Cooperative Exchange
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X12 Clearinghouse Caucus

June 5, 2018
Jacksonville Florida

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AGENDA

Welcome and Introduction - Joe Bell, Board Chair, Cooperative Exchange and Senior Program Manager, eSolutions Inc.

ASC X12N Update - Stacey Barber, ASC X12N Chair

Appropriate Use Criteria for Diagnostic Imaging - Nancy Spector, AMA, NUCC

Overview of NCVHS - Joe Bell and Sherry Wilson, Past Board Chair, Cooperative Exchange, Executive Vice President and Chief Compliance Officer, Jopari Solutions

Solicited Attachment ROI Critical Metrics for Stakeholder Adoption –

Joe Bell , eSolutions, CE Chair

Crystal Ewing, Waystar, CE Vice Chair

Sherry Wilson, Jopari Solutions, CE Past Chair

Tony Benson, Blue Cross Blue Shield of Alabama

Mary Lynn Bushman, Medicare Part A & Part B, (NGS) Anthem, Inc

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ASC X12 Update

Stacy Barber, Chair, ASC X12N

Appropriate Use Criteria for Advanced Diagnostic Imaging

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June 5, 2018

Overview of AUC Program

- Established in Protecting Access to Medicare Act of 2014 (PAMA)
- Requires clinicians to consult AUC for advanced diagnostic imaging services prior to ordering them
- AUC use evidence-based guidelines to identify if an imaging service is medically beneficial for the patient's condition
- Requires specific AUC data be reported on the claim for reimbursement
- Goal is to reduce overutilization of medically unnecessary imaging services

Regulations for AUC

- AUC requirements are being set through the Physician Fee Schedule rule
  - Included in 2016, 2017, and 2018 rules
  - Established/establishing the various components of the program
- Current implementation date is January 1, 2020
  - Date in the legislation was January 1, 2017
  - CMS is saying they can no longer delay the date

Priority Clinical Areas

- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic and non-traumatic)
- Hip pain
- Low back pain
- Shoulder pain (to include suspected rotator cuff injury)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain

Represents 40% of advanced diagnostic imaging services paid for by Medicare in 2014

Future Use for Other Services

The Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria **could be used for other services under part B, such as radiation therapy and clinical diagnostic laboratory services**.

AUC Program

The four major components of the AUC program are:

1. Establishment of AUC
2. Identification of mechanisms for consultation with AUC
3. AUC consultation by the ordering clinician and reporting by the furnishing provider
4. Annual identification of outlier ordering clinicians

1. Establishment of AUC

- AUC is developed by provider-led entities (PLEs)
- PLEs are national professional medical specialty societies or other organizations that are comprised primarily of providers
- To be qualified by CMS, a PLE must adhere to the evidence-based processes described in the law when developing or modifying AUC
- Qualified PLEs are posted to the CMS website
- All qualified PLEs must re-apply every 5 years

Currently Qualified PLEs

- American College of Cardiology Foundation
- American College of Radiology
- Banner University Medical Group-Tucson University of Arizona
- CDI Quality Institute
- Cedars-Sinai Health System
- Intermountain Healthcare
- Massachusetts General Hospital, Department of Radiology
- Medical Guidelines Institute
- Memorial Sloan Kettering Cancer Center
- National Comprehensive Cancer Network
- Sage Evidence-based Medicine & Practice Institute
- Society for Nuclear Medicine and Molecular Imaging
- University of California Medical Campuses
- University of Utah Health
- University of Washington School of Medicine
- Virginia Mason Medical Center
- Weill Cornell Medicine Physicians Organization

AUC Program

The four major components of the AUC program are:

1. √ Establishment of AUC
2. Identification of mechanisms for consultation with AUC
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2. Identification of Mechanisms for Consultation with AUC

- Clinical Decision Support Mechanism (CDSM) tools have been established as the mechanism to consult AUC
  - AUC are embedded in the tool
  - Ordering clinician inputs patient information and receives response as to whether to planned service adheres, does not adhere, or is not applicable to the AUC
  - CDSMs may be integrated into the EHR or a stand-alone tool
- To be qualified by CMS, a CDSM must meet the requirements established in the law
- Qualified CDSMs are posted on the CMS website

Currently Qualified CDSMs

Qualified as of March 2018

- AIM Specialty Health ProviderPortal®*
- Applied Pathways CURION™ Platform
- Cranberry Peak ezCDS
- eviCore healthcare's Clinical Decision Support Mechanism
- MedCurrent OrderWise™
- Medicalis Clinical Decision Support Mechanism
- National Decision Support Company CareSelect™*
- National Imaging Associates RadMD
- Sage Health Management Solutions Inc. RadWise®
- Stanson Health's Stanson CDS
- Test Appropriate CDSM*

Preliminary Qualification as of March 2018

- Cerner CDS mechanism
- Evinance Decision Support
- Flying Aces Speed of Care Decision Support
- LogicNets' Decision Engines
- Reliant Medical Group CDSM

* Free tool

AUC Program

The four major components of the AUC program are:

1. √ Establishment of AUC
2. √ Identification of mechanisms for consultation with AUC
3. AUC consultation by the ordering clinician and reporting by the furnishing provider (we are here)
4. Annual identification of outlier ordering clinicians

3. Consulting AUC and Reporting Data

The data to be reported on the claim are:

1. CDSM consulted by the ordering clinician;
2. Whether the service:
   - adhered to the applicable AUC,
   - did not adhere to the applicable AUC,
   - or whether no criteria in the CDSM were applicable to the patient's clinical scenario
3. Name and NPI of the ordering clinician

Exceptions to consulting AUC are 1) emergencies, 2) inpatient imaging services, and 3) ordering clinician meets hardship exception in Medicare EHR Incentive Program

2018 PFS NPRM Reporting Proposal

- HCPCS G-code identifying the CDSM
  - One G-code for each CDSM
  - Reported as a separate service line in professional and institutional claims
- HCPCS modifier identifying response of CDSM
  - Adhered, Not adhered, N/A
- Public comments did not support this proposal

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
08	01	17	08	01	17	21		73721		A	1000	00 1		NPI	9876543210
08	01	17	08	01	17	21		GXXXX	XX	A	0	01		NPI	9876543210

2017 PFS Final Rule - Unique Consultation Identifier

"Many commenters suggested CMS require the unique consultation identifier be appended to the Medicare claim instead of using G-code and modifier combinations. They suggested CMS, along with stakeholders, standardize the identifier to have embedded meaning that is consistent across CDSMs. They further supported the reporting of this identifier on claims so CMS can match the claim with the richer, more robust consultation data that is collected within the CDSM. It is with this more complete information that they suggested that outlier ordering professionals be identified rather than rely solely on information reported on the claim. **Commenters generally supported use of the unique identifier** as the least administratively burdensome approach to collecting AUC consultation information on Medicare claims."

2017 PFS Final Rule - Unique Consultation Identifier

"**In response to these comments we will not move forward with the G-code and modifier combinations** for reporting which CDSM is consulted, adherence, non-adherence or situations where AUC are not applicable. **We will further explore and pursue use of the unique consultation identifier** for reporting on Medicare claims. However, in order to use such an identifier we must work with stakeholders to develop a standard taxonomy. We expect to conduct stakeholder outreach during 2018 so that such standardization can be accomplished and will discuss such changes in future rulemaking ahead of the 2020 consulting and reporting effective date."

Unique Consultation Identifier

- Will need to include:
  - Which CDSM was consulted
  - The results of that consultation:
    - Adhere
    - Not Adhere
    - Not applicable
- Will need to be transmitted from the ordering clinician to the furnishing provider and be reported in the claim for the service provided

4. Outlier Ordering Clinicians

- Clinicians determined to be outliers will be required to complete prior authorizations for imaging services
- Timeline for evaluating clinicians has been postponed due to the delay in the reporting requirements
- More information is expected in future Physician Fee Schedule rules

Current Status

- A change request has been submitted to X12 to accommodate the data in the claim
- Expect more information in the 2019 Physician Fee Schedule proposed rule
  - Due out in late June – early July
- Voluntary reporting begins July 1, 2018 using HCPCS modifier QQ (Ordering Professional Consulted A Qualified Clinical Decision Support Mechanism For This Service And The Related Data Was Provided To The Furnishing Professional)
  - The modifier may be:
    - Used when the furnishing professional is aware of the result of the ordering professional's consultation with a CDSM for that patient,
    - Reported on the same claim line as the CPT code for the service, and
    - Reported on both the facility and professional claims

Concerns

- Workflow
  - Ordering clinician consulting CDSM
  - Ordering clinician reporting data to furnishing provider
  - furnishing provider reporting data on facility and professional claims
- Data reporting
  - What is the “unique consultation identifier?”
  - Where is the data reported in the claim?
  - Is the “unique consultation identifier” reported at the claim or service line level?
    - What happens if it is at the claim level and there are multiple services on the same claim?
  - What is reported when an exception applies?

Discussion

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NCVHS CIO Forum Recap

Presented by

Joe Bell, Chair Cooperative Exchange

Background

This CIO Forum will continue the Committee's work to obtain stakeholder input into the current challenges regarding the update, adoption and implementation of health care administrative standards and operating rules. The Committee's overarching objective is to help foster a "Predictability Roadmap" which seeks to improve the visibility into and increase the pace of change of the standards process. As a continuation of this effort, NCVHS is convening a group of Chief Information Officers (CIOs) who work with the standards and operating rules as end users and with leaders from the health care technology field. Agenda topics will include identification of changing business and technology needs specifically as they pertain to the standards adopted under HIPAA and ACA such as claims, eligibility, referrals and authorizations, and operating rules. Topics related to the predictability roadmap challenges will include the standards development and update process; governance and oversight of the standards review process; the Federal regulatory process to adopt new versions of standards; data harmonization; and inclusion of non-covered entities under HIPAA. Stakeholder input generated at this meeting will be considered to further inform the Committee's predictability roadmap leading toward a letter outlining recommendations to the HHS Secretary.

Participants

The forum participants came from a wide range of stakeholders including Providers, Payers and Vendors. This led to a very collaborative discussion on the current state and processes, what is working well, and suggestions of what and how things can be improved.

Topics

- Governance
- Standards Adoption Process
- Federal Regulatory Process
- Data Harmonization
- Third Parties as Covered Entities

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Common Themes

- Difficulty when relying on Volunteer Organizations
- Standards need to be more “Agile”
- Need to have proof of ROI to push adoption
- Pilot programs need to be put in place before regulation
- Need coordination between Standard Bodies
- Possibility of staggering transactions by relationships?
  - 837, 835, 276, 277
  - 277RFI, 278, 275
  - 270, 271
- Need to lower the cost of adoption

Complete Slides and Information

https://ncvhs.hhs.gov/meetings/standard-subcommittee-cio-forum/

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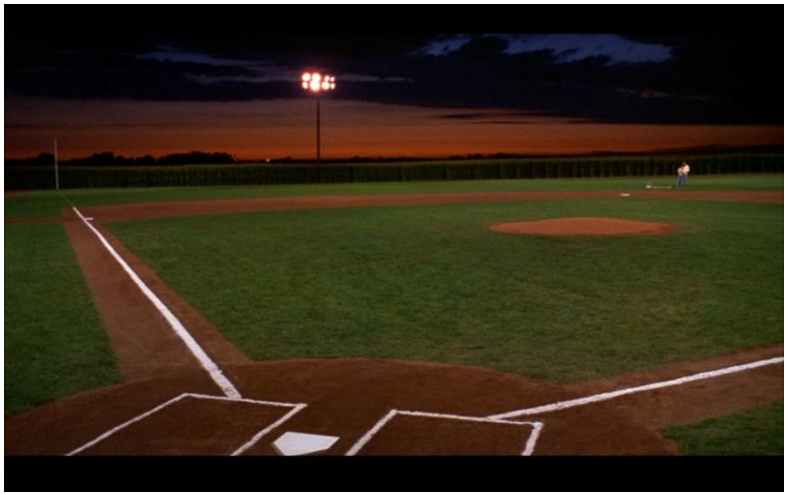
Solicited Attachment ROI Critical Metrics for Stakeholder Adoption

HOW TO BUILD A FIELD OF DREAMS

If you build it, they will come.

If you build it, will they come?

If you build it, why will they come?



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We Are All Product Managers!

- We are launching a New Product
- We need to communicate how we will solve the problems
- We need to Identify the Customer Base
- We need to provide the User Stories
- We need to coordinate input from the Key Stakeholders
- We need to identify the Return of Investment opportunities
- We need to Market the Product

Warning!

More than 30,000 new consumer products are launched annually, 80% of them fail.

* According to Harvard Business School professor Clayton Christensen

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Why do they Fail?

Reason #1: Failure to Understand Consumer Needs and Wants

Reason #2: Fixing a Non-Existent Problem

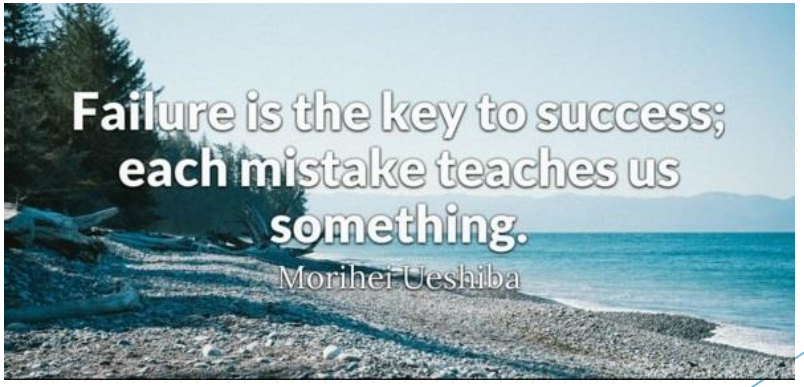
Reason #3: Targeting the Wrong Market

Reason #4: Incorrect Pricing

Reason #5: Weak Team and Internal Capabilities

Reason #6: Prolonged Development or Delayed Market Entry

Reason #7: Poor Execution



Tips to Drive End User Attachment Adoption

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#Understand Consumer Needs and Wants

Provider

Automated Workflow

- Eliminate lost manual (paper) requests and responses for attachments business needs by automating the process
- Reduce the cost associated with supporting the staff, paper and postage
- Significantly reduce administrative burden
- Leverage existing IT investment, connectivity and resource to automated one end to end workflow across all lines of business

Reduce pends, denials, appeals and faster payment

- Increase transparency of payer content needs
- Decrease AR Days

Post Adjudication Business Processes Automation

- Appeals/Denials, Case Management, Transition in care/Gaps in Care, etc.

Payer

- Reduce pends, denials and appeals/costs
- Reduce mailroom costs
- Reduce cost for processing, scanning and physical storage of documents
- Reduce resource and increase efficiency
- Reduce phone calls
- **Satisfied providers**

How to Target the **Right** Market

TAM = How many letters are being sent?

SAM = Who Can Support Electronic Attachments Solutions?

Targeted Market (Data Analytics) = Who will be the most likely to implement?

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Stakeholder Questions to Consider

- Identify and communicate what business processes will be supported for attachments
  - (Claims Adjudications, Prior Authorization, Post Adjudication (Appeals/Audits), Other business processes:, Transition to Care/ Gaps in Care, Utilization and Case Management, HEDIS/STARS, Other, etc.).
- Identify and communicate if the business process will support unsolicited, solicited or both for the business processes?
- Identify and communicate what type of response format will be supported (277 RAFI, Other) and communicate technical specifications needed to connect?
- Claims Adjudication –Defined Business Process Flows
  - For claims adjudication how long does it take to receive the acknowledgment once a claim is received to avoid a denial?
  - Turnaround times:
    - What is the expiration date of the claim attachment request (how long should be keep the request open?)
    - What is the turnaround time to process a claim attachment request once received –are you using acknowledgment to communicate this? If so, what is the timeline?
    - How much faster does an electronic attachment submission process verses the fax, paper or portal methods if supported?
- Business Flow Opportunities -TBD
  - Post Adjudication (Appeals/Audits)
  - Gaps in Care/Transition in Care
  - Quality Reporting

Service Available Market - Technology Solutions

- Leveraging existing IT investment , connectivity and resources
- End to end automated attachment workflow process
- Identify stakeholder EDI Readiness
- Technology Solutions – Low to High Tech
- Provider Solutions to Receive a Request - Clearinghouse Normalization
  - 277RFAI - EDI Standard
  - 277CA - Batch and Portal Applications
  - Provider Portal Presentment
  - Product Solution – System Integration Tools
- Provider Solutions to Send a Response - Clearinghouse Normalization
  - 275 - EDI Standard
  - Unstructured/ Structured – Clearinghouse Normalization generate 275

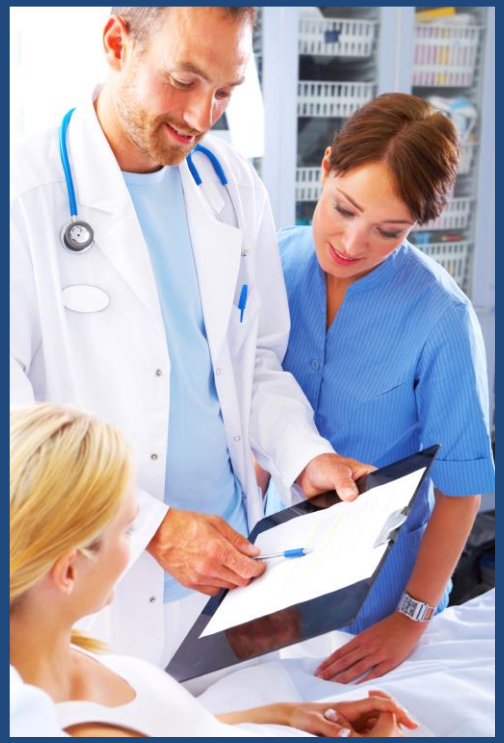
Attachment Implementation

Tony Benson
Senior Provider eSolutions Consultant

Who we are…

- We are the largest provider of healthcare benefits in Alabama.
- We are proud to provide coverage to over 3 million people.
- We pay billions of dollars in benefits each year.
- We employ over 3,600 people.
- Our corporate headquarters is located in Birmingham, Alabama.

Why Implement Attachments Now?



- 226,637 paper attachment (solicited) requests made in 2016
  - 93 different request types (ex. Ambulance Report, Lab Reports, etc.)
- Great interest among providers and vendors
- Strong interest internally

Why Implement Attachments Now?

- Large local practice management vendor has agreed to participate along with national clearinghouses.
- The University of Alabama at Birmingham Health System will also participate.
  - Together they represent hundreds of physicians and multiple hospitals
- Attachment implementation will support post-adjudication medical review, prior authorization, professional reimbursement (pricing requests) and Network Integrity (fraud & abuse)

Technical Details

Using the X12 Version 6020

Technical Details

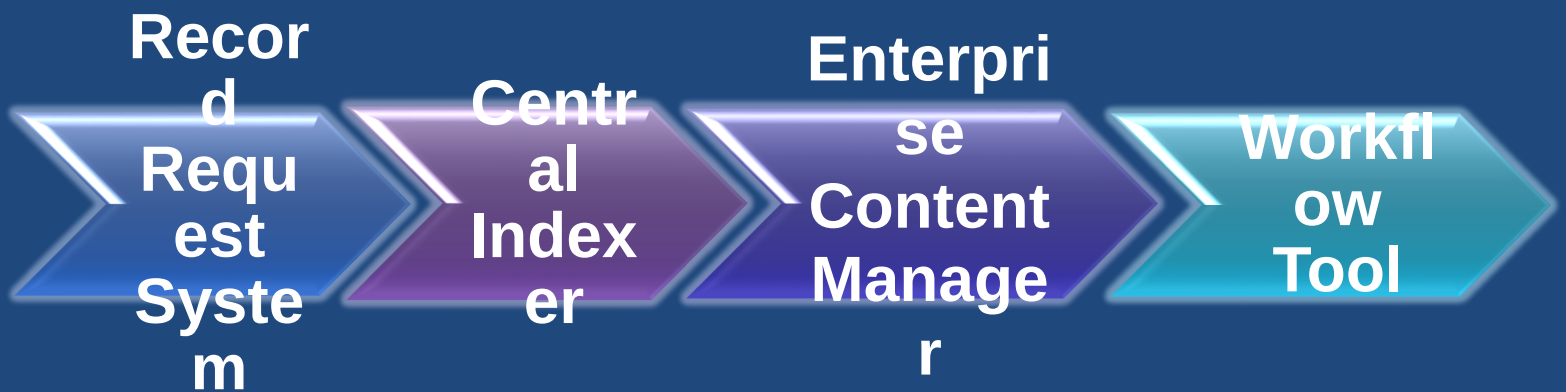
- Using version 6020 because it is the most recent published version and more easily upgradeable to 7030 if adopted
  - Also provides additional data elements within the 275

- Quick development to build internally. Pilot vendors have also stated the same
  - No additional monetary investment
  - Very little resource lift

Technical Details

- Using SFTP as the transport method
- Only accepting unstructured documents (.PDF, .TIFF, etc.)
  - Agree with NCVHS recommendation of a incremental, flexible implementation approach

Tools We Use



- Implementing solicited and unsolicited attachments
- Specific list of CPT and ICD codes being provided to vendor for unsolicited requests that always needs attachments

Benefits of Implementation

Provider Benefits

- Faster payments
- Less manual chart pulls
- Reduced denied claims
- Streamlined requests and tracking with acknowledgements
- Reduced routing problems within a health system
- No lost mail or faxes

Benefits of Implementation

Payer Benefits

- Better metadata than paper/fax to help index
- Mailroom intake decrease
- Faster claim processing
- Decreased chance for errors
- Will no longer need to pay for records by page
- Elimination of multiple requests
- No ROI yet but significant savings are expected

Questions?

National Government Services Successes and Challenges with Implementing Electronic Attachments

Presented by: Mary Lynn Bushman

NGS Electronic Attachment Workflow

- Processing the X12 275 with the embedded HL7 standard since February 2014
- Enrolled 26 providers for the X12 275 transaction
- Implemented the X12 275 version 6020 with the embedded HL7 CDA R2 or C-CDA R2.1
- Support the Operative Notes and Unstructured document C-CDA R2.1 templates
- Support unstructured file types: PDF, TXT
- Format X12 275/HL7 into an XML file

NGS Electronic Attachment Workflow

- Unstructured XML text/document is captured as a separate text or an appropriate file type, structured data is converted to a HTML file
- Both the XML and corresponding PDF, TXT or HTML files are ingested into the imaging system to start the work flow process
- Authentication and Authorization same as all EDI transactions
- Generate the 999 Acknowledgement
- Implemented the X12 277 Health Care Claim Request for Additional Information version 6020
- Support EDI enrollment and set up for the Attachment process
- NGS Companion Guides are available

NGS Electronic Attachment Successes

- Processing the X12 275 version 6020 transaction
- Processing the embedded HL7 standard, both unstructured and structured data
- Processing both unsolicited and solicited electronic attachments
- Successfully receiving and processing electronic attachments for 4½ years
- Receiving and processing X12 275 files daily
- Enrolled 26 providers to send the X12 275 transaction

NGS Electronic Attachment Successes

- Attachments reduce payer costs and reduce provider administrative
- to leverage their existing connections with the
- partners simply use the existing electronic attachments
- Electronic Attachments improve provider payment cycles

NGS Electronic Attachment Challenges

Challenge:

Lack of HL7 experience; lack of experience with the HL7 Attachment guides from a development perspective

Resolution:

Challenge

Defining unsolicited attachment criteria

Resolution

NGS Electronic Attachment Challenges

Challenge:

Mapping the required 277 transaction with limited data content. Some data was not available on the letters

Resolution:

Challenge

Mapping internal messages/codes to LOINC codes

Mapping Clinical and Non-Clinical messages

Resolution

NGS Electronic Attachment Challenges

Challenge:

Mapping internal messages/codes to LOINC codes

Some internal codes included examples of documentation that could be provided. Also there were situations where there were more than one LOINC code that could be used

Resolution:

Challenge

Mapping internal messages/codes to LOINC codes

LOINC codes available but not included on the RELMA Tool on the HIPAA Attachment Tab

Resolution

Questions

Advisory Councils

- Provider Advisory Council
- Payer Advisory Council
- Government Advisory Council
- Industry Advisory Council
- Vendor Advisory Council

If interested you will be able to apply on the Cooperative Exchange Website starting in July.

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Communicate

Website: http://www.cooperativeexchange.org

LinkedIn: https://www.linkedin.com/groups/4139428

Newsletter: http://multibriefs.com/optin.php?CE

Email: Lisa Beard – Executive Director
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Thank You

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