CAQH Committee on Operating Rules for Information Exchange (CORE)
CAQH CORE Attachments Advisory Group (AAG) Call #2
Tuesday, October 15, 2019, 2:00-3:30 pm ET Conference Call
Post Call Doc AAG Feedback Form #1 Results Full Comments

Feedback Form Comments Received on CAQH CORE AAG Feedback Form #1

The following Tables contain all feedback form comments received on the *CAQH CORE AAG Feedback Form #1*

Table 1: Comments Received

ID	Opportunity Area Category	Comments
1	Workflows	• One vendor commented "Workflows related to clinical data exchange (triggering, requests, release/review, etc.) are important." • One health plan commented "Workflows establish a good baseline." • One provider commented "Consistent workflows put all parties (providers, payers, and clearinghouses) on the same page." • One vendor commented "We have over 12 years' experience with attachment workflow processes and this is a critical component to successful implementation. This is a valuable tool to enable an enterprise approach across stakeholders to allow them to leverage their existing IT technology, resources and connectivity." • One health plan commented "We think it is appropriate for this workgroup to look at workflows if the work flow process that is being stated as an area of opportunity for improvement is the process of a provider sending an attachment to the health plan/payer, considering both solicited or unsolicited. However, upon a health plan/payers' receipt of said solicited or unsolicited attachment, it is not up to CAQH-Core or any other regulatory body to dictate/decide internal business processes." • One health plan commented "We do not have enough information about the rules that are yet to be developed to provide further input on the opportunity" • One vendor commented "Our workflow is based on specific and common PA steps. 1) who is the patient? 2) who is the ordering clinician? 3) what are you ordering? 4) why are you ordering (this is where attachments come in)? 5) where is the order going? The only chronological process we have is the timing of approval or denial notification once we receive needed data. Our organization does rely heavily on documentation/attachments for many of our clinical reviews. We would love to get out of the fax business and have electronic attachments (combined with NLP/OCR on our side). • One provider commented "Our organization did a 275 Pilot with a few payers that was not successful." • One provider commented "While the devil is in the details, the general recommendations support greater automation and streamlining of currently burdensome processes. The ability to embed predefined documentation requirements will depend on the particular use case, but the objective remains an important goal. • One provider commented "This is a critical hurdle in getting claims paid and prior authorization's approved." • One health plan commented "Workflow maps give a visual aid in making multiple groups understand concepts"

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		One vendor commented "Guidelines on workflows including standardization will facilitate adoption and eliminate proprietary implementations. It will also benefit to see where handshakes are needed for sent/received acknowledgements.
2	Data Variability	• One vendor stated lack of standards on data formats hinders the adoption and value of attachments/medical record exchange. • One health plan explained variability in implementations causes extra work and 'one offs' when implementing Standards • One health plan responded consistent data allows for a more seamless experience for end users. • One provider stated that currently, they generate unsolicited attachments in the 275 (6020 version) to NGS. As they reach out to other connections, this would be our preferred version. • One vendor stated "The majority of our stakeholders have separate workflows and PMS/EMR systems for generating attachments. Often the attachments are sent separately from claim and or are prior authorization transactions. The meta data regardless if it's 277RFAI request from a payer and or an unsolicited 275 is critical to being able to match back up the attachment request and response process. Standardization of the meta data requirements for matching the transaction sets will help stakeholders significantly with the implementation process. This falls into the same category of developing data file format requirements for quality, readability, and size efficiency." • One health plan explained yes, they support. They believe that data variability, (examples being: .png .doc .jpeg .xls .pdf, and others) are appropriate. • One health plan responded they do not have enough information about the rules that are yet to be developed to provide further input on the opportunity. • One health plan stated "We have very different data requirements, depending on which clinical area we're reviewing. The documentation to approve a chemotherapy regimen is different than the documentation we need for physical therapy sessions. We manage ten different solution areas. So, we might be able to support a common format and file type, the CONTENT will need to vary greatly. And some of our solutions require documentation EVERY time, and some only require it when standard criteria are not met." • One provider explained for the most part, documentation is sent solicited, to the extent permitted by applicable law. Monitoring the denied population of claims is our best indicator of when the payer requires additional documentation. Given that payers' policies are often not transparent and may not identify specific criteria that define the additional documentation requirements for each transaction, our organization finds that mining our data for the criteria is more efficient. • One provider stated decreasing data variability will drive development support from vendors and encourage implementation by providers. • One health plan stated, "even with TR2 and TR3 guides there is a wide variety in what is acceptable in X12 transactions." One vendor explained an operating rule prescribing guidelines and preferences on a 'limited set' of acceptable universal file formats as this will facilitate adoption i.e. the scan identified PDFs are highest, should we limit to PDFs and GIFs/JPEGs or add metadata on the type of file we are sending to make sure it is readable at the receiving end. Guidelines on number of files and sizes should be included. Is there an opportunity to standardize on how we enumerate/build a PWK 06 document control number?
3	Exchange Mechanism	• One vendor explained the lack of standards on exchange mechanisms hinders the adoption and increases complexity for attachments/medical record exchange.

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		• One health plans stated electronic data exchange is more seamless and reduces burden. • One provider organization commented they would like to see standardization. They don't think they should have to send some attachments as a 275/CDA, others as web upload, and still others as fax. • One vendor stated "Implementation experience. In working with payer and provider stakeholders there is a significant learning curve in understanding the 275/5010/ 6020 applications with the HL7 component, Base 64 and MIME requirements. While the standard organizations have been working on implementation instructions and tools to help stakeholders, there is a need to streamline the communication process. There are other business requirement considerations for these transactions that are outside of the HL7 and X12 transaction guides. Example is that 277RFAI where the X12 TR3 does not define the ""provider type"" (rendering/billing) in the GSO3 segment. One payer implementation was set up to send the rendering provider NPI and another payer implementation was set up to send the Billing Provider NPI. As a clearinghouse, we need to have the Billing Provider NPI returned to be able to identify where to send the transaction. We have an opportunity for clarification in the upcoming X12 7030 Attachment Transaction Comment Period. There is a definite need to bring uniformity to web portal transactions. Number one stakeholder complaint when discussing web portals is the lack of uniformity between payers. This impedes workflow automation for the smaller providers that do use portal exchanges." • One health plan simply stated, "Yes we support." • One vendor explained while Web Portals help to reduce the manual fulfillment requirements of printing and mailing attachments and also aide the connection of attachments to the original claim, they still represent a manual process requiring additional labor for logging into portals, electronic packaging and file upload. This solution does not scale well. • One health plan stated "Regarding the use of standards tied to this opportunity, Aetna would prefer if standards are always used, and not proprietary formats, for transporting clinical data. Note that if dental claims are included in the rules that are created then we would like this opportunity to mention vendors who act as a clinical data repository where providers send their clinical data to the vendor and payers have access to the vendor's repository to complete benefit determination." • One provider stated "Our organization did an attachment pilot with a few payers that was not successful. Each payer had their own workflow. Please consider defining workflow. When should the 277 RFAI, 275 + CDA be used and if the 278 plays a role in the workflow." • One provider explained standardizing the exchange mechanism will be critical if we are to drive automation in this area. • One health plan said they would like to see what the operating rules offer Davinci FHIR, in addition to the X12 transactions. One vendor commented they highly recommend inclusion of preference to electronic attachments and electronic exchange mechanisms including necessary handshaking and acknowledgements of send/received.
4	Infrastructure	• One vendor stated, "We support this area, especially if it considers adopting existing industry standard protocols (OAuth, etc,)." • One provider organization commented their organization advocates that existing connectivity/security protocols be used as much as possible. Secure transmission capability is already used for other transactions such as claims, remits, and eligibility. • One vendor stated "There is definite need to facilitate mapping of administrative and clinical systems. The acknowledgements at each touch point of the transaction with defined timelines is a component the business requirement documentation. Our provider stakeholders have

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		report from the CMS NGS Medicare Part A and B Attachment Program an average of 95% reduction in payer status calls due to the use of acknowledgment transactions. The electronic acknowledgement with defined timelines provides confirmation the payer received the transaction vs lost in the mail and or an 835 reject asking for missing documentation. • One health plan stated, "We do not have enough information about the rules that are yet to be developed to provide further input on the opportunity." • One vendor stated "There might need to be slight variability on WHERE in workflow exchanges happen. But we support use of standard security protocols, etc." • One provider stated "Acknowledgements help to automate the trading of information electronically and prevents the need for phone calls. Response times are a vital piece of information to help guide patient care." • One provider stated, "Less important from a provider perspective." • One health plan stated, "We need more uniformity in transactions." One vendor stated "The infrastructure operating rules should incorporate tighter requirements for acknowledging receipt of attachments. In reference to the item on workflow, it should define points where Acknowledgements are to be triggered."
5	Resources	• One provider stated "Having defined sets of procedure and diagnosis codes or categories of service would definitely help up in providing the information the payer needs to adjudicate our claims. Our organization is wondering if existing codes, such as LOINC, can be used to help categorize service documentation needs." • One vendor stated "12 years of Attachment Implementation Experience: The benefit of creating a uniform companion guide with flow and format sections to assist the vendor community in building systems and applications that can inter operate more easily with plans and other intermediaries and clearinghouses will help to yield cost effective implementation and facilitate stakeholder attachment adoption. The lack of standardization impedes adoption, especially in building and maintaining payer specific attachment rule edit requirements across multiple organizations." • One health plan stated, "We do not have enough information about the rules that are yet to be developed to provide further input on the opportunity." • One provider stated "There is very little consistency among payers' requests for medical documentation. The only consistent information requested by payers is patient demographic information. The data that we are asked to supply beyond patient demographic information may include: Diagnosis code, CPT code(s), Clinical questionnaire, Medical records, Payer proprietary form for the test." • One provider stated "We support educational efforts to ensure that vendors are able to properly implement any flow and format recommendations. Additionally, the creation of common set of procedure or diagnosis codes that most often trigger requests for additional documentation seems would be a beneficial step, assuming that they are properly tailored to the appropriate use case (because frequent documentation requests for claims will inevitably vary substantially from prior authorization documentation requests)." • One provider stated, "Currently there are too many choices in the marketplace."

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		• One vendor stated, "Detailed and unambiguous companion guide is needed. The existing standard documentation is left vague for interpretation and flexibility. Recommending for clarity by providing necessary details."