**SUBMITTED TO**
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS SUBCOMMITTEE ON STANDARDS**
**June 16-17, 2015**

**Presented By: Sherry Wilson**
**EVP and Chief Compliance Officer, Jopari Solutions**
**President, Cooperative Exchange**
***The National Clearinghouse Association***

Members of the Subcommittee, I am Sherry Wilson, President of the Cooperative Exchange (CE), representing the National Clearinghouse Association and Executive Vice President and Chief Compliance Officer, Jopari Solutions. I would like to thank you for the opportunity to submit this testimony on behalf of the Cooperative Exchange membership concerning the Adopted Transaction Standards, Operating Rules, and Code Sets & Identifiers.

**BACKGROUND ON THE COOOPERATIVE EXCHANGE**

The Cooperative Exchange is the nationally recognized resource and representative of the clearinghouse industry for the media, governmental bodies and other interested parties.

The Cooperative Exchange's 26 clearinghouse member companies[1], represent over 80% of the clearinghouse industry and process annually over 4 billion claims representing $1.1 trillion, from over 750,000 provider organizations, through more than 7,000 payer connections and 1,000 HIT vendors. Combined with our non-profit members (AMA, ASC X12N and UHIN) and Supporting Organizations (Axiom, BancTec and MEA) the Cooperative Exchange ***truly represent the healthcare industry EDI highway infrastructure*** and maintains hundreds of thousands of highways and the majority of the on and off ramp connections across all lines of healthcare business in this country.

The Cooperative Exchange member clearinghouses support both administrative and clinical industry interoperability by:

- Managing tens of thousands of connection points;
- Securely managing and moving complex data content including administrative and clinical information;
- Receiving and submitting both real time and batch transactions;

[1] Apex EDI, Availity, LLC, Cerner, ClaimRemedi, Dorado Systems, Emdeon, eProvider Solutions, GE Healthcare, Greenway Health, Health-e-Web, Inc., HDM Corp.,InMediata, InstaMed, Jopari Solutions, Inc., NextGen Healthcare, OfficeAlly, OptumInsight, PassportHealth, PracticeInsight, RelayHealth, Smart Data Solutions, The SSI Group, Trizetto Provider Solutions, WorkCompEDI, Xerox EDI Direct, ZirMed (Go to www.cooperativeexchange.org for a complete membership listing)

- Providing interoperability by normalizing of disparate data to industry standards;
- Providing flexible solutions to accommodate the different levels of stakeholder EDI readiness low tech to high tech);
- Actively participating and providing strong representations across all the national standard organization with many of our members holding leadership positions.

Therefore, we strongly advocate for EDI standardization and compliance within the healthcare industry. We are committed to promote and advance electronic data exchange for the healthcare industry by improving efficiency, advocacy, and education to industry stakeholders and government entities.

**BACKGROUND OVERVIEW**

Clearinghouses have been major participants in the health care EDI industry since before the HIPAA requirements came into effect. Initially, the industry believed that with the advent of uniform EDI standards in the industry, there would be no further need for clearinghouses – it was expected that providers would send standard transactions directly to payers. However, that has not come to pass and clearinghouses continue to play a pivotal role.

There are a number of reasons that clearinghouses continue to service the majority of transactions. Despite the attempts at standardizing transactions, there remains variability within the transactions to require expert processing and creation of a standard transaction. Providers continue to submit a myriad of formats to clearinghouses and look to the clearinghouses to provide a standard transaction for the payer. This transformation of the data is a key role that the clearinghouses perform daily. During the transition to new versions of the HIPAA transactions, clearinghouses as the rails of EDI are called on to ensure providers and payers can stay on track by managing the variability and different versions of the transactions.

Clearinghouses provide a single point of contact for providers and even payers, allowing them to exchange transactions while maintaining connectivity with very few sources. Providers do not want to (nor have the resources to) establish and maintain connectivity with the large numbers of payers that they send and receive numerous transactions. In turn, some payers do not want to maintain connections for every provider they exchange transactions.

Clearinghouses have the capability of implementing virtually any type (ASC X12, HL7, API, proprietary formats etc.) transaction for communicating between trading partners. However, we note to NCVHS that there is significant cost for each new transaction or major change in a transaction, for development, implementation, and training of customers. The Cooperative Exchange urges NCVHS to consider the expected adoption rate of transactions, to enable clearinghouses to focus resources on those transactions which will be frequently used by providers and plans. It has been frustrating for our members to build capabilities for customers which are barely used.

Somewhat more troubling is the small percentage of payers who do not support the standard transactions at all, and/or send or require non-compliant transactions. This requires considerable data maintenance for clearinghouses, adding cost and complexity to the system and prohibiting us from achieving some of the goals and return on investment (ROI of Administrative Simplification).

While a CMS enforcement system is in place, many submitters are either not aware of the process or still somewhat reluctant to file a complaint against a payer for fear of damaging an important business relationship. We would encourage CMS provide additional educational outreach regarding their complaint process and making the industry aware of successful complaint resolutions.

**SURVEY OVERVIEW**

In support of our testimony, WEDI in collaboration with the Cooperative Exchange conducted a national survey of health plans and clearinghouses between May 12, 2015 and May 27, 2015. The survey measured the adoption, use and impact of standards, code sets, identifiers and operating rules, and some of their associated challenges, barriers, and opportunities. Responses were received from 177 organizations, including 68 health plans, 12 Medicare/Medicaid plans, 17 clearinghouses, 21 software vendors, and 17 clearinghouse software vendors. The survey asked 31 questions around ten ASC X12 standards: prior authorization (278), remittance advice (835), premium payment (820), claim status (276/277), benefit enrollment (834), eligibility (270/271), healthcare claims (837I, 837D and 837P), and electronic fund transfer (EFT). [2] The clearinghouse responses from this survey were used to provide the comments contained in this testimony.

In addition to the above mentioned survey, a second joint WEDI/Cooperative Exchange Volume and Transaction survey specific to clearinghouses was conducted to further identify submitter and payer transaction usage, volume and format applications between May 12, 2015 and June 10, 2015. The survey results conveyed throughout these comments were pulled from the second joint WEDI/Cooperative Exchange Transaction Survey. Responses were received from 17 clearinghouses representing 2/3rds of the membership.

| Percentage of Clearinghouse Support | Yes | No |
|---|---|---|
| Professional Claims | 100% | 0% |
| Institutional Claims | 100% | 0% |
| Dental Claims | 82% | 18% |
| Eligibility Benefit Inquiry and Response | 88% | 12% |
| Claims Status Request and Response | 94% | 6% |
| Health Care Services Request for Review and Response (Prior Auth/Referral) | 40% | 60% |
| Claim Payment Advice (ERA) | 100% | 0% |
| Premium Payment | 21% | 79% |
| Benefit Enrollment | 21% | 79% |
| Claims Request for Additional Information | 40% | 60% |
| Additional Information to Support a Health Care Claim | 56% | 44% |

Clear instructions and scenarios were provided to the survey respondents in order to obtain informative results.

[2] WEDI June 16 and 17th 2015 NCVHS Testimony

Responders were asked if their company:

- Does not support the transaction
- Supports the transaction but no one is using it
- Supports Direct Data Entry

The following guidelines were used in the reporting of the responses:

- Clearinghouses that have a product in front of their clearinghouse (Translator, Conversion Engine, etc.) reported the format of the transaction they receive INTO their product.
- Percentages reported for every transaction and format was reported for the Clearinghouse's Direct Payers for the last year.
- Clearinghouses were asked to report, only for transactions that are typed in and do not include the actual upload process from a provider or to a payer (i.e. if the Provider is uploading an 837 file to the Clearinghouse portal it was included in the ASCX12 response.

Please note responses are indicative of the transactions that flow through the clearinghouse directly to the payer, and do not include direct submitters or other types of intermediary exchange and may not be reflective of the overall industry.

**HEALTH PLAN ELIGIBILITY, BENEFITS INQUIRY & RESPONSE – (NCVHS Panel 2)**

**Value**

The eligibility transaction is key to the success of the claim payment cycle. When properly used, the transaction could give a provider the necessary information about a patient's health insurer prior to care including, clear identification of all the entities involved in the claims payment process, available coverage, required documentation, prior authorization, requirements to help the provider file claims appropriately and get paid promptly for services. The survey results showed that the expected benefits have not been realized by stakeholders. The current transaction does not support the information needed for automating the eligibility process, which results in providers using web portal or phone applications to obtain more detail eligibility information. The next version of ASC X12 270/271 has addressed most of the content barrier issues which will help to facilitate transaction adoption if used properly.

**Barriers**

The quality of the benefit information returned in the ASC X12 271 Benefit Response is still not where it needs to be in order for providers to avoid picking up the phone to verify coverage. Often payers have disparate systems that impede real time processing and or sending incomplete information that result in providers leaving their automated workflow processes.

Patient benefit plans are becoming more and more complex and that complexity (tiered benefit, narrow networks, etc.) is not always communicated in the eligibility response. Although the transaction supports the ability to send a request specific to the services using CPT/HCPCS codes, most payers do not respond at that level of detail. Providers need specific patient benefit information at this level; they

need to know if an authorization or referral is required for a procedure or service prior to the delivery of care.

**Opportunities**

Benefit information obtainable through a payer web portal continues to contain better information than provided in the ASC X12 271 format. Web portals are a stop gap measure to meet the business needs of providers and reduce phone calls to payers. The industry needs to find a way to adjust EDI quicker to meet the constant change in business needs. That said, the ASC X12 270/271 transaction needs to be more agile. There must be a way to make subtle upgrades to the standards as new business needs arise rather than waiting years to mandate a new standard. In many cases, the standard being adopted is already out of date due to the complexity and timing of the standards development and rule making processes.

Future versions of the standard provide the ability for submitters to send the information providers need to move toward automated billing and provides the information that the AMA requested to "provide for the clear identification of all the entities involved in the claims payment process, including:

1. Entity with primary financial responsibility for paying the claim;
2. Entity responsible for administering the claim;
3. Entity that has the direct contract with the health care provider;
4. Specific fee schedule that applies to the claim;
5. Specific plan/product type;
6. Location where the claim is to be sent; and
7. Any secondary or tertiary payers.

In the current transaction, a submitter is unable to provide the majority of the above information.

We urge NCVHS to recommend the following to HHS:

- Encourage payers to respond to HCPCS/ CPT eligibility requests and provide benefit information, authorization requirements and referral requirements;
- Encourage PMS systems to maintain the capability to send/receive eligibility transactions and automate the use of this information within its workflow;
- WEDI facilitate an industry forum for stakeholders to address identified barriers and strategies for remediation;
- Move forward with the adoption of the next version of the standard transactions;
- Explore ways to move the industry forward with new versions in a timelier manner;
- Study a staggered approach to adopting each standard transaction individually based on the return on investment brought to the industry. There are limited resources allocated to the development of standard transitions and operating rules which supports a staggered approach. This must be done based on the interoperability of the transactions insuring that related changes are not negatively impacted by such an approach.

**PRIOR AUTHORIZATION – (NCVHS Panel 3)**

**Value**

Automation of the current manual prior authorization process has been a high priority for providers. However due to the low volumes of this transaction, the expected value of this transaction to automate prior authorization has not been realized warranting further research. The inability of Payers to provide real-time or timely determinations using this transaction even if they have implemented the transaction contributes to the lack of provider request for this transaction and low adoption rate.

**Volume**

| Prior Authorization | % From Providers |
|---|---|
| ASCX12 | 20% |
| WEB | 76% |
| Proprietary | 4% |

Since a majority of stakeholders do not use the Prior Authorization transaction, it is not surprising, only 20% of providers are submitting this transaction in the ASCX12 format through clearinghouses, while 76% use the Clearinghouse Web Portal. The remaining 4% use proprietary methods.

**Barriers**

This standard has not been widely used for a variety of reasons:

- Providers are not asking their PMS vendors to support this transaction, so there is no incentive for vendors to build the capability;
- The quality of the ASC X12 278 Response does not meet the provider's business need to discontinue additional methods of verification. Real time verification most often results in "I received your request and I am processing". Providers must leave their workflow to call, use a web portal or run another prior authorization transaction to check the "status" of the prior authorization request, which negates the value of the transaction;
- Often times, the process to review the request for authorization is done outside of the typical workflows. The payer may outsource its medical review or it may be performed manually by its medical review team outside of the current EDI flow. This presents a barrier for real-time responses as the transaction is routed to another system for processing. Until this workflow is changed, the expectation of an immediate response beyond "Received" is low.

**Opportunities**

We urge NCVHS to recommend to HHS that further research be completed to confirm that the next HIPAA version will remove the barriers and provide ROI before adopting.

In order for the ASC X12 278 Prior Authorization to be effective, the ability to send and receive supporting documentation is needed. We strongly encourage NCVHS to recommend to HHS to allow the 275 attachment transactions to be considered to support this purpose. The ASC X12 275 standard attachment transaction can be used as the envelope to carry the necessary attachment information when an authorization is requested. This would assist in expediting the authorization response, since

many payers are currently unable to provide a ASC X12 278 real time response that includes the authorization number or an approval process.

**HEALTH CARE CLAIM OR EQUIVALENT ENCOUNTER INFORMATION (NCVHS Panel 4)**

**Value**

Claims are the most widely adopted and used transaction in the industry, which proves EDI can bring the ROI we are requesting for each transaction. With the different formats for institutional, professional, and dental providers, the survey results showed that these transactions have generally met the current industry business needs and achieved the transaction intent.

The results clearly indicate that the role of the clearinghouse in facilitating the transition from legacy and proprietary formats continues to be critical in moving the industry forward with implementation of EDI transactions. With the clearinghouse's intermediary assistance, the adoption rates of the claim transaction and the associated ROI has been achieved.

Please refer to the Volume and Transaction Usage section below for survey results.

**Volume and Transaction Usage Survey Results**

| Professional Claims | % From Providers | % of Direct Payers | % of Transaction Volume |
|---|---|---|---|
| ASC X12 5010 Format | 61% | 93% | 92% |
| ASC X12 4010 Format | 12% | 0% | 0% |
| 1500 Image | 17% | 2% | 2% |
| Direct Data Entry | 5% | 0% | 1% |
| Other | 5% | 4% | 5% |

| Institutional Claims | % From Providers | % of Direct Payers | % of Transaction Volume |
|---|---|---|---|
| ASC X12 5010 Format | 77% | 93% | 92% |
| ASC X12 4010 Format | 8% | 0% | 0% |
| UB-04 Image | 9% | 2% | 1% |
| Direct Data Entry | 3% | 1% | 1% |
| Other | 3% | 4% | 6% |

| Dental Claims* | % From Providers | % of Direct Payers | % of Transaction Volume |
|---|---|---|---|
| ASC X12 5010 Format | 83% | 98% | 97% |
| ASC X12 4010 Format | 6% | 0% | 0% |
| ADA 2012 Image | 6% | 1% | 0% |
| Direct Data Entry | 4% | 1% | 1% |
| Other | 1% | 1% | 2% |

***Note** – Dental Claims have a greater variance and may not be reflective of the overall industry due to the small volume of dental claims being submitting through clearinghouses.

**Barriers**

While most payers tend to support the ASC X12 837, most providers relate to the claim format and use terminology applicable to the 1500 Claim and UB-04 Forms or their data entry screens. Their lack of knowledge with ASC X12 837 and other EDI formats and terminology creates a communication gap between providers and payers, requiring additional support from clearinghouses to resolve issues and better understand the status of their claims.

**Opportunities**

While our members process over 4 billion claim transactions on an annual basis in the current format, the Cooperative Exchange understands that change requests have been submitted to ASC X12 from the industry to address new business requirements. These change request support upcoming expected changes in bundled payments, ACOs, and increased patient responsibilities that may prove challenging if the next version of the claim transaction is not adopted in a timely manner.

We recommend that NCVHS urge HHS to bring together the national standards organizations, operating rule body and other appropriate associations to work together to address needed changes and to identify the optimal ways to stagger transaction implementation to meet the industry needs. We continue to believe that not all transactions must be updated to the next version at the same time and encourage further study how staggered transactions could positively benefit the industry.

We recommend that NCVHS propose to HHS that claims not be included in the next phase of operating rules.

**COORDINATION OF BENEFITS – (NCVHS Panel 5)**

**Value**

The submission of secondary claims (etc.) is not a separate transaction but is in fact a part of the mandated remittance advice (ASC X12 835) transaction. It is our experience that although many secondary payers will accept the COB information in the remittance advice, some will not process without the initial EOB. Value is realized when COB is performed electronically and the payment information on the remittance advice is accurate and accepted by the secondary payer. When the following barriers are addressed, payers should be strongly encouraged to perform COB electronically to alleviate the need for providers to handle secondary claims manually as required by their patient's dual coverage.

**Volume**

Medicare performs a large volume of COBs; however minimal use is realized by midsized and smaller payers whose contracts and formularies are more complex and detailed.

**Barriers**

There are three reasons that payers are not processing or are rejecting the COB transactions: 1) Payers do not have other payer information on the subscriber, so the payer stops the processing to validate the secondary payer; 2) Payers do not know how to handle zero dollar payments; 3) Providers receive the Remittance Advice transactions that do not balance.

Clearinghouses receive a small portion of the COB claims but handle all the COB claims received process and send them to the secondary payer.

The accuracy of the payment information coming from the remittance advices creates barriers for creating a compliant outbound secondary claim. The accuracy with the Medicare COB's needs to be investigated as it was raised as a concern. With an increase in standard valid payment information (Charge and Claim based) on the remittance advice, the larger commercials payers' payment on the secondary payments will be improved. The key to COB is the accurate and actionable payment information on the remittance advice and clear standard definitions to reduce the margin of error.

Many payers still require the payers' EOB as validation of the payment and do not adjudicate from the paid amounts in the COB section of the claim.

The complexity and detailed contracts increase the challenge for payers to provide accurate payment information. All information sent on electronic information must transparent and programmable. We encourage employers and payers to develop transparent fee schedules and benefit designs. Transparent, complex information can be programmed, but ambiguous information cannot.

**Opportunities**

Every Clearinghouse has the ability to send COB info; it is the quality and amount of the payment/rejection data that is the key to success.

The potential for COB is great, further study is recommended to address the barriers listed above.

**CLAIM STATUS INQUIRY/RESONSE – (NCVHS Panel 6)**

**Value**

The WEDI/Cooperative Exchange survey of health plans and clearinghouses survey results show there is a significant variability in the use of the claim status transaction which creates a barrier to automated processing and return on investment. The transaction can be enhanced when stakeholders comply with response times, adopt acknowledgments, and improve the specificity of code explanations for payment adjustments and denials to mitigate the need for provider phone calls to the payer that unnecessarily drive up healthcare costs.

**Volume**

The WEDI/Cooperative Exchange survey results indicated moderate to extreme variability in the usage of claim status transactions and operating rules. Reported formats used range from ASC X12, phone, Web and Proprietary formats.

The Cooperative Exchange recommends that further research be conducted to determine the actual usage and adoption of the Claims Status Transaction.

**Barriers**

Many payers continue to offer more complete responses on their web portals or IVRs versus the information on the ASC X12 277 Claims Status Response. Some payers that have not mapped their claim status rejection/pending proprietary codes to the most detailed standard codes are not providing the detail information to assist the provider in identifying the current status of the claim. The quality of the claim status response is not granular enough to stop a provider from picking up the phone or simply just resubmitting the claim. A high number of transaction still continue to fail because the payer could not locate the claim or the claim was not on file and produced false positives which again requires provider to re-verify or stop using the transaction all together. Not all payers return line level claim status information.

Many smaller providers still believe the transaction is not cost effective and checking a website or using phone verification is "free". Another barrier is the lack of a transaction audit trail that results in delay and or duplicate communications between the payer and provider. The lack of an audit trail to verify that communications were received and or sent results in manual communication processes which impedes the goal of workflow automation.

From the onset of claim EDI, the providers have adopted the unsolicited claim and the application of the ASCX12 277CA Health Care Claim Acknowledgement reports to obtain file status reporting from their clearinghouses and vendors. The use of the ASCX12 277CA transaction has been built into many PMS and provider workflows. These reports enable the providers to facilitate workflow automation and eliminate the need to request status since these reports are delivered each day. The ASC X12 277CA Health Care Claim Acknowledgment transaction reports provide an electronic audit trail reducing phone calls and duplicate claims submissions.

**Opportunities**

Any issues with ASC X12 276/277 are reduced when the ASC X12 277CA format is used in the Claim submission life cycle. In areas where the ASC X12 277CA transactions are mandated via state or local legislation there is a reduced utilization of the ASC X12 276/277. The ASC X12 277CA augments the cycle by providing immediate critical information for providers to understand the status of a claim.

The Cooperative Exchange urges NCVHS to recommend to HHS that further research be completed to confirm that the next HIPAA version will remove the barriers and provide ROI before adoption.

We further recommend that NCVHS work with WEDI and other standards organization to determine the use of the ASC X12 277CA as an alternative to the real time request and response to increase ROI.

**HEALTH CARE PAYMENT, REMITTANCE ADVICE AND ELECTRONIC FUND TRANSFER – (NCVHS Panel 7)**

**Value**

Clearinghouses see a considerable number of ERAs and EFTs, which have increased in recent years due to standardization and the requirement to support EFTs. According to the WEDI/Cooperative Exchange

survey of health plans and clearinghouses the EFT and ERA transactions and operating rules are generally providing benefits.

Please refer to the Cooperative Exchange Volume and Transaction Usage survey results for EFT and ERA below for insight to submitter and payer application usage. Please note that these numbers only ***represent Electronic Transactions that pass through a Clearinghouse and do not reflect direct communications of remittance advices from a payer to a provider***.

**Volume and Transaction Usage**

| Remittance Advice | % To Providers | % of Direct Payers | % of Transactions Volume |
|---|---|---|---|
| ASC X12 Format | 75% | 86% | 71% |
| Image file (PDF, JPG, etc.) | 1% | 2% | 0% |
| Text file (User-readable TXT) | 8% | 0% | 11% |
| Delimited (CSV) file | 0% | 2% | 0% |
| Web Portal | 14% | 4% | 17% |
| Proprietary format | 1% | 6% | 1% |
| Other | 0% | 0% | 0% |

**Barriers**

While the transaction has improved, there is still a lack of precise information given to providers to explain denials and differences in payment amounts.

However the intended business value to be able to implement an automated end to end workflow process is significantly impeded due to: 1) the complexity of enrollment ; 2) PMS not supporting auto reconciliation of ERA/EFT; non-compliant ERA transactions that result in manual intervention; and 3) lack of consistency in the use of the CARC RARC Codes across payers. These contributing factors impede ROI which directly is reflected in the adoption rate of these transactions.

In addition, the “reconciliation” process between ERAs and EFTs is still an issue for many providers. In many cases this is due to non-compliant activity such as multiple ERAs for a single EFT, or failure to supply the required reassociation data in the files. Furthermore, payers’ systems may create the payment and/or ERA files grouped differently than needed by the provider (e.g. TIN vs NPI) causing the provider to be unable to reconcile and direct the payment or remittance to the appropriate system for posting. These types of issues reduce the likelihood of providers to re-associate the ERA and EFT and can cause providers to remain on paper transactions.

Another area where ERA files may be out of compliance is in the balancing of the ERA transactions. When the ERA transaction does not balance, the provider do not know what adjustments or other information is missing, and cannot use the electronic file, which requires the use of manual processes to reconcile. Providers will remain on or revert to paper transactions rather than attempt to resolve these types of issues with the payer. These issues are barriers to adoption of the ERA and EFT. This also

reduces or eliminates the ROI for the providers because they have to create alternate manual processes and work these payments out of their typical workflow (EDI process).

Practice management systems contribute and add to the above mentioned issues when their software is out of date and do not allow providers to receive the most recent payment remittance detail. Cooperative Exchange recommends PMS systems either fall under the HIPAA umbrella or that their system MUST be content compliant with the most current ERA standard.

**Opportunities**

The Cooperative Exchange understands that change requests have been submitted for enhancing the 835 transaction to ASCX12 from the industry and supports moving forward to the next version of the ASC X12 835 transaction under HIPAA.

These change requests support an improved method of reporting Claim Adjustment Reason and Remark Codes, stronger language and additional guidance on balancing, and many other enhancements that resolve issues seen today and facilitate automated posting by the provider. The barriers reported above will continue to be seen if the next version of the 835 transaction is not adopted as the next HIPAA version in a timely manner. We would encourage NCVHS to recommend to HHS to bring together the national standard setting organizations, operating rule bodies as well as other appropriate associations to work together to identify the optimal ways to implement updated versions of the transactions to meet the industry needs.

We advocated at the last NCVHS hearing that the industry needs to establish an evaluation process to determine the ROI of the transactions and Operating Rules at the business and technology level, as well as across stakeholders, prior to implementing standards, operating rules, code sets and or transactions. Currently, all entities that are part of the "transaction chain" from the payer to the provider are not considered covered entities under HIPAA, and this causes challenges in ensuring that providers receive the information and automation that they need to realize the benefits of the electronic transactions. The Cooperative Exchange recommends that Practice Management System Vendors are to be included as covered entities under HIPAA, and thus be subject to the Transaction and Code Set rule to ensure Practice Management Systems send and receive content compliant transactions, most specifically ERA. The survey results show that regardless of mandates the infrastructure to automate these transactions are still not in place today and impedes workflow automation and ROI.

**CARC/RARC Opportunities**

To achieve the ROI of the ERA, the reasons and remarks for adjustment/denials must be assigned to the most specific actionable code and programmable to remove the costs associated with manual provider review. Payers are mandated to adhere to CAQH CORE Rule 360: Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes Rule. However, there continues to be confusion and variance in codes that are used across payers. We would highly recommend the ASC X12 Technical Report Type 2 (TR2): Code Value Usage in Health Care Claim Payments and Subsequent Claims be named as a source for those scenarios that fall outside of the current CAQH CORE Rule 360 as a

guideline to assist payers in applying the appropriate actionable reason and remark codes that promote a consistent automated workflow.

We encourage the collaboration between CAQH CORE and ASC X12 in order to provide a more comprehensive CARC RARC resource for all lines of health care business. It is recommended that the industry adopt a more comprehensive CARC RARC resource containing both the CAQH CORE Rule 360 and the ASC X12 TR2: Code Value Usage in Health Care Claim Payments and Subsequent Claims including instructions explaining how to use both resources in combination to obtain the most actionable mapping that will promote automation and reduce manual effort for both the provider and the payer.

The combination of these two resources will provide the industry with a comprehensive set of codes and scenarios with the standard code combinations, along with additional data that can assist with determining the most appropriate codes and assist with automation for all lines of business (both covered and non-covered entities).

**Additional Transactions**

The Cooperative Exchange continues to advocate as previously testified at the February 26th, 2015 NVCHS meeting that HHS adopts the ASCX12 Acknowledgement Reference Model as a standard transaction under HIPAA. One of the issues which impact the industry is the sender's lack of knowledge that their transaction has been received and also forwarded on. An acknowledgement transaction would help resolve this issue by providing an EDI transaction audit trail similar to the Federal Express model.

WEDI/Cooperative Exchange EFT and ERA Volume and Transaction Usage survey results show that the adoption of the Enrollment Transaction and the Premium Payment Transaction is low. We recommend that NCVHS recommend to HHS that these transactions be removed from the HIPAA Transactions and Code Sets Rule. Without the employer being considered a covered entity the mandate to implement does not carry any weight. The standard would still be available for voluntary adoption and free up resources with payers and clearinghouses to focus on the real ROI.

**Standardizing the Data Collection**

The Cooperative Exchange appreciates the work of the Subcommittee and the information gathering by all of the many organizations involved. We encourage the Subcommittee and the contributing organizations to work together on a standard set of questions/data requests which can be provided on a regular basis to give us a picture of the status of HIPAA transaction use and benefits. We hope this will give the committee a tool to be used in deciding on future updates to the standards.

**Summary of Recommendations**

NCVHS is encouraged to recommend to HHS:

- Adopt the next version of the ASC X12 transactions (7030) as the next HIPAA mandated version, while investigating the feasibility of a "staggered" or alternate implementation approach

- Extend HIPAA TCS standards and operating rule requirements to Practice Management Systems and other business associates, similar to the privacy and security provisions
- Increased enforcement and audits to ensure compliance with HIPAA mandated transactions and operating rules.
- An attachment standard should be adopted for use with both the claim and prior authorizations.
- Standard acknowledgement transaction should be adopted as a HIPAA mandated transactions (999 and 277CA).
- Ensure cross standard setting body development (i.e., ADA, ASCX12, CPT, HL7, ICD, CAQH CORE, HL7, NCPDP, NUBC, NUCC and others) to support upcoming emerging payment models and other innovations occurring within the industry proactively.
- CMS publicize the successful outcomes from complaints for HIPAA incompliance, which were filed.
- Payers support or return authorization and benefit information at the CPT/HCPCS code level, which will reduce the need for provider to make phone calls to payers, as well as perform unnecessary prior authorization requests.
- The subcommittee and organizations work together on a standard data set to monitor industry usage of the HIPAA transactions.
- Include the ASC X12 Technical Report Type 2: Code Value Usage in Health Care Claim Payments and Subsequent Claims along with CAQH CORE Rule 360 as part of the requirements for Claim Adjustment Reason Code and Remittance Advice Remark Code usage.

Again, we encourage NCVHS to strongly recommend to HHS that the implementation of these different components be done on an incremental approach defined by an industry interoperability road map. The financial, business and technical implementation impact to our stakeholders and the clearinghouse industry to coordinate over 7,500 provider organizations , over 1000 HIT vendors and 7,000 plus payers is significant, An incremental implementation approach would mitigate the administrative burden that our stakeholders are faced with today and increase adoption.

Thank you for the opportunity to submit this testimony of behalf of the Clearinghouse industry. We look forward to continuing to work collaboratively with NCHVS and respective stakeholders to bring about administrative simplification in the industry.

Respectfully Submitted,

Sherry Wilson, President
Cooperative Exchange
*The National Clearinghouse Association*

Cooperative Exchange
The National Clearinghouse Association

# Adopted Transaction Standards, Operating Rules, and Code Sets & Identifiers

## COORDINATION OF BENEFITS (Panel 5)

**Cooperative Exchange Testimony**

**Department of Health and Human Services**

**National Committee on Vital and Health Statistics**

**Subcommittee on Standards**

**Presented by**

**Sherry Wilson, President**

**June 17, 2015**

# Cooperative Exchange

*National Association of Clearinghouses*

- Twenty six member companies representing over 80% of the clearinghouse industry
- Exchange **BOTH** administrative and clinical transactions ( format agonistic)
- Submitting provider organizations - over 750,000
- Payer connections – over 7,000
- IT vendor connections- over 1,000
- Claims transactions - over 4 plus billion annually
- Value of transactions –over $1.1 Trillion

Cooperative Exchange
The National Clearinghouse Association

# COORDINATION OF BENEFITS (Panel 5)

**Value**

- Is realized when COB is performed electronically and the payment information on the remittance advice is accurate and reliable.
- The intent of the transaction is lacking due to gaps in payer business processes, integrity of data content and compliance use of the remittance advice transaction

**Volume**

- Medicare performs a large volume of COBs; however minimal use is realized by midsized and smaller payers whose contracts and formularies are more complex and detailed.

**Barriers**

Some CE Members report that payers are not processing or are rejecting the COB transactions for the following reasons:

- Payers do not have other payer information on the subscriber, so the payer stops the processing to validate the secondary;
- Payers do not know how to handle zero dollar payments;
- Providers receive Remittance Advice (835) transactions that do not balance

# COORDINATION OF BENEFITS (Panel 5)

**Barriers (cont.)**

- The accuracy of the payment information coming from the remittance advices 835's creates barriers in generating a compliant outbound secondary claim.
- Many payers still require the payers' EOB as validation of the payment and do not adjudicate from the paid amounts in the COB section of the claim.
- The complexity and detailed contracts increase the challenge for payers to provide accurate payment information.
- Transparent, complex information can be programmed, but ambiguous information cannot.

**Opportunities/Recommendations**

- Every Clearinghouse has the ability to send COB info; it is the quality and amount of the payment/rejection data that is the key to success .
- The potential for COB is great, further study is recommended to address the barriers listed above.

# Cooperative Exchange

## Thank You

**Contact Information:**
Sherry Wilson, President,
Cooperative Exchange
sherry_wilson@jopari.com

Tim McMullen, JD, Exec. Director
tim@cooperativeexchange.org