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Improve Your Bottom Line with Better Contract and Denial Management Tools

By Vincent Marzula, CCM, Vice President, Healthcare Solutions/e-Commerce Product Group Manager PNC Bank, N.A. Thanks to HIPAA, claims submission is mainly electronic, and some providers have also made significant headway in posting patient payments automatically. What's next? Savvy healthcare providers are now focusing on two major impacts to the bottom line: contract management and denial management.

Contract and Denial Management Challenges

A few facts on contracts: A typical contract management "system" consists of a file cabinet with alphabetized folders. Even providers who have purchased contract management software often have not implemented disciplined processes to analyze payer contracts, to document meaningful provisions, to tie clinical procedures to revenue codes, and to compare and report results for each payer against the contract on a regular basis.

Denial management systems are in a similar state. A few good software packages exist, but those that have been installed are woefully underutilized, for a number of very good reasons. Primary reasons include the fact that about 50 percent of remittances are still posted from paper Explanation of Benefits (EOB) documents, making consistent capture of denial data more difficult, and wide variations in the use of reason codes. Payers remitting via paper EOB are not obligated to use HIPAA-compliant reason codes, forcing patient billing staff to use word association to map codes for posting. ("Mmm, the note on the EOB says 'Procedure not allowed.' Is that a contractual adjustment or patient responsibility?") Some providers have built automated code maps for major payers, mapping at least the most commonly used reason codes to their HIPAA equivalents, but the sheer number of payers (and associated codes), makes development of a comprehensive map nearly impossible.

Even payers sending 835s can offer denial management challenges. There is still significant disagreement around the use of PR (Patient Responsibility), CO (Contractual Obligation), and OA (Other Adjustment) codes. Since these codes drive secondary billing and transfers to patient responsibility on integrated billing systems, discrepancies in code usage can have unpleasant consequences in terms of increased denials, missed revenue opportunities, and angry patients.

Given all these challenges, where to start?

The logical place is at the beginning of the revenue cycle, with the contract. A contract is a set of rules governing the relationship between business partners. Some of these rules relate to pricing and revenue, or revenue incentives and disincentives. The rules need to be documented in a contract management system so that actual performance under the contract (e.g., payer reimbursements) can be properly analyzed. In addition, applicable state and Federal laws must also be considered.

Unfortunately, this means a lot of hard work when a contract management system is initially installed. Each contract must be analyzed, and reimbursement rates must be detailed for hundreds of medical procedures. In addition, other significant contract terms, such as payment schedules, need to be entered. This is not an easy process. As every CFO who is fortunate enough to have a good contract manager knows, there is a talent to identifying significant contract provisions and documenting them in such a way that results can be compared systemically by individual payer and across payers.





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The best contract management technology includes advanced analytics. As an example, nearly every payer contract has underlying insurance plans negotiated with individual employers. Although the provisions for individual employer plans are not typically detailed in payer contracts, information gathered from patient/employee encounters, gathered over a period of time, can be used to develop underlying trends for larger employer groups. Strong analytics produce data that can be used to improve all aspects of the revenue cycle, from intake to claims submission to denial management.

Denial management systems are sophisticated databases that allow categorization, tracking, and reporting of denials. Key requirements for a good denial management system include:

- The ability to handle either HIPAA or non-HIPAA reason codes
- User mapping of non-HIPAA codes to HIPAA codes
- Assignment of codes to sources or causes (e.g., intake errors)
- Robust reporting tools, including trend reports by payer
- Integration with the contract management system
- Integration with the claims submission process, so that denials can be reworked and resubmitted

Improved technologies for converting data from paper EOBs to "manufactured" 835s, as well as an increasing number of payers delivering native 835s, have dramatically increased the amount of data available for analysis.

If system integration with the contract management and claims systems is not possible, then manual comparison of denials to contract terms for major payers, and an organized process for evaluating and resubmitting claims, are essential. Data from denial management reports should be compared to existing contracts and incorporated into claims scrubber business rules. Very often, payers have unwritten edits and reimbursement "tendencies" that can be documented as business rules for claim edits. preventing denials before the claim is ever submitted. In addition, denial management reports should be carefully evaluated to identify the root cause of denials so that corrective action can be taken. The fact that "patient not eligible" is the top reason for denied claims suggests an early focus on eligibility and intake processes.

Good contract and denial management systems, properly used, should reduce denials before they happen. This assumes, of course, that payment data is compared routinely against the contract database, analyzed frequently, and then used to address issues at root cause throughout the revenue cycle. Bottom line impact can only be maximized if denials and contract discrepancies are identified and addressed immediately, not at the end of the fiscal year or when payer contracts are up for renewal.

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