum.

The success of the workgroup to date rests of the fact that there were several instances where one of the three major payers was an outlier as compared to the rest of the payers, and that payer agreed to consider adjusting its edits. Although the full Edit Issues List needs to be vetted, the result is that the payers are reviewing any identified differences or outliers and determining if internal operations and business practices can be modified to standardize the manner in which payers process the edits at issue. The goal is that Medicaid and the three commercial payers would have the same edit requirements for the edits at issue and then such progress be brought to Medicare's attention. This work is continuing with the intent that the workgroup will address the already identified claim edit issues and discuss new issues identified in the open forum. The workgroup will meet on a quarterly basis to address any new concerns regarding edit standards and work to resolve the issues already identified. With the agreement of the workgroup, Blue Cross and Blue Shield of Vermont and the Vermont Medical Society are willing to convene and staff the workgroup going forward.

The secondary focus of the workgroup continued to be concerns with the language in 18 VSA § 9418a (b) requiring payers to adhere to edit standards that *are no more restrictive than* those listed in the statute. As noted in the January 2011 report issued by the workgroup to the legislature, the multiple billing standards identified in 18 VSA § 9418a(b), all of which are used by payers and providers, fail to clearly articulate and establish which standard is the least restrictive. Across the different edit standards there are inherent conflicts in how claims could be edited and paid (or denied). There could be a disagreement with a practitioner between industry standard edits (i.e., CPT-4, HCPCS Level II, and NCCI) versus national specialty society edit standards (both of which are allowed under the statute) and there could be ways of editing that would be considered not in compliance depending on which sets of edit standards were used. Failure to establish a clear standard also stifles the ability of regulators charged with enforcing this statute to enforce a clear rule. The language creates an impossible situation for the payers, as they would be out of compliance with the statutory requirements the day the language would take effect (July 1, 2012).

The workgroup acknowledges that the multiplicity of claims edits has created great concern for providers. Provider and billing representatives in the work group noted that while payers provide the online tool C3 to review how a claim will edit the tool is payer specific and does not address the different edit standards of each payer. Obtaining the full scope of the payers' edit systems is prohibitively expensive for Vermont providers to purchase, and it is not possible or cost effective for providers to upload the systems' edits into their billing systems. Additionally, the systems contain proprietary information and the payers are prohibited by their vendors from sharing edit systems. For categories of claims subject to edits, providers assert that there is no easy way for providers to know what they will be paid for a service or combination of services before they submit a claim. Thus, it can be difficult for providers to identify reimbursement for a claim at the point of service. Moreover, the appeals generated by the multitude of edit standards create unnecessary administrative burdens for both providers and payers.

Finally, the workgroup continued to follow the Colorado Medical Clean Claims Taskforce which is developing a standardized claims edit program for all payers in that state.¹ This Taskforce had its first meeting December 2, 2010 and will continue its work over the next several years. The Taskforce has funding and a broad cross-section of interested parties including commercial vendors of editing software used by most payers including commercial and government payers. The workgroup continuously monitors the work of this Taskforce as it is clear the Taskforce is working to create a uniform coding system that given the resources may be something Vermont can adapt and build off of.

As set forth above, the workgroup has made progress throughout 2011 opening up dialogue between payers and providers highlighting the intent of all parties to eliminate administrative burden throughout the health care system. While progress occurred, more work needs to be done to evaluate specific editing differences between the payers and the affect of implementing potential edit changes to providers and payers. The workgroup has agreed to continue meeting throughout the first quarter of 2012 with the goal of obtaining edit commonality where possible implementing agreed upon changes during the third quarter of 2012.

The workgroup thanks MVP for its excellent work over the past two years of convening the workgroup, scheduling meetings, and preparing agendas, minutes and reports for the workgroup.

¹ Colorado Medical Clean Claims Act:

<http://www.leg.state.co.us/CLICS/CLICS2010A/csl.nsf/fsbillcont3/0FF8C1081A257FA9872576C10067B323?Ope>

Recommendations

The workgroup reaffirmed the finding in its 2011 Report that it is not appropriate to recommend a specific claim edit standard for all payers due to the changing health care landscape. The workgroup believes it is important to continue to review other initiatives, such as the work going on in Colorado, other states and nationally prior to recommending specific claim edit standards be mandated. The workgroup has made moderate progress with the identified list of claim edits in Appendix D but that is a small subset (15 edits) of the much larger system of edits.

There are many changes coming over the next few years with Medicare and Medicaid standards, ACA reform, and movement toward payment reform in Vermont including potentially the “single pipe” concept, all of which may have an impact on the claim edit standards used by payers. It is the committee’s opinion that now is not the time to mandate specific claim edits, but rather to continue to review other initiatives and to continue to attempt to address the actual issues affecting providers and payers through an open forum and partnership focused review. Based on this opinion the committee recommends the following:

(1) Continued Committee Work:

During the first quarter of 2012, the committee will continue its work on the “Edit Issues List” identifying where commonality can be achieved by the three commercial payers and Medicaid. This will be an administrative improvement for both payers and providers and a value add for the healthcare system. The workgroup will also address specific questions/concerns about claim edits raised by providers and evaluate whether commonality can be reached among the payers on those edits. Finally, the workgroup will determine whether to identify or create a common set of rules addressing how the common claim edits identified by the workgroup should be billed.

Payers will make the information about the common edit standards available to their participating providers. The payers will work with the provider community to offer education about the agreed upon changes to claim edits, and related agreed on billing rules for the codes addressed by the committee. The education will include an explanation of the workgroup process, the provider-payer partnership created through this workgroup and workgroup’s goal to identify and address administrative waste and potential confusion within edit standards.

(2) Amended Language to § 18 VSA 9418a

The workgroup recommends that the language in 18 VSA § 9418a be amended as follows:

18 V.S.A. § 9418a. Processing claims, downcoding, and adherence to coding rules is amended as follows:

(a) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for

Prescription Drug Programs coding; or other appropriate **nationally-recognized** standards, guidelines, or conventions approved by the commissioner.

(b) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to the following edit standards, except as provided in subsection (c) of this section:

(1) The CPT, HCPCS, and NCCI; or,

(2) National specialty society edit standards; or

(3) Other appropriate **nationally-recognized** edit standards, guidelines, or conventions approved by the commissioner.

(c) Adherence to the edit standards in subdivision (b)(1) or (2) of this section is not required:

(1) When necessary to comply with state or federal laws, rules, regulations, or coverage mandates; or

(2) For edits that the payer determines are more favorable to providers than the edit standards in subdivisions (b)(1) through (b)(3), or to address new codes not yet incorporated by a payer's edit management software, provided the edit standards are developed with input from the relevant Vermont provider community and national provider organizations, and provided the edits are available to providers, on the plans' websites and in their newsletters.

(k) Blue Cross and Blue Shield of Vermont and the Vermont Medical Society shall continue to convene a work group consisting of health plans, health care providers, state agencies, and other interested parties to study the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards established by other states to determine the most appropriate way to ensure that health care providers can access information about the edit standards applicable to the health care services they provide. The work group shall provide an annual progress report to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(3) Vermont Claims Administration Collaborative (VCAC):

In the event the Vermont Claims Administration Collaborative (VCAC) is reconvened, the Edit Standards Workgroup should collaborate closely with VCAC or any VCAC-like workgroup created as part of health care reform, particularly if the workgroup addresses coding conventions, claims editing, claim processing, denials and adjustments.

(4) National Administrative Initiatives

The Green Mountain Care Board is charged with promoting the general good of the state by promoting administrative simplification in health care financing and delivery.² The workgroup may be able to serve as a resource to the Green Mountain Care Board as it works on administrative simplification.

The workgroup will continue to review the work that has been done in other states on administrative simplification. In Washington an Administrative Simplification Steering Committee was created consisting of representatives of the Hospital Association, the Medical Association, and health plans. That organization developed a number of Best Practice Recommendations (BPRs) such as one addressing *Claim Coding Policy and Edits* that calls for adoption of national correct coding initiative (NCCI) edit policies and Medicare Physician Fee Schedule Database (MPFSDB) indicators by health plans and provider organizations. Almost all health plans in Washington appear to have fully adopted this BPR.³

In Colorado the state created a legislative Taskforce charged with creating a uniform edit system for all payers in the state. The Taskforce is well funded and comprised of experts in the field of edit standards allowing them to make great progress on this mandate. This workgroup will follow their work.⁴

The workgroup will also review the AMA's guiding principles for a standard code-editing system⁵ and determine whether the principles should be adopted by the workgroup. These principle address:

- Defining the term "claim edit;"
- Defining the purpose of claim edits as a system to create a uniform, correct coding practice and to provide transparency and simplicity for point-of-service pricing;
- Requiring all claim edits to be consistent with CPT codes, guidelines and conventions;
- Retaining the NCCI review process;
- Encouraging payers to submit payer-specific code-edits to the NCCI for consideration and potential incorporation; and
- Encouraging stakeholders to work with the CPT editorial board to address concerns regarding CPT descriptions and disputes.

² <http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf>

³ BPR on Claim Coding: http://www.onehealthport.com/pdf/BPR_Claim_Coding_and_Edits.pdf; Adoption matrix for all BPRs: <http://www.onehealthport.com/worksmart/wsadoptionmatrix.php>

⁴ Colorado Medical Clean Claims Act: <http://www.leg.state.co.us/CLICS/CLICS2010A/csl.nsf/fsbillcont3/0FF8C1081A257FA9872576C10067B323?Ope>

⁵ AMA White Paper – See page 11 <http://www.ama-assn.org/resources/doc/psa/standardization-code-editing-whitepaper.pdf>

Finally, the workgroup will review the legislation promulgated in California, Massachusetts and Minnesota that requires standardization of prior authorization forms for prescription drugs and authorized committees to review prior authorization processes.⁶ This review in conjunction with the review of edit standards will be done with the intent on evaluating the administrative burdens on payers and providers.

⁶ California SB 866, http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0851-0900/sb_866_bill_20111009_chaptered.pdf

ACT 61 of 2009, Section 30

Edit Standards Workgroup Report

January 1, 2011

To

House Committee on Health Care

Senate Committee on Health and Welfare

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Executive Summary

Section 30 of Act 61 of 2009 required MVP to convene a workgroup consisting of health plans, health care practitioners, state agencies, and other interested parties. The workgroup was directed to study the explicit edit standards set forth in Act 61, as well as the edit standards found in national class action settlements and any other edit transparency standards established by other states. The goal set forth by the legislature was to ensure health care practitioners can reasonably access relevant information about the edit standards applicable to claims for the health care services they provide. The workgroup was instructed to report its findings and recommendations (including recommendations for legislative change to existing language in Act 61) to the House Health Care Committee and the Senate Health and Welfare Committee by January 1, 2011.

The workgroup held thirteen meetings between September 2009 and December 2010, and supplemented meetings with a number of informal conference calls. Meeting materials, agendas and minutes were distributed via email to seventy-six varying stakeholders throughout the State, of which approximately twenty people regularly attended the meetings.

The workgroup reached an early consensus that edit standards are highly complex and the language in Act 61 is problematic for the industry and should be addressed. The workgroup spent a great deal of time educating itself about how edits work, why they are used, and the different edits used by the primary health plans in Vermont (Blue Cross and Blue Shield of Vermont, CIGNA, MVP Health Care, and Medicare/Medicaid). The workgroup also discussed the interplay between practitioner billing practices and health plan claim edit standards. Finally, the workgroup spent its last several meetings focusing on the differences in claim edit standards across the health plans in Vermont, common reasons for administrative claims denials, and any implications the Affordable Care Act recently passed by Congress might have on state efforts to regulate edit standards.

Following more than a year of productive analysis, the workgroup reached consensus that it should continue its work. The group concluded that if it is possible to reach consensus on specific recommendations for edit standards, additional analysis is necessary. The workgroup's recommendation, therefore, is to postpone the effective date of the edit standards language in the statute. Further, the workgroup requests state action antitrust immunity in order to continue its collaborative work.

Statutory Charge and Language

18 VSA § 9418a. Processing claims, downcoding, and adherence to coding rules

(a) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for Prescription Drug Programs coding; or other appropriate standards, guidelines, or conventions approved by the commissioner.

(b) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to edit standards that are no more restrictive than the following, except as provided in subsection (c) of this section:

- (1) The CPT, HCPCS, and NCCI;
- (2) National specialty society edit standards; or
- (3) Other appropriate edit standards, guidelines, or conventions approved by the commissioner.

(c) Adherence to the edit standards in subdivision (b)(1) or (2) of this section is not required:

- (1) When necessary to comply with state or federal laws, rules, regulations, or coverage mandates; or
- (2) For services not addressed by NCCI standards or national specialty society edit standards.

(d) Nothing in this section shall preclude a health plan, contracting entity, covered entity, or payer from determining that any such claim is not eligible for payment in full or in part, based on a determination that:

- (1) The claim is contested as defined in subdivision 9418(a)(2) of this title;
- (2) The service provided is not a covered benefit under the contract, including a determination that such service is not medically necessary or is experimental or investigational;
- (3) The insured did not obtain a referral, prior authorization, or precertification, or satisfy any other condition precedent to receiving covered benefits from the health care provider;
- (4) The covered benefit exceeds the benefit limits of the contract;
- (5) The person is not eligible for coverage or is otherwise not compliant with the terms and conditions of his or her coverage agreement;

(6) The health plan has a reasonable belief that fraud or other intentional misconduct has occurred; or

(7) The health plan, contracting entity, covered entity, or payer determines through coordination of benefits that another entity is liable for the claim.

(e) Nothing in this section shall be deemed to require a health plan, contracting entity, covered entity, or payer to pay or reimburse a claim, in full or in part, or to dictate the amount of a claim to be paid by a health plan, contracting entity, covered entity, or payer to a health care provider.

(f) No health plan, contracting entity, covered entity, or payer shall automatically reassign or reduce the code level of evaluation and management codes billed for covered services (downcoding), except that a health plan, contracting entity, covered entity, or payer may reassign a new patient visit code to an established patient visit code based solely on CPT codes, CPT guidelines, and CPT conventions.

(g) Notwithstanding the provisions of subsection (d) of this section, and other than the edits contained in the conventions in subsections (a) and (b) of this section, health plans, contracting entities, covered entities, and payers shall continue to have the right to deny, pend, or adjust claims for services on other bases and shall have the right to reassign or reduce the code level for selected claims for services based on a review of the clinical information provided at the time the service was rendered for the particular claim or a review of the information derived from a health plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

(h) Every health plan, contracting entity, covered entity, and payer shall publish on its provider website and in its provider newsletter if applicable:

(1) The name of any commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer utilizes;

(2) The standard or standards, pursuant to subsection (b) of this section, that the entity uses for claim edits;

(3) The payment percentages for modifiers; and

(4) Any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product after the effective date of this section, which are made at the request of the health plan, contracting entity, covered entity, or payer.

(i) Upon written request, the health plan, contracting entity, covered entity, or payer shall also directly provide the information in subsection (h) of this section to a health care provider who is a participating member in the health plan's, contracting entity's, covered entity's, or payer's provider network.

(j) For purposes of this section, "health plan" includes a workers' compensation policy of a casualty insurer licensed to do business in Vermont.

(k) Prior to the effective date of subsections (b) and (c) of this section, MVP Healthcare is requested to convene a work group consisting of health plans, health care providers, state agencies, and other interested parties to study the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards established by other states to determine the most appropriate way to ensure that health care providers can access information about the edit standards applicable to the health care services they provide. No later than January 1, 2011, the work group is requested to report its findings and recommendations, including any recommendations for legislative changes to subsections (b) and (c) of this section, to the house committee on health care and the senate committee on health and welfare. (Added 2007, No. 203 (Adj. Sess.), § 28, eff. June 10, 2008; amended 2009, No. 61, § 30.)

Workgroup Process and Discussion

As directed by Section 30 of Act 61 of 2009, MVP convened a workgroup consisting of health plans, health care practitioners, state agencies including BISHCA and DVHA, and other interested parties. The workgroup was directed to study the claims edit standards set forth in Act 61, the edit standards in national class action settlements, and edit transparency standards established by other states. The goal of the workgroup was to determine the most appropriate way to ensure that health care practitioners can reasonably access relevant information about the edit standards applicable to claims for the health care services they provide.

The workgroup held thirteen meetings between September 2009 and December 2010, and supplemented meetings with a number of informal conference calls. Meeting materials, agendas and minutes were distributed via email to seventy-six varying stakeholders throughout the State, of which approximately twenty people regularly attended the meetings. (See Appendix A: Minutes & Appendix B: Workgroup Email List.)

The workgroup reached an early consensus that standardizing claim edits is a complex task due to a variety of concerns raised by both payers and practitioners. The workgroup quickly concluded there was no easy, quick or cost effective process readily available to address the issues associated with claim edits, much like when the same task was unsuccessfully undertaken several years ago by the Common Claims Workgroup.¹ Due to barriers initially raised by the group, it appeared in the beginning there may be another impasse, but the workgroup pushed forward to learn whether common ground could be reached. Though significant progress was made, the work group concluded it needs additional time to fully address this complex issue, and if the group is to have the discussions germane to a bona fide solution, it requires state action antitrust immunity protection.

In reaching this conclusion the group reviewed the Administrative Simplification White Paper prepared by the American Medical Association (December 23, 2008)², The Standardizing CPT Codes, Guidelines and Conventions Administrative Simplification White Paper prepared by the American Medical Association (May 19, 2009)³, the Standardization of the Claims Process: Administrative Simplification White Paper prepared by the American Medical Association (June 22, 2009)⁴, the AMA's 2010 National Health Insurer Report Card,⁵ the September 1, 2010 CMS

¹ The Improving the Efficiency and Fairness of Claims Adjudication Process sub-group of the Common Claims Work Group made two recommendations in the Final Report to the Commission on Health Care Reform, January 15, 2008. The commissioner's response (February 28, 2008) to the final report of the workgroup acknowledged that members of the workgroup as a whole have not been able to achieve consensus on this important issue; therefore the recommendations were not implemented. http://hcr.vermont.gov/sites/hcr/files/pdfs/HCR-Common_Claims_Final_Report.pdf.

²AMA Administrative Simplification White Paper, December 2008; <http://www.ama-assn.org/ama1/pub/upload/mm/368/admin-simp-whitepaper.pdf>

³AMA Administrative Simplification White Paper, May 2009; <http://www.ama-assn.org/ama1/pub/upload/mm/368/admin-simp-cpt-wp.pdf>

⁴AMA Administrative Simplification White Paper, June, 22, 2009; <http://www.ama-assn.org/ama1/pub/upload/mm/368/admin-simp-wp.pdf>

letter of the National Correct Coding Initiative⁶, the Colorado law creating “The Medical Clean Claims Transparency and Uniformity Act” (HB 10-1332), and the physicians settlement agreement reached by approximately 90% of Blue Cross and Blue Shield (BCBS) Plans in the country⁷.

The workgroup discussed the problems with the language in 18 VSA § 9418a(b) requiring payers to adhere to edit standards that *are no more restrictive than* those listed in the statute. There is concern that the phrase “no more restrictive” is too ambiguous. There is no clearly articulated test of “restrictiveness” for payers or regulators to use to determine whether a claim edit is overly restrictive. Any single edit standard could conceivably be more or less restrictive, depending on the practitioner and his/her practice and resources. Across the different edit standards there are conflicts in how claims could be edited based on industry edit standards (i.e., CPT-4, HCPCS Level II, and NCCI), as well as national specialty society edit standards, *both of which are allowed under the statute*. Each of the various editing standards cover thousands of procedures and evaluation/consultation activities, and each editing standard has claim edits that are unique to many specific procedures or evaluation/consultation activities. The current language creates a difficult situation for the health plans, as they would potentially be out of compliance with the “no more restrictive than...” statutory requirement the day the language takes effect (July 1, 2011). In order to comply with the statute, a health insurer would have to determine which of the various claim edits resulting from all of the allowed editing standards is the least restrictive for a particular procedure or evaluation/consultation activity. Given the hundreds of thousands or even millions of claims a health insurer processes in a year, making such a determination would have to be done manually and would be administratively cost prohibitive, inefficient and impracticable. The same administrative burden would be experienced by the regulators when trying to evaluate whether a health plan is in compliance with the current mandate. For these reasons, the current statutory language is highly problematic.

After identifying its concerns, the workgroup attempted to identify the differences among the edit tools used by the payers, and to assess the varying levels of usefulness these tools lend to practitioners. The three health plans all use McKesson code auditing software (proprietary software based on industry standards available in various products and/or versions). All three health plans have indicated they have very few custom edits (the health plans’ custom edits cannot be discussed in any detail absent state action antitrust immunity protection). It is unclear if McKesson will license its software to practitioners so they can load edits into their software for

⁵ AMA National Health Insurer Report Card - <http://www.ama-assn.org/ama1/pub/upload/mm/368/2010-nhirc-results.pdf>

⁶ CMS letter to Medicaid Directors re NCCI September 2010: <https://www.cms.gov/smdl/downloads/SMD10017.pdf>

⁷ The settlement agreement included a number of specific clinical edit standards. BlueCross Blue Shield of Vermont, while not a party to the settlement, has conformed to the provisions in the national settlement. <http://www.hmosettlements.com/pages/bluexcross.html>; text of settlement: http://www.hmosettlements.com/settlements/bluexcross/Thomas%20-%20Amended%20Settlement%20Agreement%20Joinder%20of%201BC_.pdf (See pages 51-55)

pre-submission analysis.⁸ However, it is expected that if McKesson does offer such a product it would be cost prohibitive for most practitioners.

The group also reviewed Medicare and Medicaid claims processes and agreed that merely adopting Medicare's edit standards would not be a viable solution. Though Medicare edits are based on NCCI, Medicare also has customized edits, as well as regional and local coverage determinations, all of which can impact claims processing. Not to mention, the workgroup, and ultimately the Legislature, would not likely be able to effectuate any changes or standardization to Medicare edits, even if the changes would align Medicare with the Vermont market.

Medicaid also uses a McKesson product, but that product also does not mirror the code audit software products currently in place for the private health plans. In a communication to state Medicaid offices, CMS noted that all five of the NCCI methodologies, including approximately 1.3 million procedure to procedure service edits used in Medicare Part B, were compatible for the Medicaid program. While section 6507 of ACA requires state Medicaid programs to implement NCCI edits to promote correct coding, states may deactivate NCCI edits that conflict with state laws and regulations⁹ allowing state Medicaid to have custom edits.

Practitioners have (or will soon have) access to a tool that was not widely available when this legislation was passed. This tool, which is called McKesson's Clear Claims Connection™ (C3), is a web-based code audit disclosure product that can be accessed via two of the three health plans' provider web portals (the third health plan is in the process of implementing this product now). C3 allows practitioners to enter a series of CPT codes and access audit rules, edit rationales, and associated clinical logic that may be applied on a CPT code level basis, in order to determine how a claim scenario might be processed. While the tool is a step in the right direction, its value among the practitioner community varies due to the technology used by practitioners and the inability of the program to apply member specific information for exact benefit determination. Moreover, in connection with the claims denial review, the group also conducted a survey of practice managers and practitioners' in offices across Vermont (including hospitals).¹⁰ The responses showed that some practices found Clear Claims Connection™ (C3) helpful after a claim had been denied; however, the tool is felt to be ineffective as a front-end tool for actually reducing claims denials due to the limitations noted above. The survey further revealed that very few practitioners were aware of or used the web-based application, and that the majority of practitioners did not know of the lists of custom edits insurers are required by law to have on their websites. Responses also indicate that practitioners would be very interested in additional training around billing and claim edit guidelines.

Notwithstanding the new tool available, the workgroup still sought areas for further improvement in the claim edits process. The workgroup further educated its members about the intricacies of edit standards through detailed discussions regarding the claims editing standards used by each of the three health plans, and a webinar by CIGNA on McKesson's Clear Claims

⁸ According to the AMA McKesson will not license the software to practices or billing companies.

⁹ CMS FAQ re NCCI: https://www.cms.gov/MedicaidNCCICoding/Downloads/NCCI_FAQs.pdf;
<http://www.cms.gov/smdl/downloads/SMD10017.pdf>

¹⁰ Surveys were given to practitioners through the MGMA, the medical society, and the hospital association.

Connection™ (C3) web-based application. The Medical Society also arranged a webinar by the American Medical Association (AMA) on its Administrative Simplification initiative.¹¹ Practitioners also educated the health plans about the problems they encounter with differing editing standards among the health plans, Medicare and Medicaid.

The workgroup proceeded with data analysis looking at the top ten reasons for claims denials by the three health plans. This process revealed that the main reasons for claims denials were administrative in nature, and not generally the result of CPT code level claims editing. The workgroup retained an external consultant to aggregate the payers' claims denial data to determine the primary reasons across all commercial payers. The three health plans, Fletcher Allen Health Care and the Vermont Medical Society funded the retention of John Chapman PhD of Markcelian Associates, Inc. to aggregate claims denial data and produce a set of seven data tables. The data was not received until late December 2010, and the workgroup had little time to evaluate it. The further analysis of the data produced by Mr. Chapman is one of the reasons the workgroup should continue its efforts into 2011. (Appendix D: Data Table Description.)

After receiving and processing all of this information, several members of the group representing practitioners drafted recommendations for changes that could be made by health plans, which they believed would have the most impact on primary care practitioners in their day to day billing activities. These recommendations were then compared against the national Blue Cross and Blue Shield settlement provisions.¹² The workgroup agreed to work to identify which recommendations from the hospitals and practitioners could be implemented by the payers so that there would be some reasonable level of uniformity among the payers. Unfortunately, this process raises significant concerns about antitrust issues, since the health plans' sharing of specific proprietary information about how they process and reimburse claims could lead to liability. Accordingly, the workgroup asked for and received an opinion from BISHCA General Counsel Herb Olson on the issue. He concluded there was no explicit state action antitrust immunity for the work of the group (Appendix E), in spite of the workgroup having acknowledged that the goal is not to stifle competition, but rather, to work to ease administrative processes within the health system that can only be addressed collectively. The ultimate discussion surrounding denials and claims edits crosses the line into reimbursement methodology, which some deem to be inherent coercion between competitors (including practitioners), so the group agreed that in order to continue the discussion on uniformity of claim processes, it would require specific state action immunity through BISHCA, from the legislature.¹³

Another barrier to Vermont claim edit standardization is that both Medicare and Medicaid are going to be significantly changing the edit standards they use over the coming year. Also, forthcoming as part of ACA, changes to the requirements around edit standards may potentially

¹¹ A summary of the information presented by the AMA in its administrative simplification webinar in September, prepared by Lauren Parker of MBA Healthcare is included as Appendix C.

¹² Text of settlement: <http://www.lmosettlements.com/settlements/blucross/Thomas%20-%20Amended%20Settlement%20Agreement%20Joinder%20of%20IBC.pdf> (See pages 51-55)

¹³ Similar state action immunity can be found in 18 V.S.A. § 9409, authorizing professional groups to bargain with state agencies. <http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=221&Section=09409>

pre-empt any state action. Additionally, by 2014 practitioners and payers must convert from ICD-9 to ICD-10, which includes tens of thousands of additional diagnosis codes (the most significant coding change in 30+ years), financially impacting administrative billing processes. Edit standards may also be further impacted by Vermont's payment reform efforts, which include the hiring of a Director of Payment Reform whose report is due to the Legislature in February 2011, as well as the possible development of Accountable Care Organizations. In summation, there are a number of factors impeding claims edit standardization at present.

An example of this changing environment is evidenced by a law recently passed in Colorado that established a Medical Clean Claims Taskforce charged with developing a standardized claims edit program for all payers.¹⁴ This Taskforce had its first meeting December 2, 2010 and will continue its work over the next several years. The Taskforce has robust funding and a broad cross-section of interested parties. The workgroup believes it would make sense to monitor the work of this Taskforce, which is already underway. That way, our workgroup may benefit from the efforts of the Taskforce without having to duplicate the same resources here in Vermont.

¹⁴ Colorado Medical Clean Claims Act:

http://www.leg.state.co.us/CLICS/CLICS2010A/csl.nsf/fsbillcont3/0FF8C1081A257FA9872576C10067B323?Open&file=1332_enr.pdf

Recommendations

As evidenced above, the claim edit process is highly complex. Plus, there are too many changes coming over the next year, including changes to Medicare and Medicaid edit standards, ACA reform, and movement toward payment reform in Vermont, all of which could have an impact on edit standards used by commercial insurers. Any change implemented now will almost definitely result in a significant increase in administrative costs to both the health plans and practitioners, and because it is impossible to know where state and national Health Care Reform will land, the group agrees it would not be prudent or financially responsible to mandate alignment reform at present. **Therefore, the workgroup recommends delaying the effective date of 18 VSA § 9418a(b) for another year (until July 1, 2012),** to allow for more time to incorporate the changes that are forthcoming as a result of Health Care Reform, and to continue its productive discussion with the goal of designing an alternative. The workgroup will not be making any specific recommendations at this time, nor is it mandating any specific edit standards.

During 2011, the committee will continue to evaluate the top ten claims denial reasons in light of the hospital and practitioner recommendations, and identify changes that can be made by the health plans in the near term that will have a lasting effect for practitioners (and will not conflict with the new Health Care Reform guidelines). In order to allow for candid sharing and use of this information, **we strongly urge the legislature to pass a state action exemption from antitrust law** that would authorize the workgroup to continue work under BISHCA supervision.

In the meantime, the committee will continue to monitor the impact of ACA on edit standards, decisions made by Medicare and Medicaid on their adoption of new standards, and the progress of the Colorado Taskforce. The committee will also work on coordinating efforts with the Health Care Reform Commission and the Payment Reform workgroup. Lastly, insurers will re-evaluate their websites to make it easier for practitioners to locate and access information needed to facilitate claims submission and reconciliation.

CONTRACT STANDARDS WORKGROUP

REVISED MINUTES

JULY 12, 2011

9-11 AM BCBSVT CONFERENCE ROOM

Meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Andrew Garland BCBS, Kelly Smith BCBS, Gerhild Bjornson CIGNA, Jeanne Kennedy CIGNA, Derek Reynes FAHC, Madeleine Mongan VMS, Steve Maier DVHA, Catherine West DVHA, and Mary Andes DVHA.

By phone: Juanita Mallory PCHP, David Martini BISHCA, Kathy Hockmuth CIGNA, Lauren Parker MBA, Gretchen Begnoche VMC, Martita Giard VMC, Lucie Garand Downs Rachlin, Brenda David Magellan, and Becky Rosen Magellan..

Welcome and introductions were made. Minutes of the January 3rd meeting were approved.

Lou briefly reviewed the charge of the group and progress to date for any newcomers to the group. She then asked David Martini of BISHCA if there was any response and guidance on the issue of state action immunity, in response to Susan's several requests to Cliff Peterson, General Counsel of BISHCA. David said he had not had time to talk with Cliff, but would do so in the next few days. Steve Maier suggested that Susan, Kelly and Madeleine put together a proposal to Cliff, and they agreed. The group agreed it could not continue its work until this immunity structure was in place, since the remaining work of the group is the analysis of the Chapman report in light of the "wish list". The group reaffirmed its intent to proceed in this manner, and make recommendations in January to the legislature re: language changes to existing law.

Steve then gave an explanation of the payment reform pilots as they are designed to date. One pilot must be up and running by January 2012, and two more by July 2012. The ultimate goal is to manage expenses in a capitated environment, but they will not try to do that all at once. They will focus on building reforms in the Blueprint and extend to specialists. The plan is to have three measures with a modifier. The three measures would be reduction in the utilization of avoidable acute care services, quality measures and patient satisfaction. This score would then be modified by an assessment factor of total costs of care. The program would cover patients with certain chronic conditions (either one or two minimum) and would apply to primary care providers as well as designated specialists. Each provider involved would get an enhanced pmpm payment, including specialists. This enhanced pmpm would be on top of the Blueprint payments to primary care providers. The expectation is that as the program evolves, fee for service payments would decrease and the pmpm would increase.

Susan asked how this interfaces with the work of the group. Lou said that the payment reform focus is on prospective payments and that as claims decrease, there would be fewer claims bumping up against an insurer's edit standards. This may lessen the importance of the language the group eventually arrives at and may help refocus what the group's end product is. However,

even as payment reform matures and fee for service claims decrease, claims for services rendered will still have to be submitted to populate VHCURES.

The discussion then turned to what changes to its edit software Medicaid might be making. Mary Andes said they are doing two specific standards to conform to NCCI requirements: 1) MUE unit limitations, and 2) code pairs identification. The deadline was originally this July but they are renegotiating to January of 2012. Mary will check with her team to see if additional changes are being made, since the group felt it is important to know what Medicaid is doing. They asked for a copy of the CMS letter.

Kelly then provided an update on the progress of the Colorado workgroup. She has been listening in to their webcast meetings and has provided them with information on what we are doing (they are very interested in our work). They are working to identify basic edits that every payer must use. Any differences or deviations must be approved by their board. They determined that the NCCI edits are not acceptable, and are looking at the top ten edits in terms of greatest dollar effect. They are also looking at MUEs. The Colorado payers are evaluating whether they can do this. Kelly will email Susan the list of participants so we can see which payers are involved (and measure their applicability to those in Vermont). The general sense is that we can use their data but since the payer mix is so different, it may not apply that much to us. They have a legislative report due in January which should contain the base edits.

The discussion then turned to the Chapman report and how to proceed. Pending BISHCA creation of the required state action antitrust immunity, the group decided to have a sub-group do analysis and a summary of the results of the report, i.e., where the greatest differences are among the payers in light of the "wish list". The sub-group will analyze the larger report, identify the inconsistencies by payer, compare to the "wish list" and identify consistency opportunities. The sub-group will make a set of recommendations that payers could use to ease the burden on providers. Members of the sub-group will be the 4 payers (BCBS, CIGNA, MVP and Medicaid), and Lauren (or designee) and Derek (or designee). They will meet Tuesday July 26th and August 9th from 8-10am at MVP's offices in Williston, and report back to the full group by email by September 1. This will give the payers time to evaluate internally whether they can make the proposed changes in time for a report in January to the legislature, and creation of proposed legislative language. All acknowledged this is an aggressive schedule and we need to get the BISHCA antitrust issue settled immediately in order for this to work.

The group then set the meeting schedule for the rest of 2011. All meetings are from 9-11am but the locations will change.

August 16th at BCBS

September 13th BISHCA

October 4th at BCBS

November 8th at BISHCA

December 6th at BCBS

Call in number: 1-866-221-9369, code 1743144#

Susan will send the group Steve's power point presentation on the payment reform pilots, the Washington State information from Madeleine, and will send the sub-group the full Chapman report. She will also send DVHA the CMS letter re: the required NCCI changes.

CONTRACT STANDARDS WORKGROUP

MINUTES

AUGUST 16, 2011

9-11am BCBS CONFERENCE ROOM

This workgroup meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Kelly Smith BCBS, Pam Biron BCBS, Gerhild Bjornson CIGNA, David Martini BISHCA, Jeanne Kennedy CIGNA, Madeleine Mongan VMS, Richard Slusky DVHA, Linda Cohen, Dinse, Knapp and McAndrew, Mike DelTrecco VAHHS.

By phone: Lou McLaren MVP, Kathy Hockmuth CIGNA, Gretchen Begnoche VMC, Juanita Mallory PCHP, Brian Danaher Magellan, Becky Rosheim Magellan, Brenda Hornbuckle Davis Magellan, Abe Berman FAHC, Martita Giard VMC, Toni Mazzariello PHIN, and Lauren Parker MBA.

The minutes of the July 12th meeting were reviewed and approved with one change from Richard Slusky.

Susan then reviewed the results of the subgroup meeting on August 9th. The meeting was primarily devoted to Cliff Peterson, BISHCA general counsel, reviewing the parameters of the state action antitrust immunity as reported in the minutes of that sub-workgroup meeting.

Lou pointed out the dollar amounts in the Chapman reports are provider charges, not payer amounts. Madeleine noted that the dollar amounts are helpful to determine the top charges and to scale the problem.

Kelly said that we should be letting the wider provider community know what we are doing so they can buy in at an early time. Madeleine noted the wide range of groups that are included on the master email list. Susan will do an email to the workgroup listing the provider groups and associations, which the group may expand.

Richard asked how the workgroup will eventually reach agreement – majority vote, consensus? Kelly said ultimately it will be what the insurers can realistically implement.

Gretchen updated the workgroup on the progress of updating the “wish list”. She said they talked August 15th and will not be ready to produce the updated list by August 24th. They will aim for September 6th. Based on that, the workgroup decided on the following meeting schedule.

The regular full workgroup meeting for September 6th is cancelled.

The sub-workgroup will meet from 8-10am at MVP in Williston:

September 13th

September 20th

October 18th (if necessary)

The workgroup will decide whether to meet in October depending on the progress of the sub-workgroup.

Kelly then updated the workgroup on what has been happening in Colorado. They are attempting to create their own claims system and create a company to operate it. In the process they are creating their own CPTs. They are using NCCI as a basis subject to their own changes. An update is due on the plan January 1, 2012. Kelly will give the updated "wish list" to the Colorado group for their comments. Kelly will send Susan the Colorado participant list who will then send to the entire workgroup.

Meeting schedule for full workgroup:

September 6th meeting **CANCELLED**

October 4th BCBS **TENTATIVE**

November 8th BISHCA

December 6th BCBS

CALL IN NUMBER:

1-866-221-9369, code 1743144#

CONTRACT STANDARDS WORKGROUP

MINUTES

NOVEMBER 8, 2011

9-11am BCBS CONFERENCE ROOM

This workgroup meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Kelly Champney BCBS, Pam Biron BCBS, Andrew Garland BCBS, David Martini BISHCA, Jeanne Kennedy CIGNA, Madeleine Mongan VMS, Mike DelTrecco VAHHS, Anthony Otis, John Asselin PCHP, Juanita Mallory PCHP, Catherine West DVHA, Lauren Parker MBA.

By phone: Kathy Hockmuth CIGNA, Gretchen Begnoche VMC, Brian Danaher Magellan, Becky Rosheim Magellan, Brenda Hornbuckle Davis Magellan, Martita Giard VMC.

The minutes of the August 16th meeting were reviewed and approved.

Lou gave an overview of the work of the sub-workgroup, which met 7 times between August 9th and November 1st. The sub-workgroup used Medicare and Medicaid as the baseline position, because their edits are publicly available. DVHA provided information on how their edits work. The options the sub-workgroup considered were 1) to bring the 3 commercial carriers' edits into alignment with Medicaid; or 2) bring the 3 commercial carriers into alignment amongst themselves, but not with Medicaid.

Madeleine noted that the statutory goal was to bring all payers into alignment, not just the big 3 commercial carriers. She noted Washington state is working on this issue and spent 7 years developing a single port of entry for edits, prior authorization and credentialing.

Kelly noted that she is doing a summary of Colorado and Washington projects. Washington is infomatics, not edit standards. Colorado is not discussing out of state payers; they may look to sell their product to other states to cover their costs of developing their standards.

Catherine said that DVHA got exceptions and waivers from adopting Medicare edit standards. Andrew noted that Medicare payment methodology is different from commercial carriers and their edits do not work for commercial payers.

Madeleine and Lauren asked for a list of Medicaid exceptions.

Lauren said she wants the commercial payers to all use Medicare for the wish list items. She said no one is asking to reform the entire process, but even for those codes that the commercial payers say they are handling the same, providers are still finding problems. This is what is leading to the provider frustration. Juanita echoed the concern. Andrew said he is willing to look at specific examples to see where the problem is.

Lou suggested that the sub-workgroup continue with the expanded wish list, including Juanita's codes, and that the 4 payers complete Lauren's Medicare document. Martita asked what will be

in the legislative report, will it be a request for an extension or an outline of progress to date? Lou suggested creating a deliverable product by first quarter 2012, to be effective third quarter 2012.

The following plan was proposed and agreed to. The sub-workgroup will put the expanded wish list in the format of Lauren's Medicare sheet. The sub-workgroup and workgroup will continue into first quarter 2012, and the results will be operationalized third quarter 2012. In the future, the workgroup will continue to work if new problems arise, a "kind of on-call" arrangement. Thresholds for reconvening the workgroup would be determined. Finally the workgroup will revise the wish list to exclude out of state issues, such as nurse practitioners and physician assistants.

The discussion then turned to the language in 18 VSA 9418a – the "no more restrictive than" language. Madeleine wanted a policy statement in the report that the workgroup is committed to continuing to work realistically toward a single set of edits. Lou said the commercial carriers are all using McKesson, but not the same claims platform. She asked what the intent was of the language in the statute – was it to ensure that the carriers are adhering to national standards and not home grown standards. If that was the intent, then all payers are meeting that standard.

After much discussion the workgroup agreed it could not make decision today on how to proceed or what the report should look like. The workgroup did agree to:

1. Get suggestions to Susan by November 21st;
2. Pam's table is the work product, which will be expanded and completed;
3. Sub-workgroup will meet November 15th 8-10am at MVP in Williston;
4. Susan will get a draft report out by December 1st.

Next meeting of the workgroup is December 6th at BCBS.

CALL IN NUMBER:

1-866-221-9369, code 1743144#

CONTRACT STANDARDS WORKGROUP

MINUTES

DECEMBER 6, 2011

9:30-11am BCBS CONFERENCE ROOM

This workgroup meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Kelly Pam Biron BCBS, Andrew Garland BCBS, David Martini BISHCA, Jeanne Kennedy CIGNA, Madeleine Mongan VMS, Anthony Otis, and Lauren Parker MBA.

By phone: Kathy Hockmuth CIGNA, Gretchen Begnoche VMC, Brian Danaher Magellan, Brenda Hornbuckle Davis Magellan, Martita Giard VMC, Juanita Mallory PCHP, Mike Barewicz FAHC, Lucie Garrand DRM, Linda Cohen.

The minutes of the November 8th meeting were reviewed and approved with two edits.

Lou gave an overview of the latest work of the sub-workgroup, which met today from 8-9:30am. The sub-workgroup worked its way through the first two pages of the 5 payer grid, to identify where there is consistency and where this is not. The sub-workgroup needs Medicaid to be in the room for these discussions as there were questions about what Medicaid had put in the grid. Lou volunteered to meet with Catherine West to get the needed information. The sub-workgroup will meet again to complete work on the grid, but this meeting will be scheduled around Catherine West's availability.

After some discussion, the workgroup agreed on the following as a way to proceed from here.

1. The sub-workgroup will complete work on the grid, and make the completed grid available to providers. At Lauren's and Martita's suggestion, the insurers will provide education and a set of rules for providers to use to better understand how to bill for the codes covered in the grid. The education will include an explanation of how much work this workgroup has put into this effort over the last 3 years, and the fact that it will be an on-going effort for this additional issues identified as hot buttons for providers.
2. The workgroup will continue to meet twice yearly to review any issues identified by providers as new hot button issues.
3. The workgroup will come up with language to amend 18 VSA 9418a(b) to deal with the issue of the problem with the "not more restrictive than" language that is currently in the statute. The workgroup agreed that if a satisfactory amendment is found, the effective date of July 1, 2012 does not need to be changed.

The proposed amendment that the workgroup agreed to consider is (*new language in yellow*) "(b) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to edit standards that are no more restrictive than **any one of** the following, except as provided in subsection (c) of this section: (1) The CPT, HCPCS, and NCCI; (2) National

specialty society edit standards; or (3) Other appropriate edit standards, guidelines, or conventions approved by the commissioner.

The process from here is:

1. Susan will circulate a draft report reflecting the above by COB this Friday December 9th.
2. Workgroup members will get comments on the report content and/or any suggested amendment language to Susan by December 21st.
3. Susan will synthesize the comments and resend to the workgroup during the week between Christmas and New Year's.
4. The workgroup will hold a conference call to finalize the report the first week of January 2012.

Members:

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**Top CPT Code Denials
1/1/2011 - 7/31/2011**

Procedure Code	Reason	Denials							
		Ins. 1	Ins. 2	Medicare	Ins. 4	Ins. 5	Ins. 6	Ins. 7	Ins. 8
36415	Inclusive		X	X	X	X	X	X	X
36416	Inclusive	X	X	X	X	X	X	X	X
81002	Inclusive	X		X	X	X	X	X	X
81003	Inclusive	X		X	X	X	X	X	X
99000	Inclusive	X	X	X	X	X	X	X	X
99051	Inclusive	X		X	X	X	X	X	X
99173	Inclusive	X	X	X	X	X	X	X	X
99213	Inclusive	X	X	X	X	X	X	X	X
99214	Inclusive	X	X	X	X	X	X	X	X
G0102	Inclusive	X	X	X	X	X	X	X	X
Q0091	Inclusive	X	X	X	X	X	X	X	X
36415	Non-Covered				X				
36416	Non-Covered				X				
99000	Non-Covered				X				
99051	Non-Covered				X				
99358	Non-Covered			X	X				
99359	Non-Covered			X	X				
99374	Non-Covered			X	X				
99464	Non-Covered			X	X				
Q0091	Non-Covered		X	X	X				

Offices do not bill because the charge will be denied.

The **code additions for review** from Juanita Mallory, Primary Care Health Partners table received 10/04 are **81003, G0102, 99358, 99359, 99374, & 99464** – all other codes were captured on the wish list and/or within the top 10 Incidental or Incidental-Like lists.

x - represents denial typically performed by carrier

Note:

99213 & 99214 billed with a 25 modifier and billed with a well visit are denied inclusive

99173 - billed with office well visit is denied inclusive

36415,36416,81002,81003 billed with an office visit are denied as inclusive

Wish list for Contract Standards

Submitted by Lauren Parker, Martita Giard and Gretchen Begnoche

This group of committee members is associated with physician billing and has elected to survey staff of practices to determine what primary care (Family medicine, Internal medicine, Pediatrics, GYN) practices encounter for issues around the transparency concerns that we have discussed for the past few years.

We have determined that the legislature has elected to focus on primary care this year and this would be a good faith effort to show an attempt to improve transparency and result in it being a little easier for primary care offices to get paid for their services. There is a general complaint that Primary Care Providers are paid too little – pay is determined by revenue, less expenses and filing and refilling claims equates to undue expenses.

This group also attended the AMA presentation of the white paper and ask that the summary of that presentation be made to the whole group. The AMA and their consulting group tracked 3.49 Million claims and determined that each resubmission costs \$48 to the system (both parties) and the overall savings for the 1,000,000 plus claim edits per carrier netted on average \$2.30 per claim.

Madeleine sent the powerpoint around to the group. Lauren Parker has offered to summarize notes from that presentation for discussion at the November meeting. Information gained in that presentation was enlightening and should be considered prior to the final report. The AMA gave the example listed at #8 below as an additional example that they found in Vermont in their study.

We would ask that the carriers create standard protocols on the following scenario's as a test:

- 1) Physical and Problem visit in same day – CPT allows it but rules between carriers are varied on how it is allowed if ever. Scenario's – not allowed at all, allowed sometimes with modifier, allowed always with modifier, appeal with notes under certain circumstances will pay. Nothing standard for the doctors to follow.
- 2) Lab test 80050 vs 80053, 85025, 84443 – Medicare and some commercial insurances require the service to be billed in the unbundled format (3 codes); at least two commercial carriers require it be billed as a bundled service (1 code). This is not just a problem for remembering which is which but is also a problem when there is a secondary payer – the codes on the CMS1500 claim will not be approved, if you print paper claim and fix the claim, the codes don't match the RA which is required for the bill to be paid.
- 3) Delivery of a baby – 2 carriers require that the global delivery CPT code be billed with all antepartum visits to be listed with actual dates – one on each line to add up to # of visits. All others pay the global delivery without listing of antepartum visits.
- 4) Pap, Pelvic and Breast exam – Medicare pays both with E&M visit, Some carriers pay if submitted without E&M visit code, some pay one with E&M visit code, some never pay these HCPCS codes
- 5) Nurse Practitioner/Physician Assistant services – some pay for some services, some don't pay at all. 2 carriers have system updates which always remove specific programming for mid-level

providers and result in the claim being paid as a specialist (with a higher copay). One carrier processes ANP's as out of network.

- 6) Injection code 96372 when billed with E&M service CPT code – some carriers deny as non-covered, even with 25 modifier added. Have to appeal and usually pays.
- 7) Modifier 59 – some pay automatically if this modifier is attached, some suspend and request notes, some require letter explaining why the modifier was used (even if the notes described why the modifier was added).
- 8) When billing 36415 with 80061 – sometimes they are paid separately, sometimes they are bundled into the 80061 (36415 adjusted as inclusive), sometimes it can be paid with modifier 90 – sent to a reference lab.