

Health insurers' report cards show need for improvement

Join the campaign to cure the ailing claims process

Diagnosing the problem

Physicians are spending as much as 14 percent of their total collections to obtain 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 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 consumers.

The American Medical Association's (AMA) **National Health Insurer Report Card** was created to provide physicians and the public with an objective and reliable source of information on the timeliness, transparency and accuracy of claims processing by the health insurance companies that are responsible for paying medical bills. These measures were selected because they are critical to the health care claims process, and provide actionable data which physicians and payers can use to improve the efficiency of billing and collections, thereby reducing overall health care costs to patients, physicians, employers, health insurers and other payers.

The AMA's remedy

Physicians continue to expend unnecessary resources to manage the basics of the revenue cycle, including spending excessive time on remittance advice reconciliation and follow up. This process can only be healed through increasing health insurer and other payer claims payment processing accuracy and transparency.

The AMA's National Health Insurer Report Card is one resource supporting the AMA's November Cure for Claims Month. The AMA's Cure for Claims Month is part of an ongoing campaign to heal the claims process. The campaign calls on both physicians and payers to do their part to eliminate waste in the claims process by getting it right the *first* time:

- We encourage **physicians** to submit timely and accurate claims the first time.
- We encourage **payers** to pay accurately and in a timely manner the first time, comply fully with the nationally mandated Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic standard transactions, and provide full transparency with respect to fee schedules, medical payment policies and other information necessary to maximize efficiency. An efficient payment process requires up-front notification of pricing, accuracy in payments and reduction of the ambiguity of adjustments through clear, specific reason and remark codes.

These steps would improve claims processing efficiency and help reduce physician practices' cost of submitting claims to the ultimate goal of 1 percent of collections.

National Health Insurer Report Card

Description

Health insurer selection

Medicare and the following seven national commercial health insurers were selected for the initial report card:

- Aetna
- Anthem Blue Cross and Blue Shield
- CIGNA Corp.
- Coventry Health Care
- Health Net Inc.
- Humana Inc.
- UnitedHealthcare

The health insurer was identified from the “payer name” field on the electronic remittance advice (ERA).

Data selection

The AMA National Health Insurer Report Card results are based on data pulled from electronic standard transactions. These transactions are reflected in the ERA (HIPAA ASC X12 835 Health Care Claim Payment/Advice Transactions) submitted to a physician in response to the receipt of an electronic claim submission (HIPAA ASC X12 837 Health Care Claim—professional transactions).

AMA Practice Management Center resource tip:

Visit the AMA Practice Management Center* Web site at www.ama-assn.org/go/pmc to access “Understanding the HIPAA Standard Transactions: The HIPAA Transactions and Code Set rule” for more information about HIPAA electronic standard transactions.

Data sources

Data has been obtained from the health insurers’ Web sites and supplemented by a database maintained by National Healthcare Exchange Services, a company located in Sacramento, California. National Healthcare Exchange Services’ database includes over 5 million services billed on over 3 million claims by the respective payers between the second half of 2007 and the first quarter of 2008. The database includes claims from over 7,500 practicing physicians representing 18 specialties from 195 practices in 20 states.

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

Sample size

An independent statistician engaged by the AMA employed standard, accepted statistical methods to: (1) determine the sample size for Medicare and for each of the commercial health insurers, (2) pull the random samples from the data source and (3) perform the statistical analysis of each report card metric.

Results from the National Health Insurer Report Card are posted for public viewing on a new Web site, www.ama-assn.org/go/cureforclaims.

AMA 2008 National Health Insurer Report Card 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 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 is used to perform the calculation as noted in the disclaimer.

Metric 3 **ERA activity during the data period**

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 did the payer's allowed amount differ from 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 complete 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 (CPT[®])[†], National Correct Coding Initiative (NCCI), Centers for Medicare & Medicaid Services (CMS) Publication 100-04 and 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?

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 payment equals \$0.

Metric 13 Claim Adjusted Reason Codes given for denials

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

Metric 14 Remark codes given for denials

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

[†] CPT is a registered trademark of the American Medical Association.

Prescription

Estimating the cost of a payer contract

The AMA's National Health Insurer Report Card objective is to encourage payers to pay both accurately and in a timely manner and to provide pricing transparency. In addition, this effort encourages physicians to understand the cost of a contract to their practices and to request and obtain the transparent, non-ambiguous electronic information they need from third-party payers in order to be paid accurately and efficiently.

Access to payer provider portals

Physicians are encouraged to consider automating their practices and fighting for what rightfully belongs to them. Physicians can sign up or visit each payer provider portal, as available, to access their contracted fee schedules, medical payment policies and claim edits that are applied to the physician's frequently billed procedures and services. Physicians should know the cost of their contract prior to signing, and not assume the payment they receive on a claim is accurate. Physicians should review their payments for accuracy and appeal any inappropriately underpaid, denied or delayed claims.

AMA Practice Management Center resource tip:

Visit the AMA Practice Management Center Web site at www.ama-assn.org/go/pmc to access links to the payers' provider portals and instructions on how to secure, if available, the physician's contracted fee schedule, claim edits and medical payment policies.

Automating the claims management revenue cycle

The "Cure for Claims" campaign urges **physicians** and their practice staff to integrate the HIPAA electronic standard transactions into their practices. These standards allow the practice to *electronically*:

- Verify patient eligibility
- Submit claims
- Receive payers' ERAs
- Receive claim payments
- Use other electronic standard transactions

Most importantly, the "Cure for Claims" campaign strives to hold **payors** accountable by calling for full transparency and accurate payment the *first* time a claim is submitted. Such transparency and accuracy will reduce unnecessary rework costs for the physician and the payer.

The "Cure for Claims" campaign also urges **payors** to adopt and fully implement the HIPAA electronic standard transactions and *electronically*:

- Provide expanded patient eligibility response
- Complete the key voluntary fields included in the ERA necessary for physicians to efficiently reconcile claims, and use accurate, specific reason and remark codes so that the physician easily can confirm whether an adjustment on a claim was indeed accurate

AMA Practice Management Center resource tip:

Visit the AMA Practice Management Center Web site at www.ama-assn.org/go/pmc to access “Understanding the HIPAA Standard Transactions: The HIPAA Transactions and Code Set Rule,” “Information technology solutions: Consider the potential savings” and “The benefits of electronic claims submission: Improve practice efficiencies” for more information on how to automate the claims management revenue cycle.

A cure is in sight

By committing to claims processing efficiency, we can dramatically reduce waste. If both physicians and payers use electronic transactions instead of manual ones for the estimated 3 billion claims submitted annually, the health care system can save over \$90 billion each year.

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.