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Special Meeting of the All Payer Claims Database Policy & Procedure Enhancement Subcommittee
Meeting Minutes

Date: Thursday, May 8, 2014
Time: 9:10 a.m. – 11:00 a.m. EST
Location: Legislative Office Building, Room 1D

Members Present
Matthew Katz, Mary Taylor, Olga Armah, Jean Rexford (phone), Demian Fontanella, Brenda Shipley

Members Absent
None.

Other Participants
AHA: Tamim Ahmed, Robert Blundo, Christen Orticari, Matthew Salner
Additional Attendees: Mary Boudreau, Matthew Giaquinto, Carol Dingeldey, Jonathon Knapp, Bruce Silverman, Vincent Doll

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I. Call to Order and Introductions

Matthew Katz called the meeting to order at 9:10 am. Mr. Katz provided a brief overview and members introduced themselves. Mr. Katz requested that participation through the phone line be kept to solely members.

II. Public Comment

Vincent Doll introduced himself and provided a public commentary on behalf of United Healthcare (UHC). Mr. Doll summarized the letter from UHC, which iterated their perspective on the addition of the dental data APCD submission requirement with regard to the administrative burdens it would impose on clinical delivery in reporting. Mr. Doll opined that the added burden far outweighed the incremental benefit of adding this small class of data in the APCD dataset for the assessment of cost and appropriateness of care. Mr. Doll noted aspects of dental data captured under the medical policy to highlight that dental data was already included to an extent. Mr. Doll requested that the APCD not require fields such as diagnosis codes and modifiers if the state decided to move forward with the inclusion of dental data.

III. Review and Approval of Minutes for February 21, 2014 Meeting

Olga Armah requested the spelling of her last name be corrected. **Demian Fontanella motioned to accept the minutes with the administrative change to correct the spelling of Ms. Armah's last name. Mary Taylor seconded. The motion was passed unanimously without abstention.**

IV. Overview of Claims Adjustment Reason Codes and Remittance Advice Codes

Robert Blundo reviewed the coding standards for denied claims by providing a brief description of claims adjustment reason codes, remittance advice codes, their use in the industry, and the benefits and challenges associated with their usage. Mr. Blundo summarized future plans in the industry to mandate and standardize the use of claims adjustment

reason codes and remittance advice codes. Mr. Blundo commented that the reason codes were received by providers as information that justified the denial of a claim. Ms. Taylor clarified that carriers had different claims processing systems that were linked to the CARCs and RARCs. Ms. Taylor informed members about carriers' ongoing efforts to standardize CACGs, CARCs and RARCs.

Mr. Blundo presented the AMA National Report Card in slide six, which presented an overview of overall denial rates. Mr. Katz commented that the report was derived from a self-reported, random sampling of provider ERA data. Mr. Blundo demonstrated that the graph showed the rate and reasons for denial varied from insurer to insurer, and year to year. Mr. Blundo presented the variation and frequency of CARC and RARC codes across different carriers. Mr. Katz commented that the information on frequently used denial adjustment and reason codes usages could be helpful for subcommittee consideration of which components of denial code information would be most useful to capture. Mr. Blundo further broke down the information on frequently used CARCs and RARCs to display total percentages and average across payers. Mr. Blundo reviewed claim denial rates across states and commented that the main challenges in the submission and translation of CARCs and RARCs was due to the variance in proprietary mapping among carriers as it would likely yield challenges in cross payer analysis. Mr. Blundo and Mr. Katz explained ongoing initiatives to resolve these difficulties through the implementation of industry mandates such as CAQH CORE operating rules to be used on increasingly more types of transactions through the progression of time. Members discussed the need for stakeholders to assume a uniform coding approach while keeping in mind that changes may affect the scrubbing of data.

V. Review of Denied Claims Data Use Cases

Mr. Katz presented reasons for the collection of denied claims. Mr. Katz included a table with data pulled from all physicians who were identified as having denials among the top insurers in various states listed, and provided information on the frequency of claim denials provided without reason for several CPT / HCPCS codes across a 13-month timespan. Mr. Katz commented that members were often not informed of the reason for the denial of their claims unless they were aware of their coverage and how the denial related to their benefits. Mr. Katz explained that imaging services and flu vaccines were prime examples since the service administration was often denied without patient information. Ms. Taylor commented that carriers may have had multiple codes for a claim wherein some codes may be denied and others accepted, which then could create barriers preventing accurate translation among other external parties, such as researchers, providers, and carriers, who might seek to understand exactly which service was denied, to what degree, and why it was denied. Mr. Katz observed from his research that claims often had ambiguous information on their denials since certain service lines or facets of the procedure coded varied by carrier and tended not to be communicated to patients or providers in full. Mr. Katz suggested that this ambiguity of information served to highlight a learning opportunity for those in the industry to troubleshoot and resolve areas of widespread uncertainty by searching for and identifying a way to communicate complex service information when recording payments. Mr. Katz continued to review the variation in claim denials across states for common procedures.

Mr. Katz provided two CPT code-specific and two general narrative use cases to afford members an understanding of benefits that may be derived through analysis of denied claims information. Mr. Katz explained the first use case, which portrayed the variation of denial rate across payers for a common health care service allocated a certain CPT code, and explained that the graph, on slide 16, showed service count volume and percentage of service denial varied across payers. Mr. Katz noted the second use case provided variance in denial per payer across states, and added that denials in Connecticut were lower than in other states in this instance. Mr. Katz explained that use of denied claims to provide this information may be useful for patients making decisions about their health plan. Ms. Taylor commented that the use cases presented seemed to focus on the carrier, did not take into account all other involved parties, and did not account for the clinical criteria used by carriers determine eligibility and coverage. Mr. Fontanella suggested that the APCD report on services that may be denied more often with one provider versus another provider. Mr. Katz explained that the use cases

served as a starting point and did not take into account all aspects of information that made up a comprehensive understanding of why a claim was denied. Mr. Katz asked for clarification regarding whether we may be able to include carrier names with the data since come states were allowed to disclose their names, while others were did not have this permission due to state restrictions. Matthew Salner commented that the issue would be clarified. Ms. Taylor opined that for the Connecticut APCD to not be contentious, it was important for all parties involved to be treated fairly and to take time to understand roles, responsibilities and challenges within this collaborative process. Mr. Katz commented that the Connecticut APCD was far from making a decision on the denied claims issue. Ms. Shipley reminded members that a large percentage of the population in Connecticut was covered by self-insured employers whose benefit plan designs were not subject to the state mandates, and commented that they may be structured by the employer to yield a higher rate of claims denials. Ms. Shipley explained that in this situation the carrier was simply a third party administrator for those plans so even if the employee had their coverage through a given carrier, it would be the employer who would more directly have an effect on the structure of the benefit plan component.

Mr. Katz presented the remainder of the use cases for denied claims to highlight the variation in denial rates across states and across carriers. He opined that information to be garnered through the analysis of denied claims denied could provide consumers more specific benefit design information, and afford them the opportunity to make more informed decisions. He asked that next steps be taken to garner information on how the denial of claims correlated with CARCs and RARCs from the carrier perspective in an effort to better understand the barriers concerns and opportunities. Mr. Katz asked that members start to deliberate approaches for the collection of CARC and RARC data, and then take next steps to toward developing a timeline for denied claims intake. Ms. Taylor requested that the subcommittee consider appropriate use cases from research and consumer stakeholders to better understand how denied claims information could productively inform health care decisions. Mr. Katz commented that the vendor would be able to provide insight to the logistics of their incorporation upon contracting phase completion. In the event a decision was made to collect denied claims, members collectively agreed on the need to take preparatory measures for the fair and accurate collection, and reporting of denied claims data.

VI. Discussion of Dental Data Collection and Stakeholder Engagement

Mr. Blundo introduced the topic of dental data collection, briefly discussed ongoing measures to prepare for dental claims collection, and asked that members be cognizant that the Data Submission Guide (DSG) required revisions to enable the dental data submission and intake process. Mr. Blundo informed members that stakeholders from the dental industry had been invited to speak as a panel to support the identification and development of next steps, such as revisions to the DSG, and to also address barriers, challenges, and opportunities for the collection and synthesis of dental claim components into the database. Mr. Blundo stated the importance of gathering viewpoints on opportunities and challenges from those in the industry. Mr. Katz introduced guest speakers from dental industry. Mary Beaudreau from the CT Oral Health Advocacy Initiative provided an overview of the report she developed based on the challenges and opportunities expressed by organizations who partnered with the advocacy group. Ms. Beaudreau explained parts of the ADA dental claim form such as types of transactions, company plan, and those typically not filled out, or filled out in an inconsistent way. Ms. Beaudreau explained that the field requesting the treating dentist for a given location was often not included by the dentist when completing the form, or was left out as a form field altogether. Ms. Beaudreau informed members that carriers tended not to submit treatment per tooth and often submitted by region differently. Mr. Silverman explained the disparity of data quality, availability and usage in the dental marketplace versus medical. Mr. Silverman informed members that the estimated average monthly volume of dental claims was approximately 78,200 with an average payout of 14.3 million dollars, and then commented that of those numbers 6,200 claims were from insured consumers with a payout of about 1.1 million dollars with the remainder applied to self-insured consumers. Mr. Silverman stated that Delta Dental of New Jersey (DDNJ) received 3.06 million claims with approximately 69 percent received electronically and the rest in paper form in 2013 for the purpose of highlighting that that just fewer than one million claims were received on paper and required time-

consuming manual entry into their systems. Mr. Doll commented that the benefits of reporting dental data per all DSG-required fields may be incremental and seemed to be far outweighed by the administrative burden of reporting. The guest speakers from the dental industry echoed these concerns, and agreed that since the dental nomenclature and coding was distinct from medical, there were several data elements and attributes that were not retained by or were unavailable to dental payers for APCD submissions.

Jonathon Knapp commented that dental benefits in terms of minimums and maximums were vastly different, and this information would need to be taken into account when planning for dental data intake. Ms. Dingeldey opined that inconsistencies in documentation originated at the provider-level and manifested in ways such as differences in the recording of benefits and recording of contractual obligation information. Ms. Dingeldey explained that in future APCD submissions, these inconsistencies would prevent valid tracking and analysis of practice patterns. Mr. Doll commented that because many PPO or POS dental plans had a limited number of dentists in-network, many out of network dentists were selected, which would further limit the successful completion of fields required by the DSG for submission to the APCD. Mr. Katz suggested that the AHA staff review and provide an update on ongoing dental claims collection practices across other states. Ms. Taylor asked that members and AHA staff be mindful of the critical importance of setting reasonable thresholds and accommodating waivers for threshold variance requests since not all thresholds would be able to be met. Mr. Katz thanked the representatives for their attendance and insight.

Mr. Salner summarized the implications of the policies and procedures for APCD collection of dental data. Mr. Salner clarified that the APCD Administrator shall establish a schedule similar to medical for submitting dental data for formal incorporation into the DSG. Mr. Salner further explained process to modify the policies and procedures.

VII. Next Steps

Members deliberated holding a June meeting to receive feedback from reporting entities on the use cases for denied claims, and potentially also from the academic perspective. Mr. Katz reminded the subcommittee the next APCD Advisory Group meeting would be held from 9:00 a.m. to 11:00 a.m. on June 12, 2014.

VIII. Future Meetings

The next meeting would be held in June on a date to be decided by members following meeting adjournment.

IX. Adjournment

Mr. Katz motioned to adjourn the meeting. The motion was seconded and passed unanimously. The meeting was adjourned at 11:00 a.m.