Administrative Simplification in the Physician Practice
Private Sector Advocacy Update

Cost estimates of inefficient health care claims processing, payment and reconciliation are between $21 and $210 billion[1]. In the physician practice, this expense comprises 10-14 percent of practice revenue[2]. The administrative simplification objective within the physician practice is to encourage automated, real-time health plan transactions, along with the reduction of manual processes throughout the physician's claims management revenue cycle, and increased payer claim payment process transparency and reduced ambiguity. The AMA is committed to addressing and advocating for the following solutions to the ongoing problems in the claims management revenue cycle that contribute to increased complexity and expense. (Standardization of the claims process white paper)

Physician practice automation and real-time claims cycle processes

Unnecessary administrative costs can be reduced, if not eliminated, through increased automation, but increased automation can only occur if the current electronic standard claims transactions, supported by electronic patient eligibility verification and benefits, along with electronic physician payment and transactions acknowledgement, are enhanced and fully enforced. The value of electronic transactions can be most fully realized when completed in real time and are immediately available online, much like banking and shipping transaction information is available virtually instantly to consumers. The AMA has made specific recommendations on these standard transactions and rules, and supports multi-stakeholder efforts to standardize and streamline health care data exchange.

Electronic remittance advice

The HIPAA X12 835 remittance advice standard transaction must be reported to the highest specificity and be syntactically compliant. The electronic remittance advice (ERA) should clearly specify: the receiver of the transaction, primary payer (fiduciary) responsible for payment of the benefit, any applicable secondary payer responsible for payment, the payer or other entity holding the contract and the associated contractual fee schedule with the physician, the payer or other entity responsible for administering the patient's benefits and coverage and the specific patient benefit plan. 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. Most importantly, when an 835 is returned in real time (before the patient has left the office), physician practice staff have the ability to complete the claims management revenue cycle while the patient is still in the practice. Addressing claim denials, claim edits, or requests for additional information, is much less expensive to manage when both the physician and the patient are immediately available to expedite that process. Collecting any balances due from the patient while the patient is still in the office is enhanced when the claim's administrator has clearly adjudicated the claim and the balance owed is accurate rather than estimated. (Report 8 of the Council on Medical Service (I-11) Administrative Simplification in the Physician Practice) (Health Plan Identifier testimony to NCVHS)

[1] PNC Bank (2007), Commonwealth Fund (2007); RAND Corporation (2005), PricewaterhouseCoopers, 2008

[2] James G. Kahn, Richard Kronick, Mary Kreger and David N. Gans, "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals", *Health Affairs*, 24, no. 6 (2005): 1629-1639

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Eligibility verification
The ASC X12 271 Health Care Eligibility Benefit Response standard transaction must be reported to the highest specificity and must be made **binding. By binding, we mean that if the payer returns a 271 affirming that the patient has coverage (within a reasonable time of services being provided), the payer may not deny the claim for lack of coverage. The following information should be mandatory on the eligibility verification**: (1) the payer or other entity holding the contract and the associated contractual fee schedule identifier with the physician; (2) the payer or other entity responsible for administering the patient's benefits and coverage and the specific patient benefit plan; (3) claim benefit status, indicating whether each service is in-network or out-of-network for the specific patient encounter; (4) patient responsibility, remaining deductible and co-insurance for each specific procedure or service; and (5) the primary payer (fiduciary) responsible for payment of the patient's covered benefit and any applicable secondary payer responsible for payment.
(Report 8 of the Council on Medical Service (I-11) Administrative Simplification in the Physician Practice) (Health Plan Identifier testimony to NCVHS) (Committee on Operating Rules for Information Exchange (CORE) HIPAA mandated operating rules)

Fee schedules
Require health plans to provide physicians with online access and the ability to download complete physician and product-specific fee schedules by CPT code into their practice management systems. If physicians or their practice have negotiated their own fee schedule with the payer, the payer must provide a like kind fee schedule by CPT code as well. Both types of fee schedules must include the payer's rules for modifiers, bundled services, accumulators, or other similar data that impact reimbursements.
(AMA led ASC X12N 832 Health care fee schedule standard transaction)

Health care acknowledgements and claims status
The AMA also recommends that "health claims acknowledgements" be added to the list of HIPAA standard transactions, and specify that the standard shall be the ASC X12 TA1, 999, and 277CA. Further, this response must be sent on an **unsolicited** basis at each of the following points in the claims adjudication process: (1) Electronic claim receipt (affirmatively identifying each claim and its disposition up to being accepted for adjudication) by each clearinghouse, claims administrator, repricer or payer (TA1 and 999); (2) acceptance/rejection of electronic claim for adjudication (277CA); (3) electronic claim forwarded to another entity or returned as "unprocessable" (new functionality or part of TA1 and 999); and (4) electronic claim pended (in process, in review, requested information [waiting] (277U)). The benefits of such transactions are clear when considering the consumer experience in the package delivery industry. An individual can mail a package from anywhere in the country (indeed, the world) to any destination and track that package's status at each point along its journey. A tracking number allows consumers to check—in real time—when the package was placed on the loading dock, when it was put on the delivery vehicle, where it has stopped along the way, and, ultimately, when it was delivered to the recipient. The recipient is even able to acknowledge receipt of the item with a real-time electronic signature. The AMA, along with multiple stakeholders throughout the health care industry, believe that comparable efficiencies are achievable in the claims management revenue cycle through using and enhancing existing industry tools. The AMA further recommends that the TA1 and 999 be used as acknowledgements for eligibility, claims status, prior authorizations or any other ASC X12 transaction that it is appropriate to expect an acknowledgement from.
(The Acknowledgment Transaction Standard testimony to NCVHS)

Claims attachments
The AMA supports MGMA's recommendation to promulgate a final rule for the Electronic Claim Attachment standard by December 31, 2009. The lack of a standard format and requirements for electronic claim

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attachments contributes to higher administrative costs and complexity by increasing variation among attachment formats, increasing rework and resubmission of pended claims, and contributing to both payer and vendor reluctance to support such standardized, electronic attachments, impeding provider adoption. A Final Rule should not mandate the use of electronic claim attachments or allow payers to force physicians to implement the standard transactions. Physicians and the provider community must be able to implement the electronic transaction on a voluntary basis to meet their business needs. The AMA would also like to see the Physician's First report of injury attachment be standardized. A HIPAA first report of injury standard should be adopted as called for in Section 1173 of the Social Security Act in 1996.
(Claims Attachment Transaction testimony to NCVHS)

Prior authorization
The priority to obtain an effective prior authorization standard transaction and processes must be elevated in order to encourage all stakeholders to begin work together to identify ways to reduce the mostly manual prior authorization process endured by physicians today. AMA supports the identification of an effective standard transaction(s) and standard prior authorization forms that will be able to electronically pass the information necessary to automate and streamline the current manual prior authorization processes for medical and pharmaceutical services that will result in a reduction of the burden and costs to payers, formularies, physicians and their patients. For this process to be truly efficient, prior authorization responses must be timely.
(Standardization of prior authorization process for medical services white paper)

Electronic Funds Transfer process
The AMA would like to see all stakeholders in the claims billing and payment process recoup the estimated $11 billion that would be saved if EFT were adopted across the health care industry. However, the complete elimination of paper checks and paper remittance advice in favor of EFT and the ERA would require complete automation of the entire claims management revenue cycle. The full economic benefit of the EFT transaction will not be realized until: (1) all the EFT issues identified in this white paper have been resolved; (2) the electronic standard transactions are thoroughly examined to ensure the appropriate information can be transferred; and (3) consistent, widespread use of the standard transactions occurs. Standardization of EFT transaction and process includes the AMA recommendations to improve EFT practices and increase the value of an EFT standard transaction. (HHS EFT Interim Rule comments)

Adoption of a single binding companion guide
The AMA supports a single, binding, uniform Companion guide for each of the implementation guides for each standard transaction. The Companion guide should include the complete set of requirements, processes and operational rules necessary to electronically submit and receive each HIPAA standard transaction, and no augmentation by any of the trading partners should be permitted. To the extent that a 5010 transaction for future version is scheduled to take effect, these new companion guides should be developed for those transactions.

Transparency and disclosure

All payers must disclose **all** information necessary to determine the relative financial rights and responsibilities of payers and patients **prior** to the provision of a health care service. This goal is best achieved through a robust pre-determination of benefits transaction that would allow a physician or a medical consumer to submit CPT codes and diagnosis codes as if it were a claim to receive what the payer would do if the claim were submitted. Accurate coverage and out-of-pocket costs are now available before services are rendered. This includes full, complete transparency of the contract-specific payer fee schedule, medical payment policies, reimbursement rules, and other payment reductions. Until that is available, the AMA has developed a

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National Health Insurer Report Card (NHIRC) as a mechanism 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 health insurers. The 2009 report card expanded the metrics to include an expanded Transparency Survey. NHIRC data demonstrate that significant opportunity exists to increase transparency and disclosure of information necessary to determine patient and payer financial responsibilities. Specifically, the AMA recommends the following actions:

Designate CPT guidelines and conventions as a HIPAA Standard

The AMA recommends 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. (Standardization of CPT codes, guidelines and conventions)

Implement standard claim edits and payment rules

The implementation of standard claim edits and payment rules would establish a single claim processing system for payers, physicians and patients in the communication of why claims were paid, rejected, or adjusted. A standard claims processing system would not dictate any payer payment rates, medical rules, claim review or product benefit level or design. The standard claim edits and payment rules must be readily available and downloadable through easy online access as NCCI edits are available today. These standardized rules would permit PMS vendors and physicians to create automated workflow rules to manage most these responses that today require manual interventions.
(Standardized claim edits and payment rules testimony to NCVHS)

Standard pricing/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. Contracts should not include language that incorporates by reference other terms and conditions that are not provided to physicians, nor should rules be changed without notice to providers and that notice allows them to cancel their contract if the new terms are not acceptable. (Standardization of Pricing Rules testimony to NCVHS)

Implement 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

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provide physicians with easy online access and the ability to download claim edits from their Web sites. (Standardized claim edits and payment rules testimony to NCVHS)

Implement the Health Plan Identifier (HPID)
The AMA urges prioritization and adoption of a Health Plan Identifier (HPID) for each payer and other entity involved in the health care billing and payment process. The HPID should clearly specify who is: the receiver of the transaction, primary payer (fiduciary) responsible for payment of the benefit, any applicable secondary payer responsible for payment, the payer or other entity holding the contract and the associated contractual fee schedule with the physician, the payer or other entity responsible for administering the patient's benefits and coverage and the specific patient benefit plan. In addition the HPID should mandate secondary payers to automatically be billed by the primary payer allowing reconciliation of the Coordination of benefits issues prior to payment to the physician. (Health Plan Identifier testimony to NCVHS)

Implement the Standardized Health Care Identification card
The Medical Group Management Association's (MGMA) Project SwipeIT is a health care industry-wide initiative meant to advance the adoption of standardized patient identification (ID) cards containing WEDI-compliant, machine-readable information. Nonstandardized patient ID cards contribute to waste and rework in physician offices, and the AMA supports efforts to standardize the current industry effort to create machine-readable health insurance identification cards and has included this message in its administrative simplification agenda. The patient ID card is one of the first steps to streamline the cumbersome process of the claims management revenue cycle, and addressing the problems stemming from the current nonstandardized ID card will support the effort to automate the claims management revenue cycle.

HIPAA Transaction and Code Set Enforcement
The success of the standardization of and automation of the claims management revenue cycle is based on increased enforcement and robust requirements for the HIPAA standard transactions. The AMA recommends the following steps be taken to increase enforcement of the HIPAA Transactions and Code Sets (TCS) rule: (1) clarify that standard transactions require both correct syntax and information that accurately reflects the circumstances, which are reported at the greatest level of specificity that the transaction and related code sets permit; (2) increase CMS' enforcement resources, including resources to conduct compliance audits, and (3) give states concurrent enforcement jurisdiction for the HIPAA TCS rules. (**HIPAA Enforcement Final Rule**)

Practice management solutions

The AMA, in concert with Federation members, will continue to advocate on behalf of its members for legislative relief and industry collaboration towards solutions to administrative complexity. We also believe that there is power within the physician practice to impact the performance of the claims revenue cycle and provide the following resources to its members to leverage that power. The AMA's Practice Management Center contains these important tools, including the administrative simplification resources below:

"Heal the Claims Process"™ campaign and practice automation resources
The AMA "Heal the Claims Process"™ campaign's goal is to help physician practices streamline and automate their practices by providing resources about using electronic health care transactions. The campaign provides physician practices with toolkits and educational webinars about practice automation.

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