



Standardization of the Claims Process: Administrative Simplification White Paper

**Prepared by the American Medical Association
Practice Management Center**

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This white paper expands on the previous Administrative Simplification White Paper, prepared by the American Medical Association (AMA) Practice Management Center (PMC) on December 23, 2008, which summarizes the AMA's recommendations to eliminate significant administrative waste from the health care system by simplifying and standardizing the current health care billing, payment and claims reconciliation process.¹ This white paper focuses specifically on the AMA recommendation to publish new Health Insurance Portability and Accountability Act (HIPAA) standards in three areas that are crucial to fully automating the health care billing, payment and claims reconciliation process: (1) a HIPAA standard claim edit package that is fully transparent and consistent with the Current Procedural Terminology (CPT®) codes, guidelines and conventions; (2) a HIPAA standard payment rule set (e.g., multiple procedure reduction logic rule, etc.); and (3) a HIPAA standard payer identifier.² This paper accompanies another white paper that focuses on the need to adopt the CPT guidelines and conventions as a HIPAA standard to achieve the administrative simplification benefits originally anticipated by the adoption of the CPT codes as a HIPAA standard code set.³

The AMA has long supported efforts to promote transparency and consumer-driven health care. We believe that empowering patients with understandable price information and incentives to make prudent choices will reduce the cost of health care. Patients are being asked to shoulder more and more financial responsibility as evidenced by both the increasing use of high deductible health plans and shrinking health insurance coverage, such as occurred when Blue Cross Blue Shield Preferred Provider Organization (PPO) plans imposed unprecedented exclusions for out-of-network surgery, anesthesia and emergency services contained in the 2009 Federal Employees' Health Benefits Program standard option plan. As patient responsibility increases, the complexity and lack of transparency in the current system is becoming increasingly problematic for both patients and physicians. If the current system is not changed, patients will have no ability to anticipate the specific, potentially significant financial obligation they may incur in conjunction with the health care services they obtain.

And without a system that ensures that third-party payers provide the transparent, unambiguous electronic information necessary to verify both what prices for health care services will be pre-service and that claims were paid accurately post-service, there is simply no way for physicians or patients to make informed choices. Payers would also experience significant savings by the

¹ The AMA Practice Management Center is a resource of the AMA Private Sector Advocacy unit.

² CPT is a registered trademark of the American Medical Association.

³ Access the AMA's Administrative Simplification White Paper at www.ama-assn.org/go/simplify on the AMA Web site.

elimination of the great majority of physician claims appeals, which are estimated to cost up to \$60 per manual appeal reconsideration.⁴

As the AMA's National Health Insurer Report Card demonstrates, there is enormous variability and lack of transparency in the current health care billing, payment and claims reconciliation process. The AMA's "Heal the Claims Process"TM campaign aims to reduce administrative waste from the health care system, and specifically, focuses on reducing the cost physicians incur just to get paid from a current industry average of 10–14 percent of revenue to 1 percent.⁵ However, everyone involved in the health care system—payers, employers, patients and health care providers—would benefit substantially from the simplification and streamlining of the current claims process. Given the estimated 2 billion commercial health plan claims processed each year, even modest savings per claim will result in dramatic savings in the aggregate.

Recommendations

The AMA recommends that the Administrative Simplification provisions of HIPAA, and the HIPAA Transaction and Code Set (TCS) rule be revised as necessary to ensure the simplification and timely disclosure of all information necessary for determining patient and payer financial responsibilities. Because of the complexity of the current pricing system for physician and other health care professional⁶ claims, complete price transparency depends not only on the disclosure of the product and contract-specific fee schedule the payer intends to apply to the services provided but also on the disclosure and standardization of the claims processing and payment practices that impact the final price, including the claim edits and payment rules that will be applied. The current opaque and unduly complex pricing system is simply unmanageable for patients and most physician practices.

Payers would retain complete control over their contracted fee schedules and benefit plans.

This recommendation would simply ensure that all parties understand and agree to the payer's fee schedule and can easily reconcile claims payments. To accomplish this, the AMA specifically recommends the following:

- I. That all HIPAA standard Code sets be accompanied by operational guidelines and instructions which govern their use, and that the CPT guidelines and conventions be designated as the operational guidelines and instructions for the CPT Code set;
- II. Implementation of HIPAA standard payment rules (e.g., a multiple procedure reduction logic rule, an assistant at surgery allowance percentage, etc.);
- III. Implementation of HIPAA standard claim edit software;
- IV. Implementation of the HIPAA National Payer Identifier;
- V. Expanded HIPAA standard electronic remittance advice and other standard transaction requirements, including the adoption of a single, binding "Companion guide" for each

⁴ *Electronic Transaction Savings Opportunities for Physician Practices*, Milliman USA, January 2006; *2006 Physician Characteristics*, National Healthcare Exchange Service, 2007.

⁵ 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*: 24.6. 2005; 1629-1639.

⁶ CPT® 2009, instructs any procedure or service in the CPT book may be used to designate the services rendered by any qualified physician or other health care professional.

HIPAA standard transaction which includes the complete set of requirements, processes and operational rules necessary to electronically submit and receive each HIPAA standard transaction;

- VI. Increased enforcement of the Health Insurance Portability and Accountability Act (HIPAA) TCS rule.

A condensed summary of these recommendations can be found at the conclusion of this white paper on pages 23–26. Refer to Appendix A for relevant AMA policies.

I. How payers process claims

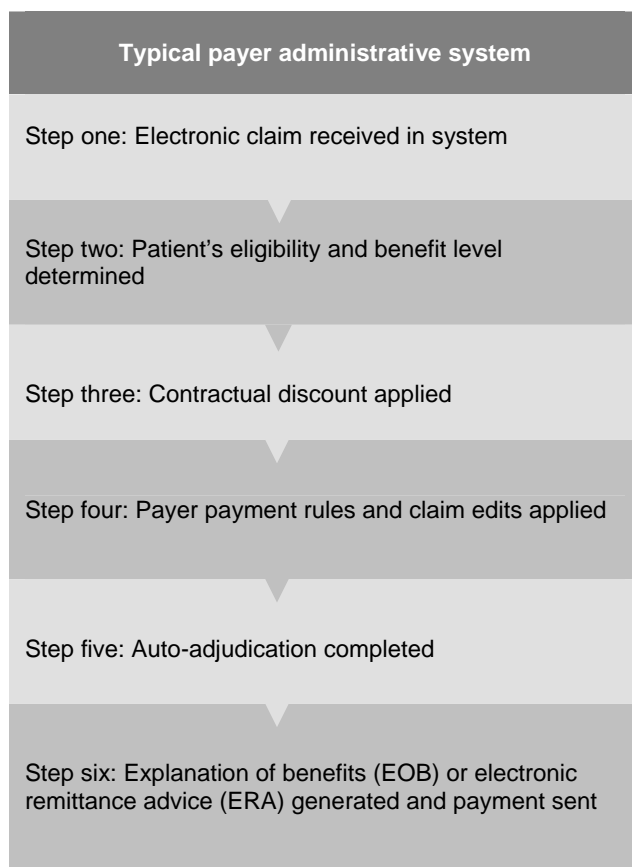
To understand the challenges presented by the current health care billing, payment and claims reconciliation process and the tremendous opportunity for savings that could be achieved if the system were simplified, standardized and made transparent, it is necessary to understand how health care claims are typically paid today. The following is a brief summary of that process.

A physician typically submits a claim electronically to a patient's health plan (payer), billing for medical care the physician has provided, generally including the physician's retail charge for those services. Once the claim is received for processing, the payer's claim adjudication system determines whether the patient is a subscriber "match" in the payer's system and is eligible to receive benefits for the date(s) of service identified on the claim. If the patient "matches" and is eligible, the payer's system then typically determines whether the services are "covered services" according to the patient's benefit plan.

Once the covered benefit level is determined, and assuming the physician has contracted with the payer to accept a discount for the services in exchange for higher patient volume and/or prompt payment, the claim is "repriced," that is, the physician's retail charge for the services rendered is reduced to reflect the agreed upon discount—the portion of the physician's billed charge which will be "allowed" (see Figure 1). To reprice the claim, the payer first reduces the physician's billed charge for the reported CPT codes to the "maximum allowed payment" under the network contract. The contracted "maximum allowed payment" for each reported CPT code on the claim is then adjusted again to reflect additional payer-specific "claim edits," which eliminate payment for certain services, and "payment rules" which generally reduce payments for certain services. Examples include the application of a "claim edit" that eliminates payment for the administration of a vaccine when the physician bills for the vaccine itself or a "payment rule" that reduces the payment when the physician performs more than one procedure during the same visit. The payer then pays the physician the difference between this payer-calculated "total allowed amount" for the medical services and procedures and the amount owed by the patient.

In the case of a physician who has not contracted with the payer (out-of-network) and is not obligated to accept a negotiated payment, the payer determines what portion of the physician's retail charge (i.e., physician's billed charge) will be paid by the patient's benefit plan (again, based both on the fee schedule amount the payer has agreed to pay for out-of-network claims on the patient's behalf and the additional reductions resulting from the payer's claim edits and payment rules). The larger the reductions the payer makes to the physician's retail charge on the claim, the less the payer pays on the patient's behalf, and the more financial responsibility the patient retains. This is because the patient is generally obligated to pay an out-of-network provider's retail charge.

Figure 1: Typical payer administrative system workflow



Step one: Electronic claim received in system

The payer may receive the claim directly from the physician or through an intermediary, such as a billing service or clearinghouse. The claim is pre-screened for missing information.

Step two: Patient's eligibility and benefit level determined

A patient's benefit level, medical necessity, and covered and non-covered services and procedures are determined based on the patient's health benefit plan.

Step three: Contractual discount applied

The payer then reduces the physician's billed charges on submitted claims to their individually contracted discounted fee-schedule rate or "maximum allowed payment."

Step four: Payer payment rules and claim edits applied

The payer further adjusts the payment by applying "payment rules," such as adjustment for modifiers, taxonomy, multiple procedures or global payment rules that either increase or decrease the payment amount. Simultaneously, the payer makes adjustments to the claim using payer claim edits that include customized payer-specific edits. These claim edits determine which of the specific codes listed on a claim are eligible for payment and which will be denied.

Step five: Auto-adjudication completed

The final payment on the claim is determined.

Step six: Explanation of benefits (EOB) or electronic remittance advice (ERA) generated and payment sent

An EOB or ERA is sent to both the physician and the patient, detailing the paid amount for the medical service provided.

Source: American Medical Association (AMA)

As noted above, the costs of this health care billing, payment and claims reconciliation process are high. For instance, the costs associated with verifying eligibility and benefits alone are estimated at \$2.3 billion per year,⁷ and studies have indicated that as much as \$210 billion could be saved through standardization and simplification of the health care billing, payment and claims reconciliation process.⁸ This white paper discusses the cost-saving steps the health insurance industry could implement to increase electronic transactions and reduce the manual processes currently associated with the complex health care billing, payment and claims reconciliation process illustrated in the typical payer administrative system workflow (Figure 1).

Step one: Electronic claim received in system—the payer may receive the claim directly from the physician or through an intermediary, such as a billing service or clearinghouse.

The greatest cost savings in the health care billing, payment and claims reconciliation process can be achieved by:

⁷ MGMA Center for Research Survey, November, 2004.

⁸ PNC Bank (2007), Commonwealth Fund (2007); RAND Corporation (2005), PricewaterhouseCoopers, 2008.

- Increasing the use of more robust and meaningful electronic claim submissions and other existing HIPAA electronic standard transactions, such as the provision of the ASC X12 277 claims status response standard transaction on an unsolicited basis to acknowledge the receipt of a claim and track its progress through the process as discussed below; and
- Adopting CPT guidelines and conventions to accompany the CPT code set as a national standard in HIPAA.

The savings to the health care billing, payment and claims reconciliation process realized as a result of full implementation of meaningful electronic transactions could be enormous—at least \$90 billion per year (see Appendix D). However, not all payers offer all current HIPAA standard transactions, and even where payers do offer current HIPAA standard transactions, there remains an enormous opportunity for improved efficiency and increased cost savings. Recommendations specific to the claims submission process and the impact on this process by increasing electronic claims submissions and standardizing CPT guidelines and conventions are expanded upon below.

Increase electronic claim submissions and other HIPAA standard transactions

The HIPAA TCS rule is the regulation the Secretary of the Department of Health & Human Services (HHS) adopted to implement HIPAA’s Administrative Simplification provisions. The HIPAA TCS rule sets forth requirements governing both the form and format of a series of specified electronic health care transactions as well as their content—such as the CPT codes and the International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes and guidelines. HIPAA’s administrative simplification provisions were created at the request of the health insurance industry to standardize and promote electronic health care transactions. The health insurance industry’s position was that electronic health care transactions would reduce administrative costs and offset the new costs associated with billing premiums and administration that HIPAA’s “portability” requirements would create.

In order to achieve the complete automation of the health care billing, payment and claims reconciliation process for all stakeholders, however, these standard transactions must become more robust and meaningful through increased enforcement of the current HIPAA TCS rule and expansion of the TCS rule to create the level of standardization necessary to achieve maximum efficiency and cost-reduction.

Electronic claims submission

The HIPAA TCS rule establishes the ASC X12 837 Health Care Claim (professional) version 004010 as the standard transaction for the submission of an electronic claim. The value of this transaction is significantly reduced by two problems: (1) the fact that different payers require claims to be completed differently (see discussion of need to standardize CPT guidelines and conventions below); and (2) the HIPAA TCS rule does not establish a standard claims acknowledgement transaction, so that there is no easy way for a physician to know whether a claim has been received or its current status in the health care billing, payment and claims reconciliation process .

This second problem, the lack of a claims acknowledgement standard, could be remedied relatively expeditiously. Indeed, some payers have voluntarily commenced using the ASC X12

277 claims status response standard transaction on an unsolicited basis to acknowledge the receipt of a claim and track its progress through the claims process. Substantial savings would be realized if a new HIPAA standard were established, mandating payers to send an unsolicited ASC X12 277 Claim Status Response standard transaction or its successor at each of the following points in the claims adjudication process:

- (1) Electronic claim receipt;
- (2) Acceptance/rejection of electronic claim for adjudication;
- (3) Electronic claim forwarded to another entity or returned as “unprocessable”; and
- (4) Electronic claim pended (in process, in review, requested information [waiting]).

This one standard transaction has the promise to reduce enormous cost for physician practices and payers and—just as important—reduce the angst of the health care billing, payment and claims reconciliation process by reducing duplicate claims and the numerous phone calls to the payer to verify the status on an electronic claim submission.

Standardizing CPT guidelines and conventions

The standardized application of CPT codes, guidelines and conventions would likely increase physician use of electronic transactions by increasing transparency and reducing complexity and confusion. This standardization would contribute to a measurable decrease in the administrative costs of appeals for payers and the cost incurred as a result of incorrect claim submissions for physicians, who currently struggle to comply with conflicting payer demands.

Currently, HIPAA-covered entities (i.e., physicians and other health care professionals, payers and clearinghouses) are only required to follow the implementation rules for the ICD-9-CM code set, which identifies and classifies patient diagnosis data. 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 guidelines and conventions were not. This oversight significantly undermines administrative simplification and pricing transparency efforts because payers currently do not follow consistent, standard guidelines and conventions for applying CPT. The AMA believes CPT guidelines and conventions must be adopted as a HIPAA standard to accompany the CPT code set to ensure all trading partners submit and respond to physicians and other health care professionals’ claims for procedures and services in a consistent fashion.

Many physicians have contracts with more than 20 payers, most with multiple products. It is extremely burdensome for coders to have to know the variation in coding rules for each of the 20 payers and their multiple products. If CPT codes, guidelines and conventions were standardized, physicians and their billing staff could code claims consistently across all payers, and automated encoding systems could be created to ensure appropriate claim submission. For a more detailed discussion of the reasons for adopting the CPT guidelines and conventions as a HIPAA standard to accompany the CPT code set, see the AMA’s “CPT Codes, Guidelines and Conventions Administrative Simplification White Paper.”

Step two: Patient’s eligibility and benefit level determined—A patient’s covered and non-covered services and procedures are determined based on the patient’s health benefit plan.

The HIPAA TCS rule establishes the ASC X12 270 Health Care Eligibility Benefit Inquiry and ASC X12 271 Eligibility Benefit Response version 004010 as the standard transaction for the electronic verification of a patient’s (subscriber) benefit eligibility. This standard is used by physicians to request from a payer a patient’s eligibility for a particular service or procedure based upon the patient’s health plan coverage, as well as by payers to respond with the eligibility verification. However, the value of this standard transaction is severely limited by the regulation’s lack of specificity; inconsistent implementation of this standard transaction across the health insurance industry; the fact that some payers appear to require physicians to pay a significant fee to utilize this standard transaction, even though the HIPAA TCS rule expressly prohibits such a charge; and some payers’ policies that consider verifications to be nonbinding.

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 can quickly assist in patient scheduling, billing the appropriate payer with financial responsibility for the service, communicating the patient’s financial responsibility and reducing the number of denied claims which the physician practice must manually handle. Some payers currently provide a robust eligibility response as the developers of the HIPAA TCS eligibility transaction envisioned. However, the current standard only requires that payers respond with a “Yes/No.”

The latest version of the X12 HIPAA transactions, version 005010, has been adopted by the HHS with a compliance date of January 1, 2012. The 005010 version of the eligibility request and response transaction has expanded payer requirements for eligibility responses, which will benefit physicians. Payers will be required to include all subscriber/dependent patient identifiers that the payer would require on subsequent transactions. The required alternate search options in version 005010 will improve matching of a patient and receipt of eligibility information by the physician. The most significant improvement is the greater detail beyond “Yes/No” that payers will be required to report. The 005010 version requires payers to return the co-payment, co-insurance, deductible amounts, plan beginning and ending dates, information about the primary care provider, and specific service types and their related information.

Given the inconsistent implementation of the 004010 eligibility transaction, uniform adoption of the 00510 version would greatly improve the efficiency with respect to the currently problematic area of eligibility determinations. There is a continued need to encourage reporting to the maximum specificity before the service is provided. Ideally, such specificity will help physicians and other health care professionals answer the following five questions at the point of service in order to enable patients to understand the financial repercussions of the treatment decisions that are made:

- (1) Is the patient eligible (does the patient have coverage under the payer’s health plan)?
- (2) If yes, what network discount does the payer intend to use for the services provided to the patient?
 - patient’s “primary network”—patient is entitled to the in-network benefit
 - patient’s “wrap network”—patient is only entitled to out-of-network benefits
- (3) Does the health plan contract with that network?
- (4) Does the physician contract with that network?

(5) What is the patient’s specific benefit coverage, including co-payment and remaining deductible?

In the absence of an answer to any one of these five questions, there is no way for (1) patients to know what their personal financial responsibility will be for the services they receive or (2) for physicians and other health care professionals to determine the payer’s financial responsibility for those services.

Information sufficient to answer the above five questions 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, and this value would encourage wide-spread utilization of the standard transactions by physicians and increased physician automation. The AMA strongly supports the efforts of the Council on Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) to not only expand the value of the eligibility standard transaction but also continue its efforts of adding value to electronic remittance advice and other standard transactions through the development of standard operating rules. Visit the CAQH CORE Web site at www.caqh.org/benefits.php for more information on the CORE initiative. Indeed, the AMA strongly supports efforts to create a single, binding companion guide for each HIPAA standard transaction, so that all trading partners would be required to implement and interpret all HIPAA electronic transactions in the same way.

It is also critical that physicians and health care professionals be able to rely on determinations of eligibility to avoid disruption and inefficiency in the health care billing, payment and claims reconciliation process. Errors in eligibility information need to be resolved by the parties that have the capacity to fix them—the employer and health plan administrator.

Please review the AMA’s Administrative Simplification White Paper at www.ama-assn.org/go/simplify for more specific recommendations to reduce cost through more enforcement and robust requirements for the HIPAA TCS ASC X12 270 Health Care Eligibility Benefit Inquiry and ASC X12 271 Eligibility Benefit Response, among other electronic standard transactions.

Step three: Contractual discount applied

The payer applies the contractual discount by reducing physicians’ billed charges on submitted claims to their individually contracted discounted fee-schedule rate, which payers refer to as the “maximum allowed payment.” The physician’s ability to confirm the accuracy of the contractual discount applied to the claim would be augmented if payers clearly identified on the electronic remittance advice (see step six below) the “contractual allowed amount,”⁹ the underlying contract and the specific product applicable to each patient. Payers are also encouraged to provide physicians with online access and the ability to download their complete physician-specific fee schedule by CPT code into their practice management system. That way, there is no question whether both parties have agreed to the discounted fee schedule amount to be applied to

⁹ Reported in the X12 ASC 835 – Health Care Claim Payment/Advice, Service Supplemental Amount segment where AMT01(Allowed-Actual)=B6 and AMT02 (Monetary Amount/Service Supplemental Amount) is not null.
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the claim. In addition, physicians need sufficient notice of changes and updates to the contracted fee schedule before they take effect from the payer in a format that is easy to understand and allows an easy way to update their practice management systems.

Step four: Payer payment rules and claim edits applied

The payer further adjusts the payment by applying “payment rules,” such as adjustments for modifiers, taxonomy, multiple procedures or global payment rules that either increase or decrease the payment amount. Simultaneously, the payer makes adjustments to the claim using payer claim edits, including customized payer-specific edits. These claim edits determine which of the specific codes listed on a claim are eligible for payment and which will be denied. The application of a “claim edit” eliminates payment of a service or procedure when the physician performs one or more services or procedures that is subject to a claim edit.

4A: Payer payment rules

Payer payment rules are programmed into the payer’s claims processing software to adjust the payment for reported procedures and services. Payment rules, such as taxonomy and modifier adjustments, are initially applied to single line items. Then, after code edits are applied, post edit payment rules are applied, which include bilateral and multiple procedure reduction logic that affect multiple line items. The following example of the variation in the application of the multiple procedure reduction logic demonstrates the complexity created by nonstandardized payment rules.

Multiple procedure reduction logic rule

In order to bill appropriately for their services and reconcile their claims payments, physician practices must understand and apply each payer’s payment rule applied to multiple procedures performed during the same session by the same physician, commonly called “multiple procedure reduction logic.” Pursuant to the CPT coding system, modifier 51 is the indicator that multiple procedures were performed. Payers apply different rules to determine which of the two or more procedures performed is primary, and payers further differ in how they handle the associated procedure(s). For instance, payers have variously based their determination of the “primary” procedure on any of the following: (1) the highest allowable amount the payer will pay for any of the services; (2) the highest relative value units (RVUs) per Medicare Resource-Based Relative Value Scale (RBRVS) of any of the services; (3) the highest billed charge by the physician for any of the services; or (4) mechanically designating as primary the service the physician listed first on the claim or listed first on the claim without a modifier 51.

Figure 2 lists the various challenges physicians and other health care professionals face when attempting to accurately report multiple procedures in accordance with the various payer requirements and to understand each payer’s electronic remittance advice as necessary to reconcile claims’ payments.

Figure 2: Challenges when reporting multiple procedures

Physicians who perform more than one procedure in the same session typically list the procedures in rank order from the one with the highest charge to the procedure with the lowest charge, as the CMS payment rule pays in this order. Following are examples of the variations in the payers' multiple procedure reduction logic rules at each step in the reporting process.

Step 1: The first step in the application of the multiple procedure reduction logic rule is to identify those services that are eligible for reduction. Not all surgical procedures should be reduced. CPT 2009 defines modifier 51 as follows: "When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provisions of supplies (e.g., vaccines) are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated add-on codes."

CPT has identified those services designated "add-on" as procedures or services that are always performed in addition to the primary procedure or service. Add-on codes describe additional intraservice work associated with the primary procedure or service. CPT has identified codes as "Modifier 51-Exempt" that are typically performed with another procedure but may be a stand-alone procedure and not always performed with other specified procedures. Modifier 51-exempt codes should not be reduced pursuant to multiple procedure reduction logic because the work values for these services have already been reduced, with removal of relative value units for the pre- and post-service that is already inherent in the primary service with which these codes are reported. Nerve conduction tests are an example of codes that are exempt from the multiple procedure reduction. (Note, however, not all payers follow the CPT coding guidelines and therefore reduce payment by inappropriately applying the multiple procedure reduction logic rule to CPT add-on codes and modifier 51-exempt codes, such as evaluation and management (E/M) services, physical medicine and rehabilitation services, and provision of supplies [e.g., vaccines].) Once the multiple procedure reduction exempt codes are excluded (CPT-designated add-on and modifier 51-exempt codes), the remaining codes must be evaluated for ranking (identifying primary and subsequent procedures).

Step 2: The second step is to identify the primary procedure. The software in many third-party payer claims adjudication systems automatically re-ranks the procedures and applies the percentages in varying ways. The primary procedure may be determined by any of the following algorithms:

- First reported code
- First reported code without a modifier 51 appended
- Code with the highest allowed amount (contracted rate)
- Code with the highest total relative value units
- Code with the highest physician fee schedule charge
- Site-specific RVUs (dependent on the rendering place of service)
- Facility RVUs only
- Non-facility RVUs

In addition to the variation of the identification of the primary procedure, there is typically no negotiated or identified reference to the RVU source. Physicians may incorrectly assume it is the Medicare RBRVS, while the payer may choose another source. Additionally, even if the current year Medicare RBRVS is specified in the physician's managed care contract, the payer's claims processing platform is not always updated on a timely basis.

Step 3: The third step is the actual application of the percentage reduction to the subsequent procedures. Although physicians often assume the rule will be consistent with the rule CMS uses—100% payment applied to the primary procedure, and 50% payment applied to the remaining procedures—payers' rules vary. Some examples of payer rules include:

- 100% applied to the primary procedure and 50% applied to the second through sixth procedures
- 100% applied to the primary procedure, 50% applied to the second procedure and 25% applied to the third through sixth procedures
- 100% applied to the primary procedure, 50% applied to the second procedure, 25% applied to the third procedure, 10% applied to the fourth procedure, 5% applied to the fifth procedure and 0% applied to the sixth procedure
- 100% applied to the primary procedure, 50% applied to the second procedure, 50% applied to the third procedure, 25% applied to the fourth procedure, and 25% applied to the fifth procedure and sixth procedures

Source: Medical Present Value Inc.

In 2007, the AMA PMC engaged Medical Present Value Inc. (MPV) to perform a study of claims payments. The MPV study analyzed the claims payments made to 75 physician groups, consisting of more than 20,000 physicians and 15 million claims from eight major payers. Figure 3 displays the results of the study, demonstrating the wide variation in payer application of multiple procedure reduction logic.

Figure 3: Payer application of multiple procedure reduction logic rule

Payer	Total contracts	100%, 50%, 50%, 50%, 50% MSR	100%, 50%, 25%, 25%, 25% MSR	Other MSR rate
A	235	76.2%	23.0%	0.9%
B	440	95.9%	2.5%	1.6%
C	3415	82.6%	12.2%	5.2%
D	478	77.4%	22.0%	0.6%
E	324	13.9%	86.1%	0.0%
F	135	87.4%	12.6%	0.0%
G	174	45.4%	54.6%	0.0%
H	250	80.8%	17.2%	2.0%
TOTAL	5451	77.7%	18.7%	3.6%

Column 1: Eight major payers included in MPV data analysis

Column 2: Total contracts

Column 3: Percentage of contracts to which 100%, 50%, 50%, 50%, 50% Multiple Service Reduction (MSR) was applied

Column 4: Percentage of contracts to which 100%, 50%, 25%, 25%, 25% Multiple Service Reduction (MSR) was applied

Column 5: Percentage of contracts to which another MSR rule was applied

Source: Medical Present Value Inc.

Other payment rules

There are many other payment rules that affect the ultimate price of health care services. Although many commercial payers follow aspects of the payment rules used by the Medicare program, this is neither always the case, nor do those payers that follow some aspects of Medicare follow them in the same way as Medicare or as other commercial payers. Appendix F details the results of a 2006 AMA survey of commercial payers concerning their use of Medicare RBRVS-based fee-schedules and payment methodologies, and includes the percentage of private non-Medicare payers that adopt global surgical periods, Medicare site of service differentials, modifiers and other payment policies.

Not only are payment rules sometimes not transparent or applied differently among payers, but new or updated payer payment rules may be posted without notice on a payer’s Web site or implemented without any notice to physicians, contributing to increased physician effort to identify, comply and file appeals on claims that have been reduced for reasons that are not clear to the physician practice. Adding to the confusion, payer contracts may not always describe the applicable payment rules or claims edits with the clarity needed by physicians and their office staff. For example, a contract may state that “payer adjudication rules are **based on CCI** [or National Correct Coding Initiative (NCCI)]” (bold added). Because the contract states “based on CCI,” the physician may interpret this language to mean that the payer will indeed comply with

NCCI. However, a payer may view this language as not mandating adherence to CCI. Such differences in interpretation may add to the challenge of calculating the actual payment amount on the claim prior to service, and also increases the cost to the physician practice because manual intervention in the health care billing, payment and claims reconciliation process is required to determine the accuracy of the payment post service.

Concerns regarding the transparency of payment rules have been raised and addressed by several state legislatures. California law requires managed care organization “payers” to disclose in an electronic format their payment policies, including, but not limited to:

- (1) consolidation of multiple services or charges;
- (2) payment adjustments due to coding changes;
- (3) reimbursement for multiple procedures;
- (4) reimbursement for assistant surgeons;
- (5) reimbursement for the administration of immunizations and injectable medications; and
- (6) recognition or non-recognition of CPT code modifiers.

North Carolina legislation requires transparency of the definition of global surgery periods and payment based on the relationship of procedure code to diagnosis code. Refer to Appendix B for more state laws mandating transparency of payment rules.

Requiring all payers to use the same payment rules would make it much easier for all stakeholders (including patients with high deductible health plans, who are increasingly likely to be affected by payment rules) to determine their financial rights and responsibilities both pre- and post-service. Moreover, as Medicare payment rules have already been adopted by many commercial payers, and as Medicare payment rules maintain the relativity of the Medicare RBRVS, the AMA suggests that the Medicare payment rules should be the starting point for the development of a national payment rule standard.

4B: Payer claim edits applied

In addition to the application of payment rules, payers may also apply claim edits that reduce physician payment amounts. Claim edits are bundling algorithms that have been programmed into the payer’s claims processing software. These claim edits are programmed to deny payment for certain CPT codes when they are included on a claim with certain other CPT codes. For example, some payers have a claim edit that will deny the CPT code physicians report to indicate they performed the administration of a vaccine when they bill for the vaccine itself.

Payers currently use **millions** of claim edits. Additionally, some payer edits vary based on the claims processing platform. The claim edit categories in Figure 4 represent a small sample of the types of claim edits used in the adjudication process. Of those claim edits, only those included in the Medicare NCCI are transparent, available in a free, downloadable format and based upon the product of broad stakeholder participation.¹⁰ Payer-specific edits (which may or may not be disclosed) reflect the specific clinical edit policy of the payer. These edits include the denial of a service as inclusive of another reported service when two or more services are billed on the same day (e.g., preventive “well” and problem-focused “sick” office visits)—this example is detailed further in Figure 7) and additional edits not contained in CPT, NCCI or Medicare. A

¹⁰NCCI claim edits may be found at www.cms.hhs.gov/NationalCorrectCodInitEd/ on the CMS Web site.
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standardized code-editing system would not only allow physicians to significantly increase the number of claims payments that could be automatically posted by their practice management systems, but would also allow physicians and other health care professionals to apply a more robust claim scrubber to increase the likelihood claims are submitted accurately the first time.

Figure 4: Sample claim edit	
Valid ICD-9 code	Procedure code/gender conflict
Date of services before date of birth	Valid CPT/HCPCS code
Procedure code/place of service conflict	Mutually exclusive
Valid modifier	Procedure code/units conflict
Add-on codes	Procedure code/age conflict
Future date of service	Separate procedure
Source: National Healthcare Exchange Service (NHXS)	

Figure 5 below summarizes the sources of claim edits applied by payers and highlights the wide variation among payers' claim edit use as reported in the 2008 AMA National Health Insurer Report Card.

Figure 5: Source of claim edits							
Health insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Humana	UnitedHealthcare (UHC)	Medicare
CPT— AMA CPT codes, guidelines and conventions	1.4%	2.5%	0.6%	32.4%	1.5%	4.5%	9.2%
ASA— American Society of Anesthesia Relative Value Guide	--	--	--	--	--	--	2.6%
NCCI— National Correct Coding Initiative	2.7%	50.4%	6.1%	50.0%	9.2%	5.2%	19.0%
Medicare payment rules CMS Publication 100-4	41.8%	31.1%	92.9%	17.6%	17.3%	57.3%	49.9%
Payer-specific claim edits— These are only disclosed payer – specific claim edits	54.1%	16.0%	0.4%	0.0%	71.9%	33.0%	19.3%

Source: American Medical Association, 2008

As Figure 5 demonstrates, the claim edits used by the major payers come from many sources, and this complexity increases the cost of the health care billing, payment and claims reconciliation process substantially for both physicians and payers. However, there are already several publicly available claims edit compilations that could be used as the basis for a single, transparent claim edit software package.

CPT codes, guidelines and conventions

CPT codes, guidelines and conventions are developed and monitored by the CPT Editorial Panel process. The CPT Editorial Panel is composed of physicians, payers and other health care professionals, and the panel incorporates comments from the national medical specialty societies, which also assist in reviewing any changes. The CPT code set is used by physicians and other health care professionals to report services and to bill payers but is not used consistently by some payers in their code-editing software. This inconsistency can result in increased denials, inaccurate payments and increased cost to the health care system.

NCCI

NCCI is widely available, transparent and the source of continued claims education for the physician practice. This information assists the physician practice in submitting a clean claim to Medicare. As demonstrated by the AMA's National Health Insurer Report Card, NCCI already accounts for a large percentage of several payers' edits, and the majority of NCCI claim edits are consistent with CPT codes, guidelines and conventions.

NCCI edit development and review process

The NCCI undergoes constant refinement—four versions of the NCCI edits are published annually. Medicare contractors implement the versions effective the first of January, April, July and October. Medicare contractors also implement four annual versions of NCCI in the outpatient code editor, also on the first of January, April, July and October. The changes appearing in the NCCI edits for Medicare contractors are loaded into the Medicare contractors' systems, and the changes appear in the outpatient code editor software one quarter later. Changes in NCCI come from three sources: (1) additions, deletions or modifications to CPT or HCPCS Level II codes or CPT manual instructions; (2) CMS policy initiatives; and (3) comments from the AMA, national or local medical specialty societies, other national health care organizations, payers, Medicare contractor medical directors and staff, other health care professionals, billing consultants, etc.

CMS notifies the AMA and national medical specialty societies of the quarterly changes in NCCI. Additionally, CMS seeks comment from national medical specialty societies and other national health care organizations before implementing many changes in NCCI. Although national medical specialty societies and other national health care organizations generally agree with changes CMS makes to NCCI, CMS carefully considers the adverse comments received. When CMS decides to proceed with changes in NCCI contrary to the comments of national

medical specialty societies or of other national health care organizations, it does so only after due consideration of those comments and other information available to CMS.¹¹

According to CMS, the HCPCS and CPT claim edits are developed based on an annual and/or ongoing review of changes in HCPCS and CPT code descriptors, HCPCS and CPT coding instructions and guidelines, local Medicare contractors and national Medicare edits and policy initiatives, and Medicare billing history. The correct coding edits that result from this process are incorporated into claims processing systems used by Medicare contractors to determine payments to physicians. As of October 1, 2008, there are approximately 320,056 active coding edits in NCCI Version 14.3. CMS has identified approximately 13,991 of these edits as “correct coding edits for mutually exclusive codes,” (i.e., those codes that represent services that cannot reasonably be performed in the same session). The remaining 306,065 edits are classified as “correct coding edits for column one/column two codes” that represent code edits in which the column one code will be paid and the column two code disallowed for two procedures performed on the same patient on the same date of service by the same physician or other health care professional.

MUEs

CMS developed **unit edits** in addition to claim edits called Medically Unlikely Edits (MUEs). MUEs were developed to reduce the paid claims error rate for Medicare Part B claims. The MUEs were implemented January 1, 2007, and are utilized to adjudicate claims at Carriers, Fiscal Intermediaries and Durable Medical Equipment (DME) Medicare Administrative Contractors. An MUE for a HCPCS/CPT code is the maximum units of service that a physician or other health care professional would report under most circumstances for a single beneficiary on a single date of service. Not all HCPCS/CPT codes have an MUE. While these unit edits were not originally disclosed, as of October 1, 2008, CMS announced that the majority of existing MUEs were made public and posted on the CMS Web site¹². While the AMA remains concerned that some of the MUE unit edits are not disclosed, all of the MUE edits are reviewed by the national medical specialty societies through the NCCI process as described above. MUE claim edits are considered part of the NCCI claim edits. Each line of a claim is adjudicated separately against the MUE value of the HCPCS/CPT code reported on that line. If the unit of service on that line exceeds the MUE value, the entire line is denied at the Carrier or the claim is returned to the provider at the Fiscal Intermediary (FI).¹³

ASA

The determination of anesthesia CPT code based unit value and the appropriate use of time units are defined in the American Society of Anesthesiologists (ASA) Relative Value Guide™ (RVG).

Payer-specific claim edit software

“Payer-specific claim edits” refer to claim edits the payer applies to deny payment for services that do not match publicly available and recognized sources: CPT, NCCI, ASA or CMS,

¹¹ INTRO.doc, Version 14.3.1 Introduction for National Correct Coding Initiative Policy Manual for Medicare Services

¹² MUEs can be accessed through the MUE Web page at www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage on the CMS Web site.

¹³ NCCI manual - Chapter I General Correct Coding Policies Version 14.3.

according to the AMA National Health Insurer Report Card. There are several claim editing software products available. These proprietary software programs allow payers to alter the claim edits they utilize in the health care billing, payment and claims reconciliation process on an ongoing basis. The companies that produce these claim edit programs charge a licensing fee and prohibit public disclosure of the included edits.

A claim edit is commonly applied when a physician practice submits a claim for two or more separate, distinct CPT codes to report procedures and services performed on a patient during a single visit. The payer considers the two or more separate, distinct procedures and services as one and reimburses the physician for only one procedure or service performed. This practice is called “bundling.” The AMA opposes the inappropriate bundling of CPT codes, which is essentially a unilaterally dictated “package discount.” Bundling is even more problematic when the claims editing software contains revised or added CPT code pair edits that are not disclosed to physicians.

Physician practices have reported numerous instances of undisclosed edits have been used to inappropriately bundle CPT codes, and bundling has become more widespread as use of proprietary code-editing software has increased. An additional layer of confusion is created when the proprietary software is repeatedly modified by an individual payer to the point that it is virtually impossible for a patient or physician to predict with a reasonable degree of certainty which services will be reimbursed when the services are provided.

Bundling also occurs when a physician reports an E/M CPT code with modifier 25 along with another procedure or service. Modifier 25 indicates the evaluation and management service was separate from the other procedure or service performed on the same date of service. For example, when a physician reports a CPT code 99242-25 (office consultation for a new or established patient) with CPT code 11600 (excision, malignant lesion including margins, trunk, arms or legs), the payer may bundle the CPT codes together, stating that the E/M service is included in the procedure. The payer will thus only pay one CPT code—often the one with the lowest payment. However, because the E/M is separate from the procedure, and the payer did not recognize modifier 25 (as required by the CPT guidelines and conventions), physicians routinely appeal this kind of payer denial.

In a 2000 report discussed further below, the Medicare Payment Advisory Commission (MedPAC) stated that Medicare moved away from applying proprietary, undisclosed edits to claims because it was too costly, and instead began to apply the newly published NCCI claim edits. Because most commercial payers use significantly more edits than were used by Medicare when Medicare abandoned proprietary edits, even more money could be saved if all payers used standard, transparent claims editing software.

Patients are harmed by these undisclosed claim edits as well. The variation of payer claim edits and its effect on a patient’s financial responsibility (independent of benefit plan design) is most clearly revealed through the claim edit applied and the percentage of the contracted rate that is actually paid when two E/M services (i.e., a preventive “well” office examination and an unexpected problem-focused examination) are performed on the same day by the same physician. This happens when a patient goes to a physician for a preventive visit, like an annual physical, and the physician identifies an unrelated illness or condition that requires separate evaluation and management. While the physician could require the patient to schedule another follow-up appointment to deal with the problem, physicians typically try to handle it at the same

time as the preventive visit, both for patient convenience and to expedite treatment. In these instances, the physician will bill both a preventive (“well”) medicine E/M code (99381–99429) and a “sick” visit E/M code (99201–99215) with a modifier 25 appended. According to CPT, both services should be recognized and paid when appropriately documented.

Figure 6 demonstrates the variation in the application of payer claims edits within and among payers when two E/M services (a preventive “well” office examination and an unexpected problem-focused “sick” examination) are performed on the same day by the same physician and documented appropriately.

Figure 6: Payer variation in reporting a preventive and problem-focused office visit

Of 63,060 adjudicated claims having both a preventive and regular office visit, 53,767 claims (or 85.3%) allowed both visits. The remaining claims had at least one of the E/M services denied—13.4% allowed the well visit only, and 1.4% allowed the sick visit only.

Payer	# of claims	Both allowed	Sick denied	Well denied
A	1,946	39.1%	60.2%	0.7%
B	15,882	93.6%	4.8%	1.6%
C	18,892	87.5%	11.2%	1.3%
D	7,450	54.4%	44.2%	1.4%
E	8,014	91.0%	8.3%	0.7%
F	1,972	95.5%	4.0%	0.5%
G	1,948	98.7%	0.8%	0.6%
H	6,956	92.9%	4.8%	2.3%
Totals	63,060	85.3%	13.4%	1.4%

Source: Medical Present Value Inc.

Figure 7 demonstrates the impact of applying varying pricing and claim edit rules on the patient and physician’s respective financial liability for the services when two E/M services (a preventive “well” office examination and an unexpected problem-focused “sick” examination) are performed on the same day by the same physician and documented appropriately.

Figure 7: Application of claim edits when two E/M services are appropriately reported and documented according to CPT codes, guidelines and conventions

Option A: Payer recognizes and allows both services at the contracted rate			
	Payer-covered benefit plan*	Patient responsibility*	Physician write-off
Preventive “well” office examination	100% of contracted rate		
Problem-focused “sick” office examination	100% of contracted rate		
The following variations inappropriately encourage a physician to require patients to come back for a subsequent visit, which jeopardizes quality patient care and safety and threatens the physician-patient relationship:			
Option B: Payer bundles the two examinations into one payment			
	Payer-covered benefit plan*	Patient responsibility*	Physician write-off
Preventive “well” office examination	100% of contracted rate		
Problem-focused “sick” office examination			100% of contracted rate
Option C: Payer pays only for the well visit, and the problem-focused visit is considered a non-covered service			
	Payer-covered benefit plan*	Patient responsibility*	Physician write-off
Preventive “well” office examination	100% of contracted rate		
Problem-focused “sick” office examination		100% of contracted rate	
Option D: Multiple procedure reduction logic rule is applied, inconsistent with CPT codes, guidelines and conventions			
	Payer-covered benefit plan*	Patient responsibility*	Physician write-off
Preventive “well” office examination	100% of contracted rate		
Problem-focused “sick” office examination	50% of contracted rate		50% of contracted rate
Option E: Global period payment rule applied, inconsistent with CMS payment rules			
	Payer-covered benefit plan*	Patient responsibility*	Physician write-off
Preventive “well” office examination	100% of contracted rate		
Problem-focused “sick” office examination			100% of contracted rate
* subject to patient’s co-payment and co-insurance Source: American Medical Association			

What effect would standard claim edits have on the health care industry?

Because the majority of payers already use claim editing software, the transition to a single, standardized system would not be unduly burdensome. In fact, payers are accustomed to regular changes to claim editing systems because these editing systems, like NCCI, are updated annually, if not quarterly.

Standard payment rules and claim edits would provide a common claim processing platform for payers, physicians and patients. A standard claims processing platform would not dictate any payer fee schedules, medical rules, claim review process or product benefit level or design.

The transparency, simplicity and consistency fostered by the adoption of standardized payment rules and claim edits would cause a measurable decrease in the administrative costs for both payers (who would benefit from more accurate claim submission and substantially fewer appeals), and for physicians and other health care professionals (who would benefit from a significant reduction in the cost of claims reconciliation). Payers incur an average cost of \$60 to process each appeal they receive. A physician practice incurs an average cost of \$25 for each incorrectly submitted claim or inappropriately paid claim which the physician practice must resubmit and/or appeal. These resources, as well as the increased goodwill that would accompany the elimination of the current adversarial payment system, would be much better directed towards improving the quality and efficiency of the health care system. Standardization of the reporting and recognition of CPT codes, payment rules and claim edits is also a key step towards providing pre-service pricing information to the consumer.

Cost of implementation of a single code editing system

As noted above, CMS attempted to implement undisclosed, proprietary edits (COTS) and then discarded them because they were not cost effective. The following excerpt from the March 2000 MedPAC report presages that decision:¹⁴

“Over approximately 3 years, HCFA (Health Care Financing Administration) has paid about \$700,000 for 120,000 CCI edits, producing average annual savings of \$236 million. In contrast, HCFA’s two-year contract for the use of COTS edits cost \$20 million, producing projected savings of only about \$8 million in 1998 (AMA 1999) based on the use of 156 edits.” MedPAC’s recommendation was: “HCFA should disclose coding edits to physicians and should seek review of the appropriateness of those edits by the medical community.”

The Medicare code editing software (NCCI) is free, transparent and can be incorporated into claim scrubbing software in various practice management systems to identify claims that should be revisited by the physician practice before they are even submitted. While Medicare’s code editing software may need to be supplemented with edits applicable to services that are not generally represented in the Medicare population (such as pediatrics and obstetrics), there is no reason to believe that this could not be accomplished relatively expeditiously through an industry collaborative effort. Indeed, the cost of developing and maintaining a HIPAA standard claims payment and editing software package should be significantly less expensive than the amount payers are currently spending to maintain their various payer-specific systems.

¹⁴ MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2000, page 93.
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Further, standardized code editing software, similar to NCCI, would not affect payers' ability to conduct appropriate medical reviews of claim submissions or their ability to respond to fraud and abuse. Sophisticated software now exists to analyze claims submissions in almost limitless ways and to identify anomalies and outliers. Indeed, many payers have implemented systems based on these tools, allowing them to better focus their efforts on those unscrupulous individuals who improperly take advantage of the system rather than unfairly and counterproductively treating the entire medical profession as though it were untrustworthy. Some payers have also used their data to help educate physicians about practice variation and to proactively engage the medical profession in quality improvement efforts.

HIPAA-covered entities are preparing for compliance with the new HIPAA standard transactions (version 005010), which will be effective January 1, 2012, and the ICD-10-CM codes, which must be used by October 1, 2013. These upgrades will provide an ideal opportunity to incorporate standard claim edit and payment rule software into payer administrative systems, practice management systems and other systems.

Step five: Auto-adjudication completed—The final payment on the claim is determined.

After a claim is adjudicated by a payer, a HIPAA standard ASC X12 835 version 004010 remittance advice is sent to the physician or other health care professional. If the payer has “repriced” the claim to less than the amount billed, the remittance advice must contain reason and remark codes to communicate why the adjustments were applied. The reason and remark codes designated as HIPAA standard codes are called claim adjustment reason codes (CARC) and remittance advice remark codes (RARC). Although the codes themselves are a HIPAA standard, as with the CPT code set, there are currently no standard operating guidelines and instructions governing the use of CARCs and RARCs. As a result, the application of the reason and remark codes on the payers' claim payment/remittance transactions varies widely and is often not reported to the highest level of specificity. The AMA's 2008 National Health Insurer Report Card revealed that out of 190 possible CARCs, only 20 of those codes were used to explain 80 percent of the payers' claim adjustments. Out of 675 possible RARCs, only 31 were used to explain 80 percent of the payers' claim adjustments. Moreover, there was no consistency in the use of these CARCs and RARCs between payers, thus requiring substantial manual effort by physician practices to reconcile their claims. Standard application of CARCs and RARCs would eliminate this variation and enable the development of automated processes for handling most—if not all—claim denials, thus dramatically reducing administrative costs and hassles for the medical community.

Please review the AMA's Administrative Simplification White Paper¹⁵ and the National Health Insurer Report Card¹⁶ for ways to reduce costs through increased enforcement and more robust requirements for the ASC X12 835 remittance advice and other electronic standard transactions mandated under the HIPAA TCS rule.

¹⁵ Access the AMA's Administrative Simplification White Paper at www.ama-assn.org/go/simplify on the AMA Web site.

¹⁶ Access the AMA's National Health Insurer Report Card at www.ama-assn.org/go/reportcard on the AMA Web site.

Step six: Explanation of benefits (EOB) or remittance advice is generated, and payment is sent to the physician and patient, detailing the paid amount for the medical service provided.

Payers frequently do not complete the ASC X12 835 electronic remittance advice to the highest specificity, nor do they always complete the voluntary fields that are critical to evaluating the appropriateness of a payment on a claim, such as the “allowed amount” field (the contracted rate between the physician and payer). If payers would voluntarily provide this basic information in a consistent manner on the ASC X12 835 electronic remittance advice, claim submission and reconciliation costs for physician practices could be dramatically reduced—from the current industry average of 10–14 percent of total revenue to a fraction of that amount. In turn, payers would experience significant savings by paying accurately the first time, instead of incurring the substantial costs of handling physician appeals on a claim, which is estimated to range up to \$60 per manual appeal reconsideration.¹⁷ The provision of robust, accurate electronic information pursuant to the HIPAA standard transactions will maximize savings to both payers and physician practices.

In version 005010 of the ASC X12 835 standard transaction, the requirements for data to be reported to the physician have been tightened. However, it is unclear at this time whether payers will meet the requirements to report the more detailed information.

Other recommended standardization efforts

National Health Plan Identifier

Along with implementation of the more robust 5010 835 transaction, a National Health Plan Identifier is needed in the HIPAA standard transactions to achieve the full benefit of electronic transactions. The National Health Plan Identifier is viewed by many as the first step toward one-stop billing. This identifier should clearly specify: the primary payer responsible for payment, any applicable secondary payer responsible for payment, the payer or other entity holding the contract and associated contractual fee schedule with the physician, and the payer or other entity responsible for administering the patient’s benefits and coverage. The AMA urges prioritization and adoption of a National Health Plan Identifier for each payer and other entity involved in the health care billing and payment process as described above. National Health Plan Identifier was required by the original, 1996 HIPAA legislation, but CMS has not published a proposed regulation to date. However, there is already a mandated National Provider Identifier and National Employer Identifier. The efficiency of the health care billing, payment and claims reconciliation process would be significantly increased if National Health Plan Identifier were finally adopted.

Electronic Claims Attachment

The AMA supports recommendations to move forward a final rule for the Electronic Claim Attachment standard by December 31, 2009. The AMA believes that the lack of a standard

¹⁷ Sources: *Electronic Transaction Savings Opportunities for Physician Practices*, Milliman USA, January 2006; *2006 Physician Characteristics*, National Healthcare Exchange Services, 2007.

format and requirements for electronic claim attachments contributes to higher administrative costs and complexity by increasing variation among attachment formats, increasing rework and resubmission of pended claims, and contributing to both health plan and vendor reluctance to support such standardized, electronic attachments, making provider adoption impossible. The AMA recommends, however, that a Final Rule not mandate the use of electronic claim attachments or place physicians in a position where they can be forced to implement the standard transactions. Physicians and the provider community must be able to implement the electronic transaction on a voluntary basis; experience to date demonstrates that physicians adopt electronic transactions as soon as those transactions are sufficiently valuable to justify the expense.

Health Insurance Identification Card Technology

The AMA supports the Medical Group Management Association's (MGMA) Project SwipeIT, a health care industry-wide initiative meant to advance the adoption of standardized patient identification (ID) cards containing Workgroup for Electronic Data Interchange (WEDI)¹⁸ 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. One of the first steps toward addressing the problems stemming from the current nonstandardized paper ID cards and payer data has the potential to move the industry toward the automation of the claim cycle more expeditiously.

Reasons to simplify the health care billing, payment and claims reconciliation process now

First and foremost, the elimination of the excessive costs of the current claims submission, payment and reconciliation process is one of the easiest things we can do to move toward our national goal of reducing health care costs in the U.S. There is simply no justification for a system that costs physicians 10–14% of revenue just to get paid. Moreover, the complexity and opacity of the current process feeds the unhealthy level of distrust which permeates the relationship between physicians and payers today, distrust which is undermining the potential for collaborative efforts that could significantly improve the quality and efficiency of health care delivery in this country.

The urgency to include transparency and standardization of the health care billing, payment and claims reconciliation process in the national discussion on health care reform is also underscored by the increasingly detailed and divergent requirements that each of the 50 states legislatures are now imposing on payers and others. While these efforts arise from good intentions, the end result is an increase in payer costs to comply with state legislation and regulations that differ from state to state, as well as an increase in the potential for claims processing errors if the payers' administrative systems are unable to handle the complexity these different rules create (such as which rule set to apply when a patient who resides in one state receives treatment while on vacation in another state). Refer to Appendix B for examples of recent state laws on these issues. Increasing activity in the legal system, such as the national class action lawsuits challenging the

¹⁸ The Workgroup for Electronic Data Interchange (WEDI) developed an implementation guide to enable automated and interoperable identification using standardized health-insurance ID cards. The guide standardizes present practice and brings uniformity of information, appearance and technology to the more than 100 million cards now issued by health care providers, health plans, government programs and others.

code editing practices of the national for-profit payers, also add additional costs to the health care system that could be avoided if there were full fee schedule disclosure and a single set of transparent, consistently applied claim edits and payment policies. Refer to Appendix C for examples of the provisions contained within the class action settlements.

In addition, substantial dissatisfaction with the adoption and use of the existing standard transactions has prompted a number of activities that can be leveraged to assist in this effort. 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 CAQH have created initiatives like the CORE, which 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 CMS.

Conclusion

The AMA’s vision is to see access to clear and concise health care administrative information made available to patients, physicians and other health care professionals before, at the time of service and upon claim payment by every payer. That information would be made available either unsolicited, following the submission of batched or real-time electronic HIPAA standard requests, or in response to requests entered into a Web portal, as best meets the needs of the recipient—the patient, the patient’s representative or the physician or other health care professional.

We need to reduce the administrative costs of our current health care system, and that everybody has a part to play—employers, payers, physicians, patients and other health care system participants:

- Physicians must submit clean claims and adopt electronic transactions as soon as their value exceeds the cost.
- Payers must increase the value of electronic transactions for physicians by increasing their use, transparency and accuracy, including paying claims correctly on the first pass.
- Employers must support accurate eligibility transactions and educate employees about their benefits.
- Patients must understand their benefit plans and make good faith efforts to meet their financial obligations.

Standardization of the Claims Process Administrative Simplification White Paper: Summary and Recommendations

Transparent, standardized health care billing and payment rules and practices are necessary to ensure that patients will have the accurate, current pricing information they need to make informed decisions about a core value—their health. Moreover, bringing health care pricing

information out of the dark will allow physicians to regain some control over their practices and focus on what they were trained for—treating and healing their patients. Toward that end, the AMA recommends simplification, transparency and disclosure of all information necessary for determining patient and payer financial responsibilities, including all of the following:

I. Adoption of operational guidelines and instructions governing the use of all HIPAA standard Code sets, and that the CPT guidelines and conventions be designated as the operational guidelines and instructions for the CPT Code

The AMA recommends: (1) that the definition of “code set” in Sec. 1171 (1) of the Social Security Act be amended to include the associated operational guidelines and instructions governing the use of those codes; and (2) that the CPT guidelines and conventions be mandated as the operational guidelines and instructions for the CPT codes. We believe CPT guidelines and conventions should be adopted in addition to CPT codes to reduce inconsistencies in the recognition and reporting of physician procedures and services. Not adopting the CPT guidelines and conventions undermines administrative simplification and transparency efforts because stakeholders do not have consistent, standard guidelines and conventions for applying the CPT code set. Additionally, the adoption of operational guidelines and instructions for the claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) should be prioritized, so that the claims reconciliation process can be automated.

II. Implementation of standard payment rules

The AMA recommends the adoption of standard payment rules as a new HIPAA standard transaction. Payment rules should be transparent and applied consistently within and among payers. The Medicare payment rules could be used as a basis for developing this HIPAA standard. Further, new or updated payer payment rules along with complete physician-specific fee schedules must be made available on the payer Web sites. Payers should provide physicians with easy online access and the ability to download their complete payment rules and fee schedule so there is no question regarding the accuracy of the application of the payment rules and the actual fee schedule amount. In addition, physicians need sufficient notice of changes and updates to the payment rules and contracted fee schedule from the payer before they take effect. Payers should provide this information in a format that is easy to understand and allows an easy way to update practice management systems.

III. Implementation of standard claim edits

The AMA also recommends the adoption of standard claim edits as a new HIPAA standard transaction. Claim edits should be transparent and applied consistently within and among payers. The national Correct Coding Initiative could be used as a basis for developing this HIPAA standard. Similar to payment rules, payers should provide physicians with easy online access and the ability to download claim edits from their Web sites.

Note to recommendations II and III: Standard claim edits and payment rules would provide a common standard claim processing platform for payers, physicians and patients. A standard claims processing platform would not dictate any payer payment rates, medical rules, claim review or product benefit level or design.

IV. Implementation of the National Payer Identifier

The AMA urges prioritization and adoption of a National Health Plan Identifier for each payer and other entity involved in the health care billing, payment and claims reconciliation process. The National Health Plan Identifier should clearly specify: the primary payer responsible for payment; any applicable secondary payer responsible for payment; the payer or other entity holding the contract and associated contractual fee schedule with the physician; and the payer or other entity responsible for administering the patient's benefits and coverage.

V. Expanded electronic remittance advice and other standard transaction requirements, including the adoption of a single, binding "Companion guide" for each HIPAA standard transaction which includes the complete set of requirements, processes and operational rules necessary to electronically submit and receive each HIPAA standard transaction

There are several other steps which should be taken to increase the use of electronic transactions and automation of the health care billing, payment and claims reconciliation process:

(1) Adoption of binding Companion guides

Section 1173 of the Social Security Act should be amended to require the adoption of a single, binding, uniform Companion guide for each of the implementation guides for each standard transaction. The Companion guide should include the complete set of requirements, processes and operational rules necessary to electronically submit and receive each HIPAA standard transaction, and no augmentation by any of the trading partners should be permitted. To the extent that a 5010 transaction is scheduled to take effect in 2012, these new companion guides should be developed for those transactions, rather than the current 4010 transactions.

(2) Health claims attachments

Adoption of a final rule establishing the HIPAA standard for health claims attachments should be expedited.

(3) First report of injury

A HIPAA first report of injury standard should be adopted as called for in Section 1173 of the Social Security Act in 1996.

(4) Electronic remittance advice

In order to effectively communicate information about the payment on an X12 835 remittance advice, the HIPAA standard transactions must be reported to the highest specificity, and fields that are currently voluntary such as the "allowed amount" (the contracted rate between the physician and payer), "class of contract" (resolves ambiguity in product type), "date of claim receipt" fields should all be made mandatory and be completed by the payer in order to move toward the complete automation of the claims processing and payment process. Additionally, the line item relationships need to be maintained between the ASC X12 837 Health Care Claim (professional) Claim Submission and the ASC X12 835 Health Care Claim Payment/Remittance Advice.

(5) Eligibility verification

In order to effectively communicate information about the eligibility of a patient's benefit coverage, the ASC X12 271 Health Care Eligibility Benefit Response standard transaction must not only be reported to the highest specificity but must also be made binding. Additionally, the following fields that are currently voluntary should be made mandatory: (1) Underlying contracted fee schedule (the name of the entity that holds the underlying agreement with the physician or other health care provider (i.e., provider network) and the name of the specific product fee schedule (e.g., 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); and (4) the entity that is responsible for payment of the patient's covered benefit.

(6) Health care acknowledgement

The AMA also recommends "health claims acknowledgement" be added to the list of standard transactions listed in Sec. 1173(a)(2) of the Social Security Act, and further, that the standard shall be the ASC X12 277 Claim Status Response or its successor, which must be sent on an unsolicited basis at each of the following points in the claims adjudication process: (1) electronic claim receipt; (2) acceptance/rejection of electronic claim for adjudication; (3) electronic claim forwarded to another entity or returned as "unprocessable"; and (4) electronic claim pended (in process, in review, requested information [waiting]).

(7) General improvements

Naming conventions for data fields used in HIPAA standard transactions should be consistent. For example, "class of contract" and "claim filing indicator" codes have different meanings in the eligibility response transaction and the claim payment/remittance transaction. Fields 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.

The AMA supports the Medical Group Management Association's (MGMA) Project SwipeIT, a health care industry-wide initiative meant to advance the adoption of standardized patient identification (ID) cards containing WEDI-compliant, machine-readable information.

VI. Increased enforcement of the Health Care Insurance Portability and Accountability Act (HIPAA) Standard Transaction and Code set (TCS) rule

The AMA recommends the following steps be taken to increase enforcement of the HIPAA TCS rule: (1) lift or remove the remaining contingency plans for standard transactions so that all payers become fully compliant with existing HIPAA TCS rules; (2) clarify that standard transactions require both correct syntax and information that accurately reflects the circumstances, which are reported at the greatest level of specificity that the transaction and related code sets permit; (3) increase CMS' enforcement resources, including resources to conduct compliance audits, and (4) give states concurrent enforcement jurisdiction for the HIPAA TCS rules.

Appendix A

American Medical Association policies relating to the standardization of the health care billing and payment process

AMA policy regarding CPT bundling and code edits

H-70.927 Prevention of Misuse of Current Procedural Terminology (CPT)

Our AMA: (1) in order to avoid harm to physicians and patients, shall continue to pursue proper use of CPT codes, guidelines and modifiers by software claims editing vendors and their customers; and (2) will explore additional ways to work with state medical associations to provide coding advocacy for members. (Sub. Res. 819, A-00)

H-70.937 Bundling and Downcoding of CPT Codes

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers; (2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards; (3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and (4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers. (Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01)

H-70.941 CMS Implementation of Commercial Off-the-Shelf Edits of CPT Codes

Our AMA: (1) continues to support the activities of its Correct Coding Policy Committee (CCPC) and urges the Centers for Medicare & Medicaid Services to accept CCPC recommendations relating to coding edits, whether from both the Correct Coding Initiative or the commercial off-the-shelf edits; (2) utilizes appropriate and vigorous advocacy efforts to ensure that any Medicare payment or coding policies, including the proprietary edits implemented on October 1, 1998, be made available to the public; and (3) continues to use advocacy tools and opportunities in both the public and private sectors to promote the appropriate use of CPT codes, guidelines, and modifiers; ensure that patients receive all needed services and the benefits to which they are entitled; protect the integrity of CPT; ensure accurate reporting of physicians' services; and ensure accurate payments for services provided. (BOT Rep. 35, I-98; Reaffirmed: Res. 813, A-99)

H-70.940 AMA Program to Readily Retrieve Billing Code Data by Payee within a Practice

Our AMA promotes the development of a **software** communications standard for medical coding and billing software programs, similar in purpose to the HL-7 and DICOM standards. (Res. 805, I-98)

H-70.954 Improper Use of AMA-CPT by Carriers/Software Programs

Our AMA: (1) continues to seek endorsement of Current Procedural Terminology (CPT) as the national coding standard for physician services; in collaboration with state and specialty societies, will urge the Secretary of HHS and CMS and all other payers to adopt CPT as the single uniform coding standard for physician services in all practice settings; and will oppose the incorrect use of CPT by insurers and others, taking necessary actions to insure compliance with licensing agreements, which include provisions for termination of the agreement; (2) will work with the American Academy of Pediatrics and other specialty societies to support state and federal legislation requiring insurers to follow the coding as defined in the Current Procedural Terminology Manual and interpreted by the CPT Assistant for all contracts in both the public and private sectors, as long as the CPT process is simple, user friendly, and does not undergo frequent changes; and (3) seeks legislation and/or regulation to ensure that all insurance companies and group payors recognize all published CPT codes including modifiers. (Sub. Res. 801, A-97; Appended: Res. 806, A-98; Appended: Res. 814, I-99; Reaffirmed: BOT Rep. 8, I-00)

H-70.963 CMS Implementation of Correct Coding Initiative

The AMA advocates that if the "Correct Coding Initiative" is implemented, distribution of the voluminous coding edits associated with this program be made available to physicians and their organizations on a no-cost or low-cost basis, in contrast to current distribution policies. (Res. 119, I-95; Reaffirmed by Ref. Cmt. H, A-96)

D-70.983 Inappropriate Bundling of Medical Services by Third Party Payers

Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices; (2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment; (3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate; (4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician; (5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and (6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its Web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue. (CMS Rep. 6, I-01)

H-190.970 Status Report on the National Uniform Claim Committee and Electronic Data Interchange

The AMA advocates the following principles to improve the accuracy of claims and encounter-based measurement systems: (1) the development and implementation of uniform core data content standards (e.g., National Uniform Claim Committee (NUCC) data set); (2) the use of standards that are continually modified and uniformly implemented; (3) the development of measures and techniques that are universal and applied to the entire health care system; (4) the use of standardized terminology and code sets (e.g., CPT) for the collection of data for administrative, clinical, and research purposes; and (5) the development and integration of strategies for collecting and blending claims data with other data sources (e.g., measuring the performance of physicians on a variety of parameters in a way that permits comparison with a peer group). (CMS Rep. 2, I-97)

Appendix B

Best state laws in the United States regarding transparency of physician fee-schedules and payment policies

Managed care organizations (MCOs) are required to provide physicians and other health care providers all information necessary for them to determine whether they have been paid correctly. The information must contain detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the amount the MCO will pay for covered services. MCOs must describe their payment and reimbursement methodologies in terms a reasonable layperson could be expected to understand. (CA, TX)

The information that Managed Care Organization (MCO) is obligated to provide must, at a minimum, include:

- (i) a complete fee schedule upon which compensation will be calculated and paid and, if applicable, CPT, HCPCS, ASA, CDT and ICD-9-CM codes, and any applicable modifiers (CA, TX);
- (ii) a detailed description and copy of coding guidelines, policies, methodologies, and processes (whether standard or nonstandard), including, but not limited to, any bundling, recoding, or downcoding guidelines, policies, methodologies, and processes that MCO reasonably expects to apply on a routine basis to the claims contracted physicians and other health care providers will submit. (CA, TX);
- (iii) a description of any other applicable policies or procedures MCO may use that affects the payment of specific claims submitted by physicians and other health care providers, including but not limited to, policies or procedures affecting recoupment, copayments, coinsurance, deductibles, risk sharing arrangements, and the liability of third parties (CA, TX, KY);
- (iv) information that will enable the physician or other health care provider to determine the effect of edits on compensation before the physician or other health care provider provides a service or submits a claim (CO);
- (v) the manner of payment, e.g. a fee-for-service or risk-sharing basis. (OR); and
- (vi) information about the methodology the MCO will use to reduce or increase the level of reimbursement, e.g. by providing a bonus or other incentive based compensation. (MD)

Specific payment rules and edits

MCO will disclose in an electronic format its Payment Policies, including, but not limited to:

- (i) consolidation of multiple services or charges (CA, NC);
- (ii) payment adjustments due to coding changes (CA, NC);
- (iii) reimbursement for multiple procedures (CA, NC);
- (iv) reimbursement for assistant surgeons (CA, NC);
- (v) reimbursement for the administration of immunizations and injectable medications (CA, NC);
- (vi) recognition or nonrecognition of CPT code modifiers (CA, NC);
- (vii) definition of global surgery periods (NC); and
- (viii) payment based on the relationship of procedure code to diagnosis code (NC).

Claims editing software information

MCO must disclose to its contracted physicians and other health care providers publisher, product name, edition, and model version of the software MCO uses to edit claims. (TX) Disclosure will be made on MCO's provider Web site and in its provider newsletters, and to its contracted physicians and other health care providers specifically upon request. (NY)

Appendix C

Class action settlements

The Multi District Litigation (MDL) settlement agreements with Aetna Inc., CIGNA Corporation, Health Net Inc., Prudential HealthCare, WellPoint Inc. (Anthem) and Humana, and a related settlement agreement with Excellus Inc. and the recent Blue Cross Blue Shield (BCBS) settlement agreements arose from a national class action lawsuit challenging the health insurer industry's lack of transparency, inconsistent payment practices and unfair business practices.¹⁹ These settlements provide for greater transparency in health insurer claims processing and payment practices.

While there are differences between the various MDL settlements, overall, each of the MDL settlements require health insurers to change their business practices by adding transparency and fairness to their claims payment processes during the settlement's term. The settling health insurers agreed to comply with most AMA Current Procedural Terminology (CPT®) codes, guidelines and conventions, unless otherwise identified on the health insurer's physician Web site.

The settlements also generally provide that if state law offers more protection than a particular settlement, then state law applies. Following is the list of business practices addressed by these settlements. Please note, this settlement did not affect all health insurers and of those health insurers that did settle, Aetna and CIGNA's settlement commitments have expired, and Anthem/Wellpoint's settlement will expire this summer.

MDL provisions

- All products clause prohibition
- Rental networks regulation and prohibition of Silent PPOs
- Usual, reasonable and customary definition/methodology disclosure
- Provide copies of contract upon written request
- Provide for faster credentialing
- Gag clauses prohibited

Coding and payment rules

- Claim editing software transparency
- Retrospective audits and overpayment recovery limitations
- Prompt payment requirement
- Recognition of Modifier 25, Modifier 51, and Modifier 59
- Annual updates of CPT and HCPCS Level II
- No automatic downcoding
- Comply with most CPT codes, guidelines, and conventions, unless otherwise identified on company Web site
- Disclosure of fee schedules for participating physicians
- Disclosure of payment rules
- Provide notice of changes in practices and policies and annual changes to fee schedules
- Improved medical necessity definitions

¹⁹ A related settlement agreement, Excellus Inc. was approved May 23, 2005. According to its Settlement, Excellus will process and make eligible for payment all physician claims consistent with the current version of the AMA CPT®, Principles of CPT Coding, CPT Assistant and CPT Changes. Visit the AMA Web site at www.ama-assn.org/go/settlements to learn more about the Excellus Inc. settlement.

- Cover the cost of recommended vaccines and injectibles and for the administration of such vaccines and injectibles
- Where physicians are paid on a “capitation” basis, provide cost and utilization information, provide periodic reporting, and capitation from date of patient’s enrollment
- Revise EOB and Remittance Advice content to reflect at minimum: information sufficient to identify Plan Member, date of service, amount of payment per line item, any adjustment to the invoice and explanation thereof for the adjustment and contact information for the Plan. EOB shall not disparage Non-Participating Physicians and each EOB shall indicate the amount the Physician may bill the Member. The EOB shall not characterize disallowed amounts as unreasonable.

Dispute resolution

- Provide for independent, external Billing and Medical Necessity dispute processes
- Provide for independent, external Settlement Compliance dispute processes
- Arbitration fees capped
- Provide for Physician Advisory Committees

Appendix D:

Health care industry cost savings from the use of HIPAA claim standard transaction and automation

An estimated 3 billion claims were submitted in 2007.²⁰ If both physicians and payers used electronic transactions instead of manual ones, the health care system could save \$90.27 billion each year.

Physician cost savings when automating referrals

A referral is required prior to the patient's appointment

- Manual cost: \$8.30 per claim [3 billion claims per year = \$24.9 billion]
- Electronic cost: \$2.07 [3 billion claims per year = \$6.21 billion]
- Savings of \$18.69 billion per year

Sources: Electronic Transaction Savings Opportunities for Physician Practices, Milliman USA, January 2006; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007

Physician cost savings when automating pre-authorization

Pre-authorization is required by the patient's health plan prior to their visit

- Manual cost: \$10.78 [3 billion claims per year = \$32.34 billion]
- Electronic cost: \$2.07 [3 billion claims per year = \$6.21 billion]
- Savings of \$26.13 billion per year

Sources: Electronic Transaction Savings Opportunities for Physician Practices, Milliman USA, January 2006; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007

Payer cost savings when automating pre-authorization

- Manual cost: \$1.50 [3 billion claims per year = \$4.5 billion]
- Electronic cost: \$0.75 [3 billion claims per year = \$2.25 billion]
- Savings of \$2.25 billion per year

Sources: John L Phelan, PhD., Milliman, Inc., Pay Incentives to Physicians for Filing Electronic Claims, Managed Care, October 2003: 92; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007

Physician cost savings when automating eligibility and benefits

- Eligibility and benefits are to be determined prior to the patient's visit
- Manual cost: \$3.70 [3 billion claims per year = \$11.1 billion]
- Electronic cost: \$0.74 [3 billion claims per year = \$2.22 billion]
- Savings of \$8.88 billion per year

Source: Electronic Transaction Savings Opportunities for Physician Practices, Milliman USA, January 2006; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007

Payer cost savings when automating eligibility and benefits

- Manual cost: \$1.50 [3 billion claims per year = \$4.5 billion]
- Electronic cost: \$0.10 [3 billion claims per year = \$300 million]
- Savings of \$4.2 billion per year

Source: John L Phelan, PhD., Milliman, Inc., Pay Incentives to Physicians for Filing Electronic Claims, Managed Care, October 2003: 92.

²⁰ *Sources: 2006 Physician Characteristics; National Healthcare Exchange Service, 2007*
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Physician cost savings when automating claim submissions

- Manual cost: \$6.63 [3 billion claims per year = \$19.89 billion]
- Electronic cost: \$2.90 [3 billion claims per year = \$8.7 billion]
- Savings of \$11.19 billion per year

*Includes cost of administrative overhead to produce, submit and process, as well as 12-month amortization of electronic set-up costs.

Source: Phelan J, Naugle A. *Electronic Transaction Savings Opportunities for Physician Practices*. Milliman Inc; January 2006; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007

Payer cost savings when automating claim submissions

- Manual cost: \$1.00 [3 billion claims per year = \$3 billion]
- Electronic cost: \$0.40 [3 billion claims per year = \$1.2 billion]
- Savings of \$1.8 billion per year

Source: John L Phelan, PhD., Milliman, Inc., *Pay Incentives to Physicians for Filing Electronic Claims, Managed Care*, October 2003: 92; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007

Physician cost savings when automating claim status inquires

- Manual cost: \$3.70 [3 billion claims per year = \$11.1 billion]
- Electronic cost: \$0.37 [3 billion claims per year = \$1.11 billion]
- Savings of \$9.99 billion per year

Source: *Electronic Transaction Savings Opportunities for Physician Practices, Milliman USA, January 2006; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007*

Payer cost savings when automating claim status inquires

- Manual cost: \$1.00 [3 billion claims per year = \$3 billion]
- Electronic cost: \$0.10 [3 billion claims per year = \$300 million]
- Savings of \$2.7 billion per year

Source: John L Phelan, PhD., Milliman, Inc., *Pay Incentives to Physicians for Filing Electronic Claims, Managed Care*, October 2003: 92; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007

Physician cost savings when automating payment posting

Manual cost: \$2.96 [3 billion claims per year = \$8.88 billion]

Electronic cost: \$1.48 [3 billion claims per year = \$4.440 billion]

Savings of \$4.44 billion per year

Source: *Electronic Transaction Savings Opportunities for Physician Practices, Milliman USA, January 2006; 2006 Physician Characteristics; National Healthcare Exchange Service, 2007*

Approximately 2.169 billion commercial claims and 981,740,579 Medicare claims were submitted by physicians in 2007, which equals an estimated total of 3 billion (3,150,740,579) physician claims.

Sources: 2006 Physician Characteristics; National Healthcare Exchange Service, 2007

Appendix E

Electronic transactions considered standard under HIPAA: Between a physician practice and health insurer

For more information, visit the AMA Web site at www.ama-assn.org/go/pmc to download the AMA PMC document, “Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule.

Table 1: Electronic transactions considered standard under HIPAA: Between a physician practice and health insurer		
Common name of transaction	Formal name of transaction	Transaction function
Claims	ASC ¹ X12 837 Health Care Claim (professional)	Submitting claims to the health insurer
EOB/RA	ASC X12 835 Health Care Claim Payment/Remittance Advice	Receiving payment and/or remittance information from the health insurer for claims
Claims status	ASC X12 276 Health Care Claim Status Report	Contacting the health insurer about the status of a claim
Claim status response	ASC X12 277 Health Care Claim Status Response	Receiving information about the status of a claim from the health insurer
Patient eligibility	ASC X12 270 Health Care Claim Eligibility Benefit Inquiry	Contacting the health insurer about the eligibility and benefits of a patient
Patient eligibility response	ASC X12 271 Response	Receiving information from the health insurer about the eligibility and benefits of a patient
Referrals	ASC X12 278 Health Care Services Review Information	Sending or receiving referrals or authorizations
Claims attachments	ASC X12 275* Additional Information to support a Health Care Claim or Encounter	Submitting claims attachments to the health insurer
First report of injury	ASC X12 148* First Report of Injury, Illness or Incident	First report of injury to the health insurer

*Note: Claims attachments and first report of injury have not been implemented (the standards are not completely defined and published).

**Table 2: Electronic transactions considered standard under HIPAA:
Between an insurance purchaser and a health insurer or between
health insurers**

Common name of transaction	Formal name of transaction	Transaction function
Membership enrollment	ASC X12 834 Benefit Enrollment and Maintenance	Enrolling members in the health plan
Premium payments	ASC X12 820 Payment Order and Remittance Advice	Making premium payments for the health insurance coverage
Coordination of benefits	ASC X12 837 Health Care Benefit Coordination Verification	Coordination of benefits

Appendix F

American Medical Association non-Medicare use of the RBRVS: Survey data²¹

Table 1: Acceptance rates for respondents who use the RBRVS

	2006	2001	1998
Global surgical periods	72%	73%	74%
Multiple surgery reduction	79%	85%	84%
Medicare site service differentials	72%	55%	26%
Geographic practice cost indexes (GPCIs)	55%	51%	45%

Table 2: Acceptance rates of modifiers by respondents who use RBRVS

Modifier	2006	2001	1998
22, Unusual procedural services	79%	68%	81%
24, Unrelated evaluation and management services by the same physician during a postoperative period	78%	N/A	N/A
25, Significant, separately identifiable E/M service by the same physician on the same day of the procedure	81%	79%	75%
26, Professional component	96%	95%	92%
51, Multiple procedures	89%	90%	89%
57, Decision for Surgery	69%	48%	64%
59, Distinct procedural services	76%	50%	63%
79, Unrelated procedure or service by the same physician during the postoperative period	72%	N/A	N/A

Table 3: Acceptance of modifiers by non-users of the RBRVS

Modifier	2006	2001	1998
22, Unusual procedural services	77%	68%	68%
24, Unrelated evaluation and management services by the same physician during a postoperative period	65%	N/A	N/A
25, Significant, separately identifiable E/M service by the same physician on the same day of the procedure	65%	68%	62%
26, Professional component	100%	90%	80%
51, Multiple procedures	81%	83%	80%
57, Decision for Surgery	65%	35%	52%
59, Distinct procedural services	73%	53%	54%
79, Unrelated procedure or service by the same physician during the postoperative period	65%	N/A	N/A

²¹ Source: American Medical Association, *Medicare RBRVS 2009 The Physicians' Guide*; 2009. Copyright 2009 American Medical Association. All rights reserved.