Vendor

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What is meant by “claim edit?” At what stage of a transaction do edits occur

- Claim Edit -Where they happen
  - Front end edits
    - Basic syntax and transaction edits
      - Ensure the EDI transaction can be consumed and follows all the basic rules field sizes, loops , repeats
    - Other payer front end edits
      - Some payers move edits that will not allow the transaction to successfully make it through their system up to be front end edits which take place before acceptance reducing appeal overhead.

What is meant by “claim edit?” At what stage of a transaction do edits occur

Claim Edits

Internal

- Claim edits
  - Procedure / Diagnosis edits compared to history, patient, Patient gender/age, CCI type edits does the procedure and modifier go together etc
- Adjudication edits
  - Edits that are applied during adjudication and are based upon many factors including, but not limited to, the benefit plan of the member, historical claims, pricing rules, reasonable and customary.

Where are there pain points and opportunities for improvement?

- *Internal Edits*
- The issue of which internal edits can be used across the industry is complex.
- *Front end edits have pain points such as :*
- Edits vary by payers
- Providers systems trying to keep up with all changes
- Notice of changes
- Inconsistency across the industry

Where are there pain points and opportunities for improvement?

Some room for improvement :

- CMS edits are different by region – these are clinical rules – if they were consistent across Medicare that would help.
- Providers and payers need to find common ground – bridge the gap of payers paying less then they should for procedures and providers billing fraudulently.

Challenges/Obstacles

- Edits changing on different timelines cause issues and then it depends upon the PMS systems if they can be updated or if they have to wait for a release.
- Some edits are purchased by payers from Vendors and are not able to be shared per contracts.
- Different group of individuals might need to be involved

Solutions

- Providers perspective – is the payers need to publish as many of their rules as they can so the providers can bill correctly
- Payers feel that the providers just need to bill for the service that is done
- Having a standard set of consistent CARC and RARC codes will help the industry move in the right direction.
- Find out what beyond CCI edits the payers are doing and determine if there is commonality among payers

Next Steps

- Select a well balanced industry group such as WEDI to bring together all the parties and develop a framework for a solution through PAGs
- Need to address low hanging fruit, common areas of similarity among payers – small successes will be key to cooperative exchanges
- PMS systems need to be on board and taking advantage of these changes or this is all for nothing.
- Communication of changes have to be managed and expectations set
- Creation of a champion to Stewart this effort through to resolution.

Additional Questions in Claim Edits

Foresight

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Other Questions

- Each insurer requires different codes and/or information to adjudicate a claim, and responds back with a different set of codes and edits – often to the same information – but it differs by plan. This is an administrative nightmare to providers. What are some solutions?
- What is the role and opportunity for the Medicare and Medicaid National Correct Coding Initiative?
- Combining these two issues perhaps a solution is to find out the delta between CCI and What the other payers are doing – see where there is common ground and start there.
- Address front end edits separate from internal claim edits.
  - Start with what CMS added as front end edits see if they are similar to what other payers would do or could do – maybe that can be the starting point

Other Questions

- Physicians “over send” information because requests are nebulous or they want to cover their bases. How can this be mitigated?
  - Create a mechanism to request just the information is needed and add to minimum necessary that just sending everything because it is easier is not allowed.

Payment Timeliness

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- ***TIMELINESS OF PAYMENT RULES: NCVHS to investigate whether health plans should be required to publish their timeliness of payment (rules).***
- Research into this topic indicated little to no interest.
- Some responses were that states have prompt pay laws and specific days within which the claims must be paid and if that was consistent, that would help.
- Others said the biggest concern is what does a “clean claim” mean? If this was defined it would be Helpful.

Additional Suggestions

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Start of the EDI life cycle?

- Some would say the eligibility is the start of the EDI lifecycle.
- The Enrollment of the member into the plan MUST be done before Eligibility.
- Research and surveys by AMA and others have
- Shown that inaccurate Enrollment is a large percent of the reason for Reversal / corrections and overpayment recoveries

Enrollment Member

- What does that mean?
- That the current enrollment of members into plans is NOT working.
- Employer groups need to be legislated to be required to send the 834 Enrollment transaction rather then fax, spreadsheets and other misc. formats
- This would create simplification for the payers currently dealing with hundreds of different formats because employer groups are not covered entities.

Moving Forward
Don’t look Back

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Worker Compensation and P/C

- The healthcare industry is moving forward
- 4010 > 5010
- ICD9>ICD10
- The WC industry was initially not included in the legislation but what about now ?

Transactions work

- WC industry which as has been stated is only 3% of the industry volume for some clearinghouses that equates to 1.3 million transactions per month !!!
- What if they do not get included?
- Payer overhead – dual processes -need to support older Transactions, ICD9 codes , proprietary codes for how long…..
- Provider overhead - dual processes - need to support older transactions, ICD9 codes, Proprietary codes for how long…..
- Vendor overhead - dual processes - need to support older transactions, ICD9 codes, Proprietary codes for how long…..

If it works – use it

Transactions that are working :

- Claims
- Acknowledgements
- Attachments
- Remittance

Pros vs Cons

	Keep outside	Include in HIPAA
Increase cost		
Decrease simplification		
Prolong dual use of the ICD9 and proprietary codes		
Decrease cost		
Increase simplification		
Remove requirement to stay in dual use mode for ICD9		

Thank You

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