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

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

June 16-17, 2015

PANEL 4 – COORDINATION OF BENEFITS

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

WRITTEN TESTIMONY

Part 1 – General Comment on HIPAA Administrative Simplification Standards' effects on Coordination of Benefits and on Health Care Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

General Questions to All Panelists Applicable to All Panels

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

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

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

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

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

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

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

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

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

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

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

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

a) The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.

b) The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

c) ADA recommends that third-party payers, representing self-funded as well as insured

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

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

General Questions to Panel 7 (ERA/EFT)

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

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

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

Status of CARC/RARC code sets

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

Testimony submitted by

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