Maintaining Adequate Third-Party Compensation

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Practice Points

- Third-party payers do not typically update their compensation schedules on a regular basis; therefore, a regular review of all your third-party contracts is mandatory.
- Discarding outdated plans and regularly renegotiating fee schedules with payers who are retained is essential to the financial solvency of any private practice.

In a previous column I discussed the challenges inherent to incorporating the Patient Protection and Affordable Care Act's health insurance exchanges into private practices.[1] While it is important to pay close attention to newer third-party vehicles, do not ignore established payers or assume their compensation schedules are up-to-date.

Because traditional insurers and managed care organizations typically do not take it upon themselves to update their payment schedules for private practices on a regular basis, you should take a close look at your third-party plans; you may be surprised to find that you have unknowingly remained associated with an outdated plan with an inappropriate fee schedule or with few patients generating negligible remuneration for your practice when you could have replaced it with a young, aggressive, well-paying organization long ago.

As is usually the case, you will never know unless you look. The process is the sort of disagreeable task that smaller practices often postpone or ignore completely, but the effort is well worth it. First, ask your employees to assemble some data. Start with lists of the last 50 patients affiliated with each third-party contract; your electronic records should allow you to assemble these data easily. For each patient, note the diagnoses; the procedure codes billed; the amounts billed and paid for each code; and any problems encountered, especially payment delays and records requests. Also ask for any correspondence you have on file with claims departments and medical directors over the last year.

Next, send out a questionnaire to the provider relations department for each third-party payer. Tell them you are updating your managed care data. Include a list of your 25 most commonly used *Current Procedural Terminology* (*CPT*) codes and ask for their maximum allowable reimbursement on each code. Then ask some basic questions. There are 5 questions we routinely ask in my practice:

1. Does your organization recognize the use of *CPT* modifier 25?
2. If a diagnostic or surgical procedure and an evaluation and management encounter are performed during the same patient visit, does your organization reimburse them as separate (unbundled) services?
3. If multiple diagnostic or surgical procedures are performed on the same day, how does your organization reimburse such procedures?
4. What are your official criteria for coding consultations versus office visits?
5. What is your average and maximum time for processing a clean claim?

Have a staffer follow-up with a telephone call 10 days later on each letter to make sure it was received and will be answered promptly.

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Once these questions have been answered, schedule a meeting with your office manager and your insurance specialist. Put the telephones on service, ask someone else to cover emergencies, and otherwise make sure you will not be disturbed during this time. Armed with the answers received from each payer and the data you have collected, analyze each plan in detail during this meeting. How many of the payer's patients are currently active in your practice? Is that number increasing or decreasing? How well does each one compensate you compared to other payers, Medicare, and your regular fees, and how promptly are you paid? What problems have you had with referral and claim forms? Are you permitted to bill patients for uncovered charges?

More specific issues also should be addressed. For instance, what services, precisely, are not covered? Which procedures are paid particularly well and which are paid poorly (or not at all) despite being ostensibly "covered"? Are there any unusual or unorthodox rules for certain surgical or diagnostic procedures? Do you get an inordinate number of requests for further information from the payer? Are you asked for the same information repeatedly? Are there problems with *CPT* modifiers 25 and 78, or other modifiers?

Then take a hard look at the numbers. What fraction of your accounts receivable is attributed to each plan at any particular moment? Is that number increasing? If so, is it because the number of patients in that plan is increasing, or is it because the plan is losing momentum in paying its bills? The latter is a red flag; either growth is outstripping efficiency or financial problems are looming.

It also is important to look at mechanics of each plan. How easy is it for patients to get a referral to your office? Do primary care practitioners dole out referrals as if they were diamonds? Be sure to review the referral requirements in each of your contracts. On those all-too-common occasions when patients show up for an appointment without a valid referral, how easy does the plan make it to get them one quickly?

Finally, talk to your insurance representatives, the staffers who deal with these plans on a daily basis. Their subjective impressions are just as important as any hard data. They will immediately separate the good plans from the bad, but it also is important to ask them some specific questions. Is your staff constantly cutting through red tape to get patients seen? Are claim forms confusing or hard to file? How hard is it to get a hold of provider relations representatives, and once contacted, are they helpful and courteous? Are provider relations representatives constantly calling your office with unnecessary or inappropriate questions?

After you collect all of this information, you will have your own up-to-the-minute managed care database, which you can consult immediately to determine which plans you will keep and which you should disengage. Repeat this exercise regularly—we now do it yearly in my practice—because the private insurance environment is evolving ever more rapidly due to the advent of the Patient Protection and Affordable Care Act and other factors.

Another important use for your managed care database is to renegotiate your fee schedule. Any payer with fees that are below your average remuneration should receive a letter informing them that the payments are below the level that is recognized as usual and customary in your area. Inform them that your office will be pleased to give them the opportunity to remain associated with your practice if their reimbursements are immediately increased. Although insurers are not always receptive to requests for increased compensation, they are usually willing to open a dialogue; if not, you will need to reconsider your practice's continued association with that plan.

This exercise requires a lot of work, but your time and effort will be well spent. In addition to ensuring that your services are properly compensated, you will be putting your third-party payers on notice that you are paying attention and that your office will not tolerate unfair remuneration or inordinate delays in payment.

REFERENCE

1. Eastern J. Should you accept insurance exchange coverage? *Cutis*. 2014;94:75-77.