# Automated Claim and Payment Verification

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*Since the start of managed care, there has been steady deterioration in the ability of physicians, hospitals, payors, and patients to understand reimbursement and the contracts and payment policies that drive it. This lack of transparency has generated administrative costs, confusion, and mistrust. It is therefore essential that physicians, hospitals, and payors have rapid access to accurate information on contractual payment terms.*

*This article summarizes problems with contract-based reimbursement and needed responses by medical practices. It describes an innovative, Internet-based claims and payment verification service,* Phynance™, *which automatically verifies the accuracy of all claims and payments by payor, contract and line item. This service enables practices to know and apply the one, true, contractually obligated allowable. The article details implementation costs and processes and anticipated return on investment. The resulting transparency improves business processes throughout health care, increasing efficiency and lowering costs for physicians, hospitals, payors, employers–and patients.*

**Key words:** Contract; payment; reimbursement; practice management.

**Editor's Note:** *The Journal presents articles that detail advances in practice technology for informational purposes only. The presentation is not meant to be an endorsement of any program or product. The principals involved in this publication have no financial interest in the sponsors of this program.*

## INTRODUCTION

As a business, health care is not very businesslike. Physicians work in a unique industry in which purchasers give "vendors" (i.e., physicians) contracts that do not detail payment terms. This article summarizes problems with contract-based health care reimbursement. It describes an innovative, Internet-based claim and payment verification service, *Phynance*™, which automatically verifies the accuracy of all claims and payments by payor, contract, and line item. The article also discusses how this service, using state-of-the-art software and database architecture, enables medical practices to know and apply the one true number that is the contractually obligated payment allowable. The resulting contract transparency improves business processes in the medical office and throughout health care, increasing efficiency and lowering administrative costs for physicians, hospitals, payors, employers—and ultimately patients.

## THE PAIN

Since the onset of managed care, there has been a steady deterioration in the ability of physicians, hospitals, payors, and patients to understand reimbursement and the contracts and payment policies that drive it. These vaguely defined contracts and policies create staggering problems.

First and foremost, this lack of transparency frustrates medical practices' efforts to budget, plan, and fi-

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Figure 1. *Phynance*™ client home page (Source: Medical Present Value, Inc., 2001).

nance operations. Practices do not know in advance what the payor will allow for submitted claims. As a result, they can neither develop accurate accounts receivable projections nor determine if and by how much allowed payments are wrong. Appeals are scattershot and ineffective. When practices challenge the allowed amount, they are generally unable to justify, with precision, the appropriate contractual value.

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This problem is worsened by two factors.

- First, reimbursement is based on contracts, not payors, and the contract terms and payment policies are often not fully disclosed.
- Second, payors use multiple line item adjudication, with the value of each Current Procedure Terminology (CPT®) code on a claim depending on the presence of other codes and modifiers, bundling edits, "medical necessity" criteria, and complex rules.

Adding to the complexity, much current physician reimbursement draws on the Medicare physician fee schedule and resource-based relative value scale (RBRVS), which have altered the reimbursement landscape in the last decade.[1]

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Payors also suffer from a mirror image of the problems facing physicians and hospitals. Their systems are increasingly unable to model the variables and payment policies in today's contracts, lowering auto-adjudication and raising error rates. Payors' complicated contracts have forced creation of a time-consuming and expensive infrastructure to handle both substantiated and unsubstantiated appeals. Although it might appear that payors could easily resolve disputes, contracting and adjudication have become so complex that the process is increasingly unmanageable.

The effect of these problems is substantial. Contracts designed to control costs have the unintended consequence of increasing them. In addition, the lack of objective data complicates negotiations between payors and

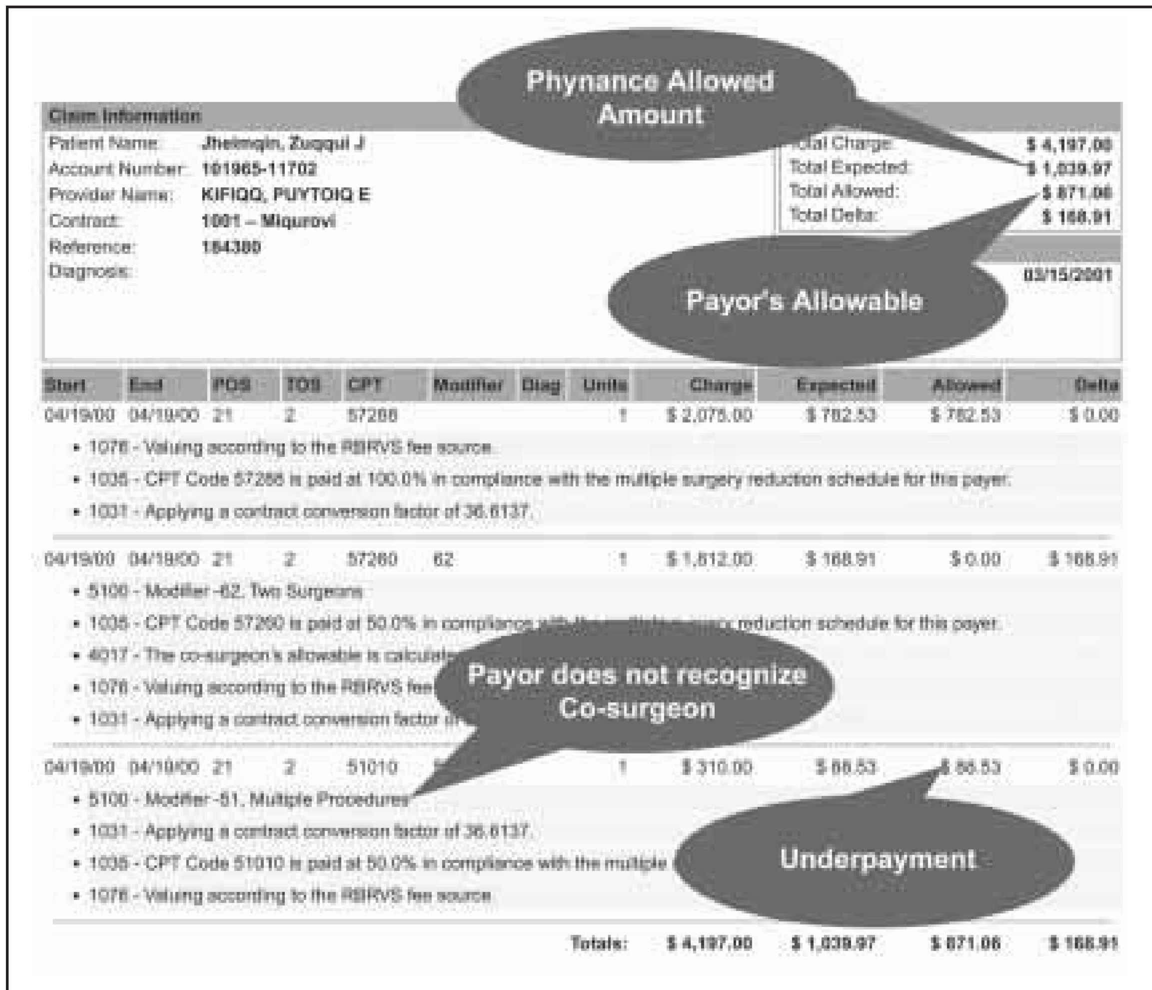


Figure 2. *Phynance*™ discrepancy report (Source: Deidentified *Phynance*™ data, Medical Present Value, Inc., 2001)

physicians and hospitals. Ultimately, employee premiums rise along with dissatisfaction with the entire process.

## WHAT SHOULD MEDICAL PRACTICES DO?

There are four things that every medical practice should do.

- First, take contracting seriously and make sure all current and new contracts are understood.[2]
- Second, use a good practice management system (PMS) and high-quality coding and reimbursement tools.
- Third, practice managers must become experts on contract provisions, reimbursement and coding rules, and appeals procedures.

Unfortunately, these initial steps, while necessary, are not a sufficient response to the challenges posed by today's contract-driven reimbursement environment. Many payment factors are not in the written contracts—this absence has motivated state legislative efforts[3] and lawsuits[4] to require disclosure of fee schedules, bundling rules and key contract provisions. In addition, even the best PMSs are not able to cope with the complexity of contracts and accurately verify payments.

- Thus, the fourth key step is development of a system for consistent and correct identification of exact overpayments and underpayments under each applicable contract.

It is this last step that creates the biggest challenge for practices seeking to optimize management of claims and payments.

## *PHYNANCE*™

Fortunately, technology has enabled an effective solution. Medical Present Value, Inc. (MPV), a physician-led company based in San Antonio, Texas, has created MPV *Phynance*™ to empower practices to deal effectively and accurately with their contracts. *Phynance*™ is an automated medical claim and payment contract verification service that picks up where practice management systems leave off. It values and verifies medical claims and payments based on

practice-specific contract data, current government rules, and deep industry expertise. Using *Phynance*™ practices can gain full understanding and control of payment contracts, with higher revenue and shorter payment cycles.

MPV has offered *Phynance*™ to Texas medical groups since the Fall of 2000, after extensive beta testing. MPV is in its national rollout, focusing initially on three markets: (1) specialty groups of ten or more physicians, (2) large, multi-specialty groups, and (3) academic practice plans. The Texas Medical Association, the Texas Orthopaedic Association, and the Illinois State Medical Society have endorsed this service for their members.

## *PHYNANCE*™ IN OPERATION

*Phynance*™ "piggybacks" on top of the client's PMS and relies on claim data that are already flowing through the PMS. This interface is read-only and requires no duplicate data entry. Figure 1 illustrates a practice's *Phynance*™ home page. On a daily basis, *Phynance*™ evaluates claims data at two points in their life cycle.

- First, *Phynance*™ values claims. Practices can now construct true accounts receivable statements. Contract-level errors are identified before filing, allowing for repair prior to submission and reducing payment cycles with cleaner claims. These errors are identified using all practice-specific contract provisions and external industry standard references.
- Second, after payments are posted to the PMS, *Phynance*™ flags contract-level errors in allowed amounts and their code-level sources, providing concise and accurate explanations for informed and successful appeals or refunds to payors. Figure 2 illustrates the reports *Phynance*™ can generate regarding payment errors.

Clients also have access, at no extra charge, to standard, semi-custom, and custom reports to manage their reimbursement and contracts. These reports can be easily generated by end-users and do not require the complex database queries or custom-purchased reports required by many practice management systems.

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Clients access *Phynance*™ over secure Internet connections, allowing valuations to be based on current data. The only needed client software is a web-browser that supports encryption. MPV supplies all needed hardware, and clients generally prefer high-speed (e.g., ISDN, Cable, or DSL) Internet connections and 17" monitors to view output.

*Phynance's*™ architecture relies on Java and WebObjects, Oracle databases, and fully scalable Sun servers. All data are transmitted using an automated, hands-off process over a secure Internet connection. MPV complies with Medicare's Internet Policy, and its security and privacy practices will be compliant with the HIPAA security and privacy regulations as issued and implemented.

### Benefits

Based on client experience, the benefits from using *Phynance*™ are substantial. They fall into four major categories.

- Billing cycle times fall as problem claims are identified and corrected before submission, reducing the costs of excessive days in accounts receivable;
- MPV clients realize an increase in net collected revenue of 3–6%, based on successful appeals of underpayments. MPV clients average 5% of their net collected revenue in allowed amounts that are less than the contracted level. Nearly 20% of clients' paid claims have an allowed amount less than the contracted level.
- Billing staff are more productive and satisfied in their work; they can focus on collecting accurate payments, knowing when to appeal and when not to. Interaction with payors is based on information; it is more efficient and less tense.
- Finally, practices have more control over existing contracts, with key variables accessible through an Oracle database and powerful, user-friendly query tools. This information is invaluable in deciding to retain or cancel contracts and in contract negotiations, where "what if" scenarios can be run on current and proposed contracts.

### Pricing and Return on Investment

MPV pricing uses a monthly subscription fee that allows unlimited use of *Phynance*™, phone consultation with customer support, and initial user training. Although pricing models (e.g., per physician, percent of revenue, etc.) vary with practice size and other factors, the monthly fee generally is the equivalent of 1–1.5% of a practice's non-capitated net collected revenue. This pricing is not contingent; practices capture all benefits of effective use of *Phynance*™.

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In addition, there is also a one-time fee, generally $20,000–$50,000 or more, for compilation and analysis of contracts and implementation of a hardware and software interface with the client's PMS. The exact fee is based on individual practice circumstances.

Clients typically see a positive return on investment by the second or third quarter of their first year of *Phynance*™—

a rare and measurable return on investment in health care information technology. This timing reflects amortization of the initial implementation fee and the time needed to move an entire billing cycle through *Phynance*™.

## Potential Alternatives to *Phynance*™

There are partial alternatives to *Phynance*.™

- Electronic data interchange and related claim edits are useful but do not provide contract-level verification of claims pricing or accuracy;
- Coding tools focus on code selection and do not encompass contract variability nor provide pricing verification;
- PMS fee schedule modules are valuable but were built to reflect payors rather than contracts, cannot generate accurate valuations of complex multi-line claims, must be manually updated, and do not provide contractual explanations for valuations or payment discrepancies; and
- Online claim adjudication speeds payments but does not help practices develop contract-compliant claims before submission and cannot verify payor adjudication.

## Training and Implementation

MPV provides a team of highly trained specialists to assist each practice in implementing *Phynance*™. An average implementation period of 6–12 weeks, leading to launch, includes the following activities:

- Definition of most of the contracts and contract variables that affect payment for that practice;
- Implementation of *Phynance's*™ read-only interface with the existing PMS;
- Training for all *Phynance*™ users and managers; and
- Data management support for client managers in using the *Phynance*™ data;

After launch, Account Managers and a Client Support Center provide ongoing support to clients. This support focuses on the use of *Phynance*™, [contract definition, training in] Phynance™ updates, and documentation of return on investment.

## CONCLUSION

The health care industry needs greater transparency in contracting and reimbursement. It is essential that physicians, hospitals, and payors have rapid access to accurate information on contract-based payment terms. *Phynance*™ uses state-of-the art technology and extensive industry expertise to provide access to this critical information as well as the tools to use it to increase accuracy and drive out wasteful administrative costs. It provides a complete solution in an industry where precise data are needed to do the job. ■

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