# Testimony to the National Committee on Vital Health Statistics (NCVHS) Subcommittee on Standards

## The Acknowledgement Transaction Standard and Maintenance and Modifications to Standards and Operating Rules (the present and the future)

Administrative Simplification under the Patient Protection and Affordable Care Act

**Centers for Medicare & Medicaid Services**

April 27, 2011

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**Introductory Statement**

Good Morning, my name is Michael Cabral, and I am a Lead Health Insurance Specialist for the Centers for Medicare & Medicaid Services (CMS) in Baltimore, Maryland. CMS is offering this testimony to the National Committee on Vital Health and Statistics (NCVHS) Subcommittee on Standards to provide CMS' background in the development of Acknowledgement Transaction Standard and Maintenance and Modifications to Standards and Operating Rules. We appreciate the opportunity to provide input and hope the information provided will be helpful as the Subcommittee undertakes this important work.

**Organizational Background**

The area within the agency where I work develops and maintains national electronic data interchange (EDI) standards by working within industry Standards Development Organizations (SDO) named in the Health Insurance Portability and Accountability Act (HIPAA) of 1996; serves to represent the Medicare program requirements in the Accredited Standards Committee (ASC) X12, the National Council for Prescription Drug Program (NCPDP), and the Health Level 7 (HL7) standards development process.

The division is also responsible to serve other CMS components' objectives, establishes EDI and Front End System requirements, contractor performance guidelines, and system interface requirements; participates in issues resolution.

Additionally the Division Serves as Medicare representatives on standards initiatives and promotes data standardization throughout the health care industry by active participation in industry groups such as the National Uniform Billing Committee (NUBC), the National Uniform Claim Committee (NUCC).

We are also responsible for maintaining liaison with industry representatives including health care payers, health care providers, vendors, clearinghouses, and national/State associations regarding Medicare implementation of standards.

Finally the Division assists in the development and implementation of paper and EDI testing protocols to ensure the effective implementation of Medicare administrative needs.

**Personal Background**

I would like to provide some of my personal background in the Standards Development arena as I believe it can provide the Committee with a historical perspective on today's topic of Acknowledgements. I began working in the Medicare Fee-For-Service (FFS) program in 1989 as a contractor. The organization at the time had several contracts related to National, Regional and

several state jurisdictions. During this time my organization participated on CMS' behalf in several of the Standards Development Organizations, specifically the Accredited Standard Committee (ASC) X12 Insurance Subcommittee, the Health Care Task Group, and I either Chaired or Co-Chair the Work Group for Health Care Claim Status. This was from 1996 until 2005 when I became an employee at CMS. I have also Co-chaired the Attachments Special Interest Group at the Health Level 7 SDO, and was an initial member of the Designated Standards Maintenance Organization (DSMO) representing HL7.

**Medicare Fee-For-Service and Standards Development Organization Work**

During the period of time after the initial set of HIPAA named ASC X12 transaction set standards, their implementation guides and addenda documents for which the work group was responsible to develop were nearing completion, efforts turned toward an additional function, standardization of the acknowledgement transaction for health care claims.

The ASC X12N - Insurance Subcommittee and Task Group 2 – Healthcare, wished to develop a single acknowledgement transaction for all X12N transactions. Given the complexity of the health care claim processing requirements, an agreement was reached to have a separate health care claim acknowledgement implementation guide developed using the *ASC X12 Health Care Claim Status Notification – 277* transaction set standard. For other non-paired transactions the *Application Advice – 824* transaction set standard could be used.

Specifically, the Clam Status work group reviewed multiple sources of proprietary reports from Medicare contractors, some commercial payers and some Blue Plan organizations. Common data elements were extracted and this information was applied to the transaction standard to determine what if any data maintenance would be needed at the standard level in order to build the implementation guide (now know as a Technical Report Type 3 (TR3).

The work group also reviewed other insurance products developed for X12 EDI transactions specifically of the Property and Casualty (P&C) area was using the 824 - Application Advice transaction standard. P&C often paired the 824 transaction set with another P&C transaction when developing the implementation guide specifications. As the review for the health care claim acknowledgement continued it was determined that only as few modifications were required to the 277 transaction set standard in order to develop an implementation guide/TR3. Data Maintenance commenced on the transaction set standard beginning with a name change to the transaction standard (277) from *ASC X12 Health Care Claim Status Notification* transaction set to *ASC X12 Health Care Information Notification*.

This change to the purpose and scope definition of the transaction set allowed for expanded use of the



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transaction set for other purposes beyond just the response status of a claim.

Other changes made to the standard to specifically support the acknowledgement of the health care claim, included the addition of two segments in the transaction set standard. Specifically, the AMT segment was included for the purposes of reporting dollar amount information, and the QTY segment was included for the purposes of reporting count type information when acknowledging health care claim transactions. These two segments would be able to report the total dollar amounts accepted and rejected along with the number of claims accepted and rejected respectively.

Other maintenance to the transaction set standard included adding additional occurrences within the transaction set of the STC segment. This segment carries the messaging related to the appropriate level of information being exchanged in the acknowledgement.

For example, if there is to be information regarding the trading partner exchanging information with the health care claim receiver, an STC segment can indicate that they are not authorized to exchange this information with the receiving organization at a summary level. When the STC segment provides information related to the Provider of Service level, the message is specific to an individual billing provider which is helpful when submitting claims for several providers in a claim transaction.

Patient and Claim or Service Line STC segments carry messages related to that business area and provide an individual claim by claim status about how the receiving entity (e.g. payer system or clearinghouse) was able to process a claim transaction set.

**Publication of a Version 004040 Acknowledgement Guide**

ASC X12N Task Group 2 – Healthcare, Work Group 5 – Claim Status, completed the work to publish the Health Care Claim Acknowledgement – 277 in February 2004. This activity brought to the health care community the opportunity to begin to standardize the claims acknowledgment process. Initially there were several entities indicating the need to add the *Health Care Claim Acknowledgement (277)* implementation guide to the named suite of HIPAA transactions in the Transactions and Code Set regulation. The Work Group recommended that before this version is required to be adopted, some industry implementations occur to determine if further changes to the standard level or the TR3 were required. Subsequently, the TR3 became part of the work product being updated as ASC X12N created work products for potential industry adoption.

**Publication of a Version 005010 Acknowledgement Guide and Medicare Fee-For-Service**

Work to develop an implementation guide for version 005010 began in October of 2003 and completed with the publication of the Health Care Claim Acknowledgment TR3 in January 2007.

About this time, due to legislation requirements, CMS was in the process of awarding new contracts for Medicare Administrative Contractors or MACs. CMS was also centralizing the Durable Medical Equipment (DME) electronic data interchange (EDI) processes for the four DME MACs into a single Common Electronic Data Interchange (CEDI) contractor. One of the benefits CMS was able to leverage was the standardization of the acknowledgment process during the development of the Statement of Work (SOW) for these contracts.

CMS viewed the timing of the MAC contract changes and the availability of the updated standards as an opportunity to remove proprietary acknowledgements from the Medicare FFS business model. This is also seen as a benefit to both the Medicare FFS program and the provider/suppliers and trading partners that exchange claims data. The benefit to the providers would be a reduction in the number of processes they would need to learn and manipulate to accomplish their claims filing activities. Instead of having to handle 15 to 19 proprietary Medicare reports, they would be exchanging acknowledgments using a standardized model across the Medicare FFS spectrum.

Also stated within the MAC SOW are requirements for EDI exchanges to be performed using a Commercial off the Shelf (COTS) translation software. The COTS software would then be utilized for the generation of the TA1 Interchange Acknowledgement. This provided a commercial application as the basis for the generation of the first level of acknowledgement generation. Providing the receivers of acknowledgements with a standardized first level health care industry acknowledgement should be similar whether it was generated by a Blue Plan payer organization, a commercial payer organization or the Medicare FFS payer organization. All receivers can accept the Interchange Acknowledgment in a standardized method and format.

At the same time CMS also included in the MAC SOW a requirement for generation of the *Implementation Acknowledgement For Health Care Insurance (999)* as a second acknowledgement requirement. This requirement was included and would be building upon the standardization and ease of use foundation for the Medicare trading partner community. This acknowledgement level specifically pertains to acknowledging technical issues.

Finally, the business acknowledgment aspect within the MAC SOW incorporated the *Health Care Claim Acknowledgement (277)* as a requirement in the acknowledgement model in order to complete the claim submission aspect. Using the standardized transaction would allow providers to have their practice management software vendor include an acknowledgement process that would be workable with any payer organization; Blue Plan payers, commercial payers, or Medicare FFS payers, resulting in requiring less training of their office staff on individual solutions for claim submission problems.

**Medicare Fee-For-Service Acknowledgement**

Historically, Medicare FFS payers have generated reports related to the exchange of claims data that would have been made available for retrieval by trading partners. Many times this was in a proprietary format and often differed from entity to entity.

At this point discussion concerning Medicare's approach to the Acknowledgment model and thoughts surrounding the intended receiver of each component in the Acknowledgement Model are described.

Medicare internally reviewed the intended receiver and considered the actual background or experience levels of the user of each acknowledgement component and in general terms categorized them into two groups, technical users and business users. For example Medicare FFS approaches looked at technical users for the TA1 acknowledgement and the *Implementation Acknowledgement for Health Care Insurance - 999* and contrast these users from the business type user who would be receiving business type information from the *Health Care Claim Acknowledgement (277)*. Specifically, the technical user understands terminology related to segments, loops and transaction sets, where as the business user will be concerned with correction of items such a Patient's Identification number, often called member id in the commercial world, beneficiary number in the Medicare program, recipient id in the Medicaid environment but all referring to the same data placement in a heath care claim. Any corrections required to this type of data could be made by staff at the provider's site, whereas the software vendor staff made need to be engaged to correct problems encountered when exchanging information in the health care claim model related to structural conformance to the transaction's implementation convention, syntactical compliance with the claim transaction and even relationship conformance between data elements within the claims transaction.

**Medicare Fee-For-Service Acknowledgement Guidance**

Medicare was able to recognize early and consider a viable workaround for an issue discovered when acknowledgements are generated at the Interchange level. Medicare FFS was able to provide a position and specific guidance on the use of the ISA – Interchange Control Header data element (ISA14) - "Acknowledgement Requested". This data element is sent by the Interchange sender and determines when the Interchange receiver is to generate an Interchange Acknowledgment (TA1) back to the Interchange sender. The values only allowed for value "0 – No Interchange Acknowledgement Requested" or "1 – Interchange Acknowledgement Requested (TA1)". This was thought to be problematic when the sender indicated that no Interchange Acknowledgement was requested and there were problems at the Interchange level.

Medicare has provided guidance to the MACs on the workaround for this.
Medicare also initiated a data maintenance request that was forwarded to ASC X12 for consideration.

The change requested was to add additional internal code value(s) to the data element in ISA14 which recommended that values be added to allow the Interchange receiver to generate an Interchange Acknowledgement (TA1) when there are errors at that level encountered even when the sender of the interchange has indicated they prefer not to receive and Interchange Acknowledgement (TA1).

Currently, until the change is available for use, Medicare is requesting that all inbound claims transactions have the ISA14 data element (Acknowledgement Requested) be set to always request an acknowledgement be generated and available for the sender of the claims interchange to retrieve. If guidance were not to be followed and in cases when an error occurred at the Interchange level, Medicare would be precluded from sending back notification of the Interchange level error according to the standard. By always creating the TA1 Interchange Acknowledgement, and making that available for the trading partner to retrieve, this provides positive confirmation as to the processing on the Interchange level.

**Real-Time Versus Batch Processing**

The rules surrounding Acknowledgments adoption also needs to consider the environment in which transactions are being exchanged, specifically, when the transaction or transactions are to be exchanged by trading partners using a real-time methodology. By minimizing the required responses the user is provided with faster response times due to less information being exchanged, receipt of only pertinent information related to the business function to be completed, and finally confirmation that the information exchanges are accurately formed and the user can move on to their next inquiry exchange scenario.

The acknowledgements that are exchanged in a batch processing environment not only indicate the information being processed satisfy the requirements of syntactical compliance, but more importantly inform the sender of the information that this step in the process completed, the timeframe for completion and provides the basis for the sender's next action in the business process.

Medicare FFS is recommending that guidance concerning the requirements in both the batch and real-time environments should be provided when any recommendation is moved forward by the Committee. Moreover that guidance should include the differences required in each processing environment separately.

**Adoption without Appropriate Foundation**

The acknowledgement development efforts that have led to creating the components contained Acknowledgement Transaction Standard demonstrate the need for appropriate foundational efforts in their development. Trading partners were able to use a draft of the implementation convention and provide feedback to the Standards Development Organization for incorporation in future updates to

the Standard, or Implementation Guide(s). This feedback is crucial in the creation of adoptable standards for exchange by all trading partners.

Also providing business reasons for information to be contained in the implementation to the SDO is only half the process. Having the requirements in time to be included for updates to the standards allows the crafting of the implementation convention for timely review by the industry stakeholders. That being said, the SDO must be staffed with membership volunteers representing impacted cross sections of the health care vertical and not by one or two people working on a project. A good national standard requires input from all stakeholders in the health care vertical to be an appropriate foundation to be adopted.

**"Being able to adopt" versus "Being required to adopt"**

Acknowledgments specifically for the health care claim transaction model, along with the inquiry and response paired transactions have matured to a point that allows the industry to be "able" to adopt the standard due to the testing and use of first or second generation implementation guides which allowed the development organization to improve upon the initial versions. Had this time and effort not been allocated, the requirement to adopt a standard may have led the health care industry to adopt unproven, untested and unworkable standards in a business model which ultimately could have proven more costly to implement, determine required changes, correct these findings.

The Committee should consider this in any new standard or rule being added to the HIPAA suite of Transactions and Code Sets rules.

**Conclusion: Support of Acknowledgements Adoption**

Medicare's support of the adoption of Acknowledgments Transaction Standard and Maintenance and Modifications to Standards and Operating Rules is based upon first hand developmental experience of the transaction standards, implementation guides, as well as input into ASC X12's Acknowledgement Reference Model. This coupled with the mutual benefit of reducing the proprietary based information exchanges aids the providers, payers, clearinghouses and other stakeholders involved in the improvement of the health care industry.

I would like to close by thanking the Committee for this opportunity to provide input on this important topic and should additional information be required of CMS or me, we would be willing to provide additional written or in-person testimony to assist the Committee.