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A MONTHLY NEWSLETTER OF THE SPOKANE COUNTY MEDICAL SOCIETY – DOUGLAS G NORQUIST, MD, SCMS PRESIDENT

## Maximize Your Reimbursement

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Dr. Steve Anderson (not his real name) is one of Washington's top surgeons whose practice focuses on patients with complicated conditions. However, until recently, the doctor and his staff didn't realize they could seek reimbursement for thousands of dollars of services and non-routine drugs and surgical supplies used in his ambulatory surgical center.

Last year, Washington Labor and Industries (L&I) notified Dr. Anderson that his many complex claims had triggered an investigation. L&I suspected fraud and upcoding. After many stressful months, he learned that he had extensive coding problems and that his documentation failed to address his patients' multifaceted diagnoses.

This story, though frightening, has a happy ending. Dr. Anderson was able to correct his billing and protect his practice.

Today, insurance companies reimburse many more of his services than before the investigation and his practice is significantly more profitable. More importantly, he is spending more time with his patients, giving them the individual attention that he thought he was going to provide when he entered medicine.

What can you do to avoid a situation like the one Dr. Anderson faced?

**First, always document the need for a specific medical procedure or care.** This is one of the most common reasons why claims are denied. Be familiar with the criteria that justify office visits, diagnostic procedures, tests, surgeries, and admissions, and be sure to include this information in every patient's chart for every visit. Don't just write general social and medical histories in your patients' charts. Notes should include any complicated details.

**Second, document all of the care that is provided to support a service for which you bill.** Insufficient documentation is a common reason why practices are accused of up-coding or inaccurate billing. Follow the widely accepted Documentation Guidelines for Evaluation and Management Services that were developed by Medicare (available at [www.cms.hhs.gov/medlearn/emdoc.asp](http://www.cms.hhs.gov/medlearn/emdoc.asp)).

**Third, make sure that both front and back-office staff are well-trained in patient intake and documentation procedures.** The majority of claims denials and delays are due to clerical errors. Train and cross-train your staff to verify the insurance for every patient visit and to enter the patient's full legal name (not just a nickname) into your computerized database. Be sure to maintain current written policies and procedures for positions that typically experience high turnover.

**Finally, actively monitor your billing and claims activities.** Practices and reputations can be ruined when physicians do not keep up with billing rules and regulations. Ask your staff to prepare regular reports for you that summarize high dollar and high volume claims that are not paid. These reports should identify and track the reasons for denials so that you can reduce the risk of repayment demands and audits.

Investigations are a fact of life in medical practice today. Taking the steps outlined above will help you avoid the mistakes that frequently trigger an audit. They will also ensure that you are fairly compensated for the care you provide and have the time to give your patients the care and attention that makes medical practice so rewarding.

