

1           **National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards**  
2           **Review Committee Hearing on Adopted Transaction Standards, Operating Rules, Code Sets &**  
3   **Identifiers**

4           **National Center for Health Statistics 3311 Toledo Road, Auditorium A&B Hyattsville, Maryland**  
5   **20782**

6   **June 16-17, 2015**

7           PANEL 4 – COORDINATION OF BENEFITS

8           PANEL 7 – HEALTH CARE PAYMENT, REMITTANCE ADVICE AND ELECTRONIC FUND  
9   TRANSFER

10          **WRITTEN TESTIMONY**

11          **Part 1 – General Comment on HIPAA Administrative Simplification Standards’ effects on**  
12   **Coordination of Benefits and on Health Care Payment**

13          Electronic Data Interchange (EDI) is the transfer of data from one computer system to another by  
14          standardized message formatting, **without the need for human intervention** (emphasis added).  
15          The transaction standards adopted in accordance with HIPAA’s Subtitle F – Administrative  
16          Simplification support EDI in theory, but not necessarily in practice.

17          Although the 837D (dental claim and encounter) and the 835 (remittance advice) transactions are  
18          able to support automated payer to payer coordination of benefits (COB), and reimbursement  
19          reconciliation, such use is far from universal in the dental community. Among practicing dentists COB  
20          is a repetitive out and back process: 1) Dentist to Payer A; 2) Payer A return to Dentist; 3) Dentist to  
21          Payer B (with Payer A’s payment information); and 4) Payer B return to Dentist.

22          **What are the circumstances that preclude full implementation and use of functions these**  
23   **transactions are capable of supporting? How might the obstacles be overcome?**

24          Coordination of benefits (COB) is one of the most confusing aspects of dental benefit program  
25          administration facing both patients and dentists. Staff at the American Dental Association (ADA)  
26          receive many inquiries regarding coordination of benefits as dentists and their office staff often are  
27          not aware of the COB rules that affect reimbursement. Dental carriers coordinate benefits  
28          inconsistently, which can be very confusing.

29          One influence on COB consistency is that the process is subject to provisions of state insurance law.  
30          While state insurance law can vary from state to state, most states follow a model adopted by the  
31          National Association of Insurance Commissioners (NAIC).

32          Such state laws apply when the medical or dental plan is a state regulated carrier, but are not  
33          applicable to employer self-funded and collectively bargained medical and dental plans that operate  
34          under the federal Employee Retirement Income Security Act (ERISA) of 1974. These self-funded  
35          plans provide dental benefits to more people (70.7 million / 53%) than fully-insured plans (62.3 million  
36          / 47%). ERISA plans have widely varied COB clauses.

37          Recently, the ADA has been receiving more calls from dentists that indicate the secondary carrier  
38          refused any additional payment because it had the same benefit level as the primary carrier. These  
39          calls refer to a non-duplication of benefits provision commonly found in self-funded plans. Non-  
40          duplication is the term used to describe one of the ways the secondary carrier may calculate its  
41          portion of the payment if a patient is covered by two benefit plans. The secondary carrier calculates  
42          what it would have paid if it were the primary plan and subtracts what the other plan paid.

1 For example, if the primary carrier paid 80 percent, and the secondary carrier normally covers 80  
2 percent as well, the secondary carrier would not make any additional payment. If the primary carrier  
3 paid 50 percent, however, the secondary carrier would pay up to 30 percent. This provision seems  
4 unfair to the patient that paid two premiums (or cost of coverage) but received no benefit from the  
5 second plan for which coverage was paid. We are aware of one state, California, which has enacted  
6 legislation prohibiting such provisions.

7 Dental offices have found that it is hard to find a consistent pattern in which carrier is primary and  
8 secondary. This is something the dentist has to determine because the secondary carrier requires an  
9 explanation of benefits (EOB) statement from the primary carrier to process a claim. Many times  
10 dental offices are told by both plans that neither plan is primary. It would be helpful if third parties  
11 providing or administering dental benefits would adopt a unified standardized formula for determining  
12 primary or secondary coverage and the formula could be readily applied by dental providers based on  
13 information easily obtained from the patient.

14 There is also confusion when the carriers covering a patient provide different types of coverage - a  
15 capitation plan, a PPO plan and an indemnity plan. Then what happens when one plan is state  
16 regulated and the other is not? The ADA believes that if COB were standardized, dentists could  
17 better estimate the appropriate reimbursement and patients would have a better understanding of  
18 how the whole COB process works.

19 The ADA policy is based on a simple premise - the patient should get the maximum allowable benefit  
20 from each plan. In total the benefit should be more than that offered by any of the plans individually,  
21 but not such that the patient receives more than the total charges for the dental services received.

22 Coordination of benefits can be a win-win for both patients and dental practices. Patients with more  
23 than one dental benefits program may be more likely to visit their dentists more frequently, knowing  
24 all or at least some of the treatment costs will be covered by a combination of the two programs. Out-  
25 of-pocket expenses for more complex and expensive procedures may be reduced or sometimes even  
26 eliminated.

27 The ANSI ASC X12 837Dv5010 transaction set named as a HIPAA standard is intended to support a  
28 variety of business purposes, including automated payer to payer COB. At this time the ADA is not  
29 aware of any instance where this capability is being exercised. The repetitive and time consuming  
30 dentist to payer to dentist process appears to be the norm. If so, one source of administrative  
31 simplification savings lies fallow. A dentist's original claim submission includes, where known,  
32 information on primary and secondary coverages. Primary payers have the opportunity and means to  
33 exchange information directly with the secondary payer or payers, but with no incentive in place. The  
34 ADA recommends that the appropriate federal agency identify and implement such an incentive, with  
35 preference given to a positive inducement in lieu of punitive action for non-compliance.

## 36 **Part 2** – Response to Specific Questions Posed by the Review Committee

37 The Review Committee has posed a number of general questions to all panelists on all panels, as  
38 well as questions applicable to specific panels. The ADA, representing dentists within the dental  
39 community, offers the following responses to those questions that fall within our experience and fact-  
40 finding.

### 41 General Questions to All Panelists Applicable to All Panels

42 **2. VALUE – Overall, do the standards, code sets, and identifiers adopted for each transaction**  
43 **meet the current (and near-term) business needs of the industry?**

44 ADA RESPONSE: The current suite of HIPAA named transaction standards, including code

1 sets and identifiers, meet the current and near-term needs of dentists. Standard transactions  
2 are, by and large, invisible to dentists. Creation, transmittal and receipt are behind-the-  
3 scenes activities performed by dental practice management system vendors or  
4 clearinghouses. Likewise, acquisition and use of National Provider Identifiers is an  
5 accomplished fact. Named medical code sets, however, present a different scenario.

6 Dentists are long familiar with the Code on Dental Procedures and Nomenclature (CDT  
7 Code) and are conversant in its appropriate use. Diagnosis codes, especially ICD-10-CM as  
8 the incipient HIPAA standard, are not widely known or used by dentists other than those  
9 specializing in oral and maxillofacial surgery. The ADA has prepared and published tables  
10 that associate CDT Codes with ICD-9-CM and ICD-10-CM codes that describe the dentist's  
11 clinical findings. The ADA has also created maps that associate SNODENT, ICD and CDT  
12 codes for use by commercial entities and dental schools. SNODENT is the recognized dental  
13 subset of SNOMED-CT that is used for clinical documentation in Electronic Health Records.

14 **7. BARRIERS – Is there any perceived or qualified degrees of variability in stakeholders'**  
15 **usage of adopted transactions and operating rules?**

16 ADA RESPONSE: Anecdotal information suggests that there is wide variation in  
17 implementation and use of the adopted transactions. The HIPAA standard electronic dental  
18 claim (837Dv5010) is the one in greatest use.

19 Dental offices make use of avenues such as third-party payer web portals for other routine  
20 activity such as eligibility verification. Portals also provide information on claim payments  
21 (e.g., Explanation of Payment or EOP) made to dentists via electronic funds transfer. ADA  
22 staff have been told by several member dentists that the 835 transaction would be of value if  
23 its content could be automatically processed by dental practice management software, as  
24 well as claim adjustment and remittance advice reason codes that are common and  
25 consistent for all third-party payers.

26 There is no information about operating rules available to the ADA, and there is no response  
27 to this part of the question.

28 **11. OPPORTUNITIES – What, if any alternatives exist for improving efficiency and**  
29 **effectiveness of the business process for each of the transactions adopted and in use?**

30 ADA RESPONSE: Coordination of benefits is one of the most confusing aspects of dental  
31 benefit programs for both patients and dentists. In an effort to streamline the whole claim  
32 adjudication process, the ADA: 1) has proposed a standardized explanation of benefits form  
33 (EOB) for the reporting of dental claim adjudication that could become the industry standard;  
34 and 2) recommends that third-party payers and administrators implement automated payer-  
35 to-payer COB, a capability long present in the HIPAA standard transactions.

36 **13. OPPORTUNITIES – What alternatives exist to achieve greater efficiency and effectiveness**  
37 **between trading partners?**

38 ADA RESPONSE: When a patient has coverage under two or more group dental plans the  
39 following rules should apply:

- 40 a) The coverage from those plans should be coordinated so that the patient receives  
41 the maximum allowable benefit from each plan.
- 42 b) The aggregate benefit should be more than that offered by any of the plans  
43 individually, allowing duplication of benefits up to the full fee for the dental services  
44 received.
- 45 c) ADA recommends that third-party payers, representing self-funded as well as insured

1 plans, should adopt these guidelines as an industry-wide standard for coordination of  
2 benefits.

3 In addition, third parties providing or administering dental benefits should adopt a unified  
4 standardized formula for determining primary or secondary coverage and the formula should  
5 be readily applied by dental providers based on information easily obtained from the patient.

6 General Questions to Panel 7 (ERA/EFT)

7 **8. What alternatives exist to achieve greater efficiency and effectiveness between trading**  
8 **partners?**

9 ADA RESPONSE: As noted in the ADA response to general question #7 (BARRIERS)  
10 member dentists state that automated reconciliation between their accounts receivables and  
11 payment information on the 835 transaction would be beneficial as this will eliminate the time  
12 and cost incurred for manual reconciliation. The current need for manual intervention arises  
13 for various reasons, such as a gap in dental practice management software functionality or  
14 deficiencies in user familiarity with the full capabilities of the software. The ADA has  
15 partnered with CAQH on a survey of major dental practice management software vendors to  
16 determine how many offer applications that support automated reconciliation between  
17 accounts receivable and payment information on the 835. Four of the five contacted have  
18 said yes and a reply from the last is pending. Our next step is, again with CAQH, to develop  
19 and implement a provider education program on this functionality with the goal of achieving  
20 broader adoption and use within the dental practitioner community.

21 Special Topic/Questions for Panel 7 – healthcare payment, remittance advice and electronic  
22 fund transfer

23 Status of CARC/RARC code sets

24 ADA RESPONSE: The ANSI ASC X12 835v5010 transaction set named as a HIPAA  
25 standard contains information that enables a recipient dentist to allocate reimbursements  
26 sent separately to patient accounts where monies are due. Both claim adjustment reason  
27 codes (CARC) and remittance advice reason codes (RARC) code sets are incorporated by  
28 reference in the 835 transaction to support transmittal of information in a consistent manner  
29 between sending and receiving entities. However, there is no requirement that the words  
30 associated with any of these codes be used verbatim on an explanation of benefits (EOB) or  
31 an explanation of payments (EOP) document delivered to patients or dentists. The ADA sees  
32 the absence of such a requirement as a gap that hinders full achievement of HIPAA  
33 Administrative Simplification goals.

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