REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (I-11)
Administrative Simplification in the Physician Practice
(Reference Committee J)

EXECUTIVE SUMMARY

In its ongoing effort to address health care costs that do not contribute to the value of care, the Council presents this report to highlight American Medical Association (AMA) advocacy efforts and successes, as well as opportunities for physician practices. Cost estimates of inefficient health care claims processing, payment and reconciliation are between $21 billion and $210 billion per year. In the physician practice, this expense comprises 10–14 percent of practice revenue. The administrative simplification objective within the physician practice is to move from manual processes to automated, real-time health plan transactions throughout the physician's claims management revenue cycle, including increased payer transparency and clarity of the claim payment process. The AMA is committed to addressing and advocating for solutions to the ongoing problems in the claims management revenue cycle that contributes to increased complexity and expense.

In particular, prior authorization continues to be a concern to patients and physicians. The Council highlights the work of two AMA multi-stakeholder work groups that are addressing the current prior authorization burden placed on physicians. The first work group is focused on streamlining prior authorization for medical services, while the second is focused on pharmacy prior authorizations. These work groups are housed under the Practice Management Federation Staff Advisory Steering Committee.

Additionally, this report reinforces the importance of selecting the correct practice management software—particularly now that all physician practices that wish to use electronic transactions must do so in compliance with the new standards for these transactions, known as HIPAA Version 5010, effective January 1, 2012. Physician practices must also comply with the ICD-10 coding standard the following year by October 1, 2013. The Council believes that vendors must increase their efforts to provide the automated functionality for physician practices, which are currently encumbered by manual processes.

The Council believes it is critical for all stakeholders to collaborate to obtain an effective and timely prior authorization standard transaction and reduce the mostly manual process physicians endure today, and presents policy recommendations to advance these activities.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-I-11

Subject: Administrative Simplification in the Physician Practice

Presented by: Thomas E. Sullivan, MD

Referred to: Reference Committee J
(Barbara J. Arnold, MD, Chair)

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In its ongoing effort to address health care costs that do not contribute to the value of care, the Council presents this report to highlight AMA advocacy efforts and successes, as well as opportunities for physician practices. Additionally, this report reinforces the importance of selecting the correct practice management software—particularly now that all physician practices that wish to use electronic transactions must do so in compliance with new standards effective January 1, 2012. The report includes recommendations for engaging vendors to streamline prior authorization and advance administrative simplification.

BACKGROUND

As adopted in 1996, HIPAA included a chapter entitled "Administrative Simplification," (HIPAA, Title II, PL 104-191) designed to encourage transmission of confidential health care data electronically. The relevant implementing HIPAA regulations appear in four interlocking rules governing: 1) Privacy; 2) Security; 3) Unique Identifiers; and 4) Uniform Electronic Transactions and Code Sets (TCS). Unfortunately, the administrative simplification expected from these Final Rules has not been fully realized. This report focuses on the unique identifiers and uniform electronic transactions and code sets. For more information, the educational document "Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set Rule" can be found online at http://www.ama-assn.org/resources/doc/psa/hipaa-tcs.pdf.

AMA POLICY

Council on Medical Service Report 8-A-07 recommended four broad strategies to address rising health care costs, including reducing non-clinical health system costs that do not contribute value to patient care (Policy H-155.960[2,c], AMA Policy Database). In addition to the broad strategy of addressing rising health care costs by reducing non-clinical expenses, Policy H-155.960 specifically states that the AMA "will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue

administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors."

Council on Medical Service Report 4-I-10 established policy supporting the simplification and standardization of the preauthorization process for physicians and patients; the adoption of a standardized paper preauthorization form by health plans for those physicians who choose to submit paper preauthorization forms; the publication and required adoption of HIPAA electronic standard transactions by health plans; the encouragement of physician adoption of HIPAA electronic standard transactions; and efforts to develop clear and complete requirements for each HIPAA electronic standard transaction (Policy H-320.944).

In addition, Policy D-450.980[2,3] advocates that the AMA continue to work with accrediting bodies and government agencies to substantially reduce hospital paperwork; and continue to work with electronic health record (EHR) system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine.

AMA ADVOCACY

The AMA identified administrative simplification prerequisites to achieve administrative savings, several of which were included in the Patient Protection and Affordable Care Act (ACA, PL 111-148). The ACA will further increase the use of electronic transactions with the required adoption of electronic transaction standards and operating rules including:

- operating rules for each of the HIPAA mandated transactions;
- a unique, standard health plan ID (HPID); and
- a standard and operating rules for electronic funds transfer (EFT), electronic remittance advice (ERA) and claims attachments.

In addition, the ACA requires health insurers to certify their compliance with published standards and associated operating rules for electronic transactions and imposes substantial penalties for health plan failures to comply starting on April 1, 2014 and annually thereafter.

Unnecessary administrative costs can be reduced, if not eliminated, through increased automation. However, increased automation can only occur by enhancing and enforcing the current electronic standard claims transactions for electronic patient eligibility and benefits verification, electronic physician payment and electronic transaction acknowledgements. The value of electronic transactions can be most fully realized when they are 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 been actively engaged with multiple stakeholders in the implementation of the ACA's administrative simplification provisions. The AMA has testified on multiple occasions before the National Committee on Vital and Health Statistics (NCVHS), an advisory body to the US Department on Health and Human Services (HHS) making specific recommendations on standard transactions and rules. In addition to NCVHS, the AMA has worked closely with the standard setting bodies and other organizations to ensure the remaining prerequisites become a

reality. These organizations include: ASC X12N Accredited Standards Committee (Insurance branch ASC X12N), which develops standards for administrative transactions to facilitate electronic data exchange in the health care industry; Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), an industry-wide stakeholder collaboration to facilitate the development and adoption of industry-wide operating rules for administrative transactions; and the Workgroup on Electronic Data Interchange (WEDI), an advisory body to the Secretary of Health and Human Services.

A summary of the AMA's significant administrative simplification efforts regarding enhancing eligibility verification and ERAs, downloadable fee schedules, health claims acknowledgements and status, claims attachments and first report of injury, prior authorization, a single binding companion guide, transparency and disclosure, standard claim edits and payment rules, a unique HPID , standardized health care identification card, vendor engagement and HIPAA transaction and code set enforcement and the resulting accomplishments follows:

Enhancing eligibility verification and electronic remittance advice: The most common reason for denials relates to eligibility. The AMA advocates that the health care eligibility benefit response standard transaction (ASC X12N 271) must be reported by payers to the highest specificity and must be binding. Likewise, the ERA standard transaction (HIPAA X12N 835) must be reported to the highest specificity and be syntactically compliant. AMA advocacy has resulted in the following improvements in the ERA standard transaction (Version 5010 of the ASC X12N):

- The allowed "amount" field for the placement of the contracted payment rate is required.
- Line item balancing is required.
- The "claim received" date is required whenever state or federal regulations or the physician's contract mandate interest payment or prompt payment discounts based on the date the payer received the claim.

AMA advocacy has resulted in the placement of fields and instruction to allow the following information to be included in the eligibility response and ERA standard transactions (Version 6020 of the ASC X12N, which is being finalized for comment by the end of 2011):

- the receiver of the transaction;
- the primary payer (fiduciary) responsible for payment of the benefit;
- the entity holding the contract and the associated contractual fee schedule with the physician;
- the entity responsible for administering the patient's benefits and coverage; and
- the specific patient benefit plan.

The AMA is awaiting the release of the Centers for Medicare & Medicaid Services (CMS) interim final rule regarding the HPID to determine whether each of the above entities will be able to obtain an HPID to include in these standard transactions or will need to use the Federal Tax ID. These changes will enable full transparency of all health insurer intermediaries, which will finally make it possible for physicians to handle eligibility and claims issues without having to pick up the phone or be put on hold.

Reason and remark codes allow practice work flows to be automated with claim review occurring on an exception basis. The AMA has advocated and is working with ASC X12N to create a crosswalk for the application of specific reason and remark codes to be placed on ERAs. In addition, CAQH CORE is developing operating rules to standardize the reason and remark codes,

which are critical to physician practices. Physicians and their practice staff can access the AMA's claim management assistant at www.ama-assn.org/go/claims-assistant, which provides recommended work flows.

Downloadable fee schedule: The AMA has been working with payers and vendors to raise awareness of the cost savings available if a downloadable contracted fee schedule standard transaction would be made available and implemented nationwide. Payers would be able to send a specific fee schedule to a physician practice that could be downloaded from the payer website or other secure access point and then uploaded into the practice management system at the time the contract is signed, reducing any ambiguity about contracted rates. The AMA advocates that health plans must be required to provide physicians with online access to and the ability to download their complete contracted fee schedules from the payer, broken down by product and CPT code. Downloadable fee schedules must be in a version that physicians can easily incorporate into their practice management systems and must include the payer's rules for modifiers, bundled services, accumulators and other similar data impacting payments. As a result of AMA advocacy, the Version 6020 of the ASC X12N eligibility and ERA will contain a designated field to pass an agreed-upon fee schedule identifier between payers and physician practices.

Health claims acknowledgments and status: The AMA recommends that health claim acknowledgements be added to the list of HIPAA standard transactions. 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 world to any destination and track that package's status at each point along its journey, and acknowledge receipt of the item with a real-time electronic signature. The AMA recommends specific standards be used as acknowledgements as appropriate for eligibility, claims status, prior authorizations or any other ASC X12N transaction when an acknowledgement is appropriate. In April 2011, the AMA provided testimony to the NCVHS regarding the need for the acknowledgement standard transactions to be mandated under HIPAA. Unfortunately, CMS did not include this recommendation in its interim final rule for operating rules. Accordingly, the AMA has formally requested that CMS, through NCVHS, require these transactions under HIPAA.

Claims attachments and first report of injury: The AMA supports the ACA provision requiring the electronic claim attachment standard. The lack of a standard format and requirements for electronic claim attachments has contributed to higher administrative costs and complexity. Format variation increases rework and resubmission of pended claims, and contributes to payer and vendor reluctance to support standardized, electronic attachments, which in turn impedes physician adoption. Physicians and the provider community must be able to implement the electronic transactions on a voluntary basis to meet their business needs. The AMA advocates that the physician's first report of injury standard attachment should be adopted as called for in Section 1173 of the Social Security Act in 1996.

The AMA is working with the National Association of Insurance Commissioners (NAIC) and others to educate physicians and their practice staff about the ability to use electronic billing when performing workers' compensation claims. North Carolina is the most recent state to have a workers' compensation e-billing law, joining California, Texas and Minnesota as leaders in this effort. The claims attachment standard transaction has been used in workers' compensation for several years and will serve as a model to move the claims attachment rule forward. The AMA is creating a workers compensation resource center that will contain access as available to each state's workers compensation fee schedule, physician's first report of injury and other instructions. In addition, a workers compensation toolkit and archived webinar will be made available to assist physicians wanting to use electronic transactions for workers compensation claims.

Single binding companion guide: The AMA supports a single, binding, uniform companion guide for each standard transaction that includes the complete set of requirements, processes and operational rules necessary to electronically submit and receive each HIPAA standard transaction.

CMS selected the entities to develop operating rules for the eligibility and claims status transactions: CAQH CORE for medical services and National Council for Prescription Drug Programs (NCPDP) for pharmaceutical services. The AMA is an active participant of the CAQH CORE efforts as well as ASC X12N's efforts to create meaningful operating rules to increase the effectiveness of the ASC X12N standard transactions, which includes transactions such those for eligibility and ERA. The ACA requires that operating rules are certified and imposes increased health insurer enforcement fines. Accordingly, the adoption of the following standard transactions should increase in the near term:

- Eligibility and claims status will take effect by January 1, 2013.
- Electronic funds transfer (EFT) and health care payment and remittance advice are to be adopted no later than July 1, 2012, to take effect by January 1, 2014. Health care providers, including physicians, must also comply with EFT standard for Medicare payments by January 1, 2014.
- Professional claims are to be adopted by July 1, 2014, and take effect by January 1, 2016
- Enrollment/disenrollment in a health plan standards are to be adopted by July 1, 2014, and take effect by January 1, 2016.
- Health plan premium payment standards are to be adopted by July 1, 2014, and take effect by January 1, 2016.
- Referral certification and authorization are to be adopted by July 1, 2014, and take effect by January 1, 2016.

Real-time payment determination: A robust pre-determination of benefits transaction would allow a physician or a medical consumer to submit CPT codes and diagnosis codes as if they were claims to receive a response indicating what the payer would do if such claims were submitted. While accurate coverage and out-of-pocket costs are now available before services are rendered, a robust pre-determination of benefits transaction would include complete transparency of the contract-specific payer fee schedule, medical payment policies, reimbursement rules and other payment reductions. Until such information is available, the AMA has developed a National Health Insurer Report Card (NHIRC) to provide physicians and the public with a reliable and defensible source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by health insurers. NHIRC data demonstrate that significant opportunity exists to increase transparency and disclosure of information necessary to determine patient and payer financial responsibilities.

Standard claim edits and payment rules: The Colorado Medical Society was instrumental in passing state legislation that mandates the creation of a standard set of claims edits and payment rules. The AMA participates in the Colorado "clean claims task force" established by the legislation, along with the Colorado Medical Society, the major Colorado health insurers (UnitedHealthcare, Aetna, Anthem [WellPoint], Kaiser Permanente and Rocky Mountain Health Plan), a number of physician and hospital groups, and the two major claims edit software developers, McKesson and Optum (formerly Ingenix). Guiding principles for the task force to consider have been drafted with national medical specialty society input. Visit www.ama-assn.org/go/simplify for more information on these efforts.

Health plan ID: The AMA urges prioritization and adoption of a HPID for each payer and other entity that conducts health care billing and payment. The AMA provided NCVHS with testimony that the HPID should be required to be contained on the eligibility and ERA response to indicate each role an entity is performing in the claims process. In addition, the HPID should mandate secondary payers to automatically be billed by the primary payer, allowing coordination of benefits prior to payment to the physician. In turn NCVHS has submitted a HPID recommendation to HHS for consideration that included many of the above recommendations. AMA continues to work closely with the HHS to maximize our effectiveness with the standard setting bodies, including X-12 and WEDI.

Standardized health care identification card: The HPID is believed to be necessary to engage the health care industry in standardizing health care identification cards for patients as well. At the request of the Federation, UnitedHealthcare has developed a standardized identification card and has included language to identify when UnitedHealthcare is serving as an administrative service organization for a self-insured health insurer verses serving as a fully insured health insurer. This information allows physician practices to better understand which contract provisions pertain to a specific patient's visit as well as what remedies are available if the insurer fails to follow state laws and regulations.

HIPAA TCS enforcement: The success of the standardization and automation of the claims revenue cycle is based on increased enforcement and robust requirements for the HIPAA standard transactions. The AMA recommends the following to increase enforcement of the HIPAA TCS rule: (1) clarify that standard transactions require both correct syntax and information that accurately reflects the circumstances, reported at the greatest level of specificity permitted; (2) increase CMS' enforcement resources; and (3) give states concurrent enforcement jurisdiction for the HIPAA TCS rule. In addition, the ACA requires health plans to file a certification statement with HHS certifying that their data and information systems are in compliance with the standards and operating rules including standards and operating rules for EFT, eligibility, claim status and health care payment/remittance advice transactions, claims or equivalent encounter information, health plan enrollment/disenrollment, health plan premium payment, referral certifications, authorizations, and health claims attachments. The ACA also requires HHS to conduct periodic audits to ensure that health plans are in compliance with standards and operating rules. The ACA further requires HHS to assess a penalty fee against a health plan that fails to comply with the administrative simplification certification and requirements starting in April 1, 2014 and annually thereafter.

Vendor engagement: To raise vendor engagement in the administrative simplification discussion, the AMA held a vendor engagement meeting comprised of key industry stakeholders in Chicago in September 2011. Representatives from CMS, ASC X12N, CAQH CORE, WEDI, MGMA and various national provider organizations and members were also expected to be in attendance. The AMA is creating a collaborative, continuing forum focused on increasing the efficient use of practice management systems within all segments of the health care system. A key goal for the vendor engagement meeting was to obtain senior leadership commitment to engage their organizations in this industry-wide collaborative process.

The AMA is addressing how practice management vendors can leverage standards, workflow rules, and common approaches to enhance product functionalities and optimize administrative simplification opportunities.

Prior authorization: It is critical for all stakeholders to collaborate to obtain an effective and timely prior authorization standard transaction and reduce the mostly manual process physicians

endure today. The AMA supports the identification of an effective standard transaction and standard prior authorization form that will enable electronic communication of the information necessary to automate the prior authorization processes for medical and pharmaceutical services. In 2010, the Federation Payment Policy Workgroup prepared a prior authorization physician survey, covering both medical and prescription drug services. Eleven state and national medical associations distributed the survey from May through June and the AMA sent the survey to its members in June.

In November, 2010, the results of the prior authorization survey were released, with 2,400 physician respondents. The survey quantified the burden of insurer's prior authorization requirements for a growing list of routine tests, procedures and drugs and indicated that prior authorization requirements have delayed or interrupted patient care, consumed significant amounts of time, and complicated medical decisions. The results also showed that this process is often a confusing and manual one.

The AMA has convened two workgroups to address prior authorization for medical services and for pharmacy. Each workgroup includes members of the Federation Payment Policy Workgroup and several national health insurers. The medical services workgroup composed ten questions physicians must answer when seeking prior authorization. NaviNet, a health care communications network and technology company, has agreed to work on a pilot for automating the prior authorization process using the ten questions. This pilot is set to be unveiled to the workgroup in the fall of 2011.

The pharmacy workgroup which includes key pharmaceutical leaders, has agreed to identify areas related to the pharmaceutical prior authorization process within their organizations and the industry that can be streamlined. With the identification of these key areas, the workgroup can now explore potential strategies to simplify the prior authorization process for pharmaceutical services.

DISCUSSION

The Council believes that the advocacy described and the improvements envisioned in this report will result in a reduction of the burden and costs to patients, physicians, payers and formularies. Practice management system and other vendors must become engaged in the administrative simplification debate and provide physician practice solutions that include the functionality necessary for a physician practice to automate its claims cycle. Vendors must increase their efforts to provide the automated functionality that is sorely needed by the physician practice, which is currently bogged down in manual processes. Many practice management systems and EHRs with integrated practice management systems do not provide the software features and functionalities that are essential for the physician practice to ensure automated claims revenue cycle management. Therefore, the Council recommends that vendors of practice management systems and EHR systems with an integrated practice management system be encouraged to provide the solutions necessary to automate the claims management revenue cycle and the additional critical functionality as more fully described in the AMA and MGMA "Selecting a Practice Management System" toolkit, which will ensure automation of claims revenue cycle by incorporating the new opportunities available through the AMA successes as identified previously in this paper that include additional transparency and clarity of the entities involved in the claims revenue cycle in the eligibility and ERA. The Council views the AMA and MGMA toolkit as complementary to AMA policy regarding increasing value in the health care system.

The Council believes that the greatest administrative burden impacting physicians is the current manual and intrusive prior authorization process. Accordingly, the Council also recommends the

AMA continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process. All stakeholders must collaborate to obtain an effective and timely prior authorization standard transaction and reduce the mostly manual process physicians endure today.

RECOMMENDATION

The Council recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association strongly encourage vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle. (Directive to Take Action)

2. That our AMA continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process. (Directive to Take Action)

Fiscal Note: Staff cost estimated at $1,914 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.