Testimony of

The Healthcare Billing and Management Association

Before

The National Committee on Vital and Health Statistics (NCVHS)
Subcommittee on Standards

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Presented By

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Mr. Chairman, and members of the National Committee on Vital and Health Statistics Subcommittee on Standards Review Committee. My name is Dave Nicholson and I am the chair of HBMA's CAQH/CORE Workgroup. I want to thank you for this opportunity to give you our perspective on the HEALTH PLAN ELIGIBILITY, BENEFITS INQUIRY & RESPONSE

The purpose of this hearing is to obtain information from the health care industry on the currently adopted standards, operating rules, code sets and identifiers used in administrative simplification transactions.

HBMA -

The Healthcare Billing & Management Association (HBMA.org) is a key stakeholder in the $38 billion physician Revenue Cycle Management industry. We have over 600 members and more than 500 companies that employ more than 30,000 individuals at billing and revenue cycle practice management firms. We estimate that annually, HBMA member companies submit more than 350 million initial claims on behalf of physicians and other healthcare providers.

In addition, HBMA members frequently perform all of the physician's practice management functions, accounts receivable management, medical billing consulting, as well as assistance in the preparation and completion of provider enrollment forms and other administrative and practice management services. This includes interactions and communications with Health Plans to verify eligibility, check claims status, seek and obtain, where necessary, prior authorization and the myriad of other administrative task required of a physician's office. Our member companies work with virtually every medical specialty and subspecialty and are knowledgeable, high-volume users of nearly every commercial billing product on the market. In addition, many HBMA members provide coding services in addition to billing – our member companies employ thousands of professional coders, many of who are expert in their respective clinical specialties. We believe HBMA is uniquely positioned to comment on the questions of concern to the Review Committee. Indeed, tomorrow, I, along with a group of colleagues from HBMA will be spending most of the day at CMS to discuss many of the operational challenges our members face interacting with not only Medicare and Medicaid, but commercial insurers as well.

HBMA has been providing education to assist our members and their clients understand and work with the various HIPAA transaction standards and operating rules and, more recently, we've been actively engaged in the CAQH/CORE process for improving the reason and remark codes (CARC and RARC).

The objectives of this hearing are as follows:

- Review currently adopted standards, operating rules, code sets and identifiers used in each of the HIPAA-named administrative simplification transactions and evaluate the degree to which they meet current industry business needs.
- Identify transactions, standards, operating rules, code sets and identifiers used in administrative simplification that require changes, deletions or new versions in order to meet industry needs.

First, we cannot undertake to respond to the many questions you posed without taking note that next year – 2016 – we will "celebrate" the 20th anniversary of the enactment of the Health Insurance Portability and Accountability Act – better known as HIPAA.

It is striking that here we sit, nearly 20 years after the healthcare industry was promised administrative simplification through enactment of that historic legislation, testifying about the status of some of the most basic of transaction requirements – eligibility, claims status, prior authorization.

1. **Overall, do the currently adopted operating rules meet the current (and near-term) business needs of the industry? Is the industry achieving the intended benefits from the operating rules? Please provide as much as possible any evidentiary information (qualitative or quantitative) to support your viewpoints**

   The answer to the question depends upon the specific transaction. The vast majority of claims are being submitted electronically using the 837 transaction standards and the vast majority of responses (Electronic Remittance Advice) are occurring using the 835

transaction standards. Beyond that key transaction, the utilization and utility of the other transactions – eligibility, claims status, prior authorization, etc. are being utilized to a much smaller degree. The failure of, or the inability of, the Health Plan to offer a true electronic option as envisioned by HIPAA or the lack of complete information available from the Health Plan when you engage in an electronic transaction has never been effectively enforced.

A. Eligibility – The experience of my company and the majority of my colleagues has been that plans can offer a web-based option to do beneficiary eligibility on a patient-by-patient basis. Very few offer a batch option (i.e. send a group of names in a "batch" and receive a timely electronic response. While the Web-based option is technically in compliance the HIPAA requirements, this process is time consuming and often still results in inadequate information from the Health Plan.

1. In Maryland, Health Plans regulated by the state insurance commission have certain balanced billing restrictions and providers are obligated to adhere to those limitations. However, ERISA plans used by Maryland based companies are not bound by this state law.

   Most ERISA plans used in Maryland utilize a Maryland based insurance plan for Administrative Services (For example Cigna). When a patient presents to a Maryland provider his/her insurance card will be for that Plan and does not specify that this is an ERISA plan.

   If we make an electronic inquiry to verify eligibility to that Heath Plan, we will be told that the individual is enrolled but we are NOT told that the individual is in an ERISA plan. Based upon this, our providers will believe they must adhere to the state balanced billing requirements when in fact, they are NOT subject to these limitations.

   Because we are not getting the full picture, we have chosen to go to the web portal of the insurer to get the complete information instead of using

the 270 transaction.

2. In Illinois, the state Medicaid program issues cards to their enrollees which is, in theory, helpful Unfortunately, there is very little information on these cards and the provider invariable must visit the state website to get eligibility information – which is generally two months behind because the state only updates the website every 60 days. In order to access the website, the physician must have a valid Illinois license. If the physician is out-of-state it generally takes 6 – 10 weeks to gain access to the Illinois Medisystem.

   Technically the state is compliant but functionally, not close. They have met the letter of the law, but have not complied with the intent of the law.

The experience with most HBMA member companies has been that plans offer a web-based option to do beneficiary eligibility on a patient-by-patient basis. Very few offer a batch option (i.e. send a group of names in a "batch" and receive a timely electronic response. While the Web-based option is technically in compliance the HIPAA requirements, this process is time consuming and often still results in inadequate information from the Health Plan. Once again, plans met the technical requirements of the law but not the intent or spirit of the law.

The net effect here, Mr. Chairman is that while we got correct information, we did not get COMPLETE information.

2. **Have there been any studies, measurement or analysis done that documents the extent to which the operating rules, as adopted and in use, have improved the efficiency and effectiveness of the business processes?**

   The Medical Billing/Practice Management community has not conducted any recent formal studies or analysis to measure the extent to which the operating rules are being used or improved efficiency or effectiveness. Several years ago we presented data to NCVHS compiled one of the Clearinghouses indicating that very few Health Plans were engaging in any electronic transactions other than the 837/835.

3. **Explain the perceived or actual adoption trend of each set of operating rules (by transaction, by industry sector – i.e., providers, health plans). Describe challenges and opportunities for broader adoption of these ORs by industry stakeholders.**

As previously noted, there is widespread adoption and use of the claims submission and remittance by both providers and payors. There is marketplace value for both the provider and the payer and the result is a dramatic reduction in the cost to the provider of submission and receipt of payment for services rendered.

A reflection of the value of the administrative simplification rules has been a significant drop in the fees our members charge for the services we provide. Our costs have dropped dramatically and these are savings that can typically be passed along to our customers – the physician.

Despite the widespread and successful use of the 837/835 transactions, we see far less use of the other transactions

The widely held perception within our segment of the healthcare transaction community is that the principle reason for lack of widespread adoption and use remains the fact that the information is not easily obtainable (i.e. eligibility is principally done on a patient-by-patient basis) or the information is incomplete or proves to be unreliable.

Many of my colleagues believe (or perceive to use your phrase) that the inability to engage in the other transactions is primarily due to the unwillingness of the payer community to make these services easy and reliable. Unlike the 837/835 transaction, which can generate tangible savings to the payer as well as the physician, the principle administrative savings benefit for these other transactions accrues almost exclusively to the provider. For the payer, it represents a cost with little in the way of a return on that financial investment.

For example, what tangible savings is generated for the payer by providing and paying for an up-to-date, real-time eligibility verification process that can handle "batch" inquiries? Little. The same thing can be said for claims status and prior authorization.

The fact that there is little incentive – and no tangible penalty – explains why the payers have invested far less in developing and implementing robust eligibility (270/271), claims status (276/277) and prior authorization transaction processes.

4. **Are there any identified areas for improvement of currently adopted operating rules?**

Yes.

Enforce the HIPAA standards with the same level of aggressiveness we have seen with respect to the HIPAA privacy standards. We are unaware of any health plan being fined for failing to provide a HIPAA compliant transaction or adhering to the operating rules.

As you well know, physicians and hospitals are very publicly fined for even minor self-report transgressions of the HIPAA privacy requirements. Even when no data has been breached or disclosed, hospitals and physicians have been fined.

The principle purpose behind these fines is to send a message that failure to comply will not be tolerated. Why isn't there a similar attitude or approach when it comes to compliance with the Administrative Simplification requirements of HIPAA?

5. **What is the degree of usage of non-batch transactions (i.e., web portals) for eligibility?**

Very High. The vast majority of Health Plans we engage with use a web-based portal. Plans use a portal on the Health Plan's website or direct the physician/billing company to a third-party vendor retained by the Plan for this purpose. Availity, one of the largest of these vendors, is a corporate affiliate member of HBMA.

Some services provided by these vendors are free (such as pulling and EOB/835); however, some serves come with a charge (batch eligibility for 270/271 transaction. It is our sense that the free services are used extensively but the charge services less so.

6. **What, if any alternatives exist for improving efficiency and effectiveness of the business process for each of the transactions for which operating rules have been adopted?**

The problem, from our perspective, appears to be that the Health Plans are not adhering to the "letter" of the law/regulations nor the spirit of the law/regulations. But this is speculation on our part. Due to the lack of enforcement, it is difficult to know what would be a violation of the "letter" of the law/regulation.

7. **Are there additional efficiency improvement opportunities for administrative and/or clinical processes of these transactions that can/should be addressed via operating rules, and strategies to measure impact**?

Similar to our comments on the adoption of other standards, many payers provide a valid CARC and/or RARC but insufficient detail in remittance messages to understand the reason for the adjudication. This lack of specificity in reporting adjudication rationale requires phone calls and unnecessary work by the billing company and/or provider to determine the "real reason" why a claim is denied.

The purpose of this entire process of operating rules was to facilitate as much of the claims processing process electronically, eliminating, to the maximum extent possible, the need for human intervention in submitting and processing medical claims.

For example, the following is a common code for a claim denial:

> CO45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

A typical code associated the above reason code is the following:

> MA02 - If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice depending upon liability.

This tells the physician/medical billing company nothing useful. And we know that we can appeal this but we again, we don't know what we are appealing. These code combinations generally result in a phone call from the physician's office/medical billing staff to the plan to get the information needed to determine next steps.

More added costs.

We also find that there are CARC/RARC code that give multiple pieces of information and again, leave the provider with more questions than answers. For example, CARC 16 states:

> Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Which is it? Did we provide insufficient information on the claim? Was there a billing or submission error? Was there a missing attachment or other documentation?

CARC/RARC Codes can be helpful and eliminate unnecessary costs if you get information that is complete, useful and actionable.

8. What alternatives exist to achieve greater efficiency and effectiveness between trading partners?

No additional comments.

9. Are there any changes that should be made to the current ORs or the mandate?

Nothing other than those already mentioned above.