

The Art of the Deal:
Make Your Medical Practice a Player
in Contract Negotiations

By Elizabeth W. Woodcock, MBA, FACMPE, CPC



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When you're challenged by managing a relationship with an insurance company, it's unlikely you can lean on the contract for help — unless your practice was involved in writing it. When the affiliation sours, medical practices often find themselves unable to recoup lost revenue or even terminate the contract. Why let an insurance company put a document in front of you for your signature without your input? Stop thinking of your practice's relationships with insurance companies as one-sided affairs. Use the contract negotiating opportunity to establish equitable terms that can benefit your medical practice. These guidelines can help.

Beware of “evergreen” clauses.

The problem starts with the end: There is none. Most contracts contain an evergreen clause, which is a fancy way of saying that the contract goes on and on until something triggers termination. The contract is automatically renewed unless one or both of the parties terminate or modify it. Termination may be so hard to effect that the contract never stops, even if you want out. An evergreen clause isn't reason to throw out the contract, but you want the document to require:

- Advance notice of the insurer's proposed change to your reimbursement, such as 60 days;
- A reasonable termination period — 90 days, for example — thus giving you time to review the new rates; and
- Immediate termination for breach of contract, with an opportunity to correct the breach within a reasonable period of time — say, 30 calendar days — of written notice. Specifically, make nonpayment or underpayment a breach of contract, so you can release your practice from a deadbeat insurer as soon as possible.

Corral credentialing delays.

Every biller knows the piles of denials — and adjustments — that recently recruited physicians take for credentialing issues. These adjustments may drag on for months, if not a full year. Use your contract to define the credentialing and enrollment process. Specify the elements the insurance company requires and the forms to be completed. Importantly, set the timeframe — such as 90 days — in which the insurer must review and accept or deny the

completed application. If the enrollment is delayed, get a guarantee that the insurer will retroactively pay claims between the completion of the enrollment process and the end of the specified enrollment period. It's wise to hammer out payment details during this 90-day interim period. For example, can your physician see the insurer's patients billing as a locum? As incident to an on-site physician? Or, holding all of the claims until the enrollment is confirmed, and submitting them for retroactive adjudication? Particularly if the insurer refuses to process any claims during this interim period, negotiate the ability to submit the enrollment application prior to the physician's enrollment. Your practice is less likely to lose out in the first few months of the new physician's employment.

Understand discounted payment rates.

Payment for services is one of the most complex aspects of our industry. You charge a fee — often referred to as the “gross charge,” but the insurer reimburses you an agreed-upon discounted rate. The key is understanding this discounted rate, commonly called the “allowable” because it's all your practice is allowed to collect. Contract language that states that the insurer sets its rates at 115 percent of Medicare, for example, won't get you anywhere. What year of Medicare is the insurer referring to? Is your practice subject to Medicare's payment-bundling rules?

You must have more information. Either get a detailed explanation of the payment formula or, better yet, run a report of the procedure codes that you use, including modifiers and common code pairings, and ask the insurer its rate for each. You also need detailed information on payment policy, including recognition of procedure codes and guidelines.

Many states require insurers to grant physicians' requests for their rate schedules; most necessitate the demand to be in writing. Require the insurer to notify your practice before any change in the rate schedule. If it fails to do so, the contract should specify that your practice is due the difference between the original schedule of allowables and the lower one substituted without notice, plus interest.

The American Medical Association has settled lawsuits with several key insurance companies. Terms with which the companies must abide include:

New physician group members will be credentialed within 90 days of the receipt of the application. Physicians also can submit an application prior to their employment.

Physician fee schedules shall be made available to all contracted physicians via hard copy, CD-ROM or by electronic means not later than 12 months after the Final Order Date. The requested fee schedule will show the applicable fee schedule amounts for up to 100 CPT codes.

[Insurer] shall not initiate overpayment recovery efforts more than 18 months after the original payment.

Source: American Medical Association
Link to: www.ama-assn.org/go/settlements



Require lump-sum reimbursement to correct underpayments.

Too often, medical practices get paid less than what they're owed. To bring in what the business earns, know what you should be paid (as per the above) and what to do if payment is incorrect. Establish by contract the ability to request lump-sum payments, instead of resubmitting every affected claim.

Define medical necessity.

Although your practice provides only medically necessary services to patients, an insurance company may not always agree. Head off lengthy and disruptive appeals by coming to an agreement on the definition of medical necessity in the next contract. Pen your own, or use a definition accepted by an industry leader such as the American Medical Association.

Health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

Source: AMA Model Managed Care Contract, Section 1.11

Outline the mechanism that the insurer offers to determine whether medically necessary services you provide to a patient are covered under the patient's benefit plan — and whether they can be retroactively denied. Negotiate the terms for retroactive denials, ideally eliminating them altogether.

For patients who knowingly choose to receive services not considered medically necessary, develop an internal waiver form to inform them of their financial responsibility. The Centers for Medicare and Medicaid Services (CMS) requires the use of a specific form for this purpose — the [Advance Beneficiary Notice](#).

Demand disclosure of “rental” networks.

You may want to blame insurers for low fee schedules, but recognize the presence of third-party companies called repricers in the mix. Insurers often outsource important administrative functions to repricers, from claims adjudication to coordination of benefits. Although some limit activities to administrative duties, others actually “rent” networks of preferred providers from insurers. Because the relationships are often hidden from physicians, these rental networks are often referred to as “silent” PPOs (preferred provider organizations). Silent PPOs operate at arm's length from the insurer, often applying the insurer's discounted fee schedule to a medical practice but establishing its own terms to the relationship.

To avoid this problem, require that insurers inform you of any rental networks they contract with. Draw up contracts that forbid insurers from allowing third-party companies to use your practice's discounted rates unless you sign off on it. Explicitly state that a third party renting a provider network must abide by the terms of the original contract. Make clear that your practice has the right to deny discounts to companies — the insurer with which you have the contract or the silent PPO — that don't follow these rules.

Avoid “all products” clauses.

You don't want your practice to be bound to participate in (and honor the fee schedules and administrative terms) of all other insurance products the insurer sells in your market area. Yet, if the insurer has inserted an “all products” clause into your contract, that's exactly what you're required to do. An “all products” clause — which forces you to participate in all of the insurer's products in your market place, even if you're only signing off to join only one — may read:

Provider agrees to participate in the products listed in this agreement's Product Participation Schedule. Insurer reserves the right to reflect other products in the Product Participation Schedule during the term of the agreement, of which Provider also agrees to participate in.

Several states have outlawed these clauses. Even if your state doesn't have an all-products ban, propose a prohibition in your contract.

Include a prompt-payment clause.

Know your state's prompt-payment law: All 50 states now have them. State law supersedes the contract, so you can hold the insurer to the law's terms whether or not they appear in your contract. However, many state prompt-pay laws apply only to specific insurers or types of health plans; others don't have corresponding punishment for failure to obey. Furthermore, self-funded plans are exempt from state law, so it pays to write your own prompt-payment clause in the contract, such as:

Undisputed and properly submitted claims not paid or acknowledged within thirty (30) calendar days after receipt by the Insurer shall bear interest at a rate of 15 percent per annum or, if greater, the maximum interest rate and fees allowed by law. Interest shall automatically be assessed beginning on the 31st calendar day following date of submission, and late claims paid without such interest amounts shall constitute a material breach of this Agreement.

Establish the ability to balance-bill patients.

An insurer puts your payment in limbo when it needs information from the patient. Because this type of claim denial puts the onus on the patient, there's little your practice can do except wait. Insurance companies prohibit participating providers from balance-billing patients. To avoid bad debt from such situations, seek a contract clause describing when your practice can balance-bill patients — after 30 days, for example — if they don't provide the insurer with requested information.

Participate upfront in consumer-directed health care.

Many consumer-directed health care plans don't allow medical practices to collect from their beneficiaries before service is rendered, even when you know a patient has an unmet deductible. Negotiate the ability to collect from the patient at the time of service so that you're not left chasing the money after the health plan gives you permission months later.

Waive timely filing requirements when patients give faulty information.

When patients provide the wrong insurance information, your practice loses money by missing timely filing deadlines. Staff spend precious time chasing reimbursement from the wrong insurers; when they eventually get the right information, the correct insurers may deny your claim because timely filing deadlines have passed. Thus, your practice must write off those claims. To avoid a game that always makes your practice the loser, ask insurers to waive their timely filing deadlines if the patient (their beneficiary) provides inaccurate coverage information. Support your negotiating stance by agreeing to provide the insurer with written proof that you filed the original claim promptly to the health plan the patient claimed to have.

Write your own timely filing exemption clause, such as:

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Provider appeals within 12 months after the date of service and can demonstrate that:

At the time the protocols required notification or at the time of the claim was due, Provider did not know and was unable to reasonably determine that the patient was a beneficiary, AND the Provider took reasonable steps to learn that the patient was a beneficiary, AND the Provider promptly provided notification or filed the claim, after learning that the patient was a beneficiary.

A closely related issue is how the insurer allows you to verify whether the patient is a beneficiary. Request detailed information about the insurer's insurance verification process — and whether they can retroactively alter the confirmed coverage. Deal with insurers that outline an efficient and timely mechanism to verify coverage — and outline the terms, if any, for the insurer's retroactive denial of coverage.

Delineate the appeals process.

Request that the insurer agree — in writing — to a timeframe for the claims appeal process, for example, 12 months, and to list the required forms and attachments. Ideally, negotiate for the entire process to be accomplished electronically. In the event that you're not satisfied with the outcome of the internal appeals process, agree to the terms regarding a grievance procedure, ideally through an independent review. These details allow your practice's business office to establish an efficient denial-management process.

Define a timeframe for “takebacks” — money that the insurer claims you owe it.

Insurers often reach back in time to review historical transactions that they now claim to have paid incorrectly. Upon retroactive review, they may have been a coding or reimbursement issue, or perhaps a patient was not entitled to the benefits. Whatever the reason, the insurer returns to the provider who received payment for the services, and requests the money back. Sending you a letter to ask for the money back gives you time to research the issue, and communicate with the insurer. However, these requests are almost exclusively being handled as “takebacks” today. Takebacks are so named because insurers typically deduct the refund amount from subsequent reimbursements for other claims — they literally take back the funds to offset the mistake they claim to have made. What’s even more frustrating is that there is rarely any information provided with the transaction — it’s a deduction without an explanation. Takebacks create major headaches for your business office — imagine the challenges related to payment posting, let alone being frustrated with the returned payment. Many services could be billable to the patient, particularly those in which the patient never really had benefits, but try collecting from a patient for a service you rendered four years ago. It’s a dead end, and your practice is left paying for the insurer’s mistake. Without a timeframe, you’ll be on the hook for problems the insurer made in payments for patients served years ago.

Since insurers set deadlines for practices to appeal denials and underpayments, it’s only fair that practices set time limits for seeking refunds from them. Indeed, dictate a timeframe in your contracts — start by suggesting six months, and negotiate from there. After receiving complaints from physicians, some states have addressed this issue: if your state has a law limiting the time in which insurance companies can request refunds from providers, use that as a guide.

A contract should be an agreement between two willing parties. If you’re feeling the pinch of lower reimbursement and climbing overhead, it pays to reflect on why you’re in the relationship in the first place. Participating with an insurer is, in essence, gaining access to its patients in exchange for offering a discount for your services. If you’re overwhelmed with patients — measure your ability to manage patient demand by tracking your time to next available appointment (new and established) and new patients as a percent of total appointment, and discuss your ability to manage the needs of existing patients then it’s time to reconsider your relationships altogether. This may mean cutting off a contract with one of your insurers (and still accepting such patients who desire to present out-of-network) — or, at minimum, being more adamant about adding the terms as outlined in this white paper.

Your practice may not get all that it asks for in negotiations, but you can make headway to protect the organization’s interests. Maybe, just maybe, you’ll come out of the talks with a better bottom line. It’s a fact: if you don’t ask, you’re not going to get it.





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