



E L E C T R O N I C
BILLER

THE OFFICIAL NEWSLETTER OF THE ELECTRONIC MEDICAL BILLING NETWORK OF AMERICA

April 2000 Vol. 6 No. 2

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VOL. 6, NO. 2

APRIL 2000

LYING DOCTORS REVEALED

The American Medical Association has released a study showing that more than a third of doctors surveyed nationwide admit lying to insurance companies to help patients get the care they want. Their tactics include exaggerating the severity of an illness to help patients avoid being sent home early from the hospital, listing an inaccurate diagnosis on bills, and reporting nonexistent symptoms to secure insurance. Doctors in the study admitted they lied "sometimes" or more often during the course of 1998, the year of the survey. More than half said they were doing this more often now than in the past. This practice will lead to intensified scrutiny from insurance carriers and the related governmental agencies, Medicare and Medicaid. With this tightening of the screws on all doctors, there is an increased need for professional billers to manage their cashflow. Any errors resulting from staff mistakes will be eyed more as attempted fraud rather than the result of workplace stress. Providers need the services of professional billers. How can they learn about you? From your marketing. Crank it up, reel 'em in.

E L E C T R O N I C BILLER

THE OFFICIAL NEWSLETTER OF THE ELECTRONIC MEDICAL BILLING NETWORK OF AMERICA

The Tough Juggling Act of the Two-Career Person *by Melanie J. Davis*

Business owners are generally described as risk takers, able to make the leap of faith required to dump the standard 9-to5 in favor of the challenges of entrepreneurship. Many, however, find that leap of faith too great a distance.

Their solution is to hold down two-careers. It isn't easy, but it can be a good compromise until you are in a position to choose one over the other.

New Jersey resident Ruth Koenig juggles a fulltime job as an office administrator for an accounting firm and a second job as co-owner of a home-based electronic medical billing company. She has held the fulltime position for 14 years; she and her husband opened their billing company two years ago.

"Late winter and early spring are very busy at an accounting firm, and I got tired of working six days a week from January to April. Two years ago when I started this business, I told my employers that when I got five clients I would leave my fulltime job. I'm not there yet, but I hope to be soon," says Koenig.

For Koenig, the decision to hold two jobs came about because her husband accepted an early retirement offer from his corporate career. They split the medical billing work so that Ruth sets up client meetings and handles marketing and her husband does data entry. Their goal is to have five medical practices on their client roster before Ruth quits her job. Of their four current clients, only two provide substantial business, so the Koenig's don't count the other two toward their goal.

Holding two jobs is challenging for many reasons, not the least of which is finding adequate time to devote to each. When the second job involves running your own company, things can get really tough.

Experts estimate that approximately two-thirds of a business owner's time should be devoted to marketing activities including networking, telemarketing, creating marketing and sales materials and customer service. It takes understanding employers and/or clients to make it work.

Says Koenig, "It's a challenge. I take a day off once in a while to concentrate on the billing work or visit doctors, and I print out statements on Saturdays and Sundays. My husband picks up charts from one doctor on Mondays, and sometimes the doctor comes to our house at 7 a.m. to go over things. We have a lot of phone contact. Another client brings his claims here, and if we have questions, we call him."

Another challenge is to avoid the inevitable confusion that can come from juggling job responsibilities. Not every employer relishes the idea of moonlighting, even if the second job is in a completely different field.

The decision to tell employers about a second job—or to tell clients about one's fulltime job—often depends on one's workplace. It pays to review an employer's

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Established in 1995, the Electronic Medical Billing Network of America, Inc. is the oldest and largest national association and school for electronic medical billers.

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MESSAGE FROM THE EXECUTIVE DIRECTOR

He: I don't want to go to school today!

She: Please, let's not go through this again. You have to go to school.

He: But all the kids pick on me!

She: Please, dear, you have to go to school today.

He: Even the teachers pick on me. I don't want to go!

She: Please, dear, you have to go to school. You're the principal.

Have you felt like this? You're the owner of your business, you're the boss. But the prospects ignore you and even your clients don't always treat you with the respect you know you deserve. Is this what I worked so hard to achieve? When does the going get easy? When can I kick back and relax while the business runs itself? I'll break it to you easy. Never. This is what it's like to be the boss, to be able to sign the checks on the front instead of just the back. As Scott Peck says, problems are always going to be part of your life. Since you've chosen to be the lead dog, you get to break the trail. Tough? You bet. Rewarding? Not always. Would I trade it in for a job? Not on your life. And neither would you. So let's keep on keepin' on. Problems? Keep 'em comin'.

She: Doctor, I keep on having this nightmare. I'm standing in front of this huge door. A single word is printed on its face. I want to get to the other side. I push and push with all my might but it won't budge. Finally, exhausted, I collapse, defeated. I wake up, trembling. I can't go back to sleep.

Doctor: That's terrible. Let's see if we can work through this. You want to get to the other side of this door but you can't open it. There's a word on the face of the door. Tell me what it says.

She: It says, "PULL."

This can't be you, can it? You're not trying to push your way into this business when all the signs read "pull?" Has anything been hidden from you? Is something not clear? Has it been suggested that you need to start from scratch and dream up all the methods of marketing and processing by yourself? Has everyone abandoned you and refused your pleas for help? Are you dejected because you've been rejected? Cheer up. McDonalds is hiring! Uniform measurements over here! Flipping training over there! What a country! What a life! Next!

We're looking for a mascot/emblem. I've always favored the frog. You have to kiss a lot of frogs to find a prince. Others have suggested Wily Coyote. No matter

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PLUGGING INTO THE NETWORK



Kelley Baldwin	Booneville SC
Lisa Castro	Levittown PA
Kathleen Connor	High Bridge NJ
Puanani Conner	Garnerville NY
Ann Constantine	Landing NJ
Jeff Dimorier	Riverdale GA
Yimmy Dina	Baltimore MD
Nina Eckels	Bridgewater NJ
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Stacy Prior	Chester NJ
Luis Gualberto	Quinones San Juan PR
Susan Rohdieck	Parsippany NJ
Latifa Sims	Edison NJ
Vicki Turi	Levittown PA
Christa Whitlock	Mannford OK
Jacqueline Williams	Malo WA
Sandra Wood	Middleburgh NY

"I am willing to put myself through anything; temporary pain or discomfort means nothing to me as long as I can see that the experience will take me to a new level. I am interested in the unknown, and the only path to the unknown is through breaking barriers, an often-painfull process."

Diana Nyad

MEDICARE MADNESS

SOME OF OUR MOST FREQUENTLY ASKED QUESTIONS

Q In general, Medicare pays for medical care of specific types for individuals from age 65 on. 80 percent of the approved charges for Part B (physician) is covered after an annual deductible of \$100. Insurance is available to pay all or a part of the remaining 20% of charges. These secondary policies are known as Medigap coverage policies. How much of the non-institutionalized population has some sort of supplemental health insurance (private or public) coverage?

A 88%.

Comment. Substantial portions of Medicare patients carry Medigap insurance, which requires a secondary billing process. Some portion of these carriers only pays for moderate coverage, after which the patient must also be billed for the balances due. For billers who charge a fee for services, these multiple billing opportunities provide additional income resulting from federal law requirements. Fee for services billers can profit from Medicare-heavy providers.



Q What types of physician services does Medicare pay for under the Part B program?

A Part B of Medicare pays for physicians' services—the professional services of physicians, including surgery, consultation, and home, office, and institutional services. A service may be considered a covered physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the involvement of a third person's judgment (direct visualization by means of descriptive indicators such as X-rays or EKGs.)

Comment. Third-party billers submit claims for Part B program services. Hospitals submit claims for Part A services.

Q What is the difference between Medicare fraud and abuse?

A Fraud is an intentional deception or misrepresentation that someone makes, knowing it is false, that could result in an unauthorized payment. The attempt itself is fraud, regardless of its success.

Abuse involves actions that are inconsistent with accepted, sound medical, business or fiscal practices. Abuse directly or indirectly results in an unnecessary cost to the program through improper payments. The real difference between fraud and abuse is the person's intent.

Comment. Third-party billers may be presented with instances of either fraud or abuse on the part of their clients. Regardless of the cause (intent, carelessness, ignorance, etc.) the biller must conform to compliance requirements in dealing with every instance. These issues demand confrontation, and the biller has prescribed actions that must be followed under penalty of the law.

Q How are complaints about Medicare fraud and abuse handled?

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WASHINGTON'S WAR ON FRAUD TURNS TO MEDICAID

In the recent past, Congress, HCFA and the Department of Health and Human Services' Office of the Inspector General have been focusing on the Medicare program. Experiencing some feeling of success here, these bodies are now turning to the sister program of Medicaid and will begin a wholesale examination of these state-run programs. As usual, they will be looking for fraudulent practices in the billing area for participating providers. This will start with a report by the General Accounting Office to determine the level of fraud and abuse in the Medicaid program. It appears this will be especially devastating to nursing homes and hospitals.

The problem is with how these programs are set up and administered. Medicaid is a joint federal-state program administered by each state with federal financial support and

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MEDICARE MADNESS

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A All Medicare contractors (the intermediaries and carriers that contract with HCFA to process Medicare claims) have Medicare Fraud Units in place to detect, deter and prevent fraud and abuse. The Fraud Unit treats each complaint to a complete investigation. The complaint may then be referred to federal law enforcement, then on to the U.S. Attorney for criminal or civil prosecution.

Q What are the consequences if a Medicare provider commits fraud?

A Fraud Units refer the results of their investigations to the U.S. Dept. Of Health and Human Services' Office of the Inspector General (OIG). The OIG's Office of Investigations then prepares the case for referral to the Department of Justice for criminal and/or civil prosecution. A person found guilty of committing Medicare fraud faces a host of different criminal, civil, and administrative sanction penalties including:

- Civil penalties of \$5,000 to \$10,000 per false claim and treble damages under the False Claims Act Criminal fines and/or imprisonment of up to 10 years if convicted of the crime of Health Care Fraud as provided in the Health Insurance Portability and Accountability Act of 1996 (HIPPA) or, for violations of the Medicare/Medicaid Anti-Kickback Statute, imprisonment of up to five years, and/or a criminal fine of up to \$25,000
- Administrative sanctions including up to a \$10,000 civil monetary penalty per line item on a false claim, assessments of up to treble the amount falsely claimed, and/or exclusion from participation in Medicare and State health care programs.

In addition to these penalties, those who commit health care fraud can also be tried for Mail and Wire Fraud. In all, these are considered serious federal crimes and are subject to a host of onerous penalties.

Comment. Third-party billers must treat all cases of suspected fraud and abuse in strict accord with the compliance regulations prescribed by the Health Care Finance Administration. Otherwise, they will be considered to be collaborators and will be subject to similar consequences.

Q What is the difference between Medicare and Medicaid?

A Medicare is an insurance program. Medical bills are paid from trust funds that those covered have paid into. Primarily, it serves people over age 65, whatever their income, and serves younger disabled people and dialysis patients. Patients pay part of costs through deductibles for hospital and other costs. Monthly premiums are required for non-hospital coverage. Medicare is a fed-

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COLLECTION SOLUTIONS

The final leg of the billing process is collecting remaining balances due. These financial odds and ends are often abandoned, with the thought that the collection process is more trouble than the value of the amounts to be collected. However, billers should encourage their clients to pursue all outstanding dollars with the help of a collection agency or a third-party letter service. Both will prove their worth when they collect the sizable amounts often found in the doctors' accounts receivable file.

Consumer debt has relentlessly risen, despite America's historic economic expansion. The last five years have seen debt grow almost 50 percent to a record \$6.3 trillion. Bill collectors will try to collect on \$135 billion of overdue debts this year, nearly double the \$73 billion in bad debts that were outstanding ten years ago. The agencies will keep 30 percent of whatever they collect, amounting to about \$10 billion for the industry.

These numbers have attracted some major players who are looking to capitalize on more sophisticated techniques now used by agencies large and small. Stealing ideas from the telemarketing promoters who created much of the debt, agencies use predictive dialers which place calls to multiple debtors at once, sending the call and information on the debtor to an agent's computer screen only when a live human answers the phone. If a debtor doesn't answer in the morning, the system will try next time in the evening. The result is that agents can talk to three times more debtors in a day than before. The software can also sift out the payers from the deadbeats, using demographic distinctions. Twenty percent will pay, eighty percent won't. A Midwestern homeowner is more likely to make good on a bad debt than a California renter.

Of special interest to billing services is the current practice of working "early outs," bills that are just 30 days past due, instead of only bills that have been charged off after 90 or 120 days. The aim is to both avoid a loss and retain a customer. You may want to pass this strategy on to your clients. Doctors are often reluctant to go after tardy payers in fear of losing a patient. By using a friendly reminder after 30 days, the patient is "prompted" to pay instead of targeted as a slow-pay or no-pay.

Cashflow management is more than billing. It is the manipulation of the stream of payments that flow through to the provider. By helping your client to stay on top of this flow, you are providing a service far beyond simple "billing." You are proving your worth as a cashflow consultant. Start it today. Your clients will love it. And so will you. ■

MEDICARE MADNESS

Continued from page 4

eral program. It is basically the same everywhere in the United States and is run by the Health Care Financing Administration, an agency of the federal government

Medicaid is an assistance program. Medical bills are paid from federal, state and local tax funds. It serves low-income people of every age. Patients usually pay no part of costs for covered medical expenses. A co-payment is required. Medicaid is a federal-state program; it serves from state to state. State and local governments, within federal guidelines, run it.

Comment. Medicare has become a highly publicized federal program, subject to increasing scrutiny. Third-party billers must be aware of the role they play here and be prepared to fulfill their increasing "watch-dog" responsibilities. Medicaid is subject to similar governmental oversight. The two programs are springboards for potential misbehavior by providers of service. Billers must be alert, responsible sentinels.

Q What is Medigap?

A "Medigap" is the term used for insurance policies that people can buy from private health insurance companies. Medigap insurance is designed to supplement Medicare's benefits by filling in some of what Medicare doesn't cover. A Medigap policy pays for Medicare approved charge not paid by Medicare because of deductibles or coinsurance amounts for which the beneficiary is responsible.

Q How many people are enrolled in Medicare managed care programs?

A As of January 1996, there were 4,854,465.

Q What were the average length of stay, days of care or discharges per 1,000 enrolled in an acute hospital setting?

A These were 7.1 days, 2,253 days of care per 1,000 enrolled and 315 discharges per 1,000 enrolled in 1995 respectively.

Q How many hospital are Medicare certified?

A There were approximately 6,273 Medicare certified hospitals as of December 1996.

Q How many enrollees are there in the Medicare program?

A As of 3/31/997, there were 38,114,973 persons enrolled.

Q How many enrollees are these in the Medicare program?

MEDICARE FRAUD CONTROL A FLOP

Medicare's highly hyped efforts at reversing fraud and abuse in the medical community came to a stunning halt last year. An estimated \$13.5 billion in improper payments were made to doctors, hospitals, and others who treat the 40 million elderly and disabled in America. This collapse came after three successful years of improvement.

Instead of further cuts, the error-ridden payments increased \$1 billion in the last year of the century, collapsing president Clinton's highly-publicized war on fraud, waste, and abuse. Health and Human Services inspector general June Gibbs Brown explained, "we've resolved a lot of the easier problems. It will take some intensive work by HCFA to get the error rate down even further."

After a 35-year history, HCFA made its first audit four years ago. It was discovered that 14 per cent of Medicare fee-for-service spending in 1996, a stunning \$23.2 billion, was made in error. The "improper payments" fell into four categories: documentation errors (the largest portion of errors with a significant \$3.5 billion increase from 1998), lack of medical necessity (a durable medical equipment DME issue), incorrect coding (everybody's headache), and noncovered services (the most fraud-prone category). In the statistical sample, the auditors found that 80 per cent lacked justifiable medical records and the remainder lacked any documentation at all.

The agency is powerless to do anything about the \$13.5 billion in wrongful payments already made last year.

Clinton has included \$48 million in the fiscal 2001 budget to hire new auditors to detect and respond to waste, fraud, and abuse. The new examiners would have direct oversight over fiscal intermediaries and carriers that process claims and payments.

If these budget funds are retained, healthcare providers will be under greater federal scrutiny and will be exposed to higher liability for billing practices that are found and deemed to be illegal. More edits will be added at the clearinghouse and carrier level, increasing the denial rate across the board. Providers who are not processing electronically will find even greater rejection of ill-prepared paper claims. By presenting this marketing message, you will demonstrate to your prospects that you are aware and alert to these potentially dangerous developments for physicians who are not current with the regulations.

Now, more than ever, electronic is essential. Get the word out. ■

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MEDICARE MADNESS

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- A** As of 3/31/1997, there were 38,114,973.
- Q** What is the Medicare Part B Premium for this year? How much are the Part A & B deductibles?
- A** The Medicare Part B premium for 1997 is \$43.80 per month. The Medicare Part A deductible is \$760 and the Part B deductible is \$100.
- Q** What are the total Medicare benefit payments?
- A** In FY 1995, there was \$191,176,132,000 in estimated benefit payments.
- Q** How many persons are currently uninsured?
- A** There were approximately 40.6 million uninsured persons in 1995.
- Q** How many Medicare users of Service are there?
- A** There were 27.4 million aged persons served and 3.3 million disabled persons served in calendar year 1995.
- Q** What are the most recent national health expenditures for all services?
- A** In 1995, total national health expenditures were \$988.5 billion.

Comment. This massive federal program must produce correlative mistakes in performance and application within providers' offices. It is an obvious target for marketing programs that will address these mistakes. It is clear that Medicare and Medicaid are bountiful fields for billers who can demonstrate their careful, diligent claims application skills. ■

MEDICAID FRAUD

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oversight. In spite the Medicaid Fraud Control Units maintained by most states, there is wide variance in how each state provides services and fights fraud.

The most common forms of fraud are misrepresentation of professional qualifications and improper billing practices. The General Accounting Office has been directed to determine:

- The general categories of fraud and abuse
- What guidance the governmental agencies are now providing to states
- The effectiveness of state efforts to control fraud

•Innovative techniques currently used by states to control fraud

•The effectiveness of new fraud detection tools and how they're used by other states

The battle against fraud in Medicare has proven surprisingly effective and is continuing to crunch illegal provider activities. The government expects to turn these effective weapons upon similar rascals operating in the Medicaid arena. All billers with Medicaid-participating clients should be especially aware of this new focus and maintain a high level of compliance with billing practices. ■

TEN MORE LIES ABOUT THE MEDICAL BILLING BUSINESS.

SEE VOL. 6, NO. 1 FOR THE FIRST TEN.

1. You can start by working with another homebased biller so you can "learn the ropes."

The most likely person to work with you is a partner in your joint business. Another business owner will often only take on as many clients as he/she can handle alone. After 3-4 clients, many companies stop looking for more work. If they choose to continue to grow their business, they typically look to close friends or relatives for data entry help.

2. From the number of billers I see listed in the Yellow Pages, my area is saturated.

Saturation is rare in this business. Half the listed billing companies will be closed, another quarter will have all the clients they want, and the final quarter is just looking to build to their projected cap of 3-4 clients, after which they will stop looking for clients.

3. The more expensive the "business opportunity" program, the better the software and training will be.

This is really an untruth. Excellent software costs a maximum of \$1000. The next level of quality for software costs \$26,000 (clinic/nursing home/large practice grade). There are no quality levels in between. The expensive "business opportunity" packages are charging heavily for their "training," which is often for superfluous courses in terminology and coding.

4. There are lists of doctors who don't submit claims electronically and who need this service.

The majority of doctors still don't submit claims electronically because they don't want to or need to. Nobody is forcing them to change, they don't want to retrain their billing staff, they don't want to subsidize the changeover cost, and their existing system is working fine. Although such lists are widely available (free from Medicare), these are the prospects that are least likely to respond to a changeover suggestion.

5. I've asked some of the doctors I know and they say everybody's submitting claims electronically already.

This is human nature. If I'm doing it, everybody's doing it. If I'm not, nobody is. To ask one or a few doctors about their billing system is hardly a survey. Ask one thousand.

6. Doctors just opening their practices are prime candidates for this service.

New doctors have heavy expenses from medical

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JUGGLING ACT

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personnel manual for prohibitions against second jobs and to bring up the subject hypothetically before spilling the beans about one's second job.

Employers are leery about moonlighting for good reasons: They want their employees' total concentration, and they despise the idea of paying for any costs related to that job, i.e., photocopies, office supplies and phone calls. It is essential that moonlighters never attend to their own business while on their employer's time clock, and it is equally important not to use, borrow or keep supplies or other items from their employer for their own business use.

The sticky issue of conflict of interest arises when business owners are in the same industry as their fulltime employers.

"We had a guy who consistently complained he couldn't fulfill his sales quota each month. It was one excuse after another. It turns out that he was competing against us by selling cheaper products to our customers through his own company. My employer is going after him hard to set an example, and he's in a lot of legal trouble," says a Midwest salesman who requests anonymity.

Telling clients about a fulltime job takes an equal amount of consideration. Some clients demand as much attention and loyalty as do employers. On the other hand, Koenig tells clients about her fulltime job and says they appreciate the full disclosure.

"I'm honest, and doctors like that. I don't try to make something of this that it isn't. Doctors know what it's like to work hard, and a lot of them also know what it takes to break away from a relationship with an employer or business partner," says Koenig.

Ruth plans to quit her job so she and her husband can move to a more physician-rich part of the state and concentrate on their billing business. Ruth believes that if she remains in her fulltime time job, she will not have enough time to market her medical billing business.

"I enjoy this work. I come home from eight hours at office, make dinner and spend two or three hours on medical billing. I relax while I'm doing it. That's how I juggle the two—I enjoy my work and don't see it as a job," says Koenig. ■

EXECUTIVE DIRECTOR

Continued from page 2

what calamity the Roadrunner visits upon him, he's always back for more. Can't keep a good coyote down. Then there's the bumblebee. According to all the laws of physics, the bee shouldn't be able to fly. Too much mass, too little lift, that sort of thing. Yet, flying is what the bee is good at. According to some, you shouldn't be a successful medical biller. Too little experience, not enough training, no other clients. Too bad.

"Destiny is no matter of chance. It is a matter of choice: It is not a thing to be waited for, it is a thing to be achieved."

Willaim Jennings Bryan

Yet, some succeed handsomely. Maybe you. Maybe now. Maybe bigtime. We can't do it here, you must do it there. Of course you can. Of course you will. Won't you? Of course! What a country! ■

10 MORE LIES

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school to worry about. They won't consider the cost of a stand-alone billing service to be efficient cash management. Breakaway doctors worry if they can survive without the backing of their experienced colleagues and want to see income before they'll think about additional expense for a luxury like an independent billing service. In either case, they'll choose their spouse, girl/boy-friend, or a multi-tasked staff person to do the billing up front.

7. Large practices will need somebody to handle the overflow of claims their staff can't process.

Comment. In the rare cases where the claims-flow can't be handled in-house, the financial manager will hire temps to come onsite and work during off-hours.

8. I don't have any billing "credentials" or experience, so I'll never get a client.

Comment. Of course everyone has "life experience" and "work experience" credentials to crow about. Yes, this is a new business for you, but your related experiences have prepared you to move into this new slot. Your preparation specifically includes membership in the national association, the timeliness of newsletter articles, connection with Network associates, your specific educational preparation from the industry books and manuals, and your certification training through the association (you are a CEMB, aren't you?)

9. I know lots of doctors who will be my clients.

Comment. Your clients will only be "doctors in distress." Unless you know lots of them, your doctor friends can only serve as referrals, passing your business cards around to colleagues and vouching for your reliability (you've never been late for one of their office visits, have you?)

10. My friend is a pharmaceutical rep who sees lots of doctors and can get appointments for me.

Comment. Doctors need to see pharmaceutical reps to stay current with medical developments in the drug industry. They also like the free samples. The doctors don't need to stay current with billing industry developments, that's what they have staff for. Your friendly drug rep can speak well of you and drop off your card, that's about it. Not a lot, but go for it, you never know. Just don't have unreasonable expectations. Getting appointments is an unreasonable expectation. ■



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