

Diagnosis and Cure for the Broken Claims Process

AMA

Tammy Banks

*Practice Management Center and Payment
Advocacy - Private Sector Advocacy*

American Medical Association



Administrative waste is rampant.

- \$20 billion per year?
- \$40 billion per year?
- \$200 billion per year?
- Could the system be restructured to reduce the average physician cost of billing and collections from 10% to 1% of gross revenue?

Getting to 1%

Transparency & Standardization

- Complete fee-schedule electronically
- Standard claim edits
- Standard payment rules
- Electronic claims acknowledgment
- Complete EOBs/RAs - Specific reason codes, Allowed amount, Network name

Accuracy

- 99+% first-pass pay accuracy rate?

Timeliness





AMA National Health Insurer Report Card— What is it?

Objective & Actionable

- Standardized measurements of the claims processing activities of Medicare and the major national health insurers
- Federally mandated HIPAA electronic standard transactions
 - X12N 837 (claim) &
 - X12N 835 (remittance advice)

National Health Insurer Report Card— What data did we use?

- 7,500 physicians' EDI files
- 5 million services
- 3 million claims
- 3Q 2007 – 1Q 2008
- 20 states
- 18 specialties
- 195 practices

National Health Insurer Report Card— Who helped us?



Mark Rieger — CEO National Healthcare Exchange Services (NHXS)

Frank Cohen — Senior Analyst, CPA Health Partners

PAYMENT TIMELINESS

Metric 1 Results

Payer claim received date disclosed

Aetna	100.00%
Anthem BCBS	99.21%
CIGNA	0.00%
Coventry	100.00 %
Health Net	99.76%
Humana	.07%
UnitedHealthcare (UHC)	99.98%
Medicare	99.99%

PAYMENT TIMELINESS

Metric 2 Results

First remittance response time
(median days)

Aetna	13 days
Anthem BCBS	7 days
CIGNA	14 days
Coventry	4 days
Health Net	11 days
Humana	13 days
UHC	10 days
Medicare	14 days

PAYMENT TIMELINESS - LESSONS

- Prompt pay laws appear to have been effective in at least ensuring a relatively quick response to a physician's electronic claim.
- Some health insurers still need to report to physicians the date a claim was received by the insurer. While health insurers are not required by law to report the date the claim was received, it is necessary information for physicians to track compliance with state prompt pay laws.

ACCURACY

Metric 4 Results

Allowed amount disclosed

Aetna	97.77%
Anthem BCBS	97.37%
CIGNA	19.25%
Coventry	99.30%
Health Net	65.72%
Humana	97.33%
UHC	93.40%
Medicare	98.53%



ACCURACY

Metric 5 Results

Payment consistency (contracted payment rate adherence)

Aetna	70.78%
Anthem BCBS	72.14%
CIGNA	66.23%
Coventry	86.74%
Humana	84.20%
UHC	61.55%
Medicare	98.12%

ACCURACY — LESSONS

- It is possible to get it right — Medicare scored 98%.
- Health insurers have a ways to go — they provided physicians with the correct contracted rate only 62–87% of the time.
- Additional analysis will be necessary to determine how often these errors were tied to inaccurate payment. When health insurers report an amount that does not adhere to the contracted rate, it adds additional, unnecessary costs to the physician practice to evaluate the inconsistency.





TRANSPARENCY OF CONTRACTED FEES AND PAYMENT POLICIES



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-specific code edits

Description: If the payer uses payer-specific code edits, are they available on the payer's Web site?

Metric 9 - Payment policies

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

TRANSPARENCY OF CONTRACTED FEES AND PAYMENT POLICIES – LESSONS

The Medicare program far exceeds the health insurers in providing physicians with the transparency necessary to an efficient claims processing system.

Need for a single standard, not single payer



COMPLIANCE WITH GENERALLY ACCEPTED PRICING RULES

Metric 10 Results

Percentage of claim lines (i.e., records) reduced by edits

Aetna	3.75%
Anthem BCBS	3.40%
CIGNA	7.33%
Coventry	0.31%
Humana	3.17%
UHC	9.15%
Medicare	1.40%

COMPLIANCE WITH GENERALLY ACCEPTED PRICING RULES

Metric 11 Results

Source of payer claim edits

	CPT	ASA	NCCI	MRP	Payer-Specific
Aetna	1.4%	0%	2.7%	41.8%	54.1%
Anthem	2.5%	0%	50.4%	31.1%	16.0%
CIGNA	0.6%	0%	6.1%	92.9%	0.4%
Coventry	32.4%	0%	50.0%	17.6%	0.0%
Humana	1.5%	0%	9.2%	17.3%	71.9%
UHC	4.5%	0%	5.2%	57.3%	33.0%
Medicare	9.2%	2.6%	19.0%	49.9%	19.3%

COMPLIANCE WITH GENERALLY ACCEPTED PRICING RULES— LESSONS

- Wide variation among payers on how often they apply edits to reduce payments: < 0.5% to > 9%
- Payers also varied on how often they use proprietary rather than public edits to reduce payments: 0 to nearly 72%
- Undisclosed proprietary edits add administrative costs to reconcile claims.

DENIALS

Metric 12 Results

Percentage of claim lines (i.e., records) denied


Aetna	6.80%
Anthem BCBS	4.62%
CIGNA	3.44%
Coventry	2.88%
Health Net	3.88%
Humana	2.90%
UHC	2.68%
Medicare	6.85%



DENIALS – Reasons/Remarks



Metric 13 – Claim Adjustment Reason codes (CARC) given for denials

- 
- 190 possible reason codes
 - 20 codes for top 80%: 1, 96, 109, 16, 26, 27, 29, 17, 31, 38, 49, 204, 18, 50, 51, 97, 160, 197, B11, B19



Metric 14 - Remark codes given for denials

- 675 possible remark codes—only 31 used for 80%
- Only two used more than once: N130 and N179

DENIALS – LESSONS

- Wide variation in how often health insurers simply pay nothing in response to a physician claim: < 3%– nearly 7%
- Wide variation in the reasons given by the payers for the denials
- Are the different payers using different reasons and combinations of reasons to describe similar results? Lack of standardization increases the physician's re-work costs.



Report Card Summary

The report card demonstrates the inconsistency and confusion that results from each health insurer using different rules for processing and paying medical claims. This variability requires physicians to maintain a costly claims management system for each health insurer.



Report Card Summary (cont.)

- Both physicians and health insurers can help reduce costs if electronic transactions and full transparency are widely adopted.
- Rework can be reduced if health insurers make better use of explanatory reason and remark codes and key voluntary fields in electronic transactions to communicate crucial information to physicians about their claims.



AMA's Health Insurer Report Card—What's next?

- Engage physicians, payers and the healthcare industry to work towards increasing efficiency
- Push for standardization of the claims process
- Decrease current administrative expense for all partners in the claims revenue cycle.
- **Join the “Healing the claims process” Campaign**



Be part of the solution - Commit to claims processing efficiency - Join the campaign

National Health Insurer Report Card

- “Heal that Claim” Campaign

www.ama-assn.org/go/healthatclaim

- Resource Library -

www.ama-assn.org/go/pmc

- Questions: Email

practicemanagementcenter@ama-assn.org



