SUBMITTED TO:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

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President, Cooperative Exchange: *The National Clearinghouse Association*

Members of the Subcommittee, I am Sherry Wilson, President of the Cooperative Exchange (CE), representing the National Clearinghouse Association and Executive Vice President and Chief Compliance Officer, Jopari Solutions. I would like to thank you for the opportunity to present testimony today on behalf of the Cooperative Exchange membership concerning the proposed Attachment Standards. We also suggest that you refer back to our testimony last February when we testified on the Attachment Standards.

Cooperative Exchange Background

Cooperative Exchange is the nationally recognized resource and representative of the clearinghouse industry for the media, governmental bodies and other interested parties Cooperative Exchange 25 clearinghouse member companies[1], represent over 80% of the clearinghouse industry and process annually over 4 billion plus claims representing $1.1 trillion, from over 750,000 provider organizations, through more than 7,000 payer connections and 1,000 HIT vendors. Combined with our non-profit members (AMA, ASC X12N and UHIN) and Supporting Organizations (Axiom, BancTec and MEA) the Cooperative Exchange ***truly represents the healthcare industry EDI highway infrastructure*** and maintains hundreds of thousands of highways and the majority of the on and off ramp connections across all lines of healthcare business in this country.

[1] American Medical Association (AMA), Apex EDI, ASC X12N, Availity, LLC, AXIOM Systems, Inc., BancTec, Change Healthcare, ClaimRemedi, eProvider Solutions, Dorado Systems , GE Healthcare, Greenway Health, Health-e-Web, Inc., HDM Corp., InstaMed, Jopari Solutions, Inc., Medical Electronic Attachments (MEA), NextGen Healthcare, OfficeAlly, OptumInsight, PassportHealth, PracticeInsight, RelayHealth, Secure EDI, Siemens HDX, The SSI Group, Trizetto Provider Solutions, Utah Health Information Exchange (UHIN), WEX, Inc., WorkCompEDI, Xerox EDI Direct, ZirMed (CLICK HERE for Cooperative Exchange industry resource information)

Cooperative Exchange member clearinghouses support both administrative and clinical industry interoperability by:

- Managing tens of thousands of connection points
- Securely manage and move complex data content including administrative and clinical information
- Receive and submit both real time and batch transactions
- Provide interoperability by normalizing disparate data to industry standards
- Provide flexible solutions to accommodate the different levels of stakeholder EDI readiness (low tech to high tech)
- Actively participates and provides strong representations across all the national standard organization with many of our members holding leadership positions.

Therefore, we strongly advocate for EDI standardization and compliance within the healthcare industry. We are committed to promote and advance electronic data exchange for the healthcare industry by improving efficiency, advocacy, and education to industry stakeholders and government entities.

Recommendation

Cooperative Exchange would like to make the following recommendations (Please reference question 16 for detail explanations on the above recommendations) to NCVHS for bringing forward to Health and Human Services for adoption of attachment standards as follows:

1. HL7 Consolidated Clinical Documentation Architecture (C-CDA) R2.1
2. HL7 Attachment Supplement Specification: Exchange Implementation Guide Release 1
3. HL7 Clinical Documents for Payers Set 1 (Optional)
4. ASC X12N 277 Health Care Claim Request for Additional Information
5. ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter (as minimal requirement)
6. ASC X12N 275 Additional Information to Support a Health Care Services Review (as minimal requirement)
7. Transport Method EDI (minimal requirement)
8. LOINC (subset HIPAA Panel)
9. ASC X12 Healthcare Acknowledgement Reference Model (ARM)

Survey Results

The recommendations put forth in this testimony are based on feedback from out member clearinghouses and validated in a preliminary Clearinghouse Electronic Attachment Survey completed in February 2016 by 56% of our membership. The results of the survey are as follows:

1. ***Over 49 Million Electronic Attachments Processed Annually***
2. ***Electronic Attachments by Healthcare Line of Business***

    - 55% Property and Casualty
    - 15% Dental
    - 15% Commercial
    - 15% Government

3. ***Electronic Attachment Utilization –Business Process***

    - 83% Claims Adjudication (high% unsolicited)
    - 11% Post Adjudication (e.g. appeal/ audit)
    - 3% Referral/Notification
    - 3% Prior Authorization

4. ***Electronic Attachment Format Type***

    - 95% Unstructured (e.g., TIF, PDF)
    - 5% Structured (C-CDA)

5. ***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)

6. ***LOINC's not widely used at this time – the Report Type Code is the most common way to identify Attachment Type***

Response to Subcommittee on Standards' Questions

Cooperative Exchange provides the following responses to the questions provided by the subcommittee:

1. ***In addition to the use of the proposed standards and code sets in health care claims transaction (Claim Attachments), what other transactions can the standard support (for example, eligibility, prior authorization, post-paid claim audits).***

    As developed, in addition to claims the current standard allows for attachments in support of prior authorizations, referrals, notifications and post-adjudicated claims.

2. ***Do the proposed standard and code sets support the intended business function/intended use?***

    Yes.

    a. ***Does it provide a complete set of information needed to achieve the purpose of the transaction?***

        Yes, since the HL7 C-CDA provides a limited set of structured attachments as well as the ability to support an unstructured document, with the intent to support more structured documents in the future.

    b. ***Does the standard achieve the transaction in the fastest, simplest, and most cost –effective manner?***

        While the HL7 data content and structured standards are a major step forward, the Cooperative Exchange believes that the envelope need not be standardized, as there are many ways to easily transmit this information. As clearinghouses, we can provide the necessary translation and/or routing between entities using different types of envelopes and transport methods. In fact, we are exchanging millions of attachments each year in a variety of ways to accommodate the different levels of stakeholder EDI readiness. We suggest that the adopting regulations be flexible enough to accommodate existing and emerging technologies.

3. ***What is the potential impact of the proposed standard and code sets to various health care entities (providers, payers, etc.) on the daily workflow/transaction process; administrative costs, required capabilities and agility to implement the standard changes?***

   a. ***Does the proposed standard provide efficiency improvement opportunities for administrative and/or clinical processes in health care?***

      Yes. It provides a standard content and format for attachments, allowing vendors to develop software for the exchange of supporting documentation; provides the ability to automate the request for additional information; and provides a mechanism to expedite routing within a provider and payer organization.

   b. ***Has the potential for decrease in cost and improved efficiency been demonstrated by using the proposed standard?***

      Yes. Please see Appendix A for a detailed analysis of a clearinghouse use of electronic attachments.

4. ***Are there potential emerging or evolving clinical, technical and/or business advances the proposed standard intends to address or facilitate?***

   Yes, the standard takes advantage of the C-CDA which is used for the exchange of clinical data between providers. The C-CDA includes an unstructured document which will allow for the exchange of new clinical information while additional structured documents are developed based on emerging business needs. The adopting regulation should allow for the use of existing and emerging technologies when addressing the envelope and transport methods.

5. ***How will the proposed standard provide consistency or limit the degree of variability to achieve optimal intended results?***

   The standard calls for consistency in both the attachment and the transmission request/envelope. We believe that the optimal approach will be to allow multiple enveloping and transport options.

6. ***How does the new set of proposed standard relate to, or affect the implementation of the standards already adopted?***

   The proposed standards relate to the claim, prior-authorization and referral standards adopted under HIPAA. These proposed standards provide additional information necessary to complete the payment or authorization of services. The standard will enhance the usefulness of the other adopted standards.

7. ***Will system changes be required by the industry to implement the proposed standard and code sets?***

   Yes, this will be the first time the industry will have to use both ASC X12 and HL7 standards to comply. It is also the first time health plans and physicians will be required to use HL7 standards in administrative transactions and they have had little experience with it.

   Vendors, especially practice management systems will need to make necessary upgrades. It will be critical that vendors are held accountable to support these transactions. Since vendors are not yet HIPAA covered entities, we recommend that

HHS consider ways to include software vendors as HIPAA covered entities. This proposed standard will require interoperability between EHR systems and practice management/hospital management systems.

8. ***Has the proposed standard and code set demonstrated ease in adoption and use? What amount of time is needed for the industry to implement the proposed standard?***

   Although certain segments of the industry have implemented attachments, given that this is a new standard for the industry and involves different transaction sets, we recommend at least a two-year adoption period. This may need to be adjusted based on results from early adopters and other requirements placed on providers (e.g., changes in meaningful use, alternative payment methods) and health plans (e.g., HPID and Health Plan Certification). Standards must be identified so entities who want to move forward with electronic attachments may do so, knowing they are developing integration that will be supported by the industry.

9. ***What lessons learned from previously adopted standards have been applied/addressed in the proposed standard?***

   We have seen that most standards seem to take longer than expected to implement. We suggest that CMS use the proposed rule comment period to gather industry input on the appropriate time frames, especially for vendors and testing. We suggest a time schedule which allows for significant industry testing of this new requirement. Clearinghouses have played a critical role in helping the industry migrate to new standards by allowing for asynchronous implementations. Early adopters (willing and able trading partners ready to begin on the effective date or shortly thereafter) tend to discover any issues or challenges allowing for adjustments as needed prior to the compliance date.

10. ***Has the industry developed strategies to measure the impact of adopting the proposed standard and code sets on the industry?***

    Not that we are aware of. Cooperative Exchange supports an industry wide development of strategies to measure the impact of proposed standards, operating rules and code sets.

11. ***Has the industry developed metrics to measure the effectiveness and value of adopting the proposed standard and code sets? What are they?***

    We are not aware of any industry developed metrics. Cooperative Exchange supports an industry wide development of metrics to measure the effectiveness and value of proposed standards, operating rules and code sets. Please refer to Appendix A for metrics developed in a previous study.

12. ***Do the proposed standard and code sets provide potential impact and/or improvement to health care related data and/or data infrastructure?***

    Yes, in standardizing the data content of attachments for specific purposes it allows payers to better express what they are looking for and for providers to be able to respond with the appropriate information at the appropriate level. This mitigates the risk of privacy breeches and helps focus on minimum necessary.

13. ***Does the proposed standard incorporate privacy, security and confidentiality?***

Privacy and security requirements are spelled out in other regulations. As noted, the standard does mitigate the risk of breeches.

14. *How will the attachment standard support interoperability and efficiencies in a health care system?*

Today, the exchange of additional information in support of administrative transactions is a manual and costly process. By setting a standard for the content and using the LOINC to drive the specific attachment being requested, it will provide the standard data content and format for providers, plans, and clearinghouses to use in exchanging attachment data. Each entity will know the information it must provide or can ask for in specific situations. Standards will allow entities to develop software and integration to a single set of requirements that will be used in exchanging information with any entity, thus reducing their cost in developing and supporting the exchange of additional information.

15. *Can the proposed standard be enforced? How?*

Yes. Explicit implementation guides have been developed with specific requirements and adherence to the standard can be measured by automated tools checking each transaction.

16. *Should NCVHS recommend the adoption of the proposed standard?*

Cooperative Exchange recommends that NCVHS bring forward the following to the Department of Health and Human Services for adoption as the standards for requesting and responding to the need for additional information in support of claims, prior authorizations, referrals and notifications.

For the clinical data we recommend the following:

<u>HL7 Consolidated Clinical Documentation Architecture (C-CDA) R2.1</u>

- Mandate the use of the unstructured document type
- Allow the use of structured document type to support the different levels of stakeholder EDI readiness.
- Mandate the use of the solicited model for the Attachment exchange between stakeholders.
- Allow for unsolicited requested for additional documentation based on pre-defined rules defined by payers and or state mandates.

<u>HL7 Supplemental Guide – Created to use C-CDA R2.1 for Attachments</u>

The supplemental guide further defines how the C-CDA R2.1 is used for exchanging attachments and includes the ability to support the structured, unstructured, solicited and unsolicited attachments.

<u>HL7 Clinical Documents for Payers Set 1 (Optional)</u>

If this is applicable to the business between entities, this standard should be used, otherwise this transaction should not be mandated.

For the request for additional information we recommend the following:

<u>ASC X12N 277 Health Care Claim Request for Additional Information</u>

For use in requesting (solicited) additional information for a claim.

For the enveloping used to exchange the clinical information, we recommend the following:

ASCX12 275 Additional Information to Support a Health Care Claim or Encounter
We recommend that the ASC X12 275 be adopted as the minimum requirement for responding to a request for additional information for a claim. We recommend that the regulation allows for other enveloping based on trading partner agreements to support existing and emerging technology.

ASCX12N 275 Additional Information to Support a Health Care Claim Services Review
We recommend that the ASC X12 275 be adopted as the minimum requirement for responding to a request for additional information for referrals and prior authorizations. We recommend that the regulation allows for other enveloping based on trading partner agreements to support existing and emerging technology.

For the transport method used to exchange the additional information we recommend the following:

We recommend that EDI be adopted as the minimum requirement for exchanging the Attachment. We recommend that the regulation allows for other transport methods based on trading partner agreements to support existing and emerging technology.

For identification of Attachment Types and data content we make the following recommendations:

LOINC (subset HIPAA Panel)
The use of a standard code set to identify the document type for information being requested and responded to allow for increased administrative efficiency and expedited routing getting the right information in a timely manner to the correct business destination (e.g., claims adjudication /post adjudication, prior authorization, utilization review and notification).

For acknowledging the receipt of the various transactions listed above, we recommend the following:

ASCX12 Healthcare Acknowledgement Reference Model (ARM)
Allows for audit/tracking (e.g., Federal Express, UPS) across every touch point. The ARM includes the ASCX12 TA1, 999, 277CA and 824 acknowledgement transaction set.

Conclusion

The Cooperative Exchange feels it is imperative that proposed standards be identified and adopted to allow entities that want to move forward to begin the software development and integration for electronic exchange of additional information. Lack of standards is causing submitters and payers to take no action to move to electronic attachments as there can be significant costs in developing software and integrating with their existing applications. There are significant cost savings in the industry to be obtained through electronic exchange of additional information, continued delay in adopting standards continues to delay the ability to take advantage of those cost savings.

In closing, we would like to thank the members of the Subcommittee for their time and attention. The changes being discussed today represent a major transformation for our industry. We appreciate all of your efforts to bring clarity and consensus to the process. We hope this information will be useful to you. Should you have questions or need any further information, please do not hesitate to let us know.

Respectfully Submitted,
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Cooperative Exchange

WHITEPAPER

Property and Casualty Electronic Medical Bill (eBill):

E-BILLING YEAR 5 PROGRESS REPORT

June 25, 2013

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Bringing Automation into the P&C Industry

Legislatively mandated electronic billing task forces began efforts in the early 2000's in California and Texas to develop regulatory frameworks encouraging workers' compensation Payers and Providers to exchange medical bills electronically. Workers' compensation system costs at that time were growing at unsustainable rates in most state jurisdictions, including these two large states whose systems had become focal points of cost inflation.

The California and Texas legislatures had concluded that assimilation of paperless processing, already well-established in federal government health programs and increasingly employed by commercial health plans and Providers to exchange health claims, could positively contribute to systemic administrative simplification while also lowering operational costs within Payer and Provider communities.[i]

Intent of eBilling

The intent of these first electronic billing (eBilling) initiatives was to promote a seamless, efficient electronic medical billing and payment system and establish comprehensive, level ground rules for providers, payers and clearinghouses across all lines of business. The result would be system-wide savings achieved by reducing administrative costs for all stakeholders, together with enhanced state data collection the analysis of which could facilitate continual system improvement.

Particular objectives evolved beyond these initial task forces to bring eBilling strategies and structure into clearer focus. These objectives were to:

- Utilize the same technology platform provider use to process claims for all other lines of insurance;
- Utilize the same group/commercial claims transaction sets to enable connectivity solutions to exchange WC and Auto transactions:

    - *ASCX12 N v5010 837 Health Care Claim: (Professional, Institutional and Dental*
    - *ASCX12 N Acknowledgments (999, TA1, 277CA)*
    - *ASC X12 N v5010 835 Remittance Advice*
    - *NCPDP D.0 and EFT;*

- Assure clean data on the front end, making "straight through" processing possible on the back end.

History

Some workers' compensation Payers and Providers had begun exchanging bills and attachments electronically with each other as far back as 2000. These early adopter arrangements were voluntary and, as pre-regulation eBill archetypes, depended largely on mutually designed EDI connectivity and bill formatting. Early eBill regulations that emerged some years later took lessons from those pioneering arrangements; however, regulatory approaches involved a variety of state-centric models, beginning in Texas (2008), Minnesota (2009), Georgia (2011) California (2012) and Louisiana (2013)

These initial jurisdiction specific state eBilling "standards" were developed independently, without benefit of any coordinating infrastructure between states. For this reason they did not align with national EDI standards applicable to the exchange of health claims. Consequently, implementations absent such alignment resulted in minimal stakeholder adoption. Provider participation was hindered because technology solutions venders (e.g.: practice management system software companies; Clearinghouses; Billing Services) demonstrated little interest in the prospect of supporting up to 50 different sets of state regulations. Moreover, because virtually all workers' compensation bills require submission of supporting documentation (attachments), Providers and vendors needed equally efficient attachment solutions.

Understanding that positive feedback from Providers and Payers was critical to the success of these initial state-centric eBill regulations, industry stakeholders soon came together to work toward a model eBilling solution that would be broadly acceptable (multi-jurisdictional) and sufficiently user friendly to drive adoption. Constructing that model would require unprecedented coordination amongst state task forces, as well as experienced input from private sector interests, industry organizations and – very importantly -- active involvement on the part of nationally sanctioned standards setting organizations.

While this level of coordination could have been difficult to commit to and pull off under normal circumstances, the extraordinary conditions in and surrounding workers' compensation compelled action. Pressure on P&C insurance markets to reduce operating costs and improve under-performing margins was continuing to increase, while broad system reform initiatives strongly embracing Administrative Simplification had already gotten underway in many states. In short, internal system conditions were favorable to a new level of industry cooperation intent on new solutions.

By mid-decade, external forces also had to be factored into the coordination effort. On the horizon were challenges to business as usual from the impact of "Healthcare Reform", and the infusion of stimulus money into the broader healthcare arena was underway. Healthcare IT offerings were expanding rapidly, making technology vendor engagement and a national standard approach to eBilling in P&C markets a realistic possibility – finally shifting P&C industry medical transaction workflow from traditional dependency on low-technology paper processes into the modern EDI based processing environment.

Five Years on: Conditions Are Changed

All of these 'historical' conditions are still gaining momentum. Administrative Simplification remains an important touchstone for state workers' compensation systems, particularly as medical costs today approach two-thirds of benefit expenditures in many jurisdictions. Health care providers are demanding a "single work flow" transaction process for all lines of business – including the P&C medical practice arena. Technology suppliers also are delivering innovations in P&C attachment handling.

Industry collaboration has coalesced amongst stakeholders in recent years, extending to key players like the Workgroup for Electronic Data Interchange (WEDI), the International Association of Industrial Accident Boards and Commissions (IAIABC), multiple jurisdictions (see chart below), the American Medical Association (AMA), and national standards development organizations such as the Accredited Standards Committee of the American National Standards Institute (ASC X12). The IAIABC in particular has assembled and is vigorously promoting a consensus eBill Model Rule Template to member state agencies that includes Attachments. IAIABC has published a National Workers' Compensation Electronic Medical Billing and Payment Guide based on ASC X12N v5010 TR3s, and NCPDP D.0 (Pharmacy eBill).

The significance of broad-based collaboration is that leveraging advanced technology to control costs has become a compelling and equally shared mission. Adoption of X12 Standards enables Providers to exchange the same 837 bill format for Property & Casualty billing they use to exchange commercial and government claims, while giving Payers a normalized eBill acceptance solution. Given these advantages, the uniform eBilling model is gaining traction remarkably quickly as more and more states adopt the X12 standard for eBilling as part of their reform initiatives.

Collaboration is Momentum

Rarely in the P&C industry does collaboration create the extensive momentum now evident in the expanding deployment of eBilling. Today, 5 additional states have enacted legislation and promulgated eBilling regulations (see chart). Fifteen additional state systems are in various stages of development or implementation of the IAIABC model eBill regulations, many of these slated for roll out in 2013.

Payers and Providers in all 50 states are making parallel progress adopting eBilling as a standard billing method, regardless of state legislation. Voluntary eBilling arrangements under mutual trading partner agreements between Payers and Provider – using the IAIABC Guidelines – are generating positive ROI and considered by all to make good business sense. Although states have set up different eBill participation and incentive models – reflecting their individual regulatory climates (mandated eBilling vs. Optional for Providers; etc.) – many multi-state Payers are leveraging the eBill compliance programs they have established in mandate states across all of their markets.

Multi-state Provider organizations (especially those operating centralized or regional billing offices) have similarly come to expect ASCX12N 12 TR3 medical transactions to be exchanged electronically with P&C Payers, regardless of jurisdiction. For medical services stakeholders in general, paper bills no longer represent a rational business case.

As a consequence, Payers that have not acquired advanced tools to receive and process eBills are experiencing compliance friction in mandate states and risking diminished technology

credibility with Provider trading partners. Risk of delayed payments attributable to manually processed paper bills, for example – long a point of friction for Providers – can be greatly reduced by the comparative speed to payment that automated processing of eBills makes possible.

eBill Participation and Incentive Models

Since the January 2008 inception of workers' compensation eBilling in Texas, more and more states have become involved. Well over 700 P&C Payers and many thousands of network Providers and individual medical professionals are exchanging medical transactions using EDI. Successful alignment with national eBill model rules and ASCX12N TR3 transaction sets has eliminated uncertainty and points of friction across state jurisdictions [Figures 1 and 2].

FIGURE 1: EBILL RULES ADOPTED

States	Applies To	Waivers	Incentives
Texas 2008	Yes Payers & Providers	Yes Providers/Payers	No
Minnesota 2009	Yes Payers & Providers Includes **Auto**	No	No
Georgia 2011	No- Voluntary Participation	No	No
California 2012	Yes Payers Only	No	Yes Prompt Pay 15 days
Louisiana 2013	Yes Payers Only Excludes Self Insured	Yes Payers exempt less 1200 bills annually	30 Day Pay

FIGURE 2: EBILL JURISDICTION PROFILES

Jurisdictions	Adopted IAIABC Guidelines	Workers compensation & Auto e-bill legislation	Workers compensation and Auto e-bill activity/discussions-	Jurisdiction EDI Health Care Discussion-*
Illinois	X	Effective Date 6/30/2012- Pushed Back 7/1/ 2013		
Louisiana	X	Effective Date 7/1/2013		
North Carolina	X	Effective Date 3/1/14		
Oregon	X	(projected late 2013)	X	X
California	X	Effective Date 10/18/2012		
Texas	X- Revised 2011	Effective Date 1/1/2008		
Minnesota		Effective Date 7/1/2009 Includes all lines		
Georgia	X	Effective Date 7/1/2011		
South Carolina			X	
Tennessee			X	
Florida			X	
New Mexico	TBD	Effective Date 1/1. 2014 Includes EFT mandates		
New Jersey			X- P&C-auto	
Connecticut			X	X
New Hampshire			X	X
Utah		X		X
Colorado			X	X
Delaware			X	X
Kentucky			X	
Maine				X
Nebraska			X-HIE effort to include WC	X
Additional States that are engaged in HIE activity are looking at initiatives to include WC- will follow up with information.				
* The list is based on state survey information from the IAIABC, AMA as well as from State HealthCare Information Exchanges that have presented at WEDI.				

The Industry Baseline Today

For almost two decades, HIPAA covered entities, such as commercial and governmental Payers and their trading partners, have lowered costs by exchanging HIPAA standard transactions – such as claims, claim status, electronic remittance advice. Going forward, accelerating eBill adoption countrywide in the P&C industry means Providers, Payers and Medical Networks are similarly lowering costs by connecting electronically with each other to handle bills, attachments and transaction communications.

Cost-benefit metrics quantifying cost-benefits of P&C eBilling are becoming a factor driving further jurisdiction support and Payer and Provider adoption rates. It is reasonable to assume at this point most P&C industry stakeholders are aware an industry centric EDI highway has been built to improve operational efficiency and is working as advertised, making HIPAA standard transactions – and operational savings – no longer just the norm in healthcare.

Starting January 2014 the next EDI phase begins. Final HHS rules for EFT / ERA transactions applicable to commercial health plans will require HIPAA covered entities to send and receive electronic funds transfer (EFT) transactions.[ii] Under the rules, Payers will heavily promote Provider enrollment. The shift in healthcare medical payment methods will present another opportunity (aka challenge) to P&C Payers, entailing procurement of modern electronic payment technology to supplement comparatively costly and inefficient legacy paper check and paper EOR/EOB processing systems. Under the new HHS rules, most Providers[iii] will normalize their Accounts Receivable operations around EFT/ERA transactions and deal with paper payments and remittance information on an exception basis.

If ready availability of advanced EFT/ERA technology and trading partner readiness were not incentives enough (delivering superior ROI, elimination of cost layers, better timeliness, improved accuracy, audit trails, data flexibility), the state of New Mexico workers' compensation system has taken action. New Mexico is the first state to enact legislation extending eBilling to encompass the full bill processing cycle – placing the first EFT requirements on the books (also beginning 2014) mandating workers' compensation Payers to offer optional EFT payments to Providers.

eBilling in Practice

To understand P&C industry eBill adoption trends since 2008 it is helpful to describe how eBilling actually works. P&C eBills are similar to group health claims in terms of bill data structure, connectivity arrangements and EDI mediated transaction exchange. However, the primary business partner relationship healthcare oriented clearinghouses assume is with healthcare providers. P&C clearinghouses, on the other hand, contract with and perform as eBill "Agents" of individual Payers. Payers can fast-track eBill acceptance capability using an Agent, or build and manage – 'in-source' – this technology (although to date, even large national Payers have not chosen to assume the investment risk, expense and uncertainty by engineering and staffing stand-alone eBill systems).

As eBill solutions in workers' compensation and auto medical markets have progressed, three basic medical provider connectivity strategies evolved to administer compliance. These strategies entail web portal (online) bill submission; portal upload of bill files from Providers' (or assignees') practice management and/or billing systems; and utilizing channel partnerships between Providers' existing group health clearinghouses and the Processing Agent. Interface solutions between PMS software companies, large billing intermediaries and EDI technology vendors also have come into play.

Five years on, the origination, transmission, validation and delivery of eBills takes three critical operations into consideration: workflow; adherence to functional requirements; and flexible (EDI or Fax) handling of Attachments. Here is a brief look at operational requirements:

- Workflow:

The end goal is administering medical billing using a 'one workflow' model that is designed not to disrupt existing bill workflow, or at least requiring minimal changes. Typical single workflow comprises 4 steps:

> **Step 1.** The Provider utilizes its **existing** Practice Management System, Billing Service, Clearinghouse or eBill Agent to process electronically bill data (837) and attachment. (If the Provider has no connectivity arrangement in place, the eBill Agent will set up online or SFTP connectivity directly with the Provider)
>
> **Step 2**. The eBill (837) is validated and edited by the technology vendor (eBill Processing Agent or clearinghouse), which in turn forwards the validated 'clean' eBill, with attachment as required) to the Payer.
>
> **Step 3.** The Payer routes acknowledgment confirming receipt of the clean eBill back to the Provider within 24 hours (via the technology vendor).
>
> **Step 4**. Payer processes payment against the eBill – paper check or EFT – and sends remittance advice (835/ERA) to the Provider, again utilizing connectivity supplied by the technology vendor.

- Functional Requirements:

Considering practical aspects of workflow, the same front-end editing and validation functionality that apply to commercial and government claims also apply to eBills. The Payer's contracted technology vendor performs typical clearinghouse activities. These activities are applicable to eBills created by the Provider using the vendor's online billing interface or uploaded directly by the Provider.

It is the eBill Agent's responsibility to perform front-end editing and satisfy validation requirements (as specified in jurisdiction eBill rules; or in voluntary states by conforming to IAIABC model rules). Vendor activities include but are necessarily not limited to:

- Validating the ASC X12N v5010 837 is "complete"

- Validating if a bill requires a supporting documentation (Attachment)
- Validating use of the appropriate/state required codes and / or modifiers
- Submitting the eBill in conformance with Privacy/Security rules as specified in regulations

■ Attachments [Supporting Documentation]:

Virtually all workers' compensation bills must be submitted to Payers together with (e.g. attached with) supporting documentation (medical reports, status reports, etc.). Vendors must execute on the ability to deliver Attachments with eBills – either electronically (preferred), or by Fax (an important secondary capability for low-tech Providers). Attachment solutions include:

- Bar coded coversheets and automated, secure Fax servers
- Web Portal upload of single or batches PDF or TIF images,
- EDI using ASCX12 N 275
- EDI using other methods

Specifications encompassing the handling of Attachments are critical to overall design and execution of an eBill processing system. Compliant processing must take into account:

- Regulations defining attachment requirements to support level of services billed (unsolicited model)
- Ability to indicate in the 837 the report type, method sent and attachment indicator number
- Attachment upfront validations / edits applied (pre-adjudication)
- Methods for submission of documentation to support a bill /claim which could be:
  - Secure Fax Server, Web Portal Upload, EDI using ASCX12 N 275 , other EDI methods, imaged documents
  - Attachments may include, but not limited to, test results, surgical reports, chart notes and other report types
- Ability to generate required attachments header or attached cover sheet data elements that allow the Payer to match the Attachment to the bill
- Ability to submit in conformance with Privacy/Security rules as specified in state and federal regulations

Cost Benefit Metrics

While legislative initiatives targeting Administrative Simplification and the independent efforts by early adopter P&C Payers emulating healthcare EDI arrangements were justified as logical projects to align handling of medical bills with modern technology, an element of uncertainty also was present. Because electronic processing of medical bills was at first novel for the industry, statistical data to measure and validate cost savings did not exist – in contrast to well-established metrics infrastructures in the healthcare sector. No research framework could be called upon. At best, early eBill regimes had to presume – with the caveat workers' compensation medical bills are inherently more difficult and costly per unit to process and adjudicate than health claims – that some equivalent or conceivably greater level of savings achieved by electronic health claims – should be expected.

Five years later, conducted surveys reveal manual bill processing costs are 55% higher than costs of electronic bill processing. Processing Agent sampling of Provider metrics is demonstrating clear and distinct cost reductions that are consistent with landmark Milliman studies in 2006.[iv]

- cost to submit manual bills (claims): $6.63 x 6,200 = $41,106*
- cost to submit electronic bills (claims): $2.90 x 6,200 = $17,980*
- annual savings per physician from automating bill (claims) submission: $23,126*

FIGURE 3: PROVIDER REPORTED EBILL METRICS

Metrics (paper vs. eBill) 1	National Occ. Health Service 2	CA-based Ortho Practice	CA-based Billing Service	CA-based Small Practice
First time acceptance	70% to 90%	50% to 83%	68% to 88%	40% to 84%
Resubmission rate	20% to 3%	40% to 8%	25% to 5%	50% to 15%
Revenue cycle improvements	DAR – 80 to 45, %over 120: 35 to 6	DAR 93 to 42, %0ver 120: 53 to 15	DAR 73 to 38, %over 120: 57 to 22	DAR 75 to 39, %over 120: 62 to 24
Payment cycle	45 to 19 days	63 to 22	58 to 23	67 to 20
Payer status calls on eBills	Reduced by 83%	Over half	30-40%	At least half

Notes:

1. *These are sample results from several practices that have been engaged in eBilling for 1 to 5+ years, with varying numbers on payers that they are submitting to.*[v]

On the Payer side of eBill transactions, it is no surprise emerging metrics support de-emphasizing manual processing of paper bills, to the extent possible, in favor of electronic medical bill workflow. Concomitantly, many Payers have found migrating to eBill acceptance programs to be comparatively inexpensive and mostly pain free, owing to eBill Agents highly configurable processing platforms.

In any event, for a Payer the electronic vs. paper bill processing equation is not yet an either-or, zero sum proposition. Although results clearly show legacy paper bill systems have reached the obsolescence point impinging on operational performance, these old systems cannot be completely dismantled. Payers must retain parallel electronic and paper bill processing capabilities in the majority of states where eBilling is optional and/or still strictly voluntary. Parallel eBill / paper bill processing will continue indefinitely. Nevertheless, the voting is in, so to speak. Payer momentum swings to where savings can be harvested; and the available P&C

eBill metrics weigh heavily in favor of pursuing, to the greatest extent possible, a 100% EDI medical bill model.

Summing Up Payers' Reported eBill Metrics:

- 63% First Time Submission- Complete Bill Rules - Front End Edits
- 70% Reduction in duplicate billing – Front End Edits
  (WC NUBC Condition Code = W2 Duplicate)
- Reduction in requests for Appeals/Reconsiderations – due to use of CARC/RARC vs. proprietary codes
- 64 % Reduction in bill status calls - 277CA
- Acknowledgement process reduces "lost bills"
- Data Quality
  - Up front edits ensure complete and proper data
  - Enables improved auto-adjudication rates – "end to end" processing
  - Information for medical management available more quickly
- Better data = Better Analytics
- Improved Provider Relations through Timely and Accurate Payment

Last But Not Least: Regulatory Reported Metrics

When the California legislature enacted workers' compensation Bill SB228 back in 2003 as part of a package of reform measures intended to reign in medical costs and simplify system administration[vi], projected 'hard' administrative savings were calculated to be $600 million per year. In Texas, reform legislation House Bill (HB) 7, passed in 2005, sought to reduce paper-intensive processes up to 60% by aligning workers' compensation electronic billing with existing (at the time) managed care billing models, while capturing cost benefit data to produce ongoing cost savings. Minnesota and subsequent states that have enacted eBilling requirements have expressed similar objectives – directed toward simplifying and reducing expense of administration.

Electronic transaction data collection is a major opportunity to drive improvement. It provides categorically better integrity and accuracy of state collected medical billing and payment data. This data is critical to medical cost containment analysis, and to establishing a more meaningful basis for state efforts to intensify control over medical component of claim costs that today constitute 60% or more of P&C claims costs nationwide.

Analysis by state systems shows eBilling supports quality / best practices. A standardized national approach mitigates potential for as many as 50 different sets of EDI requirements. Facilitating stakeholder adoption is the finding that Providers' claim submission costs decrease by 55%, and Payers' bill processing expenses get cut by up to 75%. These levels of savings justify decisions by individual states to push innovation through creative regulation. By mandating modern EDI technology states are reinforcing stakeholders' own strategic needs to embrace eBilling[vii], and can yield meaningful savings at the jurisdiction level contributing positively toward moderation of premium rate increases, not to mention business climate attractiveness.

Industry eBill Resources and Tools Now Available

Coordination and collaboration amongst public agencies, industry organizations and standards bodies in recent years has assumed a pivotal role in the success of P&C eBilling, including: aligning P&C eBilling with the continually evolving national EDI standards for healthcare; furnishing state agencies with legislative and regulatory model structures; and creating toolsets Providers and Payers rely on to automate bill workflow.

A great deal of effort by agency officials, technology evangelists, industry leaders and standards experts is bearing fruit. At this 5-year milestone, in light of both active eBill jurisdictions and 15 new states, and counting, working at various stages of eBill implementation, it may not over-reach to define electronic medical transaction exchange as the new normal for medical transaction workflow in the P&C industry. Non-connected P&C Payers unable to accept eBills will be in danger of being left behind by this important paradigm shift in Provider/Payer interactions.

For additional information, principal eBill resources are available illustrating the impressive collaboration now driving P&C eBill adoption. Complex as it may look, the future of eBilling is safe, making adoption by end users quite uncomplicated.

- **American Medical Association (AMA) eBilling Toolkit**
  http://www.ama-assn.org/resources/doc/psa/wc-toolkit-resources.pdf

- **Workgroup for Electronic Data Interchange (WEDI)** bringing together a consortium of leaders within the healthcare industry to identify practical strategies for reducing administrative costs in healthcare through the implementation of EDI: Sub Committee: Electronic Medical Bill Sub-Workgroup for Workers' Compensation, Auto and Other Property Casualty. http://wedi.org/

- **International Association of Industrial Accident Boards & Commission** (IAIABC) is a not-for-profit trade association representing government agencies charged with the administration of workers' compensation systems throughout the United States, Canada, and other nations and territories http://www.iaiabc.org/i4a/pages/index.cfm?pageid=1

- **Accredited Standards Committee (ASC)** develops electronic data interchange (EDI) standards and related documents for national and global markets. http://www.x12.org/

- **eBill State Workers' Compensation Web sites** as well as the **"AMA Workers' Compensation State-Specific Resources Map"** at http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/health-insurer-payer-relations/workers-compensation.page

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[i] California SB 228, filed 2003, modifying L.C. Sec. 4603.4; Texas, 2005 eBill provisions adopted in HB 7, and Rules 133.500 and 133.501 adopted July, 2007. Adding electronic medical billing as a novel component in these states' wide-ranging workers' compensation reforms legislation likely was influenced by ongoing implementation of CMS/Medicare electronic claim requirements affecting their large healthcare populations; as well as increasing popularization of "green" (paperless) EDI initiatives in their commercial enterprise environment.

[ii] HHS Operating Rules and Standards for EFT and Remittance Advice (ERA) http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/ComplianceCertificationandPenalties.html

[iii] Providers with exclusive occupational / industrial or P&C oriented practices, who do not submit bills to commercial payers or government programs, will not encounter EFT/ERA enrollment incentives under HHS rules; however, may be influenced by higher efficiencies and lower administrative cost of EFT/ERA transactions available to Providers serving health care markets.

[iv] Milliman, Inc., "Electronic Transaction Savings Opportunities for Physician Practices." Technology and Operations Solutions. Revised: Jan. 2006.

[v] Research measuring industry-wide eBill metrics is a collaboration objective, the research parameters, contract type and financing of which is under discussion by stakeholders

[vi] Total CA workers' compensation costs (indemnity, medical, expense, raised reserves) paid by insurers grew 220% between 1995 and 2002, with premium rates ballooning from $5.7B in 1995 to $19.7B in 2003

[vii] Starting April, 2013 the California DWC announced it is actively monitoring electronic acceptance of medical bill transmissions

Appendices

I. Quick Summary of E-Bill Benefits

- Utilize the same transaction sets as group/commercial claims to enable connectivity solutions to move WC and Auto transactions
- Cleaner, more timely data can be adjudicated by the payer faster
- Expedited information delivery can enhance creation of claims, initiation of case management, and lower indemnity, as well as medical costs
- Significantly reduces claim status calls while influencing customer and provider satisfaction
- Improved payment cycles can produce happier providers
- True end-to-end workflow automation aids in the streamlining of operational costs, as well as maximizes resource management opportunities for all stakeholders
- EDI standardization facilitates cost effective implementations
- Stakeholders adopting eBilling as a standard operating method, regardless of state legislation

II. Terms used in Property & Casualty eBilling

- **eBill -** The term "eBill" is used in workers' compensation and auto to refer to an electronic medical bill (claim) utilizing the same HIPAA X12 transactions sets that are used group

health and government claims processing (ASCX12N 837s, Acknowledgements, 835 Remittance Advice and EFT)

- **Industry Regulated by Each State:** Specific statute requirements. The workers' compensation and auto industry is a **legal system not a healthcare system**. Heavily regulated with associated penalties for any non-compliance

- **eBill Agent -** An "eBill agent" facilitates the processing of the workers' compensation and auto eBills between health care providers and payers, much the same way a group health clearinghouse facilitates commercial claims. It can also establish electronic connectivity between the various parties to the transaction.

- **E-Bill Attachments -** In workers' compensation and auto, the majority of eBills require additional information, or attachments, before the payer can adjudicate. An electronic tracking number (attachment control number) provides the link between the eBill and the attachment.