ASC X12 & WEDI Real-Time Adjudication Conference
February 13-14, 2007
Next Steps and Notes

Next Steps

Business Breakout

1. Develop a glossary of terms so we are all on the same page
2. Create marketing group to evangelize RTA
3. Create business modeling work group to address impact to existing transaction sets

Additional notes from the Business Breakout

- Consensus definition for Real-Time Adjudication (RTA) – at the time the claim is generated the claim is brought through to the adjudication
- Note that in addition to adjudication there are terms on estimate and pre-determination of benefits

Technical Breakout

1. In the short-term, establish work group to develop a "light/skinny" 835 and 837
2. In the long-term, establish work group to address RTA issues
3. Establish a communication protocols work group (consider CORE)
4. Create operating rules (follow CORE)

Additional Notes from the Technical Breakout

- Also consider leveraging the 278, and the work of HITSP (but use standards that are in place now).
- In the long term, evaluate XML technology, displays and receipts. FYI, X12 uses Context Inspired Component Architecture (CICA) to develop XML schemas.

Additional Action Items

1. Call for participation
2. Establish vendor and payer work groups
3. Obtain funding
4. Establish work group to follow up on legislative items
5. Acknowledgements
6. Develop pilot strategy
7. Develop strategy to incorporate CMS
8. Recruit legal representation within work groups as applicable

Notes from February 13 & 14 Presentations

Current State of Batch Claim Processing – Justification for Change

J. Robert Barbour, Montefiore Medical Center

Mr. Barbour indicated that the entire process of sending a claim and getting paid averages 90 days. Even in the most ideal scenario, the cycle takes weeks. Most steps are still manual requiring phone calls.

The most painful part of the process is 'denial management'. Patients have many excuses on why they should not pay the provider for their portion or in the case when the insurance company pays the patient, turn the payment over to the provider.

Providers are not asking for much, they are simply looking for it to be done faster. They need to know before the patient leaves how much the patient owes.

Knowing ahead of time allows the provider to work with all the options the patient may be able to afford, e.g. out of pocket expenses estimated accurately before services are provided, with an actual balance known immediately.

The lowest cost per claim saved is $10.00+ to manage. This represents a huge savings over the course of a year.

Montefiore experiences ~1,600,000 visits per year. Getting a real-time claim response allows enhanced denial management. Documents are still accessible; staff/providers can still provide data and – real-time feedback would be invaluable.

Brian Cutler, Mercury Data Exchange
There are models for real-time in credit card business, hunting and license, and food stamp businesses.

Massachusetts Bay State Health Plans pioneered the Eligibility and Referral transactions with their providers using POS Devices. The same is true for Washington Delta Dental. State Medicaids required real-time transactions using POS Devices. Delta Dental of VA is doing real-time adjudicated claims before the patient leaves the office.

Batch Claiming is not EDI - it is ½ EDI as most have a paper response. In the dental world, this represents 36% or ½ equaling 18% EDI.

Banking POS solutions are for all types of credit cards – not one for VISA, MasterCard, Discover, etc. This made the implementation faster and more efficient. Merchants know that they will be paid before the customer leaves with the merchandise.

<u>What dental offices want</u>
Pre-visit
- Eligibility and benefit determination

During the visit
- Patient treatment planning
- Real payment data, not estimates (refunds cost the provider a lot of money/time.)
- Payment while patient is present

Post-visit
- Electronic posting of payments to the General Ledger
- Simple reconciliation
- Electronic funds transfer

<u>What do the payers want</u>

- Fewer phone calls
- Minimize costly paper
- Cleaner Claims

<u>What do patients want</u>

- Know how much their treatments cost

<u>What do PMS vendors want</u>

- Added value to their systems
- Attract and retain business
- Establish new revenue streams, particularly recurring revenues

Robert J. Gaylord, Metro Dentalcare
What are the problems?

1. The provider's inability to have accurate information. They know what they charge, but do not now the customer benefits. Patients often use more than one provider. The manual effort to obtain information from the insurance companies is costly. Websites are problematic – 750 sites with logins and passwords are overwhelming.
2. Patients don't get needed dental work done. Patients accept the DDS diagnosis but don't know true out-of-pocket cost to them and patients generally do not know their benefits and expect the provider to know.

Solutions: Patient needs to know what they owe; provider needs accurate patient out-of-pocket amounts on the date of service. We need to look at other industries: Banking, ATMs and Internet Banking; Airlines and e-ticketing; and Pharmacy – integrated adjudication.

Spurring Healthcare into "Real-Time" Through Collaboration

Jim Lacy, ZirMed
Real-time in healthcare requires putting 'retail' into healthcare. In order to collaborate, you must have:

- Tools for RTA
- Ability to identify eligible patients and verify coverage
- PMS interface to create the claim is the biggest hurdle since most PMS (if not all) do not have the ability to send a single claim. Current systems only allow you batch the claim, but can't send the claim until all information is available to submit. Once a claim is batched, it's not available for additional work.
- Transmission protocols for a single claim transaction need to be defined
- Application of edits, payer adjudication rules, and validations need to exist at clearinghouse level – the claims must be edited prior to getting to the payer system and then these edits must be applied

- Prioritization of Real-Time claims at clearinghouse level – real time claims can't get in line with 200,000 claims already submitted as batch, and the patient can't be expected to wait while they process
- Delivery and understanding of responses – the response must come back in a way that the staff can communicate to the patient still at provider's office, and must have the ability to collect monies owed
- Real time claims will need to be integrated with other transactions, such as, eligibility, authorization, referrals, etc.

Putting retail in healthcare
Provider out sources billing and collection functions (20% or more); hospital based physicians group or practices really don't care for real-time as they are not doing the billing; workflow patterns (office logistics) pediatricians and labs are good candidates while patient is doing something – the shift is going from clerical to clinical staff; near time is good enough – large providers say if it can be turned around in 3-4 hours, that is good enough; enough money – A/R is fine.

ZirMed with Humana is able to reduce the 30 day turnaround to 30 seconds.

Setting expectations
- Hospital based physicians group or practice should be able to benefit from RT claims
- Near time is good enough – less than 30 minutes
- Rejections need workflows to correct the claim, will require work by providers and practice management systems.
- CDHP (Consumer Driven Health Plan)/HSA adoption at a micro level

David Harrell, The Availity Health Information Network
Availity is working with Humana and BCBS of Florida, and offers 3 options that support RTA if payers' back-end claim systems support it. Any provider can key claims on the Network – providers can create HIPAA compliant claims in their billing systems and send them in batch mode or they can seamlessly send claims to the billing systems that support B2B claims integration with Availity.

In order to do this the right way, vendors have to buy into the value proposition. They have integration with more than 20 vendors for other administrative related transactions. Real-time information supports consumer directed health care.

HOOPs (High Out of Pocket Plan) are expected to be adopted in Florida at 40%. Availity already has the capability to enable RTCA. Its strategy is to create awareness and demonstrate value among both payer and provider groups.

Payers value is supporting improved provider relationships - reduces rework costs and supports consumer directed health plans that payers are trying to sell moving forward.

Providers' value is in improved payer relationships and better A/R. What doesn't work for larger practices are the web enabled systems. The EDI Batch option offers a channel between Availity and payers to enable real-time claim submission for non-real-time submissions. The providers can create batches in their billing systems and sent then via EDI – payers have the option of receiving batch or near real-time.

How do we get the bulk to take advantage of real-time since there will always be ASO and self insured plans that won't be supported? Collaboration is the only way to drive this home – PMS must see the value to get this to the market.

Real-time claims adjudication does not have to result in real-time payment. There are certain markets that will not be ready – focus on the ones that can and develop the standards to support those markets.

Things that should be made available
- Integrated settlement
- Predetermination
- Automated Fee Schedules

Kenneth Willman, Humana, Inc.
RTCA enables provider offices to accurately collect private pay dollars at the time of service – before the door closes. Most companies that promote RTCA have created a web screen-entry and require a proprietary connection or information to be keyed into a separate point of sale device. The solution must provide solutions that will work for providers. The solution must be integrated – collaboration is key.

Providers have to be able to change their office workflow. They have talked to over 600 providers and completed 3 focus groups with providers in Cincinnati, San Antonia and at the MGMA conference. Adoption is consistent and feedback has been positive. Of the 600 providers less than 10% are up on RTCA. Most vendors can not transmit in RT. Today it is an 837 – does this need to be tweaked? Yes, but it works today. Most providers cannot complete a bill at the time of service – this is not done in the office - it takes 7 days to get the claim prepared.

Vendors are saying that there are no providers asking for this capability. What comes first? The need for the systems and then wait 3 years to develop the standards and systems or anticipate the need for the 2012 prediction that CDHP will take over.

Roadblocks to Real-Time Adjudication

Lynne Gilbertson, NCPDP
In the pharmacy world, it all starts with the ID Card implementation guide. There are still good reasons for batch standards: Medicaid subrogation, post adjudication history, manufacturer rebates and telecom usages. The RT Standard came out in 1988 based on credit card industry needs. It supports real-time eligibility, claim, and authorization

request. The other transaction set is called 'Script' to send between providers and pharmacies. The 2007 Script version under ballot is 10.1.

Information has to be available to payer/plan sheets, and include routing information, parameters and changes that have been made. The messages have to be explicit. These cannot be technical, they need to be business in nature and make sense to the trading partner. Every request in a real time transaction has to have a response. Requests can't just disappear or you will have to have more support staff to troubleshoot the problems.

The enrollment, eligibility data need to be available. The adjustment and reversal processes need to be adjusted. What about COB and prior authorizations?
These are difficult in batch and will not get any easier in the real-time environment.

Expect reject transactions to go up. There are new behavior patterns that need to be identified and addressed, such as duplicate checking, change management, and time-out issues.

Network monitoring of real-time transactions are a must and watch for the ebbs and flows. Look for the weakest link – when one process slows down it impacts all the rest.

Gwendolyn Lohse, CAQH
There are a lot of lessons learned from pharmacy as we move into the medical world.

The market focus is on individual organization strategies vs. all-payer solutions – how do you get payers to focus on the goals of the industry? Many entities are dealing with NPI or ePrescribing and don't have the resources to work on this. A lot of providers are using numerous different websites and are not happy with this solution.

Another challenge is the lower hit rate on eligibility transactions. There is a higher hit rate on eligibility but it is not an all-payer solution.

Key opportunity is that providers could reduce labor costs by up to 50%. They worked with CORE to get standard responses from payers –short term goal focuses on eligibility and benefits and long term goal to address other touch points. They are using standards and HIPAA. CORE has a real cross match of entities involved in healthcare – if you don't have them all represented then you don't have an all-payer solution.

Maggie O'Hara, IVANS
Road blocks to real-time with providers are technology, security, backend integration, payer/provider capability, financial business model, convergence of healthcare and consumer finance, incompatibility of systems; the need to upgrade claims systems to provide a real-time response; clean claims; and integration with PMS.

The business model needs to be built out to show where we need to be. There are transactions that cannot be done in real time today, those that need attachments, COB and others. We need to start with the ones that can be done in RTA.

Fred Richards, HTP, Inc

- Operational issues that need to be considered:
- Providers want to know that the results will be available 60-70% of the time
- Workflow may be impacted and providers need to be ready for this
- Outsourcing of billing will hinder the real-time process.
- Lack of standards, for example anesthesia, infusion therapy and others

The use of multiple clearinghouses causes issues where each one does something specific to the data to add value. How will this be done in a real-time environment? In the self insured business, claims are funded 2-4 weeks after adjudication. The payment process is dependent upon 3rd party negotiated fees. The TPA systems are not current and have no software for RTA. Self-insured coverage is high in some regions.

Registering and authenticating the provider is another operational issue. The provider banking information has to be maintained. Another challenge is the one claim/month. How can you set up your system to recognize them and maintain their connections? It is a scalability issue and must be addressed.

Really Real-Time Implementations of Real-Time Adjudication

David Boucher, BlueCross BlueShield of South Carolina

In 1999, BCBSSC launched its web site, and in 2001 it gave providers the ability to direct data enter claims, professional and institutional. All of its 837 claims are being processed within 2-3 hours. The goal is to help providers identify patients with HDHP.

They also have a web-based Superbill that the provider can customize for their top procedure codes, diagnosis codes and charges. They can update as their practice changes. They are receiving about 18,000 of these today.

They have added a 'My Remit Manager' which helps the provider know what and when they are going to get paid. They are still on a weekly payment cycle. For providers to get this free, providers have to agree to shut off the paper remits.

Allen DeGraw, Post-N-Track Corporation

Utilizing web services to achieve interoperable, real-time processing, Post-N-Track started using web services from their founding 3 years ago. The majority of the audience felt that RT adoption would take place between 5-10 years. What is driving RT now: Technologies (service-oriented applications and web services); bandwidth (internet is being adopted); standards (X12, HL7, NCPDP and WS-I); business models (HSA and CDHP) – we need to follow the money; and convergence (EMR, consumerism and automated billing)

Challenges and issues start with the current environment. We have hard static connections today. Clearinghouses will need to make changes to make this work. Provider desktop has been referred to as the weak link, but DeGraw sees it more as the 'wild card'. These people are working really hard and the bottom line is how will I get paid? We need to enforce a standard at the desktop; browse access to a portal; a device; and existing system and new systems.

Can real time be integrated into workflow? This is critical and we need integration with existing PMIS. They need to have universal or a device /process for each payer. How do we leverage the knowledge rather than replace it?

Barney Dreistadt, Blue Cross and Blue Shield of Florida
What are the current impediments? The many-to-many relationships cause us to have a complex environment. What is changing: patient responsibility, technology, and standardization.

What are the options? One is to start from the back end and move forward. Building up the 270/271 is another alternative. They will be distributing magnetic swipe ID cards. When the 271 comes back, there will be a button that does CareCalc (used in over 6,000 provider offices) which brings up the option for diagnosis and ID cards. They get back the response that BCBS would pay. It is not a claim, but gives back the same response. They plan to give them another button to allow them to submit the care-calc as a claim. This opens a whole new space for real-time opportunities.

Amy Hinrichs, UnitedHealthGroup
Websites are a tool and there is always a time and place for any tool. RTA by itself is only the beginning of what we can do with this technology. HC.com has been live since December 2006, and is used for timely filing deadlines and high volume claims. It is a specialized use of RTA. They have a 10 second response time goal but most are less than 3 seconds. RTA is an actual claim and provides an opportunity for provider to collect payment from customers. The response is a pre 835 or a 277 for the unsuccessful.

They are getting 5,000 claims today from the RTA highway. They are planning to use the same highway for their batch claims so they will be processed within seconds of begin received.

They are rolling out a claim estimator later this year, which will be used as a predetermination of benefits or for bundling capabilities.

They are looking at some real-time for secondary claim adjudication; claim estimation transaction via EDI; auto rollover to HRA accounts; real-time fraud and abuse; convert claim from the estimator; real-time re-submission of corrected or pended claims; SmaRTA (consumer claim estimator/cost comparison tool).

What do payers need to do? Build RTA; maximize value and minimize response time; use available standards whenever possible; train providers to do POS billing-provide incentives to enable the experience; work with PMS/HMS vendors to build POS workflow enabled systems; provide vendors with incentives.

Steps & Standards to Power RTA

Oscar Bryant, Delta Dental of Virginia

The value proposition for the payer is the patient receipt (EOB delivery). For the provider, there is the patient-pay collection at the time of visit, which reduces aged-receivables and invoice generation costs. The treatment planning can be done at the time of the initial consultation rather than waiting for the treatment plan to be returned. For the patient, the normal settlement for services received is initiated much like pharmacy and immediate treatment and payment planning for complex services that can be performed.

The challenges include the limitation of existing transaction standards (277 and 835). And new standards take a long time to create and implement. PMS readiness is a huge challenge to handling a single claim in real-time.

From the payer systems readiness, the challenge is the ability to handle RTC and how to overcome their 'review' requirements. Their standard response is a 277 and keeping the 835 for payment. Most providers do not want an 835 back unless the money is being posted. The web entry will be done if the provider can see the ROI. It takes less than 25 seconds to enter the claim and receive the response. PMS vendors are getting on board for this. They are adding 30-40 provider offices per month.

Anne Castro, BlueCross BlueShield of South Carolina

They have been processing RT claims for quite awhile, but that time has been very valuable as they can look at the data and see how providers really act. There are some behind the scene meetings with payers that are taking place. However, they are built to be competitive even among the Blues. We all need to agree that the standards cannot be driven by "you have to do it my way."

Facilities are run more like a business, but physician offices are not. They are often run by the spouse of the physician or the office manager who is more concerned about the patient relationship than the bottom line.

One thing she has not heard much today is about patient management. Just because you have a real time claim doesn't mean the patient will pay. Any one of the pieces from end-to-end can break along the way. Time will change this with the CDHP. We need to look at this not as a total conversion but rather what steps do we need to take to get there.

Where are we today: There is a value to web based systems for estimators as a step to help us get there. The situation of all payer cannot be underestimated. We will see variations of what is all payer. Whoever gets there first will have the competitive advantage. The 837 HIPAA transactions are too big for POS. There needs to be a 'light' version. We need to attach the problem with the 80-20 rule. SDOs need to look at the 837 and make a version that is easier and faster and conducive to a POS capture, but rather provide a receipt that does not replace the EOB.

Another step to look at is the interpayer. If anyone gets there first they ought to be able to get to other payers. This means they will need other payer information. If a payer can gather this information from other payers then they can exchange data, such as from web services. The payers must inter communicate with each other. One challenge is the 270/271 is an awful mess. How did we implement the standard without telling people how to use it? We need to take this into account when we design these standards. Denials are personal things to providers. We have to address the issue of what the provider needs to know while the patient is still at the office.

Bob Sweigart, Highmark
Highmark's approach has been to use a single 837 wrapped in a SOAP message and submitted via a HTTPS connection. This uses the standards based X12 data and leverages technology and processes implemented with HIPAA. Highmark has limited its submission to 50 line items per claim. The response is generated in 30 seconds or less.

Highmark is taking a phased approach – first to get the validation back to the provider in a real time message. They are using the standard responses – TA1 – 997 and 277. The pricing of the RT claim (estimator) will be in phase 3&4 and claim adjudication will be phase 4.

The RT validation will apply pre-adjudication edits and provide the response back to the submitter in 30 seconds or less and keep an audit trail of all transactions. They will use the same authentication that they use today for their real time transactions.

Joseph Woodside, Kaiser Permanente
Kaiser has taken the approach of using an expanded XML model using a database storage that can then be used by their internal systems for reporting or externally for requests/responses. Kaiser uses one central access method for security and authentications.

Kepa Zubeldia, Ingenix
The X12 ISO standard IHCLME, Interactive health Care Claim/Encounter is forgotten in the HIPAA era, but it is here. This is the 80/20 solution that you are looking for: an interactive claim, but not real time. The response can be in days, not seconds. This is the type of information you get when you try to book a ticket for airlines. It's a Q&A process. The expectation is that in the claim, you would send as much as you can. You would get a response and support that is conversational. It supports the Institutional, Professional, Dental and Predetermination – the information includes billing, encounter, denial reasons, error explanations, approval, adjudication information and COB. This work was started in 1996 in the ASC X12 Insurance Subcommittee.

Kepa walked the group through the IHCLME transaction and showed the simplicity of the transaction where most of the content is optional. The same message is used for the request and response. The response can do everything that the 277 and 835 do.

HIPAA has a provision that before the Secretary can adopt a standard, there needs to be a pilot project. He recommends that as an industry we do a pilot project to use this claim. Once it gets approved, NCVHS can take it through the process.

Real-Time Claim Adjudication? Not in my lifetime!...Wanna bet?
Chip Waters, Exante Financial Service, a UnitedHealth Group Company

Exante's design principles include: Response Rate; Response Time; Yield (you can respond 100% of the time, but it had to be done right); Leverage current infrastructure; Non-proprietary, and consistent results – a claim should be adjudicated the same way whether it's' paper, EDI or RTA and most importantly it needs to align with customer needs.

They delivered the project on time and within budget. They did provider research and focus groups as well as surveys across the country. Results:

- Doctors said great, but needs to support 30-40% of their business or they won't buy
- They said it is worth $1-2 per claim
- Can't be proprietary and must work with the industry to make this happen

They use a web based product to enter the claim. The results of adjudication are available to the consumer, who can pay on-line.

This process needs to include FSA and HSA accounts. All services and payments should be completed at the time of service.

The infrastructure in clearinghouses and insurance companies are all built on batch processes. Everyone has based their processes on transporting claims and not providing value. The ROI is easy to figure out – you reduce the cost on the systems and then use the savings to reinvest or to profit margin.