2015 CAQH Index™

Reporting Standards and Data Submission Guide – Health Plans Numbers of Transactions and Costs per Transaction

Data for Calendar Year 2014 Version 1, March 13, 2015







TABLE OF CONTENTS

2015 CAQH Index Reporting Standards and Data Submission Guide – Health Plans

Overview	3
Numbers of Transactions	5
Claim Submission	5
Eligibility and Benefit Verification	6
Claim Status Inquiries	7
Claim Payment	9
Claim Remittance Advice	10
Prior Authorization	11
Attachments (Claim and Prior Authorization)	12
Coordination of Benefits (COB) Claims	14
Referral Certification	15
Enrollment/Disenrollment	16
Premium Payment/Advice Transactions	17
Costs per Transaction	18
Appendix A. 2015 Index Advisory Council	20
Appendix B. Data Collection Template – Numbers of Transactions	21
Appendix C. Data Collection Template – Costs per Transaction	25
Appendix D. Guiding Principles to Measurement and Reporting	28
Appendix E. Data Submission Acknowledgment	30

OVERVIEW – 2015 INDEX REPORTING STANDARDS AND DATA SUBMISSION GUIDE

This Guide accompanies the 2015 Data Collection Template that is provided to health plans responding to the 2015 Index data request for numbers of transactions and costs per transaction, manual vs. electronic, for calendar year 2014. (The 2015 Data Submission Template is illustrated in Appendix B.) This Guide contains instructions and specifications intended to help responding health plans provide data in as consistent a manner as possible. As such, it will be revised from time to time, especially in the sections describing the new measures introduced for the first time in 2015, such as COB claims and referral certification transactions. Likewise, newer measures from last year's 2014 Index – prior authorization/pre-certification transactions and numbers of attachments submitted by healthcare providers as part of the claims or prior-authorization process – may be revised. For these newer transactions in particular, we anticipate that additional questions will arise as responding plans begin the data submission process. When this occurs, the Index Advisory Council members (see Appendix A) will evaluate the questions, decide on a standard approach if possible, and then revise this Data Submission Guide as necessary.

For 2015, this Guide contains instruction and notes on the data submission both for numbers of transactions with those for costs per transaction. The section on costs per transaction is much less prescriptive – the sections below explain the data that is needed and provide worksheets with several different methods of estimating costs per transaction for manual and electronic processes.

For some respondents, it may be possible to complete either the numbers of transactions data, or the costs per transaction estimates, but not both. While we hope that most respondents can complete both sets of data, we understand that might not be possible in all cases. The process for estimating costs per transaction include interview(s) with CAQH and our consulting analysts to help ensure that we the data are as comparable as possible among respondents, and to allow aggregation and benchmarking. Please contact Jeff Lemieux at 1 (202) 517-0428 or JALemieux@CAQH.org with any questions or comments at any time during the data submission process.

Transactions Studied for the 2015 CAQH Index

	Adopted HIPAA Standard	Description
Claim Submission	ASC X12N 837	A request to obtain payment or transmission of encounter
Claim Submission	ASC X 12N 637	information for the purpose of reporting health care.
		An inquiry from a provider to a health plan, or from one
Eligibility and Benefit	ACC V40NL070/074	health plan to another, to obtain eligibility, coverage, or
Verification	ASC X12N 270/271	benefits associated with the health or benefit plan, and a
		response from the health plan to a provider.
		A request from a provider to a health plan to obtain an
Prior Authorization	ASC X12N 278	authorization for health care, or a response from a health
		plan for an authorization.

Claim Status Inquiry	ASC X12N 276/277	An inquiry from a provider to a health plan to determine the status of a health care claim or a response from the health plan.
Claim Payment	NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)	The transmission of payment, information about the transfer of funds, or payment processing information from a health plan to a provider.
Remittance Advice	ASC X12N 835	The transmission of explanation of benefits or remittance advice from a health plan to a provider.
Claim Attachments	No standard adopted by HHS	Additional information submitted with claims or claim appeals, such as medical records to support the claim.
Prior Authorization Attachments	No standard adopted by HHS	Additional information submitted with a prior authorization or pre-certification request, such as medical records to explain the need for a particular procedure or service.
New for the 2015 Inde	x:	
COB Claims	ASC X12N 837	COB claims are a subset of all claim submissions above. We define COB claims as those sent to secondary payers with an attached or included EOP information from the primary payer.
Referral Certification	ASC X12N 278	Referral certification is request from a healthcare provider to a health plan for permission to refer a patient to another provider. While this transaction an element of the Prior Authorization suite of HIPAA standardized transactions, we do NOT count it in the Prior Authorization category above.
Non-Provider Transactions New for the 2015 Index:		
Employer/HIX/Broker Enrollment/ Disenrollment	ASC X12N 834	Enrollment/disenrollment transactions can be initial enrollments, full file replacement (enrollment changes or to true up enrollment) or add/change/terminate enrollment.
Employer/HIX/Broker Premium Payment/ Explanation	ASC X12N 820 005010X218 (employer) 005010X306 (HIX)	The HIPAA standard electronic premium payment transaction 820 can be sent to bank to move money only; sent to bank to move money with detailed remittance info; or sent directly to payee with remittance information only.

Source: 2014 CAQH Index.

Notes: HIPAA = Health Insurance Portability and Accountability Act; HHS = U.S. Dept. of Health and Human Services.

NUMBERS OF TRANSACTIONS

All measures for numbers of transactions in 2015 data submission are based on data representing the January 1, 2014 to December 31, 2014 calendar year. If for any reason the data are NOT for the full calendar year, please contact CAQH so that we can adjust the aggregation approach.

All data on numbers of transactions are based on medical/surgical and related health care claims and inquiries. If you include data for vision and/or dental claims, please categorize those results in a separate column. The 2015 Index data do not include retail pharmacy transactions. If your company's data DO include retail pharmacy transactions, please contact CAQH.

Claim Submission

Measures and reports the percentage of all legitimate claims that are received electronically as a proportion of the total of all legitimate claims received by the health plan.

Legitimate Claim is defined as an itemized statement of rendered services and costs from a healthcare provider or facility received by the health plan for payment for health care. A claim can be submitted via a manual process using paper or electronic system either directly or through intermediary billers and claims clearinghouses.

	Adopted HIPAA Standard	Description
Claim Submission	ASC X12N 837	A request to obtain payment or transmission of encounter
		information for the purpose of reporting health care.

The total number of Legitimate Claims represents the universe (sometimes called the denominator) for the Claims Submission calculation.

Note:

- If there is no direct claim for payment given reimbursement contracts, the transaction is considered
 the transmission of encounter information for the purpose of reporting health care. Encounters may
 or may not be included depending on the ability to report separately by the health plan. If
 encounters cannot be separated from claims, the participant should notify CAQH upon data
 submission. Encounters may be reported within the appropriate data submission field.
- Claims reported should be only those received for medical expense services for insured persons/enrollees participating in the health plan. Only ASC X12N/005010X2I2 Health Care Claim 837 I (Institutional) and 837 P (Professional) claims are the main categories of claims included at this time. However, dental and vision claims may be included on the designated columns.
- Reporting of claims to CAQH should be grouped based on commercial, Medicare, Medicaid,
 Dental, Medigap, or other supplementary policies when such classification is available. The Data

Collection Template for numbers of transactions allows additional columns to be added for additional lines of business reported separately, and includes space for notes explaining the lines of business used. Please notify CAQH of if data within data submission. Each product will be reported separately and aggregated.

- Adjusted claims and duplicate claims may be received by the health plan system as a legitimate
 claim and will not be rejected until after claim logic is applied. These claims should be counted in
 the measure as they are received by the health plan. Processed or Adjudicated Claims would be a
 step beyond received and should not be used for determining a received claim as it would narrow
 the universe for the intended measurement.
- COB claims are included in the claims submission measure, and are also reported separately below under COB claims submission.

Electronic Claim is defined as an electronic data interchange (EDI) of the received claims submission transaction. The HIPAA standard title is ASC X12N/005010X2I2 Health Care Claim 837 I and P. Only HIPAA compliant claims should be included as an electronic claim.

Eligibility and Benefit Verification

Measures and reports the percentage of all eligibility and benefit verifications received electronically to inquire about the eligibility, coverage, or benefits associated with a benefit plan or product as a proportion of all eligibility and benefit verifications received by the health plan.

Eligibility and Benefit Verification is defined as when a health plan receives a request to obtain any of the following information about a benefit plan for an enrollee or member:

- 1. Eligibility to receive health care under the health plan.
- 2. Coverage of health care under the health plan.
- 3. Benefits associated with the benefit plan.

	Adopted HIPAA Standard	Description
	y and Benefit ASC X12N 270/271	An inquiry from a provider to a health plan, or from one
Eligibility and Benefit		health plan to another, to obtain eligibility, coverage, or
Verification	ASC X12N 270/271	benefits associated with the health or benefit plan, and a
		response from the health plan to a provider.

The total number of Eligibility and Benefit Verifications represents the denominator for the Eligibility and Benefit Verifications calculation.

Note:

• Eligibility and benefit verifications are done in a variety of ways including the following:

- Accessing enrollee or member information via a health plan's secure Web site Portal/Direct Data Entry (DDE). Tracked individually for reporting.
- Telephone, Interactive Voice Response (IVR) and fax. Tracked individually for reporting.
- The ASC X12 270 Health Care Eligibility Benefit Inquiry.
- These modes of verifications should be reported separately to measure trend of electronic transaction adoption and the movement away from manual transactions and communications.
- As it may be difficult to differentiate and categorize between inquiries for eligibility, coverage and benefits, grouping of the inquiries is acceptable for reporting calculations.
- Total number of legitimate claims from the Claim Submission measure is used to provide a normalized calculation of the above sub-categories.

Electronic Eligibility and Benefit Verification is defined as an electronic data interchange (EDI) transaction when the health plan IT system receives a request to obtain information about a benefit plan for an enrollee electronically through direct data entry, via portal, or through batch file submission and the system responds with the requested eligibility and benefit information using the same modality as the inquiry. The HIPAA standard title is ASC X12 270 Health Care Eligibility Benefit Inquiry.

Subcategories will be reported between HIPAA compliant electronic transactions and non-HIPAA compliant transactions. Non-HIPAA compliant transactions that are electronic or automatic will be considered automated and reported separately.

Note:

- ASC X12 270 is the standard for electronic eligibility and benefit verification for both providers and health plans and is the primary metric for the measure.
- From the health plan perspective, IVR, portal and DDE may be considered electronic as they
 reduce the number of manual interactions (ie. phone calls and faxes) for health plans. Given there
 is value to track both types of electronic transactions, each subcategory will be reported and
 tracked as secondary metrics at this time. The Automated category is used to report the nonHIPAA compliant electronic transactions.

Claim Status Inquiry

Measures and reports the percentage of all inquiries received electronically to inquire about the status of a health care claim as a proportion of all claim status inquiries received by the health plan. A normalized proportion of inquiries per 1,000 claims is calculated by subcategory to show relative volume.

Claim Status Inquiry is defined as when a health plan receives a request on the status of a claim.

	Adopted HIPAA Standard	Description
Claim Status Inquiry	ASC X12N 276/277	An inquiry from a provider to a health plan to determine the status of a health care claim or a response from the health
		plan.

Note:

- Claim status inquiries are done in a variety of ways including the following:
 - Accessing claim information via a health plan's secure Web site Portal/Direct Data Entry (DDE). Tracked individually for reporting.
 - Telephone, Interactive Voice Response (IVR) and fax. Tracked individually for reporting.
 - o The ASC X12 276 Health Care Claim Status Request.
 - These modes of requests should be reported separately to measure trend of electronic transaction adoption and the movement away from manual transactions and communications.
- As it may be difficult to differentiate and categorize between inquiries for appeals, resubmissions
 and the status of the claim within the adjudication cycle, inquiries on claim status should be
 counted when there is the ability to track separately.
- Total number of legitimate claims from Claim Submission is used to provide a normalized calculation of the above sub-categories.

Electronic Claim Status Inquiry is defined as an electronic data interchange (EDI) transaction when the health plan IT system receives a request on claim status electronically through direct data entry via portal or through real time and batch file submission and system responds with requested status update using the same modality as the inquiry. The HIPAA standard title is the ASC X12N/005010X212 276 Health Care Claim Status Request.

Subcategories will be reported between HIPAA compliant electronic transactions and non-HIPAA compliant transactions. Non-HIPAA compliant transactions that are electronic or automatic will be considered automated and reported separately.

Note:

- ASC X12 276 is the standard for electronic claim status inquiry for both providers and health plans and is the primary metric for the measure.
- From the health plan perspective, IVR, portal and DDE may be considered electronic as they
 reduce the number of manual interactions (ie. phone calls and faxes) for health plans. Given there
 is value to track both types of electronic transactions, each subcategory will be reported and
 tracked as secondary metrics at this time. The automated category is used to report the non-HIPAA
 compliant electronic transactions.

Claim Payment

Measures and reports the percentage of transactions used by the health plan to make a payment to the health care provider as a proportion of all health care claim payments by the health plan.

Claim Payment is defined as any transfer of funds or payment to the financial institution of a health care provider for a health care claim.

	Adopted HIPAA Standard	Description
Claim Payment	NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)	The transmission of payment, information about the transfer of funds, or payment processing information from a health plan to a provider.

Notes:

- HSA and member payments should not be included.
- Claim payment may be done in a variety of ways including the following:
 - o Cash, check or similar paper instrument.
 - Payment via a credit or virtual card network.
 - o Electronic Funds Transfer (EFT) via the ACH Network.
- Claims submitted from the prior year may be paid within the payments being reported (e.g., claim submitted on December 15 is paid or payment is sent on January 15).

Electronic Claim Payment or Electronic Funds Transfer (EFT) is defined as any electronic data interchange (EDI) transfer of funds (EFT), other than a transaction originated by cash, check, or similar paper instrument that is initiated through an electronic terminal, telephone, computer, or magnetic tape for the purpose of ordering, instructing, or authorizing a financial institution to debit or credit an account. The term includes Automated Clearing House (ACH) transfers, Fedwire transfers over the Federal Reserve Wire Network, transfers made at automatic teller machines (ATMs), and point-of-sale terminals.

Note:

• Claims adjudicated resulting in \$0 payment (zero pay) are included.

Claim Remittance Advice

Measures and reports the percentage of transactions used by the health plan to send a remittance advice directly to a health care provider as a proportion of all health care remittance advice messages by the health plan.

A *Remittance Advice (RA)* is defined as a document or a transmission of a message supplied by the health plan or payer that provides notice of and explanation reasons for payment, adjustment, denial and/or uncovered charges of a medical claim back to the provider or facility. The RA may accompany payment and is sometimes referred to as an explanation of payment (EOP).

	Adopted HIPAA Standard	Description
Remittance Advice ASC X12N 835	The transmission of explanation of benefits or remittance	
	ASC X 12N 635	advice from a health plan to a provider.

Note:

- Claim Remittance Advice is reported and tracked by remittances made in the measurement year along with the number of claims represented within the cohort of remittances.
- A remittance advice may reference claims submitted in the prior year (e.g., claim submitted on December 15 is remittance is sent on January 15).
- A Remittance Advice or other Electronic EOP may be viewed via a health plan's secure Website.
 These modes should be reported separately to measure the trend of electronic transaction adoption and the movement away from manual transactions and communications.
 - From the health plan perspective this may be considered electronic leading to a reduction in paper based RAs.
 - The count of electronic EOPs posted on web portals should be the number of postings, NOT the number of hits or page views.

Electronic Remittance Advice (ERA) is defined as an explanation of the health care payment or an explanation of why there is no payment for the claim that is transmitted electronically through the health care payer payment or claims processing system and is received by the provider or provider's agent (e.g., clearinghouse, billing service). The ERA includes detailed identifiable health information. The ERA may be submitted electronically through a secure message or batch file.

Note:

• The HIPAA standard title is ASC X12 005010X221A1 835 Health Care Claim Advice.

Prior Authorization

Measures and reports the inquiries, requests, and submissions received by the health plan from healthcare providers for the purpose of obtaining a pre-certification or prior authorization of a service or procedure. Prior authorization transactions are used to clarify whether a treatment or procedure is covered for particular circumstances of patient care.

Prior Authorization or Pre-Certification transactions are defined as inquiries and submissions of information from healthcare practitioners and facilities, ie. physicians' offices, hospitals, and outpatient facilities, as well as responses and confirmations from health plans. Prior authorization requests and responses may pertain to many different health care events, including reviews for: treatment authorization, pre-admission certifications, certifications for health care services (such as home health and ambulance), extension of certifications, and certification appeals.

Note that referral certification requests, which use the same electronic HIPAA standard as prior authorization/pre-certification (278) are being counted separately (see below), and are NOT included in the counts of prior authorization transactions.

For the 2015 Index, we are counting prior authorization transactions for medical/surgical benefits, as well as inquiries from healthcare providers (hospitals and physicians' offices etc.) to get authorization for coverage of prescription drugs. However, we are not attempting to count inquiries made directly from pharmacies – the focus for 2015 counts will be transactions involving hospitals, physicians, and other healthcare practitioners. Optional responses on the numbers of inquiries from healthcare providers related to health plan members' prescription drug benefits, for plans that can break out Rx inquiries vs. those for medical surgical benefits, can be made in the comments.

	Adopted HIPAA Standard	Description
Prior Authorization	ASC X12N 278	A request from a provider to a health plan to obtain an authorization for health care; or a response from a health
		plan for an authorization.

For the 2015 Index, all transactions related to prior authorization, including initial inquiries and subsequent submissions of information and responses, will be counted. Therefore, some benefit events may generate multiple transactions. Each transaction counts, and should be categorized by manual or electronic processes per below. For example, an initial inquiry might be a telephone request for a determination of whether a prior authorization is necessary for a particular procedure or service. A follow up request might be an electronic transaction providing specific information or following the health plan's procedures to approve the covered status of a particular procedure or service for a particular patient.

The 2015 Index data submission includes transactions in the following categories:

- Telephone
- Fax or Email
- Interactive Voice Recognition (IVR)

- Non-standardized Website/Portal Transmission
- Standardized Electronic Transmission HIPAA 278
- Other (specify in comments)

Note:

• This category does NOT include referral certification. For the 2015 Index, we are counting referral certification transactions separately.

Attachments

An attachment is defined as a submission of supplementary information to justify or provide extra information for a claim or prior authorization request. A claim attachment can be attached to an original claim submission, resubmission, or appeal.

The purpose of the new attachment measures is to create a benchmark count of the frequency of claim submissions and prior authorization inquiries and requests that are accompanied by attachments containing additional information to justify the claim or authorization.

For the 2015 Index, we are studying two types of attachments, those submitted with claims or claims appeals, and those related to prior authorization or pre-certification requests. Attachments will be counted in the following categories for both types (claim-related and prior authorization related):

- Received via Paper Delivery (mail, FedEx etc.)
- Received by Fax
- Non-standardized -- Received by Email (PDF)
- Non-standardized -- Website/Portal Submission
- Standardized Electronic Transmission (HL7)
- Standardized Electronic Transmission (X12)
- Other (specify in comments)

	Adopted HIPAA Standard	Description
Claim Attachmants	No standard adopted	Additional information submitted with claims or claim
Claim Attachments	by HHS	appeals, such as medical records to support the claim.
Prior Authorization Attachments	No standard adopted by HHS	Additional information submitted with a prior authorization or pre-certification request, such as medical records to explain
2 2 , 2	the need for a particular procedure or service.	

Claim-Related Attachments. The universe (denominator) for counting claim-related attachments is the same as that for Claim Submission above. As with Claim Submission, claim attachments will be counted for all "legitimate claims" received.

A *Legitimate Claim* is defined as an itemized statement of rendered services and costs from a health care provider or facility received by the health plan for payment for health care. A claim can be submitted via a manual process using paper or electronic system either directly or through intermediary billers and claims clearinghouses.

Notes for counting claim-related attachments:

- If possible, attachments should be counted even if there is no direct claim for payment given reimbursement contracts; such transactions are considered the transmission of encounter information for the purpose of reporting health care. Encounters may or may not be included depending on the ability to report separately by the health plan. If encounters cannot be separated from claims, the participant should notify CAQH upon data submission. Encounters may be reported within the appropriate data submission field.
- Claims reported should be only those received for medical expense services for insured/enrollees
 participating in the health plan. Only ASC X12N/005010X2I2 Health Care Claim 837 I (Institutional)
 and 837 P (Professional) claims are included at this time. Claim attachments associated with dental
 and vision transactions may be reported separated in the appropriate column.
- Adjusted claims and duplicate claims may be received by the health plan system as a legitimate
 claim and will not be rejected until after claim logic is applied. These claims should be counted in
 the measure as they are received by the health plan. Processed or Adjudicated Claims would be a
 step beyond received and should not be used for determining a received claim as it would narrow
 the universe for the intended measurement.
- Attachments may be received via initial claims submissions or subsequent claims appeal processes.

Prior Authorization Attachments. The universe (denominator) for prior authorization attachments is the number of prior authorization transactions for Medical/Surgical (No Rx) events counted above.

Prior authorization or pre-certification transactions are defined as inquiries and submissions of information from healthcare practitioners and facilities, ie. physicians' offices, hospitals, and outpatient facilities, as well as responses and confirmations from health plans. For the 2014 Index, we are including all transactions related to medical/surgical prior authorization events, including initial inquiries and subsequent submissions of information and responses that may include attachments. These inquiries from healthcare providers may include inquiries related to authorization for prescription drug benefits. Prior authorization attachments associated with dental and vision claims may be reported separated in the appropriate column.

Coordination of Benefits (COB) Claims

COB claims are sent to a secondary payer with the primary payer's remittance advice after the primary payer has adjudicated the claim.

The new COB measure will determine to what extent the 837 COB claim submission capability is being used relative to paper COB claim submission, and is intended to help understand the frequency and costs associated with processing COB claims

Paper COB claims from EDI enabled and non-EDI able providers make up a substantial portion of claims still being submitted on paper.

The new COB claims measure is a subset of the larger Claim Submission measure:

	Adopted HIPAA Standard	Description
COB Claim Submission	ASC X12N 837	A request to obtain payment or transmission of encounter information for the purpose of reporting health care that is coded as for coordination of benefits.

Most claims submitted are either on paper or via standardized electronic transaction (837). However, since many COB claims may have attachments, we are using a larger set of possible categories for COB claim transmissions to allow for COB claims with attachments:

- Received via Paper Delivery (mail, FedEx etc.)
- Received by Fax
- Non-standardized -- Received by Email (PDF)
- Non-standardized -- Website/Portal Submission
- Standardized Electronic Transmission (837)

Note: this measure should include ONLY medical claims, not auto or liability secondary claims.

Notes for counting COB claims: Claims reported should be only those received for medical expense services for insured/enrollees participating in the health plan. For standardized electronic claims, only ASC X12N/005010X2I2 Health Care Claim 837 I (Institutional) and 837 P (Professional) claims are included at this time.

Note on separating COB claims: Some responding health plans may be able to separately count commercial COB and Medicare COB claims. If this separate counting is possible, please use the extra columns to separate the counts and label them. The total column should add to all COB claims.

Note on COB claim attachments. Claim attachments are counted under the claim attachment category above. Some responding health plans may be able to separately count COB claim attachments from other claim attachments. If this separate counting is possible, please use the extra columns under the Claim Attachments category to break out counts of COB claim attachments. The total column for Claim Attachments should add to all claim attachments.

Referral Certification

Referral Certification transactions are requests from a health care provider to a health plan to obtain authorization for referring an individual to another health care provider.

Referral Certification transactions are classified in the same suite of are transactions as prior authorization/pre-certification of insurance for medical procedures or goods and services. However, the referral certification transaction is quite different, since it confirms coverage for services delivered by a referred provider, rather than for a particular service.

	Adopted HIPAA Standard	Description
Referral Certification	ASC X12N 278	A request from a provider to a health plan to obtain authorization for referring an individual to another provider; or a response from a health plan regarding a referral certification request.

New for the 2015 Index, our goal is to get information on the numbers of referral certification transactions, their mode (electronic vs. manual) and costs. Referral certification may be used extensively by some health plans and not very frequently by others. Referral certification procedures may be more apt to be performed via standardized electronic transaction than other prior authorization transactions,

The 2015 Index data submission includes referral certification transactions in the categories of transaction types as prior authorization/pre-certification:

- Telephone
- Fax or Email
- Interactive Voice Recognition (IVR)
- Non-standardized Website/Portal Transmission
- Standardized Electronic Transmission HIPAA 278
- Other (specify in comments)

Note:

• This category does NOT include prior authorization/pre-certification. For the 2015 Index, we are counting prior authorization/pre-certification transactions separately (see above).

Enrollment/Disenrollment Transactions

Beginning in the 2015 Index, we are studying two transactions that are not claim related, and are not performed between health plans and providers. The first of these is enrollment/disenrollment transactions, which are communications between health plans and employers, brokers, or health insurance exchanges regarding enrollment lists, or modifications to enrollment list (drop, add, change)

	Adopted HIPAA Standard	Description
Employer/HIX/Broker		Enrollment/disenrollment transactions can be initial
Enrollment/	ASC X12N 834	enrollments, full file replacement (enrollment changes or to
Disenrollment		true up enrollment) or add/change/terminate enrollment.

There is one main category for reporting all or total Enrollment/Disenrollment transactions, and a separate optional breakout for transactions from health insurance exchange (HIX) Enrollment/Disenrollment transactions.

The Enrollment/Disenrollment transaction can encompass a periodic full update of an employer's health plan enrollees, or it can be a change to an existing enrollment dataset, with modification instructions to add, delete, or modify coverage terms for particular enrollees.

Most employers, brokers, or HIXs will likely use one particular method of enrollment/disenrollment transactions exclusively. We are asking health plan respondent for counts of employers/brokers/HIXs (in total) by the type of method they use. We are also asking for the number of enrollees (covered lives) and the total numbers of transactions in these categories:

Enrollment-Disenrollment (Paper by Mail or Fax)

Enrollment-Disenroll (Spreadsheet or Custom File)

Enrollment-Disenrollment (Portal/Website Data Entry)

Enrollment-Disenrollment (HIPAA 834)

Employer Premium Payment

Beginning in the 2015 Index, we are studying two transactions that are not claim related, and are not performed between health plans and providers. The second of these is employer premium payments, which are communications between employers and health plans, and their banks, regarding authorization to make a premium payment and explanations of premium payments.

	Adopted HIPAA Standard	Description
Employor/UIV/Prokor	ASC X12N 820	The HIPAA standard electronic premium payment
Employer/HIX/Broker Premium Payment/	005010X218	transaction 820 can be sent to bank to move money only;
Explanation	(employer)	sent to bank to move money with detailed remittance info; or
Ехріанаціон	005010X306 (HIX)	sent directly to payee with remittance information only.

This measure is designed to create an initial baseline for electronic premium payment transactions. The HIPAA 820 transaction can be used by employers and brokers, and (potentially) health insurance exchanges (HIXs) to initiate the movement of funds via their bank, also to communicate with health plans on the details of payment. Analogous to a remittance advice that accompanies health plan claim payments, information on the premium payment can be sent to the health plan with the payment, or as a separate explanation.

As with Enrollment/Disenrollment transactions, there is one main category for reporting all or total Premium Payment transactions, and a separate optional breakout for transactions from health insurance exchange (HIX) Enrollment/Disenrollment transactions.

Most employers, brokers, or HIXs will likely use one particular method of enrollment/disenrollment transactions exclusively. We are asking health plan respondent for counts of employers/brokers/HIXs (in total) by the type of method they use. We are also asking for the number of enrollees (covered lives) and the total numbers of transactions in these categories:

Premium Payment (Mail Delivery/Printed Check)
Premium Pay/Adv (Spreadsheet or Custom File)
Premium Pay/Adv (Portal/Website Data Entry)
Premium Payment (HIPAA 820 00501X218 or 00501x306)

Note that HIX premium payment transactions use a modified version of the HIPAA 820, which is numbered HIPAA 820 00501X306. The version used by employers is HIPAA 820 00501X218.

COSTS PER TRANSACTION

For the current 2014 Index, we are combining the data request for costs per transaction with the data requests for numbers of transactions for payers. CAQH will continue to sponsor a separate data acquisition project for costs per transaction of healthcare providers.

Health plans that participated in the 2013 and 2014 Index may already have developed methods of estimating costs per transaction for manual and electronic processes. However, many health plans will not have data on costs per transaction at hand, and may need assistance from CAQH in developing processes to estimate costs per transaction. The table below illustrates the desired result fields for the costs per transaction data submission. The Data Submission Templates also contain worksheets that illustrate some (but certainly not all) methods of estimating those costs from data that may be available.

Notes:

When a particular type of transaction can be handled in more than one way (such as individual vs. batch processing), and therefore there are different costs per transaction within a type of transaction, please use a blended average rate.

Costs for manual transactions for claim payment/RA are estimated on a per claim basis, NOT at per-mailing basis (when multiple payments/RAs are including in a bundled mailing). This is to compare transaction costs for mailed claim payments vs. those for electronic claim payments.

Worksheets for Estimating Costs Per Transaction

The Data Submission Templates provided to responding health plans include three worksheets for estimating transaction costs (see Appendix C). In some cases, internal surveys of persons handling transactions with healthcare providers may be necessary. For example, asking persons to allocate the time they spend on different transactions may be a useful foundation for building estimates of costs per transaction.

The first worksheet builds from total hours worked per transaction, and links directly to the number of transactions from the responding plan's separate report on numbers of transactions. Using estimates of overhead costs as a percentage of labor costs, estimates of total "fully loaded" costs per transaction are developed.

The second worksheet builds instead from the numbers of transaction handled per hour. Again, the total numbers of transactions, labor costs per hour, and overhead cost percentages are applied to build estimates of costs per transaction.

The third worksheet builds from a known budget for handling provider transactions, and uses estimates of time spent by transaction type as a percentage of all work time to allocate work effort to various

transactions. This method may be the most commonly used by responding plans. It would likely require a survey of personnel handling provider transactions in order to allocate work time to each transaction.

simplifying healthcare adminis	H _®		
mission Information (data for	r calendar year 2014)		
: 14 mid year or annual averag sumptions of Data Submissio		vent:	
		on in rows 25-45 as for each transacti loaded costs per transaction, but the	
	Fully Loaded Costs (\$) Per Transaction	Example: 2014 Aggregated Result	Modalities
n		\$0.66	Paper Delivery
ation		\$2.52	Phone Call, Fax
ion/Pre-Certification		\$3.98	Phone Call, Fax
Jir y		\$4.85	Phone Call, Fax
im, not per mailing)		\$0.18	Check Mail
daim, not permailing)		\$0.17	Fax, Mail
laim Related		\$0.63	Mail, Fax, Email
rior Authorization		\$0.45	Mail, Fax, Email
Benefits (COB) Claims ation		NA NA	Mail, Fax, Email Phone Call, Fax
nrollment		NA NA	Paper, Fax, Spre
nt		NA NA	Paper Check
			'
	Fully Loaded Costs (\$) Per Transaction	Example: 2014 Aggregated Result	
: n	Turioucilori	\$0.10	Automated
ation		\$0.03	IVR, Portal, Auto
ion/Pre-Certification		\$0.04	IVR, Portal, Auto
uiry		\$0.03	IVR, Portal, Auto
im, not per mailing)		\$0.05	Automated
daim, not per mailing)		\$0.04	Automated
laim Related		NA	Auto (HL7 or X12
rior Authorization			Auto (HL7 or X1)
			Automated, Por IVR, Portal, Auto
nrollment			DDE, Auto
nt		NA	Auto
Benef ation nrollr	its (COB) Claims	īts (COB) Claims	īts (COB) Claims NA NA nent NA

APPENDIX A

2015 Index Advisory Council

Member Organization

Aetna AHIP Anthem

Blue Cross Blue Shield of Michigan

Richard Nelli Advisors, LLC

CAQH CAQH

CMS Office of E-Health Standards and Services

CIGNA FloridaBlue InstaMed MGMA

Milliman, Inc. Milliman, Inc.

Nachimson Advisors, LLC

Premier Inc.

THINK-Health and Health Populi

UnitedHealthcare

2014 Advisory Council Member

Jay Eisenstock Tom Meyers Katy Blomeke John Bialowicz Richard Nelli

Robin Thomashauer

Jeff Lemieux

Denescia Green (Liaison)

Paul Keyes
Tab Harris
Bill Marvin
Rob Tennant
Andrew Naugle
Susan Philip

Stanley Nachimson

Erik Swanson

Jane Sarasohn-Kahn

Chris Kent

APPENDIX B

Data Collection Template – Numbers of Transactions

Note, the Data Collection Templates may be modified or corrected in subsequent versions. See http://caqb.org/index_contribute.php for the latest information

The data submission from below allows your company to split out results in a separate column for particular husiness lines and/or regions. Feace decailse the business and a region for each column used in the following section. Fraction of Contract Telephones Product or Business Information Fraction of Region of the Product or Business Information Fraction of Contracted Region (Fraction of Physician Return of Physician Region of Physician Return of Physician	2015 CAQH	ndex Index Data Submission Information (data for calendary	ear 2014)						
which of Contact Fire Interprine: izeneral Comments and Assumptions of Data Submission and Reporting Entity: izeneral Comments and Assumptions of Data Submission and Reporting Entity: izeneral Comments and Assumptions of Data Submission and Reporting Entity: izeneral Comments and Assumptions of Data Submission and Reporting Entity: Product or Business and or region for each column used in the following section. Separat cultumns to the right if needed and explain in the comments									
Total Comments and Assumptions of Data Submission and Reporting Entity: the data submission form below allows your company to split out results in a separate column for particular business lines and/or regions. Person describe the business and or region for each column used in the following section. Product or Business Information Product or Business Information Total Commercial Advantage Product or Business Information Total Commercial Advantage Hedicare Hedicari Medicare Hedicari Medicari Medicare Hedicari Medicare Hedicare Medicare Hedicare Medicare Hedicare Medicare Hedicare Medicare Hedicare Medicare Hedicare									
The data submission form below allows your company to split out results in a separate column for particular business lines and/or regions. Peace describe the business and or region for each column used in the following section. Product or Business Information Total Commercial Advantage Product or Business Information Total Commercial Advantage Medicare Medicare Medicare Medicare Medicarid Medi									
Product or Resines Information Total Commercial Advantage HMO/Risk Dental Vision	General Co	nments and Assumptions of Data Submission and Reporting E	Entity:						
Product or Resiness Information Total Commercial Advantage HMO/Risk Dental Vision									
Product or Resines Information Total Commercial Advantage HMO/Risk Dental Vision									
Product or Resines Information Total Commercial Advantage HMO/Risk Dental Vision									
Product or Besiness Information Product or Besiness Information Total Commercial Advantage HMO/Risk Dental Vision Wember Months Represented (2014 calendar year): Wember Months Represented (2014 calendar year) Number of Contracted Non-Physician Network Providers (NPs, PAs etc.): Number of Contracted Network Physicians (M.D. and ID.O.): Number of Contracted Network Physicians (M.D. and ID.O.): Number of Contracted Network Hospital and Outpatient Facilities: Comments: Please Fill in the numbers of transactions in the rows below for each column described above, a coording to the specifications In the 2014 Reporting Standards and Data Submission Guide. Chain Submission Chain Submission Chain Submission Chain Submission SAMP Manual - Facility Electronic (HIPAA 8377) Provider Electronic (HIPAA 8377) Facility Electronic (HIPAA 8377) Facility Comments: Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Total Reporting Portal ADD II and Portal Report Portal ADD II and Portal Report Portal Repo					icular business				
Product or Business Information Total Commercial Advantage HMO/Risk Dental Vision Wembers Represented (2014 calendar year average or mid-year): Wember Months Represented (2014 calendar year) Number of Contracted Non-Physician (RMD, and DLO): Number of Contracted Non-Physician (RMD, and DLO): Number of Contracted Network Physicians (RMD, and DLO): Number of Contracted Network Hospital and Outpatient Facilities: Comments: Please fill in the numbers of transactions in the rows below for each column described above, according to the specifications In the 2014 Reporting Standards and Data Submission Galde. Code Type of Transaction Number of Claims Submitted, Jan 1 to December 31, 2014 Claim Submission Number of Claims Submitted, Jan 1 to December 31, 2014 Claim Submission Number of Claims Submitted, Jan 1 to December 31, 2014 Claim Submission Number of Claims Submitted, Jan 1 to December 31, 2014 Claim Submission Number of Claims Submitted, Jan 1 to December 31, 2014 Claim Submission Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Inquiries (Telephonic) IVIEL Inquiries (Telephonic) IV	Please desc	ibe the business and or region for each column used in the foll	lowing section.	•					
Product or Besiness Information Wembers Represented (2014 calendar year average or mid-year): Members Months Represented (2014 calendar year): Member Months Represented (2014 calendar year): Member of Contracted Non-Physician Network Providers (NPs, PAs etc.): Number of Contracted Non-Physician Network Providers (NPs, PAs etc.): Number of Contracted Network Physicians (M.D. and D.O.): Number of Contracted Network Hospital and Outpatient Facilities: Comments: Please fill in the numbers of transactions in the rows below for each column described above, according to the specifications in the 2014 Reporting Standards and Data Submission Guide. Code					Medicare		ir une comminent	ь	Other
Member Months Represented (2014 calendar year) Number of Contracted Non-Physician (N.D. and D.O.): Number of Contracted Network Physicians (N.D. and D.O.): Number of Contracted Network Physicians (N.D. and D.O.): Number of Contracted Network Hospital and Outpatient Facilities: Comments: Please fill in the numbers of transactions in the rows below for each column described above, according to the specifications in the 2014 Reporting Standards and Data Submission Guide. Code Type of Transaction Number of Claims Submitted, Jan 1 to December 31, 2014 Chim Submission CSMIP Manual - Provider CSIMS7P Hectronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Frovider Electronic (HIPAA 837P) Frovider Electronic (HIPAA 837P) Frovider Electronic (HIPAA 837P) Frovider Electronic Standardized Adoption Rate Target? (percentage) Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Elegibility and Benefit Verification Inquiries (Fax) EVIVA Inquiries (Telephonic) EVIVA Inquiries (Fax) EVIVA Inquiries (Fax) EVIVA Inquiries (Portal/DDE) EVIVA Inquiries (HIPAA 200) EVICO Inquiries (HIPAA 20		Product or Business Information	Total	Commercial	Advantage		Dental	Vision	breakout?
Number of Contracted Non-Physician Network Providers (NPs, PAs etc.): Number of Contracted Network Physicians (N.D. and D.O.): Number of Contracted Network Physicians (N.D. and D.O.): Number of Contracted Network Physicians (N.D. and D.O.): Number of Contracted Network Hospital and Outpatient Facilities: Comments: Please ## in the numbers of transactions in the rows below for each column described above, according to the specifications in the 2014 Reporting Standards and Data Submission Guide. Code									
Number of Contracted Network Physicians (M.D. and D.D.): Number of Contracted Network Hospital and Outpatient Facilities: Comments: Please W in the numbers of transactions in the rows below for each column described above, according to the specifications the 2014 Reporting Standards and Data Submission Guide. Code									
Comments: Please fill in the numbers of transactions in the rows below for each column described above, according to the specifications In the 2014 Reporting Standards and Data Submission Guide. Code Type of Transaction Number of Claims Submitted, Jan 1 to December 31, 2014 Chaim Submission CSMP Manual - Provider SMF Manual - Provider SMF Manual - Pacility SCH837P Electronic (HIPAA 837) Provider SCH8371 Electronic (HIPAA 837) Provider SCH8371 Electronic (HIPAA 837) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and B									
Please fill in the numbers of transactions in the rows below for each column described above, according to the specifications in the 2014 Reporting Standards and Data Submission Guide. Code Type of Transaction Number of Claims Submitted, Jan 1 to December 31, 2014 Claim Submission SMP Manual - Provider SMR37 Electronic (HIPAA 837P) Provider SSMR37 Electronic (HIPAA 837P) Provider SSR837 Electronic (HIPAA 837P) Facility STOT Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification UTEL Inquiries (Tex) Liquiries (Tex) Liquiries (Fax) Liquiries (Fax) Liquiries (Portal/DDE) Liquiries (HIPAA 270) Liquiries (HIPAA	Number of	Contracted Network Hospital and Outpatient Facilities:							
Type of Transaction Number of Claims Submitted, Jan 1 to December 31, 2014 Claim Submission SMP Manual - Provider SMF Manual - Provider SMR37P Electronic (HIPAA 837P) Provider SMR37I Electronic (HIPAA 837P) Facility STOT Total Claims Submitted Comments: Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Inquiries (Telephonic) NVTEL Inquiries (Telephonic) NVTEL Inquiries (Fax) NVTE Inquiries (Portal/DDE) NVEZO Inquiries (Portal/DDE) NVEZO Inquiries (Portal/DDE) NVEZO Inquiries (Portal/DDE) NVEZO Inquiries (Portal/DDE) Electronic Standardized Adoption Rate Target? (percentage)	comments:								
Type of Transaction Number of Claims Submitted, Jan 1 to December 31, 2014 Ckim Submission SMP Manual - Provider SMR Manual - Provider SH837P Electronic (HIPAA 837P) Provider SH837I Electronic (HIPAA 837P) Facility STOT Total Claims Submitted Comments: Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification Inquiries (Telephonic) VIEL Inquiries (Telephonic) VIFAX Inquiries (Fax) VIVR Inquiries (Fax) VIVR Inquiries (Portal/DDE) VIPD Inquiries (Portal/DDE) VIPD Inquiries (Portal/DDE) VIPD Inquiries (Portal/DDE) VIPO Inquiries (HIPAA 270) VIOT Total Inquiries Electronic Standardized Adoption Rate Target? (percentage)									
Claim Submission SMP Manual - Provider SMR Manual - Provider SH837P Electronic (HIPAA 837P) Provider SH837I Electronic (HIPAA 837P) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Omments: Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification VIEL Inquiries (Telephonic) VIFAX Inquiries (Fax) VIVR Inquiries (Fax) VIVR Inquiries (Fortal/IDDE) VIPAY Inquiries (Portal/IDDE) VIPAY Inquiries (HIPAA 270) VIVIT Total Inquiries Eligibility and Benefit Verification Inquiries (IVE) VIPAY Inquiries (Fortal/IDDE) VIPAY Inquiries (Fortal/IDDE) VIPAY Inquiries (HIPAA 270) VIPAY Inquiries (INE) VIPAY INCUITED	ode		Number of Cl	aime Submittee	d Jon 1 to Dac	ambar 31 - 201.	4		
SMF Manual - Facility SNR37P Electronic (HIPAA 837P) Provider SNR371 Electronic (HIPAA 837I) Facility Total Chains Submitted Electronic Standardized Adoption Rate Target? (percentage) Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification VTEL Inquiries (Telephonic) Inquiries (Telephonic) VIVIX Inquiries (Fax) VIVIX Inquiries (Foxta) VIVIX In		Claim Submission			a, a 1 to be c				
SH837P Electronic (HIPÁA 837P) Provider SH8371 Electronic (HIPÁA 837P) Provider STOT Total Claims Submitted 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SMP								
Electronic (HIPAA 8371) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification EVTEL Inquiries (Telephonic) EVFAX Inquiries (Fax) EVIPOR Inquiries (Fax) EVPOR Inquiries (Portal/DDE) EVHZO Inquiries (HIPAA 270) EVICT Total Inquiries EVETOT Total Inquiries Electronic Standardized Adoption Rate Target? (percentage)									
Electronic Standardized Adoption Rate Target? (percentage)	CSMF	-							
Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification EVTEL Inquiries (Telephonic) EVFAX Inquiries (Telephonic) EVFAX Inquiries (IVR) EVFOX Inquiries (IVR) EVFOX Inquiries (Portal/DDE) EVFAY Inquiries (Portal/DDE) EVFAY Inquiries (HIPAA 270) EVITOI Total Inquiries 0 0 0 0 0 0 0 Electronic Standardized Adoption Rate Target? (percentage)	CSMF CSH837P	Electronic (HIPAA 837P) Provider							
Number of Eligibility and Benefit Verification Inquiries, Jan 1 to December 31, 2014 Eligibility and Benefit Verification VIEL Inquiries (Telephonic) VVFAX Inquiries (Fax) VVFAX Inquiries (Fax) VVFOX Inquiries (Fox) VVFOX Inquiries (Portal/DDE) VVFOX Inquiries (Portal/DDE) VVFOX Inquiries (HIPAA 270) VVFOY Inquiries (HIPAA 270) VVFOY Inquiries Standardized Adoption Rate Target? (percentage)	CSMF CSH837P CSH8371	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837I) Facility Total Claims Submitted	0	0	0	C) C) C)
Eligibility and Benefit Verification	25MF 25H837P 25H837I 25TOT	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837I) Facility Total Claims Submitted	0	0	0	C) C) C)
VTEL	SMF SH837P SH837I STOT	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837I) Facility Total Claims Submitted	0	0	0	C	0 0	0 0)
VFAX Inquiries (Fax) VIVR Inquiries (IVR) VPOR Inquiries (Portal/DDE) VH270 Inquiries (HIPAA 270) VIOT Total Inquiries Total Inquiries 0 0 0 0 Electronic Standardized Adoption Rate Target? (percentage) 0 0 0 0	SMF SH837P SH837I STOT	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837I) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage)			0 nefit Verificat			ober 31, 2014)
VPOR Inquiries (Portal/DDE)	CSMF CSH837P CSH837I CSTOT Comments:	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Chims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification			0 ne fit Verificat			ober 31, 2014)
IVH270 Inquiries (HIPAA 270) VTOT Total Inquiries Electronic Standardized Adoption Rate Target? (percentage)	CSMF CSH837P CSH837I CSTOT Comments:	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837I) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic)			0 ne fit Verificat			o ber 31, 2014	
VIOT Total Inquiries 0 0 0 0 0 0 0 0 Electronic Standardized Adoption Rate Target? (percentage)	CSMF CSH837P CSH837I CSTOT Comments: EVTEL EVFAX	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Chains Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax)			0 nefit Verificat			o nber 31, 2014	
Electronic Standardized Adoption Rate Target? (percentage)	CSMF CSH837P CSH837I CSTOT Comments: COMMENTS: CSTOT C	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax) Inquiries (Flox) Inquiries (Portal/DDE)			0 ne fit Verificat) (ober 31, 2014	
Comments:	CSMF CSH837P CSH837I CSTOT Comments: VIEL VFAX VIVR CVPOR VH270	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837F) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax) Inquiries (IVR) Inquiries (Portal/DDE) Inquiries (HIPAA 270)	Number of Bi	igibility and Be		ion Inquiries,	lan 1 to Decem		
	CSMF CSH837P CSH837I CSTOT Comments: VIEL VFAX VIVR CVPOR VH270	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax) Inquiries (IVR) Inquiries (Portal/DDE) Inquiries (HIPAA 270) Total Inquiries	Number of Eli	igibility and Be		ion Inquiries,	lan 1 to Decem		
	CSMF CSHR37P CSHR37P CSHR37I CSTOT Comments: CVTEL CVFAX CVIVA CVPOR CV	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax) Inquiries (IVR) Inquiries (Portal/DDE) Inquiries (HIPAA 270) Total Inquiries	Number of Eli	igibility and Be		ion Inquiries,	lan 1 to Decem		
	CSMF CSHR37P CSHR37P CSHR37I CSTOT Comments: CVTEL CVFAX CVIVA CVPOR CV	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax) Inquiries (IVR) Inquiries (Portal/DDE) Inquiries (HIPAA 270) Total Inquiries	Number of Eli	igibility and Be		ion Inquiries,	lan 1 to Decem		
	SMF SH837P SH837I SOMMENTS: OMMENTS: VTEL VFAX VIVR VPOR VH270 V10T	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax) Inquiries (IVR) Inquiries (Portal/DDE) Inquiries (HIPAA 270) Total Inquiries	Number of Eli	igibility and Be		ion Inquiries,	lan 1 to Decem		
	SMF SH837P SH837I SOMMENTS: OMMENTS: VTEL VFAX VIVR VPOR VH270 V10T	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax) Inquiries (IVR) Inquiries (Portal/DDE) Inquiries (HIPAA 270) Total Inquiries	Number of Eli	igibility and Be		ion Inquiries,	lan 1 to Decem		
	SMF SHR37P SHR37I STOT Omments: VTEL VFAX VIVR VPOR VH270 VIOT	Electronic (HIPAA 837P) Provider Electronic (HIPAA 837P) Facility Total Claims Submitted Electronic Standardized Adoption Rate Target? (percentage) Eligibility and Benefit Verification Inquiries (Telephonic) Inquiries (Fax) Inquiries (IVR) Inquiries (Portal/DDE) Inquiries (HIPAA 270) Total Inquiries	Number of Eli	igibility and Be		ion Inquiries,	lan 1 to Decem		

(Fax) ((Pax) ((Pax) ((Potal/DDE) ((HIPAA 276) (quiries	CSTEL Inc CSFAX Inc CSIVR Inc CSPOR Inc CSH276 Inc CSTOT T	laim Status quiries (Telephonic)		im Status Inqu	ıiries, Jan 1 to I	December 31, 2	2014	
(Fax) ((Portal/DDE) ((HIPAA 276) (guiries) (c Standardized Adoption Rate Target? (percentage) Number of Claim Payments Made, Jan 1 to December 31, 2014 yment Payments Made - Check or Paper Based d for future use please do not delete row] Payments Made - Bank/Virtual Card Network d for future use please do not delete row] Payments Made - ErT via ACH Network yments Made - ErT via ACH Network winents Made (c Standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice or Other Electronic EOP In data this row reserved for future use] Number of Prior Authorization Requests (Pay Advice or Other Electronic EOP In data this row reserved for future use] Number of Remittance Advices Sent, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests (Pay	CSFAX Inc CSIVR Inc CSPOR Inc CSH276 Inc CSTOT T.	iquiries (Telephonic)						
((Portal/DDE) ((Portal/DDE) ((IPORTal/DDE) ((IPORTAL) ((IP	CSIVR Inc CSPOR Inc CSH276 Inc CSTOT To Ele							
(HIPAA 276) (HIPAA 276)	CSPOR Inc CSH276 Inc CSTOT T Ele	nquiries (Fax)						
Comparison Com	CSPOR Inc CSH276 Inc CSTOT To Ele	nquiries (IVR)						
Comparison Com	CSH276 Inc CSTOT To Ele	nquiries (Portal/DDE)						
Number of Claim Payments Made, Jan 1 to December 31, 2014 yment Payments Made - Check or Paper Based d for future use please do not delete row] Payments Made - Bank/Virtual Card Network d for future use please do not delete row] Payments Made - ET via ACH Network yments Made ic Standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) d for future use please do not delete row] In o data this row reserved for future use] In o data this row reserved for futur	CSTOT T	nquiries (HIPAA 276)						
Number of Claim Payments Made, Jan 1 to December 31, 2014 yment Payments Made - Check or Paper Based d for future use please do not delete row] Payments Made - Bank/Virtual Card Network d for future use please do not delete row] Payments Made - Bank/Virtual Card Network d for future use please do not delete row] Payments Made - EFT via ACH Network ymments Made ic Standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice Sent is Standardized Adoption Rate Target? (percentage) Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Number of Prior Authorization Requests, Jan 1 to December 31, 2014	Ele		0	0	0	0	0	
Number of Claim Payments Made, Jan 1 to December 31, 2014 yment Payments Made - Check or Paper Based d for future use please do not delete row] Payments Made - Bank/Virtual Card Network d for future use please do not delete row] Payments Made - ET Via ACH Network yments Made is Standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice or Other Electronic EOP In odata this row reserved for future use Number of Front Advices Sent, Jan 1 to December 31, 2014 Therefore There Advices Sent or Other Electronic EOP Electronic Remittance Advice or Other Electronic EOP		Total Inquiries		U	U	U	U	
yment Payments Made - Check or Paper Based d for future use please do not delete row] Payments Made - Bank/Virtual Card Network d for future use please do not delete row] Payments Made - EFT via ACH Network Payments Made - EFT via ACH Network Payments Made Ino data this row reserved for future use] Number of Remittance Advice standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice (HIPAA 835) d for future use please do not delete row] Intitance Advice Sent O O O O O O Intitation Reduction Rate Target? (percentage) Number of Prior Authorization Requests, Jan 1 to December 31, 2014 whorization (Medical/Surgical No Pharmacy) thorization Requests (Fax/Email) thorization Requests (Fax/Email) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (HIPAA 278) ior Authorization Requests (HIPAA 278)	Comments:	ectronic Standardized Adoption Rate Target? (percentage)						
yment Payments Made - Check or Paper Based d for future use please do not delete row] Payments Made - Bank/Virtual Card Network d for future use please do not delete row] Payments Made - EFT via ACH Network Payments Made - EFT via ACH Network Payments Made Ino data this row reserved for future use] Number of Remittance Advice standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice (HIPAA 835) d for future use please do not delete row] Intitance Advice Sent O O O O O O Intitation Reduction Rate Target? (percentage) Number of Prior Authorization Requests, Jan 1 to December 31, 2014 whorization (Medical/Surgical No Pharmacy) thorization Requests (Fax/Email) thorization Requests (Fax/Email) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (HIPAA 278) ior Authorization Requests (HIPAA 278)								
yment Payments Made - Check or Paper Based d for future use please do not delete row] Payments Made - Bank/Virtual Card Network d for future use please do not delete row] Payments Made - EFT via ACH Network Payments Made - EFT via ACH Network Payments Made Ino data this row reserved for future use] Number of Remittance Advice standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice (HIPAA 835) d for future use please do not delete row] Into data this row reserved for future use] Ino data this row reserved for future use] Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Portal Remittance Advice (HIPAA 835) d for future use please do not delete row] Ino data this row reserved for future use] Ino data this row reserved for future use] Number of Prior Authorization Requests, Jan 1 to December 31, 2014 whorization (Medical/Surgical No Pharmacy) thorization Requests (Flephonic) thorization Requests (Flephonic) thorization Requests (Flex/Email) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (Portal/Website) thorization Requests (HIPAA 278) ior Authorization Requests (HIPAA 278)								
Check or Paper Based If of future use please do not delete row] Payments Made - Bank/Virtual Card Network If of future use please do not delete row] Payments Made - EFT via ACH Network Payments Made - EFT via ACH Network Payments Made - EFT via ACH Network Payments Made Ic Standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice (HIPAA 835) If of ruture use please do not delete row] In o data this row reserved for future use] In o data this row reserved for future use of the future u		laim Payment	Number of Cla	im Payments	Made, Jan 1 to	December 31,	2014	
Payments Made - Bank/Virtual Card Network of for future use please do not delete row] Payments Made - EFT via ACH Network syments Made ic Standardized Adoption Rate Target? (percentage) Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Protal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) of for future use please do not delete row] ic Standardized Adoption Rate Target? (percentage) Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014		ount of Payments Made - rinted Check or Paper Based						
In o data this row reserved for future use	-	· · · · · · · · · · · · · · · · · · ·	[no data this r	ow reserved	for future use]		
Payments Made - EFT via ACH Network syments Made			Ino data this r	ow reserved	for future use	1		
Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) d for future use please do not delete row] ic Standardized Adoption Rate Target? (percentage) Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests, Jan 1 to December 31, 2014 Number of Prior Authorization Requests (Fary/Email) thorization Requests (Fary/Email) thorization Requests (Portal/Website) thorization Request (HIPAA 278) ior Authorization Requests 0 0 0 0 0 0 0			ino aata tiiis i		Tor ratare ase	,		
Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) In odata this row reserved for future use) mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future use] mittance Advices Sent In odata this row reserved for future u		•	0	0	0	0	0	
Number of Remittance Advices Sent, Jan 1 to December 31, 2014 mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) d for future use please do not delete row] mittance Advices Sent				U	U	U	U	
mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) d for future use please do not delete row] [no data this row reserved for future use] emittance Advices Sent	Comments:	ectionic standardized Adoption Rate ranget: (percentage)						
mittance Advice Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) d for future use please do not delete row] in Standardized Adoption Rate Target? (percentage) Number of Prior Authorization Requests, Jan 1 to December 31, 2014 **Thorization (Medical/Surgical No Pharmacy) **Thorization Requests (Telephonic) **Thorization Requests (Fax/Email) **Thorization Requests (Portal/Website) **Thorization Request (HIPAA 278) **Thorization Requests (Portal/Website) **Thorization Requests (Portal/Website) **Thorization Requests (Portal/Website) **Thorization Requests (Portal/Website) **Thorization Request (HIPAA 278) **Thorization Requests (Portal/Website) **Thorization Request (HIPAA 278) **Thorization Request (HIPAA 278) **Thorization Request (Portal/Website) **Thorization Request (HIPAA 278) **Thoriz								
Printed or Paper Based Remittance Advice Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) di for future use please do not delete row] In odata this row reserved for future use] In odata this row reserve	CI:	laim Remittance Advice	Number of Re	mittance Advi	ces Sent, Jan 1	to December 3	31, 2014	
Portal Remittance Advice or Other Electronic EOP Electronic Remittance Advice (HIPAA 835) d for future use please do not delete row] emittance Advices Sent		ount of Printed or Paper Based Remittance Advice						
Electronic Remittance Advice (HIPAA 835) d for future use please do not delete row] Emittance Advices Sent 0 0 0 0 0 0 ic Standardized Adoption Rate Target? (percentage) Number of Prior Authorization Requests, Jan 1 to December 31, 2014 thorization (Medical/Surgical No Pharmacy) thorization Requests (Telephonic) thorization Requests (Fax/Email) thorization Requests (IVR) thorization Requests (Portal/Website) thorization Request (HIPAA 278) ior Authorization Requests 0 0 0 0 0 0		ount of Portal Remittance Advice or Other Electronic EOP						
Number of Prior Authorization Requests, Jan 1 to December 31, 2014 thorization (Medical/Surgical No Pharmacy) thorization Requests (Telephonic) thorization Requests (Fax/Email) thorization Requests (IVR) thorization Requests (Portal/Website) thorization Request (HIPAA 278) ior Authorization Requests 0 0 0 0 0 0	CRRAH835 Co	ount of Electronic Remittance Advice (HIPAA 835)						
Number of Prior Authorization Requests, Jan 1 to December 31, 2014 thorization (Medical/Surgical No Pharmacy) thorization Requests (Telephonic) thorization Requests (Fax/Email) thorization Requests (IVR) thorization Requests (Portal/Website) thorization Request (HIPAA 278) ior Authorization Requests 0 0 0 0 0 0		, , ,	Ino data this r	ow reserved	for future use	1		
Number of Prior Authorization Requests, Jan 1 to December 31, 2014 thorization (Medical/Surgical No Pharmacy) thorization Requests (Telephonic) thorization Requests (Fax/Email) thorization Requests (IVR) thorization Requests (Portal/Website) thorization Request (HIPAA 278) ior Authorization Requests 0 0 0 0 0 0							0	
Number of Prior Authorization Requests, Jan 1 to December 31, 2014 thorization (Medical/Surgical No Pharmacy) thorization Requests (Telephonic) thorization Requests (Fax/Email) thorization Requests (IVR) thorization Requests (Portal/Website) thorization Request (HIPAA 278) ior Authorization Requests 0 0 0 0 0 0				U	U	U	U	
thorization (Medical/Surgical No Pharmacy) thorization Requests (Telephonic) thorization Requests (Fax/Email) thorization Requests (IVR) thorization Requests (Portal/Website) thorization Request (HIPAA 278) ior Authorization Requests 0 0 0 0 0 0	Comments:	ectronic Standardized Adoption Rate Target? (percentage)						
·	PAFAX Pri PAIVR Pri PAPOR Pri PAH270 Pri	rior Authorization Requests (Fax/Email) rior Authorization Requests (IVR) rior Authorization Requests (Portal/Website) rior Authorization Request (HIPAA 278)	0	0	0	0	0	
e standardized Adoption rate ranges. (percentage)				0	0	0	0	
	Comments:	ectionic standardized Adoption rate ranger: (percentage)						
	At							nple COB vs.
Number of Claim-Related Attachments, Jan 1 to December 31, 2014 ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs.	ACMAIL Re	eceived via Paper Delivery (mail, FedEx etc.)						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs.		•						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax		· · · · · · · · · · · · · · · · · · ·						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax and ardized Received by email (PDF)		• •						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax and ardized Received by email (PDF) and ardized Website/portal submission	ACHL7 Sta	tandardized Electronic Transmission (HL7)						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax and ardized Received by email (PDF) and ardized Website/portal submission		tandardized Electronic Transmission (X12)						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax hadardized Received by email (PDF) hdardized Website/portal submission lized Electronic Transmission (HL7)		Total Claim-Related Attachments	0	0	0	0	0	
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax dadrdized Received by email (PDF) dadrdized Website/portal submission lized Electronic Transmission (HL7) lized Electronic Transmission (X12)	ACX12 Sta				Ü	Ü		
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax didardized Received by email (PDF) hadardized Website/portal submission dized Electronic Transmission (HL7) dized Electronic Transmission (X12) aim-Related Attachments 0 0 0 0 0 0	ACX12 Sta							
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax didardized Received by email (PDF) hadardized Website/portal submission dized Electronic Transmission (HL7) dized Electronic Transmission (X12) aim-Related Attachments 0 0 0 0 0 0	ACX12 Sta							
	ACMAIL Re ACFAX Re ACPDF No ACOR No	ttachments Claim, COB, or Claim Appeal Related (use bre eceived via Paper Delivery (mail, FedEx etc.) eceived by Fax on-standardized Received by email (PDF) on-standardized Website/portal submission tandardized Electronic Transmission (HL7) tandardized Electronic Transmission (X12)	eakout column	s, such as colu	mns J and K, to	breakout by ty	ype for exam	יו
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs.	ACFAX Re ACPDF No ACOR No	eceived by Fax on-standardized Received by email (PDF) on-standardized Website/portal submission						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax		· · · · · · · · · · · · · · · · · · ·						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax adardized Received by email (PDF)		• •						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax and ardized Received by email (PDF) and ardized Website/portal submission	LHL/ Sta							
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax and ardized Received by email (PDF) and ardized Website/portal submission								
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax hadradized Received by email (PDF) h								
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax hadradized Received by email (PDF) h		Total Claim-Related Attachments	0	0	0	0	0	
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) I by Fax I dardized Received by email (PDF) I dardized Website/portal submission I dized Electronic Transmission (HL7) I dized Electronic Transmission (X12)	CX12 Sta			0	0	0	0	
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax didardized Received by email (PDF) hadardized Website/portal submission dized Electronic Transmission (HL7) dized Electronic Transmission (X12) aim-Related Attachments 0 0 0 0 0 0	ACX12 Sta	ectronic standardized Adoption Rate Target? (percentage)						
ents Claim, COB, or Claim Appeal Related (use breakout columns, such as columns J and K, to breakout by type for example COB vs. d via Paper Delivery (mail, FedEx etc.) d by Fax didardized Received by email (PDF) hadardized Website/portal submission dized Electronic Transmission (HL7) dized Electronic Transmission (X12) aim-Related Attachments 0 0 0 0 0 0	ACX12 Sta							

		Number of Pri	or Authorizati	on Attachmen	ts, Jan 1 to Dec	ember 31, 201	4
	Attachments Prior Authorization						
APMAIL	Received via Paper Delivery (mail, fedex etc.)						
APFAX	Received by Fax						
APPDF	Received by email (PDF)						
	Website/portal						
	Standardized Electronic Transmission (HL7)						
	Standardized Electronic Transmission (X12)						
APTOT	Total Prior Authorization-Related Attachments	0	0	0	0	0	
	Electronic Standardized Adoption Rate Target? (percentage)		U	0	0	U	
Comments:	, , , , , , , , , , , , , , , , , , , ,						
comments.							
*****	***************************************	*******	******	*****	******	*****	*******
	R THE 2015 INDEX, PLEASE CALL IF YOU HAVE QUESTIONS **						
	Coordination of Benefits Claims (use breakout columns, suc	h as columns J	and K, to breal	out by type	for example o	ommercial CO	B vs. Medica
	Received via Paper Delivery (mail, FedEx etc.)						
COBFAX	Received by Fax						
COBEMAIL	Non-standardized Received by email (PDF)						
	Non-standardized Website/portal submission						
	COB Transactions via Standardized 837						
	Total COB Claims	0	0	0	0	_	
СОВТОТ		0	0	0	0	0	
Comments:	Electronic Standardized Adoption Rate Target? (percentage)						
** NEW FOR	R THE 2015 INDEX, PLEASE CALL IF YOU HAVE QUESTIONS **	Number of Re	ferral Certifica	tion/Approval	Requests, Jan	1 to Decembe	r 31, 2014
	Referral Certification/Approval						
REFCTEL	Referral Certification Requests (Telephonic)						
	Referral Certification Requests (Fax/Email)						
	Referral Certification Requests (IVR)						
	Referral Certification Requests (Portal/Website)						
	Referral Certification Request (HIPAA 278)						
REFCTOT	Total Remittance Certification/Approval	0	0	0	0	0	
	Electronic Standardized Adoption Rate Target? (percentage)						
Comments:							
******	*********************	******	******	******	*******	******	*******
OPTIONAL	L	Number of Pri	or Authorizati	on Requests, J	an 1 to Decem	ber 31, 2014	
	Prior Authorization (RX Request from Providers)						
PATEL	Prior Authorization Requests (Telephonic)						
	Prior Authorization Requests (Fax)						
	Prior Authorization Requests (IVR)						
	Prior Authorization Requests (Portal/Website)						
	Prior Authorization Request (HIPAA 278)						
PATOT	Total Prior Authorization Requests	0	0	0	0	0	
	Electronic Standardized Adoption Rate Target? (percentage)						
Comments:							

	THE 2015 INDEX, PLEASE CALL IF YOU HAVE QUESTIONS ** Employer/Broker Enrollment/Disenrollment Transactions	Number of Employers Using	Number of Transactions	Number of Covered Lives
	Employer/Broker Enrollment-Disenrollment (Paper by Mail or Fax) Employer/Broker Enrollment-Disenroll (Spreadsheet or Custom File)			
	Employer/Broker Enrollment-Disenrollment (Portal/Website Data Entry) Employer/Broker Enrollment-Disenrollment (HIPAA 834) Electronic Standardized Adoption Rate Target? (percentage)			
	Total	0	0	
Comments:				
		Number of Exchanges	Number of	Number of Covered
	HIX Enrollment/Disenrollment Transactions HIX Enrollment/Disenrollment (Paper by Mail or Fax)	Using	Transactions	Lives
	HIX Enrollment/Disenrollment (Spreadsheet or Custom/Proprietary File) HIX Enrollment/Disenrollment (Portal/Website Data Entry)			
	HIX Enrollment/Disenrollment (HIPAA 834)			
	Electronic Standardized Adoption Rate Target? (percentage)	0	0	
Comments:	Total	0	0	
	Employer/Broker (?) Premium Payment/Explanation Transactions Employer/Broker (?) Premium Payment (Mail Delivery/Printed Check) Employer/Broker Premium Pay/Adv (Spreadsheet or Custom File) Employer/Broker Premium Pay/Adv (Portal/Website Data Entry) Employer/Broker (?) Premium Payment (HIPAA 820 00501X218) Total of Premium Payment Transactions Electronic Standardized Adoption Rate Target? (percentage)	Employers Using	Number of Transactions	
Comments:		0	0	
	Health Insuranace Exchange (HIX) Premium Payment/Explanation Transact HIX Premium Payment (Mail Delivery/Printed Check)	Number of Exchanges Using	Number of Transactions	Number of Covered Lives
	HIX Premium Payment/Advice (Spreadsheet or Custom/Proprietary File)			
	HIX Premium Payment/Advice (Portal/Website Data Entry)			
	HIX Premium Payment (HIPAA 820 00501x306)			
	Total of Premium Payment Transactions			
Comments:	Electronic Standardized Adoption Rate Target? (percentage)	0	0	

APPENDIX C

Data Collection Template – Costs per Transaction

Note, the Data Collection Templates may be modified or corrected in subsequent versions. See http://caqh.org/index_contribute.php for the latest information. Formulas will autocompute when actual data is entered.

Organizat Point of (Point of (RH Index Data Submission Information {data fo			
Point of (Point of (ion Name:	or calendar year 2014)		
Point of C				
	Contact Name:			
Point or c	Contact Email:			
Members	Contact Telephone: s Represented {2014 mid year or annual avera	ge): Comm	ant.	
	Somments and Assumptions of Data Submissi		ent.	
Please en	nter estimate of fully loaded (including overhead,	benefits etc.) costs per transactio	on in rows 25-45 as for each transactio	on type (manual, electronic):
	Norksheets 1-3 below are available to help your			
M anual T	ransactions			
		Fully Loaded	Example: 2014	
_		Costs (\$) Per Transaction	Aggregated	
ID 837	Transaction Type	Transaction	Result	Modalities
	Claim Submission Eligibility Verification		\$0.66 \$2.52	Paper Delivery Phone Call, Fax
270-271 278	Prior-Authorization/Pre-Certification		\$3.98	Phone Call, Fax
	Claim Status Inquiry		\$4.85	Phone Call, Fax
835	Payment (per claim, not per mailing)		\$0.18	Check Mail
835	Remittance (per claim, not per mailing)		\$0.17	Fax, Mail
	Attachments – Claim Related		\$0.63	Mail, Fax, Email
	Attachments — Prior Authorization			
937			\$0.45	Mail, Fax, Email
	Coordination of Benefits (COB) Claims		NA	Mail, Fax, Email Mail, Fax, Email
278			NA NA	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax
278 834	Coordination of Benefits (COB) Claims Referral Certification		NA	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax
278 834 820	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment		NA NA NA	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea
278 834 820	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment	Fully Loaded	NA NA NA NA Example: 2014	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea
278 834 820 Electronio	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment c Transactions	Costs (\$) Per	NA NA NA NA Example: 2014 Aggregated	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea
278 834 820 Electronio	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment c Transactions Transaction Type		NA NA NA NA Example: 2014 Aggregated Result	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea
278 834 820 Electronia ID 837	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment CTransactions Transaction Type Claim Submission	Costs (\$) Per	NA NA NA NA Example: 2014 Aggregated	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea Paper Check Automated
278 834 820 Electronic ID 837 270 - 271	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment c Transactions Transaction Type	Costs (\$) Per	NA NA NA NA NA Example: 2014 Aggregated Result \$0.10	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea Paper Check
278 834 820 Electronio 1D 837 2270 - 271	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment cTransactions Transaction Type Claim Submission Eligibility Verification	Costs (\$) Per	NA NA NA NA Example: 2014 Aggregated Result \$0.10 \$0.03	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea Paper Check Automated IVR, Portal, Auto
278 834 820 Electronic ID 837 270 - 271 278 276 - 277 835	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment c Transactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certification Claim Status Inquiry Payment (per claim, not per mailing)	Costs (\$) Per	Example: 2014 Aggregated Result \$0.10 \$0.03 \$0.04 \$0.03 \$0.05	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea Paper Check Automated IVR, Portal, Auto IVR, Portal, Auto IVR, Portal, Auto Automated
278 834 820 Electronic ID 837 270 - 271 278 276 - 277 835	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment c Transactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certification Claim Status Inquiry Payment (per claim, not per mailing) Remittance (per claim, not per mailing)	Costs (\$) Per	NA N	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea Paper Check Automated IVR, Portal, Auto IVR, Portal, Auto IVR, Portal, Auto Automated Automated
278 834 820 Electronic ID 837 270 - 271 278 276 - 277 835	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment c Transactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certification Claim Status Inquiry Payment (per claim, not per mailing) Remittance (per claim, not per mailing) Attachments — Claim Related	Costs (\$) Per	NA N	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea Paper Check Automated IVR, Portal, Auto IVR, Portal, Auto Automated Automated Automated Auto (HL7 or X12)
278 834 820 Electronic ID 837 270-271 278 276-277 835 835	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment c Transactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certification Claim Status Inquiry Payment (per claim, not per mailing) Remittance (per claim, not per mailing) Attachments — Claim Related Attachments — Prior Authorization	Costs (\$) Per	NA N	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea Paper Check Automated IVR, Portal, Auto IVR, Portal, Auto IVR, Portal, Auto Automated Automated Auto (HL7 or X12) Auto (HL7 or X12)
278 834 820 Electronic ID 837 270-271 278 276-277 835 835	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment CTransactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certification Claim Status Inquiry Payment (per claim, not per mailing) Remittance (per claim, not per mailing) Attachments — Claim Related Attachments — Prior Authorization Coordination of Benefits (COB) Claims	Costs (\$) Per	Example: 2014 Aggregated Result \$0.10 \$0.03 \$0.04 \$0.03 \$0.04 NA NA	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Sprea Paper Check Automated IVR, Portal, Auto IVR, Portal, Auto IVR, Portal, Auto Automated Automated Auto (HL7 or X12) Auto (HL7 or X12) Automated, Portal
ID 837 270 - 271 278	Coordination of Benefits (COB) Claims Referral Certification Enrollment/Disenrollment Premium Payment c Transactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certification Claim Status Inquiry Payment (per claim, not per mailing) Remittance (per claim, not per mailing) Attachments — Claim Related Attachments — Prior Authorization	Costs (\$) Per	NA N	Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Spread Paper Check Automated IVR, Portal, Auto IVR, Portal, Auto Automated Automated Automated Auto (HL7 or X12)

	ansactions				Overhead Rate		FROM VOLUME	: WHAT	
			Labor	Lahar Osata	(IT, Vendor,	Fully Loaded	Number of	Costs	(\$) Per
D	Transaction Type	Hours	Cost/Hour	Labor Costs	Benefits,	Cost (\$)	Transactions	Transa	
337	Claim Submission			\$0.00			\$0 ***	0	#DIV/
	Eligibility Verification			\$0.00			\$0 **	0	#DIV/
278	Prior-Authorization/Pre-Certification	on		\$0.00			\$0 ***	0	#DIV/
	Claim Status Inquiry	_\		\$0.00			\$0 **	0	#DIV/
35	Payment (per claim, not per mailing	7.		\$0.00			\$0 ***	0	#DIV/
335	Remittance (per claim, not per mai	iing)		\$0.00			\$0 \$0	0	#DIV/
	Attachments Claim Related Attachments Prior Authorization			\$0.00 \$0.00			\$0 \$0	0	#DIV/ #DIV/
337	Coordination of Benefits (COB) Clai	ime		\$0.00			\$0 \$0	0	#DIV/
278	Referral Certification	IIIIS		\$0.00			\$0 \$0	0	#DIV/
334	Enrollment/Disenrollment			\$0.00			\$0 \$0	0	#DIV/
320	Premium Payment			\$0.00			\$0 \$0	0	#DIV/
520	Fremium Fayment			Ş0.00			FROM VOLUME	U	WE WAN
lectronic	Transactions						SHEET:	WILL	WE WAIN
					(IT, Vendor,				
			Labor		Benefits,	Fully Loaded	Number of	Fully L	
D	Transaction Type	Hours	Cost/Hour	Labor Costs	Admin)	Cost (\$)	Transactions	Transa	
37	Claim Submission		,	\$0.00			\$0	0	#DIV/
	Eligibility Verification			\$0.00			\$0	0	#DIV/
178	Prior-Authorization/Pre-Certification	on		\$0.00			\$0	0	#DIV/
	Claim Status Inquiry			\$0.00			\$0	0	#DIV/
	Payment			\$0.00			\$0	0	#DIV/
35									
				\$0.00			\$0	0	#DIV/
	Remittance			\$0.00 \$0.00			\$0 \$0	0	
	Remittance Attachments Claim Related			\$0.00		:	\$0	0	#DIV/
335	Remittance Attachments Claim Related Attachments Prior Authorization			\$0.00 \$0.00		!	\$0 \$0		#DIV/ #DIV/
335	Remittance Attachments Claim Related			\$0.00 \$0.00 \$0.00		!	\$0 \$0 \$0	0	#DIV/ #DIV/ #DIV/
335 337 278	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai			\$0.00 \$0.00		:	\$0 \$0 \$0 \$0	0 0 0	#DIV/ #DIV/ #DIV/
335 337 378 334 320 Workshee	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment t 2 Another Optional Method of C	ims	Loaded Costs Per	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00			\$0 \$0 \$0	0 0 0 0 0	#DIV #DIV #DIV #DIV
335 337 278 334 320 Workshee Manual Tr	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment t 2 Another Optional Method of Cansactions	ims	Loaded Costs Per Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the	following tab)	50 50 50 50 50 50 WHAT WE WAN	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 278 334 3320 Workshee Manual Tr	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment t 2 Another Optional Method of C	ms Computing Fully I	Transactions	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the	following tab) Overhead Ra	50 50 50 50 50 50 WHAT WE WAN	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 278 334 320 Workshee Manual Tr D 337	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment tt 2 Another Optional Method of Cansactions Transaction Type Claim Submission	computing Fully I	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction	following tab) Overhead Ra	SO S	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 278 334 320 Workshee Manual Tr D 337 270 - 271	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment tt 2 Another Optional Method of Cansactions Transaction Type Claim Submission	Computing Fully I Modalities Paper Delivery Phone Call, Fax	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0!	following tab) Overhead Ra 0 0	\$0 \$0 \$0 \$0 \$0 \$0 \$0 WHAT WE WAN per Transaction te (\$) #DIV/0!	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 278 334 320 Workshee Manual Tr D 337 270 - 271	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment at 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification	Computing Fully I Modalities Paper Delivery Phone Call, Fax	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0! #DIV/0!	following tab) Overhead Ra 0 0 0	\$60 \$60 \$60 \$60 \$60 WHAT WE WAN per Transaction te (\$) #DIV/0!	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 278 334 320 Workshee Manual Tr D 337 270 - 271 278 276 - 277	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment tt 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatio	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Phone Call, Fax	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0! #DIV/0!	following tab) Overhead Ra 0 0 0	\$60 \$60 \$60 \$60 \$60 \$60 WHAT WE WAN per Transaction te (\$) #DIV/0! #DIV/0!	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 778 334 320 Workshee Manual Tr D 337 270 - 271 278 276 - 277 335	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment t 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatic Claim Status Inquiry	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Check Mail	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0! #DIV/0! #DIV/0!	following tab) Overhead Ra 0 0 0 0 0	\$60 \$60 \$60 \$60 \$60 \$60 \$60 \$60	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 778 334 320 Workshee Manual Tr D 337 270 - 271 278 276 - 277 335	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment tt 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatio Claim Status Inquiry Payment (per claim, not per mailin,	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Check Mail	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!	Following tab) Overhead Ra 0 0 0 0 0	\$60 \$60 \$60 \$60 \$60 \$60 WHAT WE WAN per Transaction te (\$) #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 37 78 34 320 Vorkshee Manual Tr D 337 70 - 271 78 76 - 277 35	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment t 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatic Claim Status Inquiry Payment (per claim, not per mailin Remittance (per claim, not per mailin	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!	following tab) Overhead Ra 0 0 0 0 0 0 0 0	\$60	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
337 178 134 120 Workshee Manual Tr D 137 170 - 271 178 176 - 277 135 135	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment at 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatic Claim Status Inquiry Payment (per claim, not per mailin, Remittance (per claim, not per mail Attachments Claim Related	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Mail, Fax, Email	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!	following tab) Overhead Ra 0 0 0 0 0 0	\$60	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
337 778 334 220 Vorkshee Alanual Tr D 337 70 - 271 78 76 - 277 35 35	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment t 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatic Claim Status Inquiry Payment (per claim, not per mailin Remittance (per claim, not per mai Attachments Claim Related Attachments Prior Authorization	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Mail, Fax, Email Mail, Fax, Email	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0!	Following tab) Overhead Ra 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SO S	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
337 778 334 220 Vorkshee Alanual Tr D 337 70 - 271 78 76 - 277 35 35	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment at 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatio Claim Status Inquiry Payment (per claim, not per mailin, Remittance (per claim, not per mail Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Spre	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0!	Following tab) Overhead Ra 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	\$60	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 334 334 320 Workshee Manual Tr D 337 370 - 271 335 335 335 337	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment at 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatio Claim Status Inquiry Payment (per claim, not per mailin, Remittance (per claim, not per mail Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Mail, Fax, Email Mail, Fax, Email	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Example in the Labor Costs Per Transaction #DIV/0!	Following tab) Overhead Ra 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SO S	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 334 334 320 Workshee Manual Tr D 337 270 - 271 278 335 335 337 278 337 337 338 337	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment t 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatic Claim Status Inquiry Payment (per claim, not per mailin, Remittance (per claim, not per mail Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Spre	Transactions Per Hour cadsheet Transactions	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$1.00 Transaction (see	Example in the Labor Costs Per Transaction #DIV/0! #Costs Per	following tab) Overhead Ra 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	\$60 \$60 \$60 \$60 \$60 \$60 \$60 \$60 \$60 \$60	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 334 334 330 Workshee Manual Tr D 337 37 37 37 37 37 37 37 37 33 35 33 35 33 37 33 33 33 33 33 33 33 33 33 33 33	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment t 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatic Claim Status Inquiry Payment (per claim, not per mailin Remittance (per claim, not per mai Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Mail, Fax, Email Mail, Fax, Spre Paper, Fax, Spre Paper Check	Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 Transaction (see	Example in the Labor Costs Per Transaction #DIV/0! ADDIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! Costs Per Transaction	following tab) Overhead Ra 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	\$60 \$60 \$60 \$60 \$60 \$60 \$60 \$60 \$60 \$60	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
335 337 334 334 320 Workshee Manual Tr D 337 370 - 271 378 376 - 277 335 337 338 339 339 339 340 351 361 370 381 381 381 381 381 381 381 381	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment tt 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatic Claim Status Inquiry Payment (per claim, not per mailin, Remittance (per claim, not per mai Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment Transactions Claim Submission	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Mail, Fax, Email Phone Call, Fax Paper, Fax, Spre Paper Check Automated	Transactions Per Hour eadsheet Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$1.00 \$0.00 \$1.00	Example in the Labor Costs Per Transaction #DIV/0! Labor/IT/Support Costs Per Transaction #DIV/0!	following tab) Overhead Ra 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	\$60	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
337 337 334 3320 Workshee Wanual Tr D 337 270 - 271 278 335 337 278 337 278 339 337 278 331 337 278 378 378 379 379 379 379 379 379 379 379	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment at 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatio Claim Status Inquiry Payment (per claim, not per mail Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment Transactions Claim Submission Eligibility Verification Eligibility Verification	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Phone Call, Fax Paper, Fax, Spre Paper Check Automated IVR, Portal, Automated	Transactions Per Hour eadsheet Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$1.00 \$0.00 \$1.00	Example in the Labor Costs Per Transaction #DIV/0! #DIV/0!	Following tab) Overhead Ra 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SO S	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/
Manual Tr D 3337 270 - 271 278 276 - 277 335 335 337 278 334 330 Electronic 337 270 - 271	Remittance Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment tt 2 Another Optional Method of Cansactions Transaction Type Claim Submission Eligibility Verification Prior-Authorization/Pre-Certificatic Claim Status Inquiry Payment (per claim, not per mailin, Remittance (per claim, not per mai Attachments Claim Related Attachments Prior Authorization Coordination of Benefits (COB) Clai Referral Certification Enrollment/Disenrollment Premium Payment Transactions Claim Submission	Modalities Paper Delivery Phone Call, Fax Phone Call, Fax Phone Call, Fax Check Mail Fax, Mail Mail, Fax, Email Phone Call, Fax Paper, Fax, Spre Paper Check Automated IVR, Portal, Automated	Transactions Per Hour adsheet Transactions Per Hour	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$1.00 \$0.00 \$1.00	Example in the Labor Costs Per Transaction #DIV/0!	Following tab) Overhead Ra 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	\$60	0 0 0 0 0 0	#DIV/ #DIV/ #DIV/ #DIV/ #DIV/

Worksheet 3 -- Another Optional Method of Computing Fully Loaded Costs Per Transaction (see Example in the following tab) Instructions: To use this worksheet option to estimate fully loaded costs per transaction, enter the total (fully loaded) budget for ALL manual transactions and ALL electronic transactions in the orange boxes and FROM VOLUME Manual Transactions SHEET: WHAT WE WANT: Fully Loaded Estimated Cost of All Percentage of Provider Costs by Transactions, Transaction with Percent of Fully Loaded Type (not Fully Loaded Cost by Costs of These required to 10 Transactions - Cost per Transaction --Manual sum to 100%) - Manual Transaction (\$) ID Transaction Type Transactions \$0.00 837 Claim Submission \$0 #DIV/0! 270 - 271 Eligibility Verification \$0 #DIV/0! 278 Prior-Authorization/Pre-Certification \$0 #DIV/0! \$0 #DIV/0! 276 - 277 Claim Status Inquiry 835 Payment (per claim, not per mailin \$0 #DIV/0! Remittance (per claim, not per mai \$0 #DIV/0! 835 Attachments -- Claim Related \$0 #DIV/0! \$0 Attachments -- Prior Authorization #DIV/0! 837 Coordination of Benefits (COB) Clai \$0 #DIV/0! #DIV/0! \$0 278 Referral Certification 834 Enrollment/Disenrollment \$0 #DIV/0! 820 \$0 #DIV/0! Premium Payment 0.0% Fully Loaded Estimated Cost of All Percentage of Provider Costs by Transactions, Transaction with Percent of Fully Loaded Type (not Fully Loaded Cost by Costs of These Transaction required to 10 Transactions - Cost per **Electronic Transactions** Electronic sum to 100%) - Electronic Transaction (\$) \$0.00 Claim Submission #DIV/0! \$0 270 - 271 Eligibility Verification \$0 #DIV/0! 278 Prior-Authorization/Pre-Certification \$0 #DIV/0! 276 - 277 Claim Status Inquiry \$0 #DIV/0! #DIV/0! 835 Payment \$0 \$0 #DIV/0! 835 Remittance Attachments -- Claim Related \$0 #DIV/0! \$0 Attachments -- Prior Authorization #DIV/0! 837 Coordination of Benefits (COB) Clai \$0 #DIV/0! Referral Certification \$0 #DIV/0! 278 #DIV/0! 834 Enrollment/Disenrollment \$0 820 Premium Payment \$0 #DIV/0!

APPENDIX D

Guiding Principles to Measurement and Reporting

CAQH and the Index Advisory Council believe that when collecting and reporting industry data it is imperative that the results are collected and reported consistently and accurately from one entity to another and from year to year. While there will always be some inherent differences between business operations and there will be barriers and challenges to defining measurement standards that can be applied across the large and diverse healthcare industry, all steps should be taken to set guiding principles, standardized definitions and a foundation to measurement and reporting.

There are many characteristics, attributes and methodologies that are important to defining useful, actionable and reliable measurement and reporting.

Measures should be relevant, meaningful and address processes and outcomes that are applicable and actionable for improvement (e.g., Improve Results, Reduce Cost, Increase Efficiency).

- Meaningful and Important
 - Significant to those being measured and the findings are useful for action.
 - The item of measurement is prevalent enough to warrant measurement and/or the financial implications are large enough to be considered for measurement.
- Controllable and Actionable
 - o Impact can be made acting on the results of the measurement.
 - The item of measurement controllable and action can be taken to improve that which is being measured.
- Strategically Important or Cost Effective
 - o The measurement drives competition and recognition in the marketplace.
 - Promotes efficient uses of resources, or reduce waste/low cost-effective activities.
- Variation and Potential for Improvement
 - Wide variation shows an opportunity for improvement, cost reduction and control.
 - Benchmarking against current state and working towards better performance drives improvement and efficiency.

Standardized methods, data availability and clear definitions are required for consistent, valid and accurate measurements for comparison and action. Measurement should not create an unnecessary burden for data collection and reporting and use a reliable methodology that is feasible to implement.

- Evidence Based
 - o There is strong evidence supporting the need for measurement.
 - o There guidelines or standards documenting the benefits and need for measurement.
- Reproducible, Valid and Accurate
 - Measures should produce the same results when applied to the same population and setting using the same method.
 - Measures are logical and precisely evaluate what is being studied or measured.
- Data Availability and Comparability

- Data is accessible and available.
- Stratification to account for differences among variables and reporting entities (e.g., entity type, geography, size, level of sophistication).
- o If there is potential for inconsistent measurement or manipulation that is undetectable, clear instructions and documentation must be provided to address limitations.
- Precise Specifications for data extraction, analysis methods and reporting
 - o The measurement is clearly defined and reproducible by an independent third party.
 - Clear definitions and standardized reporting methods to drive repeatable and consistent measurement are necessary to achieve adoption and use of results as industry benchmarks.

APPENDIX E - 2014 Data Submission Acknowledgment

CAQH Index® Data Submission Acknowledgment

This Data Submission Acknowledgement (the "Acknowledgement") governs the contribution of healthcare data by the organization identified below ("Submitter") to the Council for Affordable Quality Healthcare ("CAQH") in connection with the CAQH Index® ("Index") program and website located at www.caqh.org.

Submitter acknowledges that the value of the Index is dependent on full and accurate data from the contributing organizations. Accordingly Submitter agrees to submit complete and faithful data to the Index in the designated format and in accordance with data submission standards made available to respondents. Submitter represents that any data submitted is accurate and has not been falsified.

Supplier hereby grants to CAQH, the operator of the Index, a non-exclusive, irrevocable, royalty-free, worldwide license to manipulate the data submitted by Submitter, to incorporate such data into the Index, and to present such data as aggregated into the Index for public use on the Index website. Supplier represents that it has all rights necessary to grant such license to CAQH, and will defend and hold harmless CAQH against any claims to the contrary.

The Index aggregates data to report on industry trends. Accordingly, CAQH agrees that it will keep the disaggregated data submitted by Submitter confidential and will not disclose it to third parties other than (i) to subcontractors for the purpose of aggregating the data into the Index; and (ii) if and as required by applicable law. CAQH owns all data as modified and/or aggregated into the Index, and any use of the Index data is governed by the terms available on the Index website or under a separate license agreement.

NEITHER PARTY, ITS EMPLOYEES, OFFICERS, DIRECTORS, MEMBERS, AND/OR REPRESENTATIVES WILL BE LIABLE FOR ANY SPECIAL, INDIRECT, INCIDENTAL, EXEMPLARY, CONSEQUENTIAL LOSSES OR OTHER DAMAGES ARISING OUT OF OR IN CONNECTION WITH THIS ACKNOWLEDGEMENT.

This Acknowledgement is governed by the laws of the State of New York.

Acknowledged and Agreed:		
Organization:	 	
Ву:	 	
Name:	 	
Title:	 	
Date:		