Navigating Insurance Participation for Private Practices: 
Mitigating Risk and Maximizing Reward

American College of Medical Practice Executives Professional Paper Topic and Outline

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I. Introduction

A medical practice is a business. As such, it relies on more income than outgo to be successful as does any company or organization. Medical practices operate very similarly to any other business. There are income, expenses, budgets, cost of goods sold, capital expenditures, operating plans, strategic plans, marketing plans, as well as many others. There is one exception that separates the operation of a medical practice from all other businesses: medical practices are generally not paid the list price for the goods or services they sell. According to the 2017 MGMA Data Dive Cost and Revenue report, physician-owned practices collect on average about 53.90% cents on the dollar of their Gross Charge. Gross [patient] charges are the full dollar value, at the practice’s established undiscounted rates, of services provided to all patients, before reduction by charitable adjustments, professional courtesy adjustments, contractual adjustments, employee discounts, bad debts, etc. (MGMA). Of course this will vary by practice and by specialty, but can you imagine working hard at your job and then only receiving about half of your paycheck? No other industry experiences this type of remuneration. Medical practice owners, like any other business, want to make a profit. That is why negotiating insurance contracts is critical to achieving the highest amount of contracted rates possible, so that the most revenue can be achieved. While a practice should be profitable to remain in business, which involves recognition of expenses, this paper will focus on the income revenue side of the Income Statement.

A key factor for a private practice to be successful is driven by the contracts it negotiates with insurance companies in order to receive that fraction of a payment off of the billed charge. The level of management expertise will vary greatly from practice to practice and each practice’s governing rules may impose certain restrictions on how the manager or executive treats an insurance contract. The practice may have a policy to enter or not to enter into any participation
agreement with any insurance company or a practice may accept participation with any and all insurance companies. Both of these approaches can negatively affect the income, profitability, and viability of a medical practice. It is surmised the main reasons that a medical practice may choose one of these two avenues is that, quite frankly, the stakeholders just do not understand contracts, the art of negotiating, or how reimbursement is actually calculated – and how those payments determine profitability and compensation. It is complicated, time consuming, and frustrating to deal with insurance companies and unfortunately some managers avoid negotiating just to avoid the hassle.

Doctors did not go to school to become business managers. Some physicians do not do very well at managing and operating the business side of their business. And yet again, that is exactly what a medical practice is – a business. This paper will offer instruction and guidance for those stakeholders: consciously navigating insurance participation and purposefully negotiating those insurance contracts.

The purpose of this paper is to provide the owners and managers of the medical practice business with solid tools to help them mitigate the risk associated with participating and not participating with managed care contracts, to explain and simplify wading through the terminology and jargon of contract verbiage – leading to the reward of improved data and improved revenue.

II. Background

A [Brief] History of healthcare spending in the United States

Physicians were reimbursed 100% of their billed charge until shortly after the turn of the 20th Century (McCally 1). This is referred to as fee-for-service (FFS), and most Americans were responsible for paying for physician and hospital services out of their own pockets (Rook). This origin differs greatly from the United States’ first-world European and Canadian counterparts as those countries finance healthcare nationally for their citizens (Griffin). If the US government
assisted citizens in relation to health care, the funds came from state or local agencies. Health care spending in the United States was .25% of Gross Domestic Product (GDP) at this time. GDP is the total market value of the goods and services produced by a country’s economy during a specified period of time. This figure is important, with other economic factors, to determine the financial health of a nation (Kramer).

The first glimpse of “compulsory” health care was seen in the industrialized sectors in the late 1800s to early 1900s. Unions started to offer “sickness protection” to members who held dangerous jobs in mining, steel, and railroad. This evolved to where some employers began to offer limited types of health care and employed “company doctors” to take care of their workers (Griffin).

A push for organized medicine was initially led by the American Medical Association (AMA) in the early 1900s, the focus being on how physicians would be compensated. Although the AMA had over 60,000 enrolled members, working class Americans were unconvinced and were unsupportive of this effort. Theodore Roosevelt, the 26th President of the United States, felt health care was important to the United States but did not initiate any legislation to provide government-sponsored health care (Griffin). Also, around this time period, states started licensing and approving businesses to sell health insurance to employers as well as to individual citizens (McCally 1). Private insurers were opposed to legislation that the AMA supported, because they feared it would affect their profitability and ability to stay in business if all American citizens were provided government-sponsored health care (Griffin).

In the 1920s after World War I (WWI), physician charges began increasing beyond what Americans could personally afford. A group of teachers created a non-profit program with Baylor University Hospital whereby they could pay for certain medical services in advance. This plan was the precursor to what we now know as BlueCross (“The Blues”) today (Griffin). The first “managed care” plan can be traced to Elk City, Oklahoma. In 1929, Dr. Michael Shadid established a rural health cooperative and sold shares to farmers to raise money to build a hospital...
and create an annual fee schedule that would cover the cost of the hospital and staff to provide care when the farmers and their families needed care (Appendix B).

Health and wellness was continually discussed during The Great Depression in the early 1930s, but the focus remained on unemployment and “old age” benefits (Griffin). The Blues began to spread to other states (Griffin). Kaiser Corporation felt that their employees needed to be taken care of on a regular basis by capable physicians and in the 1930s was the first company to pay a capitated rate. Kaiser paid physicians five cents per employee per month to take care of employees working in their plants on the West coast of the United States (McCally 1). In 1933, US spending on health care had increased to 1% of GDP.

The 32nd President of the United States, Franklin Delano Roosevelt (FDR), realized that healthcare spending was rapidly becoming a problem and legislation was introduced to attempt to address the issue. However the AMA aggressively opposed any proposition to provide government-sponsored care to citizens, resulting in FDR dropping the health care portion of his bill. The Social Security Act of 1935 was passed to give benefits to the unemployed and/or disabled (Griffin; Keene and Naus 2).

After World War II (WWII), as employees became more organized and sought representation, union membership increased dramatically. More employers began to offer insurance as a benefit, and this is where we see the surge in the traditional FFS plans (McCally 1-2). Around 1950 is where we start to see a shift in physicians practicing medicine and choosing medicines freely without the formal constraints of insurance regulations (McCally 2). Health care spending after WWII in the US declined to .38% of GDP. It would not be until 1961 that health care spending rose again to 1% of the GDP.

In 1965 the Medicare Act was passed during the Lyndon Johnson Administration. Johnson was the 36th President of the United States. Health care spending increased to 2% of GDP in the 1970s. The reason for the increase was that Medicare had not yet been formalized and the government did not really know or understand how much it would cost to provide health care
for a whole nation of people. In 1971, Senator Edward (Ted) Kennedy proposed a single-payer health plan that would have expanded insurance to cover almost every American. However in 1973, the 37th President of the United States Richard Nixon, had his own plan and established the Health Maintenance Organization Act of 1973 to attempt to bring order to spending that was out of control. This Act did little to help because by the end of the 1970s, the US was crippled by an economic recession and heavy inflation (Griffin; Financial 7).

In the 1980s, health care spending reached 3% of US GDP. In 1986, Ronald Regan, 40th President of the United States, signed the Consolidated Omnibus Budget Reconciliation Act (COBRA). This allowed separated employees to continue to participate in their previous employer’s group health plan as long as they paid the full premium price of the insurance. The Regan Administration loosened insurance industry regulations and encouraged privatization of insurance plans (Griffin).

In 1997, the 42nd President of the United States, Bill Clinton, signed legislation to expand Medicaid assistance with the Children’s Health Insurance Program (CHIP). This program provides health care to uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid (Griffin). By this time, health care spending had reached 4% of US GDP.

In the early 2000s the focus on health care slowed slightly. The United States was fighting terrorism and was engaged in the second Iraq War. When Barack Obama was elected the 44th President of the United States, he moved healthcare to the forefront. Obama worked with Senator Edward (Ted) Kennedy to create a healthcare law that ironically mirrored legislation that Kennedy himself and Nixon had sponsored in the 1970s. In 2010, a Marketplace was created and all Americans were required to purchase insurance regardless if their employer offered coverage. This legislation was called the Protection and Affordable Care Act (PPACA), or commonly known as the Affordable Care Act (ACA) or “Obamacare.” (Griffin) Healthcare spending rose to 5% of GDP by the end of this decade.
The Budget Control Act of 2011 was passed and claims with a Date of Service on or after April 1, 2013 are now subject to a 2% reduction. This is a mandatory across-the-board reduction in federal spending and is in effect until further notice (Palmetto). Medicare usually pays 80% of the published allowable amount on approved claims, however, the sequestration mandate reduces the payment a further 2%. Only the Medicare portion is affected and the 2% reduction does not apply to the patient’s responsibility (Medicare & You; Sequestration).

In 2017, Donald Trump was elected 45th President of the United States. Legislation was passed to eliminate the individual insurance mandate to reduce the penalty for not having insurance to $0 (Simmons-Duffin).

The United States’ attention on health care has waxed and waned since the beginning of the 20th Century. It may seem history is repeating itself as we are still trying to figure out how to cost effectively provide health care for a whole nation of people. The United States government anticipates health care spending will reach 8% of GDP in the year 2020, which equates to approximately $4 trillion dollars. By the year 2027, forecasts estimate spending will reach $6 trillion dollars.

(Historical; CMS Forecast summary)
**Why do physicians need expertise in negotiating contracts?**

Expertise is needed to negotiate managed care contracts because there is a focus for the government and insurance companies to control health care costs. There are threats, as well as opportunities, involved for the medical practice.

Typically, an insurance contract may restrict in some way the physician’s freedom to care for their patient in the manner in which they see fit. Most insurance contracts reference a Utilization Management (UM) or Utilization Review (UR) protocol that may differ from the treatment preferred by the physician. UM/UR is a set of techniques to evaluate the necessity, appropriateness, and efficiency of care and seeks to eliminate the duplication of medical services and inappropriate utilization (MGMA 349). The separate UM/UR document in the contract package should be obtained and reviewed to determine additional requirements for which the physician may be held accountable. The physician’s malpractice carrier may need to be consulted to assess if additional or a different type of coverage is needed and the contract should be appraised to see if there is a risk for an increase in malpractice claims. Verbiage terms should be evaluated, as well as the type of reimbursement, of which the latter will be discussed later in this paper.

There are many opportunities that may be made available when participating with a managed care plan. A few are:

- Participating with a new insurance plan allows the physician or group to be exposed to a larger patient pool;
- An increased patient load may mean an increase in revenue;
- The insurance plan’s Provider Directory allows the patient to now be aware that a physician is “in” their network; and
• Becoming a new provider with a new insurance plan can mean new and an increased number of referrals from the Referring Providers (Keene and Naus 15-8).

The physician may need to engage with an outside consultant to navigate through all of the threats, opportunities, questions, and strategies that will arise to determine if participation is the best decision for the practice (Keene and Naus 18).

Introduction of the RBRVS (Resource Based Relative Value System) and Relative Value Unit (RVU)

Just as the individual American paid 100% of the physician’s billed charge through the early part of the 20th Century, when Medicare was developed in 1965, Medicare likewise paid 100% of the physician’s billed charge (McCally 1). Commercial insurance companies also reimbursed in the same manner at that time.

The RBRVS was included in the Omnibus Budget Reconciliation Act of 1989, which established and phased in the Medicare Fee Schedule (MFS) in 1992. Physicians were and are still allowed to set their billed charge amount at whatever rate they wish above the Medicare Allowable, however the MFS schedule determines the amount physicians will be reimbursed for each Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS). A CPT or HCPCS code is a five digit alpha/numeric code assigned to describe a service or procedure that a physician or facility performs or provides (Financial 10-1).

There are three components to the RBRVS:

• Relative Value Unit – these are non-monetary relative value of units that adjusts relative payments among services. Further, RVUs are comprised of three types of expenses:
  ➢ Physician Work (Work) – The physician’s physical and mental effort and judgement, time, technical skill, stress, and total work;
➢ Practice Expenses (PE) – The expenses related to operating a physician practice such as rent, staffing, supplies, and other items that may vary by practice type, mix of services, and location;

➢ Malpractice Expense (MP) – The cost of risk that varies by specialty

• Geographic Practice Cost Index (GPCI) – adjusts payments based a region or area where practice costs and malpractice may differ; and

• Conversion Factor (CF) – transforms the non-monetary RVU units into dollars.

The RBRVS was based on a comprehensive study of the relative cost of the resources used to provide each medical service as a value compared to other services.

While the MFS focuses on reimbursement to providers, RVUs can also be used as an important management tool for the practice: to determine physician productivity, how much the physician’s activities contribute to the profit of the practice, estimate the cost of practice services, determine physician compensation and/or bonuses, determine cost per CPT, etc. Generally the Work RVU is used for internal practice analysis and reporting.

Formula to calculate the Allowed Amount =

\[ \text{Allowed Amount} = ((\text{Work RVU} \times \text{Work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})) \times \text{CF} \] (ACMPE 53-4; Calculate; Keene and Naus 30-1, 63; Medical Physician; RBRVS).

However Medicare provides a Look Up Tool on its website where they have pre-calculated and display the Allowed Amount: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx.

The image below is the view of the Medicare Look Up Tool. The user will select their choices in the drop down boxes. Users can select and sort the list in many different ways, and
select information by Specific Medicare Administrative Contractor (MAC) and Locality. A MAC is an organization the government contracts with to process Medicare claims and payments.

For example, for 2019 the Medicare allowable for CPT 99204 Outpatient Office Visit for a New Patient in Tennessee is $156.17. The Work component of the RVU is 2.43, the Practice Expense component is 1.99, and the Malpractice Expense component of the RVU is .21, making the total RVU 4.63.

When payment is approved, Medicare will pay 80% of the allowed amount and the patient’s secondary, tertiary, and/or patient pay the remaining 20% (The Official U.S.). The amount between the Medicare Allowed Amount and the Physician’s Billed charge amount is written off in a transaction called a Contractual Adjustment. Contractual Adjustment may also be described as Contractual Allowable or Limit of Allowance. The Medicare patient and/or their secondary or tertiary insurance cannot be billed for the Contractual Adjustment amount (ACMPE 74; Financial 11-2).

The CF portion of the RBRVS is important to identify when evaluating reimbursement calculations because as you might assume, the higher the CF, generally the higher the physician’s reimbursement may be. It is also important to note that some insurance companies may utilize their own RVU schedule and not use Medicare’s. The CF amount and RVU schedule should be obtained, as well as what percentage of the Allowable the insurance company will pay. While the insurance company likely will not change RVU values, the CF may be negotiable (Financial 10).
Identifying the Stakeholders

Typically a Practice Administrator will oversee the day-to-day operations of the practice, serve as the liaison between the administrative staff and clinicians, and provide financial analysis and reporting to the group's Board. However it is the physicians and stakeholders of the group who bear the ultimate responsibility for the practice’s activities, outcomes, and financial decisions (Financial 195).

Some stakeholders may be identified as:

- Physicians in the medical practice;
- Physicians or other providers outside of the medical practice;
- Employees in the medical practice;
- Patients of the medical practice, their family, their caregivers;
- Payers;
- Various agencies at the local, state, and federal level;
- The community in which the medical group practices; and
- Hospitals, health care entities, or other facilities (Organizational 18-9).

When the key stakeholders are identified, it allows for more effective communication and interaction among the parties who are negotiating the contract. Better communication and information are more likely to help the project succeed by possibly achieving higher reimbursement or desired term verbiage (World).

III. Physician Interview

What does it mean to one particular physician to “negotiate a contract”?

Summer Weary, DPM, a podiatrist in Cookeville, Tennessee, began her solo practice in August 2018. Prior to starting her own group, she was a non-owner associate in small single-specialty podiatry practice. In a personal interview in November 2019, she relayed that when she was an associate in her former practice, she was not involved with credentialing and insurance
contracting. She did not know if someone in the practice was actively negotiating contracts, and if they were, they did not discuss that with her.

Not having any exposure to insurance contracts before Weary started her own group; she did not know negotiating reimbursement rates was an option with some insurance companies. She only knew that somehow she needed to become a member on insurance panels. Her first thought was not about reimbursement, but rather how to grow her patient base. Weary hired an external billing and practice management consulting firm to process her billing and assist her with navigating through the managed care contracting process. Weary said, “I am very thankful I hired a management company because I didn’t know how to join those panels. During medical school, there was virtually no training or education in the management of a business, or how a podiatrist’s charges are paid. I didn’t know what it meant to ‘negotiate a contract’. The consultant really helped me understand how reimbursement works.” As each contract enrollment was processed, she was surprised, and disappointed, to learn that podiatrists in general, compared to other specialty’s publically published fee schedules, are paid less per CPT for the same work (Operations 244).

One year later, Weary’s business is thriving and she is more confident with assessing reimbursement. She stated she would not change anything about her initiation into the managed care world. Weary commented, “Learning about managed care verbiage and how to analyze the financial part of reimbursement has helped me make better decisions to grow my business and patient base.”

Weary’s advice to other physicians and practice administrators is to not be afraid to ask for help. “Hiring an outside consultant has been very beneficial for me to understand the unique nuances about podiatry reimbursement” (Weary).
Risk and Effect of blind participation and automatic acceptance:

Dr. Weary is an example of a physician devoting time to understanding the terms and reimbursement for which she is agreeing. There are a fair amount of practices that choose not to negotiate managed care contracts, and just blindly accept an initial offering or an insurance company’s “standard” contract. A survey of MGMA members was conducted in the summer of 2019. Ninety two members responded. 13.04% of the respondents answered that, “they just accept whatever the insurance company offers” (Weary). This can be problematic because this decision comes with risk to the group if:

- Actual payment does not generate enough revenue to cover costs: It is not uncommon for an insurance company to offer a contract, mention reimbursement in a certain Schedule, and then not actually provide the detailed fee schedule. Then when the first claims are submitted and the payments are remitted, some practices find that they are really unhappy with that payment amount. There may be three choices: Continue to live with the poor reimbursement until the contract ends, attempt to terminate the contract, or perhaps attempt to renegotiate the contract. Living with reimbursement that does not cover expenses for any period of time is not an ideal situation that the group should or may be able to sustain for a long period of time. The group could attempt to terminate the contract, however typically contracts do not end immediately without cause. There may be many months or years left to continue seeing patients until the effective termination date. And, once reimbursement rates are locked in, it is generally very difficult to compel the insurance company to change those rates, especially in an upward manner.

- Risk Sharing: Not knowing your reimbursement before signing a contract could mean trading a discounted payment for potential patient volume. Developing multiple flexible budgets and reviewing historical data about a particular insurance company will help determine variance in expenses related to claim submission and timely payment.
• Bonuses and Withhold Pool: Accepting a contract without thoroughly understanding the Utilization Management portion could mean that the group might forgo certain bonuses above the base reimbursement if those measures are not met. Additionally some contracts establish a “withhold pool,” whereby reimbursement is docked and those funds are diverted into a risk-sharing pool. Should a deficit arise in the pool, the group may be required to contribute some portion to make the pool “whole.”

• Capitation Demand: In a capitation agreement, the provider is paid a certain rate per member per month for a defined population of the insurance plan for a certain period of time. Capitation contracts shift the risk from the insurance plan to the medical group. This is problematic for the group if the population for which the group will be required to serve is not identified prior to signing the contract. The group may not be able to meet patient visit demand which might necessitate hiring more staff to care for this population, which results in higher cost to the group and reduced profit (Financial 332-8).

Identifying and Selecting insurances with which to Participate

Organizational Governance

It is important to identify who in the medical practice will assess the managed care contracts. In some practices a doctor owner may be the only decision maker. In another practice, the Practice Administrator may make decisions alone or in coordination with one or more physician owner(s). Other larger practices may use a team or committee approach. There is no one “right” way to approach contracts; each practice should use a method that best fits their business needs. However, using a team or a committee approach may help the practice to better understand the contract terms and the effect the reimbursement will have on the practice, which will lead to more desirable outcomes.

Using an “executive committee” approach could be very beneficial to receiving the best terms and maximum reimbursement because a variety of disciplines can give input on how
participating in a contract might potentially affect their department and/or the practice positively and negatively. Key personnel should be identified and included in contract evaluations. Below are typical areas of the practice that can give valuable input when evaluating a managed care contract:

- Legal – Some contracts are very lengthy and contain unfamiliar and confusing legal jargon. The contract may also contain risk regarding malpractice concerns and/or is additional insurance coverage required to meet contract requirements. The group’s attorney can guide the committee on the meaning of the verbiage and how those terms may affect the group and if additional coverage may required (malpractice insurance, general insurance, etc.) (Keene and Naus 51).

- Clinical Staff – Some initial questions to ask before participating with a contract are: Do the skills and certification of our current staff meet the minimum requirements of the contract? Do we have enough staff to cover the patient population of the new contract? Does our staff need any additional medical training to serve these patients? Does anyone on our staff have any past experience in dealing with this insurance company’s patients? How will requests for medical records impact the daily operational flow of the practice? How will pre-authorizations be processed? It is imperative to glean this knowledge from the clinical staff representatives because this group is responsible for the direct patient care (Keene and Naus 59-60).

- Billing – It would be very advantageous to seek input from this department because these are the employees who transmit claims and post payments and denials. This department can give input on whether the claims can be filed electronically, which speeds payment, or if certain pre-authorization requirements may slow the filing of the initial claim, delay payment, or prevent payment altogether. The [certified] coding staff may fall within this group. Are there certain CPT codes that cannot be billed or may be bundled with other services? It is
important that your financial analysis of the reimbursement be adjusted by any CPT codes that will be bundled, because this has an impact on your payment expectations.

- Information Technology (IT) – This department can assess if any changes need to be made to the practice’s Electronic Health Record (EHR) software to accommodate this insurance company’s patient population. If the patient volume will increase dramatically, do additional user workstations need to be added to process the higher patient load? Do more phone lines need to be added in anticipation of higher telephone volume? Would this additional patient volume require an upgrade to the computer server(s), software, or hardware? (Human Resource 335; Keene and Naus 49).

- Facility – Can the current facility accommodate the new patient volume? Do more exam or procedure rooms need to be added? Do any changes need to be made to the existing traffic flow, outside and inside the building? Does new or any additional equipment or supplies need to be purchased? (Keene and Naus 49).

- Accounting – If a capitation contract is being considered, does the practice have a method to verify the correct monthly payment was received from the insurance company? Are there any additional reporting needs to assess if reimbursement is being paid accurately? Are any new performance indicators needed to assess profitability? How would the purchase of new equipment affect the depreciation calculation? The Accounting and Billing representatives work together to determine if payments can be received via Electronic Funds Transfer (EFT) (Human Resource 345-6).

- Practitioners outside the group – Assess if your competition participates, or does not participate, with a certain insurance network. This can have an effect on your patient volume and payer mix.

- Patients – Assessing potential patient demand and volume is a critical component of the process.
- Practice Administrator – The Practice Administrator can give input on local demand and how participating with a contract might affect the overall operational and financial output of the practice. The Practice Administrator could act as the Committee Chairperson to organize meetings, coordinate data, and be the main liaison between the group and the insurance company.

- Owners – It is important for one or more of the practice owners to be involved in participation decisions, because ultimately they are the stakeholders who are responsible for adhering to the contract terms, clinical care, and the financial viability of the practice.

  When deciding on whether to participate with a managed care contract or not, the group should reference its Mission Statement and By Laws to ensure that the compliance with and the integrity of those items are protected. The group should review its short term and long term organizational goals. Does the decision to participate in a certain managed care contract fall within or meet those goals? Deciding to participate with a managed care contract can come with some big changes. Did the group employ SMART (Specific, Measurable, Achievable, Realistic, and Timely) goals? The more specific the goals, the greater the chance of success (Operations 31).

  Assembling a team of all of the above advisors may be problematic for a solo practitioner. He or she probably will not have all of these individuals already on staff in their practice. Solo practitioners and small groups can still have access to this expertise. There are many types of companies who offer affordable consulting services to advise the stakeholder owner in this area. Additionally, an outside consultant may be able to provide a different or unique point of view the group had not previously considered. Whether the group has all of these team members on staff or an outside consultant is engaged, forming a team to collaborate and compile data helps the stakeholders make more informed decisions about participation (Organizational 31).
**Hospital-based Private Practice vs Office-based Private Practice**

It is important to note here that a hospital-based practice may require a different strategy for participation than an office-based practice.

An example of a hospital-based practice may be a group of radiologist specialists not employed by the hospital, but who perform their work inside the hospital typically in an inpatient, outpatient, and emergency room setting. Generally the hospital-based group’s strategy would be to obtain a list of insurance companies that the hospital participates with, and then the radiology group would pursue participation with those insurance plans. The reason this is done is because the hospital is the entity that is supplying or driving the patients to this practice. The hospital-based doctor does not traditionally actively engage in marketing to drive patients to the hospital service location. That is the hospital’s mission. The result of the hospital’s marketing efforts to drive patients to their facility is a natural flow of patients to the hospital’s radiology department. If the radiology group does not participate in most or all of the same plans that the hospital does, then the radiology group could be faced with non-participating denials when their claims are processed. In this case, the insurance company would either pay the radiology group’s lower out-of-network rate, or nothing at all. The consequence is that the radiologist may be paid very little or not at all for the services he or she rendered when they do not also participate with the same plans that the hospital does.

If the hospital-based groups do not participate with most of the major insurance plans that the hospital does, this can also become a problem for the hospital. Patients do not like to be surprised when they did their homework to find an in-network facility for the service they needed, then receive a statement from the radiology group to find out that the radiology group does not participate with their insurance plan. The result is unhappy patients who might not return to that hospital for future care needs.

Generally a hospital-based only group will not seek to participate with insurance plans that their hospital does not also participate with. Typically insurance companies will not steer
patients to a facility or location with which they are not contracted. This is extra work for the hospital-based radiology group that has no benefit for them.

Office-based providers are not as constrained in developing network contracts as hospital-based providers. Examples of office-based practice types are internal medicine, podiatry, surgery, and obstetrics and gynecology (OB/GYN). The office-based doctor may have staff privileges at a local hospital, and may choose to also participate in the same plans that the hospital does. But the office-based doctor has more flexibility and freedom to participate with additional contracts outside of the hospital arena. The office-based practice can be more selective, or more strategic, when making decisions to participate or not participate with an insurance plan.

Local Employers

Catherine Marcum, DNP, ANP, AGACNP-BC, AGN-BC started the first clinical practice for genetics at one of the largest hospital systems in Chattanooga, Tennessee in 2015. In October 2019 she left that hospital as a staff employee and started her own private practice nearby. Like Dr. Weary, Dr. Marcum knew that she needed to join insurance panels but was not as familiar with that task being a private practitioner – the hospital had always taken care of that for her before (Marcum).

A medical practice is a unique kind of business. Naturally a practitioner will mostly be focused on their patient’s medical care and health management - that is the reason they are in business. However, a medical practice is still a business - there is income and outgo, and in a private practice, certain attention needs to be focused on how to attract patients to your business (Financial 51-8).

Dr. Marcum had an idea that she wanted to participate with the plans she was enrolled with while on staff at the hospital, however she did not want to limit herself to just those insurance companies (Marcum). One useful way to identify patients is to make a list of the Top Employers in your community (Keene and Naus 43-4). Listing ten to twenty [large] employers
can give the practice a place to start in identifying which insurance companies to target for participation. Conversely, that same employer list can also provide an idea of the potential patient pool that could be lost to non-participation. Information about employers can be found online at the Bureau of Labor Statistics and local Chambers of Commerce.

While the hospital also participates with BlueCross, Cigna and United Healthcare, it corroborated Dr. Marcum’s desire to target a large pool of patients in which to grow her practice. The added benefit was that these patients already know her, they trust her, and the likelihood they will want to continue to see her in her new practice setting is very high.

Below is a table displaying research gathered for Dr. Marcum. The Top 10 Employers in Chattanooga, TN were identified and each employer was called to inquire what insurance they offer their employees. The Top 10 employers offer three of the most common major insurances: BlueCross, Cigna, and United Healthcare. This information, coupled with the insurances that the hospital participates with, solidified her decision to pursue participation with the major insurance in her first targeted wave (Aetna, BlueCross, Cigna, and United Healthcare). This would comprise managed care plans that would yield the most amounts of patients in a concentrated effort.
The findings can be very informative and can help guide practice collection efforts. Dr. Marcum is pursuing participation with Cigna, however, she is also aware now that if she treats a school system employee who possesses this insurance, her expectation is that all or a portion of her charges may be applied to the patient’s deductible (Marcum). This means that she will be collecting from the patient instead of the insurance company.

Identifying the Top Employers can assist the new practice with growing the business, but it is also a valuable tool to employ for the established practice as well. Most practices capture Employer as part of the Patient Demographic data. Practice Managers may desire to periodically generate a billing report to list the quantity of patients who are employed by a certain employer. An established practice can incorporate Employer information in their marketing strategy to pursue an untapped patient pool, thereby giving potential to add revenue to the practice (Negotiating 43-40).

**And the Survey says: What Managers say about negotiating contracts**

*(MGMA Survey/Results conducted on Survey Monkey, Summer 2019)*

<table>
<thead>
<tr>
<th>Largest Employers in Chattanooga, TN as of May 2019</th>
<th># Employees</th>
<th>Insurance Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erlanger Health System</td>
<td>10,150</td>
<td>Cigna</td>
</tr>
<tr>
<td>BlueCross and BlueShield of TN</td>
<td>5,254</td>
<td>BCBS TN</td>
</tr>
<tr>
<td>Hamilton County Schools</td>
<td>6,132</td>
<td>BCBS TN and Cigna*</td>
</tr>
<tr>
<td>Tennessee Valley Authority</td>
<td>3,501</td>
<td>BCBS TN</td>
</tr>
<tr>
<td>McKee Foods Corporation</td>
<td>3,100</td>
<td>United</td>
</tr>
<tr>
<td>Unum</td>
<td>2,800</td>
<td></td>
</tr>
<tr>
<td>Volkswagen of America</td>
<td>2,498</td>
<td>Cigna</td>
</tr>
<tr>
<td>CHI Memorial Hospital</td>
<td>3,271</td>
<td>BCBS TN</td>
</tr>
<tr>
<td>City of Chattanooga</td>
<td>2,791</td>
<td>BCBS TN</td>
</tr>
<tr>
<td>Roper Corporation</td>
<td>1,900</td>
<td>Anthem BCBS</td>
</tr>
</tbody>
</table>

Total number of employees for the above Employers: 41,397

Percent these Employer insurances comprise: 14.9%

*This Cigna is a High Deductible plan*

(Chattanooga).
Question 1

Does your practice actively negotiate managed care contracts?

Answered: 92

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>68.48%</td>
</tr>
<tr>
<td>No</td>
<td>31.52%</td>
</tr>
</tbody>
</table>

Total Respondents: 92

Question 2

If you answered Yes to Question 1: Who in your practice is responsible for analyzing and negotiating managed care contract terms and reimbursement rates?

Answered: 92

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only the Business...</td>
<td>23.61%</td>
</tr>
<tr>
<td>Only the doctor/owner</td>
<td>2.17%</td>
</tr>
<tr>
<td>Business Manager and...</td>
<td>25.09%</td>
</tr>
<tr>
<td>Only the Contracting...</td>
<td>13.04%</td>
</tr>
<tr>
<td>Outside consultant</td>
<td>6.52%</td>
</tr>
<tr>
<td>N/A I answered NO to Question 1</td>
<td>30.43%</td>
</tr>
</tbody>
</table>

Total Respondents: 92
Question 3

If you answered Yes to Question 1: Who in your practice is the ultimate decision maker to participate or not participate with a managed care contract?

Answered: 92

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Manager</td>
<td>16.30%</td>
</tr>
<tr>
<td>Doctor/owner</td>
<td>11.95%</td>
</tr>
<tr>
<td>Practice's Board of Directors</td>
<td>10.67%</td>
</tr>
<tr>
<td>Practice’s Board of Directors and Business Manager</td>
<td>22.83%</td>
</tr>
<tr>
<td>Practice’s Contracting Team</td>
<td>7.61%</td>
</tr>
<tr>
<td>N/A I answered NO to Question 1</td>
<td>31.52%</td>
</tr>
</tbody>
</table>

Total Respondents: 92

Question 4

If you answered Yes to Question 1: If you are able to negotiate higher reimbursement rates, about what percentage more on average are you able to gain above the insurance company’s standard initial rate offering?

Answered: 92

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1% - 2%</td>
<td>11.06%</td>
</tr>
<tr>
<td>3% - 5%</td>
<td>29.35%</td>
</tr>
<tr>
<td>6% - 10%</td>
<td>18.48%</td>
</tr>
<tr>
<td>11% - 20%</td>
<td>4.25%</td>
</tr>
<tr>
<td>more than 21%</td>
<td>4.25%</td>
</tr>
<tr>
<td>N/A I answered NO to Question 1</td>
<td>31.52%</td>
</tr>
</tbody>
</table>

Total Respondents: 92
Question 5

If you answered No to Question 1: Why don't you negotiate contract terms and reimbursement rates?

Answered: 92

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t really understand...</td>
<td>2.17%</td>
</tr>
<tr>
<td>It is our group’s policy that we don’t participate with insurances</td>
<td>1.09%</td>
</tr>
<tr>
<td>We get paid more if we...</td>
<td>0.00%</td>
</tr>
<tr>
<td>I don’t really have the time or staff to do this</td>
<td>9.72%</td>
</tr>
<tr>
<td>We just accept what is initially offered</td>
<td>13.04%</td>
</tr>
<tr>
<td>N/A I answered YES to Question 1</td>
<td>73.91%</td>
</tr>
</tbody>
</table>

Total Respondents: 92

Open vs Closed Networks

An Individual contract is one that is assigned in the individual provider’s name and is associated with his or her Social Security Number or his or her corporation’s Tax Identification Number (TIN), if the individual has established a sole proprietor corporation.

A Group contract is one that is assigned in the group’s name and is associated with the group’s corporation’s TIN. Individual practitioners are linked under the group contract. The individual may or may not be required to establish a separate individual contract with that insurance company (Human Resource 343).
Networks that are open allow providers to enroll in their plan, closed networks do not. Closed networks can be problematic and the insurance plan may offer no indication as to when a network will open. This is something for the Practice Administrator of the group to be mindful of when onboarding new practitioners. The insurance company may not allow the new provider to participate as in-network with the group, even though they were participating as in-network under their old group.

If a group is told that a network is closed and that their newly hired practitioner may not participate, the Practice Administrator can appeal the insurance company’s decision using one or more of the justifications below:

- The net quantity of enrolled providers with the insurance company is not changing – the individual provider is just changing groups, an additional practitioner is not being “added”;
- The Group is an underserved area and the provider and/or his or her specialty would benefit the insurance company’s patient population;
- The provider has a certain skill set or unique credential(s) that would benefit the insurance company’s patient population (Keene and Naus 77);
- Perhaps the provider speaks other languages(s) which allows patients to have access to care in their own native language;
- Existing participating providers already refer patients to this provider or practice; or
- By hiring this new provider this will enable the group to expand office hours and/or offer a certain set of unique services not offered by other practices.

The insurance company may stand firm on their decision to not allow the provider to join or rejoin the network. This is unfortunate and the provider would need to wait until the network reopens to apply for participation again. If the provider sees this insurance company’s patients while he or she is non-participating, the provider may be paid the lower out-of-network rate or not at all. This is important for the Practice Administrator to know and in some extreme cases, the doctor’s hire date with the new
practice may need to be delayed until such a time that he or she can join the network as a participating provider.

Revalidation or Recredentialing is a process an insurance company uses to “recertify” an existing participating provider’s in-network status. The practice’s credentialing coordinator or Practice Manager should keep these renewal dates on hand to ensure that revalidation/recredentialing is performed by the deadline date. If a recredentialing deadline is missed, it is very possible the insurance company will terminate the provider as in-network. And if the network is closed, the provider will not be able to re-enroll until such a time as the network re-opens. Again, non-participation affects reimbursement (Keene and Naus 77; Medical Credentialing).

Who in the medical practice is responsible for negotiating contracts?

The practice should assign an individual to be the leader in the managed care negotiation process. Typically this is the Practice Manager, Office Manager, or in larger groups the Contracting Team Manager. Assigning a leader is important for three reasons: 1) Having a point person makes it easier for the insurance company’s Provider Representative to communicate with the group 2) the group’s assigned manager can summarize the information quickly for the owner(s) or Board of Directors (Board) and 3) generally better outcomes are achieved when the group’s point person can develop a relationship with the insurance company’s Provider Representative. A better relationship may not translate into higher reimbursement; however, it may yield faster processing time and decision making by the insurance company when the manager has a specific Provider Representative to contact and with which to become very familiar. Smaller groups may choose to outsource this task to an outside consultant. This may be beneficial because an outside consultant may be familiar with, or more familiar, with a particular insurance company’s contract. The consultant may have a broader knowledge of the area and how that insurance company conducts business in that area. Engaging a consultant may assist the group with identifying opportunities to expand the patient base, realize cost reductions, and/or achieve higher
productivity. “It also will maximize cash flow income through participation in sound medical and related business ventures” (Keene 18).

In addition to internal managers and external consultants, the practice also has the option to seek legal counsel to review contracts. This type of attorney should be specifically trained in health care contract law. The practice executive should be aware that engaging with outside consultants and attorneys can be an expensive endeavor and will increase expenses. The cost of the expertise however should be weighed against any risk the group might incur by signing an onerous contract (Risk 26).

Regardless of “whom” in the practice is responsible for negotiating the managed care contracts, ultimately the physician owner(s) and/or Board of the practice are responsible for all fiscal decisions and how the practice complies with the law in each contract. The physician owner(s) and Board must ensure that signing a managed care contract does not violate the group’s Compliance Plan, that no anti-kickback or Stark Laws are violated, and that the providers do not engage in any unethical or illegal behavior. The practice may wish to add “Directors and Officers” (D&O) liability insurance to assist with mitigating this risk. The physician owner(s) and Board should also understand that there may be personal liability beyond what D&O insurance may cover should a claim arise (Risk 29).

Prerequisites to signing a contract

Some initial questions to ask the insurance company are: what is your number of covered lives for my specialty, who are the Top 10 major employers who purchase your insurance for their employees, and what hospitals or facilities participate with your plan? These answers provide an estimate as to the number of potential patient pool available to be seen by the practice (Keene 43).

It is important to follow all instructions when requesting to “Join the Network.” Some insurance companies still process these requests on paper; some have an online request tool. If you mail your request to join, mail the package via a method that has delivery tracking, or save screen shots if this request was done online. The ability to prove when an insurance company received your request may
mean the difference of an earlier participation effective date, which means the provider starts being paid sooner.

**Credentialing**

Credentialing is a process whereby the insurance company identifies and vets the provider for enrollment in their plan. Information is gathered about the provider’s medical training and board certifications, medical license(s), group and facility associations, malpractice history, continuing education, pay-to TIN and remittance address, etc. This process can be done on paper or online, and the number of questions and form pages varies from insurance company to insurance company. When a provider is “recredentialed,” the provider may be required to complete the same voluminous initial enrollment forms, or the forms may be simpler and shorter. Some managed care plans require providers to be “recredentialed” on an annual basis, every three years, or every five years. The Practice Administrator and/or the Credentialing Coordinator should develop a tickler system to ensure that recredentialing deadlines are met and the proper information is submitted so that the provider’s status will remain as in-network without any lapse in participation. A dis-enrolled provider may negatively affect reimbursement.

The amount of time it takes to actually complete the credentialing paperwork can take a few minutes to several hours. Once the enrollment request is submitted to the insurance company, their process may take several days to more than 9 months (ACMPE 81). This is especially critical when hiring new practitioners to the practice. Depending on the insurance company’s processing time, there may be a period of time that the new provider’s charges will not be paid. This is critical for cash flow planning, not only for income related to reimbursement, but for payroll disbursement. The group may need to acquire a line of credit with their banking institution to be able to cover payroll costs until regular reimbursement for the new provider can be established.

The MGMA recommends that “primary source verification” be completed as a best practice before hiring or extending an offer to a new provider (ACMPE 214). This ensures that there are no
surprises and to avoid delays during the insurance plan credentialing process. This writer suggests gathering and submitting enrollment requests at least 60 days prior to the new provider’s first Date of Service Date. This help ensures that there will be a smooth and coordinated start-up of the provider’s payments to coincide with their submitted charges path, to ensure the provider is paid timely for services rendered.

**Provider Enrollment, Chain, and Ownership System (PECOS)**

PECOS is an online tool offered by the Centers for Medicare and Medicaid Services (CMS) to enroll, update, and revalidate providers, facilities, and suppliers in the Medicare program (CMS ICN903768; Welcome). Paper enrollment forms may still be used, but utilizing a paper enrollment form takes longer for CMS to process. Forms are numbered differently according to the type of request being submitted. An 855B is used to enroll a group practice; an 855I is used to enroll an individual practitioner, an 855R is used for the individual practitioner to reassign their payment benefits to the group, an 855O is for Ordering providers, an 855S is for Suppliers, etc. Prior to using the online tool, the group and individual providers must have obtained their National Provider Identifier (NPI) numbers. An NPI is a unique number that identifies a health care provider or entity. NPIs can be obtained online at the National Plan and Provider Enumeration System (NPPES) website (NPPES).

When completing the PECOS account, the provider will be asked to attach certain documents, such as an Internal Revenue Service (IRS) CP575 or 147C form. This form confirms a group entity’s TIN. Another document requested is a voided check or bank letter to confirm the account and routing numbers for the bank account to where EFT deposits will be made. If the provider reassigns his or her benefits to a group, the group entity’s name must match across all documents: CP575, bank account name, and the organization name registered with the State government). If a request is made on PECOS, generally CMS will process the request within about 30 days. If a paper form is used, it may take CMS 90 days or longer to complete the request. CMS can only process one open request at a time.
Council for Affordable Quality Healthcare (CAQH)

CAQH is a non-profit alliance consisting of many participating insurance companies (CAQH). CAQH is an online repository used to house a provider’s individual information in a central database. Individual providers do not “participate” with CAQH; however, the provider must “attest” that their information is correct at least once every 90 days. When a provider has requested to join a network, if that insurance company contracts with CAQH, the insurance company will retrieve the provider’s information from CAQH, which helps speed enrollment.

Professional Liability Insurance

Malpractice concerns create an increasing expectation to continually improve patient care that can be demonstrated by objective data and systematic measurement. When a provider’s credentialing is processed, one of the pieces of information asked for is the “malpractice face sheet.” This is a declaration by the malpractice insurance carrier that the group and/or provider are insured to provide certain services. Many times the managed care plan will define what the minimum coverage will be as a condition of participation (Keene and Naus 74).

When the malpractice policy renews, the provider may be required to submit an updated face sheet to the insurance company’s credentialing department. The provider may be asked to disclose any history of malpractice incidents, regardless if fault was admitted or not. Insurance companies may then compare the information that the provider submitted to the National Practitioner Data Bank (NPDB), and may take measures to terminate or exclude the provider from the network if that information does not match, or the practitioner was not truthful about past malpractice incidents (Home).

Curriculum Vitae

A curriculum vitae (CV) is similar to a resume, it details academic credentials and achievements. When submitting a provider’s CV during the credentialing process, the best practice is to format all dates with month, day, and year specified (MM/DD/YYYY). This will help avoid processing delays (ACMPE 214).
State Medical Licensing

Providers may be required to provide a current copy of their medical license for every state in which they are permitted to practice. Insurance companies may request that an updated copy of a renewed license be submitted (Patel).

Drug Enforcement Agency (DEA) and Controlled Dangerous Substances (CDS)

Providers who write prescriptions may be required to provide their DEA and/or CDS certificates. The DEA is a federal license to write prescription drugs and a CDS is a state-level license. Requirements of possessing a CDS vary from state to state. The types and classes of drugs the provider is permitted to prescribe will be delineated on these certificates (ACMPE 214; Risk 52).

Scope of Service and Board Certification

The insurance company’s process of credentialing ensures that the provider is licensed and will render care within his or her specialty. An insurance company may not permit enrollment into their plan if a provider is not board certified in a certain specialty (Patel).

Getting the Rejection Letter

It is not uncommon for an insurance company to reject credentialing requests. The best practice is to keep a tickler file with detailed information of the type of information submitted, the name of the person or department the item was submitted to, and the date submitted. Ensure that all items are submitted via a delivery or shipping method that can be tracked. Providers new to a group can face a six to nine month credentialing period to become enrolled as a participating provider with an insurance plan. Not following instructions or not submitting requested information can extend this time even farther, and during this time provider reimbursement can be impacted (Risk 53).

Examples of Types of Insurance Plans

Governmental Insurance (Medicare and Medicaid)
“Traditional Medicare” is a national federally funded program created in 1965 to provide health insurance to people over the age of 65 regardless of income, medical history or health status; people under the age of 65 with certain disabilities; and people with End Stage Renal Disease (ESRD) (CMS Medicare). Different divisions within Medicare pay for different types of medical care. For example, Medicare “Part A,” is relegated to hospital or facility type services. Medicare “Part B” is the division that is designated to pay for physician type services. Physicians bill Medicare Part B and are paid using the RBRVS FFS system. In 2017, approximately 33.5 million Americans were on Medicare Part B (CMS Enroll).

Medicaid is a federally and state funded program that is administered by each state. Medicaid provides healthcare to individuals with limited income and assets. Medicaid programs vary from state to state - most states still provide a “traditional” Medicaid program along with Medicaid Manage Care Organization (MCO) plans (Basic Health). Payment methodologies also vary from plan to plan. In 2017 approximately 73.8 million Americans were on Medicaid (Laporte). Typically Medicaid or a Medicaid MCO is the payer of last resort. Providers are not permitted to bill patients any remaining balance after Medicaid processes the claim.

**Commercial (BlueCross, Aetna, Cigna, etc.)**

Commercial type plans are classified by a variety of plan types, such as Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO). These plans are offered by Employers to their Employees, or, an individual can purchase this type of plan on a personal basis outside of their Employer. These plans pay physicians using an array of methods: the insurance plan’s unique fee schedule, a percentage of the Medicare Allowable, a percentage off the physician’s billed charges, etc.

**Medicare and Medicaid Managed Care Organizations (MCOs)**

Some private commercial insurance plans offer Medicare Advantage plans as an alternative to traditional Medicare. These plans may also be referred to as Medicare Replacement plans and comprise
Medicare “Part C.” These plans offer bundled Part A and Part B coverage. The patient receives the same services that traditional Medicare provides, however, the patient’s out-of-pocket responsibility may be different and there may be certain rules the patient must follow to receive care, such as needing a referral to see a specialist. These plans pay doctors in the variety of ways that the Commercial plans above pay doctors (How Do Medicare Advantage Plans Work?).

Typically indigent patients are assigned to a Medicaid Managed Care Organization. These MCOs are operated by state-contracted organizations and may pay physicians using the capitation method, which is a per member per month reimbursement. Arizona was the first state to implement a Medicaid MCO in 1982 (Keene and Naus 28). Participating with a Medicaid MCO that pays the physician on a capitated rate may come with risk. Usually Medicaid payments are almost always the lowest form of reimbursement per CPT/HCPCS code, and if the MCO has a large patient pool for the doctor to see, this higher volume of patients may prevent the doctor from seeing a patient who has a higher paying insurance. Having a robust information technology data reporting system is important to evaluate payment data and allows for appropriate feedback of financial activity (McCally 148). As with traditional Medicaid, Medicaid MCO patients cannot be balance billed by a doctor either.

Third Party Administrators (TPA)

Most payments processed are processed by a TPA company. TPAs offer administrative and claim processing services to insurance companies. An Employer may also hire a TPA to handle and process claims for its self-insured insurance plan for its workers (Financial 278).

<table>
<thead>
<tr>
<th>Rank</th>
<th>Company</th>
<th>Headquarters</th>
<th>Services</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sedgwick Claims Mgt.</td>
<td>Memphis, TN</td>
<td>Multiline</td>
<td>1.8 BN</td>
</tr>
<tr>
<td>2</td>
<td>Crawford &amp; Co./ Broadspire</td>
<td>Atlanta, GA</td>
<td>Multiline</td>
<td>1.1 BN</td>
</tr>
<tr>
<td>3</td>
<td>UMR Inc.</td>
<td>Wausau, W</td>
<td>Employee Benefits only</td>
<td>830 MM</td>
</tr>
<tr>
<td>4</td>
<td>York Risk Services</td>
<td>Parsippany, NJ</td>
<td>Multiline</td>
<td>780 MM</td>
</tr>
<tr>
<td>5</td>
<td>Gallagher Bassett Services</td>
<td>Rolling Meadows, IL</td>
<td>Multiline</td>
<td>776 MM</td>
</tr>
</tbody>
</table>

(Bonner).
Worker’s Compensation (Work Comp)

Insurance companies, like Aetna, have expanded their networks to include Work Comp plans, to help Employers control work comp costs. Work Comp has been called the last bastion of FFS. As with Medicaid, if a worker’s injury is deemed to be compensable under an Employer’s Work Comp plan, that patient may not be balanced billed (Keene and Naus 28-30).

Scrubinizing Contract Terms and Verbiage

(Structure of a contract)

Creating a Contract Terms Matrix

Each contract contains category sections of terms. While those same categories may be found in most contracts, unfortunately every contract is formatted differently, making it time consuming and difficult to compare one contract’s terms to another. Some of the main components of a contract include, but are not limited to:

• A leading paragraph stating who the contract is between and the effective date of the contract;

• What kind of contract it is: Commercial, Medicare Advantage, etc.;

• Definitions section;

• The responsibilities of the insurance company;

• The responsibilities of the provider or group;

• The length of the contract and how it renews;

• How the contract can be terminated, and responsibilities of both parties after termination;

• Hold Harmless and Indemnification clauses;

• How claims are filed and when payments will be made;

• Grievance procedures;

• How to bill and collect from patients;

• Medical records requests and/or on-site visits made by the insurance company;

• How Amendments to the contract are handled;
• Is the provider required to participate in certain programs, such as Utilization Review, Quality Assurance, etc.;
• Reference to the “Provider Manual”;
• The governing state;
• Fee Schedule;
• Signature section

Because these main topics frequently appear in most contracts, the following “Check List” was developed by this writer to assist the managed care contract reviewer. These items can be placed vertically in an Excel spreadsheet and the targeted managed care plan name can be placed across the top of the spreadsheet horizontally. This allows the contract reviewer to quickly read the contract and notate all of these major areas of concern. Then by recording the data in each column for each different insurance company, the user has a very quick and easy way to compare terms across the insurance companies with which they participate, or are thinking about participating (Keene and Naus 118). The Managed Care Contract Review Summary begins on next page.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For Practice:</td>
<td></td>
</tr>
<tr>
<td>Plan Name:</td>
<td></td>
</tr>
<tr>
<td>Type of Plan:</td>
<td></td>
</tr>
<tr>
<td>Plan Representative and Contact Info:</td>
<td></td>
</tr>
<tr>
<td>Plan Medical Director/Specialty:</td>
<td></td>
</tr>
<tr>
<td>Are the terms of this contract negotiable?</td>
<td></td>
</tr>
<tr>
<td>Plan requires providers to be credentialed/recredentialled:</td>
<td></td>
</tr>
<tr>
<td>Are appeal rights afforded for terminated provider?</td>
<td></td>
</tr>
<tr>
<td>Service Zip Code Covered:</td>
<td></td>
</tr>
<tr>
<td># Covered Lives:</td>
<td></td>
</tr>
<tr>
<td>Approximate % of Payor Mix:</td>
<td></td>
</tr>
<tr>
<td>Is this contract a Group or Individual Contract:</td>
<td></td>
</tr>
<tr>
<td>Can claims be filed electronically?</td>
<td></td>
</tr>
<tr>
<td>Initial Term of Contract</td>
<td></td>
</tr>
<tr>
<td>Is this an Evergreen contract?</td>
<td></td>
</tr>
<tr>
<td>Termination Without Cause Terms:</td>
<td></td>
</tr>
<tr>
<td>Non Renewal Terms:</td>
<td></td>
</tr>
<tr>
<td>Termination With Cause:</td>
<td></td>
</tr>
<tr>
<td>Other Termination terms:</td>
<td></td>
</tr>
<tr>
<td>Record retention requirements:</td>
<td></td>
</tr>
<tr>
<td>Clean Claim Payment Clause:</td>
<td></td>
</tr>
<tr>
<td>How many days to submit the initial claim?</td>
<td></td>
</tr>
<tr>
<td>Is interest paid on claims not paid timely?</td>
<td></td>
</tr>
<tr>
<td>How many days to dispute payment?</td>
<td></td>
</tr>
<tr>
<td>Grid Continued:</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>General Liability Requirement:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Professional Liability Requirement:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Is there a &quot;State Liability&quot; Pool?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Grievance/dispute procedure:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>List any Exclusions from Coverage:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Who decides Medical Necessity? Plan or Group?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>What is the Standard of Care?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Can the Group Opt Out after Notice? Under what circumstances?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Governing Law State:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Do Services require Prior Authorization?</strong></td>
<td></td>
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<td><strong>How will Group be paid? Paper check or EFT?</strong></td>
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<td><strong>How often will Group be paid?</strong></td>
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<tr>
<td><strong>Is there a Most Favored Nations clause?</strong></td>
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<td><strong>Are there mutual Indemnification clauses?</strong></td>
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<tr>
<td><strong>How are overpayments resolved?</strong></td>
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<tr>
<td><strong>Is there an annual increase in Reimbursement?</strong></td>
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<tr>
<td><strong>Limit or minimum on records requested for audit?</strong></td>
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<tr>
<td><strong>Required to send notice of Actions against Group?</strong></td>
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<tr>
<td><strong>On Site Reviews Conducted?</strong></td>
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<tr>
<td><strong>Plan requires providers to participate in Util. Mgmt, QA, other programs?</strong></td>
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<td><strong>Malpractice Restrictions or special requirements?</strong></td>
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Examining terms in detail – Is Negotiating Terms Possible?

Obviously there can be hundreds of terms and clauses in a contract and this paper cannot address all of them. Generally, the terms and reimbursement of a governmental-type insurance will not be able to be changed (Medicare, Medicaid, etc.). Several common terms that frequently appear on a contract will be reviewed and discussed below, and the focus of this discussion will be toward a commercial-type contract.

The suggestions below are not intended to be legal advice. Many of these points are covered in the MGMA Body of Knowledge and are listed as items for the practice contract negotiator to consider. Readers are directed to seek legal advice from a qualified health care attorney to obtain solutions that best fit the needs and specific nuances of their unique practice.

- **Medical Director/Specialty** – This individual is generally a physician that is assigned or elected by the insurance company to be their Medical Director. While this is usually not an item that can be negotiated or changed, it is important to know the credentials of this person and in what specialty their expertise lies. The medical group can ask if the Medical Director will understand the needs, concerns, and patient care activity of your particular medical group (McCally 96). As an example, will a Medical Director who is an optometrist truly be able to comprehend the nuances of a hospital-based anesthesiologist, and vice versa?

- **Initial Term** – The initial term of a contract is the length of time that the first period of the contract is in effect. This period varies among contracts and can be 1 year in length to multiple years in length. The current school of thought is for the practice to contract initially for the minimum length of time possible. This allows the practice to experience how the insurance company operates without being tied to the insurance company long term (Keene and Naus 59).

- **How does the contract renew** – A standard feature in many contracts is for the renewal term to be “evergreen” in nature, meaning that the contract *renews automatically* unless either party informs the other party of intention to cancel the contract. It is important to understand
two points about this clause: 1) When the contract renews automatically, what is the length of each subsequent term and 2) does the contract include language that when the contract renews automatically, can the insurance company change the fee schedule without prior notification to the practice? On the first point, as with the Initial Term, the practice needs to understand how long the practice will be bound to the contract, for example, renewal periods of 5 years in length may be onerous. On the second point, the practice should always be made aware of any changes to reimbursement before those changes go into effect, and then have the opportunity to negotiate those fee schedule changes, or have the opportunity to opt out or cancel the contract without cause. The practice should be aware of these items and if the terms do not fit their business needs, ask for those clauses to be modified (Keene and Naus 59).

- **Termination Clause** – Most contracts will state how the practice may terminate the contract, for example, “with cause” or “without cause,” and gives notification instructions for each.

  **With Cause** – Generally either the insurance company or the practice may terminate the contract immediately for a serious or egregious reason, such as the provider failed to meet certain medical standards of care or the insurance company did not pay the practice. In this case, the terminating party would inform the other party in writing and then instructions would be followed as to how both parties will separate. In some contracts, there is a “mediation” clause. This means that before the contract can be severed, both parties may be subject to having the terminating party’s grievance mediated. It is important to know which or if both parties bear responsibility in paying for the cost of the mediator. There may also be a waiting period before contract end date is made effective.

  **Without Cause** – Terminating a contract without cause means that the practice does not desire to renew the contract and is not required to give any particular reason of their desire to terminate. This can be burdensome for the practice. The practice may be
able to give 90 days written notice to terminate a contract without cause; however, the contract may also stipulate that the 90 day’s notice must be given prior to the end of the current term. This means that if the current term ends in December, and the practice gives written notice on February 1st, the contract does not end on April 30th. The contract actually ends on December 31st. The practice desires to end the contract as quickly as possible; however, the practice would have to wait another 8 months to actually exit the arrangement.

Some contracts may contain verbiage that it is the practice’s responsibility to inform patients that the practice is terminating the relationship with their insurance plan. Some contracts give instructions on how that is to be done. If the practice has a high volume of that insurance company’s patients, it can be very expensive to mail out thousands of notifications, especially of the reimbursement was not that great to start with. The practice should assess this patient volume when considering terminating a contract.

If terminating with our without cause, the practice will need to inform the insurance company in writing, and ensure that the delivery method is one that can be traced, to ensure that both parties can accurately assign the effective contract end date (Keene and Naus 75-6; MGMA 352-3).

Medical Record Requests/Fees

Individual, bulk, and onsite requests for the insurance company to review medical records is becoming more and more prevalent. The guise may be to evaluate medical necessity, however, these requests delay claim processing and can be very costly to the practice. There are a variety of ways the insurance company may seek to view these records: 1) the practice may be asked to fax or mail in the information or 2) the
insurance company may require an onsite visit (McCally 65). Both requests take up the practice’s staff time to retrieve stored records and/or accommodate an on-site visit. When possible, ask for a reasonable per-page remuneration if the practice is asked to provide copies of medical records. And insert a limit as to how many records can be requested at one time and a maximum frequency that the insurance company can make these requests. It is unacceptable for an insurance company to ask for records for hundreds of patients and then not compensate the practice for the time spent in collecting the information. Also, specify when the insurance company may make the on-site visit (Keene and Naus 59-60). Visits should be made by appointment in advance and occur during the practice’s normal business hours/days, and a limit should be put on the time length of the visit.

**Malpractice Level Requirements**

Ensure that these amounts are reviewed as well as the type of insurance required, such as “claims made” or “occurrence.” Most providers carry at least if not more than the insurance company’s minimum requirements (Keene and Naus 74). However, the practice should be aware of and try to exclude language from the contract where the insurance company has the discretion to specify a certain malpractice carrier. If the practice decides to pursue participation with the insurance company and does not currently possess minimum coverage amounts, the providers/practice may need to consider obtaining additional coverage to comply with the minimum amounts required. This can be an added expense to the practice.

**State Liability Pool**

The American Medical Association (AMA) recommends that the practice understand and be able to independently verify how risk pool surpluses and deficits will affect the group. For example will every provider share equally in this pool, or will income/expenses be appropriated differently based on a provider’s performance, quality
benchmarks, or provider’s higher, or lower, costs? If Primary Care Physicians and Specialists both participate in the pool, will income/expenses be shared equally among the different types of groups? Risk pools vary from state to state (AMA).

State liability pools and risk sharing are key terms that Kenneth Scott, Jr, DO, Chief Medical Director and CEO of Silversage Management Services, looks for when reviewing a managed care contract. Scott says: “Some states allow you to opt in or out of that pool. There is a significant cost if you opt in. The idea, as I understand it, is that if you opt in and pay the fee, which might be significant, if you are sued and are a part of that pool, there is a limit to how much you might have to pay out if damages were awarded. Many large practices that are self-insured tend to opt out. They feel they have good enough coverage on their own. Smaller practices or individual doctors might tend to opt in for additional security, if they can afford it” (Scott).

Having the option is important to Scott. He continues, “I would worry about a state that did not allow the practice to make that decision for themselves” (Scott). These types of terms may add risk and expense to the practice; the practice should fully evaluate the financial impact prior to signing an agreement.

**Payment of “Clean Claims”**

CMS defines a clean claim as “having no defect, impropriety, lack of any required substantiating documentation.” (CMS mc86c11). Many contracts state that clean claims will be acknowledged within x number of days. First, be sure that this number of days aligns with your state’s regulations. Make sure that the verbiage matches. Acknowledging or responding to a claim is much different than actually paying a clean claim. Insist that the insurance company insert language that clean claims are paid within x number of days, according you your state’s regulations.
**Governing State Law** – Ensure that the Governing Law is the state in which the group practices. This is especially important for arbitration, claims payment, and medical management requirements (Financial 56).

**Payments** – Ensure that you receive the actual fee schedule, not just a mention in the contract that “Provider will be reimbursed according to the current fee schedule.” Ask if the reimbursement is automatically increased at regular intervals to coincide with Cost of Living Adjustments (COLA). If the practice is not paid timely, ask that the insurance company pay interest on those unpaid claims (Keene and Naus 62-3).

**How are overpayments resolved** – The practice will need to understand how overpayments to the practice are resolved. Will the insurance company automatically “take back” monies on a future remittance advice or will the provider be expected to issue a paper refund check to return the money, and is the provider required to do this within a certain number of days from the Explanation of Benefit (EOB) date? The practice should be in control of when monies are returned and designate the method in which those monies are returned. Processing refunds is costly to the practice and returning money affects cash flow. Practices should also insist that interest not be levied on the amount to be refunded (Keene and Naus 71).

**Favored Nations Clause** – This is an important clause for the contract negotiator to be aware of. Favored Nations means that if the practice participates with other insurance companies for a greater discount, that discount must also be extended to this plan regardless of the negotiated amount in the contract. The practice should seek to eliminate this verbiage because obviously the practice does not want to be paid less than the rates that were originally negotiated (Keene and Naus 71).

An insurance company may not be amenable to changing verbiage or reimbursement in their contract. If not, the practice has a decision to make. If the practice proceeds with signing a contract
anyway, this does not relieve the practice of their obligations set forth in the contract. Make sure you can and will comply before signing. Not complying with conditions can be costly to the practice, in any written agreement (Financial 65).

**Considering contract clauses for different types of private practice groups**

(This section will briefly explore terms that may be important to different types of specialties. This is not all-inclusive, but a sampling of different types of private practices.)

Hospital-based (radiology for example) – Determine if pre-authorizations apply to the hospital-based group’s contract. Inherently a hospital-based radiologist does not have a face-to-face encounter with every patient. The radiology group relies on the hospital or facility to obtain the pre-authorization. The radiology group may not be able to apply the pre-authorization number obtained by the hospital for the separate radiology group’s use. Address language that requires pre-authorization for hospital-based radiology services to see if those requirements can be eliminated.

Hospital-based (anesthesiology for example) – Anesthesia can be quite complicated, on the provider charge billing side as well as the insurance company reimbursement side. Anesthesia provider’s reimbursement is calculated in a different way than other practitioner’s reimbursement. Anesthesia payments are figured using Base Units, Time Units, and Physical Status Modifiers. Some contracts will “cap” or pay a “flat rate” for certain cases, such as maternity deliveries. The group should obtain a list of these CPT codes and ensure that the “capped” rate is reasonable and will cover average costs. The practice should also determine what anesthesia modifier (for example QX, QK, AA) the insurance company requires you to append to your CPT codes. This is important to know before the contract is signed, to ensure that the practice bills correctly, and that the billing computer can handle the billing if this insurance company requires a modifier that is non-standard to what they file to other insurance companies.
Office-based (podiatry for example) – Prior to signing a contract, understand how billing and reimbursement will occur for supplies that are considered Durable Medical Equipment (DME). Are pre-authorizations required for such items?

Facility-based (geriatrics for example) – Some nursing homes may employ or contract with internal medicine type practitioners to provide care to their nursing home patients. Some contracts, like the Veteran’s Administration (VA), will make payment to the nursing home facility that includes payment for both the nursing home charges and the physician’s charges, and do not allow the physician to submit their charges directly to the VA. It is important for the internal medicine practitioner to be aware of this and ask that the insurance company pay the physician or his or her group directly. Accounting for these payments is costly for the physician group. If the insurance company will not separate the payment, the physician group should establish a method for the physician office to submit an invoice to the nursing home, and then the nursing home will pay the physician/group. The physician will need to be paid for his/her services rendered.

Federal Laws

Federally Qualified HMO – 42 C.F.R, Section 417.107 (a)(1) requires that the operation is fiscally sound and be able to demonstrate adequate assets, cash flow, liquidity, maintain fidelity bonds, etc.

Medicare HMO – 42 U.S.C. Sec. 1395mm(g)(6) states that a non-contracting provider may receive direct payment from the Secretary of Health and Human Services (HHS) if they do not receive “prompt payment” from the Medicare HMO for services rendered.

Antitrust – Managed care organization may risk violating the Sherman Act when they do not allow providers of a certain specialty to participate with their plan.

State Laws:

Any Willing Provider Law – this law varies by state and prevents an HMO from selectively contracting with certain providers.
Georgia, Illinois, Louisiana, Utah, and Virginia all have similar laws that state if the provider is qualified and is willing to meet the terms of participation, the insurance company may not exclude them from participating (Keene and Naus 92-100).

H. Examples of Different Types of Reimbursement Methods:

CPT code 99204 – Office Visit New will be used as an example, for the Utah Locality. Assume the physician’s billed charge amount is $300.00 and that the patient has met his or her deductible and has no co-pay amount. The 2019 RVU for this CPT is 4.63.

1. Fee For Service – Medicare Allowable

As mentioned previously, a user can go to the Medicare reimbursement tool and look up the Allowable for any CPT or HCPCS code. For Utah for 2019, the allowable is $162.87. Medicare will pay 80% of the Allowable, however there is a 2% sequestration reduction. Medicare’s payment will be $130.30.

2. Percentage Off Billed Charge

Some insurance companies will offer a “percent off” the provider’s billed charge. If the agreed discount is 80%, and the billed charge amount is $300.00, the insurance company will pay $240.00.

a. Multiple or Percent of Medicare Conversion Factor

Insurance companies may offer to pay a multiple of (for example 2 times) or a certain percentage of or over a Conversion Factor. The Medicare Conversion Factor for 2019 is $36.0391. Assuming the insurance company will pay 100% of the amount, a Multiple Factor of 2 would render a Conversion Factor of $72.08. If the insurance company used a percentage of say 120% of the Conversion Factor, the insurance company would establish a Conversion Factor of $43.25. Then the derived Conversion Factor would be multiplied by the RVU of 4.63 to arrive at a payment amount of $200.25.
b. Capitation

There are many considerations to be made when evaluating a capitation reimbursement rate, and a whole paper could be devoted just to that topic. In simplistic terms, the practice should estimate the average charge amount per member per month (PMPM) that they are currently experiencing with that insurance plan, and then determine if the insurance company’s proposed rate meets or exceeds that rate. This is an example of that calculation:

- # of members in the plan = 1,800
- Average monthly charges billed for those members = $17,130
- Calculated PMPM capitation rate = $17,130/1,800 = $9.52
- Cap rate adjusted for collection % = $9.52 x .85 = $8.10
- Cap rate offered by insurance plan = $9.00

The target capitation rate that the group should seek should be between $9.00 PMPM and $9.52 PMPM (MGMA 357-9).

Practices should also confirm their Geographic Service Area if a capitation agreement exists. It is important to identify patients in counties or outlying areas that the providers do not normally serve. This may pose a risk to the practice. It may require additional provider resources to treat those patients at a distant boundary, which means more expense to the practice (MGMA 344).

3. Percentage of Medicare Allowable

Insurance companies may state that they will pay a certain percentage of or over the Medicare Allowable. For example, the insurance company may state they will pay 100% of 125% of the Medicare Allowable. In the example above the Medicare Allowable for Utah is $162.87, the insurance company in this case will pay $203.59.
4. Incident To

Some insurance companies pay the mid-level providers in a group, such as a Nurse Practitioner (NP) or Physician Assistant (PA), a percentage of the physician’s payment when the charge is billed in the NP/PA’s name/NPI. Typically this percentage is about 80% to 85% of the physician’s payment amount. “Incident To” billing means that, under certain circumstances, the group may bill a mid-level provider’s charge under the physician’s name/NPI number, and the group will receive payment at the physician’s rate. Admittedly this arrangement does yield a much higher income to the group; however, it does not come without risk if the charges are not billed out properly. The group must ensure that all requirements have been met before they proceed with Incident To billing. First, the physician must perform the initial visit on each new patient, which includes the History and Physical (H&P), examination, and originate a treatment plan. Secondly, on subsequent visits, if the group desires to bill the NP or PA charges as Incident To, the physician must be within the office suite and “immediately available.” The physician being “a phone call away” is not permitted. The group should determine if Incident To billing is permitted by the contract, and then ensure that claims are billed appropriately. There is a dramatic difference in reimbursement and the group should not automatically bill under the physician’s name/NPI just to receive the higher reimbursement. An example of the difference in reimbursement may look like this:

Example of number of claims with CPT 99204 billed in 1 year for this insurance company = 500

Physician reimbursement for 99204 = $240.00

PA reimbursement for 99204 is 80% of $240.00 = $192.00

$240.00 - $192.00 = $48.00 difference

2,500 x $48.00 = $24,000 less in payments if the PA was billed instead of physician.

This is a significant difference, but the group should first make sure they are billing appropriately and follow contract terms before billing NP or PA claims as Incident To.
5. Payment Differential for Certain Provider Types

Just as with Incident To billing, anesthesia groups may be affected by a payment differential. Insurance companies may state that they will pay Certified Registered Nurse Anesthetists (CRNAs) a portion of the physician’s rate. This can be 75% to 85% of the physician reimbursement rate. Anesthesia groups should identify this in the contract and ask that CRNAs be paid at the same rate as the physician, because they are providing the same service.

I. Are opportunities available to further improve reimbursement?

1. Carve Outs

One strategy to gain higher payments is to identify a single or several high volume CPTs or a whole modality such as Magnetic Resonance Imaging (MRI), and then ask for, or “carve out,” those CPTs into a separate payment category to receive higher reimbursement. For example, a two-view diagnostic x-ray may be the CPT code with the highest volume for a hospital-based radiology group. The insurance company may offer to pay 125% of the current Medicare Allowable across the board on all CPTs. The 2019 professional component Medicare Allowable for two-view chest x-ray CPT 71046 is $11.02. The initial proposed reimbursement would be $13.78 ($11.02 x 1.25).

Example of 71046 annual volume = 13,200

Payment at $13.78 = $181,896

If the group could negotiate or “carve out” this one CPT to be paid at say $16.00 each, the revenue on this volume would render $211,200. The group could realize additional payments on this one CPT of $29,304 per year on this one CPT code.
2. Board Certification(s) of Providers

Some insurance companies will not credential physicians who are not board certified. If you have a provider on your staff who is not board certified, this will need to be taken into consideration when evaluating a new managed care contract, because this provider may not be able to file claims to this insurance company, may be paid the out-of-network rate, or not at all. This may cause a financial risk to the group.

J. Analyzing Proposed Reimbursement

1. Number of Covered Lives

It is essential for the insurance company to provide the number of covered lives included in the contract. This is not only important for the group to know as far as how many patients they are expected to care for, but for the evaluation of the financial reimbursement as well. If the number of covered lives is very low, the group may not want to spend time evaluating a contract. The insurance company should be able to provide statistics for the county or region that the group serves, as well as breaking down the demographics by age and gender, which may be more applicable to a particular specialty.

2. Creating a Reimbursement Matrix

One way to assess reimbursement is seen below. This is a scenario where a physician is seeing patients in a nursing home setting. In this example, this insurance company offers four different types of networks: a commercial PPO plan, a commercial HMO plan, a Medicare Advantage plan, and a Medicaid MCO plan. The Top 5 CPT codes of the practice were identified. The volume of these CPT codes make up 93.5% of all of the CPT codes billed in 2018. This is the vast majority and renders a good sampling and is seen in the section with the yellow headers. The Medicare Allowables for the CPT codes were retrieved and are identified in the column with the blue header. In the section with the orange headers, the insurance company’s reimbursement for each CPT is notated and then a calculation is figured as to what percent that reimbursement is compared to the Medicare Allowable. The Medicare and
Medicaid reimbursement portions of the contract cannot be negotiated. That leaves the PPO and HMO portions to be considered. Generally, groups may not accept commercial reimbursement that is less than what Medicare pays. This particular group has established 175% of the Medicare Allowable as their “target” reimbursement rate. As you can see, the PPO reimbursement is approximately 88% of Medicare and the HMO is approximately 92% of Medicare. Additionally, for this contract, NPs are paid 75% of the physician rate, further impacting revenue. In this example, the group will need to decide if they will approach the insurance company to ask for a higher reimbursement rate, hopefully settling on a percentage above the Medicare Allowable, and closer to their 175% target. If that cannot be achieved, the group will need to decide if they will accept this reimbursement and participate with this insurance company (Keene and Naus 62-9).

**PROPOSED PPO REIMBURSEMENT**

<table>
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<tr>
<th>Rank</th>
<th>CPT</th>
<th>CPT Description</th>
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<th>% of Practice</th>
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<th>Proposed Plan Reimbursement</th>
<th>% of Medicare</th>
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**PROPOSED MEDICARE**

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**PROPOSED MEDICAID**

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****NPs are paid 75% of MD/DO

(ASHA).
3. Effects on the Payer Mix

The group should consider how participating in a contract will affect their payer mix. A payer mix categorizes data according to the insurance the patient’s possess. The descriptions of a payer mix may vary from group to group. Broad categories are generally labeled as Medicare, Medicaid, Commercial, Self Pay, and Work Comp. The practice should identify how participating with an insurance plan might change their payer mix as well as payment level. Typically, Medicaid is the lowest paying type of insurance. Another question to ask is will participating with an insurance plan increase the practice’s market share in the community? If it is a commercial plan, do the insureds have high deductibles? Patients do not typically pay all of their bill or very fast, so will participating with a plan make it difficult for the practice to collect patient responsibility amounts? If the new contract is capitation-oriented, is the practice prepared to accept the risk of this new influx of patient population? Do competing groups or referring doctors participate in the plan, would that change the practice’s payer mix if the contract was signed? All of these questions can have an effect, sometimes negative, on the practice’s revenue, and need to be analyzed very carefully MGMA 332-3).

4. Effects on the Income Statement

An Income Statement is one of three important financial statements used to report a company’s financial performance over a specific accounting period. An Income Statement shows the company’s revenue as well as expenses during this period. The other two financial indicators are the Balance Sheet and Statement of Cash Flows. Participating, or not participating, affects both the income and expenses of a practice. Income is affected by the amount of reimbursement received, and expenses are affected by patient volume and staff and equipment required to treat a patient. If the reimbursement structure renders lower reimbursement, this may force the group to consider a new or different way to compensate the provider staff (MGMA 333; Ly and Glied).
Making the Decision to Participate

(Performing a SWOT Analysis (Strengths/Weaknesses/Opportunities/Threats))

A SWOT Analysis is an exercise that the practice will conduct to find the best match between internal capabilities and external environmental trends.

Internal capabilities include:

Strength – a resource that the group can use to effectively achieve its objective.

Weakness – a fault, defect, or limitation that prevents the organization from achieving its objective.

External trends comprise:

Opportunity – a favorable situation that will enhance the practice’s situation.

Threat – an unfavorable situation that is potentially damaging to the practice’s strategy,

A SWOT Analysis will reveal where the practice needs to focus its resources and helps answer two important questions:

1 – What are significant issues that the practice faces currently?

2 – How does the practice address those issues?

Dr. Marcum hired an outside practice management consulting firm and one of the first tasks was to perform a SWOT Analysis to determine how to approach managed care plans to answer the first question above: What are significant issues that the practice faces currently?
When asking to join networks, Dr. Marcum was able to relay strengths that were supported by her education and skills and referenced her advanced training to become board certified in multiple fields. She then relayed how those skills have had better outcomes with patients and the successes she had as a previous participating provider with a particular network. She was already known to most of the Referring Doctors in the community, so they would be familiar with her work and would desire to continue referring their patients to her.

Several weaknesses were noted. Dr. Marcum was previously associated with a large hospital system in Chattanooga, Tennessee and the patients that she saw at the hospital might not know that she has started her own private practice in the same town. This might be confusing to patients because they may see her listed as a participating provider on the in-network panel but may not realize she is no longer associated with the hospital and is located at a different practice address. Dr. Marcum and her staff will have to learn a new EHR software. The hospital took care of any pre-authorizations and insurance eligibility before, now she and her staff will have to learn to do that on their own and with a new
software. Also, before, the hospital already had clinical, business, and billing procedures established. Dr. Marcum will have to develop all of that workflow herself for her new practice.

Starting a medical practice is an opportunity to grow a new business, to set goals and meet new challenges (Strategic Planning). With the risk of cancer on the rise, there is a growing need for this type of care. A brand-new business will afford many opportunities to market and advertise these services in the community (Gesme and Weisman). Dr. Marcum served many patients while she was in the hospital setting; she has a good reputation and past patients may recommend her to new patients as word of mouth spreads in the community that she is open for business as a solo practitioner.

As with starting any new venture, there are risks and threats. Stakeholders must address cash flow – how to pay for initial expenses when payments for services will not be realized until about 45 days (or longer) after starting up after the first claims are filed. Dr. Marcum may have been an in-network provider when she was on staff at the hospital, but what if some commercial, Medicare Advantage, and Medicaid MCO networks are now closed to her new practice? How will that affect her ability to gain new patients not being recognized as an in-network provider? And more importantly, how will she be reimbursed if she is an out-of-network provider? Will Dr. Marcum’s individual credentialing under the hospital be able to be transferred to her new group’s TIN? Will that shorten the enrollment process, or will she have to enroll anew? Enrolling anew could take 9 months or more in some cases, there again putting pressure on the demand for cash flow. The need to join networks rapidly in a new practice start up may compel the stakeholders to make the decision to forgo negotiating for higher reimbursement for the ability to enroll in a plan as an in-network provider more quickly – to ensure that cash flow begins as soon as possible (MGMA 368-78). There is risk that the opportunity to renegotiate for a higher rate later may not be available, or attainable (McCally 120-3).

The goals and objectives that arose from this exercise led Dr. Marcum to determine that she needed to become an in-network provider as soon as possible to 1) establish her patient base a quickly as possible which would naturally 2) infuse cash flow as soon as possible (ACMPE 39, Keene and Naus 15-8, Operations 29-31).
Who is/are the Decision Maker(s)?

Decision makers vary among practices and may or may not be the Stakeholders in that the practice. A Practice Administrator in a solo practitioner’s office or small group may evaluate the managed care contracts and s/he may make the decision, or in collaboration with the physician owner, to participate or not to participate with a managed care plan. In larger groups, a committee may make the decisions. Larger group’s committees may be comprised of various individuals who can offer expertise from a variety of departments, or the physician board of the practice may render final decisions.

In practices where groups choose to align with a physician integration association, decision making becomes more complicated. Examples of these types of organizations are: Independent Practice Associations (IPAs), Physician Hospital Organization (PHO), or Management Service Organization (MSO). Many practices contract with the association and then the association negotiates on behalf of all of the practices collectively. There can be many advantages and disadvantages to this type of arrangement and that can be a double-edged sword. Having an association negotiate on your group’s behalf can be good in that it may enable the association to leverage reimbursement rates. However, your group may be compelled to accept those rates even if the rates are not at the level you preferred. Your group may lose some autonomy or individual bargaining power, as some of these types of organizations tend to be specialty dominated. Some associations require that membership dues be paid; so, the group must look at the cost/benefit risk before making the decision to become a member. When claim processing flows through an association, it may speed claim processing, which speeds payment. Evaluate the history of the association’s claim processing to ensure there are no problems in that area. If approached to join an association, make sure you understand your group’s responsibilities within the association and particularly how your membership will affect the final outcome of your reimbursement (Cannon).
How a bad contract can affect the group and Stakeholder’s compensation

A bad contract can obviously affect the stakeholder’s compensation, but there are other factors that can be undesirable too. By participating in a contract, will the group’s market share be affected? Will participation dramatically change the group’s payer mix? Will participating with a particular insurance company extend days in Accounts Receivable? Will costs exceed payments under a capitation arrangement? What is your competition doing? The effect of decreased reimbursement may force the group to reevaluate physician/stakeholder compensation in light of decreased revenue.

How a good contract can affect the group and Stakeholder’s compensation

Good contracts can lead to increased patient volume, a better paying payer mix, and potentially shortened Days in Accounts Receivable. You’ve probably heard the saying, “Cash is king!” (Revenue). Higher reimbursement may mean additional compensation to the physicians and stakeholders or enable the practice to grow and expand (MGMA 332-3).

Mitigating Risk: What happens after the contract is signed.

Complying with the terms you agreed to:

For those practice that choose to enroll with a managed care plan without thoroughly understanding the contents and conditions, the practice and clinical providers may be putting themselves and the group at risk.

Adam Owenby, Corporate Counsel for VSGI, specializes in contract evaluation and negotiation in Washington, DC. He observed that if a professional (a doctor, Practice Administrator, etc.) signs a contract without reading or seeking legal counsel, they are making a potentially disastrous mistake. Owenby went on to say that “Litigators love people who are ‘too busy’ to read the fine print (Owenby). There is absolutely no excuse for not reviewing any contract that has the potential to impact the business. The managed care contract defines the relationship between the parties from what is covered, to how payment will work, even down to how patient information is kept.” Owenby argues that “Failing to even read the document amounts to negligence” (Owenby). Individuals and groups are bound to the contract
terms whether they read the document or not. It is crucial to understand how a contract will impact your practice.

**Effects on Patients; Collecting Patient Responsibility Portions**

It is also important for the practice’s billing department to understand the terms in a contract. There are co-pay and deductible amounts that may be assessed as patient responsibility. In some contracts, there may be a clause prohibiting the routine waiver of co-pays and deductibles. Generally, Medicaid patients cannot be billed. Incorrectly billing patients could increase statement costs or additional staff time in processing refunds when a correct amount is not collected from the patient.

**Adding new modalities/lines of business/specialties**

When a practice signs a contract, they are agreeing to provide the services listed in the contract and will only be reimbursed for those specific services. If, for example, the practice is a diagnostic imaging center or walk in clinic, where the practice provides only routine diagnostic-type radiology x-rays (i.e., ankle, hand, arm x-rays), but the practice wants to add MRI, an MRI is considered a high-tech procedure: 1) IF the practice adds the MRI, will they get paid for those services? Payment for MRI services may not be listed in the contract as a reimbursable service. That is a risk that needs to be determined before the MRI is added and the contract will need to be renegotiated to include reimbursement for that modality. 2) Certificate of Need (CON) should be mentioned. Does the practice need to explore if a CON is required prior to adding the new service, because not being able to bill Medicare for this service is a risk? It will also need to be determined if a pre-authorization is required for this type of procedure, which again will affect reimbursement if a pre-authorization is not obtained prior to the service being rendered.

**Dealing with the Federal Government**

PECOS and CAQH have made provider enrollment much quicker and easier with their online tools. It is still time consuming, but generally speaking the insurance company will also process the
enrollment forms much quicker too. The added benefit of processing enrollments online is that it provides proof that documents were uploaded, or information was saved. Some insurance companies use an electronic signature process. DocuSign is a popular e-signature software. E-signing affords a time date stamp where it deters the insurance company from disputing the date the signed contract was received.

Revalidations/Renewals

CMS offers an easy way for providers to assess if they are due for Revalidation (CMS Revalidation). CAQH sends email alerts when documents such as licensure and malpractice are expiring soon. The credentialing specialist in a practice should pay particular attention to these deadlines to ensure that the group or a provider’s enrollment is not terminated.

When a provider Voluntarily Withdraws from Medicare, they are automatically dis-enrolled from the Medicare program for a period of two years. If the provider wishes to re-enroll in the Medicare program, they must submit a letter to rescind their withdrawal by November 30th of the second year. If the letter is not received by the deadline, the provider’s non-participating status will automatically continue for another two-year period. PECOS cannot be used for this process.

Maximizing Reward: Determining if you are being paid correctly

Every billing system is different and unfortunately how each billing software provides reporting is different. Even though software reporting varies, there are techniques that can be applied to determine if the practice is being paid accurately.

The first step is to understand the stated reimbursement in the contract. As discussed previously, many insurance companies allude to a “fee schedule” in the body of the contract but do not provide the actual fee schedule. It is essential to gather this information.

Next, if your billing software affords a way to analyze reimbursement electronically, that usually is the most efficient way to identify if the charges are being paid correctly. Most Revenue Cycle Management (RCM) software systems provide “standard reports.” These can sometimes be limited in the
number of reports available or may not “drill down” to detailed information. Some software systems offer “custom reporting,” where the user can develop reports that are very specific and unique to the practice to pinpoint payment information and identify trends. With some RCM systems, fee schedules or “Profiles” can be loaded into the computer. Then when the payment is posted, the computer can very quickly determine if the payment was accurate. Managers should become very familiar with the Explanation of Benefits (EOB). Reviewing actual EOBs in combination with technology can benefit the manager by enabling them to spot trends and identify incorrect payments very quickly.

If charges are not paid accurately, the manager should investigate and take steps to obtain the correct payment. Many contracts reference an appeals process. The manager should follow the instructions set forth to rectify the situation. This can be very time consuming but is a worthwhile effort to ensure the provider is paid accurately for the service in which they performed. The practice may want to consult with their State’s Insurance Commissioner when an insurance company does not pay or pays incorrectly according to the agreed terms in the contract. Get to know your State Legislature representatives. These representatives may be another resource to consult when the practice is continually paid incorrectly.

Not reviewing reimbursement could be a threat to the practice. Inaccurate payments can lead to incorrect or skewed analysis of reimbursement. This may affect provider compensation or prohibit the practice from achieving planned growth if budgeted funding was not actually received.

Effects of Participation on the Practice Manager and Billing Office Staff

Enrolling newly hired providers:

As discussed previously, it can take 6 to 9 months or more for an insurance company to credential and enroll a provider in their plan. Some practices will not onboard a practitioner until they are fully credentialed/enrolled with all insurance plans, or at least the “major” carriers, such as Medicare, BlueCross, Aetna, United, Cigna, or Humana. To assist with collecting the practitioner’s individual information, the following checklist was developed by this writer:
NEW PROVIDER CHECK LIST

Provider Name ___________________________  Start Date with Group* ___________

*At least 90 days’ notice prior to first Date of Service start date is requested, so that provider can be
credentialled and out of network denials can be avoided, otherwise provider may not be reimbursed for
services rendered on or after 1st DOS.

Email copy of the following items:

- IN State Medical License
- OUT of State Medical License(s)
- DEA Federal Drug Certificate (ensure legible certificate number, issue date, and expiration date)
- CDS State Drug Certificate (ensure legible certificate number, issue date, and expiration date)
- Driver’s License (include a copy of the back if the front expiration date has expired)
- Current CV (explain any date gaps in employment or education, use MM/DD/YYYY format)
- Current unexpired professional liability/malpractice face sheet for this provider
- ECFMG Certificate (if applicable)
- Medical Diploma
- All internship(s)
- All Fellowship(s)
- All Residency(ies)
- Military certifications
- Other certificate(s) acquired
- All Board Certification(s); legible Certificate #
- Provider Type, check one box: ☐ Staff Doctor (permanent provider)
  ☐ Locum (temporary provider)
- Individual NPI Number
- Social Security Number
- List all languages other than English that Provider speaks fluently
- Home Address
- Cell Phone #: Email
- Provider Date of Birth
- Place of Birth City, State, County, Country
- Provide details of ALL Medicare sanctions or adverse legal actions – attach copies of documentation
- Provide details of ALL Malpractice Suits with History/Details – attach copies of documentation
- Attach a voided personal check for payroll direct deposit
The Credentialing Specialist at the practice will need to coordinate with the provider to access or update their PECOS and CAQH accounts with the new practice’s information.

**The difference between credentialing Staff providers and Locum Tenens providers**

Up to this point, all of the credentialing that has been discussed has pertained to a staff provider individual enrolling with a group. There is a different type of provider that may be billed on a claim form when the staff provider is absent, and this does not require any credentialing. When the staff provider is absent, the practice may utilize a substitute physician. The practice may bill for the substitute provider’s charges under the staff provider’s name/Individual NPI and use either a Q5 or Q6 modifier to indicate that a substitute physician was used. One of these modifiers is appended to the CPT/HCPCS code and is placed in Block 24d on the HCFA 1500 (Health Care Financing Administration) red paper claim form, or in Loop and Segment 2400 SV101 of the electronic claim.

The Q5 modifier is used to describe a “reciprocal billing arrangement.” In a reciprocal billing arrangement physicians in different practices agree to “cover” for each other. This arrangement does not require a written agreement between the parties.

When the Q6 modifier is used, this indicates that a “locum tenens” physician was engaged. A locum tenens, or locum for short, is a Latin phrase meaning “place holder.”

There are very specific Medicare billing regulations to follow when using a Q5 or Q6 modifier:

- Only MD or DO physician provider types may serve as a substitute physician for a staff MD or DO physician;
- Acceptable reasons to use a substitute physician are when the staff physician has an illness, pregnancy, vacation, or is attending continuing medical education courses;
- Substitute physicians may not be used to cover “call”;
- Existing staff providers within a practice may not be used as substitute physicians for internal billing purposes;
• The staff physician/practice pays the substitute physician a “per diem” rate and the relationship is one of an independent contractor and not employee;

• A substitute physician may not be used for more than 60 continuous days, except under certain conditions.

CMS may request documentation to confirm a substitute physician arrangement exists, such as an independent contractor contract, or proof of military orders.

When hiring a staff provider, because the credentialing enrollment process can take many months to finalize, the practice may not bill the staff provider as a substitute provider while waiting on the newly hired physician’s Medicare PTAN (Provider Transaction Access Number) to be assigned in order to gain reimbursement for their charges (CGS Medicare; CMS clm104c01; HCPCS Modifier Q5; HCPCS Modifier Q6; Locum).

Accounts Receivable Follow Up

When substitute physicians are used, the requirement of the Q5 and Q6 modifier may vary from insurance to insurance when serving non-Medicare patients. The Practice Administrator should review the EOBs for any denials related to the billing of substitute providers. Follow the instructions of the insurance company and correct and refile claims when applicable.

Responsibilities when you give Notice to Terminate the Contract:

Know the conditions of the Termination Clause

As mentioned previously, contracts can be terminated with or without cause. Ensure that you follow the instructions for notifying the insurance company that you desire to terminate. There may be a special address for Notices that is different than the insurance company’s regular claim filing address. Be aware of the termination period. Once you give notice, there may still be multiple service years
remaining on a contract until the relationship is officially severed. This may be a risk to the practice if the reimbursement is poor (Keene and Naus 75-6).

Clinical Care Transition

The practice should review the managed care contract to determine what the requirements are for severing the provider-patient relationship and what conditions may exist for continuing care after the contract is terminated. The practice may want to speak to their legal counsel to ensure the timing of terminating the contract would not be viewed as “patient abandonment” (Healthcare Liability).

Determine if the practice and/or insurance company has an obligation to inform patients you will no longer accept their insurance. According to Keene and Naus, “The provider-patient relationship is the sole responsibility of the provider” (Keene and Naus 75-6).

Fulfilling Patient Medical Record Requests

After a contract is terminated, patients may contact the practice to obtain their medical records (Keene and Naus 76). The practice should refer to federal and state law before charging a fee to copy or provide medical records. HIPAA prohibits the practice from charging certain fees even if it is allowed by state law (Healthcare Liability).

One Practice Manager’s experience terminating a contract

Karen Bowman, FACMPE, CPC, CPMA, Practice Manager of Gastrointestinal Associates of Cleveland, PC in Cleveland, Tennessee, shared her experience with recently terminating a TennCare (Medicaid MCO) and a Medicare Advantage contract with one payer.

Medicaid contracts typically pay the least of all insurance companies. Bowman’s analysis of her practice’s visit schedule revealed that this insurance company’s patients repeatedly missed appointments and this population represented a significant volume to the practice, as they were the only GI practice within a 30-mile radius who participated with any Medicaid products. Each missed appointment resulted in a loss of revenue. This insurance did not reimburse well to start with when the patient was seen, so the
blow was magnified when no payment at all was received when the patient did not show for their appointment. This led the group to start the process of attempting to renegotiate the contract for higher reimbursement for both the Medicaid and Medicare products with this insurance company. Bowman gathered historical billing and financial data and determined the amount of revenue that would be lost if the contracts were terminated. The opportunity to fill these appointments with commercial insurance or patients who could pay was being lost. This was having a detrimental financial impact on the practice.

Bowman relayed that a new fee schedule was offered, however lamented, because initially it was deceiving. While the rates did appear higher at first glance, when she thoroughly scrutinized the new fee schedule, the higher rates were not applicable to her facility type. The reimbursement that did apply to her facility type she discovered was in fact even lower than the original contracted rates. After more than a year of discussions, the group felt it was in their best interest to terminate both contracts.

The group’s obligation in the off-boarding process was to send letters to patients that were seen in the practice within the last two years and then notify them that the practice would no longer be a participating provider with their insurance. The patient was instructed to contact their insurance for referral to an in-network provider.

After the contracts were terminated, for a very brief period, the practice did see a slight decrease in appointment volume and revenue. This was concerning because the practice had just employed a new mid-level provider five months prior to termination of the contracts. However, prior to terminating the contracts, the group had changed their marketing strategy to attract more patients with higher paying insurance to replace the revenue that was going to be lost. Bowman produced reports from her billing computer to identify the Referring Doctors who referred the highest volume of patients to the practice. Bowman, as well as the physicians and mid-levels, in a concerted effort visited those doctor’s offices to educate them about the services the practice provides. Bowman arranged for her clinical staff to attend all health fairs offered in the area. In addition, the physicians met with the newspaper, as well as a local health care magazine and provided articles on specific diseases treated in the practice. This endeavor was
wildly successful. The result was an increase in new patient volume which had a corresponding positive effect on revenue, because even higher reimbursement was achieved through better paying insurances.

Bowman and the physicians decided to rejoin the network as participating providers with the Medicare Advantage plan so they could ensure the older patient population’s health needs were being met. In the end, she was able to secure slightly higher reimbursement rates than the group experienced from the original contract.

Bowman has some sage advice for other managers and physicians, “Research, Research, Research” (Bowman). She continued, “Look at the reason why you think you need to terminate, and then look at all the data you can about your practice to identify revenue that will possibly be lost. Look at the impact it will have on your practice’s income, scheduling, and physician compensation” (Bowman). Bowman was adamant that managers should not compromise what they feel is best for their practice. “You must verify you have the correct fee schedule. The potential to lose thousands of dollars for your practice is very real” (Bowman).

IV. Conclusion

In the business of medicine, making the decision whether or not to participate with an insurance contract could mean the difference between additional revenue or lost revenue for the medical practice. The downside to negotiating insurance contracts is that it takes time. A lot of time. The resources provided in this paper will provide stakeholders and their practice executives with the tools to effectively navigate the uncertainty of contract participation, and reward to the bottom line when these tools are utilized. The point is that if the private practice executive can learn about these tools and consciously apply them to negotiate a better deal, it will benefit the Stakeholders monetarily, and sustain the viability of the practice. In this day and age of declining reimbursement and ever-increasing costs, this paper provides paths to achieve maximum revenue.
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