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 .

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

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

[4] AMA 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 Initiative[6], 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 country[7].

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

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[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/bluecross.html; text of settlement: http://www.hmosettlements.com/settlements/bluecross/Thomas%20-%20Amended%20Settlement%20Agreement%20_Joinder%20of%20IBC_.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 regulations[9] 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) wed-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.hmosettlements.com/settlements/bluecross/Thomas%20-%20Amended%20Settlement%20Agreement%20_Joinder%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 July1, 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.

APPENDIX A

CONTRACT STANDARDS WORKGROUP

MINUTES

September 9, 2009

11-1pm, BISHCA Third Floor Conference Room

Meeting convened by MVP Health Care, Lou McLaren and Susan Gretkowski, MacLean, Meehan and Rice

Attendees: Mike DelTrecco VAHHS, Gretchen Begnoche VMC, Jeanne Kennedy CIGNA, Charles Storrow AHIP and BCBSVT, Anthony Otis Vermont Chiropractic Association and Vermont Community Rx Retail Coalition, Madeleine Mongan VMS, Andrew Garland BCBSVT, Brenda Metiviea OVHA, Mary Gover OVHA, Gerhild Bjornson CIGNA, Rebecca Heintz BISHCA, Cassandra LaRae-Perez PCIA.

By phone: Martita Giard VMC, Brian Quigley AHIP, Pam Biron BCBBSVT, Scott Frey BCBSVT, Kathy Hockmuth CIGNA, Brenda Hornbuckle David Magellan, Michelle Heezen CVMC, Jon Asselin PCHP

The meeting began with introductions and a review of the statutory charge.

The discussion then turned to issues with edit standards and with the language in the law as it currently stands.

Mike DelTrecco said that the language does not recognize the evolution of coding standards that may exist in the future.

Pam Biron said that there is a set of NCCI standards for physician services and a separate set for hospital services; the language in the law is not clear as to which is to be addressed to physicians, hospitals or both. Discussions last year focused primarily around physician services. She also said that national specialty society standards vary among societies and can diverge from NCCI and CPI. This could create inherent conflicts with the national standards. Lou McLaren said that concept of national specialty society standards came from MVP. She also said there were inherent tensions in all the different sets of standards and that some providers want to use certain sets and other prefer to use other sets, which all leads to the complexity of this issue,

Martida Giard questioned the use of other standards that would be approved by the Commissioner of BISHCA, and that this could be very open ended. Lou McLaren said this would allow for individual payer standards, and Rebecca Heintz said this would allow for flexibility.

Mike DelTrecco and Pam Biron said that the Common Claims Workgroup considered this issue and could not make a recommendation. They said the Workgroup found that payers claims auditing software systems have a claims edit foundation based on the NCCI claims edits, and these systems can then be supplemented by both the software vendor and payers using different industry edits because NCCI is based on Medicare guidelines. Payers may then add customization to support state mandates and proprietary payer specific medical management, business and policy practices. Therefore, the majority of services (estimate 90%) are adjudicated in a relatively uniform methodology across various payers. However, a subset (estimate 10%) of claims is adjudicated under varying methodologies by payers because they are based on these customized proprietary payer specific rules. It is this subset that is problematic for providers.

Madeleine Mongan said that in last year's Contract Standards Workgroup there were two routes identified: 1) transparency, which is the CIGNA model; and 2) national standards.

Andrew Garland expressed concern about the responsibility of the payer as to whether they would be in compliance with "slippery" standards (because there could be a disagreement with a provider about national codes vs. specialty society codes, and that there could be ways of editing that would be considered not in compliance depending on which sets of codes were used). He also said that NCCI standards were a problem because they are designed to work with Medicare reimbursement policies and commercial payers do not use those reimbursement policies (they do not group services in the same way). The key he said is to also have a set of billing standards for providers, so that the two sides work together and the billing and editing standards go hand in hand. He also raised the issue of system change costs to accommodate a change in standards. Finally, he asked which is the purpose in doing all this – is it to create a better delivery system?

Andrew continued on to give the example of anesthesia for births – providers can find 6-7 different ways of billing, resulting in wide variations in reimbursement. ASA standards alone have 4 different ways of billing. Susan Gretkowski asked if there were any settlements or other state laws that address billing standards, and the group was not aware of any.

Mike DelTrecco wanted transparency. Gretchen Begnoche wanted an even playing field. Lou McLaren said that the law as written requires website edits, not transparency. Brian Quigley said that edit standards and transparency are two different issues. Jon Asselin complained of the administrative burden to process claims on the provider end because he never knows what will happen with the payer. Susan Gretkowski asked how often this happens in a primary care practice, given the limited number of codes used. Jon Asselin said he could not quantify that. Madeleine Mongan said the AMA is working on this and will share a white paper.

The group then tried to synthesize the issues:

1. How will self-insured plans be covered by this?

2. Do comparison of the legislatively identified edit standards – how different are they? Is one set of codes less restrictive than others?

Action: The group agreed to identify 3 procedures to review and see how each payer handles. Andrew Garland and Pam Biron were going to identify the 3 procedures and send to MVP and CIGNA, and Jon Asselin would identify 3 different procedures from the provider perspective.

At the next meeting the full group would go through each payers' evaluations of the procedures and Jon Asselin's results. BCBS will send around their 3 procedures before the next meeting.

Andrew Garland reiterated that the payers need help to get the providers to adhere to billing standards because the law as written allows providers to request BISHCA to censure payers, yet payers would have to pursue a contract action against providers to get them to adhere to standards. All of the onus is on the payer and none is on the provider.

Mike DelTrecco wants to identify the sources for hospitals, DRG groupers and revenue codes.

The meeting concluded with plans for the remaining meetings. Susan Gretkowski will coordinate BICHCA conference room availability and the group discussed preferred meeting dates and times.

CONTRACT STANDARDS WORKGROUP

MINUTES

November 10, 2009

9-11am, BISHCA Third Floor Conference Room

Meeting convened by MVP Health Care, Lou McLaren and Susan Gretkowski, MacLean, Meehan and Rice

Attendees: Jeanne Kennedy CIGNA, Chuck Storrow AHIP and BCBSVT, Andrew Garland BCBSVT, Gerhild Bjornson CIGNA, Pam Biron BCBSVT, Lucie Garand Springfield Hospital, Linda Cohen FAHC, Pat Jones BISHCA

By phone: Kathy Hockmuth CIGNA, Michelle Heezen CVMC, Mary Gover OVHA, Jennifer Kingsley MVP, Cassandra LaRae-Perez PCIA, Juanita Mallory PCHP, Mike DelTrecco VAHHS, Tracy Burns MVP

The meeting began with introductions and a review of the agenda.

The discussion then turned to the homework assignments. Pam and Andrew walked through the three billing scenarios they identified to the group. For obstetric anesthesia, they said there were a variety of billing practices used by providers, and some providers use multiple methods for the same services. They questioned how the law can hold payers to edit standards no more restrictive than NCCI when there are no billing standards for providers. Since NCCI standards are based on Medicare, Medicare does not allow providers to bill in varying way for services. Moreover, Medicare billing standards are tied to their reimbursement practices, which are different than commercial payer practices. Their concern is that payers could be in violation of the existing statutory language without doing anything, since standards vary. The law creates a static edit process for fluid billing habits.

The group asked Juanita (in on the call for Jon Asselin) about their experience with Medicare billing. She said she would have to check and get back to the group.

Pam then discussed the antitrust concerns the Common Claims Forms group had addressed. Both Mike and Pam said Herb Olson from BISHCA spoke to them saying there was no antitrust issue since the workgroup was convened by the state. Susan said she would run the activities and structure of this group by Herb to see if he saw any antitrust concerns.

Pam continued on describing what the Common Claims Forms group did vis a vis edit standards. She said they got examples from group practices of edit issues, with the

names of the payers blanked out. The group was unable to come to any consensus and left the issue for this workgroup.

Andrew said the list of edit standards in the law is reasonable, but the problem lies in the language "no more restrictive than". It would seem to mean that an insurer must use the least restrictive standards of all of those listed, otherwise they could be challenged by a provider to be in violation of the law. The law requires adherence to all standards, yet they are conflicting. Therefore, it is easy to be out of compliance at any given time. The discussion then turned to whether transparency would be a better route. They discussed CIGNA's clear claims connection program, whereby a provider could determine how a claim would be edited by going on-line. The group asked the providers whether they used this. Juanita did not know and would check, and Michelle said she did not think CVMC used it. The group asked the providers in the room and on the call to check and see if they used the CIGNA program. The group also wanted to hear from the medical society about the extent to which providers actually used the program.

The group then discussed Jon Asselin's email to the group about his inability to provide examples of edit problems. The group felt it was very important to get examples from the provider side to understand the extent of the problem and asked Juanita to talk with Jon about this, and the payers offered to work with Jon so he is comfortable providing these examples for the next meeting.

Gerhild thought it would be helpful to identify those codes most often in question.

The group then reviewed its "to do" list for the next meeting:

1. Susan will email Jon Asselin with the group's request that he work with the payers to be able to give the group his list of examples;
2. Chuck will provide any information AHIP has on federal health reform efforts on this issue, and Madeleine will be asked for any information on how other states handle this or anything in any settlements;
3. The providers in the group and the medical society will get information on the extent of use of CIGNA's clear claim connection system;
4. Chuck will check with AHIP on whether Medicare has actual billing standards;
5. Susan will contact Herb about antitrust issues;
6. The providers will try to get information about the extent of the issue – is it only 10% of the claims that have issues with edits?

Andrew then brought up a related issue, which is the maintenance and timing of new software upgrades. Clinical criteria and coding standards change more often than software upgrades are done by payers due to the costs associated with upgrading systems. In addition, different versions of software are used by payers at any given time. This creates another layer of complexity.

The group did express concern that there were not many providers on the phone or in the room, and encouraged providers to be part of this process, because their input is so important to the work of the group.

The group ended the meeting by picking meeting dates for 2010. Because of the legislative session the group will meet Monday mornings 9-11am in the BISHCA third floor conference room. The dates are:

January 18th
February 8th
March 8th
April 5th
May 17th
June 21st

There is also a meeting next month – December 8th, 9-11am.

Call in number for all meetings is: 1-866-221-9369, passcode 11743144

CONTRACT STANDARDS WORKGROUP

MINUTES

January 18, 2010

9-11am, MVP Conference Room

Meeting convened by MVP Health Care, Lou McLaren and Susan Gretkowski, MacLean, Meehan and Rice.

Attendees: Mike DelTrecco VAHHS, Lauren Parker MBA Health, Andrew Garland BCBS, Madeleine Mongan VMS

By phone: Jennifer Kingsley MVP, Cassandra LaRae-Perez PCIA, Jeanne Kennedy CIGNA, Brian Quigley AHIP, Brenda Hornbuckle Magellan, Linda Cohen Dinse, Knapp and McAndrew

The meeting began with introductions and a review of the agenda.

Madeleine reviewed the call she had with a group of providers on January 14th to work on the providers' homework assignments. On the call were Lauren Parker, Linda Cohen, Jon Asselin, Joanne Bowdoin, Gretchen Begnoche with Lou McLaren listening in. The group discussed the issues with codes, and expressed concerns that the self-insured employers also had their own sets of codes. The group next discussed how the health reform bills pending at the national level have provisions about coding and edits. Lauren discussed a list of problems with edits and will bring the list to the full meeting on the 18th. Jon suggested the group use the next MGMA meeting in March to poll the group there for examples. The group then discussed the differences in how the insurers handle appeals. The call ended with the providers agreeing to send examples to VMS and FAHC to share with the full group on the 18th. That was the end of Madeleine's report.

The meeting discussion turned to addressing eliminating variability on both sides – both providers and insurers. Lauren said that providers will follow billing standards if they are told how to bill. The insurers were concerned because they are not in the business of telling providers how to bill. This issue needs to be discussed further. Andrew said that administrative costs could be lowered for insurers if there are billing and claims edit standards.

Lauren then produced her document of identified problems, and the group spent the rest of the meeting worked its way through the document. Later that day she emailed the document to Susan who sent it on to the full contract standards workgroup. A copy of that document is appended to these minutes for convenience.

Next steps were discussed based on the content of Lauren's document.

Lou suggested that the group look at ways of providing greater clarity in their processes. Lauren suggested using the VMS communications processes to get clarity information distributed to physicians. Lauren believes that one major issue is the lack of clarity on edits for "inclusive to", meaning edits that deny one claim line as inclusive to another.

The group then returned its discussion to the original charge in the legislation:

1) to propose changes to the current statutory language;
2) standardization of edits;
3) whether plans could provide more information on the editing process.

The group then asked whether providers are using CIGNA's clear claims software? The general sense of the group was that providers are not using it. Lauren said Jon said it is not patient specific and therefore not as practical in regular practice.

Mike then said he would like to convene a meeting among hospitals and report back to the group as to their specific issues. If ready they would make a presentation at the February meeting.

The group the turned its attention to the June 22, 2009 AMA white paper, and specifically the table on page 13. Lou asked if the payers could recreate the table for Vermont. She felt it would identify divergence and perhaps point at a resolution. The group agreed with this approach. Madeleine pointed out the table does not include hospitals and she offered to have the AMA talk to the group.

Next steps:

1. Get FAHC/hospital feedback;
2. MGMA questionnaire and feedback – Lauren and VMS will draft questionnaire which the plans will review and Madeleine was going to follow up with Monique Corcoran about this meeting;
3. AMA white paper table – the plans will populate for Vermont;
4. Payer claims denials report.

For the MGMA questionnaire, the group felt that it should be broken down by payer for submission back to VMS, who would then aggregate for the group – information would not be provided to the group by individual insurer. MGMA would be asked to identify problems with specific examples, and to include Medicare and Medicaid, and identify any issues specific to self-insured groups.

The meeting ended with those in attendance expressing that they felt progress was made. This was due in large part to Lauren providing her document. The group thanked her and asked her to continue to be part of the group.

2010 meeting schedule. Meetings will be held Monday mornings 9-11am in the BISHCA third floor conference room. The dates are:

February 8th
March 8th
April 5th
May 17th
June 21st

Call in number for all meetings is: 1-866-221-9369, passcode 1743144

CONTRACT STANDARDS WORKGROUP

MINUTES

February 8, 2010

9-10am, BISHCA Conference Room

Meeting convened by MVP Health Care, Lou McLaren and Susan Gretkowski, MacLean, Meehan and Rice.

Attendees: Andrew Garland and Pam Biron BCBS, Madeleine Mongan VMS, David Martini BISHCA.

By phone: Jeanne Kennedy CIGNA, Linda Cohen Dinse, Knapp and McAndrew, Mike DelTrecco VAHHS, Joanne Beaudin Otter Creek Associates, Michele Heezen CVMC.

The meeting began with introductions and a review of the agenda.

The first item was the FAHC/hospital feedback. Mike indicated he had an initial conversation with FAHC about them coming to a meeting of this group to talk about their claims edit issues. He will continue to have this discussion with FAHC. Michelle said that CVMC would like to participate as well, and that she would try to have Karen Brown attend the next meeting to talk about their issues with claims edits.

The next item was the MGMA questionnaire. Madeleine said she and Lauren had been unable to get together on developing this, but will do so and will try to circulate a draft copy a week before the next meeting of this group.

The group then turned to the table in the AMA white paper, which the plans were going to populate with Vermont data. Both MVP and BCBS said the request to their internal folks turned out to be a bigger issue than they expected, and that it would take more time to obtain the information. BCBS also stated they are going through a computer conversion which could delay their ability to get the information by the next meeting (3/8/10). The group agreed to ask Mary Gover to get the data from Medicaid, and Jeanne to ask CIGNA to populate it specific to Vermont if possible. All agreed to try to have this information by the next meeting.

Lou then announced that MVP was purchasing the McKesson software for the clear claims connection, the same software program CIGNA has. BCBS stated they were also obtaining this software as part of their systems upgrade. The discussion then turned to whether providers were actually using this tool. There had been some comments made at an earlier meeting that providers did not find the tool useful and were not using it. Michelle said CVMC was not using it. The group asked Jeanne to find out how CIGNA rolled out and promoted the tool – how much provider education was done around it.

Madeleine suggested putting a question on the MGMA questionnaire about whether providers are using the tool.

The next item was the payer claims denial report. The idea was for the plans to identify their top 5 reasons for claims denials. After much discussion it was decided the denials should not encompass those items listed in 18 VSA 9418(j)(1)(A-H). The group asked Medicaid to do this as well. The group asked that a question be added to the MGMA questionnaire about providers' top 5 reasons for claims denials. Madeleine said she would try to get time on the MGMA agenda to talk about the questionnaire and encourage participation.

The next steps are:

1. Mike and Linda will talk about FAHC coming to the next meeting to talk about their claims edit experiences. Michelle will ask Karen Brown to come as well. Lou offered to talk with them ahead of time to specify what the group would like to know.
2. AMA white paper table – the plans and Medicaid will try to have the information for the next meeting.
3. Clear claims connection – Jeanne will ask CIGNA about the rollout and the Vermont experience (do they have the number of Vermont hits), and Michelle will ask Karen to talk about why CVMC does not use it. Also, CIGNA will be asked if they did a demo for providers, and if so, could they do it for this group?
4. The payers and Medicaid will identify the top 5 reasons for denials of claims.
5. Madeleine will finalize the MGMA questionnaire for their March 16th meeting.

2010 meeting schedule. Meetings will be held Monday mornings 9-11am in the BISHCA third floor conference room. The dates are:

March 8th
April 5th
May 17th
June 21st

Call in number for all meetings is: 1-866-221-9369, passcode 1743144

CONTRACT STANDARDS WORKGROUP
MINUTES
MARCH 8, 2010
9-11AM, BISHCA CONFERENCE ROOM

Meeting convened by Lou McLaren, MVP, and Susan Gretkowski, MacLean, Meehan and Rice.

Attendees: Jeanne Kennedy CIGNA, Gretchen Begnoche VMC, David Martini BISHCA, and Madeleine Mongan, VMS.

By phone: Pam Biron BCBS, Andrew Garland BCBS, Lauren Parker MBA Health, Dereck Reynes FAHC, Linda Cohen Dinse, Knapp and McAndrew, Jane Vizvarie, Martita Giard VMC, Juanita Mallory PCHP, Jon Asselin PCHP, Karen Brown CVMC, Lucie Garand DRM, Jo-Ann Beaudin Otter Creek, Kathy Hockmuth CIGNA, Mike DelTrecco VAHHS, Toni Mazzariello SWVMC, Mary Gover OVHA, Brenda Hornbuckle Davis Magellan, Monte Scott CIGNA.

The meeting began with welcome and introductions. The revised minutes were approved.

CIGNA then presented a webinar on its Clear Claims Connection (or 3C) edit tool. Monte Scott of CIGNA's clinical policy unit led the presentation. The tool is for clinical code editing and was implemented in November 2006. It is on a McKesson host platform. He demonstrated several examples of how the program works. No personal health information is utilized. The program will show what procedures will be allowed and disallowed, and the reasons therefore. There is also a separate Cigna application that allows a provider to check for eligibility, including how much of a patient's deductible has been met. It was noted that these programs are for professional claims onlyThe foundation of the tool is NCCI with CIGNA's internal customization. CIGNA's customized edits are outlined on Cigna's web site and built into the tool. CIGNA also has an online section on modifier policies, which basically follow CMS. The online documents shows where CIGNA deviates from CMS. Monte noted that most customizations are to allow payment for services, not to disallow.

VMS asked if a provider practice could upload software with all these edits, and Monte said no. The Cigna application does have a section that will give a real time estimate of patient liability that is patient and benefit specific. 3C is not patient specific. Monte also noted that these programs may not apply to ASO accounts that could have only NCCI edits with no customization.

It was noted that practice management software is available from CMS that contains the NCCI edits that can be uploaded to a practice's system. McKesson edits go beyond NCCI and use some specialty society edits that create a broader platform.

Lou said the key issue is the language in the current law that says the edits must be "no more restrictive" than those listed in the statute. So if an insurer uses 3C and a claim denies and the provider appeals, the provider could appeal using a different source of edits and the insurer could be in violation of the law. This issue needs to be addressed, since it shows it does not matter what tool an insurer uses – they could always be in violation of the law.

The group then turned to a discussion of the experience of providers using the 3C tool. Dereck said FAHC uses it and finds it helpful. Gretchen said FAHC uses it on the back end after a claim is denied. PCHP said they were also using on a back end basis after a claim is denied, and was not sure if their practices use it on the front end. SWVMC also uses it on the back end and said it was a big help. CVMC did not know it existed but would be using in on the back end. Using the tool on the back end allows offices to see what edits affected the claims payments.

CIGNA was then asked what the roll out was in 2006. Training schedules were disseminated along with follow up emails and provider newsletters. There was a request to post on the 3C website where providers could go to get training on an on-going basis. CIGNA will also look into how it informs new providers of this tool. CIGNA said Kevin Ciechon was the CIGNA rep to contact.

The discussion then turned to the rest of the agenda. Madeleine gave an update on preparations for the MGMA meeting on March 16th. She and Lauren met and are drafting the questionnaire and will get a copy to the group before the 3/16 meeting. VMS will ask MGMA to send the questionnaire to practice managers and will send to their own list as well. VAHHS will send to their practice managers.

AMA white paper chart: all insurers and OVHA said it was much more difficult getting the data to populate the chart than anyone realized. It is questionable whether they will be able to finalize the chart.

Top 5 reasons for claims denials: the group discussed whether this should be the top 5 clinical edits instead. Madeleine will add this question to the MGMA questionnaire.
FAHC experiences: Dereck will ask Angela about their claims edit experiences.
Lou ended the meeting by saying that much legwork and information gathering has been done and suggested it is now time to turn to the charge of the committee, which is how the current law needs to be revised. That will be the focus of the remaining meetings.
The meeting ended.

2010 meeting schedule. Meetings will be held Monday mornings 9-11am in the BISHCA third floor conference room. The dates are:
April 5th
May 17th
June 21st

Call in number for all meetings is: 1-866-221-9369, passcode 1743144

CONTRACT STANDARDS WORKGROUP
MINUTES
April 5, 2010
9-11am BISHCA Conference Room

Meeting convened by Lou McLaren, MVP and Susan Gretkowski, MacLean, Meehan and Rice.

Present: Pam Biron BCBS, David Martini BISHCA, Jeanne Kennedy CIGNA, Madeleine Mongan VMS, Gerhild Bjornson CIGNA, Andrew Garland BCBS.

By phone: Juanita Mallory PCHP, Derek Raynes FAHC, Angela Wells FAHC, Lauren Parker MBA, Karen Brown CVMC, Mary Gover OVHA, Martita Giard VMC, Kathy Hockmuth CIGNA, Jo-Ann Beaudin Matrix, Monte Scott CIGNA.

The meeting began with welcome and introductions. The minutes of the March meeting were reviewed and changes made. One change suggested by Linda Cohen was not accepted as the group did not think it accurately represented the situation. Susan will make the changes and send out the revised minutes. The minutes were not voted on.

Angela Wells from FAHC talked about their use of CIGNA's 3C. She said they use it on the back end of claims. They also have front end NCCI software, which does not include individual insurer proprietary edits. She said nationally recognized sources, such as CPT, ICD9, are built in. They have added patient demographic information and FAHC customizations. They use Ingenix Claims Manager. CVH uses a 3M product. MBA uses a product through Allscripts. PCHP uses a product but did not know the name. No one had used the new BCBS edit tool, which went live March 6th. Pam Biron said there are communications/notices posted about the ClaimCheck upgrade and there is a link to 3C on the BCBSVT secure provider portal.

AMA chart update: MVP reported they got edits from McKesson and completed the table. There is still confusion about claims edits and clinical edits. The AMA chart mixes the two. Lou asked for recommendations on how to present useful information. The statutory language talks about only clinical edits. Madeleine suggested having an AMA person on a call for the next meeting to explain how they put chart together. Martita said that providers lump both into one bucket and are concerned with whatever kicks claims out as non-reimbursable. Angela agreed. Lauren suggested tracking denials by category and told MGMA to only respond to clinical denials in the survey.

The group then turned to the top insurer denials. MVP and BCBS said their top denials were primarily administrative. The top edit was clinical – "procedure incidental to" another procedure. Lauren said clinical denials were defined in their system and that individual payer administrative denials were the issue. Kathy Hockmuth said administrative denials are less than 1% of claims, and asked for data from providers to show what the issues are. Andrew asked if the issue is custom edits. Kathy reiterated that less than 1% of denials for administrative, which seems disproportionate to

provider's response. Lauren asked for more specific information on administrative edits – actual numbers. Kathy said all payers use the same edits 95% of the time. Madeleine said while the percent may be small, the total number of claims may be high.

MGMA questionnaire: Lauren and Madeleine went to the March meeting, distributed the draft survey and asked for comments. They did not receive any at the meeting. Of the 75 attendees, one knew of CIGNA's 3C program. The group then walked through the draft survey and considered edits, including the written comments provided by CIGNA. The process going forward will be as follows. Madeleine and Lou will redo the survey and resend to the group, and the group will have a call April 12th at noon to finalize the survey. Then, distribution will be through the MGMA list, VMS list of practice managers, a link will be posted on the VMA website, a link will be posted on the VMC website and a notice in their newsletter, a link will be posted on the BCBSVT website, and OVHA said they would post a notice on the remittance advice and banner on website.

Statutory language: the question was raised whether the issue of edits be addressed in the federal health care reform legislation. It is unclear at this time and the group will check with AHIP and AMA. Andrew suggested the group turn its attention to drafting new language. The group will use the next month to think about new language and will discuss at the next meeting,

Agenda items for next meeting:

1. AMA chart and update;
2. Madeleine will send out a link to BCBS settlement edit standards and those from other states;
3. Schedule September through December meeting date and time, and address whether to have sub-workgroups meet over the summer;
4. Get to fundamental issue.

2010 Meeting Schedule:
May 17th
June 21st

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

CONTRACT STANDARDS WORKGROUP
MINUTES
May 17, 2010
9-11am BISHCA Conference Room

Meeting convened by Lou McLaren, MVP and Susan Gretkowski, MacLean, Meehan and Rice.

Present: Julia McDaniels VCA, David Martini BISHCA, Jeanne Kennedy CIGNA, Madeleine Mongan VMS, Gerhild Bjornson CIGNA, Andrew Garland BCBS, Gretchen Begnoche VMC, Lauren Parker MBA.

By phone: Juanita Mallory PCHP, Derek Raynes FAHC, Mary Gover OVHA, Linda Cohen FAHC, Mike Del Trecco VAHHS, Brenda Hornbuckle Davis Magellan.

Welcome and introductions were made. Revised minutes of the March meeting were approved with one change to the name of Cigna's Kevin Ciechon. Minutes of the April meeting, as revised by Pam Biron, were approved, pending one clarification from CIGNA (to be reviewed by the group).

MGMA questionnaire report: Madeleine and Lauren walked the group through the summary of surveys received to date. A copy of the survey summary is attached to these minutes. Payer specific comments will be provided to each payer, and for questions that asked for information by payers, that would be reported to the group as payer A, B and C. Some of the notable results were that the top response categories were chiropractors, family practice and pediatricians who combined accounted for almost 50% of the responders. There was a noticeable drop off in number of responders after question 9. The group surmised that practitioners were the ones who responded to the survey and their knowledge of the questions asked after #9 was much less, and that accounted for the drop off in number of responders. The group also noted the responded to question #22 – the question that asked if the practitioners used the payer's website on clinical edits, which they are required to have by law. The majority of responders indicated they never used these websites.

The group then turned the discussion to hospital surveys and Lauren agreed to work with Mike DelTrecco. Andrew said BCBS sees great variation among hospitals in how they code. Lauren recommended T.R. Reid's book " The Healing of America" as a way of understanding this complexity. Mike, Andrew and Derek will work on tweaking the survey for hospitals. The hospital survey would be sent to office staff and not practitioners, and will include a request that if the practice filed the original survey that they not complete the hospital one. Madeleine said she will work with the hospital sub-group and report back at the June meeting.

AMA Chart: Madeleine will set up a webinar with the AMA on how they created the chart to shed light on the administrative versus clinical claims edit issue. The AMA is also doing a national insurer report card. The only Vermont payers included will be

CIGNA and Medicare. Lou, Madeleine and Lauren will form a sub-group to work on the AMA chart clarification and the national insurer report card.

BCBS settlement language: the discussion turned to what to the with the existing Vermont statutory language re: edits. Lou suggested the group not start with the existing language but focus on what we want to accomplish. It seems the base issue is that the majority of edits are administrative not clinical, and the existing statutory language addresses clinical edits. Lou pointed out that the edits used by payers are already posted on the website. Lou asked the other payers to compile data on what percent of denials are due to administrative versus clinical edits. Madeleine said that VITL and IBM are working on a smart card and questioned whether this could be used to help with this situation. Mary Gover said that billers need to flex the codes based on documentation they receive from practitioners and that payers could implement a base for billing codes as a start. She also noted that changes will be coming at the federal level, but no one is sure to what degree these will influence this process. Medicaid edits vary by state.

Returning to the issue of Vermont statutory language, Lou said it needs to reflect what is happening in Vermont. The reality is that there are 2 Vermont-only payers, 1 3-state payer and one national payer doing business in Vermont. Andrew suggested the group read through (c) on page 53 of the BCBS settlement agreement and use that to determine principles. BCBSVT agreed to abide by the terms of this settlement, even though they were not a party. As a result of this and the other national settlement, edit practices changed on a national level. National software vendors rebuilt software to accommodate settlement provisions, so that he thinks payers are now in compliance with the settlement terms. He asked practitioners to give examples of how different payers use edits for the same claim to determine just how different they are. And, he asked for information on what happens on appeals by the different payers. He said BCBS does not overturn appeals often – but a number of practitioners disagreed.

Next steps:

1. Payers to send out denial reasons as percent of all claims;
2. The AMA sub-group will talk with AMA and prepare to have them present at the next meeting;
3. Payers will collect information regarding claims appeals;
4. David Martini of BISHCA will get a legal opinion on the proprietary policies of the various payers, and whether and what can be discussed by the group.

Future meeting schedule: now that the legislative session has adjourned, the group agreed to meet the 3rd Tuesdays from 9-11am at BCBS. So the meeting schedule will be as follows:
June 15th
July 20th
August 17th
September 21st

October 19th
November 16th
December 21st

Call in number: will be the same number we have been using: 1-866-221-9360 code 1743144#

CONTRACT STANDARDS WORKGROUP
MINUTES
June 15, 2010
9-11am BCBSVT Conference Room

Meeting convened by Lou McLaren, MVP and Susan Gretkowski, MacLean, Meehan and Rice.

Present: Jeanne Kennedy CIGNA, Madeleine Mongan VMS, Gerhild Bjornson CIGNA, Andrew Garland BCBS, Marissa Urban BCBS, Pam Biron BCBS, Linda Cohen FAHC, Kelly Smith BCBS, Mike DelTrecco VAHHS, Derek Reynes FAHC.

By phone: Julia McDaniels VCA, Mary Gover OVHA, David Martini BISHCA, Lauren Parker MBA, Toni Mazariello SWVMC.

Welcome and introductions were made. Minutes of the May meeting were approved with Madeleine's edits.

MGMA questionnaire results: Madeleine and Lauren sent the three insurers the top five reasons for denials the morning of the meeting. They also have the top five denial reasons for workers compensation carriers, Medicaid and Medicare. The group said to send this information to Susan who will forward it on, and to send workers compensation to John Hollar. Lou asked what we should do with the results.

AMA webinar: the subgroup met and developed a plan. AMA was not able to attend this meeting but Madeleine will work to get them to either one of the next two meetings.

Carrier denials: MVP handed out a claim line denial report with the top 20 denials in volume order. The top 20 reasons account for 80% of the denials. 75% are administrative denials and 25% are clinical. Linda asked Lou to run the dollar values for each category. Lauren noted that one-third are "incidental to" denials and that was significant. Mary said that 20% of Medicaid denials are duplicate billing. Lou said it appears the number one denial is "incidental to" and suggested the group focus on this as it seems to be a recurring theme.

Mary said she ran a report on Medicaid denials and it looks similar to MVPs. "Incidental to" and duplicate billings are the top two reasons. She will rerun for physician claims only and send to the group. Gerhild suggested that the group work on these top two issues and the group agreed it was a good place to focus. Lou asked how to drill down in "incidental to" – is it common to any certain specialties or across the board? Kathy said CIGNA's report showed the number one reason was duplicate (25% of denials) and the second was "incidental to". Julia asked if with respect to duplicates whether it was a clearinghouse issue? Lou suggested drilling down to see if it was paper or electronic. Madeleine asked if the 24 hour acknowledgement helped with duplicates? The group said no. Lauren said they call every two weeks on aging claims and resend if the claim is not on file. She said some clearinghouses automatically rebill if the claim is not paid in

30 days. Madeleine said duplicates are more of an education issue – not transparency or edit standard issue.

Andrew suggested the three insurers drill down on their data on duplicates and look at how to educate providers. Lou suggested the insurers drill down on duplicates and "incidental to", especially in paper vs. electronic claims. Derek said "incidental to" is the real reason the workgroup is meeting.

Pam then handed out BCBS's completion of the AMA chart, and walked the group through it. The top clinical denial was "incidental to".

BISHCA legal advisory opinion on antitrust issues: David had been asked to talk with Herb Olson about an advisory opinion on where the group should draw the lines in these discussions. David said they did not have an opinion yet, but he will follow up with Herb and send an opinion to Susan to forward to the group. The group asked for guidance on whether a state action exemption exists, and the boundaries that should be observed. Susan volunteered to do an email to David about what the group was looking for. The group also agreed to have their own legal counsel review Herb's opinion.

The group agreed to hold on items #7 and 8 on the agenda.

Colorado law: Madeleine had forwarded to the group a law passed in Colorado. It applied to professional services only. Mike asked how relevant it was to Vermont since there is a move to ACOs – claims data would still be needed. The consensus seemed to be to let Colorado go first and Vermont would monitor their progress. The group expressed interest in having Chuck Storrow get someone from AHIP to talk about the parts of the new federal health reform law relevant to edit standards, and how detailed it would be.

Madeleine will ask the AMA about ERISA implications if Vermont were to pursue standards.

Next steps:

1. BISHCA legal opinion
2. Insurers will drill down on duplicate and "incidental to" denials, separating out hospital and individual practitioners
3. Madeleine will continue to follow up with AMA re: webinar
4. Madeleine will distribute the MGMA data.

Future meeting schedule: the group agreed to meet the 3rd Tuesdays from 9-11am at BCBS.
August 17th
September 21st
October 19th

November 16th
December 21st

Call in number: will be the same number we have been using: 1-866-221-9360 code 1743144#

CONTRACT STANDARDS WORKGROUP
MINUTES
JULY 20, 2010
9-11AM BCBSVT CONFERENCE ROOM

Meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Madeleine Mongan VMS, Andrew Garland BCBS, Pam Biron BCBS, Kelly Smith BCBS, Jeanne Kennedy CIGNA, Chuck Storrow AHIP, Gerhild Bjornson CIGNA and Marissa Urban BCBS.

By phone: Lou McLaren MVP, Kathy Hockmuth CIGNA, Gretchen Begnoche VMC, Karen Brown CVMC, Linda Cohen FAHC, and Toni Mazariello SWVMC.

Welcome and introductions were made. Minutes of the June meeting were approved with two changes.

MGMA data: the group agreed that it got all the information it could from the questionnaire results, and thanked Madeleine and Lauren for their hard work.

AMA webinar: Madeleine reported that she expects this to happen at the September meeting. Topics would be the 2009 White Paper chart, the AMA report card on insurers, federal reform implications for edit standards, and PPACA.

Hospital survey: Lou will follow up with Mike Del Trecco on the status.

BISHCA antitrust opinion: the sense of the group was this did not provide any real meaningful information, except that state action immunity did not apply to the work of this group. Individual participants will have to rely on their own legal counsel opinions.

Insurer drill down reports: Lou said MVP had completed its drill down report but was waiting for their legal department's approval to distribute. In general what it showed was that for the top 5 denial categories, few specialties and CPT codes were involved. Denials were limited to only a few specialties and codes. These top 5 accounted for 50% of denials. Madeleine said their intern might be able to crunch data from the 3 insurers. Chuck also said AHIP might be able to do this. Pam distributed BCBS's report similar to Lou's from the last meeting. It showed common trends with MVPs. She will do the drill down. CIGNA read their report and will forward to the group. Kathy said duplicates accounted for 39% of denials, inclusive was 26.% and not covered service was 14%. The 3 insurers will complete their drill downs.

The discussion then turned to the rest of the meetings through December. After much discussion of how to proceed the group agreed upon the following to wrap up work for the final report, due January 1, 2011.

The August meeting is cancelled. The 3 insurers and Medicaid will complete their drill down analyses by August 23rd. The 3 insurers, Medicaid, Madeleine and Lauren will have a call with AHIP about the possibility of them doing a summary of this data for presentation to the group at the September meeting (either July 22 or July 28 at 7:30am). If they cannot, the medical society intern might be able to. Lou offered to send a blank template for the insurers to use. The goal would be to identify those edits that are common and cause the majority of the denials, and see if they can be streamlined.

The September meeting will be the AMA webinar, the AHIP analysis of the drill down data, and discussion of an outline of the final report. It will just be an outline of the table of contents, no substance. It would define the size of the task.

The group selected two additional meeting dates, if necessary, to prepare and finalize the report. We are holding October 5 for a meeting for deciding on the recommendations for the report – 9-11am at BCBS. We will decide at the September meeting if we need this date.

The October 19th meeting will be devoted to deciding on the recommendations, and assigning subgroups to work on various sections of the report.

We are holding November 2nd 9-11am at BCBS if we need it for working on the report. The November 16th meeting will be to review and work on the report to get as close to a final draft as possible.

The December 21st meeting will be to finalize the report – it is due January 1.

Future meeting schedule: 9-11am at BCBSVT.
September 21
October 5
October 19
November 2
November 16
December 21
Call in number: 1-866-221-9369, passcode 1743144#

CONTRACT STANDARDS WORKGROUP
MINUTES
SEPTEMBER 21, 2010
9-11AM BCBSVT CONFERENCE ROOM

Meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Julia McDaniel VCA, Kimberly Hess FAHC, Derek Raynes FAHC, Lauren Parker MBA, Anthony Otis, Theo Kennedy, Madeleine Mongan VMS, Andrew Garland BCBS, Pam Biron BCBS, Kelly Smith BCBS, Jeanne Kennedy CIGNA, Gerhild Bjornson CIGNA and Linda Cohen FAHC.

By phone: Kathy Hockmuth CIGNA, Gretchen Begnoche VMC, Karen Brown CVMC, Mike DelTrecco VAHHS, Martita Giard VMC, Bob Rovella CVMC, and Mary Gover DVHA.

Welcome and introductions were made. Minutes of the July meeting were approved with one change.

AMA webinar: Madeleine reported that the AMA had to cancel their presentation for this meeting, but would participate in a call for anyone who could join this Friday from 2-3pm. She will send around the call in information. The group discussed the priority topics for this call, given how late in the process it was. The group agreed to ask the AMA to focus on the ERISA issue, ACA edit standardization and the Colorado law.

Hospital survey: Derek and Mike reported that they have come up with 6-12 questions to supplement the physician survey and the hospital survey is now finalized. The group requested that they send it to their hospital folks now and ask for a response by the October 8th VPAM meeting (Vermont Patient Account Mangers).

Insurer drill down reports: AHIP was not able to do the analysis due to their counsel's antitrust concerns. They did recommend several consultants who might be able to do the analysis. Lou and Susan have been in discussions with several consultants and recommend the group use John Chapman. She will forward his resume and proposal to the group. Mary Gover stated that she was not sure what Medicaid data she could share, so the group agreed to proceed with the three commercial insurers.

Regarding payment for John Chapman's work, Lou reported he estimated $2100 for the job. Originally the three insurers each committed to $500. Derek said FAHC would agree to split the cost four ways. Madeleine stated VMS would kick in $100.

The plan is to finalize the data and determine conclusions at the October 19th meeting. November 2nd would be to discuss recommendations to the legislature.

CMS NCCI Letter: The take away from this letter was that Medicare has edits other than NCCI. The CMS letter acknowledged that NCCI was applicable for Medicare but not completely applicable for Medicaid. It is one module for McKesson and can be turned on or off. BCBS said that as part of their system upgrade, they turned it on 100% and received many complaints from providers. Their medical director determined the edits did not make sense, so they turned them off.

The question turned to what are the differences among the payers, as all use McKesson and all have very few custom edits. Plus providers now have additional tools they did not previously have – access to edit policies for insurers and information on custom edits through 3C. So, the group asked what more could be done. There is recognition that insurers have customized edits and they can't be mandated to all be the same. Even CMS has some customized edits. All in all, there was recognition that providers have more tools now than when the legislation at issue was passed.

The discussion turned to the legislative report. A suggestion was made to help the group reach consensus for the report was to have each member of the group think about what he/she would want to recommend and to get those suggestions to Susan to compile for discussion at the next meeting. A concern was also mentioned that the report needs to have a section on the impact of the APA, and that it is an unknown and that this be taken into consideration before any action is taken.

Next Steps:

1. Group members send Susan suggestions by October 5 as to what they want for legislative recommendations and she will compile
2. Chapman report will be ready by October 19th
3. Hospital survey will be ready by October 19th

Future meeting schedule: 9-11am at BCBSVT:
November 2
November 16
December 21
Call in number: 1-866-221-9369, passcode 1743144#

CONTRACT STANDARDS WORKGROUP
MINUTES
OCTOBER 19, 2010
9-11AM BCBSVT CONFERENCE ROOM

Meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Julia McDaniel VCA, Madeleine Mongan VMS, Andrew Garland BCBS, Pam Biron BCBS, Kelly Smith BCBS, Jeanne Kennedy CIGNA, Gerhild Bjornson CIGNA and Linda Cohen FAHC.

By phone: Kathy Hockmuth CIGNA, Karen Brown CVMC, Mike DelTrecco VAHHS, Bob Rovella CVMC, Lauren Parker MBA, Toni Mazariello SWVMC, Juanita Mallory PCHP, David Martini BISHCA, Heather Shouldice BRS.

Welcome and introductions were made. Minutes of the September meeting were approved.

Hospital survey: Mike reported that the idea of the survey was presented to VPAM at their October 8th meeting and it would go out the week of October 18th. Results would be available at the November 2nd meeting.

Insurer drill down reports: Due to some glitches, Chapman's report is not ready for this meeting. Issues arose about the translation of specialty codes all being different. The insurers each agreed to provide Chapman with crosswalks. The report is expected to be ready for the November 2nd meeting.

Recommendations for the legislative report: The group began this discussion by going through Lauren/Gretchen/Martita's wish list. Lauren said she focused on primary care practices and asked them for their top issues. Lauren asked carriers if they would agree on three items, and the first item on her list is the biggest. Andrew asked if Medicaid has any latitude to change? He made the suggestion that we get a list of Medicaid standards and see how closely the carriers aligned with Medicaid. Lou said she would call Mary Gover to discuss this. Madeleine said that Medicare will shortly have new prevention codes. Linda said that the experience for hospitals is different, that Medicare and Medicaid are distinct. Julia said that from a small provider standpoint, Medicare and Medicaid do not trickle down for specialty providers. How she bills Medicare is completely different than how she bills other insurers. She would not want to use Medicare as the base.

The group then walked through several of Lauren's examples. As for #1, Lauren did not know if Medicaid allows for two visits in the same day. Medicare does not pay for these services now, but will start in 2011. Madeleine suggested seeing if Medicaid and the insurers could align, then see what Medicare is doing in 2011. As for example #3, Medicaid requires CPT for antepartum visits. Lauren does not want to align with Medicaid. Madeleine said the Medicaid is changing to RBRVS in January 2011 and

asked what that might mean to edits. Gerhild said it is not a good time to align with either Medicare or Medicaid because of the coming changes in 2011.

The group then moved on to Madeleine's wish list. She asked whether MVP and CIGNA have implemented the changed mandated by the BCBS settlement process (BCBS said they implemented all the changes). The insurers said they would check into that. With regard to the idea of implementing NCCI across all payers consistent with Medicaid, she said that CMS will tell Medicaid what parts of NCCI are applicable, since not all parts will be. It is also unknown whether Medicaid will make public what parts of NCCI they will be using. Andrew pointed out that BCBS had to take down many NCCI edits because of provider complaints.

The group then turned to the Colorado law and agreed to monitor its progress. A status report was due January 30, 2010. Kelly has been trying to get on their listserve. Chuck will see if AHIP is monitoring and send an email link. (See text of Kelly's two emails at the end of these minutes with more information on this issue).

Lou then suggested that since there are so many moving parts, maybe it makes sense to not propose any changes now in the group's report to the legislature, because they may need to be changed again in 2011. Perhaps the group should propose that the effective date of the edit standard section be moved back from July 1, 2011 to 2012, and the group continue to meet to: 1) monitor the Colorado experience, and 2) monitor the Medicare/Medicaid/federal reform changes. There appeared to be agreement within the group to this approach.

Andrew then talked about his wish list. He thinks BCBS can work with Lauren's list. He also said they the group is not resourced to solve the edit standards issue. The problem is in the language of the statute (that would become effective July 1, 2011) because there is no way the insurers can meet the standard as written. The "no more restrictive than" language is the problem - there is no way of knowing if an insurer is in compliance. There is also an issue with the definition of claims edit – it would mean that every denial is a claims edit.

The group then talked about bringing language changes to the next meeting. And, Madeleine asked CIGNA and MVP to evaluate the BCBS settlement and see how compatible they are with those terms.

Next Steps:

1. Lou will call Mary Gover to ask if Medicaid is following BCBS settlement provisions.
2. Lauren will evaluate what Medicare does vis a vis her wish list.
3. Susan will send out a clean copy of the statute.
4. Folks will complete their wish lists.

5. CIGNA and MVP will evaluate how their processes line up against BCBS settlement provisions.

6. AHIP will monitor Colorado progress.

Future meeting schedule: 9-11am at BCBSVT:
November 2
November 16
December 7 (newly added date)
December 21

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

The following was provided by Kelly in two emails after the meeting. We are reproducing it here for everyone's ease of use. This refers to the Colorado process:
Kelly: Below is the website for the Colorado Department of Health Care Policy and Financing. I am going to delve in to learn more about the Department but the link I have attached will bring you to the "What's New" section of the website which is where you gain access to the application for Medical Clean Claims Task Force. In re-reading this information I realize I misquoted when the report is due to the Legislature—it is January 30, 2010. So they are not behind the 8 ball as I thought. I have reached out to the Department to determine if there would be ay method to keep informed as to the group status. I will let you know about what I hear.

Again, sorry about the incorrect dates. However, doesn't look like we will have their report in any near future but would be potentially something to note in our report.

Kelly
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251579913097

Hello again:

Colorado has been very responsive. I spoke to Barry Keene who is the Co-Chair of the Colorado Clean Claims Task Force. He and I spoke for approximately 40 minutes and it was very informative. He discussed the current status of the task force in that it will be selected in the next two weeks by the Director of Health Policy and Finance. The applicants for the task force include: AMA, Colorado Medical Society, Colorado Hospital Association, Anthem, United, Kaiser, Rocky Mountain Health Care, Aetna, McKesson, Ingenix and Ambulatory/Surgical Centers. The first meeting is tentatively slated for December 2nd.

Mr. Keene was very excited to hear another state is addressing the claims editing issues. He is convinced there needs to be a change and I summarized our work is not necessarily creating a uniform system but is presently analyzing the current status of claims administration and what affect claim edits play into administration costs (I informed him that this was a general summary and would not speak for the group of course).

He has invited me to participate in calls as the task force ramps up.

The December 2nd call may not be a teleconference event but he would summarize their work plan for me following the meeting. He asked to be kept abreast of our Workgroup's efforts and provided with a copy of our report.

One interesting tidbit I gleaned from this conversation was that the Task Force pursuant to the guidance of the legislation will be standardizing claims edits but will exempt claim edits for use in internal utilization/fraud management. Mr. Keene felt strongly that those areas of business practice can benefit by the exception and the healthcare industry as a whole would benefit from such use. I will be looking into the legislation for such exception as that on its face sounds like something our work group may want to consider.

Please let me know if you have any questions.

Kelly

CONTRACT STANDARDS WORKGROUP
MINUTES
NOVEMBER 2, 2010
9-11AM BCBSVT CONFERENCE ROOM

Meeting was convened by Lou McLaren and Heidi Tringe (in for Susan Gretkowski).

Present: Julia McDaniel VCA, Madeleine Mongan VMS, Andrew Garland BCBS, Pam Biron BCBS, Kelly Smith BCBS, Jeanne Kennedy CIGNA, Gerhild Bjornson CIGNA, Chuck Storrow AHIP, and Richard Slusky.

By phone: Kathy Hockmuth CIGNA, Karen Brown CVMC, Mike DelTrecco VAHHS, Lauren Parker MBA, Juanita Mallory PCHP, David Martini BISHCA, Lucie Garand DRM, Kimberly Hess FAHC.

Welcome and introductions were made. Minutes of the October 19th meeting were approved.

Hospital survey: Mike reported that the results of the survey were finalized last night and he emailed a pdf this morning to the group. Mike said he would compile the results in a meaningful way and resend to the group. Twelve hospitals responded to the survey. With regard to question 6, the top 5 reasons for hospital claim edits was a missing modifier. Hospitals failed to put it on UB04. Additionally, not all insurers are accepting revenue code 510 (clinic services). Mike said the overarching theme is that hospitals know allowable coding rules but not always clear how to interpret payer rules and not always consistent. He said if every insurer published a rulebook and billers could interpret it, many of the problems would disappear. Lauren said that Medicare has such a rulebook, but they don't always interpret claims the same way.

Lou asked if hospitals are finding more problems with UB claims or 1500 claims? Mike said it is about equal; Karen agreed. Mike argued for standardization among insurers. Andrew asked why providers can't do the same thing. Standardization has to be on both sides or won't be able to be maintained. Madeleine said people will code to rules if they know what they are. Lauren said she sent out AMA web conference summary out and that there are costs to both sides of the system if claims are denied. Mike said he sent out a survey asking if hospitals did not have to bill third-party payers, how much would they save? He got 7 responses and they said they would save $5 million. Andrew said this needs to be out in context – how much do consumers save because of payer edits? We know that innocent duplicate billing occurs but he thinks the amount saved through edits is well over $5 million. Providers have very different thoughts on how to code – vast range of theoretical and philosophical. Lou said MVP accepts 3 different ways to bill for routine OB care because they come in different ways.

Richard said his role in payment reform is to move away from a fee-for-service system. He asked is it possible for insurers to pool resources to create processing company. If Vermont had one company processing claims providers would have an easier time. Lou

said that through the BCBS settlement agreement and Lauren's wishlist the group might be able to find some compromise. Kelly asked with respect to missing modifiers, how many are associated with Medicare and Medicaid versus the commercial insurers. Karen said some commercial insures require modifiers and some don't. Medicare and Medicaid require them. Mike said the hospital feedback re: Medicare is that the rules are pretty straightforward and that days in AR reflect ease of the billing process.

Top 5 reasons claims modified to meet third-party billing – physicians not yet credentialed. Karen said that some payers require more forms be completed if the physician is part of a PHO. Madeleine said VMS gets calls about credentialing delays. Karen said they are having the same problem. Andrew said the process is highly regulated. Richard said if a physician is credentialed for one payer, should be credentialed for all. Andrew said there are reasons why insurers have a different approach.

Lou then asked about filtering tools. Karen said most hospitals have filtering tools during coding which guide coders along the process, and an additional tool to perform back-end billing edits. She also said that if a CPT code was supposed to have a modifier, their coding edit system may catch that, but that the billing edits would not catch it. Lou then asked if the coder is the person creating the codes that go on the bill. Karen said most CPT codes (for standard outpatient testing) come directly from the hospital chargemaster. Surgical/procedural CPT codes are added by the coders at the hospital. Mike said all of the coding filtering tools are NCCI based. Lou asked if there is a level of customization in these filtering software products. Karen said yes, and that a hospital can chose the level of specificity. Andrew noted this is unlike the insurers, who all use the same software. Lou noted that there is the same set of variation on the front end as there is on the back, meaning variation among providers in how they bill vs how insurers edit. Lou thanked Mike for his work on the survey, and Mike said he will sort the results in a more crisp way. Lucie said Springfield Hospital will have results to Mike later that week.

Insurer data analysis reports: The report has not been distributed to the group for today's meeting due to some concerns expressed about some of the data not being blinded enough. Pam will walk through how the survey was put together. Pam said the insurers gave 3 month span of data for the top 20 denials by category. Lou said we were supposed to get a certain level of detail and we didn't get it. Andrew said we need Chapman to take the data, aggregate it and say that here are examples of edits that you are all doing. The data as currently presented is not yet actionable. The missing link is how to handle differentiation. Andrew said that if the data is done well, there could be some quick wins that could solve 75% of the provider problems. Kelly explained that as to the way the data is now, there are proprietary and antitrust concerns. The group then discussed the range of antitrust issues and whether there was a state action exemption in place. Lou said the intent is to get the report changed and distributed to the group.

Wishlist/BCBS settlement: Jeanne said CIGNA is essentially in compliance with the BCBS settlement provisions but has a question on the last item. Lou said MVP is not

sure how we get around the claims edits issues and antitrust. MVP is not comfortable going forward under the current framework. Kelly said the discussion is not collusion or inherent collusion and that the group could address the wish list with some safeguards. Lou suggested that the legislative report could request that the group be extended and request state action immunity antitrust exemption to further pursue the wishlist items. Julia pointed out the challenges to a small provider understanding any insurer website edits and claims information. Andrew said BCBS was hoping that the 3C tool would have addressed these concerns.

Next Steps:

1. What can we say generally in the report.
2. What do we need legislatively to make wishlist happen.
3. Have insurer report out before next meeting.
4. Lauren will report on AMA web conference.

Future meeting schedule: 9-11am at BCBSVT:
November 16
December 7 (newly added date)
December 21

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

CONTRACT STANDARDS WORKGROUP
MINUTES
NOVEMBER 16, 2010
9-11AM BCBSVT CONFERENCE ROOM

Meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Julia McDaniel VCA, Andrew Garland BCBS, Kelly Smith BCBS, Gerhild Bjornson CIGNA, Chuck Storrow AHIP, and Derek Reynes FAHC, Linda Cohen FAHC, Richard Slusky.

By phone: Martita Giard VMC, Jeanne Kennedy CIGNA, Karen Brown CVMC, Lauren Parker MBA, Juanita Mallory PCHP, David Martini BISHCA and Madeleine Mongan VMS.

Welcome and introductions were made. Minutes of the November 2nd meeting were discussed and changes were made. A corrected copy will be available at the December 7th meeting for approval.

AMA Teleconference call: Lauren walked the group through her write-up of this call. The call primarily consisted of the AMA and their consultants explaining the 3 year study that was done of 43 states, 76 specialties and 7 carriers (only one of which does business in Vermont). The following areas were highlighted. Payment timeliness had improved primarily because of electronic funds transfer. However, improvement was still needed. Claims processing accuracy was 77-88%; Medicare is 96%. Four percent of claims were written off due to edits. The carriers in the study use more than 1 million edits, and average savings per claim due to the edit was $2.30. NCCI edits account for less than half.

Lauren and Lou agreed that the data coming out of the study has questionable applicability to Vermont, since they were all national carriers. Lauren said what she took away from the study was to see where the challenges were generally and to ask if there is a competitive advantage to using edits, since the financial benefit was so small. Richard asked what was Medicare doing that their accuracy was 96%? Derek said they are paying from a single benefit platform and that their sheer size drives their accuracy. Medicare tends to pay up front then come after providers to recoup monies paid in error. Derek went on to say that payment reform will drive cost savings, not top down edits.

Chapman report: A progress report was given. The report that John delivered was not what the payers expected. The insurers will have a call this coming Thursday with him to finalize the deliverable.

Provider wish list: MVP reported it meets the terms of the BCBS settlement with the exception of 2 areas. Concerns were expressed about continuing this discussion, or any details, without antitrust immunity. The conversation then turned toward a discussion of the effect of payment reform on the issue of edit standards. Richard said his charge is to

present a strategy on payment reform to the legislature, and that a pilot must go live January 1, 2012, and two more pilots ready for July 1, 2012. It will be built on a primary care model. What will go back to the insurer is visit information, not claims.

Legislative report: The discussion then turned to the report. Derek suggested not making a recommendation, but recognizing the complexity of the issue and that not a lot will be had from the top down perspective. The effort involved would not align with the reward. Julia asked the insurers to look at and simplify their websites – making them more transparent would be a huge gain.

The group then agreed in principal to the following recommendations:

1. The work of the committee is not done, and we recommend continuing meeting throughout 2011. MVP agrees to continue to chair the committee.
2. The committee is not making any specific recommendations at this time about changes to or mandating any specific edit standards. The reason is there are too many changes coming over the next year with Medicare and Medicaid standards, ACA reform, and movement toward payment reform in Vermont, all of which will have an impact on edit standards used by commercial insurers. Now is not the time to mandate anything specific because it will change within the year.
3. The committee does recommend a) delaying the effective date of 18 VSA 9418a(b) until July 2012, or alternatively b) coming up with replacement language (yet to be determined).
4. The committee will 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 edit standards project. The committee will also work on coordinating efforts with the Payment Reform workgroup.
5. Through 2011 the committee will continue to evaluate the top 10 claims denial reasons in light of the provider "wish lists" and identify what changes can be made to have an immediate impact. Insurers will also re-evaluate their websites to make them easier for providers to use.

Susan said she would get a draft of the report out before the December 7th meeting. A brief discussion was then held about a legislative strategy.

Future meeting schedule: 9-11am at BCBSVT:
December 7 (newly added date)
December 21

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

CONTRACT STANDARDS WORKGROUP
MINUTES
DECEMBER 7, 2010
9-11AM BCBSVT CONFERENCE ROOM

Meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Julia McDaniel VCA, Andrew Garland BCBS, Kelly Smith BCBS, Pam Biron BCBS, Gerhild Bjornson CIGNA, Chuck Storrow AHIP, Derek Reynes FAHC, Jeanne Kennedy CIGNA, Madeleine Mongan VMS.

By phone: Martita Giard VMC, Lauren Parker MBA, Juanita Mallory PCHP, David Martini BISHCA and Linda Cohen FAHC.

Welcome and introductions were made. Minutes of the November 2nd and 16th meetings were approved.

Chapman report: Pam Biron reviewed the Chapman Report. There are eight sections of the report. The first is the claim edit grouping table. There are 5 grouping and each connects to one of the sections of the report. There is one aggregate report for duplicate claim denials. The 5 grouping sections show the top 20 reasons for denials. The first is edit mixed – the left side shows the procedure codes with modifiers and the specialties are across the top. This will show how each specialty is affected. Specialties are sorted by volume on each report. Dollar amounts are provider charges, not plan payment.

Overarching themes: numbers get small quickly so we can address the big items and get results quickly. Lauren will send out code descriptions. Julia talked about duplicates and wants to flesh out the reasons why. 60% of denials are duplicates. BCBS said their research says it is a clearinghouse issue. Julia said their offices receives denials as claims being duplicate when they did not send in duplicate claims. Lauren said their practice is to resend claims within 30 days if the insurer says no claim is on file. The group will take time to digest the report and further discussion will occur at the next meeting.

Legislative report: The draft report was reviewed and edits were made. A revised copy will be circulated before the January meeting for final review.

Future meeting schedule: 9-11am at BCBSVT:
January 3, 2011

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

CONTRACT STANDARDS WORKGROUP
MINUTES
JANUARY 3, 2011
3-5 PM BCBSVT CONFERENCE ROOM

Meeting was convened by Lou McLaren and Susan Gretkowski.

Present: Andrew Garland BCBS, Kelly Smith BCBS, Pam Biron BCBS, Gerhild Bjornson CIGNA, Jeanne Kennedy CIGNA, Derek Reynes FAHC, Madeleine Mongan VMS, Richard Slusky, and Linda Cohen FAHC.

By phone: Julia McDaniel VCA, Chuck Storrow AHIP, Juanita Mallory and Jon Asselin PCHP, David Martini BISHCA.

Welcome and introductions were made. Minutes of the December 7th meeting were approved.

Legislative Plan: The group discussed strategy for getting a corrective bill passed early in this session to implement the recommendations. It was agreed to those in the group who are in the statehouse, as well as Derek and Andrew, would spearhead this effort. The focus will be to get a corrective bill passed very early in the session to postpone the effective date of the current statute and to get state action antitrust immunity.

Legislative report: The revised report was reviewed and edits were made. A revised copy will be circulated tomorrow for final review. The goal is to file the report this week so lobbying can begin asap.

Future meeting schedule: At this time no future meetings are scheduled.

APPENDIX B

Members:

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APPENDIX C

Administrative Simplification:
Standardizing the Claims Process

Sep. 24, 2010

AMA
TOGETHER WE ARE STRONGER

AMA's "Heal the Claims Process"™ Campaign

All have a role

Physicians

Billing Services/Clearinghouses

Payers

Employers

Patients

National Health Insurer Report Card—What Does It Measure?

- Actionable data:
  - Payment timeliness and type
  - Accuracy
  - Claim edit sources and frequency
  - Denials
  - Improvement of claims cycle workflow

National Health Insurer Report Card– Who helped us?

Mark Rieger – CEO, National Healthcare Exchange Services (NHXS)

Frank Cohen – Senior Analyst, Frank Cohen Group, LLC

National Health Insurer Report Card–What data did we use?

Physicians' Electronic Data Interchange (EDI) files (electronic claims and remittance advices)

- Approximately 3.49 million services
- Approximately 2.05 million claims
- February 1, 2010 – March 31, 2010
- 43 states
- 76 specialties
- Over 200 practices

National Health Insurer Report Card– Disclaimer

- Data for this report card was provided by physician groups that have adopted best practices for electronic data interchange and contract compliance.
- NHXS uses information in the standard transaction in ways that are not described within the implementation guide to help improve match rate.
- These results may be better than practices that have not adopted such technologies.

National Health Insurer Report Card

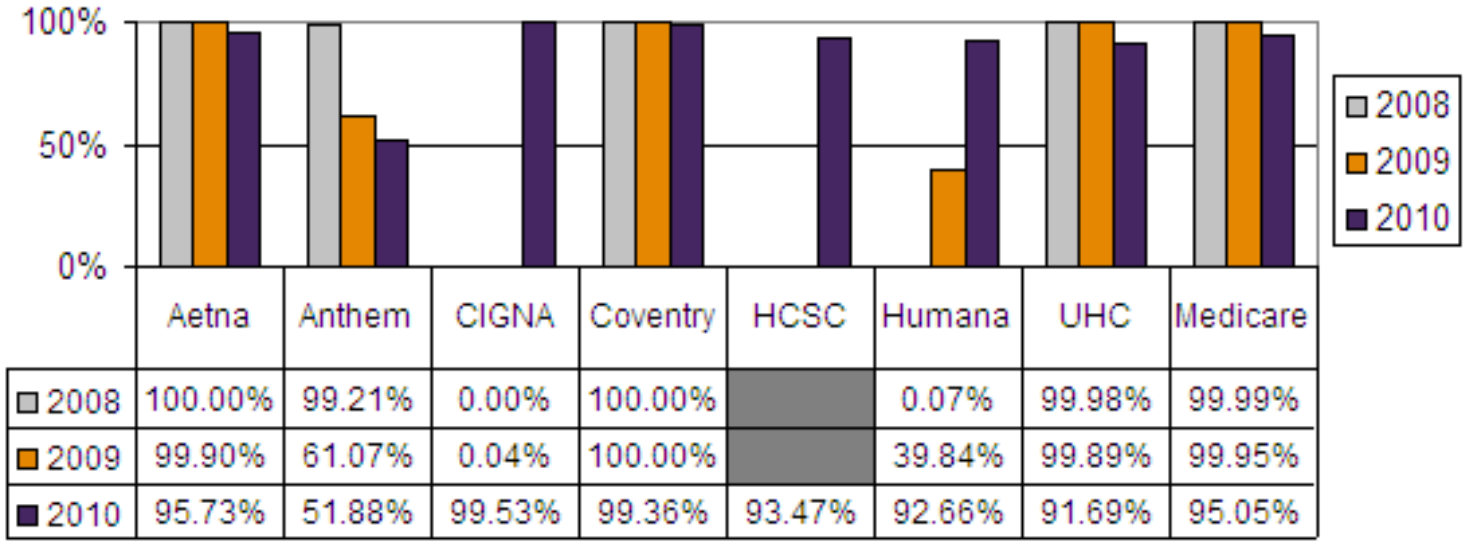
- Payers: Aetna, Anthem BCBS, CIGNA, Coventry, Health Care Services Corporation (HCSC), Humana, UnitedHealthcare (UHG), and Medicare
- 17 metrics reflecting five focus areas:
  - Data for Payment Timeliness and Type, Accuracy, Code Edit Sources and Frequency, and Denials were provided by NHXS.
  - Information on Improvement of Claim Cycle Workflow was self-reported by the payers.

Payment Timeliness and Type

Metric 1 - Payer claim received date disclosed

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
95.73%	**51.88%**	**99.53%**	**99.36%**	**93.47%**	**92.66%**	**91.69%**	**95.05%**

Metric 1 - Payer claim received date disclosed

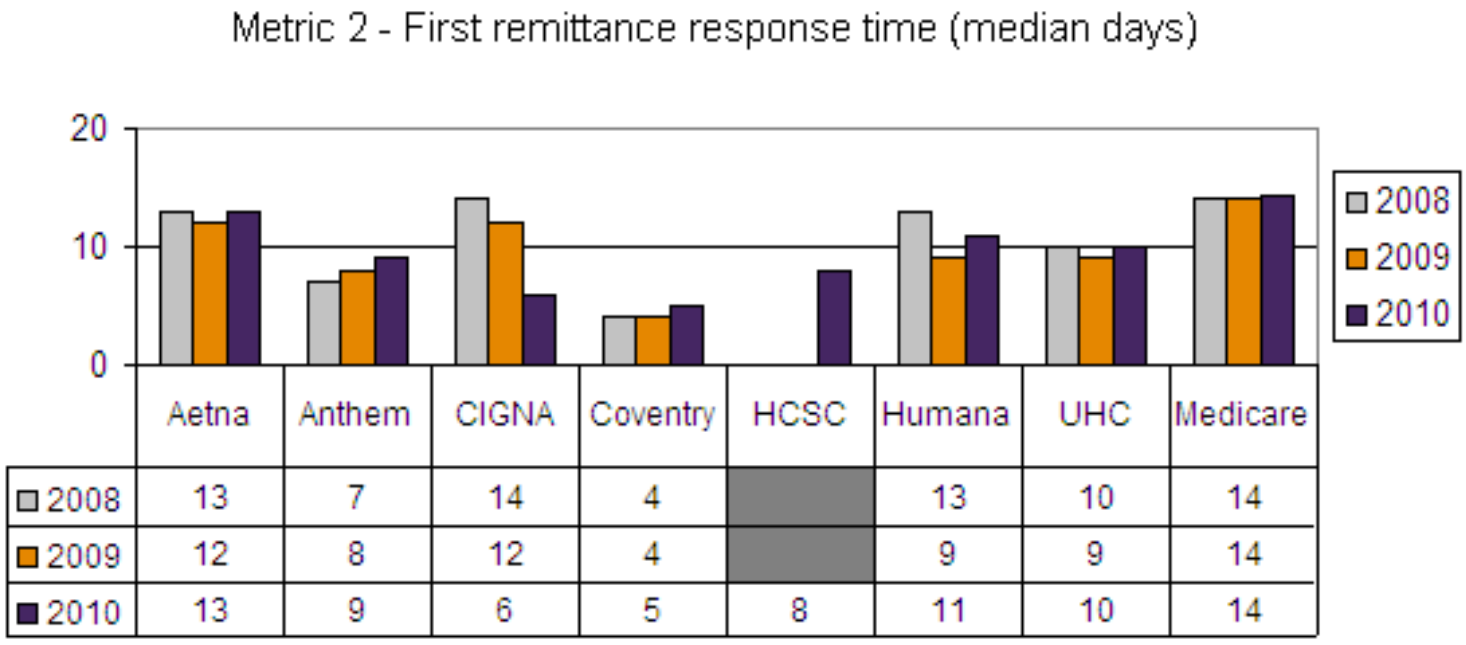


	Aetna	Anthem	CIGNA	Coventry	HCSC	Humana	UHC	Medicare
2008	100.00%	99.21%	0.00%	100.00%		0.07%	99.98%	99.99%
2009	99.90%	61.07%	0.04%	100.00%		39.84%	99.89%	99.95%
2010	95.73%	51.88%	99.53%	99.36%	93.47%	92.66%	91.69%	95.05%

Payment Timeliness and Type

Metric 2 - First remittance response time (median days)

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
13	**9**	**6**	**5**	**8**	**11**	**10**	**14**

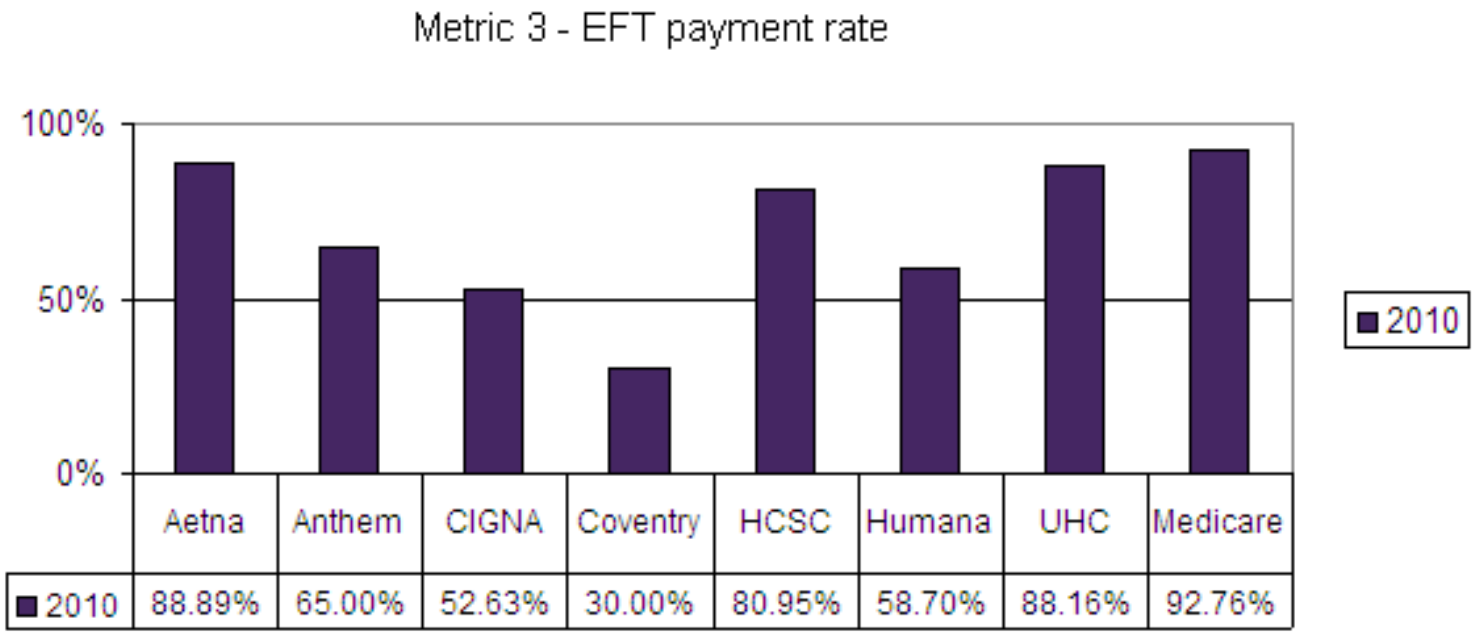


	Aetna	Anthem	CIGNA	Coventry	HCSC	Humana	UHC	Medicare
2008	13	7	14	4		13	10	14
2009	12	8	12	4		9	9	14
2010	13	9	6	5	8	11	10	14

Payment Timeliness and Type

Metric 3 - Electronic Funds Transfer (EFT) Adoption Rate*

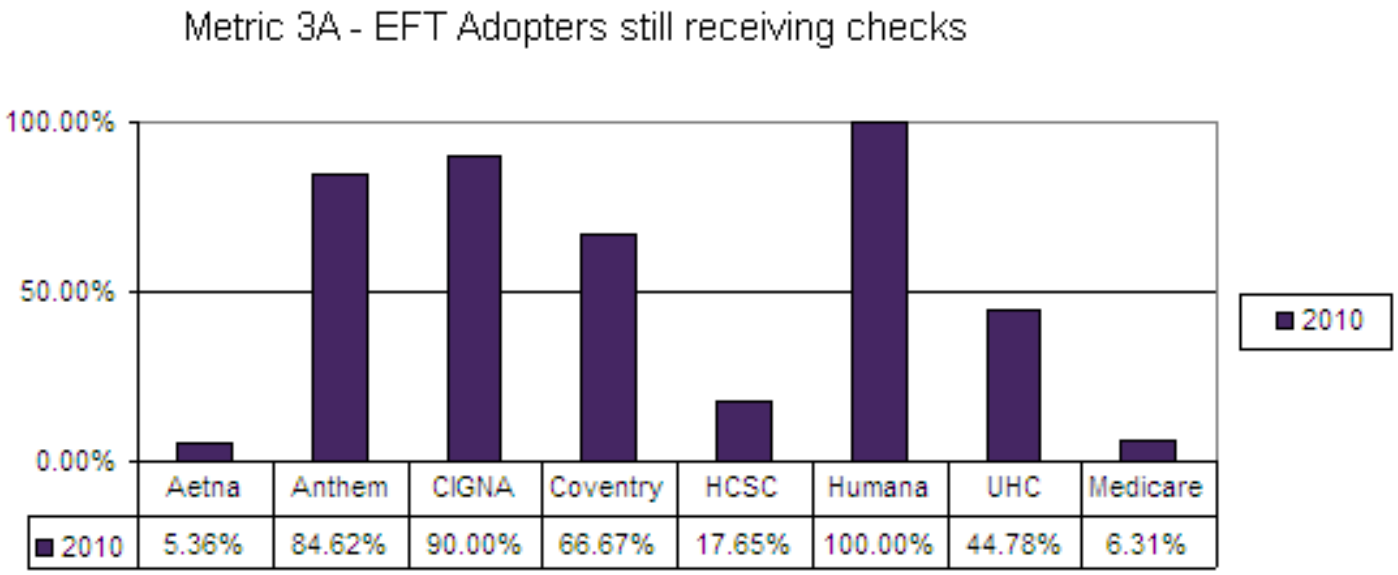
Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
88.89%	**65.00%**	**52.63%**	**30.00%**	**80.95%**	**58.70%**	**88.16%**	**92.76%**



Payment Timeliness and Type

Metric 3A - EFT Adopters still receiving checks*

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
5.36%	**84.62%**	**90.00%**	**66.67%**	**17.65%**	**100.00%**	**44.78%**	**6.31%**



Payment Timeliness—Lessons Learned

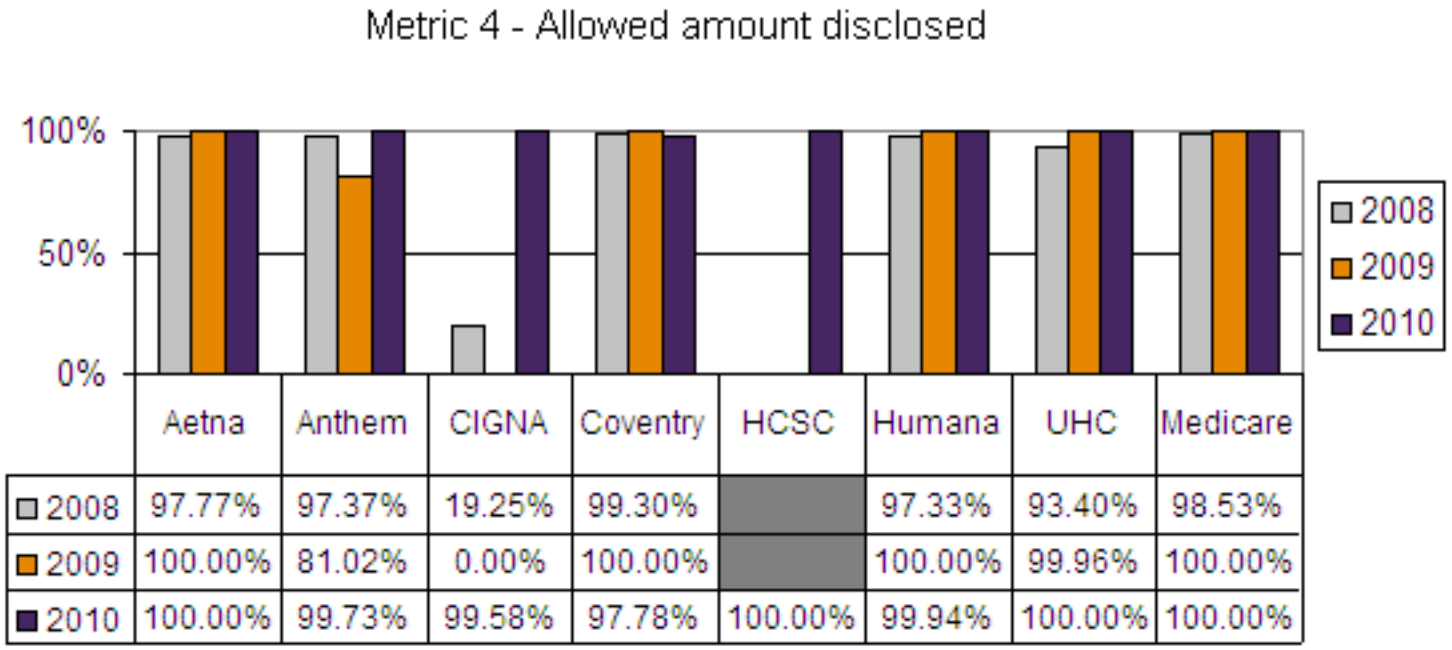
- Prompt pay laws appear to have been effective in encouraging insurers to respond to physician electronic claims with relatively quick payment transmittals.
- We are excited to see the general levels of compliance in particular the improvement shown by CIGNA and Humana.
- While health insurers are not required by law to report the date the claim was received, it is necessary information for physicians to track compliance with state prompt pay laws.

Payment Timeliness—New Issues

- Can we reduce the cost of claims reconciliation by ensuring the electronic remittance advice is received at the same time as the payment?
- How can we increase EFT adoption and usage?

Accuracy
Metric 4 - Allowed amount disclosed

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
100.00%	**99.73%**	**99.58%**	**97.78%**	**100.00%**	**99.94%**	**100.00%**	**100.00%**

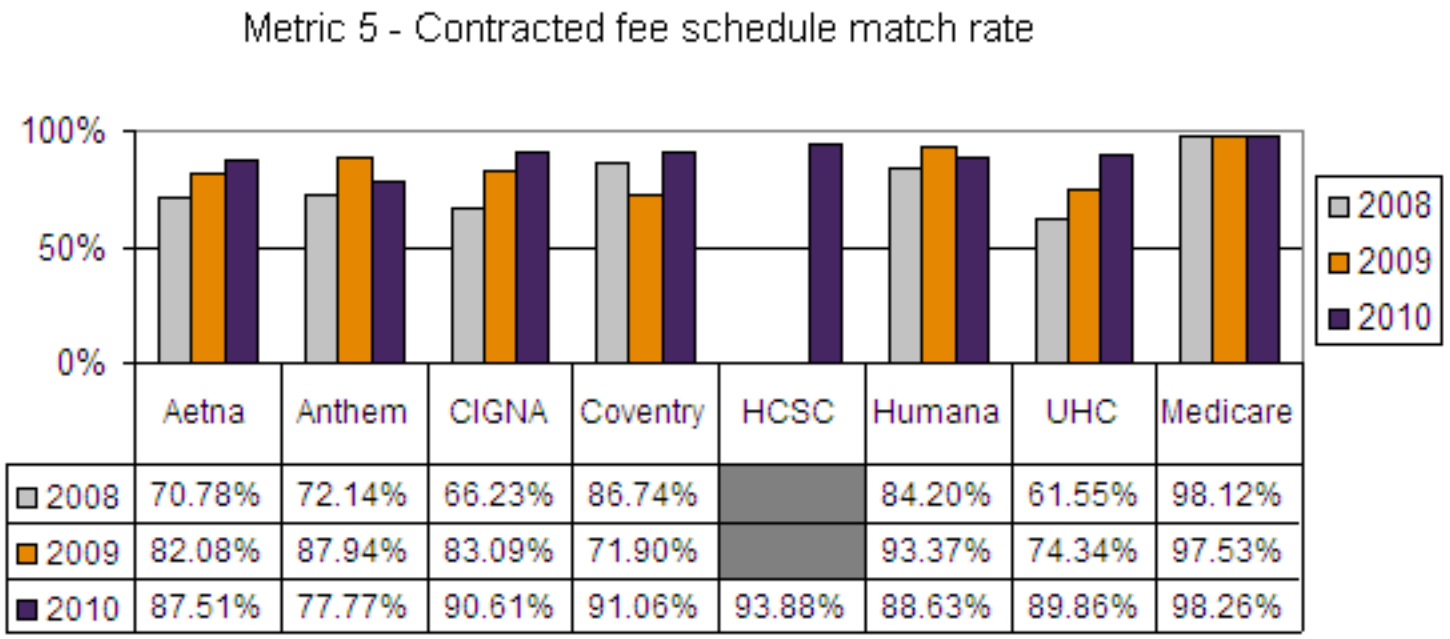


	Aetna	Anthem	CIGNA	Coventry	HCSC	Humana	UHC	Medicare
2008	97.77%	97.37%	19.25%	99.30%		97.33%	93.40%	98.53%
2009	100.00%	81.02%	0.00%	100.00%		100.00%	99.96%	100.00%
2010	100.00%	99.73%	99.58%	97.78%	100.00%	99.94%	100.00%	100.00%

Accuracy

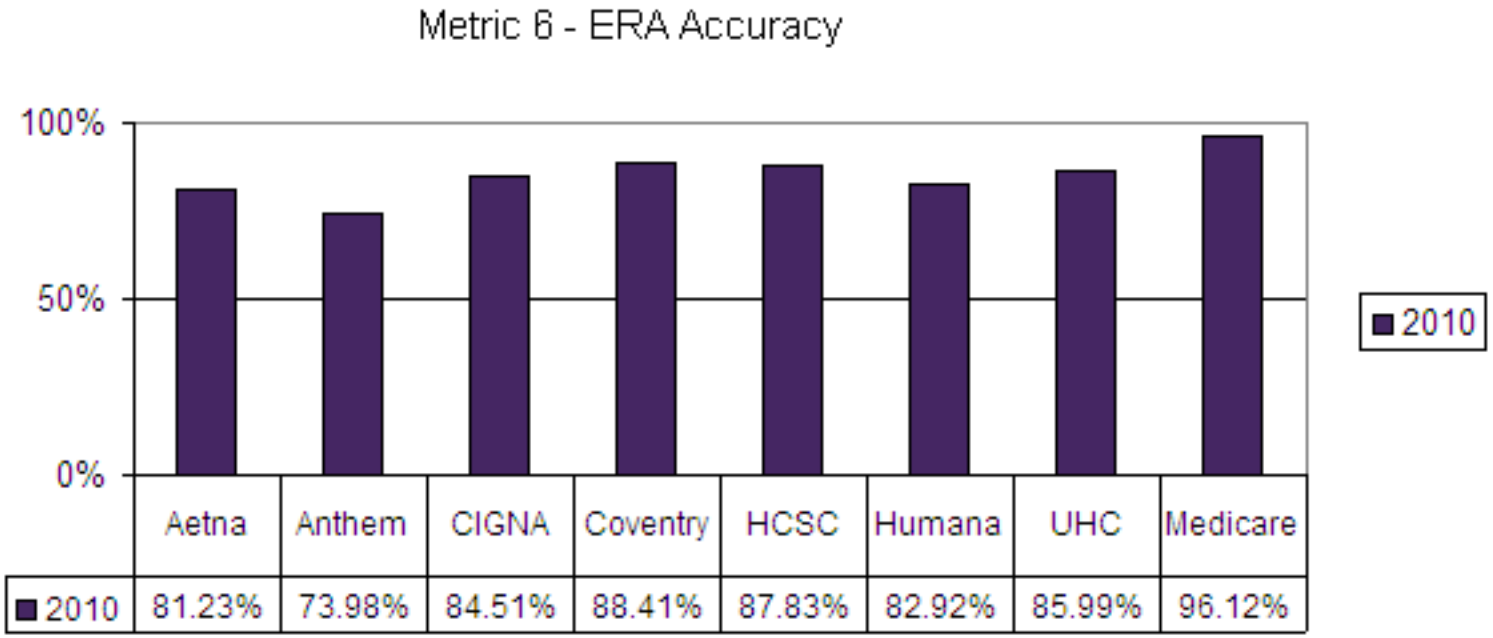
Metric 5 - Contracted fee schedule match rate

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
87.51%	**77.77%**	**90.61%**	**91.06%**	**93.88%**	**88.63%**	**89.86%**	**98.26%**



Accuracy
Metric 6 - ERA Accuracy*

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
81.23%	**73.98%**	**84.51%**	**88.41%**	**87.83%**	**82.92%**	**85.99%**	**96.12%**



Accuracy— Lessons Learned

Payers that do the following three things will continue to improve on these metrics:

- provide a complete downloadable product-specific contracted fee schedule on demand;
- clearly identify the patient's plan type (e.g., HMO, PPO, etc.) on each ERA; and then
- Correctly apply the proper contracted fee schedule to each claim.

Claim Edit Sources and Frequency

Metric 7 - Source of payer disclosed claim edits

	Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
CPT	1.10%	3.90%	1.60%	2.20%	56.10%	3.90%	1.00%	2.70%
ASA	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
NCCI	2.60%	15.20%	9.40%	11.10%	18.80%	2.10%	5.00%	20.90%
CMS	29.60%	40.20%	89.00%	86.70%	24.40%	33.40%	44.60%	63.90%
Payer Specific	66.70%	40.80%	0.00%	0.00%	0.70%	60.60%	49.50%	12.50%

Claim Edit Sources and Frequency

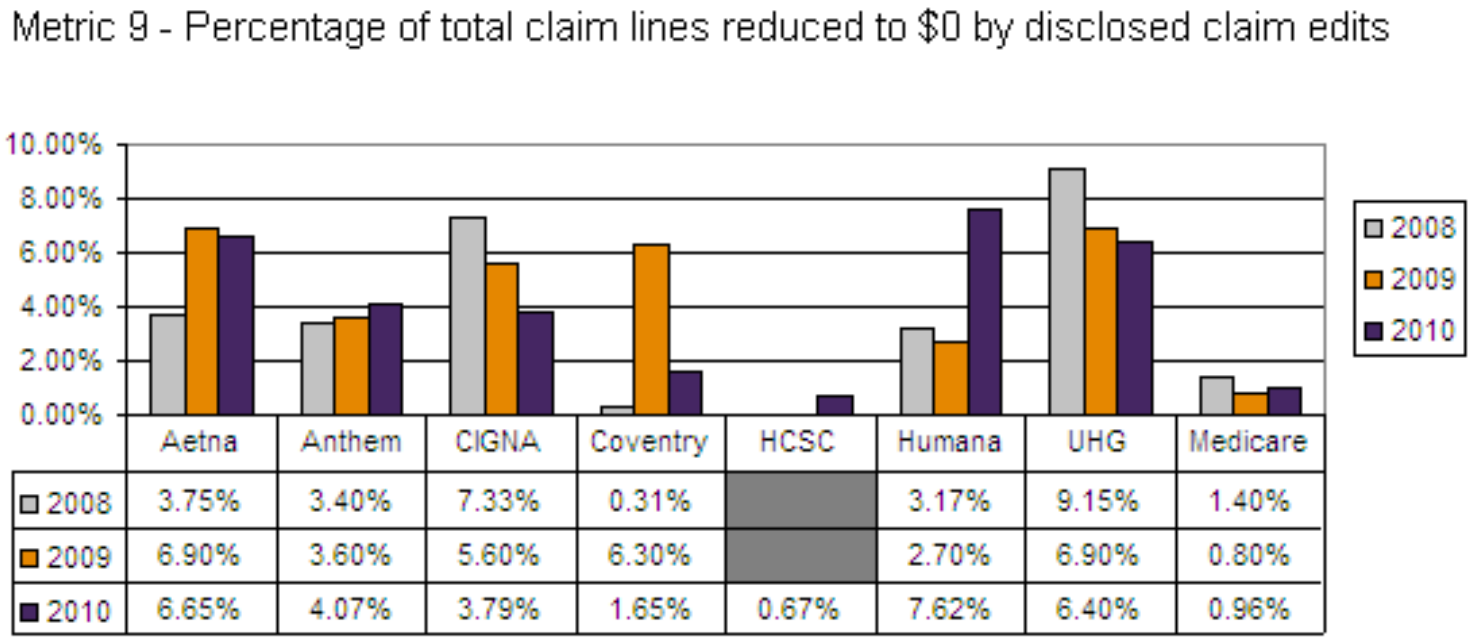
Metric 8 - Total number of available payer claim edits*

	Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
CPT	19,802	20,015	19,654	19,710	20,015	20,015	19,919	20,015
ASA	1,070	1,070	1,070	1,064	1,070	1,070	1,070	1,070
NCCI	744,605	744,265	744,678	744,272	744,475	744,678	744,678	744,678
CMS	60,164	45,118	60,420	60,051	43,291	60,420	46,533	60,420
Payer Specific	210,272	64,557	442	0	194,108	5,033	247,961	387,816

Claim Edit Frequency

Metric 9 - Percentage of total claim lines reduced to $0 by **disclosed** claim edits

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
6.65%	**4.07%**	**3.79%**	**1.65%**	**0.67%**	**7.62%**	**6.40%**	**0.96%**

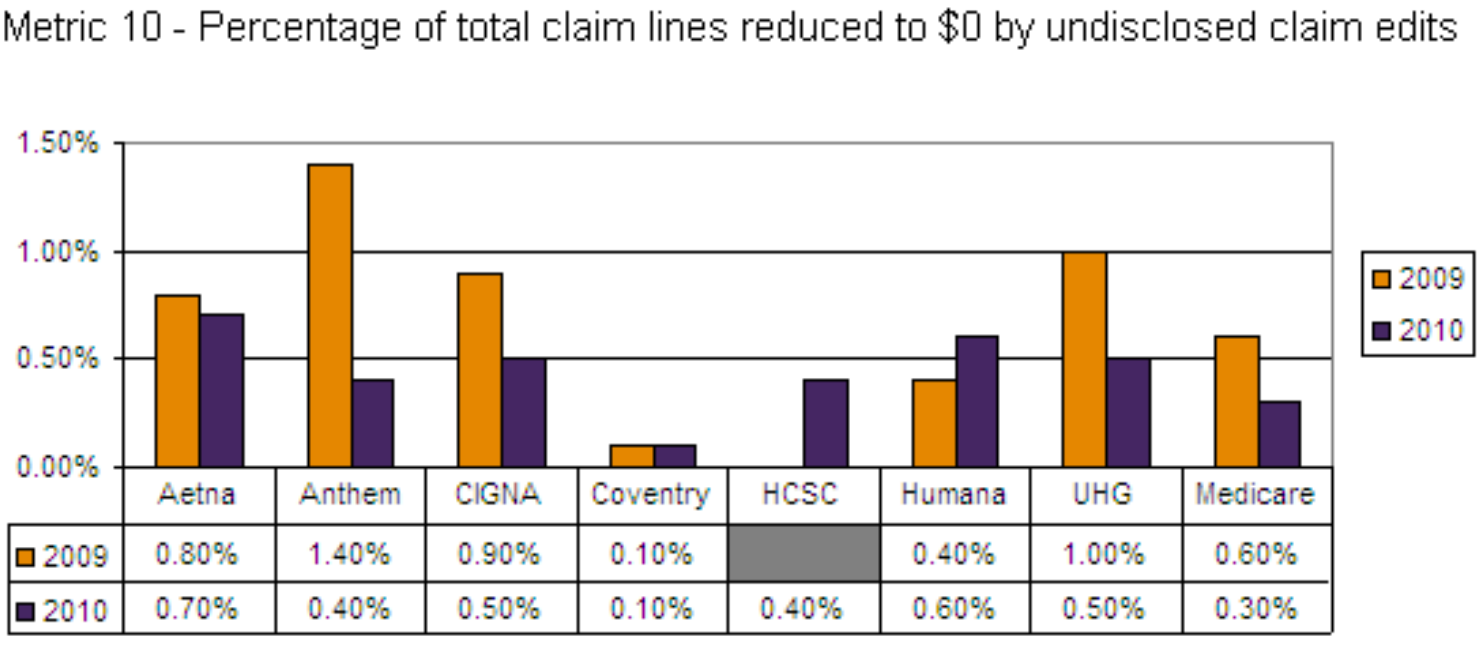


	Aetna	Anthem	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
2008	3.75%	3.40%	7.33%	0.31%		3.17%	9.15%	1.40%
2009	6.90%	3.60%	5.60%	6.30%		2.70%	6.90%	0.80%
2010	6.65%	4.07%	3.79%	1.65%	0.67%	7.62%	6.40%	0.96%

Claim Edit Frequency

Metric 10 - Percentage of total claim lines reduced to $0 by **undisclosed** claim edits

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
0.70%	**0.40%**	**0.50%**	**0.10%**	**0.40%**	**0.60%**	**0.50%**	**0.30%**



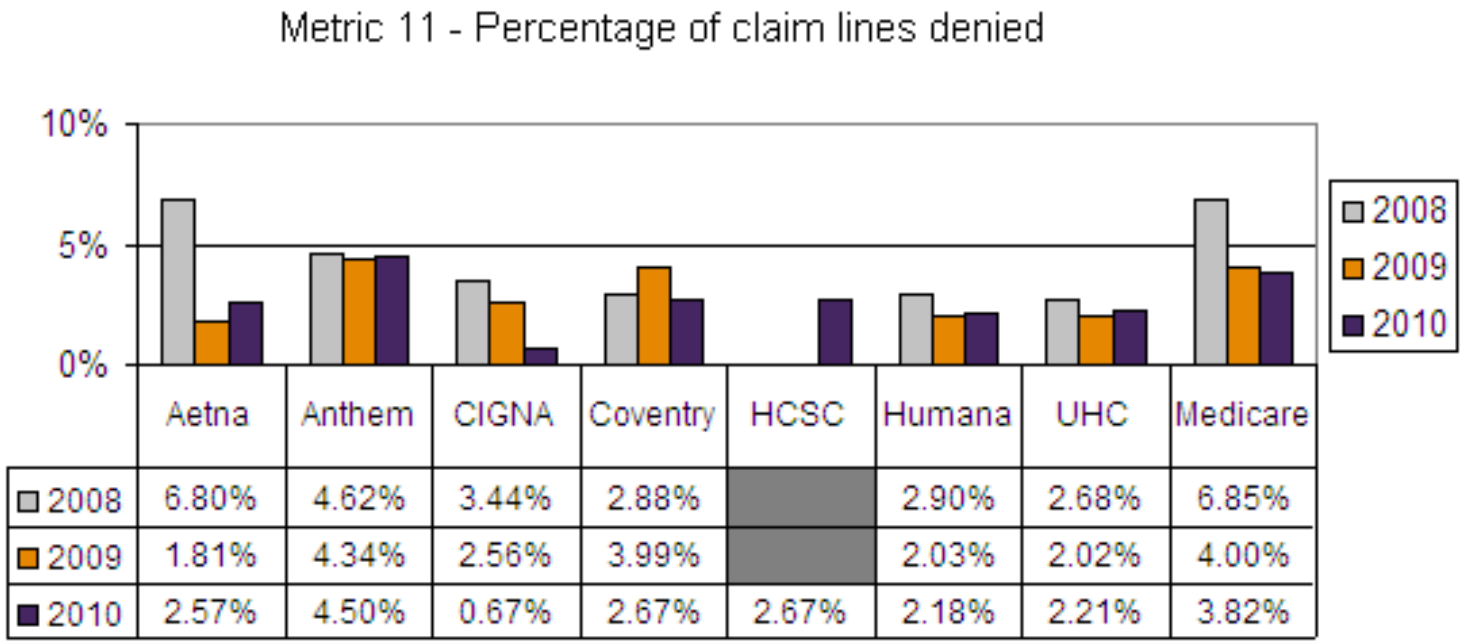
Claim Edit Sources and Frequency—Lessons Learned

- Continued wide variation between payers as to how often they apply edits to reduce payments as reflected in Metric 10A– 1.07 percent to 8.22 percent of claim lines.
- Continued variation on how often ***payer-specific edits*** are the source of edits applied to reduce payments as reflected in Metric 7 – zero to 66.70 percent.
- Wide variation in the use of payer-specific edits and undisclosed claim edits adds administrative cost.

Denials

Metric 11 - Percentage of claim lines denied

Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHG	Medicare
2.57%	**4.50%**	**0.67%**	**2.67%**	**2.67%**	**2.18%**	**2.21%**	**3.82%**



Denials

Metric 12 – Claim Adjustment Reason Codes (CARC)

	1st	2nd	3rd
Aetna	27	96	49
Anthem	16	26	204
CIGNA	96	B11	147
Coventry	27	227	197
HCSC	16	31	96
Humana	96	27	16
UHC	27	96	16
Medicare	50	109	49

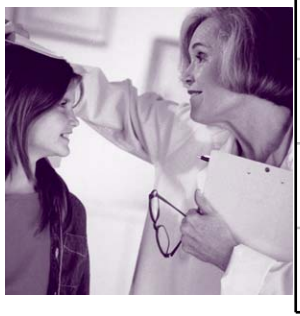
- 213 possible reason codes
- For private payers, 20 codes accounted for top 80% of codes reported.
- For Medicare, 8 codes accounted for top 80% of codes reported.

Denials

Metric 13 – Remark Codes

	1st	2nd	3rd
Aetna	N130	N102	N20
Anthem	N179	N382	N174
CIGNA	Unused		
Coventry	N179	N130	N204
HCSC	N130	N305	N4
Humana	N115	N431	N128
UHC	N115	N174	M77
Medicare	N115	M25	MA130

- For private payers, 38 codes accounted for top 80% of codes reported.
- For Medicare, 11 codes accounted for top 80% of codes reported.
- Several codes used more than once: MA130, N4, N56, N115, N130, N179



Denials

Metric 14 – Percentage of reason codes (CARC) reported with a required remark code (RARC)

	Aetna	Anthem BCBS	CIGNA	Coventry	HCSC	Humana	UHC	Medicare
CARC	%	%	%	%	%	%	%	%
16	100.00%	94.59%	0.00%	100.00%	100.00%	100.00%	97.29%	100.00%
96	95.56%	95.41%	0.00%	100.00%	100.00%	100.00%	98.04%	82.73%
125	Unused	92.71%	Unused	100.00%	Unused	100.00%	100.00%	99.88%
148	Unused	100.00%	Unused	Unused	Unused	Unused	Unused	Unused
226	100.00%	Unused	0.00%	Unused	Unused	100.00%	Unused	Unused
227	100.00%	100.00%	Unused	100.00%	100.00%	Unused	Unused	Unused
A1	Unused	Unused	Unused	Unused	Unused	100.00%	Unused	Unused

Denials—Lessons Learned

- Many denials are legitimate, including denials for non-covered services.
- Patient eligibility (expenses incurred before or after coverage) remains an enormous challenge that drains health care resources. Employers and health insurers must initiate a needed solution.
- Physicians can reduce denials by making sure all claims are complete and accurate.
- To maximize efficiency, reason and remark codes must be reported by all payers to the highest level of specificity.

Improvement of Claims Cycle Workflow—Lesson Learned

- Prior authorization efficiencies need to be realized.

  Lawrence P. Casalino, Sean Nicholson, David N. Gans, Terry Hammons, Dante Morra, Theodore Karrison, and Wendy Levinson, "What Does it Cost Physician Practices to Interact with Health Insurance Plans?" Health Affairs Web Exclusive: May 2009; w533-543.

- On average, physicians and their practice staff spend more time dealing with prior-authorization than on any other interaction with the health insurers.

Improvement of Claims Cycle Workflow—Lesson Learned

Claim acknowledgement (Unsolicited Claims Status Response)

- Electronic online tracking system is needed to allow physician practices to know where the claim is in the claims processing and payment cycle.
- The current electronic claim status response that tells the physician what action has been taken on a submitted claim (i.e., ASC X12 277 Claim Status Response) or its successor must be adopted as a HIPAA standard transaction and sent on an unsolicited basis at each of the following points in the claims adjudication process:
  - (1) electronic claim receipt;
  - (2) acceptance/rejection of electronic claim for adjudication;
  - (3) electronic claim forwarded to another entity or returned as "unprocessable"; and
  - (4) electronic claim pended (in process, in review, requested information [waiting]).




2010 Improvements

- Most payers are approaching 100% compliance with metric 4 (allowed amount disclosed).
- Substantial increase in metric 5 (contracted fee schedule match rate).
- The AMA continues to engage in collaborative discussions with the majority of payers ranked in the NHIRC and to work on jointly identified areas for process improvement.
- For every 1% increase in the first ERA match rate for physician claims across all payers collectively, there is a conservative savings estimate of $777,600,000 for physicians and payers. Thus, if the match rate increased to 100% from the current industry-wide average of 80%, there would be a savings of over $15.5 billion per year.

Continued Challenges

- The report card demonstrates the inconsistency and confusion that results from each health insurer using different rules for processing and paying medical claims. This variability requires physicians to maintain a costly claims management system for each health insurer.




Continued Challenges (cont.)

- Both physicians and health insurers can help reduce costs if electronic transactions and full transparency are widely adopted.
- Physicians are likely to adopt electronic transactions when their value exceeds the cost.
- Payers can increase the value of electronic transactions for physicians by increasing their use, transparency and accuracy.

THE GOAL – 1%

Administrative Simplification White papers

- CPT codes, guidelines and conventions administrative simplification
- Standardization of the claims process
- National health plan identifier

- Visit www.ama-assn.org/go/simplify

National Health Plan Identifier

- The entity financially responsible for payment;
- The entity responsible for administering the claim;
- The entity that owns the contract with the physician applicable to the claim;
- The fee schedule that applies to the claim;
- The specific plan/product type;
- The location where the claim is to be sent; and
- Any applicable secondary or tertiary payers who may have financial responsibility for all or part of the claim.




Simplified Recommendation National Health Plan Identifier

- Use the IRS health plan identifier (Employer Identification Number [EIN] followed by three-digit plan type), or other applicable IRS identifier, similar to the employer identifier standard, for each of the entities set forth above;
- Use a Global Unique Identifier (GUID), generated by the entity with the direct contract with the health care provider or a consistent industry standard unique identifier, following that entity's IRS identifier, to specify the applicable fee schedule; and
- Use the Claim Filing Indicator Code, coupled with the Class of Contract Code as necessary, to identify the product type.




National Health Plan Identifier

Clear identification on X12 271 eligibility and 835 electronic remittance advice of:

- each entity
- plan/product type; and the
- specific fee schedule involved in the determination of the ultimate patient benefit and claim payment.




Single Binding "Companion guide"

- **Expanded electronic remittance advice and other standard transaction requirements**
- **Single, binding "Companion guide" for each HIPAA standard transaction:**
  - **complete set of requirements, processes and operational rules necessary to electronically submit and receive each HIPAA standard transaction**




CPT and CARC/RARC

- **Current Procedural Terminology (CPT)**: Standard implementation of CPT codes, guidelines and conventions are essential for their uniform national application
- **Claims Adjustment Reason and Remark Code (CARC / RARC):** Standard implementation of CARC / RARC are essential for their uniform national application

Standard Claims Processing Platform: Claim Edits

- There are more than 2 million edits currently being used by payers
- Standard claim edits and payment rules readily available and downloadable through easy online access as NCCI edits are available today
- Standard claims processing platform would not dictate any :

  payer payment rates,

  medical coverage rules,

  claim review, and

  product benefit level or design.

Standard Claims Processing Platform: Payment Rules

Standard claims processing platform would not dictate any:

payer payment rates,

medical coverage rules,

claim review, and

product benefit level or design.

Health Claims Attachment

Raise urgency for final rule establishing the HIPAA standard for health claims attachments.

Acknowledgement/ Unsolicited Claims Status Response

Acknowledgement sent on an unsolicited basis at each of the following points in the claims adjudication process:

1. Claim receipt
2. Acceptance/rejection for adjudication
3. Forwarded to another entity or returned as “unprocessable”
4. Pending (in process, in review, requested information [waiting])
5. Finalized (paid, denied, revised, forwarded, not forwarded, complete [no payment forthcoming])

File Timely Non-Compliance Complaints

You may file a complaint with CMS electronically by using the Administrative Simplification Enforcement Tool (ASET) at **https://htct.hhs.gov/aset/**. If you have a problem using the tool, send an e-mail describing the problem to the e-mail address within the "technical problems/questions" link on the first screen, and a specialist will follow-up. For general questions about the complaint process, e-mail the Office of E-Health Standards & Services at **HIPAAComplaint@cms.hhs.gov**.




AMA Claims Workflow Tool

- Access AMA Claims Workflow Tool
- Download the AMA's "Prescription for a healthier practice: Claims process check-up"
  - Web site: www.ama-assn.org/go/pmc
  - E-mail: practicemanagementcenter@ama-assn.org

AMA Practice Management Alerts

- Stay informed: Position your practice to save time and money
- Register for free timely e-mail alerts on important practice management and payer issues
- www.ama-assn.org/go/pmc

Figure 5: Source of claim edits

Health insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Humana	UnitedHealthcare (UHC)	Medicare
CPT— AMA CPT codes, guidelines and conventions	1.4%	2.5%	0.6%	32.4%	1.5%	4.5%	9.2%
ASA— American Society of Anesthesia Relative Value Guide	--	--	--	--	--	--	2.6%
NCCI— National Correct Coding Initiative	2.7%	50.4%	6.1%	50.0%	9.2%	5.2%	19.0%
Medicare payment rules CMS Publication 100-4	41.8%	31.1%	92.9%	17.6%	17.3%	57.3%	49.9%
Payer-specific claim edits— These are only disclosed payer – specific claim edits	54.1%	16.0%	0.4%	0.0%	71.9%	33.0%	19.3%

Source: American Medical Association, 2008

Vermont Claim Edit Statute

1) § 9418 (a)(6) definition of “Edit” includes pricing rules (reductions to the fee schedule amount but > $0). None of the statue’s “approved sources” have pricing rule standards in them. Does the implementation of the statue intend to present the Commissioner with a set of pricing rules to approve (i.e., multiple procedure, bi-lateral, mid-level)?

2) The statue’s definition of “NCCI”:

> "NCCI" means the Centers for Medicare and Medicaid Services' (CMS) published list of edits and adjustments…

reads in such a way that it could include edits in addition to the NCCI Type I and Type II edits. Does the Commissioner understand NCCI to mean the broad definition including all CMS-published edits or just the edits in the NCCI Type I and Type II tables? For instance, CMS has the concept of Status Type B (always bundled into other services rendered) and Status Type P (excluded from payment), which are a CMS-published edit but not a NCCI Type I or Type II edit.




Vermont Claim Edit Statute (cont.)

3) Does the Commissioner believe that under § 9418a (g) a health plan can implement an edit wherein 36415 (phlebotomy) is considered incidental to 80061 (Lipid panel) unless mod -90 (reference lab) is appended to 80061? This edit is not found in any of section (b) "approved sources." This is an active edit today for a major VT payer. The payer established this rule based on the payer's review of the clinical circumstances, which appears to be a valid basis for using an edit under this section.

4) What is the Commissioner's understanding of "commercially available claims editing software product" described in section (h)? Does the Commissioner believe that "providers" should have equal access to purchase the same software? Does the provider have the right to get the version of the software used by a payer doing business in VT?

5) Section § 9418a (h)(4) introduces the concept of "significant edits, as determined by the health plan." Does the Commissioner believe that "claims software product" as used in this section applies to both third-party software and internal proprietary edit software used by the payer?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APPENDIX D

Data Table Description

Below is a brief description of data tables prepared by John Chapman, PhD of Markcelian Analytics, Inc. Mr. Chapman was retained by the Workgroup to aggregate claim denial and claim edit data provided by BCBSVT, MVP and CIGNA. Mr. Chapman's data tables were only received by the Workgroup in December of 2010. The Workgroup's intentions is to fully analyze the data to determine whether there are identifiable claim edit trends or practitioner specific trends that could be addressed in a uniform manner. Given the large amount of data and the timing of the receipt, the Workgroup requires additional time to fully analyze the data which will occur during the continuation period requested in the attached Interim Report.

Table Title	**Description**
1. Claim Edit Groupings Table	Description of the grouping of like edit terms used to organize aggregate denial data. The intent was to group like edit denials together, as best as possible, recognizing that there is not a perfect fit for each denial and some interpretation was necessary.
2. Edit = Mixed	Claims denied based on an edit indicating the identified CPT code is denied for a variety of common reasons such as services that are not usually performed on the same date of service, use a different surgical approach etc.
3. Edit = Incidental	Claims denied based on an edit indicating the identified CPT code is denied because the service is incidental to another procedure. Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided.
4. Edit = Incidental Like	Claims denied based on an edit indicating the identified CPT code is denied because the service is related or integral to another procedure. This is similar to incidental but does not include the term "incidental" in the denial description.
5. Edit = Informational	Claims denied based on an edit indicating the identified CPT code is not appropriate for reimbursement terms and is only accepted by the payer for informational purposes.
6. Edit = Global Price	Claims denied based on an edit indicating the identified CPT code is denied because the service is included in a bundled or global fee and there is no separate payment.
7. Duplicates report	Table aggregating denied claims based on edits including the word "duplicate"
8. All – By Specialty By Denial Category	Aggregate of all data provided in Tables 2 – 7 organized by specialty.

APPENDIX E

Re: Contract Standards Workgroup

Dear Susan,

I understand from speaking with David Martini, Assistant General Counsel, that the Contract Standards Workgroup has requested guidance on anti-trust issues and state action immunity with respect to the group sharing of individual plan claims edit customizations.

As a preliminary matter, the Department has no authority to render an opinion concerning, or create any safe harbor for conduct that might otherwise violate state or federal anti-trust laws. While the Department has participated in the Workgroup, as you have noted the statute which authorizes the Workgroup has not authorized the Department to regulate the activities of Workgroup, nor does the statute confer state action immunity on the members of the Workgroup. Of course, the Department retains anti-trust law enforcement authority with respect to certain regulated entities pursuant to other statutes, such as the Insurance Trade Practices Act.

It is also worth noting that the Department is not necessarily the exclusive law enforcement agency for anti-trust purposes in Vermont. The Vermont Attorney General's Office sometimes asserts jurisdiction over such matters, as do a number of different federal agencies.

Finally, it is my general impression that the members participating in the Workgroup have excellent legal staff, who the Workgroup members would be well-advised to consult concerning the boundaries between lawful, competitive activity, and unlawful anti-competitive activity.

Recognizing all of the above, under the Noerr-Pennington line of U.S. Supreme Court decisions[1], a general statement can be made that participation by itself in the political, policy-making process authorized by the statute for the purpose of developing standards for claims administration does not in itself violate the anti-trust laws. Of course, the devil is in the details: whereas participation in the Workgroup process per se may not violate anti-trust laws, neither does participation create an immunity or safe harbor from conduct which would otherwise be considered unlawful.

As a practical matter, the entities participating in the Workgroup may want to take care to not engage in substantive discussions with other members of the Workgroup without a representative of the Department present.

If you have any questions, please do not hesitate to contact me.

Very truly yours,

Herbert W. Olson
General Counsel

Cc: David Martini, Assistant General Counsel

[1] *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 135 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657, 670 (1965).

APPENDIX F

Vermont Medical Society - Clinical Edit Standards for Claims- Survey

SurveyMonkey

1. How many clinicians are in your practice?

		Response Percent	Response Count
1		**36.7%**	**40**
2		12.8%	14
3		11.9%	13
4		10.1%	11
5		2.8%	3
5 plus		25.7%	28
		answered question	**109**
		skipped question	**8**

2. What is your practice's specialty or specialities?

	Response Percent	Response Count
Allergy & Immunology	2.8%	3
Anesthesiology	3.7%	4
Cardiology	7.3%	8
Chiropractic	**20.2%**	**22**
Clinical Mental Health Counseling	6.4%	7
Clinical Nutrition	0.9%	1
Colo/Rectal Surgery	1.8%	2
Critical Care	0.9%	1
Dentistry	0.9%	1
Dermatology	3.7%	4
Diabetic Educator	0.9%	1
Endocrinology	0.9%	1
Family Practice	18.3%	20
Gastroenterology	2.8%	3
General Surgery	6.4%	7
Geriatrics	1.8%	2
Gynecology	2.8%	3
Hematology	2.8%	3
Home Health	0.0%	0
Hospice	0.9%	1
Infectious Disease	0.9%	1
Internal Medicine	14.7%	16

Naturopathic Medicine	0.9%	1
Neonatology	1.8%	2
Nephrology	1.8%	2
Neurology	3.7%	4
OB/GYN	6.4%	7
Obstetrics	1.8%	2
Occupational Medicine	0.9%	1
Occupational Therapy	0.9%	1
Oncology	3.7%	4
Ophthalmology	5.5%	6
Optometry	0.0%	0
Oral and Maxillofacial Surgery	0.9%	1
Orthopedics	5.5%	6
Osteoopathic Medicine	5.5%	6
Otolaryngology	2.8%	3
Pain Management	4.6%	5
Palliative Care	0.9%	1
Pediatric Primary Care	9.2%	10
Pediatric Specialty Care	0.9%	1
Physical Medicine & Rehabilitation	1.8%	2
Physical Therapy	5.5%	6
Plastic Surgery	3.7%	4
Podiatry	1.8%	2
Psychiatry	9.2%	10
Psychology	5.5%	6
Pulmonology	1.8%	2

Radiology	1.8%	2
Reproductive Endocrinology	0.9%	1
Rheumatology	0.9%	1
Social Work	1.8%	2
Substance Abuse	3.7%	4
Speech Therapy	0.9%	1
Trauma Surgery	0.9%	1
Urology	2.8%	3
Vascular Surgery	0.9%	1
	Other (please specify)	8
	answered question	**109**
	skipped question	**8**

3. How many physician assistants are in the practice?

	Response Percent	Response Count
1	10.5%	12
2	4.4%	5
3	1.8%	2
4	1.8%	2
5	1.8%	2
5 plus	5.3%	6
None	**74.6%**	**85**
	answered question	**114**
	skipped question	**3**

4. How many advanced practice registered nurses are in the practice?

		Response Percent	Response Count
1		9.9%	11
2		9.0%	10
3		1.8%	2
4		0.9%	1
5		0.0%	0
5 plus		5.4%	6
None		**73.0%**	**81**
		answered question	**111**
		skipped question	**6**

5. How many billing staff work for the practice? (for purposes of this survey billing staff include people who work on tracking unpaid claims or accounts receivable from insurance or from patients.)

		Response Percent	Response Count
1		**45.2%**	**47**
2		25.0%	26
3		6.7%	7
4		4.8%	5
5		2.9%	3
5 plus		15.4%	16
		answered question	**104**
		skipped question	**13**

6. Do you use an outsourced firm for your billing services, or do your billing in-house?

		Response Percent	Response Count
Outsourced		28.7%	31
In-house		**71.3%**	**77**
		answered question	**108**
		skipped question	**9**

7. Who is completing this survey?

		Response Percent	Response Count
Clinician		**48.1%**	**52**
Office administrator		36.1%	39
Billing specialist		15.7%	17
		Other (please specify)	5
		answered question	**108**
		skipped question	**9**

8. On a scale of 1 to 10 how willing would you be to have your staff participate in additional training on billing and claim edit guidelines? (10 indicating very willing and 1 indicating not willing)

		Response Percent	Response Count
10		**40.9%**	**45**
9		10.0%	11
8		9.1%	10
7		12.7%	14
6		5.5%	6
5		11.8%	13
4		0.9%	1
3		1.8%	2
2		0.9%	1
1		6.4%	7
		answered question	**110**
		skipped question	**7**

9. What are the top five reason that claims are denied based on clinical claim edits?

	Response Percent	Response Count
BCBS VT	**90.5%**	**57**
MVP	87.3%	55
Cigna	88.9%	56
Medicaid	**90.5%**	**57**
Medicare	81.0%	51
Workers Compensation	66.7%	42
answered question		**63**
skipped question		**54**

10. What health plan clinical edits are most often problematic to your practice?

	Response Count
	57
answered question	**57**
skipped question	**60**

11. On a scale of 1 to 10, how different do you perceive the clinical edits process to be among carriers? (10 being very different and 1 being very similar)

		Response Percent	Response Count
10		**16.7%**	**11**
9		6.1%	4
8		15.2%	10
7		**16.7%**	**11**
6		6.1%	4
5		9.1%	6
4		15.2%	10
3		6.1%	4
2		7.6%	5
1		1.5%	1
		answered question	**66**
		skipped question	**51**

12. What type of tools would you find useful to access information about clinical claim edits used by public and private insurers?

	Response Percent	Response Count
Specialty claim edit book with specialty edits such as INGENIX's Coding Companion	38.1%	24
Individual Insurer Websites	31.7%	20
Web-based tools such as Clear Claim Connection (3C)	25.4%	16
Insurer Newsletter	25.4%	16
Banner pages or remittance advices from insurers	27.0%	17
Uniform set of edits	**76.2%**	**48**
Ability to upload edits in bulk into billing system	28.6%	18
	answered question	**63**
	skipped question	**54**

13. What tools do you use to UPDATE information about clinical claim edits throughout the year?

	Response Count
	45
answered question	**45**
skipped question	**72**

14. Are you aware of C3?

	Response Percent	Response Count
Yes	30.8%	20
No	**69.2%**	**45**
	answered question	**65**
	skipped question	**52**

15. How did you learn about C3?

	Response Percent	Response Count
Notification by newsletter	14.3%	4
Notification by other method	25.0%	7
Other (please specify)	**64.3%**	**18**
	answered question	**28**
	skipped question	**89**

16. Have you ever used C3?

	Response Percent	Response Count
Yes	13.1%	8
No	**86.9%**	**53**
	answered question	**61**
	skipped question	**56**

17. If you have used C3, on a scale of 1 to 10 how frequently do you use it? (10 being very frequently and 1 being never)

		Response Percent	Response Count
10		7.1%	1
9		0.0%	0
8		0.0%	0
7		0.0%	0
6		7.1%	1
5		7.1%	1
4		0.0%	0
3		14.3%	2
2		14.3%	2
1		**50.0%**	**7**
		answered question	**14**
		skipped question	**103**

18. If you have not used C3, why haven't you used it?

	Response Count
	46
answered question	**46**
skipped question	**71**

19. If you have used C3, on a scale of 1 to 10 have you found it to be useful? (10 being very useful and 1 being not useful)

		Response Percent	Response Count
10		22.2%	2
9		0.0%	0
8		11.1%	1
7		0.0%	0
6		0.0%	0
5		0.0%	0
4		11.1%	1
3		11.1%	1
2		11.1%	1
1		**33.3%**	**3**
		answered question	**9**
		skipped question	**108**

20. Do you typically use C3 prior to submitting a claim?

		Response Percent	Response Count
Why?		54.5%	6
Why not?		**81.8%**	**9**
		answered question	**11**
		skipped question	**106**

21. Do you typically use C3 after a claim has been disallowed?

	Response Percent	Response Count
Why?	63.6%	7
Why not?	**72.7%**	**8**
	answered question	**11**
	skipped question	**106**

22. On a scale of 1 to 10, how often do you use the following tools on the insurers' websites that are associated with C3? (10 being very often, 1 bein never)

	10	9	8	7	6	5	4	3	2	1	Resp Co
List of customized edits to National Correct Coding Initiative edits (NCCI)	8.1% (3)	5.4% (2)	16.2% (6)	2.7% (1)	5.4% (2)	0.0% (0)	0.0% (0)	2.7% (1)	8.1% (3)	**51.4% (19)**	
Frequently asked questions about clinical claim edits and C3	0.0% (0)	2.9% (1)	2.9% (1)	0.0% (0)	5.9% (2)	5.9% (2)	8.8% (3)	5.9% (2)	5.9% (2)	**61.8% (21)**	
Explanations of how insurers apply modifiers 25 and 59	10.5% (4)	2.6% (1)	7.9% (3)	10.5% (4)	5.3% (2)	5.3% (2)	0.0% (0)	7.9% (3)	7.9% (3)	**42.1% (16)**	
										answered question	
										skipped question	

23. Are you aware of these lists of custom edits that insurers have on their websites?

	Response Percent	Response Count
Yes	41.7%	25
No	**58.3%**	**35**
	answered question	**60**
	skipped question	**57**

24. Do you refer to these lists of customized edits that insurers have on their websites?

	Response Percent	Response Count
Yes	29.1%	16
No	**70.9%**	**39**
	If no, why not?	31
	answered question	**55**
	skipped question	**62**

25. On a scale of 1 to 10, how useful do you find insurers' lists of customized edits to be? (10 being very useful; 1 being not useful)

		Response Percent	Response Count
10		5.7%	2
9		2.9%	1
8		5.7%	2
7		14.3%	5
6		11.4%	4
5		5.7%	2
4		11.4%	4
3		2.9%	1
2		2.9%	1
1		**37.1%**	**13**
		answered question	**35**
		skipped question	**82**

26. On a scale of 1 to 10, how useful do you find these customized lists to be PRIOR to filing a claim? (10 being very useful, 1 being not useful)

		Response Percent	Response Count
10		3.0%	1
9		0.0%	0
8		3.0%	1
7		6.1%	2
6		9.1%	3
5		3.0%	1
4		9.1%	3
3		9.1%	3
2		6.1%	2
1		**51.5%**	**17**
		answered question	**33**
		skipped question	**84**

27. On a scale of 1 to 10, how useful do you find these lists of customized edits to be AFTER claims have been disallowed? (10 being very useful; 1 being not useful)

		Response Percent	Response Count
10		8.6%	3
9		2.9%	1
8		8.6%	3
7		17.1%	6
6		5.7%	2
5		8.6%	3
4		2.9%	1
3		0.0%	0
2		0.0%	0
1		**45.7%**	**16**
	Please explain why they are useful, or why they are not.		16
		answered question	**35**
		skipped question	**82**

28. If you would like to provide your name, the name of the practice you represent, and your contact information please do so.

	Response Percent	Response Count
Name:	86.4%	19
Practice:	72.7%	16
Address:	86.4%	19
City/Town:	86.4%	19
State:	**95.5%**	**21**
ZIP:	90.9%	20
Country:	81.8%	18
Email Address:	81.8%	18
Phone Number:	72.7%	16
	answered question	**22**
	skipped question	**95**

29. If you would like to be contacted about the survey or about clinical edits, please indicate who you would like to be contacted by below.

		Response Percent	Response Count
Vermont Medical Society		**69.2%**	**9**
Blue Cross and Blue Shield Vermont		53.8%	7
Cigna		38.5%	5
MVP Health Care		53.8%	7
Office of Vermont Health Access (Medicaid)		**69.2%**	**9**
		answered question	**13**
		skipped question	**104**

APPENDIX G

My Surveys Address Book My Account

You have a **BASIC account** | To remove the limits of a BASIC account and get unlimited

VPAM Questionnaire Edit

Default Report + Add Report

Response Summary

Total Started Survey
Total Completed Survey

PAGE: DEFAULT SECTION

1. Please enter your name (optional) and hospital name for tracking purposes.

		Response Percent
Hide replies	**Your Name**	91.7%

1.	Gail Bourassa	Mon, Nov 1, 2010 3:38 PM
2.	Jane Vizvarie	Mon, Nov 1, 2010 3:29 PM
3.	MARILYN BOUDREAU	Mon, Nov 1, 2010 1:15 PM
4.	Bonnie Paquette	Mon, Nov 1, 2010 11:05 AM
5.	Gail Ransom	Mon, Nov 1, 2010 8:40 AM
6.	Dianne Bolza	Fri, Oct 29, 2010 5:13 PM
7.	Kathy Nisun	Fri, Oct 29, 2010 4:00 PM
8.	Christine Fortin	Fri, Oct 29, 2010 11:42 AM
9.	Chris Healy	Tue, Oct 26, 2010 2:07 PM
10.	Jennifer Broussard	Wed, Oct 20, 2010 10:04 AM
11.	KATHY STOVER	Tue, Oct 19, 2010 3:20 PM

25 responses per p

Show replies	**Hospital**	**100.0%**

answered question

skipped question

VPAM Questionnaire Edit

Default Report + Add Report

Response Summary

Total Started Survey
Total Completed Survey

PAGE: DEFAULT SECTION

1. Please enter your name (optional) and hospital name for tracking purposes.

			Response Percent
Show replies	**Your Name**		91.7%
Hide replies	**Hospital**		**100.0%**

1.	GIFFORD MEDICAL CENTER	Mon, Nov 1, 2010 3:38 PM
2.	Fletcher Allen Health Care	Mon, Nov 1, 2010 3:29 PM
3.	BRATTLEBORO MEMORIAL	Mon, Nov 1, 2010 1:15 PM
4.	Mt. Ascutney Hospital	Mon, Nov 1, 2010 11:05 AM
5.	Rutland Regional Medical Center	Mon, Nov 1, 2010 8:40 AM
6.	Southwestern Vermont Medical Center	Fri, Oct 29, 2010 5:13 PM
7.	Porter Hospital Inc	Fri, Oct 29, 2010 4:00 PM
8.	North Country Hospital	Fri, Oct 29, 2010 11:42 AM
9.	CVMC	Wed, Oct 27, 2010 10:08 AM
10.	Dartmouth Hitchcock	Tue, Oct 26, 2010 2:07 PM
11.	Brattleboro Retreat	Wed, Oct 20, 2010 10:04 AM
12.	GRACE COTTAGE HOSPITAL	Tue, Oct 19, 2010 3:20 PM

25 responses per p

answered question

skipped question

2. Number of billing staff FTEs

		Response Percent
Hide replies	Hospital	100.0%

1.	10 : billers do both hospital and professional	Mon, Nov 1, 2010 3:38 PM
2.	41 doing billing and follow-up, not counting supervisors	Mon, Nov 1, 2010 3:29 PM
3.	4	Mon, Nov 1, 2010 1:15 PM
4.	5	Mon, Nov 1, 2010 11:05 AM
5.	12	Mon, Nov 1, 2010 8:40 AM
6.	15 billing total 24 staff	Fri, Oct 29, 2010 5:13 PM
7.	6	Fri, Oct 29, 2010 4:00 PM
8.	9.2	Fri, Oct 29, 2010 11:42 AM
9.	9	Wed, Oct 27, 2010 10:08 AM
10.	50	Tue, Oct 26, 2010 2:07 PM
11.	6	Wed, Oct 20, 2010 10:04 AM
12.	3	Tue, Oct 19, 2010 3:20 PM

25 responses per p

answered question

skipped question

2. Number of billing staff FTEs

			Response Percent
Show replies	Hospital		100.0%
Hide replies	Professional		83.3%

1.	83.5	Mon, Nov 1, 2010 3:29 PM
2.	4	Mon, Nov 1, 2010 1:15 PM
3.	4.5	Mon, Nov 1, 2010 11:05 AM
4.	4	Mon, Nov 1, 2010 8:40 AM
5.	5	Fri, Oct 29, 2010 4:00 PM
6.	6	Fri, Oct 29, 2010 11:42 AM
7.	(billers do both hosp and professional)	Wed, Oct 27, 2010 10:08 AM
8.	33	Tue, Oct 26, 2010 2:07 PM
9.	2	Wed, Oct 20, 2010 10:04 AM
10.	3	Tue, Oct 19, 2010 3:20 PM

answered question

skipped question

3. **Number of billing locations**

		Response Percent	Response Count
Hide replies	**Hospital**	50.0%	6

1.	Define Locations/physical versus claim form? Acute care hospital, Rehab, DayOne, Seneca, Multiple PBB sites, and 6 dialysis sites.	Mon, Nov 1, 2010 3:29 PM	Find...
2.	1	Mon, Nov 1, 2010 1:15 PM	Find...
3.	1	Mon, Nov 1, 2010 11:05 AM	Find...
4.	1	Fri, Oct 29, 2010 4:00 PM	Find...
5.	1	Tue, Oct 26, 2010 2:07 PM	Find...
6.	1	Tue, Oct 19, 2010 3:20 PM	

answered question	**12**
skipped question	**0**

Professional		50.0%	6

1.	232 locations on claim forms, not address based	Mon, Nov 1, 2010 3:29 PM	Find...
2.	1	Mon, Nov 1, 2010 1:15 PM	Find...
3.	1	Mon, Nov 1, 2010 11:05 AM	Find...
4.	1	Fri, Oct 29, 2010 4:00 PM	Find...
5.	8	Tue, Oct 26, 2010 2:07 PM	Find...
6.	1	Tue, Oct 19, 2010 3:20 PM	

Combined hospital/professional		**83.3**

1.	1	Mon, Nov 1, 2010 3:38 PM
2.	Depends on definition	Mon, Nov 1, 2010 3:29 PM
3.	2	Mon, Nov 1, 2010 1:15 PM
4.	2	Mon, Nov 1, 2010 11:05 AM
5.	1	Mon, Nov 1, 2010 8:40 AM
6.	1	Fri, Oct 29, 2010 5:13 PM
7.	1	Fri, Oct 29, 2010 11:42 AM
8.	1	Wed, Oct 27, 2010 10:08 AM
9.	1	Wed, Oct 20, 2010 10:04 AM
10.	2	Tue, Oct 19, 2010 3:20 PM

4. Annual claim volume (number of billed claims)

		Response Percent	Response Count
Hide replies	Hospital	100.0%	9

1.	620,000. initial claims. does not include any secondaries or any rebilling	Mon, Nov 1, 2010 3:29 PM	Find...
2.	APPROX. 110,000+	Mon, Nov 1, 2010 1:15 PM	Find...
3.	20,000	Mon, Nov 1, 2010 8:40 AM	Find...
4.	302,536 claims original number hospital & professional	Fri, Oct 29, 2010 5:13 PM	Find...
5.	80,000	Fri, Oct 29, 2010 4:00 PM	Find...
6.	?	Fri, Oct 29, 2010 11:42 AM	Find...
7.	335400	Wed, Oct 27, 2010 10:08 AM	Find...
8.	725,000	Tue, Oct 26, 2010 2:07 PM	Find...
9.	2500	Wed, Oct 20, 2010 10:04 AM	

answered question	9
skipped question	3

4. Annual claim volume (number of billed claims)

		Response Percent
Show replies	Hospital	100.0%
Hide replies	Professional	88.9%

1.	1,153,347	Mon, Nov 1, 2010 3:29 PM
2.	APPROX. 66,000+	Mon, Nov 1, 2010 1:15 PM
3.	15,000	Mon, Nov 1, 2010 8:40 AM
4.	100,000	Fri, Oct 29, 2010 4:00 PM
5.	75000	Fri, Oct 29, 2010 11:42 AM
6.	51000	Wed, Oct 27, 2010 10:08 AM
7.	1,250,000	Tue, Oct 26, 2010 2:07 PM
8.	24000	Wed, Oct 20, 2010 10:04 AM

answered question

skipped question

5. Do you outsource the billing function to any of the following:

	Response Percent
Hospital billing	0.0%
Professional billing	0.0%
Other (please specify)	100.0%

Hide replies Other (please specify)

1.	Selfpay bills	Mon, Nov 1, 2010 3:38 PM
2.	Anesthesia Billing	Mon, Nov 1, 2010 3:29 PM
3.	NO OUTSOURCING	Mon, Nov 1, 2010 1:15 PM
4.	Some physician billing not Provider Based and hospital out of state Medcaid	Fri, Oct 29, 2010 5:13 PM
5.	NO	Fri, Oct 29, 2010 4:00 PM
6.	no	Tue, Oct 26, 2010 2:07 PM
7.	NO	Tue, Oct 19, 2010 3:20 PM

answered question

skipped question

6. Please check off the top five reasons for hospital (UB-04) claim edits:

	Response Percent	Response Count
Missing signature(s)	0.0%	0
Missing modifiers	66.7%	8
CCI-set up for various charges for multiple departments	41.7%	5
Provider Based Billing/Medicare Financial Service Class issues	25.0%	3
MUE edits	33.3%	4
Missing UB coding required for billing (i.e. value codes, occurence codes)	58.3%	7
Combine bill review - OP within 72 hours of IP or IPREHAB within 3 days of another IPREHAB	33.3%	4
Charge code/charge category mismatch	25.0%	3
Same day Financial Service Class mismatch (multiple claims for the same date with different insurances listed)	8.3%	1
Missing physician info/enrollment issues	58.3%	7
Workers comp documentation edit	25.0%	3
Hide replies Other (please specify)		2

1. Inclusive; no injury on file for Workers Comp;pt not eligible	Fri, Oct 29, 2010 5:13 PM	Find.
2. Registration Issues	Tue, Oct 26, 2010 2:07 PM	

answered question	12
skipped question	0

7. Please check off the top five reasons for professional (HCFA-1500) claim edits

	Response Percent
Missing signature(s)	9.1%
Missing modifiers	**81.8%**
CCI-set up for various charges for multiple departments	36.4%
Provider Based Billing/Medicare Financial Service Class issues	18.2%
MUE edits	45.5%
Missing UB coding required for billing (i.e., value codes, occurence codes)	9.1%
Combine bill review - OP within 72 hours of IP or IPREHAB within 3 days of another IPREHAB	0.0%
Charge code/charge category mismatch	36.4%
Same day Financial Service Class mismatch (multiple claims for the same date with different insurances listed)	9.1%
Missing physician info/enrollment issues	**81.8%**
Workers comp documentation edit	36.4%

Hide replies Other (please specify)

1. OCE edits	Mon, Nov 1, 2010 8:40 AM
2. No accident report on file for WC	Fri, Oct 29, 2010 5:13 PM
3. Demographics	Fri, Oct 29, 2010 11:42 AM
4. Registration Issues	Tue, Oct 26, 2010 2:07 PM

answered question

skipped question

8. Please check off the top five reasons claims are modified to meet third party payer billing rules

	Response Percent
Missing signature(s)	8.3%
Missing modifiers	**83.3%**
CCI-set up for various charges for multiple departments	50.0%
Provider Based Billing/Medicare Financial Service Class issues	16.7%
MUE edits	41.7%
Missing UB coding required for billing (i.e. value codes, occurence codes)	58.3%
Combine bill review - OP within 72 hours of IP or IPREHAB within 3 days of another IPREHAB	16.7%
Charge code/charge category mismatch	41.7%
Same day Financial Service Class mismatch (multiple claims for the same date with different insurances listed)	0.0%
Missing physician info/enrollment issues	41.7%
Workers comp documentation edit	33.3%

Hide replies Other (please specify)

1.	HCPCS/CPT4 payer specific changes/ payer specific bundling rules	Mon, Nov 1, 2010 3:29 PM
2.	CERTAIN PAYORS REQUIRE DIFFERENT TAXONOMY CODES THAN MOST PAYORS	Mon, Nov 1, 2010 1:15 PM
3.	PATIENT CAN NOT BE IDENTIFIED	Fri, Oct 29, 2010 4:00 PM
4.	Demographics	Fri, Oct 29, 2010 11:42 AM
5.	Bundling per various payer requirements	Tue, Oct 26, 2010 2:07 PM

answered question

skipped question

9. What administrative task or function most impacts your claims processing?

Hide replies

1.	Even standarized codes, such as reason codes, are defined and used very differently by each payer. There is no real standard. Payer Mandates	Mon, Nov 1, 2010 3:29 PM
2.	TRACKING DOWN MISSING PHYSICIAN/PROFESSIONAL CHGS	Mon, Nov 1, 2010 1:15 PM
3.	insurance enrollment	Mon, Nov 1, 2010 11:05 AM
4.	provider enrollment CCI/OCE edits	Mon, Nov 1, 2010 8:40 AM
5.	Dealing with 3rd parties who try to implement Physician inclusive edits to hospital claims. Medical Records requirement attachments	Fri, Oct 29, 2010 5:13 PM
6.	VERIFICATION OF ELIGIBILITY MEDICAL NECESSITY INDIVIDUAL PAYER REGULATIONS	Fri, Oct 29, 2010 4:00 PM
7.	Correct Registration Getting correct insurance DOB, subscriber info and policies numbers	Fri, Oct 29, 2010 11:42 AM
8.	Re-working of claims to comply with individual payer requirements	Wed, Oct 27, 2010 10:08 AM
9.	Validating Registration, Medicare Secondary Survey, Coordination of Benefits, Improper electronic adjustments creating credit balances, ABN's, Paper claims to non-electronic payers or documentation required, audits.	Tue, Oct 26, 2010 2:07 PM
10.	Data Entry	Wed, Oct 20, 2010 10:04 AM

answered question

skipped question

10. What filtering tools does your organization utilize on the front end prior to submitting claims?

	Response Percent
SSI	66.7%
Ingenix	33.3%
TES	66.7%

Hide replies Other (please specify)

1.	AHIQA	Mon, Nov 1, 2010 3:38 PM
2.	SIEMENS MED SERIES 4	Mon, Nov 1, 2010 1:15 PM
3.	cpsi	Mon, Nov 1, 2010 11:05 AM
4.	Quadramed's Affiity product and NDC's Premis product	Mon, Nov 1, 2010 8:40 AM
5.	C-MART AND UB EDITOR	Fri, Oct 29, 2010 4:00 PM
6.	Allscripts PM	Fri, Oct 29, 2010 11:42 AM
7.	3M, Meditech	Wed, Oct 27, 2010 10:08 AM
8.	MedAssets XClaim (scrubber), Accretive Health FCC (Reg. verify)	Tue, Oct 26, 2010 2:07 PM
9.	Clearinghouse - ePremis	Wed, Oct 20, 2010 10:04 AM

answered question

skipped question