STATEMENT OF LABORATORY CORPORATION OF AMERICA HOLDINGS (LABCORP) TO THE REVIEW COMMITTEE OF THE NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS (NCVHS) ON ADOPTED TRANSACTION STANDARDS, OPERATING RULES, CODE SETS AND IDENTIFIERS

Laboratory Corporation of America Holdings (LabCorp) appreciates the opportunity to share with the NCVHS Review Committee its experience in conducting electronic transactions with its trading partners for the record of the Committee's June 16-17, 2015 hearing to review currently adopted standards, operating rules, code sets and identifiers used in administrative simplification transactions.

LabCorp's clients include physicians, government agencies, managed care organizations, hospitals, clinical labs, and pharmaceutical companies. Currently our organization mainly utilizes the following transaction sets listed in Table 1. These transactions are submitted to and/or received from our trading partners in batch transactions or single transactions via a phone call or payer website. A project to trade 270/271 real time transactions with many payers via electronic transmission is currently underway. These transactions represent formats mandated by HIPAA as well as transactions agreed upon with willing trading partners such as the 277CA and the 834.

Table 1: Transaction List

Transaction	Transaction Name	Method of Trade
270/271	Health Care Eligibility Benefit Inquiry and Response (270/271) Transactions	Batch Mode and Single Transaction via Payer Website
277CA	Claims Acknowledgement	Batch Mode
278	Health Care Services Request for Review and Response	Single Transaction via Phone and Payer Website
834	Benefit Enrollment and Maintenance	Batch Mode
837P	Professional Health Care Claim	Batch Mode
835	Health Care Claim Payment Advice	Batch Mode
TA1, 997, 999	Acknowledgements	Batch Mode

	Proprietary Acknowledgements	Batch Mode

As a national provider with reported revenues of $6 billion in 2014, we submit the Professional Health Care Claim (837P) transaction to 1,190 different payers across the United States. Submission of the 837P to these payers generates an average of 10,480 files each week. LabCorp utilizes direct connections to many payers as well as the services of several clearinghouses to channel files to other payers through 168 different portals of entry. Combined, these electronic files equate to 95% of LabCorp's revenue. Of these files, 3% is sent to Medicare, 7% to Medicaid and 90% is sent to Managed Care payers. See Table 2 for specifics.

Table 2: Average Files per Week by Line of Business

Medicare		Medicaid		Managed Care		Total
Files	% of Total	Files	% of Total	Files	% of Total	Files
329	3%	694	7%	9,457	90%	10,480

As an indirect provider, LabCorp only has face-to-face encounters with approximately 30% of the patients for whom we provide testing. For this 30% of our population, performing real time eligibility via payers' web portals is beneficial despite the administrative burden of maintaining the security information for each site. For the laboratory industry, often patients are not scheduled in advance so payers' websites provide valuable insight into billing information while the patient is submitting the test request at the patient service center. For the 70% of our patient population that does not cross our threshold, billing information is obtained from the referring provider. For the eligibility transactions we do perform, our experience shows if a payer returns a negative response it is still beneficial to submit the claim to the payer identified by the referring provider. Often payers' adjudication systems are more robust so they will locate the member and adjudicate the claim despite the negative eligibility response. Members get caught in the middle of eligibility and adjudication logic differences. The eligibility transaction has the capacity to report eligibility at a service level; however many payers may only respond at

this optional level. The transaction should provide a "covered" or "not covered" response when a provider submits the date of service, CPT code and a valid diagnosis code.

There is potential for additional operating rules to improve the eligibility transaction. A rule to require member numbers on insurance cards to be the biggest, most prominent information on the card would be helpful. There is also a need for the group number to be displayed in a similar fashion. Today many payers insert the health plan number in front of the member identification creating confusion in identifying the correct information for billing. Eligibility information obtained from health plan portals should match the information a payer collects from an eligibility response transaction.

To protect LabCorp's revenue stream, receipt and processing of every submitted file is confirmed. The confirmation process is the number one challenge associated with electronic transactions with our trading partners. We deploy the following process to ensure payers receive our files and are able to process the information.

The Implementation Acknowledgment (999) is the first level of comprehensive reporting a payer may send back to a provider as part of its business exchange process. This transaction is meant to enhance the exchange of the ASC X12 transactions. The 999 reports compliance with the syntactical structure associated with the 837P standard. This report echoes back to the provider both transaction set and functional group information found in the 837P. Since this is a standard transaction, providers are able to write programs to automate the process of matching submitted 837P files with the files payers report accepting or rejecting via the 999. LabCorp is able to automate the confirmation of 85% of our submitted files at a high level using the 999. Since HIPAA did not include an acknowledgment transaction, not all trading partners are willing to develop the acknowledgement transaction that complements ASC X12 transactions. However, the 999 transaction only supplies information regarding accepted and rejected files. LabCorp's experience has shown that a payer may accept a transaction set or functional group, but that is not a guarantee the claims will be processed.

The next step in the process of confirming payers' receipt of our files and processing of our claims is to utilize the claim status reports payers may generate. These reports allow us to determine the total number of claims accepted, pended or rejected. This status information is reported at the transaction set and functional group. Then, at the claim level, the reasons for

pending or rejecting the claims are also provided. This information allows our organization to set up an audit trail to track the revenue stream. Today Medicare uses a 277 Claims Acknowledgement (277CA) transaction to report the acceptance or rejection of claims. Many payers have followed the lead of CMS and implemented the use of the 277CA in their claim acknowledgement process while others continue to generate proprietary reports. Unfortunately, the proprietary reports are very dynamic and require constant support from trained analysts to maintain the integrity of the data extracted. Many of the proprietary reports do not provide the details required to prove a payer has moved the submitted claims into its adjudication system; therefore, LabCorp employs full time employees to augment the information received.

All payers receiving files containing 10 claims or more which have not acknowledged the acceptance of the claims into their adjudication systems receive a phone call from one of our 11 employees assigned to this task. The goal is to have the payer confirm, via an interactive voice response system (IVR) or verbal confirmation, that the claims have been accepted for adjudication. For files that have 9 or fewer claims, individual claims are monitored for either a payment or rejection.

The whole process outlined above is in place to ensure LabCorp's files or portions of the files are not rejected. Rejected files create pockets of delayed revenue. The rejections may be a symptom of new edits payers have put into place, such as rejecting diagnosis codes that are not at the highest level of specificity (or in the near future, the correct version). If the rejections are not caught on the first day, the rejected files continue and the impact to the revenue stream is compounded. Timely filing limits are also a concern. Many payers have a 90 day filing limit which would prevent the resubmission of rejected files without notice by the confirmation team. In this case, the revenue is not billable.

In the interest of administrative simplification, LabCorp has several suggestions regarding how to streamline the file confirmation process. The first suggestion is to require the use of the Interchange Acknowledgement (TA1). This transaction provides immediate awareness of the file status in the file exchange process. The second suggestion is to adopt the Implementation Acknowledgment (999) for all batch transactions. The 999 reports compliance with the implementation guides, while the 997 only reports compliance with the standard on which the transaction is based. Another suggestion is for the Health Care Claim

Acknowledgement (277CA) to be adopted as the claim status format. One standard format would allow for providers to automate the audit trail of submitted files.

With each version upgrade to the transactions, providers must address differences in the interpretation of each transaction. For the 837 transaction, health plan certification is a step toward mitigating interpretation differences between payers and providers.

As the health care industry evolves, providers and payers find the need to address unexpected challenges with the submission of claims. For example, pay for performance initiatives create the need to reconcile laboratory results with claim encounter information. It is not uncommon for a test result to be sent to a referring provider and the patient's health plan, if authorized. However, once a test request is fulfilled, laboratory administrative systems may not generate a claim that exactly matches the test request. Administrative systems may consolidate information to one claim, or may hold the claims pending valid billing information or enrollment with the payer. If a laboratory does not submit a claim that a payer may associate with the test request in a timely manner, the referring physician may not be paid correctly.

Yearly updates to the code sets contained in the mandated transactions create the need for providers to perform additional analysis to protect the revenue stream. Operating rules to address when the industry should retire one code set and adopt the replacement code set would be very beneficial. Also directions to follow CPT coding guidelines associated with the use of modifiers would help providers to alleviate payer specific edits. LabCorp looks forward to working with CAQH CORE to develop operating rules to address these opportunities for administration simplification.

A thoughtful review of the adoption of ICD-10 as a HIPAA code set cannot be complete without assessing the manner in which it is being implemented, particularly when it appears it is being implemented in a manner that was not intended. It has come to our attention that certain Medicare Administrative Contractors (MACs) are using the process of converting local coverage determinations (LCDs) from ICD-9 to ICD-10 as an excuse to limit coverage without following applicable procedural requirements for coverage changes, rather than the objective crosswalking exercise it was intended to be and for which the General Equivalence Mappings (GEMs) were designed. It is important for NCVHS to be aware of this misuse of the ICD-10 implementation process and to make appropriate recommendations to CMS to protect the integrity of the HIPAA

code set adoption and implementation process in general and to preserve the intent of ICD-10 adoption in particular.

Currently the laboratory industry experiences the need to utilize both solicited as well as unsolicited claim attachment models. Requests for additional information from health plans drive the need for attachments. Attachment-type requests are received along the whole life cycle of a claim once it has been submitted to a payer for processing. Payers may need the information for adjudication, for pre-payment or post-payment reviews as well as for audits. For a laboratory, requests for information include test requests, test results, remittance notices from other payers, referring provider office notes, as well as Advance Beneficiary Notices (ABNs).

There is a need to ensure additional documentation requests are submitted to the entity that generates the required information. It is not uncommon for a payer to ask the laboratory for the medical records to support the need for a test. Laboratories have limited patient contact. They often do not have access to the information that generated the need for testing, patient chart history or data. Medical necessity information should come from the referring provider, not the indirect provider that performed the ordered service. When LabCorp receives requests for medical records, we petition the referring provider to submit the information to the payer directly. Storage of another provider's PHI presents another level of complexity for privacy and security considerations. Today, the only mechanism to track whether the ordering/referring provider submitted the additional documentation is to track the recovery of payments made by payers that did not receive the requested documentation. Referring providers do not currently have an incentive to supply the additional documentation, since the recovery of funds is collected from the laboratory instead of from the provider that generated the request for service.

As mentioned, additional documentation LabCorp may be asked to submit directly to the payer includes referring provider test requests, test results, remittance notices from other payers as well as Advance Beneficiary Notices (ABNs). A laboratory should be permitted to submit unsolicited information to payers at the time of claim submission. Guidelines around when to submit an Advance Beneficiary Notice (ABN) with a Medicare claim is an example of a possible rule. Documentation for pre-payment reviews performed by several Medicaid programs would be another example of an opportunity to submit the information to the payer along with the

claim. Willing trading partners should have the ability to define parameters to submit unsolicited information to prevent delays in claim processing.

Payers often do not utilize the correspondence address when requesting additional information. Requests are often sent to the laboratory that performed the service. The resources required to respond to requests are not located within the laboratories that perform testing. When the correspondence address is not utilized by a payer, providers are at a severe disadvantage to respond to information requests prior to the payer closing the pended claim. At this point the payer may pay the claim at a decreased rate or not at all. When requests are sent to an incorrect location, precious time is lost while the paperwork finds the correct resources within our organization. Currently payers send requests for additional information with the expectation of the additional information being returned in as little time as 24 hours, but sometimes we have up to 60 days. Recently, a few payers have expanded their response window to 75 days. Electronic transactions could solve the misrouting of requests for information. Electronic transactions require a line of communication to be established, ensuring the delivery of the payload to the correct location.

The Electronic Submission of Medical Documentation (esMD) process to return additional information requested by government audit contractors is a model that could be used to propel the industry forward in adopting claim attachments. The process today allows for the provider to return unstructured information to the auditor electronically. Admittedly, this model is not perfect. LabCorp looks forward to the day when requests for additional documentation are sent electronically by the auditors instead of by mail. However, this is a step in the right direction and provides the foundation for the attachment process to grow.

Currently adopted HIPAA transaction standards and operating rules do not meet the needs of laboratories with respect to prior authorization procedures required by many payers. The prior authorization process is extremely inefficient, subject to significant variation among payers, and often hampered by ambiguous policy requirements. Application of prior authorization requirements to services provided by indirect providers such as laboratories is problematic to begin with, from a patient care perspective; however, if payers are going to apply such requirements, they need to be simplified and expedited administratively. NCVHS should prioritize this issue for appropriate recommendations to HHS as soon as possible.

The process of acquiring a prior authorization is a challenge. Many payer policies are ambiguous. If the policy references continuity of care, LabCorp will seek a prior authorization. If the payer advises a prior authorization is not required, the next step is to request a predetermination to help secure payment for the testing. Some referring providers try to acquire the prior authorization for our organization at the same time they request authorization for their services. The referring providers are often unsuccessful in acquiring authorization for the indirect provider because they do not have information such as the tax identification or NPI of the provider that will be performing the test. Indirect providers also have to navigate the in-or out-of-network contracting provisions of the patient's health plan with the payer. A referring provider may enjoy an in-network status with the health plan while referring testing to a laboratory that may be out- of- network with that payer.

Since HHS adopted operating rules for health care electronic funds transfers (EFT) and remittance advice, LabCorp is able to match 90% of our payments to the 835 transactions we receive. This is an improvement. For the 10% of the transactions that cannot be matched automatically we find the payers may not send the 835 transaction if the money reported within the transaction is out of balance. When this situation occurs, our organization is forced to utilize the paper remittance or payer's website to obtain the details required to properly apply the payments received to patients' accounts. One solution to this challenge would be an operating rule that would require payers to identify and isolate the claims that do not balance and allow the remaining information to be sent electronically.

The overpayment and recovery process within the current 835 transaction is very cumbersome for providers to track and reconcile. Given that payers must meet so many different state regulations regarding notification of a recovery there may be another opportunity where operating rules could help improve the process. Another possible solution is for a separate transaction to be created to allow for overpayment and recovery information to be reported. It is not uncommon for payers to recover money in installments over time forcing the providers to track the recovery of money to resolution. This same transaction could be used by the payers to provide the advance notification. LabCorp appreciates the advance notification. It affords us the opportunity to investigate and proactively submit a refund to the payer.

Thank you for the opportunity to share LabCorp's experience in exchanging electronic transactions with our trading partners. We urge NCVHS to move forward in making recommendations to HHS that will address the challenges we have identified.