

## How to select a practice management system

### **New challenges and opportunities are impacting your practice today**

The physician practice environment is changing dramatically. The transition to ICD-10-CM and the 5010 version of the HIPAA electronic standard transactions will require physician practices to significantly upgrade or replace their current practice management system software. This need for change provides your practice a tremendous opportunity to take advantage of recent industry initiatives to streamline your claims revenue cycle and reduce your practice overhead.

Additionally, in light of the Medicare and Medicaid electronic health record (EHR) incentive program, you may be exploring the purchase of an EHR that may include the option of a practice management system. At the same time you evaluate the clinical capabilities of the EHR, it is critical that you also evaluate the administrative functionality of the practice management system to ensure that it meets your current and future practice needs.

For many physician practices, purchasing an appropriate practice management system can be a daunting task. Selecting software that does not integrate properly with your practice workflow or that does not contain the features your practice needs can result in unnecessary costs and reduced efficiencies. In addition, purchasing a system that is not well supported by the vendor or cannot be upgraded to accommodate the upcoming federally mandated transactions and code set changes will result in significant billing and collections challenges—not to mention unrealized administrative efficiencies.

This guide has been developed to provide a roadmap for selecting and purchasing the most appropriate practice management system for your practice. It is critical that you carefully review your practice needs and compare various practice management systems and functions prior to selection. The following five steps outline a proactive approach to the practice management system selection process.

### **Five steps to practice management system selection**

Practice management system software typically organizes your practice's administrative and billing functions. Practice management systems may include features such as:

- Capturing patient demographics;
- Appointment scheduling;
- Patient pre-registration (including insurance eligibility checks);
- Maintaining lists of insurance payers;
- Performing billing tasks; and
- Generating administrative reports.

This educational resource was developed through a cooperative effort between the American Medical Association and the Medical Group Management Association.

## 1. Establish a practice management system assessment team

The first step in the software selection process is to establish a practice management system assessment team to engage key staff who utilize, interface with or are directly impacted by your practice management system and its associated administrative processes. In smaller physician practices, this assessment team may consist of the physician and the practice manager. In larger physician practices, in addition to one or more physicians, the team should include representatives from your practice's patient registration staff, coding and billing staff, and non-physician clinical staff. By including the relevant clinical and administrative staff on this team, you can better identify the most appropriate and cost effective system for your practice. This team approach should also decrease implementation time and cost.

### **Changes to the HIPAA Transaction and Code Set requirements are rapidly approaching.**

#### **5010 version of HIPAA electronic standard transactions requirement**

Current regulation requires the use of the version 5010 HIPAA electronic standard transactions beginning Jan. 1, 2012. Optimally, system upgrades should be completed at least a year in advance of the compliance date to allow for internal testing and testing with external trading partners such as clearinghouses and payers. The regulation also allows the use of the 5010 transactions prior to the compliance date (assuming your trading partners can accept them), which will provide an opportunity to identify any issues and resolve them prior to the compliance deadline. Visit [www.ama-assn.org/go/5010](http://www.ama-assn.org/go/5010) for more information.

#### **ICD-10-CM requirement**

The transition to ICD-10-CM is expected to be one of the most significant changes for physician practices in recent times. Current regulation requires the use of the ICD-10-CM code set beginning Oct. 1, 2013. Physician practices are strongly encouraged to complete their system upgrades at least a year in advance of the compliance date to permit for internal and external testing and resolution of issues prior to the compliance date. Visit [www.ama-assn.org/go/ICD-10](http://www.ama-assn.org/go/ICD-10) for more information.

## 2. Analyze the patient and claims revenue cycle

The second step in selecting a practice management system is to analyze your practice's complete patient and claims revenue cycle. Your assessment team should obtain key staff input to help develop a comprehensive analysis of both your current claims revenue cycle and the functionality and features that would benefit your practice. Fully automating the claims revenue cycle can dramatically reduce your administrative costs and hassles while potentially increasing your revenue.

## 3. Identify software functionality and features

The next step is to identify the core set of functionalities and features your practice needs based on the assessment team's analysis of your practice's current patient management process and claims revenue cycle. This toolkit includes a comprehensive practice management system criteria checklist, which you can use to conduct this assessment. The objectives should be to:

- Analyze your practice's minimum administrative requirements (e.g., billing and collections, patient scheduling and communication)
- Identify the additional functionality and features that your practice currently utilizes (e.g., electronic claims processing, patient eligibility verification and physician credentialing)
- Ascertain the functionality and features that your current practice management system does not have but that you would like to explore with the vendor for potential inclusion (e.g., real-time transactions, electronic patient identification card reader, electronic claims reconciliation and posting)

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- Determine the types and frequency of the reports your practice needs (e.g., daily, specialty-specific, charges, collections and adjustments)
- Determine your minimum requirements for consideration of a practice management system vendor (e.g., financial stability, longevity, reputation and customer satisfaction, support and maintenance, on-site or online demonstrations, and vendor references from physician practices of similar size and/or specialty as your own)
- Ascertain how software updates are handled (e.g., timing, cost, hardware requirements and staff training)
- Consider the implications on your practice management system requirements if your practice should decide to move forward with **an EHR** or to participate in a pay-for-performance program or other data reporting and/or payment initiatives
- Familiarize yourself with what software functionality will be needed to comply with all applicable federal and state legislation and regulation. You should consider having the vendor guarantee in its contract that the practice management system contains the functionality to comply with all current and future federal and state mandates, including the HIPAA electronic standard transactions, national identifiers and Privacy and Security rules<sup>1</sup>

#### **4. Conduct a vendor survey and identify vendors you will consider**

Next, you will want to determine the functionality and features the vendors you are considering have to offer. Once you have completed the practice management system criteria checklist referenced in step 3, determine what functionalities and features the various vendors offer. Reviewing the vendors' capabilities should assist in identifying a manageable number of vendors (e.g., 3–10) that offer practice management systems to whom you may wish to send a formal request for proposal (RFP). A good place to start is with health information technology review organizations offering vendor surveys. This identification process should include networking within your physician or practice management community, reviewing association guidance, visiting vendor booths at trade shows and vendor Web sites, or by engaging a consultant.

This toolkit also provides a **vendor survey template** that you can customize with the criteria you selected from the checklist if you choose to conduct a more formal screening process. Be sure to update the survey template with any other functionality and features that your practice management assessment team identified in step 3 as essential and as beneficial to increasing practice efficiency and cost savings.

#### **5. Request and review formal proposals from practice management system vendors**

The next step is to create a formal RFP that outlines your practice's requirements. This toolkit provides a **sample RFP** to help you prepare an effective document that you can submit to practice management system vendors to assist in determining whether they can provide a system that meets your practice's requirements and at what cost. The sample RFP includes specific information vendors will need from your practice before they can respond to your RFP requirements (e.g., practice size and specialty). The sample RFP also provides a list of questions regarding vendor qualifications, a form for the vendor to list

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<sup>1</sup> For more information on the HIPAA Transaction and Code Set rule, see the educational resource "**Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule.**" Available on the AMA Practice Management Center Web site at [www.ama-assn.org/go/pmc](http://www.ama-assn.org/go/pmc) under "Health Information Technology," this resource can help you more fully understand the HIPAA Transactions and Code Set requirements and how these transactions impact the physician practice. Under HIPAA and the American Recovery and Reinvestment Act of 2009 (ARRA), physicians are required to control the ways in which they use and disclose patients' protected health information. The resource "**What you need to know about the new health privacy and security requirements**" outlines the newly expanded requirements for protection of patient health information, patient rights to this information and administrative protections physicians must have in place.

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their practice management system functionalities and features, and additional questions you may wish to include in your RFP (e.g., hardware requirements, software, installation, vendor support and training). If you wish to provide more direction to the vendor, you may also attach a copy of your completed practice management system criteria checklist. Submitting your RFP to each of the vendors you are considering will enable you to more effectively compare vendors and select a practice management system that will be a good fit for your practice.

## **Conclusion**

Physician practices have a significant opportunity to improve their bottom lines by implementing new practice management system software that leverages today's sophisticated technology and increased administrative simplification opportunities such as the HIPAA electronic standard transactions. To take full advantage of this opportunity and comply with the forthcoming regulatory changes, physician practices need to act now and evaluate their needs, make educated choices, and ensure sufficient time for implementation and testing. This guide is designed to empower physician practices to comply with federal mandates and take advantage of state-of-the-art practice automation opportunities.

## Practice management system criteria checklist

The following are a number of the key functionalities and features you should consider when selecting a new practice management system. Rate the criteria on a scale of 1–3, with 1 as “essential,” 2 as “desirable” and 3 as “unnecessary/not applicable.” Then append your completed checklist to your RFP. If you choose to conduct a formal vendor survey, download the vendor survey template and add any additional functionality and features your practice wishes to evaluate.

Visit [www.ama-assn.org/go/pmssoftware](http://www.ama-assn.org/go/pmssoftware) to download an Excel spreadsheet that you can customize according to your practice needs with additional practice management system functionalities and features.

### Patient scheduling and management

#### Rate

- 1 2 3 Appointment scheduling
- 1 2 3 Appointment scheduling system permitting “double booking”
- 1 2 3 Resource scheduling, such as procedure rooms
- 1 2 3 Patient reminder notices
- 1 2 3 Basic patient registration (including demographic and insurance information)
- 1 2 3 Electronic health identification card reader interface
- 1 2 3 Maintain patient insurance eligibility verification information
  - Ability to generate, send and receive **batch** eligibility requests and responses from payers using:
    - 1 2 3 HIPAA X12N **4010** A1 270 and 271
    - 1 2 3 HIPAA X12N **5010** A1 270 and 271
  - Ability to generate, send and receive **real-time or nearly real-time** eligibility requests and responses from payers using:
    - 1 2 3 HIPAA X12N **4010** A1 270 and 271
    - 1 2 3 HIPAA X12N **5010** A1 270 and 271

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1 2 3 Council for Affordable Quality Healthcare (CAQH) Committee for Operating Rules of Information Exchange (CORE) Phase 1 certified<sup>2</sup>

1 2 3 CAQH CORE Phase 2 certified<sup>2</sup>

**Additional considerations:**

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**Claims management**

**Rate**

1 2 3 Claims generation using the CMS 1500 claim form

1 2 3 Batch claims generation using the CMS 1500 claim form<sup>3</sup>

1 2 3 Claims generation using the UB 04 claim form

1 2 3 Batch claims generation using the UB 04<sup>3</sup>

Ability to generate and send **batch** claims processing using:<sup>4</sup>

1 2 3 HIPAA X12N **4010** A1 837P

1 2 3 HIPAA X12N **5010** A1 837P

Ability to receive **real-time or nearly real-time** electronic claims submission using:

1 2 3 HIPAA X12N **4010** A1 837P<sup>4</sup>

1 2 3 HIPAA X12N **5010** A1 837P<sup>4</sup>

1 2 3 Manual referral and authorization management

Ability to generate, send and receive **batch** referral and authorization management requests to and responses from payers using:

1 2 3 HIPAA X12N **4010** A1 278

1 2 3 HIPAA X12N **5010** 278

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<sup>2</sup> Visit CAQH CORE's Web site at [www.caqh.org](http://www.caqh.org) for more information about CORE and Phase 1 and 2 certification. CORE sets a minimum set of functionality needed for each of these transactions, reducing the participating health insurer's ability to provide less than complete data responses.

<sup>3</sup> A batch of claims is a group of claims (e.g., for all patients from one week of visits).

<sup>4</sup> Consider whether you need the functionality for dental (HIPAA X12 837 D Dental Claim) or institutional (HIPAA X12 837 I Institutional Claim) standard transactions.

Ability to generate, send and receive **real-time or nearly real-time** referral and authorization management requests to and responses from payers using:

- 1 2 3 HIPAA X12N **4010** A1 278
- 1 2 3 HIPAA X12N **5010** 278
- 1 2 3 Maintain list of referring physicians
- 1 2 3 Maintain list of referring laboratories and testing facilities
- 1 2 3 Maintain list of local hospitals
- 1 2 3 Claims scrubbing for Current Procedural Terminology (CPT<sup>®</sup>) format compliance<sup>5</sup>
- 1 2 3 Maintain list of payers including individual payer products and associated contracted fee schedules
- 1 2 3 Automatic upload of multiple payer fee schedules by product type
- 1 2 3 Ability to generate and send payers real-time or nearly real-time claims

Ability to generate, send and receive **batch** claim status inquiry and response from payers using the solicited and unsolicited standard transaction:

- 1 2 3 HIPAA X12N **4010** A1 276 and 277
- 1 2 3 HIPAA X12N **5010** 276 and 277

Ability to generate and receive **real-time or nearly real-time** claim status inquiry and response from payers using the solicited and unsolicited standard transaction:

- 1 2 3 HIPAA X12N **4010** A1 276 and 277
- 1 2 3 HIPAA X12N **5010** 276 and 277

Ability to generate, send and receive claims attachment inquiry and response from payers using:

- 1 2 3 HIPAA X12N **4010** A1 275
- 1 2 3 HIPAA X12N **5010** 275

Ability to generate and send first report of injury to payers using:

- 1 2 3 HIPAA X12N **4010** A1 148
- 1 2 3 HIPAA X12N **5010** 148

**Additional considerations:**

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<sup>5</sup> CPT is a registered trademark of the American Medical Association.

## Clinical documentation and interface

### Rate

- 1 2 3 Patient summary generation: paper
- 1 2 3 Patient summary generation: electronic (e.g., CD-ROM, USB drive)
- 1 2 3 HL7 electronic lab interface
- 1 2 3 EHR interface (if yes, specify the product your practice currently has or is interested in purchasing)

### Additional considerations:

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## Billing and collections

### Rate

Ability to receive **batch** claim payment/remittance advice using:<sup>6</sup>

1 2 3 HIPAA X12N **4010** A1 835P

1 2 3 HIPAA X12N **5010** A1 835P

Ability to receive **real-time or nearly real-time** claim payment/remittance advice using:

1 2 3 HIPAA X12N **4010** A1 835P<sup>6</sup>

1 2 3 HIPAA X12N **5010** A1 835P<sup>6</sup>

1 2 3 Maintain physician practice retail fee schedule (charge entry)

1 2 3 Creation of finance charge for claims in the system (should be able to apply finance charges automatically to overdue patient balances from the finance charge configuration window)

1 2 3 Manual payment posting and reconciliation of paper explanation of benefits (EOB)

1 2 3 Manual payment posting and reconciliation of electronic remittance advice

Automatic payment posting and reconciliation of electronic remittance advice:

1 2 3 HIPAA X12N **4010** A1 835P

1 2 3 HIPAA X12N **5010** 835P

1 2 3 Patient financial statement generation

1 2 3 Printing practice's patient financial statements and other correspondence

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<sup>6</sup> Consider whether you need the functionality for dental (HIPAA X12 837 D Dental Claim) or institutional (HIPAA X12 837 I Institutional Claim) standard transactions.

- 1 2 3 Generating and e-mailing encrypted practice patient financial statements and other correspondence
- 1 2 3 Interface with third-party patient statement printing companies
- 1 2 3 Generation of claims aging reports
- 1 2 3 Printing of encounter-specific superbills
- 1 2 3 Integrated credit card processing
- 1 2 3 Scanning of superbills
- 1 2 3 Automatic upload of guarantor statements
- 1 2 3 Patient encounter reconciliation
- 1 2 3 Patient collection tools
- 1 2 3 Recording and posting of claims payments, refunds and adjustments
- 1 2 3 Maintain payer and product-specific claim edits and payment rules

Electronic funds transfer and electronic remittance advice management using:

- 1 2 3                   HIPAA X12N **4010** A1 835
- 1 2 3                   HIPAA X12N **5010** 835
- 1 2 3 Management of rejected claims
- 1 2 3 Automatic posting of capitation payments
- 1 2 3 Automated posting of performance bonus (e.g., PQRI, gain sharing, ePrescribing)
- 1 2 3 Automated posting of bundled payments
- 1 2 3 Automated claims appeals process

**Additional considerations:**

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**Reporting**

**Rate**

- 1 2 3 Extraction of detailed data on practice financial performance and financial histories
- 1 2 3 Extraction of detailed data on practice patient financial histories
- 1 2 3 Basic reporting (predefined, such as: claim age by payer, days in accounts receivable by payer, collection percentage by payer, open slots for appointments by provider by location)
- 1 2 3 Data dictionary available to licensee
- 1 2 3 Financial decision support module

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- 1 2 3 Database is open database compliant (ODBC)
- 1 2 3 End-user customizable reporting
- 1 2 3 End-user customizable dashboard templates
- 1 2 3 End-user ad-hoc query reporting
- 1 2 3 Ability to interface with business intelligence software tools that create reports and analytics
- 1 2 3 Advanced reporting (e.g., dashboard in real-time or nearly real-time)
- 1 2 3 Ability to save reports in Microsoft® Excel® (i.e., .csv or .xls format)
- 1 2 3 Reports automatically generated in Microsoft Excel
- 1 2 3 Non-proprietary open relational database (e.g., Oracle®, SQL Server®, etc.)
- 1 2 3 Non-proprietary open connectivity with any clearinghouse, payer or portal
- 1 2 3 Ability to select and switch clearinghouses or other vendors with relative ease at no cost

**Additional considerations:**

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**Technical specifications**

**Rate**

- 1 2 3 Graphical user interface (GUI) (Microsoft Windows® look, use of shortcuts; not DOS-based)
- 1 2 3 Integration of user interface tools such as Microsoft .Net
- 1 2 3 On-site client/server or remote data center host compatible (if remote data center host compatible, software has been optimized to operate as a Web service or “software as a service”)
- 1 2 3 Modern and widely supported relational database for the underlying data structure (e.g., Microsoft SQL Server, Oracle, MySQL®, etc.)
- 1 2 3 Open interface to receive third-party patient registration data (kiosk, tablet, etc.)

**Additional considerations:**

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**HIPAA Privacy and Security compliance**

**Rate**

- 1 2 3 Role-based and facility-based security (e.g., secure passwords, audit logs, etc.)

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- 1 2 3 Ability to encrypt either the entire database or protected health information without system performance compromise
- 1 2 3 Data back-up/disaster recovery system that meets the HIPAA Security Rule requirements

**Additional considerations:**

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**Vendor support**

**Rate**

- 1 2 3 Installation cost included (e.g., cabling, labor and travel, if applicable)
- 1 2 3 Initial and ongoing staff training for upgrades and features included
- 1 2 3 After-hours or emergency vendor service hotline included
- 1 2 3 Notification about new upgrades and services and installation of new upgrades and services to comply with all federal and state mandates and with the HIPAA Privacy and Security Rules and the HIPAA Transactions and Code Sets Rule
- 1 2 3 Transition to current or new clearinghouse, as needed

**Additional considerations:**

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**Disclaimer:** This toolkit is strictly an informational tool for your use. The practice must use its own independent judgment when selecting a practice management system that best meets the needs of the practice. The practice is encouraged to consult with its own experts and/or consultants when making this decision. The resources in this toolkit do not provide legal advice. Consultation with legal counsel may be appropriate, particularly in developing an RFP. Neither the AMA nor MGMA accepts liability with respect to the use of this toolkit or any decision that is made by the practice based on the toolkit resources.

**For additional questions, concerns, information and resources, the American Medical Association (AMA) and Medical Group Management Association (MGMA) may be contacted as follows:**

**AMA Practice Management Center**

- Call **(800) 621-8335** and ask for the AMA Practice Management Center.
- E-mail questions and concerns to [practicemanagementcenter@ama-assn.org](mailto:practicemanagementcenter@ama-assn.org).
- Fax information to **(312) 464-5541**.
- Visit [www.ama-assn.org/go/pmc](http://www.ama-assn.org/go/pmc) to access the AMA Practice Management Center Web site.

**MGMA**

- Visit [www.mgma.com](http://www.mgma.com) to access the Practice Solutions and Professional Resources sections of the Web site.

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