Internal Medicine Coding Alert

Turn the Tables on Third Party Payers: Audit Your Carriers to Detect Lost Reimbursement

Its a poorly kept secret among many professionals in medical practice managementno matter how well you code or how thoroughly your physicians document, your practice may still lose thousands of dollars in reimbursement each year.

The culprit? Payer underpayment of claims.

More and more internal medicine practices are discovering that one of their biggest reimbursement problems has to do with keeping track of how well their third-party payers adhere to the agreed upon stipulations in their provider contracts.

Youd like to believe that the carriers are complying with your contracts and everyone is doing the right thing. But, sometimes, the payer can take some money out of the payment and it never gets checked, and that may encourage them to keep doing things they shouldnt be doing, says **Ian S. Easton, PhD, FACMPE,** executive director of the Clark-Holder Clinic, a 42-physician multi-specialty clinic with six internists located in LaGrange, GA.

After negotiating a new contract with one of their payers, Eastons clinic staff discovered that the claims were not being paid correctly.

This carrier agreed to pay us a certain percentage of billed charges according to our 1996 fee schedule, explains **Nancy Bloomer,** chief executive officer at Clark-Holder. We did some sample auditing and it turned out the claims were not being paid according to the contract amount.

After much negotiating and digging, Bloomer discovered that the payer had been sent a diskette that was supposed to be the practices 1996 fee schedule, but was, in fact, an older out-of-date schedule.

We were at fault, but they were as well, because they still werent paying what they had agreed to in the contract, she adds. Those were the kind of issues that made us realize that somebody has to manually go in there and check that.

The practice recently hired a reimbursement specialist to spot audit the payments sent in by third-party payers, comparing random EOBs with that payers contract.

The specialists job is to identify any problems or areas of noncompliance and resolve them by either speaking with the carrier representative or taking it to the administrative level [the medical director of the plan] if that doesnt work, Bloomer explains.

Lost Reimbursement Isnt Just Peanuts

Clark-Holder is fortunate in that it discovered the payer error before too much time had passed. Luckily, they have not found significant noncompliance with their other payers.

However, many practices are not so fortunate, says **James Bevis,** administrator of Jackson-Purchase Medical Group in Paducah, KY.

In the late 1980s, Bevis set up one of the first reimbursement tracking systems at the Jackson Clinic, an 85-physician multi-speciality clinic in Jackson, TN.
We figured out we had a problem at the clinic by accident, Bevis notes. We were getting into a really intense negotiation

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period with [a large payer] and they wouldnt give us a fee schedule, so we had to create one ourselves from the remittance.

Practice staff gathered all of the remittances from that payer to create a fee schedule of what that company was paying for each individual service and procedure.

At the time, we were submitting about a million claims per year to this carrier and we began to compare the amounts with our [existing] contract, he explains. We saw what they were supposed to be paying us under the contract and they werent doing that. They werent way off, a dollar here, two dollars there, five dollars there. For each remittance it doesnt look like a lot of money. But, it added up to almost a million dollars that year.

After that, the Jackson Clinic also began looking at their other payers and discovered the same thingseveral of them had consistently underpaid on claims.
Both Bevis and Easton emphasize that every practicelarge or smallmust have some system for tracking payer remittances and the compliance with their contracts.

Setting Up a Tracking System

Systems for tracking reimbursement will vary according to the size and resources of your practice.

When he first started tracking payments at the Jackson Clinic in the 1980s, Bevis had clinic staff manually compare each EOB with the payers fee schedule.

Its very laborious, but it was always worthwhile because you would find several dollars on almost every remittance, he says.

Tip: In order to begin tracking reimbursement, you must have a fee schedule for every payer. If they wont provide one, you must create one, Bevis advises. For example, if the contract stipulates that the payer will pay 30 percent above the Medicare allowable, then you must take the Medicare allowable for each procedure and service and increase it by 30 percent to arrive at the fee. After all procedures and services are listed, the practice has the fee schedule for that payer.

After some time, the Jackson Clinic was able to set up its billing software to compare the EOBs with each payers fee schedule.

We had our software vendor develop a program that allowed us to load the different fee schedules onto the computer and identify them by a code. The system then identified the code as being linked to a certain payer, Bevis explains.

When the billing staff entered a payment for a particular CPT code into the system, the software compared the payment entered to what the practice was supposed to get paid for that CPT code. At the end of the EOB, the computer told the staff person which transactions the practice had been underpaid (or overpaid), he continues.

Eventually, the clinic was able to set up software that automatically drafted a letter to that payer stating that they had underpaid by that amount and requesting the additional payment due.

The letter had standard text that said, you have underpaid us by $1.55 on this claim, Bevis states. The letter was stored on the computer and the program automatically filled in blanks for the claim number, date and amount underpaid.

However, at the Jackson-Purchase Medical Group, a smaller internal medicine practice, they are not equipped with a computer system that will support such software, Bevis notes. However, he still has two staffers manually audit each EOB.

You can do it manually and it works. But, its not as good or as accurate and it takes more labor, he says.
Bevis estimates that the two clerical staff currently auditing the EOBs spend about 40 percent of their time on that task alone. That probably amounts to about $30,000 a year in salaries and benefits that we are spending to just do that, but

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we are recouping probably twice that much in dollars. So, its paying for itself.

For practices that are unable to dedicate enough staff to review each EOB, Easton recommends his method of sample auditing.

For some of the smaller groups, where it is a solo practitioner or three or four physicians, they dont have the staff or the time to commit to this and they end up just trusting the payer to check it, he says. If they assign somebody on a regular basis to just audit a dozen or half dozen payments, they could at least see where the problems are.

Practices should pick EOBs at random from all of their payers, Bloom recommends. Then, if some remittances are found to be lower than they should be, the practice should go back and re-examine more remittances from just that payer to determine whether it is an ongoing problem or just a one-time error.

Although this method wont catch every lost dollar, it might keep the practice from losing thousands of dollars without knowing it.

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