

**Rhode Island Office of the Health Insurance Commissioner**



**OHIC Administrative Simplification Workgroup  
Report to the General Assembly**

**MARCH 2014**

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# OHIC ADMINISTRATIVE SIMPLIFICATION REPORT

## *Table of Contents*

<i>Legislative Charge and Structure of Report</i> .....	3
<i>Executive Summary</i> .....	3
<i>Administrative Simplification Phase II</i> .....	6
Retroactive Termination Coverage .....	8
Enhanced Coordination of Benefit Processes .....	11
Appeal of Timely Filing.....	13
Medical Record Management .....	14
<i>Future Role for Administrative Simplification Work</i> .....	16
<i>Appendices:</i>	
A. Administrative Simplification Contributor Roster .....	17
B. Administrative Simplification Priorities and Proposed Responses.....	18
C. Billing and Coding Sub-Group Contributor Roster.....	21

## **Legislative Charge**

On June 21, 2012 the Rhode Island General Assembly enacted Public Law 390 (House Bill 7784 Sub A)<sup>1</sup> to direct the Health Insurance Commissioner:

“To establish and convene a workgroup representing health care providers and health insurers for the purpose of coordinating the development of processes, guidelines, and standards to streamline health care administration that are to be adopted by payors and providers of health care services operating in the state. This workgroup shall include representatives with expertise that would contribute to the streamlining of health care administration...”

The law also requires that by March 31<sup>st</sup> of each year the Health Insurance Commissioner must submit a progress report to the Rhode Island General Assembly. The purpose of this report is to comply with the above-referenced provisions of the Rhode Island General Laws, as amended. This is the second report submitted to the legislature on OHIC’s administrative simplification activities.

## **Executive Summary**

OHIC and the Administrative Simplification Work Group completed Phase I of its activities in June 2013. Phase I focused on identifying issues that lent themselves to administrative simplification solutions and developing a common understanding of the nature and root causes of these issues. During Phase I, the Work Group also established priorities among the multiple issues identified, and recommended next steps for OHIC and the Work Group. Before proceeding with the Phase I recommendations, OHIC reached out to key stakeholders to confirm that they remained committed to moving to Phase II, which would focus on developing concrete solutions to the administrative simplification issues identified and prioritized in Phase I.

OHIC reconvened the Work Group in October 2013 and has held monthly meetings. Because of the specialized nature of billing requirement, OHIC also formed a separate work group composed of billing specialists that focused solely on claims coding issues. That group first met November 19, 2013 and has held monthly meetings thereafter.

Despite the early commitment of the participants to the Phase II process, OHIC has found it difficult to consistently engage providers and payers in a process to develop and implement consensus solutions to top priority administrative simplification issues. As a result, OHIC has identified for agency action, four key issues that have been thoroughly vetted during Phase I and Phase II Work Group meetings. Though the four issues recommended for OHIC action are

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<sup>1</sup> <http://webservice.rilin.state.ri.us/PublicLaws/law12/law12390.htm>

noted below, any disagreements by select Taskforce members presented prior to the request for stakeholder consensus are also recorded:

1. Retroactive Termination: Currently, providers bear significant risk for retroactive terminations of patient insurance coverage even though they relied in good faith on the eligibility information provided by the carrier at the time services were provided, indicating that the patient had coverage. Carriers rely on employers to report accurate and timely changes affecting employee terminations or coverage status resulting in the potential for incorrect eligibility information at the point of service. Employees may not realize they are not covered at the time of service or may take advantage of the delay in notification of termination to the carrier and continue to seek medical services knowing the insurer will not cover services. These retroactive terminations sometimes, but not always, result in carrier recouping payments from the providers. This process varies by carrier. For example, BCBSRI recently implemented a process that prevents retroactive terminations when the member has claims on file and thus holds the employer group accountable for not notifying BCBSRI in a timely manner. In these cases, no claims payments are recouped from the provider.

Based on the Taskforce intent to more equitably distribute financial risk among payers, providers, employers and individual patients, OHIC will consider action to implement the following:

- a. Carriers may build the cost of retroactive terminations into their rates;
- b. Prohibit carriers from recouping payments made to providers in the event of retroactive termination. In consultation with the carriers and providers, OHIC may request that carriers submit data to enable OHIC to track the frequency and related costs of retroactive terminations,
- c. In consultation with the carriers and providers, OHIC may request, as applicable, that carriers separately report any premium costs associated with retroactive terminations.

These requirements will not apply to state or federally funded programs where a conflict exists.

2. Enhance Coordination of Benefits (COB) Process: Because of unreliable patient information and poor cross-carrier coordination, currently it is often difficult for providers to submit a claim and reliably and consistently know if there are multiple carriers insuring the patient. While some payers post on their eligibility web page information that other insurance coverage exists, providers do not know who is primary and the information may be incorrect or dated. As a result, both providers and payers expend administrative resources denying claims, recouping incorrect payments, trying to identify the primary carrier and resubmitting claims. One recent study

conducted by the Council for Affordable Quality Healthcare (CAQH) estimated that out of a total of \$3.6 trillion spent on health care in 2013, COB issues cost the health care system nationally \$840 million annually (.02% of the total health care expense), with providers incurring 60% of the costs and carriers 40% of the costs.

To enhance COB processes OHIC will move forward on two fronts. First, OHIC will consider action for carriers to accept a uniform COB form from patients and providers that can be submitted either manually or electronically and will require carriers to develop standardized processes for doing so. This will enable providers to collect and submit COB information from patients at the point of service. Payers may continue to use their own COB form as part of their annual member survey and other uses as approved by OHIC.

Second, on a date determined by OHIC in consultation with carriers, OHIC will consider action for carriers to fully participate in a centralized registry for coverage information, designated by OHIC. This date shall be set pending annual evaluation by OHIC and shall be no later than one calendar year following use of the designated registry by Medicare. The registry designated by OHIC will have the capability to provide both payers and providers with information about duplicate coverage at the time eligibility is checked prior to providing services. OHIC will consider transition timelines necessary when a carrier participates with a registry other than an OHIC selected registry.

3. Appeal of Timely Filing Denial: Some, but not all carriers deny provider claims with no appeal rights for failure to meet timely filing requirements. This can occur even though providers have exercised due diligence in submitting the claim. Providers can fail to meet timely filing requirements due to no fault of their own for a variety of reasons including: being given the wrong coverage information by the patient, being given the wrong patient demographics, or carrier processing errors (e.g., lost claim).

To give providers the opportunity for their claim to be reviewed on its merits, OHIC will consider action to implement the following: 1) that carriers allow appeals for timely filings within 180 days of the date that the provider received proof that the carrier denying the claim was the primary carrier, and 2) prohibit carriers from denying a claim due to timely filing if providers submit specified documentation.

4. Medical Record Management: Transferring medical record information between patients and/or providers (sender) and payers can be problematic because of lost records by carriers or poorly identified records by senders, lack of tracking of receipt of medical record information by the carrier or mis-sent records by senders, and failure to notify senders that medical records were sent to the wrong carrier entity or vendor and were destroyed. Moreover, clinical information requested by carriers can be vague and/or over broad, resulting in excessive medical information being sent to a third

party such as a vendor hired to review high cost claims, raising federal and state privacy concerns.

To reduce the number of mis-sent or misprocessed records, and to assure that only the required information is sent, the following will be considered for OHIC action:

- a. Carriers submit written policies and procedures for requesting written or electronic clinical and medical record information that demonstrate compliance with all HIPAA regulations and Rhode Island confidentiality and need to know requirements;
- b. Carrier requests for medical records include information that will clearly state the scope and purpose of the request, and where and to whom the records are to be sent;
- c. Carriers maintain a process to handle clinical information once received to include a mechanism to verify receipt of this information when a patient or provider requests such verification.
- d. Carriers notify senders of the status of mis-addressed or mis-sent medical records to include information that these record were or will be destroyed when such information is requested by the payer or the provider.
- e. Carriers post on their websites all relevant information regarding when and to whom medical records are to be sent, and if more than one address is posted what types of medical record information is to be sent to which address.
- f. Ask the Coding Work Group to identify which CARC/RARC codes are most confusing and develop more descriptive codes to identify what medical data is needed, in a manner consistent with HIPPA requirements.

Separately, OHIC intends to continue holding periodic Administrative Simplification Work Group meetings to continue the process of identifying and vetting issues. It also plans to continue holding meetings of the coding work group to enable them to move toward developing recommendations regarding several complex issues. The coding work group does not have any recommendations to share at this time.

## **Phase II Activities**

OHIC and the Administrative Simplification Work Group completed Phase I of its activities in June 2013. Phase I focused on identifying issues that lent themselves to administrative simplification solutions and developing a common understanding of the nature and root causes of these issues. During Phase I, the Work Group also established priorities among the multiple issues identified, and recommended next steps for OHIC and the Work Group. Before proceeding, OHIC reached out to key stakeholders to confirm that they remained committed to moving to Phase II, which would focus on developing concrete solutions to the administrative simplification issues identified and prioritized in Phase I.

OHIC reconvened the Work Group in October 2013. A list of participants is found in Attachment A. The Work Group began by identifying as high priority the following administrative simplification issues:

- Retroactive Termination
- Standard COB Form
- Appeals Checklist
- Medical Record Submissions
- Specified Coding and Billing Issues

A list of administrative issues considered by the Work Group is included in Attachment B. The high priority issues are highlighted within the document. It is important to note that the proposed recommendations included in Attachment B were developed by the Taskforce as Phase I activity and further discussed and refined by the Taskforce in its Phase II activity. The recommendations included in this report reflect OHIC's assessment of both Phase I and Phase II Taskforce deliberations.

Because of the specialized nature of billing requirements, OHIC formed a separate work group composed of billing specialists to focus solely on the prioritized coding and billing issues. Participants in the coding work group are listed in Attachment C. That group first met in November 21, 2013 and has held monthly meetings thereafter. Though the coding work group is continuing to define issues, reconcile some and discuss potential solutions for others, it has not produced any formal recommendations for OHIC action to date. OHIC plans on continuing to hold regular coding work group meetings to facilitate continued communication among interested payers and providers in an effort to either informally resolve billing and coding issues or to make a formal recommendation to OHIC when necessary to address a systemic billing and coding issue.

The Administrative Simplification Work Group focused its attention on the first four issues listed above. To prepare for Work Group meetings, OHIC sent specific requests to providers and carriers requesting that they submit data, policy examples and policy positions on each topic. With the exception of BCBSRI, responses to these requests were inconsistent and often incomplete. Meeting agendas and meeting materials were distributed well in advance of each Work Group meeting. During Work Group meetings, data submissions were reviewed and the implementation challenges, costs and public policy issues associated with the various solutions were discussed by all meeting participants. Meeting summaries were sent to all members of the Work Group. Outside presenters were invited when appropriate. Specifically, representatives from CAQH, a national, non-profit organization funded by health plans and trade associations dedicated to simplifying healthcare administration, were asked to present information about its COB Smart initiative when this initiative was suggested as one of the solutions that the Taskforce should consider.

Despite the early commitment of the participants to the Phase II process, OHIC found it difficult to consistently engage providers and payers with the exception of BCBSRI, in a process to develop and implement consensus solutions to top priority administrative simplification issues. Therefore, OHIC shall use its form and rate review process or regulations to move forward with actions that will achieve the administrative simplification goals with regard to the four topics that the Taskforce identified as high priority. The following is an in depth discussion of each of the four topics.

### **Retroactive Termination of Coverage**

Retroactive terminations impact small and large group markets. The individual market is not impacted because the insurer will know immediately if coverage is terminated and posts that updated status almost immediately. Therefore, the likelihood of providers not knowing the current status of those with individual coverage is low.

Statement of Issue: Currently, providers bear significant risk for retroactive terminations even though they rely in good faith on the eligibility information provided by the carrier at the time services are provided, indicating that the patient has coverage. Retroactive terminations occur because employers and carriers have operational policies that permit employers to notify the carrier of terminated employee coverage after the date of employment termination. The carriers take action on the date they are notified of the termination to retroactively end coverage back to the employment termination date. When the provider is notified that coverage has been terminated, frequently services have already been rendered, billed and paid. Subsequently, the provider often must return the payment to the carrier and attempt to bill the patient, which is administratively costly and often results in non-payment as the patients are difficult to locate and often do not have funds to cover the costs incurred. Retroactive termination policies vary from payer to payer as some payers do not perform retroactive terminations if there are claims on file for that member. As a result of the Taskforce discussions of this issue, BCBSRI recently implemented a process that adjusts the retroactive termination date so that claims paid before a termination notice is given remain the responsibility of the employer.

This issue is particularly problematic for large private and public employers, since they have more difficulty with a process of timely notification to carriers of employment terminations. For example, in the case of one public employer contract, United reported that it allows this employer to notify United of a termination at any time resulting in the potential for inaccurate eligibility that could extend for years. To help explain how retroactive terminations occur and the administrative complexities they cause, two examples are provided. The hospital example illustrates a case in which the claim is denied and the professional provider example illustrates a case in which the claim is paid and funds are subsequently recouped from the provider by the carrier.

### Hospital Example

- On December 31, the employer pays its January premium for all covered employees with the employee contributing his or her contribution.
- Employer terminates Employee A on January 14.
- On January 17, the employee (now a patient) has unscheduled surgery that generates a bill in the amount of \$5,000. The patient's eligibility was confirmed at the point of service.
- On January 31, the employer notifies the carrier that Employee A is terminated. Carrier refunds prorated January premium to employer. Carrier does not have knowledge as to whether employer returns employee contribution to terminated employee.
- On February 1, provider submits the claim to the carrier.
- On February 7 the claim is denied for lack of eligibility, as the patient was retroactively terminated from carrier coverage.
- On February 15, the provider bills the patient, who is not able to pay.
- On December 31, after multiple attempts to collect from the patient, the provider designates the bill as uncollectable.

### Professional Provider Example

- On December 31, the employer pays its January premium for all covered employees with the employee contributing his or her contribution.
- On January 14, employer terminates Employee A.
- On January 15, the employee (now a patient) has the flu and seeks treatment from his PCP. PCP confirms eligibility. Patient incurs an office visit bill of \$120.00 and a pharmacy bill of \$44.00.
- On January 15, patient fills prescription.
- On January 17, provider submits claim.
- On January 24, carrier pays claim.
- On January 31, the employer notifies the carrier that Employee A is terminated. Carrier refunds prorated January premium to employer. Carrier does not have knowledge as to whether employer returns employee contribution to terminated employee.
- On March 1, carrier notifies provider that it is recouping \$120 because of lack of eligibility at the time of service. Carrier does not recoup payment from the PBM.

### Policy Considerations

Current retroactive termination processes raise issues of fairness for all involved. Is it fair for the provider, who is relying in good faith on eligibility information provided by the carrier, to

bear the majority of the burden of lack of real time eligibility information? Providers are also least able to have an impact on establishing eligibility. Moreover, even though consumer liability may exist, the ability of providers to obtain payment from consumers diminishes in the event of retroactive termination.

Is it fair for the employer that has operational constraints to be expected to provide real time information on terminations, with larger groups having more challenges with timely notification? Moreover, employers do not want to pay for health care services for terminated employees, which would add an additional business expense. Is it fair to the carrier that is constrained by the competitive market to implement notification requirements with employers that are more stringent than competing carriers have?

Finally, for the consumer the effective date of termination of coverage is not always clear because of varying employer policies. However, there may be an opportunity for consumers to take advantage of seeking services with full knowledge of coverage termination.

In considering the equities associated with each party, OHIC has determined that providers unfairly bear the majority of the financial risk for retroactive termination because of the difficulties of collecting payment from patients. On the other hand, the employer and the carrier are able to shift the liability elsewhere, yet, employers and carriers are the parties that are best able to resolve the root causes of retroactive termination. All parties bear administrative costs in processing retroactive terminations.

OHIC's policy goal is to reduce administrative burdens as well as the associated costs, create incentive for efficiencies among stakeholders for timeliness of notices of termination, and establish an equitable balance of financial liability among carrier, employer and enrollee in light of the unavailability of real time, accurate eligibility information.

#### Recommended Solution

- Carriers may build the cost of retroactive terminations into their submitted rates and cease the administrative process of seeking recoupment of payment from providers in the case of retroactive terminations. Notwithstanding the above, carriers may establish contractual requirements with providers with regard to eligibility checks at the time services are provided. Moreover, carriers may adjust the financial burden with its employer groups, so long as the process does not include recoupment of payments from providers in the event of retroactive termination.
- OHIC may, in consultation carriers and providers, request carriers to submit data elements that document the number and value of claims paid during a period of time of retroactive termination, and the value of premiums associated with the retroactive termination periods, as applicable.

- OHIC may, in consultation with carriers and providers request carriers to separately report the premium cost of this retroactive termination policy on a PMPM basis and all supporting documentation, as applicable.
- These recommendations do not apply to state or federal programs where a conflict exists.

## **Enhance Coordination of Benefit Processes**

Coordination of Benefit (COB) issues arise because of the lack of accurate, real time eligibility data, but centers on issues that arise when multiple carriers are involved, but are not readily identifiable. COB issues impact all markets.

Statement of Issue: Because of unreliable information from patients and poor cross-carrier coordination, currently it is often difficult for providers to submit and reliably and consistently know if there are multiple carriers providing coverage to a patient, and if so, which one has primary financial responsibility. While some payers post on their eligibility web page information that other insurance coverage exists, providers do not know who is primary and the information may be incorrect or dated. As a result, providers submit claims and are then notified through a denial code that a different carrier has primary payment responsibility. Sometimes the existence of another carrier becomes known after the claim has been paid, resulting in provider recoupments and administrative reprocessing costs for both providers and payers. A study by CAQH estimated that out of a total of \$3.6 trillion spent on health care in 2013, COB issues cost the health care system nationally \$840 million annually (.02% of the total health care expense) , with providers incurring 60% of the costs and carriers 40% of costs.

Separately, but related, carriers generally ask enrollees to complete an annual COB form with a low rate of return. BCBSRI reports a 48% return. Also, payers have different formats and processes for collecting COB information. Some carriers will accept COB information from patients and so

### Policy Considerations

Currently, there is no effective or uniform way to collect coverage information. Currently, COB is determined after claims are submitted or paid, rather than at the beginning of the process or at the time services are being provided. The policy goals are to increase accuracy of coverage eligibility and primacy information when multiple carriers are involved, and to reduce administrative burdens by creating uniform processes and leveraging national COB initiatives

### Recommendation

OHIC will consider action to implement a process that carriers accept a common, uniform COB form. Specifically, carriers will:

- Accept the common COB form from providers and members as proposed by the Taskforce and determined by OHIC;
- Submit to OHIC for approval a procedure to inform contracted providers of a manual and electronic use of the common COB form in provider settings;
- Not alter the common COB form except for use in the carrier setting or on the carrier website. In these instances only the carrier name and contact information may be added to the form;
- Accept the generic COB form/information submitted by the practice/provider on behalf of patient, and
- Include a flag within the insurance eligibility look-up section of its website indicating the last update of COB information.
- Carriers may continue to use their own COB form as part of its annual member survey and use as approved by OHIC.

Second, OHIC agrees with the intent of the health care industry to make COB determinations available at the beginning of the service delivery process. In assessing how this can be accomplished, OHIC believes that to date, CAQH's COB Smart initiative is the best solution, though it will consider other registry options. COB Smart involves payers sending eligibility information to CAQH weekly. CAQH then runs the eligibility data from all participating payers through an algorithm to find duplicate coverage. All carriers involved are then notified of duplications and which carrier may be primary. It is up to the carriers to resolve the duplication and primacy issues. The early studies of the costs and potential savings indicate that carriers can realize savings after two years. Because the process involves sending eligibility data to CAQH, data accuracy is essential to make the system work, which requires resources on the part of the participating payers.

This matching system works best if all payers participate. Currently, COB Smart is supported by all the major national plans, including United Healthcare, Aetna and Cigna, all of whom have a presence in Rhode Island. COB Smart is expected to be nation-wide in March, 2014. OHIC believes that supporting the expansion of COB Smart in Rhode Island will ultimately reduce administrative costs for carriers and providers. OHIC shall consider requiring commercial carriers to:

- Participate in a centralized registry designated by OHIC, such as CAQH's COB Smart centralized registry for coverage information, on a date determined by OHIC in consultation with carriers, but with full participation occurring no later than one calendar year from the date of use of the designated registry by Medicare.
- Provide OHIC with written processes to notify providers of all eligibility determinations electronically or telephonic at the time eligibility is checked by the provider.

## Timeline

- For all plans effective on a date determined by OHIC and no later than one calendar year from the date of use of the designated registry by Medicare.

## Outstanding Stakeholder Comments:

*United recommends that the standard COB form be required to include the member's signature*

## **Appeal of a Timely Filing Denial.**

Timely filing denials affect all markets.

Statement of Issue: Some, but not all carriers deny claims without appeal rights for failure to meet timely filing requirements. Providers can miss timely filing requirements even though they have exercised due diligence in submitting the claim. Provider can fail to make timely filings due to no fault of their own for a variety of reasons including: being given the wrong coverage information, being given the wrong patient demographics, or carrier processing errors (e.g., lost claim).

To help explain how the timely filing requirement can unfairly penalize providers, the following example is provided.

## Example:

- Patient is seen by professional provider and gives the provider demographic and coverage information at the time service.
- Provider submits a claim based on the demographic and coverage information provided by the patient.
- The carrier pays, but subsequently recoups payments when the carrier realizes that it is not primary.
- The provider sends the claim to the primary carrier, but the claim is denied for failure to meet timely filing deadline.
- Failure to meet timely filing deadlines is generally not appealable.

## Policy Consideration

The policy goal is to avoid penalizing a provider with timely filing denials with no appeal right when the provider performs due diligence in a timely manner using all information available at the time the claim is submitted.

## Recommendation

OHIC will consider action for implementation of the following carrier process:

- Allow a provider appeal for failure to meet timely filing requirement so long as the appeal is submitted to the carrier within 180 of date that the provider received proof that the carrier was the primary carrier.
- Prohibit carriers from denying a claim based on failure to meet timely filing requirements in the event that the provider submits all of the following documentation:
  - Copy of the timely filing denial.
  - Written evidence that the provider billed another plan or the patient within at least 90 days of the date of service.
  - If provider billed another plan, an electronic remittance advice, explanation of benefits or other communication from the plan confirming the claim was denied and not paid or inappropriate payment was returned.
  - If provider billed the patient, acceptable documentation would include benefit determination documents from another carrier, a copy of provider's billing system information documenting proof of an original carrier claim submission; or patient billing statement that includes initial claim send date and the date of service.
  - Documentation as to exact date the provider was notified of member's coverage under carrier, who notified the provider, how the provider was notified and a brief statement as to why the provider did not initially know the patient was not covered by carrier. Practice management and billing system information can be used as supportive documentation.
- Clearly state that if a provider submits all the information requested above, the carrier shall be prohibited from denying the claim due to timely filing. This does not preclude the denial of this claim for other reasons that do not meet claims processing and/or medical necessity requirements of the carrier.
- Require the carrier to utilize a standardized appeal checklist approved by OHIC when informing providers of a timely filing denial and what needs to be submitted to appeal that denial. Checklist and appeal submissions shall be made available for both manual and electronic processing.

## **Medical Record Management**

Medical Record management issues impact all markets.

Statement of Issue: The transfer of medical record between providers and carriers is problematic because of such issues as lost records by carrier, lack of tracking of receipt of medical record information by the carrier, failure to notify provider that medical records have been sent to the wrong carrier entity or vendor and were destroyed, poorly identified records sent by provider, and records sent to the wrong carrier address. Moreover, the clinical information requests by the carrier can be vague and/or overly broad, resulting in excessive amounts of medical information being sent to a third party. As a result of these complications, months can pass before providers realize that their medical record submission was not received

or effectively processed by the correct party within the carrier or vendor organization such as a vendor hired to review high-cost claims, further delaying claims payment and raising patient confidentiality concerns.

### Policy Consideration

The policy goal is to maintain patient confidentiality and to reduce the administrative burden of both the providers and carriers with regard to medical record submissions.

### Recommendations

OHIC will consider action for implementation of the following carrier process: :

- Demonstrate that requests for written clinical and medical record information from patients and/or providers (sender) are in compliance with all HIPAA regulations and Rhode Island confidentiality and need to know requirements.
- Require that all carrier medical record requests specify:
  - What medical record information is being requested;
  - Why the medical record information being requested meets 'need to know' requirements, and
  - Where the medical record is to be sent via mailing addresses, fax or electronically.
- Establish a mechanism to handle the clinical information once received to include a mechanism to verify receipt of this information when a sender requests such verification.
- Upon sender's request the carrier to notify the sender of any mis-sent or mis-addressed documents to include information that these records were or will be destroyed.
- Require the carrier to post on its website and in communications with senders a clear listing of contact information, including mailing address, telephone number, fax number, email, as to where the medical record is to be sent and if more than one address is posted, an explanation as to what types of medical record information is to be sent to which address

Because of the complexity associated with claims payment processes, OHIC will ask the Coding Work Group to identify which CARC/RARC codes are most confusing and develop more descriptive codes to identify what medical data is needed, in a manner consistent with HIPPA requirements.

## Next Steps

The Health Insurance Commissioner will review Taskforce recommendations and consider appropriate action by OHIC to implement these recommendations.

OHIC will continue to hold Administrative Simplification Work Group meetings to discuss new issues and obtain feedback regarding the implementation of the first four issues addressed. The goal is to continue to systematically discuss and develop solutions for the administrative simplification issues listed in Appendix B, as well as new issues brought to the Work Group by interested parties. By September 1, 2014, carriers and providers will be asked to submit issues for discussion with data and information to substantiate the significance of each issue along with proposed solutions. OHIC will review the provider and carrier submissions and prioritize those issues best suited to be addressed by the Administrative Simplification Taskforce given its charge. OHIC's selected discussion topics will be reviewed with carriers and providers at the first Taskforce Meeting to obtain additional input and finalize meeting agendas for Taskforce 2014. The Taskforce will gather for a series of meetings between September 15, 2014 and November 15, 2014 to make its recommendations for resolving issues submitted. If consensus is reached on resolution for the matters discussed by the Taskforce, the recommendations shall be reviewed by the Commissioner. Taskforce recommendations to the Commissioner to be finalized on or before December 31, 2014.

Finally, OHIC will continue to support the coding work group with the intent to facilitate effective communication, informally reconcile systemic issues and where an informal process fails, developing a series of recommendations for inclusion in OHIC's March 31, 2015 Legislative Report.

## ATTACHMENT A

### List of Administrative Simplification Work Group Participants

Affiliation	Name
Bailit Health Consulting	Marge Houy
Blue Cross Blue Shield of Rhode Island	Rich Glucksman
Blue Cross Blue Shield of Rhode Island	Charley Kineke
Blue Cross Blue Shield of Rhode Island	Peter Hollmann
Blue Cross Blue Shield of Rhode Island	Jack Emerson
Blue Cross Blue Shield of Rhode Island	Nancy Silva
Blue Cross Blue Shield of Rhode Island	Lisa DaSilva
Blue Cross Blue Shield of Rhode Island	Kerry Levesque
CAQH/CORE	Omoniyi Adekanmbi
CAQH/CORE	Gwen Lohse
Care New England Physician Hospital Organization	Chris Dooley
Care New England	Gail Fugere
Care New England	Helen Reed
Gateway Health	Patricia Grover
Hospital Association of RI	Cecelia Pelkey
Hospital Association of RI	Mike Souza
Jaffee OB GYN	Bonnie Jaffee
Lifespan	Donna Badger
Lifespan	Denise Peffer
Lifespan	Michelle Smith
Lifespan	Heidi Silva
Lifespan	Maria Mota
Lifespan	Kellie Johnson
Lifespan	Brenda Malone
Lifespan	Tracy Lamkin
New England Medical Billing	Michelle DeRoche
NHPRI	Rebecca Lebeau
NHPRI	Tayna Vasquez
NHPRI	Stephanie Hagopian
RIMS	Steve DeToy
Tufts	Eric Moffat
Tufts	Patrick Ross
UHC/UHCNE	Ellie Lewis
UHC/UHCNE	Steve Farrell
UHC/UHCNE	Lauren Conway
UHC/UHCNE	Shannon Alsfeld
UHC/UHCNE	Kathie Weigert
UHC/UHCNE	Jenny Hayhurst
UHC/UHCNE	Helen Cambell

## ATTACHMENT B

### List of Administrative Simplification Priorities and Proposed Responses Developed by the Administrative Simplification Phase I Taskforce

Category	Topic
Eligibility & Benefit Design	<p><b>Retroactive Termination.</b> Payers agree to include in their contracts with employer groups, union plans and brokers the requirement that payers before processing a request for a retroactive termination of eligibility must verify that there are no claims on file for the enrollee subject to the retroactive termination request that cover services provided after the date of the requested retroactive termination, and if there are claims on file, the termination will be effective on the date on which the payer was notified of the termination. This requirement does not apply to COBRA policy holders</p> <p><b>Payer/Employer coordination:</b> payers and employers conduct an intensive campaign with employees on the need to update eligibility promptly</p>
Eligibility & Benefit Design	<p><b>Standard COB Form.</b> Payers agree to accept a standard COB form that complies with the following standards:</p> <ol style="list-style-type: none"> <li>a. Pre-populate annual survey forms with known information and ask enrollee to verify and update provided information.</li> <li>b. Do not require patient to repeat information by formatting form such that demographic and employment information is entered only once</li> <li>c. Provide COB forms on-line</li> <li>d. Allow practices/providers to provide COB form to patient at time of service and to submit COB form/information to payer on behalf of patient. <ol style="list-style-type: none"> <li>i. Provide blank COB forms on line</li> <li>ii. Include a flag on insurance eligibility page that COB information is needed</li> <li>iii. Include COB fields within insurance eligibility page so that there is no need to complete a separate COB form.</li> </ol> </li> </ol>
Eligibility & Benefit Design	<p><b>Newborns.</b> Payers agree to provide all requesting providers with information that will enable the provider to distinguish patients covered by fully insured and self-insured products (including documentation on health insurance cards)</p> <p>Payers agree to add babies covered under self-insured accounts as of the date of birth.</p>
Eligibility & Benefit Design	<p><b>Insurance Status.</b> Payers agree add the insurance status (fully insured or self-insured) to the insurance eligibility page at such time the payer is making changes to that page of their website.</p>
Eligibility & Benefit Design	<p><b>Multiple births payer code edit change:</b> Payers ensure claims processing software adequately distinguishes between multiple births and duplicate claims</p>
Eligibility & Benefit Design	<p><b>State policy change:</b> The Medicaid program allows state-certified family resource counselors to inquire as to the status on their patient when the patient’s ID number is their social security number.</p>
Coding & Billing Procedures	<p><b>Coding Updates.</b> Payers agree to post on their respective websites information regarding key claims payment systems capability updates, such as code version updates, grouper updates and re-pricing. It will be the responsibility of the “coding super group” to detail what system capabilities updates must be posted and the degree of advanced notice required.</p>
Coding & Billing Procedures	<p><b>Claims Pended Report.</b> Payers will determine if they can provide a report similar to the one currently provided by BCBSRI which lists claims pended and reasons why they are pended.</p>
Coding & Billing Procedures	<p><b>Pending Claims Denial Policy.</b> Providers will determine if they can adopt a policy of pending the listed claims for 180 days, after which they are denied.</p>
Coding &	<p><b>Super Administrative Simplification Resolution Team.</b> Convene an all payer, all major provider</p>

Category	Topic
Billing Procedures	group (referred to as the “super administrative simplification resolution team”) that will initially meet monthly to resolve coding and other systemic administrative issues. The group will be composed of leaders in a position to make policy and operational changes that address root causes of problems identified, and technical specialists who can provide necessary detailed explanations of issues and implications of possible solutions. The group will focus on understanding the root cause of administrative complexities and developing possible solutions. Issues identified include:
	<ul style="list-style-type: none"> <li>• There are services that could be processed either as a medical claim or a behavioral health claim (e.g., services associated with dementia). Providers do not know how to submit a correctly coded claim.</li> <li>• Medical vs prevention claim confusion</li> <li>• Sequencing of Diagnostic Codes (claim is not fully paid and needs to be resubmitted multiple times with various diagnostic code sequencing to be fully paid)</li> <li>• Corrected Claim (claims are being denied as duplicates, if the dollar amount to be paid is identical, even though other changes have been made to a previously submitted claim)</li> <li>• Use of modifiers 50 and 59</li> <li>• Placement of V-codes</li> <li>• Harmonizing coding requirements with national standards and among Rhode Island payers.</li> <li>• Overlapping authorizations</li> </ul> <p>Identifying new business scenarios for CORE regarding use of denial codes.</p>
Medical Management and Administrative Appeals	<b>Notification Timeline.</b> Payers agree to send a written decision to providers regarding a claims appeal within 60 days of receipt of the appeal request and that this timeline will be met 95% of the time.
Medical Management and Administrative Appeals	<b>Semi-annual report.</b> Payers agree to submit a semi-annual report on July 31 and January 31 of each year to report on actual rates of compliance during the reporting periods of January 1 through June 30 and July 1 through December 31. Payers who submit this information to another state agency in fulfillment of a state requirement will be deemed to have met this requirement. OHIC agrees to work with the sister agencies to increase public availability of the information.
Medical Management and Administrative Appeals	<b>Expand Monthly Payer-Provider Meeting Participation.</b> Payers and providers agree to expand participation in the monthly claims resolution meetings that payers and providers currently hold to include key decision-makers and representatives from other areas, such as network contracting representatives, so that more claims can be resolved at the meeting.
Medical Management and Administrative Appeals	<b>Escalation Process.</b> Payers and providers further agree to develop an escalation process that both payers and providers view as effective in promptly resolving payment issues.
Medical Management and Administrative Appeals	<b>Appeals Checklist.</b> Payers and providers agree to utilize a <b>checklist</b> for timely filing requests of reconsideration or appeals requests, as developed in Administrative Simplification workgroup. The checklist should include a narrative portion for providers to explain their request. Over time, expand the checklists to include other claims types, as necessary. <b>Checklist Available Electronically.</b> Payers agree to make the checklists available electronically, if

Category	Topic
	the payer currently offers or will offer providers the ability to submit appeals electronically.
Medical Management and Administrative Appeals	<p><b>Provider Appeal Response.</b> Payers agree to provide the following in response to provider appeal request</p> <ul style="list-style-type: none"> <li>• A clear statement of what the payer understands are the providers reasons for submitting an administrative appeal.</li> <li>• A clear and complete explanation of reason for the payer’s decision, addressing each of the elements included in the provider’s appeal submission.</li> </ul>
Medical Management and Administrative Appeals	<p><b>Use of CARCs and RARCs.</b> Payers agree to use the CORE CARCs and RARCs response combinations for responding to reconsiderations that are processed through the payer’s claim payment system</p>
Medical Management and Administrative Appeals	<p><b>Medicaid Data Feed.</b> Payers and providers agree to work with Medicaid and the Medicaid Managed Care Organizations to resolve the root cause of problem and synchronize website and eligibility feeds. Payers and providers may seek OHIC involvement in the event that problem resolutions are not moving forward.</p>
Medical Management and Administrative Appeals	<p><b>Black Belt Summit on Medical Record Submission.</b> BCBSRI, Tufts Health Plan and United Healthcare agree to host a “black belt” summit to map out current processes within payer and provider organizations and develop simpler processes using LEAN and Six Sigma techniques.</p>
Medical Management and Administrative Appeals	<p><b>Mis-addressed Medical Records.</b> Payers agree to adopt policy of notifying the sender of mis-addressed medical records.</p>
Medical Management and Administrative Appeals	<p><b>Posted Addresses.</b> Payers agree to post their current lists of verified addresses for claims and medical records submissions on their respective websites in a location that is easy to locate and integrates with the enrollee eligibility look-up section of the website.</p>
Medical Management and Administrative Appeals	<p><b>X12 Transaction Summit.</b> Payers agree to fully use 278 transactions to request and submit prior authorization requests. <b>Convene an X12 transaction “summit”</b> with all necessary participants (including vendors) to coordinate the building of 5010 capacity.</p>
Medical Management and Administrative Appeals	<p><b>Retroactive Reviews.</b> Payers agree to adopt a policy of providing retroactive reviews of claims for services initially denied for lack of a prior authorization if the claim is for services that were determined to be medically necessary upon review.</p> <ul style="list-style-type: none"> <li>• To better understand the operational and policy implications of a policy change to allow retroactive reviews, Tufts Health Care and NHPRI agree to meet with providers to review issues and concerns. BCBSRI and United Healthcare agree to meet with NHPRI and Tufts Health Plan to explain their processes to reviewing claims denied for lack of a prior authorization.</li> </ul>

**ATTACHMENT C**

**List of Billing and Coding Sub-Group Participants**

Affiliation	Name
Bailit Health Consulting	Marge Houy
Blue Cross Blue Shield of Rhode Island	Dianne McCormick
Blue Cross Blue Shield of Rhode Island	Charley Kineke
Blue Cross Blue Shield of Rhode Island	Peter Hollmann
Blue Cross Blue Shield of Rhode Island	Jack Emerson
Blue Cross Blue Shield of Rhode Island	Nancy Silva
Blue Cross Blue Shield of Rhode Island	Lisa DaSilva
Blue Cross Blue Shield of Rhode Island	Sheila Reilly
Blue Cross Blue Shield of Rhode Island	Karen Labbe
Blue Cross Blue Shield of Rhode Island	Maria Andrade
Blue Cross Blue Shield of Rhode Island	Sheila Reilly
CAQH/CORE	Omoniyi Adekanmbi
Care New England	Helen Reed
Care New England	RieAnne Thomas
Care New England	Gail Fugere
CPM	Julie Sylvestre
CPM	Kelly Violette
Gateway Health	Patricia Grover
Hospital Association of RI	Cecelia Pelkey
Jaffe OB/GYN	Bonnie Jaffe
Lifespan	Donna Walker Thomas
Lifespan	Christine Rawnsley
Lifespan	Denise Peffer
Lifespan	Michelle Smith
Lifespan	Kellie Johnson
Lifespan	Brenda Malone
New England Medical Billing	Michelle DeRoche
NHPRI	Tayna Vasquez
RIMS	Steve DeToy
Tufts	Eric Moffat
Tufts	Patrick Ross
UHC/UHCNE	Shannan Alsfeld
UHC/UHCNE	Ellie Lewis
UHC/UHCNE	Jenny Hayhurst
UHC/UHCNE	Kathy Burke