BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

TESTIMONY

Before the

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

On

Healthcare Attachments

Presented by:

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BLUE CROSS AND BLUE SHIELD ASSOCIATION

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Good morning. My name is Gail Kocher and I am Director, National Programs Industry Standards & eHealth for the Blue Cross and Blue Shield Association (BCBSA). BCBSA is a national federation of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for more than 99 million – one-in-three – Americans.

On behalf of BCBSA and its member Plans, I would like to thank you for the opportunity to respond to the Subcommittee's questions and provide our perspective on healthcare attachments. While current operations for attachments vary somewhat from Plan to Plan, we believe our answers to your questions and other comments provided below reflect a representative view for all Blue Plans.

Most Common Business/Administrative Areas Requiring 'Attachment' Submission:

In some instances, Plans require or request additional information to support prior authorization or claims adjudication. The need for additional information is determined based on the services being requested or performed and whether or not the information in the authorization request or claim transaction is sufficient to complete the prior authorization or final adjudication process.

Top 10 Situations Requiring Submission of Additional Supportive Medical Documentation:

Our member Plans indicate there are four situations that account for the bulk of attachment requests for claims adjudication:

- Medical necessity determination, e.g., whether it was cosmetic, medical policy, by procedure code.
- Not Otherwise Classified (NOC) procedure reported.
- Unusual circumstances identified, Modifier22.
- Medical criteria under specific member contract benefits.

The specific attachment type will vary across these four high-level situations, e.g., a laboratory report, a clinical summary, a post-operative report. Type is dependent upon the specifics of the situation.

Current Process to Request Attachments:

Once it has been determined that there is a need for additional information, the most common form of request is via letter. If a transaction cannot be fully processed by the prior authorization or claims system, the submitted data is reviewed. When the need for additional information in order to complete processing is identified, a letter is generated requesting the specific information. A few Plans also cite use of email or facsimile to request attachments.

Current Methods of Receiving Attachments:

The most common way Plans receive attachment information currently is hard copy reports or images, e.g., x-rays, through the mail or other courier. In some instances, Plans receive the reports or images via facsimile. A few Plans can accept attachments uploaded via Internet portals as PDF documents. There is also limited use today of electronic transactions to transmit reports and images as JPEGs, i.e., the ASC X12N *Additional Information to Support a Health Care Claim or Encounter (275)*.

Attachment Types: Capable of Being Conducted as Unsolicited

We support permitting the use of unsolicited attachments, but only by trading partner agreement, not by requiring this capability be made available by payers. In situations where unsolicited attachments are appropriate, for example, where a particular type of attachment is always or almost always required, willing trading partners should have the flexibility to define the instances appropriate to submit and receive the unsolicited attachment in order to expedite the adjudication process.

Allowing unsolicited attachments outside of trading partner agreements would unnecessarily impose additional administrative burden on payers. Payers would need to develop new administrative procedures to receive, store, protect or dispose of potentially large volumes of PHI/PII for which they have no need. Payers also would face challenges marrying the unsolicited attachment, a separate transaction, with the appropriate claim in the adjudication system. For example, if the inbound claim is rejected prior to entering the adjudication system, the unsolicited attachment data would have nothing to match it back to. These are additional concerns that must be addressed in any implementation of unsolicited attachments and are unique to the unsolicited process.

Providers who send unsolicited attachments outside of trading partner agreements would bear a greater burden to document compliance with minimum necessary standards than if sending unsolicited attachments as part of a trading partner agreement. Trading partner agreements outlining when unsolicited attachments are appropriate would give providers guidelines to justify disclosing the protected health information to a health plan for payment.

Provider Signature and Authentication Needs:

Currently, Plans do not need provider signatures/authentications because they rely on trading partner agreements and provider contracts that address the verification process and procedures that establish the electronic exchange of data between the provider and the payer. This process will not work in the future if the electronic exchange of data is done through other parties outside the current trading partner environment, as in health information exchanges (HIEs). Such an environment will need to incorporate the use of electronic or digitized signatures or some other method to accurately authenticate both senders and receivers of protected health information.

Structured versus Unstructured Data:

Ultimately, moving to structured data would allow for greater auto-adjudication and processing of attachments. However, this move will take time because some electronic health record systems are unable to produce additional information data in a structured format. In the meantime, receipt of unstructured data electronically would still move the industry a step further, providing value by transporting the data more quickly electronically. This value was demonstrated through the Medicare claims attachments pilot.

Needs/Requirements Relevant to the Development/Use of Content Standards:

The 2005 proposed rule included standards for six types of electronic claims attachments. We recommend that before adopting a specific type of claim attachment standard, CMS review existing administrative standards, e.g., healthcare claims, to determine if the current version meets or could meet the need for collecting different types of required data. Modifying an existing administrative standard to capture the required data would not add nearly the burden of requiring health plans and providers to adopt an entirely new attachment standard. Only when the data cannot be collected using an existing standard should CMS pursue collecting the data as an attachment. Fortuitously, the standards development organizations (SDOs) ASC X12 and HL7 have collaborated on reviewing

potentially overlapping data, and CMS could leverage this work in determining what a mandate for claim attachments should include. We recognize that not all additional data needs can be met by modifying existing administrative standards, but given the burden imposed by ICD-10 and newer versions of the administrative standards, it is all the more important that CMS conduct a thorough review to limit additional, unnecessary administrative burdens.

Human versus Computer Types of Attachments:

The human versus computer variant is tied closely to structured versus unstructured data. Receiving additional information electronically is of value, even if it is only human-readable. The receipt time alone adds value to the process. Movement towards computer-readable additional information will create even greater efficiencies in processing and will help to substantially reduce processing time. Even greater efficiencies can be realized through fully automating the request process by the elimination of sending paper letters and receiving hard copy reports and images.

Requiring Specific Data Elements versus Full Documents:

We recommend against asking providers to extract data by specific data elements. Currently providers supply a full document rather than extracting one, two or more specific items from a report to submit to a payer. Since the number and type of data items is likely to vary by payer, providers have told us they worry that extracting data by specific data element would create a burden to their workflow and, in many instances, is likely to be an even greater manual resource. Moreover, there are also many instances where the full report is necessary to keep the clinical data in full context for the medical reviewer, e.g., laboratory results must be maintained with their normal range values as these change by testing methodology and when using the same methodology due to the calibration of the specific testing instrument.

Benefits of Standard Business Rules/Operating Rules:

First and foremost, we need rules to guide the timing of attachments submission. Operating rules could address timing requirements such as how soon after receipt of a request for additional information is received by a provider should the information be sent to the payer or how soon after a claim is received by a payer should a request for additional information be sent to a provider.

Unique timing rules for unsolicited attachments would also be important to address specific situations such as rejecting the claim transaction separate from receipt of the unsolicited attachment. Prior claim attachment pilot participant experiences will be valuable in determining other situations that can be clarified through operating rules. However, we believe it is important that the base standards first be identified and then all stakeholders can work collaboratively to identify situations for which operating rules would best lead towards administrative efficiencies.

Additionally, operating rules provide an opportunity to address other issues such as any possible need to limit the number of attachment requests per claim, assuming that the standards provide needed

flexibility for payers to make more than one request per claim. The operating rules could define specific circumstances that would warrant limiting payers to one request per claim.

Data Sources:

There is not a need to require all data be sent from a single system by the provider. If data resides in separate systems for administrative and clinical purposes, both are acceptable as a data source. There are valid business reasons for providers to maintain the data in different systems, and we would not look for a requirement that creates a burden for providers to implement new systems solely to retain administrative and clinical data in a single system. As long as the exchange of data relies on standard formats and vocabularies, same or different sources is not an issue. Standard formats and vocabularies create the ability to exchange data and the ability to understand the data being exchanged. More discussion needs to occur relative to the transfer of data from one source when the data did not originate from that source to evaluate appropriateness, integrity and other privacy and security concerns.

Conclusion:

BCBSA fully supports moving to a greater electronic exchange of data within healthcare, but three things must happen to achieve a positive return on investment (ROI). First, this must be done in a manageable fashion, starting simply by allowing, for example, exchange of unstructured and human-readable data, establishing the exchange pipeline and then developing more robust capabilities at a later time. Second, HHS must factor in the many other mandates and initiatives on the IT agenda that, like claims attachments, will necessitate significant systems changes e. g., eligibility and claims status operating rules, ICD-10 and health insurance exchanges when it sets the timeframes for adopting and implementing attachments. Third, there must be full participation across all transactions. Significant ROI will only occur when all providers as well as payers use all the HIPAA transactions beyond the healthcare claim transactions. BCBS Companies are committed to doing their part to work with providers and federal, state and local industry groups to try to improve the return on investment for HIPAA.

This concludes my comments. We appreciate the opportunity to testify today, and I will be happy to answer any questions the Subcommittee may have.