Where are we now?

Presented by:
John Kelly, Edifecs
Sherry Wilson, Jopari Solutions
Durwin Day, HCSC
Ken Willman, Zirmed
August 9, 2016
“Hey these guys are really good at this”

“Maybe we could automate some of these manual workforce management processes.”

“But healthcare is different”
The TIME is NOW
It’s time

Per NCVHS (July 5, 2016)

*In summary, the healthcare industry’s adoption and implementation of administrative simplification standards and operating rules has presented many benefits and challenges. Numerous hearings on attachments have provided an opportunity for NCVHS to learn about the successes as well as the barriers to successful implementation. The industry feedback indicates it is time to adopt attachment standards.*
3 Reason Why the Time is NOW

1. Financial and Business Reasons
2. Healthcare Deliver Improvement Reasons
3. Operation workflow Reasons
A Brief History of Claims Attachment Standards

• Proposed rule published 2005 – not adopted
• 2008 Workers’ Compensation adopted proposed regulations
• Since then, (over an 11 year period) ...
  – Continued development, testing, implementation
  – ACA 2010 – adopt standard and operating rules
  – WEDI, X12, HL7 collaboration and white paper
  – NCVHS – July 5, 2016 letter to HHS Secretary
So where are we now? (1 of 3)

Financial-Business Reasons

Underlying case/rationale is still strong (and unchanged):

- 60-110 million attachments a year, 99% paper based\(^1\)
- Estimated cost of $4.00/ paper attachment processing
- 2005 Total industry savings of $200-500 million\(^2\)
- 2016 X Volume X $ = opportunity

---

So where are we now? (2 of 3)

Healthcare Delivery Reasons

Underlying case/rationale is still strong (and unchanged):
  – Information supplemental to a claim is integral to health care reforms and new delivery and payment models

  – Per NCVHS (July 5, 2016):

    Benefits for using attachments beyond claim adjudication include improved care coordination, facilitation of transitions of care by moving clinical data across health care settings, support care management, enhance quality reporting and support of alternative health care payment models.
So where are we now?
Operation Workflow Efficiencies (3 of 3)

Underlying case/rationale is still strong (and unchanged):

– A claim is a claim is a claim....
– An attachment is an attachment is an attachment ...
– One automated workflow regardless of healthcare line of business
– Enabling technology and proven vendor attachment solutions are readily available and implemented
– State adoption of proposed 2005 Rules established foundation for Attachment “Best Practices”
Over 49 Million Electronic Attachments Processed Annually

- Electronic Attachments by Healthcare Line Of Business
  - 55% Property and Casualty
  - 15% Dental
  - 15% Commercial
  - 15% Government

- Electronic Attachment Utilization –Business Process
  - 83% Claims Adjudication (e.g., high% unsolicited)
  - 11% Post Adjudication (e.g. appeal/ audit, etc.)
  - 3% Referral/Notification
  - 3% Prior Authorization

- Electronic Attachment Format Type
  - 86% Unstructured (e.g., TIF, PDF, etc.)
  - 14% Structured (C-CDA)

- Variety of Attachment Transport Methodology
  - 53% Web Portal Upload (Single or Batch)
  - 27% EDI using ASCX12 275
  - 14% EDI (e.g., SFTP with PGP Encrypted)
  - 3% Secure Fax
  - 1% Secure Email
  - 1% IHE Profile (XDS,XDR)

*Cooperative Exchange NCVHS Feb 2016 Attachment Testimony
http://www.cooperativeexchange.org/
So where are we now (cont’d)?

Despite all the good business and health care improvement arguments:

“Unless it is adopted as a HIPAA standard, no one will commit to it.”

– Because it could change ...
– Because there will be differing varieties ...
– Because there are up front costs ...
– Because, because, because, because ....
– Same arguments for the last 11 years
“Adopt a set of mature, implementable electronic standards for the health care industry to execute the Attachments transaction.”

NCVHS July 5, 2016 letter
To Borrow a Phrase ....

JUST DO IT.
Specifics Per NCVHS – Attachment Roadmap

Addresses:

- Query (Request for attachments)
- Response (Message content, format)
- Acknowledgment
- Attachment type value set
- Routing/envelope
Considerations, remaining decision points

- Routing/envelope: ASC X12 275 – current v6020
- Clinical and Administrative transactions / versions
- Type of rulemaking: Interim final rule vs. notice of proposed rulemaking
- Implementation timeframe – Phased in approach
- Relationships /integration with Practice Management System, EMRs and exchanges of clinical data
- How to leverage industry existing connectivity and attachment “Best Practices”
- Other?
But Are They Ready?

• Who is “they”
• Payers?
  – Insurers/MCOs
  – Third party administrators
  – IPAs and MSOs
  – Medical benefit managers
  – And, and, and...
• How do they move within their constraints and considerations
  – Budget cycles
  – Build, buy or partner
  – Early adoption steps vs long term planning
  – Is it really all or nothing
But Are They Ready?

• Who else is “they”
• Large providers and systems
  – Some are not waiting
  – Need to make an impact
  – Doing pilots and direct connections to move their ball forward
• Small and medium size providers
  – Some of these are still technologically sophisticated
  – But the larger number of “they”
    • Where do they turn
    • How do they prepare
    • How do they participate
Are THEY Relying On Us?

• Who is “us”
• How do we move the ball forward
• Make it easy to adopt
  – Enable them to take interim steps
  – Meet them where they are technologically
• Leverage what we do best
  – Use existing connections, normalizing data and delivery possible
  – Deliver (and accept) what you can today
  – Enable workflow to take steps toward participation
  – Supplement and enhance where possible
• Don’t let the momentum end

Connect with willing partners today
Per NCVHS (July 5, 2016)

In summary, the healthcare industry’s adoption and implementation of administrative simplification standards and operating rules has presented many benefits and challenges. Numerous hearings on attachments have provided an opportunity for NCVHS to learn about the successes as well as the barriers to successful implementation. The industry feedback indicates it is time to adopt attachment standards.
Partners In 275 Implementation

VHA Community Care EDI
Robert Huffman

Community Health Systems
Laurie Holtsford
SSI
Tracey Tillman
David Butt
From Business Requirements to Production

- Business Requirements Document (BRD)
- Requirements Specification Document (RSD)
- System Design Document (SDD)
- Requirements Traceability Matrix (RTM)
- Initial Operating Capability (IOC)
- National Release to 128 VistA Systems
VHA Community Care EDI Systems Testing

Testing

- Component Integration/System Testing (CI/ST): Testing the interactions between software components.
- Quality Assurance (QA): Testing the desired level of quality in the application
- User Acceptance Testing (UAT): Running the application through a series of specific tests that help indicate whether or not the product will meet the needs of its users.
- Regression Testing: Retesting the application after bug fixes.
- End 2 End Testing: Testing application enhancements throughout all systems
The 275 transaction is usually thought of as a way for a Provider to send data to a Payer.

But, there are other uses of the 275:

- How can we use the 275 to send data from a Payer to a Provider?
- How can we use the 275 to send data from one Provider to another Provider?
- How can we use the 275 to send data from one Payer to another Payer?
We need a simple to understand process for Providers and Payers to test the implementation of the 275 transaction

- Provider to Payer
- Payer to Provider
- Provider to Provider
- Payer to Payer
Challenges associated with processing this new transaction

- The 275 transaction has dual purposes
  - Support to pay a claim
  - Support clinical decision making
- How do we test the dual purposes?
- Can we test them together?
- Should we test them together?
Community Health Systems

- Owns, operates or leases 159 hospitals
- 22 states
- Approximately 27,000 licensed beds.
- Six Shared Service Centers performing business office functions
- Shared Service Centers
  - Support multiple states
  - Work with multiple VA centers across the country
  - Lack of enterprise-wide infrastructure within the VA creates a challenge
Paper processes and manual intervention can lead to significant delays in claims processing.

Shared Service Centers sending records to VA
- Approved vendors can upload through portal for some VA centers
- Others require sending paper records
- Each present a challenge in matching claim to medical records for adjudication
HIPAA 275 transaction

- allows consistency throughout CHS and each Shared Service Center
- Requests and records can be easily exchanged in a standard format
- ensure the records that are needed are received along with the claim for adjudication.
CHS’s Shared Service Center in Tucson, AZ

- will be our pilot center along with the Tucson VA center in utilizing the 275 transaction

CHS’s billing vendor (The SSI group)

- Working with CHS and the VA to support the 275 transaction
- Will provide standardization throughout CHS
- Will provide a reliable means to transmit data from and to the VA
SSI’s Approach

Phase 1
• Evolving our existing Attachments Portal
  • unstructured pdf
• Expand 275 acceptance
  • esMD
  • Pilot with VA and other payers

Phase 2
• Integrate with EMR systems
  • CCDA and unstructured content
• LOINC codes to identify supporting documentation
Phase 1 - 275 Claim and Attachment

- **EMR/Host Systems**
- **Claims Vendor**
- **Clearinghouse Transactions**
- **Veterans Administration**

**EMR/Host Systems**

**Claims Vendor**

**Clearinghouse Transactions**

- Receive 837
- Validate Bill Claim
- 837 with ACN in PWK
- 275 with ACN

**Veterans Administration**

- Receive 275
- Process Claim
- Match ACN + ?

**Legend**

- Receive 837
- Validate Bill Claim
- 837 with ACN in PWK
- 275 with ACN
- Receive 275
- Process Claim
- Match ACN + ?
Phase 2 - 278 with 275 attachment

EMR/Host Systems
- Create CCDA or PDF Medical Records

Claims Vendor
- Claim /Portal New Request
- Payer requirements find a 278 is needed
- Update claim
- Medical records request based on LOINC codes

Clearinghouse Transactions
- 278 authorization request
- 278 response with control codes and LOINC codes
- 837 with ACN in PWK
- 275 with ACN / Trans Code

Veterans Administration
- Receive 278 / Generate Trans Code
- Approved
- Receive 837
- Match ACN + ?
- Process Claim
- Receive 275
What Is The Payload? Unsolicited 275

• Paperwork (PWK) segments in the 837 and 278 transactions link these transactions to a specific 275 EDI transaction.

• PWK contains Report Type Code identifying 50 some report types ranging from AS (Admission Summary) to V5 (Death Notification).

• Category of Patient Information Service (CAT) segment in the 275 indicates format of the attachment
  • HL – HL7 Computer Decision
  • IA – Electronic Image
  • MB – HL7 Human Decision non-XML
  • TX – HL7 Human Decision XML
What Is The Payload? Solicited 275

- Logical Observation Identifiers Names and Codes (LOINC) used to request specific data.
- The Regenstrief Institute created and maintains the Regenstrief LOINC Mapping Assistant (RELMA)
- RELMA identifies specific LOINC codes for HIPAA Attachments
- LOINC Codes can request:
  - Unstructured Attachments
    - ie. Explanation of Benefits, Drivers License
  - Structured Attachments – Consolidated CDA
    - ie. Continuity of Care Document, Referral note
Just some last thoughts…

The attachment process brings to the receiver Report Type Codes, Category of Patient Information Service and then Structured or Unstructured data.

What did we really get?
VHA Community Care EDI Schedule

VHA Testing Timelines as of August 9, 2016

(Always subject to change)

- QA 9/19/2016
- UAT 11/10/2016 – 12/2/2016
- Regression 12/2/2016 – 1/23/2017
- End to End 1/24/2017 – 1/30/2017

We hope to cut 25 days from Regression