Improving Claims Processing and Payment: A Self-Assessment Tool for Physicians/Providers

A major goal of physicians/providers and plans is to reduce the frustration and unnecessary expense associated with claims that are misfiled, delayed, denied, or not paid in an expedient manner. A variety of factors influence how health insurance claims are processed and the extent to which they are paid promptly and accurately. One of the first steps that a physician/provider can take to improve claims processing and payment is to undergo a self-assessment of his or her practice. The self-assessment can take the form of a diagnostic assessment (i.e., to determine the cause of a problem), or a routine maintenance assessment (i.e., to fine tune claims processing procedures). The purpose of the following set of questions is to assist physicians/providers to better understand the processes used within their own practice to submit and track claims, and to discover opportunities for improving those processes for the purpose of improving payment and accounts receivable.

Electronic claim submission is a quick and efficient way to process claims. Most health plans accept electronic claims from a variety of sources and methods. Contact them directly for more information.

Self-Assessment Questions for Physicians/Providers

Step 1: Start by collecting some basic information about how your practice is currently performing with regard to claims processing and accounts receivable. Ask your billing staff or service to provide answers to the following questions:

A) How many claims did your practice submit in a recent 30 day period? ____________

(1) Paper Claims ____________________

(2) Electronic Claims ____________________

B) Of the number of claims submitted in those 30 days, approximately what percent were denied? ___________%

C) For claims denied, what were the most frequent reasons stated by the payer for the denial?

(1) ____________________

(2) ____________________

(3) ____________________

D) Of the number of claims submitted in that 30 day period, approximately what percent were delayed (i.e., not paid within 30 days of the claim submission date)? ___________%

E) For claims that were delayed, what were the most frequent reasons stated by the payer for the delay in payment?

(1) ____________________

(2) ____________________

(3) ____________________

F) Does the percentage of denied or delayed claim payments vary between paper claims and electronic claims? ❑ Yes ❑ No

Step 2: Use the following checklist to collect additional information about specific practices and policies used by your billing staff or billing service. Your answers to the following questions should provide you with a number of specific suggestions and ideas for improving your billing practice and accounts receivable.

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1. **Does the billing staff or service track the percent of claims that are denied on the first submission?** ❑ **YES** ❑ **NO**

   If No, make tracking the percent of claim denials a part of your routine billing practice. By doing so, you and your billing staff will be able to notice and respond to increases in claim denials that may be indicative of a systematic or isolated problems.

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2. **Do you know the most frequent reasons for claim denials in your practice (as stated by payers)?** ❑ **YES** ❑ **NO**

   If No, begin collecting and noting the most frequent reasons for claim denials. The leading causes of claim denials are related to submission of duplicate claims and issues of eligibility. A variety of the tips contained in this document are directed at reducing claims denied as "duplicates" and those that are denied due to ineligibility.

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3. **Do you have claims that have been denied because they were submitted to the wrong payer?** ❑ **YES** ❑ **NO**

   If Yes, consider your responses to the following questions.

4. **Does the office staff make a copy of each new patient's insurance card?** ❑ **YES** ❑ **NO**

   If No, require the office staff to make a copy of each patient's insurance card, as well as their spouse's or other parent's insurance card if they have secondary coverage.

5. **Does the office staff ask every patient at every visit about changes in their insurance information?** ❑ **YES** ❑ **NO**

   If No, require office staff to ask every patient at every visit about changes in insurance information. If there are changes in insurance information, be sure to make a copy of the patient's new insurance card and replace the old information with the new. Keep accurate records of all insurance information (current and previous) for use in claim follow-up, appeals, disputes or COB issues.

6. **Do you have claims that are denied due to ineligibility?** ❑ **YES** ❑ **NO**

   If Yes, consider your response to the following question.

7. **Does the office staff routinely check patient eligibility before or during the office visit?** ❑ **YES** ❑ **NO**

   If No, establish a routine office procedure to check eligibility prior to the visit or at the time the patient is in the office. Most health plans allow physicians/providers to check eligibility in a number of ways, including traditional telephone contact, interactive voice response technology, and on-line.

8. **Do you have claims denied or delayed due to coordination of benefits (COB) issues?** ❑ **YES** ❑ **NO**

   If Yes, consider your responses to the following questions.

9. **Does the office staff ask each patient about secondary or other coverage?** ❑ **YES** ❑ **NO**

   If No, make it a routine practice to ask patients about whether they have secondary or other insurance coverage. Gathering this information and using it when billing the insurance carriers can reduce the number of claims that are delayed pending coordination of benefits (COB).

10. **When checking eligibility via "live" telephone contact, does the office staff ask the payer to verify that they are the primary carrier?** ❑ **YES** ❑ **NO**

    If No, use this opportunity to ask the payer to verify whether they are the primary or secondary carrier. In some instances, if the payer is secondary they may be able to tell you which payer is primary.

11. **When benefits are being coordinated between two payers, does the billing staff always send the EOB from the primary payer when submitting a claim to the secondary or other payer?** ❑ **YES** ❑ **NO**

    If No, establish a routine office procedure to ensure that when claims are sent to the secondary or other payer, they routinely include a copy of the Explanation of Benefits (EOB) from the primary payer. Failure to attach the EOB from the primary payer is likely to result in a claim that is delayed or denied due to Coordination of Benefits (COB).

12. **Do you have Medicare claims that are denied or delayed?** ❑ **YES** ❑ **NO**

    If Yes, consider your responses to the following questions.

13. **Does the office staff ask each new patient age 65 and older to provide a copy of their Medicare card?** ❑ **YES** ❑ **NO**

    If No, establish a routine office procedure to ask all patients for a copy of their Medicare card if they are 65 or older, or when they turn 65. Federal laws determine when Medicare is the primary payer. Remember that it is possible for a patient to have only Medicare Part A or Part B, or to be ineligible for Medicare despite being 65 or older. It is also important to know if Medicare eligible patients also have group health insurance. Be sure to update your records with the information provided from patients and documented on the Medicare card.

14. **If Medicare is the primary payer, does the billing staff check to see if Medicare "crosses over" with the secondary or other payer before sending a bill to the secondary payer?** ❑ **YES** ❑ **NO**

    If No, remind billing staff that many health plans pay Medicare to send them claims that are their responsibility as a secondary payer. This is called a "cross over". The billing staff should determine whether the patient's claim will be "crossed over". If so, submitting a claim directly to the secondary payer will result in a denial due to duplicate claim.

15. **Do you have claims that are denied as duplicates?** ❑ **YES** ❑ **NO**

    If Yes, consider your response to the following questions.

16. **Does the billing staff or service use a suggested minimum rebilling cycle of at least 30 days?** ❑ **YES** ❑ **NO**

    If No, use a minimum rebilling cycle of at least 30 days to allow time for the original claim to move through the payer's cycle. Resubmitting a claim in a lesser amount of time uses unnecessary resources and is likely to result in a denial for duplicate claim.

17. Does the billing staff or service reconcile claim denials and claim payments at least every 10 days? ❑ YES ❑ NO

If No, require your billing staff to reconcile claim denials and claim payments at least every 10 days. This includes regularly working through electronic error and rejection reports. This practice will help avoid common mistakes such as rebilling a denied claim or billing the patient's portion to the insurance carrier.

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18. When a claim requires follow-up by billing staff or a third party, is contacting the payer the first step in the follow-up process (as opposed to automatically resubmitting the claim)? ❑ YES ❑ NO

If No, encourage billing staff to telephone payers or use on-line tools when additional information is needed regarding a claim that is unpaid or incorrectly paid. You will reduce the number of duplicate claim denials by not automatically rebilling all outstanding claims.

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19. Does the practice have an official policy about collecting the patient's co-payment at the time of service? ❑ YES ❑ NO

If No, establish a routine office procedure to collect the patient's co-payment at the time of service. This practice improves accounts receivable by allowing your billing staff to achieve zero balances as soon as insurance payments are received, and eliminates the need to send additional bills to patients.

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20. Is there a practice or billing service policy about small balance write-offs? ❑ YES ❑ NO

If No, consider establishing a policy about small balance write-off so that the billing staff can handle such accounts quickly and efficiently. This will have a positive overall effect on accounts receivable.

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21. Do you have claims that are denied due to missing or inaccurate information supplied on the claim form? ❑ YES ❑ NO

If Yes, consider your response to the following question.

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22. Does the billing staff or service double-check every claim to be sure that it is filled out completely and accurately? ❑ YES ❑ NO

If No, establish a routine office procedure whereby the billing staff double checks every claim prior to sending it to the payer. Common billing errors include providing incorrect or incomplete patient information (i.e., member number, policy number, full name of subscriber), and incorrect or incomplete service information (i.e., date of service, diagnosis code(s), CPT code(s) and modifiers).

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23. Do you have appeals or corrected claims that are denied as duplicates? ❑ YES ❑ NO

If Yes, consider your response to the following question.

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24. Does the billing staff or service know about the special requirements that each health plan or payer may have regarding submission of claims appeals or corrections? ❑ YES ❑ NO

If No, remind billing staff that many plans and payers have specific requirements for submitting appeals or corrections. Some plans and payers require that appeals be submitted on a specific form and **not** include a copy of the original claim. Unless the plan directs you otherwise, do not stamp a claim as "Second Request" or "Appeal" because such claims will generally be treated as new claims and denied as duplicates. In addition, be sure that the appeal or correction is submitted to the correct address, as many plans and payers request that appeals be submitted to an address or P.O. Box that is different from the one used for original claims.

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25. Do you feel you have claims that were paid incorrectly because separate services were bundled? ❑ YES ❑ NO

If Yes, be sure appropriate modifiers were on the original claim, or submit a corrected claim if they were omitted. For appeals of bundling problems, include documentation of separate services.

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26. Do you feel you have claims that were paid incorrectly because services were not paid at the appropriate level? ❑ YES ❑ NO

If Yes, confirm whether the medical record documentation supports the level of service coded. If it does, submit an appeal with appropriate documentation.

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27. Is there a practice or billing service policy about bad debt collection? ❑ YES ❑ NO

If No, consider establishing a policy about bad debt collection so that the billing staff can handle such debts quickly and efficiently. This will have a positive overall effect on accounts receivable.

Step 3: Now that you have successfully completed the self-assessment, use your enhanced understanding of the claims processes used within your own practice to refine those processes for the purpose of improving claims payment and accounts receivable. Please retain this self-assessment tool and refer to it in the future to diagnose or prevent problems related to claims processing and payment.

A committee representing health plans and health care physicians/providers prepared this document. Organizations that participated in the development of this document include American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American Academy of Dermatology Association, Bethesda Healthcare System, Piedmont Hospital, Group Health Incorporated, and Health Alliance Plan. AAHP-HIAA and the Healthcare Financial Management Association convened the committee.

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