NCVHS
National Committee on Vital and Health Statistics

March 2, 2012

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Administrative simplification provisions addressed in Section 10109 of the Affordable Care Act of 2010 (ACA)

Dear Madam Secretary,

The National Committee on Vital and Health Statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (HHS). Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NCVHS is to advise the Secretary on the adoption of standards and code sets for HIPAA transactions. The Patient Protection and Affordable Care Act (ACA) [Sec. 1104. (g)(3)) enacted on March 23, 2010, calls for NCVHS to assist in the achievement of administrative simplification to "reduce the clerical burden on patients, health care providers, and health plans."

This letter addresses Section 10109 of ACA, which contains provisions that call for evaluation of the opportunity for improving standardization and uniformity in new financial and administrative activities beyond those already being addressed under HIPAA. Section 10109 requires that the Secretary seek input from NCVHS, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee on specific areas related to administrative simplification, including:

1. Provider Enrollment
2. Property and Casualty Industry Inclusion Under HIPAA
3. Consistency and Standardization in Audits
4. Consistency of Claim Edits

On November 18th, the NCVHS Subcommittee on Standards held a hearing to address these four issues identified in Section 10109. A fifth issue identified by ACA (whether health plans should be required to publish their timeliness of payment rules) was not addressed during this hearing. We expect to address

this topic later this year. Although members of the HIT Standards and Policy Committees were unable to attend the hearings, they have been apprised by NCVHS of the outcome at their monthly meeting in December 2011. A plan to enhance coordination among these Committees is currently underway

Overarching Observations

There are meaningful opportunities for increased efficiencies and simplification through standardization in the areas of Provider Enrollment, Property and Casualty Industry, Standardization and Consistency Audits and Coding Claim Edits. Achieving these improvements will require further investigation and deliberation. The complexity of each of the topics is quite significant, requiring focused study to determine which appropriate and timely national standardization and simplification steps can be taken to achieve the goals set forth in ACA.

Overarching Recommendations

1. A Strategy should be established for further exploration in each of these four areas in order to develop recommendations for comprehensive improvement. This strategy may include holding additional NCVHS hearings and convening multi-stakeholder work groups. NCVHS plans to recommend such a strategy with a timeline by June 2012.

2. NCVHS is prepared to facilitate the recommended strategy, as resources permit, but will benefit from feedback from the Secretary on the relative priority of each of the four areas.

Brief Description of Findings

In each of the four Section 10109 topics covered during the hearing, there was significant stakeholder interest, and the input received was extensive, both oral and written. This letter highlights key findings. Appendix A includes a more detailed summary from the hearing.

1. Provider Enrollment Findings

NCVHS was asked in ACA to evaluate the provider enrollment process and determine if there would be any benefit in defining any type of standardization to the process, including the use of a uniform application form.

At the hearing it was noted by several testifiers that there are different and separate enrollment processes, forms and mechanisms for providers. For example, there are processes to participate on a health plan panel, to participate in the health plan electronic funds transfer program, to become a trading partner for electronic transactions, and to meet credentialing criteria.

Use of the terms "Enrollment" and "Credentialing" varies. The two terms refer to important, distinct processes. Standardizing the definitions would eliminate confusion. Briefly, enrollment to participate in a health plan is an administrative process that enables a provider to contract with a plan in order to provide services to patients for whom they will be reimbursed. Essentially, provider enrollment establishes a contractual service and billing relationship with a provider. Credentialing, which is a separate but related process, serves to itemize, document, verify, and validate the clinical credentials of a health care provider before he or she can participate in a health plan's panel (or be provided hospital privileges). This process includes verification of degrees, licenses, residencies, fellowships, malpractice claims history, and other qualifications etc. Testimony to NCVHS focused on enrollment with a health plan and not with credentialing.

The overarching comment on the current enrollment process is that it is burdensome and redundant. There are currently hundreds, if not thousands of unique enrollment forms and processes. Further, while there is some uniformity in the elements to be collected, the format for these elements may vary (e.g. middle initial or middle name, number of digits in a zip code, etc). Minor variation can result in rework, resubmission and delays in payment. Further there currently exists a hybrid world wherein some forms are electronic and some are paper, with some even requiring handwritten or hand-typed responses. There is even a standard electronic transaction developed by X12N, a standards committee accredited by the American National Standards Institute (ANSI) that is designed to communicate electronically provider enrollment information. X12N is the same committee that develops and maintains other national standards for HIPAA-regulated transactions. Remarkably most (including electronic) require a "wet" hand written signature, (some specifying requirement for the signature to be in blue ink). The process cannot be 100% electronic in its current format.

Issues that would need to be addressed include:

- A general framework for provider enrollment (including purpose and use of data by health plans)
- Achieving consensus on the definition of provider enrollment and the scope (to include multiple purposes for enrollment)

- Identify the largest gaps and challenges
- Identify the specific opportunities where the establishment of standards and operating rules will have the biggest impact
- Identify possible candidate standards and operating rules, emphasizing electronic standards over paper-based ones
- Develop a timeline for completion

2. Property and Casualty industry inclusion under HIPAA Findings

The ACA provisions raise the question of including the property and casualty (P&C) industry – workers compensation, auto insurance – as HIPAA-covered entities for purposes of the standard transactions. Representatives from the International Association of Industrial Accident Boards and Commissions (IAIBC), Minnesota Department of Labor and Industry, and the American Insurance Association (AIA) were enthusiastic in their support for electronic standards to simplify the administration of medical payments. However, they contend that the business rules and regulatory requirements for medical billing and payment in workers' compensation and the medical component of auto insurance are vastly different than for health insurance. For example, the 'claimant' in P&C insurance is not a health plan 'enrollee'. "The policy holder is typically not the party claiming benefits, but rather is a party *against whom a third party is asserting legal rights* and to whom the insurer owes a contractual duty to defend and indemnify." Further, the relationship and dynamics among the parties (consumer, insurance, health care provider, and employer) are different under P&C insurance, than under health insurance. E-Billing initiatives for property and casualty insurance transactions are already ongoing in Texas, California, Minnesota, and other states.

Issues that would need to be addressed include:

- Review and assess the e-Billing initiatives being implemented in Texas, California, Minnesota, and other states, to determine the opportunities to expand and promote e-Billing in other states and jurisdictions
- Consider the impact of state-specific requirements on the adoption and use of national electronic transaction standards for property & casualty
- Evaluate the status of electronic standards for transactions that support the exchange of property & casualty administrative information

3. Standardization and Consistency in Audits

Various industry stakeholders gave testimony on the ways in which the auditing process and requirements are cumbersome and duplicative, and on the strong need for uniformity, consistency and transparency. We did not, however, obtain sufficient information to make recommendations on the subject of audits. We plan to do further research on this topic over the next 6 months and identify priority areas where specific recommendations are needed. Issues that would need to be addressed include:

- Understanding the differences in the multiple types, sources and purposes of external audits being implemented in the health care industry
- Identification of key areas for which standardization in the audit process can be achieved
- Creation of a common terminology framework for audit implementation

4. Consistency in claim coding edits

Claim edits are computer algorithms programmed into a health plan claims adjudication system related to the treatment of a specific service reported on a claim with a Common Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) Level II code. The claim edits are designed to promote the correct coding of services performed by physicians, ensure that health plans pay for services that are rendered, and that they pay for the work associated with each service only once. A number of issues were raised regarding the lack of standardization in the claim-edit process. Providers are often faced with multiple, inconsistent, proprietary, and non-transparent claim edit processes designed by each health plan and public health payment program. These issues result in significant inaccuracies and inconsistencies in the way claims are reported from payer to payer. There is also a definitional issue with claim edits: some edits are not associated with health plan's particular benefit levels, which creates undefined and unpredictable denial situations.

Issues that would need to be addressed include:

- Development of a set of priorities and guiding principles identifying the "low hanging fruit" and common areas of issues among payers
- Review of edit categories other than those of CMS' National Correct Coding Initiative with the goal of developing best practices for potential use by commercial market and government stakeholders

- Review of claims edits sources and feasibility of voluntary adoption that aligns with current antitrust regulations
- Standardization of claims edits related to clinical validity, specialty society recommendations, common administrative definitions, applicability to Medicare population, or other considerations
- Work with claims edit software vendors on ways to increase the transparency of the claims edits used by health plans for providers' claims
- Work with CMS to explore opportunities to increase the transparency of CMS's National Correct Coding Initiative (NCCI) development process and increase the alignment of this initiative with coding and editing initiatives of the private sector to ensure broad stakeholder input and participation in the development and implementation phases

Conclusion

As demonstrated by the brief summaries above and by Appendix A, it is clear that opportunities for greater efficiency and simplification exist in all areas. It is also true that delineation of solutions will require careful study and sufficient time so as to not to inadvertently create new inefficiencies. And it is equally important, given current limited resources and multiple external demands, that the Department and industry stakeholders prioritize these efforts and develop a roadmap that takes into account the timing, business value proposition and short term vs. long term benefits of each of these new areas.

Sincerely,

/s/
Justine M. Carr, M.D.
Chairperson,
National Committee on Vital and Health Statistics

Cc: HHS Data Council Co-Chairs

Enclosure

APPENDIX A

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUMMARY OF HEARING ON SECTION 10109 OF THE AFFORDABLE CARE ACT

NOVEMBER 18, 2011

1. Provider Enrollment

Section 10109 requires NCVHS to evaluate the provider enrollment process and determine if it could be subject to any type of standardization, including the use of a uniform application form. Our observations, based on testimony from providers, health plans, billing vendors and private sector stakeholders can be summarized as follows:

The current enrollment process is burdensome and redundant; there are currently hundreds, if not thousands of unique enrollment forms and processes as well as variations in the data elements collected. Much of the effort is manual and paper drive. Even electronic processes require some manual, paper based effort. Further, most enrollment processes still rely on "wet" signature requirements, meaning that the process cannot be 100% electronic in its current format.

Enrollment systems are not shared across industry, meaning that every provider must enroll separately with every health plan; yet much of the information collected is identical. One organization, CAQH, owns and maintains the Universal Provider Datasource (UPD) which was established to support the provider credentialing process. The system enables providers to enter all relevant professional information into the database, which can then be accessed by participating health plans, including states. There are nearly one million providers registered in the system and over 650 entities who access the system for various reasons (plans, providers and other organizations). Some presenters recommended that Medicare and Medicaid consider using the CAQH database in lieu of using the PECOS system, even on a pilot basis.

There are other organizations that provide a gateway of information servicing multiple entities; each with different audiences in the health care sector.

With respect to the ability to standardize and automate the enrollment process, there is a standard available through ASC X12 that enables the

capture of certain data elements to serve both EDI and EFT enrollment requirements. It supports all provider types (individuals, groups, institutions) and utilizes existing EDI infrastructures. However, the standard transaction is not in widespread use and has not been requested by industry. It was reported that health plans could potentially reach agreement on up to 90% of standardized data elements, recognizing that there will be some variability based on plan or contract type. The work underway on operating rules for EFT and ERA may serve to accommodate building consensus on the data elements and reducing inefficiencies.

2. Property and Casualty industry inclusion under HIPAA

We heard from representatives from the International Association of Industrial Accident Boards and Commissions (IAIBC), State of Minnesota Labor Relations Board and the American Insurance Association (AIA). All were enthusiastic in their support for electronic standards to simplify the administration of medical payments, but also explained that the business rules and regulatory requirements for medical billing and payment in workers' compensation are vastly different than for health insurance. Our observations are as follows:

This panel of testifiers were opposed to including workers' compensation insurers, employers self-insured for workers' compensation, or their agents as covered entities under HIPAA, and they opposed any modification of the HIPAA rule for uses and disclosures contained in section 164.512(l), which allows for disclosures without authorization or opportunity to object for purposes of the administration of workers' compensation law. In the original HIPAA legislation, Congress specifically exempted workers' compensation and auto insurance from the privacy provisions of HIPAA because the flow of personal medical information in these situations is essential to ensure the timely adjudication of indemnity benefits, the coordination of medical treatment, and early return to work. There was consensus that restricting information would slow the payment of indemnity checks to injured workers.

The testifiers all supported the use of standardized electronic transactions to facilitate billing and payment of medical services for injured workers. In fact, there is a medical billing initiative through the IAIABC that attempts to use of the ASC X12 transaction sets for bills, acknowledgments, and remittance advice. However, because the data needs for workers' compensation are different than for federal or private health insurance, the IAIABC has created a process for medical providers to use the standards for a successful, billing transaction for workers' compensation. The IAIABC adopted the Workers' Compensation Electronic Billing Model Rule which

includes instructions for the use of applicable X12 standards, IAIABC transaction codes, and a companion guide for submitting bills under workers' compensation.

Several states, including Texas, Minnesota, and California have passed workers' compensation "ebilling" mandates. Other states, including Oregon, Louisiana, Illinois and Georgia, have shown interest in setting policy to follow the IAIABC model rule. There are several examples of State innovation in this area, with lessons learned for trying to implement EDI standards for P&C stakeholders. Minnesota learned that the X12 remittance transaction did not accommodate the state Workers' Compensation mandated remittance reporting requirements. Therefore, the state worked with the Property & Casualty stakeholders, the IAIABC and X12 to create a 4010/5010 workaround to address the mandatory remittance reporting requirements. Minnesota developed companion guides in addition to the X12 transactions sets, to help provide stakeholder guidance on how to use the X12 transaction sets to submit and process Workers' Compensation and Auto Medical bills and associated attachments. Again, early adoption was limited due to availability of provider connectivity.

We also heard from the P&C industry representatives, of issues with the Medicare Secondary Payer requirements.

3. Standardization and Consistency in Audits

We heard from a few industry stakeholders on this subject; mostly describing the ways in which the auditing process and requirements are cumbersome and duplicative. However, testifiers also reported that efforts are underway in the Medicare and Medicaid programs, as well as in the private sector, to bring more consistency to the process. Specific to the Medicare program for example, the requirements for demand letters under the Recovery Audit Contractor (RAC) program are now more comprehensive and in line with the Medicare Financial Management Manual. Most recently, the AMA advocated for standardized audit forms in the context of the Medicaid audit program. Because there are so many more auditing contractors and agencies operating at the state level, the AMA asserted that some degree of uniformity was required to allow physicians to identify Medicaid RAC audits as such. CMS did not adopt a standardized medical record request or demand letter in the Medicaid RAC program and left this process to the States. While many States are still developing their Medicaid RAC programs, some States do require that Medicaid RACs send standardized correspondence approved by the State. Again, according to the AMA, similar problems exist in the commercial audit market. These problems are compounded because of the number and type of health plans with which providers contract and from whom they are subject to audit, as

well as the number of third-party contractors that perform audits for health plans and other payers. Furthermore, each plan or vendor uses proprietary audit forms. The number of record requests and short record production timelines often create significant administrative burden to physician practices and hospitals.

Consistency in claim edits

Claim edits are computer algorithms programmed into a health plan claims adjudication system related to the treatment of a specific service reported on a claim with a CPT or Healthcare Common Procedure Coding System (HCPCS) Level II code. They are designed to promote the correct coding of services performed by physicians, ensure that health plans pay for services that are rendered; and pay for the work associated with each service only once. Though testifiers agree that edits are an important aspect of health care payment, there are concerns that the variation in claims edits increases administrative costs for plans and providers without concomitant benefits in improved coding on the claims.

One of the concerns raised by the Health Care Billing and Management Association (HBMA) was that payers do not follow the AMA CPT© guidelines and/or the CMS Correct Coding Initiative edits, conventions, guidelines and rules. The fact that CPT© codes are part of the HIPAA standard transaction sets, but the coding conventions that explain correct code use and reporting are not, has allowed inconsistency in the application of edits and in their interpretations. HBMA explained that some payers utilize the Correct Coding Initiative edits in totality, some use unique subsets and some rely upon no known methodology.

We also heard from representatives of the National Correct Coding Initiative, a program that has been in place since 1997 for Medicare, and very recently, for Medicaid.

According to the NCCI representative, the Medicare and Medicaid edit development process is transparent. Planned or proposed changes are released for a sixty day review and comment period to interested national healthcare organizations. Over 100 organizations participate in this process. CMS reviews all comments before edits are implemented. The Medicare and Medicaid programs do allow for a request a reconsideration of an NCCI or MUE edit, and CMS makes the final determination about any request. The NCCI representative indicated that if third-party payers were required to use the NCCI edit databases and claims adjudication rules, this could be expected to save money for providers and could reduce the number of inappropriate claim payments by health plans. However, there are costs

associated with implementing this program. Health plans and/or their vendors will incur costs of writing and integrating software into their systems to apply the NCCI program edits. There may also be costs associated with provider appeals of denied claims. Additionally, there will be administrative costs related to provider education, customer service, edit file maintenance, etc. These costs could be substantial and could create problems for smaller third-party payers.

Commercial Health plans also spoke to issues about the NCCI process. They stated that a key aspect of any claims edit development process is transparency. From the commercial market perspective the process used by CMS to develop claims edits, while transparent to providers and selected national health organizations, has not been open to input from private insurers and to the public at large until the final decisions on edits are made and posted. According to testimony, the meetings related to the NCCI and mutually exclusive code (MEC) edits are not open to the public and the National Correct Coding Solutions does not provide a general means of understanding the rationale or methodology behind edits chosen. For example, there is no way to tell if a CMS decision to incorporate an edit is based on clinical considerations, provider and specialty society feedback, the limits of the CMS adjudication system, or statistical methods showing outliers in the Medicare population.

Section 10109 referenced the need for "consistent methodology and processes" used to establish claims edits used by health plans. As an alternative to the adoption of a single set of code edits, testifiers suggested that there be consideration as to whether additional governance structures and processes could be established to provide a forum for the discussion and review of the NCCI edits and the conflicts between other commonly used edits and coding recommendations when health plans incorporate these (NCCI) edits into practice. We learned that there are a variety of sources of edits applicable to all programs, including the National Correct Coding Initiative (NCCI), CPT and CPT Assistant, Specialty Society Recommendations, Coders Desk Reference – Terminology and Definitions, Medicare's Common Procedure Coding System (HCPCS) coding system, Medicare Coverage Decisions (MCDs) and DME Coding Practices. The health plan industry has proposed consideration of a public-private governance process to review claims edits sources and provide recommendations for potential use, on a voluntary basis, by various stakeholders.

Code edits in the pharmacy industry:

NCPDP reported that pharmacy claim edits are used consistently since the implementation guide, data dictionary and code values are created with industry consensus. Further, requirements for the use of Reject Codes are specific to fields within the NCPDP Telecommunication Standard and NCPDP's process allows new Reject Codes to be added, modified or discontinued on a quarterly basis using industry consensus. Once these requests are approved they are published in the next release of the External Code List and are available for use according to a formal implementation timeline. The pharmacy industry believes that the successful application of their claim edits is due to consistency in use and did not have additional recommendations for change.

#end of summary#