November 17, 2011

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

Subcommittee on Standards

Claim attachments

Comments from
VA Health Care as Health Care Provider
Department of Veterans Affairs

Good afternoon and thank you for the opportunity to make this presentation today.

These remarks address the questions posed by NCVHS on claim attachments and are organized in two main sections:

1. **VA Health Care's current use of claim attachments**
2. **VA Health Care's future perspective on claim attachments**

VA Health Care's current use of claim attachments

VA currently sends both unsolicited and solicited claim attachments to third party payers and Medicare.

To first address unsolicited claim attachments: medical records are the most common attachment type, submitted for procedures with specific modifier codes. The modifier codes for which VA submits unsolicited claim attachments include the following: incomplete procedures, discontinued procedures, increased procedural services, and procedures performed by more than one surgeon. Claims with these modifiers are identified by a claims scrubber which alerts the billing staff to retrieve and print the necessary documentation from the Veterans Health Information Systems and Technology Architecture (VistA) which houses VA's integrated electronic health record. The printed attachments are submitted along with the claim by the billing staff via fax to the Medicare intermediary, or by mail to most other payers.

Certain payers require referral and authorization documentation to be submitted with the claim. These claims are identified manually by billing staff who, after

submitting the claim electronically, alert the utilization management department. Utilization management staff retrieve the necessary documentation from the electronic health record and submit the attachments via mail to payers.

Currently, VA also submits remittance advices as unsolicited claim attachments to support coordination of benefits. For example, a high number of Medicare Remittance Advices are submitted as attachments for secondary claims. Only about 10% of VA's payers accept an electronic Medicare Remittance Advice to adjudicate secondary benefits. Over half of the enrollees in VA Health Care's system are also enrolled in Medicare, thus this is a substantial impact.

As for solicited claim attachments, medical records are the most common type of attachment requested. VA receives notification of attachment requests predominantly through claim denials on the remittance advice. For a one year period ending in June 2011, the percentage of all denied claims VA-wide attributable to general data requests was about 14%, totaling 380,000 claims. Data request denials include solicitations for medical records and coordination of benefits attachments. Many of these denied claims had a generic remark code of, "this claim has been denied without reviewing the medical record because the requested records were not received or were not received timely." Resolution of these denials requires a phone call to the payer and extensive follow up.

VA Health Care's future perspective on claim attachments

VA sees great value in the future automation of claim attachments; however, VA urges that any attachment standard and associated operating rules not be overly complicated. As the country's largest integrated healthcare provider, VA Health Care is complex itself. VA does business with about 1600 payers nationwide, submitting over 10 million claims a year.

As an overarching theme, VA supports simplification through all efforts to 1.) Reduce the number of claim attachments, and 2.) Eliminate the potential for payer specific requirements.

VA suggests that a limited number of standard submission operating rules for unsolicited attachments be established. These rules should define specific

submission scenarios that determine when claim attachments are required for all payers. For instance, an operative report is required for a modifier signifying a complicated procedure. These submission rules would be most effective if any additional unsolicited claim attachments outside of the defined scenarios were prohibited.

The establishment of such submission operating rules stands to benefit both providers and payers, of which VA is both. For providers who do business with many payers, such as VA, standard submission rules would eliminate a burdensome amount of third party agreements defining unsolicited attachment rules by payer. Standard submission rules would also allow for VA and other providers to build their systems to pull the defined claim attachments automatically from the electronic health record, resulting in greater efficiency and accuracy.

Limiting the scenarios when unsolicited claim attachments are submitted by providers would lessen the burden on payers who must process and manage these attachments. Extraneous attachments could have various negative impacts on many parties, including extended claims adjudication times and the unnecessary release of protected health information.

Furthermore, for each operating rule, VA suggests drilling down to the actual purpose of the attachment request and to consider using or adding data elements in the 837 to fulfill the purpose, wherever possible.

On solicited claim attachments, payer requests should state the reason for the request and specifically note the document or data requested. VA encourages limiting what claim attachments payers can solicit in common business scenarios. The minimum amount of patient information necessary for claim adjudication should be requested by the payer.

VA supports both structured and unstructured attachments. At this point, many documents in the VA integrated electronic health record could not be sent as codified data in a structured template as they are scanned images.

Overall, in VA's view, the claim attachments standard and associated operating rules should be simple and consistent across all payers. This will reduce the current

administrative burden of claim attachments on both payers and providers, ultimately improving the efficacy of the health care system.

I hope these remarks have been helpful, and I thank you for the opportunity to address this committee.