

What private payers do to your claim: repricing and claims editing

An analysis to determine the effect of payer claim edits on electronic claims submitted by physicians was completed by National Health Exchange Services (NHXS). This claim edit study, which was requested by the American Medical Association (AMA), involved an analysis of one major commercial payer's administrative system, including electronic claims processing, auto adjudication and payment methodologies. NHXS performed the analysis by developing a claim editing engine similar to the claims processing systems used by some of the largest commercial payers.

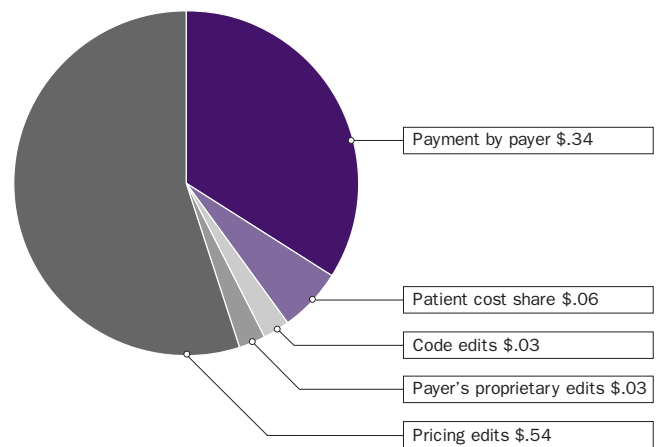
The study results are based on a sample of 32,492 claims submitted by physicians to this one commercial payer and demonstrate the relative impact that various claim edits have on physician payments for one national commercial payer, representing most physician specialties in several states.* The claims in the sample totaled more than \$8,763,000 in physician-billed charges (an average of close to \$270 in billed charges per claim).

To determine the role these edits play in both generating savings for the payer and in reducing physician payments, the following edits were entered into the NHXS claim editing engine:

1. Pricing edits that reduce the physician's billed charges to the individually contracted maximum allowed payment. In addition to fee schedule adjustments, pricing edits can also include such things as modifier and multiple procedure adjustments. Pricing edits always result in the payer's allowed payment amount being greater than zero for a medical service.
2. Edits based on AMA Current Procedural Terminology (CPT®)** codes, guidelines and conventions; National Correct Coding Initiative (NCCI); Centers for Medicare and Medicaid Services (CMS) payment rules; and physician national medical specialty societies.
3. Payer-specific proprietary edits that reflect the specific clinical edit policy and prerogative of the payer. These include edits such as the denial of a service as inclusive of another reported service along with additional edits other than those based on CPT, NCCI and Medicare payment rules.

According to the NHXS study results, for every dollar billed by a physician contracted with the payer, slightly more than \$0.54 is discounted under the fee schedule agreement and an additional \$0.06 is discounted through the application of claim edits. The net amount allowed by the payer averaged \$0.40 for each dollar billed by the physician and about \$0.06 of this amount is paid by the patient leaving the payer to pay \$0.34 per dollar billed, as shown in Figure 1.

Figure 1: What private payers do to your claim



The net amount allowed by the payer averaged \$0.40 on each dollar billed by the physician and about \$0.06 of this amount is paid by the patient leaving the payer to pay to the physician \$0.34 per dollar billed.

EXAMPLE – Payer contractual allowance by edit type: Per dollar

Pricing edits ¹	\$.54
Edits based on CPT, CCI and Medicare	\$.03
Payer's proprietary edits ²	\$.03
Patient cost share payment	\$.06
Payer's payment to the physician	\$.34

1 Application of fee schedule adjustments.
2 Application of payer-specific clinical edit policy, such as the denial of a service as inclusive of another service.

Source: National Health Exchange Services (NHXS)

* California, Arizona, Texas, Louisiana, Georgia, Florida, Minnesota, Pennsylvania, and New York

** CPT is a registered trademark of the American Medical Association

The payer's administrative system

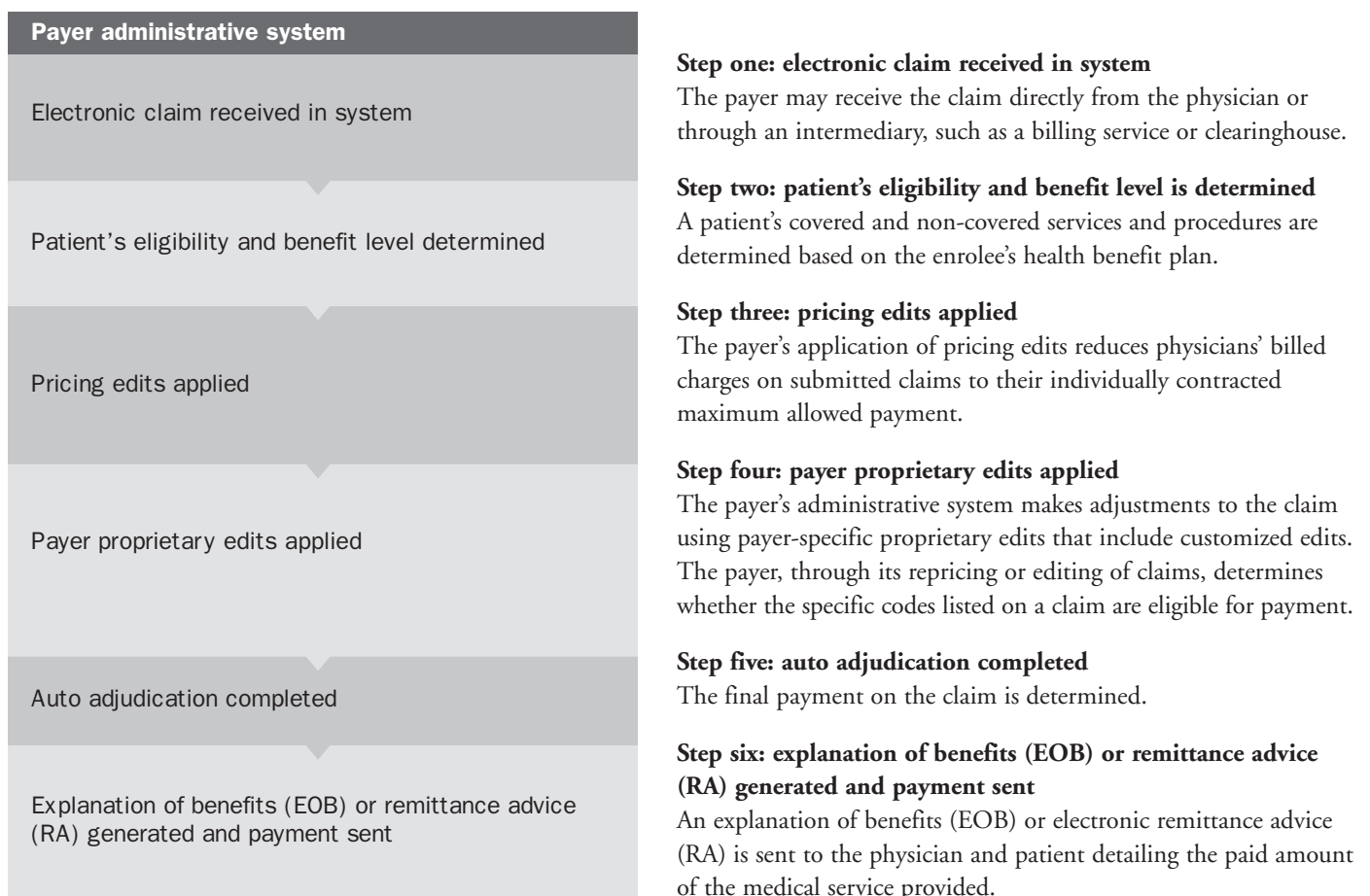
The payer, through its administrative system and/or designated repricer, reduces the physician's billed charges on a claim by applying pricing and payer-specific proprietary edits (see Figure 2). These edits occur when a physician, who has accepted assignment of benefits from a patient, submits an electronic claim to the payer on behalf of the patient. The claim will contain the appropriate CPT codes, Health Care Common Procedural Code System (HCPCS) codes, physician's billed charges and all additional data necessary (i.e., date of service, place of service, modifier) for the payer to process the claim.

Once the claim is received for processing, the payer's adjudication system determines if the patient is a "match" in the payer's system and eligible to receive benefits for the date(s) of service identified on the claim. If the patient "matches" and is eligible, then the payer's system automatically determines if the services are "covered services" according to the patient's benefit plan.

Once the covered benefit level is determined based on the enrollee's health benefit plan, the claim is *repriced* (using automatic payment and payer-specific proprietary edits) to determine what portion of the physician's billed charge is allowed under the contract. The payer's adjustment results in a reduction of the physician's billed charge to the contracted maximum allowed payment. The payer pays the physician the difference between the total allowed amount for the medical services and procedures, and the patient responsibility amount.

In the case of a non-contracted physician who is not obligated to accept a negotiated payment, the payer determines what portion of the physician's billed charge will be paid by the plan (based on the payer's medical payment policy and the patient's benefit plan) and what portion the patient is responsible to pay. The physician is eligible to collect up to full-billed charges for non-covered services.

Figure 2: Typical payer administrative system workflow



Source: American Medical Association (AMA)

Claim edits

Physicians may agree to a discounted payment rate for a procedure or service with a payer, but actual payment can be significantly affected by both pricing and payer-specific proprietary edits applied by the payer’s claim adjudication system. In 2000, Medicare moved away from applying “black box” edits to claims, which were unknown edits to the physician, and began to apply the newly published NCCI claim edits. Most commercial health plans use significantly more edits than those based on CPT, NCCI and Medicare payment rules. The NHXS study shows the effect of these additional claim edits (i.e., payer-specific proprietary edits) on physician reimbursement.

The NHXS study was able to identify specific payer claim edits and determine if these edits were based on well known sources or unique to the payer. The edits in Figure 3 represent a small sample of the thousands of edits used in the claim adjudication process.

Figure 3	
Edits	
Valid ICD-9 code	Procedure code/gender conflict
Date of service before date of birth	Valid CPT/HCCPC code
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	Separate procedure

Source: NHXS

The NHXS study revealed the likelihood of a claim edit being applied by the payer and resulting in the denial of at least one line on a claim. Typically, one line on a claim refers to one or more medical service(s) or procedure(s) that is/are reported using a single CPT procedure code on a line of the CMS-1500 claim form (see Figure 4).

Figure 4: Excerpt of Box 24 – CMS-1500 Form									
A			B	C	D		E	F	G
Date(s) of service			Place of service	Type of service	Procedures, services or supplies		Diagnosis code	\$ Charges	Days or units
From		To			CPT/HCCPCS	Modifier			
MM	DD	YY							

The NHXS study reported that almost half of all claims in the sample included two or more lines that generally reflected when the physician performed two or more services or procedures. The NHXS audit also found that in claims with two or more lines, there was a 50 percent chance that one or more of the lines would be subject to the application of a payer pricing or clinical edit (see Figure 5).

Payer-specific proprietary edits

According to the analysis by NHXS, the commercial payer can double its savings by applying edits based on CPT, NCCI and Medicare and also by applying its own payer-specific proprietary edits. For example, the NHXS study found that over 25 percent of physician claims submitted to the payer for payment will have one or more procedures and/or services repriced to \$0.00 based on payer-specific proprietary edits. The net result is that payment to the physician is *always* less than the contracted payment rate. Figure 5 demonstrates in more detail the likelihood that a medical service or procedure will be considered ineligible for payment (denied) based on the number of services submitted on the claim.

The NHXS study provided examples and frequency of the various claim edits (based on CPT codes, guidelines and conventions, CMS payment rules and payer-specific proprietary edits) that were applied to the audited claims (see Figure 7 on page 5).

Pricing edits

Most payers include “lesser of” language in their contracts with physicians. This language allows the payer to pay the physician’s billed charges when the *billed* charges are less than the payment rate in the agreed upon fee schedule. Thus, if the fee schedule indicates a payment amount of \$50 and the physician’s billed charge is \$45, the payer’s maximum payment for the medical service is \$45. In the NHXS sample there were numerous CPT or HCPCS codes that had charges below the physician’s contracted fee schedule payment rate, approximately 0.05 percent of the claim sample. On average, physicians billed \$5.15 below their contracted fee schedule per code.

Figure 5: Payer pricing and clinical edit practices

Lines per claim	Claims audited	% of total claims	Number of claims edits applied	% of edits applied to claims	Number of lines edits were applied
1	18,146	56.0	1,120	6	1.0
2	6,248	19.0	2,348	38	1.0
3	2,943	9.0	1,498	51	1.3
4	1,460	5.0	914	63	1.5
5	991	3.0	662	73	1.3
6	904	3.0	768	77	1.5
7	517	2.0	447	86	1.5
8	381	1.0	351	92	1.7
9	309	1.0	271	88	1.8
10	216	0.7	192	89	1.8
11	159	0.5	128	89	1.6
12	141	0.4	141	91	1.8
16	1	0.0	1	100	2.0
Claim sample size	32,416	100%*	8,841		

Source: NHXS

* Totals may not add to 100% due to rounding

The top CPT categories with charges below the physician’s fee schedule rate were Special Services, Procedures and Reports (e.g., CPT codes 99000 or 99058), Therapeutic, Prophylactic or Diagnostic Injections (e.g., CPT code 90782), Radiology, Other Procedures (e.g., CPT code 76083) and Medical and Surgical Supplies (e.g., HCPCS code A4550).

Typically, the physician practice staff will spend between \$14 to \$25 for each claim audited and appealed. Successful low-cost audit and appeal processes can now be performed by physician practice staff by taking advantage of electronic data interchange (EDI) standards and by following basic review and auditing procedures.

Claims accuracy

The NHXS study revealed that 70 percent of the claims were paid accurately by the payer on the first explanation of benefits (EOB) sent to the physician. For purposes of the NHXS study, inaccurate claims included partial payments without explanation, underpayments and overpayments. The payer’s first time EOB payment accuracy rate on a claim submission can have a significant impact on a physician’s practice expenses. For roughly 30 percent of the patient encounters represented in the claim sample, NHXS has estimated that it will take multiple communications between the physician practice staff and the payer to finalize the appropriate payment and the final patient balance (see Figure 6). Such delays affect both the payer’s and the physician’s ability to accurately determine the patient’s financial responsibility. Initial inaccuracies in payment can also trigger additional administrative costs for the physician practice, including multiple data entries, auditing and collections expenses.

Figure 6: Private payer claims payment accuracy

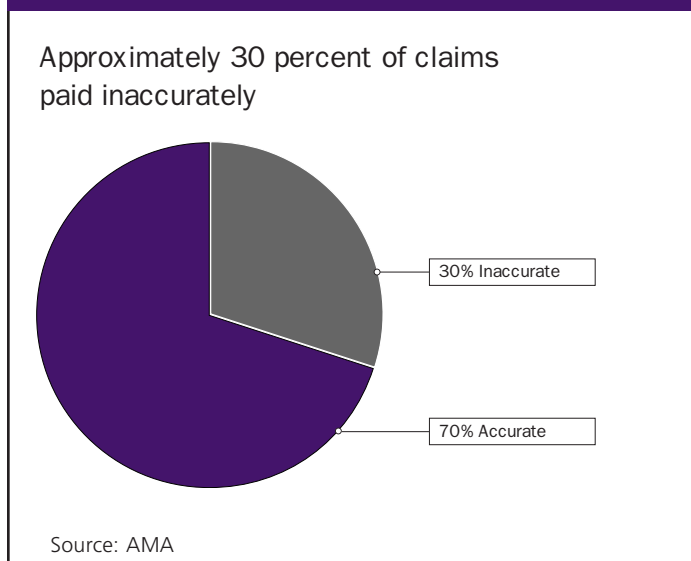


Figure 7: 2004 NHXS Study

Claim sample: 32,492 claims
 Line count: 71,021
 Physician-billed charges: \$8,763,000 (an average of close to \$270 in billed charges per claim)

CPT codes, guidelines and conventions

Edit applied to one line on a claim form	Number of claim lines edit applied
► Procedure modifier conflict	46
Procedure age conflict	11
Is only allowed with	8
Invalid procedure code	6
Is not allowed with	3

CMS payment rules

Edit applied to one line on a claim form	Number of claim lines edit applied
Invalid diagnosis code	147
Is included in the global services package	111
Is not allowed with	77
Is not allowed	18
Procedure modifier conflict	17

National Correct Coding Initiative

Edit applied to one line on a claim form	Number of claim lines edit applied
83721 is only allowed with 80061 with modifier 59	556
G0102 is not allowed with 99214	127
83550 is not allowed with 84466	120
G0102 is not allowed with 99213	50
76830 is only allowed with 76856 with modifier 59	45

Payer-specific proprietary edits

Edit applied to one line on a claim form	Number of claim lines edit applied	% of lines analyzed
► Is not allowed with	15,835	22%
Is not allowed	292	<1%
Is only allowed with payment enhancing modifier	655	1%
Is only allowed with	230	<1%
► Modifier procedure conflict	16	<1%

Source: NHXS

The 2004 NHXS study reveals a large impact on claims by payer-specific proprietary edits. For example, in the chart above, all of the “**is not allowed with**” edits found in the payer-specific proprietary edit section involved the denial of the venipuncture service when billed with a procedure from the 80000 CPT code series. The payer’s “**modifier procedure conflict**” edit does not recognize a procedure code reported

with certain modifiers (that would be recognized when the “**procedure modifier conflict**” edit identified in the CPT and CMS sections is applied). In the case of this one commercial payer, the CPT modifier 80-assistant surgeon, is not recognized for certain procedure codes that the CMS guidelines would otherwise allow.

NHXS industry summary

NHXS found through the review of numerous private commercial payers' claims that there is no clear standard in the industry for the number and types of unique payer-specific proprietary edits. In addition, there is no standard for the dissemination of payer edit rules to physicians. In fact, if there is an industry standard, it is that these types of edits share a general lack of transparency with no clear normal and customary process for the creation, maintenance, or application of these edits. Because of this lack of uniformity, no standard business tools exist for physicians to use on a claim-by-claim basis to determine if a payer edit was applied appropriately.

The inherent complexity of claim edit systems is such that the physician practice staff incurs both a practical and an economic disadvantage when attempting to audit claim payments. As a result, a high percentage of payers' repricing errors on the part of payers are undetected by the physician practice staff.

What do payer edits mean to physicians?

Review all payer contracts

Physicians should review **all** contracts with payers, including the associated fee schedules, medical payment policies, available claim edits and other payment rules before signing any contract and make sure they are receiving their contracted payment rate. The AMA provides several useful tools to educate physicians on managed care contracts. The AMA *Model Managed Care Contract* contains sample contract language designed to assist physicians in avoiding common contracting pitfalls. Its companion piece, *15 Questions to Ask Before Signing a Managed Care Contract*, provides a roadmap to help physicians evaluate whether or not to sign a managed care contract. Visit the AMA Web site at www.ama-assn.org/go/psa to download these and other helpful resources.

Review and audit all claims

When the physician performs a service or procedure and then reports it according to the AMA CPT codes, guidelines and conventions, the payer should recognize the physician work involved in providing the patient care. To ensure that the physician's work is recognized, the physician practice should:

- 1) identify all inappropriate claim denials;
- 2) communicate with the payer's provider representative; and
- 3) initiate a claim appeal, when appropriate.

When the physician practice does not audit and appeal inappropriately paid or denied claims, it may lose revenue and the opportunity to recover payments that are contractually owed. By challenging inappropriate claim payments, the physician practice demonstrates that it is making an effort to correct the payer's inaccuracy. This can lead to a positive change in the payer's business practices. Appealing claims that are inappropriately denied by payers can make a difference to the physician practice by reducing future denials and costs.

The AMA provides several useful tools to educate physicians on the claims management process. The *Appeal that claim* booklet explains the process of appealing an underpaid, delayed or inappropriately denied claim and includes claim appeal form letters for modification by the physician practice staff. The brochure and template appeal letters are available at www.ama-assn.org/go/psa and are free to AMA members.

For additional information, visit the AMA Private Sector Advocacy (PSA) unit's Web site at www.ama-assn.org/go/psa or give us a call at (800) 262-3211.