15 steps to protect your practice©

from abusive payment practices

1 Know the coverage terms of the patient's insurance policy.

- Maintain records of patient's employer including name, address and phone number.
- Maintain records of any secondary payor associated with patient, including Medicare, Medicaid and workers' compensation.

2 Obtain and review your contract with the carrier for:

- The nature and scope of covered services;
- The fee-schedule;
- Claim submission requirements (including where and how to transmit);
- Standards for claim review (retrospective review, medical record requests, etc);
- Pre-certification requirement;
- Claim adjudication policies and procedures; and
- Coding guidelines or policies.

3 Obtain all provider manuals, fee schedules, medical policy manuals and other documents referred to in the contract.

4 Obtain a specific provider and customer service representative contact, and obtain the name and contact information of the health insurer's local medical director.

5 Understand and comply with all documentation requirements.

6 Stay informed of CPT®, ICD, and other code changes and requirements. Make sure you have the most current copies of all code books, standards, and guidelines.

7 Prepare and submit timely, "clean" claims:

- Use appropriate CPT codes and modifiers;
- Identify and bill correct payor; and
- Comply with all payor requirements for claims submission (including method or mode of submission).

8 Keep contemporaneous documents in patient files to support claims.

9 Track submission of claims and receipt of EOB's.
Keep records of:

- Date of service;
- Date of submission;
- Date of acknowledgement of receipt by billing entity, clearinghouse, and payor;
- Date of receipt of EOB or any other notice from payor;
- Date of payment (partial and/or final).

10 Evaluate EOB's for accuracy to detect processing errors.
Check for:

- Coding changes;
- Reimbursement rates and adjustments;
- Explanation and denial of benefits (including reason/explanation codes); and
- Interest payments (if applicable).

11 Request written explanation for all claim delays, partial payments, and denials, and maintain follow-up log on all claims delayed beyond state law specifications.

12 Submit timely formal appeal letter with supportive documentation as required by contract and request appeal to be reviewed by a practicing, board-certified specialist representing your practice area.

13 File complaint with state insurance commissioner for claims that are delayed beyond state-required time frames.

14 Inform county and state medical societies regarding the submission of any and all complaints against health insurers for contracting and payment related issues.
Complete any complaint form offered by the medical society.

15 Complete the AMA's online Health Plan Complaint Form.
The data collected through the Health Plan Complaint Form will be used to identify trends and to facilitate discussions with national health insurers to resolve administrative hassles and physician complaints.

Information about the AMA's Private Sector Advocacy (PSA) Health Plan Complaint Form and all other PSA initiatives can be found at: *www.ama-assn.org/go/psa.*

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