Health and welfare benefit funds may have more provider network choices than in the past. Among the factors to consider in selecting a provider is how a preferred provider organization or other claim repricer handles claims electronically. The various processes that are available will affect the fund's office in different ways.

PPO Repricers:
The EDI Perspective

by Stephanie Doyle

In the changing landscape of health care, many multiemployer health and welfare benefit funds are finding they have more choices when shopping for a provider network. Competition among repricers, as well as networks expanding their provider contracts into wider geographic regions, have presented an opportunity for many funds to do some price comparison.

Fund administrators must consider a host of factors when determining which preferred provider organization (PPO) will best suit their membership. Among those factors are provider disruption, access fees and discount rates.

Administrators should also consider how—or whether—the PPO network handles the repricing of claims electronically. Most *claim repricers* (groups that contract with PPOs to reprice out-of-network claims) or *PPO repricers* (which apply discounts and other claims edits to determine what portion of a provider's bill is to be paid according to a contract) have made some type of transition to using an electronic process, which can save both time and money for a fund office.

Fund offices that are currently working with a PPO should ask about the PPO's electronic data interchange (EDI) capabilities. Different options for electronic claims transmission are available, and it is important to understand what impact these different processes will have on a fund office.

Transitions

In the last ten years, the methods fund offices have used to receive repricer discounts have changed radically. Gone are the days of faxing paper claims and receiving a cover sheet in return.

Moving away from the fax strategy, one of the first methods repricers used was to provide a data dump to fund offices. Large provider files, accompanied with larger fee schedule files, could be transmitted to the fund office for download. A fund office's software system needed to accommodate these huge downloads. If properly handled, the fund's software system could import the fee for service directly into the claim during the adjudication process. This saved time, but the downloads were often time-consuming for the fund office staff. And fee schedules were updated quarterly at best, sometimes resulting in incor-

rect payment to providers and an increase in claim adjustments.

Some provider networks, not comfortable with the release of their proprietary fee schedules, offered a different online solution—a tactic that often required double entry of data. It was easier to work with this option than with massive provider files and inadequate fee schedule updates, but claims adjusters were required to key data into both the repricer system to determine the discount and again into the fund office's claim adjudication software to process the claim.

EDI

The simple solution to all of this is the government standard Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 electronic claim format. The advent of the 837 has allowed for huge strides in the ability to electronically download claim information rather than having claims adjusters manually enter data from a paper form. Within minutes an entire day's worth of claims can be downloaded for adjudication. More time can be spent examining and analyzing the information rather than keying it, which could increase daily productivity. Beyond this, the 837 has also expedited the process for fund offices to receive discount amounts from repricers.

When moving to an electronic approach to claim processing, there must always be communication between the technical staff of the fund office and the repricer to ensure the data being transmitted is handled correctly. The first priority is security. Typically, standard "pretty good privacy" (PGP) encryption will work to secure the transfer of files electronically, but the repricer may have additional requirements.

Another potential wrinkle is that the standard 837 isn't always so standard. Different repricers have interpreted different segments of the 837 for different purposes. The first and most important is the determination within the 837 whether the claim is in or out of network. There also needs to be a conversation between the fund office and repricer regarding various other pieces of data normally received via paper. For example, how is the other carrier's explanation of benefits (EOB) for coordination of benefits (COB) claims being transmitted to the fund office? Also, different types of message codes can be passed within the 837. Types of message codes can include HIPAA-compliant clerical and administrative salaries (CAS) codes, proprietary out-of-state network codes or edit-checking codes that relate to bundled services.

Types of Repricing Through EDI Transmissions

Through work with more than 30 different repricers nationwide, the author has identified three standard methods of repricing claims through the use of an EDI transaction. In most cases, a repricer will use one of those standard methods, with no other option offered to the fund office. In other cases, repricers offer multiple electronic processes. Whether an administrator is choosing between repricers, or is working with an existing repricer to move to an electronic solution, it is important to know the options available. They can dramatically impact the workflow of a fund office.

Send and Receive

With the send and receive method, claims are still submitted to the fund office. Claims are either mailed or in some cases transmitted electronically through a clearinghouse, which will be discussed in greater detail below.

The claim is loaded, either manually or electronically, into the claim-processing software. The claim is reviewed and adjudicated up until the point of payment. Then a sweep of claims occurs at some point during the day or night, typically in a batch-processing job. The claims are transmitted to the repricer through a secure file transfer protocol (ftp) connection. The repricer receives the 837, determines if the provider is in-network and then inserts the corresponding discount amount if applicable. The claim information, unchanged except for the updated discounted amounts on either a line or claim level, is returned to the fund office. The fund office then uses the discount amounts to finish the payment calculation and process the check.

The benefit to this method is the control of the data by the adjuster. Claims examiners maintain their more traditional workflow. For example, if they are still receiving paper, they can make decisions up front based on information easily viewed on the form. They also can review eligibility and patient history and determine if they have all the necessary data from either the member or provider before sending the claims off for repricing. All the work of adjudication is done in advance so that once the discounts are returned and the payment amount is calculated, the claim can be released.

The downside to this method is that it requires claims to be submitted directly to the fund office. For most groups, this still means paper. With paper come all the drawbacks of data entry. The only enhancement here is the more efficient method of receiving the repricer discounts. It is also important to note that this requires the continued maintenance of the provider file. Most repricers require the rendering address of the provider to be submitted on the 837 in order to appropriately determine the discount. However, the fund office also needs to maintain the billing address of the provider for the purposes of check issuance. The claim-processing software needs to be capable of storing both addresses on a claim-by-claim level.

Receive-Only

In the receive-only method of electronic processing, claims—both paper and electronic—are sent directly to the repricer. The repricer accepts the information into its processing system, determines the network status of the provider and either generates or updates the 837 with the discount amounts. Typically in a batch-processing job, the 837 file is transferred to the fund office on a set schedule.

Some repricers might require the transmission of an eligibility file. Most commonly, this is handled with a HIPAA-compliant benefit enrollment and maintenance transaction (or *834 transaction*), but it may be done via a proprietary file layout as well. What's important here is that the 834 file is not used to determine patient eligibility and deny claims accordingly. Eligibility determination at time of claim processing should still be left to the fund office. The 834 file serves only as a baseline check for provider queries regarding patient coverage and sometimes as a tool for determining network access fees for billing purposes.

The benefit to this process is that claims can be automatically loaded from the repricer directly into a fund's claim-processing software, avoiding the need for manual data entry. This allows the adjusters at the fund office to focus solely on the

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adjudication of the claim, which can increase productivity throughout the office.

Unfortunately, the downside is that there must always be a confirmation of the information being received in the 837 against the maintained census data stored in the fund office's claim adjudication software system. When considering an autodownload of claim information, a careful match of patient information is crucial. To ensure that the claim is being processed for the correct dependent, patient information as well as member information needs to be matched. Name, relationship status, sex and date of birth are all standard pieces of data in the 837 that can be used for verification.

With all claims being downloaded electronically, the fund office will no longer have access to the original paper claim. This requires standards for receiving or being notified of paper attachments that are transmitted in connection with the claim. This also requires that the claim-processing software has the ability to accept and display all necessary data needed for proper claim adjudication.

Shared Administration

Similar to the receive-only method, the claim flow for the shared administration process directs that all claims are sent either by paper or electronically to the repricer. The repricer then transmits the claims to the fund office via the 837. The fund office staff adjudicates the claim and determines payment. However, rather than paying the claim at this point, the fund office instead transmits back to the repricer an 835, another HIPAA-compliant transaction that serves as an electronic EOB. In some cases, the repricer issues all provider payment checks while member reimbursement checks continue to be issued by the fund office. In other cases, all provider payment and member payment checks are still issued by the fund office, but the repricer may handle out-of-state provider reimbursement. With shared administration, regardless of who issues the checks, there must also be a reconciliation process in place that allows for both the repricer and the fund office to verify that all claims have been processed and accounted for.

The benefit to this process is, again, the electronic download of claims. Also, for those repricers that issue provider payment checks, typically all provider calls are handled by the PPO. The fund office can focus on member calls, which can also reduce the staff workload. However, the fund office does need to recognize that it is giving up some control over provider communication. And due to the turnaround time required for provider reimbursement, there can be time constraints placed on the adjusters for releasing and returning claims.

Within the shared administration environment, adjustments to claims requiring either a refund or additional payments are typically initiated by the repricer. This can result in some delays for turning around corrected claims and requires a communication procedure in place between fund office staff and PPO.

Clearinghouses

As mentioned previously, plan sponsors that are still receiving paper claims in the office and wish to move to an electronic process have the option of using a clearinghouse. Most providers have at this point signed up with a clearinghouse, and by utilizing one should see a significant reduction in the submission of paper claims. The clearinghouse process would mimic the receive-only process, but without any provider network status or discounted amounts. Clearinghouses come with a per claim transaction fee, but many funds are finding that the advantages of time saved with electronic transmission are worth the fee.

Medicare Crossover

The last piece of the technology puzzle to consider is *Medicare crossover*. This is the receipt of claims electronically directly from the Centers for Medicare and Medicaid Services (CMS). For groups with a supplemental Medicare benefit plan, utilizing crossover can expedite claim payment and eliminate the need for repricer intervention. As most funds will accept the Medicare allowance as the primary allowance in cases where Medicare assignment is accepted, processing these claims through a repricer can be redundant. Crossover gives the fund office the ability to accept claims electronically without the need to redirect those claims through the repricer where the benefit of any discount is negated. There is a per claim transaction fee associated with crossover claims, but many funds find the cost is offset by the advantage of receiving the claim electronically as well as the savings earned by not having to pay access fees to a PPO for the fund's Medicare population.

The Future

Transmittal of paper claims will soon be phased out. Funds that haven't made the transition to electronic processing need to find a PPO/repricer that provides electronic options.

Funds that can choose from among multiple repricers should base their decision not solely on the discounts offered, but also on the options for electronic processing methods that will work best for the fund office staff. B&C

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Stephanie Doyle is a graduate of Catholic University of America and has been an employee at ISSI for 15 years. She currently heads the claims department and specializes in EDI implementations for all health and welfare fund clients. Doyle has worked with more than 30 PPOs nationwide in transitioning her clients to EDI.