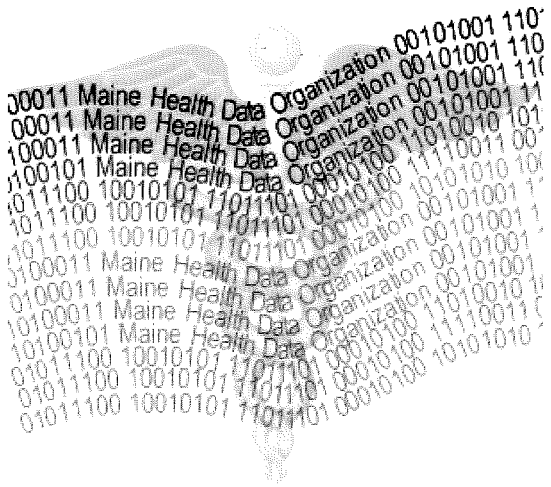



# Findings of the Work Group

## Established Under

## Resolves 2007, Chapter 155

## To Eliminate or Reduce the Health Care Data Collection Problems Associated with Global Claims

**Presented to the Joint Standing Committee on Health and Human Services**
**of**
**The 124th Maine State Legislature**

**January, 2009**



**Report Prepared**
**by**
**Alan M. Prysunka**
**Executive Director**
**Maine Health Data Organization**

## Table of Contents

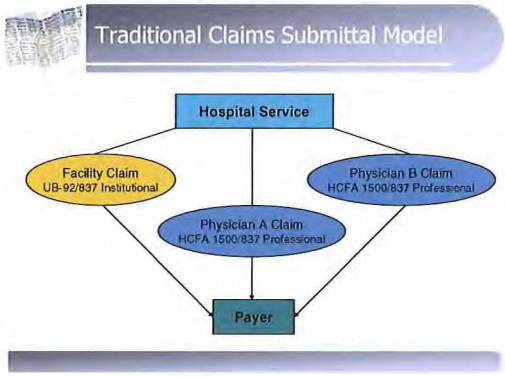
## I. Background

Eighteen months after the Maine Health Data Organization (MHDO) began receiving health care claims data from the commercial health insurance carriers and third party administrators in January of 2003, an internal analysis was conducted to determine the complexity of aggregating all claims (facility and professional) for specific services provided to individual members at Maine's acute care hospitals. As a result of that analysis, the MHDO determined that, in some cases, this could not be done and discovered the existence of what are commonly referred to as "global claims" in the data.

A global claim is a facility claim that also includes information related to services performed by physicians for the specific encounter, which are more commonly submitted as separate professional claims, as lines within the claim (Figure 1), (Figure 2). These claims are submitted in accordance with national standards, which require that inpatient claims contain lines based upon non-repeating revenue codes. All charges for a particular revenue code are aggregated with only one physician identified per revenue code. This results in the loss of the identities of other physicians providing a service under the same revenue code (particularly a problem with code 960, which includes all surgeries). Hospital outpatient claims contain lines based upon aggregated charges using Current Procedural Terminology (CPT) codes, which can also result in the loss of a physician's identity. However, it is uncommon for multiple physicians to be providing a service under the same CPT code for a hospital outpatient service.

*Figure 1*


*Figure2*




Commercial global claims can only exist when their creation and submission is allowed through the payment terms and conditions within a specific contract between the health care provider and payer. Governmental payers will stipulate under what conditions global claims may be submitted.

This type of claim most commonly occurs when a hospital owns a physician group or employs physicians directly. At present, the number of hospital-

owned/employed physicians is approximately 1,200, representing slightly over 50% of the active allopathic and osteopathic physicians, and this figure is increasing. In Maine, global claims are created by all acute care hospitals for emergency department and hospitalist services. Some hospitals, such as those within the Eastern Maine Health system, also submit global claims related to surgeries, while all other Maine acute care hospitals submit some global claims related to certain diagnostic services.

Although most global claims are generated when physicians are owned or employed by a hospital, this is not always the case. The Maine Heart Center was established as a billing entity to better manage payments for cardiac services provided by five hospitals and a number of cardiology group practices not owned by any of the hospitals. Through formal contractual relationships, the Heart Center receives individual facility and professional claims from the various participants and then combines the information on one new global claim and sends it to the member's payer. When the claim is paid in accordance with an established fee schedule, the Heart Center retains a processing fee and then, under the terms of the contracts, pays the proportionate shares to the hospital and physician(s) associated with the claim.

Currently, CMS requires separate Medicare claims for facility and professional charges unless the hospital is designated as a Critical Access Hospital (CAH). CAH's may elect to submit global bills for outpatient services. Additionally, all Tricare claims must be submitted separately.

Under the current MaineCare claim system requirements, all hospital claims related to non-office visits are submitted globally.

## II. Impacts of Global Claims

Although their existence is derived through contractual obligations, global claims can have negative cost implications for both the payment and administrative processes of hospitals and payers. In addition, because of their current construct, the information contained in global claims is usually incomplete and occasionally inaccurate, which is problematic when one is interested in identifying the physicians performing the services associated with the specific hospital encounter and claim. For those using claims databases (which includes government, health care providers and payers, researchers, employers and consumers), the inability to accurately identify individual physicians creates the following problems:

- Loss of data specificity, resulting in underreporting, procedures with no clinical reference, and inaccurate qualitative comparative analysis;

- Inaccurate payment assignments, which prevent the accurate determination of total price paid for hospital vs. professional services;
- Limiting the functionality of health care services grouping software; and
- Inefficient use of analytical resources by requiring additional human resources to evaluate alternative methodologies to identify physicians and associated codes/data.

Global claims may also create problems in the measurement and reward processes associated with pay for performance initiatives due to the inability to identify physicians and/or associate them to the services they provide.

## III. Legislative Initiatives Impacting Global Claims

In 2004 the Maine Bureau of Insurance began receiving complaints by individuals indicating that the deductible amount for a routine office visit to their primary care physician (PCP) was being categorized by their commercial health insurance carrier as a hospital outpatient service, which carries a much higher deductible and/or co-pay than an office visit. When the Bureau of Insurance investigated these complaints, it determined that the PCP's were employed by the hospitals, and the higher deductibles and/or co-pays were the result of global facility claims being generated instead of professional claims. As a result, the Bureau of Insurance introduced a piece of legislation in 2005, which was enacted during the 122nd Session of the Maine State Legislature as PL 2005, Ch. 97 – "An Act to Amend the Laws Regarding Submission of Health Insurance Claims", codified in 24-A M.R.S.A. Sections 1912, 2753, 2823-B, and 4235. This legislation requires that separate facility and practitioner claims be submitted for all services provided in an office setting (i.e. – routine health examinations, diagnosis and treatment of illness or injury) regardless of where the office is located (in the primary hospital building or off-site). Physician services provided in a hospital inpatient, emergency department, or outpatient setting not described by PL 2005, Ch. 97 would continue to be allowed to be included in a global facility claim. The specific language from PL 2005, Ch. 97 is as follows:

> All services provided by a health care practitioner in an office setting must be submitted on the standardized federal form used by noninstitutional providers and suppliers. Services in a nonoffice setting may be billed as negotiated between the administrator and health care practitioner. For purposes of this section, "office setting" means a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility.

In 2007, a bill entitled, "An Act To Improve the Quality of Health Care in Maine", was introduced on behalf of the MHDO during the First Regular Session of the 123rd Maine State Legislature. The intent of the bill (LD 1843) was to prohibit all

global claims not covered by PL 2005, Ch. 97. It would have required that all commercial health care insurance claims for professional services rendered by an allopathic or osteopathic physician licensed in Maine be submitted on a professional claim form (CMS 1500 or ASC X12N Professional). This requirement was specifically aimed at those physicians directly employed or owned by hospitals and those associated with the Maine Heart Center. A copy of LD 1843 is attached as Appendix A. At the public hearing for LD 1843 (held on May 11, 2007) representatives from a number of Maine hospitals provided testimony in opposition to the bill due to the significant costs associated with modifying their systems and the substantial increase in the number of claims to be submitted.

At the same time LD1843 was under discussion, the MHDO had been discussing the problems associated with global claims with the State Uniform Billing Committee (SUBC), a group which meets every other month to exchange information concerning the health care claim payment system and to represent Maine's concerns with the National Uniform Billing Committee (NUBC). The NUBC is the entity which establishes the national business rules for health care claim process and content. Its current rules contribute greatly to the problem of being unable to accurately identify individual physicians by not allowing revenue codes to be repeated in all facility claims and prohibiting the use of Healthcare Common Procedure Coding System (HCPCS) codes in a hospital inpatient claim.

The SUBC, which is composed of individuals from hospitals, practitioner groups, commercial health insurance carriers, public payers, and other interested private sector and governmental entities (including the MHDO), had, in years past, discussed using the UB facility claim for all hospital claims involving hospital owned physicians. Some of the SUBC members felt that expanding the number of global claims (if they could be modified to include detailed physician information) would actually save money by reducing the total number of claims and the number of lost or incomplete claims needing to be resubmitted. Although carrier members did not support or oppose the recommendation, they were clear that if it was approved, they would be unable to quantify system modification timelines or to guarantee the ability to make the necessary changes. After a specific request from the MHDO and discussion at several meetings, the SUBC petitioned the NUBC in late 2007 to undertake a one year demonstration project to assess the viability of creating and submitting global facility claims containing more detailed physician information. In January of 2008 the NUBC granted the SUBC's petition.

The demonstration project was to span a one-year period and was limited to hospitals physically located in Maine and health plans licensed to operate in Maine and only for their members/enrollees. Its purpose was to test the feasibility and efficiency of allowing hospitals to report performing hospital-based physician information on inpatient and outpatient hospital claims using a Form Locator (FL49) on the claim to reference the physician information contained in a

number of other data elements for three revenue code categories forprofessional fees. A limited range of HCPCS procedure codes for inpatient claims was also to be allowed. At the conclusion of the project, the SUBC was to provide the following information to the NUBC: identify the total volume of claims in Maine that contain both the facility (technical) and professional billed amounts separated by inpatient and outpatient; estimate the total cost for the health care providers to implement the combined (global) billing approach; and estimate the total cost for the health plans to implement the combined billing approach. The complete *Scope of Work for the Maine Combined Bill Demonstration Project* is included as Appendix B.

During the work sessions for LD 1843, the MHDO concurred that, although solving the data collection problem, prohibiting all global claims would indeed substantially increase the number of hospital claims submitted, leading to higher costs and inefficiencies in the health care payment system. Although modifying global claims to include the additional physician information would also solve the MHDO's data collection problem, it was unclear what the fiscal impact would be upon the carriers, third-party administrators, and hospitals. As a result of the financial uncertainties and the need for much more detailed analysis, the Health and Human Services Committee elected to eliminate the original language of LD 1843 and replace it with a Resolve, entitled: *To Eliminate or Reduce the Health Care Data Collection Problems Associated with Global Claims.* The Resolve charged the representatives of health insurance carriers, third-party administrators, hospitals, the Maine Association of Health Plans, the Maine Hospital Association and the Maine Health Data Organization to form a work group and evaluate the NUBC demonstration project or identify and propose an alternative that would solve the data collection problems associated with global claims. The work group was required to report its findings to the Joint Standing Committee on Health and Human Services Committee by January 15, 2009. A copy of the Resolve is attached as Appendix C.

## IV. Establishment of Global Claims Work Group

In accordance with the provisions of 2007 Resolves, Chapter 155, a Global Claims Work Group (GCWC) was established in July of 2008. The membership of the GCWG is as follows:

Health Insurance Carriers/Third-Party Administrators
Katherine Pelletreau, Maine Association of Health Plans
Martha Ridge, Anthem Blue Cross Blue Shield
Rebecca Genest, Anthem Blue cross Blue Shield
Kristen Larkin, Aetna
Stacey Forcier, Aetna
Jeffrey Tindall, Cigna
Robert Downs, Harvard Pilgrim Health Care

Terri Bellmore, Harvard Pilgrim Health Care
Paula Muller, Harvard Pilgrim Health Care
Ginna Fernandes, Harvard Pilgrim Health Care
Tony Fournier, Harvard Pilgrim Health Care
Natalie Cunningham, Harvard Pilgrim Health Care

Hospitals
David Winslow, Maine Hospital Association
Tammy Butts, Maine Hospital Association
Rhonda Obie, Central Maine Medical Center
Cynthia Olivier, Eastern Maine Health
Chris Corneil, Eastern Maine Health

Maine Health Data Organization
Alan Prysunka

The GCWG first met on August 14, 2008, with subsequent meetings held on September 11th, November 13th, and December 11th. Copies of the agendas are presented in Appendix D.

During the first two meetings, the GCWG was focused upon clearly identifying what constitutes a global claim, determining where they are generated, and establishing an annual volume estimate. Focus then shifted to the National Uniform Billing Committee *Maine Combined Bill Demonstration Project*, which would require system changes on the part of both carriers and hospitals if the proposed modifications were adopted. In order to ascertain the impact of implementing those changes, the carriers and hospitals were asked three very specific questions in early October. The questions are as follows:

1. What will be required to capture the value(s) associated with the loop 2420A line level data of the 837i electronic claim file that may be included in the data currently being sent to health plans/TPA's? (This information would allow MHDO to accurately identify physicians, with associated CPT/HCPCS and charge information.)

2. What will be required to accept and retain CPT/HCPCS codes and modifiers corresponding to Professional Fee Revenue Categories 096x, 097x, and 098x on an inpatient claim (both electronic and paper) if it is not currently accepted and retained?

3. For a paper UB-04 claim, what will be required to accept and retain the values associated with using FL49 to link individual claim lines to FL76-79 for Professional Fee Revenue Categories 096x, 097x, and 098x?

**Please respond to each question clearly identifying:**

i. Programming/staff resource time required;
ii. Total cost; and
iii. Completion date for system modifications.

After receiving the responses (some of which are presented as Appendix E), it became clear that the cost to the carriers to modify their claims processing and data warehouse systems to accept and store the information included within modified global claims would be significant. Although not of the same magnitude, a substantial cost would also be incurred by the hospitals. As a result, a consensus was reached by the GCWG to look at other options to address the global claims problem (including a total prohibition, which was the original intent of LD 1843).

## V. Proposed Options of the Global Claims Work Group

The following options (including the implementation of the NUBC proposal) were selected by the GCWG members to be evaluated with respect to: the estimated dollar cost for the payers, hospitals, and/or the MHDO to implement the option; and the perceived success in minimizing the repercussions described earlier in this report.

### A. Option #1 – Modify Payers' Systems to Receive Modified Global Claims (as proposed by the NUBC) and Retain Information in Data Warehouse and Modify Hospitals' Systems to Submit Global Claims

| | Total Estimated System Modification Costs ($) | Total Estimated Annual Processing Costs ($) |
|---|---|---|
| Payers | $5,652,000[1] | $725,000 - $1,500,000[2] |
| ME Heart Center | $5,000 | $10,000 |
| Hospitals | $1,650,000[3] | Unknown |
| **Totals** | **$7,307,000** | - |

[1] Reflects combined cost estimates from two carriers and are limited to updates for core adjudication systems only. The estimates do not include the costs of modifying other platforms which may be used to serve federal or national accounts. One carrier reported that it would not be able to undertake the proposed modification with its current system at any cost and would necessitate the purchase of an entirely new system, the cost of which could not be currently quantified.

[2] Reflects combined cost estimates from two carriers and are limited to updates for core adjudication systems only. One carrier reported that it could not quantify the estimated annual processing costs because it would need to purchase an entirely new system, with undetermined operating costs.

[3] Estimated programming costs of $50,000 (333 hours @ $150/hour) per hospital for 33 IT systems.

Pros: ❖Practitioner information currently missing from existing global claims would be included with claim submission and be incorporated with claims data file submissions

❖Potential to reduce the total number of health care claims created and submitted and create fewer opportunities for confusion in matching the facility and professional claims associated with the same service

❖Potential to reduce the current and future data processing costs of the MHDO from $150,000 - $500,000/year

Cons: ❖Higher expense for payers to modify their claims receipt and data warehouse systems

❖Additional expenses borne by providers if all payers cannot make uniform modifications, resulting in inconsistent claims submission requirements

❖Higher costs for the ME Heart Center and hospitals to modify their claims submittal systems

**B. Option #2 A – MHDO Receives Facility and Practitioner Information from ME Heart Center, Eastern ME Medical Center, and All Hospitals for ED and Hospitalist/Other Global Claims / Links with Associated Payer Claims Data / Creates Separate Facility and Professional Claims Files**

One time cost for programming: 80 hrs. = $4,000 MHDO / $5,200 MHDPC[4]

| Claim Source | Estimated Claims/Year | MHDO Processing Time (hrs.) | Annual MHDO/MHDPC Cost ($) | Programming/Annual Costs ($) for MHC & Hospitals |
|---|---|---|---|---|
| ME Heart Center | 20,000 | 125 | $6,250 / $8,125 | $15,000 / $2,400 |
| Eastern ME Medical Center | 60,000 | 375 | $18,750 / $24,375 | (included below) |
| ED (all hospitals) | 720,000 | 4,500 | $225,000 / $292,500 | Combined EMMC, ED, and Hospitalists/Other $825,000 / $66,000[5] |
| Hospitalists/Other (all hospitals) | 320,000 | 2,000 | $100,000 / $130,000 | |
| **Totals** | **1,120,000** | **7,000** | **$340,000 / $455,000** | **$840,000 / $68,400** |

Pros: ❖No need to modify payers' systems and incur significant associated expenditures

[4] Programming/processing costs for MHDO priced @ $50/hour; MHDPC priced @ $65/hour.

[5] Estimated programming costs of $24,000 (160 hours @ $150/hour) per hospital and annual processing costs of $2,000 per hospital for 33 IT systems.

❖Practitioner information currently missing from all existing global claims would be provided by the ME Heart Center and hospitals and then incorporated into the claims database

Cons: ❖Higher costs for the ME Heart Center and hospitals to write computer code to create data extraction reports, analyze the accuracy of the reports, and provide data files to the MHDO on an ongoing basis

❖Increased premiums for health insurance purchasers as a result of additional costs being passed on to carriers by the ME Heart Center and hospitals

❖Higher costs to the MHDO and the ME Health Data Processing Center to receive separate facility and professional files, link them with associated claims records submitted by the payers, and then create separate facility and professional claims records for the specific services

❖Greater costs for entities (hospitals, non-hospital providers, carriers, TPA's) paying MHDO assessments due to an increase of MHDO expenditures

**Option #2 B - MHDO Receives Facility and Practitioner Information from ME Heart Center and Eastern ME Medical Center for Non-ED and Hospitalist Claims/ Links with Associated Payer Claims Data / Creates Separate Facility and Professional Claims Files**

One time cost for programming: 80 hrs. = $4,000 MHDO / $5,200 MHDPC[6]

| Claim Source | Estimated Claims/Year | MHDO Processing Time (hrs.) | Annual MHDO/MHDPC Cost ($) | Programming/Annual Costs ($) for MHC & EMMC |
|---|---|---|---|---|
| ME Heart Center | 20,000 | 125 | $6,250 / $8,125 | $15,000 / $2,400 |
| Eastern ME Medical Center | 60,000 | 375 | $18,750 / $24,375 | $15,000 / $2,000 |
| **Totals** | **80,000** | **500** | **$25,000 / $32,500** | **$30,000 / $4,800** |

Pros: ❖No need to modify payers' systems and incur significant, associated costs

❖Practitioner information currently missing from the existing ME Heart Center and Eastern Maine Medical Center non-ED and hospitalist global claims would be provided and then incorporated into the claims database

❖No need for non-Eastern Maine Medical Center hospitals to modify their systems and incur significant associated expenditures

[6] Programming/processing costs for MHDO priced @ $50/hour; MHDPC priced @ $65/hour.

❖Much lower costs incurred by the MHDO and the ME Health Data Processing Center due to the number of separate facility and professional files being substantially reduced as a result of the omission of the ED and hospitalist global claims

Cons: ❖ Higher costs for the ME Heart Center and Eastern Maine Medical Center to write computer code to create data extraction reports, analyze the accuracy of the reports, and provide data files to the MHDO on an ongoing basis

❖ Increased premiums for health insurance purchasers as a result of additional costs being passed on to carriers by the ME Heart Center and Eastern Maine Medical Center

❖Higher costs to the MHDO and the ME Health Data Processing Center to receive separate facility and professional files, link them with associated claims records submitted by the payers, and then create separate facility and professional claims records for the specific services

❖Detailed practitioner information related to ED and hospitalist claims continues to be excluded from the payer submissions and the ME claims database

❖ Greater costs for entities (hospitals, non-hospital providers, carriers, TPA's) paying MHDO assessments due to an increase of MHDO expenditures

## Option #3 – Prohibit the Creation of Global Claims

| Claim Source | Additional Estimated Professional Claims/Year | Additional Estimated Annual Provider Costs ($)[7] | Additional Estimated Annual Payer Costs ($) |
|---|---|---|---|
| Affiliated ME Heart Center Practices[8] | 18,000 | $5,400 | - |
| Eastern ME Medical Center | 30,000 | $120,000 | - |
| ED (all hospitals) | 360,000 | $1,440,000 | - |
| Hospitalists/Other (all hospitals) | 160,000 | $640,000 | - |
| **Totals** | **568,000** | **$2,205,400** | **$575,000[9]** |

[7] Estimated average processing cost of $4/claim, which covers the cost of credentialing, billing, follow-up, print posting, etc.

[8] Estimated additional average processing cost of $.30/claim to submit claims to payers through a clearinghouse.

[9] Represents combined estimates of three carriers based upon the estimated additional claims created. The dollar amount does not include additional staffing costs.

Pros: ❖Practitioner information currently missing from all existing global claims would be provided in separate professional claims submitted to the payers by hospitals and physician groups associated with the ME Heart Center, and then incorporated into the claims database through the submissions to the ME Health Data Processing Center

Cons: ❖Significant additional processing costs incurred by the hospitals to submit an additional 600,000+ professional claims annually

❖Additional costs may be passed on in higher rates charged to carriers by the hospitals and physician groups formally associated with the ME Heart Center

❖Additional annual claims processing costs incurred by payers

**Option #4 – Global Claims Continue to be Created and Submitted in Their Current Form as Authorized by Payer and Hospital Contractual Agreements**

| | Estimated # of Global Claims Created Annually | Total System Modification Costs ($) | Total Annual Processing Costs ($) |
|---|---|---|---|
| Payers | N/A | $0 | $0 |
| ME Heart Center | 2,000 | $0 | $0 |
| Hospitals | 550,000 | $0 | $0 |
| MHDO | N/A | $0 | $0 |
| **Totals** | **552,000** | **$0** | **$0** |

Pros: ❖No additional costs incurred by the payers, ME Heart Center, hospitals, and MHDO

Cons: ❖Inability of the MHDO to accurately determine information related to professional services, including identity of practitioner, specific services provided, and payments for over 500,000 (6%) of the approximately 8,500,000 commercial medical claims submitted annually

## VI. Recommended Option of the Global Claims Work Group

Although an attempt was made to recommend an option to the members of the Joint Standing Committee on Health and Human Services, the Global Claims Work Group was unable to arrive at a consensus.

Two of the carrier representatives supported Option #3 for the following reasons:

- Consistency and standardization would be improved (in most cases, CMS currently requires separate facility and professional Medicare claims) and administrative costs would be lowered.

- Compliance with PL 2005, Ch. 97, which already requires hospitals to submit separate facility and professional claims for specified services, will be improved by removing any ambiguity regarding the type of claims that are applicable.

Two other carrier representatives supported Option #4 for the following reasons:

- No additional costs would be incurred by the payers.

- The structure of some contracts would change under Option #3, which could result in higher medical costs.

- Similar discussions are occurring in other states.

- Carriers need a coordinated, centralized approach at the national level.

The representatives of the hospitals elected to not endorse any one option. However, they also indicated that they would be comfortable with Option #4. They also recognized that there could be value in moving ahead with Option #2 B as a way to test the feasibility of such reporting and capturing a significant amount of data without involving a large number of providers.

## VII. Summary

By failing to achieve consensus, the Global Claims Work Group has de facto endorsed Option #4, the continued creation and submission of global claims in their current form, as authorized by payer and hospital contractual agreements. Consequently, the MHDO will be unable to accurately determine information related to professional services, including practitioner identity, specific services provided, and payment for over 550,000 (6%) of the approximately 8,500,000 commercial medical claims submitted annually. This will continue to adversely impact the utility of claims data when accurate identification of the individual practitioner is of primary importance.

Appendix A

LD 1843 - An Act to Improve the Quality of Health Care in Maine

# LD 1843

## May 17, 2007

**Sec. 1. 22 MRSA §8708, sub-§6-B** is enacted to read:

**6-B. Standardized submission of claims forms.** All commercial health care insurance claims for all professional services provided by an allopathic or osteopathic physician licensed in this State who works in an office setting or is employed by a hospital, an affiliate of a hospital or other health care facility or whose claims are billed by the hospital system or facility where the services are performed must be submitted to payors using the standard federal professional paper claim form, CMS 1500, or its successor and the American National Standards Institute Accredited Standards Committee X12N 837 electronic submittal standards for noninstitutional providers and suppliers. The claims form must contain an identification code for the rendering physician. For purposes of this section, "office setting" means a location where the physician routinely provides health examinations, diagnoses and treatment of illness or injury on an ambulatory basis, whether or not the office is physically located within a facility.

Appendix B

# Scope of Work for the National Uniform Billing Committee Maine Combined Bill Demonstration Project

## Scope of Work for the Maine Combined Bill Demonstration Project

### I. Purpose

The creation of the "Combined Bill Demonstration Project" in Maine is intended to test the feasibility and efficiency of allowing hospitals to report performing provider information on inpatient and outpatient hospital claims; generally, these claims will include hospital-based physician charges. This request originated from the Maine state government, specifically its data gathering agency, the Maine Health Data Organization (MHDO). MHDO currently asks health plans to report all hospital and professional paid claim data. They then try to associate the professional services to the hospital claims data. Matching the professional services (identifying the performing physician) with the institutional claim is difficult or impossible when all the data is combined on one claim form (UB-04). The Maine State Uniform Billing Committee (SUBC) is seeking a remedy for this situation and is asking the NUBC to allow them to utilize Form Locator 49 on the UB-04 paper form. This would allow the hospital to create, from the onset, a combined claim that would facilitate health plan data reporting efforts. The 837i currently has the capability to report this information at the service line level.

Much of the state effort is intended to provide greater transparency with respect to the overall cost of health care services. The purpose of this demonstration project is to examine the feasibility of this new approach and to determine whether the suggested UB-04 changes will ultimately give MHDO with the information they need. There also appears to be additional benefits that accrue to providers, health plans, and patients. The combined billing approach should reduce the number of claims submitted and processed. It also recognizes a growing trend in rural areas where hospitals are employing more physicians to improve patients' access to care.

The scope of work for the demonstration project is limited to hospitals physically located in Maine and health plans licensed to operate in Maine and only for their members/enrollees; many already have contracts with one another to allow this approach. It is not intended to compel providers or health plans to accept this combined billing approach; only willing providers and health plans would be engaged in this project. Proactive education of providers and health plans concerning this demonstration project will be undertaken by the Maine SUBC.

The National Uniform Billing Committee (NUBC) is interested in the outcomes of this approach and will be allowing participants in the state of Maine to utilize FL 49 for the duration of this project. It is our understanding that FL 49 is intended to serve as a pointer that references the physician information contained in FL76, FL77, FL78, and FL79 of the UB-04 data set. To simplify reporting, the values reported in FL 49 will utilize the last digit of the above mentioned form locators (i.e. 6, 7, 8 and 9).

This project includes the following tasks as part of the overall scope of work:

1. Identifying the total volume of claims that contain both the facility (technical) and professional billed amounts separated by inpatient and outpatient. Only the Professional Fees Revenue Categories (096x, 097x, and 098x) will utilize the pointer information in FL49.
2. On inpatient claims, the reporting of a limited range of HCPCS procedure codes corresponding to 096x, 097x, and 098x will be allowed in FL44. All other revenue codes listed on the claim will follow the HIPAA code set rules for institutional inpatient services and therefore will not include line item HCPCS codes.
3. For outpatient claims, hospitals will continue to utilize HCPCS line level reporting where it is appropriate in FL44.

### II. Specific Tasks

Participants in the Maine demonstration project will work independently and provide statistical information on a periodic basis as outlined in this scope of work.

The NUBC will provide minimum administrative support, but stands ready to provide any appropriate billing interpretations and communications that are necessary to fulfill the scope of work efficiently.

**General Requirements**

**A. Initial Meeting with Maine's SUBC and MHDO**

**Project Plan** – The Maine SUBC and MHDO will meet to discuss this demonstration project. The specific focus will be on the time frame for each of the tasks specified below. Within two weeks of this meeting, the Maine SUBC will submit a formal project plan, outlining components of the billing process and deadlines for completing the demonstration project. The project plan shall be for a **one year** period and shall provide an overview of the various components below. The project plan shall be updated as new issues or events arise.

a) Discrete volume of inpatient and outpatient claims. Individual facilities will keep track of the number of claims submitted under the proposed method as well as the aggregate of all claims that are prepared by the facility to all health plans.
    i. Volume will also identify name of participating health plan.
    ii. Volume will keep distinct the number of claims that are submitted electronically from those that are submitted on paper.
b) Provider cost of implementing the combined billing approach.
    i. Startup costs for providers.
    ii. Cost savings, if any, on the combined billing approach for providers versus the development of separate institutional and professional claims. Indicate any revenue cycle improvements (e.g., reduction in days in receivables).
c) Health Plan cost of implementing the processing of the combined billing approach.
    i. Startup costs for health plans.
    ii. Cost savings if any on the combined billing approach for health plans versus the handling of separate institutional and professional claims.

**B. Outreach Plan** – Maine SUBC will serve as the focal point for communication and outreach to participating providers and health plans. They will also identify an individual to serve as the contact for coordinating communications with the Secretary of the NUBC.

**C. Quarterly Progress Reports** will be necessary to monitor the progress of the project, evaluate any problems, and plans for any additional steps. The NUBC will be responsible for setting up the conference calls and coordinating the agenda with the Maine SUBC. Conference calls will include documented minutes of the meeting and any reports or other supporting materials prepared for the call.

The quarterly administrative progress reports will summarize the following:

1. Number of participating providers and health plans
2. Volume breakdown of claims by major payer category
3. Update of any issues on inconsistency in reporting
4. Update on any actions needing NUBC involvement or summary of problems encountered
5. Process improvements observed
6. NUBC may request slight modification of data collected, if after receipt of the first quarter reports, the data indicates that additional analysis is warranted

**D. Geographic Limitation**

The demonstration project is limited to the State of Maine and only for those providers and health plans that enter voluntarily to undertake combined billing of claims. Hospital services for residents of Maine received outside of the state are not subject to this demonstration project.

**E. One-Year Conclusion**

The duration of the project is one year. At the end of the one-year period, the NUBC will evaluate the merits of the approach and determine whether institutional and professional "Combined Billing" warrants nationwide acceptance and whether any additional limitations or specifics need to be considered. It should be noted that the use of FL49 will revert back to NUBC control if the project indicates that the approach should not go forward.

Appendix C

Resolve, To Eliminate or Reduce the Health Care Data Collection Problems Associated with Global Claims

Resolves 2007, Ch.155 – signed March 18, 2008

## Resolve, To Eliminate or Reduce the Health Care Data Collection Problems Associated with Global Claims'

Amend the bill by striking out everything after the title and before the summary and inserting the following:

'**Emergency preamble. Whereas,** acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

**Whereas,** the existence of global claims is creating serious problems with the identification of practitioners and the computation of payments in the data currently collected by the Maine Health Data Organization and used by the Maine Quality Forum and the Governor's Office of Health Care Policy and Finance and must be addressed; and

**Whereas,** the solution to the problem will be complex, involve a number of entities and take a number of months to achieve; and

**Whereas,** emergency enactment is required to enable the interested parties time to work together and to take action prior to the report due to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 15, 2009; and

**Whereas,** in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

**Sec. 1. Study. Resolved:** That representatives of health insurance carriers licensed in the State, 3rd-party administrators and hospitals licensed in the State, with representatives of the Maine Association of Health Plans, the Maine Hospital Association and the Maine Health Data Organization, all of whom are referred to in this resolve as "the work group," shall meet to evaluate the Maine combined bill demonstration project, as proposed by the National Uniform Billing Committee. The work group may identify and propose an alternative that will solve the data collection problems associated with global claims; and be it further

**Sec. 2. Report. Resolved:** That the work group shall report the findings of the study under section 1 to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 15, 2009.

Appendix D

Global Claims Work Group Meeting Agendas

# AGENDA

Global Claims Work Group Meeting

August 14, 2008

I. Introductions

II. Background/History – Ch. 155 Resolves

III. PP Presentation

IV. Verification of Global Claims Generated in Maine

V. Verification of Practitioner Data (specific FL's) Received and Stored by Payers

VI. Comments/Suggestions by Participants for Problem Resolution

VII. Action Items for September 11th Meeting

# AGENDA

Global Claims Work Group Meeting

September 11, 2008

I. Introductions

II. Update from Payers Regarding Receipt and Retention of Data from FL's 76 (Attending Physician), 77 (Operating Physician), and 78, 79 (Other Physicians)

III. Clarification/Discussion of Global Claims Submissions as Presented by Martha Ridge (Anthem of ME) and Cindy Olivier (Eastern Maine Health)

IV. Relationship of UB-04 FL's as Proposed in NUBC Demonstration Project to ASC X12N 837 Electronic Claims Standards/Submissions

V. Comments/Suggestions by Participants for Problem Resolution

VI. Action Items for October9th Meeting

# AGENDA

Global Claims Work Group Meeting

November 13, 2008

I. Introductions

II. Discussion of Three Options Proposed at September 11, 2008 Meeting (please refer to supplemental material):

   a. Option #1 - Modification to Payers' Systems to Receive Global Claims and Retain Information in Data Warehouse

   b. Option #2 – MHDO Receives Facility and Practitioner Information from ME Heart Center, Eastern ME Health, and All Hospitals for ED and Hospitalist Claims / Links with Payer Global Claims Data / Creates Separate Facility and Professional Claims

   c. Option #3 – Prohibit the Creation of Global Claims

III. Comments/Suggestions by Participants for Problem Resolution

IV. Next Steps (report to Health and Human Services Committee)

V. Action Items for December 11th Meeting (if necessary)

# AGENDA

Global Claims Work Group Meeting

December 11, 2008

I. Introductions

II. Discussion of Cost Estimates Table for Three Options:

   a. Option #1 - Modify Payers' Systems to Receive Global Claims and Retain Information in Data Warehouse and Modify Hospitals' Systems to Submit Global Claims (discussion is required to determine how to develop programming cost estimates for payers outside of the MEAHP members)

   b. Option #2 – MHDO Receives Facility and Practitioner Information from ME Heart Center, Eastern ME Health, and All Hospitals for ED Hospitalist/Other Global Claims / Links with Associated Payer Claims Files / Creates Separate Facility and Professional Claims Files

   c. Option #3 – Prohibit the Creation of All Global Claims

III. Comments/Suggestions by Participants for Problem Resolution

IV. Next Steps (content of report to Health and Human Services Committee)

   a. Overview (define global claim; existence in ME; problems created; Resolve; NUBC demonstration project)
   b. Participants/Meeting Summaries
   c. Proposed Options (define each with associated costs)
   d. Recommended Option (if consensus can be reached)
   e. Other Comments

V. Action Items for January Meeting (if necessary)

# Appendix E

## Narrative Responses to Questions Posed to Carriers and Hospitals

Aetna

As it relates to questions 2 & 3, we accept all fields but of those noted retain only 76. Bottom line, we retain only what we need to pay a claim. Any modification required would be at a significant cost if additional fields are required for data capture and the potential cost increase per transaction would also have to be assessed. In addition any revisions would also impact a host of processes and systems not to mention vendors. The cost of this can not be calculated.

We had rather hoped to have more solid answers. However, we have multiple processing systems to consider and are not comfortable giving an answer for the sake of giving an answer.

Anthem of Maine

1. EDI takes the information in but information is not sent to the claims systems for adjudication.
   -Limited data elements exist in warehouse
   -Enterprise system changes needed
   -High level of effort
   -Resources at this time difficult to attain to do cost analysis

2. Claims systems do not require CPT/HCPC on inpatient claims; 450-452
   -Emergency room requires CPT
   -Some DRG or Case Rate
   -Enterprise system changes needed
   -High level of effort
   -Resources at this time difficult to attain to do cost analysis

3. Enhancement to scanning system needed and enhancement to claims systems:
   -Enterprise system changes needed
   -High Level of Effort
   -Resources at this time difficult to attain to do cost analysis

Cigna

1. All line level claim information on professional claims, is sent within the 2400 loop. The exception to this, would be the NPI line level data. The current 1500 CMS paper form, does not provide a place to provide the line level rendering physician's name, so this presents a problem for payers. CIGNA is in the process of working to implement all NPI fields on paper claims for early 2009.

2. For paper claims, these categories are not currently keyed, so this would require CIGNA to provide the EMR vendors with keying requirement instructions

for these fields. A time cost estimate would be given regarding fees and time frames associated with when the change could be completed.

3. CIGNA paper claims are submitted on the 4010a 837 file format. There is no keying or 837 information listed within the UB04 manual on this field, so not sure how to answer this question.

Harvard Pilgrim

1. Line level attending physician data cannot be entered or stored in our claims adjudication system. This data will need to be housed in a separate datastore.

Electronic Claims/Paper
-Engine map changes; IDOC changes; Amisys preprocessor; UHG 837 creation
-HP3000
-Expand file
-Expand datastore to accommodate additional data elements
-Modify 5 programs to accept different file layout
-Modify program to store additional data – no NPI validation

Development costs estimated: $250,000
This does not include the cost of modifying extracts to include this data.

2 & 3. We cannot cost out implementation of this option because, as stated on several occasions, our claims adjudication system does not support this type of pricing/contracting on Inpatient claims and can not be changed to support it.
-The claims adjudication can not apply different fee schedule arrangements at the line level
-Inpatient claims are DRG based or global rates

Central Maine Medical Center

We apologize, but we did not attempt to answer the questions below as our vendor would charge us to estimate the modification needs to our system. If this were a Federal mandate (ie. CMS regulation), it would be included in our Federal regulatory support, which is part of our service fee agreement. We are sure others with a vested interest have information that will be helpful to you regarding these specifics.