Mapping out Managed Care Contracts for Prime Reimbursement Requires Close Attention to Negotiations, Follow up on the Back-End

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PHYSICIAN BILLING PRACTICE MANAGEMENT

It is important that managed care contracts be closely scrutinized from many angles to assure anesthesia practices are getting the proper reimbursement. Many savvy practice leaders and physicians understand that complex language within a managed care contract requires strict attention to assure reimbursement is met in follow through of what is stipulated. However, many facets of managed care contracts outside of the language can be overlooked and therefore directly affect a practice's reimbursement. This paper will address both complex contract language and negotiation tactics that can directly and positively impact reimbursement.

Pay Attention to the Language in Your Contract

While practice leaders may understand the language within each individual payor contract, it is important to dig deep into an existing contract to understand what is or is not included and what can be renegotiated for greater reimbursement opportunity.

Going beyond understanding the contract language, smart, strategy-driven renegotiation tactics can be built into a contract to affect reimbursement on an ongoing basis. Benchmarking an anesthesia practice's base and time units on procedures by calculating the number of units the group produces and then modeling out the different rates can easily illustrate differing reimbursement levels for the best fit. There are several areas of managed care contracts that anesthesia practices should be aware of, and while not all can be directly negotiated by the practice, it is important that the language within the managed care contract is scrutinized, negotiated or modeled to optimize and understand anesthesia reimbursement.

Sense of Renewal

First and foremost is the need for vendors and clients to stay on top of when a contract can be renegotiated, or the evergreen date. The time of contract renewal is one of the most important things to know in an effort to begin negotiations. There are instances when a contract must be renegotiated within a specified time period of the evergreen date. Often times, a third-party billing vendor such as Medical Management Professionals, Inc. (MMP) will begin working with a practice that already has existing managed care contracts. Early identification of contract renewal dates or evergreen date clauses is crucial to ensure renegotiations occur to increase the per unit reimbursement.

To Be or Not to Be?

Anesthesiology practices can elect to participate or not participate with the hospital's contracted payors, though sometimes this is not an option. A practice must review the verbiage in its contract with the hospital regarding managed care participation. Some hospital contracts require that practices participate with the same managed care contracts as the hospital. If this is the case, then the ability to negotiate fair reimbursement rates are diminished, and thus practices often must accept poor managed care contracts. However, if the practice works closely with hospital administration and the hospital's managed care department, it may have the opportunity to negotiate a fair market rate even when it is ultimately required to participate in all the contracts the hospital participates in.

In some cases, a hospital agreement will state that the practice must put best efforts toward participating with all managed care contracts the hospital participates with, but ultimately does not force participation. This typically gives the group more leverage in a negotiation. However, even in this case, it is prudent to have a close working relationship and regular communications regarding managed care contracting with the hospital administration and the hospital's managed care department. Whether a practice is required to participate with a managed care payor or not, having the hospital in the loop during the negotiations can be the difference between a good contract and a bad contract. Due to the complexities of balance billing when the practice is an out-of-network provider, the best option for many practices is to participate with those contracts that the hospital is participating in. If a practice is not forced to participate (and is therefore out of network) then theoretically the practice would receive 100 percent payment of charges from the payor and the patient for services rendered, which might seem like the best option. However many payors access a different managed care network with which the practice participates. If those rates are less than the offered contract rates with the payor, the practice actually loses money. Often times when a practice is not participating with a particular payor, the payor will lease provider participation from another managed care network. The rates paid by the leased network may be higher or lower than what a practice would receive in a contractual arrangement with the payor.

If a practice is contemplating not participating with a particular managed care network, it is important to evaluate the leased network rates that a payor may have access to compared with an offer from the payor. The practice may decide it is more advantageous to participate with the payor than to be subjected to the leased network claims adjudication. For example, a practice can evaluate whether it is beneficial to accept a contract with payor ABC to obtain rates that are better than what leased network XYZ reimburses.

Timely Filing

Among reimbursement factors that demand close attention and compliance in a managed care contract is the timely filing deadline. Filing is defined by the length of time agreed upon or required to submit a claim to payors. A physician will not get paid if a claim is not submitted on time and many internal and external factors can contribute as to whether or not a claim is submitted in a timely manner. Timely filing directly relates to front-end billing processes, so it is crucial that the practice's billing office or third-party vendor is also aware of the amount of days needed to file all claims. For example, practices should avoid agreeing to 90 days timely filing. A smart minimum is 120 days which typically allows enough time, though 180 days is most ideal. An example of timely filing language is as follows:

> "XYZ Anesthesia agrees that in the event a claim for service is not received by [private payor] within 180 days after the later of: (i) the date the services are rendered and (ii) the date of XYZ Anesthesia's receipt of the Explanation of Benefits from the primary payor, when the [private payor] is the secondary payor, such claim shall be denied and deemed to have been waived by XYZ Anesthesia and XYZ Anesthesia shall not seek payment for such claims from a member."

Medicare Percentages

Common knowledge among anesthesia circles is the fact that Medicare notoriously undervalues anesthesia reimbursement for cases, which is why anesthesia practices should never accept a percentage of Medicare as a basis for managed care reimbursement. A managed care company typically will not offer 300 percent of Medicare, which is the percentage needed to obtain a competitive rate in anesthesiology.

Unit Rates

In anesthesia, the time component is a variable for any surgical procedure. In managed care contracts, payors determine the time component in units, typically at 10 or 15-minute intervals; however, some payors will stipulate time units as 12 minutes. The American Society of Anesthesiologists (ASA) determines the base unit for a surgical procedure, which also bundles, or includes, all pre and post-op evaluations, etc. The unit rate is the amount of money that can be applied to the base and time units. As shown below, if a knee procedure has a base of 10 units and the payor has offered a 15-minute time unit, the conversion factor begins at $50 per time unit, referred to as $50/15. What a practice may desire is the total reimbursement to mirror a 10-minute time unit, which could yield more reimbursement than a 15-minute time unit. In this case, it would need to ask the payor for an increase on the conversion factor, or cost per unit. As illustrated in three models below, the conversion factor shows that the amount the practice would need to ask for to equalize the time unit would be $57 per time unit:

- **Initial offer: $50/15/time per case: 60 minutes**
  Base units = 10
  50 x 10 (conversion factor x base) = $500
  60 minutes/15 = 4 time units per case
  50 x 4 = $200
  Total reimbursement: $500 for base + $200 for time = **$700**

- **Conversion calculation of offer: $50/10/time per case: 60 minutes**
  Base units = 10
  50 x 10 (conversion factor x base) = $500
  60 minutes/10 = 6 time units per case
  50 x 6 = $300
  Total reimbursement: $500 for base + $300 for time = **$800**
  Net loss = $100 per case

- **New requested offer: $57/15 (at a conversion factor of 1.14)**
  Base units = 10
  57 x 10 (conversion factor x base) = $570
  60 minutes/15 = 4 time units per case
  57 x 4 = $228
  Total reimbursement: $570 for base + $228 for time = **$798**
  Net gain for group = $98 per case

Stepped Increases
If a practice determines its ultimate goal is to get to a $63 unit rate and a 15-minute time unit, realizing that a payor will not immediately agree to the new rate in one contract negotiation, then it can be agreed upon that in year one of a contract that currently reimburses at $52/15, the payor can increase to $55/15 the first year. Year two might increase to $58/15, and year three can meet the goal of $63/15. Increases can vary, but are stepped to meet the goal. Negotiations might call for a slight increase in year one, with a larger increase in year two and no increase in year three, as another example.

Escalators
If stepped increases are not the desired option, then a practice can ask for an escalator, which is a smaller, set increase that is carried out through the length of a contract. From a strategic standpoint, a practice can determine the length of its contract if it is not taking a stepped increase approach. Escalators provide practices with another tactic to raise reimbursement by using smaller automatic raises year after year. For example, a practice may request an escalator of 2 percent to 2.5 percent each year for the length of its managed care contract. Requesting an escalator does require foresight to minimize risks by looking at factors like the cost of living which could increase more than the percentages being negotiated. Occasionally payors will set the escalator at a percent of the cost of living index or the medical cost of living index.

Inappropriate Bundling

The ASA defines bundling as a payment method that combines minor medical services or surgeries and principal procedures when performed together or within a specific period of time. This definition also notes that it is "acceptable" that "some insurance plans bundle the payment of the lesser service into the payment for the principal procedure."[1] Tactically, anesthesia practices can make sure that line placements or flat fees are appropriately paid and that payors do not inappropriately bundle based on what is in the managed care contract. Without understanding the language and closely following the ASA guidelines laid forth in the contract, anesthesia practices usually lose money from several different pockets without knowing why. To avoid inappropriate bundling up front, it is important to negotiate into the contract that ASA guidelines will be followed.

Physical status modifiers, also known as the ASA modifiers, help the anesthesia care team classify a patient as to their anesthesia risk. The increased work related to a higher risk patient should result in increased reimbursement. The ASA has assigned base unit values to ASA modifiers and qualifying circumstances. Therefore it is important that a practice confirm these within the managed care contract and later, that it is paid for these as well. Specific references in the managed care contract to reimbursement per the ASA guidelines for ASA modifiers and qualifying circumstances is prudent.

Anesthesia base and time services are reported by the use of the CPT-4 codes in the anesthesia section of the CPT-4 manual (commonly referred to as ASA codes), five-digit procedure code plus the addition of a physical status modifier. The modifying units may be added to the base values and the use of other modifiers may also be appropriate. Physical status modifiers are represented by the initial letter "P" followed by a single digit from 1 to 6.

Many anesthesia services are provided under particularly difficult circumstances depending on factors such as extraordinary condition of patient, notable operative conditions and unusual risk factors. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service. These modifying units may also be added to the base unit values[1].

Many times, payors will inappropriately bundle anesthesia charges that a practice might easily overlook, such as a post-op pain management day(s), or line placements. Due to these kinds of issues, a practice must sometimes challenge bundling denials.

Ensuring each service category is addressed in the managed care contract protects the practice from multiple appeals to obtain the reimbursement it is entitled to receive. Inappropriate bundling, while becoming less prevalent due to class action lawsuits against payors, is still a part of back-end billing processes that a practice must keep in its crosshairs. If a practice does not catch these types of inappropriate bundling, then it may unknowingly lose money which is difficult to recoup if not addressed quickly with the payor.

For example, charges for insertion of invasive line monitors are not a part of standard anesthesia base and time units but payors will often bundle them. These units need to be appropriately reimbursed in addition to base and time units. To expand upon this example, when placing a swan ganz catheter (CPT-4 Code 93503), access to the central venous catheter (CVP) (36556) is included if the swan ganz is "floated" along with the CVP. However, occasionally two separate access sites to the central circulation system are required. One site is used for the measurement of cardiovascular function, the other dedicated to the administration of medications or fluids. This could result in charges for two 36556s or one 36556 and one 93503. Appropriate modifiers would be appended indicating separately identifiable units to the payor.

Finding instances of inappropriate bundling per the guidelines or reference manuals set forth in the managed care contract is a main function of denial management, which is an extensive billing process practiced by MMP. It is important that a practice and its billing team know what is detailed within the contract so that instances of inappropriate bundling do not go unnoticed.

Split Bill Claims

Split billing allows for payment to both the anesthesiologist and anesthetists, usually a percentage to each to equal a potential reimbursement of the full contract allowable, which assures that both anesthesiologists and CRNAs are paid. Typically, two claims (split bill claims) are submitted to all government payors, worker's comp and occasionally a private payor. Split bill claims occur when concurrency modifiers are required by the payor whereby one claim is for the physician who provided medical direction for the anesthesia. The second claim is the anesthetist portion. Based on the individual contract language per payor, both might receive payment as $65 per unit split between the two, as one example. Because split bill claims are always payor driven, practices can make sure claims are submitted as stipulated, otherwise reimbursement may not be met.

Specific clarifying of payor information may not be referenced in the managed care contract, but the language in the contract may reference payment through certain reimbursement guidelines. These specific guidelines are as important as the managed care contract. The important thing to remember is that payors who require split bill claims will not negotiate, and the language about split bill claims within a contract will greatly affect claims submittal and reimbursement therein.

Contract Modeling

Contracts can be modeled based on frequency of use. Looking at total units a practice performs for each managed care product is often essential in determining its financial impact. If a managed care contract offers a different rate for HMO versus PPO plans, a practice can track the number of patients from each plan in the last 12 months and create a reimbursement analysis for each plan. A practice can model which rate is a financial win based on its own historical data. Knowing where the biggest volume lies could abate any negative impact. For example, if the PPO rate is higher than the HMO rate, and practice volume is higher with the HMO, the practice must ask whether it will increase its overall reimbursement by negotiating a higher HMO and a lower PPO. Another item for consideration is a blended rate for both plan types. This may result in overall increased reimbursement.

Example:

HMO Offer: $52/15 minute/unit	**PPO Offer**: $56/15 minute/unit
HMO Base and Time Units = 9,000 annually	**PPO Base and Time Units** = 7,500 annually
Reimbursement for HMO: $52 * 9,000 = $468,000	**Reimbursement for PPO**: $56 * 7,500 = $420,000
Total annual reimbursement = $888,000	

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A counter proposal might be a blended rate of $54/15 minute unit. Combined HMO and PPO base and time units would equal 16,500 (9,000 + 7,500). The reimbursement calculation would then be as follows: $54 * 16,500 = $891,000, with a net increase of $3,000.

Flat Fees

Negotiating rates for "flat rate procedures" will impact the overall reimbursement from a payor. Flat rate procedures are those procedures performed by an anesthesia care team member that are not considered a component of base and time. The anesthesia care team member is performing a surgical service. As such, the reimbursement negotiated should be consistent with rates paid to surgeons. This can be accomplished by negotiating a percentage of Medicare. A practice manager should review each flat rate procedure's utilization and the financial impact the payor's proposed reimbursement would have on the overall reimbursement.

In closing, it is clear that not all pieces of managed care contracts can be directly changed and impacted by the practice in its negotiations, though knowing which pieces of a contract can be negotiated by the practice greatly benefits reimbursement strategies. A practice can and should be aware of what can be negotiated so that nothing falls through the cracks or goes unnoticed. Most important is a practice's ability to understand the complex language in its managed care contracts and actively affect its negotiations with language that can be built into a contract to optimize reimbursement.

[1] 2010 Relative Value Guide®, ©2009 American Society of Anesthesiologists. www.asahq.org

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About MMP
Medical Management Professionals, Inc. (MMP) was founded in 1993 and is a leading provider of billing and practice management services to anesthesiologists. It currently serves more than 60 anesthesiology practices with more than 1,100 anesthesia providers combined. MMP's flexible solutions range from billing-only services to full-practice management services.

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