

Prompt Payment Task Force **Consensus Statement on the Standardization of Medical Claim Submission and Processing**

On January 10, 2007, the Greater Flint Health Coalition Board of Directors approved the Prompt Payment Task Force Statement of Request regarding Standardization of Medical Claim Submission and Processing, which proposed the following solutions relative to improving the consistency of medical claim submission and processing between payer organizations:

- A single set of claim submissions and uniform modifiers, with uniform interpretation across payers, will be accepted, instituted, and adhered to for all claim processing (our recommendation is to adopt Medicare standards)
- Payer specific modifiers (and their associated interpretations) will no longer be acceptable
- Additionally, the entire CMS 1500 (formerly known as the HCFA 1500, HICF 1500) requires similar scrutiny and the establishment of consistency to create a single set of rules, with uniform interpretation, across payers, to be accepted, instituted and adhered to for all claims processing.

Following approval of the Statement of Request regarding Standardization of Medical Claim Submission and Processing, the Prompt Payment Task Force was charged with developing recommendations to achieve the proposed solutions. After reviewing payer rules associated with modifier application and surveying payer organizations regarding their rules and procedures for processing claims, the Prompt Payment Task Force identified the following four key issues that hinder standardization for medical claim submission and processing:

- Variations in the application of hierarchy for payment-affecting modifiers
- Customized, payer-specific edits to claim processing software
- Customized claim processing rules contribute to differences in reimbursement levels, which impacts how a provider submits a claim for payment
- Claim submission processes vary by provider

With the identification of these key issues that prevent standardization, the Prompt Payment Task Force developed the following consensus points relative to the standardization of medical claim submission and processing:

- Rules associated with medical claim processing, including the acceptance of payment-affecting modifiers, appear to be standardized, but application of these rules does not result in standardized claim processing
- The call for standardized billing requirements is focused on developing a uniform method for claim submission and processing and is not attempting to impact issues of reimbursement or coverage
- Customized (or non-standardized) claim processing causes infrastructure costs across many sectors of healthcare, including providers, payers, and purchasers, which contributes to increased costs for the overall healthcare system

- In order to achieve standardization, significant changes in the infrastructure of medical claim submission and processing will be required. These infrastructure changes may include adoption of standard claim processing software applications that do not allow customization. Payers will be required to relinquish a degree of claim submission proprietary in order to achieve standardization for medical claim submission and processing.
- Standardization for medical claim submission and processing will be a step toward achieving a common language for the healthcare system and will move the system closer to interoperability. The National Provider Identification (NPI) is a recent attempt of moving in the right direction to create a standard language for a component of the healthcare system.

Approved by the Prompt Payment Task Force on July 15, 2008.

Approved by the Cost & Resource Planning Committee on July 9, 2009.