
Retrospective Review

The good, the bad and the ugly

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Summary

Retrospective review of managed care accounts is a critical component in hospital revenue cycle management. Today, a rigorous retrospective review (or retro) must be considered a mandatory activity, not only maximizing the collection of due net revenues but also to ensure government compliance, managed care contract compliance and perhaps most importantly to set the stage for future effective contract negotiations. Incorporating resources to leverage on technical and process advancement will give rise to retro performance. This article discusses best practices for performing a successful retro, a key tool in a hospital's financial management repertoire.

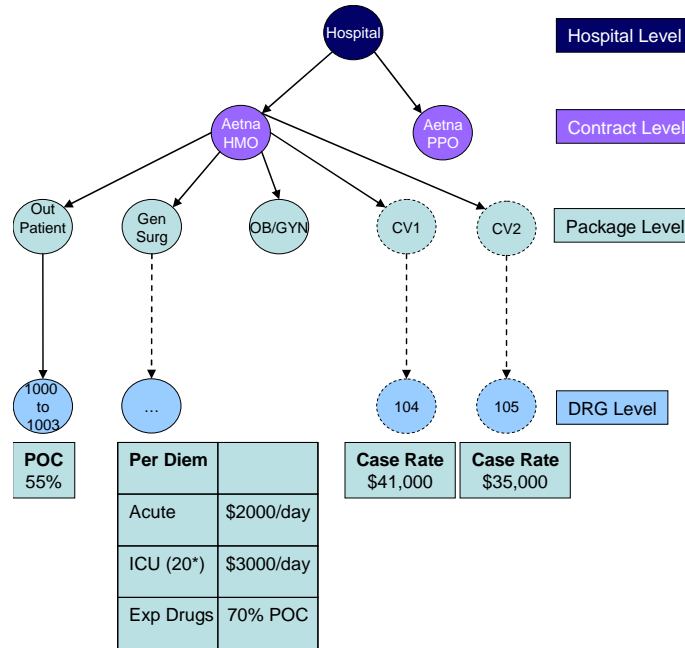
Introduction

The commercial contracting landscape

Commercial contracts (also known as managed care contracts) can cover from 30% to 70% of the hospitals gross and net revenues. Most hospitals contract with multiple payers and for every payer there are contracts for each payer product. For example, the Aetna portfolio of contracts may contain an HMO and a PPO product, oftentimes with

different terms and rates. It is not unusual for a hospital to have from 50 to 150 individual active contracts at any point in time.

Managed care contracts are complex documents and are becoming increasingly so. There is a dizzying combination of case-rates, carve-outs, per-diems, inlier and outlier (stop-loss) provisions used in modern contracts. The complexity continues to ratchet up in response to an increasingly competitive environment with new medical technologies. When one combines the triple factors of a large number of contracts, high contract complexity, and high claim volume, the stage is set for errors. An *audit* becomes a necessary process to find errors and to correct them.



“Auditing commercial payments will be the single most important job for many hospitals in the coming year, according to Martin D’Cruz and Terri Welter in their article "No Small Change" (*hfm*, December 2005). In fact, a recent survey shows that 8 percent to 14 percent of commercial revenue goes uncollected (*underpayments* from a providers’ perspective); the number is higher for hospitals that lack an effective audit function.”

In addition to the issues identified by D’Cruz et al, there is a dangerous untold story, which is that of *overpayments* to providers from payers. This creates a credit balance risk for the provider organization. It is our experience that overpayments are in the 3 to 6 % range. As will be seen the process for identifying and resolving claim denials, underpayments and overpayments is cumbersome and often expensive.

Negative impacts of errors (both underpayments and overpayments)

The impact of underpayments and overpayments on a hospital's financial standing include:

- Cost of attempting to recover lost revenue
- Lost revenue due to the time value of money
- Large financial risk due to recognized and unrecognized credit balances
- Lost future revenue in future contract negotiations

The last point deserves further elaboration. Many payer-provider relationships are long-term partnerships. At some future time, the current contracts will need to be renegotiated. If a hospital does not know if it is being underpaid or overpaid for some of its services, how can it bargain for fair and reasonable rates at the negotiation table?

In addition, anyone within the organization attempting to use potentially flawed revenue numbers for strategic planning and or expansion planning will be suffering from GIGO (garbage-in, garbage-out).

Why do underpayments and overpayments occur?

There are a multitude of reasons why the expensive underpayment/overpayment situation exists. These include:

- Denials (clinical denials based on lack of medical necessity and administrative denials based on late/inaccurate/non submission of relevant documentation)
- Errors in calculation and collection of contracted revenue

In this article, we will review issues associated with the calculation of expected net revenue (strictly speaking contract modeling and revenue calculation). The basic question that should be asked before conducting an audit is the following: *Are we collecting the revenue that we contracted for?* A corollary to this is then: *If not, why?, and how do we collect today and ensure that we continue to collect exactly what is due to us?*

To understand the fundamental issue, it is useful to consider the Medicare contracting model with hospitals. Medicare has well documented rules for submission of data, applicable code sets and its revenue calculation methodology. Furthermore, CMS provides a reference implementation of its patient classification systems (DRGs and APCs) and of its contract modeling system. It is safe to assume that because of the billions of dollars at stake, that CMS uses best software engineering practices and rigorous testing procedures in their contract modeling system. The short story is the

following: though we may not be happy with Medicare's reimbursement rates, we know (or can inexpensively find out) what we should get paid, every time.

When one considers the commercial contracting environment, the situation is vastly different. Every hospital is required to calculate the expected reimbursement for every claim for every contract. Each payer is required to do the same. A conservative estimate¹ is that there are 300,000 commercial contract implementations versus one for Medicare.

Contract modeling and revenue calculation tools (CMRCE)² are available to providers through additional modules of their hospital information systems and 3rd party bolt-ons. However these tools are expensive to acquire and are notoriously difficult to use. Larger hospitals have them; many smaller hospitals do not. Having a tool may be necessary but is certainly not sufficient. Much of the difficulty starts when a contract is put into production. Errors can and do occur because of:

- Incorrect modeling of the contract
- Incorrect or inconsistent code sets
- Misinterpretation of contract terms
- Inability to correctly model the negotiated contract because of deficiencies of the contract modeling system
- Incorrect modeling of the contract by the *payer* (for many of the above reasons)

Trying to solve the true fundamental problem is outside the scope of this article. Instead we take the approach of looking at solutions that a hospital can implement today to first identify, then correct and maintain a satisfactory underpayments/overpayments performance level.

Solutions

Hospitals have implemented retro audits for many years. The approaches that have been used include:

- Conducting the audit in-house using an internal retro audit team
- Retaining the vendor of the hospital contract modeling/management system to perform the audit
- Hiring a retro review consulting firm to perform the audit

¹ Calculation based on an average of 25 contracts per hospital, 6000 hospitals and contract revenue has to be calculated by both payer and provider.

² Contract Modeling and Revue Calculation Engine

Each of these approaches has its advantages and disadvantages. These are summarized in the below table:

	PROS	CONS
Internal audit team	<ul style="list-style-type: none"> Intimately familiar with hospital processes Cost 	<ul style="list-style-type: none"> Potential issues objectivity and transparency Don't have the FTEs to do follow-up Experience
CMRCE audit	<ul style="list-style-type: none"> Familiarity with hospital CMRCE tools Objectivity 	<ul style="list-style-type: none"> Follow-up with payers is not their core business Cost
Pure-play retro consultant audit	<ul style="list-style-type: none"> Familiar with the nuances of doing a retro Strong follow-up capabilities Can provide A/R and Denial management services Objectivity 	<ul style="list-style-type: none"> Cost Consultant selection is critical as quality can vary widely

Table 1: Comparison of audit alternatives

Cost and quality are two important considerations when choosing a retrospective review consultant. Typically, retro review companies operate on contingency and have fees between 21% and 35% of underpayments that are recovered! At the current market error rates, these fees can be in excess of \$6M for a large hospital.

Many complaints such as “*we are not looking for cherry pickers that go after the low-hanging fruit*” are often fed to prospective retro review consultants and deservedly so. Many retro consultants focus on the high dollar and low volume inpatient claims and tend to ignore the (relatively low revenue) but high volume outpatient claims. But if a hospital can find and fix a \$25 error on 100,000 outpatient claims, the financial benefits are non-trivial. Finally, as one can imagine, retro audit firms are not necessarily incentivized to help to fix the true source of the underpayments; they will put themselves out of work if they do!

As an example, the following data allows an estimate of the financial benefit to a hospital from conducting a retrospective review. The benefit is potentially very large.

	Item	Value (\$M)
1	Hospital Gross Revenue (\$M/yr)	1,584.40
2	Hospital Net Revenue (\$M/yr)	706.00
3	Hospital Net MC Revenue (\$M/yr)	437.69
4	Underpaid Accounts (\$M/yr) (assuming 4% of 3)	17.51
5	Recovered (assuming 35% recovery of 4)	6.13
6	Consultant fees (assuming 30% of 5)	1.84

7	Net benefit to hospital	4.29
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Table 2: Hospital statistics – source AHD

In short, a retro audit of a hospital's commercial book of business must be considered a mandatory activity which should be conducted at some frequency. This is not only for maximizing net revenues, but also to ensure government compliance, managed care contract compliance, and to protect the organization from disastrous rebooking of revenue in the case of overpayments.

In the following sections, we discuss best practices in retro audits for hospitals. In particular we focus on *rigorous* retrospective review. We then look at eight things that can go wrong and how they can be avoided or mitigated by following best practices.

Rigorous Retrospective Review

A fundamental objective of retrospective review is the identification and recovery of cash on underpaid managed care contracts. An effective way for hospitals to improve its effective net revenues is by knowing what it is due and collecting same. Rigorous retrospective review is very different than examining a few high-charge claims and possibly hand calculating the expected revenue. This may be feasible for a small hospital or simple contracts. However the short-cut approach is flawed with:

- Significant lost revenue opportunity particularly with high volume outpatient claims
- Expensive to conduct (labor intensive)
- Extended follow-up cycle because of errors in the calculation process

A rigorous retrospective review involves the detailed modeling and revenue calculation of every claim in every contract in a hospital's portfolio. The work-flow involved in doing a rigorous retro is shown in the below figure. The basic components are:

- Contract modeling
- Revenue calculation
- Reporting
- Follow-up

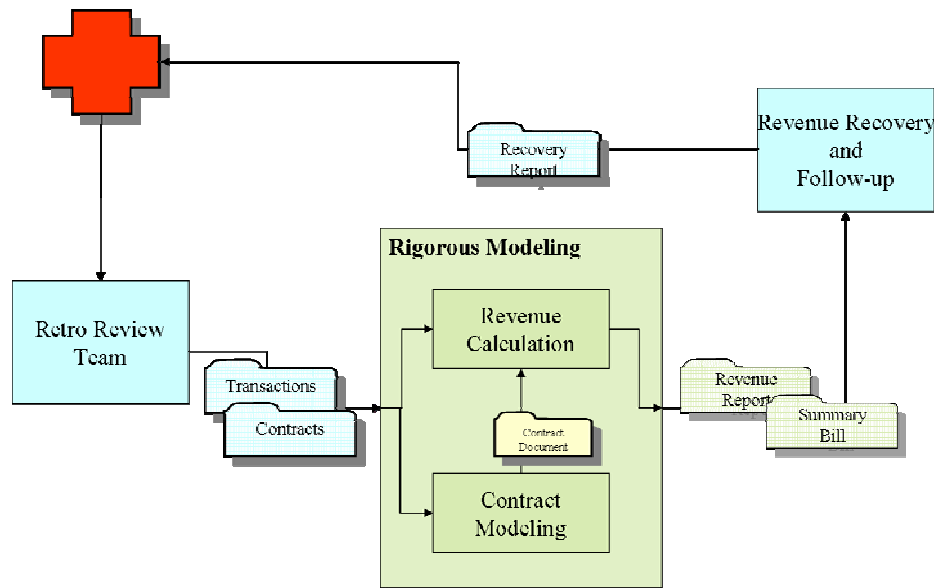


Figure 2: Rigorous retrospective review workflow

These key components are briefly discussed in the next sections.

Contract modeling

Contract modeling is the process of converting a contract document which normally exists in ad-hoc format into an *unambiguous electronic representation* suitable to support revenue calculations.

Each contract document is read by a skilled managed care consultant and the necessary information is extracted and loaded into a contract modeling tool. It should be noted that this abstraction process has to be done for every contract. For example, Aetna HMO and Aetna PPO would be modeled as two (2) different contracts. As another example, Aetna HMO with effective date of 01-Jan-2004 and Aetna HMO with effective date of 01-Jan-2005 would also be modeled as two separate contracts.

Almost invariably, there will be ambiguities that can only be resolved by having discussions with the relevant personnel at the end-user client hospital. An effective front-end contract audit helps to minimize the number of iterations required to resolve ambiguities.

Revenue calculation

Revenue calculation is the process of computing the net revenue for every patient encounter (claim). The process involves:

- Obtaining patient claim data for the hospital
- Extracting, transforming and loading (ETL) the patient claim and finance data into the CRM database

- Verifying the dataload
- Running the patient populations against their contracts in the *revenue calculation engine* to compute expected net revenue
- Populating the database with results to facilitate reporting

The ETL process is contract specific as different transformations may need to be applied depending upon the contract. For example, the ASC-CPT maps for Aetna are typically different than those for Cigna.

Reporting

The output of the revenue calculation process is loaded into a relational database. From this database reporting can be supported in a number of formats. State-of-the-art in reporting leverages powerful OLAP³ technologies to allow multi-directional drill down of the data to facilitate follow-up. The client hospital should have access to the same tool to allow tracking of the progress of the audit. The standard reports should include an underpayment and overpayment report for every contract with the ability to slice and dice the data by payer, inpatient/outpatient, service-line, reimbursement type, time and any combination of these dimensions

Follow-up

Once errors have been identified through the above steps, the recovery team takes over. This team should analyze the errors and commence discussions with the appropriate payers to ensure collection of all due net revenue. The recovery team should include analysts, clinical, medical, legal and recovery specialists and payer liaisons. During the recovery process, errors may be found with the detailed contract modeling process (e.g., contract terms were incorrectly disambiguated). The changes should be made and the process should be repeated.

Things that can go wrong and how to avoid them

There are a number of things that can go wrong during a retrospective-review. A few of the best practices for avoiding or mitigating potential problems are discussed below.

³ OLAP – On line analytic processing. OLAP tools provide easy ways of gaining insight into data. The authors like to think of OLAP tools as pivot tables on steroids. Until recently, they were prohibitively expensive, but that is no longer the case

Get buy-in – set up a retro team

Set up a retro-review team and hold a kick-off meeting with all stakeholders, including the CFO, managed care team, PFS director and IT. Ensure that team members are not threatened by the errors that may be uncovered. The process will fail without buy-in from all stakeholders.

Leverage your strengths - Co-Source rather than Out-Source

A successful retro involves many moving parts. It is unlikely that a single hospital will possess all of the resources to do a retro review internally (ignoring the issues of objectivity). This is particularly important with the follow-up portion of the review to ensure that uncollected monies are indeed collected. This in many cases involves leveraging relationships with payers that only an experienced team can provide. Create a co-source partnership with a retro company where you both combine your resources to maximize on efficiency. While you leverage on external resources that provides standardized processing and leading edge technologies, internal staff can focus on their bench strengths while implementing process improvements to strengthen the back end business function.

Manage expectations – recognize that both underpayments and overpayments will be found

The organization has to put plans in place to deal with overpayments that have been received (aka credit balances). Remember that payers are also performing retro reviews.

Don't cherry pick – do a rigorous retrospective review

It is tempting during a retro to go after the low-hanging fruit. This approach is ill-advised for many reasons. It leaves revenue on the table and it does not allow the discovery of hidden issues with the contracting process.

Collect and maintain business rules – think about the next retro

A well conducted retro review will yield significant revenue increases. However it is perhaps more important that the provider organization understands what processes were broken and to ensure that they are corrected. The next review should *not* find the same issues. During the rigorous retro review a non-trivial amount of effort will be put into creating a clean unambiguous electronic representation of the contracts in the hospitals portfolio. Better retro consultants will provide electronically readable contract documents (in XML). Any changes should be propagated back to the in-house contracting modeling system.

Review early and review often – aim for *concurrent* rather than retro review

For hospitals that have never undergone a retro review, the time to do so is now. Once the primary audit is complete, the process should not stop. Claims should continue to be run through the referee and continuously compared to in-house systems (where these exist). As new contracts are negotiated they should be subjected to the very same processes.

Think forward - Use a retro to kick-start your revenue cycle

There are many opportunities that emanate from a clean managed care shop (on the payer and provider sides of the fence). These opportunities include improved contract negotiation, strategic pricing among others.

About the author

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