White Paper

INGENIX®

# Physician Market Demanding New Systems and Functionality

## Vendors Need to Leverage Technology Partners to Improve Time to Market

# Next-Generation Integration and Automation will Help Differentiate Vendor Systems

Several factors within the physician marketplace are driving increased interest in practice management (PM) and electronic health record (EHR) solutions. These include the:

- Transition to the 5010 transaction standard for electronic data interchange (EDI)
- Adoption of the International Classification of Diseases, Tenth Edition (ICD-10) code set
- Potential for practices to earn up to $44,000 per physician in reimbursement from Medicare on the purchase of a qualified EHR under the HITECH Act within the American Recovery and Reinvestment Act (ARRA) of 2009
- Continued economic pressures that drive practices to find additional ways to reduce costs

As a result, many physician practices are looking to purchase their first EHR solution, as well as upgrade or replace their existing PM systems to make them compliant with the new transaction and code set standards. This substantial sales opportunity is dependent upon the ability of software vendors to fully prepare their products to meet requirements—whether EHR certification or compliance with the transaction standard and code set. Vendors looking to capitalize on this opportunity should set their sights beyond simply becoming certified and compliant, since these distinctions will not be a differentiator to drive sales once other vendors reach the same milestones. Instead, vendors should differentiate themselves by introducing next-generation integration, automation, intelligence, and functionality into their systems.

## Deadlines Approaching

**ICD-10 Deadline**—The Department of Health and Human Services (HHS) is mandating the transition to ICD-10 for coding and adjudicating of health care claims. The deadline for the transition is Oct. 13, 2013.

**5010 Deadlines**—There are two deadlines for the 5010 transaction standard for health care claims, and version D.0. for pharmacy claims. Trading partners must be able to exchange 5010 transactions as of December 2010, and can only exchange 5010 transactions starting Jan. 1, 2012.

**ARRA Deadline**—Within the economic stimulus bill, more than $19 billion is available to physicians and hospitals who implement a certified EHR system by 2011, and can demonstrate "meaningful use" of the technology.

The transition to the 5010 transaction standard is an opportunity for vendors to maximize the potential of EDI and offer additional value to physician practices. To accomplish this, vendors need a partner that can provide the components, functionality, content, as well as the national payer connectivity that is needed to drive these innovations. Most importantly, the partner needs to possess a technology platform that enables rapid component integration to minimize development costs and accelerate time to market. The following information highlights the benefits of high-level EDI usage and provides vendors with an overview of issues and components to consider when evaluating a potential technology partner.

## Maximizing the Potential of EDI

EDI is a powerful tool to reduce administrative costs at physician practices. A recent study shows that the average physician practice spends more than $68,000 per physician, per year in time spent interacting with payers.[1] Much of these costs are attributable to inefficient manual processes. One study shows that the typical solo physician practice could save more than $42,000 per year by using EDI to electronically process transactions versus relying on manual processes.[2]

Using EDI, however, is more than just a technical information exchange that takes standardized health care information from point A to point B. Using EDI requires providers and payers to overcome numerous internal business process management (BPM) challenges. These include integration and interoperability issues, a continued presence of paper-based processes, and workflows that attempt to work around

1. The Costs to Physician Practices for Interactions with Health Insurance Plans, conducted by the Medical Group Management Association, Weil Cornell Medical College, the University of Toronto and the University of Chicago, 2009.
2. John Phelan and Andrew Nagel, "Electronic Transaction Savings Opportunities for Physician Practices," Milliman, Inc. January 2006.

various process disconnects. For example, the current EDI transaction standard (4010A1) contains many ambiguities that lead to interpretations and inconsistencies in how the standard is applied. These interpretations, combined with the legislative nature of the standard that prevents rapid adjustments, is largely the reason for the more than 1,300 payer-specific companion guides that are being used throughout the industry.[3] The transition to the 5010 standard is a chance for the industry to resolve the issues that it has experienced while using the 4010 standard, and evolve the use of EDI to optimize data exchanges.

## The 5010 Optimization Opportunity

The 5010 standard is an opportunity to change EDI processes that are ineffective with the 4010 standard. These include hindrances and delays with trading partners resulting from the need to remap data and route it through multiple "hops" that increase the potential for error. The transition to 5010 is the right time for organizations to further leverage the use of non-claim transactions for eligibility verification, claims status, authorizations, and remittance posting.

For example, the eligibility inquiry and response transactions (X12 270/271) within the 5010 standard include more detailed response benefit information, such as plan beginning and end dates, and demographic information. This allows for more patient information to be captured automatically and will reduce follow-up phone calls to payers. Also, the transaction defines coordination of benefit (COB) information when additional payers are involved, which helps providers correctly bill the first time and reduce denials and follow-up calls. These enhancements have the potential for substantial savings. It's estimated that providers save $2 for every co-payment that is collected while the patient is on site, and save $3.70 for every claim that pays on the first pass, which reduces accounts receivable (AR) days and claim follow-up efforts.[4]

Other examples include the claims status inquiry and response transactions (X12 276/277). The 5010 version of these transactions clarifies usage instructions, making them more consistent from payer to payer and helping to reduce claim errors. The use of a claim ID within the 5010 version helps clearinghouses improve the tracking of claims and return more accurate responses to providers. Additionally, the 5010 version allows for multiple status codes per claim to reduce transaction submissions, and helps providers more accurately identify and resolve suspended claims. Combined, these factors are predicted to help providers achieve a $3.40 savings for each new electronic claim status request, as opposed to calling the payer for status.[5]

The new 5010 version of the payment and remittance advice transaction (X12 835) adds several components that promise to streamline reimbursement reconciliation. The claim status section of the transaction has clearer guidance to report how a claim was adjudicated. This includes adding medical policy information that providers can use to better understand partially paid or denied claims, which improves provider denial management, claims corrections, and the appeals process. Also, the revised transaction contains better instructions for handling reversals and corrections, interest payments, as well as prompt-payment discounts. Additional information within the transaction (e.g., remark and reason code information, etc.) will allow for more automated determination on claims. For providers, it is estimated that they will save $2 for every reimbursement that they can post via an automated process versus a manual process.[6]

### 5010 Affected HIPAA Transactions

- **837** Claims
- **835** Claim Payment & Remittance Advice
- **270 271** Eligibility Inquiry & Response
- **278** Referral & Authorizations
- **276 277** Claims Status Inquiries & Response

3. Maureen O'Neil, "EDI Has Not Overcome Interoperability Challenges," Gartner, Inc. June 2009.
4. Center for Health Transformation.
5. Center for Health Transformation.
6. Center for Health Transformation.

## Systems That Work by Exception

Adding these EDI capabilities—and others—will help create the framework for PM systems that automatically work by exception, rather than merely processing each transaction. For example, a PM system could be configured to automatically check claim status when a claim ages beyond a pre-configured number of days. Or, upon the scheduling of a patient, the PM system could automatically verify eligibility. Systems can be automated to handle many events, minimizing the need for human intervention, and only alerting users when intervention is required.

### Evolving Systems to Work by Exception

| | Crawl → | Walk → | | Run |
|---|---|---|---|---|
| **Verify Patient Data** | Manual updates entered into system | Online verification and manually update system | System integrates with each payer, verifies data, and creates report used for updates and corrections | System integrates with all payers, verifies, and corrects information in practice database |
| **Real-Time Claim Status** | Manual phone calls | Payer web portal | System integration with payer to obtain verification of receipt and current status | Exception items queued to root cause area based on status reason returned from payer |
| **Electronic Payments** | Manual posting | Bank lockbox and manual posting off reports | ERA data auto-posting to PM system and electronic funds transfer (EFT) established with some payers | All payments (payer and patient) received electronically and auto-posted, patients have online payment options |

These are only a few examples, but there are numerous processes that can be automated to help practices save money in terms of reduced reliance on labor, and increased collections that improve cash flow. Taken a step further, these transactions set the stage for broader clinical health information exchanges that are envisioned for the future, such as exchange of evidence-based guidelines, drug formularies, orders and results, gaps in care messaging, plus much more. These capabilities illustrate the value of enhanced EDI functionality to providers who translate efficiency improvements into more time spent with patients and the ability to deliver higher levels of care.

## 5010 Transition Timeline


**January**
- Final rule published

**March**
- Rule in effect
- Conduct internal analysis
- Begin design

- Design build
- Internal (Level 1) testing

**December**
- Complete Level 1 testing

**January**
- Testing with trading partners (Level 2)

**December**
- Complete Level 2 testing

**January 1**
- 5010 compliance deadline

Each step in the process of preparing for the 5010 transition needs to test the transactions to verify that they are compliant with HIPAA standards. Gap analysis reports can help organizations identify the differences between the 4010A1 and 5010 standards. Pre-production testing helps ensure that EDI transactions are compliant with standards, regulations, and payer requirements. Finally, transaction certification helps organizations identify business partners that are able to exchange compliant transactions.

## Evaluating Technology Partners

Vendors looking to make their solutions 5010 compliant and enhance their capabilities should begin by doing a gap analysis to determine the areas that need to be addressed in terms of achieving compliance and attaining desired functionality. The findings from this analysis will help in the selection of a technology partner(s). The following are some capabilities that vendors should evaluate when selecting a technology partner.

**EDI X12 Transaction Verification Tools**—The switch to the 5010 standard will require vendors to test and verify their EDI capabilities before placing their solutions into production. These tools examine transactions in relation to all seven WEDI-SNIP types of recommended testing, validate transactions against currently maintained code sets, and test against known payer companion guides. Transaction certification allows organizations to know the transaction capabilities of business partners in advance, reducing the time spent getting trading partners up to speed.

**Application Programming Interface (API)**—Investigate what types of tools that the technology partner has to help integrate its functionality into existing systems. Does it have web-based capabilities to handle transactions, testing, and the posting of documents? Does it help integrate other components that will be added to the system at a later date? Will it decrease development time?

**Claims Editing**—Tools are available that review the clinical accuracy and reimbursement viability of claims before submission in order to reduce claim denial rates, shorten accounts receivable cycles, and increase the rate of collection. These solutions need to include a robust knowledgebase to check claims against business rule edits for Medicare, Medicaid, and commercial payers. It's important for these systems to offer pre-configured business rules, but also accommodate user-defined rules. The result is higher first-past rates for claims, reduced AR days, and improved cash flow.

**Referential Materials**—Online code lookup applications deliver code detail and reference information on CPT®, Healthcare Common Procedure Coding System (HCPCS), correct coding initiative (CCI) edits, ICD-9-CM codes, and ICD-10 codes once a final version is released.

**Automated Payment Posting**—Providers using remittance management capabilities within PM systems can benefit from automated payment posting features, since they no longer need to manually reconcile reimbursement

with original billings. The automated posting reduces administrative costs.

**Patient Payment Manager**—Patients are responsible for paying an increasingly higher percentage of health care bills, due to the tremendous growth in consumer-directed health plans (CDHPs), health savings accounts (HSAs), and high-deductible health plans (HDHPs). Physician practices are responsible for collecting the self-pay portions of patient balances. A patient payment manager can extract billing data from the PM system to print and mail patient statements, and provide patients with online payment capabilities. Integration of these capabilities can help speed collections and simplify payment posting.

**Clearinghouse Connectivity**—National payer connectivity for all physician and hospital X12 transactions can open broad markets for HIS, PM, and EHR solution vendors. Partnering with a clearinghouse with national presence can benefit potential clients with expansive connectivity. A clearinghouse with flexible business terms, broad capabilities, and simple integration options can provide competitive advantage in the marketplace and deliver improved value for end users.

**Workers' Compensation Compatibility**—With an expanding number of state mandates for electronic workers' compensation billing, it is now a necessity for HIS, PM, and/or EHR systems to be able to exchange electronic workers' compensation bills. Ingenix operates one of the largest national electronic clearinghouses for workers' compensation and property and casualty payers.

## Single Partner versus Piecemeal Approach

Ingenix provides vendors with the benefit of one-stop-shopping for all of their technology, connectivity, and service needs. Ingenix offers vendors more than 20 solutions that are integrated and can be embedded within other applications, not only simplifying implementation, but also facilitating information sharing between components.

For example, Ingenix ClaimsManager can be embedded in PM systems to scrub and edit claims before submission to reduce errors and rejections. Upon finding an error, ClaimsManager's tight integration with EncoderPro™ enables the solution to automatically pull up the appropriate coding reference within its online database, helping coders correct the error and get the claim submitted promptly.

Managing only a single relationship—instead of a patchwork of different companies and technologies—reduces administrative burdens and development costs for software vendors. Ingenix understands the importance of integrating and automating administrative, financial, and clinical functionalities, all while helping its partners bring additional value to their customers via a comprehensive suite of health care information technologies.

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## About the Company

Ingenix, a wholly owned subsidiary of UnitedHealth Group (NYSE: UNH), transforms organizations and improves health care through information and technology. Organizations rely on its innovative products, services, and consulting to improve the delivery and operations of their business. More information about Ingenix can be obtained at http://www.ingenix.com.

## About the Author

Hugh Sullivan is Vice President of Ingenix Provider Connectivity & Channels. Hugh has over 18 years of health care-related electronic data interchange (EDI) experience and has held leadership positions within software development, operations, marketing, and sales. Mr. Sullivan was a cofounder of a national EDI clearinghouse and has served on the board of directors for WEDI, the Workgroup for Electronic Data Interchange.



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