ADMINISTRATIVE EFFICIENCIES

SUMMIT – 2ND MEETING

JUNE 10, 2019
Chicago, IL

Meeting Report
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PARTICIPANT ROSTER

Panelists

1. Ms. Suzanne Achenbaugh, Director, Provider and Industry Relations, Delta Dental Plans Association
2. Mr. Robert Bowman, CAQH CORE Director, CAQH
3. Dr. Chris Bulnes, Summit Chair, and Chair, Council on Dental Benefit Programs, ADA
4. Mr. Zachary Church, Principal Product Analyst, Henry Schein Practice Solutions
5. Mr. Nick Deitman, Sr. Manager, Dental Client Strategy, Change Healthcare
6. Dr. Vince Dougherty, Council Member, Council on Dental Benefit Programs, ADA
7. Mr. Brian Flynn, Manager of Informatics, National Association of Dental Plans
8. Ms. Pam Grosze, VP, Senior Product Manager, PNC Bank Healthcare
9. Dr. Duc Ho, Council on Dental Practice, ADA
10. Ms. Amy Hoelscher, Patterson
11. Dr. Mark Jurkovich, Consultant to the Council on Dental Benefit Programs, ADA
12. Dr. Brett Kessler, vice-chair, Council on Dental Benefit Programs, ADA
13. Mr. Eric Kirnbauder, Senior Account Manager – EDI Expert, Tesia Clearinghouse, LLC
14. Mr. Thomas Meyers, VP, Americas Health Insurance Plans
15. Dr. Mark Mihalo, Chair, Council on Dental Benefit Programs Subcommittee on Coding and Transactions, ADA
16. Dr. Cynthia Olenwine, Council Member, Council on Dental Benefit Programs, ADA
17. Dr. Jesley Ruff, Senior VP, Chief Professional Officer, American Dental Partners
18. Ms. Christine Ruiz, Manager, Professional Relations, Delta Dental of California
19. Mr. Art Schoen, VP Insurance Operations and Revenue Cycle Management, Aspen Dental Management
20. Mr. Brad Smith, Senior Director, Industry Verticals, NACHA - The Electronic Payments Association
21. Dr. Steven Snyder Consultant to the Council on Dental Benefit Programs, ADA
22. Ms. Jennifer Westendorf, Director Inside Sales & Operations, Patterson
23. Mr. Chris Williams, Manager, Group Dental Claims and Quality Compliance, Guardian Life Insurance Company
24. Mr. Jason Wolan, Director of Electronic Health Records, Great Expressions Dental Centers
25. Dr. Gregory Zeller, Chair, Standards Committee on Dental Informatics, ADA
26. Mr. Tim Brown, Deputy Executive Director, National Association of Dental Plans (not present)
ADA Secretariat Staff

1. Ms. Sarah Tilleman, senior manager, Center for Dental Benefits, Coding and Quality, Practice Institute
2. Mr. Frank Pokorny, senior manager, Center for Dental Benefits, Coding and Quality, Practice Institute
3. Dr. Krishna Aravamudhan, senior director, Center for Dental Benefits, Coding and Quality, Practice Institute
CMS Presentation – Benefits of Compliance and Overview of the ASETT Program

This presentation described actions being taken by CMS’ Division of National Standards (DNS) to promote efficient and accurate implementation of HIPAA standard administrative simplification transactions, and programs that aid covered entities identify and resolve implementation and compliance issues. Delivered by Ms. Gladys Wheeler, MA, CPC, Health Insurance Analyst with DNS, the content explains how the guidance and compliance enforcement programs in place are applicable to the dental sector.

Appendix 1 contains the complete presentation.

The following are key highlights of the presentation and discussion:

- DNS is authorized to publish sub-regulatory guidance, even though the guidance does not have the force of regulation.

- Enforcement’s primary goal is to obtain compliance via successful completion of a corrective action plan instead of imposing a financial penalty.

- Compliance issues arise mostly with Payers than with Clearinghouses, and the problem is usually with a single type of transaction (e.g., presence or absence of a data element; data content).

- Regulatory authority extends to the named HIPAA standards, which means that any other type (e.g., paper such as the ADA Dental Claim Form) is not subject to DNS oversight.

- To date there have not been any complaints from the dental sector filed through the ASETT program, and dental plans are HIPAA covered entities.

  - **Post-meeting update:** after the Summit’s conclusion, Ms. Wheeler provided an update regarding the current compliance review process that is CMS-DNS is conducting. At the time of her presentation, it was noted that there were no dental entities included in CMS’s current compliance review selection. However, one of the selected entities did not qualify so CMS did a subsequent random selection, and a dental entity is now included.
Dental Front Office Survey

Results of a short ADA survey fielded to the Advisory Circle, an established cohort of research panelists in May 2019 were presented to provide AES participants to validate the range of administrative “pain points” from the provider perspective.

- ADA Practice Institute’s goal was to gain a better understanding of the level of burden dental office manager’s face interacting with 3rd party payer organizations.

- More specifically, the objective was to zero in on identifying and rank ordering specific pain points related to administrative workflows as identified through the worked of the Administrative Efficiencies Summit.

- The outcome will be used to inform AES efforts on addressing solutions that will reduce administrative burdens across the dental industry, particularly for dentists.

Delivered by Ms. Sarah Tilleman, Senior Manager, ADA, the findings addressed seven categories of recurring administrative activity: 1) Coordinating Benefits; 2) Eligibility & Benefits Verification; 3) Credentialing; 4) Electronic Remittance Advice; 5) Audits; 6) Claim Submission; and 7) Electronic Funds Transfer.

Appendix 2 contains the complete presentation.

The following are key highlights of the presentation and discussion:

- Coordination of Benefits (COB) is the greatest pain point with 59% in the “red” zone, EFT the lowest with 23% in that zone, and claims in the middle with 35%.
• Claims is unexpectedly high, and the thought is that although there is a significant percentage of electronic claim submissions (see discussion of CAQH Index), payer processing policies and requirements for attachments remains an issue.

• COB is an issue since the traditional manual process where the dentist submits to both the primary and then to the secondary plan continues, even though the 837D HIPAA standard electronic dental claim can support direct payer-to-payer COB.
To provide context for the individual topic discussions the following Figure from CAQH’s 2018 Index Report was presented. The 2018 report is the latest annual survey of HIPAA electronic administrative simplification transactions across the healthcare community. Notable in figure is the contrast between growth of three transactions, and the two-year declines for two. One declining percentage is for eligibility and benefit verification – an AES issue topic addressed later in this report.

The following are key highlights of the presentation and discussion:

- The likely reason for the eligibility and benefit verification decline is the robust information content published on proprietary third-party payer Internet portals; this is content that is not clearly conveyed in the 271 transaction.

- It is possible that the claim status inquiry decline also reflects increased use of proprietary payer portals.

- Claim payment percentages measure use of the NACHA CCD+ format (e.g., electronic funds transfer) and do not include electronic payment via virtual credit cards (VCC).

- The Remittance Advice measure is for the 835 only.

- ADA assisted CAQH with the dental survey design modifications and worked with CAQH Index team to encourage dentists to participate in providing data for the 2019 CAQH Index dental survey.
GOAL AGREEMENT

We need to strive for marginal improvements; not make perfect the enemy of good.
SUMMARIES OF TOPIC DISCUSSIONS

Eligibility and Benefits Verification Issues

Problems

Lack of complete information; standardization of information transmitted; and the difference between full eligibility versus treatment specific eligibility.

Adoption of Electronic Eligibility and Benefit Verification

2016 – 2018 CAQH Index Findings

The CAQH Index provides detailed information about specific administrative transactions, including mode of transmission (fully electronic, partially electronic and manual), volume and the estimated cost and time to process each transaction for providers and health/dental plans.

- By electronic transaction CAQH means automated transactions conducted using the adopted HIPAA standard.
- By manual transaction CAQH means transactions requiring paper, phone, fax, email or mail.
- By partial transaction CAQH means electronic mode of communication NOT the HIPAA standard. This includes web portals, IVR and direct messaging.

Solutions and Next Steps

- Conduct research on why dental offices continue to call payers even when the payer meets Top 56 requirements (both broad eligibility as well as treatment specific eligibility)
- Inform NDEDIC of the findings to help them review the Top 56 documents in light of these findings
- Create a common model to interpret the Top 56 appropriately (explore through SCDI working with NDEDIC)
- Submit the request to CAQH Core Board to point to the Top 56 in their Operating Rules
- Inform the 7030 of needs as it relates to dental (e.g., tooth-specific information)
- Increase education regarding standard transactions among providers/ payers/ clearinghouses and vendors
- ADA to gather data on best practices through Best Practices Self-Assessment Tool and share information with Associations to encourage their members to improve
EFT/ERA Reconciliation Issues

Problems
Lack of complete information on EOB’s including CARC/RARC, alternate benefits, information to tie to claim form; re-association and reconciliation problems; lack of auto-enrollment for dentists.

Solutions and Next Steps

• Identify the specific differences between the information that is carried through a standard 835 transaction versus the information contained in the PDF version of the EOB displayed in the payer’s web-based provider portal

• NDEDIC is undertaking a project to create a standardized “explanation” guide for the CARC/RARC codes (i.e., “use XYZ code when you are applying a frequency limit” etc.)

• ADA to develop education for dentists on how to better understand and interpret CARC/RARC codes

• ADA to gather data on best practices through Best Practices Self-Assessment Tool and share information with Associations to encourage their members to improve
Claims Submission and Attachment Issues

Problems
Multiple versions of the ADA claim form in use; percentage of required attachments increasing; payer processes policies are unclear and vary drastically; current electronic submission options are equally as burdensome as manual submission methods such as email, fax or mail.

Top 3 CDT codes that are submitted with attachments*

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Nomenclature</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing – four or more teeth per quadrant</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown – porcelain/ceramic</td>
</tr>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
</tr>
</tbody>
</table>

Percentage of claims submitted with attachments*

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2016</td>
<td>7.4%</td>
</tr>
<tr>
<td>2017</td>
<td>8.1%</td>
</tr>
<tr>
<td>2018 (annualized)</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

*SData provided by Change Healthcare

Solutions and Next Steps
- Continue to encourage providers and payers to use most recent version of the ADA claim form
- Promote use of the use of the new ANSI ADA standards that have been developed for orthodontic & periodontics by SCDI in conjunction with HL7 along with the CCDA for ANSI standard 1084
- ADA to gather data on best practices through Best Practices Self-Assessment Tool and share information with Associations to encourage their members to improve
Coordination of Benefits Issues

Problems
The 837D has “amount paid” or “covered by the primary” but doesn’t provide detailed information (e.g., whether the dentist is in-network, if there is an alternate benefit, etc.) so it prevents the secondary payer from being able to properly adjudicate the claim.

Solutions and Next Steps

- AES participants, including the ADA, need to inform the 837 public comment process to improve that standard for COB (late 2019 timeline)

- NADP to pursue additional effort in streamlining the use of the NAIC guidelines and what it would take to improve payer-to-payer coordination

- ADA to gather data on best practices through Best Practices Self-Assessment Tool and share information with Associations to encourage their members to improve
Credentialing Issues

Problems
Dentists have to submit credentialing info to numerous dental plans; many dental payers are continuing to use proprietary forms that require repetitive entry of the same information; multiple submission formats (paper versus digital); varying update frequencies and lack of alignment among payers re: re-credentialing cycles.

Solutions and Next Steps

• Promote sole use of digital universal online credentialing form that securely stores a dentist’s demographic info required for credentialing

• Explore alignment of re-credentialing cycle frequency for dentists across all dental payer types (long-term)

• Encourage dentists to update their stored digital profile with most up to date info so it is available to dental payers at any time (commercial or public)

• Implement proposed changes to dental specific applications

• ADA to gather data on best practices through Best Practices Self-Assessment Tool and share information with Associations to encourage their members to improve
APPENDIX

Appendix 1: CMS Presentation “HIPAA Administrative Simplification: CMS Enforcement and Overview of the ASETT Program”

June 10, 2019
Gladys Wheeler
Division of National Standards

Appendix 2: Dental Front Office Managers Study: Administrative Pain Points (May 2019)
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June 10, 2019
Gladys Wheeler
Division of National Standards
The **Division of National Standards (DNS)**, within the Department of Health and Human Services, is responsible for establishing and updating regulations that adopt standards for the electronic exchange of health care transactions, in accordance with the HIPAA Administrative Simplification statutory provisions.

In addition to issuing regulations regarding HIPAA Administrative Simplification, DNS is responsible for:

- Establishing outreach to and education of HIPAA-covered entities and other stakeholders
- Increasing industry participation in Administrative Simplification
Division of National Standards
Status Update

☑ Continued coordinating with our stakeholders at conferences and on workgroups

☑ Received the NCVHS recommendations on the “predictability roadmap” for modernizing the update and adoption process for standards and operating rules and we are evaluating the recommendations.

☑ Completed the transaction and operating rule audit pilot
  ☑ DNS will post de-identified results
Developed Subregulatory Guidance Communications Plan
  - In addition to our existing communication methods, we have developed two new tools
    - Administrative Simplification Guidance Letters, and
    - Administrative Simplification Information Bulletins

- Developing a number of regulations
  1. HPID Repeal
  2. NCPDP D.0
  3. Health Care Attachments
August 2018: Committee developed 23 recommendations, calls to action and measurements focused on the standard development process, the regulatory process, education, enforcement and oversight/evaluation.

December 2018: Hearing with 36 stakeholders in roundtable format to obtain input for development of final recommendations.

February 2019: Recommendation letter with five (5) recommendations sent to Secretary.

2019 NCVHS Work Plan – Re-envision the evaluation process for adopted transaction standards and operating rules. Develop recommendations for “DSMO 2.0.” in collaboration with HHS.

All NCVHS letters and hearing testimony are available on the NCVHS website: [https://ncvhs.hhs.gov](https://ncvhs.hhs.gov)
Introduction of New Administrative Simplification Communication Tools

DNS has established a protocol for developing and issuing guidance documents to bring more timely information and greater clarity to our stakeholders.

DNS has developed 3 types of communications:

1. Administrative Simplification Guidance Letters (Go-to Guidance)
2. Administrative Simplification Information Bulletins (Go-to Info)
3. Q&A (Go-to Answers), in addition to existing social media communications

All three types are intended to improve DNS communications and are aligned with the OMB Final Bulletin for Agency Good Guidance Practices.

Our messaging through social media and other means will continue.
What is Administrative Simplification Subregulatory Guidance?

Subregulatory Guidance letters are used to:

- Explain the Department’s interpretation of a statute or regulation
- Address complex policy implementation topics
- Provide technical information regarding the Department’s processes and procedures
Benefits of Subregulatory Guidance

Subregulatory Guidance Benefits:

• Keeps industry up-to-date with Administrative Simplification as it applies to the latest advances in technology and business practices

• Allows the Department to be more responsive to recommendations from advisory bodies, questions from the public, changing industry needs, and environmental and technological developments

• Allows the agency to issue guidance documents quickly and allows for greater flexibility
Regulatory Update
The Health Care Attachments proposed rule would:

- Adopt standards for health care attachments transactions and electronic signatures to be used in conjunction with health care attachments transactions.

- Adopt operating rules that require acknowledgments to be used for eligibility for health plans, health care claim statuses, and health care electronic funds transfers (EFT) and electronic remittance advice (ERA) transactions.

- Adopt acknowledgments transactions standards for the health care claim status, enrollments and disenrollments in health plans, health plan premium payments, coordination of benefits, referral certifications and authorizations, and health care attachments transactions.

- Modify the standard for the referral certification and authorization transaction from ASC X12 version 5010 to ASC X12 version 6020.
June 2017: NCVHS sent letter to HHS recommending that HPID/OEID be rescinded based on written & oral testimony

December 19, 2018: HHS published an NPRM to rescind the HPID and automatically deactivate existing identifiers

March 2019: Comments are being reviewed and considered for incorporation into a final rule; publication expected October, 2019
• This proposed rule would adopt a modification to the use of Telecommunication Standard Implementation Guide, Version D.0, August 2007

• The modification would enable covered entities to clearly distinguish whether a prescription for Schedule II drugs is a “partial fill” in claims where less than the full amount prescribed is dispensed.
Enforcement Program
HIPAA Enforcement

Overview

- Complaints
- Compliance Reviews
To help the health care industry use electronic standards for administrative transactions, HHS released the following videos:

Enforcing HIPAA Administrative Simplification Requirements
https://www.youtube.com/watch?v=-9EH2pAo0yQ

Reaching Compliance with ASETT
https://www.youtube.com/watch?v=3u1772Bb6Pg&feature=youtu.be
The Department of Health and Human Services (HHS) has delegated HIPAA enforcement authority to CMS within the Office of Information Technology/Program Management and National Standards Group/Division of National Standards (DNS)

- DNS assists with implementation and enforces compliance with HIPAA electronic transactions, code sets, unique identifiers and operating rules

- HHS OCR handles HIPAA privacy, security and enforcement
DNS enforces Administrative Simplification standards by:

- Responding to complaints about noncompliance
- Conducting proactive compliance reviews

**Goals**

- Reduce the burden on compliant entities of needing to conduct transactions with trading partners that aren’t compliant
- Improve efficiency across the health care system by streamlining billing and insurance-related functions, allowing providers and health plans to spend less time on these tasks
HIPAA Enforcement

• Complainants have the option to remain anonymous to the filed against entity

• The X-Engine Transaction Testing Tool supports X12 and NCPDP, versions 5010 and D.0, ICD-10 and transaction testing for compliance, syntax and business rules

• The complaint website is https://htct.hhs.gov/asett/public/home.act

• ASETT User Guide and Quick Start Guides are available on our website
Revised Paper Complaint Form

- Revised version – Updated to mirror ASETT system fields and address comments received from industry stakeholders
- This revised form is printable from CMS.gov under the Regulations & Guidance in the Enforcement section

Enforcement Complaint Tool

- ASETT is a web-based application which enables individuals or organizations to file a HIPAA and/or ACA complaint against a HIPAA covered entity for potential non-compliance with the non-Privacy/Security provisions of HIPAA

- Not for privacy or security complaints

- Allows submission of identifying information about the involved entities, details of the alleged violation, and any supporting documentation from both entities
HIPAA-covered entities must comply with Administrative Simplification:

- Health care providers that transmit transactions electronically
- Health plans
- Clearinghouses
All covered entities, which include Medicare & Medicaid, must comply with standards for the following transactions:

Health Care Eligibility Benefit Inquiry and Response (270/271)
Health Care Claim Status Request and Response (276/277)
Health Care Claims: Professional (837P), Institutional (837I), Dental (837D)
Health Care Claim Payment/Advice (835)
Payment and Remittance Advice (EFT/ERA) [NACHA CCD+/835]
Health Care Services Review – Request for Review and Response (278)
Benefit Enrollment and Maintenance (834)
Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
Health Care Claims for Coordination of Benefits: Professional (837P), Institutional (837I), Dental (837D)
National Council for Prescription Drug Programs (NCPDP) Medicaid Pharmacy Subrogation

It is important to note that some entities/providers use clearinghouses to make their transactions compliant.
DNS Complaint Management Process

1. **Complaint Intake**
   - New Complaint Received
   - Complaint Review & Triage

2. **Contact Complaint Parties**
   - Complainant Notice
   - FAE Notice

3. **Initial Response**
   - Subsequent Response & Mediation

4. **Administer CAP**
   - CAP Response
   - CAP Monitoring

5. **CMS Assistance**
   - CAP Completion
   - Complainant Confirmation

6. **Complaint Resolution**

7. **Complainant Confirmation**

8. **FAE Notice**

9. **Complaint Closure**
   - Complainant Closure Notice
   - FAE Closure Notice
Compliance Review Pilot

- 4 Clearinghouses and 1 health plan participated
- Providers were not included in the pilot
- Participants were randomly selected from the pool of volunteers
- Testing included all of the standard transactions that an entity conducted
- Entities attested to compliance with the operating rules
- Pilot successfully completed November 2018
- Pilot results will be posted on our website and distributed through an information bulletin in the near future
Compliance Review Program

• Launched April 2019

• 9 covered entities (clearinghouses and health plans) Randomly selected

• Currently in various phases of testing and collecting data
Complaint Statistical Reporting

• We are in the process of revising the type and amount of complaint information that will be posted on the enforcement page of our website

• We welcome industry feedback on the revised reports and posting enforcement statistics

• Expect to see an Information Bulletin announcing the revised reports soon
Office Managers Study

ADA Advisory Circle

ADA American Dental Association®
Background

- Practice Institute expressed desire to gain a better understanding on the level of burden office managers face interacting with 3rd party payer organizations
- More specifically, they wanted to zero in on identifying and rank ordering specific pain points
- The outcome will be used to focus internal efforts on addressing 3rd party payers
Unique Hybrid Approach

A two-part study aimed at securing feedback from the office manager who deals directly with payers

1. A short survey fielded to Advisory Circle panelists, asking them to either answer the survey directly, or forward it to the right staff member

2. A link at the end directed respondents to a more comprehensive annual survey fielded by CAQH. Respondents were offered $100 to participate in the CAQH survey.
ADA Methodology

- Questionnaire developed jointly with Practice Institute staff
- Deployed to the Advisory Circle research panel (1,263 member dentists) on Apr 26, 2019
- A reminder was sent on May 2, 2019
- 535 panelists responded
- Response rate = 42% (this is quite high, especially given the unusual ask)
Results of Part 1 (ADA Survey)
How often do you access payer portals to acquire information regarding a patient’s benefits and/or claims?

- Frequently: 68%
- Sometimes: 16%
- Seldom: 7%
- Never: 10%
## Administrative Burden, by Task

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<th>6%</th>
<th>6%</th>
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<tbody>
<tr>
<td>Coordinating Benefits</td>
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<td>6%</td>
<td>6%</td>
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<td>12%</td>
<td>20%</td>
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<tr>
<td>Eligibility &amp; Benefits Verification</td>
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<td>17%</td>
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<td>9%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Level of Burden**: (blue is low, red is high)
Practice Management Software Used

- Dentrix: 32%
- Eaglesoft: 26%
- Open Dental: 7%
- SoftDent: 4%
- Easy Dental: 2%
- Carestream: 2%
- Others: 26%
Practice Type of Respondents

- Solo practice: 53%
- Small group practice: 32%
- Other federal services: 4%
- DSO affiliated practice: 3%
- Dental school: 3%
- Non-DSO group practice: 2%
- Other: 3%