NCVHS Hearing
Development and Implementation of Operating Rules

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Today's Agenda

1. What has your organization's experience been with internal preparation and transition to the new required operating rules?
2. What business or technical issues arose when your organization implemented the operating rules? What improvements have you experienced?
3. What else should the subcommittee know regarding the preparation/transition to the new operating rules for eligibility and claim status?
4. Are you involved in the development of the new operating rules? If so, in what way?
5. What milestones must industry meet in order to have operating rules for our review and consideration for adoptions if they are to be recommended for January 2014?

Phase I CORE Eligibility and Benefit

Medicare FFS is compliant with the Phase I Operating Rules including the internet connectivity which became available with Healthcare Eligibility Transaction System (HETS) in May. Despite the significant effort that went into creating this connectivity, currently only one submitter is using this submission method with four submitters in various states of readiness for internet connectivity.

Concern/issue:

- The effort it took to get the first submitter properly set up to use their certificate. The set-up requires knowledge in WS-Security & Public Key Infrastructure (PKI &Cryptography), which is used for authorization of the internet submission.

Phase II Claim Status

Medicare FFS is working toward compliance with the Phase II operating rules. Medicare FFS plans to be compliant with the requirement to offer batch claim status via internet by January 1, 2014. Medicare FFS is currently working on the strategy for offering claim status on a real-time basis.

Concerns/issues:

- Level of funding needed to implement the real-time rules.
- Level of effort and time to implement the real-time rules.

Phase III CORE Healthcare Claim Payment /Advice

Medicare FFS is working toward compliance with the Phase III Operating Rules by the January 1, 2014 compliance date.

Concern/issue:

- Frustrations trying to coordinate the CARC and RARC database updates and the CORE code combination lists update with our Medicare FFS quarterly release schedule. The CARC and RARC databases are updated and published early March, July and November every year. Subsequently, the CORE Code Combination lists are then updated about three months later, therefore the possibility of variation in usage of the code lists are endless.

Development of the Next Phase of Operating Rules

Medicare FFS plans active participation in the development of the next phase of the operating rules. This includes participation in all CAQH CORE hosted planning and development sessions scheduled to commence in August 2013.

Concerns/issues:

- Payer issues are not being taken into consideration during the development process. For example, the surveys used to gather information have been very restrictive in providing direction on the next phase of operating rule. The results from the survey are then used to draft the rules. The rules are then brought to the subcommittee meeting for a vote. This method is not using a collaborative process in the development of the operating rules.

Operating Rules and ASC X12

Medicare FFS is an active participant with the Accredited Standards Committee (ASC) X12. As such Medicare FFS is participating in the development of the next version of the standards to be recommended for adoption under HIPAA.

Suggest that CAQH CORE should reach out to the ASC X12 workgroup to determine what aspects of the operating rule should be incorporated into the next version of the standard. CAQH CORE attended the June ASC X12 Standing Meeting, although they didn't participate in all collaborate meetings involving multiple work groups focused on discussing the current survey.

In response to the follow up survey on the Third Set of operating rules we see overlap in what CAQH CORE is suggesting versus what seems to be the responsibility of the Standards Development Organization. Examples:

- Requiring a unique Patient Control Number in CLM01 in Loop 2300 for each claim.
- Requiring data fields in the 837 that would reduce the need for claim attachments..

Issues with the Process

- Payers only have one vote on surveys and on the rules themselves.
- Lack of a formalized change management process for the previously adopted operating rules (Phases I, II, III).
- Concerns with the current process of developing CARC/RARC and code combinations lists.
  - Developed using three separate code committees
  - Creates timing and publication problems
  - Suggest creation of one committee responsible for all codes and combinations

Issues with the Process – Cont.

- Timeframe for sending the next phase of operating rules to NCVHS for review is problematic:
  - The January 2014 deadline does not provide enough time for collaboration across the industry.
  - Participation in these efforts is a major effort for Medicare, as for any large organization. It requires collaboration across many business lines. (We were fully engaged with 5010 during Phases I, II and III and that took priority)
  - The first two phases were developed before legislation. The third phase was rushed to meet dates in the law.
  - The fourth deals with claims and it will be much harder to come to consensus, especially if all parties are fully engaged.