

July 29, 2019

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-6082-NC  
P.O. Box 8016  
Baltimore, MD 21244-8016

RE: File Code CMS-6082-NC – Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork

Dear Administrator Verma:

The American Dental Association (ADA) is the world's oldest and largest professional dental association with over 163,000 members. As a longstanding member of the dental community and active proponent of patient oral health, and as a named Consultant to the Secretary on HIPAA Administrative Simplification Standards, the ADA appreciates the opportunity to provide comment on the subject RFI – Reducing Administrative Burden to Put Patients Over Paperwork.

The ADA considers an unfettered patient-dentist relationship as the foundation for ongoing oral health. Further, this patient-centric relationship is supported by efficient and effective administrative processes that enable the dentist and her or his practice staff to provide necessary care. Paperwork, electronic or otherwise, requires time and resources to compile, complete, file or transmit.

Such distraction from the delivery of patient care is exacerbated when paperwork and associated administrative activities are proprietary and do not adhere to recognized standards (e.g., P.L. 104-191, Title II, Subtitle F – also known as HIPAA Administrative Simplification). Between Medicaid, CHIP and Medicare Advantage, approximately 87.8 million individuals are covered for some oral health services. This volume of patients can be positively impacted were CMS to understand and promote changes to achieve administrative simplifications within the dental care system.

This letter addresses five paperwork intensive administrative activities that have standards-based solutions. Continuing active pursuit of each, in lieu of proprietary and often paper driven processes, is congruent with the Put Patients Over Paperwork objective of this RFI.

#### 1. Credentialing

In August 2018 the ADA prepared correspondence directed towards state Medicaid agencies concerning continuing efforts to improve the credentialing process for all U.S. licensed dentists and the dental plans they participate with, including public insurance programs such as Medicaid and the Children's Health Insurance Program (CHIP). The ADA and the Council for Affordable Quality Healthcare (CAQH), a nonprofit alliance of health

plans and trade associations, formed a strategic alliance with the shared goal of streamlining the credentialing process for dentists and participating organizations, including public and commercial payers, hospitals and employers. This streamlined process reduces duplication. Currently, dentists submit credentialing applications and other related information to numerous dental health plans, employers of dentists, and other healthcare organizations for credentialing, screening, revalidation, directories and other data requirements multiple times each year. The number of times that a Medicaid enrolled dentist needs to be credentialed can be increased exponentially when a Medicaid and/or CHIP program contracts with numerous managed care organizations (MCOs) to provide services to its Medicaid population.

Furthermore, the time it takes for a credentialing application to be approved by payers, including state Medicaid agencies, is increasing. It has been reported that approvals are taking as long as 6 months from the time a completed application is accepted before a decision is made. This not only is challenging for dentists eager to participate in Medicaid, but it truly limits access to care for Medicaid recipients.

CAQH ProView® is the widely accepted universal credentialing system in place that resolves these issues across healthcare disciplines (including both medical and dental). It is accepted as a standard in several states, including TennCare, the Tennessee Medicaid program. CAQH ProView® is a web-based solution in use for more than 15 years that is utilized and trusted by more 1.4 million U.S. healthcare providers, including over 53,000 dentists.

The ADA is encouraging the use of CAQH ProView® by all U.S. licensed dentists, at no cost, regardless of their membership status with the ADA. We ask that such a standard, credentialing process be promoted as a means to reduce credentialing paperwork required of any healthcare practitioner. Such a process will expedite data collection, maintain the integrity of credential verification and reduce the number of times a practitioner must submit the same credentialing information to multiple payers.

## 2. Eligibility

The HIPAA standard eligibility inquiry and response transactions – X12 270 and 271 – were intended to eliminate protracted paper-based or telephonic interactions involving health care practitioners, and payers, staff. Within the dental community utilization of these transactions shows a decline from 58% in 2016 to 48% in 2018 according to the 2018 CAQH Index (©2019 CAQH).

To our knowledge this decline is due to deficiencies in the current 270/271, which is version 5010, compounded by the fact that several payers do not transmit the complete information within even the existing transaction. Increasingly more robust information is being made available from individual payer proprietary Internet portals. Accessing eligibility information via the portals has brought some efficiencies to the practitioner as access is direct and does not require telephonic interaction with the payer. However, the proliferation of proprietary

web sites places a new set of administrative burdens on a dental (or other healthcare provider) office staff – specifically the need to learn each payer portal’s different login routine and information presentation format. In addition, the available eligibility information must be manually transcribed into the patient’s health record. There is no automated interface with the dentist’s practice management and electronic health record applications, a problem that also exists when the 270/271 standard transactions are used.

Solutions are available. The ADA believes that a more robust 270/271 transaction set combination can supplant the proliferation of proprietary payer portals.

To reduce paperwork and related administrative time and resources the ADA recommends that 270/271 v7030 now in the public comment process be modified to accept the content described in the National Dental Electronic Data Interchange Council’s (NDEDIC) Top Dental Eligibility and Benefit Questions Response Guide so that these transaction sets accommodate the needs of dentistry before they, or their successors, are named as HIPAA standards. Further, CMS should support efforts at X12 to develop a specification that enables “real-time” transmittal and receipt of the 270/271 transaction sets.

CMS must use its authority to urge dental benefit administrators, including those who manage care in the Medicaid and CHIP Managed Care arena, to implement and transmit standard transactions. Concurrently, CMS must be prepared to support these efforts with consistent and adequate funding. CMS and the Office of the National Coordinator for Health IT (ONC) must also collaborate on defining and implementing a technology certification program for practice management system software vendors. This will ensure that their applications are able to process and display information carried within the standard transactions in a manner that genuinely reduces the administrative burden of dentists serving the Medicaid, CHIP, and commercial benefit plan populations.

### 3. Claim Submission

The percentage of electronic claims, by volume, continues to increase for procedures covered by medical and by dental benefit plans. According to the 2018 CAQH Index (©2019 CAQH) the figures are 95% and 79% respectively, with comparable downward trends for paper claim submissions.

ADA by policy and practice encourages dentists to implement the HIPAA standard electronic dental claim transaction, and for those who continue to submit on paper, to use the current version of the ADA Dental Claim Form (©2019 American Dental Association). On the paper side there are entities that have not fully embraced the current ADA form.

State Medicaid agencies are one type of these entities that have not universally adopted the current ADA form. For example, in New York dental providers who choose to submit their claims on paper forms must use the New York State eMedNY-000201 claim form. In Iowa instructions published for dentists who bill for Medicaid-covered services are directed to use “...the 2012 *Dental Claim Form* published by the American Dental Association.”

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Inconsistent requirements for programs that are federally funded, place a unique administrative burden on dentists who serve the Medicaid covered population. These dentists must be able to create these specified forms for patients covered by Medicaid, and also be able to prepare the current ADA form for claims filed with patients covered by a commercial dental benefit plan. Such a burden is compounded for those dentists whose practices are in metropolitan areas that cover more than one state (e.g., New York City, which includes both New Jersey and Connecticut).

While we encourage CMS to urge use of the electronic 837D transaction, to address this administrative burden in the interim the ADA recommends federal guidance to state Medicaid agencies concerning consistency in dental claim submission via paper. We believe that the existing federal regulations requiring covered entities to use the HIPAA standard transaction for electronic dental claims establishes a precedent for sub-regulatory guidance concerning paper submissions. The ADA dental claim form data content and code sets used therein are, in accordance with ADA policy, in harmony with that of the 837D v5010. In addition, that transaction's implementation specification (X12 v5010 837D TR3), which is referenced in HIPAA regulations, maps the ADA form's content to the transaction set.

The ADA asks that such federal guidance concerning consistency in dental claim submission via paper not be limited to federally funded programs. When there is no alternative all paper-based dental claims should use the current ADA form. Otherwise, dentists and third-party payers will be faced with the overhead cost and time necessary to support myriad formats.

In addition to claim submission format variations there are other requirements, or lack thereof, that add to paperwork. One example is claim attachments, additional information that conveys diagnostic or other information that explains why a patient service was provided. Dentists report to us that individual payers have their own attachment requirements. Such differences result in dentists either coming up with their own method for tracking and providing each payer's required attachments, or sending attachments as a matter of course to all payers for process simplicity whether or not they are required.

A solution, affecting the dental community at large, would be adopting a HIPAA standard for claim attachments (e.g., X12 format for request; HL7 format for response). Further, we believe that CMS should use its authority to ensure that processing policies, prior authorization guidelines and attachment requirements are clear and consistent.

We also ask that CMS be prepared to fund all these efforts if it wishes to achieve this RFI's goal of putting patients over paperwork.

#### 4. Coordination of Benefits

The X12 Healthcare Claim Transaction (837) supports several business functions in its various HIPAA specified uses (Institutional, Professional and Dental) – claim or encounter reporting, pre-determination of dental benefits, and coordination of benefits (COB). Two types of COB are supported – the indirect process where the Provider submits separate 837 transactions to the primary Payer and then to the secondary Payer, and the direct process where the Provider only sends a single 837 to the primary Payer, who then creates and sends its own 837 to the secondary Payer directly without the Provider serving as the middleman.

For dentistry these two types of COB processes are documented in the May 2006 X12 Technical Report Type 3 005010X224 *Health Care Claim: Dental (837)*, section 1.4.1.1 on pp 3-5.

Direct Payer to Payer COB is efficient and eliminates Provider paperwork. However, to the best of our knowledge third-party payers in the dental arena do not appreciate that the current HIPAA standard (837D v5010) is capable of supporting this business function. This is why the provider-centric COB process continues where the dentist or other healthcare provider remains as the middleman in the process and is not able to reap the full benefits of HIPAA's electronic solution.

Although v5010 can transmit information about primary payer coverage and reimbursement amounts, the perceived inability in some situations for the 837 to convey other information (e.g., provider network participation status; alternate benefits) within the transaction precludes the secondary payer from being able to properly adjudicate the claim. The perceived inability reinforces continuation of the current scenario where the dentist is the middleman. This makes no sense as the primary third-party payer already has this other information and should be fully capable of transmitting it to the secondary payer to effect payer to payer COB.

To reduce paperwork and related administrative time and resources the ADA recommends that the appropriate federal authority publish regulations that require third-party payers to implement payer to payer COB. This regulation could be initially directed towards Managed Care Organizations that administer state Medicaid Programs. Doing so would have a beneficial “ripple effect” where implementation for the federally funded program would be expected to affect the MCO's commercial sector business.

Another avenue to promote payer to payer COB is CMS' Administrative Simplification Enforcement and Testing Tool (ASETT). The scenario would be a provider complaint that a third-party payer does not offer payer to payer COB, thereby adding to the practitioner's administrative burden, a scenario that puts paperwork over patients. A successful compliance program in response to such a complaint would be congruent with this RFI's goal – putting Patients Over Paperwork.

The net positive effect of the actions just described would be to remove the provider from her or his middleman position and reduce the time and costs associated with “pushing paper” (to use the colloquial term) that takes away from the direct provider-patient interactions necessary for proper health care. Another elegant solution with a similar positive effect would be to accelerate naming the 837D v7030 as the next HIPAA standard. This version of the transaction set supports transmittal of COB information not carried by v5010 (e.g., provider network participation status; alternate benefits). When so named this version would present an administrative cost saving that accrues to third-party payers, as well as to dentists and other healthcare providers.

To conclude, widespread adoption of Payer to Payer COB is a goal that the ADA sees as a collaborative effort that involves HIPAA covered entity education, modification of third-party payer processing software, and upgrades to provider practice management software. There are short-term expenses associated with these efforts, all of which lead to achieving greater overall efficiencies through reduction of manual interventions and paperwork.

## 5. Reimbursements

There are two broad categories of administrative issues concerning third-party payer payments to dentists and other healthcare practitioners for services delivered to patients, first the reimbursement mechanism and second the reconciliation processes. Opportunities to reduce the costs and paperwork associated with each exist.

Reimbursement mechanisms in use today – paper checks, electronic funds transfers (EFT) and virtual credit cards (VCC) are a mix of technologies. Paper checks are the longest lived alternative and bring the benefits of familiarity and established processing routines. The ADA supports continued use of paper checks for those dentists who prefer this method, but we also strongly encourage implementation of the applicable HIPAA standard transactions for their long-term benefits of lowering administrative time and costs for reconciliation. The ADA has the opposite view of VCC as the payment mechanism, as they simultaneously add to practice administrative costs since new protocols must be put in place to process the reimbursement, and reduce the amount actually received after accounting for transaction costs and card processing fees.

We ask that there be regulations in place that will permit reimbursement via VCC only when specifically requested by a dentist or any other healthcare provider.

The ADA, through its own educational efforts and collaborative work with other organizations, promotes the HIPAA standard EFT transaction (NACHA Healthcare CCD+) and ERA (X12 835v5010) as the efficient and low-cost solutions to dental practice reimbursement and reconciliation administration processes. There are some obstacles on the road to this goal that we would like to bring to your attention, and request your assistance in resolving through the regulatory or sub-regulatory process.

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- a) There is no universal single site, single stop, EFT enrollment mechanism. Some third-party payers require a dentist or other healthcare practitioner to enroll using a proprietary process in order to receive payments electronically.
- b) The X12 v5010 835 transaction does not support the TOO segment, used to report tooth number and oral cavity information on the 837D. This has been a significant obstacle to reconciliation of claim payments. The ADA did ask for its inclusion in v5010 while being developed by X12, but was outvoted by third-party payer who participated in the process at that time. The next version of the 835, v7030, does include the TOO segment so its adoption would go a good way to helping solve the ERA/EFT problem.
- c) There are some payers that bundle EFT and ERA enrollment, with no option to select one or the other in lieu of both. Such requirements do not recognize that all dentists are not prepared to simultaneously accept these transactions. A phased adoption of standard transactions, where the implementation costs for a dental practice can be spread over time, becomes out of the question. As a result the benefits of incremental time and cost savings are lost.
- d) The Reassociation Trace # is either not always present or is incorrectly placed on the EFT Addenda record (CCD+) and the ERA (835TRN02), which makes matching of payment and claim information very difficult or impossible without significant manual intervention.
- e) Neither the existing Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) entries, nor their standard mappings, are sufficiently robust to enable reconciliation (automated or not) of dental claims and payments. In addition, the RARC code set maintenance process is opaque and unresponsive to industry requests for changes.

We recommend that CMS open the RARC maintenance process to permit the industry's full participation, which would be achieved by adopting an external, independent code management process akin to X12's external code maintenance process. Participants would represent a balance of interests, per ANSI rules, and need not be done in conjunction with X12 standing meetings.

The five paperwork intensive administrative activities discussed herein illustrate how standards-based solutions enable efficient and effective administrative processes for dentists in practice. Relief from inefficient processes, both electronic and paper, frees time for the dentist and her or his practice staff to provide needed patient care.

Before closing, the ADA encourages CMS to appoint a Chief Dental Officer (CDO), as this position has been vacant since the previous CDO's retirement in 2017. For several years the prior incumbent and his predecessors have been active participants in ADA initiatives that concern the administrative burdens faced by dentists. One example is the CDO representing CMS as a voting member on the CDT Code's maintenance committee, the body that oversees content of this named HIPAA administrative simplification standard code

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set. We believe that the agency needs a CDO to oversee the oral health care provided to patients and reduce the administrative burden faced by dentists.

The ADA thanks CMS for the opportunity to comment on this RFI. Please do not hesitate to contact Mr. Frank Pokorny, Senior Manager, Center for Dental Benefits, Coding and Quality (312-440-2752 / [pokornyf@ada.org](mailto:pokornyf@ada.org)) regarding any part of these comments.

Sincerely,

/s/

Jeffrey M. Cole, D.D.S., M.B.A.  
President

JMC:KTO:ry

/s/

Kathleen T. O'Loughlin, D.M.D., M.P.H.  
Executive Director