Statement

of the

Medical Group Management Association

to the

National Committee on Vital and Health Statistics
Subcommittee on Standards

Presented by
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RE: Electronic Funds Transfer and Electronic Remittance Advice

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The Medical Group Management Association (MGMA) is pleased to submit our testimony to the National Committee on Vital and Health Statistics Subcommittee on Standards. My name is Larrie Dawkins and I am the chief compliance officer at Wake Forest University Health Sciences, Wake Forest University, located in Winston-Salem, North Carolina.

MGMA is the premier membership association for professional administrators and leaders of medical group practices. Since 1926, MGMA has delivered networking, professional education and resources, and political advocacy for medical practice management. Today, MGMA's 21,500 members lead 13,700 organizations nationwide in which some 275,000 physicians provide more than 40 percent of the healthcare services delivered in the United States.

In our testimony today, we will focus our attention on what MGMA has learned from its members regarding electronic funds transfer (EFT) and electronic remittance advice (ERA), key issues facing medical groups with these transactions and offer a series of recommendations assist the industry as it moves to standardize these important transactions.

Background and Process

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in an effort to standardize the electronic exchange of information between providers and payers. The ASC X12N 835 Health Care Payment/Advice (Remittance Advice) transaction was adopted by HIPAA to be the standard communication instrument for reporting payments, adjustments, and patient responsibility. Originally, it was hoped that providers would be able to program their practice management systems one time to process payments from all payers from whom they receive electronic files.

Effective implementation of the ASC X12 835 transaction, however, have been hindered by payer variations in the association of Claims Adjustment Reason Codes (CARCs) and Claim Adjustment Group Codes. Non-uniform or incorrect coding typically leads to unnecessary manual follow-up, faulty electronic secondary billing, inappropriate write-offs of billable charges, and incorrect billing of patients for co-pays and deductibles, all of which cost providers time and money. As a consequence, providers are often reluctant to implement the 835 transaction, reducing the return on investment for both providers and payers. This is clearly an example of the promise of HIPAA not being fulfilled.

Current RA and EFT Environment

Once a payer has processed a claim, either an ERA or a standard paper remittance (SPR) is sent to the practice with the final claim adjudication and payment information. (An ERA or SPR could include adjudication decisions
Itemized information is reported within the ERA or SPR for each claim and/or line to enable the practice to associate the adjudication decisions with those claims/lines as submitted. The ERA or SPR then reports the reason for each adjustment, and the value of each adjustment. Adjustments can happen at line, claim or provider level. In the case of an ERA, the adjustment reasons are reported through standard codes. For any line or claim level adjustment, three sets of codes could be utilized, (i) Group Code; (ii) Claim Adjustment Reason Code (CARC) and (iii) Remittance Advice Remark Code (RARC).

Group Codes are employed to assign financial responsibility (i.e., CO refers to “contractual obligation” and PR would mean “patient responsibility.” CARCs provide an overall explanation for the financial adjustment, and may be supplemented by more specific explanation using RARCs.

With EFT, payers can send payments directly to a provider’s financial institution whether claims are filed electronically or on paper. The advantage of EFT is similar to other direct deposit operations such as paycheck deposits, and it offers a safe modern alternative to paper checks. However, for many providers the specific enrollment process is cumbersome and time consuming and often requires the provider to initiate a relationship with a bank selected by the payer. Because of this stipulation and other issues, some providers refuse to participate with EFT programs.

Payers currently use one of two permitted formats for conducting the EFT transaction. Cash Concentration or Disbursement Plus (CCD+) can be used to consolidate and sweep cash funds within an entity's controlled accounts, or make/collect payments to/from other corporate entities. CCD+ can support one addendum record. Corporate Trade Exchange (CTX) supports the transfer of funds (debit or credit) with another entity in which you have an existing trading relationship. This format supports ANSI ASC X12 payment related information, which can be placed in multiple (up to 9,999) addendum records. Both the CCD+ and CTX formats are considered national standards.

The CCD+ format contains one addendum record, which should be used by payers to send a tracking number. This tracking number can also be transmitted in the associated X12 835, which is sent separately. When the tracking number is sent with the 835, providers are able to “re-associate” funds that are sent separately from the remittance information in the X12 835. Some payers replace this tracking number with their own proprietary number, or modify the tracking number by including an asterisk or other nonconforming delimiter which defeats the matching purpose of the tracking number.
The CTX format permits the entire remittance data to move through the financial system with the payment. Providers receiving CTX payments can query their bank to confirm that the funds deposited in the transaction match the total payment referenced in the associated remittance information. When the institution transmits the remittance file, the provider then has the information to post it in their practice management system. While this eliminates the need for manual matching, financial institutions typically charge additional fees for these services. Due to the complex nature of remittance advice reconciliation and posting, this typically requires careful review by provider staff. As a result, most providers prefer to use the CCD+ format.

Advantages of Well Constructed ETF and ERA Transactions

There are numerous advantages to fully standardizing and automating the claims payment process and implementing well constructed EFT and ERA transactions, including:

- Electronic Funds Transfer (EFT) payments are more convenient, reduce paper handling, streamline lockbox services, and reduce the risk of lost payments. Even more significant are the advantages of getting an ERA with each EFT. Delivered in a format requested by the practice, the ERA can be directly imported into a practice management or health information system, eliminating the need to re-key remittance details from check stubs, a process that is time consuming and often introduces errors.

- When a practice receives payment via EFT, payment and remit typically are faster than a paper check and corresponding paper RA. Considerable time is saved not sorting mail, opening envelopes, posting the checks, depositing the checks, and ultimately reconciling the paper checks with the paper remittance.

- For many providers, EFT and ERA transactions assure that the payments are being posted correctly yet the practice is notified if the health plan sends them reimbursement or messages out of the ordinary. The provider can post a large voucher in a few minutes rather than a few hours. For some practices, payment posting time has gone from 6 – 7 hours per day to 3 – 4 or even less. Posting via ERA ensures that the explanation of benefits (EOB) message is attached to the charges rather than relying on a posting person to add them individually.

- Utilizing ERA, the amount payable for each line and/or claim, as well as each adjustment applied to a line or claim can be automatically posted from the ERA, eliminating the time and cost for staff to post this information manually.
• Many provider practice management systems are not only configured to receive and post ERAs but also produce comprehensive and efficient management reports. These uniform reports are easy to read and interpret and can be saved electronically, eliminating the need for printing.

• EFT and ERA transactions can also facilitate the autoposting within practice management systems. These transactions can also allow other third-party software to analyze the transactions in ways and in details practice management systems cannot.

• Providers engaged in EFT typically experience reduced banking costs, as banking institutions often charge more for paper check deposits than they do for EFT deposits. EFT also eliminates the risk of lost or stolen paper checks.

• ERA cuts down on the labor of keying information and allows practice staff to focus only on the task of identifying incorrect payments on that ERA. Some practices have been able to decrease administrative FTEs as a result of automating their claims revenue cycle.

• EFT can also permit practices to post allowable charges from primary payers in practice management systems and consequently use these allowables for submitting electronic secondary claims to payers.

**Challenges of EFT/ERA Transactions**

• One challenge with ERA is that some payers conduct direct deposit by processing site, so practices could receive multiple EFT deposits and remits from the same payer on the same day, thus significantly increasing the time required by practice staff to process. Many providers would prefer to receive only one or two bundled ERAs a week.

• Practices experience significant difficulties on the last day of the practice’s fiscal year when they are trying to make income distributions. The lack of control and knowledge regarding the timing of the EFT deposits significantly complicates this function.

• Some practices report that the denial codes on their paper remittances do not match the HIPAA transaction codes on the electronic remits. This causes additional work on the part of practice staff. HIPAA transactions codes are what post to the accounts and because many of the payer systems sending paper remittances are not aligned with the electronic HIPAA codes. When practices look at their account the denial on the account may not provide them the true denial reason, therefore practices must refer to the paper remit for the actual denial reason. As a consequence, these practices cannot turn
off paper remits.

- Since there is no universal remittance code set for denial reasons, payers will use denial reasons specific to their transactions, which makes it difficult to analyze and appeal a practice’s entire payer mix with a single piece of software.

- Practices are concerned that secondary and tertiary payments do not work well with some practice management systems because the transactions include adjustments that have already been made by the primary payer. The autoposting function then calculates this adjustment and results in an "overpayment" because the adjustment was counted already with the primary payment.

- There is also a problem with electronic reconciliation of "zero-pays." These are difficult because information regarding the denial is not always clear and/or present at the claim level and invoice level, which is required by practice management systems to even post to a patient's account.

- Practices report that some payers do not send both the EFT and ERA's using the standard formats thus making it difficult for practices to reconcile. While HIPAA transactions were intended to be consistent across all payers, there are still some payers that want to conduct the transactions using a proprietary format, thus not producing a cost-effective environment for the providers.

- Practices convey that a frustrating and annoying part of using EFT and/or ERA occurs when a refund is due to the payer. The payer will often take the refund right out of the ERA, thus the balance does not match the accounts. Practices are forced to find ways to post to accounts without having the actual funds there. Refunds need to be made a separate situation and not posted on ERA's or EFT's.

- There is often disjunction between payments and remittance – a significant challenge for those providers looking to automate the claims revenue cycle is the difficulty in associating the payments with the correct remittance. This is exacerbated when the payer utilizes tracking numbers on the remittance that do not correspond with the payment.

- Practices are also concerned about the issue of debiting of accounts. Some providers have avoided enrolling in EFT programs because they fear that the payer will debit their account for a duplicate payment or overpayment. Some providers participating in EFT and "sweep' or zero balance accounts that are cleared of any balances face overdraft fees when payers debit these accounts.
MGMA Recommendations

MGMA offers the following recommendations to improve the effectiveness and further encourage the adoption of the EFT and ERA transactions:

- **Standardized claim edits and payment rules** - Payers should be required to provide critical information in a consistent manner on the ASC X12 835, such as “allowed amount.” Should this be included in a standard set of operating rules, reconciliation costs for providers would be significantly reduced.

- **Tracking numbers** - Payers should be required to include the tracking number on the EFT, and that identical tracking number should also be required on the 835. This would facilitate the matching of the critical EFT and ERA information. Efficiently matching this information will permit providers to perform claim payment review and reconciliation and to post appropriately paid claims or determine appropriate claim follow up.

- **Enrollment** – Providers seeking to enroll in a payer’s EFT program often face vastly different enrollment formats and requirements. We recommend that as part of the operating rules, standard enrollment format and content be developed.

- **CCD+ versus CTX** - The CCD+ EFT format is currently utilized by the large majority of providers. The CTX EFT format is less applicable for the healthcare industry, requiring the transactions to be routed through a financial institution, adding cost and complexity to the payment and remit process. In addition, we expect that providers entering into contracts with the financial institutions utilizing the CTX format will be required to enter into business associate agreements, adding further cost and complication to the process.

  We recognize, however, that in some instances these financial institutions offer a value add to the provider in the form of payment reconciliation, tracking, reporting, and other services. Thus, we recommend that both national standards be permitted for use in the EFT transaction, with the caveat that the payer be required to offer the provider the choice of either transaction, with no penalty for providers selecting one format over the other.

- **Timing of the EFT/ERA** – Providers face significant challenges with reconciliation should the EFT and ERA be sent separately with long delays between the two. At the same time, providers do not want their payments inordinately delayed while the payer develops and transmits the ERA. It is important to remember that the ERA cannot be posted by the


provider until the EFT has been transmitted and the funds deposited in the provider's bank account. Posting of the ERA within reasonable conjunction with the processing of the EFT will allow providers to complete the revenue cycle, including billing the patient when necessary for any remaining balance, within an acceptable time frame. We recommend that operating rules be developed to outline the most appropriate timing of EFT and ERA.

- **Bundling of EFTs and ERAs** – Since providers report significant inefficiencies when receiving multiple EFTs and ERA in a single day, we recommend that the payer be required to offer the provider the option of bundling EFTs and ERAs on a daily, weekly, or monthly basis.

- **Tax Identification Numbers** – To facilitate improved internal processing of EFTs and ERAs, we recommend that payers be required to offer providers the option of consolidating payments and remits to be sent to one tax identification number or to multiple providers within the organization, with no penalty for the provider selecting one format over the other.

- **CARCS and RARCS** - Considerable efficiency would be gained with standardization of the CARC and RARC code sets. A mandated uniform implementation guide for each code set would significantly improve the claims posting and follow-up processes. This would result in increased automation and a reduced need for manual processes, thus saving time and expense.

- **Debiting of provider accounts** – Under EFT operating rules, payers should not be permitted to electronically remove funds from a provider’s bank account. Duplicate payments or overpayments should be required to be addressed through the remittance and provider refund process.

- **Payment timing** – We recommend that “clean claims” payments via EFT be transmitted to the provider within 14 days.

- **Secondary and tertiary payments** – Operating rules criteria should include requirements that secondary and tertiary payments have an electronic identifier that differentiates those transactions from primary payments. This would be particularly useful when querying data from a payer’s ERA.

- **Availability of data** - Payers should be required to make their ERA data available to enrolled providers not just at the patient level, but in summary form on the payer’s website so that providers can reconcile their electronic direct deposits with their ERAs. This summary list could then expand to show all the patients that were included in that remittance. This list should
be tied to the provider’s NPI number.

- **Appropriate support for the development of operating rules** – Any organization selected to create operating rules identified in the Patient Protection and Affordable Care Act should receive sufficient funding from the Department of Health and Human Services (HHS). This will facilitate expeditious development and testing of the most appropriate standards and operating rules. Failure to appropriately fund these entities will result in protracted development and adoption of these important rules and delay the efficiencies expected for the industry.

**Conclusion**

In conclusion, MGMA strongly supports the development and use of national standards for the health care industry. Standards for the collection and transmission of electronic health data will improve the quality of health care and lower the cost of providing it. It is clear that EFT payments are more convenient, reduce paper handling, streamline lockbox services, and reduce the risk of lost payments. Even more significant are the advantages of receiving an ERA with each EFT. Delivered in a format most appropriate for the provider, the ERA can be directly imported into a practice management system, eliminating the need to re-key remittance details from check stubs, a process that is time consuming and often introduces errors.

While MGMA is confident that full implementation of EFT and ERA will ease administrative burdens and facilitate improved data interchange within the health care community, roadblocks must be addressed before full implementation can be achieved. We appreciate the subcommittee’s interest in this important topic and thank you for inviting us to present our views.