Claims Attachments State's Perspective

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Q: 1.) Which are the most common business/administrative areas that require the submission of 'attachments' or additional supportive medical documentation (for example, Claims, Eligibility, Referral Authorization, workers' compensation, etc)

- TPL
- Filing limit
- Manual pricing
- Certification statement for sterilizations
- Prior Authorizations
- Eligibility intake, screening & assessments
- Limited claims situations (DME, multiple surgery claims, second opinions and transportation)
- Utilization Reviews
- Provider Enrollment
- Adjustments
- Long Term Care level of care determinations

Q: 2) Which are the top 10 situations that require the cover the vast majority (over 80 or 90%) of the instances where submission of additional supportive medical documentation (attachments) is needed (i.e., for claims – ambulance runs, others)

Claims

- **Sterilization, hysterectomy, abortion**
- **Timely filing**
- **Miscellaneous codes**
- **Medicare benefits exhausted**
- **Ambulance, air**
- **Ambulance, facility to facility - claims**
- **Third party liability, no response**
- **Hearing aid repairs, expiration of warranty – claims**
- **Medical Necessity**
- **Invoice Pricing.**
- **Nursing home claims**
- **manual pricing**
- **duplicate copies of claims**
- **multiple surgery claims,**
- **plastic surgery/cosmetics**
- **breast surgeries**
- **claims exceeding the max units**

Authorizations

- Home Health
- Wheelchairs. DME, medical supplies
- Surgical
- replacement hearing aid
- medication dispensers
- Synagis
- transplants
- Bariatric
- Orthodontics
- Botox,
- Transplants

Q: 3) How are **requests** for submission of attachments currently handled (i.e., letter, claim/transaction reject, electronic request, via phone, fax, electronic transaction using 277CA, etc)

- Attachment submitted electronically assigned a confirmation number which is then matched to the claim with same confirmation number.
- Claim denial
- Providers are notified in advance through provider publications of specific situations which require submission of attachments.
- Claim denials contain explanation of benefit codes which indicate the denial was due to no attachment.

➢Pharmacy claims- The very vast majority of drug claims are electronic. There are very few paper claims left, probably 0.05%. As to attachments for prior authorization for medication that is another matter. We have tried to automate as much as possible using either historical claim information or web submission of request, but laboratory results are a significant portion of many of our criteria.

➢**Telephone, Fax, E-mail, or Letter. Faxed or mailed correspondence is scanned into our OCR/workflow system. Return to provider letters. For claims: typically we just deny the claim with a denial message specifying what is needed, on occasion will call.**

➢Molina Medicaid Solutions, working with the State, designed what we refer to as the HIPAA Attachment Cover Sheet which must be completed and submitted with any hard copy claim attachment when the provider elects to submit the claim electronically. The cover sheet requires the provider to enter the Internal Control Number that we assign to the claim that uniquely identifies the claim in our system. This Internal Control Number is then used to systemically rendezvous with the pended claim which is then released to a queue to be worked by a resolution clerk.

This feature is barely used by our provider community with the community at large allowing the claim submitted electronically to deny and to then submit the claim on paper with the required attachment. The biggest roadblock to this process being accepted and used by the provider community is that the code sets that are supported for reporting the status of a pended claim to the provider (277) lack the specificity to identify to the provider the specific attachment that is required for payment of the claim.

Q: 4) What are the ways you are currently **responding/submitting** (for providers) or **receiving** (for payers) attachments and additional supportive medical documentation

- Attachment submitted electronically assigned a confirmation number which is then matched to the claim with same confirmation number.
- Attachments are faxed in accordance with X12 PWK requirements
- We accept attachments via paper claims submission and via an indicator on the electronic submissions which require the attachment to be mailed or faxed and matched up with the claim.
- Fax/mail; uploading via web portal; secure email

Q: 5) Which types of attachments are or can be done as 'unsolicited' attachments? What are the implications (including privacy) of submitting attachments/additional medical information in an unsolicited manner?

- PHI would be applied, however; unsolicited attachments would not have a confirmation number assigned. Ultimately, claim would be denied if submitted.
- All attachments are unsolicited at this time
- EOB/RA from primary insurance, sterilization consent, hysterectomy, abortion – privacy would be the largest implication.
- Fax or secured email; ensure that attachment is associated with proper claim; uploaded via web portal to a specific claim at the time of DDE on portal
- All submissions are scanned (or received electronically via Right Fax), and stored in our document retrieval system with key words to identify the provider and/or member. Unsolicited attachments do run the risk of not being worked into a queue for lack of knowing where to direct the attachment.

Q: 6) What are the needs/requirements (business, regulatory) for provider signature/authentication on attachments

- Electronic signature accepted provider checks box on enrollment form. Paper claims signature is required. .
- Federal requirements for consent forms– 42 CFR §441.256
- Not otherwise classified DME or Medical Supplies – official invoice, letterhead, or catalog page
- TPL attachments do not require a provider signature.
- Sterilization Consent forms, Hysterectomy forms, and Abortion forms do require the actual provider signature and date of signature.
- Some states accept stamped signatures; dependent on type of claim submitted

Q: 7) What are your perspectives on structured data messages and non-structure data messages for the submission of attachments? (i.e., inability to do auto-adjudication when data is not submitted in structured format)

- Claims not submitted in structured data messages would likely be denied.
- Inefficient and often inconsistent adjudication if not structured format
- Structured data messages allows for accurate claims processing. Non-structured data messages can result in claim denials and rejected claims requesting information from the provider. Can be more time consuming in non structured format
- Structured format would allow more possibilities with auto-adjudication but many services require a significant amount of information that would be difficult to capture in a structured format.

Q: 8) What are other specific needs/requirements on attachments that are relevant to the development/use of content standards?

- Not all additional information needs to be sent as an attachment – use all "sender discretion" data elements on the claim Dates, beneficiary signature, dollar amounts, type of other insurance (i.e. Medicare or Medicare replacement)
- some claims need physician signatures
- Identifying the type of attachment, dos, client id, billing/NPI, taxonomy, name of patient, amount billed and units; procedure codes, dcn/tcn assigned

Q: 9) What are your perspectives on ‘human’ vs ‘computer’ types of attachments

- Provider benefit
- At the present time we are only capable of human readable attachments
- There is no preference.
- Industry may not be ready for computer attachments
- There would be less staff able to view PHI if the attachments were electronic

Q: 10) What are your perspectives/practices regarding requiring a specific data element, rather than a full document (for example, requiring a specific lab reading rather than the entire lab results)

- System has note capability. For example, provider could note THS lab results.
- We require the minimum necessary
- As long as the full document is retained in the patient's records and the specific data element can be supported if the need arises, submission of the specific data element would be an acceptable practice.

- Most reviews require many data elements.

Q: 11) What are the areas where national standard business rules/operating rules for requiring /submitting attachments would be most beneficial?

- Federally mandated, insure Medicaid is payer of last resort.
- We don't think national standard business or operating rules can be applied to business requirements for attachments
- Third Party Liability (Both for insurance and Medicare carriers) – A standard form/rule including CARC/RARC and group code such as CO –contractual obligation or PR- patient responsibility, other payer type (Medicare, Medicare replacement, Major Medical, etc)
- timeliness- how long? Rules surrounding the attachments, data elements requirements; allow a free text field to accommodate any one offs
- Receipt of medical records and lab

Q: 12) What are your perspectives on the source of data: In many cases, data being requested or needed to be included as an attachment resides on the electronic health record, rather than the administrative system; in other cases, the data is in other systems outside of EHRs or administrative systems.

- Data needs to be available from all record systems; EHR and administrative
- The provider/facility is accountable for accurate submission of any claim and should retain data to support the submission. If the data can be supported through the different sources, we have no preference with which source is utilized as long as the source is authenticated. Considerations will need to reflect sources of data that do not have access to electronic records.