NGSMedicare University Virtual Conference

Medicare 2021

A Journey to a Healthier Future and Partnership

Electronic Attachments From the Beginning

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Today’s Presenters

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  - EDI Agile Product Manager

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Objectives

- The objective of this session is to provide you with all the information on the benefits and ROI of electronic attachments, as well as how to get started in the NGS Electronic Attachment Program

Agenda

- Overview of Attachments
- Attachment White Paper
- Skills Set and Resources
- Recommended Standards
- Attachments Workflow
- NGS Participating Providers ROI
- How to Get Started with NGS
- Questions

Why is There a Need For Attachments?

- Payers may need additional documentation to determine if the service being billed or requested meet their medical policy guidelines
- Most documentation required is clinical in nature and not included in the claim or prior authorization request
- Type of information varies among payers due to payer specific policy or state mandates

Benefits of Electronic Attachments

- Benefits for providers, include but not limited to
  - Savings on printing and mailing of the additional information and postage
  - Savings on staff time for pulling the information
  - Savings on mailroom costs of opening and delivering mail, as information flows more efficiently
  - Streamlines the process of sending the information to payers in a consistent manner
  - Maintaining an audit trail of who has viewed personal health information and where it has been sent
  - Providing more accurate information due to the specificity of LOINC code requests
  - Savings on the cost of appeals as information flows in a more efficient manner
  - Ability to automate some processes when request is in a structured format
  - Reduction in turn-around time for accounts receivable

Benefits of Electronic Attachments

- Benefits for patients, include but not limited to
  - Increased speed of prior authorization decisions leading to more timely treatment and planning of treatment
  - Increased efficiency in determination of financial responsibility for medical services

Background

- Claim and Health Care Services Review Attachments
- Required by the original HIPAA legislation as well as the Affordable Care Act (Claim only)
- Not widely automated today
- Will allow health plans to request, and providers to send "extra" information needed to adjudicate a claim or finalize a utilization review for services
- Will be a bridge between administrative and clinical records
- Ties in with movement towards Electronic Health Records

Background

- Claim Attachment Transaction usage requirements – expected to be same as previous transactions
  - Provider has choice to
    - Request 277 from payer
    - Respond to request via 275/HL7
  - Payer has responsibility to
    - Create 277 when provider elects to receive
    - Receive and process a 275/HL7 when providers elect to send

Background

- The standards proposed for electronic attachments span multiple standards development organizations
- X12N and HL7 have worked together to ensure that their standards are compatible to meet the needs of the industry
- Use of multiple standards in a single transaction is new to the industry, X12N, HL7 and WEDI collaborated to provide guidance
- Joint effort to develop a White Paper, posted on WEDI website, Guidance on Implementation of Standard Electronic Attachments for Healthcare Transactions, published November 2017

Attachment White Paper

- Scope of the Attachment White Paper
  - An overview of Attachments
  - Resources needed to have a successful implementation of Attachments
  - A review of current processes for requesting and responding to the need for additional information to help understand the challenges
  - Examples of implementation approaches in the industry
  - A review of electronic attachment business flows for claims, prior authorizations and notification
  - Business use cases and examples
  - Guidance on how to embed additional information within applicable ASC
  - X12N transaction

Attachment White Paper

- Why is additional information necessary?
  - Payers need based on medical policies
  - Policy requirements are different for each payer or state mandates
- What information is necessary?
  - Documents examples include but not limited to
    - Consultation note
    - Discharge summary
    - History and physical
    - Operative note
    - Procedure note
    - Progress note

Attachment White Paper

- **Current Process**
- Majority of the payer letters requesting the information are hard copy letters mailed to the providers, some exceptions
- Majority of the providers manually print or copy the documents and send the hard copies back to the payers, some exceptions
- Several challenges with the process, such as but not limited to
  - Provider address on file with the payer is not the appropriate department or individual to respond
  - Providers have challenges routing the request internally as well
  - Payer may have challenges matching the additional information to the appropriate claim
  - Cost of mailing
  - Timeliness

Skills Set

- Knowledge Base
  - Understanding of internal business processes and workflows
  - Technical and business understanding of the standards
  - ASC X12N Technical Reports and standards
  - HL7 C-CDA (Consolidated Clinical Document Architecture)
  - Basic XML
  - LOINC
  - Base64 Encoding
  - Transport Methods

Resources

- Provider Staff Resources (not all inclusive)
  - Operations for practice management and other support systems
- EHR vendor, practice management vendor, clearinghouse, IT (programmers, business analysts and quality assurance), office manager, medical records department, billing staff, policy, security and privacy, cyber security, training, legal and contracting (business associate agreements), compliance, technical writers, contractors, consultants, clinical staff

Resources

- Clearinghouse/Intermediary Staff Resources
  - EDI department
  - Operations
  - Imaging systems (data warehouse)
  - IT (programmers, business analysts and quality assurance)
  - Security and privacy
  - Cyber security
  - Training
  - Legal and contracting staff (business associate agreements)
  - Compliance
  - Technical writers
  - Contractors, consultants

Recommendation to NCVHS

- Recommended X12 transactions and versions
- ASC X12N Type 3 Technical Reports (TR3)
  - ASC X12N TR3 for the 275 Transaction (006020)
  - Additional Information to Support a Health Care Claim or Encounter
  - Additional Information to Support a Healthcare Service Review
  - ASC X12N TR3 for the 277 Transaction (006020) Health Care Claim Request for Additional Information
- ASC X12N TR3 for the 278 Transaction (006020) Health Care Services Review – Request for Review and Response

Recommendation to NCVHS

- Recommended HL7 documents
- HL7 Implementation Guide for CDA Release 2: Consolidated Clinical Document Architecture Templates for Clinical Notes (US Realm) Release 2.1 Volume 2 (C-CDA R2) (STU)
- HL7 Implementation Guide for CDA Release 2: Consolidated Clinical Document Architecture Templates for Clinical Notes Release 2 Volume 1 (Introductory material) (US Realm) (STU)
- HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 – US Realm (STU) (HL7 Guide)

Solicited Model

- Solicited model is when the payer requests the information from the provider
- Provider sends a claim (or health service request)
- Payer determines there is not enough information to process the claim (or approve the service request)
- 277 or 278 (health service request) transaction is used to request the additional information
- 275 is used to respond to the request

Unsolicited Model

- Unsolicited model is when the provider knows that the payer requires additional information to process the claim (or health service request)
- Provider sends additional information when submitting the claim (or health service request)
- Provider sends the 275 with the 837 (or 278)
- Sender has the option to send the 275 in the same Interchange as the 837 (or 278) OR sender has the option to send the 275 in a separate Interchange – based on agreement with payer

Top Three Strategies To Reduce Appeals and Denials

- **Strategy # One - Unsolicited Electronic Attachment Program**
  - **Provider driven**
  - Knows NGS Attachment use case for supporting documentation
  - Electronic acknowledgement audit trail
  - Eliminates fax/mail
  - EDI submission keeps claim in 14 day prompt pay window
  - Enable leverage existing technology vendor solutions to generate 275
  - Provider reported ROI
    - **80% reduction** in medical review denials and appeals associated with missing documentation
    - Revenue cycle reduced on an average from **35 days plus to 17 days**

Top Three Strategies To Reduce Appeals and Denials

- **Strategy # Two - Solicited Electronic Attachment Program**
  - **Payer driven** process
  - Eliminates fax and mail process
  - Electronic acknowledgement audit trail
  - Expected provider reported ROI – same as unsolicited
    - **80% reduction** in appeals associated with missing documentation
    - Revenue cycle reduced on an average from **35 days plus to 17 days**
  - Key Performance Indicators
    - Are you getting request for additional documentation?
    - **Action:** Assess Strategy # One Attachment Control Failures

Top Three Strategies To Reduce Appeals and Denials

- **Strategy # Three - Electronic Appeals**
  - Enables providers to electronically submit appeals vs mailing (process delay)
  - Electronic acknowledgment receipt – audit trail
- **Key Performance Indicators**
  - What percent of your claim submissions are denials/appeals
  - **Action:** Assess Strategy # One and Strategy # Two Attachment Control Failures

Top Three Strategies To Reduce Appeals and Denials

- **Appeals Enrollment Requirements**
  - If provider is already enrolled in the 275 **no additional enrollment requirements**
  - Use the same technology attachment vendor – no additional IT resources
- **Electronic Appeals – Expected ROI**
  - Decrease revenue cycle resolution timeline vs mail
  - Production ready
  - **Sign Up Now**

Market Benchmark KPI's

Key Performance Indicator	Paper	EDI*
Receive Notification	**10-14 Days**	**None**
Deliver Documentation	**7-10 Days**	**Same Day**
Process Payment	**31-35 Days**	**17-19 Days**
Denial / Appeal	**52%**	**7%**
First Time Claim Submission	**68%**	**+90%**
Payer Claim Status Calls	**55%**	**< 5%**

How to Get Started – Five Easy Steps

1. Contact your vendor, clearinghouse or billing service to ensure they support the electronic attachment program.
2. Review the NGS Attachment Companion Guides: NGS X12/HL7 Claim Attachment Companion Guide and 277 Request Additional Information Companion Guide. Send to your vendor or clearinghouse as needed. The guides can be found on the NGS Website.
3. Download the X12 275 v6020 and 277RFI v6020 TR3's and the HL7 Attachment Implementation Guide and C-CDA R2.1 guide, if needed. The X12 guides are available at Washington Publishing Company; the HL7 guides are available at HL7 International.
4. Enroll for the attachment transactions with NGS through the online EDI enrollment tools on the NGS Website.
5. Contact EDI Helpdesk with any questions
   - J6: 877-273-4334, JK: 888-379-9132

NGS EDI Partners Contact Information

EDI Partners	Contact	EMail	Phone#	Website
Athenahealth	Melissa Fiore	mfiore@athenahealth.com	617-402-6917	Athenahealth
Epic	Assigned Technical Service Representative		608 -271-9000	Epic
eSolutions Inc.	Brigitte Rehak	info@esolutionsinc.com	866-633-4726	eSolutions Inc.
Jopari Solutions Inc.	Monica Donato	info@jopari.com	800-630-3060	Jopari Solutions Inc.
Waystar	Waystar Assigned Account Manager		844 -6WAYSTAR (844-692-9782)	Waystar
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Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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