



Standardizing CPT Codes, Guidelines and Conventions

Administrative Simplification White Paper

**Prepared by the American Medical Association
Practice Management Center (PMC)**

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This white paper expands on the previous Administrative Simplification White Paper prepared by the American Medical Association (AMA) Practice Management Center (PMC) on December 23, 2008.¹ These white papers summarize the AMA recommendations to eliminate significant administrative waste from the health care system by simplifying and standardizing the current health care billing and payment process. This white paper specifically focuses on the recommendation to legislate the standard implementation and processing of AMA Current Procedural Terminology (CPT®) codes, guidelines and conventions.²

Physicians and their practice staff report the provision of medical procedures and services through the Current Procedural Terminology (CPT), commonly referred to as the CPT codebook. CPT is a listing of descriptive terms and identification codes for reporting medical services and procedures performed by physicians and other qualified health care professionals. The purpose of the terminology is to provide uniform language that accurately describes medical, surgical and diagnostic services, and provide an effective means for reliable nationwide communication among physicians and other qualified health care professionals, patients and third parties. The CPT code set is maintained by the CPT Editorial Panel. This panel is authorized by the AMA Board of Trustees to revise, update and modify CPT codes, descriptors, rules and guidelines. The panel is comprised of 17 members. Of these, 11 are physicians nominated by the national medical specialty societies. One seat is reserved for each of the following: a designee of an approved quality measurement group, the BlueCross BlueShield Association (BCBSA), America's Health Insurance Plans (AHIP), the American Hospital Association (AHA) and the Centers for Medicare & Medicaid Services (CMS). The remaining two seats are reserved for two members of the CPT Health Care Professionals Advisory Committee.

While the uniform code set, guidelines and conventions for how physicians and other qualified health care professionals report medical procedures and services on claims have clearly benefited the health care system, there are no uniform rules for how health insurers and other third party payers process medical service claims. For example, while guidelines in the CPT codebook instruct a physician who performs a specific service, in addition to an office visit, to bill the second service and append the modifier 25, some payers have programmed their claims processing systems to disregard the second service, treating the service as though it had not been provided. Similarly, CPT guidelines and conventions instruct a physician or other qualified health care professional on how to submit a claim when a procedure is performed on both sides of the body. Yet some payers require physicians to use a different coding convention, as described further below. Other examples of payer-specific adjustment of claims processing rules identified by state legislatures can be found in Appendix A.

The CPT coding guidelines are the result of the careful construction and definition of services by the CPT Editorial Panel and are an indicator that these services are separately defined and not included in the CPT office visit codes. Prior to

¹ The AMA Practice Management Center is a resource of the AMA Private Sector Advocacy unit.

² CPT is a registered trademark of the American Medical Association.

publication of CPT codes and guidelines, the CPT code set undergoes careful scrutiny by the CPT Editorial Panel, the CPT Physician Advisory Committee, the CPT Health Care Professionals Advisory Committee and the Relative Value Update Committee (RUC) to ensure that no duplication of services is supported by or inherent in the CPT codes. CPT guidelines are developed to assist in the distinction of services and defining inappropriate overlaps in CPT codes for reporting purposes.

The CPT codebook is the most widely accepted nomenclature for reporting physician procedures and services under government and private health insurance programs. The failure of payers to respond consistently to claims that are coded properly according to the CPT codebook makes it impossible for physician practices to efficiently reconcile their claims payments. They must grapple with inconsistent coding requirements and regularly changing payment edits by multiple payers, both of which are inconsistent among commercial payers and with the rules applied by the Medicare program. This needless complexity imposes a substantial administrative burden on physician practices and makes it difficult, if not impossible, to predict what they will be paid.

The standard application of CPT codes, guidelines and conventions is essential to an efficient claims processing system. Currently, the only implementation guidelines which Health Insurance Portability and Accountability Act (HIPAA) mandated covered entities, that is, physicians and other qualified health care professionals, payers and clearinghouses, are required to follow are the implementation rules for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code set, which identifies the patient's diagnosis associated with a given service. While CPT was adopted as a standard code set under HIPAA, the CPT guidelines and conventions were not. Payers thus are permitted to implement and interpret the CPT code set as they see fit. The AMA believes CPT guidelines and conventions must be adopted as a HIPAA standard along with the CPT code set, in order to standardize the billing and recognition of physician procedures and services. The lack of CPT implementation standards significantly undermines administrative simplification and pricing transparency efforts. This concern is magnified by the increasing share of financial responsibility for medical care being borne by patients. Simplification of the health care billing and payment process is imperative if patients are to understand what various medical services cost and thus become fully empowered consumers of health care services.

HIPAA and the adoption of the CPT code set

HIPAA began as a bipartisan effort to provide portability of health insurance benefits to individuals who left employment in a company that provided group health insurance. In response to this initiative and the additional expense of billing individuals for continuation of coverage, the health insurance industry requested standardization and promotion of electronic health care transactions. The health insurance industry argued that electronic health care transactions would reduce administrative costs and justify the new costs associated with premium billing and administration that portability would create. The health insurance industry's request became the "Administrative Simplification" component of HIPAA, called "Health Insurance Reform: Standards for Electronic Transactions." These standards include both the form and format of electronic transactions, as well as their content. The medical and nonmedical code sets selected for use include the ICD-9-CM Guidelines for Coding and Reporting and ICD-9-CM (Volumes 1, 2 and 3) code sets for reporting diagnoses in both the inpatient and outpatient settings and procedures in the inpatient setting. Although the CPT code set was also selected, the guidelines and conventions for using CPT were not adopted.

The Final Rule for Standards for Electronic Transactions released on August 17, 2000 discusses the standard data content for adopted standards designed to facilitate consistent and identical implementation. Although this includes data dictionaries and modifiers for code sets, it explicitly excludes operational guidelines and instructions for code sets. (See 65 FR 50322-50323, August 17, 2000.) The Final Rule argues that while standardization of code set guidelines are highly desirable, "objective, operational definitions for most codes are not available...the level of detail varies widely from code to code...the processes for developing guidelines and instructions are typically not open and include limited participation compared to the code development processes." (*Id.* At 50323) Despite this position, the Final Rule goes on to adopt the Official ICD-9-CM Guidelines for Coding and Reporting as maintained and distributed by the Department of Health & Human Services (HHS) but does not name guidelines for other code sets. On January 16, 2009, HHS published a final regulation that named ICD-10-CM as the new code set for reporting diagnoses beginning October 1, 2013 and also named the guidelines for use with the code set.

For the following reasons, AMA contends that the reasons expressed in the August 17, 2000 Federal Register for refusing to adopt the CPT guidelines and conventions along with the CPT codes as a HIPAA standard no longer pertain, and the CPT guidelines and conventions should be mandated as a HIPAA standard, just as the ICD-9-CM and ICD-10-CM guidelines have been mandated. First, on June 9, 2006, subsequent to the release of the Final Rule for Standards for Electronic Transactions on August 17, 2000, the process for development of guidelines and instruction for the CPT code set became open to observation and comment.

Second, recommendations of payer representatives on the CPT Editorial Panel from CMS, BCBSA and AHIP are an important part of the process for development of CPT coding guidelines. Recommendations for coding instructions are also frequently considered and accepted from representatives of the National Correct Coding Initiative (NCCI), which was developed and is produced by CMS to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Medicare Part B claims. The coding policies developed in the NCCI system are based on coding conventions defined in the CPT codebook. Other sources for CPT guidelines and conventions are national and local policies and edits, coding guidelines developed by national medical societies, analysis of standard medical and surgical practice, and review of current coding practice.

Third, and contrary to the comments contained in the August 17, 2000 Federal Register, the instructions and guidelines contained in the CPT codebook are subject to the same rigorous editorial process used to develop CPT codes. The CPT Editorial Panel and CPT Advisors consider CPT section guidelines, specific CPT code level instructions and definition, and the application of modifiers in conjunction with their development of language for CPT code descriptors. Thus, proper use of CPT codes is based on all the associated material contained in the CPT codebook. For example, so that users understand the circumstances for reporting each CPT code, simple, intermediate and complex integumentary (skin and underlying structure) wound closure procedures are defined in the CPT codebook prior to the actual wound closure CPT codes. Also, CPT coding conventions, such as “add-on codes,” are explained in the guidelines. For example, CPT code 15431 is a designated “add-on code,” intended to be reported only for additional service beyond what is already described by 15430 (implantation of acellular xenograft). The instruction that follows this CPT code indicates that CPT code 15431 can only be reported in conjunction with the base services described by CPT code 15430. The use of CPT codes and descriptors apart from this information limits the functionality of CPT and its uniform application. Parenthetical instructions and references in the CPT codebook also provide important information related to appropriate reporting of CPT codes or ranges of CPT codes. For example, the instruction that follows CPT codes 15430 and 15431 instructs users that these codes cannot be reported with debridement services, wound preparation CPT codes or a fistula repair CPT code because these services are considered to overlap and describe similar services.

More globally, instructions for the accurate use of the CPT code set are presented in the introduction of the CPT codebook and prior to each section or subsection of specific CPT codes. There are also parenthetical statements following many CPT codes that indicate procedures and services that are included and thus are not separately reportable. For example, an instruction follows the 3-D rendering CPT code 76376, which indicates a list of more than 20 radiology procedures that include 3-D imaging and cannot be separately reported. The first step when applying a CPT code to a service or procedure performed is to select the service or procedure descriptor that accurately identifies the service or procedure performed—not a CPT code that merely approximates it—and to review any guidelines, notes or parentheticals associated with the CPT code selected. (For an example of a comprehensive set of guidelines and instructions related to a CPT code(s), see Appendix C of this paper.) It is also important to code any additional procedures performed or pertinent special services provided. Additionally, an appropriate CPT modifier (according to the specific CPT guidelines for the modifier) must be appended to describe any modifying or extenuating circumstances when necessary. Diligent adherence to these guidelines preserves the integrity of CPT coding and thus ensures a common language whereby all stakeholders can understand precisely what services have been performed. This information is not just necessary for an efficient billing and payment system, but it is critical to the outcomes and other medical research necessary to achieve the optimal health care delivery system.

Finally, experience since the implementation of the standard electronic transactions clearly demonstrates that the lack of standard implementation rules for the CPT code set has in fact undermined the intent of administrative simplification. The CPT code set alone is inadequate to achieve this goal. There is wide variation among commercial payers, and between commercial payers and the Medicare program, both as to rules they impose on physicians and other qualified health care

professionals for the coding of claims prior to submission and as to the rules they use to process the claims once they are filed. Indeed, there is variation even within individual payers, depending on the product or claims platform on which the claim was processed. On the flip side, experience with ICD-9-CM has demonstrated the value of code set guidelines that accompany the code sets themselves. This value is conclusively evidenced by the fact that when HHS adopted the updated HIPAA diagnosis code set, ICD-10-CM, in January 2009, it also adopted the accompanying ICD-10-CM code set guidelines.

Since the release of the Final Rule, various requests have been made by the AMA to HHS and the National Committee on Vital and Health Statistics (NCVHS), a federal advisory committee to the Secretary of HHS on HIPAA and health information technology (HIT) matters, to have the CPT guidelines and conventions named in HIPAA. In April 2008, the AMA submitted a request to the Designated Standards Maintenance Organizations (DSMO), organizations named in law to develop and maintain HIPAA standards, to have the CPT guidelines and conventions named in HIPAA. The DSMO Steering Committee reviewed the responses from each DSMO and concluded that an assessment should be conducted to determine the impact that selecting coding guidelines will have on certain transactions (such as outpatient institutional claims) and the relationship with other HIPAA-adopted code sets, such as the Code on Dental Procedures and Nomenclature (CDT). The DSMO recommended that an industry group including all affected stakeholders be established to explore the issues and implications prior to the adoption of any recommendations by NCVHS. The DSMO reached out to the Workgroup for Electronic Data Interchange (WEDI), a body HHS is required by law to consult with on HIPAA matters, to begin this work.

The lack of CPT guidelines and conventions costs the health care industry, physicians and patients

1. Added administrative complexity and cost for the physician practice

Physicians are spending as much as 14 percent of their total revenue to obtain accurate payment for their services from payers.³ Even when a physician double checks the coding for the services provided, runs the claim through a practice management system code verification program and submits the correctly coded health care claim, payers may still inappropriately delay, deny or significantly reduce payments for the physician's services. The significant savings that would result from removing inefficiencies in the billing and payment process could be better spent on enhancing the quality of patient care and reducing the burden of high premium costs.

A physician who has contracts with multiple payers must maintain a different set of medical payment policies and claim submission requirements for each of the payers with whom he or she contracts. Imagine the complexity of a physician who contracts with 20 or more payers (which is not uncommon) and must maintain 20 or more differing sets of billing requirements and claims reconciliation policies. As another example, CMS accepts the use of CPT modifiers, but not all payers recognize modifiers. Different interpretations as to the application of a modifier may be defined by each individual payer (see the CPT modifier 50 discussion and example provided below). In addition, some payers "rebundle" the office visit into another procedure and/or service performed on the same day or "rebundle" a procedure into another procedure or service when performed on the same day in a fashion that is inconsistent with CPT guidelines and conventions.

How is a coder to keep each payer's coding and claim requirements straight? If CPT codes, guidelines and conventions were to be used, a coder could conceivably follow one set of guidelines and be able to meet each payer's claim requirements, making sure all claims are complete and accurate. This coding process would then parallel the process that coders currently use today following the ICD-9-CM coding guidelines to select the appropriate ICD-9-CM code to identify the patient's diagnosis. Similarly, claims reconciliation could be done following a standard algorithm, ideally programmed into the physician's practice management system.

Please refer to the AMA's "Standardization of the claims process" white paper, which specifically focuses on the AMA recommendation to concentrate future efforts on publishing new standards in areas that are crucial to fully automating the health care billing and payment system by requiring all payer claim edit packages to be transparent, standard and

³ James G. Kahn, Richard Kronick, Mary Kreger and David N. Gans, "The cost of health insurance administration in California: Estimates for Insurers, Physicians and Hospitals." *Health Affairs*: 24.6. 2005; 1629-1639.

consistent with the CPT codes, guidelines and conventions and for payers to apply payment rules (e.g., multiple procedure reduction logic rule) in the same manner.

2. System updates occur at varying times throughout the year, sometimes not until the next year

Annual updates of the CPT code set, including the guidelines and conventions, are released in the early fall, and the updated CPT code set is effective every January 1. The interval between the release of the update and the effective date is considered the implementation period to allow all users of CPT codes, guidelines and conventions to update their systems and charge masters to facilitate this annual system update. While physician practices are instructed to begin coding per the current CPT year as of January 1, many payers do not update their systems until June, if they update their systems during the current year at all. The inconsistency among payer updates results in unnecessary denials due to the payer not recognizing the current CPT codes.

3. Increased confusion regarding varying nontransparent payer coding guidelines

Some payers do not provide their coding guidelines to physicians, causing physicians to struggle with submitting the expected codes and modifiers that the payer will accept. The result is unnecessary delays and denials of the claims and added administrative costs, which is borne by the physician and, ultimately, the health care system. For example, a common nontransparent and inconsistent reporting of the CPT codes occurs when a physician performs a procedure that is commonly performed on one side on both sides of the appendage, such as the following example of the bilateral hernia repair below.

CPT coding guideline, bilateral procedure

“Unless otherwise identified in the listings, bilateral procedures performed at the same operative session should be identified by adding the modifier ‘50’ to the appropriate five-digit code.”

Illustration of modifier 50

A physician repairs bilateral inguinal hernias on a 2-year-old. The physician reports CPT code 49500—“repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible” with the modifier 50 appended.

AMA CPT coding guidelines

AMA CPT coding guidelines indicate that a single claim line entry is the appropriate method to report the above procedure.

Single claim line entry

For CPT code 49500—“repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy, reducible,” the CPT modifier 50 is appended to this unilateral procedure when a bilateral procedure performed at the same operative session is listed on the same line as the procedure performed bilaterally.

The appropriate single claim line entry reporting is: 49500 50.

CMS payment rules

The CMS payment rules include the coding rule that indicates that the physician should report a single claim line entry with the CPT modifier 50 appended to report a unilateral procedure performed on both sides. This policy is consistent with CPT coding guidelines, as set forth above.

Third-party payer payment policy

Third-party payers may require a double claim line reporting entry that is inconsistent with CPT coding guidelines. This simple contradiction results in increased administrative costs to payers and physician practices through misapplied claims.

Double claim line entry

For CPT code 49500—“repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible”: The first line item reflects the unilateral procedure (CPT code 49500) performed by the physician. The second line item reflects the second side of the unilateral procedure performed (CPT code 49500), appending the CPT modifier 50. The appropriate double claim line entry reporting is:

- CPT code 49500
- CPT code 49500 50

To further complicate the proper reporting of bilateral services, payers that require the single line item reporting may additionally require physicians to report one unit, while other payers may require two units to be reported on the claim form. Therefore, physicians who adhere to the payer requirement and report the performance of a bilateral procedure in a single line reporting method may still experience a denial if they report an incorrect unit on the claim.

The following demonstrates the three different ways different payers may require physicians and other qualified health care professionals to bill bilateral services:

24.	A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPICOT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From MM DD YY	To MM DD YY	CPT/HCPCS	MODIFIER												
1									49500 ¹	50			1		NPI	-----
2									49500 ²	50			2		NPI	-----
3									49500 ³	50					NPI	-----
4									49500 ³						NPI	-----
5															NPI	-----
6															NPI	-----

1. The appropriate single claim line entry reporting is: 49500 50 Days or units 1
2. The appropriate single claim line entry reporting is: 49500 50 Days or units 2
3. The appropriate double claim line entry reporting is:
 - CPT code 49500
 - CPT code 49500 50

This inconsistent reporting of bilateral procedures impacts the physician practice and the payer. If a physician reports the performance of a bilateral procedure in a format that is inconsistent with the way a specific payer’s claim platform processes claims that are appended with modifier 50, inappropriate or inaccurate payment will be applied to the claim. This results in an unnecessary chain of costly manual events: the payer makes an inappropriate claim denial and inaccurate payment; the payer submits an incorrect explanation of benefits to the physician; the physician is required to submit an appeal on the claim; the payer performs a reconsideration of the appropriateness of the claim payment; the payer makes a reversal to the claim; and finally, the payer submits another explanation of benefits and the associated payment to the physician.

Additionally, one payer recently turned on an audit set in its payment system, which automatically suspends claims with the modifier 50 appended for review. The payer explained that the suspension rules do not specify whether the claim can be paid or not paid. It merely states that the reviewer may check to make sure that there is not a second line listing for the same service. Consequently, the claim is sometimes approved, but often denied for those physicians who are using double claim line entry as they are required to do by some other payers. The payer considers this to be a clerical error on the physician’s part, and denies the claim. The practice could either call the clerical error phone line, or they could batch the denied claims and fax them to the clerical area reopening office for reprocessing. The problem is left for the physician practice to catch the denials and make the correction, even though it is a result of the variation within payers’ claim

platforms due to lack of adherence to the CPT coding guidelines for the appropriate reporting of bilateral procedures. The burden of staff time and expense to manually review each claim and submit an appeal to the payer is expected to be incurred by the physician practice. The payer is also incurring additional staff time, resources and expenses required for re-review and reconsideration of a claim that could have been paid appropriately the first time, if CPT guidelines and conventions were the applied standard across payers.

In 2007, the AMA engaged Medical Present Value Inc. (MPV) to perform a data analysis study on claims payments. MPV provided the AMA with a study of 75 physician groups, consisting of more than 20,000 physicians and 15 million claims from eight major health insurers. The following chart indicates the confusion created by the lack of adherence to CPT guidelines and conventions in relation to bilateral procedure reporting. Note how the reporting of this procedure varies among payers and even within a single payer. How can a physician practice keep up with the varying requirements based on which platform the claim submission will be processed?

Column 1	Column 2	Column 3	
	Bilateral procedure errors	One line item requirement	Two line item requirement
Payer A	37.1%	74.4%	25.6%
Payer B	39.4%	81.7%	18.3%
Payer C	35.1%	80.9%	19.1%
Payer D	46.1%	84.5%	15.5%
Payer E	57.4%	80.2%	19.8%
Payer F	51.1%	75.1%	24.9%
Payer G	26.0%	40.5%	59.5%
Payer H	43.0%	81.6%	18.4%

Column 1: Eight major payers included in MPV data analysis.

Column 2: Lists the rates at which the payers erroneously underallowed bilateral procedures billed according to the payers' requirements. Payer E has an extremely high error rate of 57.4%. Payer E represents 4,117 claims billed with bilateral procedures, which equals a total underallowed amount of \$362,064.

Column 3: Lists the payer's bilateral billing requirement according to its contracts with physicians or other qualified health care professionals.

Source: Medical Present Value Inc.

Cost to the system

If the physician practice staff does not report the bilateral procedure according to the method required by the payer, an underpayment could result, or the claim could be rejected. Typically, when the payer requires a double claim line entry but a single claim line entry consistent with CPT guidelines is submitted instead, the payer erroneously pays for the performance of only one side of the bilateral procedure.

In the absence of standard implementation guidelines, physicians and other qualified health care professionals today need to know the appropriate coding method of each payer, product and claim processing platform to ensure the appropriate reporting of a unilateral procedure that is performed bilaterally. The added cost to maintain and ensure compliance with the varied reporting requirements for each payer, product and claims processing platform is impossible for the small physician practice, and extremely costly even for very large physician groups. The misapplication of CPT codes results in increased costs. Industry estimates indicate it costs physicians around \$25 to resubmit or appeal a claim. Payers, in turn, incur approximately \$60 or more to reverse an erroneous determination, depending on how many claim appeals are required to rectify the inappropriate payment. This single yet significant coding convention is only one of numerous examples of the added cost and confusion that is created in the health care payment process through the inconsistent application of CPT guidelines and conventions during the processing of physicians and other qualified health care professionals' claims by payers.

4. Increased appeals on inappropriate claim payments

Because each payer has a different set of payment claim submission requirements, the physician who has contracts with multiple payers has a difficult time holding each payer accountable to the varying and oftentimes nontransparent coding rules and payment policies. This results in a greater number of appeals on claims that are processed and paid

inconsistently with CPT codes, guidelines and conventions. If CPT codes, guidelines and conventions were to be used consistently across payers, these types of inappropriate payments and unnecessary appeals on claims could be eliminated.

This profound imbalance in transparency, consistency and accountability has cost physicians dearly. An estimated 90 percent of claim denials are preventable, and 67 percent of denials are recoverable, according to the Advisory Board Company, a Washington-based research organization. Based on those estimates, physicians collectively lose billions of dollars of revenue to health insurers per year. This does not include the time, effort and expense to review, audit and appeal inappropriately paid claims.

Standardized application of CPT codes, guidelines and conventions would increase transparency between payers and physicians and between payers and patients. Standardization would also contribute to a decrease in the administrative costs associated with appeals and incorrect claims submissions for payers. Finally, standardization would increase the accuracy of the information available for outcomes and other medical research purposes on which services are actually being provided to patients.

AMA policy supports prompt, fair payment for properly coded claims

The AMA encourages payers to accept physician claims that have been accurately reported using applicable CPT codes, guidelines and conventions. Payers should report back to physicians and other qualified health care professionals and patients using the same codes or terminology, regardless of payment methodology and levels. Payers should not be allowed to require different submission requirements, nor should they be allowed to bundle and pay for only one of two services submitted, downcode a service or procedure to one of less intensity or less cost, or recode the physician's claim in the remittance advice.

CPT codes, guidelines and conventions should be adopted as a HIPAA standard

An AMA priority is to encourage consistent use of CPT codes, guidelines and conventions, as well as to advocate for the adoption of these standards to promote reporting consistency, increase communication in the health care community and reduce transaction costs. Acceptance of the CPT code set, guidelines and conventions does not standardize payment for documented and reported services. Rather, CPT guidelines and conventions only aid the users in applying CPT codes correctly and reporting payment in a consistent fashion, directly responsive to the claim as submitted. For example, one payer may pay \$100 for a particular procedure, while a second payer pays nothing, and a third payer pays \$110. Use of CPT guidelines and conventions would not dictate either benefit design or the amount of payment. The adoption of the CPT guidelines and conventions as a HIPAA standard, in addition to the CPT codes themselves, will reduce significant, unnecessary administrative costs in the health care billing and payment process and the associated reconciliation work incurred by all parties due to inconsistencies in the reporting and payer acknowledgement of physician procedures and services. Adoption of the CPT guidelines and conventions will also improve the integrity of the data on medical service utilization, which is critical to outcomes and other medical research. Given these profound benefits and the fact that the CPT guidelines and conventions meet the same tests for detail and stakeholder participation as the CPT codes themselves, there is no justification for further delay in mandating compliance with both the CPT codes and the accompanying guidelines and conventions.

Appendix A

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

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

The information that MCO is obligated to provide must, at a minimum, include:

- (i) a complete fee schedule upon which compensation will be calculated and paid and, if applicable, CPT, HCPCS, ASA, CDT and ICD-9-CM codes, and any applicable modifiers (CA, TX);
- (ii) a detailed description and copy of coding guidelines, policies, methodologies, and processes (whether standard or nonstandard), including, but not limited to, any bundling, recoding, or downcoding guidelines, policies, methodologies, and processes that MCO reasonably expects to apply on a routine basis to the claims contracted physicians and other qualified health care professionals will submit (CA, TX);
- (iii) a description of any other applicable policies or procedures MCO may use that affects the payment of specific claims submitted by physicians and other health care providers, including but not limited to, policies or procedures affecting recoupment, copayments, coinsurance, deductibles, risk sharing arrangements, and the liability of third parties (CA, TX, KY);
- (iv) information that will enable the physician or other qualified health care professional to determine the effect of edits on compensation before the physician or other qualified health care professional provides a service or submits a claim (CO);
- (v) the manner of payment (e.g., a fee-for-service or risk-sharing basis) (OR); and
- (vi) information about the methodology the MCO will use to reduce or increase the level of reimbursement (e.g., by providing a bonus or other incentive based compensation). (MD)

Specific payment rules and edits

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

- (i) consolidation of multiple services or charges (CA, NC);
- (ii) payment adjustments due to coding changes (CA, NC);
- (iii) reimbursement for multiple procedures (CA, NC);
- (iv) reimbursement for assistant surgeons (CA, NC);
- (v) reimbursement for the administration of immunizations and injectable medications (CA, NC);
- (vi) recognition or nonrecognition of CPT code modifiers (CA, NC);
- (vii) definition of global surgery periods (NC); and
- (viii) payment based on the relationship of procedure code to diagnosis code (NC).

Claims editing software information

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

Appendix B

Class action settlements

The Multi District Litigation (MDL) settlement agreements with Aetna Inc., CIGNA Corporation, Health Net Inc., Prudential HealthCare, WellPoint Inc. (Anthem) and Humana, and a related settlement agreement with Excellus Inc. and the recent Blue Cross Blue Shield (BCBS) settlement agreements arose from a national class action lawsuit challenging the health insurer industry's lack of transparency, inconsistent payment practices and unfair business practices.⁴ These settlements provide for greater transparency in payer claims processing and payment practices.

While there are differences between the various MDL settlements, overall, each of the MDL settlements require health insurers to change their business practices by adding transparency and fairness to their claims payment processes during the settlement's term. The settling health insurers agreed to comply with most AMA Current Procedural Terminology (CPT®) codes, guidelines and conventions, unless otherwise identified on the health insurer's physician Web site.

The settlements also generally provide that if state law offers more protection than a particular settlement, then state law applies. Following is the list of business practices addressed by these settlements. Please note, this settlement did not affect all health insurers and of those health insurers that did settle, Aetna and CIGNA's settlement commitments have expired, and WellPoint/Anthem's settlement will expire this summer.

MDL provisions

- All products clause prohibition
- Rental networks regulation and prohibition of Silent PPOs
- Usual, reasonable and customary definition/methodology disclosure
- Provide copies of contract upon written request
- Provide for faster credentialing
- Gag clauses prohibited
- Claim editing software transparency
- Retrospective audits and overpayment recovery limitations
- Prompt payment requirement
- Recognition of Modifier 25, Modifier 51, and Modifier 59
- Annual updates of CPT and HCPCS Level II codes
- No automatic downcoding
- Comply with most CPT codes, guidelines and conventions, unless otherwise identified on company Web site
- Disclosure of fee schedules for participating physicians
- Disclosure of payment rules
- Provide notice of changes in practices and policies and annual changes to fee schedules
- Improved medical necessity definitions
- Cover the cost of recommended vaccines and injectibles and for the administration of such vaccines and injectibles
- Where physicians are paid on a "capitation" basis, provide cost and utilization information, provide periodic reporting, and capitation from date of patient's enrollment
- Revise EOB and Remittance Advice content to reflect at minimum: information sufficient to identify Plan Member, date of service, amount of payment per line item, any adjustment to the invoice and explanation thereof for the adjustment and contact information for the Plan. EOB shall not disparage Non-Participating Physicians and each EOB shall indicate the amount the Physician may bill the Member. The EOB shall not characterize disallowed amounts as unreasonable.

⁴ A related settlement agreement, Excellus Inc. was approved May 23, 2005. According to its Settlement, Excellus will process and make eligible for payment all physician claims consistent with the current version of the AMA CPT®, Principles of CPT Coding, CPT Assistant and CPT Changes. Visit the AMA Web site at www.ama-assn.org/go/settlements to learn more about the Excellus Inc. settlement.

Dispute resolution

- Provide for independent, external Billing and Medical Necessity dispute processes
- Provide for independent, external Settlement Compliance dispute processes
- Arbitration fees capped
- Provide for Physician Advisory Committees

Appendix C

Example of CPT code guidelines and instructions

Hydration

CPT codes 96360–96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (e.g., normal saline, D5-1/2 normal saline+30mEq KCl/liter), but are not used to report infusion of drugs or other substances. Hydration IV infusions typically require direct physician supervision for purposes of consent, safety oversight or intraservice supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff that administer these do not typically require advanced practice training. After initial set-up, infusion typically entails little patient risk and thus little monitoring.

- 96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour
(Do not report 96360 if performed as a concurrent infusion service)
- 96361 Each additional hour (List separately in addition to code for primary procedure)
(Use 96361 in conjunction with 96360)
(Use 96361 for hydration infusion intervals of greater than 30 minutes beyond 1 hour increments)
(Report 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service [96360, 96361, 96365, 96374, 96409, 96413] is administered through the same IV access)
(Do not report intravenous infusion for hydration of 30 minutes or less)