Effective Use of the HIPAA Eligibility Transactions

Key to Improved Claims Processing
The Tenth National HIPAA Summit
April 7, 2005
Baltimore, MD

Topics

- Eligibility Economic Impact on Payers/Providers
- Problems with the 271
- Solving the Problem

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Provider Impacts: Denied Claims*

- Downcoding: 1-20%
  - Incorrect coding: family physicians, surgeons, internists
- Service not medically necessary: 27%
  - Radiologists
- Service not covered: 26%
  - Pediatricians, ob-gyns
- Denials =
  - Lost money >$2,500/physician
  - Lost patient time
  - Lost staff time to bill patients

**AMA Council on Medical Service Report December 2000 Survey of 28,0000 doctors*

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Provider Impacts: Denied Claims*

- Incorrect registration information
  - Patient not recognized by payer
- Incorrect code or modifier
  - Not recognized as payable by payer
- Missing information
  - Additional info required by payer to determine payment responsibility or correct payment amount
- Missing referral
- Duplicate claim

**Med News, publication of RSM McGladrey, Inc. 3rdQtr 2002*

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Economic Impact on Providers

*A denied claim can be money lost forever. If it is not pursued, it becomes profit for the payer at the expense of the provider.**

**Med News, publication of RSM McGladrey, Inc. 3rdQtr 2002*

Most, if not all, denials begin at the point the patient is scheduled and/or pre-registered.
*The data gathered at the time the patient makes first contact is key to ensuring the claim is billed as "clean" and reimbursed properly.***

***Claims Denial Management, Lori Laubach, CPA, Moss Adams LLP*

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Payer Impacts: Payer Eligibility Case Study

- Paper Claims with invalid member information cost Harvard Pilgrim $3,500 per month in staff and postage
  - Wasted intake processing costs
  - Manual notations required in imaging system
  - Claims require sorting, bundling and return mailing
  - Second submissions of claims with corrected member information artificially inflate daily receipts and increase the cost of mail room staff

- EDI claims rejected for bad eligibility information require resubmission and increase transaction processing fees by 10%
- EDI staff spend significant time supporting billing offices who manage claims reject reports
- Harvard Pilgrim denies over 33,000 claims per month back to providers as "member ineligible"
  - Wasted claims processing time
  - Wasted processing and mailing costs for EOP's (Explanation of Payment)
- Rejected Claims result in calls to the Provider Call Center
  - Bad eligibility information costs HPHC over $7,500 per month handling calls in the provider call center

CSC & NEHEN LLC Proprietary, December 2004

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Tuesday, 08/03/04 | Middle Tennessee News & Information

Competition grows in electronic insurance verification

By BILL LEWIS
Staff Writer

A troubling trend in health care — hard-pressed patients having difficulty paying rising insurance deductibles and co-payments — has sparked new competition in Nashville among three technology businesses.

Those three businesses, Nebo Systems Inc., Passport Health Communications and WebMD Envoy, provide Internet-based services that let health-care providers find out how much they can expect to be paid by an insurance company for treating a particular patient. The services also tell subscribers how much of the bill the patient is

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Marketplace Response

- New competition
  - Nebo Systems, Inc.
  - Passport Health Communications
  - WebMD Envoy
- Internet-based services
  - Providers can find out how much to expect to be paid for treating a particular patient
  - Tells how much the patient should pay up front
- Information compiled from commercial insurance companies
  - Medicare/Medicaid included
- One stop shop for providers to obtain insurance verification
  - Can check 25 insurance companies – Passport Health
- Costs among 3 vendors vary
  - Per transaction
  - Software
    - No transaction costs

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The Problems

- No standardized approach to
  - usage/content of 271
  - connectivity
  - response time
  - Acknowledgements: TA1, 997, 824, 999, proprietary
- Patient identification/matching
- Discrepancies in search elements submitted
  - Patient/Subscriber ID, Patient First/Last Name, Patient DOB
- Data interpretations different among plans
- Data elements available are limited and vary among plans
  - Providers still call the payer
- Info not available for all plans or plan products
- Yes/No response no value to providers
- Vendors
  - Can't offer provider friendly or affordable solutions
  - Must maintain multiple interfaces
  - Low provider uptake of solutions

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Patient Identification/Matching

Agree on Several Search Logic Options and Corresponding 271 Responses

SEARCH LOGIC OPTION #1: PATIENT ID, LAST NAME, FIRST NAME, DOB

1. Validate Patient ID and DOB
   - Unique Match → Positive 271
   - Search result with multiple matches → Go to Step 2
   - Invalid Patient ID → Go to Search Logic Option 2
   - Invalid DOB → Search Logic Option [illegible]
2. Validate Last Name
   - Search result with unique or multiple matches → Go to Step 3
   - No match on Last Name → Go to Search Logic Option 4
3. Validate first 3 characters of First Name
   - Unique Match → Positive 271
   - Search result with multiple matches → Go to Step 4
   - No match on first 3 characters of First Name → Negative 271 (invalid/missing patient name - 65)
4. Validate all characters of First Name
   - Unique Match → Positive 271
   - Search result with multiple matches → Negative 271 (patient not found - 67)
   - No match on all characters of First name → Negative 271 (invalid/missing patient name – 65)

Example

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Usage/Content of 271

Top Priority Providers' Needs

Confirm which health plan covers patient	NM1 segment in Loop 2100A
Confirm health benefit plan coverage	EB segment at either subscriber level (2110C) or dependent level (2110D)
Confirm type of service –Major medical, long-term care, pharmacy, etc.	EB01-1390 Eligibility or Benefit Information Code Value
Provide co-pay amount as defined in member contract*	EB segment at either subscriber level (2110C) or dependent level (2110D) –Specifically where EB07=Co-Pay Monetary Amount when EB01=B and EB06=22
Provide base deductible as defined in member contract*	EB segment at either subscriber level (2110C) or dependent level (2110D) –Specifically where EB07=Deductible Monetary Amount when EB01=C and EB06=22
Provide coinsurance levels as defined in member contract*	EB segment at either subscriber level (2110C) or dependent level (2110D) –Specifically where EB07=Benefit Percent (expressed as a decimal) when EB01=A and EB06=22

**Not accumulators*

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Response Times

- Real-time is expected/required mode
  - Batch also important but lower priority
- HIPAA IG requires < 30 seconds or less for real-time
- Actual experience around country shows sub-second to 2-8 seconds acceptable

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Acknowledgements

- 271 is ***only*** response wanted for real-time
- TA1 of limited value – not widely used
- 997 has mixed use depending on payer's EDI system capabilities or other business rules
  - i.e., trading partner not found, EDI system or member system not available
- 824 & 999 not widely used
- Proprietary reports primarily from clearinghouses

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Communications/Connectivity

- Mixed bag around the country
  - Portal with single sign-on
  - Portal with single sign-on and user authentication (certification authority)
  - Regional switch with standard connectivity specifications
  - Low cost/free browser-based software for small providers

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Efforts to Solve Issues

- New England Healthcare EDI Network (NEHEN)
- Minnesota HIPAA Collaborative
- Utah Health Information Network (UHIN)
- OneHealthPort – Pacific Northwest
- Delta Dental for Member Plans
- National Dental EDI Council
- Blue Exchange for BCBSA

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National Approach Needed

- Fragmented regional approaches a good start – but don't address all issues
  - Some don't address 271 data content
  - Some don't address connectivity or communications
  - Vendors still must address multiple payers' different capabilities

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Vision

Give providers access to information before or at time of service . . .

Using any system for any patient or health plan

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Committee on Operating Rules for Information Exchange (CORE)

- A committee initiated & supported by the Council for Affordable Quality Healthcare (CAQH)
- Launched January 2005
- Membership & participation open to any interested organization
  - Includes health plans, government, providers, vendors, standards bodies, industry associations

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CORE Mission

Devise, disseminate, implement and revise operating rules enabling healthcare providers to quickly obtain reliable patient-specific information on the patient's health plan benefits and eligibility.

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What Are Operating Rules?

- Agreed-upon business rules to use and process eligibility transactions
- Enables marketplace to achieve interoperable network governing eligibility transactions

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Key Components: Operating Rules

- Rights & responsibilities of all parties
- Transmission standards & formats
- Response time standards
- Security
- Exception processing
- Error resolution
- Liabilities

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Target Date

- Begin testing of proposed operating rules in Summer 2005
- Finalize first set of operating rules by end of December 2005

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Contact

- CAQH – CORE
  - 202-778-1142
  - http://www.caqh.org/benefits.html

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questions

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