National Committee on Vital and Health Statistics (NCVHS)
Subcommittee on Standards
Review Committee

Hearing on Adopted Transaction Standards, Operating Rules, Code Sets & Identifiers

June 16-17, 2015

Testimony for Panel 4 – Health care claim or equivalent encounter information (837)

Good morning. My name is John Evangelist. I am the Director of the Business Applications Management Group within the Office of Technology Solutions at the Centers for Medicare & Medicaid Services (CMS.)

I would like to thank the National Committee on Vital and Health Statistics for inviting me to testify and for the opportunity to provide information on the currently adopted standards, operating rules, code sets and identifiers used in administrative simplification transactions and the degree to which the aforementioned meet current industry business needs

During the previous session with NCVHS in February of this year, Medicare highlighted three areas we believe are important in drafting and implementing operating rules, flexibility of use, investment protection, and process improvement. We believe it is important for NCVHS to consider these three areas as it reviews the current adopted standards and operating rules related to value, volume, barriers, alternatives, opportunities and changes.

Today I will be presenting from the perspective of my area of responsibility within CMS. The group that I manage is responsible for maintaining Medicare Fee-for-Service claims processing and front-end systems as well as representing Medicare at various Standards Development Organization and data content committee meetings.

Specific to this panel regarding the Health care claim, we believe the currently adopted standards, operating rules, code sets and identifiers used in administrative simplification transactions do meet the business needs of Medicare in most cases, hence they provide value. However, there are instances where the current ASC X12 837 Technical Report 3s (TR3s) do not meet the business needs of Medicare. Locum tenens and subrogation are examples. Medicare has already submitted requests to ASC X12 to change a future standard.

Volume

Currently, 99% of Medicare Fee-For-Service claim transactions are being conducted electronically.

Barriers

Time and funding constraints are barriers for Medicare in implementing standards, operating rules, code sets and identifiers. The time it takes to develop, adopt and implement a standard may result in the standard becoming obsolete by the time of implementation thus, not addressing all of current business needs of the industry. Comparably, Phase IV operating rules have not been adopted under a final rule. Therefore, it is not fiscally sound to invest development time and funding until a final rule is in place.

Medicare continues to focus on process improvement when implementing standards and operating rules. We strive to follow an enterprise approach in developing and updating systems; serving as good stewards of the tax payer dollars entrusted to us.

Alternatives

Medicare does not recommend any alternatives to the ASC X12 837 claim at this point.

Opportunities

Opportunities for improvement submitted through the ASC X12 Request for Interpretation (RFI) process and the Designated Standard Maintenance Organization (DSMO) change request process should be incorporated in the new standard. RFIs often contain a recommendation for changes (improvements) to the next implementation guide (Technical Report 3) which could enhance the standard.

Changes

At this time, other than those for which CMS has made the appropriate change requests, CMS is not aware of any changes that are needed to the ASC X12 837 transactions, or to the proposed operating rules that affect the ASC X12 837 transactions.

Clean Claims

Medicare is satisfied with the quality of the clean claims being received. For Medicare Part A, clean claims are being achieved on average at 99% and for Medicare Part B 98%. For our durable medical equipment (DME) line of business we are achieving an average of 95.6% clean claims.

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Testimony for Panel 6 - Health Care Claim Status (276/277)

Value

As discussed in panel 4, the current adopted transactions meet the business needs of Medicare in most cases.

Volume

During calendar year 2014, CMS MACs transmitted 8,981,491 ASC X12 277 claim status responses for institutional claims and 92,950,231 ASC X12 277 claim status responses for professional claims. Medicare currently does not capture the percentage of claim status requests received electronically versus via the interactive voice response (IVR) systems, helpdesks, or Internet portals available through our Medicare Administrative Contractors.

Barriers

We have not identified any barriers for the health care claim status.

Alternatives

Medicare remains satisfied with the operating rule methodology. It is important to remember when moving forward that there may be multiple approaches to conducting attachment standards since the publication of the attachment proposed rule and alternatives should be considered when developing the recommended approach.

Opportunities

CMS Medicare is already using this transaction pair and sees no additional opportunities for its use.

Changes

Medicare recommends that previously adopted operating rules be amended to permit batch as an option rather than to force real-time claim status responses. Additionally, Medicare feels it would be helpful to make current requirements optional when they have been replaced in later operating rules. An example of this is the connectivity requirement with Phase II and Phase III operating rules requiring SOAP/WSDL and HTTP/MIME. With Phase IV, it appears the industry is moving toward only one method, SOAP/WSDL. For consistency, it would be best to have the same connectivity and security across all transactions, therefore removing the second connectivity requirement from Phase II and Phase III.

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Testimony Panel 7 – HEALTH CARE PAYMENT, REMITTANCE ADVICE AND ELECTRONIC FUNDS TRANSFER (835)

Value

Specific to the Remittance Advice, we believe the currently adopted standards, operating rules, code sets and identifiers used in the transactions do meet the business needs of Medicare fee-for-service.

Volume

Medicare Fee-For-Service issued 62,409,574 Electronic Remittance Advices (ERAs) during calendar year 2014. Therefore, the current Medicare Fee-For-Service percentages of remittance advice transactions being conducted electronically is: 70%.

Barriers

We have not identified any barriers in implementing the health care payment and remittance advice.

Alternatives

Specific to the ASC X12 835 remittance advice, Medicare does not recommend any alternatives.

Opportunities

Medicare believes that continued collaboration with future versions of the ASC X12 835 standard will yield greater opportunities for improvement.

Changes

CAQH CORE is continuously improving the processes for maintaining the code combination list and ERA/EFT enrollment form. These changes will greatly address the business needs of the industry.

Status of use of CARC/RARC code sets

Medicare Fee-For-Service is in the process of ensuring that all CARC/RARC code combinations included in the ASC X12 835 remittance advice comply with Operating Rule 360: Uniform Use of CARCs and RARCs. Medicare is abiding by the CAQH CORE 360 Rule for use of the CARC/RARC code combinations and is using the most current version of the CORE Code combinations.