

## Hassle Factor Log Program User Guide

Please observe the following Hassle Factor Log (HFL) guidelines to expedite processing and enable us to help you with insurance-related hassles while maintaining the integrity and credibility of the HFL program.

### General Guidelines

- The Texas Medical Association accepts HFLs only from current TMA members.
- Submit HFLs by mail or fax, Attn: Payment Advocacy Dept. (You do not need to mail us originals of faxed information.)
- Exhaust and document reasonable attempts to collect, including the appeals process, before submitting an HFL (unless you are submitting an HFL as “informational only”).
- Clearly identify payers and/or contractual relationships on the HFL form (e.g., carriers, IPAs, MCOs).
- All information should be clear and legible.
- Medicare’s Correct Coding Initiative determines bundling “standards.”
- Do not report slow-pay issues until 45 to 60 days after you have submitted the claim.
- TMA will copy to the physician any letter TMA sends a payer regarding the physician’s HFL.
- TMA generally processes HFLs within two to four weeks of receipt.

### Hassle Factor Log Form

- Use the current HFL form available on the TMA Web site at [www.texmed.org](http://www.texmed.org).
- The HFL form should be complete and legible.
- Give a brief description of the hassle on the form (avoid “See Attached”).
- You may use one form to submit multiple hassles that are like in nature and from the same insurance carrier.
- Use separate forms to submit multiple hassles that are unlike in nature.
- Use separate forms to submit hassles from different TMA physician members.
- Attachments are necessary for all HFLs.

### Attachments

Examples of frequently needed attachments are as follows:

- CMS-1500 claim forms
- Remittance notices (e.g., EOBs, RAs, R&S reports) with definitions of comment indicators and/or denial messages
- Appeal letters and/or denial letters
- Copies of relevant prior correspondence to and from the carrier
- EMC reports for **proof of timely filing** (e.g., batch acceptance reports from the payer or clearinghouse showing claims were accepted by the payer)
- Operative notes/Medical records
- Patient insurance identification cards
- Preauthorization/Referral forms

### Informational Only HFLs

TMA will return HFLs or add them to the database as “informational only” in situations such as the following:

- The HFL was submitted to TMA expressly for “informational only” purposes.
- The claim is concurrently being appealed with the carrier.
- The claim is for services older than 12 months.
- The physician office failed to follow up timely on the claim.
- The information submitted is a copy of a complaint filed with the Texas Department of Insurance.
- The hassle is not visually clear, legible, and understandable.
- The HFL contains unclear issues and /or conflicting information.
- Physician billing errors are construed as payer hassles.
- The HFL lacks appropriate attachments.