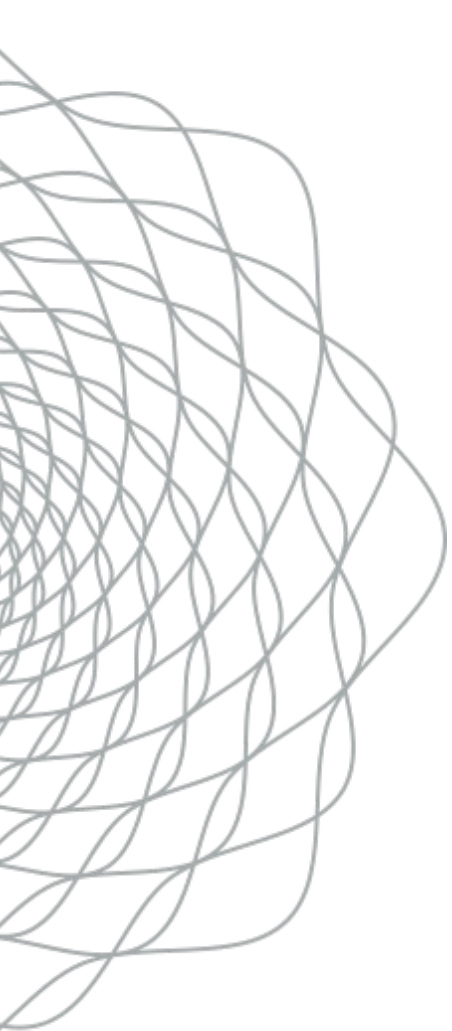




TARPON
HEALTH

a healthcare automation community

How Clearinghouses Work

June 2024

Agenda

1. Overview and History
2. EDI and X12
3. Automation Hierarchy
4. Common Challenges
5. Future Proofing Your Connections
6. Q+A

What is a clearinghouse?

Follow the directions on how to write and structure your presentation

Definition: *A healthcare clearinghouse is an entity that processes or facilitates the processing of nonstandard health information into a standard format. They act as intermediaries between healthcare providers (such as doctors and hospitals) and insurance payers (such as insurance companies and government programs) to ensure that the electronic transmission of medical claims, billing, and other healthcare-related information is accurate, secure, and compliant with regulatory standards.*

Benefits:

- **Increased Efficiency:** Streamlines the submission and processing of claims, reducing administrative burden.
- **Error Reduction:** Minimizes errors and increases the likelihood of claims being accepted on the first submission.
- **Cost Savings:** Reduces costs associated with manual claims processing and rework due to errors.
- **Compliance:** Ensures that transactions comply with HIPAA and other regulatory requirements, protecting sensitive patient information.

Note: There are two slides to these connections:
Payerside and Providerside

Who are the key players?

Change and Availity have consolidated much of the market over the past 15 years.



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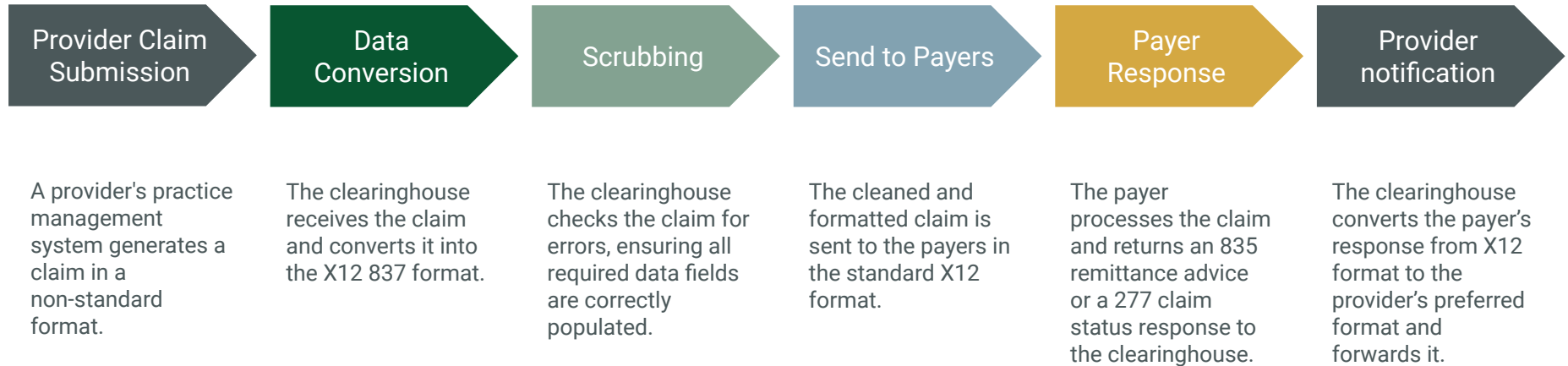


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How a clearinghouse impacts a claim



What other functions do they play?

Processing Remittances: Handling Electronic Remittance Advices (ERAs) and providing explanations of benefits (EOBs) to providers.

Eligibility Verification: Providing real-time or batch eligibility checks to verify patient insurance coverage.

Status Tracking: Offering tools for tracking the status of claims, Authorizations, Referrals, and other transactions.

EMRs and clearinghouses

How EMRs connect with clearinghouses depends on which EMR you are using

Epic

- Does not have tools to submit the claim
- More choice in how organizations can send/receive claims
- Does not have a team that is dedicated to helping clients set up their connections, giving clearinghouses an outsized role

Non-Epic EMRs (e.g., Athena, Cerner)

- Have tools to submit claims
- Generally less choice in how organizations can send/receive claims
- These companies have teams dedicated to helping clients set up their connections

Electronic Data Interchange (EDI)

EDI is a file used in computer-to-computer exchange formatted using certain standards such as: XML, CSV, EDIFACT, ANSI X12, etc. The standards dictate the content of the file. Healthcare using the ANSI X12 standards.

Area	EDI
General purpose	EDI is suited for secure system-to-system exchange between organizations. EDI standards in healthcare are used for communication between providers and health insurance companies, often through a clearinghouse.
Integration	There are 3 main methods for exchanging EDI files: Applicability Statement 2 (AS2), Secure File Transfer Protocol (sFTP), and Value Added Network (VAN). Both organizations that are trading EDI documents between each other have to decide on a common industry-specific EDI standard (e.g., the ANSI x12 format).
Stability	EDI and APIs are very stable connections.
Speed	EDI transactions are much slower than APIs. They can take minutes or hours to complete.
Learning curve	Building EDI transaction files requires a niche skill set, but not traditional development skills. Most often, hospitals use clearinghouses to help facilitate the data exchange. Report writers can build files to EDI standards.

HHS and ANSI X12 Standards



The Department of Health and Human Services (HHS) adopted standardized implementation specifications for electronic transactions used in the electronic exchange of health care data. These adopted transactions include:

- Health care claim **X12N 837** transaction
- Health care claim payment advice **X12N 835** transaction
- Health care claim status request/notification **X12N 276/277** transaction
- Eligibility, coverage, or benefit inquiry/information **X12N 270/271** transaction
- Benefit enrollment and maintenance **X12N 834** transaction
- Health care service review information **X12N 278** transaction
- Payment order/remittance advice **X12N 820** transaction

Great CMS resource [Here](#)

What about the name? The American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for inter-industry electronic exchange of business transactions, namely electronic data interchange.

Thus the “ANSI X12” was born.

Common issues with EDI / X12

1. Payers interpret the X12 rule set differently
 - a. E.g., Aetna responds with the X code while United responds with Y code for the same issue
2. Payers use non-specific codes when specific codes are available
 - a. E.g. Cigna may use a blanket code for multiple situations in lieu of a more specific code that would be helpful to operations
3. Claims stay in the same status (Pending) for much of the adjudication process
 - a. Organizations using RPA with claims status shouldn't send a bot-out everyday, only after the average adjudication period

Did you know?

X12 and CMS both offer a pathway to submit complaints if there are significant issues

Submit a complaint with CMS [Here](#)

Automation Hierarchy

Consider this hierarchy of options anytime you are evaluating a process to automate

Priority	Automation Approach	
1	Enterprise Software	→ Why? You are already paying for it
2	EDI / ANSI X12	→ Why? These are industry standards
3	API	→ Why? Stable and fast
4	ETL / Scripting	→ Why? Stable and fast
5	RPA	→ Why? Flexible, but requires maintenance
6	Manual	→ Why? People can be cheaper than technology in some cases (small volume / one-time projects)

Future Proofing



Discussion

How can providers protect themselves from the consolidation and cyber-threats similar to those caused by the ChangeHealth outage?