# Transactions and Code Sets and the National Provider Identifier (NPI)

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*Strategies for workflow, productivity, quality and patient satisfaction improvement through health care information*

- Business process consultant focusing on electronic health records, and electronic transactions between organizations
- Former positions with MGMA, University of Denver, Dartmouth College
- Active leader in the Workgroup for Electronic Data Interchange (WEDI)
- Speaker and author (two books on HIPAA Security and one on electronic health records)
- Recipient of the HIMSS 2006 Book of the Year Award
- Recipient of Vision and Leadership as WEDI Chairman, WEDI Corporate Leadership Award, and WEDI Distinguished Service awards

- **Strategic IT business process planning**
- **ROI / benefits realization**
- **Project management and oversight**
- **Workflow redesign**
- **Education and training**
- **Vendor selection and enhanced use of vendor products**
- **Facilitate collaborations among organizations to share / exchange health care information**
- **EHR and RHIO training and facilitation**

# Today's Agenda

- Steve Lazarus
  - Boundary Information Group
- Karen Trudel
  - Office of e-Health Standards and Services
- James Whicker
  - WEDI Chair

# Administrative Simplification – Beyond Compliance: Finding the ROI

- Workflow
- Operating rules
- Standards Harmonization
- Plan ahead – Be strategic

# 1. Workflow

- HSAs
- Eligibility
- Better eligibility versus Real Time Transactions (RTA)

# Health Savings Accounts (HSAs) and High Deductible Health Plans (HDHPs)

HSAs were created in Medicare legislation signed into law by President Bush on December 8, 2003.

# WEDI's 6 Business Process Models for HSA HDHP

- HSA – Health Savings Account
- HDHP – High Deductible Health Plan
- The big challenges
  - The HDHP deductible is for medical **and** drug claims
  - The patient is responsible for a larger share of the amount due
  - The patient and provider maybe unclear about how HDHPs work and the patient's responsibility

# WEDI HSA/HDHP Business Models

- Models Developed by Task Group:
  - Model 1-Patient Assigns Health Plan benefits and is responsible for any remainder
  - Model 2-Patient Assigns Health Plan benefits and permits payment of HSA funds by Health Plan
  - Model 3-Patient Assigns Health Plan benefits and permits payment of HSA funds by Financial Institution

# WEDI HSA/HDHP Business Models

- Model 3a-Patient Assigns Health Plan benefits and permits payment of HSA funds by Financial Institution via hold on card
- Model 4-Patient does not assign Health Plan benefits and is responsible for total payment
- Model 5-Patient assigns Health Plan benefits and arranges for full payment by Health Plan

# Example: Model 2 Summary

- Patient permits Health Plan to make payments from HSA accounts
- Patient responsible to pay any remaining balance

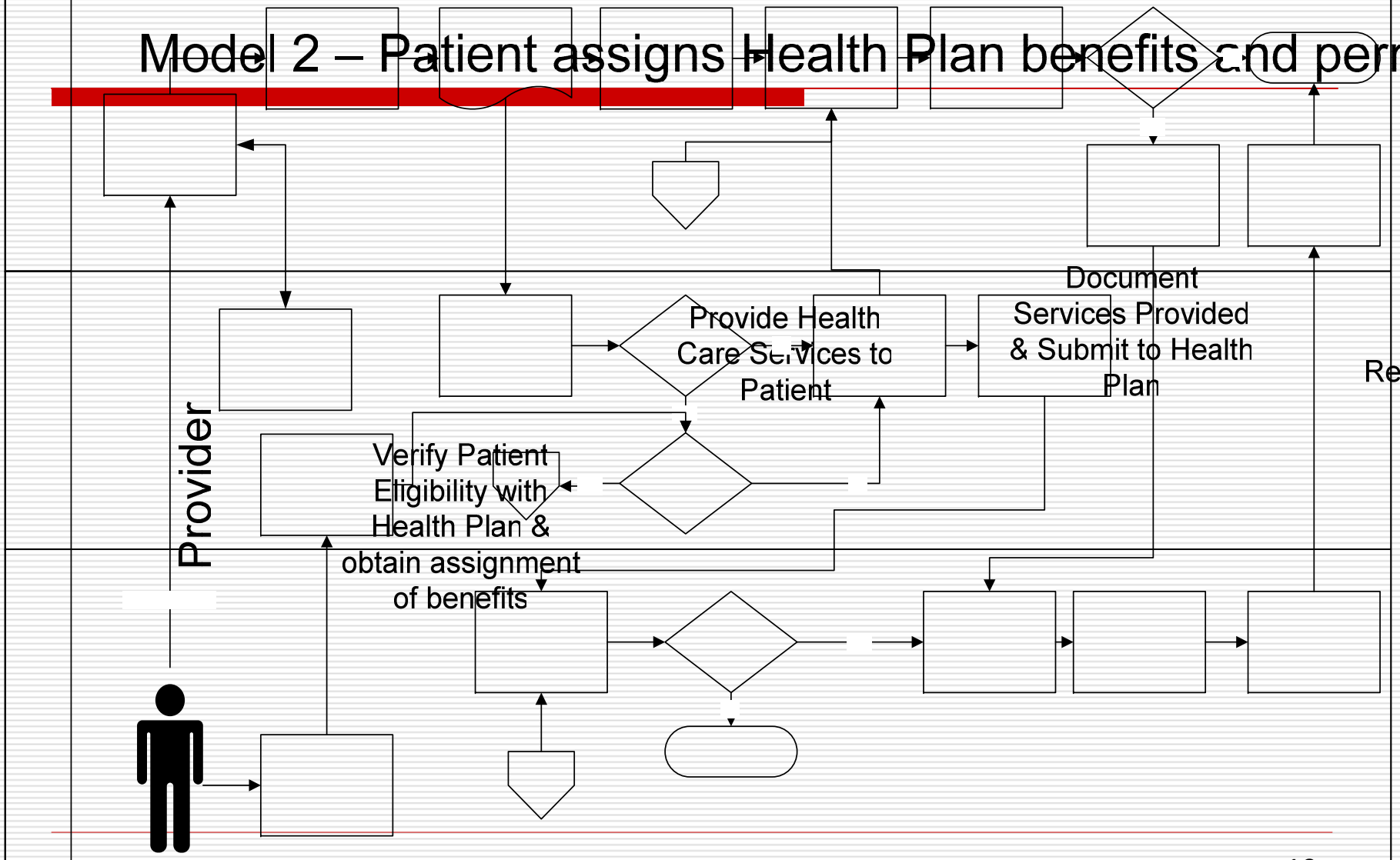
# Model 2-Provider Challenges

- Provider needs a way to be aware that the patient has a payment service with the health plan (not on ID card or X12 271).
- Provider is not guaranteed that there are sufficient funds for health plan to make full patient payment.
- Provider needs clear communication of payment details that distinguish plan payment from patient payment. (This has X12 835 and 1099 implications.)
- As patient responsibility amounts increase with new style health plans, potential for provider bad debt to increase.
- Patient may have been told by health plan not to pay provider until after the claim is adjudicated by Health Plan.

# Model 2-Provider Challenges

- Provider is not aware of the amount of the deductible or where the patient is in their deductible. (CORE Phase II Operating Rules will help.)
- Provider may not know how much they can charge for the service if they are under contract with the Health Plan until the claim has been adjudicated by the Health Plan.
- Provider under contract with the Health Plan may be prohibited from billing patient at time of service.
- Provider handling of payment adjustments when corrections are made to prior payments.
- There is no standard use of the 837 for the provider to indicate that they do not want to accept in a payment via the health plan and instead are collecting directly from the patient
- Need to understand the NCPDP implications for these challenges

# Model 2 – Patient assigns Health Plan benefits and perm



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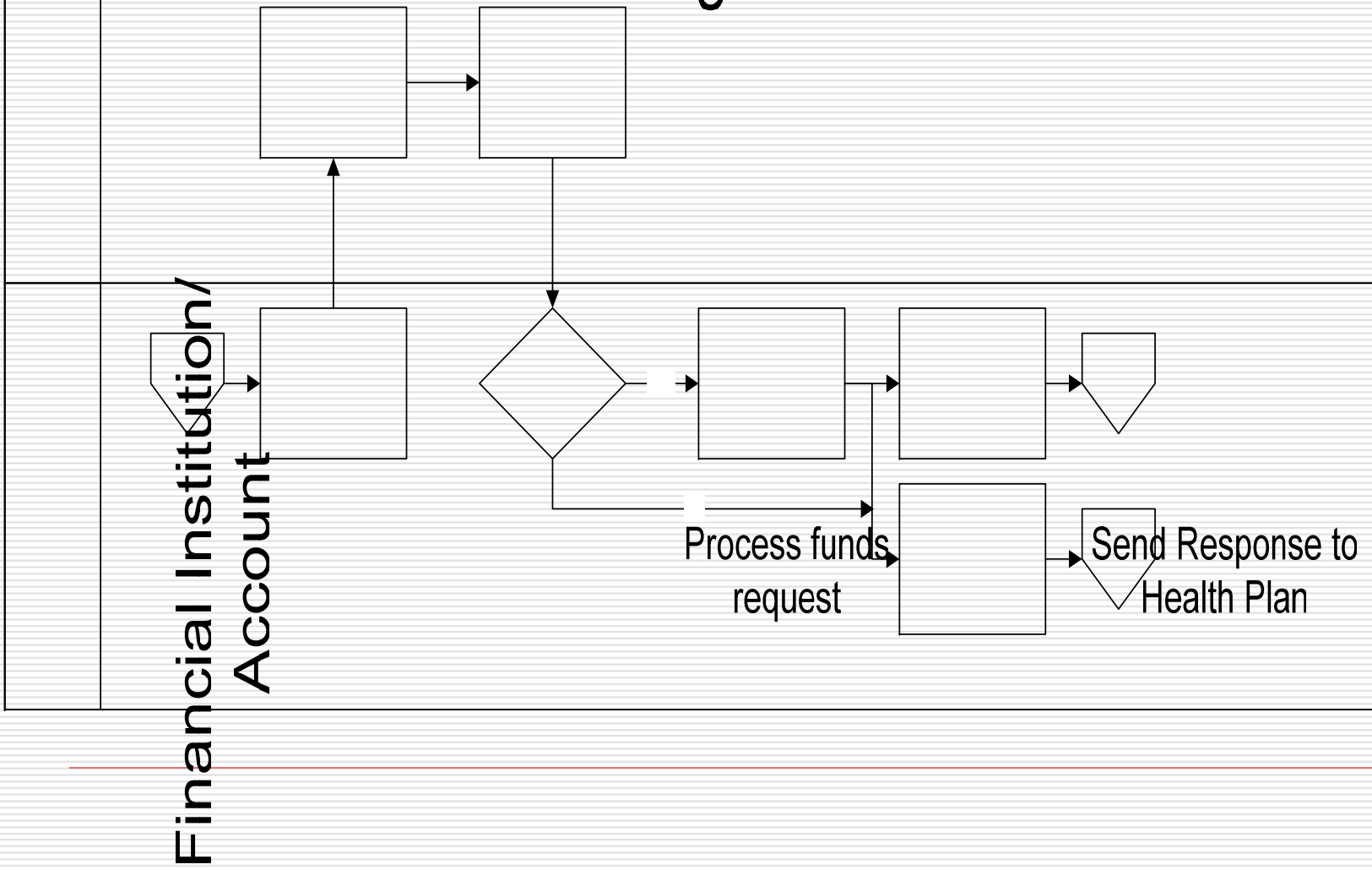


# Need to Place the Eligibility Information in the Workflow Real-time

- At appointment scheduling
- At check-in (registration) or preregistration
- At e-prescribing
- At checkout
- At insurance posting
- At patient collection
- Conclusion
  - Batch does not work
  - Critical to collections and e-prescribing

# HDHP Transactions and Code Set Impacts - Example

- 837 Claim – Need indicator that the provider does not want the health plan to seek payment from the "patient's" HSA
- 835 Remittance Advice – Need policy and indicators as to which payments are on behalf of the health plan and which are on behalf of the patient

# Better Eligibility vs. RTA

| **Better eligibility – real-time and more data** | **Real-time Adjudication (RTA)** |
|---|---|
| Supports all 6 business needs | Supports 1 of 6 business needs |
| Can prepare the patient for payment prior to service | No patient support prior to service |
| Can be used by all providers | Only supports providers who can prepare a claim at checkout |
| Supports all collection practices | Provider needs to have a dedicated checkout process for collection |

# Better Eligibility vs. RTA

| **Better eligibility – real-time and more data** | **Real-time Adjudication (RTA)** |
|---|---|
| Supports all claims | Only supports claims that can be auto-adjudicated |
| Can not tell the provider if they are in or out of network for a specific patient | Does account for whether the provider is in or out of network for a specific patient |
| Can be implemented in 2008 | Can not be implemented until there is a new RTA transaction set developed, approved and adopted |

# 2. Operating Rules

- Based on NACHA, the Electronic Payments Association (www.nacha.org)
  - Develop operating rules and business practices for the automated clearinghouse (ACH) network
- CAQH CORE
  - Phase I rules voted on in 2006
  - More than 100 participating organizations
  - Phase II rules nearing completion at the end of 2007; voting in early 2008

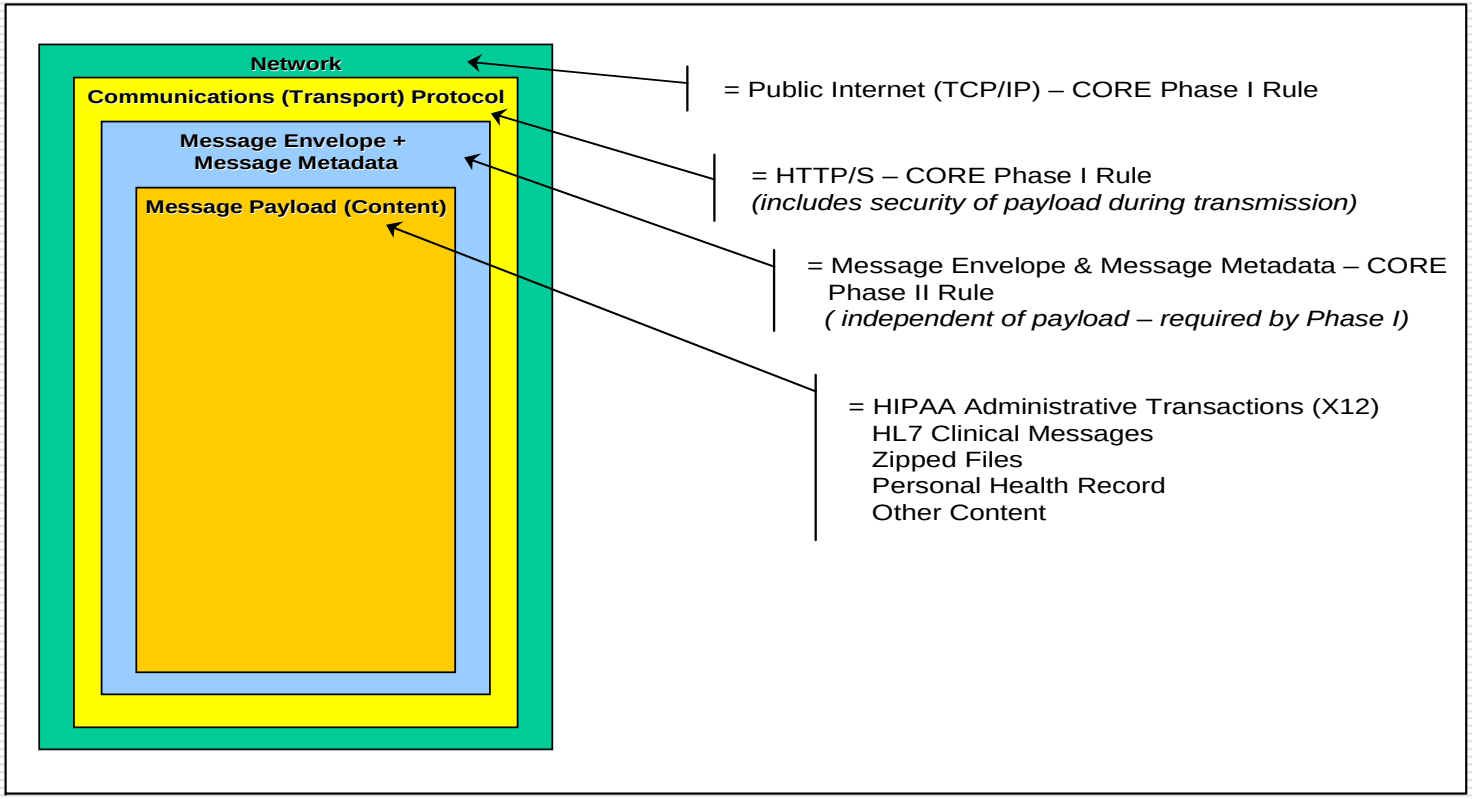
# CAQH CORE


Committee on Operating Rules for Information Exchange (CORE)

# CAQH CORE Phase II Draft Operating Rules

1. Patient identification
2. Data content
   - Require remaining deductible
   - Require more service codes
   - Address preventive services in a standard way
   - Definition of terms
3. Connectivity rule
   - Beyond HTTP/s
   - Envelop metadata
   - Designed to be used with any payload

# CORE Connectivity Rule



# 3. Standards Harmonization

- HITSP (Health Information Technology Standards Panel)
- Moving fast – new phase of work completed each year
- Has been primarily clinical, now beginning to include administrative (e.g., PHR) transactions
- Not enough experience to know if the implementation to the private sector and the non-federal public sector will work
- No HITSP education program on workflow, use, implementation, etc.

# 4. Plan Ahead and be Strategic

- Message management (internal and extreme)
  - Administrative transactions
  - E-prescribing
  - Clinical data exchange
  - E-Fax
  - Other
- Real Time
  - 24 x 7
  - CORE Response Time Rules
- Health Information Exchange
  - On a regional basis my become the external infrastructure

# References

- CAQH CORE Operating Rules
  - www.caqh.org
- HSA Business Process Models
  - www.wedi.org (available January, 2008)
- Healthcare Information Technology Standards Panel (HITSP)
  - http://www.ansi.org/standards_activities/standards_boards_panels/hisb/hitsp.aspx?menuid=3

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