

Join the “Heal the Claims Process”™ campaign

Diagnosing the problem

Physicians enter the medical profession to care for patients. But with the current ailments of the claims process, physician practices have to focus a significant amount of time and resources—as much as 14 percent of their total collections—just to ensure accurate payment for their services.* When physicians submit correctly coded health care claims, health insurers and other third-party payers may still inappropriately delay, deny or significantly reduce payments. The significant savings that could be realized by all participants in the health care claims process from more efficient claims processing could be better spent on increasing the quality of patient care and reducing the burden of high premium costs to patients and their employers.

The AMA’s remedy

The American Medical Association’s (AMA) designation of November as “**Heal that Claim**”™ month is a focused effort of the AMA’s ongoing “Heal the Claims Process”™ campaign. The campaign calls on all participants in the health care claims process to do their part to eliminate waste in the claims process by committing to efficiencies and getting it right the **first** time:

- We encourage **physicians, their practice staff and their billing partners** to submit timely and accurate claims the first time and implement practice efficiencies.
- We encourage **payers** to pay accurately and in a timely manner the first time and comply fully with the Health Insurance Portability and Accountability Act (HIPAA) electronic standard transactions. We also call on payers to provide full transparency with respect to fee schedules, payment policies and other information necessary to maximize efficiency.
- We encourage **employers** to comply fully with the HIPAA electronic standard transactions, provide benefit transparency to their employees and, when appropriate, offer incentives to their payers or third-party plan administrators to pay accurately and in a timely manner the first time.
- We encourage **patients** to understand their health insurance policies and payment practices and make a good faith effort to meet their financial obligations.

These steps would improve claims processing efficiency and help reduce health care costs for all participants in the health care claims process. The campaign’s ultimate goal for the physician practice is to reduce the cost of submitting claims from as much as 14 percent to just 1 percent of revenue, freeing up more time and resources to devote to patient care.

* National Healthcare Exchange Services 2008.

The physician's prescription

Through the AMA's "Heal the Claims Process"™ campaign, physicians, their practice staff and their billing partners can join their peers around the country in improving practice efficiencies that can result in reduced costs for the physician practice and increased time and resources to devote to patient care. Physicians, their practice staff and their billing partners can help heal the claims process with the following actions:

- **Review their internal claims process** to ensure claims are submitted accurately and in a timely manner to the appropriate payer.
- **Review and reconcile claims payments** they receive from payers for accuracy and appropriateness.
- **Perform a practice management check-up** to identify opportunities to improve practice efficiency.
- Evaluate their practice management systems to prepare for the approaching **5010** and **ICD-10** mandated updates and enhanced use of electronic transactions.

The payer's prescription

Health insurers and other third-party payers can join the "Heal the Claims Process"™ campaign by committing to accuracy, transparency and cost efficiencies. The "Heal the Claims Process"™ campaign urges payers to adopt and fully implement the HIPAA electronic standard transactions and further:

- Work toward complete payment accuracy and transparency with a goal of eliminating rework costs for both physicians and payers.
- Accurately process and appropriately pay claims the first time.
- Complete the key voluntary fields included in the electronic remittance advice (ERA) necessary for physicians to efficiently reconcile claims; provide expanded electronic patient eligibility responses; and use accurate, specific reason and remark codes so that the physician can easily confirm whether an adjustment on a claim was indeed accurate.
- Provide clear, descriptive and understandable benefit plan summaries for subscribers, including policies about out-of-network services and assignment of benefits.

The employer's prescription

Employers play an important part in the health care claims process through employee enrollment, relationships with payers or third-party plan administrators, and education of employees. Employers can do their part to heal the claims process if they:

- Transmit real-time employee health plan enrollment and disenrollment information to the health plan administrator.
- Provide clear, descriptive and understandable benefit plan summaries for employees.
- Consider enhancing employee education with resources, such as an online employee benefit plan calculator.
- If appropriate, offer incentives to their payers or third-party plan administrators to pay accurately and in a timely manner the first time.

The patient's prescription

Patients can play an active role in healing the claims process by understanding their responsibility to provide accurate insurance information to their physician's practice staff and taking steps to understand their personal financial responsibility for their medical care. Patients should:

- Understand their **health insurance policy and payment practices** and disclose up-to-date personal and health insurance policy information to their physician's practice staff at the start of each visit.
- Recognize their payment responsibilities and make a good faith effort to meet their financial obligations.
- Familiarize themselves with their health insurer's internal complaint and appeals process.
- Know their coverage and benefits, including coverage for out-of-network services, whether their health insurer recognizes assignment of benefits and how their different health insurers will perform coordination of benefits if the patient is insured by more than one health insurer.

A cure is in sight

By committing to efficiency, transparency and accuracy in every step of the claims process, waste can be dramatically reduced from the claims process. For instance, if both physicians and payers use electronic transactions instead of manual ones for the estimated 3 billion claims submitted every year, the health care system can save more than \$90 billion each year. Help heal the claims process and return the focus to the reason physicians enter medicine in the first place—caring for their patients.

The AMA Practice Management Center[†] helps physicians take charge of the business side of their practices with educational resources and tools that help physicians and their practice staff address private payer and practice management issues with ease. Working side by side with national medical specialty societies and state and county medical associations, the AMA Practice Management Center helps physicians and their practice staff navigate a challenging marketplace.

To help physicians process claims efficiently, the AMA's Practice Management Center has created a Web site. Visit www.ama-assn.org/go/pmc to access a variety of materials on submitting accurate claims, reviewing and reconciling inappropriate payments, and other aspects of managing the physician practice. New resources are added frequently, so check back often for updates.

AMA members and their practice staff may e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance.

[†] The Practice Management Center is a resource of the AMA Private Sector Advocacy unit.