Statement To

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

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Presented By: Laurie Darst
Mayo Clinic
Revenue Cycle Regulatory Advisor

Members of the Subcommittee, I am Laurie Darst, Revenue Cycle Regulatory Advisor at Mayo Clinic. I would like to thank you for the opportunity to present testimony today concerning electronicclaim attachments.

A Claim Attachment Project

In 2005, Mayo Clinic and Wisconsin Physician Services (WPS), Minnesota's Part B Medicare carrier, began discussions on the possibility of implementing electronic claims attachments. The goal was to look at cost reduction and savings opportunities. Our intent was to go beyond 'proof of concept' and implement electronic claim attachments long term. In addition, we wanted to develop a process that could be replicated to other payers.

The following cost reduction and savings opportunities were identified: staff time associated with handling the incoming request via our Post Office, our pre-reading staff sorting the letters and routing to the appropriate area, billing staff time reviewing the paper request and copying the data, and savings in postage. More importantly, we found the mail process created an average of 22-30 day delay in receiving payment due to the existing manual process. The opportunity to reduce our days of outstanding receivables was a key factor in moving forward with this project.

We reviewed the incoming Additional Document Request (ADR) letters from WPS and identified ahigh volume and high cost request. An operative report was consistently requested in situationswhere a surgical procedure was performed and complications occurred or additional surgeons were required. When this situation occurred, the coding department would attach a modifier(22/62) to the surgical CPT code to reflect that additional costs associated with the complications were included in the surgery charge. The payer needed the operative report to review in order to pay the additional cost appropriately. Mayo Clinic and WPS discussed the opportunities associated with this type of scenario and determined Mayo Clinic would send the operative report

“unsolicited”. Instead of waiting for the ADR request, we proposed to send this operative report “electronically stapled” to the claim.A claim attachment control number linked the claim and the attachment so programming done at WPS allowed the nurse reviewer to view the operative reports at the same time the claim was received.

We worked with our internal IT staff to develop edits to flag these scenarios and to automatically pull the required operative report from our EHR system (based on edits), link it to the claim, and send it in theX12 EDI transactions (837 and 275) directly to WPS. Mayo Clinic and WPS worked together with a CDA R2 expert to populate the BIN segment with the required HL7 messaging inside the X12 275 transactions. Mayo Clinic sends this data as text messages, not scanned images.

Results: Mayo Clinic discovered payment for these types of services were received 20-30 days sooner than the cumbersome development letter process. We also experienced reduced staff time associated with eliminating handling of the paper processes. We have successfully transmitted electronic operative reports to WPS for the past 5 years. Our original plan was to implement other high volume unsolicited attachments, such as miscellaneous code descriptions, however, other competing priorities prohibited this expansion.

We strongly support the unsolicited attachment as a highly effective tool to communicate additional information in an efficient way. In situations where it is known that an attachment is always needed, it is burdensome and expensive to have the claim either pend for more information or reject due to lack of information. However, it’s important for payers and providers to collaborate on what scenarios are appropriate for unsolicited attachments.

Minnesota Initiative

Minnesota has implemented a community-wide best practice to standardize the submission of unsolicited claim attachments. While Minnesota’s best practice provides guidance for faxing these unsolicited attachments, a standardized transaction would be much more efficient.

Request for Information

Currently there is not a standard process for payers to request or communicate the need for additional information. Providers receive request for additional information in the following formats (based on payer adjudication process):

1. Claim is pended at the payer’s office and a request is sent to the provider via a letter or through the use of the claim status transaction (277).

    a. Provider usually has 30-60 days to respond before the claim is denied

2. Claim is denied on the 835 remittance advice and the additional informationrequired is communicated using a CARC/RARC code.
    a. Provider must resubmit the claim on paper with the attachment, or
    b. Provider must appeal the denial on paper with the attachment

Both of these notification methods can be challenging for the provider if the information needed is not clearly communicated. Too often providers receive a request for generic "medical records" and it is unclear what the payer actually needs. Providers either have enough experience with a specific payer to know what they need or they need to call the payer for more specific information. This is an area where operating rules can help eliminate the inefficiencies.

Types of Claim Attachment

In reviewing our pended claims and denied charge amount data from all payers, we found the following high volume requests for additional information that was consistently requested by payers:

- Operative report requests associated with 22/62 modifiers
- Miscellaneous procedure code descriptions
- Invoice purchase price
- Radiology Medical Necessity
- Lab test results
- Clinical notes

In large academic medical centers such as Mayo Clinic, data flows from multiple "bolt-on systems" versus a single system. In the high volume claim attachment scenarios described above, the requested information is acquired from multiple sources including: practice management system, purchasing system (invoice price) and the EHR (which includes multiple bolt-on systems). It will be important to consider these multiple sources when determining the best solution for enveloping the claim attachment data. In addition, it is essential to link the claim control number with the requested data so the payer can link this information when received. We support the use of the X12 275 transaction as the routing vehicle because it allows us to link the administrative data with the requested data.

Summary

In summary, our claim attachment project provided opportunities for efficiency and cost reduction. We see opportunity for administrative simplification and cost savings with the unsolicited attachment, where it is mutually agreed upon. We strongly support the claim

attachment transaction along with the associated operating rules which would help provide clarity in payers requests for additional information.

I’d like to thank you again for the opportunity to testify today.