CAQH CORE

CAQH CORE Health Care Claims Subgroup

Meeting #1

April 13, 2023

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Agenda

	Agenda Item
1.	**Welcome and Antitrust Guidelines**
2.	**Subgroup Level Set** ➢ CAQH CORE overview ➢ Subgroup scope, goals, and timeline ➢ Participation expectations
3.	**Research Overview** ➢ Research summary ➢ Rule development opportunities
4.	**Initial Areas of Opportunity**
5.	**Rule Development Discussion** ➢ Telehealth Place of Service (POS)
6.	**Next Steps**

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Subgroup Level Set

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CAQH CORE Mission/Vision & Industry Role

Industry-led, CAQH CORE Participants include healthcare providers, health plans, vendors, government entities, associations and standard-setting organizations. Health plans participating in CAQH CORE represent **75 percent of the insured US population.**

MISSION

Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability and align administrative and clinical activities** among providers, payers and consumers.

VISION

An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

DESIGNATION

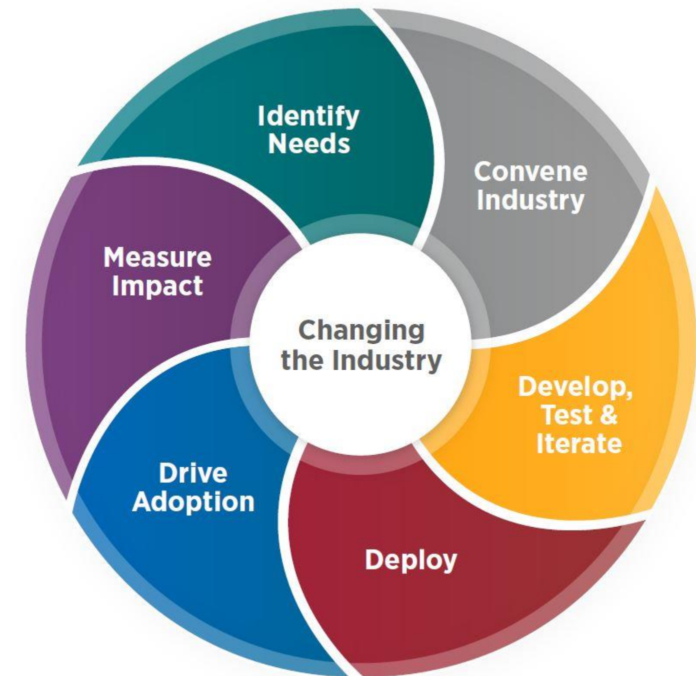
CAQH CORE is the **national operating rule author to improve the efficiency, accuracy and effectiveness of industry-driven business transactions.** The Department of Health and Human Services (HHS) designated CAQH CORE as the author of national operating rules for the HIPAA-covered administrative transactions.

INDUSTRY ROLE

Develop business rules to help industry effectively and efficiently use electronic standards while remaining technology- and standard-agnostic.

CAQH CORE BOARD

Multi-stakeholder. Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs (X12, HL7, NACHA, NCPDP) and WEDI.



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Health Care Claims Subgroup Co-Chairs

Representation across health plan, provider, vendor, and associations.

Randy Gabel

OhioHealth

Senior Director, Revenue Cycle

Olga Khabinskay

Healthcare Business Management Association and WCH

Director of Operations

Mahesh Siddanati

Centene

Staff Vice President
of Digital Initiatives

Megan Soccorso

Gainwell Technologies

Solutions Supervisor
HC EDI/Oxi Services

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Diverse Representation Among Participants

Health plans, vendors, and providers alike are eager to streamline claims submission.

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Scope, Goals, and Timeline

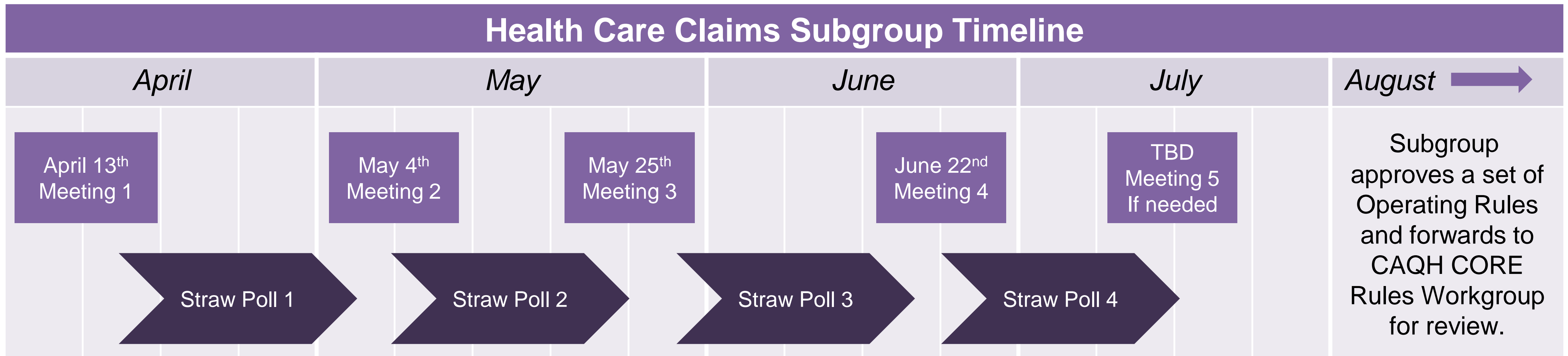
Directly contribute to developing operating rules and industry guidance that improves claims submission, adjudication and payment.

Subgroup Scope

Identify how potential CAQH CORE Data Content Operating Rules can enhance health care claims workflows with a focus on preliminary opportunity areas.

Subgroup Goals

Inform and prioritize CAQH CORE Operating Rule content and development.



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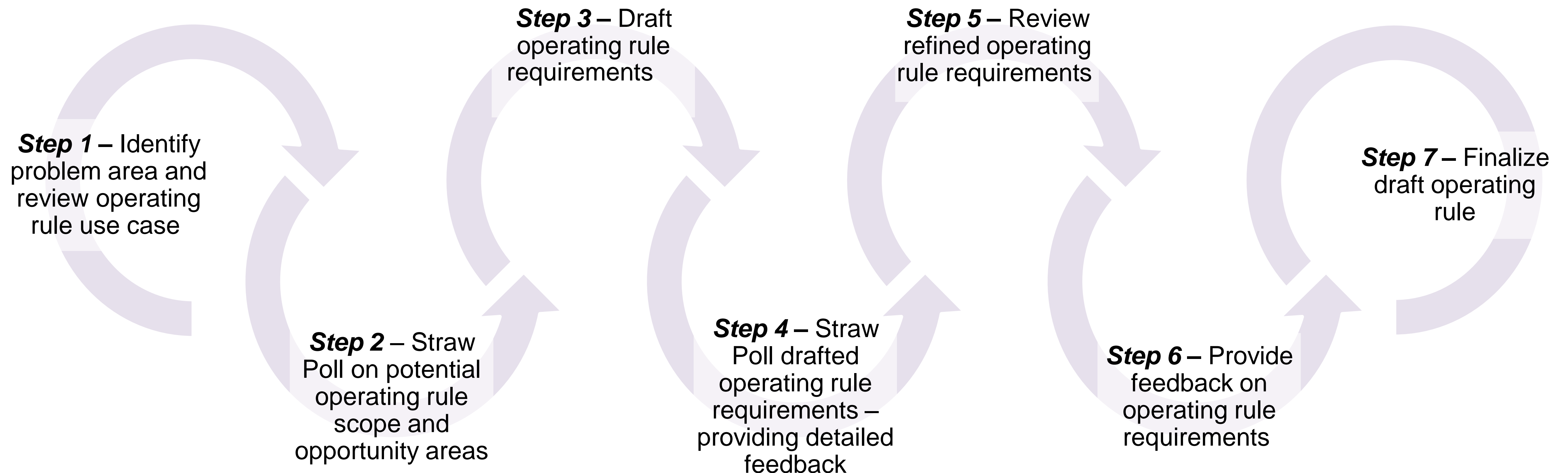
Drafting an Operating Rule

Rule development is an iterative, consensus-based process.

Sample Progression for Operating Rule Development



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Participant Expectations & Responsibilities

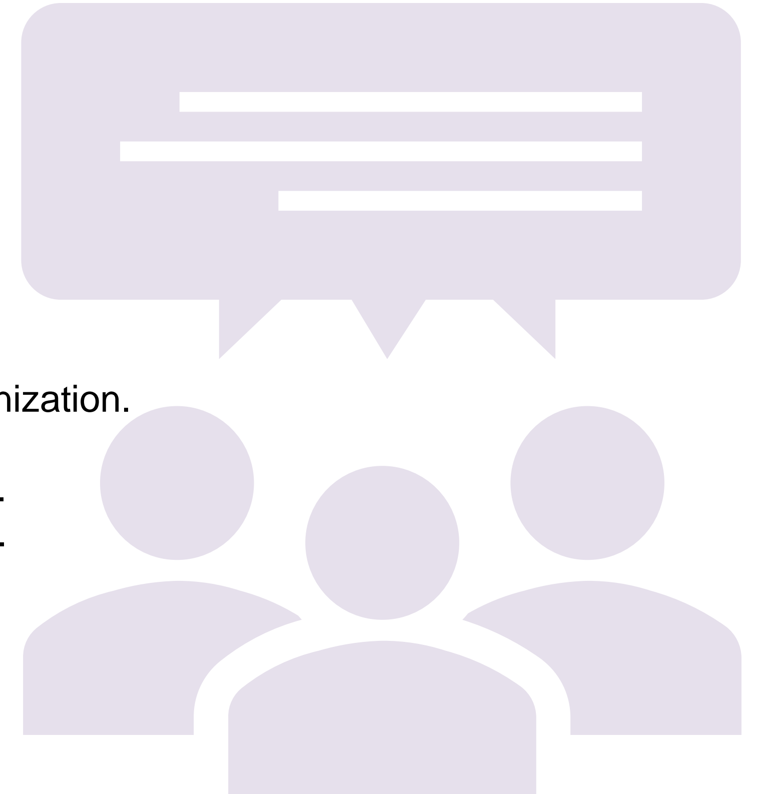
Rules are developed at the direction of participants, who are expected to prepare and share opinions in both Subgroup meetings and follow-up correspondences.

1. Review CAQH CORE background documents detailing use cases and considerations to support uniform operating rules.

2. Attend, prepare for, and actively participate in Subgroup calls.
- ✓ Read materials provided by CAQH CORE and share questions ahead of time.
  - ➢ Prior to calls, CAQH CORE provides participants with documents for review.

3. Share knowledge and insights from the Subgroup with other stakeholders at your organization.
- ✓ Disseminate key takeaways to subject matter experts within your organization.
  - ➢ Call summaries with key takeaways are distributed following each discussion.
- ✓ Provide regular updates on Subgroup progress to executive sponsors, if applicable.

4. Provide feedback to CORE team and co-chairs via:
- ✓ Straw polls
- ✓ Subgroup discussions
- ✓ Email – reach out to CORE@caqh.org



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Research Overview

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Summary of Findings from CY 2022 Focus Groups, Interviews, and Polling

Research identified shared sentiments for standardization opportunities across the industry.

Research Conducted

Focus Groups with ***36 unique participants***

10+ interviews across vendors, health plans, and providers

Surveying of 12+ organizations, including live polling in group discussions and detailed surveying

Follow up discussion and analysis to inform initial areas of opportunity for a health care claims data content rule

Findings

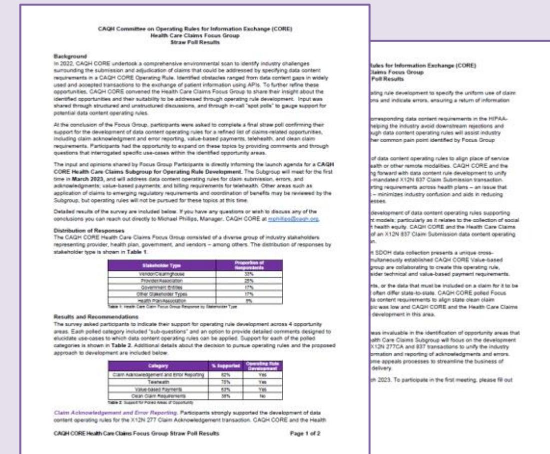
82% of those surveyed support ***a focus on the 277CA***

For crossover claims, "we had to build something where ***the customer would have to identify the secondary payer"***

75% of those surveyed support ***alignment of Telehealth POS standards***

Publications

CAQH CORE Health Care Claims Focus Group Straw Poll Results



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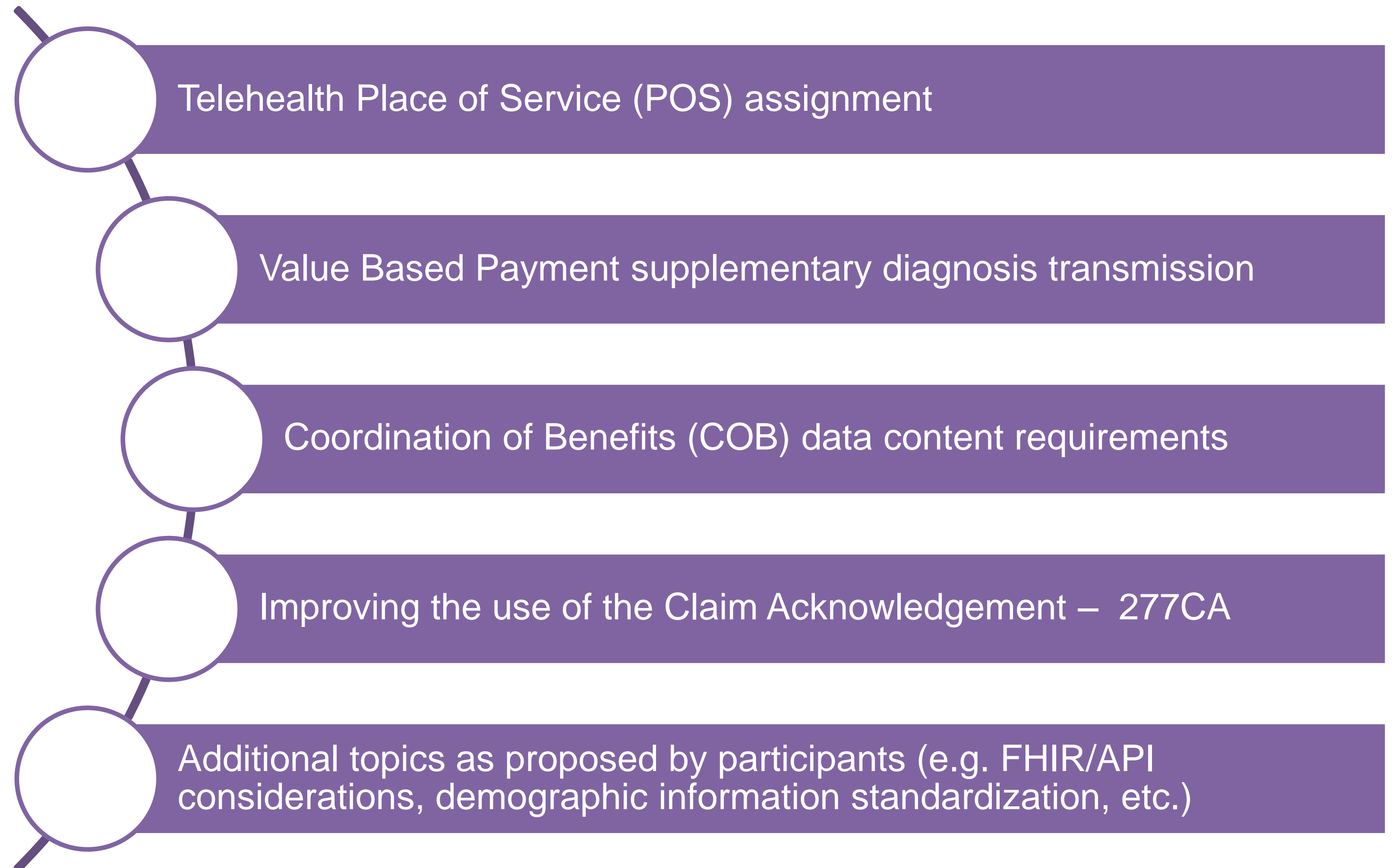
Rule Development Opportunities

Subgroup participants are expected to share additional topics that require operating rule guidance.

Preliminary opportunities result from environmental scanning and targeted additional research conducted through 2022 and Q1 2023



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Initial Areas of Opportunity

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Aligning Approach to Telehealth Claim Submission

Commonly defining required data components for telehealth claims submissions may minimize confusion upon expiration of the public health emergency (PHE).

Different POS Indicators Required for Telehealth Visits

Health Plan	Telehealth Billing Indicators Required by Plan	
	POS Code	***Modifier***
Plan A	02	N/A
Plan B	Code used when services are furnished in person	95 or FQ
Plan C	02 or 10	95 or GT
Plan D	02 or 10	93, 95, or GT
Plan E	02	95, 96, GT, 96 and G0; or GT and G0

Key:
- **POS Code 02**: Telehealth provided Other than in Patient's Home
- **POS Code 10**: Telehealth provided in Patient's Home
- **Modifier 93:** Synchronous telemedicine service via telephone or other audio-only telecommunications system
- **Modifier 95:** Synchronous telemedicine service via audio *and* video telecommunications system
- **Additional modifiers are defined on Slide 21**

Health plans have different POS and Modifier requirements for billing telehealth visits.

Can uniform data components ensure a standardized approach to telehealth billing as policies continue to change?

What other factors impede clean claim submission for telehealth?

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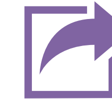
Supporting Value-Based Payment with the 837 Transaction

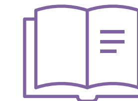
Aligning industry to a best practice pathway for supplementary diagnosis submission.

Sample X12N 837-P Data to Support VBP		
	Data Point	*VBP Standardization Consideration*
1.	*Scope of initial claim*	All claims or only those with an evaluation and management (E/M) CPT *E.g.,* 99202 – 99499
2.	*Matching information*	Matching information must avoid duplicates *E.g.,* Member ID, dates of service, total charge amount, etc.
3.	*Procedure Code*	HCPCS to use on a claim *E.g.,* 99499 or 99080
4.	*Amount*	Nominal amount necessary to avoid rejections *E.g.,* $0.00 or $0.01
5.	*Claim Frequency*	Coded as initial or zero-amount claim *E.g.,* Claim frequency code '1' or '0'
6.	*Primary Diagnosis*	ICD-10 must qualify as principal diagnosis *E.g.,* Proprietary lists; avoid duplication
7.	*Supplemental Diagnosis*	Define use-cases within and outside of VBP *E.g.,* Risk adjustment, quality measurements, attribution

Best practice EDI submission pathways are in use by health plans to support the documentation of supplemental diagnoses and Medicare risk adjustment.



Some implementation variation exists, and operating rules can unify methodologies and avoid unnecessary rejections caused by duplication.



Operating rules streamline workflows and support care innovation by empowering value-based payment methodologies.

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Standardizing Coordination of Benefits in the 837

Uniform data content requirements can remediate questions on payment and care attribution.

Snapshot of COB Claim Data Requirements by Health Plan				
Sample Data Elements	**Plan A**	**Plan B**	**Plan C**	**Plan D**
COB Payer Amount Paid	✓	✓	✓	✓
Monetary Amount	✓	✓	Not required	Not required
Other Payer Name	✓	✓	✓	Not required
Claim Adjustment Group Code	✓	✓	Not required	Not required
Claim Level Adjustment(s)	✓	✓	✓	Not required
Claim Check or Remittance Date	✓	Not required	Not required	✓
Patient Responsibility Amount	✓	Not required	✓	✓

- **Impact:** Lack of uniform 837 COB requirements creates additional administrative burden and delays payment.
- **Goal:** Standardizing the minimum required data elements for successful processing of COB can make claim submission more predictable and reduce COB denials.

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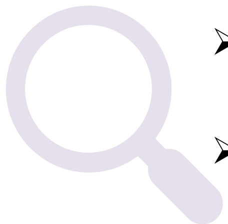
Improving the Use of the 277CA

Varied code usage causes confusion, extends time to claim re-submission, and increases cost per claim.

277CA Companion Guide Analysis Examples						
		Plan A 277CA Reporting		Plan B 277CA Reporting		
	Error	*CSCC/CSC*	*Description*	*CSCC/CSC*	*Description*	
1.	*Date of Birth*	A8, 158	Entities Date of Birth	A8, 158	Invalid Pat. DOB, DOB Exceeds DOS for Mem-ID, Wrong DOB for Mem, DOB > Begin DOS, DOB > Today, Dob > End Date, DOB > Adm Date, or Invalid DOB for Member	*Matching code combinations with different descriptions*
2.	*Provider NPI*	A3, 562	Unable to find Billing Provider NPI	A7, 562	Invalid Provider NPI	*Matching/similar descriptions with different code combinations*
3.	*Subscriber ID*	A7, 33	Subscriber and Subscriber ID not found	A3, 33	Subscriber/Patient ID not found	



- Claim Status Category Codes (CSCC) and Claim Status Codes (CSC) are **paired inconsistently to communicate similar errors** across health plans.
- At the same time, some plans are communicating **different or multiple error reasons** through a single code pairing.

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Rule Development Discussion – Telehealth Place of Service (POS)

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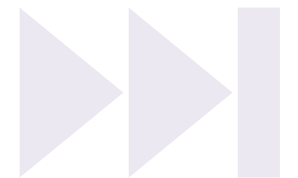
The Utility of Place of Service (POS) Codes

POS codes help to communicate where services are rendered.

- POS codes are two-digit codes placed on professional claims to indicate where service(s) are provided to a patient. Their definitions are maintained by the Centers for Medicaid and Medicare (CMS).

- Accurate use of POS codes helps inform health plans how a service should be reimbursed, particularly in the case of telehealth vs. in-person services.

- The Public Health Emergency (PHE) brought on by the COVID-19 pandemic increased the use of telehealth services and provided industry guidance on telehealth billing practices that included POS and modifier guidelines. Telehealth has since become an integral part of patient care and will continue to be after the end of the PHE. A report by the AMA revealed that ***the percentage of physicians utilizing telehealth grew from 14% in 2016 to 80% in 2022.***[1]



- Moving forward, it is important for the healthcare industry to identify uniform telehealth billing guidelines to avoid confusion that increases administrative burden on stakeholders, ***especially as we transition out of the PHE***.

1) AMA. (2022, September 28). AMA digital health care 2022 study findings. American Medical Association. https://www.ama-assn.org/about/research/ama-digital-health-care-2022-study-findings

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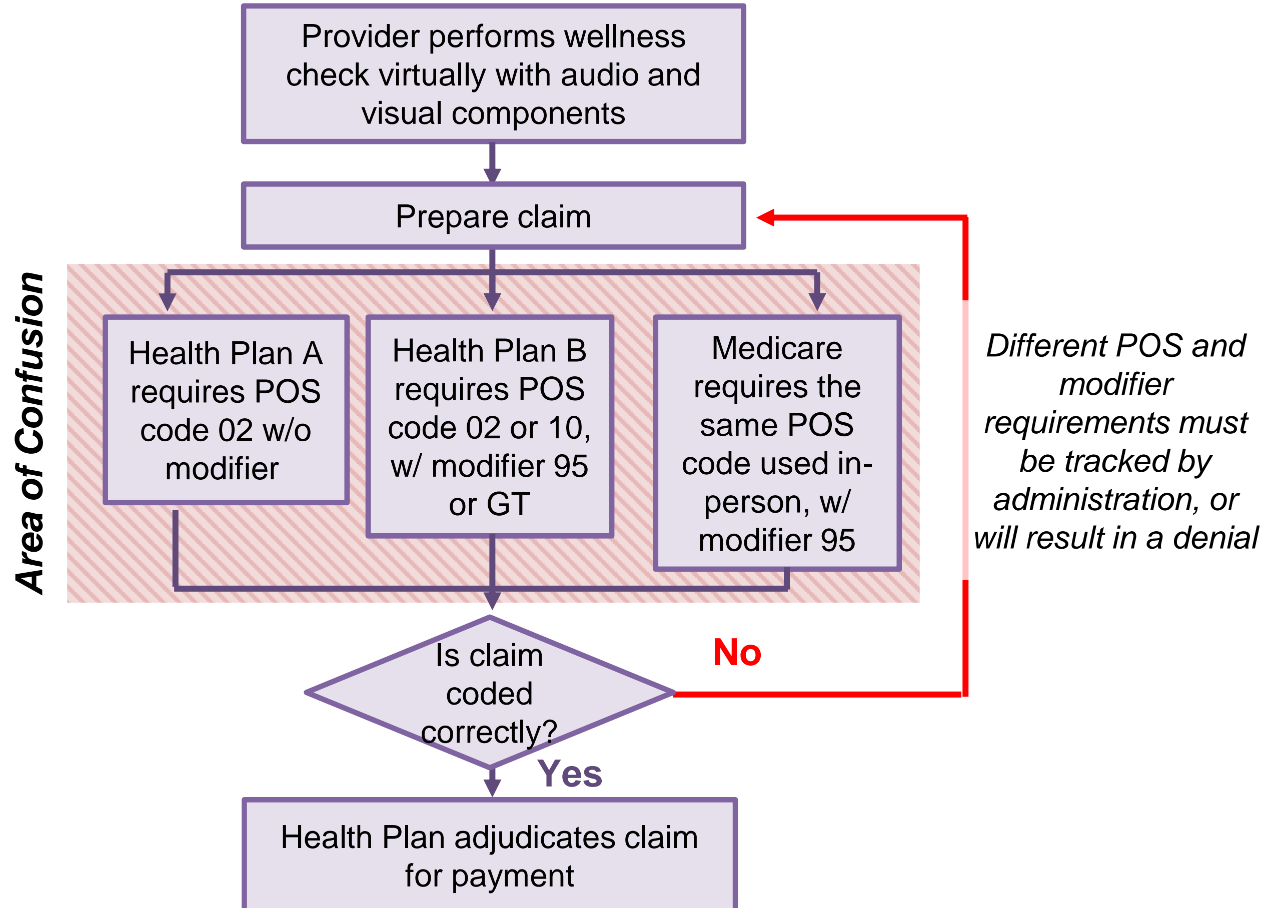
Impacts of POS Code Variability on Telehealth Billing

Non-uniform billing guidelines for common use cases creates administrative burden.



- Providers must be aware of federal and state regulations, and each health plan's policies when determining accurate telehealth billing. PHE guidelines have set the "floor" for standardized telehealth billing practices; however, billing requirements within individual health plans can create confusion as to what is necessary for billing telehealth visits for each health plan.

- A potential health care claims operating rule could reduce administrative burden and claim denials by outlining standard data elements to include on telehealth claims, eliminating variation when coding for specific modalities and locations of care delivery, bringing consistency and uniformity to billing.

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Codes and Corresponding Definitions

Plans use a variety of POS and modifier combinations to describe the same encounters.

POS Codes	Place of Service Name
02	Telehealth provided Other than in Patient's Home
10	Telehealth Provided in Patient's Home
11	Office

What is the balance between simplifying telehealth billing and maintaining codes to accurately describe care delivery?

What POS codes and modifiers are not generally associated with each other?

Modifier Codes	Definition
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system for specific service types
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
GT	Provided via interactive audio and video telecommunications systems
GQ	Provided via an asynchronous telecommunications system
G0	Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke
FQ	The service was furnished using audio-only communication technology

Telemedicine Encounter Descriptions				
Telehealth Visits	Virtual Check-Ins	E-Visits	Physician Telephone Services	Non-Physician Telephone Services

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Next Steps

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Next Steps from Subgroup #1

	Action Item	*Timeline*
1.	**Complete Straw Poll #1** ➢ *Telehealth-focused* - Participants to complete straw poll on potential telehealth operating rule requirements. Please connect with colleagues at your organizations to align on feedback.	**April 17 – April 28, 2023**
2.	**CORE Staff** to analyze and evaluate Straw Poll results and draft call documents.	**April 28 – May 3, 2023**
3.	**Participants** to attend next Subgroup meeting. Agenda items will include: ➢ Review Straw Poll results and feedback ➢ Discuss potential Value-based payment operating rule requirements	**May 4, 2023**

Have any questions? Please reach out to the CORE team
CORE@CAQH.ORG

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