Administrative
Uniformity
Committee

November 15, 2011

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Dear Ms. Doo:

Thank you for your recent email announcing the National Committee on Vital and Health Statistics (NCVHS) full committee meeting scheduled for November 16-18, 2011. We understand that a purpose of the meeting is to better understand the industry's "current state and suggestions" in several areas.

We are submitting brief written comments on behalf of the Minnesota Administrative Uniformity Committee (AUC) for consideration by NCVHS at its upcoming November meeting regarding:

A. Enrollment of health care providers by health plans;
B. Standardized claim coding;
C. Claims attachments;
D. Applicability of standards to other insurance types; and
E. The need for a single overarching umbrella organization to manage standards and operating rule maintenance/modifications.

About the Minnesota Administrative Uniformity Committee (AUC)

We have introduced the AUC in previous communications to NCVHS and CMS. The organization's hallmarks include:

- The AUC is a large, voluntary stakeholder advisory organization that has served for nearly twenty years to achieve consensus between payers and providers on standardizing health care administrative processes to reduce administrative costs and burdens.
- It is comprised of health care providers, payers, state agencies, and health care associations.
- It has no dues or membership fees. All AUC meetings and activities are well publicized in advance and are open to anyone wishing to attend. Remote access through dial-in and webinar capabilities is provided.
- As required under Minnesota Statutes, section 62J.536, the AUC is the primary advisor to the Minnesota Department of Health (MDH) in the development of first-in-the-nation rules requiring the adoption and use of single, uniform companion guides for several ASC X12 TR3s and NCPDP Implementation Guides.
- Additional information regarding the AUC is available at www.state.mn.us/auc and we are happy to respond to questions to requests for additional information.

AUC Comments

A) Re.: *Whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized*

This question was somewhat vague and could possibly refer to enrollment of providers for EDI transactions with payers, and/or the more extensive enrollment of providers by payers for credentialing and other needs.

Nonetheless, the enrollment process, especially with regard to credentialing, is often variable, lengthy, time and labor intensive, and cumbersome. In our discussions, particular concerns were raised regarding enrollment in Medicare, requiring as long as six to nine months, and very laborious, variable processes for enrolling with out-of-state Medicaid programs. These processes may require signatures, affidavits, and other submissions that are especially challenging if the goal is a more electronic, automated, efficient system.

We support continued standardization and automation of routine health care administrative activities. However, it will be important to first lay the foundation for a national enrollment model. Significant discussion and agreement is needed on the data that should be collected, verified, and how it will be used, before the technical specifications can be refined for an overarching national enrollment system that best meets the needs.

The Minnesota community is undertaking a collaborative approach involving payers and providers to jointly work through and resolve enrollment and credentialing issues. It will be important to assess this and other related initiatives, and to ensure that a solid conceptual foundation is established, as part of efforts to implement a national enrollment solution.

B) Re.: *Whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5)))*

While the term "claims edit" is not well defined, the AUC supports the concept of —and a focus on—"standardized claim coding", with agreed-upon, standard use of modifiers, units, coding for coordination of benefits (COB), etc., independent of payment considerations or policies. An example of this approach in practice was the AUC's successful collaboration to address the issue of coding for bilateral procedures. The AUC's recommended approach has been successfully adopted and implemented as part of Minnesota's uniform companion guide requirements. See for example, "Appendix A" in Minnesota's uniform companion guides for professional and institutional claims at http://www.health.state.mn.us/auc/guides5010.htm. Based on its experience, the AUC feels that standardized claim coding should be a higher priority, and is more feasible and practical at this time, than undertaking standardization of other claims edits that reflect or involve payment and payment policy.

C. Attachments

Current business practices in claim attachments: Priority attachments, business practices, mechanisms for request and submission, other

The AUC supports the use of unsolicited claims attachments and has successfully adopted and implemented a community-wide best practice to standardize the submission of unsolicited claims attachments. The best practice provides guidance regarding: how to populate a claim to indicate an attachment is being sent; submission of a unique attachment control number to link the attachment to the claim; and how to access to and use a single, standard, fax cover sheet to use with an attachment submitted via fax. The best practice is available at: http://www.health.state.mn.us/auc/profguide.htm.

If unsolicited attachments are not allowed, providers must: submit claims without the attachments; have the claim rejected due to lack of information (information that is subsequently requested by a payer via an attachment); and then must resend the claims with the necessary solicited attachment, which is often an iterative process with several submissions of different attachments that were requested. This is not only administratively burdensome and expensive, but often creates undue financial hardship for patients who have to pay their share of the bill until insurance coverage issues are resolved.

While faxing attachments is less desirable than an automated, electronic means of submission, more study and evaluation is needed before implementing a national claims attachment standard. This is particularly the case given the other competing demands on the industry's IT resources and expertise due to nearly simultaneous requirements to implement v5010 of the HIPAA transactions standards, ICD-10, and recently adopted and anticipated operating rules, as well as preparations for the exchange and "meaningful use" of patient clinical data, Health Information Exchange (HIE), and other market and regulatory pressures.

D. Applicability of standards to other insurance types

The AUC also supports extending applicable HIPAA standards and operating rules to workers compensation, property-casualty, and auto insurers. Minnesota requires that health care providers, group purchasers (payers), and clearinghouses exchange certain administrative transactions electronically, according to a single, uniform companion guide. The requirement applies to non-HIPAA covered entities, including workers compensation, property-casualty, and auto insurers unless:

> (i) a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or
>
> (ii) another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.

To date, MDH, which administers the requirements, has exempted non-HIPAA entities from only the requirement to exchange eligibility inquiries and responses, on the basis that this transaction was found to satisfy criterion i above. Additional information regarding MDH's decision is available at http://www.health.state.mn.us/asa/inpcompupdt021811.pdf. However, Minnesota's regulations for the standard, electronic exchange of claims, remittance advices, and acknowledgments still apply to workers' compensation, auto, and property-casualty carriers covered by the state's rules.

A goal of health care administrative simplification and standardization is that common standards and rules should apply as broadly as possible to minimize the potential for "one-off" customization of administrative transactions with particular subsets of the industry. This goal cannot be met if the common standards and rules do not apply to an important sector of the industry such as workers compensation, auto, and property-casualty insurers.

E. Umbrella organization

The need for a single overarching umbrella organization to manage standards and operating rule maintenance/modifications

In correspondence to CMS and testimony earlier this year to NCVHS, the Minnesota AUC communicated several concerns and recommendations regarding maintenance and modifications to standards and operating rules. Considering NCVHS's interest in the state of the industry and the recent adoption of the first of several anticipated sets of operating rules, these concerns and recommendations remain timely. We are forwarding, as an attachment, the transcript of testimony provided by Laurie Darst, AUC Co-chair, to NCVHS in April of this year regarding this topic. We are also including a related slide presentation that Ms. Darst referenced during her testimony.

In particular, we are concerned that:

- Many independent parties play a variety of roles in the maintenance and modifications of standards and operating rules;
- It is often difficult for some stakeholders and end-users to participate in the maintenance/modification process; and,
- The process is not as efficient or timely as it could and should be.

We recommend that a single, overarching umbrella organization manage standards and operating rule maintenance/modifications. This concept is suggested to facilitate greater coordination of the process, to reduce the time spent by industry requestors of changes and maintenance, and to reduce overall administrative costs. The umbrella entity could serve as both the coordinator of changes, as well as a communicator/facilitator for their implementation by the industry.

Thank you for this opportunity to provide written comments. We would be happy to respond to questions and to provide any follow-up. We look forward to continuing to work with NCVHS and CMS on health care administrative streamlining and standardization in the future.

Sincerely,

Paige Hinz
AUC Co-chair

Laurie Darst
AUC Co-chair

Beth Stanley
AUC Co-chair

Attachment:
Minnesota AUC Comments Regarding Maintenance and Modifications to Standards and Operating Rules

In correspondence to CMS and testimony earlier this year to NCVHS, the Minnesota AUC communicated several concerns and recommendations regarding maintenance and modifications to standards and operating rules. Considering NCVHS's interest in the state of the industry and the recent adoption of the first of several anticipated sets of operating rules for eligibility and claim status transactions, we think that these concerns and recommendations are especially timely, and are providing them in an attachment that includes a transcript of testimony provided by Laurie Darst, AUC Co-chair and an accompanying slide presentation that Ms. Darst referenced during her testimony.

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This attachment includes two parts: a transcript of testimony provided by Laurie Darst, AUC Co-chair, and an accompanying slide presentation that Ms. Darst referenced during her testimony.

AUC Testimony Presented at the NCVHS Subcommittee on Standards Hearing on *"Administrative Simplification under the Patient Protection and Affordable Care Act: The Acknowledgment Transaction Standard and Maintenance and Modifications to Standards and Operating Rules (the present and the future)",* April 27, 2011

Thank you to the co-chairs, members, and staff of the Subcommittee for the opportunity to present today. I am Laurie Darst, Revenue Cycle Regulatory Advisor at Mayo Clinic. I am also one of the co-chairs for the MN Administrative Uniformity Committee (AUC) and will be presenting today on behalf of the MN AUC.

You have received a brief written testimony sent on behalf of the MN AUC which will supplement our oral testimony. Our testimony reiterates several of the concerns and recommendations made by the MN AUC previously submitted to CMS in letters dated February 2010 and again in March 2011.

You've heard about the make up of the MN AUC in previous testimony today, but I want to reiterate a couple of important points that we feel attributes to our success in Minnesota. We feel some of these attributes may be valuable to consider replicating at a national level as they promote participation, adoption, and balance. First, we have an equal representation balance of payers and providers. Voting is done requiring a quorum of payers and providers, guaranteeing a balanced vote. Second, our meetings are open to the public and meeting information and documents (such as our companion guides) are available to anyone free of charge on the MN AUC website. Third, administrative support is funded by appropriations, thereby making participation free to anyone who wants to participate.

Slide 2

We'd now like to turn our focus to the current state of the maintenance and modifications update process. Our comments are intended to address the medical transaction process only. (not pharmacy or dental – although I will mention them briefly on a slide). What the MN AUC would like to go over are three points: 1) the current process is not as efficient as it should be 2) we'd like to present an alternative approach to the current system 3) and finally talk about the benefits of change.

Slide 3

Let's start by looking at the current process: Based on ever-changing billing requirements and new emerging payment models, the industry may need to request new administrative data for billing purposes. This may be in the form of actual data or maybe a new billing "indicator". To best illustrate the process, we'd like to use a hypothetical example. In our example here, let's say we need to be able to bill for "package billing or bundled services" for both chronic and acute conditions. Other examples of new administrative data might include billing data for medical homes or data needed to support the implementation of the HPID.

- We first go to X12 to get an indicator/data element for a number of different electronic transactions. We might first seek a data field in the eligibility transaction that would specify what type of "package billing coverage" that a patient has coverage for. (For example, the patient may have a package billing coverage for a chronic condition, such as diabetes which

is for a year duration, or it may be for a shorter time-period such as a knee replacement package.) An indicator would also likely be needed in the professional & institutional claim which would alert the payer the services or particular service lines submitted should be "bundled" into a package when payment is made. The same type of indicator would likely need to be requested in the remit and potentially other transactions.

- A next step might be to go to the Remit Code Committees to request a number of Claim Adjustment Reason Codes and Remittance Advice Remark Codes. Although this meeting is held at the same time as the X12 meeting, these are separate committees on different timelines.

- We should also take into consideration the paper billing process since some of the smaller providers will continue to bill via paper. If an indicator or field is needed on the professional and/or institutional paper claim, we would need to address this with the NUCC and NUBC respectively.

- If a taxonomy code is needed, we would need to seek this from NUCC.

- Value codes, Condition Codes, Occurrence Codes would need to be requested from the NUBC.

- Perhaps a solution might involve seeking new procedure codes from the AMA, the ADA or ICD 10 codes from CMS. We recognize these are medical code requests and outside of the scope of the DSMO process, but yet another potential request the industry would need to pursue none- the - less.

- If the package billing requires an attachment, we might need to seek a specific attachment data field with Health Level Seven (HL7).

- We've included the Dental Content Committee and NCPDP on this example only because there may be an *occasion* where we'd need to consult with them (i.e. oral surgery package or children with asthma package).

- Finally, we now have new "operating rules" added to the process and need to consult with the entity or entities who will oversee the operating rule process for each of these transactions.

The MN AUC feels the time and energy that stakeholders need to invest to get everything done is costly and time consuming. It also assumes that each of these separate entities would agree to the same solution and make efforts to provide a coordinated response – a coordinated, *timely* response. If entities don't' move forward in unison or an entity or two don't agree with the request, this causes solutions to be out-of-synch and can derail the overall request.

(DSMO Highlights)

- We recognize there is currently a DSMO process in place which includes six of the organizations highlighted in yellow. But the MN AUC feels there is significant opportunity

to facilitate better solution coordination **between** entities. Our intent is not to criticize any of these individual organizations – they all do a good job independently. It's the overall need for coordination we feel needs to be addressed. Now, with the addition of mandated operating rules, this just adds another "cog/spoke" to the wheel. *

Slide 4 (Wheel) --- Speaking of wheels - we feel the wheel needs to be fixed.

- We can view this analogy another way - - as a vehicle going to a destination, with each organization representing a different sized wheel on the vehicle - each moving at it's own speed - arriving at the destination at different times – some may even have a breakdown along the way. The MN AUC feels it's time for an upgrade, for a new vehicle."

Slide 5 (Timeline)

This slide reflects stakeholder time commitment and costs. In order for stakeholders to have a voice in the administrative simplification process or addressing challenges and new requirements, it requires time and money. This timeline provides a glimpse of some of the meeting schedules and the time required to participate. There are cost associated with travel, meeting fees, membership dues, and document fees for most of these organizations. The ability to vote on particular issues varies by organization. Some are open voting based on dues paid, others only allow designated members to vote.

- It is difficult for industry stakeholders to stay abreast of all the different activities with all the different organizations – and all the different timelines.

Slide 6

- Another concern expressed by the MN AUC is with the timing in which each organization releases updates. The most stringent timelines are those named in legislation, which take additional legislation to adopt to a new version. There is too much time lapsed between updates for these organizations due to this requirement. Other entities have their own schedules. We feel this disjointed update schedule stands in the way of moving forward with administrative simplification. In our "package billing example", we may not even be able to implement our billing solution if different entities can not make the necessary changes along with their other counterparts.

Slide 7

We need a new approach ~ ~

Slide 8

So we come to the MN AUC recommendation: an umbrella organization to manage the process. This concept would facilitate the coordination process, reduce the time spent by industry requestors, and reduce overall costs. This entity could be both coordinator of the changes and communicator to the industry.

Business Needs Identified (looking to the left side of umbrella)

We envision this umbrella organization would receive the new business requests and would provide a coordination point between the standards organizations; the non-medical code set committees and the operating rule entities. The MN AUC feels it's important that the umbrella organization oversight committee would include balanced stakeholder representation, to ensure

all points of view were taken into account when forwarding the request to the different entities. The umbrella organization should be tasked to establish clear expectations and timelines for the different organizations under the umbrella. They would also be a tasked to providing timely responses back to the requester on the status of the request. This is illustrated by the two way directional arrow below the umbrella.

Innovation (looking to the right side of umbrella)
The umbrella organization should also facilitate new innovations and new billing needs, such as future payment models, P4P, ACOs, medical home, and outcome based payment models. These new innovations also need to be coordinated between organizations to move forward efficiently and timely.

Slide 9
This next slide just summarizes some of the characteristics of the "Umbrella" that we discuss on the previous slide. We need a single, one-stop shop to go to for administrative simplification updates. This umbrella entity needs to include a feedback loop on response and updates. The umbrella entity would allow for common prioritization and a coordinated solution. The MN AUC feels it is essential to have balanced representation and voting on this type of umbrella committee. This would also provide a more nimble process for innovation and facilitates meeting future opportunities and challenges

Slide 10
This slide illustrates the benefits of a coordinated & balanced process. The MN AUC feels the umbrella organization model would streamline the process for the industry, thereby making this a less costly process. There would be greater transparency and accountability so industry representatives would be aware of the status of the requests and plan accordingly.

With balanced representation at the umbrella level, we feel it would be a more equitable and representative process.

Finally, we feel this concept provides the tools to achieve the levels of Administrative Simplification really desired by the industry.

Slide 11
In summary – the MN AUC feels now is the time to implement change to the process. We need this change to meet current and future challenges and opportunities. We recognize there are considerable details that need to be worked out with this concept, but change is possible, manageable, and desirable. Administrative Simplification is the ultimate goal – not only with implementing administrative billing changes, but we also need changes to the update process. The MN AUC feels the update process itself also needs an "administrative simplification" review.

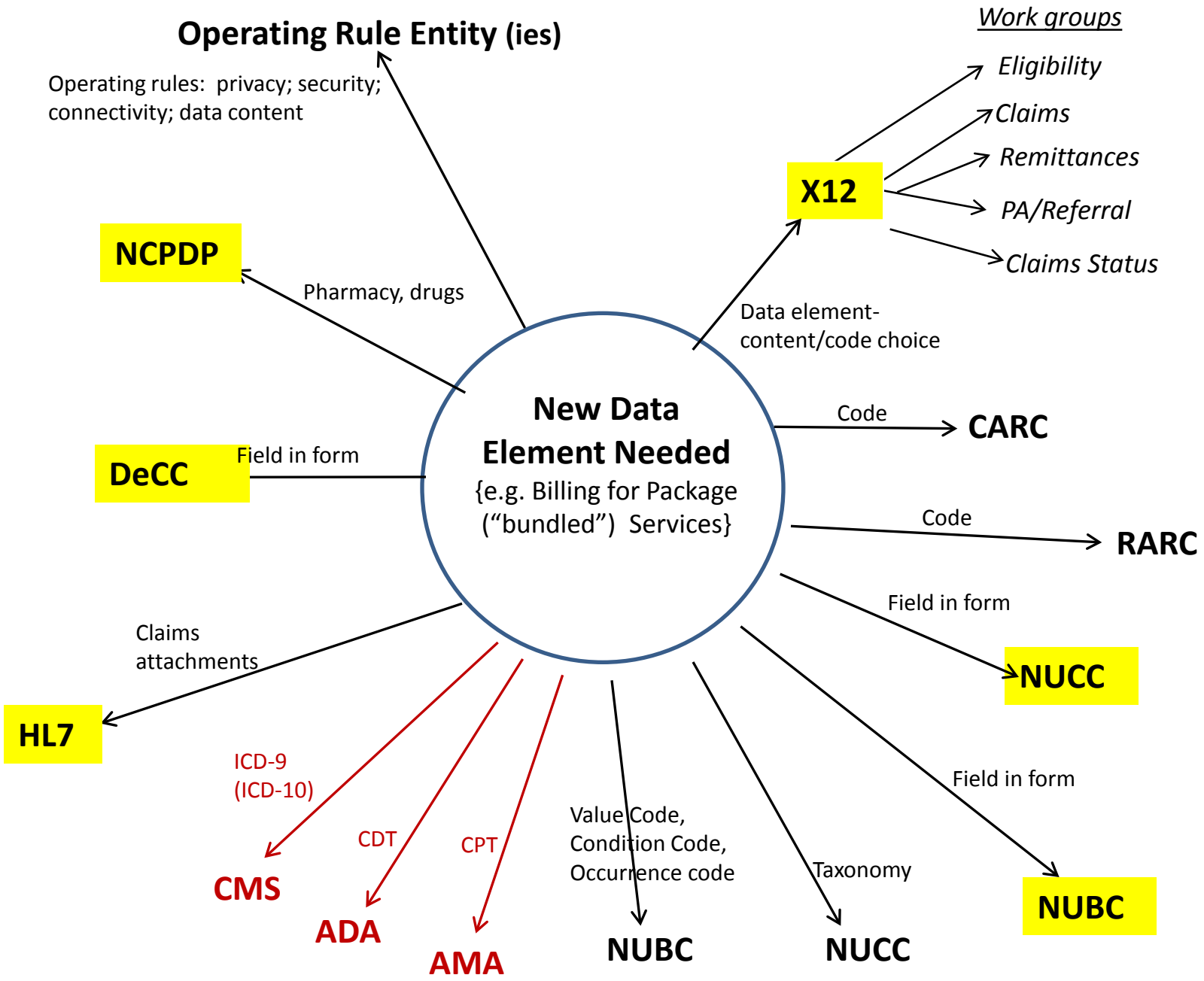
Again, I would like to thank the Committee for the opportunity to testify on behalf of the MN Administrative Uniformity Committee.

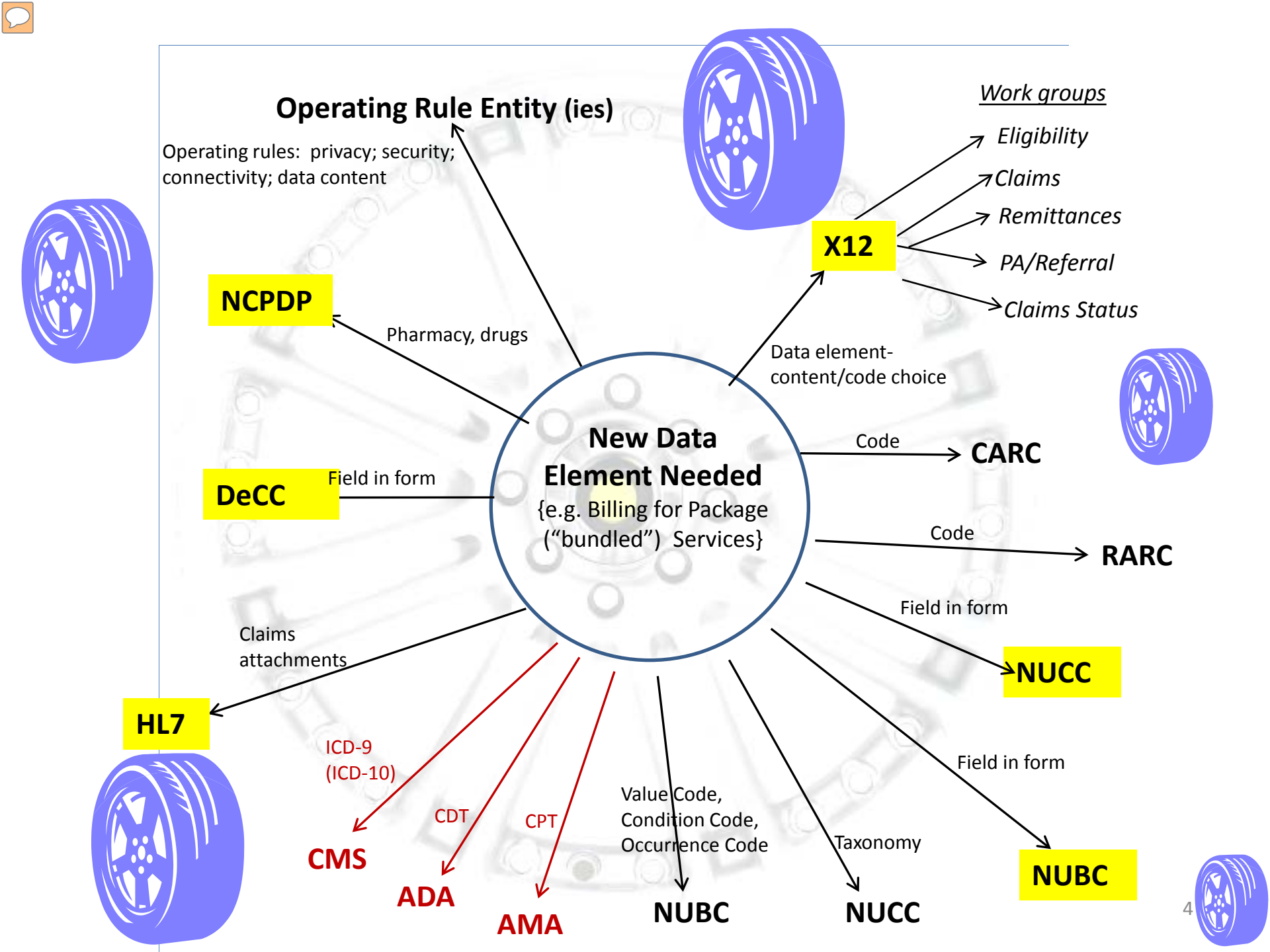
MN Administrative Uniformity Committee (AUC) Testimony to NCVHS on DSMO Process

April 27, 2011

Overview

- Current process is not efficient
- Present an alternative approach
- Benefits of change


Operating Rule Entity (ies)
Operating rules: privacy; security; connectivity; data content
Work groups
Eligibility
Claims
Remittances
PA/Referral
Claims Status
X12
NCPDP
Pharmacy, drugs
Data element-content/code choice
New Data Element Needed
{e.g. Billing for Package ("bundled") Services}
Code
CARC
DeCC
Field in form
Code
RARC
Field in form
NUCC
Claims attachments
HL7
ICD-9 (ICD-10)
CDT
CPT
Value Code, Condition Code, Occurrence code
Taxonomy
Field in form
NUBC
CMS
ADA
AMA
NUBC
NUCC
-- Clinical data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CDT
CPT
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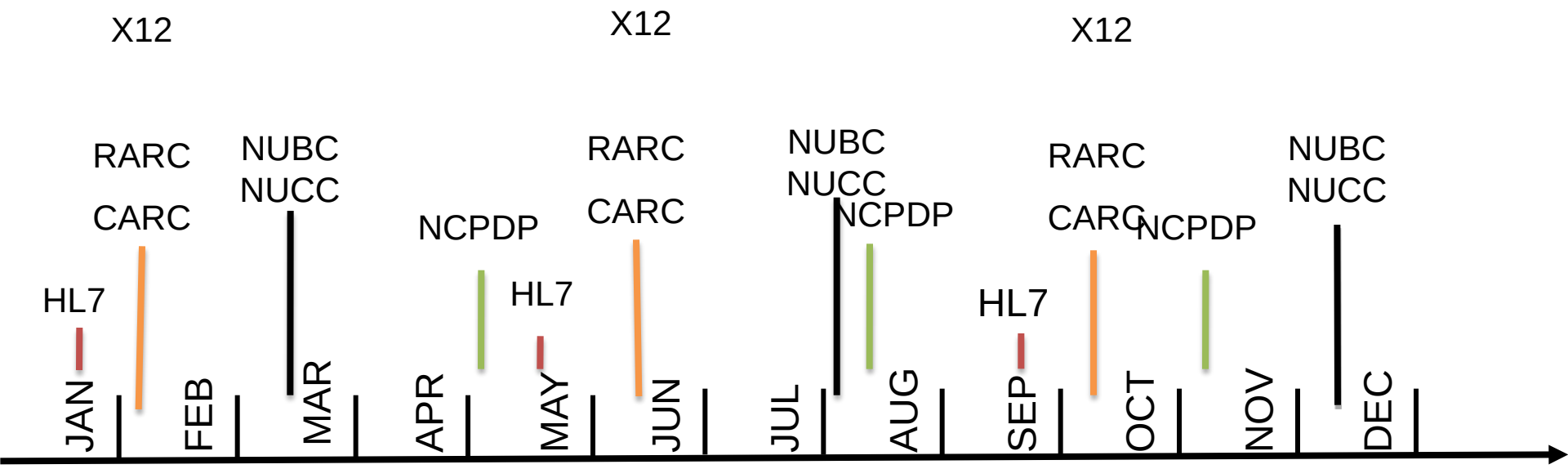
Taxonomy
Field in form
NUBC
CMS
ADA
AMA
NUBC
NUCC



- In-Person meetings occur most months
- Travel time and costs for in person meetings may limit who can participate
- Membership dues costs
- Cost of Documents
- Voice in the process – ability to vote
- Difficult to stay abreast of all the different activities with all the different organizations

APPROXIMATE MEETING SCHEDULE - MEANT TO SHOW TIMING NOT ACTUAL DATES

Transactions, Codes & Other Update Timelines

X12 – Based on HIPAA regulatory compliance dates

HL7 – (Attachment Transaction) -Based on HIPAA regulatory compliance dates

CARC - Can be three times a year

RARC - Can be three times a year

NUCC – Varies based on update type:

Instruction Manual * Form * Taxonomy codes

NUBC – Varies based on update:

Instruction Manual * Form * Non-Medical codes

Operating Rule Entity (ies) – Schedule TBD

We Need a New Approach
One that Promotes:

Coordination & Timeliness Across all Organizations

Communication

Balanced Representation

Affordable Costs

Business needs – e.g., data content, response times, etc.

Innovations – e.g., future payment models (P4P, ACOs medical home) and real time claims

STANDARD SETTING ORGANIZATIONS

e.g. X12, HL7, NUCC, NUBC, etc.

NON MEDICAL CODE SETS

CARC, RARC, add new service type, etc

OPERATING RULES

Characteristics of the “Umbrella”

- Single one-stop shop for administrative simplification
  - Accountable: Includes feedback loop and response/updates
- Common prioritization of work
- A coordinated solution
- Balanced representation
- More nimble process for innovation, meeting future opportunities and challenges

Benefits of “Umbrella”

- Easier and less complicated process
- Fewer costs
- Greater transparency and accountability
- Equitable and more representative process
- Encourages greater participation and action at all levels
- Provides the levels of Administrative Simplification really desired by the industry

Summary

- Need process improvement now
- Need improvement to meet future challenges
- Many details to be further discussed, but change is possible, manageable, and desirable

- Ultimate goal is Administrative Simplification