

Follow that Claim

Claims submission, processing, adjudication and payment

The original Follow that Claim booklet, copyright 2002 American Medical Association (AMA), was compiled in consultation with Sheldon I. Dorenfest & Associates, Ltd., a health care information technology consulting and market research firm. The following document is a version that the AMA has thoroughly revised in consultation with David Ginsberg, president of PrivaPlan Associates Inc., a HIPAA compliance and consulting firm.

Visit the Practice Management Center Web site at www.ama-assn.org/go/pmc for more information.* AMA physician members and their practice staff can also send questions or concerns about claims appeals and other practice management issues via e-mail to the AMA Practice Management Center at practicemanagementcenter@ama-assn.org. Please include the physician's name and his or her AMA member ID number.

Note that this document contains links to several AMA members-only publications and tools. For more information on becoming an AMA member, please visit the [AMA Member Center](#). Please be aware that AMA Practice Management Center documents are in PDF format (PDF files require Adobe® Reader®, which you can [download](#) free of charge).† Some of the links contained in this document will take you to non-AMA Web sites. The AMA is not responsible for the content of other Web sites.

This document does not provide legal advice. Consultation with legal counsel may be appropriate to help review health insurer contracts and identify and pursue claims that should be appealed.

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

† The AMA is not responsible for the content of other Web sites.

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Overview

Navigating health insurers' systems and managing reimbursement denials, mistakes, reductions and delays is a difficult and involved task. Physicians are spending hundreds of thousands of dollars as they attempt to collect appropriate payment for services rendered from their patients' health insurers. (Note: In this document, "health insurer" refers to any third-party payer responsible for payment on claims.)

According to a report by the Center for Information Technology Leadership, a nonprofit health-technology research group commenting on the issue of claims denial management, the current state of affairs "is costing medical providers and health insurers around \$20 billion—about \$10 billion for each side—in unnecessary administrative expenses."[‡]


This tool is designed to educate on how you can get your claims through health insurers' administrative systems and receive timely and appropriate payment.

Claims submission

The increase of physician practices submitting claims electronically is due to a number of factors, including the rising number of health insurers that have instituted processes to receive electronic claims. Additionally, because health insurers save money when they receive and process claims electronically rather than manually, the number of health insurers requiring electronic claims is likely to grow over the next few years. As physician practices upgrade their existing practice management software or purchase newer technologies that incorporate electronic health records, the number of physician systems capable of generating electronic claims will also increase.

[‡] "Fights Over Health Claims Spawn a New Arms Race," *Wall Street Journal*, Feb. 14, 2007.

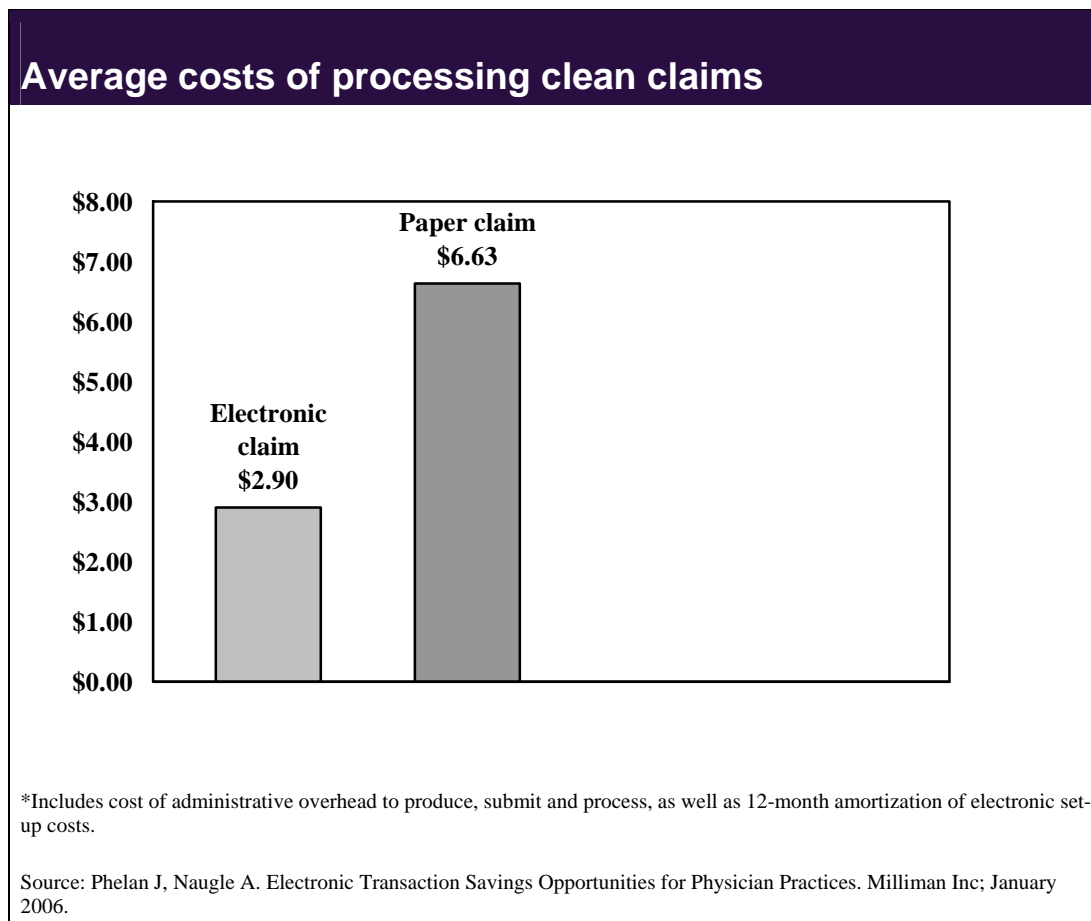
Practice Management Center resource tip:

The American Medical Association (AMA), in collaboration with the Connecticut State Medical Society (CSMS), developed the educational resource, “[The benefits of electronic claims submission—improve practice efficiencies](#),”  (PDF, 125KB) to help you understand the electronic claim submission process and the many benefits that your practice may realize by submitting claims electronically to health insurers. The resource discusses the reduction of claim submission costs and errors and offers tips on getting started with electronic submission.

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Health insurers save money by receiving and processing claims electronically and so can your practice. Electronic claims submission offers a straightforward, efficient and cost-effective process for you to submit patient claims to a health insurer. When compared with manual claims, electronic claims are inexpensive to produce, submit, process and track. While the average cost of processing a “clean” (complete and error-free) manual claim is \$6.63, the average cost of processing a “clean” electronic claim is only \$2.90 (see Figure 1: Average costs of processing clean claims).

Figure 1



A typical solo physician practice that processed and submitted 6,200 claims in 2006 had an estimated annual cost for manual claims transactions of \$70,000, while the annual cost for processing and submitting 6,200

electronic claims during the same year was less than \$28,000.[§] According to these figures, a solo physician practice using and submitting electronic claims could save more than \$42,000 (nearly 60 percent) of funds spent on claims transactions per year (see Table 1: Potential savings for the physician practice when utilizing electronic transactions).

Table 1

Potential savings for the physician practice when utilizing electronic transactions					
HIPAA standard transactions	Manual claims cost	Electronic claims cost	Savings per transaction	Transactions per year	Estimated annual savings
Claims	\$6.63	\$2.90	\$3.73	6,200	\$23,124.21
Eligibility verification	\$3.70	\$0.74	\$2.95	1,250	\$3,693.04
Referrals	\$8.30	\$2.07	\$6.22	1,000	\$6,223.17
Preauthorization	\$10.78	\$2.07	\$8.71	100	\$870.62
Payment posting	\$2.96	\$1.48	\$1.49	4,340	\$6,456.59
Claim status	\$3.70	\$0.37	\$3.33	620	\$2,065.59
Total					\$42,433.23

Source: Electronic Transaction Savings Opportunities for Physician Practices, Milliman USA, June 11, 2006.

Manual (paper) claims submission

Manual claims (often referred to as paper claims) submission and processing entails a lengthy stream of activity. Simple manual errors in the workflow can result in payment delays to physician practices of 120 days or more (although many states have prompt payment laws requiring applicable health insurers to process a clean claim within a defined time period). For example, you must generate, review, and then place the manual claim in an envelope and mail it to the correct health insurer claim center. Payment delays can occur when there is a breakdown in the workflow (for instance, if an employee is at home sick for several days and does not generate claims, if the claim is mailed with insufficient postage, or if the claim is sent to the wrong claim center).

Manual claims generally require the health insurer to enter data from the claim into the health insurer’s administrative system. The manual data entry step raises the opportunity for human errors that can result in delay, denial or incorrect payment of a claim (for example, an employee of the health insurer may mis-enter a Current Procedural Terminology [CPT®] code). (Even in the best health insurer administrative systems, electronic claims can take longer than a few days to move through the adjudication process. Variables such as heavy claims volume, staff shortages and so forth can shorten or lengthen the process.)

[§] Phelan J, Naugle A. *Electronic Transaction Savings Opportunities for Physician Practices*, Milliman Inc, January 2006. Accessed January 4, 2007.

Unfortunately, such claim denials usually require extensive effort on your part as you follow up and resubmit the claim to ensure appropriate payment by the health insurer. It is important that you resubmit any contested claims in accordance with your contract provisions and applicable state prompt payment, prompt processing and fair business practice laws. If you resubmit rejected claims, and correct denied claims accurately and in a timely manner (consistent with health insurer filing requirements and applicable state and federal laws), you will dramatically increase the likelihood of receiving appropriate payment. For example, some health insurers' filing requirements only allow a certain timeframe (e.g., 90 days) to submit an appeal, so it is important to file within that timeframe to receive payment.

Electronic claims submission

Submitting and processing claims electronically reduces the amount of manual data entry a health insurer must perform by using computer systems to automatically adjudicate the claims with minimal human intervention. Automatic adjudication refers to the process of a health insurer receiving and processing a claim for payment electronically. In addition, electronic claims submission typically processes complete and error-free claims, or clean claims, in a shorter period of time than manually submitted claims. Electronic claims submission is a relatively smooth and efficient process of filing claims via some form of electronic communication. Submitting claims electronically can potentially expedite processing (or **adjudication**) and payment processes within the health insurer. However, a claim submitted electronically might still go through the same processes within the health insurer as a manual claim.

Physician practices that submit electronic claims to health insurers typically submit them through a **clearinghouse**, or in the case of a few high-volume health insurers (such as Medicare), may submit directly to the health insurer. In some cases, you may submit claims through another entity, such as a rental network PPO.

Please note: Electronic claims might take between a few minutes and a few days to reach the claims adjudication process, but manual claims can take substantially longer, depending upon the health insurer's internal claims administration system.

HIPAA

While physicians and practice staff are generally more familiar with its Privacy and Security rules, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) also requires the Department of Health and Human Services (DHHS) to adopt national standards for conducting health care transactions electronically. This is referred to as "administrative simplification" because the use of electronic health care transactions should reduce errors and administrative burdens and improve turnaround time of claim payments.

Just like the HIPAA Privacy and Security Rules, the electronic health care transactions standard is a federal law. It went into effect (for physicians and most health insurers) on October 16, 2003. This law is commonly known as the HIPAA Transactions and Code Set Rule (TCS) (officially as "Health Insurance Reform: Standards for Electronic Transactions"). All HIPAA-covered entities must comply with this law. (HIPAA defines three kinds of covered entities: virtually all health insurers, clearinghouses—which may include your billing service—and physicians and other health care providers who submit one of the standard transactions electronically.) The HIPAA TCS rule adopts the standard transactions, as defined by the Accredited Standards Committee (ASC X12). ASC X12 is a standards development organization recognized by the DHHS that focuses on developing the various standards for electronic information exchanges. ASC X12 has subcommittees that focus on electronic information exchange standards for other industries, such as finance, government and transportation.

The various electronic HIPAA standard transactions are represented by numbers. For instance, submitting an electronic request for patient eligibility and obtaining a response is known as X12 270/271. Physicians can require a health insurer to accept and provide a HIPAA standard transaction (for example, an electronic claim

submission to a health insurer is the **X12 837 standard transaction**—see **Table 2: Current HIPAA standard transactions**). On the other hand, health insurers can require physicians to submit and use new HIPAA standard transactions code sets (code sets are the content of a standard transaction code on a claim). Examples of HIPAA-designated transaction code sets are CPT, **National Provider Identifier (NPI)** and Place of Service. The HIPAA standard transactions code sets may be different from and are more comprehensive than those required for a **CMS-1500** manual claim.

Health insurers describe their conformance with the HIPAA transactions and code sets as well as their particular **claim edits** and formatting requirements in their companion guides. Because there are over 1200 unique companion guides, physician practices would have to visit each health insurer’s Web site or provider portal to view their individual companion guides prior to submitting electronic transactions. A clearinghouse typically performs this service on your behalf by maintaining the health insurer requirements for claims submission that are specified in each individual companion guide for the physician practice.

For further information regarding HIPAA standards related to claims processing, visit the AMA Web site at **www.ama-assn.org/go/pmc** to view the resource, “**Understanding the HIPAA standard transactions**” (PDF, 106KB).

Table 2

Current HIPAA standard transactions*		
ASC X12 Identifier	Transaction	Explanation
X12 270	Eligibility inquiry	Physician practice query or request sent for eligibility and benefit query
X12 271	Inquiry and response	Health insurer response to eligibility and benefit query
X12 275	Claims attachment	Not yet in effect
X12 276	Claim status inquiry	Physician practice query on status of claim
X12 277	Claim status response	Health insurer response to claim status query
X12 278	Referral authorization request and response	Physician practice request for review of health care services (typically a referral authorization) and the health insurer response (authorization or certification)
X12 820	Health insurance premium payment	Health plan premium payment remittance information that a plan sponsor, broker or other entity can use to respond to a bill from the health insurer
X12 834	Beneficiary enrollment	Electronic enrollment and disenrollment submitted to a health insurer, typically by an insurance broker or plan sponsor
X12 835	Payment and remittance advice	The electronic remittance advice (explanation of benefits) coming back from the health insurer
X12 837	Claim or encounter	The electronic claim sent from the physician practice to the health insurer; a "P" following the identifying number represents "professional" claim; institutional providers, such as hospitals, identify the claim as an "837I"; and dental providers use an "837D"
<p>*These are the current HIPAA standard transactions. The HIPAA claims attachment standard ("275") has been announced via a Notice of Proposed Rulemaking and should go into effect in the future. Health insurers will use the 277 transaction to request additional information that physician practices will send via the 275 transaction.</p>		


Billing entity/service or system

Physician practice managers, billing managers and other practice staff dedicate a major part of their workflow to claims-related activities within the **claims management revenue cycle**, such as:

- Entering patient services
- Generating and reviewing claims
- Submitting claims electronically or printing and mailing manual claims
- Following up and tracking unpaid claims
- Receiving payment and posting payments
- Auditing **explanations of benefits** (EOBs)/copies of **remittance advice** (RAs) for accuracy
- Adjusting and posting contractual terms (such as allowed amounts, non-covered services and deductibles)
- Appealing incorrect payments or denials
- Billing secondary health insurers
- Billing patients for their payment responsibility


To effectively process claims before submitting to a health insurer, you need industry-specific knowledge about public and private health insurers. In light of the ever-changing requirements health insurers and government agencies impose, you will likely find it difficult to remain current with claims processing requirements. To resolve this problem, your practice may outsource these processes to billing services for completion. Otherwise, your practice might use practice management software and maintain this process internally.


Practice Management Center resource tip:

Before you consider working with one, it is important to know what a medical billing service is and what it can do for your practice. A medical billing service may help physician practices save time and increase profitability by reducing billing expenses and increasing revenues. A good medical billing service also allows physician practices to concentrate on their patients while increasing the bottom line. Learn more about billing services by reading “**What is a medical billing service?**”  (PDF, 23KB)

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Practice Management Center resource tip:

The AMA, in collaboration with the Healthcare Billing and Management Association (HBMA), has developed the educational resource, “[Data ownership issues for the physician practice and a medical billing service](#),”  (PDF, 54KB) to help physicians recognize the questions they should consider addressing prior to contracting with a billing service. This resource addresses topics such as data ownership and issues related to what happens when the relationship between the physician and billing service terminates. Physicians can use this informational resource when considering entering into an agreement with a billing service.

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Clearinghouse definition and functions

Like billing entities or services, clearinghouses can aid your practice in making claims transactions. A clearinghouse primarily serves as a middleman between physicians and health insurers. Clearinghouses are necessary because of the number of health insurers to whom you must send a claim. Rather than sending electronic claims to each health insurer as a separate transmission, you can use the clearinghouse’s service as a central portal to submit transmissions to multiple health insurers. When you send your claims to the clearinghouse, the clearinghouse can use internal software to then forward each claim to the appropriate health insurer.

Health insurers usually require you to complete a series of test claims transmissions before they issue a submitter number and approval that will allow you to submit electronic claims. Claims submission software must stay up to date and adjust to each health insurer’s changes. Additionally, some health insurers still do not use or accept a X12 837 claim or encounter transaction, which requires you to send data in another format or, in some cases, convert an electronic claim to a CMS-1500 manual claim and forward that form. This can be a daunting process to complete when you submit electronic claims to numerous health insurers. The clearinghouse typically performs this service on your behalf.

Some health insurers also require a designated gateway clearinghouse; that is, the health insurer uses a clearinghouse as its front-end claims processor to receive your claims electronically. In such cases, your practice’s clearinghouse will need to coordinate with that designated clearinghouse. Increasingly, health insurers are also purchasing independent clearinghouses, making it more difficult for physician practices to understand and keep track of these “alignments.”

When your practice selects a clearinghouse, you should carefully evaluate the clearinghouse to ensure that you select one that supports the majority of the health insurers your practice bills. You should also determine whether the clearinghouse can accommodate the output from your practice management system.

Many older practice management systems still do not generate a HIPAA 837 transaction (an electronic claim the physician practice submits). In these cases, the clearinghouse must be able to accept a print image (electronic flat file format) of the manual CMS-1500 form. This process usually entails the practice management system generating a claims submission [batch file](#) and transmitting the print image of its claims to the clearinghouse. You should be aware that transmitting print image claims is not efficient. Many of the code sets that a health insurer may require on an electronic claim, such as birth weight, cannot be printed on a CMS-

1500 manual claim (there is no specified field or space). A typical physician practice may choose to use a practice management system that generates a complete X12 837 electronic claim and sends this to the clearinghouse for submission to the health insurers.


Once the clearinghouse receives the claims transmission, it sorts, formats and submits the claims either directly to the health insurer for payment or to the health insurer's designated clearinghouse for processing. Health insurers are required to accept electronic claims from physician practices at no cost to the physician practice, according to HIPAA regulation. If a health insurer does not accept electronic claims from you or your selected clearinghouse, the AMA encourages you to file a complaint using the [AMA HIPAA Complaint Form](#).


Some clearinghouses also run certain claim edits on your behalf to verify that all fields are completed or to initiate certain claim edits at the health insurer's discretion. These claim edits often depend upon whom is contracting with the clearinghouse. On occasion, the clearinghouse may have contracts with both the physician and the health insurer. Most clearinghouses should have the ability to meet basic industry-wide claim edits, such as use of a ten-digit NPI, an [ICD-9-CM code](#) that is up to five digits and a five-digit CPT code. The clearinghouse may then send you a status report that informs you if a required field on the claim is incomplete or missing, such as the patient's address or date of birth, or if the ICD-9 code is invalid. You can then correct and resubmit the claims to the clearinghouse to send to the health insurer.

Clearinghouses generally charge you for their services. Most clearinghouses charge a start-up fee, a monthly flat fee and/or a per-claim transaction fee based on volume. Clearinghouses frequently introduce new features, and many clearinghouses now offer services, such as inquiries for eligibility, claim status, secondary health insurer billing services and even patient statement printing and mailing.

Please note: A clearinghouse owned or exclusively contracted by a health insurer may essentially be working on behalf of the health insurer, not the physician practice. This can mean claim edits are more extensive, resulting in higher rejection levels and delayed payment.

Practice Management Center resource tip:

The AMA has developed the educational resource, "[What is a clearinghouse?](#)"  (PDF, 33KB) in collaboration with the Kentucky Medical Association to educate physicians and practice staff who are considering selecting a clearinghouse to handle their practice's claims process and submission functions. This resource explains the nuances that relate to submitting and transmitting your practice's claim information through an outside clearinghouse.

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Direct claims submission to health insurers by direct data entry

Physician practices that submit electronic claims directly to health insurers generally do so by directly connecting their practice management software to the health insurer administrative system and transmitting the claim through an approved connection. However, some health insurers offer a direct data entry (DDE) methodology as well. DDE typically requires an Internet connection; the physician practice logs on to a secure Web site that the health insurer hosts, manually enters the specifics related to the claim and submits these specifics. This option is reasonable for physician practices that do not have existing practice management software or a billing service to perform these services. However, if you already have a practice management system, DDE amounts to duplicate data entry.

A more detailed description: Electronic claims processing and adjudication once the health insurer receives the claim in its administrative system

Table 3

Typical health insurer administrative system workflow	
Step one:	<p>Receive claim in administrative system</p> <p>The health insurer may receive the claim directly from you or through an intermediary, such as a billing service or clearinghouse.</p>
Step two:	<p>Determine patient's eligibility and benefit level</p> <p>The health insurer determines the patient's covered and non-covered services and procedures based on the enrollee's health benefit plan.</p>
Step three:	<p>Apply pricing claim edits</p> <p>The health insurer applies pricing edits, which reduce the physician's billed charges on your claim to their individually contracted maximum allowed payment.</p>
Step four:	<p>Apply health insurer proprietary claim edits</p> <p>The health insurer's administrative system makes adjustments to your claim through health insurer-specific proprietary claim edits that include customized claim edits. The health insurer, through repricing or editing claims, determines whether the specific codes listed on your claim are eligible for payment.</p>
Step five:	<p>Complete adjudication</p> <p>The health insurer determines the final payment for your claim. The health insurer queues the "to be paid" amount and details into its payment system.</p>
Step six:	<p>Generate EOB/RA</p> <p>The health insurer sends an EOB/RA to the physician and patient, detailing the paid amount of the medical service provided.</p>
Step seven:	<p>Send payment</p> <p>The health insurer mails a check or submits an electronic funds transfer (EFT) to your bank. The health insurer typically sends the manual payments along with the EOB/RA.</p>

Step one: Health insurer receives the claim in its administrative system

Electronic claims: Once the health insurer receives your electronic claim (either directly from you or through an intermediary, such as your clearinghouse), the health insurer translates or converts the claim into its administrative system before it can begin the adjudication process. Claims processing generally entails sorting claims upon their receipt and extracting and verifying pertinent patient and physician information, such as the initial validations for eligibility, in- or out-of-network physician status, duplicate dates of service and related information, and the patient diagnosis and treatment the physician rendered.

Manual (paper) claims: When the health insurer receives your manual claim, it date stamps and scans or microfilms the claim using a document management system that assigns a claim routing number. The health insurer may then route your claim to specific claims examiners or processors, based on your practice's specialty or the type of claim. The claims examiner pulls up the claim and manually enters it into the health insurer administrative system. During this step, the health insurer performs the initial validation for eligibility, in- or out-of-network provider status, duplicate dates of service and related information, and the patient diagnosis and treatment the physician rendered.

Despite the advantages that the expanded use of a common format (i.e., CMS-1500) has brought about, processing these forms can still be a labor-intensive task for the health insurer. In addition, some health insurers still use claims processing forms that vary considerably. Physician practices must therefore be familiar with and complete the required claims form if they expect to receive payment for providing patient care. Some industry experts have asserted that there could be more than 70 variations of the CMS-1500 claim form that health insurers currently use. Individual health insurer rules governing which data they will and will not accept on the form are voluminous and ever-changing, creating significant difficulties for physician practices in determining what constitutes a clean claim.

Some health insurers are attempting to reduce claims processing time by automating their claims operations through software that combines scanning, image processing and recognition technologies (data capture workflow). This software automatically reads or interprets the information on the claim form; analyzes, corrects and validates the data; and reduces the need for manual error correction. Many of these systems apply unique rules to check for claims accuracy.

Step two: Health insurer determines patient's eligibility and benefit level

A health insurer determines a patient's covered and non-covered services and procedures based on the enrollee's health benefit plan. Once the health insurer has received the claim for processing, their administrative system determines whether the patient is a match in the system and whether the patient is eligible to receive benefits for the date(s) of service identified on the claim. If the patient matches and is eligible, the health insurer's administrative system then typically determines whether the services are covered services, according to the patient's benefit plan.

Step three: Health insurer applies pricing claim edits

Because the health insurer applies pricing claim edits, the physician's billed charges that you submit on your claim will be reduced to their individually contracted maximum allowed payment.

Typically, with manual claims, the health insurer manually enters each line into its administrative system, and in some health insurer administrative systems (especially older software), the claims processor must manually review the line items during entry and make the non-fee determinations, such as whether the service is covered and whether the service should be downcoded or bundled.

For electronic claims, the health insurer's software automatically adjudicates each item using a complex series of claim edits that determine the applicable fee schedule, the allowed amount, whether the service is covered, whether the service should be downcoded or bundled, and so forth. If you have contracted with the health insurer, the health insurer's automatic pricing adjustment reduces the physician's billed charge for the CPT codes you reported to the maximum allowed payment under the network contract. The health insurer then adjusts the contracted maximum allowed payment for each CPT code you reported on the claim to reflect multiple procedure adjustments and other health insurer-specific proprietary claim edit adjustments that may reduce the maximum allowed payment for the CPT codes you reported. The health insurer pays you the difference between the total allowed amount for the medical services and procedures and the amount the patient owes.

Pricing and claim edit rules generally fall into the following categories:

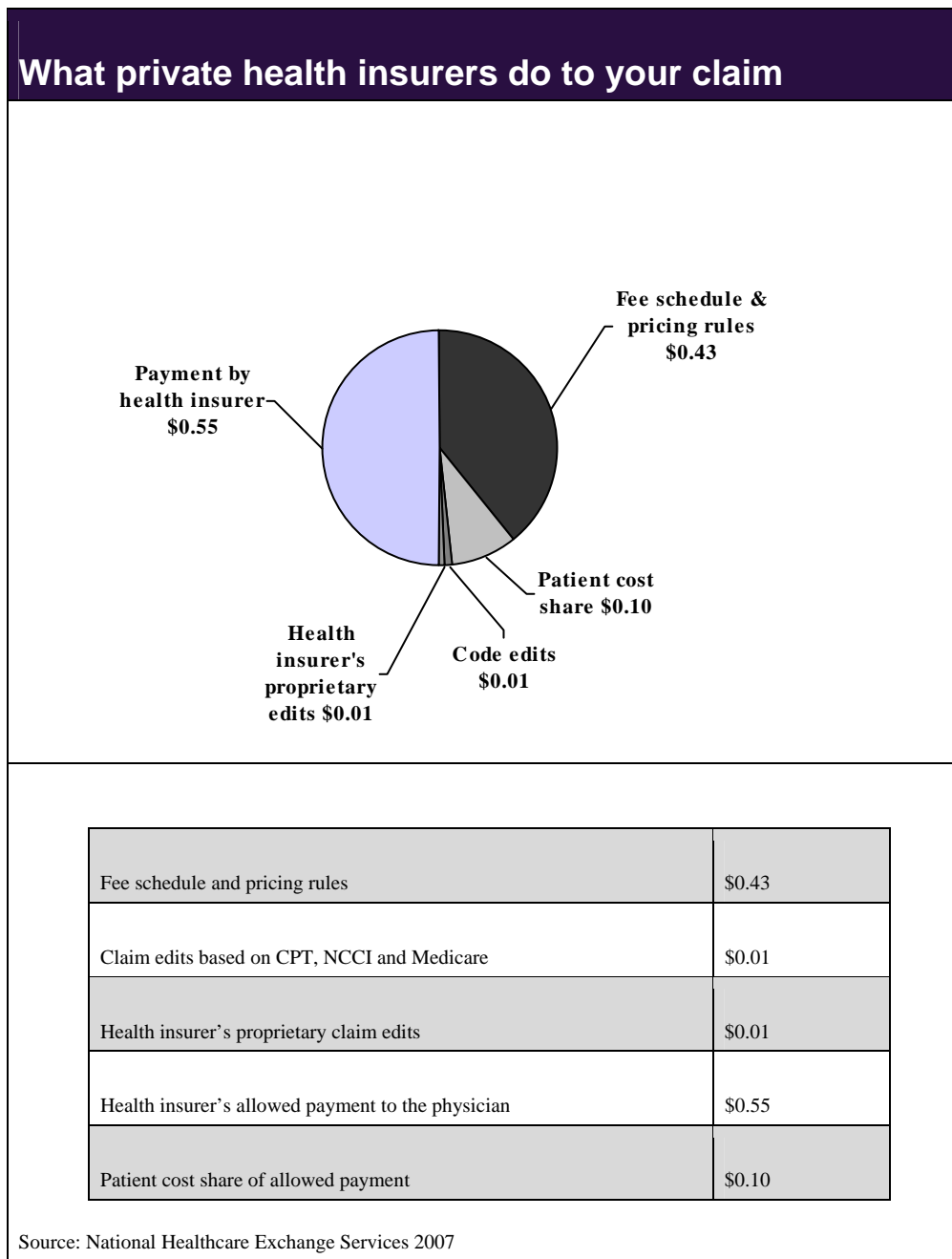
1. Pricing rules. These rules reduce the physician's billed charges to the individually contracted maximum allowed amount. In addition to fee schedule adjustments, pricing rules can also include such things as modifier and multiple procedure reduction adjustments. Pricing rules result in an allowed amount greater than zero for a medical service as opposed to a claim edit that results in denial of the service.
2. Claim Edits are based on AMA CPT codes, guidelines and conventions; National Correct Coding Initiative (NCCI); CMS payment rules; and national medical specialty societies.
3. Health insurer-specific proprietary claim edits. These claim edits may work like CPT or NCCI claim edits (such as the denial of a service as included in another service) but are based on the health insurer's own medical payment policies. Like the result of CPT, NCCI and CMS claim edits, health insurer-specific proprietary claim edits result in denial of the service.

The AMA engaged National Healthcare Exchange Services (NHXS) to conduct a study on the effect health insurers' claim edits can have on the repricing and payment of physician practice claims. The study included over 1.7 million claims that were adjudicated by 14 commercial health insurers and several Medicare carriers between June 1 and September 30, 2007. According to the sample represented in the 2007 NHXS study, for every dollar billed by a physician contracted with private health insurers, \$0.43 is discounted by using a combination of fee schedule adjustments and pricing rules. The health insurer discounts an additional \$0.01 by applying claim edits based on CPT, NCCI and Medicare and another \$0.01 by applying proprietary claim edits. The net allowed amount of the health insurer averaged \$0.55 for each dollar the physician billed, and about \$0.10 of this amount was paid by the patient, leaving the health insurer to pay \$0.45 per dollar billed, as shown in **Figure 2: What private health insurers do to your claim.**

The effect of health insurer applied code edits to claims payments

The \$0.01 adjustment that results from proprietary claim edits does effect your practice. For instance, if your practice submitted \$50,000 in contracted allowed amounts per month, you would see an adjustment of \$1000 per month as a result of the health insurer proprietary claim edits.

Figure 2




If you have not contracted with the health insurer or rental network PPO on the patient's health insurance card, you are not obligated to accept a negotiated payment. The health insurer determines what portion of the physician's billed charge the patient's benefit plan will pay (based on the health insurer's payment policy) and what portion the patient is responsible to pay. As a non-contracted physician practice, you are not obligated to accept any discounted amount listed on the EOB/RA. It is your responsibility to collect the full-billed charges for non-covered services from the out-of-network patient.

Please note: In some health insurer administrative systems, the software automatically calculates the fee schedule and payment according to your contract. Some software searches for the lowest fee schedule attached to you as a result of the many affiliations with provider networks you have created over the years. A rental network PPO is not a managed care product offered by a health insurer to its clients. Rather, a rental network PPO exists to market a provider's network and the associated physician's contractually discounted rates

primarily to third-party payers, such as insurance brokers, third-party administrators, local and regional PPOs, and self-insured employers. The opportunity for health insurers to shop for the physician's lowest contracted payment rate (i.e., highest discounted rate) is created when a physician signs contracts with multiple rental network PPOs. By renting multiple physician networks, a third-party can then load all of the physician's available discounts into its claims system.

Practice Management Center resource tip:

Multiple payers could be taking advantage of your lowest contracted payment rate through the use of a rental network preferred provider organization (PPO). The AMA developed the educational resource "[Read your contracts: Is your practice losing revenue through rental network PPOs?](#)"  (PDF, 161KB) to educate physicians about how to identify and protect their practices from inappropriate discounts.

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Pre-processing and post-processing claim edit software

Some health insurers use pre-processing software that reviews the claim detail and flags line items or entire claims that the health insurer should handle in a special way (including pended, denied, and downcoded). Some health insurer administrative systems do the same review as a post-processing claim edit. The health insurer administrative system may perform post-processing claim edits before the final claim approval by pulling out suspicious claims for additional review. Though the health insurer may pay the claim, the health insurer may request retrospective refunds on a claim of an individual physician.

These two claim edit systems have common goals and objectives:

- Provide an automated method to reduce payments and deny or pend a claim based on unique health insurer claim edits
- Provide an automated method to identify physician billing trends and practices for education, further claim edits or other uses
- Provide a mechanism to identify possible fraud and abuse

Step four: Health insurer applies its proprietary claim edits— How the health insurer reduces your payment

The health insurer's administrative system makes adjustments to your claim using health insurer-specific proprietary claim edits that include customized claim edits. Through repricing or editing claims, the health insurer determines whether the specific codes listed on your claim are eligible for payment.

You may agree to a discounted payment rate for a procedure or service with a health insurer, but actual payment can be significantly affected by both pricing and health insurer-specific proprietary claim edits that the health insurer's administrative system applies.

In 2000, Medicare moved away from applying "black box" claim edits (hidden ambiguous claim edits) to claims and began to apply the newly published NCCI claim edits. Most private health insurers use significantly more claim edits than those based on CPT, NCCI and Medicare payment rules.

The 2007 NHXS study, which included over 1.7 million claims adjudicated by 14 commercial health insurers and several Medicare carriers between June 1 and September 30, 2007, was able to identify specific health insurer claim edits and determine whether these claim edits were based on well-known sources or were unique to the health insurer. The claim edits in [**Table 4: Most common health insurer claim edits**](#) represent a small sample of the thousands of claim edits health insurers use in the claim adjudication process.

Table 4

Most common health insurer claim edits	
Edits based on CPT, CCI, and Medicare	
Procedure code is only allowed with one or more other procedure code(s)	Procedure is only allowed with other procedure with modifier
Procedure code is only allowed with other procedure code with 25 or 59 modifier	Procedure is not allowed
Procedure and age conflict	Global services package
Procedure code is not allowed with other procedure code	Automated lab panel adjustment
Procedure and gender conflict	Diagnosis and age conflict
	New patient E&M not allowed
Edits based on health insurer proprietary edits	
Procedure is not allowed with other procedure	Modifier code and place of service conflict
Procedure is not allowed	Procedure code is only allowed with one or more other procedure code(s)
Global services package	
Source: National Healthcare Exchange Services 2007	

The 2007 NHXS study revealed the likelihood of a health insurer applying a claim edit that will result in the denial of at least one line of a claim. Typically, one line of a claim refers to one or more procedures or services that you report using a single CPT procedure code on a line of the CMS-1500 claim form (see Figure 3: Excerpt of box 24, CMS-1500 form).

Figure 3

Excerpt of box 24, CMS-1500 form													
A						B	C	D			E	F	G
Date(s) of service						Place of service	Type of service	Procedures, services or supplies			Diagnosis code	\$ Charges	Days or units
From			To					CPT/ HCPCS	Modifier				
MM	DD	YY	DD	FF	YY								

The health insurer allowed amount as a percentage of billed charges is shown both by geography (see [Table 5: Health insurer allowed amount as a percentage of billed charges by state](#)) and specialty (see [Table 6: Health insurer allowed amount as a percentage of billed charges by specialty](#)) for the NHXS study claims sample.

Table 5

Health insurer allowed amount as a percentage of billed charges by state		
State	Private health insurer	Medicare
Alabama	43%	29%
Arkansas	30%	26%
California	65%	33%
Florida	51%	29%
Georgia	53%	31%
Kansas	47%	28%
Kentucky	58%	38%
Louisiana	55%	24%
Maryland	29%	30%
Missouri	45%	25%
Mississippi	72%	25%
North Carolina	79%	21%
New York	78%	26%
Ohio	49%	35%
Oklahoma	93%	28%
Pennsylvania	59%	57%
Tennessee	51%	32%
Texas	51%	30%
Virginia	53%	86%
Washington	74%	47%

Source: National Healthcare Exchange Services 2007

The purpose of a claim edit, regardless of the author of the rule, is to deny a service based on the correct application of the claim edit rule. A claim edit can be based on coding errors, such as a procedure code-gender conflict or clinical rationale. In the case of the former, the claim would typically be corrected, resubmitted and re-adjudicated. Correcting the claim, however, is not a guarantee of payment because the new code(s) may be subject to a different claim edit rule.

Table 6

Health insurer allowed amount as a percentage of billed charges by specialty		
Specialty	Private health insurer	Medicare
Anesthesiology	50%	18%
Cardiovascular	57%	42%
Dermatology	87%	98%
Emergency	29%	35%
Family practice	75%	49%
Hospitalists	64%	51%
Internal medicine	45%	37%
Multi-specialty	62%	33%
Neurology	52%	25%
Oncology	40%	27%
Ophthalmology	61%	29%
Orthopedics	46%	24%
Pathology	33%	33%
Pediatrics	54%	55%
Radiology	50%	26%
Surgery	59%	46%
Vascular surgery	26%	n/a

Source: National Healthcare Exchange Services 2007

Table 7: Increased number of billed services on separate lines per claim and likelihood of claim edits and denials shows how increasing the number of services billed for a patient encounter increases the likelihood that the claim will be subject to a claim edit. The preponderance of rules developed by groups such as NCCI target claims with multiple services. This is also true of proprietary claim edits that the various private and public health insurers have developed.

Table 7

Increased number of billed services on separate lines per claim and likelihood of claim edits and denials			
Services billed	% of total claims	% of services denied	Services denied
1	74%	6%	1.0
2	19%	8%	1.2
3	5%	12%	1.5
4	2%	30%	2.3


Source: National Healthcare Exchange Services 2007

Health insurer-specific proprietary claim edits

An example of health insurer-specific claim edits for Medicare are the National Coverage Determinations (NCD)/Local Coverage Determinations (LCD) rules that require specific diagnosis codes to support the procedure codes billed. An example of a CMS reimbursement rule that health insurers commonly use is global day logic, which allows health insurers to consider whether an office visit or procedure that was performed within 0, 10 or 90 days of another surgery/procedure is included in the original payment for the surgery/procedure.

According to the 2007 NHXS study, the private health insurer can generate savings by applying claim edits based on CPT, NCCI and Medicare reimbursement rules and also by applying its own health insurer-specific proprietary claim edits. For example, the sample represented in the NHXS study found that over 25 percent of claims physician practices submit to health insurers for payment will have one or more procedures and/or services repriced to \$0.00 as a result of health insurer-specific proprietary claim edits. The net result is that payment to the physician practice is less than the contracted payment rate.

Practice Management Center resource tip:

The AMA developed the educational resource “[The effect a payer’s claim edits can have on the repricing and payment of your claim](#)”  (PDF, 262KB) to raise awareness of how a claim edit applied by a payer could affect the physician practice’s bottom line. This resource also highlights how a negotiated fee with a payer for a specific service performed does not necessarily translate into payment of that fee for that service on a claim.

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Practice Management Center resource tip:

The AMA developed the tool, [Appeal that Claim](#), which explains the process of appealing underpaid, delayed or inappropriately denied claims and includes form letters that you can modify and use as you appeal claims.

Pricing claim edits

Most health insurers include “lesser of” language in their contracts with physicians. This language binds the health insurer to pay the physician’s billed charges only when the billed charges are less than the payment rate in the agreed upon fee schedule. Thus, if the fee schedule indicates a payment amount of \$50, and the physician’s billed charge is \$45, the health insurer’s maximum payment for the medical service is \$45. According to the sample size represented in the 2007 NHXS study, on average, physicians billed one health insurer \$5.15 below their contracted fee schedule per code.

Practice Management Center resource tip:

The AMA has developed the educational resource, “[Fee schedule analysis: Using your complete practice cost as a guide.](#)” (PDF, 68KB) to help physicians and their practice staff recognize the need to establish their practice fee schedule based on what it actually costs to provide a service rather than basing their fee schedule on what a third-party payer or other entity decides is fair payment. This resource includes a 12-step guide to help physician practices create their own unique physician practice fee schedule with an easy-to-complete spreadsheet that will allow physician practices to include additional markup percentages, profit contributions to reserves and future expenditures.

The typical physician practice has an average of 12 managed care contracts, and the average health insurer has five plan types (PPO, HMO, POS, EPO and IND). Such complexity requires you to diligently maintain your charge master (your master list of charges) to be sure that the billed charge is equal to or greater than the

contracted allowed amount. For greater detail of this part of the 2007 NHXS study, see Table 8: Twenty most common procedure codes in which the physician's billed charges were less than contracted amount.

Table 8

Twenty most common procedure codes in which the physician's billed charges were less than contracted amount

Procedure	Description	Average charge below fee schedule
90471	Immunization administration	\$14.54
95115	Immunotherapy; single injection	\$3.54
99213	Office/outpatient visit; established patient	\$11.91
90772	Therapeutic, prophylactic or diagnostic injection; subcutaneous or intramuscular	\$5.79
90715	Tetanus diphtheria toxoids and acellular pertussis vaccine (Tdap); patient 7 years or older.	\$29.74
90649	Human Papilloma virus (HPV) vaccine; 3 dose, intramuscular	\$109.36
G0101	Cervical or vaginal cancer screening, pelvic and clinical breast examination	\$29.18
99173	Visual acuity screen	\$18.98
93325	Doppler color flow add-on	\$5.60
80061	Lipid panel	\$31.65
95165	Antigen therapy services	\$19.83
84443	Assay thyroid stimulating hormone	\$44.92
90472	Immunization administration, each add	\$3.35
G0202	Screening mammography; digital	\$1.23
92015	Determination of refractive state	\$66.52
90700	Diphtheria, tetanus toxoids, and acellular pertussis (DtaP) vaccine; patient younger than 7	\$10.03
90713	Poliovirus vaccine, inactivated (IPV); subcutaneous or intramuscular	\$7.47
92551	Pure tone hearing test; air only	\$3.18
90633	Hepatitis A vaccine; pediatric/adolescent, 2 dose, intramuscular	\$17.71
90734	Meningococcal conjugate vaccine; intramuscular	\$65.52

Source: National Healthcare Exchange Services 2007


The top CPT categories with charges below the physician's fee schedule rate were: Special Services; Procedures and Reports (e.g., CPT codes 99000 or 99058); Therapeutic, Prophylactic or Diagnostic Injections (e.g., CPT code 90782); Radiology; Other Procedures (e.g., CPT code 76083); and Medical and Surgical Supplies (e.g., HCPCS code A4550).


According to the 2007 NHXS study sample, fee schedule underpayments represented 94 percent of underpaid services, which equates to an average underpayment amount for fee schedule claim edits of \$33. Clinical claim edit underpayments represented 6 percent of underpaid services, which equates to an average underpayment amount for clinical claim edits of \$92. The typical mix of health insurers for a physician practice will result in a fee schedule underpayment rate of 7.2 percent of paid services.

According to the 2007 NHXS study sample, the average physician billed for 374 services per month, and the average monthly underpayment rate was a total of \$889 per physician. Using the typical research and correspondence methods employed by most physician practices, the cost to dispute a single underpaid service is \$22 for the physician practice and equally as much or more for the health insurer. The economics of dispute resolution overwhelmingly favor first-time payment accuracy by the health insurer.

Although all states have timely payment requirements (referred to as prompt payment laws), only a few have payment accuracy statutes. California is one of the states that has a payment accuracy statute that requires the first EOB/RA accuracy rate to be at least 95 percent. Only one health insurer in the NHXS study met that requirement.

Practice Management Center resource tip:

To learn more about state prompt payment laws, visit the AMA [Advocacy Resource Center \(ARC\)](#) Web site and view the document "[State Prompt Payment Laws Chart](#)."  (PDF, 206KB)

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Step five: Health insurer completes auto-adjudication (electronic processing of your claim)

The health insurer determines the final payment for your claim. Once the health insurer validates the accurate completion of the claim data fields, the health insurer sends your claim through what is referred to as the pre-adjudication process (the health insurer administrative system completes the initial health insurer claim edits). During claims adjudication, the health insurer reviews your claim for health care benefits to verify that: (a) your claim is consistent with health insurer rules and procedures, (b) your claim is not a duplicate, (c) the service provided is a covered benefit, and (d) all required information is available to process the claim completely. The claim adjudication step determines the level at which the claim will be paid.

Health insurers adjudicate your claims at the individual line item level, not at the level of the total claim (or bill). This method of adjudication is how the health insurer is able to downcode, bundle or otherwise adjust individual line items of your claim. Medical payment policies and procedures vary from health insurer to health insurer. Health insurers might arbitrarily change or inconsistently apply their rules and often do not provide easily accessible reimbursement and coverage policies. Additionally, health insurers may misapply or misunderstand CPT and ICD-9 codes, guidelines and conventions. Over the years, health insurers' claims adjudication procedures have become more complex as a result of the introduction of new technology. Unfortunately, new technology has not always resulted in a more accurate and precise process and frequently translates into extended processing time and delayed payments to physicians.

The status of the claim, such as whether the health insurer has received the claim, has pended, paid, or rejected the claim, can be obtained from the health insurer by using the HIPAA standard transactions for claim status. Claims status information and requirements, designated by HIPAA, apply to all health care claims transactions. These claim status transaction code sets will allow you to track a claim within the health insurer's administrative system.

When a health insurer denies your claim, it could be for many possible reasons. Unfortunately, many of these reasons are the result of:

- The health insurer's individual medical payment policies
- Missing CPT codes
- Missing physician or patient identifiers
- Incorrect health insurer information

- Lack of referral, authorization, or enrollment and eligibility information, which usually results in denial of a claim and may be a by-product of confusing and complicated individual health insurer policies and procedures

Health insurers may indicate that they did not receive or that they have no record of your claim and may require you to resubmit it.

If the health insurer approves your claim, the claim payment is queued into a payment register (or “to pay” system). The health insurer reviews the payment register and places the claim in the cycle for the next check run. During the check run, the health insurer cuts the check and mails it to your practice, along with a paper EOB. In the case of electronic remittances, the health insurer processes the X12 835 EOB/RA and sends it to you or your clearinghouse. This paper or electronic EOB/RA may or may not accompany a paper check or an electronic funds transfer (EFT) deposit directly into your bank account.

Practice Management Center resource tip:

Access the AMA educational resource “[15 steps to protect your practice from unfair payment tactics](#)” for more information about protecting your practice against losing revenue as a result of health insurers’ methods of inappropriately reducing payment.

Step six: Health insurer generates EOB/RA

The health insurer sends a paper or an electronic EOB/RA (X12 835 standard transaction) to you and the patient that details the allowed amount, the contracted adjustment amount (discount), the health insurer paid amount and the patient responsibility amount of the medical service provided.

Claims payment processing

During the adjudication process, the health insurer first determines how much of the claim it will reimburse and then approves the claim for payment processing. The health insurer issues you a check, then processes and forwards an EOB/RA to you and the health insurer’s subscriber (patient). Information provided on the EOB/RA varies by health insurer. Table 9: Information routinely found on EOBs/RAs outlines information most health insurers routinely provide.

Table 9

Information routinely found on EOBs/RAs
■ Patient name
■ Date of service
■ Physician (service provider)
■ Patient account number
■ Patient group number
■ Subscriber (insured)
■ CPT codes billed
■ Charges at 100%
■ Amount allowed (negotiated rate)
■ Amount paid (negotiated rate minus co-payment, coinsurance and/or deductible)
■ Contractual adjustment amount
■ Patient responsibility (including co-payment, coinsurance and deductible)

Your practice (or designated **billing entity/service**) can use the information from the EOBs/RAs to process and post payments and adjustments to a patient's account. It is important that you evaluate EOBs/RAs for accuracy to detect processing errors (i.e., inappropriate CPT code changes, inaccurate reimbursement rates, inappropriately applied multiple procedure reduction logic, or quantity of units not recognized, etc.). Once you review the EOB/RA, you can begin the posting process (i.e., apply payments and adjustments). When you complete the posting process, you will be able to follow up with health insurers for: claims denials, partial payments, downcoding and bundling of individual line items, and payments that the health insurer has delayed beyond state required timelines, and you will be able to appeal as appropriate. The careful review of a health insurer's EOB/RA is vital to the financial soundness of a physician practice. Physician practices should review each health insurer's EOB/RA to ensure that contracted allowed amounts are applied and paid appropriately on each claim. If they are not, the physician practice should appeal the inappropriately paid claims.

HIPAA's Administrative Simplification Transaction and Code Sets Final Rule established guidelines requiring health insurers to use standardized reason codes as part of the **835 payment/remittance advice**. This national administrative code set identifies the reasons for any differences or adjustments between the original physician charge for a claim or service and the health insurer's payment. These code sets have the potential to help you understand what is missing from a claim and/or what a claim requires before the health insurer will issue you a payment. Visit **www.ama-assn.org/go/pmc** for more information about the **HIPAA standard transactions**.

Step seven: Health insurer sends payment

Payment transmission or electronic funds transfer (deposit)

Health insurers are adopting electronic methods for sending payments and their accompanying advice (X12 835). An electronic funds transfer (EFT) is a payment method utilizing electronic means (as contrasted with paper checks) to transfer monies between parties. EFT payments can be nearly instantaneous (avoiding postal delays) and may reduce administrative steps associated with issuing or depositing payments. Health insurers cannot dictate that the physician practice accept EFT payments in order to receive an X12 835. An EFT agreement that permits the health insurer to take adjusting entries, service fees or offsets out of the physician's account may prevail over applicable regulatory requirements. However, HIPAA does not allow offsets out of a designated physician account. The AMA cautions physicians to review the EFT agreement closely to determine whether the agreement allows the health insurer to unilaterally apply and deduct a service fee, refund request, adjusting entry or otherwise make debit entries from funds due to the physician. The AMA encourages you to know up front how these credit and debit entries will be recorded and whether your bank will charge a fee for such entries or for a debit that exceeds the balance of the account.

There are many ways health insurers can combine the electronic EOB/RA and the actual payment. A health insurer may forward an EOB/RA to you with an actual check, or the health insurer may transfer the payment electronically through a depository financial institution (DFI) or bank to your account.

Regardless of the method of receipt of the health insurer payment, it is critical that you review the payment and the remittance information for consistency with the information the health insurer presents on the EOB/RA as well as the information from the original claim form you submitted. The AMA encourages you to verify that the payment amount you received correlates with the contractually obligated amount for the provision of care that you specified on your original claim form.

If the health insurer approves your claim, the health insurer cuts a check and delivers it to you. If the health insurer partially pays your claim, the health insurer check and EOB/RA forwarded to you should contain the reason and remark codes that provide the rationale for the partial payment. Additionally, the health insurer processes and forwards an EOB/RA to the health insurer's subscriber (patient). If the health insurer denies your claim, the health insurer returns the denied claim to you with a zero remittance EOB/RA.

Practice Management Center resource tip:

The AMA developed the educational resource **“Frequently asked questions regarding electronic funds transfer agreements”** (PDF, 29KB) in response to physician concerns regarding electronic funds transfer agreements.

Table 10: Health insurer electronic payment process outlines the process after the health insurer approves the payment and the physician practice accepts an EFT of the health insurer payment.

Table 10

Health insurer electronic payment process

1. The health insurer sends you an EOB/RA (either paper or electronic). The EOB/RA is either accompanied by a check or a notice of an EFT the health insurer makes to your DFI.
2. If the health insurer sends your reimbursement via EFT, the health insurer simultaneously sends notification to its DFI authorizing the EFT payment. A copy of the EOB/RA accompanies this authorization.
3. The health insurer’s DFI then sends notification of the debit to the health insurer.
4. The health insurer’s DFI simultaneously transfers funds to your practice’s DFI.
5. Your practice’s DFI then notifies the health insurer’s DFI of a successful debit.
6. Your practice’s DFI notifies you of the successful wire transfer and fund deposit.

Note: The health insurer can make additional payments or adjustments using the outlined electronic payment process. Similarly, this process works in reverse if the health insurer requires you to refund any portion of the initial payment.

DFI: Depository financial institution/bank

EFT: Electronic funds transfer

Funds: actual dollars, check or other

The first time a submitted claim is accepted for processing

The importance of a clean claim cannot be understated. It is no secret that physician practice billing staff work tirelessly to ensure that all the required information on a claim submission is accurate when they submit a claim. This helps protect against a denial and the associated work of resubmitting the claim. However, submitting a clean claim does not necessarily ensure that your claim will be processed correctly the first time around.

As you can see in **Table 11: First time a submitted claim is accepted for processing**, the 2007 NHXS study, which included over 1.7 million claims adjudicated between June 1 and September 30, 2007, found that between 90 and 96 percent of clean claims are accepted during the first submission. Claims that are not accurately adjudicated the first time require rework by the physician practice in order to obtain the appropriate reimbursement.

Table 11

First time a submitted claim is accepted for processing					
Health insurer	First submission acceptance rate	% of services denied	Health insurer	First submission acceptance	% of services denied
Aetna	90.7%	9.3%	Blue Cross Blue Shield of Texas	96.3%	3.7%
Anthem Blue Cross and Blue Shield	93.7%	6.3%	Blue Shield of California	93.0%	7.0%
Blue Cross of California	91.6%	8.4%	CIGNA	95.0%	5.0%
Blue Cross of Pennsylvania (Independence Blue Cross)	94.3%	5.7%	Humana	96.4%	3.6%
Blue Cross Blue Shield of Florida	91.1%	8.9%	Medicare	93.4%	6.6%
Blue Cross Blue Shield of Georgia	91.6%	8.4%	UnitedHealthcare	96.7%	3.3%
Source: National Healthcare Exchange Services 2007					

The most common reasons that health insurers deny billed services on the first submittal are shown in Table 12: Top reasons health insurers deny physicians' billed services.

Table 12

Top reasons health insurers deny physicians' billed services			
Private health insurers	% of denied services	Medicare	% of denied services
Non-covered service	50%	Non-covered service	31%
Patient not eligible for benefits	25%	Claim lacks information	23%
Claim lacks information	9%	Claim sent to the wrong health insurer	16%
Prior authorization required	5%	Not medically necessary	14%
Claim sent to the wrong health insurer	4%	Patient not eligible for benefits	13%
Documentation required	3%	Documentation required	1%
Source: National Healthcare Exchange Services 2007			

Claims accuracy

The 2007 NHXS study revealed that health insurers on average paid 78.5 percent of claims accurately on the first EOB/RA they sent to physician practices. For the purposes of the NHXS study, inaccurate claims included partial payments without explanation, underpayments and overpayments. The health insurer's first-time EOB/RA payment accuracy rate on a claim submission can have a significant impact on your practice expenses. For roughly 21 percent of the patient encounters represented in its claim sample, NHXS estimated that it took multiple communications between physician practices and health insurers to finalize the appropriate payment and the final patient balance. In **Table 13: Health insurer claims payment accuracy**, the second column lists the accuracy rate for the health insurers' first EOBs. The third column lists the additional percentage of accuracy after the health insurers issued two or more EOBs. Some of these revised EOBs were prompted by a physician's first-level appeal, and some were unsolicited health insurer corrections. Such delays affect both the health insurer's and your ability to accurately determine the patient's financial responsibility. Initial inaccuracies in payment can also trigger additional administrative costs for your practice, including multiple data entries, auditing and collections expenses.

Typically, you will spend between \$14 and \$25 for each claim that you audit and appeal. You can now perform successful low-cost audit and appeal processes by taking advantage of the various HIPAA Transactions available, such as obtaining electronic eligibility and benefits (270/271) prior to the patient's visit and obtaining claim status (276/277), authorization (278) and remittance (835). Utilizing these simple electronic features will reduce the administrative burden and cost within your practice.

Table 13

Health insurer claims payment accuracy		
Health insurer	% of accurate payments on the first EOB/RA	% of accurate payments on subsequent EOBs/RAs
Aetna	82.5%	4.4%
Anthem Blue Cross and Blue Shield	95.5%	2.8%
Blue Cross of California	94.2%	2.6%
Blue Cross of Pennsylvania (Independence Blue Cross)	71.0%	1.0%
Blue Cross Blue Shield of Florida	50.4%	32.6
Blue Cross Blue Shield of Georgia	88.5%	2.3%
Blue Cross Blue Shield of Texas	40.1%	54.3%
Blue Shield of California	85.8%	5.2%
CIGNA	71.4%	5.1%
Humana	83.9%	5.8%
Medicare	91.1%	8.3%
UnitedHealthcare	87.8%	8.5%
Source: National Healthcare Exchange Services 2007		

Conclusion

It is critical to understand your practice's own internal claims and billing processes, including the medical payment policies and procedures of any contracted entity that handles or submits your claims or claims information. Additionally, you should familiarize yourself with the following:

- The typical ways health insurers can pend, deny or incorrectly pay your claim
- How to determine your claim's status with the health insurer
- How to use the electronic HIPAA transactions to improve the efficiency and accuracy of claims submission and processing and to improve payment timeliness (for example, electronically verifying eligibility and benefits prior to each date of service or obtaining required referral authorizations)
- How to prepare and submit an appeal when appropriate

Review all health insurer contracts

If you understand a health insurer's contractual requirements for claims submission, you will be more likely to receive timely and accurate payment. For your existing health insurer contracts, make sure you have access to its administrative manual, the associated fee schedules, medical payment policies, available claim edits and other payment rules, and make sure you are receiving your contracted payment rate. You should also carefully review all potential contracts with health insurers, including the associated fee schedules, medical payment policies, available claim edits and other payment rules before you sign any contracts.


Practice Management Center resource tip:


The AMA provides several useful tools for your education on managed care contracts. The AMA [Model Managed Care Contract](#) (PDF, 857KB) contains sample contract language designed to assist you in avoiding common contracting pitfalls. Its companion piece, [15 Questions to Ask Before Signing a Managed Care Contract](#) (PDF, 119KB), provides a roadmap to help you evaluate whether to sign a managed care contract.

Review and audit all claims

Carefully reviewing health insurers' EOBs/RAs is vital to the financial soundness of your practice. You should not rely on the health insurer to correctly process and pay the claims it received from you. Be sure to audit each EOB/RA you receive in order to determine the accuracy and appropriateness of the claims processed. By carefully auditing EOBs/RAs, you will be able to pinpoint and address underpayments and denials based on a health insurer's inappropriate adjustments.

Practice Management Center resource tip:

The AMA developed the educational resource, "[Is your practice losing revenue through inappropriate health plan adjustments?](#)"  (PDF, 176KB) to alert physician practices of the need to carefully review health insurer EOBs and RAs in order to pinpoint and address underpayments based on a health insurer's inappropriate adjustments.

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Appeal all inappropriately paid and denied claims

When you perform a service or procedure and then report it according to the AMA CPT codes, guidelines and conventions, the health insurer should recognize the physician work involved in providing the patient care. The AMA encourages you to (1) identify all inappropriate claim denials, (2) communicate with the health insurer's provider representative and (3) initiate a claim appeal, when appropriate.

By not auditing and appealing inappropriately paid or denied claims, many physician practices may lose revenue and the opportunity to recover payments that the health insurer contractually owes. By challenging inappropriate claim payments, you demonstrate that you are making an effort to correct the health insurer's inaccuracy. This action has the potential to lead to a positive change in the health insurer's business practices.

Carefully preparing, following and appealing each of your claims can reduce the number of claims you will have denied in the future and increase your practice efficiencies and revenue.

Practice Management Center resource tip:

The AMA developed the tools, [Prepare that Claim](#) and [Appeal that Claim](#), which explain the process of preparing and appealing underpaid, delayed or inappropriately denied claims; Appeal that Claim also includes form letters that you can modify and use as you appeal claims.

Questions or concerns about practice management issues?

The AMA Practice Management Center is here to assist AMA members and their practice staff with practice management issues. The following are some of the issues that the AMA Practice Management Center can assist you in dealing with:

- Fair contracting
- Accurate payment
- Practice efficiency
- Clinical integrity
- Defensible fee schedule

AMA members and their practice staff may e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance. Please include the physician's name and his or her AMA member ID number.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call (800) 262-3211 and ask for the AMA Practice Management Center
- Fax information to (312) 464-5541
- Visit www.ama-assn.org/go/pmc to access the AMA Practice Management Center Web site

Glossary

835 payment/remittance advice Also called “X12 835 Health Care Claim Payment and Remittance Advice Transaction,” it is the standard format for the electronic data interchange of EOB data and the electronic transfer of payment for health care services.

Adjudication The process of a health insurer receiving and processing a claim for payment.

American National Standards Format (ANSI ASCX12N) Transaction Set 837 The format HIPAA authorized as the federal standard for electronic health insurance claims. ANSI and ASC refer to the designated standards maintenance organization that has developed this format.

Batch file The aggregation of multiple claims into one data file.

Billing entity/service A company that has been contracted to complete and submit health claims for a physician practice. The billing entity may provide some additional services on behalf of the physician practice, including verifying physician and physician practice information (on the claims forms) as well as making sure that the physician practice has entered all fields the clearinghouse or health insurer requested.

Claim edits Claim edits are a set of business rules that the health insurer establishes to ensure that specific fields are completed and CPT codes are paid in accordance with the health insurer’s business design.

Claims pricing/claims repricing The process of adjusting payment to meet the health insurers’ complex contracts and fee schedules.

Clean claim A claim that meets all of the standard submission requirements of a health insurer and is accepted for adjudication. A “clean claim” is a complete and error-free claim submitted to the health insurer on the health insurer’s claim form.

Clearinghouse A private company that provides connectivity between physicians, billing entities, health insurers and other health care partners for transmission and translation of claims (primarily electronic) information into the specific format the health insurer requires. Clearinghouses may contract with or act on behalf of one or a number of health insurers or may contract with physician practices to transmit and/or translate claims information.

CMS-1500 The universal claim form (with instructions) non-institutional providers and suppliers use to bill Medicare (Part B) for covered services. It is also used for billing some Medicaid-covered services and is the claim form most health insurers accept.

Explanation of benefits (EOB) An EOB is specific to one patient’s reimbursement. It explains the total versus covered (allowed) charges, the deductible and co-pay amounts due (from the insured), any applicable

contractual adjustments, and the amount the health insurer paid. EOB format, as well as the information it presents, varies from health insurer to health insurer.

International Classification of Disease–9th Edition–Clinical Modification (ICD-9-CM) The standard diagnosis coding system for health care claims coordinated by the National Centers for Vital and Health Statistics (NCVHS). ICD-9-CM codes assist physicians in transforming verbal descriptions of diseases, injuries, conditions and certain procedures into numerical destinations (diagnostic coding).

National Provider Identifier (NPI) The NPI is a HIPAA-mandated Administrative Simplification standard. The NPI consists of unique identifying numbers that are required for all physicians and other health care providers (individuals and organizations) who conduct electronic transactions.

Remittance advice (RA) A report that outlines reimbursement data for multiple patient claims. The information provided varies by health insurer. Most reports will include basic information that outlines: patient account number, dates of service, the total/covered/allowed charges, the deductible and co-pay amounts due (from insured), contractual adjustments if applicable, and amount the health insurer pays.