

Prescription for a healthier practice: Physician claims process check-up

You perform patient check-ups every day. But when was the last time you examined your practice's health? Perform this physician claims process check-up to evaluate your practice's capability to submit claims efficiently and accurately; analyze health insurer payments for accuracy; and effectively address delays, denials and reductions in payment.

Examine the health of your claims process

Does your practice:

- Prepare and submit accurate claims** in a timely manner? Do you update and verify patient insurance coverage and eligibility information prior to each visit to make sure that you submit eligible claims to the correct health insurer? ("[Prepare that Claim](#)")
- Have a practice staff member(s) specifically responsible for **reviewing health insurer payments** for accuracy? When you receive explanations of benefits (EOBs) and electronic remittance advice (ERAs), do you address delays, denials and reductions? ("[Appeal that Claim](#)" Step 1)
- Keep copies** of your contracted fee schedules in order to verify accurate payment from health insurers? Does your practice management software allow you to store (via electronic download or manual input) contracted fee schedules? Do you maintain all health insurer contracts in a central and easy-to-locate file cabinet or drive? ("[Appeal that Claim](#)" Step 2)
- Run a monthly collection report** and review EOBs and ERAs for each claim? ("[Appeal that Claim](#)" Steps 3 and 4)
- Identify the basis** for health insurer payment adjustments? Do you understand the claims adjustment reason and remark codes reported on EOBs and ERAs to explain adjustments to payments and **address** them quickly and appropriately? ("[Appeal that Claim](#)" Step 5)
- Gather supporting documentation** to respond to health insurers' claims adjustments and routinely submit appeal letters using easily accessible templates to streamline and standardize appeals for common denials? ("[Appeal that Claim](#)" Steps 6 and 7)
- Maintain a follow-up log** to monitor your practice's communications with insurers regarding claims? ("[Appeal that Claim](#)" Step 8)
- Hold internal claims processing and review meetings** to periodically evaluate your practice's workflow for ways to improve efficiency? ("[Appeal that Claim](#)" Step 9)
- Persist in appealing** your delayed, denied or reduced payments until they are paid accurately? ("[Appeal that Claim](#)" Step 10)
- Have a plan for complying** with the approaching **5010** and **ICD-10** mandated updates? The deadline for upgrading your electronic transactions to the HIPAA-mandated 5010 version is January 1, 2012, and the deadline for reporting ICD-10 codes is October 1, 2013. Now is the time to prepare your practice for these massive updates. Make sure your practice is ready: Examine your practice management system, billing vendors and other software systems to determine whether they can make the updates and what the process and expenses will be for your practice. (www.ama-assn.org/go/hipaa)

Couldn't check every box? Visit www.ama-assn.org/go/pmc for an interactive library of resources and tools to help you ensure a healthier practice. American Medical Association (AMA) members and their practice staff may e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance.

As part of its “Heal the Claims Process”™ campaign, the AMA’s Practice Management Center has created a Web site to help you streamline your internal claims process and appeal inappropriately delayed, denied or underpaid claims.

- **“Prepare that Claim”** and **“Appeal that Claim”** contain information to help you efficiently and accurately submit claims and address denied claims. AMA members can download the “Appeal that Claim” health insurer follow-up logs and template appeal letters as a member benefit.
- **“The benefits of electronic claims submission—improve practice efficiencies”** helps you reduce claims submission errors that lead to denials, delays and reduced payments.
- **“Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule”** and its accompanying **vendor survey** provide insights for a smooth transition to the approaching **5010** and **ICD-10** mandated updates. Visit www.ama-assn.org/go/hipaa to access additional steps that will help you ensure your practice is ready.

Visit www.ama-assn.org/go/pmc to access these comprehensive resources and help give your practice a clean bill of health.