



Private Sector Advocacy

Administrative Simplification in the Physician Practice

Cost estimates of inefficient health care claims processing, payment and reconciliation are between \$21 and \$210 billion. In the physician practice, this expense comprises 10-14 percent of practice revenue. The administrative simplification objective within the physician practice is to encourage automated, real-time health plan transactions, along with the reduction of manual processes throughout the physician's claims management revenue cycle and increased health insurer claim payment process transparency and reduced ambiguity. The AMA is committed to addressing and advocating for the following solutions to the ongoing problems in the claims management revenue cycle that contribute increased complexity and expense.

Physician practice automation and real-time claims cycle processes

Unnecessary administrative costs can be reduced, if not eliminated, through increased automation, but increased automation can only occur if the current electronic standard claims transactions for patient eligibility verification and benefits, physician payment, and claims acknowledgement are enhanced and fully enforced. The AMA advocates legislation to expand and enforce the Health Care Insurance Portability and Accountability Act (HIPAA) standard transaction and code set (TCS) rules, which would assist in moving the health care industry toward the efficient, fully automated health care billing and payment process that we all desire. Expansion includes reporting all fields to the highest level of specificity, making current voluntary fields mandatory, expanding the data content of transactions, and standardizing the formats. The AMA has made specific recommendations for legislative action on the following standard transactions and rules:

- **Electronic remittance advice**
- **Eligibility verification**
- **Claims acknowledgement**
- **Claims attachments**

In addition to legislative advocacy, the AMA supports and is an active participant in the CAQH Committee on Operating Rules for Information Exchange (CORE) multi-stakeholder initiative to standardize and streamline patient administrative data exchange. CORE encourages adoption of standardized operating rules that build upon HIPAA standard transactions and is an initiative that holds promise to successfully deliver consistent and robust information exchange functionality to the claims management process.

In addition to the standard transactions, the AMA sees opportunity for simplification in the initial phases of the cycle when the patient first presents to the physician office. The Medical Group Management Association's (MGMA) Project SwipeIT is a health care industry-wide initiative meant to advance the adoption of standardized patient identification (ID) cards containing WEDI compliant, machine-readable information. Nonstandardized patient ID cards contribute to waste and rework in physician offices, and the AMA supports efforts to standardize the current industry effort to create machine-readable health insurance identification cards.



Increased Transparency and Disclosure

All health plans need to disclose to their beneficiaries and the physicians, other healthcare professionals and health facilities providing services to those beneficiaries, **all** information necessary to determine the relative financial rights and responsibilities of all parties **prior** to the provision of a healthcare service. This includes full, complete transparency of the contract-specific payer fee schedule, payer medical payment policies, reimbursement rules, and other payment reductions. In 2008, the AMA unveiled the first National Health Insurer Report Card (NHIRC) as a mechanism to provide physicians and the general public a reliable and defensible source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by health insurers. The 2009 report card expanded the metrics to include an expanded Transparency Survey. Data from the NHIRC demonstrate that significant opportunity exists to increase transparency and disclosure of information necessary to determine patient and payer financial responsibilities. Specifically, the AMA recommends regulation to:

- **Designate CPT guidelines and conventions as a HIPAA standard**
- **Implement standard pricing/payment rules**
- **Implement standard claim edits**
- **Implement the National Payer Identifier**

Practice Management solutions

The AMA, in concert with Federation members, will continue to advocate on behalf of its members for legislative relief and industry collaboration towards solutions to administrative complexity. We also believe that there is power within the physician practice to impact the performance of the claims management cycle and provides the following resources to its members to leverage that power. The AMA's Practice Management Center contains these important tools, including the administrative simplification resources below:

Heal the Claims Process™ Campaign

The claims management cycle in the physician practice spans from patient registration to full payment and collection for services. In between those two points, there are a series of complex processes that can thwart efficient completion of the cycle. The AMA's Heal the Claims Process™ Campaign toolkit provides a number of resources to assist physicians to prepare, follow, and appeal claims throughout the entire cycle.

Enforcement

The AMA provides guidance to physicians on addressing unfair health insurer practices or reporting HIPAA compliance violations. Without physicians taking an active role in enforcing the provisions of settlements or highlighting deficiencies in the use of the HIPAA standard transactions, meaningful advocacy is challenging.