Welcome to the 2024 CAQH Index Dental Data Collection Tool.

The CAQH Index is the only industry benchmarking tool that tracks and reports progress on the adoption of electronic administrative transactions and the potential savings associated with switching from manual to electronic transactions. By tracking progress and saving opportunities, the industry can more easily identify barriers that may be preventing providers and health plans from realizing the benefits of electronic transactions and prompt new initiatives to address and reduce those barriers.

Thank you for participating in the 2024 CAQH Index. We appreciate your time and effort in helping make the Index a valuable resource for the industry.

***NOTE: This fillable form survey differs from the online version. There is no need to enter your data into the online version if you complete this form. Once completed, please send this form to the NORC team at IndexHelp@norc.org**

General Instructions

For the 2024 CAQH Index please report data from **January 1, 2023 through December 31, 2023**. In the following pages, you will be asked to provide **volume numbers** for various HIPAA and other transactions as well as **the time it takes** and the **staff resources needed** to complete the transactions.

Privacy

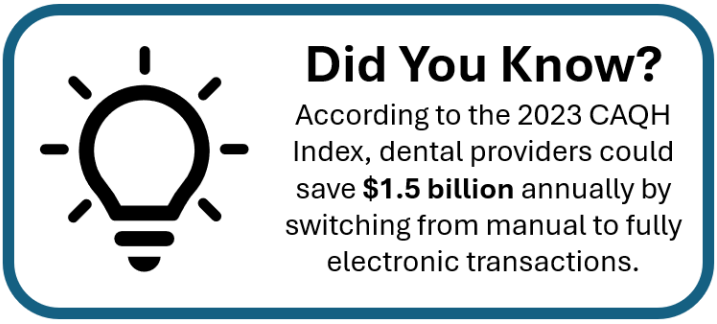
Individual provider submissions and data will be kept **confidential** by CAQH and our consulting experts. The aggregate deidentified results and findings will be published in the 2024 CAQH Index Report. Your participation is voluntary.

Responding providers will receive a **$100 honorarium and individualized reports** explaining how results compare with ranges of performance and national benchmarks.

Please submit your data by August 31, 2024.

For questions, please contact:
Kristine Burnaska, PhD
Senior Director, Research and Measurement
insights@caqh.org
(202) 517-0377

For help completing the Index, please refer to the 2024 CAQH Index Frequently Asked Questions.



CAQH Insights℠ | INDEX™

1. **Please provide contact information for the main person completing these questions.**

Organization _____

Point of Contact _____

Email _____

Telephone _____

2. **Please indicate your provider type (select only one).**

- ◯ Solo private practice
- ◯ Small group private practice
- ◯ Non-dental service organization (DSO) affiliated group large practice (10+ dentists)
- ◯ Dental service organization (DSO) affiliated practice
- ◯ Dental School
- ◯ Armed forces
- ◯ Other federal services (e.g. VA, PHS, FQHC)
- ◯ Hospital
- ◯ Other dental/health organizations
- ◯ Not in practice/retired
- ◯ Other (please specify) _____

3. **Please provide the number of full time and part time affiliated physicians at your organization.**

Number of Full Time Affiliated Dental Providers: _____

Number of Part Time Affiliated Dental Providers: _____

4. **Does your practice file primarily with commercial plans or primarily with Medicaid?**

◯ Primarily with commercial plans

◯ Primarily with Medicaid

5. **TRANSACTIONS**

Please indicate which transactions your organization transmitted with trading partners in 2023 using one or more of the following modes:

- **Electronically** - An automated transaction or exchange of information that is conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.

- **Partially Electronic** - Using a health plan or proprietary web portal, Interactive Voice Response (IVR), etc. or direct messaging to exchange information. NOT the HIPAA standard.

- **Manually** - Exchanging information through phone, fax, mail, paper documents, etc.

Only mark 'Don't Know' if you have no way of verifying whether your organization performs a certain type of transaction.

	Yes	No	Don't Know
Eligibility and Benefit Verification *An inquiry from a provider to a health plan, or from one health plan to another, to obtain eligibility, coverage, or benefits associated with the health or benefit plan, and a response from the health plan to a provider. Does not include referrals.* *HIPAA Standard: ASC X12N 270/271*	○	○	○
Prior Authorization/Pre-Determination *A request from a provider to a health plan to obtain authorization for health care services; or a response from a health plan for an authorization. Does not include referrals.* *HIPAA Standard: ASC X12N 278*	○	○	○
Claim Submission *A request to obtain payment or transmission of encounter information for the purpose of reporting health care.* *HIPAA Standard: ASC X12N 837*	○	○	○
Attachments *Additional information submitted with claims for payment, claim appeals or prior authorizations, such as medical records to support the claim or medical records to explain the need for a procedure or service.* *Transaction Standards: X12 275, HL7 C-CDA*	○	○	○
Acknowledgements *A health plan's response to a provider or provider's clearinghouse that they received information from the provider or clearing house; or a confirmation received by a provider that information shared with a health plan has been rejected or accepted.* *Transaction Standard: ASC X12N 277CA, 999, 824.*	○	○	○

	Yes	No	Don't Know
Claim Status Inquiry *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.* *HIPAA Standard: ASC X12N 276/277*	○	○	○
Claims Payment *An electronic funds transfer (EFT) from a health plan's bank to a provider's bank; including payment and data specific to the payment.* *HIPPA Standard: NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)*	○	○	○
Remittance Advice *The transmission of explanation of benefits or remittance advice from a health plan to a provider.* *HIPAA Standard: ASC X12N 835*	○	○	○

For the remainder of the survey, we will ask you about the transactions that are conducted in your organization**.** We'll ask about the transactions by the mode in which the information is exchanged. The three modes are included below.

1) *By **fully electronic transaction** we mean automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.*

2) *By **partially electronic transaction** we mean transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*

3) *By **manual transaction** we mean transactions conducted using paper, phone, fax, email or mail.*

We will ask you about the **average monthly volume by processing mode** for each transaction type as well **the average time per transaction, in minutes**, it takes to process one transaction of that type by mode.

If your organization has multiple locations, please enter the **total average for all locations**. Please consult your records to answer these questions. If records are not available, please provide your best estimate.

Again, please report data from **January 1, 2023 through December 31, 2023**.

6. VOLUME

For each transaction type presented below, please provide the average monthly volume by mode your organization conducted during January 1, 2023 through December 31, 2023.

**Please do not write in a cell if you do not process a transaction type in one or more of the modes (manual, fully electronic, partially electronic).*

	Average Monthly <u>Fully Electronic Volume</u>: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and <u>do NOT require logging into a health plan web portal or website</u>. This mode is conducted using the HIPAA standard.*	**Average Monthly <u>Partially Electronic Volume</u>: -** *Transactions conducted using a <u>health plan web portal or website</u>, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average Monthly <u>Manual Volume</u>:** *Transactions conducted using paper, phone, fax, email or mail.*
Eligibility and Benefit Verification *An inquiry from a provider to a health plan, or from one health plan to another, to obtain eligibility, coverage, or benefits associated with the health or benefit plan, and a response from the health plan to a provider. Does not include referrals. HIPAA Standard: ASC X12N 270/271*			
Prior Authorization/Pre-Determination *A request from a provider to a health plan to obtain authorization for health care services; or a response from a health plan for an authorization. <u>Does not include referrals.</u> HIPAA Standard: ASC X12N 278*			
Claim Submission *A request to obtain payment or transmission of encounter information for the purpose of reporting health care. HIPAA Standard: ASC X12N 837*			

Claim Status Inquiry *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.* *HIPAA Standard: ASC X12N 276/277*			

7. **TIME**

For each transaction type presented below, please provide the **average time per transaction, in minutes**, it takes to process one transaction of that type by mode.

Please report data from **January 1, 2023 through December 31, 2023**.

Please **only include** labor time required to conduct the transaction not time associated with gathering information for the transaction or follow-up.

If records are not available, please provide your best estimate.

Please do not write in a cell if you do not process a transaction type in one or more of the modes (manual, fully electronic, partially electronic).

	Average time per <u>Fully Electronic Transaction</u>: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and <u>do NOT require logging into a health plan web portal or website</u>. This mode is conducted using the HIPAA standard.*	**Average time per <u>Partially Electronic Transaction</u>: -** *Transactions conducted using a <u>health plan web portal or website</u>, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average time per <u>Manual Transaction</u>:** *Transactions conducted using paper, phone, fax, email or mail.*
Eligibility and Benefit Verification *An inquiry from a provider to a health plan, or from one health plan to another, to obtain eligibility, coverage, or benefits associated with the health or benefit plan, and a response from the health plan to a provider. Does not include referrals. HIPAA Standard: ASC X12N 270/271*	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds
Prior Authorization/Pre-Determination *A request from a provider to a health plan to obtain authorization for health care services; or a response from a health plan for an authorization. <u>Does not include referrals.</u> HIPAA Standard: ASC X12N 278*	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds
Claim Submission *A request to obtain payment or transmission of encounter information for the purpose of reporting health care. HIPAA Standard: ASC X12N 837*	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds

Claim Status Inquiry *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.* *HIPAA Standard: ASC X12N 276/277*	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds

8. For the next set of questions, please report on **Attachments**.

Attachments
Additional information submitted with claims for payment, claim appeals or prior authorizations, such as medical records to support the claim or medical records to explain the need for a procedure or service.
Transaction Standards: X12 275, HL7 C-CDA

For **Attachments only,** please provide the average monthly volume by mode your organization conducted during **January 1, 2023 through December 31, 2023**. For **Attachments only**, please consider the following modes:

Fully Electronic- Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.

Clearinghouse- Attachments submitted electronically through a clearinghouse.

Partially Electronic- Transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.

Manual- Transactions conducted using paper, phone, fax, email or mail.

**Please do not write in a cell if you do not process a transaction type in one or more of the modes (manual, fully electronic, partially electronic).*

	Average Monthly <u>Fully Electronic Volume</u>: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and <u>do NOT require logging into a health plan web portal or website</u>. This mode is conducted using the HIPAA standard.*	**Average Monthly <u>Clearinghouse Volume</u>:** *Attachments submitted electronically through a clearinghouse.*	**Average Monthly <u>Partially Electronic Volume</u>: -** *Transactions conducted using a <u>health plan web portal or website</u>, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average Monthly <u>Manual Volume</u>:** *Transactions conducted using paper, phone, fax, email or mail.*
Attachments *Additional information submitted with claims for payment, claim appeals or prior authorizations, such as medical records to support the claim or medical records to explain the need for a procedure or service. Transaction Standards: X12 275, HL7 C-CDA*				

9. For **Attachments** transactions, what percentage of monthly attachments were solicited? If you are unsure of the answer, please give us your best estimate between 0 and 100.

	Percent Solicited	**Percent Unsolicited**
Average Monthly <u>Fully Electronic Volume</u>: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and <u>do NOT require logging into a health plan web portal or website</u>. This mode is conducted using the HIPAA standard.*	_____%	_____%
Average Monthly <u>Clearinghouse Volume</u>: *Attachments submitted electronically through a clearinghouse*.	_____%	_____%
Average Monthly <u>Partially Electronic Volume</u>: - *Transactions conducted using a <u>health plan web portal or website</u>, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	_____%	_____%
Average Monthly <u>Manual Volume</u>: *Transactions conducted using paper, phone, fax, email or mail.*	_____%	_____%

10. For **Attachments only,** please provide the average **time per transaction, in minutes**, it takes to process **one transaction** of that type by mode.

Please report data from **January 1, 2023 through December 31, 2023**.

Please **only include** labor time required to conduct the transaction not time associated with gathering information for the transaction or follow-up.

If records are not available, please provide your best estimate.
Please do not write in a cell if you do not process a transaction type in one or more of the modes (manual, fully electronic, partially electronic, clearinghouse).

	Average time per Fully Electronic Transaction: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.*	**Average time per Clearinghouse Transaction:** *Attachments submitted electronically through a clearinghouse.*	**Average time per Partially Electronic Transaction:** *Transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average time per Manual Transaction:** *Transactions conducted using paper, phone, fax, email or mail.*
Attachments *Additional information submitted with claims for payment, claim appeals or prior authorizations, such as medical records to support the claim or medical records to explain the need for a procedure or service. Transaction Standards: X12 275, HL7 C-CDA*	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds

11. For the next set of questions, please report on **Acknowledgements**.

Acknowledgements
A health plan's response to a provider or provider's clearinghouse that they received information from the provider or clearing house; or a confirmation received by a provider that information shared with a health plan has been rejected or accepted.
Transaction Standard: ASC X12N 277CA, 999, 824.

If you use **Fully Electronic Acknowledgements**, which electronic transmission standards do you use? *Please select all that apply, and leave this item blank if you are not sure of which standard you use.*

- ☐ X12 227CA
- ☐ X12 999
- ☐ X12 824

12. For **Acknowledgements only,** please provide the average monthly volume by mode your organization conducted during **January 1, 2023 through December 31, 2023**. For **Acknowledgements only**, please consider the following modes:

Fully Electronic- Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.

X12 227CA: Transactions conducted using the X12 227CA transaction standard.

X12 999: Transactions conducted using the X12 999 transaction standard.

X12 824: Transactions conducted using the X12 824 transaction standard.

Partially Electronic- Transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.

Manual- Transactions conducted using paper, phone, fax, email or mail.

**Please do not write in a cell if you do not process a transaction type in one or more of the modes (manual, fully electronic, partially electronic). If you are unsure of which fully electronic transaction standard you use, please use 227CA for your data entry.*

	Average Monthly <u>Fully Electronic Volume</u>: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and <u>do NOT require logging into a health plan web portal or website</u>. This mode is conducted using the HIPAA standard.*	**Average Monthly <u>Partially Electronic Volume</u>: -** *Transactions conducted using a <u>health plan web portal or website</u>, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average Monthly <u>Manual Volume</u>:** *Transactions conducted using paper, phone, fax, email or mail.*
Acknowledgements *A health plan's response to a provider or provider's clearinghouse that they received information from the provider or clearing house; or a confirmation received by a provider that information shared with a health plan has been rejected or accepted. Transaction Standard: ASC X12N 277CA, 999, 824.*	**227CA**		
	999		
	824		

13. For **Acknowledgements only,** please provide the average **time per transaction, in minutes**, it takes to process **one transaction** of that type by mode.

Please report data from **January 1, 2023 through December 31, 2023**.

Please **only include** labor time required to conduct the transaction not time associated with gathering information for the transaction or follow-up.

If records are not available, please provide your best estimate.
Please do not write in a cell if you do not process a transaction type in one or more of the modes (manual, fully electronic, partially electronic, clearinghouse). If you are unsure of which fully electronic transaction standard you use, please use 227CA for your data entry.

	Average time per Fully Electronic Transaction: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.*	**Average time per Partially Electronic Transaction: -** *Transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average time per Manual Transaction:** *Transactions conducted using paper, phone, fax, email or mail.*
Acknowledgements *A health plan's response to a provider or provider's clearinghouse that they received information from the provider or clearing house; or a confirmation received by a provider that information shared with a health plan has been rejected or accepted. Transaction Standard: ASC X12N 277CA, 999, 824.*	**227CA** ____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds
	999 ____ Minutes ____ Seconds		
	824 ____ Minutes ____ Seconds		

14. Do you receive or download proprietary reports to ensure that all your claims were received by the clearinghouse or Health Plan?

- ◯ Yes
- ◯ No

15. For the next set of question, please report on ***Claim Payment***, which includes payment made/received via a paper check, virtual credit card or electronic funds transfer (EFT)

Claim Payment An electronic funds transfer (EFT) from a health plan's bank to a provider's bank; including payment and data specific to the payment.

HIPAA Standard: NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+).

When you get paid by a health plan, how long does it take you to **process a payment**?

Minutes: _____

Seconds: _____

16. For **Claim Payments only,** please provide the average monthly volume by mode your organization conducted during **January 1, 2023 through December 31, 2023**. For **Claim Payments only**, please consider the following modes:

> **Fully Electronic-** Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.
>
> **Virtual Credit Card (VCC)-** Transactions conducted using Virtual Credit Cards, a subset of Electronic payments.
>
> **Partially Electronic-** Transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.
>
> **Manual-** Transactions conducted using paper, phone, fax, email or mail.

Please do not write anything in a cell if you do not process a transaction type in one or more modes (manual, fully electronic, partially electronic, VCC)

	Average Monthly <u>Fully Electronic Volume</u>: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and <u>do NOT require logging into a health plan web portal or website</u>. This mode is conducted using the HIPAA standard.*	**Average Monthly <u>Credit Card (VCC) Volume</u>**: Virtual Credit Cards are a subset of Electronic Payments	**Average Monthly <u>Partially Electronic Volume</u>: -** *Transactions conducted using a <u>health plan web portal or website</u>, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average Monthly <u>Manual Volume</u>:** *Transactions conducted using paper, phone, fax, email or mail.*
Claims Payment *An electronic funds transfer (EFT) from a health plan's bank to a provider's bank; including payment and data specific to the payment. HIPPA Standard: NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)*				

17. For **Claim Payments only,** please provide the average **time per transaction, in minutes**, it takes to process **one transaction** of that type by mode.

Please report data from **January 1, 2023 through December 31, 2023**.

Please **only include** labor time required to conduct the transaction not time associated with gathering information for the transaction or follow-up.

If records are not available, please provide your best estimate.
Please do not write anything in a cell if you do not process a transaction type in one or more of the modes (manual, fully electronic, partially electronic, VCC).

	Average time per Fully Electronic Transaction: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.*	**Average time per Credit Card (VCC) Transaction**: Virtual Credit Cards are a subset of Electronic Payments	**Average time per Partially Electronic Transaction:** *Transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average time per Manual Transaction:** *Transactions conducted using paper, phone, fax, email or mail.*
Claims Payment *An electronic funds transfer (EFT) from a health plan's bank to a provider's bank; including payment and data specific to the payment. HIPPA Standard: NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)*	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds

What is the average fee per **Claim Payment** transaction?
Please write a dollar amount, or "Don't Know"

$_____

Lastly, what is the average percent charged per **Claim Payment** transaction?
Please write a number between 0 and 100, or "Don't Know"

_____%

18. For the next set of questions, please report on ***Remittance Advice*** which includes the transmission/receipt of explanation of benefits related to services rendered and adjustments and payment methods.

Remittance Advice
The transmission of explanation of benefits or remittance advice from a health plan to a provider.
HIPAA Standard: ASC X12N 835

For **Remittance Advice only,** please provide the average monthly volume by mode your organization conducted during **January 1, 2023 through December 31, 2023**.

Please do not write anything in a cell if you do not process a transaction type in one or more modes (manual, fully electronic, partially electronic)

	Average Monthly <u>Fully Electronic Volume</u>: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and <u>do NOT require logging into a health plan web portal or website</u>. This mode is conducted using the HIPAA standard.*	**Average Monthly <u>Partially Electronic Volume</u>: -** *Transactions conducted using a <u>health plan web portal or website</u>, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average Monthly <u>Manual Volume</u>:** *Transactions conducted using paper, phone, fax, email or mail.*
Remittance Advice *The transmission of explanation of benefits or remittance advice from a health plan to a provider. HIPAA Standard: ASC X12N 835*			

19. For **Remittance Advice only,** please provide the average **time per transaction, in minutes**, it takes to process **one transaction** of that type by mode.

Please report data from **January 1, 2023 through December 31, 2023**.

Please **only include** labor time required to conduct the transaction not time associated with gathering information for the transaction or follow-up.

If records are not available, please provide your best estimate.
Please do not write anything in a cell if you do not process a transaction type in one or more of the modes (manual, fully electronic, partially electronic).

	Average time per Fully Electronic Transaction: *Automated transactions conducted using a Practice Management System (PMS) or electronic health records (EHR). Transactions are submitted within the practice workflow and do NOT require logging into a health plan web portal or website. This mode is conducted using the HIPAA standard.*	**Average time per Partially Electronic Transaction:** *Transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard.*	**Average time per Manual Transaction:** *Transactions conducted using paper, phone, fax, email or mail.*
Remittance Advice *The transmission of explanation of benefits or remittance advice from a health plan to a provider. HIPAA Standard: ASC X12N 835*	____ Minutes ____ Seconds	____ Minutes ____ Seconds	____ Minutes ____ Seconds

20. SALARIES

What is the approximate average annual salary of staff processing each of the following **types** of transactions? Additionally, are the staff primarily administrative or clinical?

*For example, if **two staff members** are involved in eligibility verification processing, and one makes $30,000 a year and the other makes $50,000 a year, the average annual salary for eligibility verification would be $40,000 a year. If there is only one staff member and they spend less than 1 hour a week verifying eligibility, this staff's reported salary should still be $50,000.*

*Also, if the employee that processes these transactions is a **part time employee**, please take their hourly rate and multiply it by 40 hours and then 52 weeks to calculate their annual salary if they were to be full time. For example, if the employee makes $12/hour their annual full time salary would equal $24,960 (12x40x52=24,960).*

	Approximate average annual salary	Staff type
Eligibility and Benefit Verification *An inquiry from a provider to a health plan, or from one health plan to another, to obtain eligibility, coverage, or benefits associated with the health or benefit plan, and a response from the health plan to a provider. Does not include referrals.* *HIPAA Standard: ASC X12N 270/271*	$_____	◯ Administrative ◯ Clinical
Prior Authorization/Pre-Determination *A request from a provider to a health plan to obtain authorization for health care services; or a response from a health plan for an authorization. Does not include referrals. HIPAA Standard: ASC X12N 278*	$_____	◯ Administrative ◯ Clinical
Claim Submission *A request to obtain payment or transmission of encounter information for the purpose of reporting health care.* *HIPAA Standard: ASC X12N 837*	$_____	◯ Administrative ◯ Clinical
Attachments *Additional information submitted with claims for payment, claim appeals or prior authorizations, such as medical records to support the claim or medical records to explain the need for a procedure or service.* *Transaction Standards: X12 275, HL7 C-CDA*	$_____	◯ Administrative ◯ Clinical

	Approximate average annual salary	Staff type
Acknowledgements *A health plan's response to a provider or provider's clearinghouse that they received information from the provider or clearing house; or a confirmation received by a provider that information shared with a health plan has been rejected or accepted.* *Transaction Standard: ASC X12N 277CA, 999, 824.*	$_____	◯ Administrative ◯ Clinical
Claim Status Inquiry *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.* *HIPAA Standard: ASC X12N 276/277*	$_____	◯ Administrative ◯ Clinical
Claims Payment *An electronic funds transfer (EFT) from a health plan's bank to a provider's bank; including payment and data specific to the payment.* *HIPPA Standard: NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+)*	$_____	◯ Administrative ◯ Clinical
Remittance Advice *The transmission of explanation of benefits or remittance advice from a health plan to a provider.* *HIPAA Standard: ASC X12N 835*	$_____	◯ Administrative ◯ Clinical

21. For the staff that process transactions, are these staff all full-time employees, some full-time and some part-time employees, or all part-time employees?

◯ All full-time

◯ Some full-time and some part-time

◯ All part-time

Thank you for providing information about the transactions you conduct!

Before you go, each year we enhance the CAQH Index with new questions to provide additional insights to the industry. These questions are meant to be relevant and meaningful to the industry. Unlike the rest of the Index, which asked about information from 2023, these topics are about events and activities from **2024**.

Thank you for helping shed more light on these topics.

In late February 2024, Change Healthcare, a health care technology company that is part of Optum and owned by UnitedHealth Group, was hit with a cyberattack that disrupted many of its systems and services across the country.

The next set of questions attempts to better understand the impact the attack has had on your administrative operations.

22. Was your organization or practice **impacted by the Change Healthcare cyberattack?**

- ◯ Yes
- ◯ No (Skip to 29)
- ◯ Prefer not to answer (Skip to 29)

23. (ONLY IF YES TO 22) How did your organization or practice **deal with the Change Healthcare cyberattack disruption**? *Please select all that apply*.

- ☐ Changed Clearinghouses
- ☐ Updated or increased security protocols
- ☐ Conducted electronic transactions using portals
- ☐ Increased phone calls
- ☐ Began using paper transactions
- ☐ Other (please specify): _____

24. **(ONLY IF YES TO 22)** Thinking about your **manual transaction volume** from February 2024 through May 2024, **how have they changed** from the same period last year (February through May 2023)? *If your transaction volume increased or decreased, please indicate by what percentage.*

	Increased	**Remained the Same**	**Decreased**	**No Manual Transaction Volume**
Eligibility and Benefit Verification	_____%	☐	_____%	☐
Prior Authorization/Pre-Determination	_____%	☐	_____%	☐
Claim Submission	_____%	☐	_____%	☐
Claim Payments	_____%	☐	_____%	☐
Remittance Advice	_____%	☐	_____%	☐

25. **(ONLY IF YES TO 22)** Thinking about your **denial rates** from February 2024 through May 2024, **how have they changed** from the same period last year (February through May 2023)? *If your denial rate increased or decreased, please indicate by what percentage.*

	Increased	**Remained the Same**	**Decreased**
Denials due to **Eligibility issues**	_____%	☐	_____%
Denials due to **Prior Authorization/Pre-Determination issues**	_____%	☐	_____%
Denials due to **not meeting timely filing requirements for claims**	_____%	☐	_____%

26. **(ONLY IF YES TO 22)** Thinking about your practice, how has the cyberattack impacted clinical care? *Please select all that apply.*

- ☐ It had little impact on clinical care
- ☐ Time was redirected from clinical activities to deal with the cyberattack
- ☐ Practice/Office was closed for one or more business days
- ☐ Increased overall costs of patient care
- ☐ Patient services (e.g. labs) or prescriptions were delayed
- ☐ Some other way: _____

27. **(ONLY IF YES TO 22)** Since February of 2024, approximately how many hours have been redirected from clinical activities to deal with the cyberattack?

_____

28. **(ONLY IF YES TO 22)** How is the cyberattack **still impacting** your organization/practice **today**?

29. The application of Artificial Intelligence (AI) in the healthcare industry is evolving. The use of AI in healthcare includes the use of machine learning (ML), natural language processing (NLP), deep learning (DL), and other AI-enabled tools. By examining data patterns, AI technologies can increase efficiency and improve performance of clinical and operational workflows to assist and, ideally, improve the patient experience, including diagnosis, treatment, and outcomes.

Providers are using AI for a variety of administrative and clinical tasks, ranging from generating visit notes to reading diagnostics such as x-rays.

Thinking about **2024**, did **you or anyone at your practice** use **AI** for any of the following tasks? *Please select all that apply.*

- ☐ Verifying patient eligibility.
- ☐ Identifying diagnosis and/or treatment.
- ☐ Translating and generating visit notes.
- ☐ Reading x-rays/lab results.
- ☐ Reviewing claims to ensure they represent unique and complete episodes of care.
- ☐ Identifying errors and inconsistencies in coding of services.
- ☐ Patient/payer communications, notifications, chat messaging, or reminders.
- ☐ No one at this practice has used AI for administrative or clinical tasks/processes in 2024.
- ☐ I am unsure if anyone at this practice has used AI for administrative or clinical tasks/processes in 2024.
- ☐ Other (please specify): _____

30. Over the next year, what do you see as the **biggest challenge** to automating administrative tasks that begin when a patient schedules an appointment and end when a provider gets paid?

31. Thinking about the administrative transactions asked about in this survey, how are they mainly conducted in your practice?

- ◯ **Electronic** – *Automated transaction conducted using a Practice Management System (PMS) or electronic health records (HER). Transactions are submitted within the practice workflow and do NOT require logging into a health plan portal or website. This mode is conducted using the HIPAA standard.* .
- ◯ **Partially Electronic -** *Transactions conducted using a health plan web portal or website, Interactive Voice Response (IVR), and direct messaging. NOT the HIPAA standard***.**
- ◯ **Manual** – *Transactions conducted using paper, phone, fax, email or mail.*

32. What is the **main reason** your practice has **not automated administrative processes** between health plans?

- ◯ High implementation costs.
- ◯ Challenges associated with updating/changing existing systems.
- ◯ Not sure if there would be a financial benefit.
- ◯ Concerns with cybersecurity issues.
- ◯ Automation will not meet business needs.
- ◯ Uncomfortable using new technology/processes.
- ◯ Unsure how to get started.
- ◯ Lack of training or knowledge.
- ◯ Preference for manual processes.
- ◯ Too busy to consider this.
- ◯ Some other reason: _____

33. Do you have any other comments or caveats for our consideration?

Thank you for your data contribution! We appreciate your time and effort in helping make the Index a valuable resource for the industry.

Please feel free to reach out to Kristine Burnaska, PhD at insights@caqh.org or (202) 517-0377 if you have any questions.

Would you be willing to participate in the CAQH Index survey next year?

- ◯ Yes
- ◯ No
- ◯ Don't Know

If we have additional questions, would you be willing to participate in a short interview?

- ◯ Yes
- ◯ No

***NOTE: This fillable form survey differs from the online version. There is no need to enter your data into the online version if you complete this form. Once completed, please send this form to the NORC team at**
IndexHelp@norc.org