

# Payer Contracts: The Key to Practice Revenue



A Tennessee-based medical group identifies potential underpayments, negotiates better payer contracts and strengthens their bottom line.

According to industry estimates, as much as 20 percent of a medical group's claims volume is paid incorrectly. When it comes to tracking payment errors and recovering lost revenue, these groups must deal with the growing complexity of today's payer contracts—from Medicare payment rules and bundling edits to modifiers and place-of-service edits. Effectively managing these details—and the contracts that define them—helps medical groups to decrease underpayments, leading to increased revenue and improved cash flow.

## Problem

UT Medical Group Inc. is the faculty practice plan for physicians on staff at the University of Tennessee Health Science Center College of Medicine in Memphis, Tenn. The 325-physician group is one of the largest multispecialty group practices in the South, and employs more than 75 staff members in its billing and contracting departments.

In 1999, we consolidated billing functions for our 12 different clinical departments. We started by implementing a claims scrubber to ensure all of the claims we submitted were as clean as possible. By doing so, we hoped to improve cash flow and eliminate the time and expense associated with reworking denied claims. We also increased our use of electronic claim submission, which would allow us to further minimize payment lags and better track denials. To streamline the entire claims management process, we purchased an imaging system that enabled us to scan all payments, denials and insurance follow-up information and make it readily available to staff members. This saved a significant amount of staff time that was previously spent pulling paper batches.

We focused on perfecting front-end processes and submitting cleaner claims because we knew it was the key to reducing back-end tasks, such as appealing denials. We realized, however, that once this technology was in place, we would have no way to ensure we were being paid according to the terms of our payer contracts. Determining accurate payment requires the calculation of more than 50 different variables, including carve-outs, global fee periods and site of service adjustments—and none of this information was available electronically.

To address this challenge, we initially employed a manual process for tracking underpayments where we ran queries from our practice management system and compared payments received against contract terms. Without the staff required to track all of our payments, we focused on high-dollar claims. We also attempted to periodically track payment variances by payer, but this process was so detailed that we were unable to manage it consistently. While this method may have demonstrated the payer was reimbursing us accurately at the time of monitoring, it did not ensure we received appropriate payment going forward. Plus, most payer contracts specify appeal deadlines, such as 120 days, so if we did not catch the underpayment quickly, we missed the opportunity to submit an appeal altogether. Over time, the process revealed two problems:

- **We had been underpaid.** We knew our payers constantly changed their payment activity, which created numerous payment variances.
- **We did not have the resources to track underpayments manually.** We either had to increase staff or find a more efficient process.

## Solution

In late 2002, a search committee with representatives from the revenue services, contracting and information services departments, as well as UT Medical Group executives, focused on finding a solution that would allow our group to electronically verify reimbursement and monitor overall contract performance. The committee also sought a vendor that would enable our group to better understand our contracts and improve communications

### Source

Shannon Tacker  
Director of  
Reimbursement  
UT Medical Group Inc.  
Memphis, Tenn.  
[www.utmedicalgroup.com](http://www.utmedicalgroup.com)

### Product/Company

MPV Phynance  
Medical Present Value  
Austin, Texas  
[www.mpv.com](http://www.mpv.com)



with payers, as well as support denials management and improve cash flow.

After an extensive two-year search that included product demonstrations and reference checks, we selected Phynance from Austin, Texas-based Medical Present Value (MPV) Inc. While we considered products from four different vendors—most with good functionality—we ultimately selected MPV because it was the only company we researched that offered both the software and the contract modeling services. We wanted to tap MPV's expertise in contract modeling to create an electronic database that fully defined and modeled the terms outlined in our payer contracts.

### Implementation and Training

MPV met with us in mid-December 2004, to define the reimbursement logic contained in our payer contracts. We defined payment policies, rules and variables through this process that determined appropriate payment, including carve-outs, global fee periods, multiple surgery reductions, modifier multipliers, bundling edits and place of service differentials. We also re-evaluated financial status classification and paycode assignments in our practice management system to ensure easy tracking of these contracts. Making these changes before the system went live streamlined our use of the system and allowed us to quickly reap the financial rewards of the technology.

We reorganized our internal billing and insurance follow-up teams to better utilize Phynance's capabilities. We reassigned two staff members—one from the billing department and another from our clinical denials division—to create a five-member team. One staff member focused exclusively on identifying contractual underpayments, while an additional four managed coding related denials and zero valued claims. This staff was responsible for communicating any errors it uncovered, helping to close the loop in all claims-related communications, particularly posting errors.

Once the contract data was loaded into the Phynance application, MPV worked with us to establish an implementation timeline and to build an interface between our practice management system (PM) and Phynance. This interface facilitated the extraction of claims data from our PM on a nightly basis. After completing the interface, the transition to the Web-based system went smoothly and we went live within 90 days.

MPV provided approximately 12 hours of online training to familiarize everyone with the system, in preparation for the onsite training sessions. Simultaneously, we identified a super-user who championed Phynance internally and spearheaded continued training and education. Our super-user was one of our top insurance follow-up representatives and was very familiar with payer activity.

We did have some staff members who were slow to accept Phynance. Most of them were comfortable work-

ing through our practice management system and, since the "old way" still existed, some were hesitant to use the new method. However, once these individuals recognized the application's depth and breadth of functionality, they began to rely on it as an indispensable tool. We completed training by mid-March 2005, and began using MPV to identify contractual underpayments and support our denials management efforts.

For more information about MPV Phynance, [www.mpv.com](http://www.mpv.com).

### Results

We use Phynance daily to identify and validate payment errors against contractual terms. When we appeal underpayments, it provides us with contract-based explanations for each underpayment, which streamlines communications with payers. At the end of each month, we generate reports that specify how much money we have appealed and recovered to date. We have already recovered approximately \$200,000, after just seven months of use.

We also use Phynance to manage and track bundling and medical necessity denials, in addition to identifying and appealing contractual underpayments. This helps us increase overall efficiency of the appeals process. It gives billing representatives online access to a centralized contract database, so they can quickly reference the specific contract language related to the appeal. It also enables our group to track recoveries and monitor the success of our appeals, a task that was impossible using our manual system.

Filters in the application help staff to identify what claims have been denied and what needs to be appealed. They also allow us to monitor payment trends and possible issues with payers. For example, when a payer recently changed its interpretation of the contract language and its payment policy accordingly, we were quickly able to identify and address the change as a contract issue, rather than a payment issue.

During contract negotiations, we use the data stored in Phynance to perform "what if" analyses to determine the impact of new and proposed contract terms on the actual mix of services we provide. We also generate detailed reports of current payment patterns, which assist us during negotiations.

How Phynance enhanced our communications internally is the most impressive change, especially between revenue services and the managed care department, which oversees contracting. In many healthcare organizations, these two functions are separate entities that operate independently of each other. Through our implementation of Phynance, the two groups forged a strong bond that continues to this day. By working as a team, these departments regularly review payments received and the policies that drive them, allowing us to appeal and recover more revenue than each department could on its own.

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