requests for further information.

An additional source of lost revenue is the failure to periodically spot check the data that is forwarded to carriers. This simple management responsibility should be performed at least once per year whether claims are processed manually or on a computer system. If insurance forms are being typed manually, the physician needs to periodically confirm that all sections of the form are being completed and that they are legible. If office billing is computerized, it is imperative to periodically confirm that proper ICD-9 and CPT-4 codes are in the system. Although diagnosis codes normally are not changed in code books, there are frequent changes to CPT-4 code structures. New codes are introduced and existing codes are deleted. The use of a CPT-4 code book that is older than the current year's edition increases the possibility of erroneous data being processed and, consequently, carriers are left to decide what procedures were actually performed.

For better or for worse, practitioners must recognize that coding is here to stay, and it is destined to become an increasingly important factor in the financial viability of modern health care practices. The solution, as frustrating as it may seem, is to take steps to ensure that proper ICD-9-CM diagnosis codes and correct CPT-4 codes are used so that swift and accurate claims processing is possible.

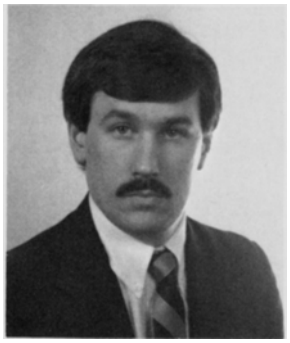
Although the processing of all patient insurance claims and the coordination of benefits is time consuming and, in reality, the responsibility of patients, these tasks are better performed by a physician's office personnel. Most of the time, patients are too ill to be concerned about the timely forwarding of billing information to their insurance carriers. Furthermore, when it comes to filing Medicare claims, many patients may not know what information is important to the carrier.

Follow-up procedures are also important to ensure maximum reimbursement within a reasonable timeframe. First of all, physicians should know what level of reimbursement is expected from each insurance carrier. A well-designed computer claims processing system should allow a physician to establish profiles of anticipated reimbursement from various carriers. As claims are paid, the payments can be compared to these profiles to determine whether or not they were properly reimbursed and to trigger reviews for inappropriately reimbursed procedures.

When it comes to insurance reimbursement, it is best not to take anything for granted. Claims data has to be entered by people, and people are prone to error. The more closely physicians monitor reimbursement and the better their edit checks, the less likely they are to be victims of carrier errors.

There are no magic formulas for maximizing physician reimbursement. It is simply a matter of consistent management with appropriate checks and balances. Many of the ideas discussed here may seem obvious, but if physicians frequently review office policies for consistency, rightfully earned fees are less likely to slip through the cracks. The alternative is the frustration of lost revenues. ■

Other Areas that Merit Review: Forms, Denials, and Appeals



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Claims processing information is often so disjointed that some offices use the services of a third party to help them learn how the reimbursement system works. Such an extreme isn't necessary if office staff adopt some of the following strategies and avoid some common pitfalls.

OBTAINING POLICY INFORMATION

- Do not disregard the materials received from carriers. Most provide updates on policy changes and reporting requirements through periodic letters, notices, or newsletters. All information that carriers send should be filed in a central reference book in case of reimbursement denials or the need to file an appeal.
- Attend carrier-sponsored seminars and conferences on reimbursement policies.
- Information on a broader range of health care insurance issues is available through the following publications (a free copy of the latest issue should be available for review):

American Medical News
312/645-5000

Health Manger's Update
202/463-1700

Health Policy Week
301/961-8777

Medicine and Health
202/463-1700

Part A News
301/961-8777

Part B News
301/961-8777

State Health Legislative Report
312/645-5000

The National Report on Computers & Health
301/961-8777

- Build a resource library that contains both carrier information and trade publication articles to help improve reimbursement management.

DIFFERENCES IN FORMS

- Carefully review the types of carrier forms that are currently being used. Forms, codes, prices, and reimbursement amounts can vary from carrier to carrier. A case in point is the "standard" HCFA 1500 form for Medicare, which is modified from intermediary to intermediary.
- Know what forms are accepted by a carrier. Do not be afraid to contact carriers to see if they will accept a different type of form, but make sure that using a different form will not increase the time required to process a claim.
- Learn what information is required and what information is optional. Be aware that some optional information is useful to carriers and may speed up the time required to process a claim.
- Obtain the following patient information before insurance forms are generated: social security number, medical identification number, and insurance company name.

ACCURATE CODING

- Learn what procedure codes are accepted by carriers. Most carriers will accept physicians' Current Procedural Terminology (CPT) coding and HCFA's Common Procedural Coding System (HCPCS). All Medicare and Medicaid programs are supposed to recognize CPT codes. However, some carriers still use the California Relative Value System (CRVS) for reimbursement.
- Perform an audit of all diagnosis and procedure codes currently being used. These codes should be audited for both completeness and appropriateness in relation to the patient's condition. Make sure office staff are familiar with the various diagnosis and procedure codes that are available, such as codes for phone consultations, special services, etc. For example, the cost of materials used during an office visit may be recovered by using code 99070, which allows materials to be itemized and billed up to a preset limit.
- Use modifier codes whenever appropriate. Modifiers are usually two digit codes that further identify the procedure being performed. But beware, if they are used incorrectly, they can decrease reimbursement levels.
- Include an explanation of coding in the description field when unusual services are provided. Attach a cover letter to the form when extraordinary circumstances prevail. The more information provided up front, the less likely it is that claims will be delayed or rejected.
- Carefully scrutinize explanations of benefits (EOBs). Spot checks are not sufficient; consistent and constant review is the only way to ensure accurate reimbursement and to flag changes in reimbursement levels.

WHEN A CLAIM IS REJECTED

- Find out exactly why a claim was rejected (a change in reimbursement policy, the procedure was related to another diagnosis, the form was not completed properly, etc.).
- To facilitate discussions with carriers, track all claims and make sure they were received. (Some offices use mailing services to ensure prompt delivery and to provide receipts of deliveries.)
- Maintain complete records of the submission status and stage of all claims. You should know when a form was submitted and what information it contained.
- Be assertive enough to point out any mistakes, either on the part of the carrier or the office. Just because a mistake was made does not mean that a procedure cannot be properly reimbursed. The claim may have to be resubmitted or a letter of explanation written, but it will be worth the time.
- In talking to carrier representatives, do not be afraid to quote regulations or refer to previous carrier publications. Follow up every conversation with a letter addressed to the person with whom the issue was discussed. Keep the letter brief, stating the points of contention and listing agreed-upon remedies.
- Above all, work with carriers to resolve problems. Avoid developing adversarial relationships. If the first person contacted is not helpful, call again and talk with someone else or write a letter to the appropriate office. Create a list of contacts at carrier offices that includes representatives' names, positions, and some type of helpfulness rating. Over time, a list of sound contact people will emerge.

USING THE APPEALS PROCESS

- Do not overlook or underestimate the importance of using the appeals process. It is a fairly simple process and does not involve lawyers or complicated legal procedures. In most cases, offices are required to fill out a form. However, there are several levels of appeals; some cases will require a meeting with the carrier, others will only require a telephone call. Carriers should be able to provide complete information on the appeals process. ■

CORRECTIONS

In the Winter issue of the *Journal*, Joyce Kane, a member of the ACCC Core Committee of the Clinical Indicator Project, is a representative of the National Tumor Registrars Association, not Johns Hopkins in Baltimore.

In the article, "Audit Indicates Half of Current Chemotherapy Uses Lack FDA Approval," by Lee E. Mortenson (Winter issue of the *Journal*), the total sales amounts for selected antineoplastic agents in the figure on page 23 should be reversed. Sales totaled $232 million in 1984 and $280 million in 1986.

SURVIVING CANCER: A PATIENT RESOURCE GUIDE

This new reference guide lists numerous patient resources and contains practical advice on such topics as getting a second opinion, communicating with your doctor, working towards quality living, and much more.

Written by Danette Kauffman, a woman who had both surgery and adjuvant chemotherapy for breast cancer, the book provides the names, addresses, and telephone numbers of such resources as cancer support groups, adult and youth camps, home health and hospice care facilities, who can assist with insurance forms, NCI-designated cancer centers, long distance transportation services, and many other associations and groups that provide needed treatment and support services.

Surviving Cancer: A Practical Guide for Those Fighting to Win is available from Acropolis Books Ltd., 2400 17th St., N.W., Washington, DC 20009-9964 (202/387-6805). Quantity discounts from the $7.95 cover price are available for health care professionals.