

# Insurance Claims 101: Avoiding Common Payment Pitfalls

by APAppractice.org

February 1, 2005 -- If you are like many psychologists, the health of your practice finances is tied directly to the insurance claims process. Beyond outlining how the claims process is supposed to work, this article provides tips for avoiding errors and delays and for handling actions taken by payers that can plague the claims process.

Submitting and following up on insurance claims is one of the most important, yet often time-consuming and frustrating, administrative activities that psychology practices face. Without an organized system for timely and accurate claims submission, the process can be a greater drain on resources, whether you submit claims yourself or use administrative staff.

The recent trend toward electronic claims submission has improved the process for some practitioners. By standardizing data, electronic claims submission can speed up claims processing, reducing the errors and payment delays or denials that are common with manual or paper claims submissions. It is important to recognize that switching to electronic claims submission will trigger compliance requirements related to the Health Insurance Portability and Accountability Act (HIPAA) for those who are not already subject to those regulations.

For both electronic and manual submissions, the claims process generally follows similar steps. Claims processes vary by payer, but the following general outline describes how the system is supposed to work.

## **Claim Submission**

A psychologist submits a claim either electronically or manually to a health plan. Electronic claims are translated or converted into a standard format, while paper claims are scanned or typed into the computer system. If you submit a claim to an intermediary such as a billing service or clearinghouse, the intermediary typically processes the claim and submits it to the payer.

## **Claims Adjudication**

After the claim data is entered into the company's computer system, it goes through a process called "claims adjudication." The company checks the validity of the claim by comparing it against the coverage and benefit requirements of the health plan. The claim is checked for all of the information necessary to activate payment.

## **Notification of Adjudication**

An explanation, or "remittance advice," is typically sent to the practice describing the outcome of the adjudication process. In addition, an "explanation of benefits" is typically sent to the practice and the insured client outlining the services performed and how the payments have been settled.

If the claim is approved, the company forwards payment to the practice. If the practice uses an intermediary such as a billing service, the health plan may remit payment to the billing service, which will in turn forward the payment to the practice. A claim may be approved but only partially paid; in that case, the payer should provide an explanation.

If the claim is put on hold, the practice may be asked to resubmit the claim with additional information.

If the claim is denied, the practice or intermediary may file an appeal.

### **Tracking and Payment**

The time that elapses between submitting a claim and receiving payment can vary. Generally, electronic claims take much less time to process than paper claims. One of the benefits of using a billing service or clearinghouse is that these intermediaries may track claims until they are paid, helping to identify and resolve problems in a timely manner. Practices who don't use an intermediary can check on the status of claims by calling the company or checking the company's website.

### **COMMON PITFALLS**

Throughout the claims process, there are many opportunities for errors or delays. Major reasons that payers reject or delay payment on a claim include:

- The health plan didn't receive the claim
- A CPT code is missing or incorrect
- Provider and/or patient identifiers are not included
- The health plan information is incorrect
- The plan does not cover the service

Administrative errors or delays by the payer can also result in processing errors and delays.

### **AVOIDING PROBLEMS AND MINIMIZING DELAYS**

Some of the ways you can help to ensure the accurate processing of your claims and avoid payment delays include:

#### **Before Providing Services**

- Review your contract with the health plan regarding the claim submission requirements, preauthorization requirements, fee-schedule and adjudication process.
- Obtain preauthorization (also called pre-certification) if that is required.
- Verify that the patient's insurance covers the service before providing treatment. Ask the company if there are any limitations or restrictions, such as the number of visits or length of the sessions.

#### **When Submitting a Claim**

- Use the required forms and check that all claim submissions are completed fully and accurately.
- Follow the payers' requirements for claims submission as described in their contract or provider manual.
- Check your procedure codes and diagnosis codes to ensure they are accurate and, if necessary, HIPAA-compliant.

#### **After Receiving Notification of Adjudication**

- Carefully review the notification for accuracy and confirm that you were paid for the correct services, that no diagnosis or procedure codes were changed, and that you were paid the correct amount.

- If a claim is denied and you believe denial was improper, submit a timely appeal letter and ask the insurance carrier for reconsideration.

### **On a Regular Basis**

- Establish and follow a schedule for submitting claims on a routine basis.
- Inquire regularly with the health plan or intermediary about the status of unpaid claims, generally within one month after filing.
- Keep current information on file regarding the terms of your clients' insurance policies.
- Know how to access provider manuals and other documents related to your contract. Many are available online. Read health-plan bulletins and newsletters to keep track of the most current information and be alert to upcoming changes. File documents describing any changes with your contract and provider manual.
- Understand the collection policies required by various payers. For example, while acknowledging that there may be circumstances affecting patients' ability to pay, it can be considered fraud for providers not to collect co-payments from beneficiaries.

### **Two Final Tips for Problem Resolution**

- Psychologists in states with prompt payment laws may be able to use such laws to press insurance companies to pay within the required time. These laws typically require the company to pay within 30 days of receiving a "clean claim" that contains all of the information that the payer needs to process the claim.
- The state insurance commissioner's office is a potential source of help, especially if there is a pattern of problems or an egregious situation with a payer.

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