

15 steps to protect your practice from unfair payment practices

1. Know the coverage terms of the patient's insurance policy.
 - Maintain updated records of the patient's employer, including name, address and phone number.
 - Maintain updated records of any secondary payer associated with the patient, including Medicare, Medicaid and workers' compensation.
2. Obtain and review your contract with the health insurer or other third-party payer for:
 - The nature and scope of covered services
 - The fee schedule
 - Claim submission requirements (including where and how to transmit)
 - Standards for claim review (retrospective review, medical record requests, etc.)
 - Precertification requirements
 - Medical payment policies
 - Coding guidelines or claim editing policies
3. Make sure you have access to all administrative manuals, associated fee schedules, medical payment policies and available claim edits and other payment rules.
4. Obtain a specific provider and customer service representative contact, and the name and contact information of the health insurer's local medical director.

AMA Practice Management Center resource tip:

The first step in the claims management cycle is to improve physician practice viability through efficient contracting. When entering into negotiations with the health insurer's representative, physicians need to be well prepared. The more physicians understand about health insurers, the better they will be able to decide if a health insurer is suitable for their practice.

Visit the American Medical Association (AMA) Practice Management Center Web site at www.ama-assn.org/go/pmc to access the educational resources "A guide to working with health insurer representatives" and "15 questions to ask before signing a managed care contract." AMA members can download these informative practice management resources free of charge.

5. Understand and comply with all documentation requirements.
6. Stay informed of AMA Current Procedural Terminology (CPT®)*; International Classification of Diseases, Ninth Edition, Clinical Modifications (ICD-9-CM); and other code changes and requirements.
 - Make sure you have the most current copies of all code books, standards and guidelines.
7. Review and monitor all claims before submitting them to the health insurer to ensure that you are filing complete and accurate claims.
 - One way to avoid a claim denial is to correctly code the original claim. Implement a check-and-balance system between the physicians and the coding and billing professionals in your practice to determine whether the claims are being coded appropriately.
8. Keep contemporaneous documents in patient files to support claims.
9. Evaluate the health insurer's explanation of benefits (EOB) or electronic remittance advice (ERA) for accuracy (e.g., potential processing errors, lack of recognition of a CPT modifier, incorrect physician fee schedule).
10. Know your contracted fee schedule rate with each health insurer for procedures and services commonly performed in your practice, and review each EOB you receive to ensure that the negotiated reimbursement and discount rate with each health insurer is calculated appropriately.
11. Thoroughly explain your rationale for challenging the health insurer's claim denial when you submit a formal claim appeal letter to the health insurer.
 - Include the appropriate documentation to support your request to reverse the denial.
 - Keep appealing. It may take more than one appeal to reverse a health insurer's incorrect denial.
12. Streamline your practice's claims auditing and appeals processes by maintaining an appeals resource file with appeal template letters, rationales and supporting documentation of previously submitted claim appeal letters that resulted in overturning a denial.
13. File for an external review, if available through the appropriate state or federal regulatory agency, if the health insurer does not overturn the appeal after you have exhausted the appeals process.

AMA Practice Management Center resource tip:

The AMA developed the interactive resource "Appeal that claim" (available at www.ama-assn.org/go/pmc) to simplify the claim audit and appeals processes for physicians and their practice staff. This interactive resource can help reduce the administrative burden by delivering a step-by-step course of action to appeal an underpaid, delayed or inappropriately denied claim.

14. Visit the AMA Web site at www.ama-assn.org/go/clickandcomplain to file complaints against payers about claims that are delayed beyond state-required time frames or otherwise not in compliance with state laws or regulations with your state insurance commissioner, state medical association and with the AMA.
15. Contact your national medical specialty society.

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

Questions or concerns about practice management issues?

AMA members and their practice staff may e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call **(800) 262-3211** and ask for the AMA Practice Management Center.
- Fax information to **(312) 464-5541**.
- Visit www.ama-assn.org/go/pmc to access the AMA Practice Management Center Web site.

The AMA Practice Management Center is a resource of the AMA Private Sector Advocacy unit.