AMA 'Report Card' Shows Improved Claims Accuracy

BY SUSAN BIRK

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION'S HOUSE OF DELEGATES

CHICAGO – Twenty percent of health insurance claims are processed inaccurately, according to the American Medical Association's third annual National Health Insurer Report Card, which rates the nation's largest commercial insurers on timeliness and accuracy of claims processing.

Eliminating discrepancies in expected payment amounts would save doctors and insurers $15.5 billion annually, according to the report, which is based on a random sample of 2 million claims for 3.5 million services filed electronically February-March 2010 by 200 practices in 43 states.

Each year, claims processing costs as much as $210 billion and takes up 10%-14% of physicians' gross revenue and the equivalent for each physician of 5 work weeks, Dr. Nancy H. Nielsen, then immediate past president of the AMA, said in an educational session.

To remedy the problem, the AMA urges the creation of a single, transparent insurance industry standard "so that everybody knows in a seamless way how those claims are to be submitted and processed," Dr. Nielsen said, adding that such a standard would reduce errors and free physicians to focus more on patients and less on administrative red tape.

Insurers made gains in some areas, including accuracy in the reporting of contract fees to physicians. They correctly reported contract fees 78%-94% of the time in 2010 versus 62%-87% of the time in 2008, Dr. Nielson said.

They also increased the transparency and accessibility of their fee schedules, according to Mark Rieger, chief executive officer of National Healthcare Exchange Services, Inc. of Sacramento, which conducted the research.

Physicians' electronic access to complete fee schedules plays a major role in processing accuracy, he said. "Where the payer makes the fee schedule available we have higher match rates."

"There's still a need for better transparency. But we're optimistic that if payers continue to demonstrate some of the improvements that they've shown" additional efficiencies can be gained, he said.

Coventry Health Care, Inc. had the highest overall accuracy (88%), while Anthem Blue Cross Blue Shield had the lowest (74%). Other insurers addressed by the report were Aetna, CIGNA, Health Care Services Corporation, Humana, and UnitedHealth Group.

Allowing physicians to have electronic access to payers' complete fee schedules contributes significantly to increasing the accuracy of claim processing.

Mr. Rieger said that every 1% increase in the match rate for claims would generate a conservatively estimated $777.6 million for physicians and payers. A 100% match rate would yield an annual savings of $15.5 billion.

The AMA asked physicians to do their part to improve the claims process by working to submit claims correctly the first time and implementing practice efficiencies such as an effective electronic practice management system, said Tammy Banks, AMA director of practice management and payment advocacy. "There's a lot going on in the next five to 10 years. Make sure that your vendor is willing to notify you of changes and upgrades" in federal and state mandates and transaction codes, she emphasized.

Administrative portals for claims processing are not a long-term replacement for a direct relationship with payers through an effective electronic practice management system, she said.

The National Health Insurer Report Card is available at http://www.ama-assn.org/ama1/pub/upload/mm/368/2010-nhirc-results.pdf. ■

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ACR Asks for Relief

The American College of Rheumatology said that "patient access to necessary care will be compromised" if parts of the 2011 Medicare Physician Fee Schedule are implemented as proposed. Specifically, the ACR asked for reversal of existing policies on consultation codes and the Physician Quality Reporting Initiative program. In a letter to the Centers for Medicare and Medicaid Services, ACR President Stanley Cohen said that the CMS's decision to eliminate reimbursable consultation codes has been "devastating" to rheumatologists. On PQRI, he said that physicians too often lose out on deserved quality payments when they inadvertently file incorrect reports, an event that also can publicly label them as poor-quality providers. "The ACR requests that CMS implement a program to instruct physicians on proper reporting," Dr. Cohen wrote.

Study: Mistake Policies Needed

When several patients are affected by a medical mistake – even one that probably will harm none of them – the event ought to be disclosed to the public, said authors of a study funded by the Agency for Healthcare Research and Quality (N. Engl. J. Med. 2010;363:978-86). The authors said that "large-scale adverse events" from around the world have included everything from malfunctioning to poorly sterilized lab equipment. They advocated timely disclosure of such mistakes to government authorities, to potentially affected patients, and to the media. Health care facilities should follow up on possible physical and psychological effects of adverse events. In a statement, AHRQ Director Carolyn M. Clancy said, "It's clear that health care organizations face a dilemma regarding disclosure of large-scale adverse events – whether these events lead to patient harm or not."

Stop-Smoking Coverage Expanded

Physicians will be reimbursed for counseling any Medicare patient about smoking cessation, not just those with tobacco-related illness, under new guidelines approved by the CMS. Previously, a patient needed to at least show signs of illness related to smoking before Medicare would pay. Now, any smoker covered by Medicare can have up to eight smoking cessation sessions per year from a physician or another Medicare-recognized health practitioner, CMS said. American Medical Association President Cecil Wilson applauded the coverage expansion. "More than 400,000 Americans die needlessly every year as a direct result of tobacco use," Dr. Wilson said in a statement. "This expansion of coverage takes an important step toward helping Medicare patients lead healthier, tobacco-free lives."

$14 Million for Minority Research

Economic stimulus funds totalling $14.2 million have been allocated to "patient-centered outcomes research" among racial and ethnic minorities with diseases including arthritis, the U.S. Department of Health and Human Services announced. The money is part of the $1.1 billion earmarked for outcomes research in the American Recovery and Reinvestment Act of 2009. "Patient-centered outcomes research must become a critical part of our strategy as a nation to understand and eliminate health disparities," said John Ruffin, Ph.D., director of the National Institute on Minority Health and Health Disparities.

Worries About Pharma Influence

Almost 70% of Americans who take prescription drugs believe that drug makers have too much influence over doctors when it comes to those prescriptions, and 50% believe that doctors prescribe drugs even when a person's condition could be managed without medication. The data are the result of a Consumer Reports magazine poll. On the basis of the survey of more than 1,150 adults, the magazine asserted that 51% of Americans don't think their doctors consider patients' ability to pay for prescribed drugs, 47% think gifts from pharmaceutical companies influence doctors' drug choices, 41% think their doctors tend to prescribe newer and more expensive drugs, and 20% have asked for a drug they've seen advertised. In those cases, 59% of the respondents said their doctors prescribed what they requested.

Deals Keep Generics Off Market

Branded- and generic-drug manufacturers have made at least 21 deals so far this year that potentially delay the production of cheaper, generic versions of existing brand-name drugs, the Federal Trade Commission said. In three-quarters of the settlements reported to the FTC, the branded- and generic-drug makers came to terms without money changing hands. The agency, which is attempting to crack down on these "pay-for-delay" deals, told congressional lawmakers that generic- and branded-drug manufacturers inked 19 such deals in 2009, and 16 in 2008. The 2010 deals protect $9 billion in brand-name drug sales from generic competition, FTC Chairman Jon Leibowitz told a House subcommittee. The FTC estimated that "pay-for-delay" deals cost consumers $3.5 billion each year.

–Denise Napoli