Tips to Maximize Reimbursement with Contract Management

Topics Covered

About the Author

Kristen Wood, CPC
Senior Account Manager, PMMC

Kristen brings over 30 years of Revenue Cycle, Medical Coding and Billing experience to PMMC. Kristen has software implementation and training experience at over 100 medical practices nationwide.

What is Contract Management?

The hospital contract management system is the key to maximizing financial performance, minimizing risk, and ultimately managing all aspects of payer contracts to get reimbursed accurately.

A contract management system is designed to help keep track of Healthcare payer agreements and calculate the rates and terms of those agreements. This includes access to reporting tools that help analyze data and model potential contract changes to provide the necessary information to make financial decisions. Specifically, contract management systems should have the ability to:

- Calculate reimbursement for individual claims as well as analyze all posted transactions including payments, contractual and administrative adjustments
- Accurately identify correctly and incorrectly paid claims and provide detailed analysis of denials and payer performance
- Model proposed contract reimbursement changes to aid in negotiations and provide analysis of upcoming payers trends

Mystery Contracts

The importance of having reliable staff dedicated to managing and renegotiating your contracts cannot be understated. This starts with identifying the hospital's top 20 payers and completely understanding all the reimbursement methodologies those payers use.

The following should be part of the contract management process:

- Organized method of tracking the effective and renegotiation date for every one of the hospital's payer agreements
- Saved copies of each contract, addendum, and fee schedule electronically to allow the collections team to access
- Process in place for communicating all reimbursement changes internally as well as to the contract management vendor
- Tracking reimbursement changes from the payer
- Regularly attending payer meetings and Government update calls

Contract management software should be able to display changes and trends that staff can easily handle with the payer in a timely manner. It is important that under-payments and overpayments are reviewed as soon as they are received and posted into the system.

Registration Errors

The Registration desk has a notoriously high turnover rate so it is important that hospitals have a comprehensive on-boarding process and training program. Inconsistent training or lack of supervision will result in sloppy insurance plan registration and low collections of patient balances. Accurate patient registration starts with verifying plan eligibility.

Incorrect plans can cause claim rejections but are easily preventable if good processes are in place. It's recommend that each facility use an electronic process to verify insurance coverage at the time of admission. Self-pay patients should be identified early and routed through charity care if possible. Price transparency is important to patient collections as well. Potential registration pitfalls to look out for include:

- The primary payer may be entered but the secondary plan is missed
- A generic place holder payer mnemonic may be used such as 'Commercial plan' or 'Medicare HMO' which are not tied to a specific insurance plan. These may be entered because the Registrar does not have a way to correctly identify the correct payer or verify eligibility. Using 'place holder' payer mnemonics is not recommended because it jeopardizes reporting as well as claim submission. Take the time to review the payer master quarterly and make sure a good process is in place so that adding new ones is controlled and the registration team has the tools they need to identify the correct plans for all patients.

Additionally, the Registration manager should meet often with Billing and Collections managers so that issues caught downstream can be corrected quickly.

Billing Errors

Incorrect or inconsistent billing and coding practices can result in lowered payments or even complete denials. A billing policy manual that is updated often is crucial for correctly coded claims and compliance to government regulations.

This policy manual should address pre-authorization and pre-certification requirements for each payer in addition to providing guidance on correct coding initiatives. Adequately trained and certified staff is critical so that claims can be sent out correctly the first time. It's also important to address current processes for posting payer payments.

Using billing software to automatically post electronic transactions into the system is faster, more accurate, and helps free up staff to perform other work. It is highly recommended to take the time to work with vendors to set this up.

Common billing errors include:

- Missing or incorrect use of modifiers
- Missing charges and late charges
- Posting errors
- Non-covered services
- Bill types
- CCI edits
- Missing Authorizations or pre-certifications on claims

Denied Claims

Prevention is the best cure for claim denials whether they are denied at the Clearinghouse or later, when the claim is received. Contract management vendors should be able to provide reports as well as other tools to quickly identify the most common cause of denied claims.

Hospitals should also be able to see the biggest payers by volume and charge amount as well as the most common reason claims or line item services are denied for payment. It is recommended that denial monitoring is an active and ongoing practice in addition to underpayment trending and analysis.

It's recommended to divide denial types into a minimum of three categories: Clinical, Administrative, and Contractual:

1. Clinical: Ensure a process is in place for tracking provider trends as well as payer habits
2. Administrative: Coding and billing errors should be quantified and tracked for process improvement
3. Contractual: These can be vague and may require a call to the payer. These denials should be researched against the contract to make sure they are legitimate

Commercial Payer Tactics

It's likely that hospitals have identified their "problem" commercial payers, but it's important to track all payers' performance.

Here are some of the most common commercial payer tactics that should be monitored:

- Silent PPOs – These are instances of commercial payers moving patients to different payer contracts that reimburse at lower rates. This is only caught if the collections team regularly monitors payer reimbursements using a comprehensive contract modeling tool.
- Length of Stay (LOS) underpayments – Payers will sometimes reduce the approved Length of Stay days so the payment to the facility is reduced. It is highly recommend that you have adequate resources reviewing your payer payments for all accounts, not just the big dollar claims so that patterns and trends can be identified.
- Medical necessity denials
- Vague denial and remark codes – Some insurance plans have been making subtle changes to payer agreements adding changes to contract wording, so if there is a sudden increase in any type of denial for a payer that has a new agreement in place, it is possible this policy change was missed by billing staff. It's not safe to assume that just because a payment was received on a claim that it was paid correctly.
- Paying under old rates
- Bundling - Incorrectly bundling specific codes has always been a common tactic by some commercial payers.
- Service denials for outlier accounts

Medicare and Government Reimbursement Changes

Hospitals are entitled to recoup underpaid dollars for government payers just as they are for commercial payers. Many Medicare and Medicaid HMOs routinely underpay Emergency room services, inpatient days, and ignore outlier provisions. Additionally, there have been many changes in state Medicaid reimbursement recently, making it that much more important to have a reliable way to identify underpayments.

Hospitals should be doing the following:

- Reviewing government denials and underpayments
- Keeping track of inpatient and outpatient cost-to-charge ratio updates and make sure they are being paid correctly by Medicare HMOs
- Identifying recovery opportunities for denied LOS, Transfers, ER services, Observation, and outlier thresholds due to recent changes that HMOs have not kept up with

ICD-10 Conversion

The Center for Medicare & Medicaid Services (CMS) has communicated that it expects a big increase in claim rejections at the time of ICD-10 implementation on October 1, 2015. Hospitals need to be prepared and work with vendors to prevent issues.

CMS predicts that claim error rates will be more than two times higher with ICD-10. Some other factors that will impact cash flow include:

- Claim error rates will possibly be more than twice as high under ICD-10
- The time to correct an error will take longer with ICD-10, causing a coding backlog
- Billers will have to refer to the physician, nurse and/or clinical documentation

- It may take up to 18 minutes longer to code a claim with ICD-10

Contract Modeling

Contract modeling is an extremely useful tool that empowers Managed Care with information on how proposed reimbursement changes will impact the financial bottom line in advance. The ability to understand the impact of new payer contracts with new potential contract rates and terms is invaluable.

Each hospital's patient populations are different, so the contract management vendor should offer tools that can be used to test and model payer contracts during the negotiation process. Two examples of how powerful this type of tool can be:

1. As a hospital was negotiating a new contract proposal, they realized that the commercial payer was dropping ER rates by a small percent, but in exchange, was offering a big increase in their orthopedic service (i.e. knee replacements). After analysis, the hospital realized that with its patient mix, the new result would be a significant loss in revenue because their ER utilization was so high. The hospital rejected that proposal and negotiated one that was more beneficial.

2. Adena Health System, a three-hospital system in Ohio, faced the challenge of their payer contracts moving from percent-of-charge to value-based reimbursement. With 32 different commercial payers, predicting the change in reimbursement became especially difficult. Adena chose to strategically target their top five largest payers and model their proposed terms. After running the calculations, Adena realized they would have lost $3.7 million in reimbursements if they just accepted the contract terms from their commercial payers.

As more state Medicaids are beginning to move to different reimbursement methods- especially APR-DRGs, contract management software should be able to process the information and analyze the financial impact on your reimbursement. This information will help hospitals weather these changes and reduce any negative impact on the bottom line.

Reporting

Contract management systems should have a robust suite of reports, including:

- **Recovery Productivity** – It is strongly recommended to track the collection team's productivity on a monthly basis. Make sure to have a reliable method of tracking the accounts individual collectors are working that includes successful and unsuccessful recovery appeals.
- **Underpayment and Denial Recovery Collection** – It is recommended that underpaid account recovery efforts be tracked separately from denials. This type of reporting should also include payer trending analysis and a root cause analysis so denials can be evaluated and processes put in place to prevent them.
- **Claim Inventory and A/R Reports** – One area that is often missed is unbilled claims. If the billing system does not provide an easy way to identify unbilled charges, contract management software should. Billed claims should be compared to charge code files to make sure each patient is billed in a timely fashion. If a high number of unbilled claims exist, it is important to identify the gaps in the processes to correct it quickly.
- **Slow Pay and Unpaid Claims Analysis** – Slow pays should also be tracked. Each payer contract should have a contract provision addressing timely payment for clean claims, so make sure each payer is following those rules. There should be someone responsible for working claims that error out at the electronic claim clearinghouse. If the most common reason for rejections is unknown, it's important to address this immediately.
- **Overpayments** – Insurance plan refunds can come as a surprise, so a best practice is to run a periodic overpayment analysis since this can impact bottom line.
- **Denial Trend Reporting** – This should also be watched closely. For example, if denials for a specific code are rising, it could be an easy fix. The explanation for one facility who noticed a sudden rise in denials for CT and MRI services was the payer changed the precertification requirements but that change was not communicated to the Radiology department.

7 Things to Do Now

1. **Meet with collections and determine areas of improvement**

Many facilities find that different departments are separated and operate in silos. It is crucial that these different departments are brought together regularly so they can work together to solve problems.

2. **Meet with the Management team (Registration, HIM, Coding managers, Billing office, and Collections department) to identify urgent issues**

Work with the budget office to solve resource issues if adequate staff is not available. Discuss areas that could be outsourced, even temporarily, to improve revenue reimbursement. For example, Business office functions or Collection work can be supplemented by an outside vendor while new staff is filled.

3. **Identify the top payers and most common reasons for denials**

Identify current reports that outline the top payers as well as detailed denial trends. Insight into these two areas will help focus collection efforts to maximize reimbursement.

4. **Make sure a Chargemaster review was completed in the last two years**

Find out when the last charge master review was done or when prices were most recently raised. If it has been over a year, make sure a thorough analysis is done that also compares fees with other local facilities to remain competitive. It is crucial to ensure charges remain competitive within the market and that revenue opportunities are not getting away due to charges lower than the market.

5. **Actively participate in ICD-10 testing with your vendor**

Make sure all departments are kept in the loop in regards to ICD-10 testing and that it's clear which payers utilize diagnosis codes directly for reimbursement. Pay close attention to new contracts and look for ICD-10 specific provisions and understand how they will affect reimbursement.

6. **Assess all electronic processes that affect reimbursement and make automation a priority**

Automation of many business offices processes can prevent errors that lower payer payments, so take the time to review all areas that could improve with more electronic functionality.

7. **Meet with your contract management vendor to discuss reporting needs**

Finally, identify realistic revenue benchmarks and set goals for the collections team. Track progress carefully and communicate it to all areas in the Business office, as it's important for all departments to be engaged to make sure goals are met.

About PMMC

PMMC provides industry leading revenue cycle solutions to more than 400 hospitals and 21,400 physician clients. By finding additional cash and creating more efficient workflow processes, PMMC helps healthcare providers improve their margins so they can focus on serving their patients.

PMMC is a Microsoft-certified provider and has earned the Healthcare Financial Management Association (HFMA) Peer Review designation for its Contract PRO and Estimator PRO solutions, meeting an objective third-party assessment of overall effectiveness, quality, and value.