National Committee on Vital and Health Statistics (NCVHS)
Subcommittee on Standards

Hearing on Health Care Claims Operating Rules
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Testimony from the American Medical Association

Presented by Heather McComas
Director, Administrative Simplification Initiatives

The American Medical Association (AMA) thanks the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards (Subcommittee) for the opportunity to provide our written comments on the operating rules for the electronic health care claim transaction. The AMA strongly supports adoption of electronic standard transactions and their associated operating rules to reduce administrative burdens across all industry stakeholders.

We are pleased to note that the electronic claim is the most successful of the mandated electronic transactions. The 2014 CAQH Index[1] reports the adoption of the electronic claim at 92% across both health plans and providers. These data suggest that the transaction is largely meeting the needs of industry stakeholders. However, some remaining issues continue to impact optimal implementation of the claim transaction, and we believe that these concerns could be successfully addressed via operating rules.

The existing operating rules for the electronic professional claim transaction (X12 837P) address infrastructure issues. While the AMA agrees with these infrastructure requirements—with the few exceptions noted later in this document—we believe that the rules could be enhanced to improve the overall functionality of the claims transaction. To be sure, infrastructure elements such as connectivity, response times, and system availability are all important to the success of transactions, but data content is also critical to ensuring the overall consistency and uniformity of transaction implementation across stakeholders. We urge the Subcommittee to recommend the addition of the following data content requirements to the X12 837P operating rules:

- **Required compliance with Current Procedural Terminology (CPT) Guidelines:** While the current health care claim standard, code sets, and identifiers generally meet the current business needs of physicians in submitting claims, there continue to be concerns about inconsistencies with the application of the CPT code set. In the Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets Final Rule, the CPT Guidelines were not specifically named with the code set. Without the CPT Guidelines adopted under HIPAA, users of the code set are able to develop their own rules for how and when to report codes and modifiers, which decreases the standardization that was the intent of the regulation. We therefore believe that providers and their agents should be required to follow the current CPT Guidelines for reporting

[1]2014 CAQH Index™ Electronic Administrative Transaction Adoption and Savings Calendar Year 2013. Available at: http://www.caqh.org/pdf/2014Index.pdf.

services in the electronic claim, and that health plans be prohibited from contradicting the CPT Guidelines in their companion guides or in any other guidance pertaining to claim adjudication. This will remove the current variability in the use of the CPT codes and improve the efficiency of the electronic claim transaction.

- **Prohibit addition of information not required for adjudication to the claim transaction:** We have concerns that the success and high adoption of the electronic claim transaction make it attractive for adding reporting requirements for additional data potentially unrelated to claims processing. If added, these extra data requirements will increase the burden to generate the claim and increase the risk of processing errors. To prevent these problems, we recommend that the claim operating rules prohibit the reporting of additional data not needed for adjudication in the claim transaction.
- **Require acceptance and processing of all information, including diagnosis codes, reported on the claim:** Health plans do not always process all of the information reported on the claim, as providers report that plans later request information that was previously included on the claim. This situation obviously creates unnecessary, duplicative work for providers. The operating rules could require health plans to process and use all information included on the claim to prevent this administrative waste.

As we indicated previously, the AMA generally supports the infrastructure requirements outlined in the current X12 837P operating rules. However, we do have concerns on the following two items:

- **Response time:** The claim operating rule allows the health plan to acknowledge a batch claim by 7:00 am Eastern Time the second business day after the original submission. Since the requirement is for an acknowledgment only—not complete adjudication—we believe that this response time is unnecessarily long. We would recommend that the rule be changed to require a claim acknowledgment by the next business day following submission.
- **Authentication:** We disagree with removing Username+Password as an authentication option and mandating the X.509 digital certificate as the single authentication standard. The X.509 digital certificate requirement may impose undue financial hardship on physician practices. The additional digital security options in development and on the horizon may eventually replace both the Username+Password and X.509 options, and we therefore believe that it is premature to select a single authentication standard. We also note that it will be confusing for the industry to have different authentication requirements for different electronic transactions, as the transactions covered by Phase I-III operating rules will still allow both authentication options.

We believe that these changes to the infrastructure requirements will benefit the industry and improve the efficiency of electronic claims processing.

Finally, we must take this opportunity to again underscore the importance of requiring transaction acknowledgments. Without required acknowledgments, physician practices have no way of knowing whether or not a submitted claim was received by the health plan. While acknowledgements are included in the claim operating rule, acknowledgments have yet to be required for any of the standard electronic transactions. We urge NCVHS to recommend a

mandate for the use of acknowledgments for all electronic transactions, including the health care claim. There is widespread industry agreement that the absence of an acknowledgments mandate is a major gap in our current electronic data interchange environment.

We again thank you for the opportunity to provide our comments on the electronic claim operating rules. We believe that the success of this transaction can be further enhanced through adoption of the data content requirements and infrastructure changes we outlined above We look forward to continuing to work with the Subcommittee and all industry stakeholders in identifying and implementing innovative ways to improve the efficiency of health care in our country.