

# Preventing Billing Problems

Even though doctors go into the medical field to help patients, they can't do that without covering their expenses. How can physicians expedite payment of money due to them and keep their own focus on patient care?

## ***Chapter in Brief:***

- ▲ *Prevention is the best medicine when it comes to billing and coding problems.*
- ▲ *The front desk staff plays an important role by checking demographic information, confirming eligibility, and collecting co-pays and past due amounts.*
- ▲ *According to the AMA, 90 percent of claims denials are preventable and 67 percent are recoverable.*

**W**hile the office's biller and coder are definitely key to the billing cycle, almost everyone in the office plays a role in making sure the process runs smoothly. Without accurately capturing the patient's demographic and insurance information up front, mistakes can be made when submitting bills. Without the proper documentation in the medical record and knowledgeable coding staff, the office may not bill correctly for reimbursable services. Without cross-checking funds received with funds owed, the office may overlook an inappropriately low insurance payment.

To make sure everyone is playing his or her role effectively, Rita Bowen, MA, RHIA, CHPS, SSGB, enterprise director of HIM Services for Erlanger Health System in Chattanooga, Tenn., suggests holding occasional revenue cycle meetings, including

## TREAT HEARTBURN AND BEYOND

Prescribe ACIPHEX to relieve heartburn & other symptoms of nonerosive GERD—regurgitation, belching & early satiety, because...

TREAT HEARTBURN  
AND BEYOND **AcipHex**<sup>®</sup>  
rabeprazole sodium

**“There’s more to  
my life than GERD”**

20 Winning Seasons, 5 County Championships, 1 ACIPHEX tablet daily

*Frank Johnson*

GERD=gastroesophageal reflux disease  
Hypothetical representation of  
a patient with nonerosive GERD.

### INDICATION

ACIPHEX 20 mg is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD in adults and adolescents 12 years of age and above.

### IMPORTANT SAFETY INFORMATION

In clinical trials the most common side effect assessed as possibly or probably related to ACIPHEX with a frequency greater than placebo was headache (2.4% vs 1.6% for placebo).

Symptomatic response to therapy does not preclude the presence of gastric malignancy.

ACIPHEX is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles, or to any component of the formulation. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

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**ACIPHEX®**  
(rabeprazole sodium)  
Delayed-Release  
Tablets

**BRIEF SUMMARY**

Before prescribing ACIPHEX®, please see full prescribing information.

**INDICATIONS AND USAGE**

**Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)**

ACIPHEX is indicated for short-term (4 to 8 weeks) treatment in the healing and symptomatic relief of erosive or ulcerative gastroesophageal reflux disease (GERD). For those patients who have not healed after 8 weeks of treatment, an additional 8-week course of ACIPHEX may be considered.

**Maintenance of Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)**

ACIPHEX is indicated for maintaining healing and reduction in relapse rates of heartburn symptoms in patients with erosive or ulcerative gastroesophageal reflux disease (GERD Maintenance). Controlled studies do not extend beyond 12 months.

**Treatment of Symptomatic Gastroesophageal Reflux Disease (GERD)**

ACIPHEX is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD in adults and adolescents 12 years of age and above.

**Healing of Duodenal Ulcers**

ACIPHEX is indicated for short-term (up to four weeks) treatment in the healing and symptomatic relief of duodenal ulcers. Most patients heal within four weeks.

***Helicobacter pylori* Eradication to Reduce the Risk of Duodenal Ulcer Recurrence**

ACIPHEX in combination with amoxicillin and clarithromycin as a three drug regimen, is indicated for the treatment of patients with *H. pylori* infection and duodenal ulcer disease (active or history within the past 5 years) to eradicate *H. pylori*. Eradication of *H. pylori* has been shown to reduce the risk of duodenal ulcer recurrence. (See **CLINICAL STUDIES (14.5)** and **DOSAGE AND ADMINISTRATION (2.5)** in full prescribing information).

In patients who fail therapy, susceptibility testing should be done. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted. (See **CLINICAL PHARMACOLOGY, Microbiology (12.2)** in full prescribing information and the clarithromycin package insert, **CLINICAL PHARMACOLOGY, Microbiology.**)

**Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome**

ACIPHEX is indicated for the long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome.

**CONTRAINDICATIONS**

**Hypersensitivity to rabeprazole**

Rabeprazole is contraindicated in patients with known hypersensitivity to rabeprazole, substituted

benzimidazoles or to any component of the formulation.

**Use of Clarithromycin and hypersensitivity to macrolide antibiotics**

Clarithromycin is contraindicated in patients with known hypersensitivity to any macrolide antibiotic.

**Concomitant use of Clarithromycin with pimozide and cisapride**

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. There have been post-marketing reports of drug interactions when clarithromycin and/or erythromycin are co-administered with pimozide resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsade de pointes) most likely due to inhibition of hepatic metabolism of pimozide by erythromycin and clarithromycin. Fatalities have been reported. (Please refer to full prescribing information for clarithromycin.)

**Amoxicillin and hypersensitivity to penicillin**

Amoxicillin is contraindicated in patients with a known hypersensitivity to any penicillin. (Please refer to full prescribing information for amoxicillin.)

**WARNINGS AND PRECAUTIONS**

**Clarithromycin use in pregnant women**

**CLARITHROMYCIN SHOULD NOT BE USED IN PREGNANT WOMEN EXCEPT IN CLINICAL CIRCUMSTANCES WHERE NO ALTERNATIVE THERAPY IS APPROPRIATE.**

If pregnancy occurs while taking clarithromycin, the patient should be apprised of the potential hazard to the fetus. (See **WARNINGS** in prescribing information for clarithromycin.)

**Anaphylactic reactions associated with antibiotic use**

**Amoxicillin:** Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens.

There have been well-documented reports of individuals with a history of penicillin hypersensitivity reactions that have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before initiating therapy with any penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillin, cephalosporin, and other allergens. If an allergic reaction occurs, amoxicillin should be discontinued and the appropriate therapy instituted. (See **WARNINGS** in prescribing information for amoxicillin.)

**SERIOUS ANAPHYLACTIC REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.**

## **Pseudomembranous colitis associated with antibiotic use**

**Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin and amoxicillin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.**

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of "antibiotic-associated colitis".

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluid and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *Clostridium difficile colitis*.

## **Presence of gastric malignancy**

Symptomatic response to therapy with rabeprazole does not preclude the presence of gastric malignancy.

Patients with healed GERD were treated for up to 40 months with rabeprazole and monitored with serial gastric biopsies. Patients without *H. pylori* infection (221 of 326 patients) had no clinically important pathologic changes in the gastric mucosa. Patients with *H. pylori* infection at baseline (105 of 326 patients) had mild or moderate inflammation in the gastric body or mild inflammation in the gastric antrum. Patients with mild grades of infection or inflammation in the gastric body tended to change to moderate, whereas those graded moderate at baseline tended to remain stable. Patients with mild grades of infection or inflammation in the gastric antrum tended to remain stable. At baseline 8% of patients had atrophy of glands in the gastric body and 15% had atrophy in the gastric antrum. At endpoint, 15% of patients had atrophy of glands in the gastric body and 11% had atrophy in the gastric antrum. Approximately 4% of patients had intestinal metaplasia at some point during follow-up, but no consistent changes were seen.

## **Concomitant use with warfarin**

Steady state interactions of rabeprazole and warfarin have not been adequately evaluated in patients. There have been reports of increased INR and prothrombin time in patients receiving a proton pump inhibitor and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

## **ADVERSE REACTIONS**

Worldwide, over 2900 patients have been treated with rabeprazole in Phase II-III clinical trials involving various dosages and durations of treatment.

Because clinical trials are conducted under varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

## **Clinical Studies Experience**

The data described below reflect exposure to ACIPHEX in 1064 patients exposed for up to 8 weeks. The studies were primarily placebo- and active-controlled trials in patients with Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD), Duodenal Ulcers and Gastric Ulcers. The population had a mean age of 53 years (range 18-89 years) and had a ratio of approximately 60% male/ 40% female. The racial distribution was 86% Caucasian, 8% African American, 2% Asian and 5% other. Most patients received either 10 mg, 20 mg or 40 mg/day of ACIPHEX.

An analysis of adverse reactions appearing in  $\geq 2\%$  of ACIPHEX patients (n=1064) and with a greater frequency than placebo (n=89) in controlled North American and European acute treatment trials, revealed the following adverse reactions: pain (3% vs. 1%), pharyngitis (3% vs. 2%), flatulence (3% vs. 1%), infection (2% vs. 1%), and constipation (2% vs. 1%). The 3 long-term maintenance studies consisted of a total of 740 patients; at least 54% of patients were exposed to rabeprazole for 6 months while at least 33% were exposed for 12 months. Of the 740 patients, 247 (33%) and 241 (33%) patients received 10 mg and 20 mg of ACIPHEX, respectively, while 169 (23%) patients received placebo and 83 (11%) received omeprazole.

The safety profile of rabeprazole in the maintenance studies was consistent with what was observed in the acute studies.

Other adverse reactions that were seen in controlled clinical trials which do not meet the above criteria ( $\geq 2\%$  of ACIPHEX treated patients and > placebo) and for which there is a possibility of a causal relationship to rabeprazole include the following: headache, abdominal pain, diarrhea, dry mouth, dizziness, peripheral edema, hepatic enzyme increase, hepatitis, hepatic encephalopathy, myalgia, and arthralgia.

In a multicenter, open-label study of adolescent patients aged 12 to 16 years with a clinical diagnosis of symptomatic GERD or endoscopically proven GERD, the adverse event profile was similar to that of adults. The adverse reactions reported without regard to relationship to ACIPHEX that occurred in  $\geq 2\%$  of 111 patients were headache (9.9%), diarrhea (4.5%), nausea (4.5%), vomiting (3.6%), and abdominal pain (3.6%). The related reported adverse reactions that occurred in  $\geq 2\%$  of patients were headache (5.4%) and nausea (1.8%). There were no adverse reactions reported in these studies that were not previously observed in adults.

**Combination Treatment with Amoxicillin and Clarithromycin:** In clinical trials using combination therapy with rabeprazole plus amoxicillin and clarithromycin (RAC), no adverse reactions unique to this drug combination were observed. In the U.S.

multicenter study, the most frequently reported drug related adverse reactions for patients who received RAC therapy for 7 or 10 days were diarrhea (8% and 7%) and taste perversion (6% and 10%), respectively.

No clinically significant laboratory abnormalities particular to the drug combinations were observed.

For more information on adverse reactions or laboratory changes with amoxicillin or clarithromycin, refer to their respective package prescribing information, **ADVERSE REACTIONS** section.

### Postmarketing Experience

The following adverse reactions have been identified during postapproval use of ACIPHEX. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure: sudden death; coma, hyperammonemia; jaundice; rhabdomyolysis; disorientation and delirium; anaphylaxis; angioedema; bullous and other drug eruptions of the skin; severe dermatologic reactions, including toxic epidermal necrolysis (some fatal), Stevens-Johnson syndrome, and erythema multiforme; interstitial pneumonia; interstitial nephritis; and TSH elevations. In addition, agranulocytosis, hemolytic anemia, leukopenia, pancytopenia, and thrombocytopenia have been reported. Increases in prothrombin time/INR in patients treated with concomitant warfarin have been reported.

### DRUG INTERACTIONS

#### Drugs metabolized by CYP450

Rabeprazole is metabolized by the cytochrome P450 (CYP450) drug metabolizing enzyme system. Studies in healthy subjects have shown that rabeprazole does not have clinically significant interactions with other drugs metabolized by the CYP450 system, such as warfarin and theophylline given as single oral doses, diazepam as a single intravenous dose, and phenytoin given as a single intravenous dose (with supplemental oral dosing). Steady state interactions of rabeprazole and other drugs metabolized by this enzyme system have not been studied in patients.

#### Warfarin

There have been reports of increased INR and prothrombin time in patients receiving proton pump inhibitors, including rabeprazole, and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. (See **WARNINGS AND PRECAUTIONS**).

#### Cyclosporine

*In vitro* incubations employing human liver microsomes indicated that rabeprazole inhibited cyclosporine metabolism with an  $IC_{50}$  of 62 micromolar, a concentration that is over 50 times higher than the  $C_{max}$  in healthy volunteers following 14 days of dosing with 20 mg of rabeprazole. This degree of inhibition is similar to that by omeprazole at equivalent concentrations.

### Compounds dependent on gastric pH for absorption

Rabeprazole produces sustained inhibition of gastric acid secretion. An interaction with compounds which are dependent on gastric pH for absorption may occur due to the magnitude of acid suppression observed with rabeprazole. For example, in normal subjects, co-administration of rabeprazole 20 mg QD resulted in an approximately 30% decrease in the bioavailability of ketoconazole and increases in the AUC and  $C_{max}$  of digoxin of 19% and 29%, respectively. Therefore, patients may need to be monitored when such drugs are taken concomitantly with rabeprazole. Co-administration of rabeprazole and antacids produced no clinically relevant changes in plasma rabeprazole concentrations.

Concomitant use of atazanavir and proton pump inhibitors is not recommended. Co-administration of atazanavir with proton pump inhibitors is expected to substantially decrease atazanavir plasma concentrations and thereby reduce its therapeutic effect.

### Drugs metabolized by CYP2C19

In a clinical study in Japan evaluating rabeprazole in patients categorized by CYP2C19 genotype (n=6 per genotype category), gastric acid suppression was higher in poor metabolizers as compared to extensive metabolizers. This could be due to higher rabeprazole plasma levels in poor metabolizers. Whether or not interactions of rabeprazole sodium with other drugs metabolized by CYP2C19 would be different between extensive metabolizers and poor metabolizers has not been studied.

### Combined Administration with Clarithromycin

Combined administration consisting of rabeprazole, amoxicillin, and clarithromycin resulted in increases in plasma concentrations of rabeprazole and 14-hydroxylclarithromycin. (See **CLINICAL PHARMACOLOGY, Combination Therapy with Antimicrobials (12.3)** in full prescribing information).

Concomitant administration of clarithromycin with pimozone and cisapride is contraindicated. (See **PRECAUTIONS** in prescribing information for clarithromycin.) (See **PRECAUTIONS** in prescribing information for amoxicillin.)

### USE IN SPECIFIC POPULATIONS

#### Pregnancy

#### Teratogenic Effects. Pregnancy Category B:

Teratology studies have been performed in rats at intravenous doses up to 50 mg/kg/day (plasma AUC of 11.8  $\mu\text{g}\cdot\text{hr}/\text{mL}$ , about 13 times the human exposure at the recommended dose for GERD) and rabbits at intravenous doses up to 30 mg/kg/day (plasma AUC of 7.3  $\mu\text{g}\cdot\text{hr}/\text{mL}$ , about 8 times the human exposure at the recommended dose for GERD) and have revealed no evidence of impaired fertility or harm to the fetus due to rabeprazole. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

## Nursing Mothers

Following intravenous administration of  $^{14}\text{C}$ -labeled rabeprazole to lactating rats, radioactivity in milk reached levels that were 2- to 7-fold higher than levels in the blood. It is not known if unmetabolized rabeprazole is excreted in human breast milk. Administration of rabeprazole to rats in late gestation and during lactation at doses of 400 mg/kg/day (about 195-times the human dose based on  $\text{mg}/\text{m}^2$ ) resulted in decreases in body weight gain of the pups. Since many drugs are excreted in milk, and because of the potential for adverse reactions to nursing infants from rabeprazole, a decision should be made to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

## Pediatric Use

Use of ACIPHEX in adolescent patients 12 years of age and above for short-term treatment of GERD is supported by a) extrapolation of results from adequate and well-controlled studies that supported the approval of ACIPHEX for adults (see **CLINICAL STUDIES (14.1, 14.2, 14.3)** in full prescribing information and **INDICATIONS AND USAGE**); b) safety and pharmacokinetic studies performed in adolescent patients (see **Pharmacokinetics, Pediatric (12.3)** in full prescribing information). The safety and effectiveness of ACIPHEX for the treatment of GERD patients <12 years of age have not been established. The safety and effectiveness of ACIPHEX for other uses have not been established in pediatric patients.

In a multicenter, randomized, open-label, parallel-group study, 111 adolescent patients 12 to 16 years of age with a clinical diagnosis of symptomatic GERD or suspected or endoscopically proven GERD were randomized and treated with either ACIPHEX 10 mg or ACIPHEX 20 mg once daily for up to 8 weeks for the evaluation of safety and efficacy. The adverse event profile in adolescent patients was similar to that of adults. The related reported adverse reactions that occurred in  $\geq 2\%$  of patients were headache (5.4%) and nausea (1.8%). There were no adverse reactions reported in these studies that were not previously observed in adults.

## Geriatric Use

Of the total number of subjects in clinical studies of ACIPHEX, 19% were 65 years and over, while 4% were 75 years and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

## Gender

Duodenal ulcer and erosive esophagitis healing rates in women are similar to those in men. Adverse reactions and laboratory test abnormalities in women occurred at rates similar to those in men.

## OVERDOSAGE

**Because strategies for the management of overdose are continually evolving, it is advisable to contact a Poison Control Center to determine the latest recommendations for the management of an overdose of any drug.** There has been no experience with large overdoses with rabeprazole. Seven reports of accidental overdosage with rabeprazole have been received. The maximum reported overdose was 80 mg. There were no clinical signs or symptoms associated with any reported overdose. Patients with Zollinger-Ellison syndrome have been treated with up to 120 mg rabeprazole QD. No specific antidote for rabeprazole is known. Rabeprazole is extensively protein bound and is not readily dialyzable. In the event of overdosage, treatment should be symptomatic and supportive.

Single oral doses of rabeprazole at 786 mg/kg and 1024 mg/kg were lethal to mice and rats, respectively. The single oral dose of 2000 mg/kg was not lethal to dogs. The major symptoms of acute toxicity were hypoactivity, labored respiration, lateral or prone position and convulsion in mice and rats and watery diarrhea, tremor, convulsion and coma in dogs.

## PATIENT COUNSELING INFORMATION

### How to Take ACIPHEX

Patients should be cautioned that ACIPHEX delayed-release tablets should be swallowed whole. The tablets should not be chewed, crushed, or split. ACIPHEX can be taken with or without food. (See **PATIENT COUNSELING INFORMATION (17)** in full prescribing information.)

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anyone with revenue cycle contact. At her hospital, staff members discuss any system kinks and share feedback on payer denials. “Everybody who touches that information needs to understand how that information can flow and impact the revenue cycle,” she says.

### **Set Up Your Staff for Success**

Billing and coding accuracy should be taken into consideration when structuring your staff and hiring people to assume certain functions. Debbie Sword, CCBS (certified coding and billing specialist), who established her own medical billing service after working in medical offices, says practices should consider having one person take care of both the billing and posting of funds. “Don’t let someone who has nothing to do with accounts receivable post the payments, because they won’t recognize [when something is amiss],” she says.

Ms. Sword feels that billing shouldn’t be done by multitasking front desk staff, even if it’s cheaper for doctors to organize staff that way. “I’m a big advocate that the billing should be in back, away from the front desk,” Ms. Sword says. “Those doing it at the front desk are also checking in patients and doing data entry. It’s too confusing.”

Some revenue problems start because the coding and billing departments are separated, says Deborah Grider, CPC, CPC-H, CPC-P, CCS-P, CCP a consultant and president of the National Advisory Board of AAPC (American Academy of Professional Coders). “We’re turning out coders who don’t have a clue what an EOB [Explanation of Benefits] looks like, what a Medicare denial looks like, how to go through the appeal process,” Ms. Grider says. “Most of the practices were small when I started, and everyone understood each other’s pieces.”

Patricia Hubbard, CPC, CPC-OBGYN, a medical practice manager who has worked at several practices in New York State, agrees that billers and coders need a working knowledge of each other’s jobs. “There has to be really good communication between the doctor, coder, and biller to make sure they get the money the doctor has earned,” Ms. Hubbard says.

Ms. Hubbard advises billers to reconcile the incoming payment against the claim to be sure they’re correctly paid. She

warns that some insurers use software with claim edits that may change the code even if it was submitted correctly. “They down-code it and may only pay you for a level-three visit even if you submitted it as a level-four,” she says. Having someone in the

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accounts receivable department who is familiar with coding gives the office a better chance of catching payer system edits that decrease the level of a visit and reduce the payment.

### **Perfecting the Front-end Process**

A lot of problems can be headed off at the front desk by making sure information from patients is accurately entered into the record. “Errors can start at the front desk if that person doesn’t get the patient demographics into the system or if you’ve got their insurance ID number or primary beneficiary wrong or name misspelled,” says Marie Felger, CPC, CCS-P, a medical practice auditor and former office manager based in Granger, Ind. Ms. Felger relates that in some offices, the front desk is staffed by the least-experienced person. “That can end up costing them money,” she says.

Ms. Hubbard agrees, adding that front desk staff should have a knack for details as well as the ability to multitask efficiently. “Common sense and patience as well as training and experience are crucial to success,” she says. “Mistakes in this area can have far-reaching and costly consequences.”

Front desk staff should try to get as much contact information from the patient as possible, including home, office, and cell-phone numbers. To make sure correct information is on file for established patients, front desk staff should print out a new face sheet each quarter with the patient’s name, address, date of birth, and insurance information. Patients can check the information while they wait for their appointment.

While the patient is still in the waiting room, the check-in staff should make sure all questions are answered, all forms are signed, and all information lines up with what is in the record. If there are questions, ask. "Once the patient is out the door, that opportunity may be lost," says Ms. Hubbard.

In addition to getting accurate demographic data, the front desk must verify insurance coverage. If this check is done verbally, the question to patients should be, "Is XYZ still your insurance carrier?" This will often elicit a more accurate response than "Is your insurance still the same?"

"A lot of people carry around cards that are two to three years old," says Ms. Hubbard. "You send in the claim and get a denial saying, 'They're not covered with us anymore.'"

Nancy Enos, FACMPE, CPC, CPC-I, CPC-E/M, a consultant and coding instructor, recommends taking advantage of the 834 and 835 electronic eligibility requests that confirm a patient's valid insurance. Ms. Enos says that if an office is using a Web-based practice management system or has access to the patient's payer portal, it can send a batch request confirming insurance status. The office will receive an electronic response confirming eligibility, possibly with details on coverage and co-pay.

"The newer Web-based practice management systems automatically take all the patients from the appointment schedule and send [insurance data] out to the payer" to check for eligibility status before the appointment, Ms. Enos says. When the patient shows up for his or her appointment, the physician's office can inform him or her of co-pay and deductible status.

If the doctor will perform a service that isn't or may not be covered by insurance, the staff should have the patient sign a waiver agreeing to pay for it personally. "They're not apt to be receptive to getting a bill if they're not told up front."

This policy becomes even more important when the physician is not a participating provider for the patient's insurance company. Any reimbursement will then go directly to the patient, not the physician. "I'd heavily recommend that you let the patients know what the anticipated office fees are for that visit and have them pay up front," says Gerald J. Russo, MD, FAAP, chief medical officer of Bloodhound Technologies, a claims-editing provider based in North Carolina.

If a Medicare patient needs or is offered treatment that may be denied by Medicare, the office staff needs to discuss the matter with patients and ask them to sign an advance beneficiary notice (ABN). The sheet must specify the recommended treatment and the estimated cost for that treatment. By signing the form and agreeing to treatment, the patient agrees to pay any associated fees not covered by Medicare.

### Getting Co-pays Upfront

Even with a small co-pay, it's easier to get the co-pay up front, when the patient is registering. While \$10 here and \$20 there don't seem like much, these co-pays add up to real money. Offering to take payment by credit card makes it easy for patients to fulfill this obligation when they check in.

"If it costs you eight to ten dollars to mail out a statement, you're in a losing situation," Ms. Felger says.

Consider putting up signs in the waiting area that state the office's expectations for payment. Ms. Hubbard recommends something like this: "Please come to your appointment prepared to pay your share. Co-payments are due at the time of your visit. If we must send you a bill, a statement fee will be added to your account." Ms. Hubbard adds that her office charges the patient \$10 to send a bill for a co-pay.

Collecting a deductible up front can be more difficult than co-pays since it's not always clear where the patient stands. Some insurance companies have different deductibles for the family and each individual; this can be complicated for patients to track. "You can call or go online to check if it's been met," Ms. Grider says. But the information is not always available or up-to-date, and most practices wait and collect it on the back end.

If possible, a practice should perform a "patient financial clearance" prior to any procedure, according to Deborah Walker Keegan, PhD, FACMPE, president of Medical Practice Dimensions, Inc., and co-author of *The Physician Billing Process: 12 Potholes to Avoid in the Road to Getting Paid* (MGMA, 2009). She says practices want to find out how much the insurance will



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pay and the extent of the patient's financial responsibility.

Real-time claims adjudication promises to change the front-end process and may even have staffing implications, Dr. Keegan says. Some payers are already using these systems, which allow medical practices to input claims information into the payer Website while the patient is still at the office. The payer responds immediately with the patient's portion of the bill. "If everyone is on board, and if it works smoothly and efficiently, it could eliminate accounts receivable," says Dr. Keegan.

### **Building a Solid Payment Plan**

Once the patient has left the physician's office, the only way to collect from patients is to have a solid payment plan in place, says Ms. Enos.

The night before a visit, a staff member should look at the next day's schedule to see who has a balance, advises Ms. Felger. When making reminder calls about appointments, office staff can tell the patients their balance and remind them to bring payment with them. The balance should be noted on the encounter form so the patient can be reminded to pay at check-in. "It's fairly effective," Ms. Felger says.

Once the patient is out the door, the office can send letters and bills and also phone the patient as a reminder to send the money in. Ms. Felger says that when she did collections, phone contact was most effective for her. "Trying to get them to agree to a payment plan was probably the best way," she says. "Bill them with a handwritten notation, 'Per our agreement please send in \_\_\_\_\_', and then I'd list the amount."

As for patient statements, Ms. Enos recommends sending them out every 28 days or programming your system to trigger a bill when the patient has a minimum balance.

Anita Weis, an office manager for a practice in Illinois, says that each office should have a clear policy for when a patient's bill isn't paid in a certain time frame, like two or three months, or when he or she hasn't arranged payment. The bill would then go to collections.

Whatever the reason for nonpayment, Ms. Sword recommends that the doctor pick a set amount of money where he or she draws the line for additional treatment. Then the doctor has to

decide whether to dismiss the patient from the practice. “Then you go through that process with a termination letter, since the patient is not holding up their end by paying for services.”

Dr. Keegan recommends performing “risk segmentation” on patient balances based on the patient’s prior payment record. “If we have a higher probability of collecting ourselves, we’d put a lot of resources in early to get payment,” she says. “If the patient historically hasn’t paid bills on time or is unemployed, we’re going to devote fewer resources to collecting before sending them to collections,” she says. Risk segmentation factors to consider are the amount of money owed, demographic variables, and even the patient’s ZIP code, says Dr. Keegan.

Dr. Keegan understands that times are tough financially for everyone, but she says, “Our goal is to keep practices in business tomorrow to see the next patient.” She recommends that medical practices identify some resources to send the patient to for healthcare credit, which is admittedly harder to get in this economy. The office can also help a patient apply for drug programs with pharmaceutical companies. “We have a list of resources,” she says. Dr. Keegan adds that bills going to collections are essentially written off the books, so you should track how much you sent to the agency and the recovery rate.

### Insurance Billing Cycles and Follow-up

When dealing with insurance carriers, most sources agree that daily billing is the best choice. “You have to bill every day,” says Ms. Weis. “If you save the claims for a week, you’ll have a cash flow crisis.”

Another reason to bill on a daily basis is to catch the problematic claims earlier. With electronic billing, practices can send out the day’s claims and get a report that explains how many were submitted and how many were rejected, Ms. Weis explains: “You



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can download why they're rejected and clean them up before you lose a day."

Coding in a timely manner goes hand in hand with billing. "If they only have one coding person, and if she's out for two weeks, the billing piles up until she gets back," Ms. Sword says. Hiring a temporary coder or using a backup billing service that can do the job in the short term can help avoid that backlog.

If these reasons aren't enough incentive to file more frequently, consider that you need to file on time if you want to be paid. Ms. Sword notes that timely filing rules vary by the carrier. "Some carriers you have to bill within 30 days of service even if they don't pay it right away. With mental health, there's a lot of timely filing issues. That's another reason to bill daily," Ms. Sword says.

Billing an incorrect claim can reset the timely filing clock. "Sometimes I'll bill claims knowing they're going to be denied, based on my info," Ms. Sword says. "But I'll bill anyway just so my 30 days start all over. If you have that paper EOB stating 'Claim missing info,' you have proof they got it on time."

Ms. Weis says it takes two to three weeks for Medicare to pay; then leftover claims are sent to the secondary insurance carrier. Her experience matches Medicare policy, according to a CMS official. Under Medicare law, claims cannot be paid until 14 days after receipt, but most physician claims are paid within 30 days of receipt. "The best way to ensure prompt payment is to make sure your claims are complete and correctly coded, both as to diagnosis and services furnished," the official says.

Follow up on claims based on payer guidelines, advises Dr. Keegan. If Medicare pays within 17 days, "On day 18 you want to know where your payment is," she says.

At the minimum, Dr. Keegan notes, follow each account at least every 30 to 45 days. Each state has a prompt payment law, specifying a timeline for insurers to pay on clean claims, she explains: "You need to be managing those indices so you can pursue payment."

Cindy Hughes, CPC, PCS, coding and compliance specialist for the American Academy of Family Physicians, recommends following up on electronic claims submissions within 20 to 25 days since those should be paid in 10 to 14 days. For paper

claims, she recommends following up in 30 days “because it takes so long to get into the payer system,” she says. “Since you’re dealing with paper, if you have to resubmit, you’re going to cut it close on those 60-to-90-day filing-time limits.”

Practices should monitor their billing at the payer level, not just on a macro level, says Dr. Keegan. “It’s important to monitor at the payer level, because one payer can skew your levels,” she says, adding that practices should also monitor self-paying patients separately.

One calculation Dr. Keegan likes for practices to use is net collection rate, or net collections divided by net charges. “We would expect to have a net collection rate at 97 percent or greater. That’s one measure you want to look at, at the payer level,” she says. Dr. Keegan also likes for practices to analyze the number of days in accounts receivable. She calculates this by taking the total accounts receivable days divided by an average daily charge (12 months of gross charges divided by 365 days). “We want that to be between 35 to 40 days. That’s going to vary based on certain payers,” she says. It can also vary by practice, as she notes that an orthopedic surgeon with a lot of worker’s compensation claims would have a longer span.

After looking at the accounts receivable days, she then looks at the percentage of accounts receivable days greater than 90 days, which she hopes will be no greater than 15 to 20.

Dr. Keegan says that in order to get the benchmarking correct, a practice needs to be vigilant about whether it ages reports by date of entry or date of service. “That matters a lot,” she says, noting that a doctor may do a procedure on February 1, but not get the charge in until March 1. “It’s really important to look at the definition of the parameters in the report you’re requesting, so you’re comparing apples to apples in benchmarking.”

## Getting Out of Denial

The AMA quotes a study showing that 90 percent of claims denials are preventable and 67 percent are recoverable. The AMA estimates that physicians spend up to 14 percent of their office income trying to collect payment from payers.

Dr. Keegan recommends that practices track one week of EOBs per payer. “Based on each EOB, look at claim denials,”

## Working with Collections Agencies

Medical practices should have a plan in place for referring patients to collections if their bills aren't paid in a certain time frame. This should be spelled out on a financial policy each patient signs when he or she first receives care. "Decide at what point it's going to happen, 90 days past due, 120 days, and then stick by it," says Patricia Hubbard, CPC, CPC-OBGYN, a medical practice manager in New York State.

Deborah Walker Keegan, PhD, FACMPE, president of Medical Practice Dimensions, Inc., and co-author of *The Physician Billing Process: 12 Pot-holes to Avoid in the Road to Getting Paid* (MGMA, 2009), says that the office should have a parallel process when sending the final letter to the patient warning that the bill is about to go to collections. When that letter is sent, the physician or practice manager should sign off on it so that he or she can intervene if necessary.

she says, whether they're denied due to unbundling, coding a non-covered service, or lack of medical necessity, for example. "You can add up your denials and see if you have a trend with that particular payer. You probably have it with other payers, too." Once you've identified the problem, it's easier to prevent it in the future.

Dr. Keegan notes that beefing up the process on the front end costs money, but the practice will save money on the back end in account follow-up and in denials. "They're saving money over all," she says.

Sometimes the EOB analysis will expose a pattern of denials that are not preventable. In this case, office staff should talk to the payer directly to figure out a solution. "Some medical groups have leverage in the market," Dr. Keegan says. But for smaller offices without that leverage, she recommends bringing the point up during contract renegotiations. If the denial issue can't be solved, the office can try to negotiate for increased rates although she acknowledges that this is difficult.

Even if a bill is coded and submitted accurately, the payer may not remit payment accurately. An AMA survey found that health insurers paid only 79 percent of claims accurately the first time. The AMA 2008 National Health Insurer Report Card shows that Medicare comes closest to paying the full contracted amount—98 percent of the time—while some managed care companies

Practices should think twice about sending a patient who is very ill or who had an unexpected outcome to collections. “That patient might proceed with litigation,” says Dr. Keegan. A practice should consult with its medical malpractice carrier about how (or whether) to pursue payment from those patients. The practice should follow through on sending the approved patients to collections if they haven’t met the practice’s terms. “You don’t want to prolong that time,” says Dr. Keegan.

Just three months after a bill is due, the likelihood of collecting the fee is 73 percent, according to the Commercial Collection Agency Section of the Commercial Law League of America, as quoted by the AMA. By waiting six months, the likelihood of collection drops to 50 percent, then to 25 percent after a year. “Even though it seems harsh to turn someone over to a collection agency, if you wait a year before you do that, it’s very unlikely you’ll ever see your money,” says Ms. Hubbard.

were found to pay the contracted rate only 61 to 86 percent of the time. (To see the complete AMA report, go to <http://www.ama-assn.org/ama1/pub/upload/mm/368/reportcard-short.pdf>.)

Appeals take time and money; according to the AMA, it costs physicians approximately \$14 to \$25 to appeal a claim. Costs include staff time, postage, and other supplies. Doctors are hesitant to make that investment, especially for a low amount like \$25. However, when multiplied by a large number of claims, even small amounts can add up quickly.

Understanding what payers do and don’t cover is important in knowing what to appeal, says Donna D. Wilson, RHIA, CCS, senior director in the consulting division of Compliance Concepts, Inc., a Pennsylvania-based firm that helps healthcare organizations comply with federal regulations, including coding and audits. Ms. Wilson recommends appealing any denial if you believe the coding is correct, referencing official coding guidelines when you send the claims. “Payers don’t always hire credentialed coders. You are the coding expert,” she says. “Appeal when you know your coding is correct.”

It’s important to appeal immediately, according to Gail Jones, MAOA, MICT, manager for practice management for the American Academy of Family Physicians. “A lot of billers have a tickler file for appeals, but they get busy and then miss the deadline for filing.”