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Automating the Claims Attachment Process: A Review of our California Experience

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History

- ◆ Four years ago, the Hospital Assn of So CA members and major CA payers: Blue Cross (Wellpoint), Cigna, PacifiCare, Health Net, Blue Shield and Aetna came together to begin to address back office issues.
- ◆ Number one issue: Claims attachments
 - Claim attachments - any document-medical records, itemized bills, authorizations, etc. needed by payer to complete adjudication.



The Problems

- ◆ Attachments are a major revenue cycle problem for Providers and a cost/operations issue for Payers
 - Providers don't know when or what attachments will be needed...lack of standardized definitions
 - Requests go to wrong person/department
 - Requests get misplaced or lost in hospital
 - Providers try to second guess what the payer will need and submits attachments on large dollar claims or by type of service whether needed or not by payer
 - Payers lose attachments or cannot re-associate them with the claim resulting in denials or a re-request
 - Major process delays on all sides
 - Major factor impacting denials and increased contractual write-offs



The Metrics:

- ◆ Hospitals spend \$20-\$30+ to respond to a request for attachments...one major CA medical center averages \$33+ per request
- ◆ Total time from payer request to payer receipt and processing of attachment is 30-40+ days or more
- ◆ Cost for payers to request, receive and process an attachment approaches \$20+
- ◆ Payers receive more than 5 billion claims per year from providers nationally (est.)
- ◆ 10% require attachments or 500 million per year (est.)



The Metrics:

- ◆ Major limitation on payer's goal of 100% electronic submission of claims are claims with attachments
- ◆ COB claims with primary explanation of benefits (EOB) is a major portion of the problem
CA payers stuck at 60% electronic submission---
other 40% on paper due to attachment needs
- ◆ Payers are incurring interest and other costs due to claims delays under Prompt Pay laws



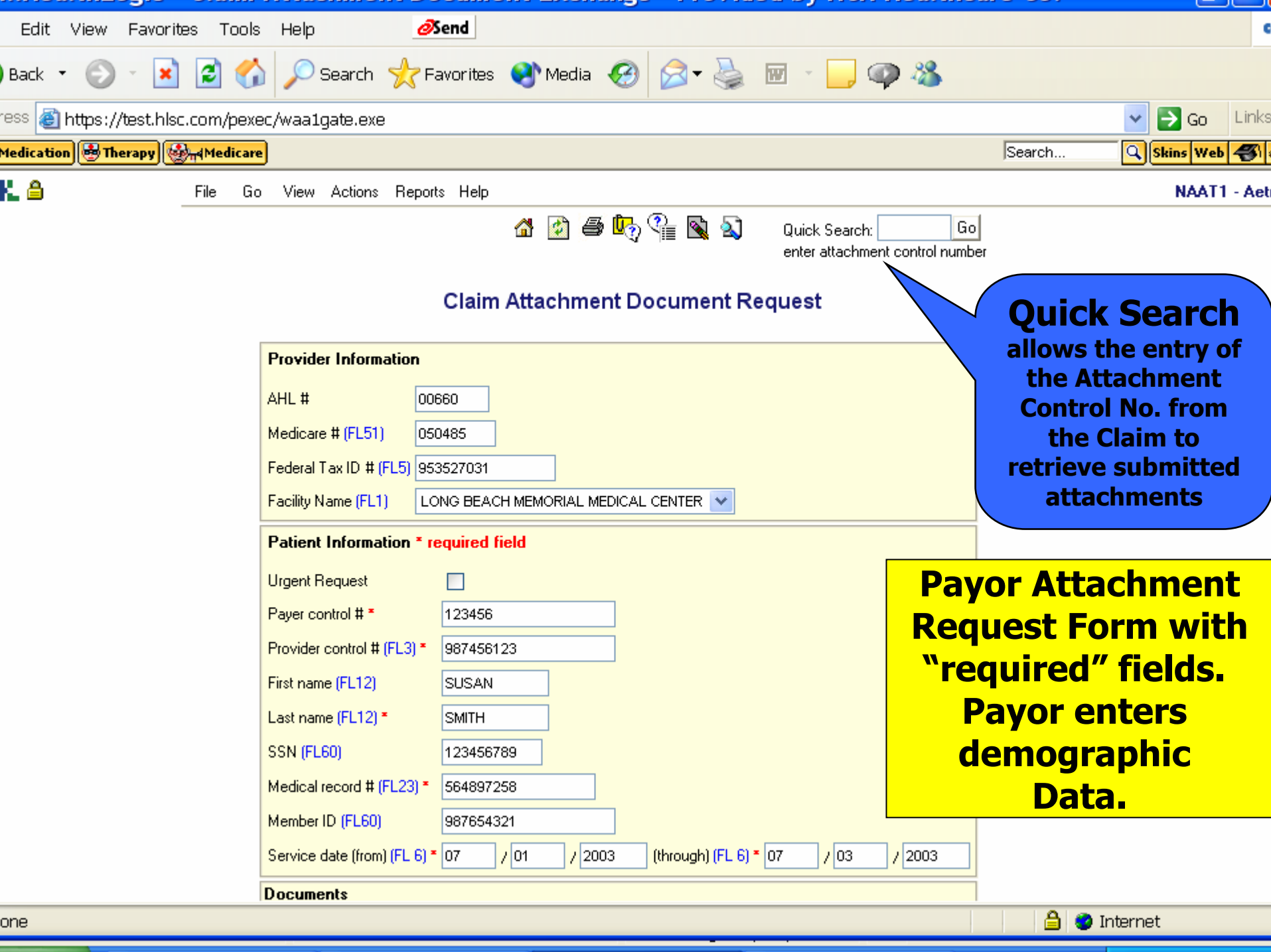
The Objectives

- ◆ Replace the current process of requesting and receiving attachments
- ◆ Expand into all payers and providers to create one standard way of doing business
- ◆ Lower the cost of doing business with fewer touches per claim
- ◆ Improved business process and relations between providers and payers
- ◆ Must minimize I.S. role and work in all size providers with the technology available today on the desktop...Microsoft® Windows software



CADX[©]: A Solution Was Developed

- ◆ Payer requests claims / medical record attachments via the secure CADX[©] website
- ◆ Provider staff monitor payer requests and scan or upload documents to the CADX[©] website
- ◆ Provider may submit attachments at time of billing with an attachment control number on the bill (X12-837 using PWK segment)
- ◆ Providers may fax documents to payers via CADX[©], if payer is not on CADX[©]
- ◆ Payer reviews submitted documents and completes adjudication process



Quick Search: Go
enter attachment control number

Claim Attachment Document Request

Provider Information

AHL #

Medicare # (FL51)

Federal Tax ID # (FL5)

Facility Name (FL1)

Patient Information * required field

Urgent Request

Payer control # *

Provider control # (FL3) *

First name (FL12)

Last name (FL12) *

SSN (FL60)

Medical record # (FL23) *

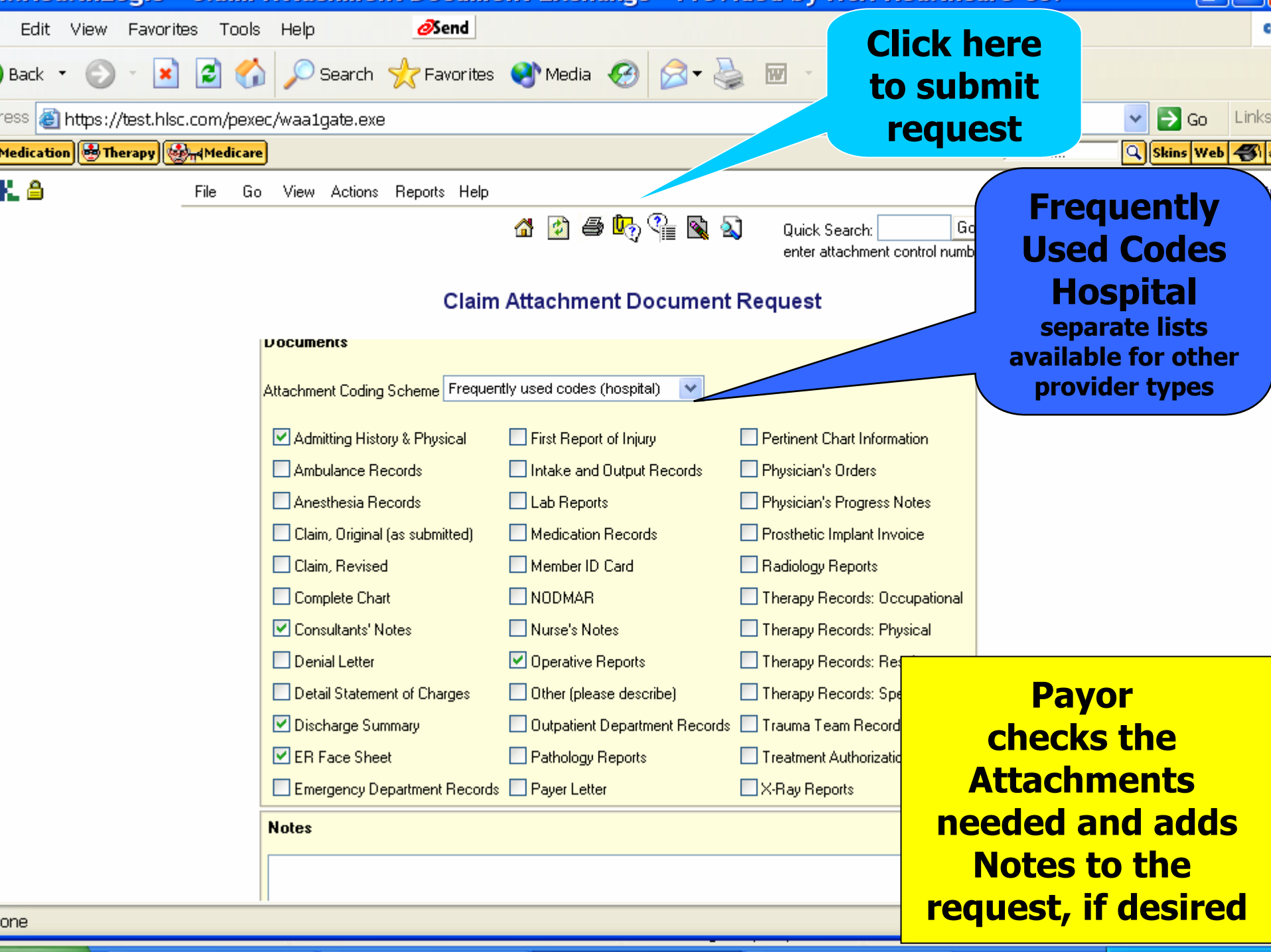
Member ID (FL60)

Service date (from) (FL 6) * / / (through) (FL 6) * / /

Documents

Quick Search
allows the entry of
the Attachment
Control No. from
the Claim to
retrieve submitted
attachments

**Payor Attachment
Request Form with
"required" fields.
Payor enters
demographic
Data.**



Click here to submit request

Frequently Used Codes Hospital separate lists available for other provider types

Payor checks the Attachments needed and adds Notes to the request, if desired

Claim Attachment Document Request

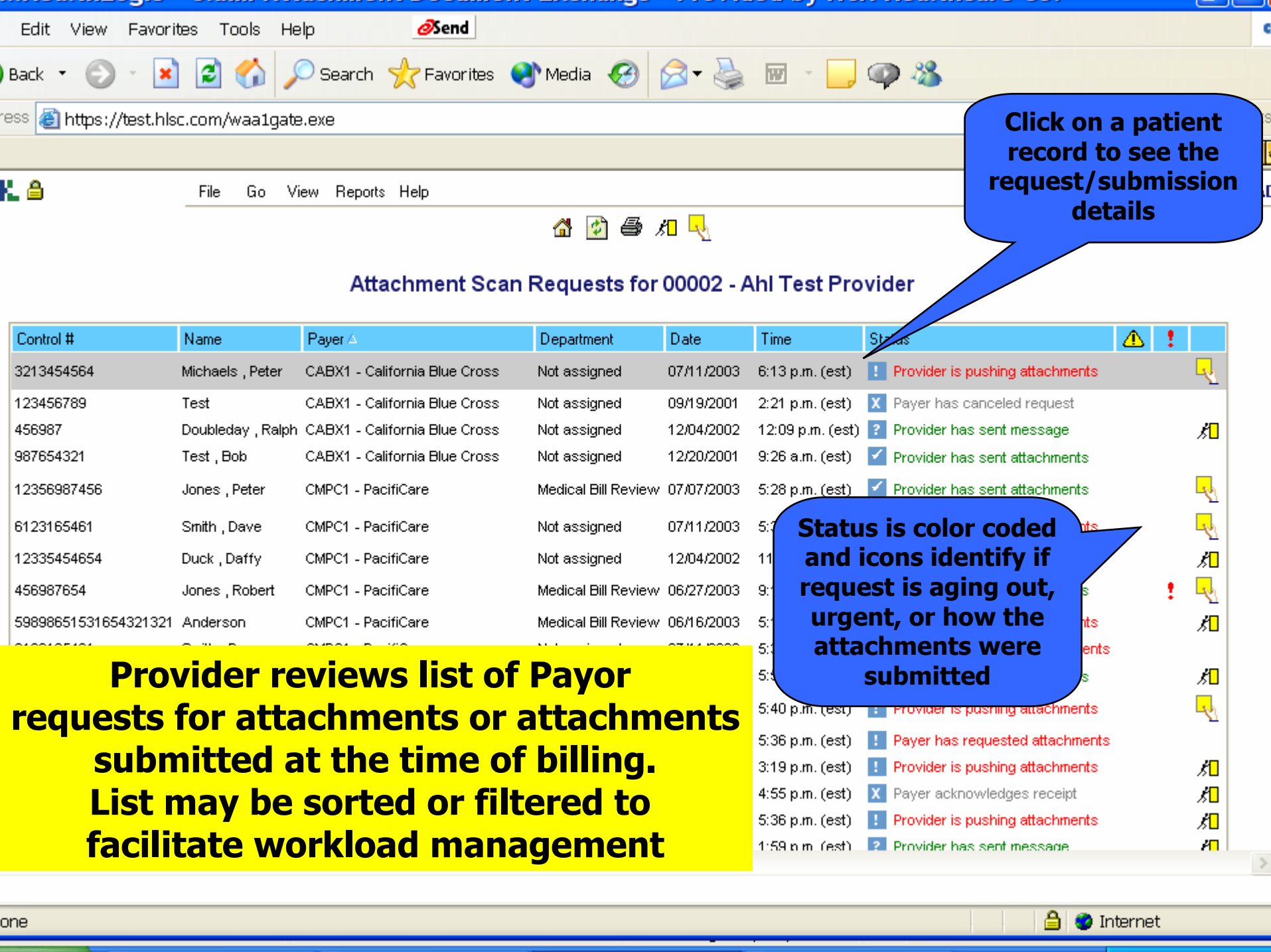
Documents

Attachment Coding Scheme: **Frequently used codes (hospital)**

- Admitting History & Physical
- Ambulance Records
- Anesthesia Records
- Claim, Original (as submitted)
- Claim, Revised
- Complete Chart
- Consultants' Notes
- Denial Letter
- Detail Statement of Charges
- Discharge Summary
- ER Face Sheet
- Emergency Department Records
- First Report of Injury
- Intake and Output Records
- Lab Reports
- Medication Records
- Member ID Card
- NODMAR
- Nurse's Notes
- Operative Reports
- Other (please describe)
- Outpatient Department Records
- Pathology Reports
- Payer Letter
- Pertinent Chart Information
- Physician's Orders
- Physician's Progress Notes
- Prosthetic Implant Invoice
- Radiology Reports
- Therapy Records: Occupational
- Therapy Records: Physical
- Therapy Records: Res...
- Therapy Records: Spe...
- Trauma Team Record
- Treatment Authorizati...
- X-Ray Reports

Notes

Text input area for notes



Attachment Scan Requests for 00002 - Ahl Test Provider

Control #	Name	Payer	Department	Date	Time	Status	Icons
3213454564	Michaels , Peter	CABX1 - California Blue Cross	Not assigned	07/11/2003	6:13 p.m. (est)	! Provider is pushing attachments	👉
123456789	Test	CABX1 - California Blue Cross	Not assigned	09/19/2001	2:21 p.m. (est)	X Payer has canceled request	
456987	Doubleday , Ralph	CABX1 - California Blue Cross	Not assigned	12/04/2002	12:09 p.m. (est)	? Provider has sent message	👉
987654321	Test , Bob	CABX1 - California Blue Cross	Not assigned	12/20/2001	9:26 a.m. (est)	✓ Provider has sent attachments	
12356987456	Jones , Peter	CMPC1 - PacifiCare	Medical Bill Review	07/07/2003	5:28 p.m. (est)	✓ Provider has sent attachments	👉
6123165461	Smith , Dave	CMPC1 - PacifiCare	Not assigned	07/11/2003	5:...	!	👉
12335454654	Duck , Daffy	CMPC1 - PacifiCare	Not assigned	12/04/2002	11...	!	👉
456987654	Jones , Robert	CMPC1 - PacifiCare	Medical Bill Review	06/27/2003	9:...	!	👉
59898651531654321321	Anderson	CMPC1 - PacifiCare	Medical Bill Review	06/16/2003	5:...	!	👉
5:...						!	👉
5:40 p.m. (est)						! Provider is pushing attachments	👉
5:36 p.m. (est)						! Payer has requested attachments	
3:19 p.m. (est)						! Provider is pushing attachments	👉
4:55 p.m. (est)						X Payer acknowledges receipt	👉
5:36 p.m. (est)						! Provider is pushing attachments	👉
1:59 p.m. (est)						? Provider has sent message	👉

Click on a patient record to see the request/submission details

Status is color coded and icons identify if request is aging out, urgent, or how the attachments were submitted

Provider reviews list of Payor requests for attachments or attachments submitted at the time of billing. List may be sorted or filtered to facilitate workload management



HIPAA Compatibility

- ◆ CADX[©] built to meet all known HIPAA requirements
- ◆ CADX[©] team members have been active participants in the Attachment standards development process since 1995 and are working with payers and providers to develop simple, clear rules
- ◆ CADX[©] is committed to fully supporting the HIPAA standards



Current State of CADX[©]

◆ Health Plans

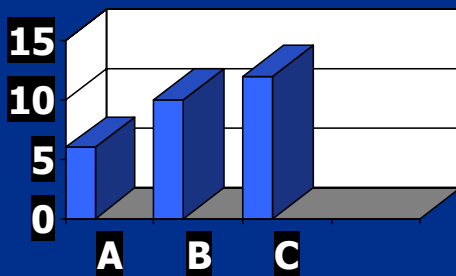
- PacifiCare operational in CA, OR and WA
- Health Net operational in CA, OR & WA
- Aetna operational in CA Summer 2004
- EDS-CA Medicaid (MediCal) operational Summer 2004
- Utah Health Information Network (UHIN) – Fall 2004
- Fax attachments to payers, providers, P&C & Workers Comp operational
- CMS Mutual of Omaha Medicare pilot (2003), additional Medicare pilots under review-CMS Office of Program Integrity

◆ Providers: 70 hospitals committed or live; Expanding to other provider types in 2004

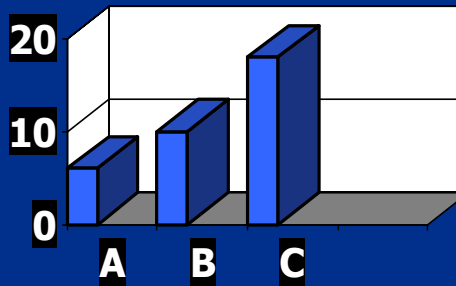
◆ Out-of-State: Working with Hospital Assns. and Health Plan partners to implement CADX in OR, WA, UT, & GA

Results to Date

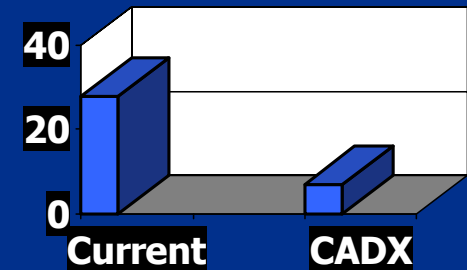
Reduced Days in AR



Reduced Processing Time



Reduced Cost



- ◆ Days for CADX[®] claims in AR decreased ~10 days
- ◆ Requests for claims attachments & medical records quickly processed by providers
 - 6 to 18+ day reduction in cycle time to clean claim
 - some processed same day
 - most completed in 3-4 days vs 30-40 days
- ◆ Cost per transaction reduced by more than \$21



What have we learned...

- ◆ Its less about technology and more about standardized process & nomenclature.
- ◆ It is about developing trust. If a provider changes his process will they get paid timely and efficiently by the payer.
- ◆ Providers need simple and clear guidelines on when & what type of attachments are needed.



What have we learned...

- ◆ LOINC[®] codes have little appeal to providers or payers...it is not how they do the work & it will be a significant training and workforce issue.
- ◆ Payers & Providers generally work at the document level related to attachments. The proposed HL7 Clinical Document Architecture (CDA) utilizing XML is a step in the right direction, but will still be very challenging for most providers and payers.



What have we learned...

- ◆ Providers prefer to submit attachments at the time of billing, if they know what is needed by the payer. However, they are reluctant to separate the claim from the attachments and over submit today trying to accelerate their revenue cycle.
- ◆ The 837 PWK segment attachment information is generally unsupported in the Patient Accounting System (PAS), claims editor, clearinghouse and if received by the payer is generally not yet visible to the claims examiner.



What have we learned...

- ◆ The 837 COB transaction set and the PAS, claims editor, clearinghouse and payer adjudication tools to easily support the COB billing process appears to be a few years away.
- ◆ Providers & Payers need simple tools that work with what they have on the desktop today.
- ◆ PAS & Electronic Medical Records (EMR) systems generally do not easily support electronic claims attachments today.



Our Recommendations

- ◆ In order to achieve the fiscal goals of the Transactions and Code Set regulations, the proposed attachments rule must be published soon.
- ◆ The proposed rule should support multiple approaches to claims attachments (X12/HL7 and HTML) consistent with the specified data content developed by X12 to support the rapid adoption of the rule by providers and payers alike based on existing desktop technology.



Our Recommendation

- ◆ Payers must provide clear guidelines on when and what attachments (documents/data) are needed.
- ◆ LOINC[®] codes should only be used at the document level for claims attachments to support claims adjudication.
- ◆ The attachment rule should permit alternate submission modes (i.e.; imaging) for the COB claim and EOB other than the 837 COB.



Thank for your interest.

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