

The benefits of electronic claims submission— improve practice efficiencies

Electronic claims submission vs. manual claims submission

An “electronic claim” is a paperless patient claim form generated by computer software that is transmitted electronically over telephone or computer connection to a health insurer or other third-party payer (payer) for processing and payment. A “manual claim” is a paper claim form that refers to either the Centers for Medicare & Medicaid Services CMS-1500 form (formerly HCFA-1500) or a Uniform Billing UB-04 form, both of which are typically sent to the payer through the mail and require postage. Electronic claims submission helps physician practices reduce the administrative burden and expense generally associated with manual claims processing and submission.

The use of electronic claims can result in significant financial savings for both physician practices and payers. Health information technology (HIT) solutions are on the rise as more physician practices are submitting electronic claims to payers. By doing so, physician practices may potentially realize increased practice efficiencies and savings in their practice’s claims revenue cycle.

The American Medical Association (AMA) and the Connecticut State Medical Society encourage the use of electronic claims by physician practices. Physician practices are also encouraged to enhance their electronic data interchange (EDI) capabilities and to contract with vendors and payers that accept Accredited Standards Committee X12 (ASC X12) standards, especially those mandated under Health Insurance Portability and Accountability Act (HIPAA) administrative simplification. These vendors should also provide electronic remittance advice (ERA), eligibility and benefit information, claim status and prior authorization, as well as electronic claims processing.

Physician practices can realize several benefits from introducing electronic claims submission into the practice’s claims revenue cycle. Electronic claims submission can:

- Reduce the amount of time and resources physician practices devote to manual administrative functions—time that can be better spent with patients or focused on other practice efficiencies
- Pre-audit claim fields automatically for potential errors before submission to a payer
- Identify claim issues and provide online claim resolution before processing by a payer
- Submit claims almost instantaneously to a payer
- Reduce postage, supplies and mailing expenditures
- Track a claim’s progress between intermediaries (e.g., a billing service or clearinghouse) and a payer through an electronic audit trail

This educational resource was developed through a cooperative effort of the American Medical Association and the Connecticut State Medical Society.

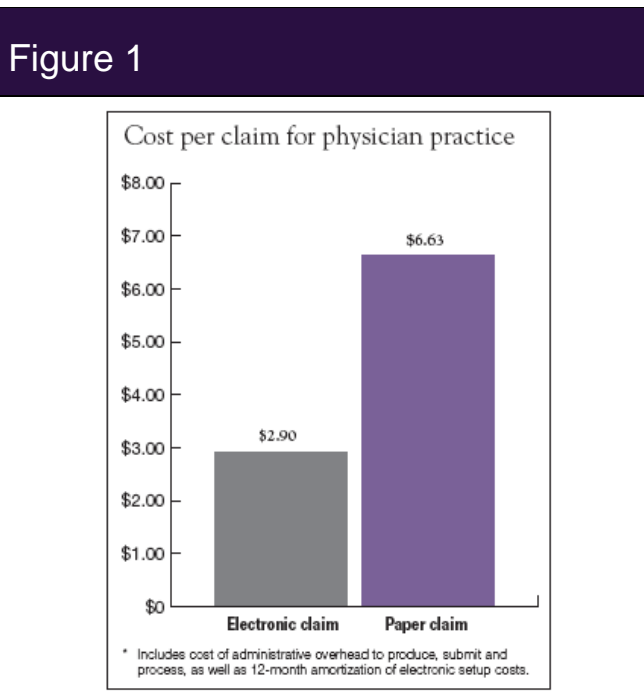
Copyright 2008-2013 American Medical Association. All rights reserved.

- Confirm a payer’s receipt of a claim through electronic reports
- Expedite a payer’s claims processing turnaround and potential payment time frame
- Improve the practice’s accounts receivable

Cost comparison

Electronic claims submission offers a straightforward, efficient and cost-effective process for submitting patient claims to a payer. In 2006 the estimated annual cost for a solo physician practice to perform manual claims transactions was \$70,000, while the annual cost for electronic claims submission was less than \$28,000.¹ In this example, a savings of more than \$42,000 (or nearly 60 percent) was realized by a physician practice using and submitting electronic claims. This type of savings may or may not be realized by all physician practices.

Electronic claims are inexpensive for physician practices to produce, submit, process and track when compared with manual claims. The average cost of processing a “clean”² electronic claim is \$2.90, while the average cost of processing a clean paper claim is \$6.63 (see Figure 1). Additionally, manual claims submission can be a time-consuming process for a payer, as claims submitted this way typically are manually scanned into the payer’s administrative system and/or manually processed by payer personnel—extra steps that may result in delays in payment.



Source: Phelan J, Naugle A. *Electronic Transaction Savings Opportunities for Physician Practices*. Milliman Inc; January 2006.

¹ Phelan J, Naugle A. *Electronic Transaction Savings Opportunities for Physician Practices*. Milliman Inc; January 2006. http://transact.webmd.com/milliman_study.pdf. Accessed January 4, 2007.

² A clean claim refers to a claim that meets all of the standard submission requirements of a payer and is accepted for adjudication.

This educational resource was developed through a cooperative effort of the American Medical Association and the Connecticut State Medical Society.

Copyright 2008-2013 American Medical Association. All rights reserved.

Getting started

Physician practices should first consider what method of electronic claims submission is appropriate for the practice setting. Electronic claims may be transmitted by:

- Dial-up method, which uses a telephone line or digital subscriber line for claims submission. (Clearinghouses typically supply the physician practice with the software required for communication between the physician practice's computer and the clearinghouse's system.)
- The Internet, which allows for secure, direct transmittal of claims submission to health plans over the Internet and eliminates the need for transmittal software.

Electronic claims can be generated in a practice management system and then transmitted either directly to the payer electronically in accordance with the health plan's submission requirements or indirectly through an application service provider (ASP) or cloud computing service, a clearinghouse, a billing service or another third-party vendor.

An ASP or cloud computing service is a company that contracts with a payer and/or physician practice to supply software applications and/or software-related services for use over the Internet. A clearinghouse is a private company that provides connectivity, often serving as a "middleman" between physician practices, billing entities, payers and other health care partners for transmission and translation of claims information into the specific format required by payers. A clearinghouse acts for an electronic claim like the Post Office does for a manual claim. Physicians or physician groups often contract with clearinghouses for a nominal fee. A contracted billing service, an ASP or even a payer may meet the definition of a clearinghouse if it performs such translation and transmission services.

Physician practices submitting electronic claims directly to a payer must follow the national standard formats currently in place—these require completion of extra fields beyond the standard fields of the CMS-1500 claim form. Each payer has a companion manual containing specific requirements above and beyond the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated requirements that must be met in order for claims to be processed for payment. Those specific requirements should be programmed into your practice management system electronic claims module and be handled automatically. Health insurers are required by HIPAA to accept electronic claims. The physician practice should have checks and balances in place to protect the privacy of information and to ensure that the electronic claims are submitted in compliance with HIPAA requirements.

Physician practices may not have the opportunity or resources to submit electronic claims that meet the payer's specific requirements directly. However, physician practices can discuss options as to how best to send their manual or electronic claim information to a clearinghouse, billing service or other transaction entity in order to convert the information into a claim format that can be electronically submitted to the payer.

Pre-auditing claims

Practice management software systems, clearinghouses, billing services or other claims transmission vendors can pre-audit electronic claims for missing or incorrect information (such as an invalid patient identification number, a diagnosis code that is no longer valid or gender misidentification) **prior** to their

This educational resource was developed through a cooperative effort of the American Medical Association and the Connecticut State Medical Society.

Copyright 2008-2013 American Medical Association. All rights reserved.

submission to a payer. A pre-audit claim check for these types of potential claim issues can help expedite claim processing and reduce payment delays or denials by a payer. Pre-auditing claim checks may also allow for automatic cross-referencing of procedures according to a health plan's requirements to help ensure that only approved procedures are submitted. Verifying electronic claims for accuracy **before** they are submitted to a payer decreases the time spent on claim review and adjustment, and allows for more timely claims processing and payment by a payer.

Tracking claims

The physician practice is encouraged to request claim transmission status reports from a payer, clearinghouse or other claims transmission vendor. These reports will supply the practice with an electronic audit trail to assist in tracking the accepted or rejected status of all the electronic claims sent to the various payers. When the physician practice is notified of a claim rejection electronically, it can quickly and easily correct and resubmit the claim electronically. Manual claim rejections, on the other hand, are received by the physician practice via mail and offer a paper copy of the payer's explanation of benefits (EOB) form. Based on the information presented on the EOB, the physician practice must then research, correct and resend a revised manual claim via mail to the payer. This process can add several weeks to the physician practice's accounts payable cycle.

Clearinghouse reports will typically list the patient's name, the date of service, the AMA Current Procedural Terminology (CPT®)³ and the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes on the claim, in addition to the payer information and the claim acceptance or rejection remark. The remark description is the stated reason the electronic claim was rejected by the payer.

Physician practices can use electronic claim forms to submit and resubmit large quantities of claims at one time, in bulk, quickly and efficiently. For example, if categories such as a specific date of service, a date range or a specific patient's claims are required by the payer to be resubmitted, the practice management system or transmission vendor may be able to quickly sort and resubmit these claims. The categories can be resubmitted to the payer in a bulk file without taking up valuable staff resources and time searching, sorting and resubmitting manual claims. Concurrently, health plans will save on the administrative costs generally associated with the manual processing of resubmitted claims.

Physician practices may consider automating their claims revenue cycle by requesting that EOBs be delivered electronically and that claim payments be automatically transferred through an electronic funds transfer (EFT) by a payer and deposited into the physician's designated bank account. An electronic EOB in the mandated standard format can be posted into the physician's system with little or no staff intervention. An electronic EOB is also known as an electronic remittance advice (ERA). Visit www.ama-assn.org/go/era to access the AMA's ERA toolkit. Several payers offer EFT programs, which, in contrast to paper checks, use electronic means to transfer monies between parties. EFT payments can be nearly instantaneous (avoiding postal delays) and may reduce administrative steps associated with issuing or depositing payments. However, physician practices need to fully review the EFT program to determine if the prospective program provides enough flexibility for the physician to maintain banking relationships. Visit www.ama-assn.org/go/eff to access additional information.

³ CPT is a registered trademark of the American Medical Association.

Effective January 1, 2014, all health plans are mandated to offer EFT to any provider that asks for it for their claim payments.

The potential elimination of manual processes from the claims management cycle through the introduction and use of HIT solutions may allow physician practices to increase their focus on auditing, appeals and collection of claim payments from payers. By streamlining the manual processes, physician practices can help ensure that the practice is performing revenue enhancing functions, such as making sure the appropriate reimbursement for providing medical services and procedures is received from patients and payers.