The American Clinical Laboratory Association ("ACLA") is pleased to respond to the request of NCVHS to participate in the NCVHS hearing on February 16, 2016 on the proposed Phase IV Operating Rules by providing the following written testimony. ACLA is an association representing national, regional, and local clinical laboratories in the United States. As our member laboratories provide millions of clinical laboratory testing services to patients every day, they are directly impacted by the rules governing the administrative transactions necessary for reimbursement. Our testimony focuses on the questions below.

QUESTIONS FOR PANELISTS

We understand that NCVHS is using the following factors in evaluating exiting and new standards, code sets, identifiers and operating rules for possible adoption:

- Does the standard/operating rule meet the industry's business need/use/problem resolution?
- Does the standard/operating rule decrease cost and/or administrative processes?
- Is the standard/operating rule flexible/agile to meet changes in technology and/or healthcare delivery systems?
- Can the standard/operating rule be operationalized?
- Can the standard/operating rule be enforced?

In addition to these concepts, we also understand that NCVHS is also looking at the following variables to evaluate the degree to which the standards and operating rules being recommended for adoption meet the overall goal of administrative simplification:

- Completeness: does the standard or operating rule provide the complete information necessary to execute the transaction and achieve the business purpose?
- Efficiency: does the standard or operating rule decrease resource utilization and the time to perform the transaction function?
- Complexity: Do the standard or operating rule requirements exceed the healthcare industry's cost and resource capacity resulting in limited or non-adoption?

- Flexibility: does the standard or operating rule allow for interim updates and can it adapt to changes in technology and health delivery models?
- Consistency: is the standard or operating rule able to be implemented in the same manner across all healthcare entities?
- Effectiveness: does the standard and operating rule solve the business need?
- Ambiguity: does the standard or operating rule result in differences in interpretation and in implementation?

With respect to any question not answered below, ACLA does not have an opinion on the matter at this time, but reserves the right to supplement its response at a later date.

PART 1 – OPERATING RULES

Proposed Operating Rules – Questions for Industry and ACLA's Responses

Describe the industry's perspective on the proposed operating rules regarding the following:

- Do the proposed operating rules comply/support with the existing standards?
    - Claims: Yes.
    - Prior Authorization: For the laboratory as an indirect provider, there is a gap in supporting prior authorization, and the prior authorization process is inefficient. When a laboratory receives a specimen for testing, the number one focus is patient care. Regardless of administrative information, testing is performed as quickly as possible. In many cases, the services that require prior authorization may drive life changing decisions. A one day delay in delivering the test results could alter the treatment plan.

      Since ordered tests drive patient care, testing is begun immediately upon receipt of a specimen and a test order, while the prior authorization or predetermination process is concurrently submitted to the payer. If prior authorization is required, the only way for laboratories to secure payment is for the laboratory to receive the prior authorization before the test result is returned to the ordering provider. If a payer returns the authorization after a test is resulted, the laboratory will submit the claim to the payer knowing that the probability of payment is minimal. Some payers will accept the claim into their adjudication systems but request additional documentation. Currently, the

submission of the requested documentation leads to a payment for about 40% of the requests.

ACLA member laboratories are passionate about patient care and quality despite the administrative struggles of prior authorization. The health care industry needs to find a way to put the patient in the center of care and craft a plan of treatment that requires only one touch point between all of the providers associated with the patient's care and the patient's health plan. The Accountable Care Organization (ACO) model seems to be a step in that direction. The coordination of care within an ACO has the potential to be very patient centric. In the absence of a patient centric system, the health care industry needs to re-evaluate whether collecting prior authorization or pre-determination information from an indirect provider is valuable if the referring providers are obtaining the appropriate documentation.

- Does the standard require modification before implementing the proposed operating rules?
  - Claims: No.
  - Prior Authorization: No.

- Do the proposed operating rules support the intended business function/intended use?
  - Claims: Yes.
  - Prior Authorization: Yes.

- Do they provide a complete set of information needed to achieve the purpose of the transaction?
  - Claims: Yes.
  - Prior Authorization: Yes.

- Do the operating rules achieve the transaction in the fastest, simplest, and cost –effective manner?
  - Claims: An additional rule or clarification regarding system availability could help improve cost effectiveness. We applaud the rules associated with notification requirements for unscheduled downtime. Additional guidance to report system availability could be very beneficial. Without formal notification

that the payer's system is available or knowing an estimated time when to resume submitting claims, providers could incur unexpected charges from clearinghouses and vendors that charge for each transaction submitted to a payer.

- Prior Authorization: Yes; however, there is room for improvement. Rule 452, §4.4 states that the maximum response time for the receipt of a 278 Response from the time of submission of a 278 Request must be 20 seconds when processing in Real Time Processing Mode. The rule goes on to state in §4.45, that the maximum response time for availability of a 278 Response when processing 278 Requests submitted in Batch Process Mode by 9:00 PM Eastern Time of a business day by the provider or on a provider's behalf by a clearinghouse/switch must be no later than 7:00 AM Eastern Time the third business day following submission. It would seem that if a provider's system is capable of responding to a prior authorization request within 20 seconds in a real time mode, the window for the batch mode response could be shortened from 3 days to 2 days.

Clinical laboratory tests guide more than 70% of all medical decisions made by health care providers; therefore, laboratories begin testing immediately upon receipt of a test request and specimen while the prior authorization or predetermination process is concurrently submitted to the payer. As previously noted, if prior authorization is required, the only way for laboratories to secure payment is for the laboratory to receive the prior authorization before the test result is returned to the ordering provider. If a payer returns the authorization after a test is resulted, the laboratory will submit the claim to the payer knowing that the probability of payment is minimal. Some payers will accept the claim into their adjudication systems but request additional documentation. If the additional documentation is associated with the patient's medical record, laboratories must acquire the information from the referring provider. Often, the referring provider will charge the laboratory a service fee for the additional information. Currently, the submission of the requested documentation leads to a payment for about 40% of the claims, which equates to the laboratory being held accountable for 60% of services ordered by referring providers, where prior authorization is involved. If an ordering provider has requested prior authorization for a service, the prior authorization should be applied to all

providers that perform services associated with the request. It would be very beneficial to consider adding an operating rule to address this gap in the workflow. As previously noted in the context of claims, an additional rule or clarification regarding system availability could help improve cost effectiveness with respect to prior authorization. We applaud the rules associated with notification requirements associated with unscheduled downtime. Additional guidance to report system availability could be very beneficial. Without formal notification that the payer's system is available or knowing an estimated time when to resume submitting claims, providers could incur unexpected charges from clearinghouses and vendors that charge for each transaction submitted to a payer.

Indirect providers such as laboratories typically do not see the patient; therefore, minimal medical information is available to complete a prior authorization. Laboratories are dependent on the ability of referring providers to generate appropriate documentation to defend the services ordered.

- What is the potential impact of the proposed operating rules to various health care entities (providers, payers, etc.) on the daily workflow/transaction process; administrative costs, required capabilities and agility to implement the operating rules changes?
    - Claims and Prior Authorization: There is minimal improvement to the daily workflow and transaction process outside of the rules associated with reporting system availability unless the use of the 999 Implementation Acknowledgement and 277CA, Claims Acknowledgement are adopted.

      The confirmation process is the number one challenge associated with electronic transactions with our trading partners.

      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. ACLA member laboratory experience has shown that a payer acceptance of a transaction set or functional group is not a guarantee the claims will be processed.

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 indeed moved the submitted claims into its adjudication system; therefore, ACLA member laboratories employs full time employees to augment the information received.

The whole process outlined above is in place to ensure that laboratory 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. 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, ACLA supports the use of the 999 Implementation Acknowledgement and 277 Claim Acknowledgement to streamline the file confirmation process.

While HIPAA-covered entities or their agents would be required to use the Phase IV CAQH CORE 470 Connectivity Rule for the exchange of claims, prior authorization, benefit enrollment and maintenance, and health plan premium payment transactions, HIPAA-covered entities or their agents may also use this Phase IV CAQH CORE 470 Connectivity Rule v4.0.0 for the exchange of eligibility, claim status and ERA transactions in accordance with the Safe Harbor provision of the Phase II CAQH CORE 270 Connectivity Rule v2.2.0. However, this does not permit any HIPAA-covered entity or its agent to discontinue support for the exchange of the eligibility, claim status and ERA transactions as required in the Phase II CAQH CORE 270 Connectivity. These ACA-mandated CAQH CORE Operating Rules currently remain in effect and cannot be modified by Phase IV CAQH CORE Operating Rules. The possible requirement to support 2 different Connectivity Rules creates an administrative burden. Connectivity with trading partners is set up using methods that offer more security; therefore, supporting the safe harbor within the rules is an added expense.

- Do the proposed operating rules provide efficiency improvement opportunities for administrative and/or clinical processes in health care?
  - Claims: Yes.
  - Prior Authorization: Yes.

- Has the potential for decrease in cost and improved efficiency been demonstrated by using the proposed operating rules?
  - Claims and Prior Authorization: We are not aware of any pilots demonstrating the use of the proposed operating rules.

- Do the proposed operating rules support changes in technology and health care models?
  - Claims and Prior Authorization: Yes. The proposed operating rules are minimal.

- How will the operating rules provide consistency or limit the degree of variability to achieve optimal intended results?
    - Claims and Prior Authorization: Defined response times for transactions allows for the industry to streamline business processes and create standardized workflows.

- How does the new set of proposed operating rules relate to, or affect the implementation of the operating rules already adopted?
    - Claims and Prior Authorization: While HIPAA-covered entities or their agents would be required to use the Phase IV CAQH CORE 470 Connectivity Rule for the exchange of claims, prior authorization, benefit enrollment and maintenance, and health plan premium payment transactions, HIPAA-covered entities or their agents may also use this Phase IV CAQH CORE 470 Connectivity Rule v4.0.0 for the exchange of eligibility, claim status and ERA transactions in accordance with the Safe Harbor provision of the Phase II CAQH CORE 270 Connectivity Rule v2.2.0. However, this does not permit any HIPAA-covered entity or its agent to discontinue support for the exchange of the eligibility, claim status and ERA transactions as required in the Phase II CAQH CORE 270 Connectivity. These ACA-mandated CAQH CORE Operating Rules currently remain in effect and cannot be modified by Phase IV CAQH CORE Operating Rules. The possible requirement to support 2 different Connectivity Rules creates an administrative burden. Ensuring that the correct connectivity rule is applied to the appropriate transactions could prove to be a challenge. If trading partners choose to utilize the Phase IV CAQH CORE 470 Connectivity Rule for the exchange of eligibility, claim status and ERA transactions, new trading partner agreements will need to be executed and communication methods will need to be updated.

    - Are there any consistency issues between the two versions?
        - Claims and Prior Authorization: While HIPAA-covered entities or their agents would be required to use the Phase IV CAQH CORE 470 Connectivity Rule for the exchange of claims, prior authorization, benefit enrollment and maintenance, and health plan premium payment transactions, HIPAA-covered entities or their agents may also use this Phase IV CAQH CORE 470 Connectivity Rule v4.0.0 for the exchange of eligibility, claim status and ERA transactions in accordance with the Safe Harbor provision of the Phase II CAQH CORE 270 Connectivity

Rule v2.2.0. However, this does not permit any HIPAA-covered entity or its agent to discontinue support for the exchange of the eligibility, claim status and ERA transactions as required in the Phase II CAQH CORE 270 Connectivity. These ACA-mandated CAQH CORE Operating Rules currently remain in effect and cannot be modified by Phase IV CAQH CORE Operating Rules. The possible requirement to support 2 different Connectivity Rules creates an administrative burden. Ensuring that the correct connectivity rule is applied to the appropriate transactions could prove to be a challenge.

    - What are the benefits or concerns with implementing the two versions concurrently?
        - See above.
- Will system changes be required by the industry to implement the proposed operating rules?

    - Claims and Prior Authorization: No.
- Have the proposed operating rules demonstrated ease in adoption and use?
    - Claims and Prior Authorization: We are not aware of any pilots demonstrating the use of the proposed operating rules.
- What amount of time is needed for the industry to implement the proposed Operating Rules?
    - Claims and Prior Authorization: The technology exists today to support the Operating Rules; therefore, minimal time is needed. We would recommend an 18 month window for adoption of the proposed rules.
- What lessons learned from previously adopted operating rules have been applied/addressed in the proposed operating rules?
    - Requirements for response time are the major improvement brought about by prior operating rules. Defined response times for transactions allows for the industry to streamline business processes and create standardized workflows.
- Do the proposed operating rules incorporate the concerns raised by the industry at the June 2015 Review Committee hearing? Which concerns? How?
    - Yes. During the June 2015 hearing, organizations stated the need for acknowledgement transactions. This set of operating rules addresses the gap in the workflow process that the industry has identified. The one concern with this set of operating rules is that the rule, as written, would only cover supplying acknowledgements for claims, prior authorization, benefit enrollment and maintenance, and health plan premium payment transactions. The exchange of eligibility, claim status and ERA transactions would still

be without a required acknowledgement transaction. We recommend that Phase IV CAQH CORE Operating Rules be modified to include all transactions that enjoy the direction of operating rules to include the acknowledgement transactions.

- Has the industry developed strategies to measure the impact of adopting the proposed operating rules on the industry?
    - The lessons learned from the implementation of ICD-10 could be used to help the industry to identify strategies to measure the impact of adopting operating rules.
- Has the industry developed metrics to measure the effectiveness and value of adopting the proposed operating rules? What are they?
    - Each organization has key performance indicators that could be used to determine the value of adopting the proposed rules. Several metrics that could be used include:
        - Turnaround time for responses
        - Payment rates
        - Denials
- How do the proposed operating rules facilitate potential emerging or evolving clinical, technical and/or business advances?
    - The proposed operating rules are a base minimum and do not have a ceiling that prevents the use of new technology.
- Do the proposed operating rules provide potential impact and/or improvement to health care related data and/or data infrastructure?
    - There is minimal improvement to the data infrastructure unless the use of the 999 Implementation Acknowledgement and 277CA, Claims Acknowledgement are adopted.
- If applicable, do the proposed operating rules incorporate privacy, security and confidentiality?
    - Connectivity with trading partners is set up using methods that offer more security; therefore, supporting the safe harbor within the rules is an added expense.
- Do the proposed operating rules sufficiently align with the HITECH Stage 3 Final Rules on interoperability/Health Information Exchange so as to be reasonable for effectiveness and efficiency of the industry?
    -
- Can the proposed operating rules be enforced? How?
    - Yes. The operating rules call for each HIPAA-covered entity or its agent to capture, log, audit, match, and report the date, time and control numbers from its own internal systems and the corresponding data received from its trading partners. Each HIPAA-covered entity or its agent must support these response time requirements in this section and other

CAQH CORE Operating Rules regardless of the connectivity mode and methods used between trading partners. Any discrepancies between logs could be used to help identify noncompliance.

- Should NCVHS recommend the adoption of the proposed Operating Rules? Please explain.
    - Yes, with the exception of the Phase IV CAQH CORE 470 Connectivity Rule v4.0.0 for the exchange of eligibility, claim status and ERA transactions. If the rule is adopted, HIPAA-covered entities would be required to support the Phase II CAQH CORE 270 Connectivity Operating Rule for the exchange of the eligibility, claim status and ERA transactions, while supporting the Phase IV CAQH CORE 470 Connectivity Rule for the exchange of claims, prior authorization, benefit enrollment and maintenance, and health plan premium payment transactions. The possible requirement to support 2 different Connectivity Rules creates an administrative burden. Ensuring that the correct connectivity rule is applied to the appropriate transactions could prove to be a challenge.

      This set of operating rules does provide for minimal improvement to the daily workflow/transaction process with the use of the 999 Implementation Acknowledgement and 277CA, Claims Acknowledgement transactions. This set of operating rules addresses the gap in the workflow process that the industry has identified. The one concern with this set of operating rules is that the rule, as written, would only cover supplying acknowledgements for claims, prior authorization, benefit enrollment and maintenance, and health plan premium payment transactions. The exchange of eligibility, claim status and ERA transactions would still be without a required acknowledgement transaction. We recommend that Phase IV CAQH CORE Operating Rules be modified to include all transactions that enjoy the direction of operating rules to include the acknowledgement transactions.

PART 2 – ATTACHMENTS

Questions for Panelists - Proposed Standard For Attachments – INDUSTRY – ACLA Responses

- In addition to the use of the proposed standards and code sets in health care claims transaction (Claim Attachments), what other transactions can the standard support (for example, eligibility, prior authorization, post-paid claim audits)?
    - Several business functions could be supported by the standards for attachments. Within the laboratory industry, the standards could be used for prior authorization, to submit documentation to support pre-payment and post payment audits, as well as requests for additional documentation. With improved infrastructure between laboratories and ordering/referring provider EHR systems, the standards could also be used to request additional documentation from the ordering/referring provider to support the services ordered.

- Do the proposed standard and code sets support the intended business function/intended use?
    - For the most part, yes. From a laboratory perspective, there could be a challenge with the size limit of 64 megabytes within the 275, BDS segment. An XML format coupled with lengthy genetic test results could bypass the size limitations.
- Does the standard achieve the transaction in the fastest, simplest, and most cost –effective manner?
    - Yes.
- What is the potential impact of the proposed standard and code sets to various health care entities (providers, payers, etc.) on the daily workflow/transaction process; administrative costs, required capabilities and agility to implement the standard changes?
    - Currently, laboratories 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 that 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 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 a laboratory receives requests for medical records, it petitions the referring provider to submit the information to the payer directly. Storage of another provider's PHI presents another level in complexity for privacy and security considerations. Today, the only mechanism to track whether the ordering/referring provider indeed 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 have an incentive to supply the additional documentation, since any recoupment would be collected from the laboratory instead of from the provider that generated the request for service.

As mentioned, additional documentation a laboratory may submit directly to the payer includes referring provider test requests, test results, remittance notices from other payers as well as Advance Beneficiary Notices (ABNs). The laboratory business model may support submission of 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. 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.

- Does the proposed standard provide efficiency improvement opportunities for administrative and/or clinical processes in health care?
- Has the potential for decrease in cost and improved efficiency been demonstrated by using the proposed standard?
    - The Mayo Clinic/WPS electronic claims attachment project that was done in 2005 was reported as a success. Mayo Clinic reported receipt of payment 20-30 sooner than the paper process.

- Are there potential emerging or evolving clinical, technical and/or business advances the proposed standard intends to address or facilitate?

- How will the proposed standard provide consistency or limit the degree of variability to achieve optimal intended results?
    - A pilot using the proposed standards is needed to determine the degree of variability and identify whether gaps exist between the expected and actual outcome.
- How does the new set of proposed standard relate to, or affect the implementation of the standards already adopted?
    - Are there any consistency issues between the two versions?
    - What are the benefits or concerns with implementing the two versions concurrently?

- Will system changes be required by the industry to implement the proposed standard and code sets?
    - Both provider and payer systems will need to be enhanced to link additional information requests to responses. Providers systems will need to be modified to pull medical documentation from their clinical systems. For unsolicited attachments, provider systems will need to be enhanced to allow for the concurrent creation of both an 837, Health Care Claim and 275, Additional Information to Support a Health Care Claim or Encounter. Payer systems will need to be enhanced to match unsolicited attachment information with the claims that enter their adjudication system. Business processes will need to be created to address what happens to an unsolicited 275 if the associated claim does not enter the payer's adjudication system due to the payer's pre-adjudication edits.
- Has the proposed standard and code set demonstrated ease in adoption and use? What amount of time is needed for the industry to implement the proposed standard?
    - A pilot using the proposed standards is needed to determine the ease of adoption and use.
    - A 36 month window is required for adoption. Providers need time to create the infrastructure between their clinical and administrative systems to support an automated version of claim attachments. Part of the 36 month window is needed to allow for testing between trading partners. The testing process would focus on ensuring that the entire loop is closed for both the solicited and unsolicited transactions.
- What lessons learned from previously adopted standards have been applied/addressed in the proposed standard?

- Has the industry developed strategies to measure the impact of adopting the proposed standard and code sets on the industry?
    - The lessons learned from the implementation of version 5010 of the HIPAA transactions and ICD-10 could be used to help the industry to identify strategies to measure the impact of adopting claims attachment standards.
- Has the industry developed metrics to measure the effectiveness and value of adopting the proposed standard and code sets? What are they?
    - Each organization has key performance indicators that could be used to determine the value of adopting the proposed rules. Several metrics that could be used include:
        - Turnaround time for responses
        - Payment rates
        - Denials
- Do the proposed standard and code sets provide potential impact and/or improvement to health care related data and/or data infrastructure?
    - There is a need to ensure that 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 substantiate the need for a test. Laboratories have limited patient contact. They 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 a laboratory receives requests for medical records, it petitions the referring provider to submit the information to the payer directly. Storage of another provider's PHI presents another level in complexity for privacy and security considerations. Today, the only mechanism to track whether the ordering/referring provider indeed 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 have an incentive to supply the additional documentation since any recoupment would be collected from the laboratory instead of from the provider that generated the request for service.
- Does the proposed standard incorporate privacy, security and confidentiality?
    - Yes.
- How will the attachment standard support interoperability and efficiencies in a health care system?

- Currently, it is a challenge for providers to respond to all requests for additional information on time due to the various mailing addresses the payers and auditors may use for notifications and the very tight timelines allowed for response. If a laboratory is unable to respond to a request for additional information due to the misdirection of the request, it leads to the perception of being non responsive as well as the possible recoupment of the alleged overpayments by the payer. Once the money is recouped by the payer due to lack of response from the laboratory, the laboratory must still address the request for additional information. If the team finds that the money was recouped incorrectly, then an appeal process may be initiated. The appeal process is additional work for the laboratory that may have been avoided if the request for additional information was delivered to the correct location in a timely manner. Incorrect recoupments do not allow a laboratory the use of cash recovered by the payer during the appeal process. The policy for the appeals process ranges from 4 months to 17 months.
  One electronic location will ensure receipt of all requests for additional information preventing recoupment of funds due to lack of response. Electronic transactions lend themselves to a confirmation and tracking process that may be used to ensure the delivery of both the request and response for additional documentation. Electronic transactions lead to automation which leads to the reclamation of full time employees, which supports lower health care costs.

- Can the proposed standard be enforced? How?
- Should NCVHS recommend the adoption of the proposed standard? Please explain.
  - Yes. Currently, it is a challenge for providers to respond to all requests for additional information on time due to the various mailing addresses the payers and auditors may use for notifications and the very tight timelines allowed for response. If a laboratory is unable to respond to a request for additional information due to the misdirection of the request, it leads to the perception of being nonresponsive as well as the possible recoupment of the alleged overpayments by the payer. Once the money is recouped by the payer due to lack of response from the laboratory, the laboratory must still address the request for additional information. If the team finds that the money was recouped incorrectly, then an appeal process may be initiated. The appeal process is additional work for the laboratory that may have been avoided if the request for additional information was delivered to the correct location in a timely manner. Incorrect

recoupments do not allow a laboratory the use of cash recovered by the payer during the appeal process. The policy for the appeals process ranges from 4 months to 17 months. One electronic location will ensure receipt of all requests for additional information preventing recoupment of funds due to lack of response. Electronic transactions lend themselves to a confirmation and tracking process that may be used to ensure the delivery of both the request and response for additional documentation. Electronic transactions lead to automation which leads to the reclamation of full time employees.