Industry Perspectives on Proposed Attachment Standard

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Medical Group Management Association

Advancing Leaders. Advancing Practices.™

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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Current Attachments Environment

- MGMA survey results: 51% answered “always” or “often” that payers request attachments for claims, 78.4% for WC
- Nearly 100% for some specialties (i.e., orthopedics)
- Payer requests sent by paper
  - Often lost or sent to incorrect address
  - Difficult to determine what is being requested by payer
- Paper claim attachments are a significant cause of claim denials, payment delays, write-offs
- Providers concerned that CAs simply used to delay payment
- MGMA survey-avg. provider cost per request is $21.34

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Benefits of Automation - Providers

- Virtually eliminates lost requests/responses
- Reduced cost associated with staff, paper, postage
- Hope is documentation requests will decrease
- Improved predictability of payer content needs
- Improved claim reassociation
- Reduced pends, denials, appeals, faster payment
- Decreased days in AR
- Significantly reduced administrative burden
- Opens door for additional functionality…

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Opportunities for Attachments - Clinical

- Beyond claims…
  - Care coordination
  - Transitions of care
  - Care management
  - Quality reporting (MIPS)
    - MU / PQRS / VBM
  - Support for alternative payment models
    - Patient-centered medical homes
    - Accountable care organizations
- All will benefit from standardized and automated clinical data exchange

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Recommendations

Standards

- MGMA supports the following attachment standards:
  - **Request for additional information**
    - ASC X12 278 Services Review Response (prior authorization)
    - ASC X12 277 Request for Additional Information (claim)
  - **Envelope**
    - ASC X12 275 Additional Information to Support a Health Care Claim (claim)
    - ASC X12 275 Additional Information to Support a Health Care Services Review (prior authorization)
  - **Clinical Content**
    - HL7 C-CDA R2 Consolidated Clinical Document Architecture Release 2

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No Trading Partner Agreements

- Permitting “trading partner agreements” to set a standard between payers/providers could unfairly penalize providers with limited contractual power
- Recommend a similar approach to EFT - require payers to use the CA standard if requested by provider
- However, TPAs acceptable for determining when payer would accept unsolicited attachments

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Glide Path Required to Avoid Slow Adoption

	Health Plans (HIPAA standardized, Web Portal, IVR)	Healthcare Providers (HIPAA standardized)	Plans and 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%

Source: 2014 CAQH Index. All responding health plans.

We need attachments to work in the real world of HC

- 1st step is unstructured documents sent electronically in a secure manner
- 2nd step focus on structured data with narrative text
- 3rd step support structured, codified data

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Additional Recommendations

- We support the C-CDA R2 and oppose including the Clinical Document for Payers 1 (CDP1)
  - Two standards would force practices to create two forms
- HHS should, working with provider organizations and WEDI, aggressively educate industry (similar to ICD-10) on ROI and how to implement
- Emphasize accreditation/ certification levers such as EHNAC/WEDI PMSAP
- Establish PMs/EHRs as business associates

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Rule will be delayed until 2019+, recommend moving forward with operating rules

- Move forward with CORE ORs such as:
  - Payer prohibited from requesting information already included on the claim
  - Payers prohibited from requesting the same clinical data multiple times from providers
  - Timing of payer requests—no request after X days following receipt of claim
  - Maximum time for payer to adjudicate claim after attachment received
  - Consistent formats:
    - Payer ID / ID of claim
    - Payer request
  - Infrastructure / transmission standards

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Thank you

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