Get favorable terms from managed care contracts depends to a great extent on how well an office negotiates.

Unfortunately, contract negotiation is a job few offices take on – or take on with much success – because they don’t understand what they should negotiate for, says one health care attorney who also provide contract review and negotiation services to medical offices.

They tend to focus on getting higher rates. Yet many times they could fare better by fighting for relief from “the constant headaches” individual contracts carry.

Dennis G. Hursch of Hursh & Hursh in Middletown, PA, points out that it’s usually just a few CPT codes that cause the problems. The payer might be denying certain claims as not medically necessary or forcing the codes or requiring preauthorization when no other payer does.

Solve just one or two of those holdups, and the office has achieved a significant improvement in the contract, he says. Not only will it see otherwise lost revenues, but it will recoup the staff time now being absorbed in tracking those claims.

One significant problem to attack is denials based on medical necessity.

Yet ask for the reason for the denial, and invariably the payer will say it can’t reveal the criteria for determining medical necessity because that comes from a proprietary software.

And the payer is right. “It can’t download the entire medical necessary criteria, because the software licensing agreement prohibits distribution.”

But don’t accept that answer.

Virtually all softwares allow plans to give individual code criteria to a physician who is disputing a claim. “That makes sense,” Hursh says, because payers have to respond to disputes.

So point that out. And then explain that the office has had a series of denials on a particular CPT and needs to know the criteria used to determine medical necessity for that procedure so it can avoid future denials.

It could be the computer is kicking out the claims for nothing more than the lack of some minor documentation element.

But it could also be that medical literature supports some treatment that the payer says is medically unnecessary. If so, attach a copy of the literature to the contract and put in a provision that the service is appropriate under XYZ circumstances.

That latter point may be difficult to negotiate, he admits, because it requires the payer to treat the office’s claims differently from the way it treats claims from other practices.

The arguing point, however, is that the payer's

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Early check on wellness coverage helps satisfaction and collections

When it started seeing too many denials for preventive care services, five-physician Ridgefield Primary Care in Ridgefield, CT, set up its own preventive financial measures—a pre-appointment payment check and patient notification.

Payment for preventive care varies significantly, says practice manager SUE DUFNER. Some payers cover once-a-year physicals, others allow them every two years, some don’t cover them at all.

The office was running into all sorts of nonpayment situations as a result—patients came in unaware that there was no coverage for wellness care or that the appointment was scheduled too soon to fall within the coverage limits. Many times a patient was forced to cancel or reschedule, leaving the office with a 45-minute gap in the schedule.

Also, Dufner says, “‘physicals are expensive,’” and there were enough self-pay bills going to collections “to ring bells” that the office needed to do something about the coverage confusion.

The solution was a simple one.

Each day, the office runs a list of the physicals scheduled two days out and calls the payers for coverage requirements and copay amounts. Then it calls the patients to remind them of their appointments, explain their payment responsibility, and tell them that payment is due at the time of service. If there’s no coverage, the office gives the patient the options of canceling, rescheduling, or paying for the service personally.

That early check not only ensures payment, but if the appointment is canceled, there’s time enough to fill the slot or manipulate the schedule to maintain patient flow.

It’s not unusual for a patient to be taken by surprise, Dufner notes, because people are generally not aware of the exact provisions of their plans. That became obvious on a personal level when she scheduled her own husband for a physical at the office. The check showed that his plan covered wellness visits only every other year for persons in his age group.

Mostly, the benefit comes in terms of patient satisfaction, she says. “Patients appreciate the fact that we catch the problem” so they don’t wind up with unexpected bills.

The office sees financial benefits as well. There is no revenue loss on unpaid physicals. And there’s no billing time loss on self-pay amounts, because those now get paid at the time of service.

If your office has devised a system that makes management easier, MOM would like to write about it. Contact the Editor, Medical Office Manager, P.O. Box 52843, Atlanta, GA 30355. Telephone 404/367-1991 and fax 404/367-1995. We pay $100 for every idea we write about in this column.
medical director has a duty to assure correct treatment for all patients. The director may be forced to lend support to the office’s request.

leveling out the time limits

Another element to negotiate is the time limit for amending claims.

Most payers allow offices only a short time to do that—sometimes as little as 90 days. But on the other side of the coin, they give themselves unlimited time to adjust their paid claims, and offices don’t realize how baleful a provision that is “until they get toasted by it,” Hursh says.

With no time limit to honor, the payer is free to adjust payments made several years ago, and to contest the payback, the office has to produce its billing records. Yet by that time the financial records may be in a warehouse or lost or even destroyed, leaving the office with no alternative but to sit by and watch the payer offset the amount on current claims.

If it’s a major payer, a significant retroactive payment reduction can cut the cash flow enough to ruin a practice.

Work for a reasonable time limit on claim disputes. Work too for a provision that the payer will give advance notice of adjustments so that if they do occur, the office will have time to plan for the potential cash flow interruption.

It’s not unreasonable to ask for equality on both sides of the picture so that whatever limit the office has for amending claims, the payer has the same for amending payments.

The most reasonable time limit is one year after a claim is submitted or paid. But even two years “is not horrible,” because most offices have those records available.

looking for more money

There’s also the obvious element of higher reimbursement to work for.

“Don’t expect miracles,” Hursh says. There won’t be any “fabulous” raise. But if the current payment is grossly lower than that of other payers,” a company is usually willing to talk.

The plan should at least meet what others are paying. And if the office provides specialty services that aren’t available elsewhere, the payer may even be willing to hand out as much as a 3% pay increase without much argument.

To a great extent, the reimbursement negotiation success will depend on the office’s position in the marketplace.

Any payer has to offer “a complete and full panel” of physicians, so if the office is the only cardiology specialty in town, for example, the plan needs it on board and will pay reasonably.

On the other hand, being only one of many in the specialty reduces the bargaining power, though even then, he says, payers will often respond positively to good logical negotiation.

presenting the office’s case

To start the negotiation procedure, the first point of contact is usually the provider relations representative, Hursh says. That person “may or may not be able to answer questions fully.” If not, try to go up the ladder to someone who can.

Lay out exactly what the office wants:

“Our office is really unhappy about this contract and here is why. Is this something you can fix?”

—or—

“We have been getting the same reimbursement for the past three years, but our expenses have increased and our current fee schedule is now higher.
Don’t go in without good ammunition.
If some service is being repeatedly denied as medically unnecessary, point to the standard of care that requires that procedure.
If payments are too low, show a reasonable fee schedule and what other plans are paying.

dropping the atomic bomb

The office’s strongest weapon in the negotiations is the payer’s fear that the doctors will drop the contract, Hursh says.

“That’s what gets the attention.”

Keep at least a hint of termination alive during the negotiations, but don’t exercise that option unless an issue is truly significant and the payer refuses to solve it.

At that point, send the payer a formal termination letter.

Termination is the ultimate weapon, he cautions. Don’t pull it out until the situation is intolerable.

“There’s no sense using an atomic bomb for a border skirmish.”

If it’s just a case of wanting a rate increase, it’s overkill. But if 85% of the office’s claims for a major CPT code are being kicked out, it’s appropriate.

Even so, don’t drop the bomb unless the physicians appreciate the potential repercussions and are willing to see it through.

The maneuver is not a pleasant one. Waiting for the response “will be a nail-biter,” especially if it’s a major contract.

And count on it that the payer won’t make the wait
any easier. If there’s a 60-day termination clause, don’t be surprised if it’s not until day 48 that somebody “with a little more authority than the provider representative” finally calls and says “what can we do?”

The payer may offer to extend the contract for another 30 days and ask to talk, and if that happens, say yes. When a payer goes that far, the office “usually gets some kind of satisfactory result.”

Patients relations will suffer in the interim, Hursh says. If the office is scheduling appointments several weeks out, it will have to tell those patients that it may not be participating in their plan by that time. They aren’t going to be unhappy, “and the doctors will have to take the heat.”

On the positive side, however, the heat is worth taking, because when patients learn their doctors may drop their plan, they will complain to their employers who in turn will complain to the payer. “And it tends to work.”

The office may find it has other leverage points as well, he says, the “classic” being the patient who just happens to be in charge of buying the insurance for a major employer.

Any patient has “a closer relationship with the physician than with the payer,” so when news of impending termination gets out, the complaints will go to the plan, not to the office. What the payer is going to hear is “our company writes you a check for $X every month, and I just found out that Practice A is dropping out of your plan.”

When that happens, even the smallest of offices gets noticed.

**he said it; we didn’t!**

Who should do the office’s negotiating?

It’s not unheard of for the manager to take on the job, Hursh says, but there are definite advantages in hiring a CPA or an attorney to do the work.

To the payer, that says the office means business. The doctors are serious enough about their requests to hire somebody to fight for them.

What’s more, an attorney “can be more of a jerk” than the office can, because an outsider doesn’t have to maintain a relationship with the payer. An attorney can “pound the table with a fist” and shout “This is totally unacceptable! You are killing my client!” while leaving the office room to acquiesce later with “our attorney went too far and spoke out of turn. We want to stay with you.”

More still, an outsider approaches the negotiations objectively. After all, it’s not that person’s money that’s being lost. By contrast, the office takes the negotiation process personally, which colors its thinking.

In addition, he says, an attorney has wider knowl-

edge of the standard managed care contract provisions than the office does and knows when terms need to be changed or softened “and when they’re not such a bad deal after all.”

The attorney may need to show the office that even though the contract is not exactly what it wants, viewed in light of what other payers are offering, it’s quite acceptable.

**Why and how to hold quarterly staff reviews after the annual review**

Once a year just isn’t enough.

Staff reviews need to be quarterly, and for several reasons.

With the frequent meetings, problems don’t have a chance to fester. Goals can be changed, tweaked, or even scrapped if they are unattainable.

Moreover, there’s continued emphasis on improvement, says ANDRA L. WATKINS, CPA, of Posisus, a Charleston, SC, business improvement consulting practice. All those great plans and expectations laid out at the annual review get repeated reinforcement so staff never have time to fall back into “the same old rut.”

**once a year, the big-picture items**

Use the quarterly reviews as a constant follow-up as well as “an enhancement” to the annual review, Watkins says.

At the annual review, evaluate six categories:

- accuracy of work,
- meeting deadlines,
- attitude and working as a team player,
- attendance,
- contributions above and beyond the call of duty, and
- financial contributions (if applicable).

Then set the staffer’s objectives or goals for the coming year. Phrase them in terms of an agreement such as

- I agree to check all demographic data for accuracy before sending patient information to the billing department.
- I agree to get to work on time every day.
- I agree to learn software X.

Both manager and staffer sign the plan, and the staffer gets a copy.

Right then and there, set a date for the first quarterly review, and don’t let anything interfere with that