AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

December 4, 2009

Denise Buenning
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Solicitation Number: CMS-RFI-100177

Dear Ms. Buenning:

We appreciate the opportunity to respond to the Request for Information (RFI) published by the Centers for Medicare & Medicaid Services (CMS) under Solicitation Number CMS-RFI-100177 concerning, "Monitoring of Compliance with the Transactions and Code Sets, National Provider Identifier and Unique Employer Identifier Rules."

The American Medical Association (AMA) believes that clear and concise health care administrative information must be made available to patients, physicians, and other health care professionals before and at the time of service, and upon claim payment by every payer. Toward that end, the Health Insurance Portability and Accountability (HIPAA) transactions and code sets (TCS) rules must be enforced to: 1) ensure that all health plans accept and respond appropriately to the designated electronic transactions; and 2) stop other improper payer actions (e.g., requiring physicians to accept electronic remittance advice when submitting electronic claims or charging inappropriate clearinghouse transmission fees or other fees for standard transactions). The AMA is pleased to provide CMS with feedback on enforcement of and compliance with HIPAA transactions, code sets, and national identifiers to encourage increased adoption of these standards. Please find our responses to the below questions posed in the RFI.

1. <u>Information about the extent of the industry's noncompliance</u>

(i) Key problem areas (technical vs. business)

First and most problematic to physicians are those payers that are unable to accept or respond to one or more of the HIPAA standard transactions. The biggest issue appears to be patient eligibility requests, but there have also been issues with remittance advice, claim's status, and prior authorization standard transactions. Some plans simply do not provide electronic remittance advice or respond to requests for patient eligibility or referral authorization.

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- Many proprietary formats are still being sent and received. One clearinghouse had over 50 different formats of a claim status response from payers. Another clearinghouse indicated that the bulk of X12 837 electronic claims submitted did not result in an X12 835 electronic remittance advice. In addition, one to five percent of claims received electronically from physicians were reported to be dropped to paper submissions to accommodate the payers.

- Health insurers do not complete mandated fields. According to the 2009 American Medical Association National Health Insurer Report Card, many payers are not reporting claims adjustment remark codes that HIPAA mandates when certain reason codes are reported.

- The current HIPAA requirements are being interpreted to require only syntactical correctness, that is that numeral or alpha characters of the correct length populate the required fields contained within the HIPAA standard transaction. However, syntactical correctness does not alone ensure that a transaction has any business value. Moreover, even when a payer provides reason and remark codes in a fashion that meets the syntax requirements, often the most generic codes are chosen, which dilutes the value of and the intended administrative simplification intent of HIPAA TCS. The following accuracy errors have been found with syntactically correct X12 835 electronic remittance advices that negates the value of the transaction:

    - Changes to patient account number (e.g., dropping leading zeros or suffixes);
    - Changes to line control number or not returning line control number;
    - Incorrect use of claim status code (e.g., payers that always claim they are secondary);
    - Incorrect specified allowed amounts; and
    - Invalid reason codes and remark codes.

  Only with meaningful data accuracy contained in all HIPAA standard transactions will the full value of these transactions be recognized. Please see **Appendix A** for a list of requirements that should be met for each transaction in order to meet syntactical compliance.

  One solution for addressing the syntax problems is through a functional audit process. The Council for Affordable Quality Healthcare (CAQH) is one entity that tests health insurers and vendors to ensure that they are compliant with the Committee on Operating Rules Exchange (CORE) Phase II criteria. CORE does look for whether the fields are completed in the correct way. Visit www.caqh.org for more information on the CORE initiative.

- Additional problems areas include:

    - Lack of clear identification of each payer, claim's administrator, plan/product type, and the specific fee scheduled involved in the determination of the ultimate patient benefit and claim payment; and

- Non-standard formats of electronic data interchange (EDI) transactions which significantly reduce the value of conducting professional claims transactions (ASC X12 837) under the current HIPAA version 004010. Also, contributing to this problem is the fact that various payers require claims to be completed differently by creating their own coding rules that are non-compliant with the Current Procedural Terminology (CPT) instructions.[1] The CPT code set is a nomenclature system that should be interpreted consistently by all partners in the claims revenue cycle. While CPT was adopted as a standard code set under HIPAA, the CPT instructions were not. The lack of the instructions significantly undermines administrative simplification and transparency efforts.

- The HIPAA TCS rule does not establish a standard claims acknowledgement transaction, so that there is no easy way for a physician to know whether a claim has been received or its current status in the health care billing, payment, and claims reconciliation process. This could be remedied relatively expeditiously if a new HIPAA standard were established, mandating payers to send an unsolicited ASC X12 277 Claim Status Response standard transaction.

- The complexity of the claims process produces payment problems. For example, payers adjust payments by applying "payment rules," such as adjustment for modifiers, taxonomy, multiple procedures, or global payment rules that either increase or decrease the percentage of the payment amount. They also simultaneously make adjustments to the claim using payer claim edits that include customized payer-specific edits for the purposes of specifying whether the codes listed on a claim are eligible for payment or will be denied, distinct and separate from medical coverage policies. Instituting standard HIPAA payment rules such as multiple procedure reduction logic rule[2] and a standard code-editing system would not only allow physicians to significantly increase the number of claims payments that could be automatically posted by their practice management systems, but would also allow physicians and other health care professionals to apply a more robust claim scrubber to increase the likelihood claims are submitted accurately the first time.

The AMA Recommends that CMS:

1. Enforce the requirement that all payers accept and respond to standard transactions. (Compliance with HIPAA standard transactions has been mandatory even for small ERISA self-insured plans since October 2004, yet many payers, including Medicaid, still do not provide HIPAA standard electronic responses to HIPAA Standard requests);
2. Increase HIPAA TCS enforcement resources;
3. Conduct compliance audits and certification of health plans, rather than just relying on physician complaints, to ensure transactions are both syntactically and functionally

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[1] The AMA's May 19, 2009 white paper, "Standardizing CPT codes, guidelines and conventions Administrative simplification white paper, " can be accessed at: http://www.ama-assn.org/go/simplify.

[2] The AMA's June 22, 2009 white paper, "Standardization of the Claims Process: Administrative Simplification White Paper," includes a robust example of the problems posed by various payer rules for applying multiple procedure logic. See: http://www.ama-assn.org/ama1/pub/upload/mm/368/admin-simp-wp.pdf.

compliant. As a practical matter, physician compliance with these rules is self-enforcing—the health plans simply do not respond to a non-compliant transaction. However, physicians have no comparable leverage to enforce payer compliance. Please see **Appendix B** for suggested regulatory language;

4. Clarify that standard transactions require both correct syntax and information that accurately reflects the circumstances, which are reported at the greatest level of specificity that the transaction and related code sets permit;
5. Give state governments concurrent enforcement jurisdiction for the TCS rules;
6. Ensure all HIPAA standard code sets are accompanied by operational guidelines and instructions which govern their use, similar to ICD-9-CM code set, and that the CPT guidelines and conventions be designated as the operational guidelines and instructions for the CPT Code set;
7. Mandate payers send an unsolicited ASC X12 277 Claim Status Response standard transaction or its successor at each of the following points in the claims adjudication process: (a) electronic claim receipt; (b) acceptance/rejection of electronic claim for adjudication; (c) electronic claim forwarded to another entity or returned as "unprocessable"; and (d) electronic claim pended (in process, in review, requested information [waiting]);
8. Implement standard HIPAA payment rules (e.g., a multiple procedure reduction logic rule);
9. Implement a HIPAA standard code-editing system; and
10. Lift the remaining contingency plans so that all payers become fully compliant with existing HIPAA TCS rules.

(ii) Prevalence of specific TCS, NPI and EIN non-compliance, and
(iii) Patterns of non-compliance among specific transaction types and entity types

One area of ongoing non-compliance involves payers requiring providers to enumerate according to payer rules. The AMA has concerns with the Medicare requirement that calls for physicians who are incorporated to obtain two National Provider Identifier (NPI) numbers, one for their person and the second for their corporation. On page 3441 of the final NPI rule, it states, "A health plan may not require a health care provider or a subpart of an organization health care provider that has an NPI to obtain another NPI for any purpose." Yet, this directly conflicts with CMS' stance that NPI means, "One doctor one number." The ongoing NPI problems are due to the requirement that physicians who are solo practitioners and are incorporated need to get both a Type I and a Type II NPI. This has created significant confusion as well as claims processing and payment disruptions.

We are also aware of another area of payer non-compliance with the two approved EFT National Electronic Association (NACHA) formats that are listed in the X12 835 electronic remittance advice (ERA) standard transaction implementation guides (CTX and CCD+ formats) that are subject to banking laws and regulations. Payers are encouraged to adopt one of these two formats. However, not all payers use these standard formats, and of those that do, only a small portion provide the necessary information as stated in the X12 835 implementation guide to allow re-association of the ERA and the electronic funds transfer (EFT) payment. Only when meaningful data accuracy contained in all HIPAA standard

transactions and NACHA EFT formats is assured will autoposting solutions be offered by practice management systems and accounting software.

(iv) The extent of implementation of the TCS, NPI and EIN standards

One standard that could significantly alleviate the administrative burden on physicians is a National Health Plan Identifier. Although required under HIPAA, to date CMS has not published an adopted standard. The National Health Plan Identifier (NHPI) is viewed by many as a crucial step toward one-stop, automated billing. To achieve the goal of a fully automated claims payment and reconciliation cycle, all relevant information concerning the payer, the payer's agents, and the fee schedule amount must be transmitted on all relevant transactions in unambiguous terms. With the informed experience gained from the implementation of the HIPAA employer and provider unique identifiers, including the use of existing identifiers to the extent feasible, the disruption from this initiative can be minimized. The AMA has published extensive recommendations on the NHPI which can be found at: www.ama-assn.org/go/simplify.

2. Comments on barriers to complaints being filed, and how to eliminate those barriers, and 3. Comments on the strength and weakness, with explanation, of the current complaint process

Two of the main reasons physicians do not report HIPAA violations more frequently are: 1) they fear retribution from payers, which is a substantial detractor to the current process; and 2) they are unaware that a process exists to report violations. As discussed above under question 1 (Information about the extent of the industry's noncompliance), we recommend that a more proactive approach be taken to monitor payer compliance such as through functional compliance audits. While the strength of the current complaint process lies mostly with its simplicity, it often does not foster a sense of trust among physicians and they often remain fearful of payer retribution.

The AMA Recommends that CMS:

1. Supplement (not replace) the current complaint-driven process with a robust audit and certification process. If OESS determines a payer is not fully compliant with all HIPAA transaction standards, the payer would have to complete and submit to OESS a corrective action plan. Additionally, the payer would be required to contract with a clearinghouse (at the payer's expense) that has been certified compliant with the standard transactions to handle any and all transactions for which the payer has not been certified until such payer can demonstrate through a functional audit that it is indeed fully compliant;
2. Provide a method for physicians to file a follow-up complaint if the problem persists including supplying CMS with any supplemental information a physician has to demonstrate the payer's non-compliance; and
3. Open up the complaint process to vendors, associations and other entities that represent the partners in the claims revenue cycle. This would allow those partners that wish to remain anonymous to do so, yet system issues with a certain entity or claims pathway could be highlighted and investigated to ensure a successful resolution.

4. <u>The usefulness of compliance reviews</u>

The AMA strongly supports required functional audits by payers as found in the AMA's white papers on administrative simplification[3] and as discussed earlier. The case for functional compliance standards and a potential functional audit test specifically for the X12 835 standard transaction is contained in the National Healthcare Exchange Services, Inc. (NHXS)[4], white paper that can be found in **Appendix C**.

The AMA Recommends that CMS:

Require functional audits and certification requirements be developed for each of the standard transactions designated under HIPAA.

5. <u>The methods that could be employed to execute the compliance reviews, including the process for identifying entities for review and __6. Recommendations for the logistics for conducting compliance reviews</u>

The purpose of functional compliance with HIPAA standard transactions is to ensure the automation of the transactions. Because physician practices work with so many different payers each with several different products, all payers must be compliant with HIPAA standard transactions before true automation and elimination of manual work flows will truly become a reality in the physician practice. As a practical matter, physician compliance with these rules is self-enforcing—the health plans simply do not respond to a non-compliant transaction. However, physicians have no comparable leverage to enforce payer compliance. Thus, the AMA strongly supports a certification requirement for all clearinghouses and health plans, rather than relying on complaints or even random audits. Moreover, this certification requirement creates an equal playing field as providers today are prohibited from submitting noncompliant electronic standard transactions and must go through a clearinghouse if they cannot send compliant electronic transactions.

In addition, until such time as the standards themselves are sufficiently robust as to eliminate the possibility of companion guides, the AMA also strongly supports efforts to create a single, binding companion guide for each HIPAA standard transaction, so that all trading partners would be required to implement and interpret all HIPAA electronic transactions in the same way. While this may require legislation for mandatory use, Medicare could help create and advocate for voluntary industry adoption of such a companion guide now.

The AMA Recommends that CMS:

1. Develop both a full syntactic and functional compliance review and certification process to ensure all health plans are using only HIPAA compliant transactions, as well as a process designed specifically for handing a single complaint;

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[3] AMA Administrative Simplification white papers are located at www.ama-assn.org/go/simplify on the AMA Web site.
[4] NHXS is an application service provider that provides contract compliance and denial management solutions.

2. Require submission of process improvement plans toward compliance, and employment of approved HIPAA compliant clearinghouses for each and every transaction for which the health plan is not certified compliant;
3. Solicit feedback from providers and their representative vendors and organizations on which payers may be in violation of any HIPAA TCS rule; and
4. Develop, with industry feedback, and make available, a single companion guide format applicable to the version 5010.

The AMA appreciates the opportunity to provide CMS with feedback on enforcement of and compliance with HIPAA transactions, code sets, and national identifiers to encourage increased adoption of these standards. Should you have any questions regarding these comments, please contact Mari Savickis by phone, 202-789-7414, or by email, mari.savickis@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

Attachments

Appendix A

Syntactical compliance shall mean that all the following requirements are met for each transaction:

- All required segments are present;
- Required segments are in the correct position;
- All required elements are present;
- All elements comply with the variable type, length, and code set;
- All elements comply with frequency and loop requirements;
- Valid delimiters are used; and
- To the extent applicable to the transaction, the file must balance at each of the following levels: 1) the service line, 2) the claim, and 3) the transaction.

Below are the most common syntactical errors with the 835:

- Changes to patient account number - dropping leading zeros, suffixes, or just change;
- Changes to line control number or not returning line control number;
- Incorrect use of claim status code (payers that always claim they are secondary);
- Incorrect specified allowed amounts; and
- Invalid reason codes and remark codes.

Appendix B

Suggested regulatory language on compliance audit and certification process.

Not later than _____, the Secretary of Health and Human Services shall promulgate an annual audit and certification process to ensure that all health plans and clearinghouses are both syntactically and functionally compliant with all the standard transactions mandated pursuant to Section 1173 of the Social Security Act. The annual audit and certification process shall cover separate testing and certification of each claims platform used by health plans and clearinghouses. In carrying out this obligation, the Secretary shall consult with each organization designated under section 162.910(a) of title 45, Code of Federal Regulations.

As of _____, no health plan or clearinghouse may respond to any standard transaction with a response which has not been certified to be both syntactically and functionally compliant, and any health plan must respond to any transaction for which its response has not been so certified through a clearinghouse which has been certified for that transaction.

"Syntactical compliance" shall mean that all the following requirements are met for each transaction:

- *All required segments are present;*
- *Required segments are in the correct position;*
- *All required elements are present;*
- *All elements comply with the variable type, length, and code set;*
- *All elements comply with frequency and loop requirements;*
- *Valid delimiters are used; and*
- *To the extent applicable to the transaction, the file must balance at each of the following levels: 1) the service line, 2) the claim, and 3) the transaction.*

"Functional compliance" shall mean that the information contained in the transaction meets the business requirements that the transaction supports, such that the trading partner who receives the information is able to process it without human intervention.

Appendix C

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reimbursement accuracy made simple

July 2009

The case for functional compliance standards in the X12N 835 transaction

Even though the industry is approaching six years of experience with the X12N 837 Claim and X12N 835 remittance transactions, realizing the full potential of administrative savings has yet to be realized. The primary barrier to maximizing savings is the gap between syntactical compliance and functional compliance.

Functional compliance, for purposes of this document, is defined as meeting the business requirement that the transaction supports. It is all too common that the 835 transaction can be syntactically correct but fail to meet the business requirement of the payee. For instance, the payee has a critical business need to know if the payer is primary or secondary for the liability. The payee may be syntactically correct in selecting a status code of 'secondary', but may in actuality be the 'primary' payer. The resulting ambiguity and rework for one or both parties cancels the expected efficiency of the transaction standard.

While the industry has robust testing of syntactical compliance (www.claredi.com) and experience suggests good compliance with the implementation standards, an equivalent level of robustness has yet to be achieved for functional compliance. The following levels of syntactical compliance are assumed for purposes of this document:

- All required segments are present
- Required segments are in the correct position
- All required elements are present
- All elements comply with the variable type, length, and code set
- All elements comply with frequency and loop requirements
- Valid delimiters are used
- The file MUST balance at three different levels — the service line, the claim, and the transaction

The essential business requirements that MUST be supported by the combination of syntactical compliance and functional compliance are as follows:

- Reassociation
- Balancing
- Matching
- Reconciliation
- Resolution

In the WPC COMBINED 004010X091 & 004010X091A1 835 Implementation Guide dated March 2003, pages 9 -10, we read:

"It is important that these trading partner agreements NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
- Add any additional data elements or segments to this Implementation Guide
- Utilize any code or data values which are not valid in this Implementation Guide

- Change the meaning or intent of this Implementation Guide

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid."

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Our purpose here is to focus on the fourth bullet point above. The meaning of the data in the file is critical to creating the business processes and efficiencies contemplated by the framers. "Meaning", in fact, is no less critical than the syntax of the EDI file. We also believe that 1) if the information is available from the payer and is necessary for the payee to eliminate human intervention and, 2) the specification provides for the information, then it should ALWAYS be provided.

For instance, the instruction, "without human intervention" is used twice in the notes for the CLP06 Claim Filing Indicator element. The instructions go further by stating, "This code allows the provider to separately identify and manage the different product lines or contractual arrangements between the payer and the provider." pg 92 The functional compliance of CLP06 is a significant issue for payee's today. To that end below are functional standards that depend on the correct meaning within the 835 form.

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Item	Business Requirement	Functional Compliance	Business case
1	Resolution	If the DTM*405 element Claim Production Date is NULL then it is equal to the BPR16 Payment Date.	The lag between service date, claim received date, production date, and payment date are essential to monitor intermediaries used by the provider to deliver 837 transactions to the payer and to monitor whether certain types of services effect processing lag by the payer.
2	Resolution	The DTM*050 element Claim Received Date is always reported.	This element is essential to monitor intermediaries used by the provider to deliver 837 transactions to the payer.
3	Reassociation	If the remittance data and dollars are split, both files are available to the payee within 24 hours of receipt of either file.	A lag of more than 24 hours puts an unreasonable burden on the payee reconciliation process.
4	Reassociatoin	Reassociation of payer, transaction number, and monetary amount is always successful. TRN02, TRN03, and BPR02 match exactly between the split transactions.	This is a critical accounting requirement.
5	Matching	The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable).	This element is critical to matching a remittance and a claim. Truncation on the ends or in the middle of the element or adding characters to the element are catastrophic to the matching process.
6	Reconciliation	The payer NEVER reports CLP02 Claim Status Code = 4 (Denied).	It is more critical in the business process to know that the payer is primary, secondary, or tertiary than to know the claim is denied. CLP02 contains non-mutually exclusive codes. The Adjustment Reason Codes in the CLP and SVC loops provide adequate codes to convey that the claim was denied.
7	Reconciliation	The CLP02 Claim Status Code is correct.	A primary payer should never describe themselves as secondary and visa versa

8	Resolution	If CLP02 Claim Status Code = 19 or 20 [processed as primary transferred to additional payor and processed as secondary transferred to additional payor, respectfully] then include the NM1*TT Cross over payer entity.	This is essential to prevent the submission of a duplicate claim and to check claim status with the additional payer.
9	Reconciliation	The CLP06 Claim Filing Indicator Code is unambiguous. Meaning there is only one possible allowed amount for the stated Claim Filing Indicator Code. If ambiguity exists <REF*CE*product description> is used to further differentiate the plan product type.	The proliferation of products within a payer and the multiple rates that a payee may be subject to under the managed care agreement, make positive identification of the applicable fee schedule a critical business function.
10	Reconciliation	Claim header CAS04 is populated only when the units are adjusted.	Essential to contract compliance monitoring.
11	Reconciliation	All services reported on the claim are reported in the SVC segment of the first 835.	Reduces rework to research unpaid services, eliminates duplicate claim submissions, aids in matching.
12	Matching	SVC01-3 thru SVC01-6 includes all modifiers from the claim in the same order.	Essential to matching
13	Matching	If the SVC06 element is used, the original procedure code and modifier(s) for the service are used. This applies if the procedure code is changed and/or a modifier added, changed, or deleted.	Essential to matching
14	Matching Reconciliation	SVC07 element is always used when the paid units is different from the submitted units.	Essential to matching and contract compliance
15	Matching	If the REF*6R Line Item Control Number is not included in the claim, the order of the SVC01 elements are the same as the service items in the claim.	Essential to matching
16	Reconciliation	The service level sum of the CAS*PR Group Code adjustments is always equal to the CLP05 patient responsibility amount	Essential to reconciliation of service level and header level adjustments
17	Reconciliation	The CAS*CO Group Code adjustment is only used when a 'contractual obligation' or a regulatory requirement exists between the payer and the payee.	Determining the correct allowed amount is essential to contract compliance and determining patient responsibility
18	Reconciliation	When a contractual obligation or regulatory requirement exists, the SVC02 Charge Amount less the sum of the CAS*CO Group Code adjustments is always equal to the AMT*B6 Allowed - Actual amount.	Balancing between the payer's stated allowed amount and the line level adjustments is essential to contract compliance and determining patient responsibility

19	Reconciliation	In the absence of a contractual obligation or regulatory requirement, the SVC02 Charge Amount less the sum of the CAS*PI Group Code adjustments is always equal to the paid amount.	Determining the correct allowed amount is essential to contract compliance and determining patient responsibility
20	Reconciliation	In the absence of a contractual obligation or regulatory requirement, the AMT*B6 Allowed - Actual amount is always equal to the SVC02 Charge Amount.	Balancing between the payer's stated allowed amount and the line level adjustments is essential to contract compliance and determining patient responsibility
21	Reconciliation	The AMT*B6 Allowed - Actual is equal to the SVC02 Charge Amount less the sum of at least one combination of service level adjustments.	Balancing between the payer's stated allowed amount and the line level adjustments is essential to contract compliance and determining patient responsibility
22	Reconciliation	The OA Group Code is never used for financial adjustments, except when doing predetermination of benefits. (pg 24)	
23	Reconciliation	When a contractual obligation or regulatory requirement exists, CLP04 Paid Amount plus CLP05 Patient Responsibility equals CLP03 Charge Amount less the sum of the CAS*CO Group Code adjustments.	Essential to contract compliance.
24	Reconciliation	In the absence of a contractual obligation or regulatory requirement, CLP04 Paid Amount plus CLP05 Patient Responsibility equals the CLP03 Charge Amount.	Essential to determining patient responsibility.
25	Matching Reconciliation	"When **bundling** or unbundling occurs, the information must be reported back to the payee accurately to facilitate automatic entry into a patient accounting/accounts receivable system. In the interest of standardization, payers are to report bundling or unbundling in a consistent manner." (pg 26) • "When bundling, report all of the originally submitted procedures [modifier(s)] in the remittance advice. Report all procedures as paying on the changed (bundled) procedure code, and reference the original submitted code in SVC06. • The bundled service line must be adjusted up by an amount equal	Essential to matching and contract compliance.

		to the sum of the other line charges. This is reported as a CAS segment with a group code OA (Other Adjustments) and a reason code of 94 (Processed in Excess of Charges) with a negative dollar amount. • From that point, apply all normal CAS adjustments to derive the reimbursement amount. • Report the other procedure or procedures as originally submitted, with an adjudicated code of the bundled procedure code and a Claim Adjustment Reason Code of 97 (payment is included in the allowance for the basic service) and an adjustment amount equal to the submitted charge."	
26	Matching Reconciliation	• "When **unbundling**, report the original service [procedure - modifier(s)] as the first of the new services with the original submitted charge in SVC02. • Use subsequent SVC loops for the other new services. For these other services, report the submitted charge as zero dollars ($0.00). • As in bundling, CAS is used to increase the submitted charge from $0.00 to the allowed amount for each procedure. • Report the original procedure code in all of the SVC loops in SVC06. Balancing must be maintained for all service lines."	Essential to matching and contract compliance.
27	Matching Reconciliation	"**Partial unbundling** [must] report the regular allowed and payable amounts for the panel, then use a negative payment with the single adjusted service to offset for that reduction and to link that individual service to the HCPCS for the affected panel. The allowed amount for the single unbundled adjusted service in the panel must be reported as 0 when there is partial unbundling." pg 27	Essential to matching and contract compliance.
28	Matching Reconciliation	• "**Reverse** the original payment, restoring the patient accounting	Essential to matching and contract compliance.

		system to the preposting balance for this patient. • Then, the payer sends the corrected claim payment to the provider for posting to the account. • Reversing the original claim payment is accomplished with code 22, ‘‘reversal of previous payment’’, in CLP02; code CR, ‘‘corrections and reversals’’, in CAS01; and appropriate adjustments. • All original charge, payment, and adjustment amounts are negated." pg 29	
29	Reconciliation	PLB*L6 Interest and penalty amounts include reference to the patient account, date of service, and total charge for the claim.	Essential to matching and contract compliance.
30	Resolution	If NM1*74 Corrected Patient or Insured element is used, always provide the original patient and/or subscriber information in NM1*QC	Essential to matching and patient master indexing.
31	Matching	The NM1*82 Rendering Provider Code(s) matches the rendering provider code(s) on the claim.	Essential to matching
32	Matching	The REF*HPI service level Rendering Provider Code matches the service level rendering provider code on the claim.	Essential to matching

NHXS recommends that the industry adopt these functional compliance standards and testing for this compliance be included as part of the best practices methods of the trading partners.

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