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AUC Update

April 23, 2014

The AUC Update is published monthly and provides news and updates regarding the Minnesota Administrative Uniformity Committee (AUC) and Minnesota's health care administrative simplification initiative pursuant to Minnesota Statutes, section 62J.536 and related federal and state regulations. The Minnesota Department of Health (MDH) administers MS §62J.536 and publishes this newsletter in association with the AUC.

More information about the AUC is available at: AUC home page.

Inside this issue:

ICD-10 Implementation Delayed Until at Least October 1, 2015

On April 1, 2014, President Obama signed the Protecting Access to Medicare Act of 2014 (HR 4302), with a provision that delays the implementation of ICD-10 coding from October 1, 2014 to no sooner than October 1, 2015.

The federal Centers for Medicare & Medicaid Services (CMS) recently posted a statement on its ICD-10 website regarding the delay, noting: "…CMS is examining the implications of the ICD-10 provision and will provide guidance to providers and stakeholders soon."

The Minnesota Department of Health (MDH) posted a similar notice on April 2, 2014 regarding the delayed ICD-10 compliance date, and will post additional follow-ups as further information from CMS becomes available.

WEDI to Convene "ICD-10 Summit" April 30, 2014 in Response to ICD-10 Delay

The Workgroup for Electronic Data Interchange (WEDI) has announced an emergency industry "*ICD-10 Summit: Developing an Industry Action Plan for ICD-10 Implementation*" April 30, 2014 in Reston, Virginia. The purpose of the summit is to prepare an "action plan in response to the ICD-10 implementation delay."

Topics to be discussed at the summit include:

- Background information on what has transpired;

- What are the real underlying issues, obstacles and fears?;
- Impact and unintended consequences of the delay to all industry stakeholders;
- Building the industry roadmap forward; and
- Next steps for WEDI and the industry.

Participants may attend in-person or via teleconference but must register in advance as a fee is being charged for the summit. Those attending via teleconference will not be able to participate in the live discussion but will have the opportunity to submit feedback that will be taken into consideration following the summit. Additional information and registration instructions are available at: WEDI ICD-10 summit (http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=4A1E30000005C).

CMS Announces e-Health Summit May 19, 2014

CMS recently announced an e-Health Summit on Monday, May 19, 2014 from 9:00 a.m. to 3:30 p.m. ET. The Summit will provide opportunities to:

- Get the latest on Administrative Simplification initiatives;
- Learn more about Information Governance for Healthcare through a panel led by the American Health Information Management Association (AHIMA);
- Hear from the Center for Medicare & Medicaid Innovation (CMMI) about Stage 3 meaningful use and how it will affect care delivery and payment reform; and,
- Join in on a Healthcare Information and Management Systems Society (HIMSS) panel discussion on quality initiatives and the impact they have on primary care.

All summit sessions will be webcast live. You must be registered to view the live webcast sessions.

For the summit agenda, please go to May 14 CMS Summit (http://www.cmsehealthsummit.org/index.php/agenda/).

To register please go to CMS Summit Registration (http://www.cmsehealthsummit.org/register/webcast.php).

AUC Technical Advisory Group (TAG) Updates

Information about AUC committees and TAGs and their activities can be accessed from the AUC TAG page and by clicking on the TAG or committee name in the following article.

With the exception of the Medical Code TAG, all TAG meetings are generally conducted via teleconference rather than in-person. All AUC meetings are open, public meetings. Meeting agendas and other materials are posted on the AUC website in advance of meetings. TAG meeting schedules and information are also available on the AUC calendar page. (http://www.health.state.mn.us/auc/calendar.htm).

Executive Committee

The Executive Committee April 7 meeting included updates, discussions, and planning regarding:

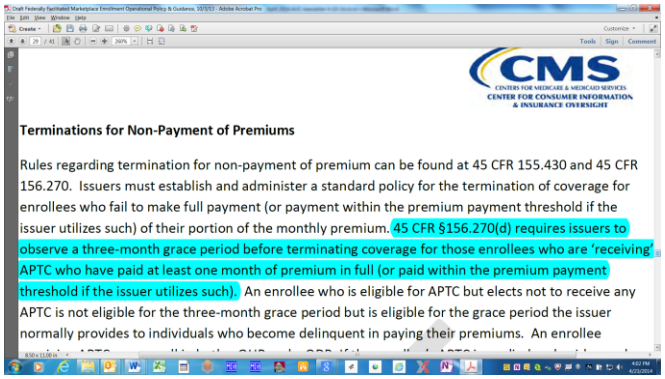
- AUC TAG activities;
- ICD-10 delay;
- Pending legislative proposals for technical updates to Minnesota's health care "Administrative Simplification Act (ASA)" and other pending proposals to delay the implementation of state requirements for prescription drug electronic prior authorization;
- Proposed revisions to the AUC mission statement to reflect changes in meeting schedules and structure;
- A forthcoming "customer satisfaction survey" to help MDH obtain feedback regarding our work with the AUC and for internal quality improvement efforts;

- MDH-Department of Labor and Industry joint communications and efforts to assure compliance with e-billing requirements for workers' compensation;
- AUC interests in and next steps for addressing administrative aspects of new forms of health care delivery and financing (e.g., bundled payments, ACOs, others)

Operations Committee

The next Operations Committee meeting is June 11, 2014. Meeting details will be posted at: AUC Operations meeting information.

Eligibility & EOB/Remit TAGs



As announced in the March issue of the AUC Update the Eligibility and EOB/Remit held a joint meeting on March 26, followed by separate meetings on April 21 and April 23. The purpose of the joint meeting was to coordinate on best practices to notify health care providers when Health Insurance Exchange ("HIX") enrollees have entered a "grace period" for nonpayment of premiums, as required by federal rule. Because of the importance of the notification to providers, they were particularly encouraged to attend the meetings.

Both the Eligibility and EOB/Remit TAGs had met and developed draft best practice notifications in advance of the March 26 meeting, based on the eligibility inquiry and response and the remittance advice transactions. Pete Anderson, EOB/Remit co-chair, presented the best practice developed by the EOB/Remit TAG at the March 26 meeting, followed Tim Lopez, who presented the Eligibility TAG's notification best practice. At the conclusion of the meeting, questions were raised regarding the start of the 90-day grace period and recoupment of claims paid by insurers during the grace period. The TAGs agreed that the questions needed to be addressed before they could complete the best practices and approve them.

The questions were researched and resolved with the finding that health plans must pay applicable claims during the first 30 days of the grace period, regardless of whether the enrollee subsequently paid premiums for the first 30 days or not. With these issues addressed, the EOB/Remit TAG met on April 21 and voted to approve its best practice for the grace period notification. The Eligibility TAG met on April 23 and similarly voted to approve its notification best practice. The best practices next must be reviewed and voted on by the AUC Operations Committee. If approved they will be published on the AUC web pages for best practices (http://www.health.state.mn.us/auc/bp.htm).

Medical Code TAG

The Medical Code TAG met April 7, 2014 at HealthPartners with a full meeting agenda, which included the review and discussion of nine SBARs regarding request for new codes, clarification of coding issues regarding modifiers, recommendations to determine appropriate place of service codes, etc. Discussion of remaining agenda items included: draft Medical Coding Issues Tracking Grid/Index and Membership Review were postponed until the MCT's May meeting.

Upcoming TAG meetings

- **April 23**, 2:00 p.m. – 4:00 p.m. – **Eligibility TAG** (Teleconference & WebEx only)
- **May 5,** 8:30 a.m. – 10:30 a.m. – **Executive Committee** (In-person only [Fairview Health System])
- **May 8,** 9:00 a.m. – 12 noon – **Medical Code TAG** (In-person and Teleconference/WebEx)
- **May 19,** 1:00 p.m. – 2:30 p.m. – **EOB/Remit TAG** (Teleconference & WebEx only)

- **May 28** 2:00 p.m. – 4:00 p.m. – **Eligibility TAG** (Teleconference & WebEx only)

National Industry News

WEDI Survey to Explore Progress and Impact of CORE Phase III rules

Two WEDI workgroups have announced a new survey to explore the implementation progress and overall impact that the CAQH CORE Phase III operating rules have had on the industry.

WEDI has requested that only one response per organization be completed. If interested, please go the WEDI survey site for the survey.

CORE Town Hall Held April 9, 2014 – Selected Highlights

The national Committee on Operating Rules for Information Exchange (CORE) is the federally designated author of operating rules mandated under the administrative simplification provisions of the Accountable Care Act (ACA). CORE holds regular monthly "town hall" meetings to provide updates and opportunities for discussion. Below is a brief summary of select highlights from the April 9 town hall meeting, which included updates and discussion of: health plan certification; health plan identifier (HPID) discussion with CMS; EFT and ERA operating rules; and a "third set" of operating rules. The slide deck used for the call is available at April 9 CORE Town Hall (http://www.caqh.org/Audiocast/04-09-14/CORETownHallCall4-9-14.pdf).

Selected highlights of April 9, 2014 CORE Town Hall meeting include:

- **CORE seeks feedback on "HIPAA Credential" forms**

The US Department of Health and Human Services (HHS) published a notice of proposed rulemaking (NPRM) on December 31 regarding requirements for health plans to certify that they are compliant with applicable transactions standards and operating rules. The NPRM proposes that health plans may obtain the necessary certification by obtaining a CORE Certification Seal, or a proposed "HIPAA Credential." CORE recently announced that it has developed sample HIPAA Credential application forms, for illustrative purposes only, based on the proposed requirements in the NPRM. The sample links can be viewed at the links below.

- *Draft CAQH CORE® HIPAA Credential Application Form*
- *Draft CAQH CORE® HIPAA Credential – Attestation of HIPAA Compliance Form*
- *Draft CAQH CORE® HIPAA Credential – Attestation of Trading Partner Testing*

Note: On April 16 CORE emailed its members to announce that the CORE Certification and Testing Subgroup is convening for a two-month period, to review industry input on the draft HIPAA Credential Forms and a Tip Sheet for Self-Insured Plans. The Subgroup is open to CORE members and plans a series of four phone meetings, May 1 – June 27. Any CORE members interested in participating in these calls, please send your name, title, organization name, email address, and phone number to core@caqh.org.

- **Maintenance of Uniform CARC/RARC**

The CORE Code Combinations Task Group (CCTG) conducts three compliance-based reviews (CBRs) and one market-based review (MBR) of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) each year. The CBRs consider only those additions, deactivations, or modifications to the current published CARC and

RARC lists by the code committees since the last update to the CORE Code Combinations. The MBRs consider industry submissions addressing:

- Adjustments to the existing CORE Code Combinations for existing CORE-defined Business Scenarios (additions, removals, etc.) based on real-world usage data and/or a strong business case; and,
- Addition of new CORE-defined Business Scenarios and associated CORE-required Code Combinations based on real-world usage data and a strong business case.

The CCTG is currently conducting a CBR for code adjustments published by Washington Publishing Company (WPC) on March 1, 2014; updates from the CBR are planned to be published June 1, 2014.

The CCTG is also in the process of reviewing MBR submissions and plan to have an updated CORE code combination list also available June 1, 2014. The CCTG has reviewed 437 unique requests representing 80 unique CARCs that were submitted for adjustments (additions/removals). Any CORE participating organization can participate in the CCTG, which meets bi-weekly on Tuesdays, from 3-4:30 pm ET.

- **Operating Rules Effective January 1, 2016**

CORE is currently conducting research and planning to develop operating rules for a "third set" of five ACA-specified transactions, to be effective January 1, 2016. The goal of CORE's effort is to complete draft operating rules by the end of this year, 2014. (See related article in new feature later in this newsletter on "Operating Rules – What's Next.")

ASC X12 Examples Available – General submissions accepted this summer

ASC X12 has posted a number of examples on its website to clarify the use of ASC X12 transaction sets. The examples library will expand as ASC X12 and other entities contribute additional examples. Beginning in the summer of 2014, external organizations will be able to upload examples directly to the web site. For more information and links to the examples, please go to the X12 examples page.

NEW New Feature: Operating Rules – What's Next?

Note: With this month's newsletter we are starting a new feature to provide regular information and updates regarding a group of federal operating rules that are to be developed and required for use beginning January 1, 2016. The coming rules include:

- *Health claims or equivalent encounter information;*
- *Enrollment and disenrollment in a health plan;*
- *Health plan premium payments;*
- *Referral certification and authorization; and*
- *Health care claim attachments.*

The designated operating rules author is CORE, which is already planning and undertaking work on the rules. Our goal with this series of articles is to help keep the AUC informed of operating rule-related developments so that it can be aware of and participate in the operating rule process as effectively as possible.

We kick off the series with a focus below on health care claims attachments, which have been defined generally as "any supplemental health documentation needed to support a specific event." We chose this topic for a variety of reasons, including prior AUC exploration of attachments, their importance with other transactions such as claims and remittance advices, and their integral role as part of workers' compensation billing.

Operating Rules for Health Care Claim Attachments

ACA Compliance Date for Attachments Operating Rule:	January 1, 2016

Adoption of Operating Rule:	Pending development of rule and adoption of standards
Please note: Specific information regarding claims attachments can be found by accessing any of the links in the following article.	

Why is This Important?

1. Opportunity to impact standards and operating rules
2. Convergence of clinical and administrative data exchanges -- Discussions of standards and operating rules for claims attachments have linked standards associated with clinical data exchange (e.g., HL7) with administrative standards (e.g., X12)
3. Likely broad impact and applicability
4. Unusual – Operating rules have been developed previously in reference to an underlying national standard; no standard has yet been adopted for claims attachments

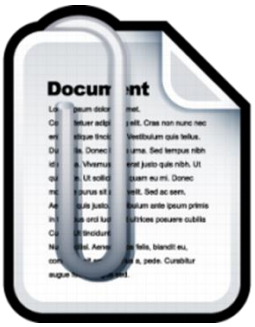
Background

Efforts to standardize and automate claims attachments via electronic data interchange are not new. As noted in a recent National Committee on Vital and Health Statistics (NCVHS) letter to CMS, the original HIPAA law enacted in 1996 identified the claim attachment as one of the transactions for which standards were to be adopted. A standard was developed and published as a proposed federal rule in 2005, but it was not adopted due to questions about the proposed standard and the ability of users to implement it.

However, the lack of an adopted national standard for attachments has not prevented further research and discussions of ways to send attachments electronically most efficiently and effectively. For example, the AUC submitted comments to CMS in 2011 supporting the use of unsolicited claims attachments and noting at the time that additional work was needed before adopting a national attachments standard. The AUC Claims DD TAG also discussed claims attachment at its December 2012 meeting and identified the following types of attachments that TAG members would like to see included in the Operating Rules for Attachments:

- Medical records (includes operative notes, lab test results, clinical notes, etc.);
- Invoices for drug purchase price;
- Itemized statements; and
- Medical authorization/certification forms.

In addition, NCVHS held hearings and collected testimony regarding claims attachments in late 2011, and forwarded a letter to CMS in early 2012 summarizing the testimony. It held another hearing on claims attachments on February 27, 2013, and received testimony from the industry, SDOs, and industry advocates, including a summary of attachments-related research findings from CAQH CORE. In June 2013, NCVHS sent a letter recommending a range of attachments standards to the HHS Secretary for developing a final rule to adopt standards for electronic attachment (*see* 2013 letter).



Recent attachment updates

On April 17, 2014 CORE conducted a members-only "Initial Dialogue on Administratively-Related Attachments Operating Rules" to receive information and feedback regarding attachments as part of its planning and preparations for developing the attachments rules. The meeting included a number of polling questions to learn more about CORE members' use of attachments and their views about a variety of operating rule development choices and pathways.

A key consideration in planning for the operating rules is the pace and scope of the effort at this time. Previous research by CORE, as well as polling at the meeting, indicated that the majority of members were exchanging most attachments by paper, either via mail or fax. A key decision then will be whether the industry transitions from the current largely paper-based exchange of attachments directly to structured, electronic data interchange (EDI, computer-computer data interchange) in a single step, or whether a more gradual transition is needed, with interim steps of "electronic transmission of paper" (e.g., exchanges of pdf documents) and some initial limited use of structured data before becoming completely EDI-based.

In addition, it was noted on the call that over 85% of hospitals and 50% of physicians have received federal incentive funding for meaningful use of electronic health records (EHRs). As a result, the growing availability of clinical data from EHRs that could provide information sought in administrative attachments will be increasingly important, and needs to be considered in planning for attachments operating rules.

[*Watch for additional articles and updates in the AUC Update regarding claims attachment and other operating rules*.]

NEW New Feature: Test Your AdminSimp IQ

Note: ***Coding*** *is the "Test your AdminSimp IQ" topic for this issue.*

More than 200 inquiries are received in the AUC's inbox annually. When SBARs are submitted, they are primarily for coding issues which require either clarification or new codes. The inquiry below was sent to one of the AAPC's discussion Forum. We can't recall receiving one similar. In our efforts to encourage feedback and suggestions, we thought it would be fun to experiment in this issue of the AUC newsletter and solicit a response from the AUC Medical Code TAG or any AUC Updates reader.

Please send your response to the AUC inbox (health.auc@state.mn.us).

Medicare guidelines indicate the following supervision levels for:

EEG = 01 (general physician supervision)
BAER = 02 (direct physician supervision)
NCV – 7A (either certified PT or direct physician supervision)
VEP = 09 (concept does not apply)
SSEP = 09 (concept does not apply)

What does the 09 (concept does not apply) really mean? No supervision is required? Cannot be performed by anyone but the physician?