Addressing Billing and Staff Issues

Chapter FastFACTS

1. **Physicians let thousands of dollars leak out of their practices in various administrative ways—from lost charges to misused petty cash.**
2. **Capturing all charges while the patient's still there, and getting the bill out before the end of the day, are keys to healthy cash flow.**
3. **Benchmarking your practice will give you a better handle on how you compare with others and where you can improve.**
4. **A severely overworked front desk staff can have a negative impact on your bottom line.**
5. **Hiring healthcare specialists can help you pinpoint problem areas and find solutions.**

Judy Aburmishan is mystified at the haphazard way bills arrive after she or one of her family members has a hospital stay. Although one or two bills may be waiting by the time the patient gets discharged, the rest—from the hospital, the surgeon, the anesthesiologist, the pathologist, and maybe a few other providers—trickle in over several months. As a certified healthcare business consultant, she's amazed that the physicians stay in business with such a casual approach to cash flow.

"The most efficient, fastest way to kill a practice is to slow down cash flow," says Ms. Aburmishan, a CPA with consulting

Treat today with NAMENDA

Proven efficacy and tolerability

- Improves function, delays onset of behavioral symptoms, and provides benefits in cognition[1-3]
- Proven safety and tolerability with low risk of gastrointestinal side effects may lead to therapy persistence[4,5]
- Reduces caregiving time, cost, and caregiver distress[3,6,7]
- Effective first-line and in combination with an acetylcholinesterase inhibitor[1,2]

Broad patient access—covered on 98% of Medicare Part D formularies[4]

Namenda® memantine HCl

Extending memory and function

NAMENDA® (memantine HCl) is indicated for the treatment of moderate to severe Alzheimer's disease.

NAMENDA is contraindicated in patients with known hypersensitivity to memantine HCl or any excipients used in the formulation. The most common adverse events reported with NAMENDA vs placebo (≥5% and higher than placebo) were dizziness, confusion, headache, and constipation. In patients with severe renal impairment, the dosage should be reduced.

References: 1. Reisberg B, Doody R, Stöffler A, Schmitt F, Ferris S, Möbius HJ, for the Memantine Study Group. Memantine in moderate-to-severe Alzheimer's disease. *N Engl J Med.* 2003;348:1333-1341. **2.** Tariot PN, Farlow MR, Grossberg GT, Graham SM, McDonald S, Gergel I, for the Memantine Study Group. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004;291:317-324. **3.** Cummings JL, Schneider E, Tariot PN, Graham SM, for the Memantine MEM-MD-02 Study Group. Behavioral effects of memantine in Alzheimer disease patients receiving donepezil treatment. *Neurology.* 2006;67:57-63. **4.** Data on file. Forest Laboratories, Inc. **5.** NAMENDA® (memantine HCl) Prescribing Information. Forest Pharmaceuticals, Inc., St Louis, Mo. **6.** Wimo A, Winblad B, Stöffler A, Wirth Y, Möbius HJ. Resource utilisation and cost analysis of memantine in patients with moderate to severe Alzheimer's disease. *Pharmacoeconomics.* 2003;21:327-340. **7.** Winblad B, Poritis N. Memantine in severe dementia: results of the ³M-BEST Study (Benefit and efficacy in severely demented patients during treatment with memantine). *Int J Geriatr Psychiatry.* 1999;14:135-146.

Forest Pharmaceuticals, Inc.

For more details, please visit **www.namenda.com**.

Please see brief summary of Prescribing Information on the adjacent page.

62-1014307R R2 03/09

Namenda
memantine HCl

Tablets/Oral Solution
Rx Only

Brief Summary of Prescribing Information.

For complete details, please see full Prescribing Information for Namenda.

INDICATIONS AND USAGE
Namenda (memantine hydrochloride) is indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

CONTRAINDICATIONS
Namenda (memantine hydrochloride) is contraindicated in patients with known hypersensitivity to memantine hydrochloride or to any excipients used in the formulation.

PRECAUTIONS
Information for Patients and Caregivers: Caregivers should be instructed in the recommended administration (twice per day for doses above 5 mg) and dose escalation (minimum interval of one week between dose increases).

Neurological Conditions
Seizures: Namenda has not been systematically evaluated in patients with a seizure disorder. In clinical trials of Namenda, seizures occurred in 0.2% of patients treated with Namenda and 0.5% of patients treated with placebo.

Genitourinary Conditions
Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine.

Special Populations
Hepatic Impairment
Namenda undergoes partial hepatic metabolism, with about 48% of administered dose excreted in urine as unchanged drug or as the sum of parent drug and the N-glucuronide conjugate (74%). No dosage adjustment is needed in patients with mild or moderate hepatic impairment. Namenda should be administered with caution to patients with severe hepatic impairment.

Renal Impairment
No dosage adjustment is needed in patients with mild or moderate renal impairment. A dosage reduction is recommended in patients with severe renal impairment (see CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION in Full Prescribing Information).

Drug-Drug Interactions
N-methyl-D-aspartate (NMDA) antagonists: The combined use of Namenda with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution.
Effects of Namenda *on substrates of microsomal enzymes: In vitro* studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. In addition, *in vitro* studies indicate that at concentrations exceeding those associated with efficacy, memantine does not induce the cytochrome P450 isoenzymes CYP1A2, CYP2C9, CYP2E1, and CYP3A4/5. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected.
Effects of inhibitors and/or substrates of microsomal enzymes on Namenda: Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the metabolism of memantine.
Acetylcholinesterase (AChE) inhibitors: Coadministration of Namenda with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine and donepezil was similar to that of donepezil alone.
Drugs eliminated via renal mechanisms: Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system, including hydrochlorothiazide (HCTZ), triamterene (TA), metformin, cimetidine, ranitidine, quinidine, and nicotine, could potentially result in altered plasma levels of both agents. However, coadministration of Namenda and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%. In addition, coadministration of memantine with the antihyperglycemic drug Glucovance® (glyburide and metformin HCl) did not affect the pharmacokinetics of memantine, metformin and glyburide. Furthermore, memantine did not modify the serum glucose lowering effect of Glucovance®.
Drugs that make the urine alkaline: The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate) and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions.

Carcinogenesis, Mutagenesis and Impairment of Fertility
There was no evidence of carcinogenicity in a 113-week oral study in mice at doses up to 40 mg/kg/day (10 times the maximum recommended human dose [MRHD] on a mg/m^2 basis). There was also no evidence of carcinogenicity in rats orally dosed at up to 40 mg/kg/day for 71 weeks followed by 20 mg/kg/day (20 and 10 times the MRHD on a mg/m^2 basis, respectively) through 128 weeks.
Memantine produced no evidence of genotoxic potential when evaluated in the *in vitro S. typhimurium* or *E. coli* reverse mutation assay, an *in vitro* chromosomal aberration test in human lymphocytes, an *in vivo* cytogenetics assay for chromosome damage in rats, and the *in vivo* mouse micronucleus assay. The results were equivocal in an *in vitro* gene mutation assay using Chinese hamster V79 cells.
No impairment of fertility or reproductive performance was seen in rats administered up to 18 mg/kg/day (9 times the MRHD on a mg/m^2 basis) orally from 14 days prior to mating through gestation and lactation in females, or for 60 days prior to mating in males.

Pregnancy
Pregnancy Category B: Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 9 and 30 times, respectively, the maximum recommended human dose [MRHD] on a mg/m^2 basis).
Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the post-partum period. The no-effect dose for these effects was 6 mg/kg, which is 3 times the MRHD on a mg/m^2 basis.
There are no adequate and well-controlled studies of memantine in pregnant women. Memantine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers
It is not known whether memantine is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother.

Pediatric Use
There are no adequate and well-controlled trials documenting the safety and efficacy of memantine in any illness occurring in children.

ADVERSE REACTIONS
The experience described in this section derives from studies in patients with Alzheimer's disease and vascular dementia.
Adverse Events Leading to Discontinuation: In placebo-controlled trials in which dementia patients received doses of Namenda up to 20 mg/day, the likelihood of discontinuation because of an adverse event was the same in the Namenda group as in the placebo group. No individual adverse event was associated with the discontinuation of treatment in 1% or more of Namenda-treated patients and at a rate greater than placebo.
Adverse Events Reported in Controlled Trials: The reported adverse events in Namenda (memantine hydrochloride) trials reflect experience gained under closely monitored conditions in a highly selected patient population. In actual practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior and the types of patients treated may differ. Table 1 lists treatment-emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled dementia trials and for which the rate of occurrence was greater for patients treated with Namenda than for those treated with placebo. No adverse event occurred at a frequency of at least 5% and twice the placebo rate.

Table 1: Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving Namenda and at a Higher Frequency than Placebo-treated Patients.

Body System Adverse Event	Placebo (N = 922) %	Namenda (N = 940) %
Body as a Whole		
Fatigue	1	2
Pain	1	3
Cardiovascular System		
Hypertension	2	4
Central and Peripheral Nervous System		
Dizziness	5	7
Headache	3	6
Gastrointestinal System		
Constipation	3	5
Vomiting	2	3
Musculoskeletal System		
Back pain	2	3
Psychiatric Disorders		
Confusion	5	6
Somnolence	2	3
Hallucination	2	3
Respiratory System		
Coughing	3	4
Dyspnea	1	2

Other adverse events occurring with an incidence of at least 2% in Namenda-treated patients but at a greater or equal rate on placebo were agitation, fall, inflicted injury, urinary incontinence, diarrhea, bronchitis, insomnia, urinary tract infection, influenza-like symptoms, abnormal gait, depression, upper respiratory tract infection, anxiety, peripheral edema, nausea, anorexia, and arthralgia.

The overall profile of adverse events and the incidence rates for individual adverse events in the subpopulation of patients with moderate to severe Alzheimer's disease were not different from the profile and incidence rates described above for the overall dementia population.

Vital Sign Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure, and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with Namenda. A comparison of supine and standing vital sign measures for Namenda and placebo in elderly normal subjects indicated that Namenda treatment is not associated with orthostatic changes.

Laboratory Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Namenda treatment.

ECG Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with Namenda treatment.

Other Adverse Events Observed During Clinical Trials

Namenda has been administered to approximately 1350 patients with dementia, of whom more than 1200 received the maximum recommended dose of 20 mg/day. Patients received Namenda treatment for periods of up to 884 days, with 862 patients receiving at least 24 weeks of treatment and 387 patients receiving 48 weeks or more of treatment.

Treatment emergent signs and symptoms that occurred during 8 controlled clinical trials and 4 open-label trials were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized categories using WHO terminology, and event frequencies were calculated across all studies.

All adverse events occurring in at least two patients are included, except for those already listed in Table 1, WHO terms too general to be informative, minor symptoms or events unlikely to be drug-caused, e.g., because they are common in the study population. Events are classified by body system and listed using the following definitions: frequent adverse events - those occurring in at least 1/100 patients; infrequent adverse events- those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to Namenda treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies.

Body as a Whole: *Frequent:* syncope. *Infrequent:* hypothermia, allergic reaction.

Cardiovascular System: *Frequent:* cardiac failure. *Infrequent:* angina pectoris, bradycardia, myocardial infarction, thrombophlebitis, atrial fibrillation, hypotension, cardiac arrest, postural hypotension, pulmonary embolism, pulmonary edema.

Central and Peripheral Nervous System: *Frequent:* transient ischemic attack, cerebrovascular accident, vertigo, ataxia, hypokinesia. *Infrequent:* paresthesia, convulsions, extrapyramidal disorder, hypertonia, tremor, aphasia, hypoesthesia, abnormal coordination, hemiplegia, hyperkinesia, involuntary muscle contractions, stupor, cerebral hemorrhage, neuralgia, ptosis, neuropathy.

Gastrointestinal System: *Infrequent:* gastroenteritis, diverticulitis, gastrointestinal hemorrhage, melena, esophageal ulceration.

Hemic and Lymphatic Disorders: *Frequent:* anemia. *Infrequent:* leukopenia.

Metabolic and Nutritional Disorders: *Frequent:* increased alkaline phosphatase, decreased weight. *Infrequent:* dehydration, hyponatremia, aggravated diabetes mellitus.

Psychiatric Disorders: *Frequent:* aggressive reaction. *Infrequent:* delusion, personality disorder, emotional lability, nervousness, sleep disorder, libido increased, psychosis, amnesia, apathy, paranoid reaction, thinking abnormal, crying abnormal, appetite increased, paroniria, delirium, depersonalization, neurosis, suicide attempt.

Respiratory System: *Frequent:* pneumonia. *Infrequent:* apnea, asthma, hemoptysis.

Skin and Appendages: *Frequent:* rash. *Infrequent:* skin ulceration, pruritus, cellulitis, eczema, dermatitis, erythematous rash, alopecia, urticaria.

Special Senses: *Frequent:* cataract, conjunctivitis. *Infrequent:* macula lutea degeneration, decreased visual acuity, decreased hearing, tinnitus, blepharitis, blurred vision, corneal opacity, glaucoma, conjunctival hemorrhage, eye pain, retinal hemorrhage, xerophthalmia, diplopia, abnormal lacrimation, myopia, retinal detachment.

Urinary System: *Frequent:* frequent micturition. *Infrequent:* dysuria, hematuria, urinary retention.

Events Reported Subsequent to the Marketing of Namenda, both US and Ex-US

Although no causal relationship to memantine treatment has been found, the following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in labeling: aspiration pneumonia, asthenia, atrioventricular block, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, cholelithiasis, claudication, colitis, deep venous thrombosis, depressed level of consciousness (including loss of consciousness and rare reports of coma), dyskinesia, dysphagia, encephalopathy, gastritis, gastroesophageal reflux, grand mal convulsions, intracranial hemorrhage, hepatitis (including increased ALT and AST and hepatic failure), hyperglycemia, hyperlipidemia, hypoglycemia, ileus, increased INR, impotence, lethargy, malaise, myoclonus, neuroleptic malignant syndrome, acute pancreatitis, Parkinsonism, acute renal failure (including increased creatinine and renal insufficiency), prolonged QT interval, restlessness, sepsis, Stevens-Johnson syndrome, suicidal ideation, sudden death, supraventricular tachycardia, tachycardia, tardive dyskinesia, thrombocytopenia, and hallucinations (both visual and auditory).

ANIMAL TOXICOLOGY

Memantine induced neuronal lesions (vacuolation and necrosis) in the multipolar and pyramidal cells in cortical layers III and IV of the posterior cingulate and retrosplenial neocortices in rats, similar to those which are known to occur in rodents administered other NMDA receptor antagonists. Lesions were seen after a single dose of memantine. In a study in which rats were given daily oral doses of memantine for 14 days, the no-effect dose for neuronal necrosis was 6 times the maximum recommended human dose on a mg/m^2 basis. The potential for induction of central neuronal vacuolation and necrosis by NMDA receptor antagonists in humans is unknown.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class: Memantine HCl is not a controlled substance.

Physical and Psychological Dependence: Memantine HCl is a low to moderate affinity uncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 2,504 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

OVERDOSAGE

Signs and symptoms associated with memantine overdosage in clinical trials and from worldwide marketing experience include agitation, confusion, ECG changes, loss of consciousness, psychosis, restlessness, slowed movement, somnolence, stupor, unsteady gait, visual hallucinations, vertigo, vomiting, and weakness. The largest known ingestion of memantine worldwide was 2.0 grams in a patient who took memantine in conjunction with unspecified antidiabetic medications. The patient experienced coma, diplopia, and agitation, but subsequently recovered.

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.

As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine.

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firm FGMK, Bannockburn, Ill. "A medical practice is like a grocery store—there are small margins on every item, and if you don't bill everything that's coming to you, it ends up coming out of [your] pocket."

Doctors go to medical school so they can practice medicine, not necessarily run a business. But a medical practice is also a business; and if it isn't run like one, it can't be financially viable. "Too many primary care practices are run as mom-and-pop shops because the doctor doesn't have business training," says David J. Zetter of Health Care Professional Management Serv-

"If you can capture the charges when the patient's there, and get the bill out before the end of the day, you have a shot at getting cash flow going."

Judy Aburmishan, CPA

ices, Mechanicsburg, Pa., a coding expert who helps physicians tighten their business practices, including billing. Often the nurses or medical assistants who may double as office managers in a small practice don't have business training, either.

As a result, Mr. Zetter routinely finds physicians letting thousands of dollars leak out of their practices in little ways—like not charging for a venipuncture when they collect a sample for a blood test—or fruitlessly sending statement after statement to patients who haven't paid an outstanding bill. "If they didn't pay attention to the first [bill], they're not going to pay attention to the second or third one, either," he says.

In addition, there's often no one keeping an eye on mounting paperwork, like claim denials, says Katherine I. Moghadas, RN, president and founder of Associated Healthcare Advisors, Fern Park, Fla., and author of *Medical Practice Policies & Procedures* (American Medical Association, 2005). "You may not think it's worth it, but then you look at them and realize there's

$50,000 in revenue locked up in those denials."

Medical errors can threaten your patients; administrative and billing errors can threaten your practice. Money can slip through the cracks every day, from lost charges to a misused petty cash box to even more problems if you've decided to sell products like nutritional supplements and personal care products. If you do sell products, Ms. Aburmishan suggests taking a leaf out of Wal-Mart's book: Make sure your staff is trained to handle this responsibility, track sales carefully, and keep tabs on inventory.

Plugging those holes can mean the difference between just hanging on and making a comfortable profit. As director of healthcare services for Stone Carlie, a St. Louis management consulting firm, Karen Schecter sees her share of desperate doctors. "[Physicians] call me in because they're working harder and longer and not making as much money as before," she says. For some who wait, it gets even more dire. "When they can't take home a paycheck, they pick up the phone," she says.

Document, Document, Document

A good rule for all practices is this: If it's not written down, you won't get paid for it. While all physicians understand this principle, it's easy to fall behind or lose track of details, says Ms. Moghadas, who works predominantly with primary care physicians. "We understand the plight of primary care docs—they're the ones responsible for coordinating the care, but they don't get paid for a lot of it. And they lose a lot when they fail to capture and document all the services done in the office."

Ideally, all of that documentation should be done before the patient walks out of your office. "There's one time when you have access to every piece of information necessary to bill, and that's when the patient is actually there," Ms. Aburmishan says. "In most practices the billing is done after that grand moment in time. Then you find out that the patient is no longer covered by insurance. Or you have their demographic information wrong, so when you check to see whether they're covered, it doesn't look as if they are. Finding and going after that data and fixing it takes a lot of time and money. If you can capture the charges when the patient's there, and get the bill out before the end of the day, you have a shot at getting cash flow going." In order to

make the most of that opportunity, it's vital to do the following:

- Verify coverage.
- Collect any necessary co-pays.
- Thoroughly document all diagnoses.
- Get authorization for any ordered tests, procedures, or services.

To increase your efficiency even further, gather as much information as you can before the patient arrives in the office, Ms. Schecter advises. "If you don't do insurance verification ahead of time, you may end up with patients you can't see because they don't have insurance benefits [and can't afford to self-pay]. It's an expense to do that verification, but it's worth it."

Curing the Out-of-network Headache

Patients often assume that if one physician in a practice accepts a certain coverage plan, they all do. But if their usual physician isn't available and they make an appointment with one who doesn't accept their insurance, complications may ensue at billing time. For example, they may have a co-pay for an in-network physician but not an out-of-network one—although they'll eventually be slapped with a higher bill for the latter. Ms. Aburmishan recommends minimizing these difficulties by adding the following steps to your standard procedures:

Six Overlooked Payment Opportunities

Are you inadvertently missing out on some revenue? In a January 30, 2009, article in *Family Practice Management*, Terry Mills, MD, partner and department head in the Wichita Clinic, Newton, Kan., said many primary care physicians are probably providing but not billing for the following six services:

- Tobacco cessation counseling
- Home health or hospice certification
- Home health and hospice care plan oversight
- Medicare pelvic exams
- Prostate cancer screening
- Prolonged services for inpatient care

- Thoroughly review which insurances are accepted by each doctor in the practice; then keep that information scrupulously up to date.
- Promptly add new physicians to any insurance plans that they should be on.
- Verify each physician's participation in the insurance plan of any patient seeking an appointment, especially if the patient doesn't usually see that physician.
- Load the fee schedules for all insurance plans into your billing software so that if a payment is sent back, the system can quickly identify the problem.

Finding the fee schedules may be time consuming. Except for Medicare, payers may make those schedules difficult to get, Ms. Aburmishan explains. But it's well worth it. "Pick the [fee schedule] that gets the bulk of your business and concentrate on getting it," she advises. "Then go after the next biggest one. Before long you'll have them for 95% of your billings."

How Does Your Practice Compare?

Before you can really error-proof the administrative side of your practice, you should take its pulse—something many physicians don't do, Ms. Schecter says. They don't know how many patients come into the practice, how much they're billing, or how much they collect.

As a starting point, Ms. Schechter and other healthcare business consultants recommend developing an ideal of what your practice should look like. Your specialty society or the Medical Group Management Association can be good sources for benchmarking data. By comparing your staffing structure, salaries, total payroll, patient volume, revenue, and other practice characteristics with those of other practices your size, you'll see areas where you need to take a closer look. For more suggestions, see "Ten Key Practice Administration Questions," p. 47.

Developing and Retaining Staff

An adequate and properly trained support staff is a medical practice's single most powerful weapon against costly administrative errors; but many physicians regard it as the first place to cut costs, Ms. Aburmishan says. "The more practices get their reimbursement cut, the more they feel they have to save their way into a profit, so they cut staff. You can't save your way into a profit. If you're short-staffed, you might save $25,000 or $35,000, but not having enough front-desk help could cost you patient volume of $100,000."

Many doctors find attorney and accounting services through their circle of friends; but if the professionals you use don't specialize in the intricacies of healthcare, you may not be getting the best advice.

A front desk staff that is severely overworked or has skewed priorities can cost a practice a lot of money by being rude to patients, missing incoming calls, not posting co-pays properly, or even scheduling fake patients toward the end of the day (and conveniently cancelling them) if they want to leave early—all situations that Ms. Aburmishan has seen more than once.

Once you've found reliable staff, pay them enough to keep them and give them the resources—such as classes and up-to-date manuals—to develop the business expertise you need.

Hiring Outside Help

Many doctors find attorney and accounting services through their circle of friends; but if the professionals you use don't specialize in the intricacies of healthcare, you may not be getting the best advice. Instead, consider using professionals—attorneys, accountants, and practice management consultants—who are trained to help a sick medical practice get better fast. They can help you negotiate better contracts, get a handle on your expenses, and even find lost money.

In another example, one of Mr. Zetter's clients was a physician opening a small practice. In addition to Mr. Zetter, he hired an attorney and a CPA who both specialize in healthcare clients. The practice has been able to analyze its payer mix and elimi-

Ten Key Practice Administration Questions

You should be able to answer "yes" to all of the following, according to Chris Zaenger of Z Management Group, Elgin, Ill.; Karen Schechter of Stone Carlie, St. Louis, Mo.; and Kathy Moghadas of Associated Healthcare Advisors, Fern Park, Fla.

1. Do you have an up-to-date manual of policies and procedures that all your employees are familiar with and regularly follow?*
2. Does your practice verify each patient's insurance coverage before he or she arrives for an appointment?
3. Does your front desk collect a co-pay from every single patient who owes one?
4. Have you, your clinical staff, and your billing staff all taken coding classes in the past year? Do you update your coding materials yearly?
5. Does your practice routinely obtain pre-authorization for all in-office or outside procedures and services?
6. Does your practice reconcile all superbills at the end of the day to make sure one was completed for each visit and contains all appropriate charges?
7. Do you complete your charts by the end of every day and make sure there's appropriate documentation for each item billed?
8. Does one of your administrative staff balance the office cash box daily and lock it up at night?
9. Do you have an attorney and an accountant who specialize in healthcare clients and understand the issues faced by medical practices?
10. Do you know the performance benchmarks (number of patients, revenues, size and composition of office staff, etc.) that are typical for a successful practice of your size and specialty so that you have something to measure your practice against?*

**See "For More Information," p. 73, for links to practice management help at specialty societies and the Medical Group Management Association. All have materials to help members develop policy-and-procedure manuals as well as benchmarking data.*

nate payers who contribute too little to the practice's bottom line to be worth the trouble. The practice has improved collections and after three years in business is well on its way to being debt free.