Provider Perspective: Proposed Operating Rules

NCVHS Subcommittee on Standards

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Represented Provider Organizations

- Today's joint testimony is provided on behalf of the following organizations:
  - American Hospital Association (AHA)
  - American Medical Association (AMA)
  - Medical Group Management Association (MGMA)

Background

- Existing operating rules have enhanced and improved electronic exchange of information
- Significant challenges as well as opportunities exist in reducing manual processes and improving efficiencies in health care
- Operating rules can be further leveraged to address barriers to administrative simplification and respond to changing business needs of all stakeholders

Overview of Recommendations

- Support more frequent updates to operating rules
- In addition to infrastructure requirements, address data content requirements in draft operating rules
- Analyze overall authorization/referral workflow and address gaps in standards to facilitate automation of the entire process

Frequency of Operating Rule Updates

- After initial operating rule development for each standard, there has not been the opportunity to revisit and revise rules in order to meet provider and health plan needs
- Current timeframe for development and implementation of new version of standards is 10+ years
- The rapidly evolving health care industry necessitates a more agile response to changes
  - Example: Health insurance exchange grace period notification in eligibility responses emerged as a business need after implementation of initial eligibility transaction operating rules
- An annual review/update of operating rules facilitated by the Review Committee would allow industry to more rapidly respond to and address issues

Need for Data Content Requirements

- Recent draft operating rules just address infrastructure requirements, not data content of transactions
- Connectivity, response times, and system availability are important to success of transactions, but **content** is also critical
  - Speed of transaction immaterial without exchange of **meaningful** data
- Previously established operating rules have successfully addressed data content and increased transaction quality, standardization, and adoption

  Examples:
  - Inclusion of real-time patient copay, coinsurance, and deductible information in eligibility response
  - Uniform use of CARCs and RARCs in electronic remittance advice

Proposed Data Content: ASC X12 837 Claim

- Require support of all data elements in UB-04
- Require compliance with CPT guidelines
- Require acceptance and processing of all reported diagnosis codes

Proposed Data Content: ASC X12 278

- Require 278 response to indicate if prior authorization is not needed
- Require 278 response to indicate approval or denial of prior authorization if no additional information is required for processing
- Require 278 response to request additional information when needed for prior authorization processing
- Standardize data content of transactions by reviewing Companion Guides and developing operating rules to create uniformity in areas of greatest variability

Additional Proposed Data Content Requirements for Existing Operating Rules

- Require procedure-specific eligibility response (X12 271) to procedure-specific eligibility inquiry (X12 270)
  - Enables providers to determine procedure-specific coverage restrictions (e.g., prior authorization requirements) using automated process vs. phone calls or payer portals
- Require standard reporting of health insurance exchange grace period information in mandated electronic transactions
  - X12 271 Eligibility Response
  - X12 277 Claim Status Response
  - X12 835 Claim Payment/Advice
- These suggested changes underscore the importance of frequent operating rule updates to respond quickly to emerging industry needs

Prioritize Prior Authorization Automation

- First and foremost: the current prior authorization process **delays patient care** and is also a major and ongoing pain point for providers

- Current manual prior authorization process represents significant administrative burden to the practice of medicine[1]
  - 1.1 physician hours/week
  - 13.1 nursing hours/week
  - 5.6 clerical hours/week

- Payer prior authorization processes are also largely manual

- *Any process that is such a significant drain on resources and impacts care quality deserves our full attention and prioritization for improvement*

1. Casalino LP et al. *Health Aff* (Millwood). 2009;28:w533-w543.

Current State of X12 278 Services Review Adoption

- The draft operating rule for the X12 278 correctly references the current manual nature of the authorization process and low industry adoption of the transaction
  - Consistent acknowledgment across stakeholders that the 278 transaction is not being widely used
- Today providers still make telephone calls and/or visit payer portals to identify when prior authorization is needed, to submit additional information, and to determine health plan's final decision on their request
- Draft operating rule infrastructure requirements are **not sufficient** to automate process or drive industry toward adoption—need to <u>address data content</u> and any other issues impeding transaction's adoption

Gap Analysis of X12 278 Services Review

- Need to require support of X12 278 responses other than AU (pended) or CT (contact payer)
- Major multi-stakeholder effort is needed to examine X12 278 and determine what other changes are needed or required in order for transaction to function well and be widely adopted
- Providers stand ready and willing to join this drill-down and problem-solving effort

Gap Analysis of Entire Authorization Process

- Mandated X12 278 transaction is just one piece of the authorization process
- Authorizations/referrals are a unique, multi-step, back-and-forth process, as illustrated by NCPDP ePA transactions
  - Provider inquires if authorization required
  - Payer indicates if authorization needed
  - Provider requests authorization
  - Payer requests additional information
  - Provider submits additional supporting documentation
  - Payer approves or denies authorization request
- All pieces must be in place for overall process automation
  - Need eligibility response to identify prior authorization requirement for specific service
  - Need attachment standard, as most authorizations/referrals require additional supporting clinical documentation for processing
- If these process gaps are not addressed—particularly the attachment piece—draft operating rules will not achieve promised automation or increase industry adoption

Summary

- Provider community appreciates efforts of CAQH CORE to improve efficiency and standardization through operating rule development
- Opportunities for operating rules to be increasingly leveraged to address current and future industry needs
- More frequent operating rule review and faster development will facilitate agile response to better meet provider needs
- Operating rules can be made more robust, meaningful, and impactful through inclusion of appropriate data content components
- Burdensome manual prior authorization processes merit close scrutiny to ensure complete automation and timely patient care

Questions?

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