National Committee on Vital and Health Statistics (NCVHS)

Subcommittee on Standards

CIO Forum

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Testimony from the Pennsylvania Medical Society

Presented by James A. Goodyear, MD, FACS

The Pennsylvania Medical Society (PAMED) thanks the National Committee on Vital Health Statistics (NCVHS) Subcommittee on Standards for the opportunity to address the CIO Forum concerning updates to administrative standards and operating rules. As a representative of the end-user community, I look forward to the exchange of ideas on how administrative standards and operations can provide improved efficiency and burden reduction as it relates to independent physician practice moving forward with the predictability roadmap.

As a practicing physician for more than 30 years, I have experienced the changes in billing and remittances, and the conversion of local and regional codes to standards and code sets. After 1996 and the implementation of HIPAA, my practice underwent a significant financial outlay with the purchase of a computerized practice management system. Our investment has resulted in improved efficiency to handle the day-to-day standard transactions implemented into our workflow.

The benefits of electronic transactions far outweigh the shortfalls. After the transition period, our practice experienced reduced accounts receivable days, which allowed for a more streamlined source of revenue and permitted our business office to budget finances in a more predictable way. Utilizing electronic transactions has reduced duplicative work of manual entry. Manual entry creates the opportunity for an increase in errors, which interferes with workflows. Overwhelmingly, small practices who were able to make the leap to electronic claims submissions would not wish to go back to paper.

The introduction of the 837 transaction has been paramount in the flow of claims data to payers and has reduced the cost of claims submissions significantly. However, when an 835 remittance advice is returned to our practice, it is evident there is a lack of consistency between payers. The billing office has stated repeatedly that when a denial is reviewed, the Claim Adjustment Reason Codes (CARC)

and Remittance Advice Remark Codes (RARC) do not always match the explanation of adjustments or match the reason for denial.

At times it appears lines on submitted claims have been manipulated in order to process for payment, creating a workaround pushing claims through systems to enforce policy. For example, it is not uncommon for a modifier to be moved to another procedure code on a claim, or the modifier may be amended to something entirely different. Additionally, a copay for an evaluation and management code could be moved to another procedure code billed on the same claim.

The claim status function has been helpful. Using practice management software, claims reports are monitored daily to look for errors that prevent claims from transmitting successfully. We can cross reference these reports with claims status reports to identify any issues that need to be addressed within a timely filing limit. The claim status responses have been helpful in timely filing and front-end edits. The method of processing results of these reports continues to remain fairly manual. Smaller practices continue to log into a provider portal or clearinghouse portal to rework claims that have not been accepted for adjudication.

The eligibility function is most helpful when verifying if a patient is enrolled in a plan, and depending on the plan, it may also name any other plans in which a patient may participate. On the other hand, the eligibility function has not been as advantageous as we would have hoped. Deductibles, coinsurance, and copayment data is not drilled down far enough to be valuable. Expected copayments may be incorrect due to physician tiering based on preferred network status, or a specialist copay may be reflected as a result of a primary care practice query. Often, deductible amounts are not accurately reflected when running an eligibility verification.

This is also true when referencing coordination of benefits. CAQH said it best in their Administrative Inefficiency in Coordination of Benefits (COB) whitepaper, "[…]transaction standards are only effective if payers and providers have good information about all of the forms of coverage involved so that the transactions can be sent to the correct health plans."[1]

More often than not, there is not enough data to facilitate COB, since billing departments need more than the health plan name to comply. It would be beneficial if the health plan could share a patient identification number of the additional plan or plans, alleviating the guesswork in the billing department. There are patients who sometimes are not aware they are covered under additional plans, or they may not comply when additional information is requested by either the payer or the provider. This tends to leave the charges uncollectible, or fruitlessly attempting to collect the obligation from the patient.

Authorization requests are where our practice and physician practices on a national level would like to see more innovation.**This is an issue of high priority for both PAMED and the American Medical Association (AMA).** We need to see a more efficient approach for prior authorization of procedural care. In an age where we can attach consolidated clinical document architecture (C-CDA) to a direct secure message for a referral to another provider, how can we integrate this with our payers? Large and small physician groups hire additional staff to work on prior authorizations, and most requests continue to be fulfilled via fax, telephone, and even mail. I understand electronic prior authorization can be initiated by an electronic request or through a provider portal – for example, Navinet – but most follow up occurs by telephone or fax. This is an administrative burden and we

ask that payers be held to the same standard as providers. The workload is unsustainable and interrupts patient care. Processes need to be streamlined and accountability shared equally between the two entities.

Using the direct secure message could allow for burden reduction simply by allowing for the attachment of the C-CDA to send any necessary documentation and ease communication barriers between end users and payers.

My fear is that with the advancement of application programming interfaces (APIs) to complete the prior authorization task, end-users will only have to bear more expense. **I ask that you urge health plans to reduce their prior authorization requirements and limit application to true outliers and to consider using existing infrastructure of the practice management system/electronic health record to enable the prior authorization request, encouraging interoperability, transparency, and the ability to manage data in one central location.**

With the expectations and regulations put upon providers, practices are focusing their resources on referrals and prior authorization. Overwhelmed billing departments are contracting out these transactions due to workflow and lack of confidence. Depending on the type of billing agreement a practice has with their vendor, these costs can range between a few hundred to a few thousand dollars a month.

Overhead has not decreased, dollars have not been saved. Funds have been reappropriated to technology support, vendors, security risk analysis, and upgrades to hardware and software. These changes to electronic standards and operations have the potential to disrupt these workflows and have a significant financial impact to a small practice due to upgrade costs or fees passed down through software support. I ask you to be mindful of these costs as decisions are made to advance innovation through technology and setting a standard for the frequency of these updates.

Thank you for the opportunity to provide feedback on the impact of the current work as an end-user of administrative standards. I appreciate having a voice as an industry stakeholder to help identify a roadmap that can benefit everyone. As we move toward predictability, transparency, and interoperability, I look forward to continuing the discussion as to how we can encourage innovation and advance meaningful data exchange that allows all users marked improvement in efficiency in the business of health care.

[1]Administrative Inefficiency in Coordination of Benefits, Prepared with assistance from Manatt Health Solutions, February 2014. Available at: https://www.caqh.org/sites/default/files/solutions/cob-smart/COBwhitepaper.pdf