FROM THE PRESIDENT’S DESK...

Time Flies by Too Fast.

2018 is nearly gone, but it gives us time to reflect on all the good things that have happened this year due to HATA and its engaged membership.

We released our first HATA Industry Roadmap — engaging industry partners to promote interoperability and drive down healthcare costs. On behalf of the PMS vendors, HATA created the HATA Industry Roadmap to raise industry awareness of the PMS vendor need to bring solutions to their clients that promote interoperability and drive down costs. In addition, HATA shared this roadmap with the National Committee on Vital and Health Statistics (NCVHS) and Office of the National Coordinator for Health Information Technology (ONC) to encourage the inclusion of these recommendations on their roadmaps. Thank you to all of you who participated in its development and serves on the HATA Industry Roadmap Committee.

HATA is strongly supportive of interoperable administrative and clinical information exchange utilizing standard transactions and code sets. HATA is focused on the development of its Certification in Healthcare Administrative Technology (CHAT) program which recognizes PMS vendors providing a standard level of privacy and security, software functionality and features that focus on both the electronic health record (EHR) and PMS revenue cycle management (RCM) workflow. Many of you contributed to the development of this program. Thank you for your willingness to share your time and expertise.

In 2019, HATA looks forward to engaging with industry partners to determine the best strategic path toward enacting these recommendations and/or providing increased education in those areas where solutions already exists.

Thank you to Optum for hosting our recent onsite membership meeting in Schaumburg. I valued my time meeting those of you who attended. HATA onsite meetings are always informative, engaging and a great venue for networking. Those of you who were unable to attend can access the informative presentations from the HATA member site. You are encouraged to consider placing these meetings on your calendar in 2019.

I found it an honor to serve as your President this year and look forward to seeing HATA grow and expand its influence in 2019.

Eric Christ, HATA President
HATA Industry Roadmap Survey Results!

Thank you, to all of you, who completed the HATA Industry Roadmap survey. Your responses resulted in the following prioritized focus of the HATA Industry Roadmap.

You will note several articles in this and upcoming newsletters providing education and requesting feedback/referrals on the high priority topics. If you or your staff is not already part of the active HATA Industry Roadmap bi-monthly calls, be sure to join today — Let’s make a difference. Reach out to Tammy Banks (tammy.banks@optum.com) to be added to the Committee. Betty Gomez and I, as co-chairs, appreciate the support and active participation of the committee members.

HIGH PRIORITY
(3+ Ranking)

1) Release dates of new/revised standards at a set time each year with a minimum of 12 months implementation time;
2) Mandate Attachments, for use with claims, prior authorization and other relevant standard transaction usage.
3) Require/Encourage disclosure of payer-specific prior authorization requirements — standard format creation/usage.
4) Mandate/encourage payers to make available a detailed companion guide with limited permitted usage and transparency requirements in a standard template.

5) Mandate Claim acknowledgment standard transaction usage.
6) Exchange of clinical information/attachments in support of administrative use cases, such as claims, prior authorization and quality measures across stakeholders should be facilitated.
7) Require/Encourage payer online automated appeals processes.
8) Encourage development of a standard data dictionary across applicable standards and operating rules (X12, Health Level 7, National Council for Prescription Drug Programs (NCPDP, etc.)
9) Encourage increased payer transparency at the front end of the provider revenue cycle to address claim issues upfront.
10) Mandate Pre-determination standard transaction usage.
11) Mandate ASC X12 Provider Enrollment for EDI Services (838) standard transaction for best practice usage.
12) Require funds for a pilot to demonstrate that the new standard or operating rule addresses a specific business need that is not currently met and brings the intended efficiency or value to the industry prior to a national mandate.
13) ONC and HHS partner with the private sector to reach a common approach for patient matching across the industry.
14) Expand ONC API transparency requirements to administrative use cases.
15) Mandate Fee schedules standard transaction and best practice usage.
16) Data sharing requirements across all stakeholders.

continued...
HATA Industry Roadmap Survey Results!

**MEDIUM PRIORITY**
(2 Ranking)

17) Reduce noncompliance, including the use of proprietary formats by increasing the ability of standards to accommodate payer-specific information, above and beyond current external code sets within the provider workflow.

18) Enforce semantic (content) instead of syntactical (alpha and/or numeric) compliance.

19) Encourage increased payer-specific billing transparency.

20) Ensure Centers for Medicare & Medicaid Services complaint process is fully anonymous and not subject to Freedom of Information Act (FOIA).

21) Promote the ability to use a future version of a HIPAA mandated transaction standard in a voluntary pilot.

22) Require identification of implementation costs and benefits for existing transactions and operating rules, including client marketing and support costs.

23) Require specific-compelling business use cases that are solved within a proposed standard that cannot be met within the existing standard and operating rules before moving to a new or updated standard.

**LOW PRIORITY**
(<2 Ranking)

24) Mandate minimum floor allowance for HIPAA mandated transactions.

25) Mandate/encourage proactive compliance audits with increased enforcement of the required and situational usage requirements across X12 mandated standards transactions.

**YOUR FEEDBACK REQUESTED**
Are you surprised by this prioritization? If yes, please share what surprised you.

**CLICK TO RESPOND!**
HATA Industry Roadmap—
Priority #2: Mandate Attachments, for use with claims, prior authorization and other relevant standard transaction usage

Looking for a great guide to assist with determining attachment implementation options for claims, prior authorization and other relevant standard transaction usage? Access the white paper Guidance on Implementation of Standard Electronic Attachments for Healthcare Transactions, November 2017. This guide was jointly created by X12, HL7 and the Workgroup for Electronic Data Interchange (WEDI).

This white paper includes the practice management systems perspective, thanks to Mary Dooley, Alpha II who monitored, contributed and kept us up to date on this work. Be sure to note on page 18, “What is supported by the vendor?” section that many of our members contributed. The section introduces the need to integrate both the administrative and clinical standards within the solution workflow. Practice Management systems should have a plan or begin to solution how to retrieve the required supporting data from the Electronic Health Record to support claims, prior authorizations and other processes that may require electronic claim attachments, if they do not do so currently. This white paper is for you to share and educate your staff and your customers — another benefit of your HATA membership.

YOUR FEEDBACK REQUESTED  Do have or know of a PMS system that has coordinated efforts with its EMR solution to send attachments and would be willing to share its experience? Send your referral to Betty Gomez at bgomez@medinformatix.com.

THIS WHITE PAPER IS FOR YOU TO SHARE AND EDUCATE YOUR STAFF AND YOUR CUSTOMERS—ANOTHER BENEFIT OF YOUR HATA MEMBERSHIP.
HATA Industry Roadmap
Priority #4: Mandate/encourage payers to make available a detailed companion guide with limited permitted usage and transparency requirements in a standard template.

Has your team experienced unworkable, lengthy or costly requirements within one or more companion guides? If so, you may wish to consider referencing the following Best Practices Companion Guide Templates as potential guides for your business partners to consider.

**Workgroup for Electronic Data Interchange (WEDI) and Accredited Standards Committee X12 (ASC X12)**


The Principles Document clarifies the requirements for creating proprietary Companion Guides based on ASC X12’s published implementation guides. The Companion Guide Template is used to ensure a consistent look and feel with consistent content across the companion documents developed by various entities in the health care industry. Visit the X12 Store to access these free documents.

**CAQH Committee on Operating Rules for Information Exchange (CORE)**

Established in 2005, CAQH CORE is a multi-stakeholder collaboration of more than 130 organizations – providers, health plans, vendors, government agencies, and standard-setting bodies – developing operating rules to simplify healthcare administrative transactions. The CAQH CORE Phase I operating rules include the CAQH CORE 152:

Companion Guide Rule Version 1.1.0, which is limited to the X12 270/271 eligibility and benefits inquiry/response transactions but can be used for all standard transactions.

This rule was created in 2011 and is based on the CAQH/WEDI Best Practices Companion Guide Template developed jointly in 2003, with input from multiple health plans, system vendors, provider representatives and healthcare/HIPAA industry experts. The template organizes information into several simple sections and provides for a common information flow and format, while at the same time giving health plans the flexibility to tailor the document to meet their particular needs. The template covers a broad range of HIPAA-mandated transaction sets and is not specific to any one of them.”

Visit CAQH CORE web site for more information on the CAQH CORE 152 Operating Rule Companion Guide Rule Version 1.1.0 and to access the CAQH CORE v5010 Master Companion Guide Template.

**YOUR FEEDBACK REQUESTED**

*Has your team experienced unworkable, lengthy or costly requirements within one or more companion guides? The HATA Industry Roadmap is looking for requirements received (blinded—remove originator) to help quantify the costs/administrative burden incurred by vendors to accommodate these types of requirements. Send your examples to Tammy Banks at tammy.banks@optum.com for the Committees review.*
Engagement, Industry Knowledge, Innovations, Relationship Building and Synergetic

These are five words to describe the HATA Fall Membership Meeting hosted by Optum 360 in Schaumburg. The attendees and presenters took the opportunity to network at the Monday night dinner and all day membership meeting held the following day. The meeting contained a wide variety of sessions impacting the practice management system vendors.

Join me in thanking all the presenters listed below for providing thought provoking information for current and future roadmap consideration. We look forward to continuing these conversations:

- **Eric Christ, CEO, PracticeAdmin, LLC | HATA Report – PMS Industry Landscape – Expansion;**
- **Tammy Banks, VP, Optum 360 and Gary Beatty, Director Advisory Services, Optum (X12 Chair) | NCVHS Predictability;**
- **Steve Morelli, Director, UHC & Steve Sewell, VP, Optum 360 | Proactive Claims Handling – Increasing Payer-Provider Actionable Communication;**
- **Tim Mills, Chief Growth Officer, Alpha II | Patient as a Consumer;**
- **Mary Lynn Bushman, Senior Business Analyst, National Government Services, Inc. | Payer EDI Attachment Opportunity;**
- **Donna Campbell, Provider Portal & Provider Connectivity IT Product Manager, Health Care Services Corporation (HCSC) (X12 270/271 Co-Chair) | Streamlining the Eligibility Process – 5010 & 7030 X12 270/271 Standard Transaction;**
- **Gary Beatty, Optum | Solving for Interoperability: X12 Innovative Messaging Pilot Opportunity;**
- **Sergiu Rata, Senior Director, Edifecs | Smart Attach – making attachments work within the PMS;**
- **Patrick Drewry, Product Manager, Optum 360 | Streamlining the Contract Administration Process – Addressing Gaps, and**
- **Brad Gnagy, Senior Business Development Manager Northeast, Healthpac Computer Systems, Inc. | The Future is Wide Open – Artificial intelligence in the Revenue Cycle and other Emerging Innovations.**
HATA Industry Roadmap & NCVHS Predictability Roadmap Testimony Development

Join the renamed Government Affairs & Liaison Committee to flesh out HATA’s comments to the NCVHS Predictability Roadmap. Gary Beatty at the HATA annual meeting shared many key changes in place to streamline the standard transaction development and we need your feedback to ensure HATA’s comments are meaningful and actionable to reduce our unnecessary cost expended on standard development and one offs. Access the NCVHS Predictability Roadmap or search for NCVHS Predictability Roadmap to access the current recommendations. Contact Tammy Banks, HATA Government Affairs —Liaison Committee Board Liaison to receive an invite at tammy.banks@optum.com.

New Membership Retention and Recruitment Committee Chair

Congratulations to Betty Lengyel-Gomez, Regulatory Compliance and Industry Outreach from Medinformatix who has been appointed Membership Retention and Recruitment Chair. Be sure to reach out to Betty for more information on how to become more involved, increase your staff involvement and refer a potential member to engage. Contact Betty for more information at bgomez@medinformatix.com.

Looking for Industry Leaders - Become a HATA Liaison

Do you or one of your staff participate at CAQH CORE, Care Equality, DaVinci, Direct Trust, HL7, NUBC, NUCC, WEDI, X12 or other industry organization and would be willing to become a liaison and report on current activity to keep HATA members up to date on industry trends and potential changes affecting our roadmaps? Contact Tammy Banks HATA Government Affairs — Liaison Committee Board Liaison for more information at tammy.banks@optum.com.

If you have no idea what these acronyms’ mean, look for a webinar on this topic in the near future. Be proactive, stay in the game, remain aware of industry trends and potential changes affecting your roadmaps.

Communication & Education Committee

Thank you to Daniel Wojta, Director of eSolutions, EDI and Business Development, Office Ally for serving as the HATA Board Liaison for the newly formed Communication & Education Committee. Contact Daniel for more information at daniel.wojta@officeally.com.
Stop the Denial Insanity! Effective Prevention Outweighs Denials.

Timothy Mills, Chief Growth Officer, Alpha II, LLC

The vast majority of both ambulatory and acute care providers deal with the reality of denials management every day and employ dedicated resources that focus exclusively on chasing their hard-earned revenue. Two very familiar phrases come to mind as I reflect on this reality: the first is “the definition of insanity is doing the same thing over and over again expecting different results” and the second is “an ounce of prevention is worth a pound of cure.” Which leads me to the question, “what if the best possible denials management strategy was to prevent denials before they occur?”

While there are certainly some healthcare providers who are doing better than others, several studies suggest that most providers see overall denial and rejection rates as high as 15-20%. This equates to as many as one in five claims that need to be reworked, resubmitted, or even appealed. Many providers have limited or overworked resources, so a good percentage of denied and rejected claims never get resubmitted, which results in lost revenue. Providers also need to consider the true cost and financial effect of this traditional approach. The average cost to rework a single claim is $25. Furthermore, only two-thirds of denials are recoverable through traditional denial management efforts. Let’s try some simple math to put this provider cost and financial effect into perspective:

- For every 10,000 claims with a below average eight percent denial/rejection rate, 800 claims are affected.
- If all 800 claims were reworked and some not simply lost, multiplying these by the $25 cost per claim has a cost effect of $20,000.
- The financial impact to chase and reclaim (hopefully) as much as 70 to 80% of their own hard-earned reimbursement is significant.
- The net result is increased days in AR, decreased cash flow, and reduced reimbursement.

FOR EVERY 10,000 CLAIMS WITH A BELOW AVERAGE EIGHT PERCENT DENIAL/REJECTION RATE, 800 CLAIMS ARE AFFECTED.
It’s also important to evaluate where many claim errors originate within the overall revenue cycle workflow and determine what some of the more common types of denial/rejection causes are. There is a common misconception that most claim errors are administrative issues and/or back-of-the-office challenges. However, clinical and coding factors play a major role in contributing to the ongoing battle with denials management. Consider a few of the top denial/rejection reasons.

- Lack of medical necessity
- Mismatched procedure codes with diagnosis codes
- Up-coding and/or unbundling
- Incorrect coding
- Missing or wrong modifiers

The great news is that many errors like these can be avoided and eliminated before they happen. Unfortunately, both government and commercial payers have become specialists at constantly changing the rules and regulations which increases the difficulty in heading off denials before they occur. Proving the one constant in healthcare reimbursement is change. A truly proactive approach should include best practice process improvement but also assessing advancing clinical and coding-editing technology that maintains compliance with the constantly-changing billing and coding rules and regulations. To effectively prevent these types of errors from occurring, providers need to be proactive, not reactive. A preemptive workflow assessment can be very beneficial to evaluate and implement preventative maintenance much earlier in the workflow at the encounter level, when coding a patient visit, and during charge capture or charge entry.

Many providers assume they have attacked this challenge with traditional claim scrubbing. But most providers who are using an old-school claim scrubber are still chasing their revenue. Perhaps it’s time to rethink everything about the traditional approach and stop the denial insanity: don’t do the same thing over and over expecting different results. Consider proactive approaches that can be seamlessly integrated early in the clinical workflow from within your practice management system, electronic health record, revenue cycle management, or clearinghouse system. And remember that an ounce of proactive prevention clearly does outweigh a pound of denials.

Sources:
- "Health insurance denial rates routinely 20%, data shows," Phil Galewitz, Kaiser Health News, featured in USAToday.com, September 2011