



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

Testimony from the American Medical Association

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The American Medical Association (AMA) thanks the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards Review Committee (Committee) for the opportunity to provide our written comments on the current status of the adopted standards, operating rules, code sets, and identifiers used in the administrative simplification transactions mandated under the Health Insurance Portability and Accountability Act (HIPAA). The AMA is a long-time champion and supporter of administrative simplification and recognizes the important role that reduction in manual burdens and processes can play in achieving the Triple Aim of improved patient experience of care, improved health of populations, and reduced per capita health care costs.

We applaud the significant progress that the health care industry has made in reducing administrative costs through the implementation of the HIPAA-mandated transactions. However, we believe that further refinement and improvements could ensure that the maximum value and promise of these transactions is fully realized. We urge the Committee to consider our comments on the current status of automation and recommendations to improve the utility and efficiency of the transactions. In addition to these written comments, we refer you to our oral testimony slides for the prior authorization and health care payment and remittance advice panels.

Eligibility and Benefit Inquiry and Response

The Eligibility and Benefit Inquiry and Response transactions provide physicians with crucial information regarding patient coverage, benefit restrictions, and financial responsibility for services at the point of care. Improvements in transaction implementation and consistency could ensure that physicians receive the most accurate, granular, and current information regarding patients' coverage at the time of care and further industry goals related to health care cost transparency. We note the following barriers to optimal implementation of the current eligibility transaction and offer our recommendations.

Barriers:

- There is a lack of consistency in eligibility information content across health plans.
- Health plan portals frequently contain better information—either in terms of quantity or quality— than the standard transaction response, which incentivizes use of portals and is

prohibited under HIPAA. Portals provide administrative simplification to health plans but are labor-intensive for providers to use and divert critical health care resources away from patient care.

- Not all payers are populating the required minimum level of information in the eligibility response. In addition, some intermediaries and vendors are not transmitting all information to the provider. This results in limited functionality for the transaction and a need to revert to other mechanisms, like portals or phone, for more eligibility details.
- Specific current eligibility issues include:
 - Information regarding a provider's network status is often not sufficiently granular, nor is it patient- or product-line specific. Since many plans have multiple networks, network status for one product is not globally applicable.
 - Example: A response to a request for a patient's eligibility under a plan's benefits for physical therapy may indicate "Yes," the patient is eligible but will not denote under what circumstances he or she could be eligible or for how many sessions. Additionally, the response may not accurately convey the provider's network status with the plan.
 - Procedure-specific requests frequently result in general responses instead of procedure-specific eligibility information. This reduces the value and utility of not only the eligibility and benefit transaction, but also the services review transaction (Accredited Standards Committee [ASC] X12 278), as physicians are not receiving procedure-specific coverage restriction information, such as prior authorization (PA) requirements, with the eligibility response.
 - Example: Although a physician may submit an eligibility request for a specific type of radiotherapy, health plans may respond with just general information about the patient's benefits, with no indication that coverage for this particular type of radiotherapy requires PA or is otherwise restricted.
- Operating rules have not been optimally leveraged to support an agile response to emerging industry needs.
 - Example: Although ASC X12 has provided direction through multiple Request for Interpretation (RFI) responses regarding how to report information pertaining to patients in the health insurance exchange (HIX) premium payment grace period, there is no requirement to follow this guidance. This has resulted in significant variation in HIX grace period information reporting in eligibility responses across health plans.
- Reporting of information regarding tiered benefits is challenging using the current version of the ASC X12 eligibility standard.
 - Example: A patient's plan may specify different patient co-pay amounts based on a provider's preferred status or some other tiered benefit design. Under the current version of the eligibility standard, it is difficult for health plans to communicate information about tiered benefits and the associated variance in patient financial responsibility in a way that is understandable to physicians.

Recommendations:

- **Increase the minimum requirements for the eligibility and benefit response through new operating rules. New rules should require procedure-specific responses to**

procedure-specific requests (including identification of any PA requirements) and granular, patient- and product-specific information regarding a provider's network status.

- **Standardize the reporting of HIX grace period information through new operating rules that require compliance with the related ASC X12 RFIs.**
- **Through accreditation or other mechanisms, establish vendor responsibility for compliance with transaction standards and operating rules.**
- **Adopt the next version of the eligibility transaction standard to support reporting of tiered benefits as well as other enhancements that will increase industry automation and efficiency.**

Prior Authorization

The AMA believes that PA is currently over utilized by health plans, and that its use should be limited to outliers. However, in recognition that PA will continued to be used as a utilization control mechanism by health plans for the foreseeable future, the AMA urges the industry to reduce the associated administrative burdens on physicians through automation. Indeed, the delays in patient care, burden to physician practices, administrative costs for health plans, and manual nature of the current PA process make this functionality a top priority for increased automation. Unfortunately, as we indicate in our summary points below and in our oral testimony slides, adoption of the standard transaction for medical services PA is extremely low; we offer several recommendations to increase the utility and appeal of this transaction. While there have been significant efforts to automate the PA process for pharmacy benefits in recent years, further work is needed to ensure the maximum return on investment, as we indicate below.

Medical PA Barriers:

- There is currently no mandate for using the ASC X12 278 Health Care Services Review Inquiry and Response or Notification implementations.
- Neither the ASC X12 278 standard nor the draft operating rule contain data content requirements, such as requiring responses beyond "pending."
- The industry has failed to analyze the PA process holistically and ensure that all the necessary electronic transaction components are in place to support end-to-end automation of PA. In addition to the ASC X12 278 standard, other process gaps, such as the need for procedure-specific PA requirements in the eligibility response and a mandated standard for electronic attachments, must also be addressed before significant progress in PA automation can be achieved.
- Internal health plan workflows require manual processes and limit real-time PA capabilities.
- Vendor support for the ASC X12 278 is limited, particularly for implementations that integrate with physicians' electronic health record (EHR).

Medical PA Recommendations:

- **Mandate additional ASC X12 278 implementations (Health Care Services Review Inquiry and Response, ASC X12N005010X215, and Health Care Services Review Notification, ASC X12N005010X216).**

- **Address data content requirements in the ASC X12 278 operating rules, to include requiring: (a) indication if PA is not needed; (b) indication if PA is approved or denied; (c) request for additional information needed for a PA decision; and (d) a final answer to PA requests (vs. response of “pending” or “contact payer”).**
- **Mandate a standard for electronic attachments to support transmittal of supporting clinical documentation.**
- **Enhance eligibility operating rules to require provision of procedure-specific responses with any PA requirements.**
- **Create an industry multi-stakeholder workgroup to analyze and solve issues impeding X12 278 adoption.**

Pharmacy PA Barriers:

- The AMA recognizes the industry momentum towards pharmacy PA automation using the National Council for Prescription Drug Programs (NCPDP) transactions. However, the lack of accurate, granular formulary data at the point of prescribing limits the current value and utility of these transactions.
- Due to deficiencies in EHR formulary data quality and completeness, physicians cannot ascertain PA requirements at the time of prescribing. Thus, despite the progress in implementation of the NCPDP transactions, rejected pharmacy claims remain the trigger for PA requests. Failure to prospectively identify PA requirements and deliver “clean” (i.e., PA-approved) prescriptions to the pharmacy increases the risk of patient medication nonadherence.
- The industry will not achieve a full return on investment without solving the formulary data issue and supporting a prospective PA process. Until practices can rely on the accuracy of EHR formulary data, physician adoption of the NCPDP PA transactions will be suboptimal.

Pharmacy PA Recommendations:

- **Urge swift industry action on development and piloting of a real-time pharmacy benefit inquiry transaction.**
- **Mandate a standard real-time pharmacy benefit inquiry and response transaction to support provision of PA requirements and other critical formulary data at the point of prescribing.**

Health Care Claim or Equivalent Encounter

The health care claim transaction is meeting current business needs of physicians to submit claims for the services and procedures they perform and receive reimbursement. However, some issues still remain that impact optimal implementation of the claim transaction. The AMA submits the following comments and recommendations regarding health care claims.

Health Care Claim Barriers:

- We have concerns that the success and high adoption of the electronic claim transaction make it attractive for adding reporting requirements for additional data potentially unrelated to claims processing. If added, these extra data requirements will increase the burden to generate the claim and increase the risk of processing errors.

- Although the health care claim transaction generally functions well, we continue to hear sporadic anecdotal issues of payer noncompliance with situational and required data reporting in the ASC X12 Technical Report Type 3 (TR3). We encourage physicians who encounter noncompliance issues to report them to CMS.
- While the current health care claim standard, code sets, and identifiers generally meet the current business needs of physicians in submitting claims, there continue to be concerns about inconsistencies with the application of the Current Procedural Terminology (CPT) code set. In the HIPAA Transactions and Code Sets Final Rule, the CPT Guidelines were specifically not named with the code set. Without the CPT Guidelines adopted under HIPAA, users of the code set are able to develop their own rules for how and when to report codes and modifiers, which decreases the standardization that was the intent of the regulation. For example, a physician provides psychotherapy services. The CPT Guidelines indicate that psychotherapy services should be reported with codes 90833, 90836, or 90838, and when necessary, that Evaluation and Management (E/M) services be additionally reported. One payer may follow this guideline while another payer may require the physician report a single E/M for both the psychiatry and the patient's E/M services that are separate from the psychotherapy. The process for the development of CPT codes and guidelines is open, and anyone can submit a code change application if they believe the current codes or guidelines do not meet current business needs. As we move to a more digitally rich environment, the need for "clean data" will grow. Situations like these not only complicate claims processing and create hassles for physicians, they also create "dirty data" situations, making analysis across the health care system harder.
- Coordination of Benefits (COB) continues to be a cumbersome process for physicians. The ASC X12 claim transaction requires that the core data of the claim remain unchanged from the primary payer to the secondary payer. Physicians regularly encounter payers requiring different coding for the primary claim vs. the secondary claim, which is a violation of the transaction.

Health Care Claim Recommendations:

- **Adopt the CPT Guidelines, along with the CPT codes, under HIPAA to remove the current variability in the use of the codes and improve the efficiency of the claim transaction.**
- **Prohibit the reporting of additional data not needed for adjudication in the claim transaction.**
- **Increase compliance enforcement for the claim transaction, to include addressing the variability between health plans in claim core data and coding requirements.**

Health Care Claim Status

Any healthy electronic revenue cycle must support the ability of physician practices to quickly and easily ascertain the status of a previously submitted claim. Current health plan search mechanisms result in physicians receiving inaccurate, and often useless, responses to claim status requests. We note the following barriers to optimal functioning of the health care claim status transaction and offer our recommendations for improvement below.

Health Care Claim Status Barriers:

- Health plans' search/filtering processes can result in a large number of improper "claim not found" responses. Problems can occur even when the practice sends a payer's claim number with the status request due to health plans' inability to identify the most recent record in their adjudication system.
- Health plans often direct practices to portals for claim status information. Payer portals frequently offer more accurate claim status information than the claim status response (e.g., claim status related to patients in the HIX grace period), which again represents an incentive to use an option other than the standard transaction and is prohibited under HIPAA.
- Required and standard use of the 277CA Claims Acknowledgment transaction could reduce providers' need to submit claim status inquiries and reduce practices' per-transaction costs. There is currently wide variability in industry implementation of the 277CA, resulting in different meanings of the acknowledgment. For example, a 277CA from a clearinghouse does not confirm that a submitted claim was accepted by the health plan's adjudication system.

Health Care Status Recommendations:

- **Create and adopt additional operating rules for the claim status transaction that would: (a) detail how health plans search for and identify claims in response to status requests to avoid improper "claim not found" issues; and (b) require compliance with the ASC X12 RFIs regarding reporting of claim status information for patients within a HIX grace period.**
- **Mandate the 277CA under HIPAA to promote uniform use of the claim acknowledgment and reduce the need for practices to submit claim status requests.**

Health Care Payment, Electronic Remittance Advice (ERA), and Electronic Funds Transfer (EFT)

The HIPAA-standard ERA and EFT transactions offer significant administrative simplification improvements and efficiency across health care industry stakeholders. For physician practices, the transition to electronic remittance and payment reduces manual processes, speeds payment, and frees up valuable resources for patient care. While many physicians have successfully implemented ERA and EFT, current challenges with both transactions limit wider adoption and prevent attainment of the maximal value of these synergistic transactions. The AMA's comments on current barriers surrounding ERA and EFT adoption, as well as our recommendations to overcome these issues, are listed below and in our oral testimony slides.

ERA Barriers:

- Health plan compliance with the ERA standard and operating rules is essential to convincing physicians to adopt the transaction. Current ERA compliance issues include:
 - Failure of ERAs to properly balance;
 - Provision of more accurate/complete information in payer portals;
 - Assessment of additional vendor/clearinghouse charges for ERA generation;

- Improper use of claims adjustment reasons codes (CARCs) and remittance advice remark codes (RARCs) (e.g., use of CARC 45 as a default “catch-all” code when there are more appropriate messages to send practices); and
- Failure to send one ERA for one EFT (ERA/EFT ratio of 1:1).
- Compliance issues are exacerbated by the inability of many health plans to regenerate a compliant ERA upon physician request.
- ERA enrollment is usually a plan-by-plan process, which is extremely burdensome for practices.
- Reporting of patients in the HIX grace period is inconsistent between health plans, causing confusion for practices.
- ERA issues related to COB can be challenging for physicians. For example, many payers fail to differentiate when they are serving as both a primary and subsequent payer.
- Despite the fact that the ERA and EFT transactions were designed to be implemented together to maximize payment efficiency, many practices report significant problems with reconciling an ERA to the related EFT. Contributing factors include lack of vendor support for automated reconciliation and banks’ truncation of the reassociation trace number. Reconciliation issues drive providers back to using manual processes to match remittance and payment information.

ERA Recommendations:

- **Create and adopt additional ERA operating rules to improve the quality of information in the ERA, to include:**
 - **Requirement of Alert RARCs for specific scenarios (e.g., reversal claims);**
 - **Prohibition of “dummy” codes to force ERA balancing;**
 - **Requirement for payers to indicate when they are serving as both the primary and secondary payer on a claim and notify the practice that there will be two separate processes using the “crossover” notification capability;**
 - **Requirement of health plans to regenerate ERAs upon provider request (e.g., after receipt of a noncompliant ERA);**
 - **Provision of “roll up” capability by provider choice, so that large facilities are not forced to receive separate ERAs for each physician or patient;**
 - **Expansion of CARC/RARC compliance to include not just use of valid codes but conveyance of an accurate message; and**
 - **Required compliance with ASC X12 RFIs regarding standard reporting of HIX grace period information in the ERA.**
- **Strengthen ERA compliance enforcement to encourage increased provider adoption.**
- **Increase industry pressure on vendors to adequately automate reconciliation of the ERA with the associated EFT payment.**
- **Adopt the next version of the ASC X12 transaction set to support improved use of CARCs and RARCs. Enhancements in the next version of the standard include the ability to directly associate a RARC with its related CARC, as well as report a RARC that is not associated with a CARC.**

EFT Barriers:

- Burdensome enrollment processes are among the most significant disincentives for provider adoption of standard EFT payments. A recent informal online survey conducted

by the AMA, Medical Group Management Association (MGMA), and American Dental Association (ADA) revealed that 56 percent of physicians find the EFT enrollment process to be burdensome. Issues surrounding EFT enrollment include:

- Providers must enroll separately with each health plan, and sometimes even with different products for the same health plan.
- Some health plans' EFT vendors have separate provider enrollment forms. As a result, providers often must complete two different forms in order to receive EFT payments from a single health plan.
- Although current operating rules set a maximum set of information to be collected for EFT enrollment, they do not standardize enrollment information. This results in substantial differences between health plan enrollment processes and forms.
- Additionally, some health plans require physicians to enroll individually, which burdens group practices and facilities.
- Current EFT operating rules fail to establish a timetable for health plan EFT enrollment processing. Providers report that the time from enrollment until the start of EFT payments can range anywhere from one to five weeks. These processing delays can be extremely problematic for physicians, particularly small practices that may not be able to absorb a five-week delay in revenue flow.
- Health plan compliance issues also reduce physician adoption of standard EFT.
 - In the ADA/AMA/MGMA survey, 44 percent of providers reported not enrolling in standard EFT because it was not offered by a particular health plan. Since health plans are required to offer standard EFT upon provider request, this represents a troubling compliance issue.
 - The survey further revealed that 11 percent of respondents pay percentage-based fees for standard EFT, with 29 percent of these providers indicating that they were only offered a fee-based option when enrolling in EFT.
- Virtual credit cards (VCCs), a nonstandard form of EFT under which providers pay percentage-based interchange fees of up to five percent, have impacted provider adoption of standard EFT. In the ADA/AMA/MGMA survey, more than two-thirds of respondents (67 percent) reported receiving VCC payments, with 86 percent indicating that usage had increased throughout the past year. The increased health plan reliance on VCCs for provider claims payments is a considerable obstacle to maximizing standard EFT adoption and the associated industry-wide savings. Additionally, the pervasive use of an opt-out model for VCC implementation further hinders standard EFT adoption, as suggested by the recent provider survey:
 - An overwhelming number of survey respondents (87 percent) reported that they first learned of a health plan's VCC usage when receiving their first payment. Several respondents shared accounts of the extreme difficulties and hassles they experienced in opting out of VCC payments.
 - Of the survey respondents who received VCC payments, 46 percent were unaware that they could switch to another payment method, while 84 percent reported receiving no clear instructions on how to switch to an alternative payment form.

EFT Recommendations:

- **Create and adopt additional operating rules to improve the provider enrollment experience to include standardization of required enrollment information, a**

maximum time for EFT enrollment processing, and a prohibition of multiple enrollment processes if health plans use vendors.

- **Address EFT compliance issues, to include issuance of guidance on fee assessment for standard EFT.**
- **Establish parameters around VCC use that will minimize the impact of VCCs on provider standard EFT adoption, to include requiring VCC programs to be opt-in and provide clear instructions on how providers can switch to alternative payment mechanisms.**

The AMA enthusiastically supports the industry's administrative simplification efforts, and we thank you again for the opportunity to provide our feedback on the existing HIPAA-mandated electronic transactions. We urge you to consider the recommendations outlined above and in our oral testimony, as we believe that they will streamline workflows, reduce costs, and increase the time and resources available for patient care. We look forward to continuing to work with the Committee and all industry stakeholders in identifying and implementing innovative ways to improve the efficiency of health care in our country.