2005 Survey:

Health Care Claim Payment/Advice Version Migration

Acknowledgments

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Disclaimer

Rounding adjustments are a normal and expected artifact of the analysis methodology.

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Background

X12 Insurance Subcommittee has brought forward the 835-transaction version 4050 for the healthcare industry to adopt for use under HIPAA to address a number of issues that have been identified to the Healthcare Task Group and Healthcare Claim Payment (Remittance) Work Group by the healthcare industry. Vendors and providers have had numerous issues with this transaction under version 4010A1 because the Implementation Guide did not provide enough guidance to consistently implement this transaction as was intended by the X12 developers. As a result, vendors and providers have not been able to effectively integrate this transaction into their Account Receivable systems to automate the billing reimbursement process. When this process can be automated, providers have realized significant benefits from this automation; while for those health plans that are not completing the 835-transaction as envisioned by the X12 transaction developers have not been able to realize this benefit. Consequently, many of these claim payments from these health plans remain a manual process even though they are receiving electronic transactions.

X12 has prepared a summary document (appendix A) that describes the benefits they believe will be realized by implementing this transaction using the Implementation Guidelines found in X12's Technical Report Type 3 for the version 4050 835 Healthcare Claim Payment transaction. X12 believes the cost associated with the implementation of this transaction will be off-set by the benefits that can be realized. The following information in this document addresses WEDI's findings regarding the anticipated costs to implement version 4050 of the 835-transaction based on these underlying assumptions.

The Designated Standards Maintainence Organization (DSMO) recommended to NCVHS the migration of the 835 from version 4010 to 4050 as articulated by X12. WEDI was approached to create a benefit analysis. This document was created as a result of that request. The scope of this document is not to address the migration of any other transactions, or versions of the standards. It is not within the scope of this document to recommend the migration from 4010 to 4050.

During the summer of 2005, the administrative component of the US health care industry was asked to participate in a survey to better understand the impact of migrating from the current HIPAA-mandated version of the ***Health Care Claim Payment/Advice*** electronic format to a revised version. The potential benefit statements were derived by the workgroup utilizing the survey information, the X12 document and industry expertise of the workgroup.

Survey Structure

The web-based survey asked participants to select one of three domains:

- Health Plan (Payer)
- Provider
- Vendor

Note: It is important to note that respondents did not necessarily answer every question in the survey. In addition, there may be some outlier responses that skew the response averages up or down.

Survey Interpretation

Health Plan (Payer) Interpretations and Findings

The Health Plan (Payer) survey had 40 valid responses. The summary of the responses and the detail of the responses can be found in the sections 'Payer Survey Summary' and 'Payer Survey Results'.

The Task Group evaluated the content of the 40 respondents. The Task Group concluded that the survey results were representative of the industry. The content was found to be valid for the purposes of this ROI study.

When asked about the utilization of the Health Care Claim Payment/Advice 004010X091A1 (835) 97% of the respondents reported the capability to utilize the transaction. However, when asked about the percentage of trading partners currently receiving the 835 transaction, 69.7% stated less than 50% of their trading partners were currently receiving the 835 today.

When asked about the EDI implementation approach, 93.9% reported utilizing 'in house' staff for their EDI implementation, while 21.2% utilized a vendor/outsourced approach for their EDI implementation and 15.2% specifically reported utilizing a clearinghouse for the EDI. When asked about the ability to handle concurrent versions of the X12 standard/835 transaction, the respondents reported 60.6% were capable, while 39.4% were not.

The remaining questions were more difficult and were not a yes/no or multiple choice question. For this reason, the results were more difficult to compile.

Concerning the overall time implementation tasks would take the organizations (reported in man days) the average for:

- Installing new software 74.70
- User Training 25.08
- Internal testing 58.86
- External testing 82.83

When asked about how many trading partners would require validation for the 835, the reported average was 1,463 trading partners. Of note, one respondent reported no trading partners, while the highest reported was 10,000 trading partners.

The survey asked the cost of additional software to support the 4050 835, the respondents reported:

- New Software $287,750.00 Average Cost
- Upgrading Existing Software $223,545.00 Average Cost
- Custom Solutions $219,136.00

The highest cost reported for any software costs was $2,000,000.00 and the lowest cost reported $0.00.

The survey concluded with asking the organization to identify any additional costs not accounted for within the survey. The average monetary amount reported for additional costs was $2,854,167.00. The lowest amount reported was $10,000.00 and the highest was $15,000,000.00. The justification for the additional costs was wide and varied, including items such as:

- Validation/Credentialing/certification costs
- Membership to organizations such as X12, HIPAA task forces
- Increased provider relations costs
- Customer service education
- Unknown whether the current HIPAA solution could accommodate for multiple versions of the 835
- If a need to test with all trading partners. The timeframe and resources would be additional.
- Lost time on other projects

- Additional state requirements
- Possible external costs with business associates (TPA)

Findings

- Small number of health plans (payers) responded overall
- Representation from all sectors
- The overwhelming majority of the Payers responding are capable of sending the 835 today
- Although 97% of payer community is capable of sending the 835, the majority of the trading partners (60%) (provider community) receiving the 835 are 50% or below
- Average costs for implementing the 835 range from 219,000.00 -287,000.00
- The cost for the payer community is higher than that of the average provider organization.
- There are unidentified costs that will raise the implementation costs for the payer community (ie. Companion guide creation, testing, etc)

BENEFIT opportunities

- There may be room for potential benefit for the health plan.
- The 4050 835 provides clearer instructions providing consistency that may potentially lead to further utilization of the 835 by the trading partners.
- Although not specifically addressed in this survey, the increased acceptance of the 835 may reduce ancillary costs, such as customer service, paper based payment and reporting, increasing the potential benefit by the health plan.

Provider Interpretations and Findings

The Provider survey had 93 valid responses. Of these 93 respondents, 42% indicated they are best described as a 'Hospital, Nursing Facility, Health System or other institutional setting', 18% indicated they were an 'Individual or Group of Physicians', and 40% indicated they would be described as something 'other' than these categorizations (includes Ambulance, Lab, Pharmacy, DME and all other clinics and practitioners). The summary of the responses and the detail of the responses can be found in the sections 'Provider Survey Summary' and 'Provider Survey Results'.

The Task Group evaluated the content of the 93 respondents. The Task Group concluded that the survey results were representative of a small number of providers overall, and that they are representative of larger providers, with the small groups/practices not well represented. However, we do believe the survey to be representative of provider organizations who have implemented the Health Care Claim Payment/Advice 004010X091A1 (835), since these tend to be the larger organizations. Therefore, the content was found to be valid for the purposes of this BENEFIT study.

When asked whether they receive the Health Care Claim Payment/Advice 004010X091A1 (835), 92% of the respondents who answered reported that they receive the transaction. However, only 39% of total number of the total respondents answered the question. This may indicate that a third party is receiving the 835 on their behalf (such as a clearinghouse or billing services) or that they do not know whether or not they are receiving the 835.

When asked about whether data on the 835 is posted automatically vs. manually, the percentage of remittance items posted manually was, on average, 80%. This indicates a lack of automation of the 835. The committee believes this is a combination of situations where providers have not implemented the 835 for all of their payers or payers' implementations of the 835 did not provide adequate data for posting. Note that there was some disparity in responses on this question (manual percentages as high as 300% and as low as 1%), indicating that there may have been some confusion about the question.

When asked about the EDI implementation approach, 77% reported utilizing 'in house' staff for their EDI implementation, while 30% utilized a clearinghouse for their EDI implementation and 15.% reported utilizing a vendor/outsourced approach for the EDI. When asked about the ability to handle concurrent versions of the X12 standard/835 transaction, the respondents reported 53% were capable, while 47% were not.

The remaining questions were more difficult to compile, since they were not yes/no or multiple choice questions. Moreover, the committee determined that it is best to separate the 'Individual or Group of Physicians' category from the others related to cost items, since responses were significantly different.

Concerning the overall time implementation tasks would take the 'Individual or Group of Physicians' (reported in man days) the average responses were:

- Installing new software 9.4
- User Training 11.7
- Internal testing 54.4
- External testing 33.6

Note: It is important to note that 2 of these organizations reported a high number of days required for internal testing (item 3 above) – 260 and 100, while the others indicated a much lower range of days – 1 to 8.

Concerning the overall time implementation tasks would take the 'Hospital, Nursing Facility, Health System or other institutional setting' and the 'Other' organizations (reported in man days) the average responses were:

- Installing new software 52.8
- User Training 23.6
- Internal testing 47.4
- External testing 76.7

Note: It is important to note that 2 of these organizations indicated a particularly high number of days required for external testing (item 4 above) – 500 and 480 days, while the others indicated a much lower range of days – 2 to 150.

When asked about how many trading partners would require validation for the 835, the 'Individual or Group of Physicians' indicated an average of 2.7 trading partners. For all other provider organizations, the answers were disparate, ranging from a high of 300 to a low of 0. The reported average for these providers was 45 trading partners.

The survey then asked the cost of additional software to support the 4050 835, the 'Individual or Group of Physicians' respondents reported:

- New Software $ 6,420.00 Average Cost high of $25,000
- Upgrading Existing Software $30,800.00 Average Cost high of $80,000
- Custom Solutions $10,700.00 high of $25,000

Note: Note that there were numerous respondents who indicated no costs in some areas.

The cost of additional software indicated by all other providers was reported as follows:

- New Software $ 3,300.00 Average Cost high of $50,000
- Upgrading Existing Software $59,100.00 Average Cost high of $336,000
- Custom Solutions $81,250.00 high of $1,000,000

Note: Note that there were numerous respondents who indicated no costs in some areas.

The survey concluded with asking the organization to identify any additional costs not accounted for within the survey. About 10% of respondents indicated that there are additional costs. All but 1 of these were unable to estimate the additional costs. The additional costs included items such as:

- Validation/Credentialing/certification costs
- Membership to organizations such as X12, HIPAA task forces
- Software upgrades – both implementation and downtime
- Determining new payer-specific implementations and impacts
- Manual posting costs during transition – assurance of continued cash flow
- Customer service education
- Clearinghouse costs for testing and implementation
- Trading partner and clearinghouse/vendor agreement analysis / changes
- Lost time on other projects

Findings

- Small number of providers responded overall
- Representation from the larger providers, limited representation from small groups/practices
- For the part of the provider community that is capable of receiving the 835, the majority of the remittance items are still posted manually
- Average costs for 'Individual or Group of Physicians' respondents implementing the 835 consist of around 110 man days plus software costs of around $48,000 for survey respondents
- Actual costs for smaller provider groups/practices is unknown since we there were few to no small practice respondents
- Average costs for 'Hospital, Nursing Facility, Health System or other institutional setting' and 'Other' respondents implementing the 835 consist of around 200 man days plus software costs of around $144,000 for survey respondents
- There are unidentified costs that could raise the implementation costs for the provider community

BENEFIT opportunities

- There may be room for potential benefit for the provider.
- The 4050 835 provides clearer instructions providing consistency that may potentially lead to providers' ability to further implement/automate the 835 where it is already in use with payers, and begin to use the 835 with more payers.

The 4050 version of the ASC X12 835 may remove obstacles to industry-wide implementation of the 835 for the reporting and posting of electronic remittance advices. This implementation has significant potential benefit for both providers and health plans. One aspect of the potential for 835 implementation is the cost savings attributable to remittance management, secondary billing and even the timely generation of patient statements. The task group has estimated that providers may conservatively save $4 per payment posted in an electronic versus paper environment. The task group has identified other possible benefits which include cash flow improvements, reallocating staff to other functional areas that impact operating costs, savings in paper management and storage, easier retrieval of EOBs for follow-up purposes (appeals process) if the 835 is stored in a file for future reference and other benefits.

Overall, enterprise management is impacted when cash is posted accurately and timely, and can be used to track the financial performance of specific treatment modalities and how they may be changed to increase overall performance (i.e., eliminated, improved, etc). Finally, other regulations are creating pressures in the area of remittance management, to ensure that financial records accurately reflect fiscal posture. Implementation of the 835 can streamline both operating and compliance procedures for the healthcare provider.

The ASC X12 835 may require changes before it can be "operationalized", including issues around coding of denial reasons and other areas. As these issues resolve, implementation of the 835 to automate workflow processes could become just as important as the automation that has already occurred with the 835. If the administrator was faced with "turning off" the 835, it would create a strain at many hospitals because the savings have already been internalized. The 835 offers the opportunity to reduce costs related to the remaining remittance classes.

Vendor Interpretations and Findings

The Vendor survey had 32 valid responses. The summary of the responses and the detail of the responses can be found in the sections 'Vendor Survey Summary' and 'Vendor Survey Results'.

The Task Group evaluated the content of the 32 respondents. The vendor survey is unique in that the customers of the vendors that responded are both providers and payers. 53.1% of the respondents support Institutional healthcare providers, 87.5% support Professional healthcare providers, and 43.8% support payers. These percentages add to more than 100% because some vendors could potentially support any or all of the categories listed. The Task Group concluded the survey results were representative of the industry. The content was found to be valid for the purposes of this BENEFIT study.

When asked if the vendor supported the Health Care Claim Payment/Advice 004010X091A1 (835) in their software solution 87% of the respondents reported affirmatively that they support the transaction. However, when asked

about the percentage of the vendor's customers currently receiving/sending the 835 transaction, 58.6% stated less than 50% of their trading partners were currently receiving/sending the 835 today.

When asked about the EDI implementation approach, 83.3% reported utilizing 'in house' staff for their EDI implementation, while 16.7% utilized another vendor partner for their EDI implementation. When asked about the ability to handle concurrent versions of the X12 standard/835 transaction, the respondents reported 75% were capable, while 25% were not.

The remaining questions were more difficult and were not a yes/no or multiple choice question. For this reason, the results were more difficult to compile.

Concerning the overall time implementation tasks would take the organizations (reported in man days) average for:

- Delivery of software 37.22
- User Training 8.38
- Testing with Customer 17.65
- External testing 36.61

Note: One respondent stated that the external testing would take one man-day per trading partner. Without knowing the number of trading partners for this entity, we are not able to use that estimate.

The survey the asked the level of investment needed by the vendor companies in order to develop the software solutions that support the 4050 835, 23.1% reported the cost would be less than $25,000, 11.5% reported a cost between $26,000 and $100,000, and 30.8% reported a cost between $101,000 and $500,000.

When asked what would drive the business decision of the vendors 83.3% reported customer demand and 75% reported regulatory requirement. The vendors were asked to check all that applied and that is the reason for the response total being greater than 100%.

The survey asked how long it would take the vendors to get their updates to market after issuance of the Final Rule and 30.8% stated it would take 91-180 days. 53.8% reported it would take 90 days or less.

Findings

- Small number of vendors responded overall
- Representation from all sectors
- The overwhelming majority of the Vendors' report their software is capable of receiving/sending the 835 today
- Although 83.3% of the vendor software is capable of receiving/sending the 835, the majority of the trading partners (58.6%) receiving/sending the 835 are 50% or below the total potential volume.
- Average costs for creating the new version of the 835 range from less than $25,000 with only one respondent reporting costs up to $5 million.

BENEFIT opportunities

- There may be room for potential benefit for the vendors through improved remittance capabilities which may drive sales of remittance products. The 4050 835 provides clearer instructions providing consistency that will potentially lead to further utilization of the 835 by the trading partners.
- Although not specifically addressed in this survey, the increased acceptance of the 835 may reduce ancillary costs, such as customer service, paper based payment and reporting, increasing the potential benefit.

Survey Results

Survey results for each domain are presented as a quick summary followed by a detail section. Each respondent was assigned a number in the first question of each section that identifies that respondent's answers. See the figure below.

Assigned Respondent Numbers →

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
Traditional Indemnity Insurance Program	●	●									●				●		●												●												
HMO–Health Maintenance Organization		●	●		●	●					●				●		●												●												●
PPO–Preferred Provider	●	●			●						●				●		●	●											●				●								●

Subsequent reference to respondent's number ↓

	Installing new software	User Training	Internal validation testing	External validation testing with each trading partner
2	30	10	20	10
3	100	20	10	10
4	5	2	30	60
5	30	5	2	2
6	30	10	30	3
7	2	30	7	30

PART 1:

PAYER SURVEY

Payer Survey Summary

The payer survey consisted of 12 questions. Forty organizations answered the survey and are identified throughout this document as Payer 1 through Payer 40. The twelve questions and when appropriate, a quick summary of response statistics, are followed by complete details. A link is available for each question to jump to the detail for that question.

1. For purposes of this survey, the health plan or organization I represent can best be described as: (check all that apply).

DETAILS

Totals	Traditional Indemnity Insurance Program	6	15%
	Health Maintenance Organization (HMO)	9	22.5%
	Preferred Provider (PPO)	10	25%
	Point of Service (POS)	7	17.5%
	Long Term Care	1	2.5%
	Dental HMO	2	5%
	Dental PPO	7	17.5%
	Vision Only	2	5%
	Pharmacy	2	5%
	Pharmacy Benefit Manager (PBM)	11	27.5%
	Medicare Managed Care Plan	2	5%
	Medicaid	9	22.5%
	Medicare Carrier	9	22.5%
	Medicare Fiscal Intermediary	12	30%

2. Indicate the number of Institutional Providers (hospitals and other facilities) participating in this plan (or plans).

DETAILS

Totals	0	2	5.4%
	1-100	6	16.2%
	101-250	3	8.1%
	251-500	5	13.5%
	501-1,000	7	18.9%
	1,001+	14	37.8%

3. Indicate the number of professional providers (all types) that participate in this plan(s).

DETAILS

Totals	0	3	8.6%
	1-500	1	2.9%
	501-1,000	3	8.6%
	1,001-5,000	3	8.6%
	5,001-10,000	4	11.4%
	10,001+	21	60%

4. How many trading partners currently engage in electronic transmissions? DETAILS

Totals	Institutional	24	85.7%
	Professional	25	89.3%
	Health Plan	19	67.9%

5. Do you currently utilize the Health Care Claim Payment/Advice 004010X091A1 (835) mandated under HIPAA? DETAILS

Totals	32	Yes	97%
	1	No	1%

6. What percentage of trading partners currently receive the 835 transaction today? DETAILS

Totals	Less than 10%	9	27.3%
	10-25%	6	18.2%
	26-50%	8	24.2%
	51-75%	4	12.1%
	76-85%	0	0%
	86-95%	2	6.1%
	96%+	4	12.1%

7. Does your organization handle the EDI implementation via: (choose all that apply) DETAILS

Totals	In house staff	31	93.9%
	Vendor / Outsourced	7	21.2%
	Clearinghouse	5	15.2%

8. Is your organization capable of handling concurrent versions of the X12 standard (example 004010 and 004050)? DETAILS

Totals	20	Yes	60.6%
	13	No	39.4%

9. Estimate the overall time that each of the following implementation tasks would take your organization per system(s): (use ‘estimated man-days,’ a man-day is equivalent to 1 full day of an FTE). DETAILS

10. How many trading partners must be validated for the 835? DETAILS

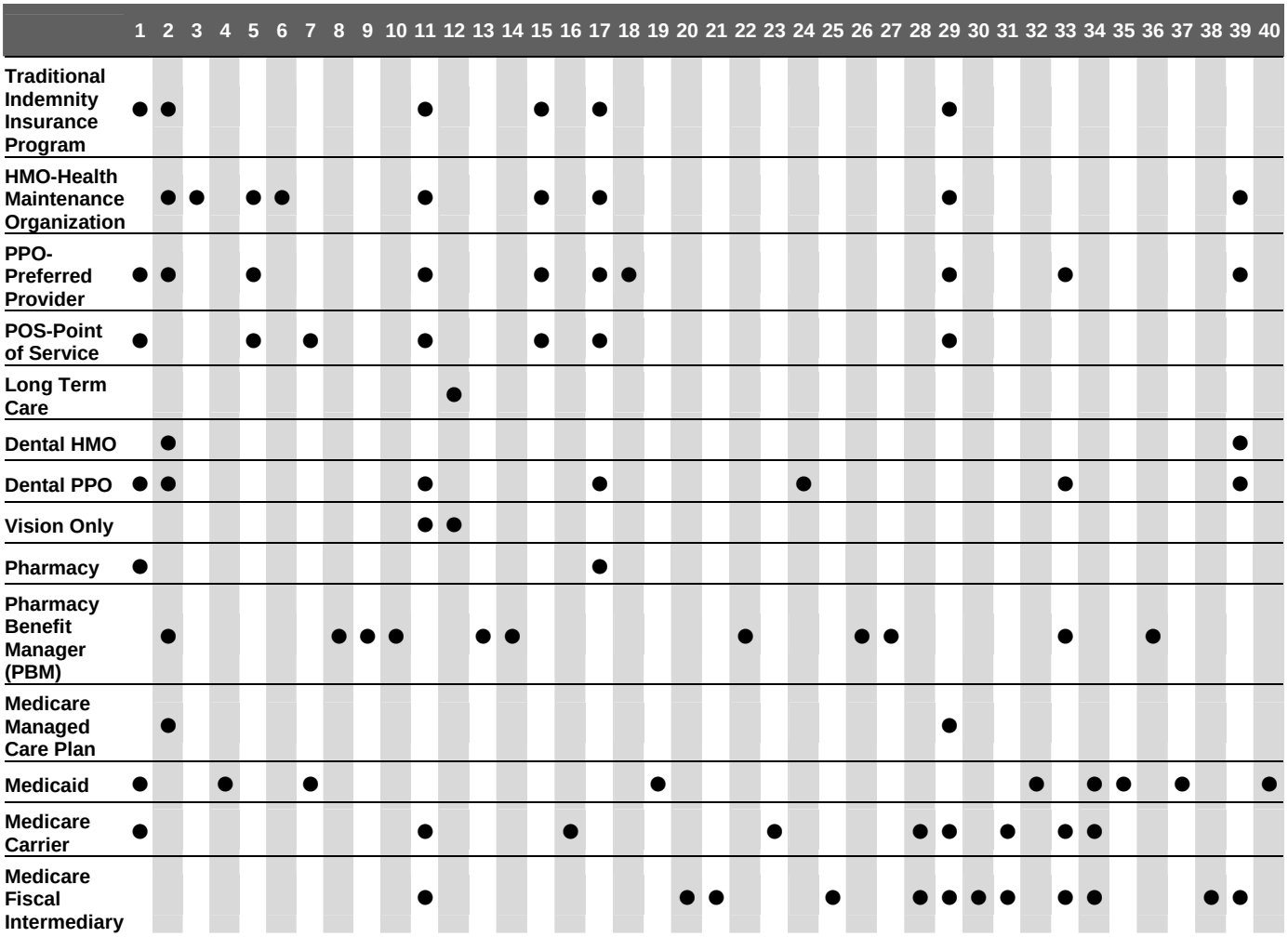
11. Estimate the cost of additional software to support 4050: (answer all that apply). DETAILS

12. List any additional costs to your organization not accounted for in this survey. DETAILS

Payer Survey Details

1. For purposes of this survey, the health plan or organization I represent can best be described as: (check all that apply)

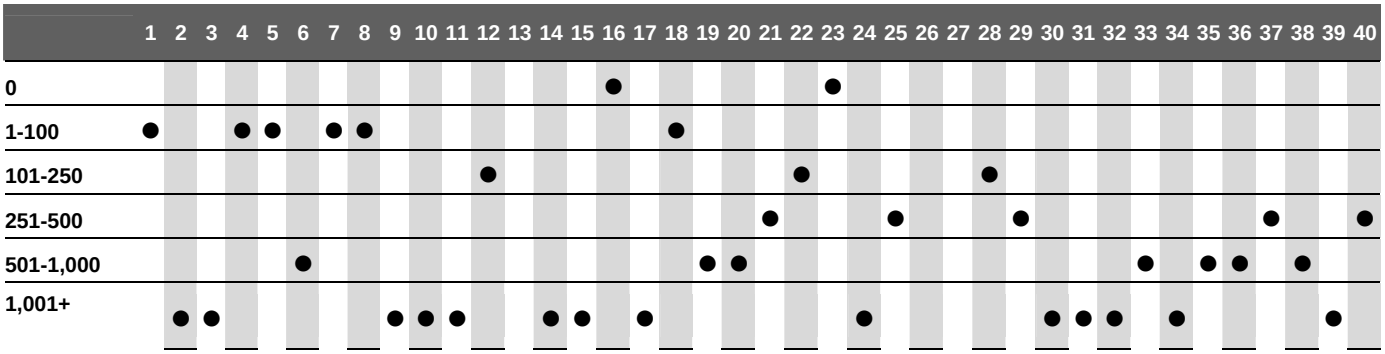
Forty organizations answered this question.



Totals	Traditional Indemnity Insurance Program	6	15%
	Health Maintenance Organization (HMO)	9	22.5%
	Preferred Provider (PPO)	10	25%
	Point of Service (POS)	7	17.5%
	Long Term Care	1	2.5%
	Dental HMO	2	5%
	Dental PPO	7	17.5%
	Vision Only	2	5%
	Pharmacy	2	5%
	Pharmacy Benefit Manager (PBM)	11	27.5%
	Medicare Managed Care Plan	2	5%
	Medicaid	9	22.5%
	Medicare Carrier	9	22.5%
	Medicare Fiscal Intermediary	12	30%

2. Indicate the number of Institutional Providers (hospitals and other facilities) participating in this plan (or plans).

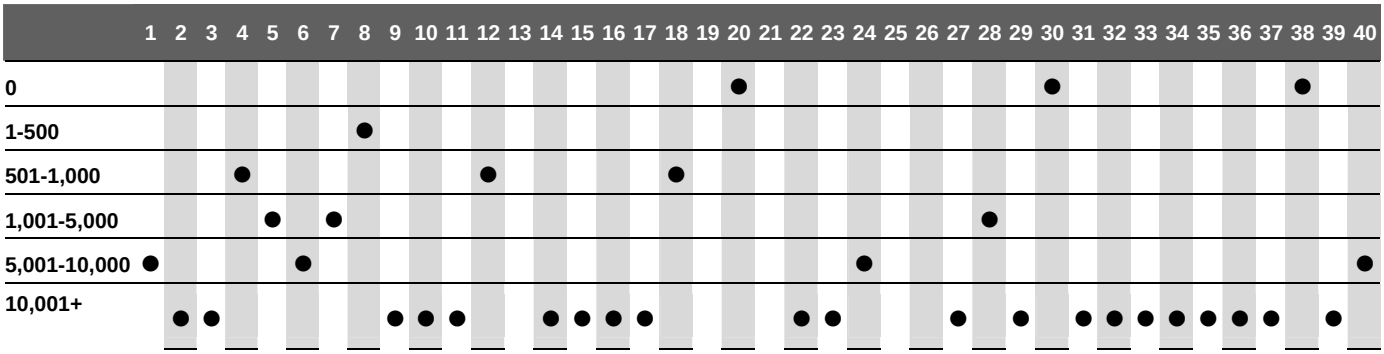
Thirty-seven organizations answered this question.



Totals	0	2	5.4%
	1-100	6	16.2%
	101-250	3	8.1%
	251-500	5	13.5%
	501-1,000	7	18.9%
	1,001+	14	37.8%

3. Indicate the number of professional providers (all types) that participate in this plan (plans).

Thirty-five organizations answered this question.



Totals	0	3	8.6%
	1-500	1	2.9%
	501-1,000	3	8.6%
	1,001-5,000	3	8.6%
	5,001-10,000	4	11.4%
	10,001+	21	60%

4. How many trading partners currently engage in electronic transmissions?

Twenty-eight organizations answered this question.

	Organization Type	Institutional	Professional	Health Plan
2	Indemnity, HMO, PPO, Dental HMO, Dental PPO, PBM, Medicare Plan	3	16	10
3	HMO	250	500	
4	Medicaid	1	2	
5	HMO, PPO, POS	6	13	
6	HMO	29	89	
7	POS, Medicaid		1,000 – 5,000	
8	PBM		100	
10	PBM	1,000	60,000	
14	PBM			10,000
16	Medicare Carrier		5,238	50
17	Indemnity, HMO, PPO, POS, Dental PPO, Pharmacy	153	2,398	12
18	PPO	100	82	
20	Medicare FI	341		17
22	PBM			30+
23	Medicare Carrier		4,000	
28	Medicare Carrier, Medicare FI	246	4,817	
29	Indemnity, HMO, PPO, POS, Medicare Plan, Medicare Carrier, Medicare FI	Approximately 300	Approximately 3,100	Approximately 45
30	Medicare FI	1440		
31	Medicare Carrier, Medicare FI	520	6,495	
33	PPO, Dental PPO, PBM, Medicare Carrier, Medicare FI	345	7,140	
34	Medicaid, Medicare Carrier, Medicare FI	363	3,936	
35	Medicaid	750	13,000	200
36	PBM	Varies	Varies	Varies
37	Medicaid	131	358	23
38	Medicare FI	115		1
39	HMO, PPO, Dental HMO, Dental PPO, Medicare FI	25	314	349
40	Medicaid	116	1,708	1

Totals	Institutional	24	85.7%
	Professional	25	89.3%
	Health Plan	19	67.9%

5. Do you currently utilize the Health Care Claim Payment/Advice 004010X091A1 (835) mandated under HIPAA?

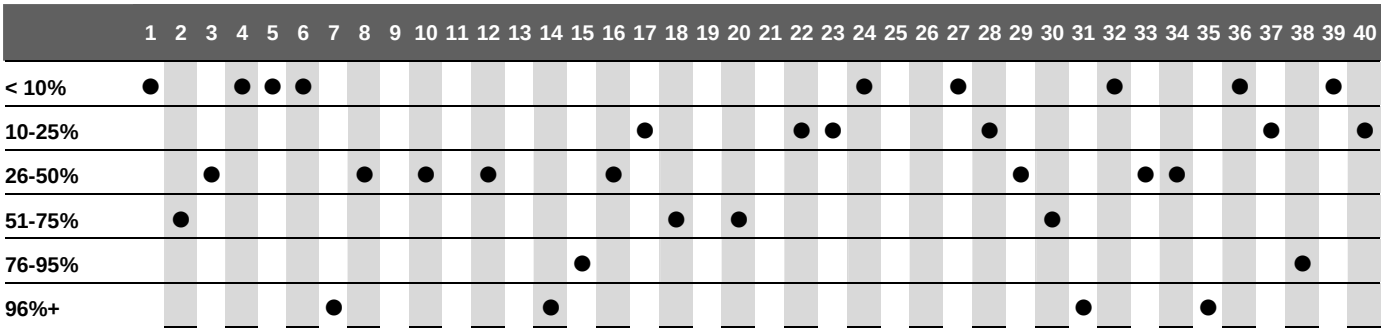
Thirty-three organizations answered this question. A ☑ indicates Yes, a ☒ indicates No, a blank entry indicates that the question was skipped.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
✓	✓	✓	✗	✓	✓	✓	✓		✓		✓		✓	✓	✓	✓	✓		✓		✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Totals	32	Yes	97%
	1	No	1%

6. What percentage of trading partners currently receive the 835 transaction today?

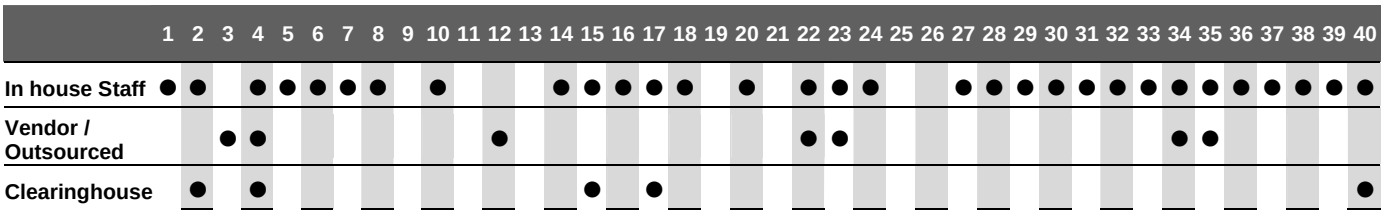
Thirty-three organizations answered this question.



Totals	Less than 10%	9	27.3%
	10-25%	6	18.2%
	26-50%	8	24.2%
	51-75%	4	12.1%
	76-85%	0	0%
	86-95%	2	6.1%
	96%+	4	12.1%

7. Does your organization handle the EDI implementation via: (choose all that apply)

Thirty-three organizations answered this question.



Totals	In house staff	31	93.9%
	Vendor / Outsourced	7	21.2%
	Clearinghouse	5	15.2%

8. Is your organization capable of handling concurrent versions of the X12 standard (example 004010 and 004050)?

Thirty-three organizations answered this question. A ☑ indicates Yes, a ☒ indicates No, a blank entry indicates that the question was skipped.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
✓	✓	✗	✓	✓	✓	✓	✓		✗		✓		✗	✗	✓	✗	✗		✓		✗	✓	✓			✓	✓	✗	✓	✓	✗	✓	✓	✗	✓	✗	✗	✓	✗

Totals	20	Yes	60.6%
	13	No	39.4%

9. Estimate the overall time that each of the following implementation tasks would take your organization per system(s): (use 'estimated man-days,' a man-day is equivalent to 1 full day of an FTE)

Twenty-seven organizations answered this question. Detailed information is provided in two tables.

	Organization Type	Installing new software	User Training	Internal validation testing	External validation testing with each trading partner
2	Indemnity, HMO, PPO, Dental HMO, Dental PPO, PBM, Medicare Plan	30	10	20	10
3	HMO	100	20	10	10
4	Medicaid	5	2	30	60
5	HMO, PPO, POS	30	5	2	2
6	HMO	30	10	30	3
7	POS, Medicaid	2	30	7	30
8	PBM	5-10	1 – all done in house	30-60	30-60
10	PBM	50	110	330	55
14	PBM	365	100	200	365
15	Indemnity, HMO, PPO, POS	20 days	10 days	45 days	10 days
16	Medicare Carrier	60 days	2 days	1 ½ days	5 days
17	Indemnity, HMO, PPO, POS, Dental PPO, Pharmacy	15 man-days	10 man-days	25 man-days	60 man-days
18	PPO	1	3	1	1
22	PBM	180+	45+	365+	365+
23	Medicare Carrier	No estimate	30	60	100
24	Medicare Carrier, Medicare FI	10	5	3	30
28	Medicare Carrier, Medicare FI	10	10	20	120
29	Indemnity, HMO, PPO, POS, Medicare Plan, Medicare Carrier, Medicare FI	Total estimate based on original = $1M to $2M	Not included	Included above	Included above
30	Medicare FI	45	45	45	45
31	Medicare Carrier, Medicare FI	60	5	30	478
33	PPO, Dental PPO, PBM, Medicare Carrier, Medicare FI	200	0	50	45
34	Medicaid, Medicare Carrier, Medicare FI	60	60	60	CMS mandate dependent
35	Medicaid	275	60	50	125
36	PBM	100	15	15	2
37	Medicaid	Unknown	Unknown	Unknown	Unknown

	Organization Type	Installing new software	User Training	Internal validation testing	External validation testing with each trading partner
38	Medicare FI	60 man-days	.5 man-day (PCACE) x 68 = 34 man-days	2 man-days	2 man-days w/o issues
39	HMO, PPO, Dental HMO, Dental PPO, Medicare FI	10	5	10	5

		Installing new software			User Training			Internal validation testing			External validation testing with each trading partner		
Organization Type	Count	Low	High	Avg	Low	High	Avg	Low	High	Avg	Low	High	Avg
Dental HMO	2	10	30	20	5	10	8	10	20	15	5	10	8
Dental PPO	7	10	200	64	5	10	6	3	50	22	5	60	30
HMO	9	10	100	34	5	20	10	2	45	20	2	60	14
Long Term Care	1	No responses for any questions											
Medicaid	9	2	275	86	2	60	38	7	60	37	30	125	72
Medicare Carrier	9	10	200	78	0	60	18	2	60	37	5	478	150
Medicare FI	12	10	200	64	0	60	23	2	60	31	2	478	116
Medicare Plan	2	30	30	30	10	10	10	20	20	20	10	10	10
PBM	11	30	365	154	0	110	40	15	365	149	2	365	129
Pharmacy	2	15	15	15	10	10	10	25	25	25	60	60	60
POS	7	2	30	17	5	30	14	2	45	20	2	60	26
PPO	10	1	200	44	0	10	6	1	50	22	1	60	19
Indemnity	6	15	30	22	10	10	10	20	45	30	10	60	27
Vision Only	2	No responses for any questions											

10. How many trading partners must be validated for the 835?

Twenty-seven organizations answered this question. Detailed information is provided in two tables.

	Organization Type	Responses
2	Indemnity, HMO, PPO, Dental HMO, Dental PPO, PBM, Medicare Plan	2
3	HMO	3
4	Medicaid	100
6	HMO	5
7	POS, Medicaid	4,000
8	PBM	80
10	PBM	120
14	PBM	10,000
16	Medicare Carrier	1,976
17	Indemnity, HMO, PPO, POS, Dental PPO, Pharmacy	372
18	PPO	182
20	Medicare FI	343
22	PBM	30+
23	Medicare Carrier	650
24	Medicare Carrier, Medicare FI	0
28	Medicare Carrier, Medicare FI	Approximately 7,500
29	Indemnity, HMO, PPO, POS, Medicare Plan, Medicare Carrier, Medicare FI	Approximately 1,000
30	Medicare FI	1,000
31	Medicare Carrier, Medicare FI	2,325, Carrier 180, Intermediary
33	PPO, Dental PPO, PBM, Medicare Carrier, Medicare FI	Our goal is to test with enough practice management software vendors whose combined clients represent at least 80% of our claim volume.
34	Medicaid, Medicare Carrier, Medicare FI	2,395
35	Medicaid	1,000
36	PBM	175
37	Medicaid	124
38	Medicare FI	115
39	HMO, PPO, Dental HMO, Dental PPO, Medicare FI	All
40	Medicaid	All

Organization Type	Count	Low	High	Avg
Dental HMO	2	2	2	2
Dental PPO	7	0	372	124
HMO	9	2	1,000	276
Long Term Care	1	No responses for any questions		
Medicaid	9	100	4,000	1,524
Medicare Carrier	9	650	7,500	2,671
Medicare Fiscal Intermediary	12	115	7,500	2,123
Medicare Managed Care Plan	2	2	1,000	501
PBM	11	2	10,000	2,075
Pharmacy	2	372	372	372
POS	7	372	4,000	1,791
PPO	10	2	1,000	389
Traditional Indemnity Insurance	6	2	1,000	458
Vision Only	2	No responses for any questions		

11. Estimate the cost of additional software to support 4050: (answer all that apply)

Twenty-four organizations answered this question. Detailed information is provided in two tables.

		New software	Upgrade existing software	Custom Solutions
2	Indemnity, HMO, PPO, Dental HMO, Dental PPO, PBM, Medicare Plan		$100,000	
4	Medicaid	$20,000	$10,000	$15,000
5	HMO, PPO, POS	0	$20,000	0
6	HMO		$150,000 (includes translator)	$250,000 (in house programming)
8	PBM			$10,000
10	PBM		$81,000	$13,500
14	PBM	$1,000,000	$2,000,000	$2,000,000
16	Medicare Carrier	N/A	N/A	N/A
17	Indemnity, HMO, PPO, POS, Dental PPO, Pharmacy		$45,000	$20,000
22	PBM		$45,000+	
23	Medicare Carrier	No estimate	No estimate	No estimate
24	Medicare Carrier, Medicare FI	0	0	$5,000
28	Medicare Carrier, Medicare FI	$50,000		
29	Indemnity, HMO, PPO, POS, Medicare Plan, Medicare Carrier, Medicare FI	Unknown	Included above	Included above
30	Medicare FI	CMS Supplied	CMS Supplied	0
31	Medicare Carrier, Medicare FI	N/A	As a Medicare contractor, version upgrades are implemented within the current budget for a particular fiscal year.	N/A
33	PPO, Dental PPO, PBM, Medicare Carrier, Medicare FI	0	$153,000	$72,000
34	Medicaid, Medicare Carrier, Medicare FI		Dependant on outsource vendor	
35	Medicaid	$1,000,000	$500,000	
36	PBM	0	$125	2 days per trading partner
37	Medicaid	Unknown	Unknown	Unknown
38	Medicare FI	FISS Supplied	FISS Supplied	Depends on the scope
39	HMO, PPO, Dental HMO, Dental PPO, Medicare FI		$25,000	$25,000

		Installing new software			Upgrade existing software			Custom Solutions			List any additional costs not accounted for in this survey		
Org. Type	Count	Low	High	Avg	Low	High	Avg	Low	High	Avg	Low	High	Avg
Dental HMO	2	0	0	0	25,000	100,000	62,500	25,000	25,000	25,000	25,000	25,000	25,000
Dental PPO	7	0	0	0	0	153,000	64,600	5,000	72,000	30,500	10,000	25,000	17,500
HMO	9	0	0	0	20,000	150,000	68,000	0	250,000	73,750	10,000	2,000,000	5,175,000
Long Term Care	1	No responses for any questions											
Medicaid	9	20,000	1,000,000	510,000	10,000	500,000	255,000	15,000	15,000	15,000	15,000,000	15,000,000	15,000,000
Medicare Carrier	9	0	50,000	25,000	153,000	153,000	153,000	72,000	72,000	72,000	2,000,000	2,000,000	2,000,000
Medicare FI	12	0	50,000	25,000	25,000	153,000	89,000	0	72,000	72,000	25,000	2,000,000	1,012,500
Medicare Plan	2	No responses			100,000	100,000	100,000	0	0	0	2,000,000	2,000,000	2,000,000
PBM	11	0	1,000,000	333,000	125	2,000,000	396,521	10,000	2,000,000	523,875	55,000	55,000	55,000
Pharmacy	2	No responses			45,000	45,000	45,000	20,000	20,000	20,000	10,000	10,000	10,000
POS	7	No responses			20,000	45,000	32,500	0	20,000	10,000	10,000	2,000,000	100,500
PPO	10	No responses			500	153,000	57,250	0	72,000	29,250	10,000	2,000,000	678,333
Indemnity	6	No responses			45,000	100,000	72,500	20,000	20,000	20,000	10,000	2,000,000	1,005,000
Vision Only	2	No responses for any questions											

12. List any additional costs to your organization not accounted for in this survey.

Twelve organizations answered this question.

6	HMO	Claredi - validator/credential $12,000/yr X12 Membership including travel etc $5,000/yr WA State HIPAA Task Force $6,000/yr External Provider Relations Administrative Costs $12,000
16	Medicare Carrier	N/A
17	Indemnity, HMO, PPO, POS, Dental PPO, Pharmacy	Customer Service education / training $10,000.
22	PBM	Time/Salary : $50,000+ Phone/Communications: $5,000
23	Medicare Carrier	None
29	Indemnity, HMO, PPO, POS, Medicare Plan, Medicare Carrier, Medicare FI	We have approximated our costs at 1 to 2 Million Dollars. Our new HIPAA software/hardware solution has not been required to support multiple versions of HIPAA transactions. The above estimate is our best ballpark estimate. We are a large Blue Cross Blue Shield Plan and using the Blue Card EDI processes between Plans.
31	Medicare Carrier, Medicare FI	If there is a need to test with all trading partners, the timeframe to accomplish this testing would determine additional costs.
34	Medicaid, Medicare Carrier, Medicare FI	Datacenter, Mailings, Translation, Education
35	Medicaid	Lost time could be spent on other projects 15,000,000

37	Medicaid	Arizona Medicaid Concern. Section 2.2.19 Reporting Encounters in the 835. From this section, 'A service that the provider believes is an encounter was submitted with a charge of $0.00. An encounter claim would have all services and the claim with a charge of $0.00. The provider can also identify to the payer an 'encounter only' submission by sending the CN1 segment in the 837I and 837P. In this situation, the CN101 value will be Code 05 - Capitated and applies to the entire claim.' Capitated services account for a significant number of total services received by Arizona Medicaid. The provider's billed charge amount on encounters (services covered under a capitation agreement between the payer and the provider) is a critical and integral component for Arizona Medicaid's rate-setting, reconciliations, and financial analysis. Providers do not separate a claim by 'payable' and 'nonpayable' [encounter] service lines. Each face-to-face encounter with the recipient is generally billed on one claim. There can be encounter [non payable] and 'claim' [payable] lines on this same claim. Currently, Arizona's capitated encounters are reported (CN101 value of '05' for capitated services) with the provider's usual and customary billed charge amount (there are a few exceptions) and with an expected payment amount of $0.00. Arizona providers electing to report capitated services as $0.00 billed charge, instead of their U & C charge and CN101 value of '05', would jeopardize and cripple Arizona's ability to set rates, make reconciliation payments, and conduct meaningful financial analysis. Our MCOs process these encounters and forward them to the State. The encounters are edited with approximately 600 claims-like edits. In addition to editing demographic and clinical data, the financial data is edited for reasonability. When the processing outcome is final, the data is available for financial analysis and rate-setting. Billed charge amounts are used for: ▪ Rate-setting, which includes the development and setting of the State's fee-for-service rates and the State's MCO capitation rates; ▪ MCO reinsurance and payment reconciliations; ▪ Fiscal impact analysis, which includes financial impacts and what-if analysis to providers, MCOs, and the State's budget; and ▪ Utilization cost analysis, which includes legislative and programmatic requests and analysis. When this issue was discussed with other states via the NMEH listserv, other states collecting post-adjudicated claim information shared Arizona's concern. The actual cost impact for this change, if the 4050 version is mandated, has not been calculated.
38	Medicare FI	Not determined at this point.
39	HMO, PPO, Dental HMO, Dental PPO, Medicare FI	Possible external costs with TPA: $25,000

PART 2:

PROVIDER SURVEY

Provider Survey Summary

The provider survey consisted of 15 questions. Ninety-three organizations answered the survey and are identified throughout this document as Provider 1 through Provider 93. The 15 questions and when appropriate, a quick summary of response statistics, are followed by complete details. A link is available for each question to jump to the detail for that question.

1. The care setting I work in can be best described as:

DETAILS

Totals	Individual or Group of Physicians (MD, DO, DDS, DMD)	17	18.3%
	Hospital, Nursing Facility, Health System or other institutional setting	39	41.9%
	Other (includes Ambulance, Lab, Pharmacy, DME and all other clinics and practitioners)	37	39.8%

2. The institution I work in can best be described as:

DETAILS

Totals	Multi-hospital Health System	14	36.8%
	Acute Care Hospital	14	36.8%
	Critical Access Hospital	3	7.9%
	Specialty (i.e. Cardiac, Psychiatric, Substance Abuse, or Rehab Facility, Urgent Care, etc)	2	5.3%
	Hospice	0	0%
	Dialysis/ESRD	0	0%
	Intermediate Care Nursing	0	0%
	Skilled Nursing Facility	1	2.6%
	Other (please specify)	4	10.5%

3. For this type of facility, I would describe our institution as:

DETAILS

Totals	Large (500 beds +)	17	45.9%
	Medium (101-499 beds)	9	24.3%
	Small (100 beds or less)	8	21.6%
	Not sure	3	8.1%

4. The number of physicians/practitioners in this practice or group is:

DETAILS

Totals	1	0	0%
	2-9	3	8.3%
	10-25	5	13.9%
	26-50	2	5.6%
	Over 50	26	72.2%

5. Approximately how many total claims does your organization process a month? DETAILS

6. Do you currently receive the Health Care Claim Payment/Advice 004010X091A1 (835) mandated under HIPAA? DETAILS

Totals	Yes	33	91.7%
	No	3	8.3%

7. Does your organization support the integration of the 835 into secondary Billing? DETAILS

Totals	Yes	16	45.7%
	No	19	54.3%

8. If 'Yes', enter the volume for the following that apply. DETAILS

9. Does your organization post remittance data from the 835? DETAILS

10. Does your organization handle the 835 implementation via: (choose all that apply) DETAILS

Totals	In house staff	26	76.5%
	Vendor / Outsourced	5	14.7%
	Clearinghouse	10	29.4%

11. Is your organization capable of handling concurrent versions of the X12 standard (example 004010 and 004050)? DETAILS

Totals	Yes	18	52.9%
	No	16	47.1%

12. Estimate the overall time required by your organization to implement the following tasks (use 'estimated man-days', a man-day is equivalent to 1 full day of an FTE): DETAILS

13. How many trading partners must be tested to implement the 835? DETAILS

14. Estimate the cost of software to support the 835 transaction: (answer all that apply) DETAILS

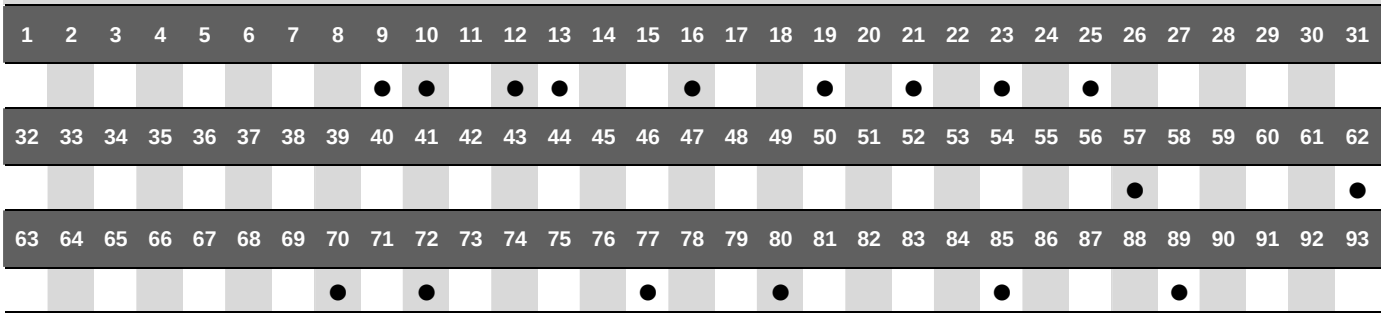
15. List any additional costs to your organization not accounted for in this survey. DETAILS

Provider Survey Details

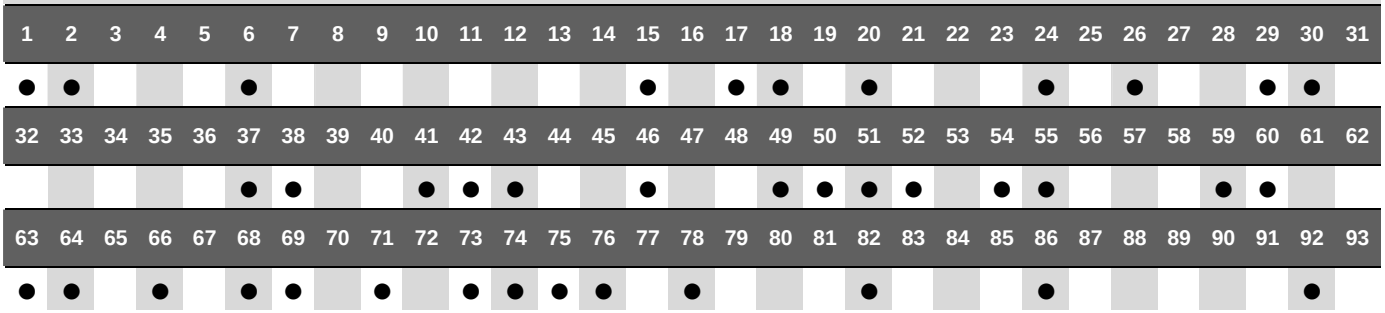
1. The care setting I work in can be best described as:

Ninety-three organizations answered this question.

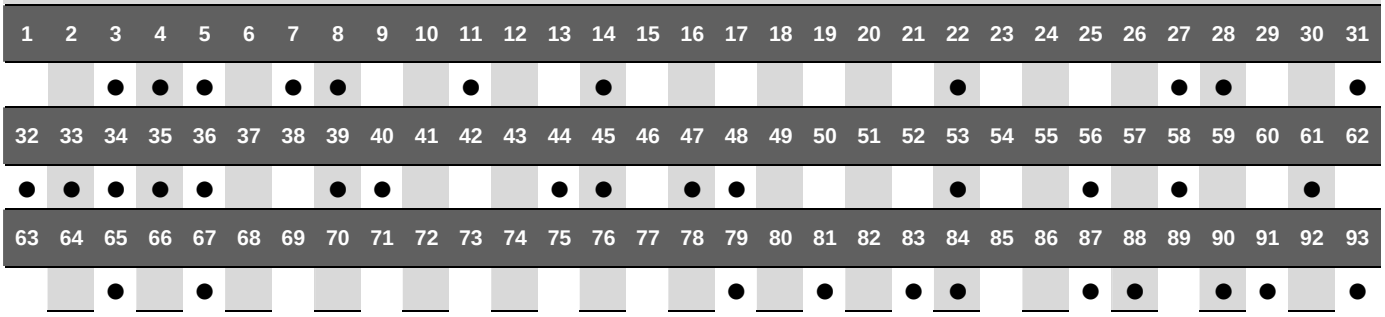
Individual or Group of Physicians (MD, DO, DDS, DMD)



Hospital, Nursing Facility, Health System or other institutional setting



Other (includes Ambulance, Lab, Pharmacy, DME and all other clinics and practitioners)

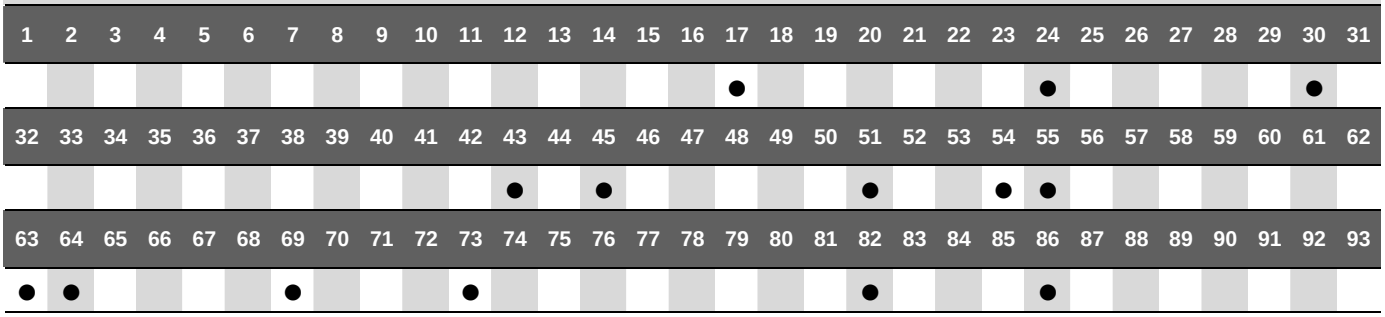


Totals	Individual or Group of Physicians (MD, DO, DDS, DMD)	17	18.3%
	Hospital, Nursing Facility, Health System or other institutional setting	39	41.9%
	Other (includes Ambulance, Lab, Pharmacy, DME and all other clinics and practitioners)	37	39.8%

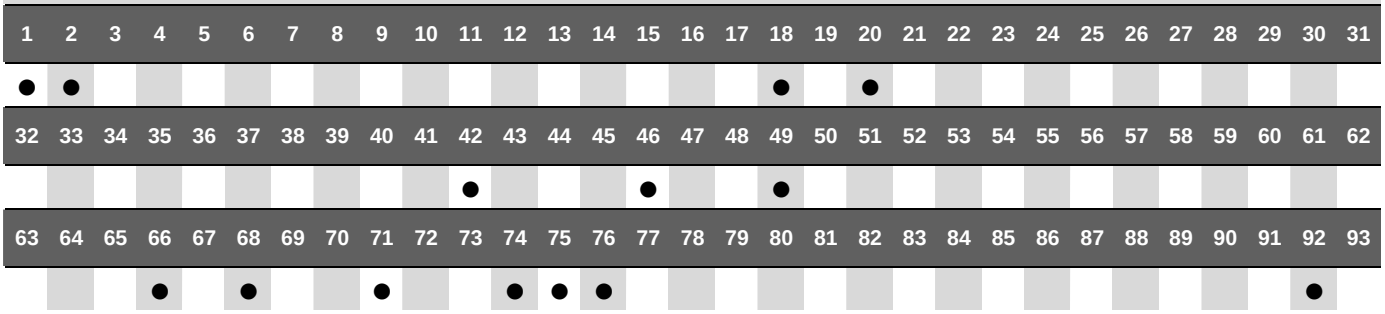
2. The institution I work in can best be described as:

Thirty-eight organizations answered this question.

Multi-hospital Health System



Acute Care Hospital



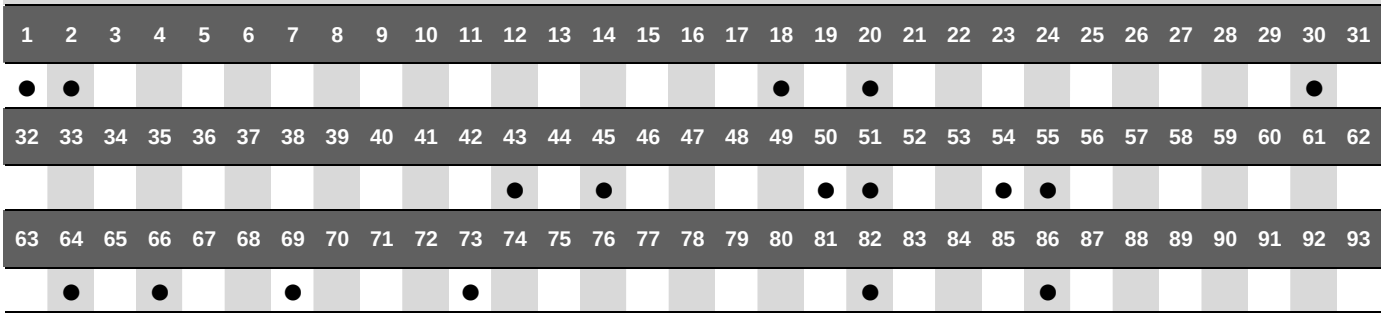
- **Critical Access Hospital**
  Providers 29, 59, and 60
- **Specialty (i.e. Cardiac, Psychiatric, Substance Abuse, or Rehab Facility, Urgent Care, etc)**
  Providers 26 and 52
- **Skilled Nursing Facility**
  Provider 6
- **Other**
  Providers 15 and 41: **HMO**
  Provider 37: **Homecare**
  Provider 50: **Multi-Hospital and Multi-Specialty Clinics**

Totals	Multi-hospital Health System	14	36.8%
	Acute Care Hospital	14	36.8%
	Critical Access Hospital	3	7.9%
	Specialty (i.e. Cardiac, Psychiatric, Substance Abuse, or Rehab Facility, Urgent Care, etc)	2	5.3%
	Hospice	0	0%
	Dialysis/ESRD	0	0%
	Intermediate Care Nursing	0	0%
	Skilled Nursing Facility	1	2.6%
	Other (please specify)	4	10.5%

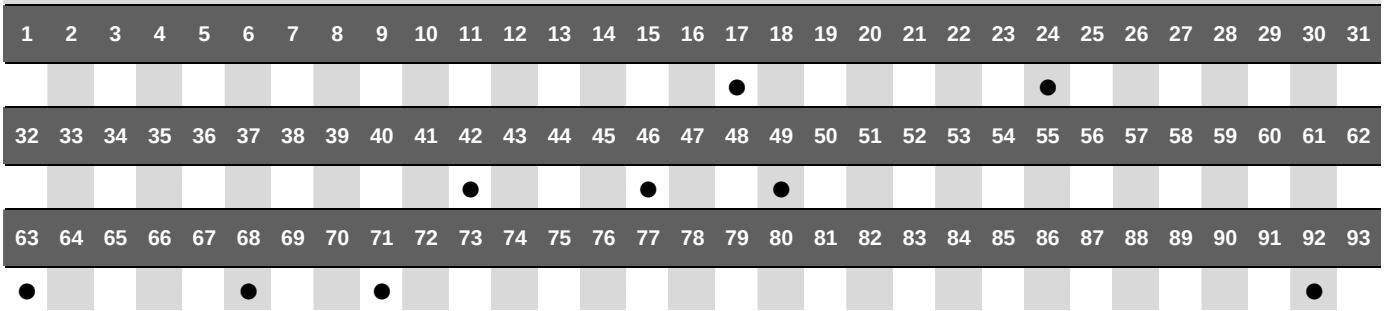
3. For this type of facility, I would describe our institution as:

Thirty-seven organizations answered this question.

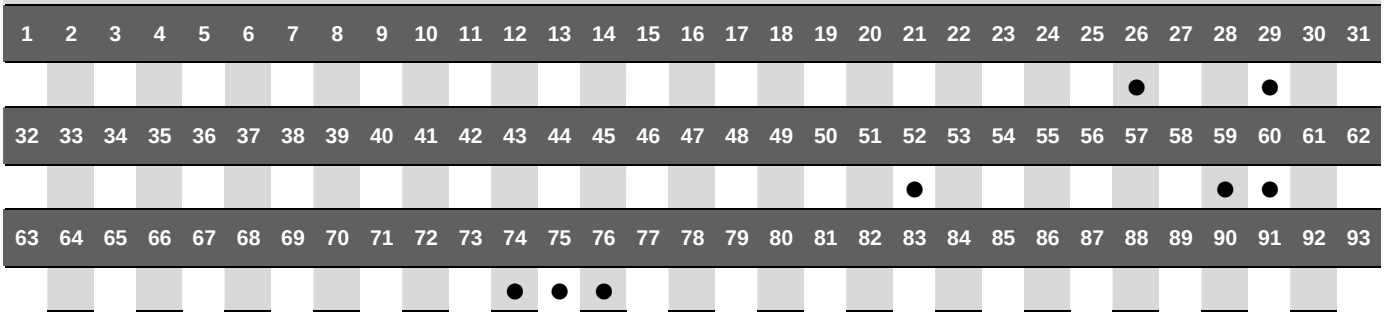
Large (500 beds +)



Medium (101-499 beds)



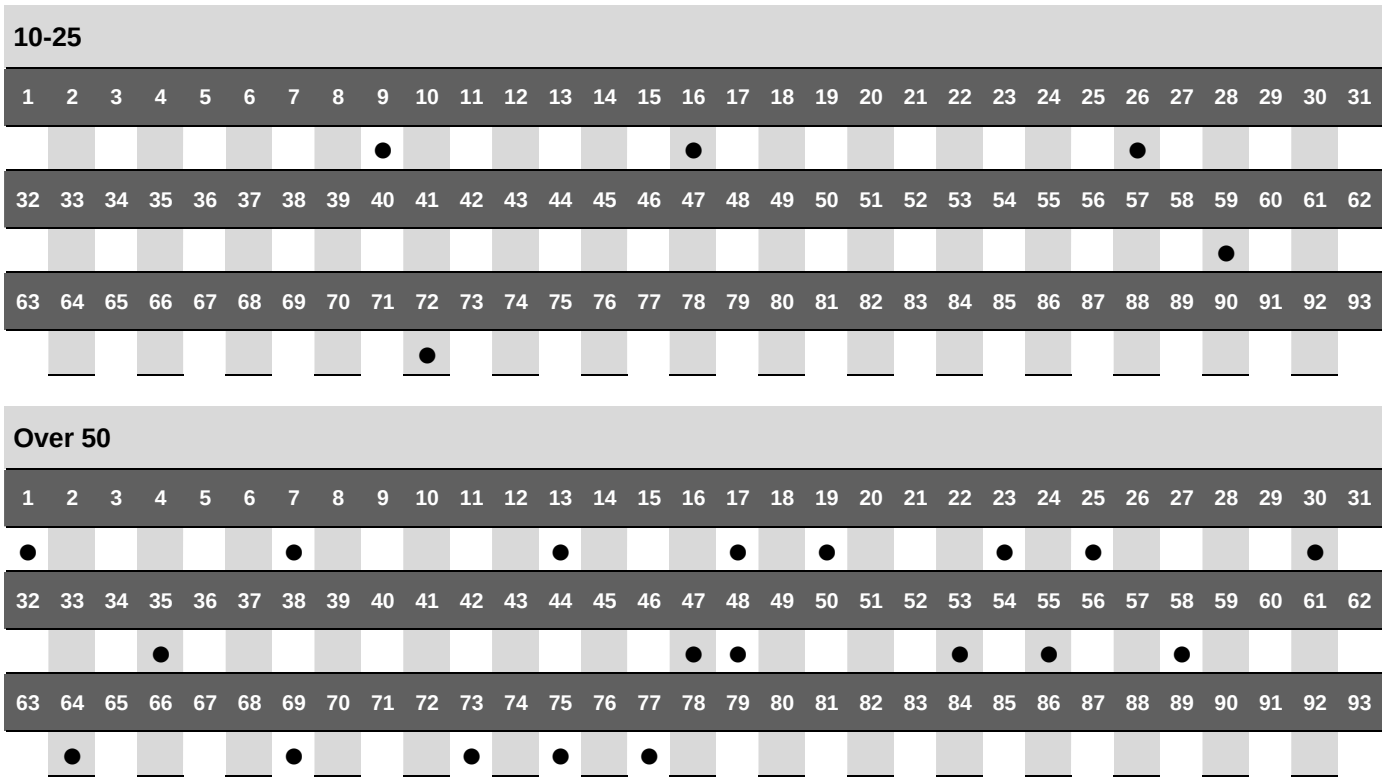
Small (100 beds or less)



- **Not sure**
  Providers 6, 15, and 37

Totals	Large (500 beds +)	17	45.9%
	Medium (101-499 beds)	9	24.3%
	Small (100 beds or less)	8	21.6%
	Not sure	3	8.1%

4. The number of physicians/practitioners in this practice or group is:



- **2-9**
  Providers 10, 62, and 66
- **26-50**
  Providers 6 and 52

Totals	1	0	0%
	2-9	3	8.3%
	10-25	5	13.9%
	26-50	2	5.6%
	Over 50	26	72.2%

5. Approximately how many total claims does your organization process a month?

Thirty-three organizations answered this question.

	Organization Type	Paper	Electronic
7	Other	50,000	350,000
13	Physician	34,000	80,000
16	Physician	1,000	4,000
19	Physician	50,000	125,000
25	Physician	60,000	128,000
26	Hospital		35,000
29	Hospital	600	2,400
33	Other		15,000
35	Other	10,000	>2,000,000
37	Hospital	>500,000	>1,000,000
47	Other	700,000	Several Million
48	Other	1,000	3,000,000
49	Hospital	2,000	13,000
52	Hospital	1	1
53	Other	250,000	2,500,000
55	Hospital	300,000	100/m … in pilot phase
58	Other	?	11,000,000
59	Hospital	10-20	>1,500
60	Hospital	200	1,800
62	Physician	15	72
64	Hospital	???	>20,000
68	Hospital	200	16,000
69	Hospital	1,000	25,000
72	Physician	250-300	3,000
73	Hospital	12,500	75,000
76	Hospital	100	1,200
77	Physician	30,000+	350,000
85	Physician	30,000+	350,000
87	Other	100,000	30,000,000
88	Other	376,664	$3,470,000 claims per month
89	Physician	250,000	237,500
91	Other	5,000-6,000	4,000-5,000
93	Other		4,000,000

6. Do you currently receive the Health Care Claim Payment/Advice 004010X091A1 (835) mandated under HIPAA?

Thirty-six organizations answered this question. A ☑ indicates Yes, a ☒ indicates No, a blank entry indicates that the question was skipped.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
✓						✓			✓			✓			✓			✓				✓		✓	✓					

32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62
	✗		✓		✓										✗	✓	✓			✓	✓					✓	✓			✓

63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93
	✓				✓	✓			✓	✓		✓	✓	✓								✓	✓	✓	✓	✓		✓	✗	✓

Totals	Yes	33	91.7%
	No	3	8.3%

7. Does your organization support the integration of the 835 into secondary Billing?

Thirty-five organizations answered this question. A ☑ indicates Yes, a ☒ indicates No, a blank entry indicates that the question was skipped.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
☒						✓			☒			☒			☒			☒				✓		☒	✓					
32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62
	☒		✓		☒										☒	✓	✓			✓	✓					✓	☒	✓		☒
63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93
	✓				☒	☒			✓	✓			✓	☒								☒		✓	☒	✓		☒	☒	☒

Totals	Yes	16	45.7%
	No	19	54.3%

8. If 'Yes', enter the volume for the following that apply.

Nine organizations answered this question.

	Organization Type	Paper	Electronic
7	Other	10,000	70,000
26	Hospital	5,000	
35	Other	10,000	>2,000,000
48	Other		1%
49	Hospital	600	2,000
58	Other		5,000,000
64	Hospital	???	>5,000
73	Hospital	10,000	7,000 claims
76	Hospital	225	

9. Does your organization post remittance data from the 835?

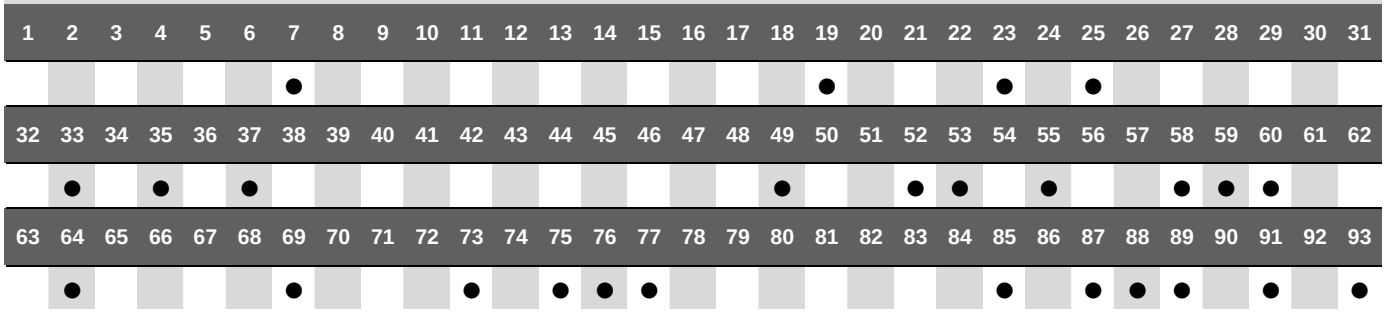
Twenty-eight organizations answered this question.

		Automatically	Manually
7	Other	350,000	50,000
13	Physician	70,000	210,000
16	Physician	40%	60%
19	Physician	25,000	2,500
25	Physician	30,000	70,000
26	Hospital	25,000	
35	Other	>2,000,000	10,000
37	Hospital	>1,000,000	100,000
48	Other	2,700,000	300,000
49	Hospital	4,000	500
53	Other	2,500,000	
58	Other	4,000,000	7,000,000
59	Hospital	All BCBS/Medicare	None
60	Hospital		1
62	Physician		87
64	Hospital	Posting ERA's for 4 to 8 payers per day	None
68	Hospital	75% of payors	
69	Hospital	2,000	5,000
72	Physician	1,000	>3,000
73	Hospital	69,000 claims	18,000 claims
76	Hospital		1,200 per month
77	Physician	40% of claim volume	
85	Physician	40% of claims payments posted via 835	We don't post manually from 835
87	Other	25,000,000	5,000,000
88	Other	2,776 claims per month	694,000 claims per month
89	Physician	95%	
91	Other		2,000-5,000/month
93	Other	50 per week	

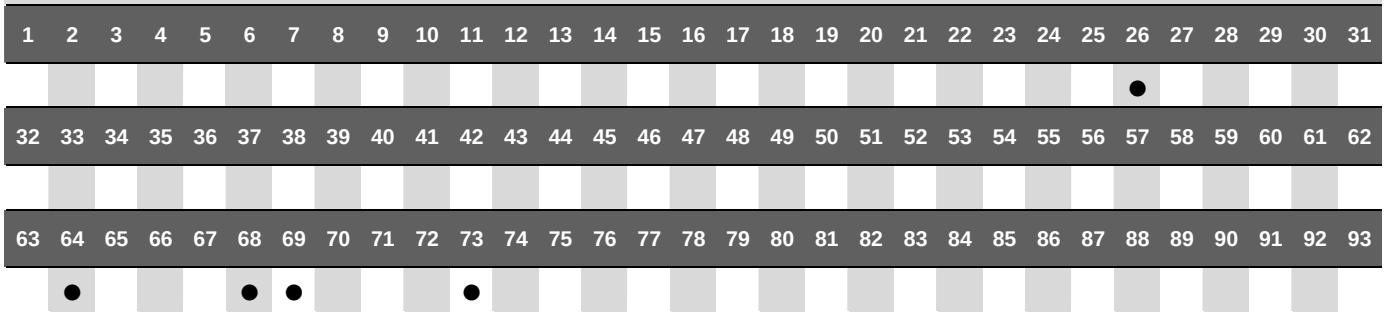
10. Does your organization handle the 835 implementation via: (choose all that apply)

Thirty-four organizations answered this question.

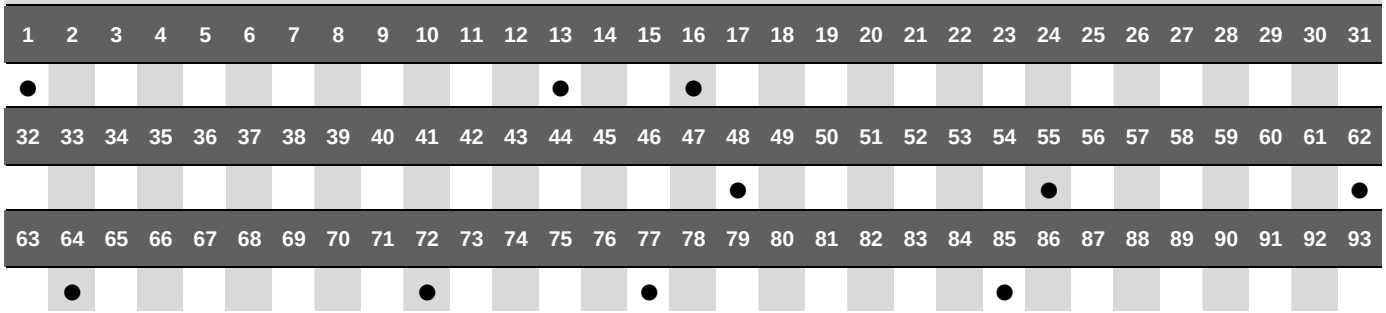
In house



Vendor/Outsourced



Clearinghouse



Totals	In house staff	26	76.5%
	Vendor / Outsourced	5	14.7%
	Clearinghouse	10	29.4%

11. Is your organization capable of handling concurrent versions of the X12 standard (example 004010 and 004050)?

Thirty-four organizations answered this question. A ☑ indicates Yes, a ☒ indicates No, a blank entry indicates that the question was skipped.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62
	☒		✓		✓											☒	✓			☒	✓		✓			✓	✓	☒		☒

63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93
	☒				✓	✓			✓	☒		☒	☒	✓								✓		☒	✓	✓		☒	☒	✓

Totals			
	Yes	18	52.9%
	No	16	47.1%

12. Estimate the overall time required by your organization to implement the following tasks (use `estimated man-days', a man-day is equivalent to 1 full day of an FTE):

Twenty-six organizations answered this question.

	Organization Type	Delivery of New Software	Training	Internal validation testing	External validation testing with your trading partner
7	Other	270	90	270	30
13	Physician	24	40	260	20
19	Physician	25	25	100	25
25	Physician	15	2	8	5
26	Hospital	30	60	60	90
33	Other	20	10	5	5
35	Other	20	2	10	2
37	Hospital		10	20	5
48	Other	100	10	80	500
49	Hospital	1	1	5	10
53	Other	10	2	5	15
59	Hospital	7	7	7	7
60	Hospital	1	1		
62	Physician	.5	2	1	1
64	Hospital	90	60	90	90
68	Hospital			5	5
69	Hospital	15	40	25	35
72	Physician	6	11	5	5
73	Hospital	14	17	17	24
76	Hospital	.5	1		
77	Physician	3	1		
85	Physician	7	2	5	90
87	Other	150	25	150	150
88	Other	140	80	140	480
91	Other	10	5	10	10
93	Other	100	15	15	2
	Mean	45.9	20.7	56.2	69.8
	Maximum	270	90	270	500
	Minimum	0.5	0	1	1

13. How many trading partners must be tested to implement the 835?

Twenty-eight organizations answered this question.

	Organization Type	Response
7	Other	10
13	Physician	1
19	Physician	
23	Physician	5
25	Physician	6
26	Hospital	2
33	Other	1
35	Other	1
37	Hospital	11
48	Other	300
49	Hospital	4
53	Other	50
58	Other	125
60	Hospital	1
62	Physician	1
64	Hospital	10
68	Hospital	4
69	Hospital	12
72	Physician	1
73	Hospital	5
76	Hospital	0
77	Physician	
85	Physician	
87	Other	100
88	Other	161
89	Physician	2
91	Other	2
93	Other	175
	Mean	39.6
	Maximum	300
	Minimum	0

14. Estimate the cost of software to support the 835 transaction: (answer all that apply)

Twenty-three organizations answered this question.

		New Software	Upgrade Existing Software	Custom Solutions
7	Other			250,000
13	Physician	7,000	80,000	3,500
19	Physician	25,000	25,000	25,000
25	Physician			
33	Other	50,000	25,000	5,000
35	Other		5,000	
37	Hospital	0	0	0
48	Hospital			
49	Other	4,500		
53	Other		25,000	
58	Hospital			
62	Physician	100	50	
64	Hospital	5,000	20,000	20,000
68	Hospital	0	10,000	
69	Hospital		75,000	35,000
72	Physician			10,000
73	Hospital		250,000	
76	Hospital	0	0	0
77	Physician			
85	Physician		17,500	15,000
87	Other		200,000	1,000,000
88	Other	0	336,000	
93	Other	0	125	
	Mean	8,327.3	66,792.2	123,954.5
	Maximum	50,000	336,000	1,000,000
	Minimum	0	0	0

15. List any additional costs to your organization not accounted for in this survey.

Nine organizations answered this question.

7	Other	Validation software 12,000 per year. Time to debug files and be able to load. 70,000 per month. Renegotiating trading partner agreements. 5,000 Participation in X-12 3000.00 per year plus travel expenses for multiple participants. Participation in local forums. Time and expenses for travel, cost depends.
19	Physician	The HR cost for implementing 835 - 25 man-days per trading partner for programming, testing internally and w/ the trading partner. - Hardware such as direct ftp/dial-up connectivity for secure electronic transmission - one time cost of approx 10K + ongoing ~3K - HR cost for monitoring, balancing and tracking spec changes by trading partners - 1/4 FTE
37	Hospital	Training testing
58	Hospital	We would need to make changes to our current in house software so the cost would not be in purchasing new software but it would be in the # of man-hours that it would take to update the software and then number of hours that it would take away from doing other in house projects dealing with cash posting. There would also be considerable amount of testing in our over 35 pharmacies (some processing many different state Medicaids, Medicares and third party insurances).
72	Physician	Downtime for software upgrades as well as downtime during training of front line production staff. This will result in paying overtime to ensure current work flow and cash flow is not disrupted.
77	Physician	Additional clearing house costs for testing.
85	Physician	Clearinghouse costs for transition testing and implementation.
87	Other	There are significant costs trying to code around payers who are not following the standard and there are significant costs paying for outside entities keying the remittances.
91	Other	Software upgrades are included in the Maintenance Agreements

PART 3:

VENDOR SURVEY

Vendor Survey Summary

The vendor survey consisted of 13 questions. Thirty-two organizations answered the survey and are identified throughout this document as Vendor 1 through Vendor 32. The 13 questions and when appropriate, a quick summary of response statistics, are followed by complete details. A link is available for each question to jump to the detail for that question.

1. The company I represent is a vendor of: (check all that apply)

DETAILS

Totals	Practice Management Systems (PMS)	16	50%
	DME systems	1	3.1%
	Laboratory Systems	3	9.4%
	Hospital Information Financial or Billing Systems (not the same as PMS)	8	25%
	Hospital Information Clinical Systems	7	21.9%
	Claims Adjudication Systems	9	28.1%
	Document Management Systems	5	15.6%
	EDI translator or Integration software	12	37.5%
	Validation/editing/scrubbing middleware	6	18.8%
	Health Care Clearinghouse services	11	34.4%
	General Purpose EDI VAN	4	12.5%
	Bank/Financial services	2	6.2%
	Other software or services (please specify)	2	6.2%

2. Our customers are: (check all that apply)

DETAILS

Totals	Institutional Health Care Providers	17	53.1%
	Professional Health Care Providers	28	87.5%
	Health plans	14	43.8%
	Other (please specify)	3	9.4%

3. Please indicate the relative size of the customers you serve. (answer all that apply)

DETAILS

4. Please check all X12N transaction that you currently conduct electronically (either received, transmitted, and/or processed).

DETAILS

Totals	837 Health Care Claim: Professional	28	93.3%
	837 Health Care Claim: Institutional	21	70%
	837 Health Care Claim: Dental	8	26.7%
	835 Health Care Payment Advice	26	86.7%
	270/271 Health Care Eligibility/Benefit Inquiry and Response	17	56.7%
	276/277 Health Care Claims Status Inquiry and Response	14	46.7%
	277 Health Care Claim Status: Claim Acknowledgement	18	60%

278 Health Care Services Review: Request for Review and Response	5	16.7%
834 Benefit Enrollment and Maintenance	8	26.7%
820 Payroll Deducted and Other Group Premium	5	16.7%
997 Acknowledgements	20	66.7%
Not sure	0	0%
Other (please specify)	4	13.3%

5. Does your organization currently support the Health Care Claim Payment/Advice 004010X091A1 (835) mandated under HIPAA? DETAILS

Totals	Yes	27	87.1%
	No	4	4%

6. What percentage of your customers have implemented the 835 today? DETAILS

Totals	<10%	5	17.2%
	11-25%	6	20.7%
	26-50%	6	20.7%
	51-75%	7	24.1%
	76-85%	1	3.4%
	86-95%	1	3.4%
	96%+	3	10.3%

7. Does your company rely on other vendors to provide software or services for the 835? DETAILS

Totals	Yes	5	16.7%
	No	25	83.3%

8. Is your solution capable of handling concurrent versions of the X12 standard (example 004010 and 004050)? DETAILS

Totals	Yes	21	75%
	No	7	25%

9. Estimate the overall time (total time estimate, not elapsed time) that each of the following implementation tasks would take your organization per system(s) (use `estimated man-days', a man-day is equivalent to one full day of an FTE): Note: Estimates should be based on average time per customer. DETAILS

10. What level of investment is your company planning to make for this solution? DETAILS

Totals	<$25,000	6	23.1%
	$26K – 100K	3	11.5%
	$101K – 500K	8	30.8%
	$501K – 99K	2	7.7%
	$1 – 5M	1	3.8%
	>$5M	0	0%
	Not sure, no estimate at this time	6	23.1%

11. What factors will drive your decision to provide a solution? DETAILS

Totals	Customer demand	20	83.3%
	Competition	7	29.2%
	Trading Partner, Business associate or other contract requirements	5	20.8%
	Federal/State regulatory mandates	18	75%
	Upgrade/technological constraints of installed versions of software	2	8.3%
	Readiness of our technology business partners	7	29.2%

12. What is your time frame for market introduction and deployment after issuance of the Final Rule? DETAILS

Totals	<30 Days	5	19.2%
	31 – 60 Days	4	15.4%
	61 – 90 Days	5	19.2%
	91 – 180 Days	8	30.8%
	181 – 365 Days	3	11.5%
	>366 Days	1	3.8%

13. List any additional costs to your organization not accounted for in this survey. DETAILS

Vendor Survey Details

1. The company I represent is a vendor of: (check all that apply)

Thirty-two organizations answered this question.

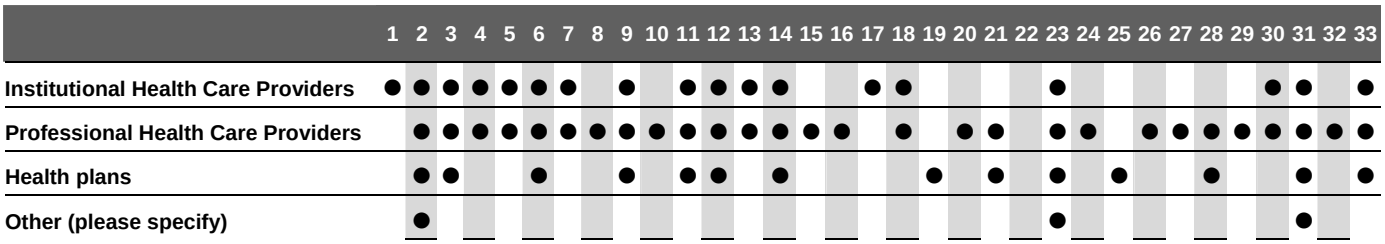
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
Practice Management Systems (PMS)	●			●	●	●	●		●	●			●		●	●	●	●						●		●			●			●	
DME systems															●																		
Laboratory Systems													●					●												●			
Hospital Information Financial or Billing Systems (not the same as PMS)			●	●		●							●	●				●		●										●			
Hospital Information Clinical Systems				●		●							●					●						●	●					●			
Claims Adjudication Systems		●	●			●							●			●		●	●									●					●
Document Management Systems		●				●					●		●																				
EDI translator or Integration software			●				●		●		●	●	●	●	●				●		●						●						●
Validation/editing/scrubbing middleware		●	●				●				●	●																			●		
Health Care Clearinghouse services		●	●			●	●	●	●		●	●			●								●										●
General Purpose EDI VAN		●	●	●																	●												
Bank/Financial services			●																				●										
Other software or services (please specify)																					●		●										

- **Vendor 21**
  Selected Other and entered: Clearinghouse
- **Vendor 22**
  Did not specify what type of vendor they are
- **Vendor 23**
  Selected Other and entered: Backend healthcare payments; secure messaging

Totals	Practice Management Systems (PMS)	16	50%
	DME systems	1	3.1%
	Laboratory Systems	3	9.4%
	Hospital Information Financial or Billing Systems (not the same as PMS)	8	25%
	Hospital Information Clinical Systems	7	21.9%
	Claims Adjudication Systems	9	28.1%
	Document Management Systems	5	15.6%
	EDI translator or Integration software	12	37.5%
	Validation/editing/scrubbing middleware	6	18.8%
	Health Care Clearinghouse services	11	34.4%
	General Purpose EDI VAN	4	12.5%
	Bank/Financial services	2	6.2%
	Other software or services (please specify)	2	6.2%

2. Our customers are: (check all that apply)

Thirty-two organizations answered this question.



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
Institutional Health Care Providers	●	●	●	●	●	●	●		●		●	●	●	●			●	●					●							●	●		●
Professional Health Care Providers		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●		●	●		●	●		●	●	●	●	●	●	●	●
Health plans		●	●			●			●		●	●		●					●		●		●		●			●			●		●
Other (please specify)		●																					●								●		

- **Vendor 2**
  Selected Other and entered: PBMs, TPAs, Pharmacies
- **Vendor 23**
  Selected Other and entered: Banks, clearinghouses
- **Vendor 31**
  Select Other and entered: Clearinghouses

Totals	Institutional Health Care Providers	17	53.1%
	Professional Health Care Providers	28	87.5%
	Health plans	14	43.8%
	Other (please specify)	3	9.4%

3. Please indicate the relative size of the customers you serve. (answer all that apply)

Twenty-one organizations answered this question.

	Average size of your Institutional Health Care Provider customers	Average size of your Professional Health Care Provider customers	Average size of your Health Plan (number of covered lives)
1	100		
2	15,000 Beds	200 physician groups	450,000
3	Various	Various	Various
5	50-75 Employees	20 Employees	
6	500 Beds	250 Physicians	100,000 Lives
7		35	
9	Surgicenters	30	>100,000
10		20 Providers	
11	>50,000 Transactions per day	>50,000 Transactions per day	
13	300 Beds	10 Physicians	
14	300,000 Encounters		40,000 Lives
15		4,000	
17	3,300 Facilities average 120 Beds		
19			30,000
20	23	43	
21		5	<50,000
26		10	
27	14		
29		22	
30	Large	Large	
33	Unknown	Unknown	150,000

4. Please check all X12N transaction that you currently conduct electronically (either received, transmitted, and/or processed).

Thirty organizations answered this question.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
837 Health Care Claim: Professional	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			●		●	●		●	●	●		●
837 Health Care Claim: Institutional		●	●	●	●	●			●	●	●	●	●	●		●	●	●	●	●	●				●					●	●		●
837 Health Care Claim: Dental	●	●							●					●					●								●			●	●		●
835 Health Care Payment Advice		●	●	●	●	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●		●	●		●			●	●	●		●
270/271 Health Care Eligibility/Benefit Inquiry and Response		●	●			●	●			●	●		●	●	●			●	●		●					●	●			●	●		●
276/277 Health Care Claims Status Inquiry and Response		●	●			●	●			●	●		●	●				●	●		●							●		●	●		●
277 Health Care Claim Status: Claim Acknowledgement			●		●	●	●	●	●	●	●		●	●	●	●	●	●	●		●									●		●
278 Health Care Services Review: Request for Review and Response		●	●			●									●															●		
834 Benefit Enrollment and Maintenance		●				●								●					●	●	●									●		●
820 Payroll Deducted and Other Group Premium		●				●								●																●		●
997 Acknowledgements		●		●	●	●	●	●	●	●	●	●	●		●	●	●		●		●		●			●				●		●
Not sure																																	
Other (please specify)		●									●								●												●		

- **Vendor 2**
  Selected Other and entered: NCPDP V5.1 and Batch 1.1
- **Vendor 11**
  Selected Other and entered: 275, HL7
- **Vendor 19**
  Selected Other and entered: NCPDP Batch 1.1
- **Vendor 31**
  Selected Other and entered: BI

Totals	837 Health Care Claim: Professional	28	93.3%
	837 Health Care Claim: Institutional	21	70%
	837 Health Care Claim: Dental	8	26.7%
	835 Health Care Payment Advice	26	86.7%
	270/271 Health Care Eligibility/Benefit Inquiry and Response	17	56.7%
	276/277 Health Care Claims Status Inquiry and Response	14	46.7%
	277 Health Care Claim Status: Claim Acknowledgement	18	60%
	278 Health Care Services Review: Request for Review and Response	5	16.7%
	834 Benefit Enrollment and Maintenance	8	26.7%
	820 Payroll Deducted and Other Group Premium	5	16.7%
	997 Acknowledgements	20	66.7%
	Not sure	0	0%
	Other (please specify)	4	13.3%

5. Does your organization currently support the Health Care Claim Payment/Advice 004010X091A1 (835) mandated under HIPAA?

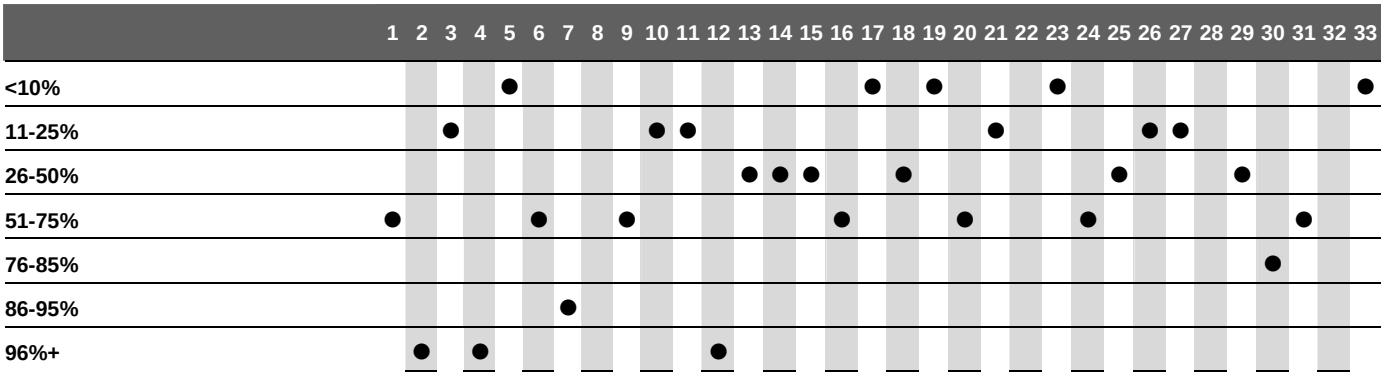
Thirty-one organizations answered this question. A ☑ indicates Yes, a ☒ indicates No, a blank entry indicates that the question was skipped.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
☒	✓	✓	☒	✓	✓	✓	✓	✓	✓	✓	✓	☒	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	☒	✓	✓	✓		✓

Totals	Yes	27	87.1%
	No	4	4%

6. What percentage of your customers have implemented the 835 today?

Twenty-nine organizations answered this question.



Totals	<10%	5	17.2%
	11-25%	6	20.7%
	26-50%	6	20.7%
	51-75%	7	24.1%
	76-85%	1	3.4%
	86-95%	1	3.4%
	96%+	3	10.3%

7. Does your company rely on other vendors to provide software or services for the 835?

Thirty organizations answered this question. A ☑ indicates Yes, a ☒ indicates No, a blank entry indicates that the question was skipped.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
☒	☒	☒	☒	☒	☒	☒		☒	☒	☒	☒	✓	☒	☒	☒	☒	☒	☒	✓	☒	☒	✓	☒	✓	☒		✓	☒	☒	☒		☒

Totals	Yes	5	16.7%
	No	25	83.3%

8. Is your solution capable of handling concurrent versions of the X12 standard (example 004010 and 004050)?

Twenty-eight organizations answered this question.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
✗	✓	✓	✗	✗	✓	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓			✓	✗			✗

Totals	Yes	21	75%
	No	7	25%

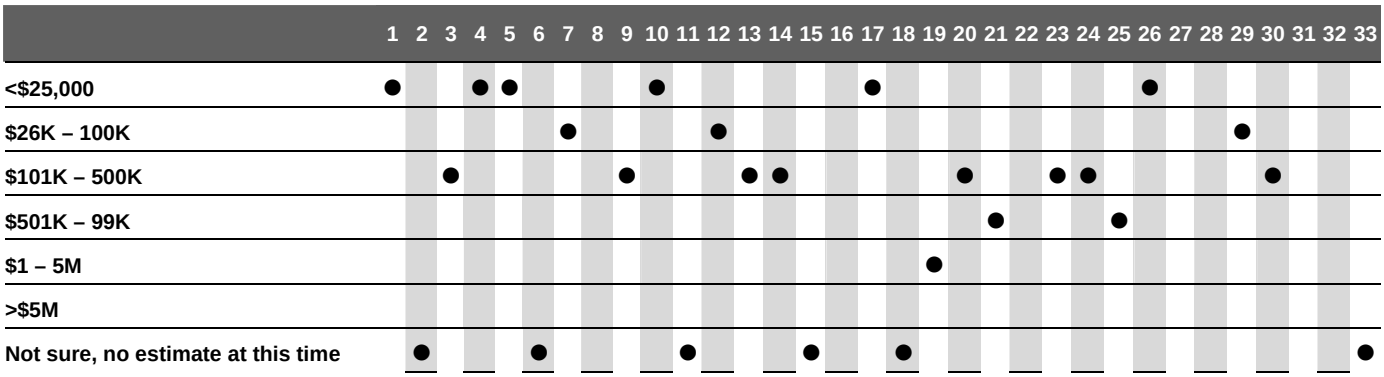
9. Estimate the overall time (total time estimate, not elapsed time) that each of the following implementation tasks would take your organization per system(s) (use `estimated man-days', a man-day is equivalent to one full day of an FTE): Note: Estimates should be based on average time per customer.

Twenty organizations answered this question.

	Delivery of software	Training	Testing with customer	Testing with trading partners
2	30	5	30	180
3	2 Days	.5 Days	2 Days	4 Weeks
4	2 Man-days	20 Man-days	30 Man-days	30 Man-days
5	20 Minutes	30 Minutes	20 Minutes	3 Hours
7	90 Days	0	30 Days	30 Days
9	1	5	1	1 per Trading Partner
12	250	30	50	7
13	6 Months	2 Months	2 Months	2 Months
14	2.5	1	5	100
15	24	10	0	Unknown
17	1	1	5	10
19	2	3	5	5
20	5	1	1	1
21	2	.2	1	1
23	15	2	5	5
24	1	2	1	14
26	1	1	1	30
29	15	5	5	5
30	120 Days	Included	120 Days	120 Days
33	0	20	0	40

10. What level of investment is your company planning to make for this solution?

Twenty-six organizations answered this question.



Totals	<$25,000	6	23.1%
	$26K – 100K	3	11.5%
	$101K – 500K	8	30.8%
	$501K – 99K	2	7.7%
	$1 – 5M	1	3.8%
	>$5M	0	0%
	Not sure, no estimate at this time	6	23.1%

11. What factors will drive your decision to provide a solution?

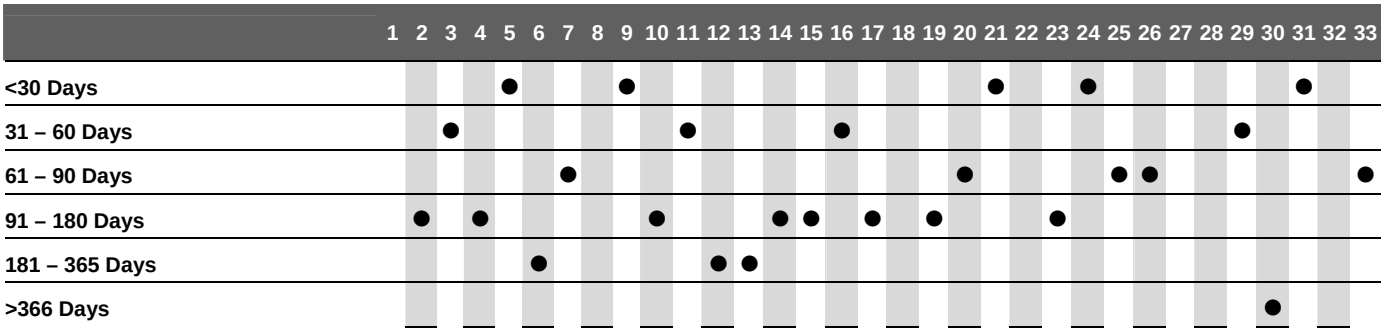
Twenty-four organizations answered this question.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33
Customer demand		●	●	●	●	●			●	●	●	●	●	●			●		●	●			●	●		●			●	●			●
Competition		●	●		●								●						●	●				●									
Trading Partner, Business associate or other contract requirements		●	●	●											●																		●
Federal/State regulatory mandates		●		●	●	●	●		●			●	●		●		●		●	●	●		●	●	●				●			●
Upgrade/technological constraints of installed versions of software						●																											●
Readiness of our technology business partners			●				●						●				●				●		●										●

Totals	Customer demand	20	83.3%
	Competition	7	29.2%
	Trading Partner, Business associate or other contract requirements	5	20.8%
	Federal/State regulatory mandates	18	75%
	Upgrade/technological constraints of installed versions of software	2	8.3%
	Readiness of our technology business partners	7	29.2%

12. What is your time frame for market introduction and deployment after issuance of the Final Rule?

Twenty-six organizations answered this question.



Totals	<30 Days	5	19.2%
	31 – 60 Days	4	15.4%
	61 – 90 Days	5	19.2%
	91 – 180 Days	8	30.8%
	181 – 365 Days	3	11.5%
	>366 Days	1	3.8%

13. List any additional costs to your organization not accounted for in this survey.

Four organizations answered this question.

3	There are significant costs involved for customizing the 835's for providers proprietary AR systems. Significant costs dealing with Payers prorietary implementations and balancing issues.
7	There are a lot of insurance systems that are still not on the 4010 version. Let that become fully implemented before doing a version update.
9	The idea that you should mix standards is idiotic. few commercial payers are ready for the suite of transactions beyond claims and acks. The current push for changes in standards is a thnly veiled attempt to keep ANSI and WPC in business. It is welfare for cleartinghouses.
21	Maintenance; On-going support - odd ways payers utilize the 835 structure.

APPENDIX A

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Health Care Claim Payment

Version 4050 Cost and Benefit Analysis

Authored by:

ASC X12N TG2 WG3 – Claims Payment Co-Chairs

The ASC X12N 004050X124 implementation guide for the Health Care Claim Payment (835-4050) transaction has been proposed as the replacement for the 004010X091A1 implementation. Adoption of the 835-4050 as the HIPAA Standard for Electronic payment and remittance will involve costs and benefits in multiple categories, administrative (recurring), administrative (non-recurring), standardization and new business.

Administrative (recurring) Costs

This cost includes obtaining the new version from vendors (where applicable), implementing within the company's infrastructure, and migrating to the new version with all trading partners. This cost will vary depending upon the specific organization. These costs have no direct benefit in and of themselves. These costs are incurred every time a new version is implemented independent of the specific changes in the version.

Administrative (non-recurring) Costs

These are the costs to support specific changes in the new version of the underlying ASC X12 standard. These are changes to the structure that are not used, coding changes and structural changes not related to any business issues or benefits. There are six structure changes in this version of the underlying standard. Five result in new elements not being used in the implementation. The sixth element is used to convey the IG number and has no specific business impact. The last change is a code change from one value to another. The cost of implementing these changes is minimal in this instance.

Standardization Cost/Benefit

These costs and benefits relate to changes that result in improved standardization and clarity within the guide. Items in this category include tightening up business rules to eliminate options, clarifying intent where it had been ambiguous, providing instructions for business situations where none existed before and eliminating code values that had been listed as "Not Recommended". The 835-4050 includes major changes in this category (which are addressed below). The costs for implementing these will need to be incurred whenever a new guide is implemented that includes this type of changes. The benefits to the industry can be increased by early adoption.

In the less standardized environment, payers had an easier time of implementing the version 4010A1 835 because of the volumes of options within the implementation specification. With options, payers could choose to implement the one that involved less cost and problems for their systems. Providers incurred more implementation costs for version 4010A1 since they needed to be prepared to receive an 835 with all of the options, in any conceivable combination. In some cases, providers would choose to not implement with some payers, or incurred additional administrative overhead in processing the 835 from those payers.

Implementation of the 835-4050 will primarily impact the payers in this category. Payers that implemented a specific business issue or feature under 4010 in a way consistent with the 835-4050 standard will incur no cost to implement that specific feature. Those that choose a different solution under 401A1 will incur costs to alter their business processes to be consistent with the new 835-4050 instructions. Providers that implemented with many payers will probably already have the ability to handle the 835-4050 business processes. The provider's costs would only involve altering the payer specific nature of their 835 processing software to remove any parts that are not consistent with the standard approach.

Payer benefit would occur through increased conversion to electronic remittance advices with their provider community. Those with more work (farthest from the standard) would theoretically be the ones to reap the larger benefit.

Providers would be the largest benefactor from implementation. With more standard remittance information, software maintenance costs and human intervention with electronic remittance would be reduced while also increasing the percentage of electronic remittance received as payers provide standard data content.

All of the benefits will eventually be available whenever the standardization reaches the industry. Since the benefits are recurring (savings every month), the sooner implemented the greater the savings will be.

New Business Cost/Benefit

This version of the 835 also includes support for new business not available under the 4010A1 version.

The business features in this category are:

Support for Subrogation Claim Payment

Costs for implementation will be zero for those parties not involved in subrogation business, and there will be no benefit either. In effect, that costs would move into the Administrative (non-recurring) category. Costs for implementation of subrogation business will be borne by those choosing to participate, with benefits commensurate with standardization for those same parties.

Other Subscriber Support

This new support will impact all payers and providers. As a new business element, it will require expenditure by all payers and providers. Benefits, however, will also be to all. Providers will receive adequate information to

submit to a corrected priority payer without needing to contact the patient. Payers will also receive better information in the resulting claims, reducing the number of calls and administrative support.

Benefits Related to Modifications made to the 4050:

#	Change	Benefit
1.	Changed TS3-06 to 12, 14, 16, 19 to not used	Since the 835 is expected to be an electronically processed transaction, the claim totals are seen as an output from that process, rather than as a direct part of the 835. This is a cost savings for the payer. If the receiver desires claim totals, this information can easily be obtained from data contained within this transaction. The total that is always included in the 835 is the total paid amount in the BPR02. In instances where the business situation makes use of the TS3 segment required, the TS3 segment will provide total number of claims for a 2000 loop in TS304 and the total claim charge in TS305.
2.	Removed some CLP02 codes (Not Advised codes)	CLP02 Segment is intended to communicate to the provider that the claim was processed as primary, secondary, or tertiary. This segment is often mis-understood by those implementing the 835. To help clarify the purpose and thus standardize usage, the codes that detracted from its intent were removed. The qualifiers that were removed from CLP02 in 4050 are used in another HIPAA transaction; specifically the HIPAA mandated 277. The note in the 4010A1 states that these situations should be reported in the 277 response to the 276.
3.	Added new data element CLP14 as not used (new element)	There was a modification made to the 835 standard through the X12 Data Maintenance process. CLP14 was added to meet the needs of industries other than Healthcare. The yes/no qualifier does not have an identified business use within context of the Health Care Claim Payment/Advice transaction (835).
4.	Added NM112 element as not used to all NM1 segment iterations (new element)	New data element was added to the standard effective with the 4050-guide. The additional identification of the organization does not have an identified business use within context of the Health Care Claim Payment/Advice transaction (835).
5.	Max use of Corrected Priority Payer NM1 reduced to 1 (to make room for Other Subscriber)	In order to minimize the impact of addition of a new segment, the authors reduced the number of repetitions of the Corrected Priority Payer NM1 to 1 since there was no business need identified that more than 1l repetitions were needed.
6.	Other Claim Related Identification REF segment added (2) and removed (1) qualifiers to	For consistency with the Health Care Claim (837) guides, replaced A6 (Employee Identification Number) with 28 (Employee Identification Number) In order to facilitate identification of the other payer's group

	REF01	numbers, a second group number identifier was added (6P)
7.	Removed a Claim Supplemental Information Quantity QTY01 qualifier	Removed qualifier NA for non-covered days. Qualifier was in conflict with information conveyed within the CAS segment. Eliminated confusion as to where to place information.
8.	SVC01 and 06 added and removed code values (consistent with 4010A1)	Updated 4050 to be consistent with the addenda items that were added to the 4010.
9.	Service Identification REF changed repeat to 8 and added code to REF01 (APC)	Business need was identified to add a new qualifier for the Ambulatory Payment Classification Code (APC). In order to accommodate the addition of a new qualifier, the number of repetitions needed be increased from 7 to 8.
10.	Service Supplemental AMT01 removed qualifiers	Removed qualifier DY. Information can be conveyed in the TS3 segment. In addition, NE was removed since a business need for this qualifier has not been identified within the context of Health Care Claim Payment/Advice transaction (835).
11.	Service Supplemental Quantity QTY01 deleted code value	Removed qualifier NE since the information can be conveyed at the Claim Level.
12.	PLB03-1 replaced code ZZ with HM for Hemophilia Clotting Factor Supplement	ZZ was removed to minimize usage of this 'catch all' qualifier. Business need was identified for a qualifier to denote provider adjustments made for Hemophilia Clotting Factor Supplement.

Specific Enhancements of the 835 4050:

The Front Matter has been enhanced so that the intent of the 835 is clarified and it better defines specific business uses. Specifically, the following business issues are addressed in the 4050-835:

- Lost and Re-Issued Payments
- Balance Forward Processing
- Post Payment Recovery
- Claim Overpayment Recovery
- Reporting Secondary and Tertiary Payments
- Service Line Splitting and Considerations
- PPO's, Networks and Contract Types
- Totals within the 835
- Reporting Encounters in the 835

Qualifiers were added or deleted to facilitate communication between payers and providers. Qualifiers such as APC, Ambulatory Payment Classification Code were added to meet the industry need of reporting this type of code. In addition, qualifiers were removed such as 5, PENDED, to eliminate the redundancy with another HIPAA transaction (the 277 response to a 276).

To reduce telephone calls to payers and to aid providers in locating related, published medical policies used in benefit determinations, such as Medicare's Local Medical Review Policies, a new segment called Medical Policy Segment was added to the 4050.

The clarifications and definitions that were added to the 4050 address many of the industries needs that are missing in the 4010X91 and 4010X91A1 (HIPAA adopted implementation guides for Health Care Claim Payment/Advice transaction (835)).

Below are specific examples of improvements to version 4050 that better meet industry needs:

Secondary Reporting Issues:

The 4010X91 and 4010X91A1 does not provide specific instructions on how to report secondary and tertiary payments. Consequently, payers did not know how to consistently report coordinated benefit payments to providers.

Benefits of Other Subscriber Information:

When a payer discovers that there is another payer that should have been billed first, the payer may also know that there is a different subscriber for that policy. This additional information, if known, will allow the provider to accurately bill the other payer.