PRACTICE MANAGEMENT CENTER

AMA AMERICAN MEDICAL ASSOCIATION

Prepare that Claim

Taking an active approach to the claims management revenue cycle

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This document is a revised version of the Prepare that Claim booklet developed in 2003 by the Private Sector Advocacy (PSA) unit of the American Medical Association (AMA) in consultation with Kristie L. Martinez, CMM, CCS-P, Northwestern Nasal+Sinus Associates, John T. McMahan, MD, FACS.

Visit the Practice Management Center Web site at **www.ama-assn.org/go/pmc** for more information.* AMA physician members and their practice staff can also send questions or concerns about claims appeals and other practice management issues via e-mail to the AMA Practice Management Center at **practicemanagementcenter@ama-assn.org**. Please include the physician name and his or her AMA member ID number.

Note that this document contains links to several AMA members-only publications and tools. For more information on becoming an AMA member, please visit the **AMA Member Center**. Please be aware that AMA Practice Management Center documents are in PDF format (PDF files require Adobe® Reader®, which you can **download** free of charge).** Some of the links contained in this document will take you to non-AMA Web sites. The AMA is not responsible for the content of other Web sites.

This document does not provide legal advice. Consultation with legal counsel may be appropriate to help review payer contracts and identify and pursue claims that should be appealed.

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

health insurer contracts before you sign

Carefully evaluating a **health insurer** contract is extremely important. Before a physician signs a contract and his or her practice staff prepare a claim to submit to a health insurer, they should have a solid understanding of how that contract will affect their practice's revenue and expenses. Health insurer contracts include provisions that will affect patient-physician relationships and also have a significant impact on the business aspect of a physician's practice. If a physician practice glosses over or ignores contract provisions, these provisions can spring to life in new and often unpredictable ways—especially during a controversy that requires the health insurer to interpret or clarify the contract.

If practice staff are not aware of the health insurer's payment policies, claims submission requirements or appeals processes, it becomes increasingly difficult to submit claims appropriately. This kind of unawareness can also impair a physician practice's ability to understand and apply the health insurer's payment method or patient coverage policies.

For these reasons, contracting with a health insurer is a continual problem for physician practices. Physicians and/or their legal counsel should carefully read and fully understand any contract they plan to sign. Physicians should also recognize that even if a health insurer presents a contract as non-negotiable, that does not prevent the health insurer from attempting to negotiate objectionable provisions.

By asking a number of questions, physicians can clarify the health insurer's claims and submission processes and requirements during the negotiation process. The following five questions can help obtain critical information about how physician practices can submit **clean claims** and obtain appropriate, timely payment for services rendered.

Practice Management Center resource tip

The AMA Practice Management Center has created several educational tools to assist you with the contracting process:

15 questions to ask before signing a managed care contract (PDF, 119KB)

15 steps to protect your practice from unfair payment tactics (PDF, 169KB)

AMA/Federation National Managed Care Contract (PDF, 611KB)

A guide to working with health plan representatives (PDF, 146KB)

Read your contracts: Is your practice losing revenue through rental network PPOs? (PDF, 161KB)

Read your contracts—protected health information (PHI) (PDF, 38KB)

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1. What is your reimbursement under this contract?

Health insurer contracts are essentially contracts in which one party, the health insurer, pledges to pay for the services of another party, the physician. Yet many health insurer contracts not only fail to set forth which services they cover but also do not provide enough information for the physician to determine what the health insurer will pay him or her. For example, many contracts refer to an attached fee schedule, which the health insurer can modify "from time to time"—but the health insurer never attaches the fee schedule.

Physicians should assess whether the health insurer contract provides enough information to determine reimbursement for a service rendered. Does the health insurer contract include a comprehensive fee schedule? If not, physicians should ask the health insurer to provide fee schedules, rates and information for their practice's most commonly performed and billed procedures. The health insurer may argue that producing an accurate fee schedule is too complex. However, health insurers can readily determine payment when a physician practice submits a claim. The health insurer should also provide physicians with detailed information on their payment methodology, including their recognition of **Current Procedural Terminology, Fourth Edition (CPT®)** codes, guidelines and conventions.* A physician practice cannot assess the appropriateness of a health insurer's claim payment without access to its comprehensive fee schedule or payment methodology.

2. Can the health insurer unilaterally change the reimbursement terms?

A health insurer contract may include language that essentially gives the health insurer the right to unilaterally change the reimbursement terms. For example, when a contract provides for a fee schedule that can be modified "from time to time," it permits the health insurer to unilaterally reduce reimbursement amounts. If a contract includes such a term, physicians should note whether the contract requires the health insurer to provide notice of any reimbursement change. It is also important to note whether there is a mechanism for the physician to terminate the contract if the change in reimbursement is not acceptable. Without advance notice of a change in the health insurer's payment policy, practice staff will find it difficult to assess the appropriateness of a claim reimbursement that appears to be underpaid.

3. Is the health insurer obliged to pay you promptly?

Delayed payment of claims submitted to health insurers is a chronic problem for physician practices. When a health insurer contract is silent about prompt payment, it does not give the physician any rights to prompt payment or the health insurer any responsibilities to pay promptly. The physician should review the health insurer contract to determine whether it includes a specific payment period and whether the health insurer agrees to pay interest if it delays payment beyond that time period. When health insurers delay payments, the result is increased administrative follow-up, billing and patient inquiries for the physician practice.

Many states now have laws requiring prompt payment of claims. Physicians can determine whether their state has such a law by viewing a **chart created by the AMA's Advocacy Resource Center** (PDF, 206KB) or contacting the physician's state medical association. If their state has such a law, physicians should determine whether the health insurer contract complies with the time frames, interest penalties and other claims processing and payment provisions. If their state does not have such a law, it becomes more important for the contract to contain such a timely payment provision.

Determining how the contract defines a clean claim is also important. A health insurer may deny a claim that does not meet its definition of a clean claim. Such claim denials add an additional administrative cost for the physician practice because the practice staff will have to resubmit the claim.

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4. How does the contract define “medically necessary” care? How does a physician determine whether a patient’s benefit plan covers medically necessary services?

A health insurer generally pays for covered services if they are medically necessary. The health insurer contract should contain an objective standard for determining medical necessity. The AMA’s policy defines medically necessary care as “health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.”

Physicians should be aware that some contracts define medical necessity according to the health insurer’s own arbitrary cost criteria, such as the “least costly alternative.” Physicians should also be concerned when a health insurer’s contract makes medical necessity decisions the responsibility of the health insurer’s medical director. When a physician determines that a particular service or procedure is medically necessary for his or her patient, that clinical decision does not determine whether the patient’s health insurance will cover the service or procedure. Physicians should closely review the health insurer’s contract to determine whether or not it poorly defines or does not define the services the health insurer covers. This lack of specificity works to the health insurer’s advantage, giving them more discretion to deny medically necessary care.

Regardless of how the contract defines covered services, a health insurer should have an easily accessible system for physician practices to confirm whether a service is covered at the time the patient receives care. Such confirmation at least enables the physician to inform the patient that the service is not covered and that he or she will be responsible for payment.

5. Does the contract or administrative manual clearly designate all services and procedures subject to prior authorization requirements?

If a physician provides medically necessary care to a patient and finds out after the fact that the health insurer requires prior authorization, the health insurer may deny the claim and refuse to pay for the service provided. If neither the health insurer contract, the administrative manual nor the provider Web site provides this information, physicians should insist on obtaining a list of services and/or procedures that require prior authorization in writing before signing the contract. Physicians should also determine whether the health insurer provides an efficient, reliable mechanism through which the practice can obtain prior authorization 24 hours a day, seven days a week.

These questions are a good starting point for obtaining necessary claims submission and payment information when reviewing a health insurer contract. However, there are additional topics physicians also need to address. The AMA/Federation **National Managed Care Contract** (PDF, 611KB) includes 12 issue briefs on numerous issues, including prompt payment, **rental network PPO** arrangements (in which a health insurer rents its provider networks to a third party), **all-products** provisions and medical necessity. Visit the AMA Web site at **www.ama-assn.org/go/pmc** to view the AMA/Federation National Managed Care Contract and other related educational tools.

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Overview

The **claims management process** is the physician practice's internal workflow for preparing, submitting and collecting claims. The claims management process begins at the front desk when practice staff collect the necessary patient and health insurance information. The process ends only when the physician practice receives the appropriate payment for the service rendered.

The purpose of this document is to help physician practices review the efficiency of their current internal claims management process. Physician practices can adapt this document's sample forms and policies to fit their specific needs. However, the AMA encourages physicians and their practice staff to review their practice's existing policies and health insurer requirements, along with applicable state and federal laws and regulations (i.e., Health Insurance Portability and Accountability Act of 1996 [HIPAA]), before using a sample form or implementing suggested policy. By visiting **www.ama-assn.org/go/hipaa**, physicians and their practice staff can obtain more information regarding how HIPAA will affect their practice.

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Claims management process

The claims management process involves every member of the physician practice team: registration staff, coding staff, billing and collection staff, clinical staff and physicians. The benefits physician practices can experience with a successfully implemented claims management process include:

- Increased staff efficiency
- Streamlined claims billing processes
- Increased number of clean claims submitted
- Reduced number of claims denied
- Timely and accurate payment from the health insurer

Physician practices often greatly underestimate the financial impact of an efficient claims management process. An efficient process will significantly reduce the physician practice's administrative costs—including time-consuming administrative efforts like investigating and appealing claims that health insurers have denied—and will help the physician practice retain applicable interest revenue. More importantly, having an efficient claims management process will alleviate the negative effect on physician-patient relationships that delayed or inappropriate health insurer payments can cause—especially when patients receive inappropriate balances due on the health insurers' **explanation of benefits (EOB)**.

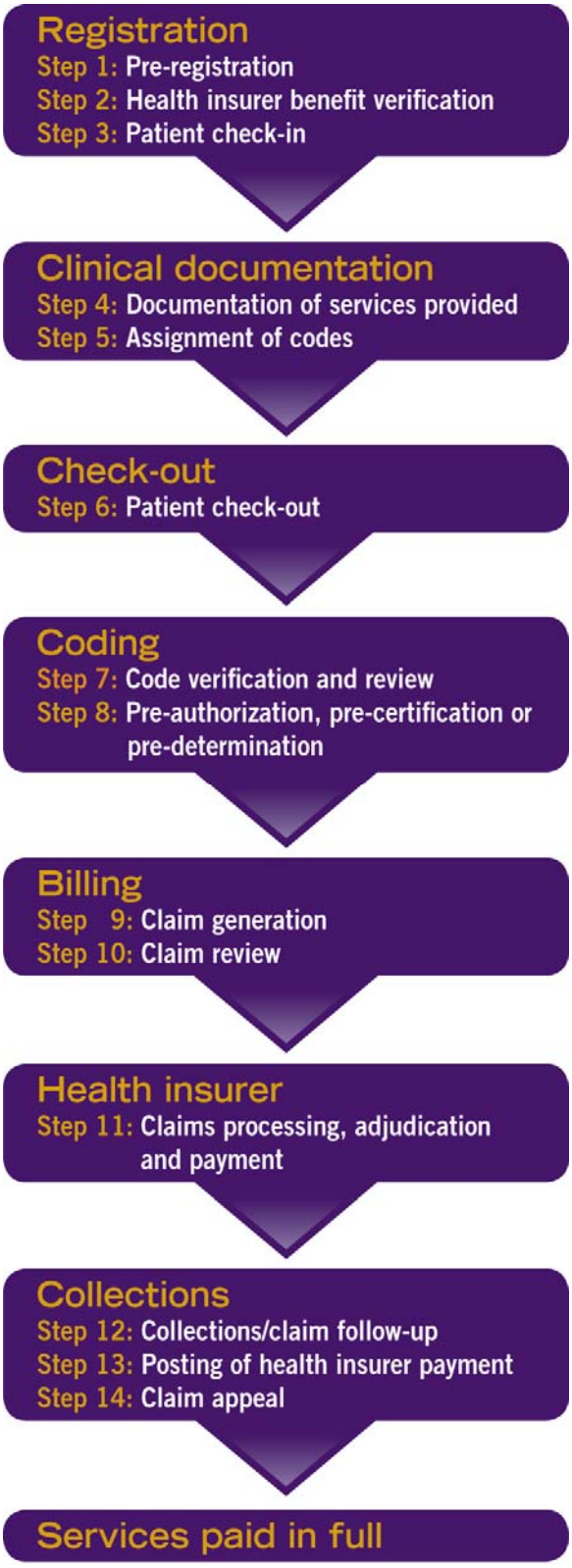
The following graphic shows the job functions a physician practice should perform in a sample claims management revenue cycle. This sample cycle is not one-size-fits-all; physician practices should modify the cycle to fit their specific needs. Several factors that will dictate the number of staff needed for these functions include:

- Type of facility
- Number of physicians
- Specialty focus
- Online capabilities

Smaller physician practices may have one or two staff members dedicated to performing these functions, while larger multi-specialty practices with several physicians may have a department dedicated to each functional area. Regardless of the size of the physician practice, however, it is critical for the physician practice to assign each function to a specific staff member

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Sample physician practice claims management revenue cycle



Registration

1. Pre-registration The registration staff should collect the patient's demographic information and health insurance information and accurately enter it into the practice management database.

2. Health insurer benefit verification The registration staff should confirm the patient's benefits, applicable deductibles and/or co-payments by calling the health insurer or through online verification.

3. Patient check-in The registration staff should make a copy of the patient's health insurance card to obtain his or her health insurance information. Registration staff can enter this information in their **health insurer reference log** and health insurer **follow-up log** for future reference. The registration staff should also verify whether a returning or established patient has had any change in his or her health insurance information. The registration staff should also give the patient a copy of the physician practice's payment and privacy policies during check-in.

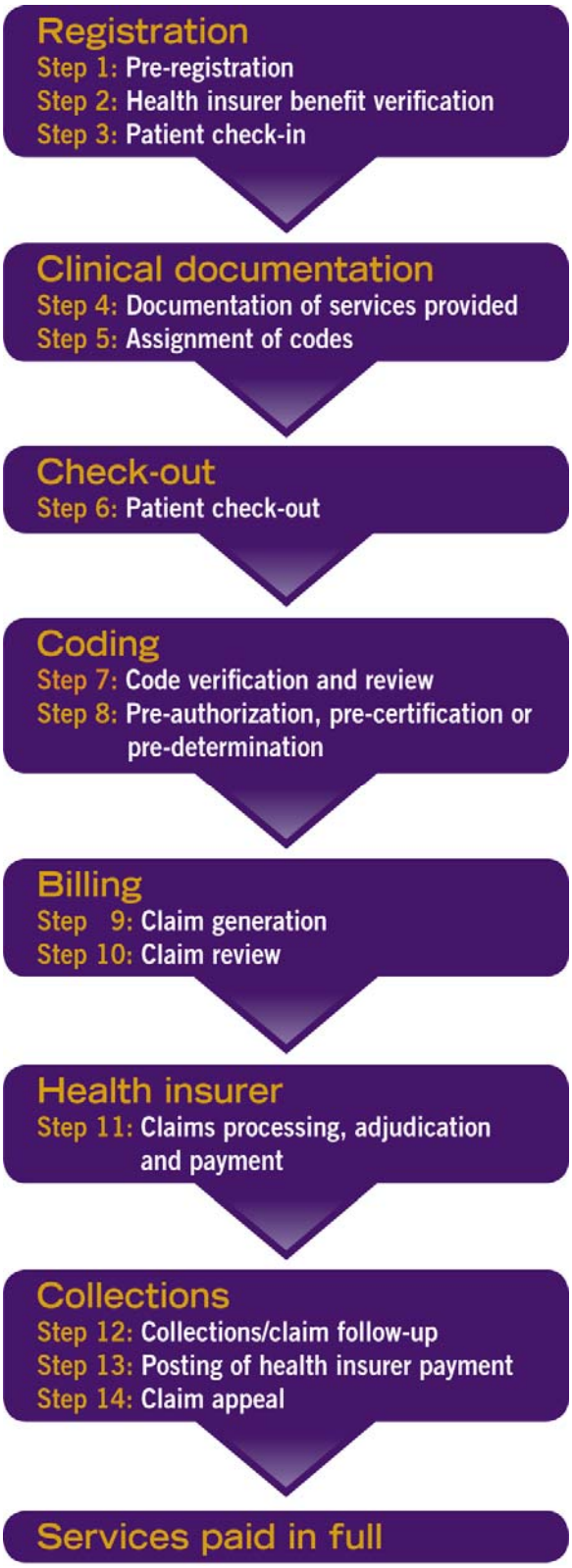
Clinical documentation

4. Documentation of services provided The treating physician and/or clinical staff should document the patient's history, symptoms, diagnosis and treatment plan—including appropriate tests that may be ordered—in the medical record.

5. Assignment of codes The treating physician and/or clinical staff should assign the appropriate **International Classification of Disease–9th Edition–Clinical Modification (ICD-9-CM)** code(s) and CPT code(s), document these codes in the medical record, and record code information on the physician practice's **super bill**.

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Sample physician practice claims management revenue cycle (continued)



Check-out

6. Patient check-out The registration staff should collect the patient's balance (e.g., deductible, co-payment) and schedule the next appointment.

Coding

7. Code verification and review The coding professional should verify and review the codes the physician and/or other clinical staff provide, based on the documentation in the medical record.

8. Pre-authorization, pre-certification or pre-determination, as needed The coding professional should contact the health insurer for **pre-authorization**, **pre-certification** or **pre-determination** of the patient's benefit coverage prior to a procedure or service; the health insurer may require this step. The coding professional should document the health insurer's authorization number and supporting documentation and forward this information to the staff responsible for billing.

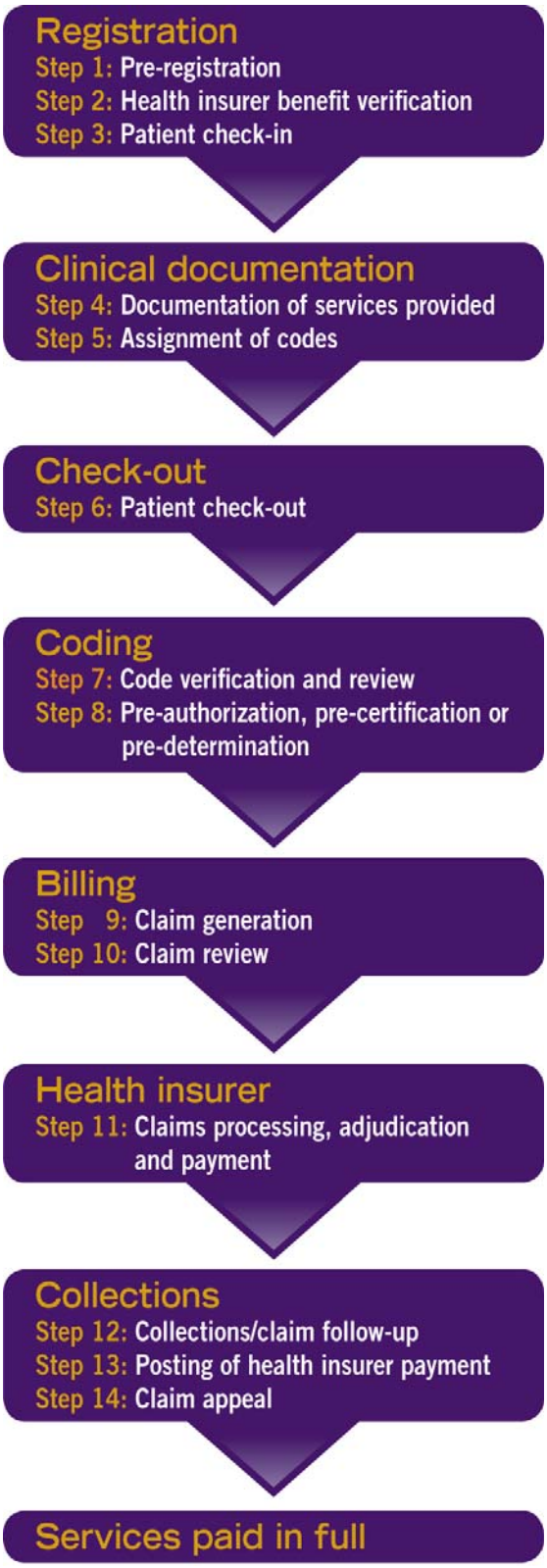
Billing

9. Claim generation The billing staff should enter the codes and fees accurately—as they appear on the physician practice's super bill or patient encounter form—and then generate a paper or electronic claim.

10. Claim review The billing staff should review each claim for completeness and accuracy before submitting it to the health insurer.

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Sample physician practice claims management revenue cycle (continued)



Health insurer

11. Claims processing, adjudication and payment The health insurer should process the claim, and if they approve it, they should route a payment to the physician practice along with a copy of the EOB. The health insurer should route the original EOB to the patient.

Collections

12. Collections/claim follow-up The collections staff should follow up with the health insurer after submitting the claim to verify that the health insurer received the claim and ensure that they are processing it.

13. Posting of the health insurer payment The collections staff should verify the payment and post it in the physician practice's accounts receivable.

14. Claim appeal If the collections staff deem the payment inappropriate, they should investigate why the health insurer did not pay the claim appropriately and determine whether they should appeal it.

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Components of an effective claims management revenue cycle

Registration

Step 1: Pre-registration (appointment scheduling) Back to graphic

The registration staff play an important role in the claims management revenue cycle. These individuals identify the reason for the visit, gather the general patient registration information (such as the patient's demographics and health insurance information) and schedule a convenient appointment time for the physician and patient. The registration staff might also verify the patient's health insurance coverage, pre-authorization requirements and/or referral physician information and then complete the necessary forms.

Practice Management Center resource tip:

The AMA Practice Management Center has created the educational tool in collaboration with the Kentucky Medical Association (KMS), "**Appointment scheduling to improve your bottom line**," (PDF, 26KB) which will assist you in formulating questions to ask the patient when scheduling an appointment.

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Figure 1: Sample new patient information sheet contains the typical information the registration staff should request when a patient registers. This information streamlines the benefit verification and claims data entry processes. The information includes the name of the health insurer, type of plan, policyholder's name, identification number, group/plan, policy number and the health insurer's telephone number for benefit verification. The practice staff must include all the patient information that the health insurer requires to submit a complete and error-free claim.

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In addition to recording the general patient information, the registration staff should remind the patient of any outstanding balances and confirm the physician practice's payment policies prior to the date of service. The practice staff should also mention these payment policies when the patient arrives for a scheduled visit. Tools a physician practice might consider using to convey patients' financial responsibility for their health care include:

- Patient welcome letters
- Educational brochures
- Insurance fact sheets
- Medical cost estimate forms for complex services

Practice Management Center resource tip:

It is also important to determine whether the patient will be in-network or out-of-network, because this status will effect which method of payment the health insurer will use and how much they will pay you. The AMA Practice Management Center has created the educational resource, "**Out-of-network payment challenges for the physician practice**," (PDF, 151KB) to assist you with these issues.

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The AMA's publications, **Mastering the Reimbursement Process, Fourth Edition** and "**Helping your patients understand their billing and payment responsibilities**," (PDF, 323KB) provide samples of these tools that convey patients' financial responsibility and suggest ways physician practices can effectively communicate their payment policies and procedures and insurance processing policies.

Sample practice payment policy script

It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. This may only be your co-payment and deductible, but we do ask for payment at the time of your visit.

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Step 2: Health insurer benefit verification

Back to graphic

The registration staff should verify a new patient's benefits and coverage before the physician practice accepts him or her or initiates services. Verifying benefits and coverage is another important step for physician practices to secure payment and prevent health insurer denials. Frequently, patients present outdated health insurance cards with invalid information. Practice staff have no way of knowing whether the patient is eligible for coverage without verifying this information directly with the health insurer. A health insurer is more likely to deny a claim a physician practice submits if that practice does not verify patient benefits.

The registration staff can verify a patient's benefits simply by calling the health insurer at one of the phone numbers listed on the patient's insurance card or in the health insurer's provider manual. It is becoming more common for physician practices to verify patient benefits online through the health insurer or an **Application Service Provider (ASP)**. The most important data to verify when obtaining patient benefit information by telephone or online is contained in **Figure 2: The employer/insurance verification information form** and **Figure 3: The patient/insurance coverage verification form**. This information includes confirmation of the applicable deductibles and co-payments; benefit coverage for in-network versus out-of-network services; and the patient's coverage for any procedures, services or tests that the physician practice may perform.

The physician practice should keep patients informed about their health insurance benefits and coverage—particularly any health insurer requirements that may affect the patient's coverage, such as a policy exclusion or an unmet pre-existing condition waiting period. These types of insurance provisions may produce claim denials that physician practices are typically not permitted to appeal. When dealing with a self-insured group, the employer—not the health insurer—has the final authority to approve or deny coverage. If the physician practice identifies these types of coverage provisions in advance, the practice staff can discuss payment options with the patient. Physician practices should also be aware that the information the health insurer sends is only a quote of benefits—not a guarantee of payment. Health insurers commonly communicate this disclaimer before releasing a patient's benefit information.

Claim generation

The registration staff are responsible for collecting and accurately entering the required patient demographic and health insurance coverage information into the practice management database. The registration staff must be thoroughly trained to enter the required health insurance data; an incorrect keystroke or placement of information in the wrong data field may result in a health insurer claim denial. If the registration staff overlook or enter just one number or letter in the policyholder's ID number incorrectly, the health insurer will be unable to identify the policyholder, and they will deny the claim.

Health insurers may deny or delay a claim if the registration staff have not updated or properly entered the health insurer's billing address and/or electronic payer number in the practice management database. When this information is incorrect, the health insurer will not receive the claim—at least, not on time—and the physician practice may go unpaid. If the health insurer returns a claim because of an invalid or expired mailing address, the contractual timeframe for the physician practice to submit a claim might have expired. The result is a **stale**

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claim that, depending on the health insurer contract, may stipulate that the physician practice must write off the billed charge(s).

The physician practice cannot bill the patient for the unpaid procedure and/or service when the claim submission deadline has passed; balance billing is usually not allowed. Therefore, it is important that the registration staff have the essential training and tools to perform registration procedures that will increase the accuracy and efficiency of patient registration services.

The registration staff need to maintain two additional reports that list pertinent health insurer contact information for coverage issues and electronic claims submission. The registration staff should locate and record such information in the practice's **health insurer reference log**. The first report should list each health insurer's specific requirements and include a name and number for the health insurer provider representative. The second report, which registration staff should request from the practice's billing service or claims **clearinghouse**, should contain the list of health insurers and their payer numbers for billing purposes.

The **health insurer reference log** can be a useful reference for locating and complying with the insurer's claims processing procedures. The registration staff should list the applicable process requirements for each health insurer because the coding professional will need this information to obtain the necessary approvals before the physician provides services. If the physician practice does not meet these processing requirements, the health insurer will most likely deny the claim. See **Step 8: Pre-authorization, pre-certification or pre-determination** for more detailed information regarding pre-authorization, pre-certification and pre-determinations.

Processing requirements

Practice staff should enter health insurer contact and policy information as well as state and contract regulations that will help them in their practice's claims management revenue cycle in the **health insurer reference log**. Including information such as the following can be particularly beneficial:

Eligibility verification

The registration staff should verify eligibility to ensure that the health insurer's conditions or qualifying factors for the patient (i.e., member) are met and that the patient is eligible for the procedure and/or service. This includes determining whether the patient was covered by the health insurance policy when he or she first sought medical treatment.

Pre-determination

Under the pre-determination health insurer requirement, the registration staff must typically request written confirmation that a service or procedure to be performed is contained in the patient's benefit coverage. This pre-determination, however, is not a guarantee of payment. The health insurer might provide the maximum dollar amount for the procedure and/or service, but payment is subject to the member's benefits and eligibility at the time of service, and the health insurer will not pay if the member has exceeded his or her maximum benefits.

Pre-authorization

The coding professional should contact the health insurer to verify the patient's coverage and determine that the proposed care is medically necessary (according to the health insurer) before the procedure and/or service is performed.

Pre-certification

Prior to treatment like hospitalization, diagnostic tests or surgical procedures, the coding professional should contact the health insurer to determine whether the member's proposed care is covered under their insurance contract.

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Referral requirement

Health insurers have specific requirements for introducing or transferring a patient's care from one physician to another or to another health care provider. It is important for practice staff to familiarize themselves with the requirements of each health insurer with whom their physician practice has an agreement.

Second surgical opinion requirement

The member must obtain a second surgical opinion from a physician regarding the necessity of the originally prescribed treatment plan.

Practice staff should include additional health insurer requirements for claims submission in their practice's health insurer reference log.

The clearinghouse report serves as a quick reference tool to locate the correct health insurer payer number to transmit electronic claims. Practice staff should verify this information on the front end of the claims management revenue cycle to reduce potential claim submission errors. Completing and reviewing the steps in the registration process will enhance the claims management revenue cycle, reduce the number of claim denials and increase revenue.

Table 1

Sample clearinghouse report

	Health Insurer A	Health Insurer B
Accept electronic claims	Yes	Yes
Payer numbers	111111	222222
Notes		

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Step 3: Registration: patient check-in

Back to graphic

The registration staff should obtain a copy of the patient's health insurance card at the time of his or her first visit. Reviewing the card before the follow-up visit as well will help the physician practice routinely verify the required patient and health insurance information. As remedial as this task may seem, it is the most critical component in securing a health insurer payment for a claim the physician practice submits appropriately. The registration staff should routinely update patient health insurance information, including secondary health insurance information, by asking patients at each visit whether their health insurance information has changed or if they have received a new health insurance card since their last visit.

The AMA encourages physician practices to involve and educate patients about medical treatment decisions, as well as health insurer payment policies and procedures. Industry trends indicate that both health insurers and employers are shifting more of the responsibility and cost of health care treatment and payment to the patient. In response to this shift, physician practices need to proactively consider either establishing or revising their payment and collection policies accordingly.

Practice Management Center resource tip:

The AMA Practice Management Center created the following two educational resources to help you establish payment and collection policies in your practice:

"**Helping your patients understand their billing and payment responsibilities**" (PDF, 324KB)

"**Understanding your health insurance policy and payment practices**," (PDF, 28KB) created in collaboration with the Kentucky Medical Association (KMS)

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Clinical documentation

Step 4: Patient encounter: medical record documentation

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The physician and clinical staff assess the patient's condition and thoroughly document the symptoms, diagnosis and treatment plan (including lab requests), and all procedures and services provided in the medical record. This is a critical step in the claims management revenue cycle. An appropriately documented patient medical record can reduce many of the hassles associated with claims processing. It may also serve as a legal document to verify the care provided. **Table 2: Principles of documentation** lists ten things physicians and practice staff should keep in mind when recording information.

Table 2

Principles of documentation

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include: the date; the reason for the encounter; appropriate history and physical exam; review of lab, x-ray data and other ancillary services, where appropriate; assessment; and plan for care (including discharge plan, if appropriate).
3. Past and present diagnoses should be accessible to the treating and/or consulting physician.
4. The reasons for and results of x-rays, lab tests, and other ancillary services should be documented or included in the medical record.
5. Relevant health risk factors should be identified.
6. The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient non-compliance, should be documented.
7. The written plan for care should include, when appropriate: treatments and medications, specifying frequency and dosage; referrals and consultations; patient/family education; and specific instructions for follow-up.
8. The documentation should support the intensity of the patient evaluation and/or treatment, including thought processes and the complexity of medical decision-making.
9. All entries to the medical record should be dated and authenticated.
10. The CPT/ICD-9 codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

Source: Principles of Medical Record Documentation, 1992, American Health Information Management Association, American Hospital Association, American Managed Care and Review Association, American Medical Association, American Medical Peer Review Association, Blue Cross and Blue Shield Association and Health Insurance Association of America.

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The medical record should be a tool of clinical care and communication. The physician practice should support the ICD-9-CM and CPT codes it reports on the health insurer claim form with specific documentation of the diagnosis, procedures and services. A guideline to keep in mind is that if the physician practice does not document a procedure or service, then as far as the health insurer auditor is concerned, the physician practice did not provide that procedure or service. The physician practice should include the following in the documentation:

- The site of service
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided
- Indication of the complexity of the procedure or services provided, which will support the accuracy of the CPT codes the practice reported

Unless the health insurer can easily infer these items by reviewing the medical records, the physician practice should report them.

Practice Management Center resource tip:

Another way to interact with your patients is through the Internet. Online medical consultations, also known as e-visits, present opportunities for growth and increased efficiency in the physician practice. Read the Practice Management Center educational resource, "**Online medical consultations: Connecting physicians with patients**," (PDF, 679KB) to learn more about this new patient convenience and whether it is right for your practice.

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Step 5: Assignment of codes

Back to graphic

Identifying diagnostic and procedural codes

Physicians should include the appropriate ICD-9-CM code in the dictation and/or medical record to describe the appropriate patient diagnosis and the CPT codes to describe the services and procedures provided during the patient encounter. Physicians should be aware of the physician work included in a CPT code that defines a specific procedure and/or service to ensure that they accurately report the services provided during a patient encounter.

Coding reference card/super bill

A **coding reference card** contains a listing and description of the physician's most commonly recorded ICD-9-CM and CPT codes in the physician's own terms. Typically contained on one page or less, this listing can be a useful tool, especially for physicians who routinely perform a distinct or select set of procedures and/or services. The coding reference card will help the physician select the appropriate diagnostic or procedural codes for placement on his or her practice's **super bill** (**Figure 4: Encounter form—super bill**).

The practice staff responsible for the billing function should create the super bill, which should contain the ICD-9-CM and CPT codes the physician practice commonly uses, as well as any other codes the physician practice commonly reports. The physician should check the appropriate ICD-9-CM and CPT codes on the super bill that apply to the patient encounter to assist in documenting and simplifying the billing process.

To help ensure correct coding, the practice staff responsible for the billing function should frequently update the coding reference card and super bill, incorporating new and revised ICD-9-CM and CPT codes and making the documents reflect changes in the commonly provided services. Also, the practice staff should include extra space in the super bill for recording additional procedures or services the practice does not commonly provide.

If the physician practice does not have a super bill available, the **AMA Express Reference cards** can be useful. They are available for the following:

- CPT codes
- ICD-9-CM
- Health Care Financing Administration's Common Procedure Coding System (HCPCS)
- CPT modifiers

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Check-out

Step 6: Patient check-out

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During check-out, the registration staff should schedule the next convenient appointment time for the patient, if needed, and collect the patient's co-payment and/or deductible if they did not collect it during the check-in process.

The registration staff should refer to the patient's policy to determine the appropriate co-payment to collect from the patient. If the patient indicates that he or she is unable to make a payment for the services provided, the registration staff should call the practice manager to discuss the co-payment with the patient. The practice manager should reinforce the seriousness of the practice's billing policy, referring the patient to the copy of the practice's billing policy that they received during check-in, and resolve the non-payment issue directly with the patient through a payment plan the practice manager and patient agree upon.

The co-payment and deductible collected at patient check-out may seem to be a small amount at first glance. However, the importance of this collection is evident when taking the following formula into account:

Amount of patient co-payment	X	Number of patients seen in one day	X	Approximately 260 billable days per year	=	Amount of co-payments collected

Failure to collect co-payments and deductibles can add up to considerable lost revenue. It also costs the physician practice additional time spent billing and collecting the co-payments after the fact.

The registration, clinical coding and billing staff should maintain a reporting relationship that reinforces the role that each staff member plays in ensuring accurate claims entry and routine collection of patient co-payments. Developing a report card with the following performance measures may assist the practice staff in this joint effort.

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Table 3

Sample physician practice report card: Staff productivity expectations	
Explanation of benefits (EOB) denial rates	%
Collection of co-payments at time of service	%
Scheduling of following appointment at check-out	%
Charge entered within 24 hours	%
Collection of past-due balances	%
Registration accuracy	%
Coding accuracy	%

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Coding

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Step 7: Review and/or assignment of ICD-9-CM and CPT® modifiers, codes and conventions

The optimal coding process in physician practices occurs when physicians and coding professionals work as a team to accurately record the patient diagnosis and services provided. Because the physician is ultimately responsible for the codes selected and billed, the AMA recommends that the physician initiate the process by providing the ICD-9-CM and CPT codes describing the diagnosis and services provided during a patient encounter. The coding professional should then review the code selections for appropriateness, based on the medical record documentation. Open communication between physicians and coding professionals is highly effective in streamlining the reporting process and allowing a quality control measure.

After reviewing the medical record documentation and code selection on the super bill, the coding professional should ensure that the physician practice has identified and coded all the physician services rendered as well as medications and supplies the physician practice provided. If appropriate, the coding professional will add modifiers based on AMA CPT coding guidelines and conventions and rank the ICD-9-CM and CPT codes in the appropriate order. The most comprehensive CPT code should be listed first. The coding professional should also report the primary ICD-9-CM code to the highest level of specificity (e.g., make sure the fifth digit is included when required).

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Step 8: Health insurer pre-authorization, pre-certification and pre-determination

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The physician should carefully review the health insurer contract—including its definitions of specific terms, such as pre-authorization, pre-certification and/or pre-determination—to ensure that the physician practice complies with the health insurer's verification of a patient's coverage for benefits. Physicians should be aware that health insurers, and even employer groups, may have their own inclusion and exclusion criteria.

Pre-authorization

Practice staff may obtain health insurer pre-authorization by directly calling the health insurer's registered nurse, another designated health insurer employee or an affiliate company conducting medical reviews on the health insurer's behalf. Some health insurers will allow the physician practice to complete a health insurer pre-authorization form that the practice staff can either fax or mail to the health insurer for review and determination (**view a sample fax form**). Other health insurers have online pre-authorization processes available. The physician practice should determine which method of pre-authorization is the most time- and cost-efficient for their specific practice.

The health insurer may require pre-authorization if the physician practice provides in-office laboratory services or routinely orders other outpatient diagnostic tests, such as ultrasounds, MRIs or CT scans. It is important for the physician practice to determine whether a health insurer requires pre-authorization (also called prior authorization) for these services. Health insurers generally require pre-authorizations for specific in-office and/or outpatient diagnostic tests and surgical procedures.

The purpose of health insurer pre-authorization is to establish that the health insurer's medical necessity guidelines have been met for the proposed service. Pre-authorization is most often provided for cost containment purposes.

Health insurers require the following information for pre-authorization:

- Patient's name, ID number, health insurer group name and/or number
- Treating physician's name and tax ID/PIN
- Date, type and place of service
- CPT code (service/procedure), if available
- ICD-9-CM code (primary diagnosis)
- Brief history of present illness

The coding professional should have the patient's medical record available for reference when calling the health insurer representative. The questions the health insurer representative will ask will be related to the nature of the

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patient's symptoms and their duration and previous and current medical management. When the health insurer obtains and processes the necessary information, the coding professional should receive a pre-authorization reference/approval number. The coding professional should always document the name of the health insurer representative who authorized the service, the date and the reference number. The coding professional must include the pre-authorization reference/approval number in the required field on the **CMS-1500** (formerly HCFA-1500) claim form to help prevent the health insurer from denying or underpaying the claim.

Sometimes the health insurer representative cannot immediately approve a requested test or procedure, and they must forward the request to the health insurer's medical director or another designated clinician for review. In this instance, the practice staff should send the patient's relevant documents to the health insurer representative, who typically will forward them for review to the medical director or another designated clinician the health insurer employs. At times, the medical director or another designated clinician may need to speak directly to the treating physician before the health insurer determines the authorization status.

another designated clinician. **Keep in mind that pre-authorization is not a guarantee of payment.** The health insurer representative conducting the review should always inform the coding professional that, although the pre-authorization requirement was met, the coding professional must still contact the health insurer's claim department for patient eligibility and benefit requirements.

Physician practices should be aware that retrospective denials of pre-authorizations are becoming an increasing problem for many physician practices.

Pre-certification

In most cases, the health insurer requires pre-certification for a patient's hospital admission and/or surgical procedure. The physician practice should contact the health insurer representative and provide the required patient information, including the procedure to be performed, explanation of its medical necessity and the expected length of stay. If the information meets the health insurer's pre-certification criteria, the health insurer should provide the physician practice with a pre-certification number, also called a case reference number or authorization number. The practice staff should document the pre-certification number in their practice's **health insurer follow-up log** for future reference. Typically, health insurers require physician practices to record the pre-certification number on the claim submission form before they will process the claim.

The pre-certification and pre-authorization processes verify that the service meets the health insurer's medical necessity criteria. This process differs from the pre-determination of benefits procedure in which the health insurer authorizes the benefits for the service.

Pre-determination

Unlike submitting pre-authorization requests, the coding professional cannot communicate the required information for a pre-determination of benefits request via telephone. Instead, the coding professional must submit the information in writing on the physician practice's letterhead. The purpose of a pre-determination is to request in advance the determination of a patient's coverage for a specific service or procedure. The health insurer will usually inform the coding professional which procedures require pre-determination.

The health insurer will advise the coding professional to submit a letter (**view sample**) for prior evaluation of the planned patient procedure and/or service. If the physician practice does not submit this letter, the health insurer will most likely deny the claim. Because it is more difficult to substantiate medical necessity after services are provided, the coding professional should submit **pre-determination letters** to health insurers for certain procedures and/or services the health insurer commonly denies for medical necessity. Submitting this information in advance will prevent the need to appeal an adverse determination later.

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A pre-determination letter should include the following information:

- Patient's name, ID number, health insurer group name and/or number
- Treating physician's name and tax ID/health insurer PIN
- Date and place of service
- Length of time the patient has been under the physician's care
- Description of service and CPT code
- ICD-9-CM code
- Fee for the test or procedure
- Detailed history of the patient's present illness, including subjective and objective findings, previous treatment, exam finding and outcome (if applicable), and medical necessity

The coding professional should be sure to include copies of applicable medical records, such as progress notes and test results, with the pre-determination letter.

It is important for the practice staff to notify the patient when his or her health insurer requires or recommends a pre-determination for the necessary service and give him or her the approximate timeframe of the health insurer review process. Health insurers typically require or recommend pre-determinations for tests or procedures with potential benefit restrictions, such as those deemed experimental, investigational, cosmetic or not medically necessary (according to the health insurer's definition).

The health insurer representative should review the pre-determination letter and supporting documentation and forward a determination letter to the physician and patient, indicating whether the health insurer will cover the test or procedure. The letter may also include coverage information, maximum dollar amount allowable for the procedure and/or service and a specific time period for which the pre-determination authorization is valid (some health insurers' pre-determinations have expiration dates).

Health insurer pre-determinations are the only payment guarantee that a physician practice might receive from a health insurer. However, payment is subject to the member's benefits and eligibility at the time of service as well as subject to whether the member has exceeded the health insurer's maximum benefits. For this reason, many physician practices seek health insurer pre-determinations before the physician performs a procedure or service, regardless of whether the health insurer requires it. The physician should be aware that the health insurer may pre-determine a service as meeting their criteria, but if the patient's condition changes, the health insurer may later determine that this service no longer meets their criteria, overturn the decision and deny the claim.

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Billing

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Practice Management Center resource tip:

In addition to the information below, the Practice Management Center has created several educational documents to help you in the automation of your practice:

The effect a payer's claim edits can have on the repricing and payment of your claim (PDF, 262KB)

Frequently asked questions regarding electronic funds transfer agreements (PDF, 29KB)

What is a medical billing service? (PDF, 24KB)

Appeal that Claim (PDF, 2MB)

The benefits of electronic claims submission—improve practice efficiencies, (PDF, 126KB) developed in collaboration with the Connecticut State Medical Society (CSMS)

What is a clearinghouse?, (PDF, 33KB) developed in collaboration with the Kentucky Medical Association (KMS)

How to select a billing software vendor for the physician practice, (PDF, 29KB) developed in collaboration with the Kentucky Medical Association (KMS)

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Step 9: Claim generation and submission: charge capture

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The billing staff is responsible for accurately entering the ICD-9-CM and CPT codes and fees as they appear on the practice's super bill. The practice staff should generate a claim and either mail it or transmit it electronically to the health insurer, according to its submission requirements, or through a billing service, clearinghouse or application service provider.

Practice Management Center resource tip:

You can find information on the health insurer claims review process in the second document of this series, **Follow that Claim**.

It is important for the practice staff to review each claim before submission to ensure that they have completed all of the form's required fields. The physician practice might also use a medical billing software program that is designed to flag or prompt practice staff when a required field is missing or the data entered is invalid.

Sometimes a claim the physician practice created and transmitted to the health insurer will become lost. Here are a few options to help avoid having lost claims:

- Send the claim electronically and save the acknowledgement of the health insurer's receipt.

If allowed:

- Send the claim by U.S. certified mail, return receipt requested, or
- Personally deliver it to the health insurer's claim processing office.

If health insurers regularly challenge practice staff on claims submission issues, the practice staff should schedule weekly phone calls with those health insurers to discuss any outstanding charges. Building a rapport with the health insurer representatives can assist in resolving future issues.

Physician practice health insurer claims processing revenue cycle

The practice staff will need to examine the volume of patients seen, types of services provided and third-party payer mix to determine each health insurer's claims-processing revenue cycle. Whether practice staff generate claims at the end of each day or process them only once a week, the sooner practice staff generate and submit a claim, the sooner the health insurer can process the claim.

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Step 10: Physician practice claim review

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The practice staff should perform random claim reviews—preferably once a month but at least once a quarter. The coding professional should also review claims each day. This random review will demonstrate that the practice staff perform day-to-day claim and chart reviews and that they are submitting claims to the health insurer accurately, based on the medical record documentation. The purpose of the review is to assess the appropriateness of the physician practice's coding, billing and documentation and to examine the physician practice's compliance with federal regulations against improper inducements, kickbacks and self-referrals.

There are many ways to complete a claim review. One recommended way is to pull five to ten random medical records. Practice staff can pull this random sample per physician, per payer or by frequently denied codes.

Practice Management Center resource tip:

The AMA has created the educational resource in collaboration with the American Academy of Neurology (AAN), "**How to perform a physician practice internal billing audit**," (PDF, 58KB) to assist you in reviewing claims.

After the review, the practice staff should perform the appropriate follow-up action to correct any potential errors. Depending on the circumstances of the errors found, the physician practice should follow up with one or more of the following:

- Assigning targeted staff
- Providing physician education
- Resubmitting the claim with an explanation
- Seeking advice from a coding consultant or another physician practice expert about resolving the errors

Billing policy

The practice staff are also responsible for implementing the physician practice's billing policy. The billing policy serves to notify a patient of the billing procedure or process for medical services and the methods of payment the practice accepts. The policy should include specific billing information for each type of contracted health insurer because billing and payment requirements differ from one health insurer to another. In addition, the billing policy should address the patient's financial responsibility if the practice does not receive payment from the health insurer.

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It is important to include a statement in the billing policy that indicates the patient's financial responsibility for services provided. Many patients mistakenly believe that once they give the physician practice their health insurance information, any claim denials or fee disputes are between the health insurer and the physician practice—and are not the patient's responsibility. The practice staff should request a signed acknowledgement from the patient prior to the delivery of care to help secure appropriate payment for procedures and services. This acknowledgement should include the physician practice's policies on primary and secondary health insurer processing and patient billing and payment.

If the physician practice arranges payment plans for patients, the collection policy should include the procedures associated with patient financial agreements. The patient and the practice staff should each retain a signed copy of the financial agreement.

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Health Insurer

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Step 11: Claims processing, adjudication and payment

The health insurer should process the claim and, if they approve it, route a payment to the physician practice along with a copy of the EOB. Health insurers route the original EOBs to the patients.

Practice Management Center resource tip:

The Practice Management Center has created several educational documents to aid you in understanding what happens to a claim once it reaches the health insurer and assist you in dealing with health insurers:

Follow that Claim: Claims submission, processing, adjudication and payment

Read your contracts: Is your practice losing revenue through rental network PPOs? (PDF, 138KB)

The effect a payer's claim edits can have on the repricing and payment of your claim (PDF, 262KB)

How to prepare for a health plan retrospective audit, (PDF, 582 KB) created in collaboration with the American Academy of Neurology (AAN)

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Collections

Step 12: Collections: claim follow-up

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The practice staff responsible for handling the collection function should implement claims follow-up procedures to confirm that the health insurer received the claims and has processed them. The claims clearinghouse or health insurer will usually confirm whether or not it successfully received the claims and has them on file.

The AMA encourages physician practices to submit claims electronically. Electronic claims submission can reduce the time administrative staff would otherwise need for the claims follow-up process.

Collection policy

A physician practice collection policy establishes guidelines for handling past-due and delinquent patient accounts. Some items the collection policy should include are:

- How the physician practice handles a health insurer's account balance that is more than 60 days past due, 90 days past due or 120+ days past due (i.e., whether the physician practice sends these to a collection agency, collection attorney or credit bureau)
- How the physician practice handles a patient's account balance that is more than 60 days past due, 90 days past due or 120+ days past due (i.e., whether the physician practice sends these to a collection agency, collection attorney or credit bureau)
- How the physician practice assesses a patient's financial hardship
- A statement that addresses strong opposition to waiver of health insurer co-payment requirements

Practice Management Center resource tip:

The Practice Management Center, in collaboration with the Ohio State Medical Association (OSMA), developed "**Internal collections in the physician practice**" (PDF, 151KB) to help physicians and their practice staff understand the importance of establishing an internal collections policy in order to address outstanding patient balances and the necessary steps to take prior to sending a patient account to an outside collection agency.

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Waiver of co-payments—Physicians should be aware that forgiveness or waiver of co-payments may violate some health insurers' policies. Other health insurers may permit forgiveness or waiver if they are aware of the reasons for it. Routine forgiveness or waiver of co-payments may constitute fraud under state and federal laws. Physicians should ensure that their co-payment policies are consistent with applicable laws and with the requirements of their health insurer agreements.

The physician practice should follow its collection policy and make every attempt to collect the appropriate health insurer and patient balances due. In addition, the physician practice should handle past-due accounts as outlined in its collection policy. The physician practice may choose to outsource to a collection agency, collection attorney or credit bureau.

Practice Management Center resource tip:

Collection services can play an integral role in helping physician practices improve cash flow by securing payment from hard-to-collect delinquent accounts. The Practice Management Center developed "**How to select a collection service**" (PDF, 176KB) to offer guidance in selecting a service.

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Step 13: Posting of payment

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The practice staff responsible for billing should finish the claims management revenue cycle by monitoring every claim the physician practice has submitted to the health insurer. Their job is to verify that the physician practice receives payment in accordance with the state's prompt payment law and the prompt payment provisions outlined in the physician's contractual agreement with the health insurer.

Practice Management Center resource tip:

The Practice Management Center developed the educational resource, "**Is your practice losing revenue through inappropriate health plan adjustments?**," (PDF, 176KB) to alert physician practices of the need to carefully review health insurer EOBs in order to pinpoint and address underpayments based on the health insurer's inappropriate adjustments.

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Step 14: Claim Appeal

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If the health insurer does not pay a claim in accordance with the state's prompt payment law or the health insurer's contractual provisions, the physician practice should appeal the claim.

Practice Management Center resource tip:

The Practice Management Center developed two educational resources regarding the appeals process:

"**How to appeal inappropriate health plan claim denials**," which educates physicians and their practice staff about appealing erroneous payment reductions and denials and provides tips to assist physicians in identifying and appealing inappropriate health insurer claim denials.

Appeal that Claim, which simplifies the claim audit and appeals processes for physicians and their practice staff and helps reduce the administrative burden by delivering a step-by-step course of action to appeal an underpaid, delayed or inappropriately denied claim.

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Glossary

All products An "all-products" provision is a clause in a managed care organization (MCO) physician contract that requires, as a condition of participating in any of the MCO products, that the physician participate in all of the MCO products.

AMA Express Reference cards The AMA Express Reference coding cards are designed to facilitate proper coding by supplying the most common codes per specialty. AMA Express Reference cards allow physicians and other providers or staff members to easily find a desired code, which can then be referenced in the proper coding book. Express Reference cards are available for CPT codes, HCPCS, ICD-9-CM codes and CPT modifiers. They are available to order **online** or by calling (800) 621-8335.

Application Service Provider (ASP) A company that supplies software application and/or software-related services over the Internet via a browser. Health insurers generally contract with ASPs for their services, though the physician practice may also be charged a per-transaction fee along with a one-time set-up or monthly fee. ASPs allow physicians, payers and primarily health insurers to connect via the Internet.

Claims management process A physician practice's process of managing the preparation, submission and collection of health care claims.

Clean claim A claim that, if submitted non-electronically, meets all of the health insurer's standard submission requirements and that the health insurer has accepted for adjudication. If a practice submits a claim electronically, and it is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then this clean claim meets all the submission requirements to be in compliance with that Act.

Clearinghouse A private company that provides connectivity between physicians, billing entities, health insurers, payers and other health care partners to transmit and translate claims information (primarily electronic) into the specific format the payers require. Clearinghouses may contract with or act on behalf of one or a number of payers or contract with physician practices to transmit and/or translate claims information.

CMS-1500 (formerly HCFA-1500) The universal claim form (with instructions) non-institutional physicians and other providers and suppliers use to bill Medicare Part B for covered services. It is also used for billing some Medicaid-covered services and is the claim form most health insurers accept.

Current Procedural Terminology, Fourth Edition (CPT) A systematic listing and coding of procedures and services physicians and other providers perform. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies reporting services. This code set accurately identifies the procedure or service the physician or other provider rendered.

Explanation of benefits (EOB) The EOB may also be called the "explanation of medical benefits" (EOMB), "remittance advice" (RA) or "provider claim summary." The health insurer EOB indicates the services submitted on the claim and delineates how much of the charged amount for each service they approved, reduced or denied. The EOB might provide a reason for a particular adjustment. In addition, the EOB delineates how much of the charged amount is applied to the patient's co-payment and/or deductible.

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Health insurer In the context of this document, health insurer refers to any and all third-party payers, not limited to an exclusive provider organization (EPO), health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO) or third-party administrator (TPA).

International Classification of Disease–9th Edition–Clinical Modification (ICD-9-CM) The standard diagnosis coding system for health care claims, coordinated by the National Centers for Vital and Health Statistics (NCVHS). ICD-9-CM codes assist physicians in transforming verbal descriptions of diseases, injuries, conditions and certain procedures into numerical destinations (diagnostic coding).

Pre-authorization A prospective process to verify coverage of proposed care and establish covered length of stay.

Pre-certification A utilization management program that requires the member or the physician to notify the health insurer prior to a hospitalization, diagnostic test or surgical procedure. The notification allows the health insurer to provide an authorization number.

Pre-determination A health insurer requirement that the physician practice request confirmation from the health insurer. In some cases, this confirmation must be in writing, ensuring that a service or procedure the physician or health care provider will perform is contained in the patient's benefit coverage.

Rental network PPO A rental network PPO is not a managed care product offered by a payer to its clients. Rather, a rental network PPO exists to market a physician's contractually discounted rates primarily to third-party payers, such as insurance brokers, third-party administrators, local or regional PPOs, health insurers or self-insured employers. Here is how a rental network PPO generally works: a physician contracts with a rental network PPO and accepts a discounted rate in exchange for identification as a network physician in the PPO directory. Under this arrangement, the third-party payers that contract with the rental network PPO usually gain the advantage of having access to any and all discount agreements that the rental network PPO has negotiated with the physician, usually without the physician's prior knowledge or permission. A rental network PPO, which "sells" or "rents" its physician network to a third-party payer, generally does not take any financial risks and does not pay claims or ensure that any associated physician claims are paid.

Stale claim A health care claim that a physician practice submits after the health insurer's allowable claims submission time limit.

Super bill or patient charge slip A form a physician practice uses to record services rendered by a physician or health care professional during the patient encounter. This form typically lists all the diagnostic, service, procedural and other related codes that can be performed in the office.

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Health insurer follow-up log instructions

(Go to **health insurer follow-up log**)

Open the Excel workbook, "Health Insurer Follow-up Log."

Go to File, and click on Save As.

Save the workbook, either as "Health Insurer Follow-up Log," or a more specific name that you will remember and others will recognize.

Arrange the columns in the order of your preference.

Each worksheet in the workbook is for a different health insurer. Double click on the tab to insert the name of the health insurer you will keep track of in that worksheet. (For example, you might double click on "Health Insurer #2" and enter "Blue Cross Blue Shield.")

Each row in the worksheet is for a separate claim, so each time you file a claim, enter the relevant information in each pertinent column.

As you follow through the claims and appeals processes, update the information for that claim.

Keep track of what you've entered. Use this workbook as a record of which claims the health insurer has denied or inappropriately paid, and make sure that you follow through with appropriate appeals processes.

Periodically sort your entries by category to determine a given health insurer's payment habits. (For instance, you might sort by "Reason for Denial" and find that over half the claims that the health insurer denied are bilateral procedures. You may need to address this issue with the health insurer, or you may notice that the health insurer did appropriately pay certain bilateral procedure claims. You can look at the claims and appeals process for those successful claims to determine whether certain methods produce better results.)

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Health insurer reference log instructions

(Go to **health insurer reference log**)

Open the Excel workbook, "Health Insurer Reference Log."

Go to File, and click on Save As.

Save the workbook, either as "Health Insurer Reference Log," or a more specific name that you will remember and other staff members will recognize.

Arrange the columns in the order of your preference.

Each worksheet in the workbook is for a different health insurer. Double click on the tab to insert the name of the health insurer you will keep track of in that worksheet. (For example, you might double click on "Health Insurer #2" and enter "Blue Cross Blue Shield.")

Enter as much information as possible about each health insurer.

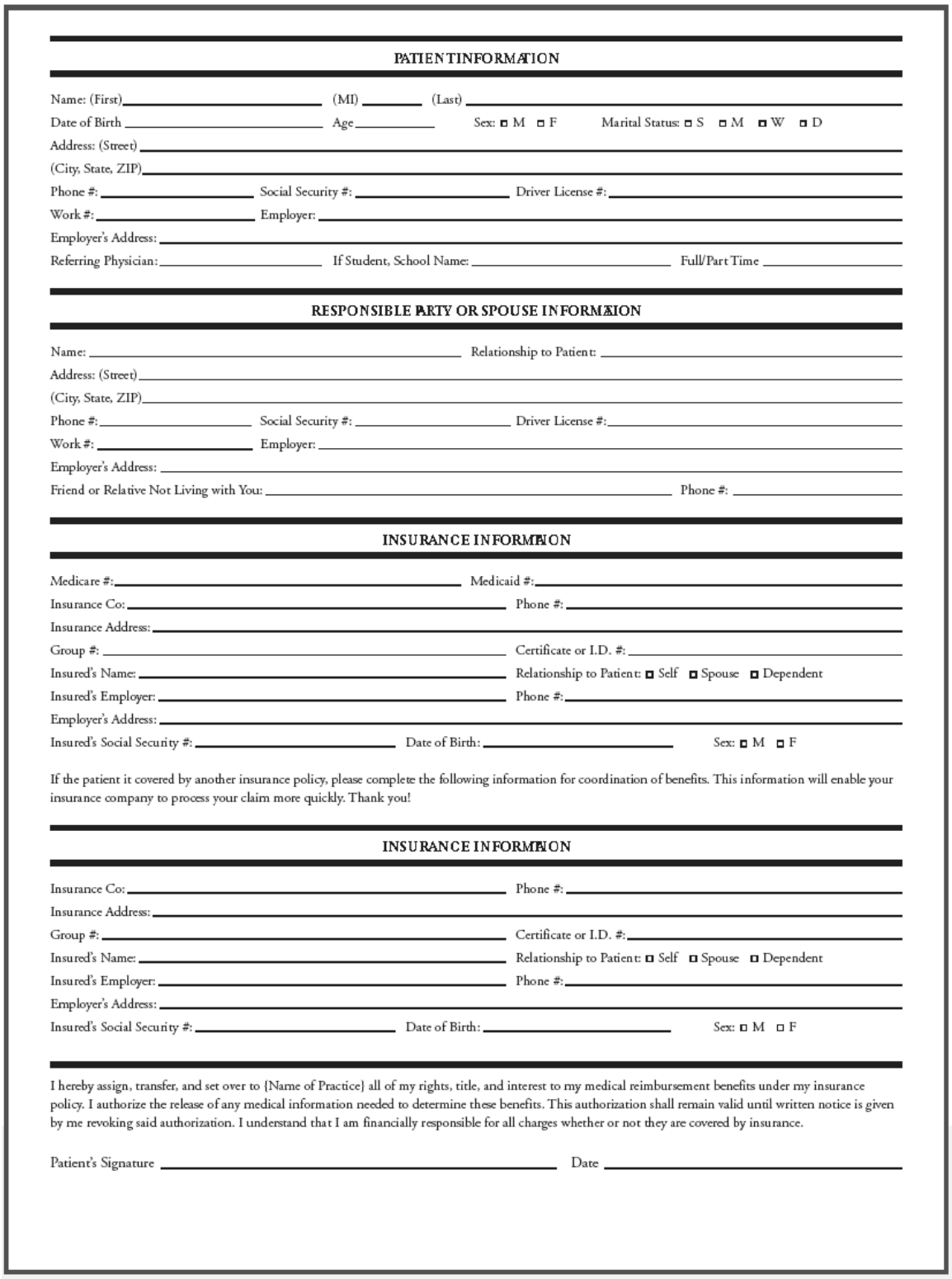
As you continue to audit, file and appeal claims with that health insurer, make sure you update the information for that health insurer. The more specific information you have, the better equipped you will be to ensure your physician practice receives appropriate payment.

Keep track of what you've entered. Use this workbook as a reference when submitting claims and filing appeals. Use the information you and other staff in the practice have already gathered and the nuances of the claims and appeals processes you have already encountered to save you time and make your current and future claims and appeals more effective.

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Figure 1: Sample new patient information sheet

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PATIENT INFORMATION

Name: (First) _____ (MI) _____ (Last) _____

Date of Birth _____ Age _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Address: (Street) _____

(City, State, ZIP) _____

Phone #: _____ Social Security #: _____ Driver License #: _____

Work #: _____ Employer: _____

Employer's Address: _____

Referring Physician: _____ If Student, School Name: _____ Full/Part Time _____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: _____ Relationship to Patient: _____

Address: (Street) _____

(City, State, ZIP) _____

Phone #: _____ Social Security #: _____ Driver License #: _____

Work #: _____ Employer: _____

Employer's Address: _____

Friend or Relative Not Living with You: _____ Phone #: _____

INSURANCE INFORMATION

Medicare #: _____ Medicaid #: _____

Insurance Co: _____ Phone #: _____

Insurance Address: _____

Group #: _____ Certificate or I.D. #: _____

Insured's Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

Insured's Social Security #: _____ Date of Birth: _____ Sex: ☐ M ☐ F

If the patient it covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

INSURANCE INFORMATION

Insurance Co: _____ Phone #: _____

Insurance Address: _____

Group #: _____ Certificate or I.D. #: _____

Insured's Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Insured's Employer: _____ Phone #: _____

Employer's Address: _____

Insured's Social Security #: _____ Date of Birth: _____ Sex: ☐ M ☐ F

I hereby assign, transfer, and set over to {Name of Practice} all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

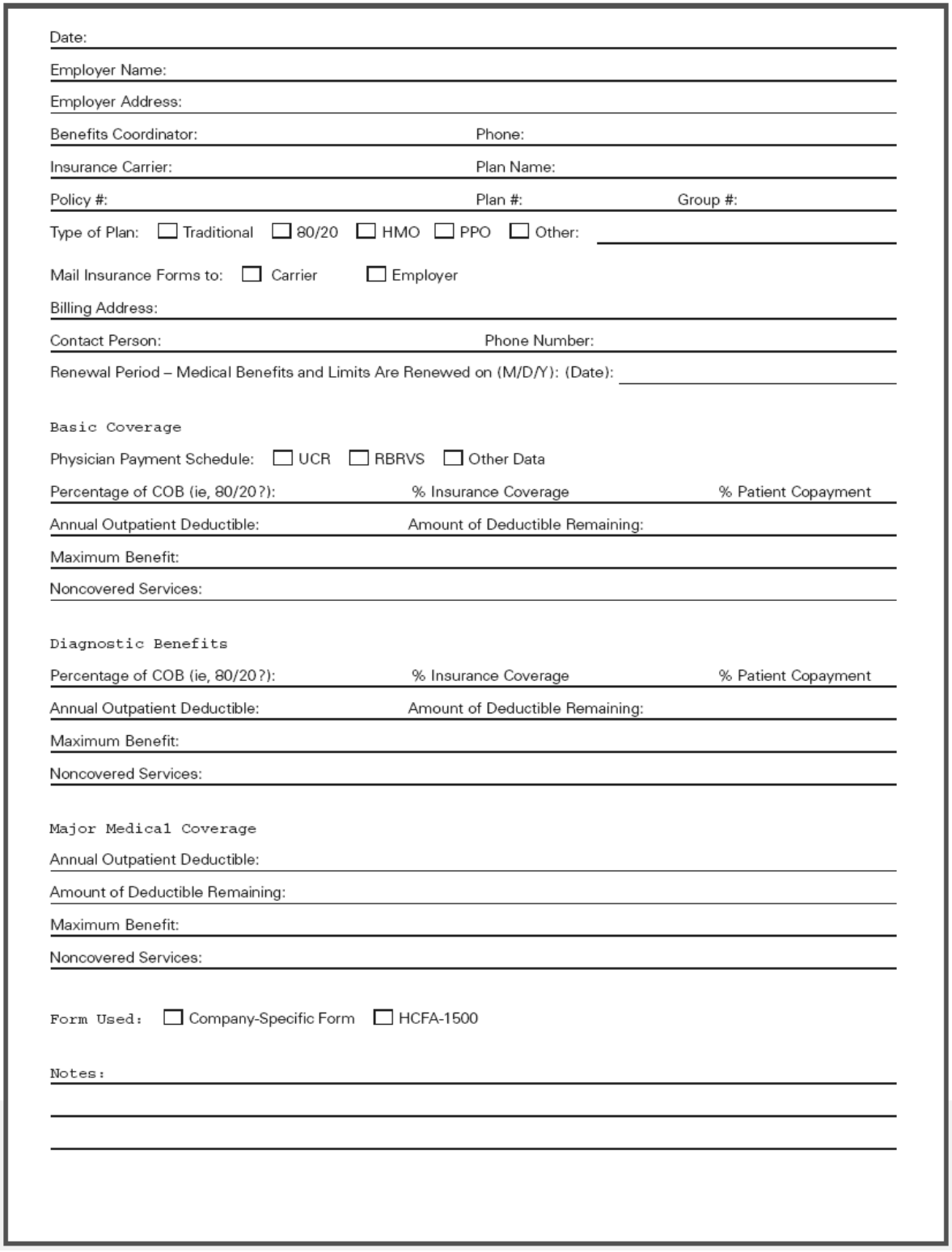
Patient's Signature _____ Date _____

Source: Mastering the Reimbursement Process, 3rd Edition, AMA Press, 2000. To order call (800) 621-8335.

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Figure 2: Sample employer/insurance verification information form

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Date:

Employer Name:

Employer Address:

Benefits Coordinator: Phone:

Insurance Carrier: Plan Name:

Policy #: Plan #: Group #:

Type of Plan: ☐ Traditional ☐ 80/20 ☐ HMO ☐ PPO ☐ Other:

Mail Insurance Forms to: ☐ Carrier ☐ Employer

Billing Address:

Contact Person: Phone Number:

Renewal Period – Medical Benefits and Limits Are Renewed on (M/D/Y): (Date):

Basic Coverage

Physician Payment Schedule: ☐ UCR ☐ RBRVS ☐ Other Data

Percentage of COB (ie, 80/20?): % Insurance Coverage % Patient Copayment

Annual Outpatient Deductible: Amount of Deductible Remaining:

Maximum Benefit:

Noncovered Services:

Diagnostic Benefits

Percentage of COB (ie, 80/20?): % Insurance Coverage % Patient Copayment

Annual Outpatient Deductible: Amount of Deductible Remaining:

Maximum Benefit:

Noncovered Services:

Major Medical Coverage

Annual Outpatient Deductible:

Amount of Deductible Remaining:

Maximum Benefit:

Noncovered Services:

Form Used: ☐ Company-Specific Form ☐ HCFA-1500

Notes:

Source: Mastering the Reimbursement Process, 3rd Edition, AMA Press, 2000. To order call (800) 621-8335.

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Figure 3: Sample patient/insurance coverage verification form

Back

Date: Practice: Verification By:

Patient Name: Account #:

Date of Birth: Social Security #:

Employer: Phone/Contact:

Accident Date: Accident Location:

Patient Care Plan

Dx: (1) (2)

Dx: (3) (4)

Patient Care Plans/Services:

Insurance Data

Insurance – 1

Billing Address:

Ins. Contact Name: Phone:

Policy #: Plan: Group:

Coverage Effective Dates – (From) (To)

Policyholder: Relationship:

Insurance – 2

Billing Address:

Ins. Contact Name: Phone:

Policy #: Plan: Group:

Coverage Effective Dates – (From) (To)

Policyholder: Relationship:

Basic Benefits	Primary	Secondary
1. Preexisting Wait Period		
2. Annual Deductible Amount	($)	
3. Deductible Paid to Date		
4. Out-of-Pocket Expenses:		
a. Coinsurance ($ or %)		
b. Copayment @ TOS?		
5. Calendar Year Maximum:	$ / days	$ / days
6. Lifetime Maximum:	$ / days	$ / days
7. Remaining Benefits:	$ / days	$ / days
8. Medical Records Required?	Y / N	Y / N
9. Coordinate Benefits (X-Over)?	Y / N	Y / N
10. 2nd Opinion Requirements?	Y / N	Y / N
11. Verified with (name):		
12. Phone # of Above:		
13. Date Verified:		

Procedures & Servies	Covered?	Coverage Details Limits
1. Office Services	Y / N	
2. Hospital	Y / N	
3. Consultations	Y / N	
4. ER Visits	Y / N	
5. Laboratory (Chem)	Y / N	
6. Procedures	Y / N	
7. Injections / Tx	Y / N	
8. Supplies	Y / N	
9. Drugs / Medications	Y / N	
10. Exclusions:		

Source: Mastering the Reimbursement Process, 3rd Edition, AMA Press, 2000. To order call (800) 621-8335.

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Figure 4: Sample encounter form (super bill)

Back



Jane Doe, M.D.
Internal Medicine
300 Practitioner Road
Smallville, State 99999

Telephone: (555) 555-1212

DATE:

LAST NAME	FIRST	ACCOUNT#	DOB	☐ Male ☐ Female
INSURANCE		PLAN#	SUBSCRIBER#	GROUP#

OFFICE CARE

	DESCRIPTION	CPT-MOD		
	NEW PATIENT			
	Focused	99201		
	Expanded	99202		
	Detailed	99203		
	Comprehensive-Mod.	99204		
	Comprehensive-High	99205		
	ESTABLISHED PATIENT			
	Minimal	99211		
	Focused	99212		
	Expanded	99213		
	Detailed	99214		
	Comprehensive-Mod.	99215		
	Comprehensive-High	99216		
	CONSULTATION OFFICE			
	Focused	99241		
	Expanded	99242		
	Detailed	99243		
	Comprehensive-Mod.	99254		
	Comprehensive-High	99265		
	Dr.			
	Post-op Exam	99024		
	EVALUATION/MANAGEMENT			
	Brief - 30 minutes	99361		
	Intermediate - 60	99362		
	Telephone-Brief	99371		
	Telephone-Intermed.	99372		
	Telephone-Complex	99373		

PROCEDURES

DESCRIPTION	CPT-MOD		
Treadmill	93015		
24 Hour Holter	93224		
Recording only	93225		
Interp. & Report	93227		
EKG and interp.	93000		
EKG (Medicare)	93005		
Sigmoidoscopy	45300		
Sigmoidoscopy (flex)	45330		
Sigmoid (flex) w/bx	45331		

DIAGNOSIS

052.9	Chickenpox, NOS	266.2	B12 deficiency w/o anemia	309.9	Adjustment reaction, unspecified
111.9	Dermatomycosis, unspecified	276.5	Dehydration	305.00	Alcohol abuse, unspecified
009.1	Gastroenteritis, infectious	250.91	Diabetes mellitus, I, compl	303.90	Alcoholism, unspecified
007.1	Giardiasis	250.01	Diabetes mellitus, I, uncompl	331.0	Alzheimers
098.0	Gonorrhea, acute, lower GU	250.90	Diabetes mellitus, II, compl	307.1	Anorexia nervosa
054.9	Herpes simplex, any site	250.00	Diabetes mellitus, II, uncompl	300.00	Anxiety state, unspecified
053.9	Herpes zoster, NOS	250.13	Diabetic ketoacidosis	314.01	Attention deficit, w/ hyperactivity
042	HIV Disease	271.9	Glucose intolerance		
V08	HIV positive, asymp	240.9	Goiter, unspecified	314.00	Attention deficit, w/o hyperactivity
136.9	Infectious/parasitic dis unspec	274.9	Gout, unspecified		
487.1	Influenza w/ upper resp sx	275.42	Hypercalcemia	307.51	Bulimia
007.9	Intestinal protozoa, NOS	276.7	Hyperkalemia	312.90	Conduct disorder, unspecified
088.81	Lyme disease	276.0	Hypernatremia	311	Depressive disorder, NOS
055.9	Measles, NOS	252.0	Hyperparathyroidism	305.90	Drug abuse, unspecified

DIAGNOSIS		
RETURN APPT	REFERRING MD	SIGNATURE

☐ Cash
☐ Check
☐ Credit

Source: HMA

Source: Mastering the Reimbursement Process, 3rd Edition, AMA Press, 2000. To order call (800) 621-8335.

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Figure 5: Sample practice pre-authorization fax sheet

Back

Request for pre-authorization

To _____ Fax _____

From _____ Phone _____ Fax _____

Number of pages sent (including cover page) _____

If you have any problems with this transmittal please contact (*insert name*) at (*insert telephone number*).

Re: Pre-authorization request

Health plan member name:

Patient name:

Patient health plan identification number (Policy #):

Group number:

Examining physician:

Date of examination:

We are requesting your expedited review for the pre-authorization of the following procedures and/or services for the above-mentioned patient. The above-named physician, as a result of the evaluation on (*insert date*) has evaluated the patient and recommended the following procedures and/or services.

Procedure:

CPT code:

Practice fee schedule amount:

Total amount:

We request your assignment of pre-authorization for the above listed procedures and/or services.
Please fax the completed information consisting of:

- Assigned pre-authorization number for all the listed procedures and/or services;
- Listing of any non-authorized procedures and/or services with supporting rationale; and
- Any pre-surgical requirements of the health plan that must be met prior to delivery of services to the patient.

If you require any additional information, please contact (*insert name*) at (*insert telephone number*) between the hours of __ and__.

Pre-authorization form

Please complete the following information and fax to (*insert name*) at (*insert fax number*)

Name of authorizing representative for health plan _____

Telephone number for authorizing representative _____

Pre-authorization number _____

Comments or requirements _____

_____

_____

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Figure 6: Sample medical/surgical pre-determination request

Back

Health Plan
Attn: Medical Pre-Determination
Pay Me Appropriately Drive
Physician, USA 11111

Re: Pre-determination request
Patient name:
Health plan member name:
Patient health plan identification number (Policy #):
Group number:
Examining physician:
Date of examination:

To Whom It May Concern:

The following information is being provided to pre-determine surgical benefits for an outpatient surgical procedure. Outlined below are the procedural and diagnostic codes, description and cost for the recommended surgery. Copies of applicable medical records are included to support the medical necessity of the procedure reported.

CPT Codes **ICD-9-CM code(s)**

Description of procedure/service

Fees

The following information provides a brief summary of the patient's chief complaints and history of present illness:

Please be advised that the above named patient has been **under** *(physician)'s* care since *(date)* for the **treatment of** *snoring and nasal obstruction associated with allergic rhinitis, chronic sinusitis, and obstructive sleep apnea with daytime hypersomnolence.* His symptoms have been *present for three years.* He describes his *symptoms* as *severe, getting worse and moderately interfering with normal daily activities. Nasal endoscopic* **exam findings demonstrated** *3+ osteomeatal complex (OMC) blockage on the right and 4+ on the left, 3+ nasal septal deviation with S-shaped deformity on the right and 4+ on the left, and 3+ turbinate hypertrophy on the right and 4+ on the left. Oropharynx exam revealed an elongated, hypertrophic uvula/palatal deformity and 1+ bilateral tonsillar hypertrophy. Attended sleep study findings are indicative of moderate obstructive sleep apnea resulting in moderate oxygen desaturation, with a nadir of 82%.* **Despite comprehensive medical management** including *antibiotics, steroid, nasal sprays, antihistamines and decongestants, his snoring and sleep apnea persist unabated. He is not a candidate for nasal continuous positive airway pressure (CPAP) due to his severe septal deformity causing near-total nasal airway obstruction.*

Please be advised that his snoring and sleep apnea are resultant from the deformity of the uvula/palate that can effectively be remedied via surgery. He will also be **undergoing** *nasal and sinus surgery to drain chronic infection from the maxillary and ethmoid sinuses and to correct deformities of the nasal septum and turbinates causing nasal obstruction so that the upper airway is restored to normal function. The uvulopalatopharyngoplasty (UPPP) is* **medically necessary** *in that the excess uvular/palatal tissue causing the obstruction will be surgically excised to prevent positional obstruction causing the sleep apnea and snoring while asleep.*

Please provide our practice with written notification regarding benefit coverage upon determination of this case. Should additional information be needed, please contact our practice at *123 456-7890.*

Sincerely,

Physician and/or Practice Manager

Enclosures

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