December 2, 2008

Gwen Lohse  
Managing Director  
CORE  
Council for Affordable Quality Healthcare  
601 Pennsylvania Avenue, NW  
South Building, Suite 500  
Washington, DC 20004

Dear Ms. Lohse:

The American Medical Association (AMA) and the undersigned organizations support the Council for Affordable Quality Healthcare’s (CAQH) Committee on Operating Rule Exchange (CORE) multi-stakeholder initiative to standardize and streamline patient administrative data exchange. CORE encourages adoption of standardized operating rules that build upon the Health Insurance Portability and Accountability Act (HIPAA) standard transactions and is an initiative that holds promise to successfully deliver consistent and robust information exchange functionality to the claims management process. CORE also complements the AMA’s “Heal the Claims Process”™ campaign and many state and county medical associations and national medical specialty societies’ (Federation) administrative simplification initiatives.

CORE Phases I and II have moved the health care industry toward adoption of standard operating rules for verifying patient eligibility and benefits, patient responsibility, and claims status, and toward making access and connectivity to disparate administrative systems possible. As increasing numbers of payers, vendors and other entities participate in CORE, it will become increasingly important to demonstrate the substantial value of this initiative to physicians. CORE needs to demonstrate to physicians that selecting a CORE certified vendor or contracting with a CORE-certified health insurer can: (1) reduce the staff time and resources they currently spend on manual administrative processes (i.e., eligibility verification), (2) streamline the revenue cycle, and (3) improve payer and patient collections. Helping physicians see the value of these benefits will increase utilization of CORE-certified payers, vendors and other entities. Physicians may also influence their current business partners toward CORE-certification in order to incorporate the value of electronic transactions into their practices. Not all physician practices are required to obtain CORE certification to obtain the benefits of CORE; however, physicians in practices that directly submit HIPAA compliant standard transactions are asked to become CORE certified to ensure standardization of the operating rules by all parties.

As CORE moves into Phase III of its multi-phase approach and continues to expand and seek implementation of CORE standard operating rules, active engagement of physicians is critical. In order to fully realize the potential benefits of CORE to the physician practice, the AMA and the undersigned Federation members make the following recommendations and commitments to CAQH leadership:

CAQH CORE Phase III Recommendations
The AMA and the undersigned Federation members support inclusion of the following recommendations into Phase III:

1) Expand current eligibility standard transactions to require that all entities voluntarily report the following optional fields on the ASC X12 271 Health Care Eligibility Response:
Underlying contracted fee schedule (the entity that holds the underlying agreement with the physician or other health care provider (i.e., provider network) or the specific product fee schedule (i.e., Medicare Advantage PPO or commercial PPO product).

Claim status regarding in-network or out-of-network benefits for each specific procedure or service (i.e., CPT/HCPCS code).

Patient responsibility, remaining deductible and co-insurance for each specific procedure or service (i.e., CPT/HCPCS code).

The entity that is actually responsible for payment of the patient’s covered benefit.

2) Modify existing HIPAA standard transactions by requesting voluntary compliance with completion of the following fields in the ASC X12 835 Health Care Claim Payment/Remittance Advice:

- **Allowed amount**, which determines whether the payment was made at the correct contracted rate.
- **Class of contract**, which provides information to resolve ambiguity in product type when the mandatory “claim filing indicator code” is insufficient.
- **Date of claim receipt**, which allows verification necessary to confirm timely payment and reconcile payment.

3) Enhance current specifications to or expectations of the existing standards:

- **Recognize line item relationships**—The lack of line control between the electronic claim submission (ASC X12 837 Health Care Claim [professional]) and the electronic remittance advice (ASC X12 835 Health Care Claim Payment/Remittance Advice) is problematic. Currently, payers do not have to maintain line item relationships when they process claims with a CPT code appended with a modifier on one line and the related CPT code on the subsequent line. This causes inappropriate reductions, increased administrative costs to reconcile payments and inability to automatically post accurate payments.

- **Establish consistency between HIPAA standard transactions**—“Class of contract” and “claim filing indicator” codes are not applied in the payer’s eligibility verification response (ASC X12 271 Response) and the electronic remittance advice (ASC X12 835 Health Care Claim Payment/Remittance Advice) standard transactions. Fields with the same names need to be established in a way that allows them to be completed with the same codes and interpretations for all standard transactions.

- **Standardize and establish consistency among electronic remittance advice code sets**—The use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) applied on the payer’s electronic remittance advice (ASC X12 835 Health Care Claim Payment/Remittance Advice) varies across payers; standardization would eliminate the variation among plans.

- **Enhanced patient eligibility inquiry and response querying**—The patient eligibility inquiry for a specific service with a specific physician at a specific facility is important information for the physician practice. Receiving an explicit response from the payer can assist physicians and their practice staff in scheduling patients, determining patient eligibility of benefits, and determining the appropriate payer and patient financial responsibilities prior to the delivery of care.

4) **Health plan (payer) identifier**: All entities and resources involved in the payment process, including rental network PPOs, third-party administrators (TPAs) and claims platforms would have unique identifiers that could be found on each electronic eligibility transaction, remittance advice/explanation of benefits or other transaction in which these payers are involved.

5) **Machine-readable Health Insurance Identification Cards**: Standardize the current industry effort to create machine-readable health insurance identification and integrate it into the CORE initiative.
6) Current Procedural Terminology (CPT): While CPT was adopted as a standard code set under HIPAA, the CPT coding guidelines and conventions were not. CPT coding guidelines and conventions should be adopted with the CPT code set to reduce inconsistencies in the recognition and reporting of physician procedures and services by payers and other entities.

Physician Outreach

The AMA applauds CORE’s success in developing enhanced standardized operating rules and gaining participation among payers, vendors and other entities. As CORE Phase III unfolds, the initiative will expand to include critical standard operating rules involved in electronic transactions that significantly impact physician practices’ financial viability. It is therefore critical to educate physicians to leverage the CORE standard operating rules to achieve meaningful results in their practices. Physicians who recognize the value of CORE standard operating rules and see tangible results in their financial performance are most likely to move toward increased adoption of electronic transactions and seek payers, vendors and other entities that are CORE-certified. A collaborative physician outreach among CORE, the AMA, and Federation members can leverage the strengths of each organization to raise awareness and encourage active engagement among physicians both regionally and nationally. Strong physician advocacy and demand for CORE-certified payers, vendors and other entities are essential to driving health care industry adoption of CORE Phase III.

Pilot Test/Measures Study

The AMA is encouraged by preliminary results of a CORE study that demonstrate declining physician practice costs associated with fewer manual eligibility requests, claim denials due to patient ineligibility, and improved workflows. The AMA looks forward to the results of the CORE study to be released by the end of the year. Physician and their practice staff are keenly interested in the accessibility and reliability of patient eligibility information from payers and the potential to realize a reduction in practice costs. To that end, the AMA and the undersigned Federation members support participation in CORE pilot testing and measures studies that will clearly quantify the benefits of the CORE initiative and thereby encourage physicians to automate their transactions and partner with CORE-certified payers, vendors and other entities. As with physician outreach, the AMA favors a collaborative approach to targeting physician groups to participating in such studies and is happy to provide educational content, foster outreach efforts and provide specific operational support as needed.

We sincerely appreciate CORE’s attention to the physician perspective of this important initiative. The AMA and the undersigned organizations express our support of the above mentioned CORE Phase III recommendations that underscore CORE’s recognition of the physician’s stake in administrative simplification and transparency. With the support of physicians and their practice, broad adoption could occur. Such adoption has the potential to transform the opaque, paper-based health care claims process to a fully transparent, fully electronic system that dramatically reduces cost and complexity in the physician practice, resulting in increased time and resources that physicians can devote to their patients’ care.

Sincerely,

American Medical Association