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## AMGA Member Best Practices

# *Power Your Payment Velocity with Better Payer Performance*

# Power Your Payment Velocity with Better Payer Performance

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***Webinar, February 24, 2021***

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> — **Kevin Mulcahy, Senior Director Payer Relations Special Billing and Provider Enrollment, Mass General Brigham**

Ensuring fair and correct payment for services rendered is an important element of health care, supporting providers and the healthcare system in delivery of care to patients. Implementing contract management systems that sort data and help identify variances in payment and other revenue cycle challenges is key to ensuring fair and proper payment.

With the support of Merideth Wilson, senior vice president of Revenue Cycle Solutions, Implementation, and Customer Care, at Experian Health, Mass General Brigham's Kevin Mulcahy, senior director of Payer Relations, Special Billing, and Provider Enrollment, and his colleague Michael Pace, senior manager of Special Billing and Contract Management, discussed how they utilize Experian Health's Contract Manager & Contract Analysis, a contract management tool, to address challenges in their revenue reimbursement cycle.

## Contract Management and the Revenue Cycle

Ms. Wilson began with some interesting statistics about the current state of affairs with regard to reimbursements. In particular, over the course of the COVID-19 pandemic, one in four healthcare leaders has seen a change in their payer mix. "So the idea of making sure provider groups are paid correctly, whether it's from patients or payers, is really on the forefront, and that payer mix is important," noted Wilson. As well, 78% of all claims have variances of less than $50. Wilson noted that percentage is "meaningful when you're talking about high quantities of certain procedures delivered." It may look small on an individual claim basis, she said, but in the aggregate those potential underpayments can total millions of dollars.

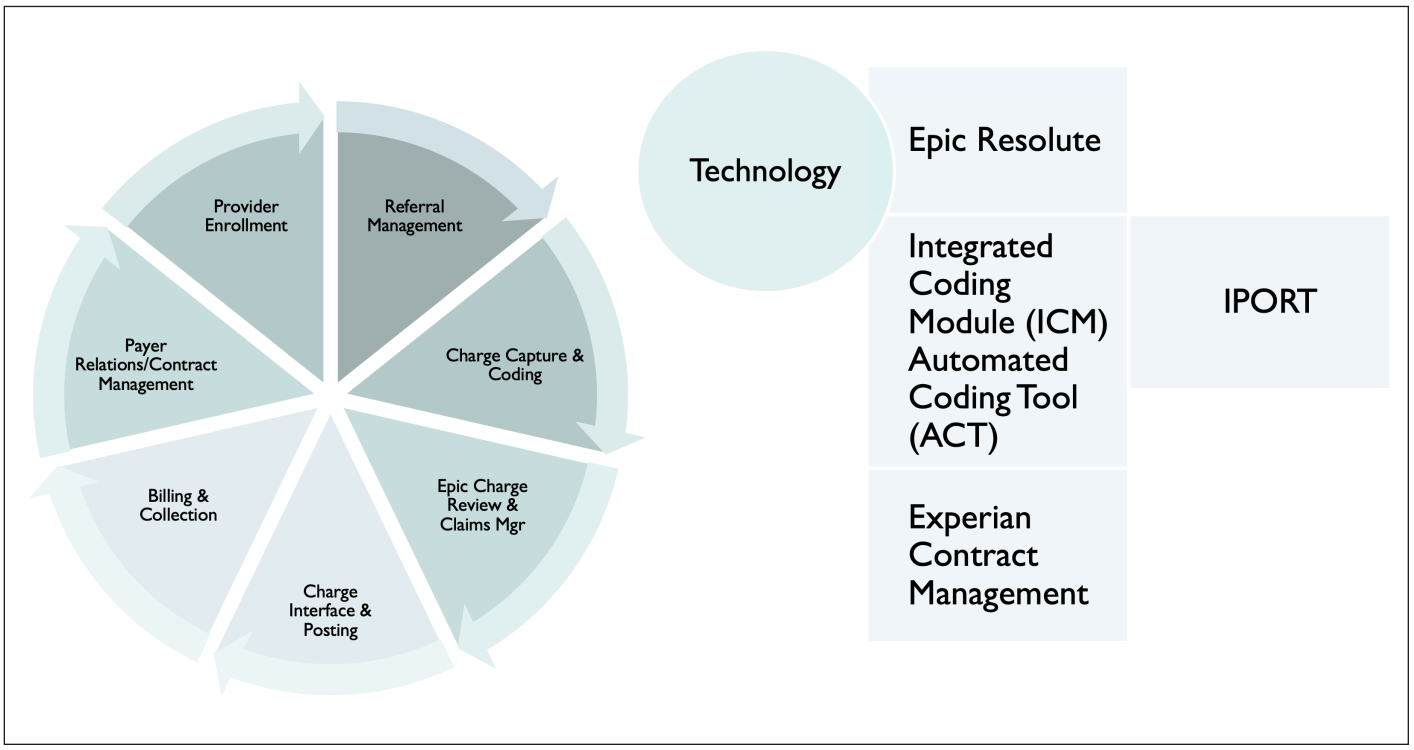
Kevin Mulcahy agreed that identifying underpayments is very important, but noted that his goals for contract management at Mass General Brigham (formerly Partners HealthCare) are broader. He's spent the last 10 years building and refining the contract management system utilizing Experian Health's contract management tool "to make sure that we are being paid correctly," to "use the information that we obtain from the system and looking at variances in payments and bringing that forward to our contracting team so that we can make changes operationally" or work with payers to address particular issues.

To provide some background, Mulcahy noted that the Professional Billing Office (PBO) of Mass General Brigham supports over 30 unique Taxpayer Identification Numbers (TINs), including solo practice groups, freestanding labs and radiology services, Department of Public Health (DPH)-licensed urgent care centers, and two major academic groups, over 7,500 providers in total. The groups include a variety of specialties and licensure levels, all of which have unique payment arrangements. The PBO has refined the Experian contract management tool to allow for easy transition to new groups.

There are several "key factors" Mulcahy says they focus on with regard to billing. First, is striving for a high collection rate, which is currently at 96%. "We're right now annually billing $4.6 billion in professional services and we have $1.8 billion coming in in net collections." Next is average time in accounts receivable, which is currently 31 days across all specialties. Another focus is research, utilizing the tools available and coordinating among different departments to reduce denials and write-offs. When they started using the Epic electronic medical record (EMR) system in 2014, Mulcahy noted, their denial rate was 12%. It's now down to 7.2%. He attributes this to distinguishing true denials from contractual issues and "streamlining those across all of our entities." Denial write-off is down to 1%. Then, said Mulcahy, it's about implementing process improvements to eliminate identified issues going forward and, finally, focusing on the documentation of the policies and procedures.

"That's the basic fundamental structure that we use in any of our business opportunities throughout our organization." Thus, although Mulcahy's group has a specific role in the revenue cycle, part of the job is to make sure everyone involved is on the same page, "because everything that we do from the beginning of the revenue cycle of provider enrollment [Figure 1], if you don't have your provider set up, it's just going to flow through the rest of the revenue cycle and create the various issues at the end that we see."

## Figure 1: Revenue Cycle



What does contract management do for your organization? According to Mulcahy, a key driver is the peace of mind that comes from knowing you are being paid correctly, whether you are addressing under-payments or over-payments. While providers focus intensely on the former, Mulcahy said the latter are just as important. Paying attention to over-payments allows the organization to set reserves for possible return of payments and provides credibility.

"Now, obviously, everybody knows with Medicare and Medicaid, once you identify an overpayment, we have to, you know, resolve those quickly and expeditiously. And we do. When it comes to the commercial payers," Mulcahy acknowledged, "sure, you don't always pay them back as quickly, but we'll identify them and be upfront with the payer to say, 'hey, you know, we've identified an overpayment situation. We want to verify with you that it's correct,' because when we go to them with the underpayments, we want them to move along as quickly as possible." Addressing overpayments builds trust with payers, said Mulcahy, "it's in our best interest to work proactively with them on all payment variances."

Having accurate data available is key. "Our approach when we look at payment variances," Mulcahy said, "we want to research it, report it, fix it if it's something on our side or fix it with the payer, and then recover any potential variances out there." He stressed that it's important to not just say to a payer, "hey, you're not paying me correctly." "We go to them saying, 'we have looked at X, Y, Z, and here's the information. You are not paying us correctly, according to the contract, as we have it documented.' And the tool has allowed us to do that along with the team that Mike has assembled."

"Experian works very hard to build rules around the Medicare CMS guidelines." Then, Mike Pace (who later spoke about the technical aspects of their contract management system) and his team tweaks those rules to meet local payer policy, documents, etc. "We can only go back X period to look at payment variances," Mulcahy noted, "If we wind up getting them to change a policy based upon it, it's not retroactive. It's from the date they write the new policy. So all of those things are pretty much standard in the industry, but at least we can define those, and everybody lives by the same rules."

Mulcahy told the story of how their contract management identified a significant payment variance that otherwise might not have been found for a year or more. "It was a July 4th weekend," said Mulcahy, "several years ago." He was driving to Cape Cod when Mike Pace called and indicated a group of claims with their largest commercial payer were suddenly being paid at a different fee schedule. Mulcahy continued, "So I called them and said, 'We've got an issue, I don't really know the magnitude of it yet, but is there anything going on?'" It turned out someone had made changes in the payer's dental system and that logic was transferred to the health insurance side, diverting all providers at the academics to the community level fee schedules. "The impact to us was a million dollars," said Mulcahy, but the problem was "network-wide across the state and so every provider in the state benefited from this" and the quick result. "Had we not had that tool," said Mulcahy, "we would have never known it had happened."

Again, it provides peace of mind: "Our physicians and providers are happy to hear that we have this and that we're looking at all of this information on a daily basis." Later in the program, he noted a meeting with the anesthesia department several years ago, "and I said, 'you know, last month, we recovered 17,000 dollars for you.' You have thought I'd said 17 million dollars," they were so appreciative.

The system also facilitates correction of issues that ultimately are not really variance issues. Mulcahy used registration issues as an example. "We use blended rates in most of our contracts, but if somebody gets registered with Blue Cross commercial but they really have the Medicare Advantage product, it'll come through as a paid claim, but it will hit the variance because we're looking for a commercial rate based

upon the registration." This allows the team on his side to look at the data and see that the payment is at the Medicare rate and then they can work with the registration team to get that end of the system updated. Other times, the "variance" might be a point of service issue—such as a doctor's office that receives technical and professional payments versus a hospital-based clinic which only gets the professional component—or patient co-pays and deductibles impacting the payment level. The Experian contract management tool has also assisted in identifying provider contract set up issues, linking to incorrect fee schedules, and manual processing errors.

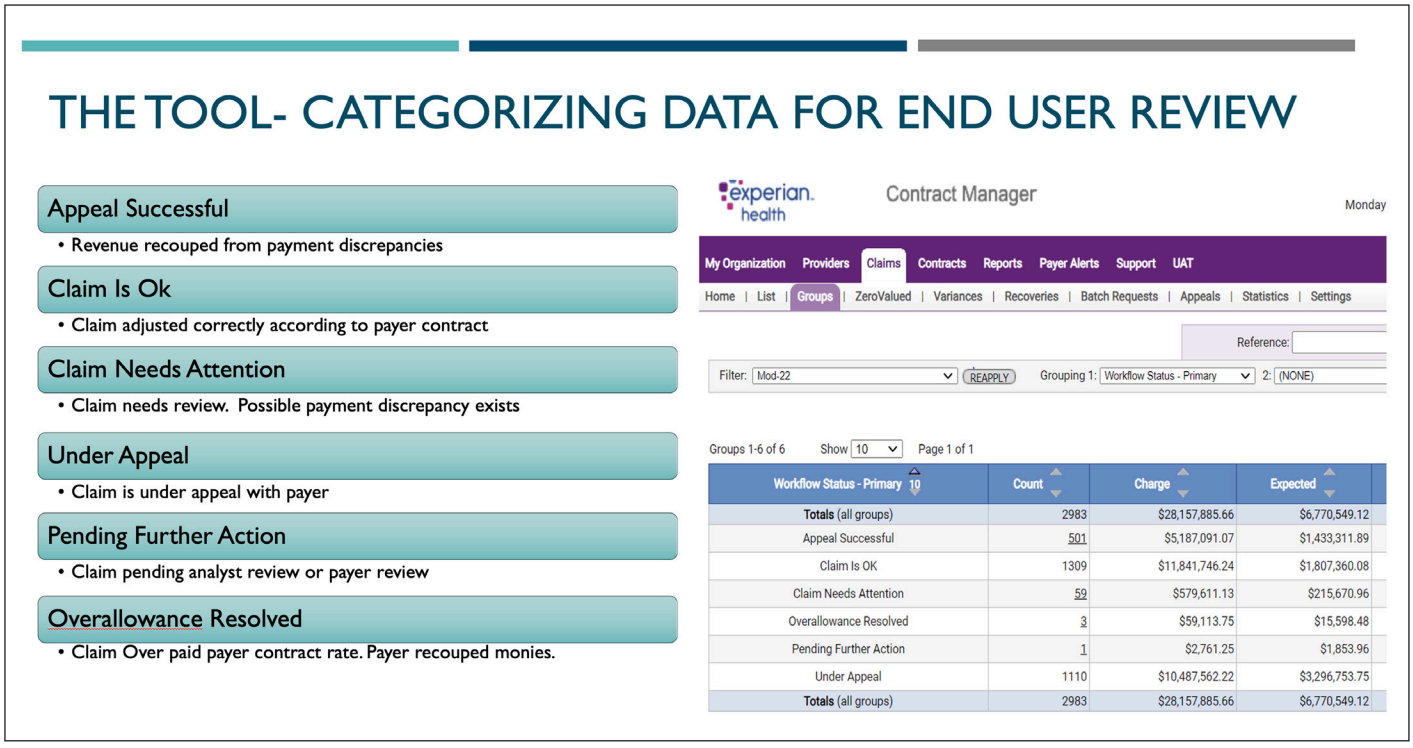
Mulcahy stressed that appropriate staffing is key: "You have to have experienced billers looking at a lot of this stuff, because they understand all of the rules; they understand bundling, they understand how we get a claim out the door and how it comes back in, and that's one of the keys to successes." He noted that Mike Pace's group includes those experienced billers as well as analysts, and he turned the presentation over to Pace to discuss the technical aspects of their contract management system.

## Using Experian's Contract Management Tool

Pace manages payer contracts, fee schedules, and reporting, and works with four analysts who conduct variance review, report on payment trends, etc. He noted that Mass General Brigham started its contract management system in 2012. Since that time, they have recouped over $14 million. They saw a drop in recoveries in 2014 related to a transition to a new practice management system, but recoveries have trended upward since that time, totaling approximately $500,000 to $3 million annually. Pace noted that they added two analysts to his team in 2018 and, in 2020, recovered over $4 million, "so the more eyes we have looking at this," he said, "it seems that our recoveries seem to rise as well."

He indicated the simplest way to think about contract management technology, is that "it categorizes data for you." The Experian contract management tool buckets claims based on status, as shown in Figure 2.

**Figure 2: Experian Health Contract Management Tool**



Pace noted many of the category buckets are self-explanatory, but one, Pending Further Action, deserves particular mention. Pace said that category is for claims that require additional research on an issue. This bucket "allows us to move those claims aside so it doesn't create noise for other analysis."

Pace described various forms of reporting based on information from the Experian contract management tool, such as quarterly recovery reports, which he breaks down by provider group and payer, with notes about the reason(s) for recovery dollars, as well as more specific reports for each individual group broken down by billing area.

The data is especially helpful for appeals. Pace said they do most of their appeals "in bulk," trying to focus on trends. He noted, "it could be the flavor of the month, or, in this case, the flavor of the year: telehealth has been on the front lines. So that may be a driver in what an analyst is researching." He tells his analysts to "start with the easy stuff. Experian does a great job of configuring anesthesia payments, so a lot of our research goes into anesthesia, modifier research, bilaterals, modifier 50 …. it starts with the variance and then we peel back that onion." Ultimately, the so-called variance could be the result of improper coding, a modifier, a provider set up issue, or a policy issue. Variance drives the research, but the results of that research can lead many places.

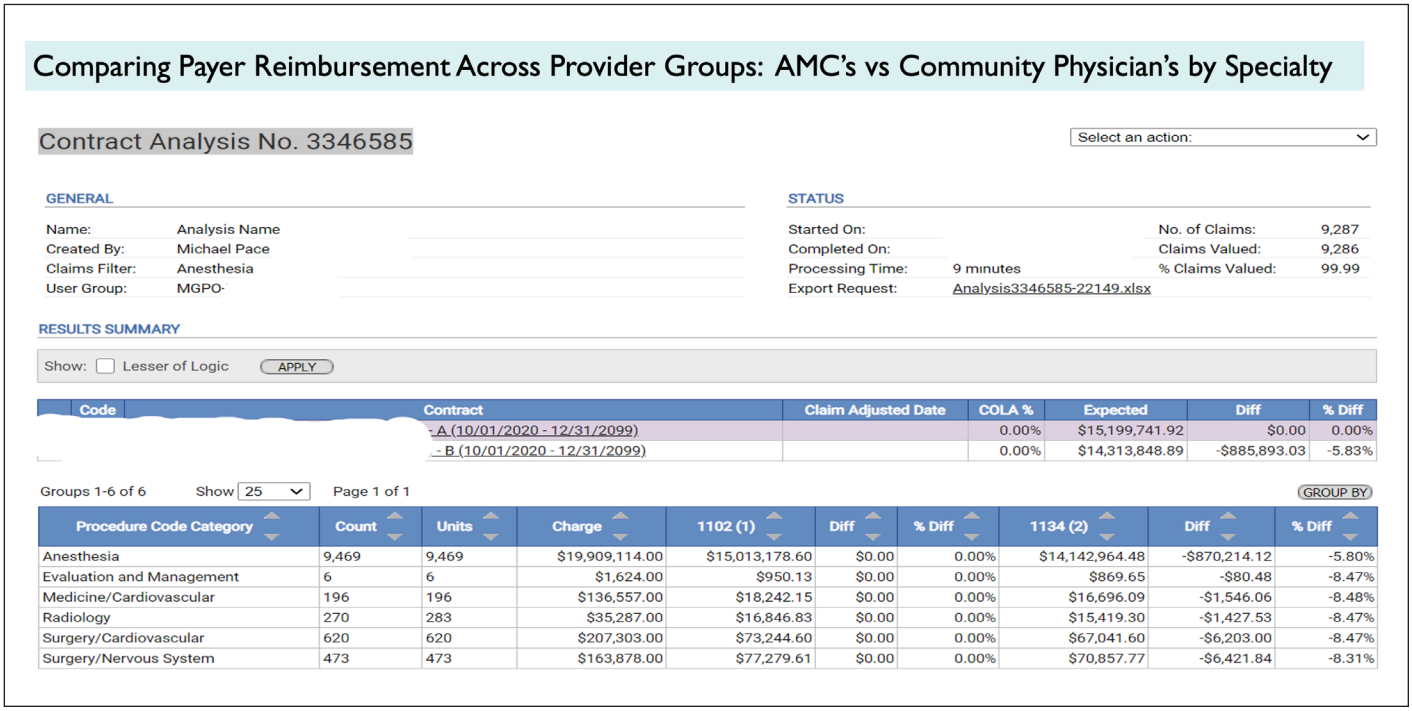
One area Mulcahy noted their contract management technology has been especially helpful is appealing Modifier 22 practices. "We have a lot of different surgical practices. We do some really high-end stuff. You know, we're not just doing orthopedic cases. We're doing the revisions of the revisions of the revisions. And so our doctors have utilized Modifier 22 a lot." Payers don't look at a Modifier 22 up front, it's usual to have to appeal for that additional reimbursement. Pace developed reports to identify all claims including Modifier 22, which prompts the PBO to make sure the coding department is keeping all the notes necessary to provide the triggers for acceptable Modifier 22 use. This ensures that the patient financial services team has all they need for the appeal. Pace then flags the claims in the system so, when additional payments come in, the recovery can be noted in the system. They started this practice in 2015 and, to date, Mulcahy said, they've recovered almost a million dollars related to Modifier 22. Again, he stressed presenting payers with accurate data. "We do a lot of the due diligence up front and then leverage the relationships that we have. And if we made a mistake, we're the first ones to admit that we made a mistake and that we billed it wrong."

He also noted that, while recoveries from appeals "are great, being paid correctly the first time is our goal." Thus, the research team puts a real focus on things like registration errors and operational issues. "We use the system to present the data to our teams and make operational changes so that we can make things better," said Mulcahy. This includes, for example, working with the contracts department to make contracts simpler, using blended rates to eliminate as many variances as possible.

Pace showed how the Experian contract management tool assists contract analysis, including fee schedule comparison and forecasting. An example of the former is shown in Figure 3, which Pace explained shows an $870,000 difference between academic reimbursement and community reimbursement. He noted that many organizations use this function for contract negotiations.

Pace added, "It's really good, for 'percent of Medicare' type contracts." The tool allows comparison of as many as three fee schedules, and "it's pretty robust. You can drill down on this by specialty by provider, by CPT [current procedural terminology] code, and things of that nature."

## Figure 3: Contract Analysis



Comparing Payer Reimbursement Across Provider Groups: AMC's vs Community Physician's by Specialty

Contract Analysis No. 3346585

Select an action:

GENERAL

| | |
|---|---|
| Name: | Analysis Name |
| Created By: | Michael Pace |
| Claims Filter: | Anesthesia |
| User Group: | MGPO |

STATUS

| | | | |
|---|---|---|---|
| Started On: | | No. of Claims: | 9,287 |
| Completed On: | | Claims Valued: | 9,286 |
| Processing Time: | 9 minutes | % Claims Valued: | 99.99 |
| Export Request: | Analysis3346585-22149.xlsx | | |

RESULTS SUMMARY

Show: Lesser of Logic APPLY

| Code | Contract | Claim Adjusted Date | COLA % | Expected | Diff | % Diff |
|---|---|---|---|---|---|---|
| | - A (10/01/2020 - 12/31/2099) | | 0.00% | $15,199,741.92 | $0.00 | 0.00% |
| | - B (10/01/2020 - 12/31/2099) | | 0.00% | $14,313,848.89 | -$885,893.03 | -5.83% |

Groups 1-6 of 6 Show 25 Page 1 of 1 GROUP BY

| Procedure Code Category | Count | Units | Charge | 1102 (1) | Diff | % Diff | 1134 (2) | Diff | % Diff |
|---|---|---|---|---|---|---|---|---|---|
| Anesthesia | 9,469 | 9,469 | $19,909,114.00 | $15,013,178.60 | $0.00 | 0.00% | $14,142,964.48 | -$870,214.12 | -5.80% |
| Evaluation and Management | 6 | 6 | $1,624.00 | $950.13 | $0.00 | 0.00% | $869.65 | -$80.48 | -8.47% |
| Medicine/Cardiovascular | 196 | 196 | $136,557.00 | $18,242.15 | $0.00 | 0.00% | $16,696.09 | -$1,546.06 | -8.48% |
| Radiology | 270 | 283 | $35,287.00 | $16,846.83 | $0.00 | 0.00% | $15,419.30 | -$1,427.53 | -8.47% |
| Surgery/Cardiovascular | 620 | 620 | $207,303.00 | $73,244.60 | $0.00 | 0.00% | $67,041.60 | -$6,203.00 | -8.47% |
| Surgery/Nervous System | 473 | 473 | $163,878.00 | $77,279.61 | $0.00 | 0.00% | $70,857.77 | -$6,421.84 | -8.31% |

## Adopting Contract Management

Clearly, there are many benefits to contract management technology. Determining whether this kind of system will work for you, said Mulcahy, involves several considerations.

First, he said, "Whether large or small, everybody needs to look at their payments and their processes. Smaller groups, start with the basics of your practice and your contracts, primary care versus specialty base, are you E&M [Evaluation & Management] dominated or are you procedure based?" He noted variances are more often seen in procedure-based practices, as well as anesthesia and radiology. E&M-based practices generally do not experience payment variances.

Next, he said, look at participation. Are you a heavily dominated Medicare practice? If so, you'll not see significant recoveries through contract management technologies because Medicare is "pretty good at their payments" and variance recovery "is going to be very, very small" because of the level of the fee schedules. If you're associated with PHOs [Physician-Hospital Organizations], however, even getting fee schedules can be an issue. "Who has them?," asked Mulcahy. It could be your contracting department or not. "Payers? They're typically the last resort where you're going to go get the fee schedule," Mulcahy said. He suggested asking your physicians to be your advocate when it comes to obtaining fee schedules.

Finally, Mulcahy noted, you have to stay up on changes and assign someone accountability to manage that information. It's difficult to keep up with daily provider updates from payers. His team uses an Experian tool that scans the various payer websites for informational changes. "And so they will send us updates about policy changes or things we may need to look at." Then Pace and his team can make any necessary changes in the Experian contract management tool.

Even a small practice that's not ready to invest in a contract management system can utilize similar processes. Mulcahy suggested downloading information to Excel and doing basic pivots, "looking at your basic CPT codes and getting a review of that. And if you have

questions, outreach to your provider rep and say, 'hey, can you explain to me what I'm seeing here?' and open those lines of communications."

## Using Contract Management for Quick Pivots

Mulcahy and Pace saw another real benefit from their contract management technology with the onset of COVID-19. Said Mulcahy, "You know, the last year has been totally disruptive. It changed our world. Like everybody, we went from being in the office five days a week to 100% remote. The pandemic hit and things really escalated with telehealth, which became the majority of our business." Although such a drastic change had not been a focus of the system, the Experian contract management tool "allowed us to react and build quickly." Pace built contracts in the system "to start to reflect the true place of service, and then as everything started to happen with payment parity and billing different places of service, even though they were telehealth visits, we were going to be paid this fee schedule." In 2020 their team recovered $2.1 million on issues related to the pandemic. Mulcahy noted not all of that was telehealth. "There were issues with other things that happened with testing, but we built them quickly and typically these types of recoveries would have taken over a year to try to get through the system." Mulcahy recognized that could not have happened but for all the research and systems work they'd done over the past several years. "I was thankful we had the tool in which to do this because we leveraged it for a lot of different people, and a lot of different community providers benefited from the fact that we were on top of this so fast."

And that gives them peace of mind moving forward. Mass General Brigham is adding full scale to ambulatory surgical centers in 2022. "So we will be building them into our contract management system and the reimbursement guidelines there."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