



Standardization of the Claims Process Administrative Simplification Summary and recommendations

The AMA recommends simplification, transparency and disclosure of all information necessary for determining patient and payer financial responsibilities. In addition, the AMA recommends support of the following:

I. Increased enforcement of the Health Care Insurance Portability and Accountability Act (HIPAA) standard transaction and code set (TCS) rules

The AMA recommends regulation to: (1) lift 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, reported at the greatest level of specificity that the transaction and related code sets permit; (3) increase enforcement resources through compliance audits; and (4) state concurrent enforcement jurisdiction for the HIPAA TCS rules.

II. Designation of CPT guidelines and conventions as a HIPAA standard

The AMA recommends regulation to: (1) change the definition of “code set” in Sec. 1171 (1) to include the associated operational guidelines and instructions; and (2) mandate 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 the 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 CPT.

III. Implementation of standard pricing/payment rules

The AMA recommends regulation to develop standard payment rules. Payment rules should be transparent and applied consistently within and among payers. 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 physician practice management systems.

IV. Implementation of standard claim edits

The AMA also recommends regulation to develop standard claim edits. Standard claim edits would provide a common standard claim processing platform for payers, physicians and patients. A standard claims processing platform would not dictate any payer medical rules, claim review or product benefit level and design. The platform would, however, create a level playing field for all payers, including third-party administrators and self-insured employers, by bringing the competition back to price rather than on the application of additional edits in the health care billing and payment process. Similar to payment rules, payers should provide physicians with easy online access and the ability to download claim edits from their Web sites.

V. 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 and payment 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.

VI. Expanded electronic remittance advice and other standard transaction requirements

HIPAA TCS standard transactions must require both **correct syntax** and **information** that accurately reflects the circumstances, reported **at the greatest level of specificity** permitted by the transaction and related code sets. **Consistency must be adhered to in naming conventions for data fields used in HIPAA standard transactions.** For example, "class of contract" and "claim filing indicator" codes have different meanings in each payer's eligibility response transaction and the claim payment/remittance transaction. Codes with the same names need to be established in such a way that allows them to be uniformly applied and interpreted for all standard transactions. Additionally, the **line item relationships must be maintained** between the ASC X12 837 Health Care Claim (professional) Claim Submission and the ASC X12 835 Health Care Claim Payment/Remittance Advice.

The AMA strongly encourages the expansion of the following standard transactions, which would assist in moving the health care industry toward the efficient, fully automated health care billing and payment process that we all desire.

▪ **Electronic remittance advice**

In order to effectively communicate information about payment in an X12 835 remittance advice, the HIPAA standard transactions must be reported to the highest specificity. Fields that are currently voluntary, such as the "allowed amount" (the contracted rate between the physician and payer), "class of contract" (specification of the product type) and "date of claim receipt" fields, should all be made mandatory, and the payer should complete these fields in order to move toward the complete automation of the health care billing and payment process. Additionally, the adoption of **operational guidelines and instructions for electronic remittance advice code sets**—that is, the claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs)—along with the requirement for full specificity and explanations of claim adjustments and denials via standard CARCs and RARCs is imperative.

▪ **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 be reported not only to the highest specificity but also must be made **binding**. 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 qualified health care professional (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.

▪ **Health care acknowledgement**

The AMA also recommends regulation to add "health claims acknowledgement" to the list of standard transactions listed in Sec. 1173(a)(2) and specify 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]).