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I am Chris Bruns, President of the Healthcare Administrative Technology Association (HATA), the national association for the Practice Management System industry and Product Manager for MedInformatix. I would like to thank NCVHS for the opportunity to present testimony today on behalf of HATA concerning adopted transaction Standards, Operating Rules, Code Sets & Identifiers.

Background on the Healthcare Administrative Technology Association (HATA)

The Healthcare Administrative Technology Association (HATA) is a non-profit trade association to provide a forum for the practice management system (PMS) industry and other affiliated stakeholders. The association serves as the representative voice to advocate and influence key stakeholders and government representatives on PMS Vendor issues.

Our members, ADP AdvancedMD, HealthPac, InMediata, MDSynergy, Medinformatix, NextGen, Optum, PracticeAdmin, SwervePay, TransFirst and WorkCompEDI represent over 250,000 providers.

HATA's mission is to be an invaluable resource for its members to receive education and healthcare industry information quickly and easily, provide the tools to expand and build upon a member's client base, network and collaborate with practice management system (PMS) peers and other industry stakeholders, advocate with one representative voice, and influence the healthcare community on issues vital to the healthcare administrative technology industry.

Formal representation of such an important piece of the healthcare ecosystem is critical to the advancement of the industry. HATA is a key stakeholder in the $40 billion physician revenue cycle industry and is an active and influential voice promoting the goals and values within the healthcare administrative industry and driving administrative efficiencies.

The practice management system industry has more than 600 companies providing a variety of technology solutions for the full range of healthcare professionals. The industry represents nearly 100 percent of all initial claims submitted on behalf of hospitals, physicians and allied healthcare professionals. Administrative simplification of claim processing is a key factor in influencing the cost of healthcare in the United States, and HATA will lead the movement in this area.

Our testimony is based on HATA Member remarks from the WEDI-Cooperative Exchange Survey recently conducted for the NCVHS Review Committee Hearing. It is important to note that even if specific transactions ranked high as meeting a need, benefit, efficiency or effectiveness the actual implementation and usage of those transactions are not without challenges and many times fall short of their potential. While all stakeholders have to support the transaction, there is not 100% adoption across the industry.

HATA believes we also need to withhold policy changes while a major implementation is taking place (e.g. 5010/ICD-10 was originally scheduled to be implemented on same date). Transaction adoption and changes need to happen one-by-one before going on to another. And for all transaction standards, HATA Members believe in mandatory adoption and use.

HEALTHPLAN ELIGIBILITY, BNEFITS INQUIRY & RESPONSE (PANEL 2)

HATA notes that the Eligibility (270/271) transaction meets minimum needs, but it should provide more detailed benefits information in an industry-standard format that would be actionable. Expected benefits have not been attained from a provider perspective, and they continue to check eligibility by the payer's website directly or use of the telephone.

Some health plans appear to use the NPI and the taxonomy code to determine what type of eligibility response to return to the provider, instead of relying solely on the inquiry type as specified in the 270. This also requires cumbersome extras on the 270 that restrict level of benefit detail on response, such as place of service, type of service, provider zip code.

CMS needs to limit the ability for health plans to tailor benefit details based on enrolled specialty of NPI submitted, and limit the ability for health plans to require non-standard inquiry criteria elements such as type of service, place of service, and zip code.

<u>Recommendations for Eligibility (270/271)</u>

1. Maintain 270/271 eligibility databases such that they are always in sync with any other eligibility databases, files, or direct website eligibility services.
2. Consistently include Participating and non-Participating copay, coinsurance, deductible, and out-of-pocket maximum information as well the patients' met amounts.
3. Support all service type codes beyond Health Benefit Plan Coverage (service type code 30). Providers need benefit information per service type in order to better predict patient coverage and estimated patient financial responsibility.
4. Include plan product types, names/descriptions, and provider networks in the 271.
5. Return the PCP NPI with 2100C Loop in EBL. Providers increasingly must coordinate with specialists inside and outside of their practice. Clear identification of the patient's PCP will allow providers to better coordinate across specialties.
6. Include referral required information to reduce referral related denials and phone calls after the office visit.
7. Include whether Prior Authorization is required per service type code in order to reduce denials related to benefit coverage, pre- certification, and pre-authorization calls.
8. Accept inquiries for HCPCS Codes in the EQ02 to determine coverage and patient financial.

PRIOR AUTHORIZATION (PANEL 3)

HATA believes for Prior Authorization (278) there needs to be increased adoption of this transaction, as it is not as widely offered by health plans as is the 270/271; there needs to be more adoption of this transaction before benefits will be seen. Payers often have portal functionality, but are not capable of accepting EDI transactions.

Recommendations for Prior Authorization (278)

1. Implement and support both the 278/215 and 278/217 transactions: Even for providers that have care collaboration software, a tremendous amount of manual work is needed to obtain precertification and referral authorizations, which some payers leverage to automate and reduce phone calls to payers.
2. Ensure payer portals, call centers, and HSR systems are updated simultaneously. With so many different informational access points, it is important to maintain standardization across all systems to ensure consistent information is being disseminated. This is critical for providers' trust of the automated transactions as we've seen in our experience with eligibility and claim status inquiry.
3. Support HSR linkage to third party vendors, if applicable. The majority of precertification volume is either cardiology or radiology, which many payers employ third party vendors to administer.

HEALTHCARE CLAIM OR EQUIVALENT ENCOUNTER INFORMATION (PANEL 4)

While the benefits of the Health Care Claim (837) may be met, variances by payers contribute to a lack of standards for the provider. Most differences occur in the acknowledgement reports and rejection codes.

Recommendations for Health Care Claims (837) Standard

1. Payer rejection reasons in claim acknowledgement reports should align with actual rejections. We often find that payers will reject claims for missing information when really the information is present but simply does not match what the payer has on file for that provider or patient. For example, we receive many rejections for missing address that occur when address information is present but do not match what the payer has on file for the patient. These rejections should say address mismatch or something that better articulates the true rejection reason. The clearer rejection reasons are, the more accurate our claims will be.

HEALTH CARE CLAIM STATUS (PANEL 6)

For Claim Status (276/277), the 277CA is achieving industry acceptance, though it is not a HIPAA required transaction. HATA recommends Standard Industry Rejection Codes with plain English explanations. CMS should require an unsolicited 277CA for every 837 transaction sent, within a set time period.

CMS should require that facility NPI is sufficient to process transactions, not rendering or attending NPI. They should also require health plans return matches on a claim's Facility NPI (do not restrict to attending or rendering NPI). The current business needs are not being met in terms of payer responses to 276 inquiries and again, there needs to be Standard Industry Rejection Codes with plain English explanations.

Recommendations for the Claim Status (276/277)

1. Quality Responses - Payer entities should provide clear, actionable explanation of the error responses they send in claim status response files, allowing enough information for the transaction or claim to be resolved using the CSI Response.
2. Multiple Adjudications - payers should include all adjudications of a specific claim in the claim response to account for the full history of the claim.
3. Claim Payment Matching - payers should include adjudication dates and check numbers in their response files to ensure payment information is accurately matched with the appropriate claim adjudication.
4. Real-time Services - payers should offer real-time services rather than only batch transmission of files.
5. Maintains Call Support - payers should not completely shut off the option for providers to call regarding claim status when they implement CSI.
6. Having both real-time and batch processing adds a level of technical complexity. Moving to real-time only would eliminate this. We also see many variations in messages returned from different carriers, which means that we have to create our own standard messages to display to users. Creating and enforcing a standard would be highly beneficial.
7. Call centers should remain available as a back-up for additional follow-up.

HEALTHCARE PAYMENT, REMITTANCE ADVICE AND ELECTRONIC FUND TRANSFER (PANEL 7)

The benefit of the 835 is clear: it reduces cost and processing time. However, while minimum needs may be met, variances by payer contribute to a lack of standards from a provider perspective. Variances in how payers use reason and adjustment codes as well as contractual adjustments continue to erode “standard transaction” use from a provider perspective and it needs to be enhanced to better support recoupment and overpayment situations. Many 835's are out of balance, or have duplicates or other data conflicts.

ERA requires non-standard provider enrollment, which is often an obstacle. Payers sometimes do not stop sending paper when they begin sending ERA which means providers receive duplicate copies of the same remittance, making it complicated to track payments with claims.
HATA recommends creating an opt-out enrollment process for ERAs.

Electronic Funds Transfer (EFT), payers always require enrollment. Testing is sometimes required as well, since there are variances in the information included in remittance and we need to confirm how PMS Vendors will post the payment to the appropriate claims. HATA Members note that there is great variance between payers for Claim Adjustment Reason Codes (CARCs) for Remittance Advice Reason Codes (RARCs) usage.

Recommendations for the Remittance Advice (835) Standard

1. The ERA should not require enrollment; instead, it should be an opt-out choice.
2. Balancing Remittance - The payments in the claim level payment (CLP) loop should always equal the sum of the payment of the Service level (SVC) loops. Furthermore, the total check payment in the Financial Information (BPR) segment should be equal to the sum of the CLP and provider adjustment (PLB) loops.
3. Transparent Patient Responsibility - payers should not use a negative contractual adjustment to increase the balance transferred to the patient. In addition, the claim level patient responsibility (located in CLP05) should equal the sum of the PR claim adjustment reason codes in the claim adjustment (CAS) segments.

4. Multiple ERA to one EFT - A single check number or EFT trace number should correspond to a single ERA. The BPR segment should indicate the type of payment (ACH, for EFT transfers, or CHK for check payments).
5. The Reassociation Trace Number (TRN) should indicate the specific payment number (check or tracer number).
6. Additional (non-claim) payments or reductions (i.e. incentive payments, management fees, taxes, interest, penalties etc.).
7. Additional payments outside of the typical claim's adjudication should be in the PLB segment and transparently defined. Identifying information should be used to indicate exactly what the payment is for and if it relates to a provided service (if so the provider's internal claim number should be referenced).
8. Paying more than the billed amount or more than the coordination of benefits amount allows - The industry needs to consistently use one negative claim adjustment reason code (OA94) to increase the balance being paid. It should become standard practice so that these negative claim adjustment codes are not questioned. If a provider is paying more than the billed amount or coordination of benefits amount, it should be clear when the additional payment is valid.
9. Compliant use of claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) - Standardization of CARCs and RARCs should be implemented to reduce interpretation errors.

Recommendations for Electronic Funds Transfer (EFT)

1. Multiple ERA to one EFT - A single check number or EFT trace number should correspond to a single ERA. The BPR segment should indicate the type of payment (ACH, for EFT transfers, or CHK for check payments). The Reassociation Trace Number (TRN) should indicate the specific payment number (check or tracer number).
2. For Electronic Funds Transfer (EFT), just adoption into the office workflow by providers would help.

HATA conducted a survey that measured practice management systems' capabilities and role within the ERA/EFT process. While the survey results highlighted barriers that could only be overcome through industry stakeholder collaboration, HATA took the lead on this multi stakeholder initiative to raise awareness of ERA/EFT issues and seek resolution within the industry. We released a whitepaper on our findings with recommendations, and held an ERA EFT Summit in Chicago with multiple stakeholders who all took ownership of this issue under HATA's guidance. For complete information on the white paper and summit, go to www.hata-assn.org.

OPERATING RULES

HATA finds that Operating Rules are being selectively used based on lack of adoption. They would be utilized by providers more if there was greater adoption across payers. The Electronic Funds Transfer Operating Rules would be utilized by providers more if there was greater adoption across practice management systems.

Respectfully Submitted,

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