December 21, 1999

Mr. Gary Carneal, President/CEO
AAHC/URAC
1275 K Street, NW, Suite 1100
Washington, DC 20005

Dear Gary:

On behalf of over 116,000 physician members of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), I am writing to urge the American Accreditation Healthcare Commission/URAC (AAHC/URAC) to develop and implement claims processing accreditation standards. We are willing to assist AAHC/URAC in devising such standards.

Claims processing accreditation standards will stimulate competition among third party payers to improve their claims processing systems. The end result should reduce medical claims hassles for patients and their health care providers. Standards are necessary to ensure that physicians and other health care providers have adequate cash flow to care for their patients. The need for claims processing accreditation standards is great since state-regulated prompt payment laws are often inadequate to resolve the problem of chronic payment delays.

In recent years, our members have repeatedly reported to us that the practice of delaying claims and requiring claims to be resubmitted multiple times unnecessarily has become commonplace. These practices can cause great consternation among patients because their medical care bills go unpaid for long periods of time. It has been reported that some third party payers are believed to be exploiting these delay tactics to earn interest on the sums owed to doctors and other health care providers.

Recently, several lawsuits have been filed challenging the delayed payment practices of third party payers. Legal battles are costly, provide only a temporary point-in-time solution, and often result in poor relations between the payers and its health care providers. The presence of a standard that will affect accreditation status and plan performance rating should decrease the reliance on the judicial system to the benefit of all parties in the health care system.

In some geographic areas, the situation shows signs of improving. State governments are beginning to put health insurers on notice that they must pay error-free claims quickly or pay fines. Since January 1998, New York health insurers are required to pay undisputed claims within 45 days of receipt or face monetary consequences. In Virginia, The Fair Business Practices Act requires carriers to pay clean claims within 40 days and allows providers who suffer damages as a result of late payment to recover damages. These State laws do not solve the problem, however. Plans can still delay payment because of ambiguity over what constitutes a clean claim. Private sector accreditation standards would fill the void in these laws by clearly defining claims processing standards. Further,

many plans are self-funded and exempt from state regulations. A preferable solution to the patchwork of state regulation is private sector accreditation standards.

Most health insurers do not have a definitive standard for what constitutes a "clean claim." AAHC/URAC should start with creating a definition of clean claims for its accreditation standards. AAHC/URAC standards should also, at a minimum, require the third party payer to provide the claims processing criteria that it requires.

Attached are policies excerpted from the ACP-ASIM Policy Compendium 1998-1999, which provide a framework from which AAHC/URAC may wish to begin to develop draft standards.

ACP-ASIM recognizes the tribulations faced by patients and their health care providers in pursuit of timely claims payment and commends AAHC/URAC in its recognition of the need for claims processing accreditation standards. ACP-ASIM believes claims processing accreditation standards will be an asset to the entire healthcare community. If you have any comments or questions about this issue, please contact ACP-ASIM's Director of Managed Care and Regulatory Affairs, John DuMoulin, at (202) 261-4535.

Sincerely,

Robert B. Doherty
Senior Vice President

Attachment

The following policies excerpted from the ACP-ASIM Policy Compendium 1998-1999 provide a framework from which AAHC/URAC may wish to begin to develop draft standards.

Timely Payment on Claims

ACP-ASIM supports legislation which requires all payors in all health care payment systems to pay physicians' clean claims promptly within thirty days of receipt of claims. (adopted 1996)

Disclosure of Denials

ACP-ASIM will seek at the national level, to require health plans or the entities which perform preauthorization review, to track and regularly publish, in a form accessible to the public and physicians, and of worth to health services researchers, information about the numbers and rates of denials of health care services, rates of denial payment for services and of rates of reversal of denials on appeal. (adopted 1997)

Payment for Providing Information to Third Party Payers

ACP-ASIM seeks regulations that would require third-party payers to pay costs of providing information beyond standard billing information (services provided, CPT/RVS codes, diagnosis codes, date and place of service, patient and physician identifying information). This applies to information provided on paper, by fax, or by telephone. ACP-ASIM encourages national regulations for interstate payers and payers who are currently exempt from state regulation. (adopted 1993)

Electronic Billing

ACP-ASIM seeks through HCFA to insure that for electronic billing, hardware be a matter of personal choice or preference for physician users; that software packages provided by carriers be compatible with multiple operating systems and user friendly; that third parties provide updates of software to physicians operating within their system; and that a consistency of quality be maintained in software development and use for all. (adopted 1992)

Medical Paperwork

ACP-ASIM encourages third-party payers whenever they wish to initiate a new policy which results in a significant increase in the work-load of the physician provider (reimbursement information, disability forms, other information from medical records) to explain the reasons for such new policy in writing to representatives of practicing physicians, such as the state medical society and appropriate specialty societies such as the respective state society of internal medicine, and solicit comments from same before the institution of the policy; and to reimburse the provider for such additional information. (adopted 1991)

Third Party Manipulation of Terminology

ACP-ASIM opposes the modification of procedural descriptions or conversions to different terminologies by third-party employees without appropriate professional medical consultation. The use of any terminology system containing modified data shall be considered invalid and inappropriate for the purposes of reimbursement, measures of practice patterns, peer review, utilization review, or any other related uses. (adopted 1987)