Statement To

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS
SUBCOMMITTEE ON STANDARDS

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Good afternoon everyone and thank you for giving me the opportunity to speak with you today on electronic claim attachments. I am Laurie Burckhardt, EDI Manager at WPS Health Insurance.

Claim Attachment Project

In 2005, Mayo Clinic and Wisconsin Physician Services (WPS) began discussions on the possibility of implementing electronic claims attachments for Minnesota Part B claims. Our goal was to look at cost reduction and savings. 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 providers.

Electronic claim attachments offered WPS opportunities for cost reduction due to staff time handling the outgoing request via our Post Office, our mailroom staff, nursing staff, imaging and routing time including postage.

WPS reviewed a report of all development letters sent to Mayo in which additional information was requested. We determined that the high volumes of requests were made for situations where there was a procedure performed and complications occurred or additional surgeons were required. In these scenarios, a modifier of 22 (unusual services) or 62 (co-surgeon) was attached to the procedure code. As a payer we need 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". It was determined to have Mayo send the operative report "electronically stapled" to the claim, instead of waiting for WPS to send the development letter. A claim attachment control number links 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 a method to flag claims from Mayo which indicated an attachment would be coming, link it to the attachment, and send it to the

Medicare Medical Review Department. Mayo Clinic and WPS worked together with a CDA R2 expert to populate the BIN segment inside the X12 275 transaction.

WPS nursing staff reported that attachment received has been more than sufficient to process the claim and there has been no need to request additional information. At this time, we have not had any cases in which the provider is sending more than what is necessary to process the claim. It is important to note that our nursing staff have had great results with unsolicited attachments and are excited for more providers to implement since the process of unsolicited is much cleaner and faster than solicited.

WPS has had ongoing discussions with providers who submit a large volume of paper claims because of additional information needed to be attached to the claim. Many of these providers have expressed a positive interest in unsolicited claims attachments with WPS but needed to wait until their new EHR system was installed or wanted to wait until after 5010 implementation was completed.

WPS strongly supports 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 needed, it is burdensome and expensive to have the claim either pend for more information or reject back to the provider due to lack of information. It is important for payers and providers to collaborate on what scenarios are appropriate for unsolicited attachments.

Today's process on how additional information is requested
Currently, additional information is communicated to the provider through two different methods:
Claim is pended within our processing system and a request is sent to the provider via a letter, fax or secured email message. In most cases, provider must respond within 35 days by providing the information requested as well as attaching the original letter to the requested information. When information is received, it must be matched to the correct claim, review documentation and process service accordingly. If requested information is not received, the service/claim is denied with a message of; Information requested from the Provider was not provided or was insufficient or incomplete

The second method of communication is when service is rejected on provider electronic remittance (paper remit) with message that Claim/service lacks information which is needed for adjudication.

Types of Attachment
In reviewing the current request for additional information, we found the following top requests for WPS which includes Medicare, Commercial and Tricare business.

- Miscellaneous procedure codes
- Medical Necessity
  - Documentation to support quantity/dosage billed
  - Pain pump injections
  - Progress notes on physical, occupational & speech therapy
  - Skilled Nursing Facility claims require
- Invoices and documentation for
  - Intravenous Immunoglobulin
  - Radiopharmaceutical
- Ambulance
  - Documentation on why air ambulance was necessary rather than ground transport
  - Documentation on why transfer did not go to nearest facility
  - Documentation whether or not the transport was related to the illness for which the patient is under hospice care.
- Operative report requests
  - When modifier 22 (unusual services) or 62 (co-surgeons) are billed
  - Anesthesia time over 500 minutes
  - Multiple anesthesia procedures during a single session
- Lab reports
- Authorization requests

Overall we determined that less than 5% of electronic claims in which additional information was requested could be codified. Therefore although WPS supports codified data whenever possible we do not believe it is possible for the industry to codify all attachments.

OTHER COMMENTS
WPS supports the use of the 275 transaction as the wrapper around claims attachment. The structure of the 275 identifies the sender, what the file is for and who is the receiver of the data. Providers already have connections established either directly or through clearinghouses to WPS for their other electronic transactions. The use of the 275 ensures that current methods of transport established can continued to be used with limited costs for health plans and providers. The use of the 275 transaction would allow the current use of EDI agreements in place to continue to cover the provider signature requirements that may be necessary for attachments.

We support the use of the X12 275 transaction as the routing vehicle as this allows us to link the claim with the requested data.
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Summary

In summary, our claim attachment project provided opportunities for efficiency and cost reduction and we are looking forward to increasing number of providers to utilize unsolicited whenever possible.

I'd like to thank you again for the opportunity to provide input.