National Committee on Vital and Health Statistics
Subcommittee on Standards

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TESTIMONY OF THE AMERICAN MEDICAL ASSOCIATION

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Standard Claim Edits and Payment Rules

The American Medical Association (AMA) would like to thank the National Committee on Vital and Health Statistics' (NCVHS) Standards Subcommittee (Subcommittee) for the opportunity to provide our comments on claim edits and payment rules. The AMA is committed to eliminating administrative waste in the health care delivery system. Cost estimates of inefficient health care claims processing, payment and reconciliation are between $21 billion and $210 billion. In the physician practice, the claims management revenue cycle consumes an unsustainable 10-14 percent of practice revenue. The complexity and lack of transparency in the current system is becoming increasingly problematic for patients as well, who are being asked to shoulder more and more financial responsibility for health care services. Today, it is difficult if not impossible for patients to anticipate the specific, potentially significant financial obligation they may incur in conjunction with the health care services they obtain.

Because of the complexity of the current pricing system for physician and other health care professional[1] claims, price transparency depends upon the disclosure of the three separate components that go into the repricing of physician claims:

1. the product and contract-specific fee schedule;
2. the claim-edits; and
3. the pricing rules.

See AMA's testimony on standardization of pricing rules for further elaboration on these three components.

Unfortunately, except with respect to the Medicare program, none of these three elements are routinely disclosed in the current environment. Thus, neither physicians nor patients can predict what payments will be until the electronic remittance advice/explanation of benefits is received, and even then there is no easy way to validate the accuracy of the payment. Moreover, those commercial companies that have attempted to maintain ongoing, updated catalogues of each payer's claim edits and pricing rules report the need to commit several full-time staff to this effort, resources which are clearly not available to the vast majority of physician practices.

[1] CPT® 2009, instructs any procedure or service in the CPT book may be used to designate the services rendered by any qualified physician or other health care professional.

The current opaque and unduly complex pricing system is simply unmanageable for patients and most physician practices. Standardized claim edits would remove a large element of the ambiguity and complexity of this process, further enabling the adoption of point-of-service pricing. A standard claim edit set would not interfere with the ability of health plans or their agents to negotiate fee-schedules or otherwise limit contractual arrangements or terms that could be negotiated with health care providers. Nor would standardized claim edits dictate benefit plan design or medical policies.

Historical perspective

Since the first code-editing software was implemented in the early 1990s, a host of things have changed. The Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) has developed a robust catalogue of nearly 1 million claim edits that all trading partners can access and download into their practice management systems or repricing engines without charge. Auditing for outliers is increasingly addressed through sophisticated data analytic programs, such as FAIR ISAAC uses for credit card fraud. All trading partners are encouraged to bring ambiguities and concerns regarding CPT codes and definitions to the CPT Editorial Panel, where code change proposals are considered in an open process and where the CMS, America's Health Insurance Plans (AHIP), and the Blue Cross Blue Shield Association (BCBSA) all have official representatives. And last—but certainly not least—the patient's financial responsibility for health care services has increased dramatically. This shift toward patient responsibility has placed an increased urgency for real-time adjudication of claims, to ensure both that patients can manage their bills and that physicians and other health care professionals can keep the cost of collections to manageable levels by billing at the time of service. The variation in claim edits across payers makes little sense in this environment and indeed is adding complexity and cost that is counterproductive.

Any doubt as to the business case for a standard set of code edits that would be applied industry wide is eliminated by consideration of the most recent results from the AMA's 4th annual National Health Insurer Report Card (NHIRC) on the claims processing and claim edit activities of the nation's largest health insurers which was published in June 2011.[2] The 2011 NHIRC demonstrates both the administrative burden physician practices are experiencing due to the large number of $0 payments each of which physician practices typically evaluate manually, and the significant reduction in this burden which would result from a standard code edit set.

Impact of $0 payments

Cash flow metric 2B was added to the NHIRC in 2011 in response to complaints from physician practices that the "denials" reported in the NHIRC were extremely low compared to their experience. Many physician practices use the term "denial" in a less precise fashion than that used in the NHIRC to mean every service for which the practice received $0. The NHIRC, on the other hand, distinguishes "denials" from other sorts of $0 payments and uses the term to refer only to those $0 payments where the "allowed amount" is equal to the "billed charge."

Metric 2B is designed to reflect this more global zero payment experience by measuring the percentage of claims that were filed, but for which the payer paid $0. Because of the lack of transparency, accuracy, and standardization of the current claims payment process, a $0 payment is a sentinel event, and every physician practice will analyze the appropriateness of each and every $0 payment. Thus, the "cash flow" metric has great saliency with physician practices as a measure of administrative burden.

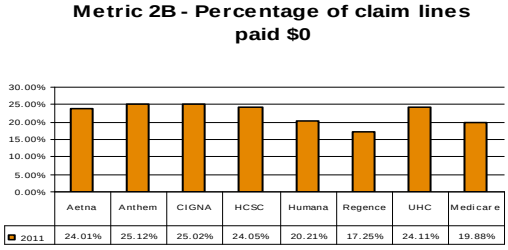
[2] The AMA's 2011 National Health Insurer Report Card can be accessed at www.ama-assn.org/go/reportcard.

The cash flow metric indicates that during January through February of 2011, ***from 17 to over 25 percent of claim lines resulted in a $0 payment:***

Cash Flow

Metric 2B – Percentage of claim lines paid $0

Aetna	Anthem BCBS	CIGNA	HCSC	Humana	Regence	UHC	Medicare
24.01%	25.12%	25.02%	24.05%	20.21%	17.25%	24.11%	19.88%



The reasons for the $0 payments are many—not just lack of patient eligibility or non-covered services. $0 payment could also occur as a result of patient responsibility (such as deductibles), subrogation (when the claim is the responsibility of a secondary payer) or because of the host of different claim edits applied inconsistently by the various payers.

As noted above, physician practices typically evaluate every $0 payment manually. ***With $0 payments constituting as much as one quarter of all payments, the administrative burden imposed is obvious.*** Just think how much time and energy could be refocused on patient care if this review process could be automated! **But such automation can only occur if the industry is fully transparent, has adopted standard definitions and is using manageable levels of complexity.**

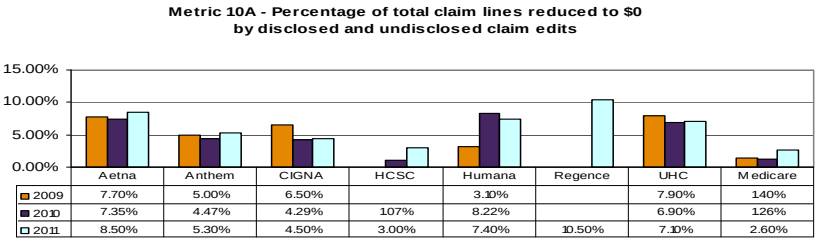
Impact of code-edits as a source of $0 payments

Metric 10A eliminates any doubt as to the need for a standardized claim edit set. It reveals that of the 17-25 percent of $0 pay lines, 2 percent to over 10 percent of those $0 claim lines resulted from the application of the *hodgepodge of claim edits.* The wildly varying application of claim edits by the various payers makes it impossible for physicians to price services at the point of care for their patients, or to efficiently reconcile their payments from the health plans:

Claim Edit Frequency

Metric 10A - Percentage of total claim lines reduced to $0 by **disclosed and undisclosed** claim edits

Aetna	Anthem BCBS	CIGNA	HCSC	Humana	Regence	UHC	Medicare
8.50%	5.30%	4.50%	3.00%	7.40%	10.50%	7.10%	2.60%



Moreover, the number of $0 payments resulting from code edits dwarfs the $0 payments which result from denials, thus demonstrating the importance of focusing on code edit simplification. As shown in Metric 11, only 1-4 percent of $0 lines are caused by denials.

Potential impact of a standard code edit set

If there were a transparent HIPAA standard code-editing system, the practice's review of all these $0 lines could be completely automated. The electronic remittance advice would convey that the $0 payment was the result of the application of a HIPAA standard claim edit. The practice management system would then screen these edits against the transparent and publicly sourced HIPAA standard claim edits, thus eliminating any need for manual review to determine the appropriateness of the edit.

Metric 2B also demonstrates the need for a standard code edit set to support the increasing need for real-time adjudication. A large portion of the $0 pay lines reported in this metric are patient responsibility, and patient responsibility for health care services is only increasing. The cost of collections will become unsustainable in this environment if physicians are not able to bill at the point of service. But there is no way to bill at the point of service so long as there is no certainty as to which claim edits will be applied.

The Solution

The pricing of claims must be made clear and transparent. To accomplish this, the ambiguity in the terminology which is used to discuss the various aspects of the claims revenue cycle must be eliminated, and systems that can be operationalized by all stakeholders and programmed into their practice management and claims adjudication systems must be developed.

Clear, uniform definitions required

As a threshold matter, a uniform definition of "claim edit" must be adopted. Automation cannot occur until the ambiguity of the current claims payment system is addressed. To eliminate confusion, the AMA suggests that the term "claim edit" be defined to mean "payment rules applied by a health plan or its agent to reduce the agreed payment for a specific claim line to $0 in those circumstances where that is required to ensure the correct coding of the claim." The AMA further recommends that this definition be

operationalized in the ASC X12 835 transaction by the inclusion of $0 in the "allowed amount" field, the inclusion of $0 in the payment field, and a Claim Adjustment Reason Code (CARC) indicating "standard claim edit" in the explanation field. Examples of such "claim edits" include code pairs disallowing services for which there is a procedure-gender conflict, where an add-on code is billed improperly, or where the coding violates the mutually exclusive or inclusive rules found in Current Procedural Terminology (CPT) Guidelines, among many others. The edits in the following chart represent a small sample of the thousands of edits used in the claim adjudication process to ensure correct coding according to CPT codes, guidelines, and conventions.

Claim edits	
Valid CPT/HCPCS code	Procedure code/gender conflict
Date of services before date of birth	Separate procedure
Procedure code/place of service conflict	Mutually exclusive
Valid modifier	Procedure code/units conflict
Add-on codes	Procedure code/age conflict
Future date of service	Is only allowed with

Source: National Healthcare Exchange Service (NHXS)

To be clear, we are not suggesting that there cannot be other bases for $0 payments. Rather, we are simply suggesting that, if we are ever to automate the claims payment and reconciliation processes, other types of payment adjustments need to be clearly identified and separated from claim edits. For example, claim edits must be distinguished from "denials" where the allowed amount is *billed charges* and the paid amount is $0. While a physician will never receive payment for a claim line which is subject to a valid claim edit, physicians often recover payment for claim lines that have been denied, as such services often become patient responsibility (denials for lack of eligibility or for non-covered services), or will be paid when the claim is corrected (denials for missing information). Claim edits must also be distinguished from "pricing rules," because a claim edit results in a payment of $0, whereas a "pricing rule" results in payment of some percentage of the fee schedule amount *other than* $0. Finally, claim edits must be distinguished from other fee schedule adjustments which are now often commingled with claim edits, such as those indicating non-payment due to fraud and abuse concerns, benefit level or other coverage determinations, or "never allowed" edits, which should simply be included in the fee schedule as a $0 fee-schedule amount. See AMA's "Standardization of a code edit system" white paper for one way in which other fee-schedule adjustments including denials, benefit level or other coverage adjustments, fraud and abuse concerns, and "never allowed" edits could be automated consistent with the AMA's standardized claim edit proposal.

The appropriate reporting of evaluation and management services performed with a urinalysis in the office as described below provides a perfect example of the importance of a national code edit set.

Today, let's take one example: appropriate reporting of evaluation and management services performed with a urinalysis in the office.

From an accurate coding perspective, CPT codes, guidelines and conventions require the physician practice to record all documented physician work that is performed. In this instance the appropriate Urinalysis Dipstick CPT Code would be recorded along with the appropriate Evaluation and Management (E/M) code. The E/M code should be appended with modifier 25 to denote the significant, separately identifiable nature of the E/M service from the urinalysis.

E/M codes that may apply:

- 99201-99205 New patient office or other outpatient visit;
- 99211-99215 Established patient office or other outpatient visit;
- 99241-99245 New or established patient office consultation; and
- 99381-99397 Initial and periodic comprehensive preventive medicine

Urinalysis dipstick CPT codes that may apply:

- 81002 Urinalysis, by dipstick or tablet non-automated, without microscopy; and
- 81003 Urinalysis, by dipstick or tablet automated, without microscopy

In the event that a plan chooses to not pay for an urinalysis performed in the office, then that health insurer should deny the claim line and appropriately apply a claim adjustment reason code (CARC) or remark adjustment reason code (RARC) to indicate which of the following, if any, apply:

1. the service is an uncovered benefit, so the physician practice understands that the service falls under the patient's responsibility; or
2. a fee schedule agreement exists with a provider for $0 payment, which the physician practice would be aware of when negotiating the contract and its associated fee schedule.

While the AMA would argue that both services should be recognized for payment, that question is irrelevant to the development of a national code edit set. In this discussion, the focus should remain on the correct coding of procedures and services performed—not on the payment of services.

Unfortunately, payers are commingling their benefit plans and fee schedule adjustments within their payer-determined claim edits. The adjustment of the claim line to $0 is made utilizing a claim edit, which does not allow an explanation of why the adjustment was made. This vagueness often results in a claim appeal to be sent to the payer.

A national code edit set must be created to ensure the accurate reporting of physician procedures and services performed. The application of benefit plans and fee schedule adjustments by payers should be transparent, and should be handled separately from the application of a correct coding claim edit. This will provide an incentive to accurately report the procedures and services performed by physicians and other health care providers.

Complexity must be reduced

Because there is no standard claim edit set, there continues to be wide variation between payers as to their claim edit libraries. This seems especially true in the use of payer-defined edits, as is demonstrated by Metric 8A:

Claim Edit Sources and Frequency
Metric 8A – Total Number of Available Payer Claim Edits

	Aetna	Anthem	CIGNA	HCSC	Humana	Regence	UHC	Medicare
CPT	20,167	20,454	19,953	20,454	20,454	20,454	20,358	19,953
ASA	1,070	1,070	1,070	1,070	1,070	1,070	1,070	1,070
NCCI	841,833	841,904	841,904	841,904	841,904	841,904	841,904	841,904
CMS	54,853	55,345	55,339	55,345	55,345	55,345	41,458	55,339
Payer-Specific	223,985	170,027	6,795	199,610	10,534	10,490	253,462	2,224,145

This variation and lack of transparency adds substantial costs for physicians trying to reconcile their claims. On the other hand, the NHIRC makes it is clear that where public edit libraries are available, the vast majority of payers take advantage of them.

It is inefficient, burdensome, and costly for both payers and physicians to maintain the claim systems necessary to handle over a million additional payer-defined rules; for most physician practices, the size and regularly changing nature of these edits makes it impossible to maintain the updated catalogues of each payer's claim edits that would be required for real-time adjudication of claims. Moreover, the lack of clear sourcing of the payer-specific edits remains a huge challenge for physician practices, as the lack of sourcing and public edit development process means that physicians have no way to determine the logic and rationale for these edits, or any clear avenue for dialogue as to whether the existence of the edit is even appropriate.

National Correct Coding Initiative as potential basis for a standard code edit set

The Medicare National Correct Coding Initiative (NCCI) appears to be the best basis for developing a standard code edit set. NCCI has a number of demonstrated benefits:

1. it already contains nearly a million claim edits that are easily downloadable by health plans and physicians without charge;
2. it is built on an established process which includes input from all stakeholders, and has a history of maintaining currency with CPT updates and other relevant changes;
3. pursuant to Section 6507 of the Affordable Care Act (ACA), its use has already been extended to state Medicaid programs; and
4. it is already widely utilized by all commercial payers.

While some have objected that NCCI does not currently include claim edits of relevance to specialties, such as obstetrics and pediatrics, which are largely irrelevant to Medicare, an objective evaluation of the NCCI edits indicates that obstetrics and pediatric edits are indeed included. Moreover, there is no reason why the NCCI process could not include these specialties, and indeed the NCCI expansion to Medicaid would appear to eliminate any question as to whether claim edits relevant to all specialties will be fully incorporated. It is true that NCCI currently includes only two edit types: "inclusive edits" (is only allowed with) and mutually exclusive edits (is not allowed with). However, given that NCCI's purpose is

to ensure correct coding, there is no policy reason why NCCI edits could not be expanded to include the other edit types that are required to ensure correct coding, such as procedure-gender conflict edits, procedure-age conflict edits, valid code or modifier edits, etc.

State-based initiatives, such as the attached Colorado House Bill 10-1332, Medical Clean Claims Transparency, and Uniformity Act, are also underway and could provide the Medicare and Medicaid NCCI contractor a forum to identify enhanced methodologies to increase the ability of a NCCI standard edit set to promote correct coding and to control improper coding leading to inappropriate payment as directed by Section 6507 of ACA.

Benefits of a standard code edit set

A standardized code-editing system would not only allow physicians to significantly increase the number of claims payments that could be automatically posted by their practice management systems and make the reality of point of service pricing that much closer, but it would also allow physicians and other health care professionals to apply a more robust claim scrubber to increase the likelihood claims are submitted accurately the first time, thus eliminating significant rework for both physicians and payers. As noted above, a standard claims processing platform would not dictate any payer fee schedules, medical rules, claim review process or product benefit level or design.

Recommendation

Billions of dollars of cost savings for physicians, payers, patients, and the health care industry can be realized by moving to real-time adjudication of claims. However, to get there, we must eliminate the opacity and complexity that permeates the current payment system. Adoption of a standardized claim edit system is a crucial step towards that end. **Therefore, the AMA calls on all stakeholders to support the Colorado Clean Claim Task Force initiative.**

The AMA further recommends that the following guiding principles inform any effort to develop standardized claim edits.

Guiding principles for standardized claim edits:

- "Claim edits" are defined to mean payment rules applied by a health plan or its agent to decrease the agreed fee schedule amount to $0 whenever a claim line is not billed correctly.
- The purpose of claim edits is to create uniform, correct coding practice in the marketplace and to provide transparency and simplicity for point of service pricing.
- Claim edits must be consistent with CPT codes, guidelines and conventions, adopted after thoughtful consideration has been given to all AMA and national medical specialty society policy documents, clinical vignettes, comments, etc., as currently occurs in the NCCI review process.
- Benefit coverage or other payment policies must not be commingled with claim edits; claim edits must apply to all health plans, regardless of these plan specific policies.
- Because they are already widely used by both public and private payers, the Medicare NCCI should be the starting point for the development of a national claim edit set.

The routine receipt of accurate, understandable payment in response to the initial claim is required for real-time claims adjudication increasingly demanded by patients, and to re-establish the trust necessary to support future partnerships between health plans and physicians focused on improving the quality and

efficiency of health care delivery. We can no longer afford an opaque, complex payment system that diverts time and staff resources from the practice of medicine and keeping patients well.

Conclusion

The AMA recommends: 1) that the Health Insurance Portability and Accountability Act's (HIPAA) Transaction and Code Set (TCS) rule and other HIPAA Administrative Simplification provisions be revised as necessary to ensure the simplification and timely disclosure of all information necessary for determining patient and payer financial responsibilities at the point of care; and 2) that the Medicare NCCI should be the starting point for the development of a national claims edit standard.

For more information on the AMA's administrative simplification agenda, as well as other associated AMA efforts, visit www.ama-assn.org/go/simplify to access the AMA's "Administrative simplification" white paper and "Standardization of the claims process: Administrative simplification" white paper.