Electronic Attachments: The Group Practice Perspective

CMS Stakeholder Meeting

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MGMA®

About MGMA

MGMA is the premier association for professional administrators and leaders of medical group practices

Through its national membership and 50 state affiliates, MGMA represents more than 40,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties.

Current Attachments Environment

- Payer requests (claims, prior authorizations) sent manually
  - Often lost or sent to incorrect address
  - Often difficult to determine what clinical data is being requested by payer
- Provider responses (claims, prior authorizations) sent manually
  - Take significant staff time to compile, mail, fax, or upload
  - Often include more information than was requested
- Manual claim attachments are a significant cause of denials, payment delays, write-offs
- Manual prior authorization attachments often require physician intervention, delays patient treatment

What do Manual Attachments Cost?

2016 CAQH Index

- Provider cost for a manual claim attachment: $5.25 per submission
- Provider cost for a manual prior authorization response: $7.50

MGMA Survey (2011)

- MGMA survey-avg. provider attachment cost per request is $21.34

MGMA 2011 Survey

"How often do the following business/administrative areas require the submission of attachments or additional supportive medical documentation?"

	Always	Often	Sometimes	Rarely	Never
Claims	3.5%	47.5%	42.9%	5.1%	1%
Eligibility	2.6%	13.2%	19.6%	43.9%	20.6%
Prior auth/ referrals	12.6%	41.6%	27.4%	12.6%	5.8%
Workers Comp	56.8%	21.6%	6.3%	4.5%	10.8%

Recent MGMA Data

- 2016 MGMA survey results: 51% answered “always” or “often” that payers request attachments for claims, 78.4% for WC
- Nearly 100% for some specialties (i.e., Orthopedics)

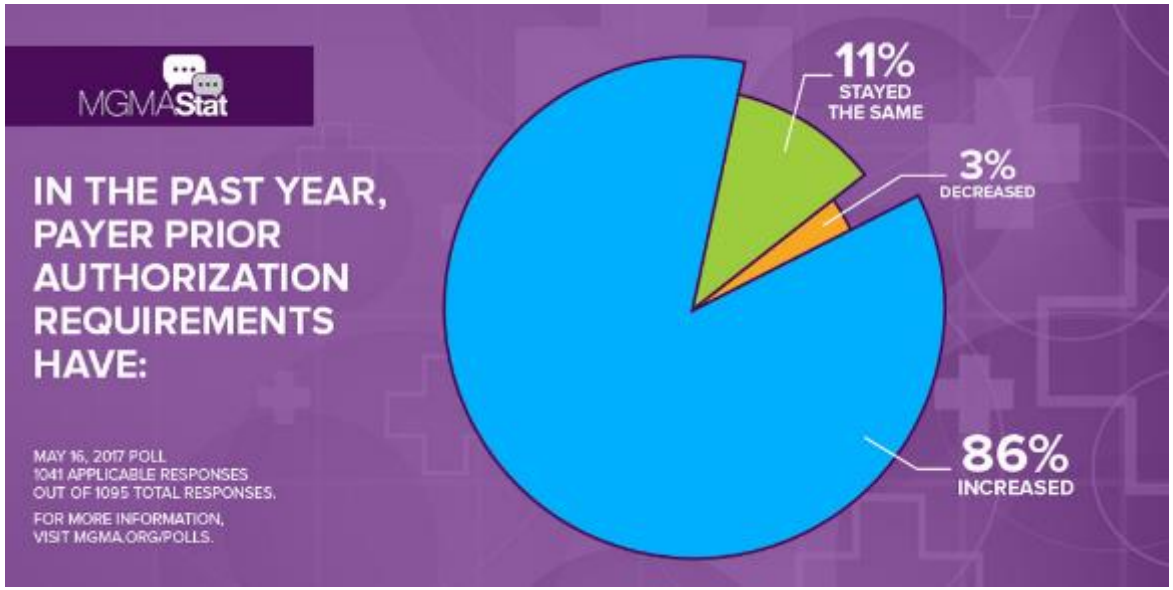
MGMA 2011 Survey

"How are you currently responding/submitting attachments or additional supportive medical documentation?"

	Always	Often	Sometimes	Rarely	Never
US Postal Service Letter	15.3%	55.8%	20.2%	6.1%	2.5%
Other mail (i.e., FedEx, UPS)	0.8%	8.6%	7%	30.5%	53.1%
Electronic Response	2.1%	17.2%	20%	22.1%	38.6%
Phone	1.4%	7.8%	23.4%	26.2%	41.1%
Fax	5.1%	53.5%	30.6%	7%	3.8%

MGMA Stat Poll

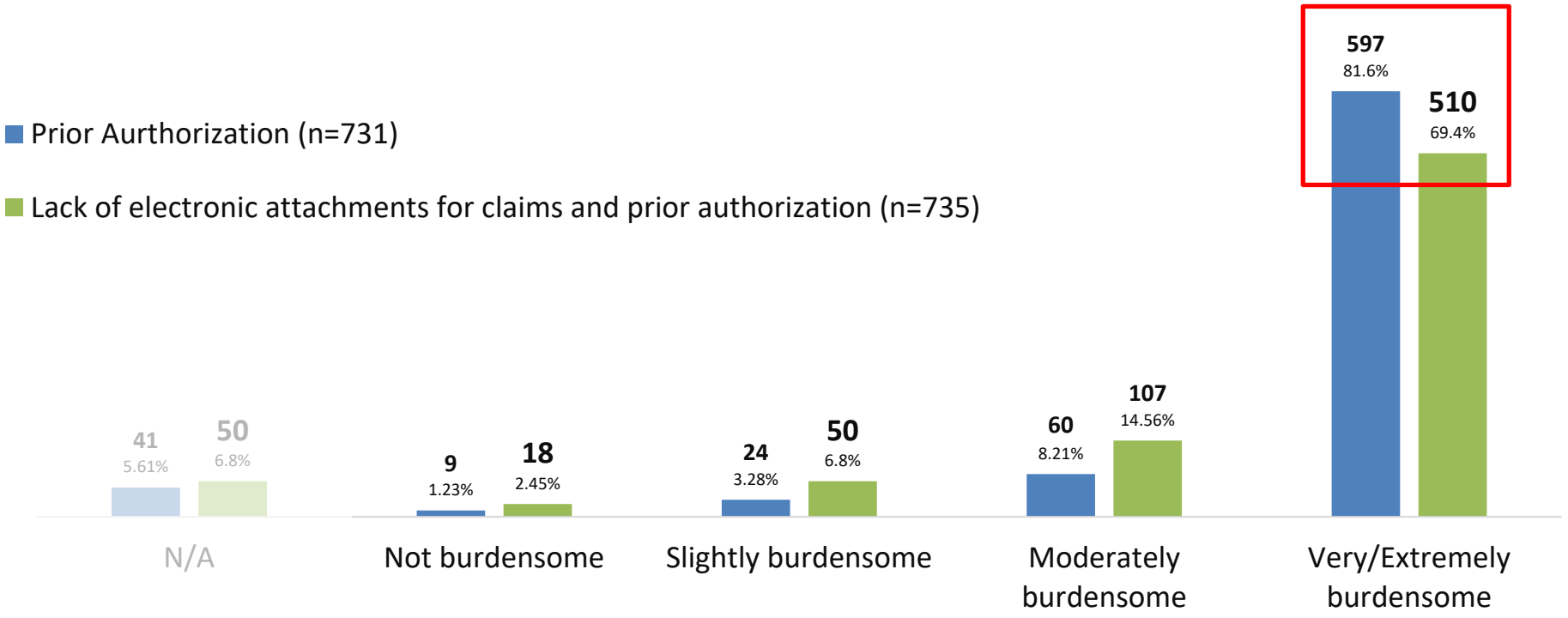
- **Overview**
  - Poll of medical practice leaders throughout the country
  - Conducted in real-time via text on May 16, 2017
  - 1041 applicable responses



- **Results**
  - **<u>86% of respondents indicated that prior authorization requirements have grown over the past year</u>**
    - **A similar poll conducted in May, 2016 found that 82% believed that prior authorization had grown in the preceding year.**

2017 MGMA Regulatory Relief Survey

"How burdensome would you rate the following regulatory and administrative issues?"



Benefits of Automation for Providers

- Virtually eliminates lost requests/responses
- Reduced cost associated with staff, paper, postage
- Payer documentation requests should decrease
- Improved predictability of payer content needs
- Reduced pends, denials, appeals, faster payment
- Decreased days in AR
- Significantly reduced administrative burden
- Opens door for additional functionality…

Attachments Opportunities – Clinical Data

- Beyond claims and prior authorization…
  - Care coordination
  - Transitions of care
  - Care management
  - Quality reporting (MIPS)
  - Support for alternative payment models
    - Patient-centered medical homes
    - Accountable care organizations
- All will benefit from standardized and automated clinical data exchange

Recommended Standards

- **Request for additional information**
  - ASC X12N 278 Services Review Request
  - ASC X12N 277 RFAI Request for Additional Information
- **Envelope**
  - ASC X12N 275 Additional Information to Support a Health Care Claim
  - ASC X12N 275 Additional Information to Support a Health Care Services Review
- **Clinical Content**
  - HL7 CDA R2.1 IG: Consolidated CDA Templates for Clinical Note
  - HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents
- **LOINC Code Set**
  - limited to HIPAA Panel for the types of requests
  - any document type code for the response
- **ASCX12 Healthcare Acknowledgement Reference Model (ARM)**

Additional Recommendations

- Do not allow “trading partner agreements” to set the standard between payers/providers (would unfairly penalize providers with limited contractual power)
- Recommend a similar approach to EFT - require payers to use the CA standard if requested by provider
- Expedite the release of the rule (Interim Final preferably)

Thank you.

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