ADMINISTRATIVE EFFICIENCIES

SUMMIT

AUGUST 17, 2018
Chicago, IL

Meeting Report
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PARTICIPANT ROSTER

Panelists

1. Mr. Robert Bowman, CAQH CORE Director, CAQH
2. Dr. Chris Bulnes, Vice Chair, Council on Dental Benefit Programs, ADA
3. Mr. Zachary Church, Principal Product Analyst, Henry Schein Practice Solutions
4. Dr. Mary Lee Conicella, Chief Dental Officer, Aetna, National Association of Dental Plans
5. Mr. Nick Deitman, Sr. Manager, Dental Client Strategy, Change Healthcare
7. Mr. Brian Flynn, Manager of Informatics, National Association of Dental Plans
9. Ms. Pam Grosze, VP, Senior Product Manager, PNC Bank Healthcare
10. Mr. Norman Hartman, VP of Revenue Cycle Management, Great Expressions Dental Centers
11. Mr. Michael Herd, Senior VP, NACHA - The Electronic Payments Association
12. Dr. Duc Ho, Council on Dental Practice, ADA
13. Dr. Mark Jurkovich, Consultant to the Council on Dental Benefit Programs, ADA
14. Dr. Brett Kessler, Council on Dental Benefit Programs, ADA
15. Mr. Eric Kirnbauer, Senior Account Manager – EDI Expert, Tesia Clearinghouse, LLC
16. Mr. Thomas Meyers, VP, Americas Health Insurance Plans
17. Dr. Mark Mihalo, Chair, Council on Dental Benefit Programs Subcommittee on Coding and Transactions, ADA
18. Mr. Sandip Pathak, Senior Business Analyst, Delta Dental Plans Association
19. Dr. Craig Ratner, Chair, Council on Dental Practice, ADA
20. Mr. Art Schoen, VP Insurance Operations and Revenue Cycle Management, Aspen Dental Management
21. Mr. Steve Slaton, Director, Product Management, CAQH
22. Mr. Brian Smith, Vice President, Tesia Clearinghouse, LLC
23. Dr. Steven Snyder (Summit Chair), Chair, Council on Dental Benefit Programs, ADA
24. Ms. Jennifer Westendorf, Director Inside Sales & Operations, Patterson
25. Mr. Chris Williams, Manager, Group Dental Claims and Quality Compliance, Guardian Life Insurance Company
26. Mr. Jason Wolan, Director of Electronic Health Records, Great Expressions Dental Centers
27. Dr. Gregory Zeller, Chair, Standards Committee on Dental Informatics, ADA
28. Mr. Matt Ackerman, Senior Product Line Manager, Carestream Dental (not present)
29. Mr. Tim Brown, Deputy Executive Director, National Association of Dental Plans (not present)
30. Dr. Jesley Ruff, Senior VP, Chief Professional Officer, American Dental Partners (not present)

ADA Secretariat Staff
1. Mr. Frank Pokorny, senior manager, Center for Dental Benefits, Coding and Quality, Practice Institute
2. Ms. Sarah Tilleman, 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
To provide context for the individual topic discussions, CAQH (Mr. Robert Bowman and Mr. Steve Slaton) presented findings from the latest annual survey of HIPAA electronic administrative simplification transactions across the healthcare community. Of particular relevance was that the 2017 CAQH Index contains more information specific to adoption within the dental sector.

Industry adoption of key electronic transactions are as follows:

- Claim submission has the highest level of fully electronic transaction adoption by the dental industry at 74 percent.
- Use of partially electronic methods (portals) drove significant declines in use of manual transactions as well as some of the declines in fully electronic adoption.
- Electronic claim payment (EFT) is the transaction with the widest gap between the dental and medical sectors.
- Only 13% of the industry uses the electronic remittance advice (ERA) transaction.
- Full adoption of electronic processes for the transactions studied could save the dental industry nearly $2 billion in direct cost each year.

Attachment 1 includes the summary presented to Summit participants.
AGREED UPON NEXT STEPS

Four immediate next-step areas have been identified, with progress reports due by November 2018:

1. Eligibility Verification
   
a. NDEDIC to comment on the 270/271 v7030 transaction set, due in November, by assessing how this potential next version of the HIPAA standard addresses NDEDIC’s “Top 56” data elements needed for accurate transmittal of patient coverage information.

b. ADA to promote use of functionality within patient management software to access eligibility information through Webinars

c. Tesia and ChangeHealthcare to share industry trend data on how many payers achieve transmission of “Top 56” with panel

d. Phase II Activity (post-November): Feasibility of clearinghouse solution to support eligibility verification.

2. Claim Submission
   
a. Software vendors to assess systems to ensure default to latest version of claim form

b. ADA to promote use of functionality within patient management software to submit 837D

  c. Tesia and ChangeHealthcare to provide industry trend data regarding submission and use of attachments.

  d. ADA to convene a working group to address how to promote use of the ANSI standards for periodontics and orthodontics attachments, and how to streamline attachments requirements.

3. ERA/EFT/EOB
   
a. ADA, NACHA, CAQH and PNC Healthcare to collaborate on EFT/ERA Webinar.

  b. ADA to convene a working group to address how to implement standard electronic information flows so that reconciliation between receivables and payments can be automated to the fullest extent possible.

  c. Phase II Activities (post-November): (1) CARC/RARC codes; (2) Tracking reassociation of EFT/ERA]

4. Coordination of Benefits (COB)
   
a. NADP to report back on NADP Electronic Data Interchange (EDI) Workgroup efforts to achieve consensus on following NAIC guidelines for COB and assess usability of X12’s 837D dental claim and 835 transaction for COB.

Note: The two ADA working groups (ERA/EFT/EOB and Claim Submission) will convene electronically.
SUMMARIES OF TOPIC DISCUSSIONS

Eligibility & Benefits Verification: Determining Available Coverage before the Patient Encounter

Participants addressed several facets of the eligibility and benefits verification affecting both ends of the process – dentists in practice seeking information and dental benefit plans that provide the information. Facets discussed were the: HIPAA standard electronic eligibility inquiry and response transactions (270/271); dental office’s role in explaining available dental benefits to patients; use of provider portals in lieu of 270/271 integration into dental PMS software; and the role that could potentially be played by clearinghouses.

Areas of Discussion

Role of the Dental Office in Explaining Dental Benefits to Patients

A notable difference between dental and medical offices is that dental patients have the expectation that treatment plan costs will be discussed up front. Complexity of dental benefits is ever increasing with rising burden for offices to meet the patient’s expectations of knowing what they are going to pay before they proceed with treatment. This is why dental offices need for the payers to be setup to deliver this information before a patient leaves the dental office (i.e., informed of related co-pays, deductibles, etc.). Dental offices typically have full time staff engaged in verifying eligibility information prior to a patients’ appointment either via telephone or increasing through online portals. These are inefficient processes.

Further, in order to adequately explain cost information to patients dental offices sometimes need tooth-level eligibility information given the frequency limitations in most dental benefit plans (e.g. Is the patient eligible for payment for a crown on tooth X). Current 270/271 transactions (standards that stipulate the type and format of information to be communicated to verify eligibility) do not carry this level of detail.

The issue of patients moving between carriers due to changes in employment or changes in group coverage is significant because there are frequently substantial delays in those changes being reported by the payers’ and that information reaching the dentist’s office resulting in eligibility changes after a service was performed. It is important for the dental office to know if their patient has changed dental carriers before the patient leaves the office, especially from the non-participating/out-of-network providers’ perspective.

While the software vendors say the capability around receiving and digesting the 270/271 transactions exists within the dental patient management systems, dental offices remain unaware of these capabilities or find these inadequate.

Status of the current 270/271 Transactions

According to the CAQH Index 2017 Report, the dental industry is at 54% use of 270/271 transactions which is 30% below the medical industry’s use of the same transactions. While manual transaction have decreased, so have fully electronic transactions using the 270/271 standards. CAQH attributes this to the rise in the use of partially electronic transaction including payer specific provider portals – online portals that allow access to payer specific eligibility information.
As noted above the current version of 270/271 does not carry the level of detail necessary to explain cost information especially as related to tooth level frequency limits. Often important eligibility information is transmitted through the “message” section of the 270/271 transaction rather than discrete structure data elements limiting machine readability by software lower in the chain of transmission.

**Use of Provider Portals vs. 270/271 Integration in Dental Practice Management Software (PMS)**

While portals offer improved efficiency over phone calls to determine eligibility, they still require staff time to access proprietary user interfaces without seamless integration into the practice management software. Some payers are offering monetary incentives if the providers do not call the carriers’ call centers when they need assistance, encouraging them to instead use the portals.

With the multitude of different dental benefit plan types and designs, software vendors are challenged to integrate non-standardized eligibility information into their system. For these reasons, even when accessing the information through the proprietary portals, the responses are inconsistent.

**Role of the Clearinghouses**

In future, clearinghouses could play a significant role in streaming eligibility by leveraging the Plan ID number (and potentially a fee schedule ID number) with a response pre-populating into the patient management software. Challenges including addressing issues relating to competition and access to proprietary information for all plans need to be resolved.

**Points of Agreement**

The leading reason behind claim denials is patient ineligibility. To combat this, the goal is for the dentist to be able to get real time info for the patient in the chair from the patient’s dental benefit company.

Enabling office managers to move away from proprietary portals and towards meaningful “easy button” automation of the 270/271 within dental software is key.

The NDEDIC has created a guide for payers detailing the top 56 data elements necessary to transmit comprehensive eligibility information. This guide is accepted by X12 and has been voluntarily accepted by some payers and endorsed by the National Association of Dental Plans (NADP). Several stakeholders including the NADP and WEDI continue to promote use of this guide.

Of note, the current version of the 270/271 standard is under revision and may offer the opportunity to address some of these gaps.

**Next Steps**

a. **NDEDIC** to comment on the 270/271 v7030 transaction set, due in November, by assessing how this potential next version of the HIPAA standard addresses NDEDIC’s “Top 56” data elements needed for accurate transmittal of patient coverage information.

b. **ADA** to promote use of functionality within patient management software to access eligibility information through Webinars
c. **Tesia and ChangeHealthcare** to share industry trend data on how many payers achieve transmission of “Top 56” with panel

d. **Phase II Activity (post-November):** Feasibility of clearinghouse solution to support eligibility verification.
Claim Submission: the Role of ICD Codes and Attachments

Participants addressed several facets of the current claim submission alternatives – the ADA Dental Claim Form (paper) and the HIPAA standard electronic dental claim transaction (837Dv5010). Of note was continued use of non-current paper forms, which means that those submissions were not capable of including ICD codes when applicable, and lack of consistency regarding the necessity and nature of claims attachments.

Areas of Discussion

Default use of current ADA Claim Form

Many PMS systems are not currently set up to default to the most recent version of the ADA claim form. While use of the 1500 Claim Form is standardized on the medical side, there is no comparable standard on the dental side, so many different forms are still being used by the dental payers. Not only is the issue that the older ADA claim form still being used, there are payers that have developed non-ADA claim forms that are also in use.

Dental software vendors are trying to adapt the use of the varying versions of ADA claim forms to all the different ways payers are using the various fields differently. This inconsistent use of dental claims forms is also the reason why payers have given up on using optical character recognition (OCR) on dental claim forms, which results in yet another reduction in efficiency for the dentist.

There is an overarching need to work with the dental software vendors to set up their software to default to the current version of the ADA Claim Form while the more obvious solution is to use the 837D.

Issue of Attachments

Currently the requirements for attachments varies greatly among dental payers, and these requirements are becoming a significant burden for dentists. Because it is often unclear to dental offices when attachments are required and when not, some offices routinely send attachments with every claim simply to avoid the need to refile a claim or appeal. Other offices struggle with refiling claims and appealing denials.

ICD diagnostic information may offer a solution to reducing the growing burden and complexities related to the attachments being required by the dental plans for the purpose of dental necessity review. However, payers noted a lack of understanding of ICD codes and incorrect coding being submitted on claims. While payers accept any reported ICD codes into their system, this information remains unused.

To address the issue of attachments, ANSI standards for periodontal and orthodontic attachments (under development) could be adopted by payers for dental necessity review and approval.

Points of Agreement

Keeping in mind that according to the CAQH Index 2017 Report, 75% of claims are filed electronically, dentists rely on their dental software being up to date with industry standards.
Furthermore there was unanimous agreement that there’s not good industry understanding of what the required attachments are for dental necessity review.

Next Steps

a. **Software vendors** to assess systems to ensure default to latest version of claim form
b. **ADA** to promote use of functionality within patient management software to submit 837D
c. **Tesia and ChangeHealthcare** to provide industry trend data regarding submission and use of attachments.
d. **ADA** to convene a working group to address how to promote use of the ANSI standards for periodontics and orthodontics attachments, and how to streamline attachments requirements.
Getting Paid: Filling in the EFT Information Flow Gaps

Before discussing this topic Pam Grosze (PNC Bank) delivered a presentation titled *What Information Do Provider’s Need for Reassociation – and Where to Find It*. This presentation provided a framework and introduction to the technical aspects of Reassociation of the HIPAA standard Electronic Funds Transfer (EFT) transaction (NACHA CCD+) with its matching HIPAA standard Electronic Remittance Advice (ERA) transaction (X12 835). It focused on the answers to two key questions: 1) Where do you find the Reassociation Trace Number information in the ERA and EFT; and 2) What is the standard format for transmitting EFT information from the dentist’s bank to the dentist’s practice management system (the Federal Reserve Bank’s “FedPayments Reporter Service”)?

Attachment 2 includes the presentation received by Summit participants.

Areas of Discussion

Barriers to Dentist Implementing the EFT/ERA

Many dentists fear ERA/EFT because they are concerned about payers taking back monies from their accounts electronically. Adoption of EFT/ERA cannot become a reality until these transactions and the associated safeguards are better understood by the provider community.

While payers wish to realize cost savings on their end by moving away from printing and mailing paper checks and paper EOB’s, barriers to implementation on the practice side have resulted in limited success in moving the industry forward. For example, Guardian has advertised EFT to its providers on EOBs for years yet they have only been able to increase participation by 2% over the last 8-10 years.

Further, current status requires a significant staff resources to implement ERA and EFT due to the lack of end-to-end electronic processes through the patient management software. Given the lack of automated reconciliation capability within software noted above, the initial cost of implementation (both software and human resources training) is daunting. For example, in practice, there is nothing ‘automated’ about the check card reconciliation process any more than paper checks.

Status of 835 ERA Transaction

Even though most software systems are able to receive ERA’s, only 13% in the dental industry is actually utilizing the ERA transaction (per CAQH Index 2017 Report presentation). Among payers that do communicate ERA’s often necessary information to reconcile the ERA and EFT is not included.

Further, in order to understand the payment associated with each claim, it is important for dental offices to understand reasons for denial and altered payment amounts. These are communicated through the CARC and RARC codes. The current set of CARCs and RARCs codes are not specific for dental claims making it essential that dental offices receive paper EOB’s with more specific denial reasons to enable communication with their patients. Every payer has a proprietary set of claim denial reason codes that populates their EOB with no standardization within the industry. Further, some practice management software may not have the capability of displaying the RARC codes.
Lastly, line item level information must be a 1-to-1 match in order to tie the payment to patient, procedures, etc. and can handle scenarios where dentists work in multiple practice environments in order for the tracking of multiple providers’ production and related payments.

Status of 835 ERA Transaction Reassociation in Dental Practice Management Software (PMS)

From the Practice Management Systems (PMS) software vendors’ perspective, timing of reconciliation within the system is a challenge because 835 ERAs do not always arrive at the same time as EFT (CCD+) information is received from the dentist’s financial institution.

Currently deployed versions of dental software can accept 835 ERAs but lack the ability to auto reconcile with the EFT. Matching EFT and ERA information remains a largely manual process for dental offices. Some software vendors appear to be working on proprietary solutions to enable auto-reconciliation.

CAQH CORE offers resources regarding the required 835 reassociation data addressed in their CORE Phase 3 Operating Rules. There are several implementation resources including a template draft letter that dentists may use to send to their banking institution requesting the necessary information from their bank. (caqh.org/core/implementation-resources).

In the process of looking for opportunities to create efficiencies, “standardization isn’t always standard.” For example, the dental PMS vendors work to integrate with all the different systems used by the large payer enterprises yet they still build a multitude of HL7 interfaces because the large entities all address HL7 data content differently. Because of this variability the dental PMS vendors need to see a market need in order to move forward.

Points of Agreement

There are developed ways to reconcile the EFT/ERA within PMS. Summit participants agreed that reviewing standards that already exist to enable EFT/ERA in the medical sector was an important first step in moving the dental industry forward.

Payers have exclusive contracts with clearinghouses to facilitate electronic transactions. Dental office software interacts with clearinghouses to electronically transact business. Thus all three components must implement standardized processes to assure seamless workflows.

Further development of the dental specific CARC/RARC codes would benefit the 835 ERA transaction. CARC/RARC code maintenance and updates occur three times per year. The code set changes are conveyed to the X12 835 workgroup where their effects are evaluated and third-party payer issues are addressed.

Next Steps

a. ADA, NACHA, CAQH and PNC Healthcare to collaborate on EFT/ERA Webinar.
b. ADA to convene a working group to address how to implement standard electronic information flows so that reconciliation between receivables and payments can be automated to the fullest extent possible.
c. Phase II Activities (post-November): (1) CARC/RARC codes; (2) Tracking re-association of EFT/ERA]
Coordinating Benefits: Clear & Consistent Rules

Participants addressed the complexities of Coordination of Benefits processes, from situations where there is only primary and secondary coverage to cases where it is possible that there are benefits payable from three or more dental benefit plans. Another facet that affects the COB processes is the dentist’s in or out of network status, which may also vary between plans offering reimbursement. Discussion also included NAIC’s COB guidelines and the 837D’s COB capabilities.

Areas of Discussion

Payers do not seem to be able to vocalize how benefits will be processed and what will flow downstream from the primary carrier to the secondary, tertiary, etc. This requires some clarity in NAIC guidelines as well as consistency around use of the NAIC guidelines for COB.

Further complicating the operations is that when billing secondary and tertiary claims dentists are required to include the denial from primary carrier. There is also no industry standard on what denial information needs to be transmitted. Some payers appear to require a copy of the EOB from the primary carrier while others appear to simply require the information contained within.

To begin to address this, the payers confirmed that they need to know the payment arrangement (in-network or out-of-network), the covered amount, and paid amount for each service line item. Furthermore, some dental plans list patient responsibility, some do not making it hard to coordinate benefits without this information. Payers do not necessarily need the actual EOB but they do need all the information captured on the EOB, and currently requiring the inclusion of the denial from the primary carrier appears the only effective way to obtain this information.

Summit participants noted that the 837D is built to provide the needed COB information as just described. It populates down in the service level info in the 24-30 loop, which is specifically designated as a COB loop. It is unclear if network status is clearly defined on the 835.

To begin to address this industry-wide issue, CAQH has created a product call “COB Smart” and health & dental plans contribute to it every week. The idea is for the carriers to put the information into the systems, and run members to see if there are on other plans. CAQH has about 50% of their membership in the system currently (equal to approximately 20M dental lives in the system right now) but not actively using it currently.

Points of Agreement

Providing the claim denial from the primary carrier represents a significant administrative burden for dental practices and there needs to be an automated process that allows the secondary and tertiary carriers to know the details of the primary carrier’s payment arrangement.

The 837D may be key for moving towards a universal solution because it is built to provide COB information, even though there was agreement that there is still a need to verify that the 837D is addressing all the necessary data elements regarding COB.
Next Steps

a. **NADP** to report back on NADP Electronic Data Interchange (EDI) Workgroup efforts to achieve consensus on following NAIC guidelines for COB and assess usability of X12’s 837D dental claim and 835 transaction for COB.
Dentist Credentialing: One-stop Shopping

Participants engaged in a general discussion of the needs for credentialing dentists, and the available proprietary and single-source processes for this activity. Included in the discussion was an overview of the ADA’s credentialing service, as a single source solution.

Areas of Discussion

The ADA® credentialing service, powered by CAQH ProView® is an important and significant move in the right direction. Dentists and their staff appreciate that all of the dentists’ information is housed in the CAQH ProView system forever and the functionality of the attachments upload and supports are easy to use. The ADA and CAQH are actively working on the issue of the data entry fields contained in the CAQH ProView credentialing application being too medical centric because it is generally agreed upon that dentists would like to see a dental specific application.

Some other areas for improvements underfoot by CAQH ProView include providing a way to manage all of the practices’ dentists under one the ‘umbrella’ of the office and to align all of the re-attestations timelines for all dentists in the same group to be due at the same time.

In addition to creating a dentist-friendly credentialing application experience, CAQH ProView is working on the capabilities around group management. Phase 1 is focused on delegated practices and is set to launch in early October, 2018. CAQH plans on also looking into way to streamline non-delegated group management of provider profiles in Phase 2 in 2019.

Points of Agreement

The critical mass needed to tip the market is ~50% of all U.S. licensed dentists. Once 50% adoption is reached among dentists, the use of CAQH ProView will be seen as the norm in dental, just as it is in medical.

Likewise, the alignment of re-credentialing dates would be seen as a significant value add as it would address the issue of plans taking an extended time to credential a dentist.

Next Steps

a. Encourage use of the ADA® credentialing service, powered by CAQH ProView (ada.org/credentialing).

b. CAQH ProView implementation of Delegated Group Module begins October, 2018

c. Work towards re-attestation timeline alignment for dentists in the same group
Administrative Efficiencies Summit –
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CAQH Index®

A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings

2017 Dental Highlights

August 2018
CAQH Initiatives Transform Healthcare Business Processes

National operating rules for electronic business transactions.

Shared utilities to collect and manage provider and member data.

Research and collaborative endeavors as a catalyst for industry progress. Includes the CAQH Index®.
The 2017 CAQH Index is available for download at [www.caqhindex.org](http://www.caqhindex.org).

This is the fifth annual report released by CAQH.
## What is the CAQH Index?

### National Survey
- Commercial medical health plans.
- Commercial dental health plans.
- Healthcare providers.

### Industry Source
- Tracks progress in the ongoing transition from manual to electronic administrative transactions.
- Measures adoption of fully electronic administrative transactions.
- Estimates the cost savings opportunity and provider time savings opportunity.

### Guided by Industry Experts
- The CAQH Index Advisory Council.
- Experts in administrative transactions, data analysis and healthcare management.
- Represent providers, health plans, vendors and other industry partners.
Why Track Progress?

- Monitoring progress makes it possible to identify successes – and make course corrections when necessary.
- The transition from manual to electronic transactions is critical for a modern healthcare system.
  - Reduces unnecessary healthcare costs.
  - Eases health plan and provider administrative burden.
  - Reduces friction between providers and health plans.
  - Complements clinical use of health IT.
Who Participated?

Health Plans

- Medical health plans covering more than half (51%) of U.S. commercially insured covered lives.
- **Dental plans** covering nearly half (48%) of the commercially insured dental population.
- Data for calendar year 2016.
- CAQH managed health plan participation.

Healthcare Providers

- Represent a range of specialties.
- Large, more diverse sample.
- Data for calendar year 2017.
- NORC at University of Chicago managed provider participation.
Participation Levels Over Time

Health Plans:
- Data for calendar year 2016 were collected from commercial medical and **dental health plans**.

Healthcare Providers:
- Partnered with NORC at the University of Chicago to manage the provider data component.
- Data submissions were received from a large, more diverse sample of providers representing a variety of specialties and reflect calendar year 2017.

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<td>Enrollment</td>
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<td>Covered Lives (total in millions)</td>
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<td>Proportion of Total Commercial Enrollment (%)</td>
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<td>Number of Claims Received (total in billions)</td>
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<td>Number of Transactions (total in billions)</td>
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## Which Transactions Were Tracked?

### Medical

- Claim Submission (837)
- Eligibility and Benefit Verification (270/271)†
- Prior Authorization (278)
- Claim Status Inquiry (276/277)†
- Claim Payment (NACHA/CCD+)†
- Remittance Advice (835)†

### Dental

- Claim Submission
- Eligibility & Benefit Verification†
- Claim Status Inquiry†
- Claim Payment†
- Remittance Advice†
- Claim Attachments
- Acknowledgements

### Since 2014 Index

- Claim Submission (837)
- Eligibility and Benefit Verification (270/271)†
- Prior Authorization (278)
- Claim Status Inquiry (276/277)†
- Claim Payment (NACHA/CCD+)†
- Remittance Advice (835)†

### 2015 Index

- Claim Attachments (X12 or HL7)
- Prior Authorization Attachments (X12 or HL7)

### 2016 Index

- Coordination of Benefits Claim (837)
- Referrals (278N)
- Employer/HIX/Broker Enrollment/ Disenrollment (834)
- Employer/HIX/Broker Premium Payment/ Explanation (820)

### 2017 Index

- Transaction Acknowledgements for 277CA for 837 and 999 Functional Acknowledgement for 270, 276, and 278 or a Proprietary Acknowledgment

† Both HIPAA standards and operating rules are federally mandated.
Context

The Transition to Electronic Administrative Transactions

- Affordable Care Act (ACA).
- Industry- and government-led efforts.
- Today: A CMS “proactive compliance review” is pending.
High-Level Findings: Dental and Medical
## Annual Volume of Administrative Transactions

*Reported by Dental Health Plans*

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Transactions (in millions)</th>
<th>Number of Transactions per Member</th>
<th>Number of Transactions per Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Submission</td>
<td>182</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>Eligibility &amp; Benefit Verification</td>
<td>129</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Claim Status Inquiry</td>
<td>24</td>
<td>&lt;1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Claim Payment</td>
<td>146</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Remittance Advice</td>
<td>129</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Transactions</strong></td>
<td><strong>610</strong></td>
<td><strong>6</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>
Medical Industry
Only Modest Progress

- Claim Submission: 94% (2016), 95% (2017)
- Eligibility & Benefit Verification: 76% (2016), 79% (2017)
- Claim Status Inquiries: 63% (2016), 69% (2017)
- Claim Payment: 62% (2016), 60% (2017)
- COB Claims: 56% (2016), 56% (2017)
- Remittance Advice: 55% (2016), 56% (2017)
- Prior Authorization: 18% (2016), 8% (2017)
Dental Industry Has Not Yet Caught Up

<table>
<thead>
<tr>
<th>Service</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Submission</td>
<td>74%</td>
<td>75%</td>
</tr>
<tr>
<td>Eligibility &amp; Benefit Verification</td>
<td>58%</td>
<td>54%</td>
</tr>
<tr>
<td>Claim Status Inquiries</td>
<td>28%</td>
<td>17%</td>
</tr>
<tr>
<td>Claim Payment</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>Remittance Advice</td>
<td>N/R</td>
<td>13%</td>
</tr>
</tbody>
</table>
Dental Specific Findings
Transaction Types

- Participating health plans reported the volume of administrative transactions by type and method.
- Transactions are classified as:
  - **Fully Electronic** – conducted using the adopted HIPAA standard.
  - **Partially Electronic** – conducted using web portals or interactive voice response (IVR) systems.
  - **Fully Manual** – conducted using telephone, fax, or postal mail.
Dental Industry Made Modest Progress

Use of partially electronic methods (portals) drove significant declines in use of manual transactions as well as some of the declines in fully electronic adoption.

<table>
<thead>
<tr>
<th>Service</th>
<th>2016 Index</th>
<th>2017 Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Submission</td>
<td>74%</td>
<td>74%</td>
</tr>
<tr>
<td>Eligibility &amp; Benefit Verification</td>
<td>58%</td>
<td>54%</td>
</tr>
<tr>
<td>Claim Status</td>
<td>31%</td>
<td>50%</td>
</tr>
<tr>
<td>Claim Payment</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td>Remittance Advice</td>
<td>86%</td>
<td>86%</td>
</tr>
</tbody>
</table>

- **Electronic**: Represents the fully electronic adoption.
- **Partially Electronic**: Represents the use of portals leading to declines.
- **Manual**: Represents manual transactions.
Claim submission has the highest level of fully electronic transaction adoption by the dental industry at 74 percent.
Use of Online Portals drove sharp increases in the use of partially electronic transactions and declines in adoption of some fully electronic transactions.
Electronic claim payment (EFT) is the transaction with the widest gap between the dental and medical sectors.
Electronic remittance advice (ERA) benchmarks are reported for the first time in this report.

Electronic Remittance Advice (ERA)

Remittance Advice

2017 Index

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Cost of Administrative Transactions
The 2016 CAQH Index expanded cost estimates to include:
- Cost per transaction for seven of the twelve medical health plan transactions with the addition of costs for claim attachments.
- First time reporting initial four transactions for dental health plans.
  - Claim Submission.
  - Eligibility and Benefit Verification.
  - Claim Status Inquiries.
  - Claim Payment.
- Potential savings opportunity for dental health plans and providers for four of the seven transactions for medical health plans.

The 2017 CAQH Index expands even further:
- Cost per transaction for remittance advice added for dental health plans.
- Deeper exploration and more robust analysis of the practice management system and provider-facing clearinghouse vendor fees and pricing models.
Producng Cost Per Transaction Estimates for Health Plans

- Participating health plans provide cost-per-transaction estimates, which are weighted and averaged.
- Health plans use a variety of internal reporting systems to estimate fully loaded, direct cost for each transaction factoring:
  - Staffing.
  - Transactions.
  - Vendor Fees.
Full adoption of electronic processes for the transactions studied could save the dental industry nearly $2 billion in direct cost each year.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Submission</td>
<td>$50</td>
<td>$176</td>
<td>$226</td>
</tr>
<tr>
<td>Eligibility &amp; Benefit Verification</td>
<td>$106</td>
<td>$268</td>
<td>$374</td>
</tr>
<tr>
<td>Claim Status Inquiry</td>
<td>$32</td>
<td>$150</td>
<td>$182</td>
</tr>
<tr>
<td>Claim Payment</td>
<td>$133</td>
<td>$111</td>
<td>$244</td>
</tr>
<tr>
<td>Remittance Advice</td>
<td>$105</td>
<td>$868</td>
<td>$973</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$426</strong></td>
<td><strong>$1,573</strong></td>
<td><strong>$1,999</strong></td>
</tr>
</tbody>
</table>
On average, each manual transaction costs the industry **$4.40 more** than each electronic transaction.

A provider practice could save **more than $15** by using all seven electronic transactions for a single medical claim.

A dental practice could save **nearly $11.75** by using all five electronic transactions for a single dental claim.
On average, manual transactions require **five minutes more** than electronic transactions.

A medical provider practice could save **almost 40 minutes** on average, per claim, by switching from manual to electronic for all **seven** transactions.

A dental practice could save **almost 30 minutes** on average, per claim, by switching from manual to electronic for all **five** transactions.
Why Participate in the 2018 CAQH Index?

- More data translates to **more meaningful insights** and more precise measures of progress.
- Your data contribution can **support planned enhancements**:
  - Portal use and its ultimate effects on the transition to electronic administrative transactions.
  - Practice management system and clearinghouse vendor fees and product research.
  - Call inquiry drivers and barriers to use of electronic transactions.
- All participants receive **benchmark reports**, which provide important information specific to your organization:
  - How your company compares to the industry at-large.
  - How much time and effort your staff spends on electronic and manual transactions.
  - Potential for efficiency gains by further transition to electronic transactions.
The 2018 Index data collection is currently underway.

Dental plans can participate in the 2018 Index by submitting data for calendar year 2017.

For more information:
- Contact explorations@caqh.org.
What Information Do Provider’s Need for Reassociation – and Where to Find It

Alan Dupree
Retail Payments Director
Federal Reserve Bank of Atlanta

Priscilla C. Holland AAP, CCM
Senior Director Healthcare Payments
NACHA – The Electronic Payments Association
Reassociation of EFT with the ERA

- Two key pieces of information are needed to reassociate the EFT with the matching ERA
  - Trace Number in the Reassociation Key Segment – TRN02
  - Company ID Number – TRN03

- The trace number in conjunction with the company ID number provides a unique number that identifies the transaction. (ASC X12 835 vs 5010 TR3 page 20)

Key Questions Are -
- Where do you find this information in the ERA and EFT?
- How do you receive or what format do you receive the information from the EFT?
Additional Information for Reassociation

- Payee Name
- Effective Entry Date
- Payment Amount
- Provider Site Tax ID (TIN) or NPI
- Trace Number (Not the same as the ACH Trace Number)
Where Do You Find The Reassociation Information

**ASC X12 835**
- Federal Tax ID (Payer) – BPR 10 and TRN 03
- Payer Name – N104
- Effective Entry Date – BPR16
- Amount – BPR02
- Provider Site Tax ID (TIN) or NPI – N104
- Trace Number Segment – TRN02 – trace number, TRN03 – payer tax ID

**ACH File Record**
- Company ID (Payer) – Batch Header, Record Type 5, Field #5, positions 41-50
- Company name – Batch Header, Record Type 5, Field #3, positions 5-20
- Effective Entry Date – Batch Header, Record Type 5, Field #9, positions 70-75
- Amount – Record Type 6, Field #6, positions 30-39
- Identification Number – Record Type 6, Field #7, positions 40-54 (optional)
- Trace Number – Record Type 7 (Addenda), Field #3, positions 04-83
ACH File Format

- ACH file format is over 40 years old – back from the time of punch cards
- Fixed-field format with 94 characters per Record Type
- Record Types are designated with a number
  - 1 File Header Record
  - 5 Company/Batch Header Record
  - 6 Entry Detail Record
  - 7 Addenda Record
  - 8 Company/Batch Control Record
  - 9 File Control Record
## NACHA Data Specifications

<table>
<thead>
<tr>
<th>Type of Field</th>
<th>ALPHABETIC/ALPHAMERIC</th>
<th>NUMBERIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Characters</td>
<td>0-9, A-Z, a-z, space, EBCDIC values greater than hexadecimal “3F”, ASCII values greater than hexadecimal “1F”</td>
<td>0-9</td>
</tr>
<tr>
<td>Justification</td>
<td>Left</td>
<td>Right</td>
</tr>
<tr>
<td>Empty Field Handling</td>
<td>Space filled</td>
<td>Zero filled</td>
</tr>
<tr>
<td>Special Notes</td>
<td>Certain fields require the use of UPPER CASE characters</td>
<td>Must be unsigned (neither positive (+) or negative (-) signage)</td>
</tr>
</tbody>
</table>

ACH fields are Mandatory, Required, or Optional
NACHA Operating Rules

• Require a bank to deliver the information carried in the Payment Related Information field on the ACH Addenda Record (7 Record) if it is requested by a Receiver (Provider). For healthcare this is the TRN Reassociation Trace Number

• The bank must have one secure electronic deliver method available to deliver the information to the Receiver (Provider)

• Majority of banks can deliver an electronic version of the ACH file record to the Provider
FedPayments Reporter Service

• Many banks utilize the Federal Reserve Banks FedPayments Reporter Service
  – Main page:  
    https://www.frbservices.org/serviceofferings/fedach/fededi.html
  – Overview:  

• Reports can be sent directly from the Providers bank to the Provider or a party designated by the Provider
## Sample ACH File Report

| 101 599999999 6910001314032201447*09410*BIG BANK | 106003492DDHMCPYMT1 | 130221052103110000000000066 |
| 5200AETNA LIFE INS | 106003492CCDHMC | 130221052103110000000000066 |
| 5200AETNA LIFE INS | 106003492CCDHMC | 130221052103110000000000066 |
| 62999999990424105740 | 0000906529XXXXX7765 | SOUTHAMPTON HOSP ASSOC 1051100020741139 |
| 82000000200214079100000000000000000009065291060034342 | 03110020000000466 |
| 0000906529XXXXX7765 | SOUTHAMPTON HOSP ASSOC 1051100020741139 |
| 8000000020021407910000000000000000009065291060034342 | 03110020000000466 |
| 5200AETNA LIFE INS | 106003492DDHMCPYMT1 | 130221052103110000000000066 |
| 5200AETNA LIFE INS | 106003492DDHMCPYMT1 | 130221052103110000000000066 |
| 62999999990424105740 | 0000906529XXXXX7765 | SOUTHAMPTON HOSP ASSOC 1051100020741139 |
| 82000000200214079100000000000000000009065291060034342 | 03110020000000466 |
| 0000906529XXXXX7765 | SOUTHAMPTON HOSP ASSOC 1051100020741139 |
| 8000000020021407910000000000000000009065291060034342 | 03110020000000466 |
| 5200AETNA LIFE INS | 106003492DDHMCPYMT1 | 130221052103110000000000066 |
| 5200AETNA LIFE INS | 106003492DDHMCPYMT1 | 130221052103110000000000066 |
| 8000000020021407910000000000000000009065291060034342 | 03110020000000466 |
| 0000906529XXXXX7765 | SOUTHAMPTON HOSP ASSOC 1051100020741139 |
| 8000000020021407910000000000000000009065291060034342 | 03110020000000466 |

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### Sample Remittance Advice Detail Report

**ACH Bank, Pleasant Town, USA**  
Telephone: 555-555-5555, Fax: 555-555-5556, Email: Customer.Service@ACHBank.com

**Physicians Group**

**REMITTANCE ADVICE DETAIL REPORT**

<table>
<thead>
<tr>
<th><strong>RECEIVER INFORMATION</strong></th>
<th><strong>ORIGINATOR INFORMATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiver Name: Physicians Group</td>
<td>Originator Name: Blue Care</td>
</tr>
<tr>
<td>DFI Account number: 987654321</td>
<td>Company ID: 1555555555</td>
</tr>
<tr>
<td>Receiving DFI ID: 051099999</td>
<td>Originating DFI: 091088888</td>
</tr>
<tr>
<td>ID Number: 123456</td>
<td>Company Descriptive Date:</td>
</tr>
<tr>
<td>Settlement Date: March 2, 2014</td>
<td>Effective Entry Date: March 1, 2014</td>
</tr>
<tr>
<td>Transaction Type: 22</td>
<td>Transaction Description: Demand Credit – Auto Deposit</td>
</tr>
<tr>
<td>Amount: $5,000.00</td>
<td></td>
</tr>
</tbody>
</table>

**TRANSACTION DETAILS**

<table>
<thead>
<tr>
<th>Discretionary Data:</th>
<th>Entry Description: HCCLAIMPMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEC Code: CCD</td>
<td>Company Name/ID#: Physicians Group</td>
</tr>
<tr>
<td>Service Class Code: 200 – ACH Entries Mixed</td>
<td>Addenda Rec. Count: 1</td>
</tr>
<tr>
<td>Batch Number: 75</td>
<td>ACH Trace Number: 999999999000001</td>
</tr>
</tbody>
</table>

**Reassociation Trace Number**

<table>
<thead>
<tr>
<th>Current Transaction Trace Numbers: EFT1111111</th>
<th>Reference Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originating company identifier: 1222222222</td>
<td></td>
</tr>
<tr>
<td>Reference Number: 000333333</td>
<td></td>
</tr>
</tbody>
</table>

*** END OF REPORT ***
WEDI Offers EFT and ERA Guidance

The Workgroup for Electronic Data Interchange (WEDI) has developed a whitepaper, EFT and ERA Enrollment Process, that offers for implementation of the EFT/ERA enrollment process.

Truncate the TRN Number?

If the conditional TRN04 data segment is used it should be truncated if the overall TRN Reassociation Trace Number data segment exceeds 80 characters.

Healthcare EFT Standard Frequently Asked Questions

Questions about the healthcare EFT standard? Find answers to your questions on our FAQs page.

Collaboration
...a catalyst for improved efficiencies and innovation.

Healthcare legislation will impact every financial institution in the United States. WEDI and Healthcare EFT (HACH EFT) is helping the efficient

https://healthcare.nacha.org/
Healthcare EFT Standard Implementation Guide

- Healthcare EFT Standard Implementation Guide
  - What is the EFT standard?
  - How does it work?
  - Includes the CCD format
  - How to populate the specific fields
  - What are NACHA Operating Rules and how do they impact the standard?
- Available from NACHA at https://www.nacha.org/eStore
NACHA Resources

• Healthcare Payments Resources Website
  – Provides a repository of information on a wide variety of topics for both financial institutions and the healthcare industry. Includes links to many other resources, as well as customized information to help “translate” concepts from one industry to the other (FAQs, reports, presentations).
  – http://healthcare.nacha.org/

• Healthcare EFT Standard Information
  – Located within the healthcare industry tab of the above website, specific information can be found on the healthcare EFT standard.
  – http://healthcare.nacha.org/

• Healthcare Payments Resource Guide
  – Publication designed to help financial institutions in implementing healthcare solutions. It give the reader a basic understanding of the complexities of the healthcare industry, identify key terms, review recent healthcare legislation, and discuss potential impacts on the financial services industry.
  – Order from the NACHA eStore “Healthcare Payments” section: www.nacha.org/estore.

• Healthcare ePayments Newsletter
  – Quarterly newsletter for healthcare and financial services industry. Must register to receive the free newsletter at listrequest@nacha.org

• ACH Primer for Healthcare Payments
  – A guide to understanding EFT payment processing. Introduces the healthcare industry to the Automated Clearing House (ACH) Network, explains ACH transaction flow and applications, and includes two “next steps checklists,” one each for origination and receipt. (Free pdf publication)
  – https://healthcare.nacha.org/ACHprimer