



Administrative Simplification White Paper

**Prepared by the American Medical Association
Practice Management Center (PMC)**

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This white paper summarizes the American Medical Association (AMA) recommendations to eliminate significant administrative waste from the health care system by simplifying and standardizing the current health care billing process.

The AMA recommends:

- 1. Increasing the enforcement, accuracy, and transparency of existing electronic Health Care Insurance Portability and Accountability Act (HIPAA) standard transaction and code set (TCS) rules, including the rules governing patient eligibility and payment transactions,**
- 2. Modifying existing HIPAA standard transactions to reduce the variation in transaction data and further simplify how billing and other health care transaction data is collected and processed; and**
- 3. Concentrating future efforts on publishing new standards in areas that are crucial to fully automating the health care payment system.**

Background

Approximately 25–30 percent of the country’s total health care expenditures are direct transaction costs and the resulting downstream inefficiencies associated with the “claims management revenue cycle”—the process of creating, submitting and analyzing claims for payment of patient medical bills. The AMA is committed to addressing and advocating for solutions to the ongoing problems in the claims management revenue cycle that increase administrative expenses in the physician practice. These challenges include but are not limited to lack of payment transparency, inaccurate and unfair payment, and administrative hassle factors. Physicians continue to spend substantial resources managing just the basics of the claims management revenue cycle, including spending excessive time on electronic remittance advice (ERA) reconciliation and follow up. These unnecessary administrative costs can be reduced, if not eliminated, through increased automation, but increased automation can only occur if the current electronic standard transactions are both enhanced and fully enforced. Increased health insurer and other payers’ claim payment process transparency, up-front notification of pricing, accuracy in payments, and reduced ambiguity of adjustments, including clear and specific reason and remark codes are among the areas where significant efficiencies can be achieved.

This paper will detail the actions necessary to make each standard transaction fully transparent and electronic, thus reducing the cost and complexity surrounding today’s opaque, paper-based payment process. As an illustration, consider the consumer experience in the package delivery industry. An individual can mail a package from anywhere in the country (indeed, the world) to any destination and track that package’s status at each point along its journey. A tracking number allows consumers to check—in real time—when the package was placed on the loading dock, when it was put on the delivery vehicle, where it has stopped along the way, and, ultimately, when it was delivered to the recipient. The

recipient is even able to acknowledge receipt of the item with a real-time electronic signature. The AMA, along with multiple stakeholders throughout the health care industry, believe that comparable efficiencies are achievable in the claims management revenue cycle through using and enhancing existing industry tools.

Deficiencies and barriers that exist in the complex, often manual, claims processes management revenue cycle, place unfair burdens on patients, as well as health insurers, physicians, and other health care providers. In particular, consider the burden placed upon patients with chronic illnesses and the elderly. These patients must sift through numerous payer explanation of benefits (EOB) statements and hospital, physician, and other health care provider invoices to determine which medical services were not covered, which services should have been covered, which invoice amounts they are responsible to pay, and, finally, what supporting documentation they must send (manually) to their secondary or supplemental health plans.

Estimates of inefficient claims processing, payment and reconciling of health care claims are between \$21 and \$210 billion.¹ In the physician practice, this expense comprises 10–14² percent of practice revenue. Considering such significant administrative waste, the AMA strongly encourages Congress, the Administration, and other legislators to consider addressing administrative reform immediately. Physician practices cannot continue spending as much as 14 percent of revenue to obtain appropriate payment from payers. The AMA believes that the health care industry can create operating rules, code standards and conventions that allow transactions to be processed in the same, consistent manner, and seeks legislative support in its effort.

HIPAA Standard Transactions and Code Sets Final Rule

As adopted in 1996, HIPAA included a chapter entitled “Administrative Simplification,” designed to encourage transmission of confidential health care data electronically. The relevant implementing HIPAA regulations appear in four interlocking rules governing: 1) Privacy, 2) Security, 3) Unique Identifiers and 4) Uniform Electronic Transactions and Code Sets. Unfortunately, the administrative simplification expected from these Final Rules has not been fully realized more than five years after going into effect. Of particular concern, fully compliant implementation of all the standard transactions and code sets has not been completed by many payers—let alone by their third party administrators and other agents. Moreover, some payers using standard transactions and code sets have implemented them with variations—which the standard transaction rules allow. Thus, true standardization has not been obtained despite the TCS Rule. As a result, those providers who have adopted electronic transactions continue to be burdened by many manual processes, and many providers continue to use paper transactions. Reports from the Centers for Medicare & Medicaid Services (CMS) complaint process that covered entities can use to report when the HIPAA standards are not being met underscores this variation. The primary reasons for complaints include: (1) trading partners not using the standard transactions; (2) incorrect application of the implementation guides; and (3) misuse of the code sets. With the next version of HIPAA standard transactions on the horizon (known as “5010”), covered entities are unlikely to work to further implement the current versions of the standard transactions (known as “4010”).

¹ PNC Bank (2007), Commonwealth Fund (2007); RAND Corporation (2005), PricewaterhouseCoopers, 2008.

² James G. Kahn, Richard Kronick, Mary Kreger and David N. Gans, “The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals,” *Health Affairs*, 24, no. 6 (2005): 1629-1639

Other considerations

A number of additional factors further highlight the need to quickly and actively address the need for this administrative reform:

- Consumer-Driven Health (CDH) has emerged as one of the most dramatic shifts in the health care industry since the advent of managed care. CDH requires immediate, point-of-service information about a patient's financial responsibility for services he or she is about to receive. The industry's ability to deliver that information in real time is nearly nonexistent today, and physician practices and other health care providers face tremendous challenges in requesting payment for services at the time care is delivered. Consumers opting for CDH plans need to understand their financial obligations before care is delivered in order to make informed, reasonable choices.
- Upcoming regulatory changes and the associated complexity of implementation will compete with these administrative simplification initiatives. It is important that the industry act before the changes described below:
 - CMS has proposed adopting the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding (CMS-0013-P 2) as the standard transaction code set under HIPAA in 2011. These new codes (ICD-10-CM) would replace the codes currently in use under HIPAA. While the AMA supports ICD-10-CM, we are concerned about its implementation timeline and the implementation's impact on administrative simplification efforts.
 - The AMA is deeply concerned with HHS' plan to rapidly mandate the adoption and implementation of the new HIPAA electronic standard transactions (5010), particularly because a significant number of payers—including some state Medicaid programs—remain challenged by the current 4010 standard transactions. Implementing a new version of the electronic administrative standard transactions is a complex and costly undertaking for physicians; their practices need time to adequately complete testing of and migration to the updated HIPAA electronic standard transactions with their trading partners in order to avoid significant disruptions to their practice, patient care and claims payments.

Enforcement of the HIPAA Standard Transactions and Code Sets Final Rule requirements

HIPAA TCS Rule enforcement needs to ensure that covered entities comply with all standard transaction guide instructions and that data is reported accurately and to the highest level of specificity available, not that it only be syntactically correct. Until the information being conveyed electronically eliminates the need for follow up phone calls and other manual processing, administrative simplification will remain an unfulfilled promise. Moreover, the information in the electronic standard transactions **must** be at least as robust as the information contained in the current paper claim still used by many physician offices—as long as the paper transactions provide more useable information for these physicians, physicians will not see value in moving toward the adoption of electronic transactions.

Recommendations

The AMA makes the following recommendations to help improve compliance:

1. Lift remaining contingency plans in place for standard transactions so that all payers become fully compliant with the existing TCS Rule now.
2. Enforce the requirement that all payers accept and respond to standard transactions. (Compliance with HIPAA standard transactions has been mandatory even for small ERISA self-insured plans)

3. Stop other improper payer actions, such as requiring physicians to accept electronic funds transfers as a condition of obtaining electronic remittance advice, charging inappropriate clearinghouse transmission fees or fees for standard transactions, or failing to respond to HIPAA standard transactions at all.
4. Clarify that standard transactions require both correct syntax and information that is reported at the greatest level of specificity; both are needed to make information truly accurate. (Providing a reason code may meet syntax requirements, but providing the wrong or a generic reason code dilutes the intended administrative simplification intent.)

Substantial unhappiness with adoption and use of the standard transactions has prompted a number of activities in the industry. The Workgroup for Electronic Data Interchange (WEDI) has established various work groups of health care industry stakeholders to address issues related to the standard transactions and provides ongoing education on the implementation of the standard transactions. Organizations such as the Council for Affordable Quality Healthcare (CAQH) have created initiatives like the Committee on Operating Rules for Information Exchange (CORE) that bring health care industry stakeholders together to define voluntary standards for using code sets and encourages adoption of standardized operating rules that build upon the HIPAA standard transactions. Further, there are efforts at the state level to increase the efficiencies intended by HIPAA. For instance, beginning in 2009, Minnesota (i.e., Minnesota 62J.536, “Uniform Electronic Transactions and Implementation Guide Standards”) will begin requiring electronic claims transactions to adhere to HIPAA standards, thus establishing a state law enforcement mechanism to supplement that which is available through the CMS. The AMA’s vision is to see physician and other healthcare provider access to healthcare administrative information available before or at the time of service for every patient or health plan, following the submission of either batched or real-time HIPAA standard requests as best meets the needs of patients and streamlines the provider’s workflow.

HIPAA standard transaction modification and reductions in variation

ASC³ X12 270 Health Care Eligibility Benefit Inquiry and ASC X12 271 Response

Despite the HIPAA-required ASC X12 270 Health Care Eligibility Benefit Inquiry and ASC X12 271 Response, the value and transparency of this standard transaction is severely limited by the lack of specificity of the regulation, the failure of many payers to implement this standard transaction, and the requirement of many that physicians pay a signification fee to utilize this standard transaction, even though the HIPAA standard transaction rule expressly prohibits such a charge.

The query of whether a patient is eligible for a specific service with a specific physician at a specific facility is important information for the physician practice. Receiving an explicit answer back can quickly assist in patient scheduling, billing the appropriate financial responsibility, and reducing further denied claims. However, the current version only requires that health insurers respond with a “Yes/No”, and payers often do not respond at all, despite the legal requirement to do so. The establishment of an electronic eligibility verification process that encourages maximum specificity **prior to the service** would ameliorate this problem by helping physicians and other health care providers:

1. determine whether a health plan covers the patient;
2. determine the patient’s benefit coverage; and
3. confirm coverage and the patient’s financial responsibility for specific medical services.

³ Accredited Standards Committee

Recommendations

The AMA supports initiatives that recommend **expansion** of current eligibility standard transactions which require that all covered entities and their agents and subcontractors complete the following optional fields on the ASC X12 271 Health Care Eligibility Benefit Response:

1. **Underlying contracted fee schedule** (the entity that holds the underlying agreement with the physician or other health care provider (i.e., provider network) and the specific product fee schedule (i.e., Medicare Advantage PPO or commercial PPO product))
2. **Claim benefit status indicating whether** each specific procedure or service (i.e., CPT/HCPCS code) is an in-network or out-of-network service
3. **Patient responsibility**, remaining deductible and co-insurance for each specific procedure or service (i.e., CPT/HCPCS code)
4. The **entity that is responsible for payment** of the patient's covered benefit

This level of information will enable physicians and patients to clearly understand patient responsibility at the time of service and submit accurate claims the first time, obviating the need for duplicate claims and avoiding the rework created by inaccurate claims submissions or missing information. Such information would also be extraordinarily valuable to physicians to ensure accurate and timely payment, outcomes that would encourage utilization of the standard transactions through practice automation.

ASC X12 835 Health Care Claim Payment/Remittance Advice

The AMA's primary focus with respect to the electronic remittance advice transactions is ensuring all claims are paid correctly on the first submission and that payers provide detailed, unambiguous reasons for any denials.

Recommendations

To that end, the AMA recommends the following enhancements to this standard transaction:

1. Convert from "optional" to "mandatory" the following fields in the ASC X12 835 Health Care Claim Payment/Remittance Advice:
 - **"Allowed amount"**: allows physicians to determine whether the payment was made at the correct contracted rate.
 - **"Class of contract"**: gives physicians information that allows them to resolve ambiguity in product type when the mandatory "claim filing indicator code" is insufficient. This is particularly important because many health insurers offer multiple PPO products at different contracted rates with a single physician, and the number of Medicare Advantage products has increased dramatically.
 - **"Date of claim receipt"**: allows physicians to confirm timely payment. Many payers currently do not report this information, as it is optional in the standard transaction rules.
2. Enhance current specifications for or expectations of the existing standard transactions:
 - **Recognize line item relationships**: The lack of line control between the ASC X12 837 Health Care Claim (professional) Claim Submission and the ASC X12 835 Health Care Claim Payment/Remittance Advice is problematic. Currently, payers are not required to maintain line item relationships when they process claims with a CPT code appended with a modifier on one line and the related CPT code on the subsequent line. This deficiency causes inappropriate reductions, increased administrative costs to reconcile payments, and makes it impossible for physicians' practice management systems to automatically post accurate payments.

- **Standardize and establish consistency among electronic remittance advice code sets:** The use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) applied on the payer’s claim payment/remittance transaction varies among payers; standardization of CARCs and RARCs would eliminate this variation and enable the development of automated processes for handling most—if not all—claim denials.
- **Establish consistency between HIPAA standard transactions:** “Class of contract” and “claim filing indicator” codes have different meanings in each payer’s eligibility response transaction and the claim payment/remittance transaction. Codes with the same names need to be established in such a way that allows them to be uniformly applied and interpreted for all standard transactions.

ASC X12 277 Health Care Claim Status Response

The ASC X12 277 Claim Status Response standard transaction is intended for use as a response to a physician’s inquiry about the status of a claim already submitted for adjudication and payment. The payer’s response to this inquiry gives the physician office important information, such as whether the claim has been received, forwarded, is pending adjudication, or has been denied. Similar to the package tracking number described earlier, the claim status response standard transaction tells the physician where the claim is in its journey to its destination – payment. The limitation of this standard transaction is that it is generally transmitted only in response to a specific inquiry that must be generated by the physician using a standard request format that requires eighteen pieces of information about the claim in question.

Recommendations

The AMA recommends that the ASC X12 277 Claim Status Response standard transaction convert from a solicited response standard transaction to a **required** acknowledgement or status report using existing acknowledgement, pending, and finalized status codes. In order to add the most value to the transaction, the standard transaction should be sent on a routine, unsolicited basis at the following points in the claims adjudication process:

- Claim receipt
- Acceptance/rejection for adjudication
- Forwarded to another entity or returned as “unprocessable”
- Pending (in process, in review, requested information [waiting])
- Finalized (paid, denied, revised, forwarded, not forwarded, complete [no payment forthcoming])

The AMA has received positive feedback from many physician offices about some payers that have begun sending **unsolicited** claim status response standard transactions to report progress on a claim. Such proactive information exchange is invaluable to physicians; in particular, this measure can significantly reduce duplicate claims, which practices report sending routinely as a safety net against lost claims rather than employ the cumbersome claims status inquiry standard transaction. Physicians will be able to immediately respond to payer inquiries, communicate with patients about information that may be required to complete a claim, more efficiently anticipate and address denials, and avoid violating payers’ timely filing requirements by receiving claim receipt notification automatically and unsolicited.

Future efforts on publishing new standards in areas that are crucial to fully automating the health care payment system

In addition to stronger enforcement, modification and expansion of the aforementioned HIPAA standard transactions, the AMA also sees significant opportunity for moving today’s opaque paper-based processes to transparent automated processes.

Recommendations

The AMA recommends legislative support of the following:

- **Eliminate variation among companion guides:** Currently, there are more than 1,200 different companion guides, which health insurers use to assist physicians navigate payer-specific claims processing rules that exist despite the standardization intended by HIPAA. This makes it virtually impossible for small physician practices to participate in electronic commerce without the help of large clearinghouses. The AMA strongly encourages the establishment of a single, standard companion guide for each standard transaction. The Minnesota statute described earlier requires such guides.
- **Health plan (payer) identifier:** A National Health Plan Identifier is needed in the HIPAA standard transactions to achieve the true benefits of real-time adjudication. HIPAA requires the assignment of unique health identifiers for each individual, employer, health plan and health care provider in the health care system. To date, the unique identifiers for employers and health care providers have been implemented. The development of a unique patient identifier standard for each patient has not occurred due to privacy concerns. However, there have been no announcements from CMS on the development and implementation of a unique health plan identifier.

The National Health Plan Identifier is viewed by many as the first step toward one-stop billing and should clearly identify:

- the primary health plan responsible for payment;
- any applicable secondary health plan responsible for payment;
- the health plan or other entity holding the contract and associated contractual fee schedule with the physician; and
- the health plan or other entity responsible for administering the patient's benefits and coverage.

We urge prioritization and adoption of a National Health Plan Identifier for each health plan and other entity involved in the claims management process as listed above.

- **Claim Edits:** There are more than 2 million edits currently being used by payers to deny payment for health care services performed by physicians' and other health care professionals. Of them, only those included in the Medicare National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUEs) are transparent, easily available, and based upon the product of broad stakeholder participation. Requiring all claim edit packages to be transparent and consistent with CPT codes, guidelines and conventions would provide all stakeholders, including patients with high deductible health plans who are increasingly likely to be affected by the edits that will be applied, to determine their financial responsibility.
- **Current Procedural Terminology (CPT):** Standard implementation of CPT codes, guidelines and conventions are essential for their uniform national application. Currently, HIPAA covered entities, that is, health plans, physicians and hospitals, are only required to follow the implementation rules for the ICD-9 code set. These same covered entities are permitted to implement and interpret the CPT code set as they see fit. While CPT was adopted as a standard code set under HIPAA, the CPT codes, guidelines and conventions were not. We believe CPT codes, guidelines and conventions should be adopted as well to reduce inconsistencies in the recognition and reporting of physician procedures and services. This oversight significantly undermines administrative simplification and pricing transparency efforts as stakeholders do not have consistent and standard guidelines and conventions for applying CPT.

- **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.

Again, as patients' financial responsibility increases, the lack of transparency in the current system is becoming increasingly problematic for patients as well as physicians. The increasing number of patients covered by high deductible health plans, and unprecedented exclusions from traditional Blue Cross Blue Shield Preferred Provider Organization (PPO) plans such as those for out of network surgery, anesthesia, and emergency services contained in the 2009 Federal Employees' Health Benefits Program (FEHPB) standard option plan, will have no way of anticipating the specific financial obligation they may incur if the current system is not changed.

Finally, it is critically important that determinations of eligibility be **binding** to avoid disruptive and costly to administer "takebacks" from physicians and other healthcare providers and to maintain patient confidence in their calculations of their financial responsibility for medical services.

The savings generated by full implementation of and compliance with electronic standard transactions could be enormous, given the excessive administrative costs and wasteful spending in the health care system. A number of studies have indicated that if simplified, the cost of the administrative expenses alone in our health care system could be reduced annually by almost \$300 billion.⁴ As stated previously, inefficient claims processing is estimated to be one of the top three areas of wasted health care spending that ranges between \$21 billion to \$210 billion annually⁵. To date, health insurers and employers are responding to cost pressures with strategies such as tiered/exclusive networks, disease management, consumer-driven health plans, increased patient cost-sharing, reduction in benefit packages and pay-for-performance initiatives, none of which address administrative simplification. Recent congressional calls to action, for instance, Senator Max Baucus' (D-MT) "Call to Action: Health Reform 2009" touches on the issue of unnecessary administrative expenses through a request for the health care industry, including physicians, to post their prices and to provide pricing transparency to patients. Pricing transparency, however, cannot truly occur without standardization of payment policies and full, complete transparency of payer medical payment policies, reimbursement rules, and other payment reductions applied to the physician's contracted rates. Senator Ron Wyden (D-OR) also outlined several recommendations to simplify health care billing yet did not address the transactions that comprise the billing process. While these calls to action to improve health care's infrastructure, achieve pricing transparency, and promote technology are encouraging, but these calls fail to specifically address the issue that drives the expenditures: administrative paperwork and processes.

The claims management revenue cycle can best be simplified by creating operating rules, guidelines and conventions that ensure all transactions will be processed in the same, consistent manner. Administrative simplification is the surest path to the transparent and efficient electronic health care system required by the 21st century, and to enable resources that are now wasted on administrative burdens to be redirected to activities that truly improve the health of all Americans.

⁴ Heffler, S, Smith, S, Keehan, S, Clemans, MK, Won, G, Zezza, M. "Health Care Spending Projections for 2002-2012" Health Affairs Web Exclusive, Feb. 7, 2003.

⁵ PNC Bank (2007), Commonwealth Fund (2007); RAND Corporation (2005), PricewaterhouseCoopers, 2008.