



## 2008 National Health Insurer Report Card

The purpose of the AMA's National Health Insurer Report Card (NHIRC) is to provide physicians and the general public a reliable and defensible source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by the health insurance companies that are responsible for paying these claims. Billions of dollars in administrative waste would be eliminated each year if third-party payers sent a timely, accurate and specific response to each physician claim.

The NHIRC is for informational purposes only. Physicians and payers are encouraged to review the NHIRC results and begin healing the health care claims process by supporting the AMA's "Heal the Claims Process"<sup>TM</sup> campaign and committing to the goal of reducing the cost of claims administration to 1 percent of collections. Visit the AMA Practice Management Center Web site at [www.ama-assn.org/go/pmc](http://www.ama-assn.org/go/pmc) for information on the "Heal the Claims Process"<sup>TM</sup> campaign.

Health Insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Health Net	Humana	United Healthcare (UHC)	Medicare
<b>Payment Timeliness</b>								
<b>Metric 1</b> Payer claim received date disclosed	100%	99.21%	0%	100%	99.76%	0.07%	99.98%	99.99%
<b>Metric 2</b> First remittance response time (median days)	13	7	14	4	11	13	10	14
<b>Metric 3</b> ERA activity during the data period	Not Reported (NR)	NR	NR	NR	NR	NR	NR	NR
<b>Accuracy</b>								
<b>Metric 4</b> Allowed amount disclosed	97.77%	97.37%	19.25	99.30%	65.72%	97.33%	93.40%	98.53%
<b>Metric 5</b> Contracted payment rate adherence	70.78%	72.14%	66.23%	86.74%	NR	84.20%	61.55%	98.12%
<b>Transparency of contracted fees and payment policies on payer Web sites</b>								
<b>Metric 6</b> Contracted fee schedule	No	Yes	No	No	No	Yes	Yes	Yes
<b>Metric 7</b> Contract fee schedule codes allowed per request	0	25	0	0	0	30	30	All
<b>Metric 8</b> Payer-proprietary claim edits	Yes <sup>1</sup>	Yes <sup>1</sup>	Yes <sup>1</sup>	No <sup>3</sup>	Yes <sup>1</sup>	Yes <sup>1</sup>	Yes <sup>1</sup>	Yes
<b>Metric 9</b> Medical payment policies	Yes <sup>2</sup>	Yes <sup>2</sup>	Yes <sup>2</sup>	No	Yes <sup>2</sup>	No	Yes <sup>2</sup>	Yes

<sup>1</sup> At least some payer proprietary edits are available.

<sup>2</sup> At least some medical payment policies are available.

<sup>3</sup> May not be applicable given that no payer-proprietary claim edits were identified by this analysis.

Health Insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Health Net	Humana	United Healthcare (UHC)	Medicare						
<b>Compliance with generally accepted pricing rules</b>														
<b>Metric 10</b> Percentage of claim lines reduced to \$0 by edits	3.75%	3.40%	7.33%	0.31%	NR	3.17%	9.15%	1.40%						
<b>Metric 11*</b> Source of payer claim edits														
CPT	1.4%	2.5%	0.6%	32.4%	NR	1.5%	4.5%	9.2%						
ASA	0.0%	0.0%	0.0%	0.0%	NR	0.0%	0.0%	2.6%						
NCCI	2.7%	50.4%	6.1%	50.0%	NR	9.2%	5.2%	19.0%						
Medicare reimbursement policies	41.8%	31.1%	92.9%	17.6%	NR	17.3%	57.3%	49.9%						
Payer-proprietary claim edits	54.1%	16.0%	0.4%	0.0%	NR	71.9%	33.0%	19.3%						
<b>Denials (Payer allows the physician's billed charge, but payment is \$0)</b>														
<b>Metric 12</b> Percentages of claim lines denied	6.80%	4.62%	3.44%	2.88%	3.88%	2.90%	2.68%	6.85%						
<b>Metric 13*</b> Reason codes  (Claim adjustment reason codes [CARC] given for denials out of 190 available reason codes.	<b>Aetna</b>		<b>Anthem BCBS</b>		<b>CIGNA</b>		<b>Coventry</b>		<b>Humana</b>		<b>UHC</b>		<b>Medicare</b>	
	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%
	<u>97</u>	65.8%	<u>16</u>	20.1%	<u>1</u>	37.6%	<u>26</u>	53.6%	<u>27</u>	34.2%	<u>27</u>	37.9%	<u>16</u>	27.8%
	<u>17</u>	7.8%	<u>27</u>	14.9%	<u>B11</u>	17.0%	<u>109</u>	11.5%	<u>109</u>	14.2%	<u>29</u>	17.5%	<u>50</u>	20.9%
	<u>1</u>	6.8%	<u>96</u>	11.8%	<u>96</u>	13.7%	<u>1</u>	6.6%	<u>B9</u>	9.7%	<u>1</u>	7.9%	<u>109</u>	13.8%
	other	19.6%	<u>31</u>	10.4%	<u>18</u>	5.7%	<u>29</u>	4.4%	<u>16</u>	9.4%	<u>204</u>	4.7%	<u>96</u>	8.5%
			<u>204</u>	8.9	<u>38</u>	5.5%	<u>197</u>	3.7%	<u>96</u>	5.9%	<u>96</u>	4.5%	<u>31</u>	5.8%
			<u>1</u>	7.7%	<u>17</u>	2.6%	<u>160</u>	3.1%	<u>26</u>	5.4%	<u>51</u>	3.0%	<u>49</u>	3.9%
			<u>109</u>	4.3%	other	17.8%	other	17.1%	<u>38</u>	4.9%	<u>26</u>	2.5%	other	19.3%
			<u>29</u>	3.7%					other	16.4%	<u>49</u>	2.5%		
		other	18.1%							other	19.6%			
<b>Metric 14*</b> Remark codes (RC) given for denials out of 675 available remark codes	<b>Aetna</b>		<b>Anthem BCBS</b>		<b>CIGNA</b>		<b>Coventry</b>		<b>Humana</b>		<b>UHC</b>		<b>Medicare</b>	
	RC	%	RC	%	RC	%	RC	%	RC	%	RC	%	RC	%
	<u>N19</u>	62.4%	<u>N197</u>	16.1%	<u>MA67</u>	83.1%	<u>N418</u>	37.4%	N/A		<u>N174</u>	59.2%	<u>N115</u>	16.2%
	<u>N130</u>	16.2%	<u>N4</u>	11.4%	other	16.9%	<u>N130</u>	11.0%			<u>M86</u>	13.1%	<u>M25</u>	15.0%
	<u>N102</u>	8.5%	<u>M81</u>	11.3%			<u>M127</u>	9.2%			<u>MA130</u>	8.2%	<u>N365</u>	10.2%
	other	12.9%	<u>N225</u>	9.7%			<u>N179</u>	9.2%			other	19.5%	<u>M27</u>	8.0%
			<u>N155</u>	7.3%			<u>N59</u>	9.2%					<u>N286</u>	6.0%
			<u>N179</u>	6.7%			<u>N29</u>	8.6%					<u>N285</u>	4.5%
			<u>M20</u>	5.6%			other	15.3%					<u>N269</u>	4.4%
			<u>M50</u>	5.6%									<u>N270</u>	4.4%
			<u>M51</u>	5.6%									<u>N290</u>	4.2%
			<u>M64</u>	5.6%									<u>M15</u>	4.0%
			other	15.1%									<u>M16</u>	2.8%
												other	20.2%	
The AMA NHIRC results are based on data pulled from the nationally mandated Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic standard transactions. The technical references for these transactions are the electronic remittance advice (ERA) (HIPAA ASC X12 835 Health Care Claim Payment/Advice Transaction) submitted to a physician in response to the receipt of an electronic claim submission (HIPAA ASC X12 837 Health Care Claim—professional transactions).														
* may not total 100% due to rounding error														

# 2008 National Health Insurer Report Card—Complete Metrics

## PAYMENT TIMELINESS

### **Metric 1—Payer claim received date disclosed**

Description: What percentage of time does the payer provide the date it received the claim (payer claim received date) in its electronic remittance advice (ERA) or explanation of benefits (EOB) response to the physician?

### **Metric 2—First remittance response time (median days)**

Description: What is the median time period in days between the date the physician claim was received by the payer and the date the payer produced the first ERA or EOB? If a payer did not provide the payer claim received date, the most current date of service that was reported on the claim was used to perform the calculation, as noted in the disclaimer.

### **Metric 3—ERA activity during the data period (We have chosen not to report at this time)**

Description: How many ERAs (one, two, three or more) does the physician receive for the same claim within the data period?

## ACCURACY

### **Metric 4—Allowed amount disclosed**

Description: On what percentage of records (lines on claims) does the payer provide the physician contracted rate (allowed amount) in its ERA response to the physician?

### **Metric 5—Contracted payment rate adherence**

Description: On what percentage of records does the payer's allowed amount equal the contracted payment rate?

## TRANSPARENCY OF CONTRACTED FEES AND PAYMENT POLICIES ON PAYER WEB SITES

### **Metric 6—Contracted fee schedule**

Description: Is the physician's contracted fee schedule (payer allowed amount) available on the payer's Web site?

### **Metric 7—Contract fee schedule codes allowed per request**

Description: If the contracted fee schedule is available on the payer's Web site, how many procedure codes are available per request?

### **Metric 8—Availability of payer proprietary code edits**

Description: If the payer uses proprietary code edits, are they available on the payer's Web site? Proprietary code edits are edits other than those found in one or more of the following: AMA Current Procedural Terminology<sup>1</sup> (CPT<sup>®</sup>), National Correct Coding Initiative (NCCI), Centers for Medicare and Medicaid Services (CMS) Publication 100-04 and the American Society of Anesthesia (ASA) Relative Value Guide.

### **Metric 9—Medical payment policies**

Description: Are the payer's medical payment policies available on its Web site?

## COMPLIANCE WITH GENERALLY ACCEPTED PRICING RULES

### **Metric 10—Percentage of claim lines (i.e., records) reduced by edits**

Description: On what percentage of records does the payer apply a claim edit that reduces the payment (allowed amount) of the line to \$0?

### **Metric 11—Source of claim edits**

Description: On what percentage of records is the source of the claim edit applied by the payer based on one or more of the following: CPT, NCCI, CMS Publication 100-04, ASA Relative Value Guide or payer proprietary edits?

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<sup>1</sup> CPT is a registered trademark of the American Medical Association.

## DENIALS

### Metric 12—Percentages of claim lines (i.e., records) denied

Description: What percentage of records submitted are denied by the payer for reasons other than a claim edit? A denial is defined as: allowed amount equal to the billed charge and the payment equals \$0.

### Metric 13—Reason codes (Claim Adjusted Reason Codes [CARC\*]) given for denials

Description: What are the most frequently reported reason codes for a denial?

Reason Code	Description	Effective Date	Modified Date
B9	Services not covered because the patient is enrolled in a Hospice.	1/1/1995	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	1/1/1995	
1	Deductible Amount.	1/1/1995	
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	6/30/2006
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). This change to be effective 4/1/2008: Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	9/30/2007
18	Duplicate claim/service.	1/1/1995	
26	Expenses incurred prior to coverage.	1/1/1995	
27	Expenses incurred after coverage terminated.	1/1/1995	
29	The time limit for filing has expired.	1/1/1995	
31	Claim denied as patient cannot be identified as our insured.	1/1/1995	
38	Services not provided or authorized by designated (network/primary care) providers.	1/1/1995	6/30/2003
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	1/1/1995	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	1/1/1995	
51	These are non-covered services because this is a pre-existing condition	1/1/1995	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	6/30/2006
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	1/1/1995	10/31/2006
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	1/1/1995	
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. This change to be effective 4/1/2008: Injury/illness was the result of an activity that is a benefit exclusion.	9/30/2003	9/30/2007
197	Payment adjusted for absence of precertification/ authorization.	10/31/2006	
204	This service/equipment/drug is not covered under patient's current benefit plan.	2/28/2007	

**Metric 14—Remark codes given for denials**

Description: What are the most frequently reported remark codes for a denial?

Remark Codes	Description	Effective Date	Modified Date
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1/1/1997	
M16	<b>Alert:</b> Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	1/1/1997	4/1/2007
M20	Missing/incomplete/invalid HCPCS.	1/1/1997	2/28/2003
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	1/1/1997	11/5/2007
M27	<b>Alert:</b> The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	1/1/1997	8/1/2007
M50	Missing/incomplete/invalid revenue code(s).	1/1/1997	2/28/2003
M51	Missing/incomplete/invalid procedure code(s).	1/1/1997	12/2/2004
M64	Missing/incomplete/invalid other diagnosis.	1/1/1997	2/28/2003
M81	Missing/incomplete/invalid provider/supplier signature.	1/1/1997	2/28/2003
M86	Service denied because payment already made for same/similar procedure within set time frame.	1/1/1997	6/30/2003
M127	Missing patient medical record for this service.	1/1/1997	2/28/2003
MA67	Correction to a prior claim.	1/1/1997	
MA130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	1/1/1997	2/28/2003
N4	Missing/incomplete/invalid prior insurance carrier EOB.	1/1/2000	2/28/2003
N19	Procedure code incidental to primary procedure.	1/1/2000	
N29	Missing documentation/orders/notes/summary/report/chart.	1/1/2000	8/1/2005
N59	<b>Alert:</b> Please refer to your provider manual for additional program and provider information.	1/1/2000	4/1/2007
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	10/31/2001	
N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at <a href="http://www.cms.hhs.gov/mcd">http://www.cms.hhs.gov/mcd</a> , or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.	5/30/2002	4/1/2004
N130	Consult plan benefit documents for information about restrictions for this service.	10/31/2002	4/1/2007
N155	<b>Alert:</b> Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	10/31/2002	4/1/2007
N174	This is not a covered service/procedure/equipment/bed; however, patient liability is limited to amounts shown in the adjustments under group "PR."	2/28/2003	
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	2/28/2003	

<b>Remark Codes</b>	<b>Description</b>	<b>Effective Date</b>	<b>Modified Date</b>
N197	The subscriber must update insurance information directly with payer.	2/25/2003	
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	8/1/2004	8/1/2005
N269	Missing/incomplete/invalid other provider name.	12/2/2004	
N270	Missing/incomplete/invalid other provider primary identifier.	12/2/2004	
N285	Missing/incomplete/invalid referring provider name.	12/2/2004	
N286	Missing/incomplete/invalid referring provider primary identifier.	12/2/2004	
N290	Missing/incomplete/invalid rendering provider primary identifier.	12/2/2004	
N365	This procedure code is not payable. It is for reporting/information purposes only.	4/1/2006	
N418	Misrouted claim. See the payer's claim submission instructions.	8/1/2007	