Testimony on Section 10109

NCVHS Hearing 18 November 2011

Debra Strickland

PROVIDER ENROLLMENT: NCVHS to evaluate whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized.

It is imperative that one differentiate between enrollment for EDI and other electronic transactions such as EFT, and the credentialing process.

Enrollment in EDI transactions can and should be made electronic and this is in the process of being developed at ASC X12. While that electronic process is developing and evolving a standard form with comment data elements is a good first step. This will get the industry used to a standard set of data elements that one needs for EDI enrollment. Enrollment in transactions once the communications have been set up is typically just a check box with the exception of EFT which requires additional security steps and potentially passing of bank account information

Credentialing is a very detailed profile of a provider that requires an indepth look into the providers back ground, education, track record etc. There are processes in place today to collect the details of credentialing so they can be shared with multiple payers so the provider only has to do this exhaustive process once. I do believe however they must do this yearly. I think any credentialing central location should be set up where the provider has to go to that collected data and update (not re fill out everything) just update what has changed. This should be able to be shared across any payer regardless of affiliation in any particular organization in order for this to truly be an industry solution.

How many provider enrollment forms and processes exist today? Discuss the issues this creates for providers and their business associates.

There is likely no complete commonality around the enrollment forms used by payers today. They each have their own unique forms with their own nuances.
This creates a learning curve every time a provider has to add a new payer or provider to a payer.

Some forms allow the provider to list all the providers signing up others require a form for each provider. This can be a burden to the providers as there is no consistency and they cannot just save the information and pass it along, they have to recreate it each time.

Is anyone sharing an enrollment system for providers to allow for one gateway that serves several entities?
There is one entity that is starting down this path, at this time that I know of SecureEXsolutions they are attempting to create a secure process for the storage of sensitive information that would use triple security layers – that would allow the information to be shared only with the correct credentials.

How different is the data that is compiled by each health plan?

The data elements collected is probably not that much different between payers. There may be slight nuances but nothing that could not be easily enough compromised.

Would it be onerous to consolidate an enrollment data set?

No this would be simply collecting the forms and comparing the data elements. The difficult part would be the "wet" signature part or getting all the payers lawyers to agree to a single secure process to accept the EFT signatures.

Are there systems that could be leveraged to be a shared enrollment system for providers with all health plans?

Unknown for EDI enrollment at this time

Are paper enrollment forms still used extensively across health plans? Are "wet" signatures required on enrollment forms by most plans?

Yes paper forms are the primary means of EDI enrollment. Wet signatures are often required from the CFO or other like executives.

X12 has a potential standard for provider enrollment. What is the industry's perception of that transaction?

This is a new concept but there might be a transaction that is viable to make this happen.

FINANCIAL AUDITS: NCVHS to determine if standardized forms apply to financial audits required by health plans, Federal and State agencies (including State auditors, the Office of the Inspector General of the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), and other relevant entities?

Providers complain that they get audited by various organizations at various times for different purposes, for the same information, asked in different ways… Certain entities (unnamed here) ask for the same information at different times which is cumbersome, redundant and expensive. Validate and discuss.

Any process that involves going to a provider more than once for similar reporting is a burden on the provider's business office staff. We must remember they are there to service patients and the more we take them from that the harder it is for them to do their job.
If this information is necessary I suggest that the reporting entities get together and ask for a yearly report on a compromised set of data that they can all use rather than going to the provider multiple times.

CLAIM EDIT TRANSPARENCY: NCVHS to investigate whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5))). It is believed that uniform edits could improve the quality of comparability across multiple payers in an all payer claims data base, and simplify claim submission compliance for providers….
What is meant by "claim edit?" At what stage of a transaction do edits occur and where are there pain points and opportunities for improvement?

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.

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.

Pain Points
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

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 than they should for procedures and providers billing fraudulently.

Challenges and 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.

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?

Yes this is a burden that would be removed if there was consistency in the claim edits.
I do feel however when you start to get into the debate of the payers that the edits is proprietary we should back off. Clear concise CARC and RARC messages or proprietary codes (if on paper) should explain the edit done and why it is not being paid.
Payers diligence in mapping well to the industry codes will help the providers to understand the edits if they are valid edits and good remittance mapping.

Physicians "over send" information because requests are nebulous or they want to cover their bases. How can this be mitigated?

I would suggest adding providers response to an Attachment request to minimum necessary which would hopefully reduce sending TOO much information if there is a small set of information that is needed. The Request should be as specific as possible.
Note: vendors systems may not be capable of doing small sections of a medical record – that is an area to explore.

What is the role and opportunity for the Medicare and Medicaid National Correct Coding Initiative?

I suggest review of those coding initiatives and compare to the edits the payers do, that they will share, perhaps include those in the initial set of claim edits.

TIMELINESS OF PAYMENT RULES: NCVHS to investigate whether health plans should be required to publish their timeliness of payment (rules).
What is the pain point this item is addressing?
Did not find this to be a pressing issue the industry wanted to work on

> Could "rules" mean policies about timeliness and how the plan will handle late claims?
> Could it simply be that providers want plans to publish statistics about their payment timeliness (based on number of clean claims processed in x, y or z days?)

My research found limited to no interest in this topic by Providers. The only thing that I gathered related to this is there is a need for definition of clean claim.

OTHER INSURANCE TYPES: should these entities be required to use the standard transactions required for the health care industry under HIPAA?

In this section I am referring to the answers that I feel I can speak to with my experience with the IAIABC liaison and the jurisdictions needs for data elements in the 835 remittance transaction.
I have assisted the WC and AUTO MEDICAL industry to get the standard transactions to align to the needs of the industry. Including working through over a hundred codes they felt could not map to industry standard codes. We found codes that worked and where

there was not a good solid match new codes were added. All within the standard processes that are in place today.
These transactions that pertain to WC and AUTO MEDICAL work in the industry – there is not a need for a new transaction just education and reassurance. One vendor that is specific to this industry processes 1.4 million EDI transactions for WC /AUTO MEDICAL per month!! These transactions are working in the industry today with great time and cost savings.

What are the different terms used in other insurance industries that are in conflict with, or different from those used in health care (e.g. the terms "bill " and "claim")

There is not that much different from the AUTO MEDICAL and WC industry from the healthcare industry. Bill vs claim is the largest difference and that is easily combatted with education. This education has started at ASC X12 and as a result brought about more awareness of the terms for Electronic remittance transaction, Eligibility transactions, claim status transactions and claim transactions.

Do providers use the CPT, HCPCS and ICD-9 code sets for "claims" sent to other insurance entities? If not, what codes are used to identify services rendered and request reimbursement?

The AUTO MEDICAL and WC industry use some proprietary codes (these should go away) and also use ICD9 codes. These entities should be brought under the HIPAA umbrella and should move to the standard transactions and code sets as applicable. Failure to do so will require that the Healthcare industry support dual versions and code sets which will reduce the simplification that we are trying to achieve.

Will providers be allowed to use ICD-10 codes in 2013 when they transition with health care transactions?

They should be required to do so. If they are not brought under HIPAA the use of ICD9 codes will continue and all payers and providers and vendors will incur the cost of dual maintenance of transactions and code sets.

What would the benefits be to moving to standard transactions?

Moving to the standard transactions is smart, it is aligning with the administrative simplification that the legislation originally intended. Keeping them outside of it however,

puts burden on the payers, vendors and providers to maintain dual processes one for the HIPAA entities and one for the non-HIPAA covered entities. This might not seem like a big deal but it means dual code set maintenance in all adjudication systems, CSPs have to be dual trained in ICD9 and ICD10 (also proprietary which should be eliminated). As well as continued support of old versions of transactions and code sets by clearinghouses and vendors all the way through the EDI path to the provider. That will cost an incredible amount of money to support these dual transactions.

What would the challenges be, and what kinds of costs would be involved?

There is a steep education layer, but once it is named and the states that are not involved in ebill regulations already, understand this is coming there are tremendous resources for the WC and AUTO MEDICAL industry to work with such as models etc. to follow. The Healthcare did not have such models to follow but these industries have them and even though it may be slightly uncomfortable at first it will provide administrative simplification for the industry as a whole.

Items that are added off the suggested topics

Member Enrollment - While many feel that Eligibility is the beginning of the EDI lifecycle it is not. I have worked for over a decade on the remittance transaction dealing with issues around reversal and corrections – over payment recoveries etc. Within this time I have had the pleasure to work with the AMA to attempt to pinpoint why these correction transactions happen at such high rates.

Since these types of items reversal / correction, over payments, underpayments etc are extremely manually intensive by the providers we surveyed the payers to find out why these things happen so often.
The result was largely due to member enrollment errors – wrong plan – wrong network – wrong group paid at wrong rates so all the claims have to be reversed and corrected adding to the burden on the providers!!

While enrollment is named under HIPAA and many payers are ready to receive, it the employer groups are not sending it. They are not covered entities therefore they do not have to by law. I propose that if the employer groups that are sending napkins , excel sheets, Faxes etc were to send the standard 834 transaction for member enrollment the information within it would be of better quality and would reduce some of the burden that is caused by inadequate enrollments.

PMS Vendors

While I did not have a Segway to report this in my oral testimony I would like to suggest that the PMS vendors and all vendors supporting the providers are required to keep up

with the content of the current versions of the HIPAA standard transactions. There are some vendors that have not updated their PMS systems to include the passing of RARC Remittance advice remark codes or Provider level balancing segments, which is a huge part of the 835 standard remittance transactions. This causes many issues within the industry and adds burden on to the provider as they have to call the payer even though the payer did send the information within the standard transaction.

The providers are the beginning and the end of the EDI cycle and they need to trust their PMS system and entities they contract with. If these entities are not required to comply with the HIPAA rules the well-intended process is broken.

So I would suggest that the vendors be held to a high standard. The providers are not educated in the ins and outs of the EDI industry and when they select a vendor they are not sure the questions to ask. In working with the AMA we will be attempting and help educate the providers, and the AMA Toolkits are helping to educate the providers. But in order to ensure some level of responsibility there should be a requirement for these systems to all be content capable for all standard HIPAA transactions.

Content capable – to ensure that a system is able to send/receive all the information required in order for a HIPAA compliant transaction can be created/ fully used within the providers system. This does not preclude the systems from continuing to supply value add components but it does require that if the provider wants to supply all the HIPAA elements that they are able to. Additionally on the remittance the system must provide to the provider all elements within the transaction so the provider has the ability to decide how to use it .