The Need For Complete and Transparent Health Care Claims Remittance Data in State All Payer Claims Databases
ABOUT THE PHYSICIANS ADVOCACY INSTITUTE, INC. (PAI)

The Physicians Advocacy Institute, Inc. (PAI) is a not-for-profit 501(c)(6) advocacy organization established in 2006 with funds from Multi-District Litigation (MDL) class action settlements against major national for-profit health insurers. The basic allegations in these settlements were that these national health insurance companies, among other complaints, systematically denied, delayed and/or reduced payment to physicians who had delivered services to covered patients. The PAI was founded under the settlements to ensure compliance with settlement terms, which promoted fair and transparent payment by national health insurer defendants.

Today, the PAI’s mission is to advance fair and transparent payment and contractual policies by payers and others in order to sustain the profession of medicine for the benefit of patients.

STATE MEDICAL ASSOCIATIONS REPRESENTED ON THE PHYSICIANS ADVOCACY INSTITUTE BOARD OF DIRECTORS

California Medical Association
Connecticut State Medical Society
Medical Association of Georgia
Nebraska Medical Association
Medical Society of the State of New York
North Carolina Medical Society
South Carolina Medical Association
Tennessee Medical Association
Texas Medical Association

To contact PAI regarding this paper or other PAI efforts, please contact Kelly Kenney at k2strategiesllc@gmail.com
The Need for Complete and Transparent Health Care Claim Remittance Data In State All Payer Claims Databases

PAI’s Case for Transparency in State All Payer Claims Databases

Since its inception, the PAI has worked to arm physicians with data to help enhance their practice efficiencies and empower them to make better business decisions as they attempt to meet the demands of a rapidly evolving health care system. In keeping with these values, PAI lauds state efforts to establish all payer claims databases (“APCDs”) to support the ever-growing demand for information regarding health care utilization, expenditures and transactional functions. Well designed and administered state-sponsored APCDs serve as critically needed resources for all health system stakeholders by establishing a comprehensive repository of data on transactions between health care providers and payers.

States planning an APCD must define the scope and format of reported claims data considering both current and potential uses for the data as health care analytics grow more sophisticated. If a state’s approach yields data that is transparent, comprehensive and consistent with national standards, stakeholders throughout the health care system will utilize APCD data to fuel a wide range of analytics aimed at improving health care quality and system efficiencies. To ensure compliance and support for APCDs, all stakeholders should have confidence that the information collected is comparable and consistent with the standards established under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

This issue brief addresses a critical aspect of data reporting that is a top priority to physicians and essential to the goals of state APCDs – the need for states to require reporting of complete and accurate remittance information consistent with HIPAA standards.

Experience has shown that some payers balk at reporting certain types of information, and in particular remittance data relating to denied, adjusted or pended claims. Given the historical context of PAI’s involvement with payers, we must ask the obvious question: why, when this information is readily available and collected, don’t payers want it revealed publicly to physicians, other providers and consumers?

In PAI’s view, it is imperative that states capture this important data from the very onset of collection efforts, based on the following facts:

- Partial or incomplete reporting skews the data necessary for business analytics of key stakeholders and undermines state efforts to promote transparency, improved quality and increased efficiencies through development of an APCD.

- Payers must already communicate this information in HIPAA’s standard electronic remittance transaction known as the “835” transaction. Reporting information that already exists is in no way burdensome to payers.

- The stakes of having accurate and complete remittance information are very high for physicians and other health care providers whose “efficiency and performance” are being measured using data from APCDs. State-sponsored data warehouses must be fair to all those submitting data as it will inevitably be used in ways that impact the
livelihoods, business decisions and professional reputations of physicians and other health care providers.

➢ From a national perspective, the importance of standardized data reporting across state APCDs cannot be overstated. Collecting HIPAA-consistent data will facilitate analytics on national health care utilization, spending and other key metrics. Consistent reporting requirements also make compliance less costly for multistate payers as well as for the states that are funding APCDs, which will be able to share development costs with other states.

➢ Once reporting standards are set, it is extremely challenging to change them. Doing so is expensive for reporting entities and undermines the consistency of data collected.

Utilization of APCD Data by Stakeholders

A full picture of the adjudication of health care claims is necessary for stakeholders to review and assess their business and financial practices and inform future decisions. This maxim is best understood in the context of how collected data will be utilized.

State policymakers will utilize APCD data to:

• Track health care utilization, expenditures and outcomes, including health care services provided under publicly funded health care programs and state mandated health benefits, to assess what benefits are being provided and covered;
• Identify trends in health care delivery and payment;
• Monitor the efficacy of various state-sponsored health care reform initiatives and other state regulatory policies; and
• Identify payers and providers who are not complying with state regulations relating to billing and reimbursement. Detailed, complete remittance information is needed for these analytics.

Physician practices will utilize remittance data collected in the APCD to:

• Assess and address problems with the practice’s billing workflow and adopt more efficient billing processes where needed, reducing administrative expenses over time;
• Track payer-specific adjudication and payment trends for particular claims or claim lines, including claims denials, adjustments (such as down-coding and/or bundling of claims) or pended claims. This functionality is critical to resolving ongoing disputes over adjudication issues;
• Evaluate and respond to payer and other third party efforts to profile and/or tier physicians based on economic and utilization data derived from the APCD; and
• Track timeliness for payment of claims, both in aggregate by payer and for specific claims.

On a larger scale, ACOs and larger integrated health care systems’ access to APCD data will drive business intelligence operations. For instance, complete historical claims data, including denials and other adjustment information, is critical for analytics to inform risk-based payment arrangement between these health systems and payers.
Consumers and employer plan sponsors also benefit from information collected by state-sponsored APCDs to facilitate educated health care decision-making. The consumerism movement demands access to unbiased information, and APCDs will help promote efforts on this front by consolidating data that can be presented to the public in formats that inform decisions. Assuming current trends hold, patients will continue to assume greater financial responsibility for their medical expenses, and as such, access to payer-specific claims information will be increasingly important to them. With regard to remittance data, employers, other sponsors and consumers all need data that reflects whether benefits for covered services are indeed being paid.

Finally, *payers* will utilize data from APCD to assess key business metrics against other payers.

**Why Reporting HIPAA-Consistent Remittance Data to APCDs is Essential**

Considering these important uses of state-collected data, it is imperative that states develop rules from the onset that generate reporting that captures all relevant data points. State data reporting standards that yield less than complete remittance data will impede system efficiencies afforded from these data-dependent analytic and system improvement activities.

Invariably, state policymakers will encounter reluctance among payers to report certain remittance information -- for example, information regarding pended or partially denied claims -- to state APCDs. Notwithstanding this stance by some payers, there is no compelling rationale for excluding remittance information from state data reporting requirements. APCDs collect data from existing IT systems employed by providers and payers to handle electronic claims processing functions. Of necessity, today’s systems comply with requirements adopted pursuant to the HIPAA, which govern the manner in which health care providers and health care payers interact via electronic transactions. Even payers that utilize intermediaries to process 835 remittance transactions should be able to submit the same remittance information to state APCDs.

In addition, HIPAA-compliant 835 information should be reported because:

- Health care providers and payers are under close scrutiny for HIPAA compliance, facilitating compliance with state reporting requirements that mirror HIPAA standards.
- Utilizing HIPAA standards will allow APCDs to leverage the investment of stakeholders who have installed HIPAA compliant IT solutions.
- Following nationally standardized transactions, including the 835-remittance transaction, will increase standardization of collected data across states.
- Following national standard helps assure fair and equal treatment of all stakeholders by using a common language and a common set of definitions.

**Understanding the 835 HIPAA Remittance Standard Transaction**

It is important that state policymakers understand HIPAA electronic remittance requirements. The key HIPAA standard electronic transaction code set for payers to communicate remittance
information to submitting physicians is the ASCX12 835 Health Care Claim Payment/Advice transactional code set (“835”). Payers must submit an 835 electronic remittance advice transaction upon adjudication of every claim. For any claim or claim line that is not paid as billed, payers must include a HIPAA-compliant standardized adjustment reason code or codes. These codes are called Claims Adjustment Reason Codes (“CARCs”) and Remittance Advice Remark Codes (“RARCs”). CARCs and RARCs provide providers and consumer-patients with important information regarding how the payer has adjudicated and paid, or refused to pay, claims or specific lines of claims for health care services. CARCs define what is being done with a particular service or claim and must be included on every 835 if the payment is less than the submitted charge. RARCs are essentially a second level of greater specificity or granularity of information and, when applicable, appear on most 835s. This greater specificity helps providers and insurers understand what has occurred with the associated claim line adjudication.

HIPAA requires all payers to submit 835s utilizing only the standardized list of CARCs and RARCs included on the ASCX12-approved list, which is maintained and updated regularly through a formal CMS-approved process that provides opportunity for industry input regarding business needs. For physicians, utilizing a single, consistent list of CARCs and RARCs provides a common language for understanding remittance information, regardless of the payer. This allows a physician practice to assess why a specific claim, or claim line, was denied or otherwise adjusted, which the practice needs to inform next steps. For instance, the physician practice may need to take corrective action to amend and resubmit a claim if necessary or it may appeal a payer’s decision to deny a claim if appropriate.

**Conclusion**

The PAI supports state efforts to facilitate the collection of health care data to promote meaningful improvements throughout the health system. To facilitate the myriad purposes that APCD-collected data will serve over time, state data reporting requirements should reflect the nationally standardized requirements developed pursuant to HIPAA. APCDs that collect all 835-remittance data will capture valuable information about which claims for health care services are routinely approved, denied or adjusted in some manner by payers. Without access to accurate and complete data, it will be impossible for physicians and other stakeholders to confront the demands of today’s health care marketplace.