Statement of the
Medical Group Management Association
to the
National Committee on Vital and Health Statistics
Subcommittee on Standards
RE: Electronic Claims Attachments
JUNE 17, 2011

Co-Chairs and members of the Subcommittee, the Medical Group Management Association (MGMA) is pleased to submit our testimony on the issue of HIPAA electronic claims attachments standards to the National Committee on Vital and Health Statistics Subcommittee on Standards. We are pleased that the NCVHS is developing recommendations to the Centers for Medicare & Medicaid Services (CMS) to assist in the development and implementation of these important transactions.

In our testimony today, we will focus our testimony on what MGMA has learned from its members with our recent HIPAA claims attachments research and offer a series of recommendations to assist the NCVHS in its deliberations on this important issue.

MGMA is the premier association for professional administrators and leaders of medical group practices. In 2011, members of the Medical Group Management Association (MGMA), and its standard-setting body, the American College of Medical Practice Executives (ACMPE) voted to merge to form a new association. Since 1926, the association has delivered networking, professional education and resources, political advocacy and certification for medical practice professionals. The association represents 22,500 members who lead 13,600 organizations nationwide in which some 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States.

We are pleased that the NCVHS is developing recommendations to the Centers for Medicare & Medicaid Services (CMS) to assist in the development and implementation of these important transactions. In our testimony today, we will focus our testimony on what MGMA has learned from its members with our recent HIPAA claims attachments research and offer a series of recommendations to assist the NCVHS in its deliberations on this important issue

Current Environment

MGMA estimates that between 5 - 20% of claims submitted to payers require some form of additional documentation. The requests from payers for this additional documentation varies widely among medical specialties-with some (especially surgical) reporting that virtually 100% of their

claims require additional documentation.

Currently, providers face a significant challenge when it comes to requests from payers for additional documentation to support a claim submission. In many cases, providers are unsure of what attachments are needed to support the claim as the request from the payer is unclear. In some cases, providers will proactively submit attachments "just in case" which can delay the claim adjudication process and add cost on the payer side.

The current paper attachment process is a major source of claim delays, claim denials and, ultimately, claim write-offs for providers. Indeed, some argue that the requesting of additional documentation on paper essentially defeats the use of electronic claims in some cases as the follow-up must be conducted manually.

MGMA Research

In an effort to leverage the expertise of our members regarding implementation this newest of administrative transactions, MGMA initiated our Legislative and Executive Advocacy Response Network (LEARN) research in early November of this year. More than 200 practice administrators participated in this research, representing organizations where more than 10,000 physicians practice medicine. Survey respondents were from multiple practice types and sizes, from small 1-5 physician single-specialty organizations to large multi-specialty practices with more than 1,000 physicians.

Table 1

How often do the following business/administrative areas require the submission of 'attachments' or additional supportive medical documentation?					
	Always	**Often**	**Sometimes**	**Rarely**	**Never**
Claims	3.5%	47.5%	42.9%	5.1%	1%
Eligibility	2.6%	13.2%	19.6%	43.9%	20.6%
Referral Authorization	12.6%	41.6%	27.4%	12.6%	5.8%
Workers' compensation	56.8%	21.6%	6.3%	4.5%	10.8%

As shown in Table 1, 51 percent of respondents indicated that claims often or always require the submission of 'attachments' or additional supportive medical documentation. An additional 42.9 percent indicated their claims sometimes require the submission of such attachments. In all, Table 1 clearly illustrates that claim attachments are very prominent in all practices, in regards to claim submissions.

Table 2

Approximately what percentage of your claims submissions receive a request from the health plan for additional supportive medical documentation?	
Percent of all claims	**Response Percent**
100%	0%
50-99%	13%
20-49%	32.3%
10-19%	27.1%
5-9%	19.3%
1-4%	8.3%
None	0%

As Table 2 indicates, a large percentage of claims receive a request from a payer for additional documentation. Fully, 32.3 percent report that between 20-49 percent of the claims require additional documentation, 27.1 percent report that 10-19 percent of the claims require additional documentation and an additional 13 percent state that between 50-99 percent of their claims require additional documentation.

Table 3

How are requests for submission of attachments currently sent to your practice?					
	Always	**Often**	**Sometimes**	**Rarely**	**Never**
U.S. Postal Service Letter	15.6%	52.7%	25.7%	4.8%	1.2%
Other mail delivery system (i.e., FedEx, UPS)	0%	4.7%	12.6%	37%	45.7%
Claim/transaction reject	8.4%	47.4%	24.7%	9.7%	9.7%
Electronic request	4.6%	19.9%	22.5%	27.2%	25.8%
Phone	0.7%	10.5%	25.9%	32.9%	30.1%
Fax	1.9%	27.1%	32.3%	25.2%	13.5%
Electronic transaction using 277CA	0.8%	3.2%	15.3%	23.4%	57.3%

Table 3 and 4 reflect the current methods practice's use when sending and receiving requests for submission of attachments. As you can see in Table 3, the majority of health plans currently send

practice's a request for submission of attachments via some type of mail delivery system. Over 73% of participants said they always or often receive requests for submission of attachments via U.S. Postal Service or other mail delivery systems, such as Fed-Ex and UPS.

Table 4

How are you currently responding/submitting (for providers) or receiving (for payers) attachments and additional supportive medical documentation?					
	Always	**Often**	**Sometimes**	**Rarely**	**Never**
U.S. Postal Service Letter	15.3%	55.8%	20.2%	6.1%	2.5%
Other mail delivery system (i.e., FedEx, UPS)	0.8%	8.6%	7%	30.5%	53.1%
Electronic response	2.1%	17.2%	20%	22.1%	38.6%
Phone	1.4%	7.8%	23.4%	26.2%	41.1%
Fax	5.1%	53.5%	30.6%	7 %	3.8%

When asked how their practice responds to requests for additional supportive medical documentation, 80% said they always or often submit attachments via U.S. Postal Service or other mail delivery systems, such as Fed-Ex and UPS (Table 4). This illustrates the enormous postal expense that bothpractice's and payers incur when submitting requests or sending attachments.

Table 5

If an electronic claim attachment standard was available, how many attachments would your practice send as 'unsolicited'?	
Percent of all claims	**Percent of all claims**
100%	6.3%
50-99%	14.5%
20-49%	13.8%
10-19%	16.4%
5-9%	16.4%
1-4%	17.6%
None	15.1%

Table 5 suggests that if an electronic claims attachment standard existed, a significant number of providers would elect to send them "unsolicited." 6.3 percent state that they would send an unsolicited attachment for every claim, another 14.5 percent would send them for between 50-99 percent of claims and a further 13.8 percent of respondents would send unsolicited attachments with between 20-49 percent of claims.

Sending unsolicited attachments offers a number of important advantages for providers, including:

- Allowing providers to anticipate additional documentation requirements from payers and thus ensuring that they are capturing critical data during the patient care process, or least while capturing this data while preparing claim.
- For some medical specialties, payers request additional documentation on most if not all claims submitted. Send this documentation unsolicited will greatly speed up the claim adjudication process for both the provider and payer.

For payers, there is also value in the provider sending additional documentation via an unsolicited attachment:

- Providers sending unsolicited attachments, especially for claims that historically have been followed by a payer request for the same additional documentation, allow plans to receive less irrelevant content.
- More specific content converts to less time reviewing the material (decreased medical review required)
- Permits the payer to establish processes to adjudicate claims faster and enable increased use of auto-adjudication.

Table 6

Business rules could be developed to make the electronic claim attachment standard more efficient. Rate the importance of the following potential business rules:					
	Very Important	**Important**	**Somewhat important**	**Not very important**	**Not needed**
Consistent format for the identification of the health plan making the request for additional supportive medical documentation	67.5%	26.1%	5.1%	0.6%	0.6%
Consistent format for the identification of the claim	75%	22.4%	1.9%	0%	0.6%
Minimum time required for the health plan to adjudicate the claim once the attachment is received	76.3%	19.2%	3.8%	0%	0.6%
Consistent format for the request for additional supportive medical documentation from the health plan	75.8%	20.4%	2.5%	0.6%	0.6%
Transmission standards for the request for additional supportive medical documentation from the health plan	70.7%	25.5%	2.5%	0%	1.3%

Table 6 reflects how participants rate the importance of potential business rules that could be developed to make the electronic claim attachment standard more efficient. Fully 93% stated it was

important or very important to have a consistent format for the identification of the health plan making the request for additional supportive medical documentation. Additionally, 75% responded that it is very important to their practice to have a consistent format for the identification of the claim.

Provider Costs Associated with Attachment Requests

Respondents were also asked to estimate the average total cost to their practice for responding to these requests for submission of attachments, factoring in variables such as staff time and postal expense. MGMA asked respondents to "*Estimate the approximate average total cost to your practice for responding to these requests for submission of attachments (i.e., staff time, postal costs)."*

Our research showed that the average cost per additional documentation request was $21.34. When this figure is calculated with the number of attachments sent by physician practices identified in the 2005 NPRM, between 414,000,000 and 538,000,000 per year, we can estimate the total cost to physician practices of this burden to be $8.9 billion to $11.4 billion. Note that these figures do not take into account the cost incurred by hospitals to process requests from payers for additional documentation. In the 2005 NPRM, CMS estimates that more than 100,000,000 attachments are sent from hospitals.

Benefits of Automation

For providers there are significant benefits associated with the electronic claims attachments. These include:

- The virtual elimination of lost attachment requests and responses.
- A reduction in practice overhead expenses associated with claims attachments, including costs due to staff time, paper copying and mailing costs.
- A reduction in the amount of supported data exchanged between payer and provider.
- Improved predictability of payer data content needs.
- Improved internal claim reassociationprocesses.
- Reduction in appeals.
- Fewer claim denials.
- All leading to a decrease in days in accounts receivables for claims.

For payers, we expect that ROI from the following:

- Reduced costs related to staffing and processing of paper attachment requests and responses.
- More complete information received from the provider.
- Increased number of 1st pass claim adjudication.
- Limiting early implementation costs by providing basic Qs and As.
- Improved denials management.
- Reduction in appeals.

We assert that the initial investment by the payer will be more justified by higher provider participation (though education and outreach efforts). We anticipate that as more payers offer this electronic claims attachment functionality, practice management system vendors will begin to produce the supporting software, thus allowing providers to take advantage of this transaction.

Solicited vs Unsolicited Attachments

The 2005claims attachment NPRM proposes that the request for claim attachment information would be a single iteration process to allow a single request (277) with the provider responding with a complete set of information to answer the request.   NPRM asks for comments on the workflow implications.

MGMA asserts that health plans should, whenever possible, complete the billing transaction by asking all known questions at the initial attachment request. However, we understand that there may be situations where the health plan has a need for further clarifications, based on information contained in the initial response. In those limited situations, health plans should be permitted to send additional claims attachments requests as long as they are sent in a timely manner. Delays in requesting additional information from providers can negatively impact the practice workflow.

The 2005 proposed rule also suggested that unsolicited attachments could continue if "instructions" between health plan and provider exist. To this, MGMA asserts that providers should be permitted to send unsolicited attachments. If the health plan does not wish to receive these unsolicited attachments, they should inform the provider and make other arrangements to collect the necessary data. In addition, should the plan instruct the provider that an attachment is not required but resumes requesting the attachment, CMS should permit the provider to resume sending unsolicited attachments.

MGMA also has concerns that health plans may send unnecessary attachment requests in an effort to slow the payment cycle. In order to avoid this, MGMA recommends that CMS not permit the requesting of information in a claims attachment that is already contained in a compliant 837.

Separately Submission of Unsolicited Attachment

Should the attachment transactions allowed a separately submitted unsolicited attachment (separately submitted from the claim)? MGMA believes that CMS should allow an unsolicited attachment to move separately from the 837. We do not believe CMS should place a time limit on when a provider is permitted to send an attachment in support of an 837. Trading partner agreements between providers and health plans will determine the appropriate time limits.

Other Business Use of Attachment Standards

Should it be permissible to use the attachment standard for purposes other than claims adjudication, including request for comment on Post-adjudication and trading partner agreement?Yes, regulation should not disallow health plans from collecting information via claims attachment process for purposes other than the purposes defined in this rule - such as, post-adjudication.

Recommendations

MGMA offers the following recommendations that we believe the NCVHS should consider recommending to CMS regarding electronic claims attachments:

- Although the ACA legislation requires CMS to publish rule by 2014, we contend that there is no reason to wait that long. The longer the industry waits, the more it misses out on the benefits.
- CMS should permit unsolicited attachments as one opportunity to speed up the claims adjudication process.
- Payers should be required to request similar documents for similar services.
- Operating rules should be developed that augment the functionality of the claims attachments standard.
- Providers should be encouraged to respond with codified data. This would reduce costs by automating the response and enable increased deployment of real time processes.

Conclusion

In conclusion, MGMA strongly supports the expedited development and implementation of the electronic claims attachment standard and associated operating rules. While barriers remain to be overcome, the ROI promised by this transaction and highlighted in the 2005 pilot should be realized as soon as possible. We appreciate the Subcommittee's interest in this important topic, and appreciate the opportunity to present our views.

Appendix
Member Comments on Claims Attachments

MGMA Claims Attachment LEARN question: *"Please share any thoughts you have regarding your practice's current experiences with claims attachments and with the potential impact of standards for electronic claims attachments"*

The Current Claims Attachments Process is time Consuming:

Very time consuming. Different payers request different things at different times.

We would expect electronic claims to help reduce denial rates and expedite claims payment.

The ability to attach documents to electronic claims would most definitely make my practice more efficient and cut administrative costs. My staff would have more time for other tasks such as working denials and AR.

Payers would be forced to process in a timely manner

We need to increase efficiency and reduce overhead.

This (electronic approach) would be time saving and therefore more efficient.

Claims attachments are very time consuming.

Providing attachments from unsolicited requests are time-consuming, costly, and disrupt the flow for claims processing.

It seems the largest problem is with Medicare and the coordination of benefits. The time our office spends trying to help patients get this resolved has grown. In addition, certain procedures for example a Durasphere injection almost always causes a request for records and or operative reports.

The ability to send attachments during the claims process would speed up our claims and payment and processing times.

If the authorization process had the same ability to send documentation electronically, the work load could be significantly reduced and hold times on the phone could be eliminated.

Biggest issue for our practice is secondary claims requiring a printed claim and a copy of the original explanation of benefits. Very time consuming and delays payments

We have found that requesting documentation is used by several insurance companies as a way to delay payment. We are a GI practice and our codes are standard for our specialty. One insurance company requests documentation for every procedure. This is a waste of time and resources as they have to be emailed or mailed.

Current Process is Costly:

I believe we could reallocate our resources more effectively if we didn't have to spend so much time jumping through each individual payer's hoops. It's frustrating that such a significant portion of the "simplification" part of HIPAA has fallen so far behind what the actual providers have had to implement since the Act was initially put into place. A good portion of the continuing rise in healthcare costs could be eliminated if the system was actually an efficient one and the payers were held more accountable for the methodologies they use to conduct business.

It's expensive to attach and mail. Often attachments are separated in the "mail room" of the receiving party and not sent to correct department with the claim. Often have to submit more than once. Extremely time consuming.

We have a large payer that requires our high priced medical appeals to be generated via the mail. In some cases we have re-sent these same records over six times and they have never been 'received.' In addition all of our Workers Comp and Auto claims require records and our A/R with those payers is extremely problematic and inefficient.

Payers use the excuse at least 50% of the time that they never received our paper attachments, thus stalling claims payment and forcing additional follow up from our office. Huge labor dollars. If we had an electronic standard process, the payers would be held accountable for receipt of our info.

Expense in time and research is revenue lost to our practice. Insurance companies are requesting additional information more often than used to. The importance of a quick return for additional information requested, and return efficiently, and minimize time and cost, is what is needed for medical practices.

Without fair standards for attachments billing costs will continue to escalate.

It would reduce FTE salary benefits and wages by a LOT.

If we could submit the claim electronically with all attachments the first time, it would cut down on re-work and FTE costs.

Infuriating to spend money on hard-copy attachments when you have an EMR!

We have to wait for Medicare to request info. It would be nice to send immediately to eliminate the delay.

It is very expensive to have to justify getting payment. Reimbursement keeps going down but our costs to receive payment for our goods and services keeps going up because of insurance requirements.

Electronic Claims:

Payers often claim they did not receive the submitting information. Electronic attachments would ensure info was received.

We have found the most success in mailing hard copies, if we really want to get paid, because the insurance companies can't seem to manage incoming faxes. But they won't accept an electronic attachment.

We have lots of work comp and auto claims as an orthopedic practice- hence- the medical record is always a required attachment. I don't know that Standards would impact these claims. Standards would be helpful so long as the carriers don't take a more cumbersome approach and feel they need to request info more frequently simply because standard guidelines have been developed. In general we are pleased with the ability to process claims electronically and prefer the methodology over any other methodology.

We are currently working with the local clearing house and payers to provide attachments electronically.

Currently, when a service has been removed from the original submitted claim and an "updated" service has been updated to the claim, the health plans want the entire claim content resubmitted (i.e. 5 service lines, one is removed and replaced with an updated cpt) our practice management system makes a new "encounter" for the new cpt therefore, in order for a replacement claim to be submitted the entire content of the claim needs to be removed and then posted back onto the account with the new cpt and then submitted as a "replacement" claim referencing the claim number of the original claim - this claim then is then printed, printing of the office notes, faxing the material to the health plan - the ability to attach electronic records would be a huge saving of time, doesn't help with the updated claim submission as there is still a lag of time due to the process that needs to take place before we can submit for the replacement claim.

Both receiving the request for attachment electronically and the ability to send the attachment electronically will yield significant days in receivable improvement.

One concern for electronic attachments with the payer is that their systems claims payment vs. adjudication/appeals are not always in sync to be able to know what piece of the claim is where

Even if an electronic attachment is sent these claims still require manual/human intervention

I think the different formats of electronic attachments are an important consideration. Various formats (pdfs, word documents, etc...) should be accommodated to really make electronic attachments useful.

If we could attach documentation electronically that would be ideal. We have an EHR system which I think it should be able to do this. It would mean much less time for our insurance personnel to send in paper claims just because of the attachments needed.

Electronic claims attachments would be very helpful and reduce a lot of after the fact work which takes considerable manpower.

Our biggest frustration is that the attachments always seem to get lost and we repeatedly send them. If they could somehow be electronically attached to the claims, this would probably save an enormous amount of time, energy and money for all parties involved.

Would be nice to have a website or reference that shows what documentation is needed for what CPT code/diagnosis code so we could build rules in our EHR/PM systems to send the attachments in the first place (assuming the standards are finalized and work well.)

We currently use paper charts. I believe this would be much better for a practice with EMR, although I do have the ability to scan and send documents via PDF.

Need to standardized claims & claims process:

All payers need to be held to the same standards for electronic attachments. As we are experiencing with the 5010 transition, there are still discrepancies amongst the payers which makes it very difficult for the provider. It is also very difficult in most cases to get answers from them for specific questions.

Some clearinghouses have these types of services, but are very expensive.

We feel some insurance companies ask for attachments merely to prolong the payment. I believe there should be more stringent standards for these companies, including a shorter turn-around time once attachments are received.

This is extremely important. With all the additional things practices are being required to do for the carriers, is imperative that they share some of the expense and are required to be standardized. This standard would eliminate denials and improve healthcare to Migraine patients

A standardized format would be extremely helpful. We already have to "remember" the rule for each carrier. Being able to use the same format for everyone would save the practice money and time.

It would help tremendously as would some help with standards for EFT's. We must submit claims in the same format to all insurance companies, but then nothing they send us is required to be in any particular format including denial codes. It is all very counterproductive.

More claims are rejecting with requests for additional information. The criteria for rejection are

somewhat arbitrary and difficult to anticipate. It should be simple and easy

Require uniformity in attachments on the same basis as uniformity in claim submissions

Consistency and uniformity in payer guidelines and notification would be beneficial. If everything was received in a standard format through a standard communication medium the office could more efficiently deal with the issue.

We would really like to be able to send all of things, with the charges, in the same format.

Anytime there can be consistency anywhere in the total process both parties are going to experience better outcomes. If you know what is expected and how to proceed to get the necessary results, the getting the documentation either way (from insurance or to insurance) will be most helpful.

Lack of consistency between payers and requests.

It would be helpful if all plans had the same standard for submitting additional information.

I have the most trouble with the secondary insurance receiving COB information electronically and end up having to resubmit again electronically for MN providers or mail which is a huge delay in payment of claims or incorrect payment which results in more re-work.

Claims easily lost; payer-provider disconnect:

We currently experience a high volume of attachments that are "lost". There is also a significant delay in reviewing the information and then processing the claims. They don't seem to have to abide by the same timeframes that we do. For example, if they request information, we may only have 15-30 days to respond, including postal service time both ways. However, they may then take months to process the information once they receive it.

Currently, if we are asked to send chart notes, we can fax directly from our EMR. But what we're hearing is that insurance companies get the fax, then they PRINT the fax, then they SCAN the fax into some kind of routing system, then they route it to a destination where nobody reads it, and nobody looks for it until we call them and ASK them to find the documents. When they can't see what they're looking for, we are asked to fax it again.

We have major problems with CareFirst BlueCross BlueShield asking for records. When the documentation is sent in, it somehow never makes it to the "home plan". Documentation must be sent multiple times. Multiple follow up calls must be made. Before payment is received, the patient returns for another treatment and the whole process starts over again. Many claims requiring documentation take a year or more to be paid.

A huge payer excuse is that the payer received but it got "stuck" in their system. If payers would be enforced to follow laws with penalties this would eliminate a huge burden on practices.

We have found some payers do not acknowledge our claim attachments and indicate they have not received them or the claim. This happens even if we use electronic submission of claims or fax the documentation to the fax number they supply.

Too convoluted. Faxes sent aren't received. Faxes sent to certain people aren't received. Truth is they are just stacked up somewhere on someone's desk and no one wants to go through it! Documentation is not noted and you have to re-start process.

Constantly having to follow up with the Payor - in most cases the payor states they never received the information and you have to send a second or third time.

Carrier's left unregulated disguise requests for medical information to pay a claim in order to obtain records from persons applying for health coverage. Also, requests for additional information are often simply a stall tactic. The first is unethical and unacceptable behavior. The second costs practices precious revenue that we don't have.

The payers often state they have not received the claims attachments so we have resorted to sending everything certified, return receipt mail. Very expensive for the providers, but has helped improve payer acknowledgement of receipt.

Notable delay times for requests for documentation from payers when sent through the mail. We sometimes received letters dated as much as a month prior. There is almost no information provided when responding to a request for documentation as to how long the review will take and, even when there is, the payer rarely meets it. A bigger impact to consider is that payers purposefully use obscure language in denials regarding additional documentation making it extremely difficult to respond in appeal. We generally end up sending way too much info, not being sure what they did or didn't look at in making their decision.

This appears to be a standard delay technique by several major health plans on large dollar claims. They wait until the 30 day clean claim timeline is almost expired, then send a pended claim or denial requesting additional information. Many times, they state we did not respond to their initial request when no initial request had ever been received. As a neurosurgery practice, this occurs very frequently.

Many claims attachments are more due to the health plan's requirements rather than for a legitimate medical reason. Most of these claims attachments are never looked at by anyone but just act as a checklist for someone at the health plan to check. It is also a way to hold up payment of a claim to deny the claim because a certain attachment was missing.