Panel 1
Industry Perspectives on Operating Rules – Claims

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About MGMA

- MGMA is the premier association for professional administrators and leaders of medical group practices

- Through its national membership and 50 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties.

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CAQH Index – Electronic Claims

	Plans (HIPAA Standard, Web Portal, IVR	Providers	Combined Average
Claim Submission	92%	92%	92%
Eligibility and Benefit Verification	95%	69%	82%
Prior Authorization	64%	7%	35%
Claim Status Inquiry	90%	54%	72%
Claim Payment	58%	58%	58%
Remittance Advice	55%	47%	51%

	Plan Savings Opportunity	Provider Savings Opportunity	Combined
Claim Submission	$.057	2.23	2.80
Eligibility and Benefit Verification	2.49	3.07	5.56
Prior Authorization	3.95	8.93	12.88
Claim Status Inquiry	4.81	1.23	6.04
Claim Payment	.014	3.04	3.18
Remittance Advice	.013	4.17	4.30

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Supportive of the Majority of the Connectivity Rules

- **Payload(s):** X12 Administrative Transactions NCPDP, HL7 V2.x or V3 Messages Other
- **Message Envelope Metadata**: CORE Specified Message Envelop Metadata
- **Message Envelope(s):** SOAP + WSDL
- **Communications Channel Security**: Secure Sockets Layer (SSLv3.0 with optional use of TLS1.1 or higher. Entities needing higher security can use TLS1.1 in lieu of SSLv3.0)
- **Transport Layer**: HTTP over TCP
- **Network:** Public Internet

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Real-Time Claims

- 20 second real-time rule (same as 270/271) is critical for practice workflow
  - Increased use of high deductible plans equates to increased financial risk for providers
  - Key is identifying patient financial responsibility at the time of service
- Industry should be encouraged to offer real-time adjudications (and even RT EFT payments)
- RT valuable for providers in cases where eligibility was established, but for different or fewer medical services.

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Batch Claims

- Batch-transmitted by 9 PM, acknowledgement back by 7 AM in 2 business days
  - Important for practice workflow, but 2 business days seems excessive
  - Recommend acknowledgment be sent within 1 business day

Acknowledgements

- We support the following requirements for the 837:
  - A health plan must return an ASC X12C v5010 999 to indicate that the claim was either accepted, accepted with errors, or rejected
  - Payers must acknowledge each claim received using the ASC X12N v5010 277CA unless previous processing resulted in a rejection of the Interchange or a Transaction Set in a Functional Group
- These have been agreed to by many payers (many offer now)
- Time now to require them for the industry
- Potential concern: cost of receiving acknowledgements from numerous “hops” and paying vendors a “per click” fee
- Providers should be given option of receiving them and industry should be encouraged to minimize cost

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Payment Issue

- Current workflow:
  - Provider receives green light from a 270 and treats patient
  - Claim is submitted and paid by payer
  - At a later point, payer determines employer failed to update employment status of patient
  - Payer recoups payment from provider often weeks or months later
- Recommendation: the onus be placed on the employer. Should they fail to notify the payer of the change in status, they would then be held financially responsible to the payer

Authentication

- We have concerns with eliminating Username+Password as an authentication option and mandating only the X.509 digital certificate as the single authentication standard
  - The X.509 digital certificate requirement may impose implementation challenges and financial burden on practices forced to acquire the required technology
  - Industry is rapidly developing additional digital security options and both Username+Password and X.509 options may be obsolete
  - Differing authentication requirements for the various electronic transactions (Phase 3 vs Phase 4) could prove problematic
- Recommend not mandating an authentication standard at this time

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Current Procedural Terminology (CPT) Compliance

- Concerns about inconsistencies with the application of the CPT code set
- In the HIPAA T & CS Final Rule, CPT Guidelines were not specifically named with the code set
- Absent standard guidelines, users are able to develop their own rules for how and when to report codes and modifiers
- Recommend ORs require CPT Guidelines

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General Comments

- HHS should:
  - Significantly increase provider and vendor education on HIPAA transactions
  - Endorse/support the EHNAC/WEDI PMSAP
  - Foster additional collaboration between provider organizations and SDOs (go where the providers are)
  - Proactively audit for payer compliance
- Acknowledge excellent process/work of CAQH CORE

Thank you

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