

Practice management system criteria checklist

The American Medical Association (AMA) and Medical Group Management Association (MGMA) have created the following checklist as a starting point for assessing your practice's needs and priorities for a practice management system (PMS). The list includes a number of the key functionalities and features you should consider when selecting a new PMS.

Rate the criteria on a scale of 1–3, with 1 as “essential,” 2 as “desirable” and 3 as “unnecessary/not applicable.” Note that this is an editable Word document that can be downloaded and adjusted to reflect any additional functionality and features that are important to your practice.

You may wish to share your practice's completed checklist with potential vendors to assist in the PMS vendor screening and selection process. You can also append a copy of the completed PMS checklist to your formal requests for proposal (RFPs). For a step-by-step guide to PMS selection, see [Six Steps to PMS Selection](#).

Industry Accreditations and Certifications

Rate

- | | | | |
|---|---|---|---|
| 1 | 2 | 3 | Accreditation through the Practice Management System Accreditation Program (PMSAP) offered by the Electronic Healthcare Network Accreditation Commission (EHNAC) and the Workgroup for Electronic Data Interchange (WEDI) (See PMSAP criteria) |
| 1 | 2 | 3 | Council for Affordable Quality Healthcare (CAQH) Committee for Operating Rules of Information Exchange (CORE) Phase 1 certified (see Phase 1 criteria) |
| 1 | 2 | 3 | CAQH CORE Phase 2 certified (see Phase 2 criteria) |
| 1 | 2 | 3 | CAQH CORE Phase 3 certified (see Phase 3 criteria) |

Patient Scheduling and Information 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 Customizable patient reminder notices
- 1 2 3 Basic patient registration (including demographic and insurance information)
- 1 2 3 Established standard method for electronic patient identification document scanning and storage (e.g., insurance card, state identification card, driver's license, etc.)
- 1 2 3 Electronic health identification card reader interface (magnetic stripe or bar code)
- 1 2 3 Electronic health identification card reader interface ("smart" chip)
- 1 2 3 Electronic health identification card reader interface (Quick Response "QR" code)
- 1 2 3 Maintain patient insurance eligibility verification information

Additional considerations:

Patient Communication Functionalities

Patient portal

Rate

- 1 2 3 Patient appointment self-scheduling via patient portal
- 1 2 3 Patient completion of forms via patient portal
- 1 2 3 Payment of patient bills via patient portal
- 1 2 3 Provision of appointment summaries or other clinical data to patients via patient portal

Email

Rate

- 1 2 3 Email encryption technology
- 1 2 3 Generation and sending of encrypted emails containing patient financial statements

- 1 2 3 Generation and sending of encrypted emails to patients with appointment summaries or other clinical data
- 1 2 3 Generation and sending of encrypted appointment reminder emails
- 1 2 3 Generation and sending of encrypted emails for other patient correspondence
- 1 2 3 Generation and sending of emails via “Direct” secure messaging

Other

Rate

- 1 2 3 Support of patient-facing application
- 1 2 3 Other unique patient communication features (specify: _____)

Additional considerations:

Revenue Cycle Automation: Transactions with Health Plans

Note: In all instances, “batch” refers to a group of transactions submitted together. For example, a batch of claims is a group of claims (e.g., for all patients from one week of visits).

Eligibility

Rate

- 1 2 3 Ability to generate and send **batch** eligibility requests and receive responses from payers using the Health Insurance Portability and Accountability Act (HIPAA) ASC X12N 00**5010** A1 270 and 271 and supporting operating rules
- 1 2 3 Ability to generate and send **real-time or nearly real-time** eligibility requests and receive responses from payers using the HIPAA ASC X12N 00**5010** A1 270 and 271 and supporting operating rules

Prior authorization and referrals

Rate

- 1 2 3 Ability to generate and send **batch** referral and authorization management requests to and receive responses from payers using the HIPAA ASC X12N 005010 278
- 1 2 3 Ability to generate and send **real-time or nearly real-time** referral and authorization management requests to and receive responses from payers using the HIPAA ASC X12N 005010 278
- 1 2 3 Maintain list of referring physicians and other clinicians (e.g., physical therapy)
- 1 2 3 Maintain list of referring laboratories and testing facilities
- 1 2 3 Maintain list of referring local hospitals

Claims

Rate

- 1 2 3 Printing of encounter-specific superbills
- 1 2 3 Scanning of superbills
- 1 2 3 Claims generation using the CMS 1500 (outpatient) claim form
- 1 2 3 Batch claims generation using the CMS 1500 (outpatient) claim form
- 1 2 3 Claims generation using the UB 04 (inpatient) claim form
- 1 2 3 Batch claims generation using the UB 04 (inpatient) claim form
- 1 2 3 Supports diagnosis and procedure codes for submitted claims in accordance with federal mandates and deadlines
- 1 2 3 Offers diagnosis coding assistance tools for claim submission using ICD-10
- 1 2 3 Offers claims scrubbing for Current Procedural Terminology (CPT®) format compliance

Generate and send **batch** claims using:

Rate

- 1 2 3 HIPAA ASC X12N 005010 A1 837P (professional claim)
- 1 2 3 HIPAA ASC X12N 005010 A1 837I (institutional claim)
- 1 2 3 HIPAA ASC X12N 005010 A1 837D (dental claim)

Receive **batch** claim acknowledgments using:

Rate

1 2 3 ASC X12N 005010 277CA

1 2 3 ASC X12 005010 999

Generate and send **real-time** electronic claims submission using:

Rate

1 2 3 HIPAA ASC X12N 005010 A1 837P (professional claim)

1 2 3 HIPAA ASC X12N 005010 A1 837I (institutional claim)

1 2 3 HIPAA ASC X12N 005010 A1 837D (dental claim)

Receive **real-time or nearly real-time** claim acknowledgments using:

Rate

1 2 3 ASC X12N 005010 277CA

1 2 3 ASC X12 005010 999

1 2 3 ASC X12 005010 835 remittance response

Claim status and tracking

Rate

1 2 3 Ability to generate and send **batch** claim status inquiry and receive response from payers using the HIPAA ASC X12N 005010 276 and 277 and supporting operating rules

1 2 3 Ability to generate and send **real-time or nearly real-time** claim status inquiry and receive response from payers using the HIPAA ASC X12N 005010 276 and 277 and supporting operating rules

1 2 3 Generation of claims aging reports

1 2 3 Automated reporting of claims showing problems in the claim status response

1 2 3 Automated generation of claim status requests and receipt of responses for aged claims pending health plan adjudication

Attachments

Rate

- 1 2 3 Ability to receive requests for attachments electronically using the HIPAA ASC X12N 005010 277 or HIPAA ASC X12N 005010 278
- 1 2 3 Ability to send electronic attachments with claims (837) and prior authorization/referrals (278) using the HIPAA ASC X12N 00**5010** 275

Ability to support electronic attachments in the following formats:

Rate

- 1 2 3 HL7 Consolidated Document Architecture (CDA) (*specify C-CDA R1 or C-CDA R2*)
- 1 2 3 HL7 Clinical Documents for Payers (CDP-1)
- 1 2 3 PDF
- 1 2 3 Other attachment formats (*specify*)

Remittance advice and health plan payment processing

Rate

- 1 2 3 Ability to receive **batch** claim payment/remittance advice using the HIPAA ASC X12N 005010 A1 835 and supporting operating rules
- 1 2 3 Ability to receive individual claim payment/remittance advice using the HIPAA ASC X12N 005010 A1 835 and supporting operating rules
- 1 2 3 Manual payment posting and reconciliation of paper explanations of benefits (EOBs)
- 1 2 3 Manual payment posting and reconciliation of electronic remittance advice (ERA) (HIPAA ASC X12N 005010 A1 835)
- 1 2 3 Automatic payment posting and reconciliation of ERA
- 1 2 3 Ability to define payer-specific automatic payment posting and reconciliation exceptions for ERA
- 1 2 3 Automatic verification of payer allowed amounts from the ERA against stored fee schedules
- 1 2 3 Ability to integrate with bank lock box services to reconcile received checks against the ERA
- 1 2 3 Automatic posting of capitation payments
- 1 2 3 Automated posting of performance bonus (e.g., Physician Quality Reporting System, Meaningful Use, gain sharing, other health plan performance measurement programs)

- 1 2 3 Automated posting of bundled payments
- 1 2 3 Automated reconciliation of electronic funds transfer (EFT) payments with the ERA

Coordination of benefits

Automated generation and submission of electronic secondary (and tertiary) claims containing prior payer adjudication from the ERA using the:

Rate

- 1 2 3 HIPAA ASC X12N 005010 A1 837P
- 1 2 3 HIPAA ASC X12N 005010 A1 837I
- 1 2 3 HIPAA ASC X12N 005010 A1 837D

Claim denials, overpayments and appeals

Rate

- 1 2 3 Management of rejected claims
- 1 2 3 Automated tracking of overpayment recovery by health plans
- 1 2 3 Manual entry of overpayment recovery notification letter information
- 1 2 3 Automated claims appeals process

Additional revenue cycle support

Rate

- 1 2 3 Offers real-time price estimation and predetermination tools in conjunction with health plan fee schedules
- 1 2 3 Maintains a 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 Maintain payer and product-specific claim edits and payment rules
- 1 2 3 Ability to generate first report of injury to payers using HIPAA ASC X12N 005010 148

Additional considerations:

Clinical Documentation and Interface

Rate

- 1 2 3 Patient summary generation: paper
- 1 2 3 Patient summary generation: electronic (e.g., CD-ROM, USB flash drive, posting in patient portal, email)
- 1 2 3 HL7 electronic lab interface
- 1 2 3 Electronic health record (EHR) interface (if yes, specify the product your practice currently has or supports)

Note: Integration of a new PMS with the practice’s EHR is a critical factor to consider. Because seamless integration of technology products is crucial, many practices choose an integrated PMS and EHR product from the same vendor to ensure interoperability of administrative and clinical data. Practices simply replacing their PMS must ensure that this new software can appropriately be integrated with the existing EHR. For more information and resources on how to choose an EHR, see the STEPS Forward [EHR Software Selection and Purchase module](#).

Additional considerations:

Patient Billing and Collections

Rate

- 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 Patient financial statement generation
- 1 2 3 Printing practice’s patient financial statements and other correspondence
- 1 2 3 Interface with third-party patient statement printing companies

- 1 2 3 Integrated credit card processing (magnetic stripe)
- 1 2 3 Integrated credit card processing (“smart” chip)
- 1 2 3 Automatic upload of guarantor statements
- 1 2 3 Patient encounter reconciliation
- 1 2 3 Patient collection tools

Additional considerations:

Systems 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
- 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 create reports identifying gaps in care
- 1 2 3 Ability to create reports supporting health plan quality measure physician performance reporting programs
- 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 (direct) or portal
- 1 2 3 Ability to select and switch clearinghouses or other vendors with relative ease at no cost

Additional considerations:

Technical Specifications

Rate

- 1 2 3 Vendor offers “cloud-based” software
- 1 2 3 Vendor offers “server-based” software
- 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 architecture for the system
- 1 2 3 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:

HIPAA Privacy and Security Compliance

Rate

- 1 2 3 Vendor supports practice policies and procedures to ensure full compliance with applicable requirements of the HIPAA Privacy and Security Rules

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|---|---|---|--|
| 1 | 2 | 3 | Role-based and facility-based security (e.g., secure passwords, audit logs, etc.) |
| 1 | 2 | 3 | Ability to encrypt either the entire computer, database or selected protected health information without system performance compromise |
| 1 | 2 | 3 | Data back-up/disaster recovery system that meets the HIPAA Security Rule requirements |
| 1 | 2 | 3 | Vendor provides documentation to support your HIPAA Privacy and Security risk analysis |
| 1 | 2 | 3 | Vendor will sign your organization's business associate agreement |

Additional considerations:

Vendor Fees

Rate

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|---|---|---|--|
| 1 | 2 | 3 | System costs based on the number of concurrent users |
| 1 | 2 | 3 | System costs based on the number of providers (vendor to define "providers," i.e., physicians vs. mid-level providers) |
| 1 | 2 | 3 | Electronic transaction fee(s) over and above selected clearinghouse's fees |

Additional considerations:

Switching PMS Products

Rate

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|---|---|---|--|
| 1 | 2 | 3 | Capability to incorporate practice information (e.g. billing, accounts receivable (A/R), patient information, etc.) from current PMS |
| 1 | 2 | 3 | Capability to migrate practice information (e.g. billing, A/R, patient information, etc.) out of future PMS |
| 1 | 2 | 3 | Vendor fees associated with transitioning to new PMS |

Additional considerations:

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
- 1 2 3 Maintenance agreement annual cost
- 1 2 3 Automatic upgrade of system to latest version as part of the maintenance agreement
- 1 2 3 “User group” face-to-face meetings or online communities

Additional considerations:

Disclaimer: This guide is strictly meant as an informational tool. The practice must use its own independent judgment when selecting a PMS 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.