Payer Contracting - Assessment & Renegotiation, Modeling Offers/Counters & Other Key Contracting Issues

2019 MGMA LA & MS Southern Summer Conference

Penny Noyes, President, CEO & Founder

Guiding the business side of healthcare

www.healthbusinessnavigators.com
Learning Objectives

• Find and Manage current payer and network agreements
• Create & Implement a renegotiation strategy and timeline
• Model and Evaluate Offers and Counter Offers
• Identify Language … Renegotiate or Manage Provisions
• Weave Value Based into your agreement strategy
Goal for this session

Start to Finish Walk through of your Daunting Payer Contracting Renegotiation Project… to improve the bottom line and manage the process going forward.

• No more excuses!
• Take Charge!
• You can do this!
• And you can do it right!
What We’ll Cover to Get There

- Gather your current contracts and rates
- Determine *which* contracts need tackling & *when* to renegotiate
- Initiate the Renegotiations Properly
- Negotiate – Know your worth, Analyze Offers & Overcome Objections/Bluffs – Think Like a Payer
- Control timelines – notices, terminations, effective dates
- Ensure new agreement/amendment reflects terms
- Manage a termination process if you walk
- Validate your Value-Based Report Cards
- Set Alerts for future escalators & negotiations
- Manage Payer/Network notices/amendments

...and a few interesting stories to illustrate the importance of each step
Before we delve in... a couple of Important NOTES

- CPT is the trademark of the American Medical Association (AMA) and may be referenced on several pages of this presentation

- Discouraging Process: Perseverance Needed
  The process of getting started on a payer contracting project is frustrating. Expect it to take:
  ~ 2 months just to gather info if you are diligent,
  ~ A year to complete your first few re-negotiations and
  ~ 2 years to feel you have a solid handle on most/all

- Then plan on maintenance
Gathering Your Contracts, Rates & Utilization

- Find all of your current FULLY EXECUTED (Both Practice & Payer/Network signed) agreements filed at the office.
- Find all the Addenda/Amendments between original effective date and present.
- If you cannot find, don’t be embarrassed... you are in the majority and can blame the manager before you.
- Request from payer or network _ Each payer has its unique means of requesting copies of agreements and fee schedules... ask Rep, Portals, Fax #s, 800 Request lines.
What Payers/Networks to Include In Contract and Schedule Gather Stages

- **Commerical** (BCBS, Aetna, UHC, Cigna, Humana etc)
- **Government** (No contract per se, get Fee Schedules)
  - Medicare
  - Medicaid
  - Tricare
- **Government Replacement**
  - Medicare Advantage Organizations (MAO)
  - Medicaid Managed Care Organizations (MCO)
- **Workers Comp** (find state fs if one applies – few states based on UCR)
- **Networks** – rented by med/wc/auto payers such as … Multiplan, TPRN, Corvel, more
Can you negotiate with Tricare Contractors or Medicare/Medicaid MAOs and MCOs? YES

**Tricare –**
- Tricare Max Allowable essentially = Mcr rates
- % discount is assumed by contractors that is not required of its contractors by Dept of Defense

**Medicare Advantage MAOs:**
- CMS does not require rates be same as Mcr
- Plans can cover services not covered by Mcr
- Sequestration reduction not implied – See CMS Memorandum

**Medicaid MCOs:** Administered by states with significant variation by state
- Most states have Mcd fee schedule and MCOs offer % of these
- MS implemented increased E&M for PCPs 7/1/19
- Some states like TN do not have Mcd FS; MCOs offer % Mcr
- If OON, some state protect MCOs with Ex: 95% of Mcd max
Inventory Your Agreements

Distinguish Individual vs Group & Direct vs IPA/PHO

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th>ABC Practice, TIN# 22-0000120</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contract</th>
<th>Original Eff. Date</th>
<th>Last Anniversary Date</th>
<th>Days to Anniv.</th>
<th>Term (Years)</th>
<th>Tied to Anniv.</th>
<th>Term Notice Days</th>
<th>Notice Due Date</th>
<th>Notice Notes</th>
<th>Reimbursement Rates</th>
<th>Rep Contact Info</th>
<th>Notice Address</th>
<th>Termination Date</th>
<th>Contract Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueField (GROUP)</td>
<td>05/06/11</td>
<td>05/06/15</td>
<td>83</td>
<td>1</td>
<td>No</td>
<td>30</td>
<td>2/6/2016</td>
<td>30 days at anytime</td>
<td>Lesser of billed charges or: All; 2011 State MCR/RVU CF; DME 70% of DMS; DMERC, default 80% billed</td>
<td>NikiEvans</td>
<td>123 Street, Suite 3</td>
<td>PPO Town, USA 02220</td>
<td>BlueField HMO (Group)</td>
</tr>
<tr>
<td>Red Cross (INDIV Contracted through ABC/PHO)</td>
<td>01/01/10</td>
<td>06/30/16</td>
<td>323</td>
<td>1</td>
<td>Yes</td>
<td>60</td>
<td>11/2/2015</td>
<td>30 days after initial term, tied to anniversary</td>
<td>Lesser of billed charges or: PPO: 100% Current Year MCR HMO: 105% 2005 MCR</td>
<td>JohnJames</td>
<td>J.James@ABC/PHO.com</td>
<td>Red Cross Health</td>
<td>1542 W. Em. Blvd, HCO</td>
</tr>
<tr>
<td>ABC Player</td>
<td>05/02/08</td>
<td>06/30/16</td>
<td>323</td>
<td>1</td>
<td>Yes</td>
<td>120</td>
<td>9/3/2016</td>
<td>120 days after initial term, tied to anniversary</td>
<td>Lesser of billed charges or: Commercial: 120% PPO Health Market FS MCR Advantage: 100% CY/NCR Worker’s Comp: 95% where MCFS</td>
<td>No Rep Assigned</td>
<td>Provider Relations - Contracting Dept 500-544-4444</td>
<td>PPO Health Network Inc</td>
<td>47774 E. Highway 222 SE</td>
</tr>
<tr>
<td>WorldHealthNat’l Di: Dr. Jones</td>
<td>04/01/12</td>
<td>09/01/16</td>
<td>201</td>
<td>1</td>
<td>No</td>
<td>60</td>
<td>7/2/2016</td>
<td>60 days at anytime</td>
<td>Lesser of billed charges or: All: 90% of 2005 MCR</td>
<td>SusanBones</td>
<td><a href="mailto:susanbones@OneHealth.com">susanbones@OneHealth.com</a></td>
<td>OneHealth Inc</td>
<td>P.O. Box 55491</td>
</tr>
<tr>
<td>WorldHealthNat’l Di: Dr. Rolls</td>
<td>09/01/10</td>
<td>09/01/16</td>
<td>201</td>
<td>1</td>
<td>No</td>
<td>60</td>
<td>7/2/2016</td>
<td>60 days at anytime</td>
<td>Lesser of billed charges or: All: 100% of 2009 MCR</td>
<td>SusanBones</td>
<td><a href="mailto:susanbones@OneHealth.com">susanbones@OneHealth.com</a></td>
<td>OneHealth Inc</td>
<td>P.O. Box 55491</td>
</tr>
<tr>
<td>MultiPlan</td>
<td>01/01/10</td>
<td>12/31/15</td>
<td>240</td>
<td>1</td>
<td>No</td>
<td>120</td>
<td>12/30/15</td>
<td>120 days at anytime</td>
<td>Lesser of billed charges or: All: 90% of 2005 MCR</td>
<td>Broll</td>
<td>BRoll</td>
<td>PPO Town, USA 02220</td>
<td>MultiPlan (Group)</td>
</tr>
</tbody>
</table>

Show All | Hide Termined Contracts | Embed PDF File

Sort | Sort | Sort
Finding Your Current Rates
While there are lots of sources ...
... Easier said than done

- Vague Contract Exhibits referring to undefined standard market schedules

- Rates change over the years due to amendment and proprietary market schedules or CY Mcr based schedules

- Special Fax and Email queries

- Web Portals

- EOB Allowables – NOT most reliable way to determine contract rates

- Request population of CPT* list by rep – ideal if they will do it
Create a List of All CPT Codes Performed with Modifiers & Fac/Non-Fac column

- Create MS Excel Spreadsheet with ALL Practice Codes with Modifier and Place of Service (Facility or Non-Facility) for each product (HMO, PPO, Med Adv, Exchange, Medicaid, etc)

- If primary care Non-Fac only; if surgical specialty Fac & Non-Fac needed

- Send to rep to populate the dollar amount of your current reimbursement by product

- Typical responses:
  - Rep populates sometimes or limits to top/sample codes
  - Rep sends FULL fee schedule for you to cull your CPTs
  - Rep sends you to a web-portal/email/fax #
Web Portals for Rates
Reliable but...

- Payer specific portal or NaviNet/Availity with ID/PW
- Often portal is not “enabled” for FS lookup
- Numerous product/plan names that do not match contract plan names, ugh! – which apply?
- Unclear if contractual percentage has been applied yet or not
- Limit the # codes you can retrieve at one time to 10 or 20… tedious cut and paste
- Often labs and/or injectibles are limited or not there
Rates Change – How can this happen?

Two primary ways...

- Amendment provisions often allow the payer or network to modify the rates without the written consent of the provider.
  - Sometimes notice is required but silence = acceptance.
  - Sometimes no notice is required at all, especially on Payment Policy Changes (i.e. 25 modifier) & Injectibles.

- Rates are tied to a *payer’s proprietary* Market or Standard Fee Schedule or RBRVS. As the payer decides to modify its market schedule in your market, your practice has essentially agreed to accept that modification without notice or signature, especially for injectibles.

Therefore, make sure you have updated the rates very recently and verify with your staff from where and when exactly the schedules were pulled.
Gather Utilization Data from PMS

- Select a recent but mature one year period
- ALL billed codes and new codes should be addressed
- Include CPT, Mod, Payments, Charges, Place of Service (Facility/Non-Facility)

and Marry it with your rates
Run a 12 Month Utilization Report with **ALL** CPT Codes by Facility (Hosp/ASC) & Non-Facility (Office)

Total All Payers Most Important; Payer Specific Helpful

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>% of Medicare</th>
<th>Non-Facility</th>
<th>Facility</th>
<th>RBRVS</th>
<th>RBRVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>20520</td>
<td></td>
<td>Removal of foreign body</td>
<td>100.0%</td>
<td>$204.72</td>
<td>$147.09</td>
<td>$204.09</td>
<td>$145.64</td>
</tr>
<tr>
<td>20525</td>
<td></td>
<td>Removal of foreign body</td>
<td>100.0%</td>
<td>$484.96</td>
<td>$247.16</td>
<td>$463.45</td>
<td>$245.40</td>
</tr>
<tr>
<td>20526</td>
<td></td>
<td>Ther injection, carp tunnel</td>
<td>35.8228</td>
<td>$76.63</td>
<td>$66.93</td>
<td>$76.39</td>
<td>$56.76</td>
</tr>
<tr>
<td>20550</td>
<td></td>
<td>Inj tendon sheath/ligament</td>
<td>35.8228</td>
<td>$59.12</td>
<td>$41.62</td>
<td>$58.94</td>
<td>$41.49</td>
</tr>
<tr>
<td>20551</td>
<td></td>
<td>Inj tendon origin/insertion</td>
<td>35.8228</td>
<td>$60.58</td>
<td>$42.71</td>
<td>$60.40</td>
<td>$42.58</td>
</tr>
<tr>
<td>20552</td>
<td></td>
<td>Inj trigger point, 1/2 muscl</td>
<td>35.8228</td>
<td>$55.38</td>
<td>$37.87</td>
<td>$55.21</td>
<td>$37.75</td>
</tr>
<tr>
<td>20600</td>
<td></td>
<td>Drain/inject, joint/bursa</td>
<td>100.0%</td>
<td>$47.52</td>
<td>$35.49</td>
<td>$47.38</td>
<td>$35.38</td>
</tr>
<tr>
<td>20605</td>
<td></td>
<td>Drain/inject, joint/bursa</td>
<td>100.0%</td>
<td>$49.70</td>
<td>$36.94</td>
<td>$49.55</td>
<td>$36.82</td>
</tr>
<tr>
<td>20610</td>
<td>50</td>
<td>Drain/inject, joint/bursa (50)</td>
<td>100.0%</td>
<td>$89.72</td>
<td>$68.37</td>
<td>$89.44</td>
<td>$68.16</td>
</tr>
<tr>
<td>20610</td>
<td></td>
<td>Drain/inject, joint/bursa</td>
<td>35.8228</td>
<td>$69.81</td>
<td>$46.58</td>
<td>$69.62</td>
<td>$45.44</td>
</tr>
<tr>
<td>20612</td>
<td></td>
<td>Aspirate/inj, ganglion cyst</td>
<td>100.0%</td>
<td>$60.97</td>
<td>$41.64</td>
<td>$60.79</td>
<td>$41.52</td>
</tr>
<tr>
<td>20670</td>
<td></td>
<td>Removal of support implant</td>
<td>100.0%</td>
<td>$388.04</td>
<td>$148.05</td>
<td>$386.85</td>
<td>$147.60</td>
</tr>
<tr>
<td>20680</td>
<td></td>
<td>Removal of support implant</td>
<td>100.0%</td>
<td>$621.10</td>
<td>$420.87</td>
<td>$619.19</td>
<td>$419.57</td>
</tr>
<tr>
<td>20690</td>
<td></td>
<td>Apply bone fixation device</td>
<td>100.0%</td>
<td>$586.84</td>
<td>$566.84</td>
<td>$586.03</td>
<td>$555.03</td>
</tr>
<tr>
<td>20592</td>
<td></td>
<td>Apply bone fixation device</td>
<td>100.0%</td>
<td>$1,109.40</td>
<td>$1,109.40</td>
<td>$1,105.98</td>
<td>$1,105.98</td>
</tr>
<tr>
<td>20900</td>
<td></td>
<td>Removal of bone for graft</td>
<td>100.0%</td>
<td>$424.65</td>
<td>$187.94</td>
<td>$423.34</td>
<td>$187.37</td>
</tr>
</tbody>
</table>

**FeeCreator** / DATA / Calcs / Util. and Charges / Premera / Cigna / First Choice / Regence / GH / UHC / Tricare / Aetna
Create a Side-By-Side Line Up of all your Payers’ & Medicare Rates
Best to Include Charges, Max Allowable & Utilization too

| Code | Modifier | Description                      | MCR | MCR | Facility | RBRVS NF | RBRVS F | Units/Yr | Charges | Max Allow | Payer 1 | Payer 2 | Payer 3 | Payer 1 | Payer 2 | Payer 3 | Payer 1 | Payer 2 | Payer 3 | Payer 1 | Payer 2 | Payer 3 | Payer 1 | Payer 2 | Payer 3 |
|------|----------|----------------------------------|-----|-----|----------|----------|---------|----------|---------|----------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
| 10060| 0        | Drainage of skin abscess         | $108.65 | $87.75 | $103.48 | $87.75 | 52 | $160.00 | $155.22 | 77.704 | 77.64 | 62.01 | 106.5894 | 114.29 | 122.29 |
| 10061| 0        | Drainage of skin abscess         | $180.78 | $150.98 | $172.17 | $150.98 | 3  | $218.00 | $261.52 | 131.856 | 107.01 | 189.3192 | 199.94 | 213.94 |
| 10120| 0        | Remove foreign body              | $133.46 | $85.68 | $127.10 | $85.68 | 9  | $218.00 | $191.50 | 94.92 | 91.08 | 79.31 | 138.2506 | 139.98 | 149.78 |
| 10121| 0        | Remove foreign body              | $258.42 | $171.94 | $246.11 | $171.94 | 1  | $ -     | $369.16 | 183.632 | 173.55 | 151.85 | 250.9034 | 0  | 0 |
| 11055| 0        | Trim skin lesion                 | $47.97 | $19.68 | $45.69 | $19.68 | 1  | $ -     | $68.00 | 33.768 | 26.98 |
| 11200| 0        | Removal of skin tags             | $83.06 | $66.58 | $75.10 | $66.58 | 3  | $ -     | $118.65 | 58.896 | 58.03 | 45.95 | 79.945 | 86.4 | 92.45 |
| 11730| 0        | Removal of nail plate            | $94.12 | $50.47 | $89.64 | $50.47 | 2  | $177.00 | $178.80 | 67.992 | 63.23 | 55.97 | 73.6438 | 97.64 | 104.47 |
| 11732| 0        | Remove nail plate, adj           | $43.06 | $26.24 | $41.01 | $26.24 | 1  | $ -     | $136.00 | 31.432 | 30.29 | 26.03 |
| 12001| 0        | Repair superficial wound         | $94.49 | $51.78 | $89.99 | $51.78 | 10  | $253.00 | $202.40 | 105.744 | 86.55 | 81.6678 | 93.45 | 100 |
| 12011| 0        | Repair superficial wound         | $113.15 | $61.84 | $107.76 | $61.84 | 18 | $189.00 | $173.56 | 112.192 | 128.49 | 92.09 | 99.6982 | 112.05 | 119.89 |
| 12013| 0        | Repair superficial wound         | $121.73 | $70.02 | $115.93 | $70.02 | 1  | $ -     | $328.00 | 123.544 | 101.28 | 109.3506 | 0  | 0 |
| 16020| 0        | Dress/debrid p-thick             | $80.66 | $53.38 | $76.82 | $53.38 | 4  | $126.00 | $115.22 | 57.224 | 48.26 | 74.576 | 80.76 | 86.41 |
| 17110| 0        | Destruct lesion, 1-14            | $107.84 | $64.81 | $102.70 | $64.81 | 31 | $177.00 | $154.05 | 76.08 | 51.25 | 56.62 | 98.7188 | 110.85 | 118.61 |
| 17250| 0        | Chemical cauterity, tis           | $74.20 | $33.75 | $70.67 | $33.75 | 32 | $111.00 | $106.00 | 51.584 | 37.31 | 42.64 | 71.6732 | 77.7 | 83.14 |
At this Stage, STOP and Evaluate Charges

Why?

• All too often, practices have certain codes that fall below contract rates and almost all contracts have “lesser of charges or contract rate” provision

• Contracts that are primarily based on a percent off of charges will be devastating if …

  For Example: Charges are at 150% of CY Mcr and the agreement pays 50% of charges – you are getting paid 75% of CY Mcr.

• Many agreements default to a very low % of charges if no value for a specific code is in payer FS...default often at 35 to 50% of billed charges

• Note: With few exceptions - Charge the same for all payers, even self-pay, for single analysis base
## How to Evaluate Charges

Add State Workers’ Comp Schedule if Practice does considerable amt of comp

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>% of Medicare</th>
<th>% of Medicare</th>
<th>Non-Facility Conversion Factor</th>
<th>Facility Conversion Factor</th>
<th>RBRVS</th>
<th>RBRVS</th>
<th>Total</th>
<th>NF</th>
<th>FAC</th>
<th>Charges as % of 2016 MCR</th>
<th>Charges as % of 2015 MCR</th>
<th>Max Allowable of All Payers</th>
<th>Max of Current Rate, 250% of 2015 MCR and Max Allowable of</th>
</tr>
</thead>
<tbody>
<tr>
<td>10120</td>
<td>__</td>
<td>Remove foreign body</td>
<td>$159.49</td>
<td>$109.11</td>
<td>$159.49</td>
<td>$109.11</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td></td>
<td></td>
<td>$70.00 (13% of $538.00)</td>
<td>$253.92 (39% of $640.00)</td>
<td>$398.73 (39% of $1,000.00)</td>
<td></td>
</tr>
<tr>
<td>11000</td>
<td>__</td>
<td>Debride infected skin</td>
<td>$56.74</td>
<td>$30.06</td>
<td>$56.74</td>
<td>$30.06</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$0.00 (0% of $141.85)</td>
<td>$141.85 (100% of $141.85)</td>
<td>$141.85 (100% of $141.85)</td>
<td></td>
</tr>
<tr>
<td>12001</td>
<td>__</td>
<td>Repair superficial wound(s)</td>
<td>$93.35</td>
<td>$46.68</td>
<td>$93.35</td>
<td>$46.68</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
<td>$280.00 (300% of $93.35)</td>
<td>$273.61 (300% of $91.20)</td>
<td>$280.00 (300% of $93.35)</td>
<td></td>
</tr>
<tr>
<td>99349</td>
<td>__</td>
<td>Home visit, est. patient</td>
<td>$132.06</td>
<td>$132.06</td>
<td>$132.06</td>
<td>$132.06</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$245.00 (186% of $132.06)</td>
<td>$202.84 (150% of $135.23)</td>
<td>$330.15 (250% of $132.06)</td>
<td></td>
</tr>
<tr>
<td>99350</td>
<td>__</td>
<td>Home visit, est. patient</td>
<td>$182.65</td>
<td>$182.65</td>
<td>$182.65</td>
<td>$182.65</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$330.00 (181% of $182.65)</td>
<td>$299.01 (161% of $185.50)</td>
<td>$456.63 (250% of $182.65)</td>
<td></td>
</tr>
<tr>
<td>99381</td>
<td>__</td>
<td>Prevvisit, new, infant</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$155.00 (135% of $115.00)</td>
<td>$196.61 (170% of $116.01)</td>
<td>$286.88 (250% of $115.00)</td>
<td></td>
</tr>
<tr>
<td>99382</td>
<td>__</td>
<td>Prevvisit, new, age 1-4</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$165.00 (138% of $121.00)</td>
<td>$299.72 (210% of $140.39)</td>
<td>$299.72 (210% of $140.39)</td>
<td></td>
</tr>
<tr>
<td>99385</td>
<td>__</td>
<td>Prevvisit, new, age 5-11</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$175.00 (140% of $125.00)</td>
<td>$206.39 (162% of $126.00)</td>
<td>$311.59 (250% of $125.00)</td>
<td></td>
</tr>
<tr>
<td>99391</td>
<td>__</td>
<td>Prevvisit, est. infant</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$185.00 (131% of $139.00)</td>
<td>$352.90 (223% of $159.00)</td>
<td>$352.90 (223% of $159.00)</td>
<td></td>
</tr>
<tr>
<td>99392</td>
<td>__</td>
<td>Prevvisit, est. age 1-4</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$195.00 (142% of $137.00)</td>
<td>$424.82 (232% of $169.78)</td>
<td>$424.82 (232% of $169.78)</td>
<td></td>
</tr>
<tr>
<td>99393</td>
<td>__</td>
<td>Prevvisit, est. age 5-11</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$215.00 (121% of $177.00)</td>
<td>$257.41 (148% of $172.00)</td>
<td>$257.41 (148% of $172.00)</td>
<td></td>
</tr>
<tr>
<td>99394</td>
<td>__</td>
<td>Prevvisit, est. age 12-17</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$150.00 (125% of $119.00)</td>
<td>$179.61 (147% of $117.00)</td>
<td>$300.48 (250% of $119.00)</td>
<td></td>
</tr>
<tr>
<td>99395</td>
<td>__</td>
<td>Prevvisit, est. age 18-39</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$165.00 (134% of $123.00)</td>
<td>$181.91 (142% of $128.00)</td>
<td>$307.85 (250% of $123.00)</td>
<td></td>
</tr>
<tr>
<td>99406</td>
<td>__</td>
<td>Behav chng smoking 3-10 min</td>
<td>$14.59</td>
<td>$12.84</td>
<td>$14.59</td>
<td>$12.84</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$75.00 (109% of $68.70)</td>
<td>$65.95 (100% of $65.95)</td>
<td>$75.00 (100% of $75.00)</td>
<td></td>
</tr>
<tr>
<td>99443</td>
<td>__</td>
<td>Phone e/m phys/chp 21-30 min</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>$45.00 (109% of $41.44)</td>
<td>$60.87 (100% of $60.87)</td>
<td>$103.61 (100% of $103.61)</td>
<td></td>
</tr>
</tbody>
</table>
Use Your Contract Inventory Notice Dates and Line Up of Reimbursement Rates & Utilization to determine what to tackle and when

- Which payers’ rates need most attention
- Payer Mix – what % of business for each payer
- What date can you notify the payer or network
- Does contract allow off-anniversary notice
- Send notices to initial payers – don’t negotiate too many at one time – overwhelming
- Get concurrence of your physicians/managers
- Send notices
Term & Termination Provisions Set
Timeline For Re-Negotiations –

Know when you can go to the table

Days prior to renewal

Example assumes 90-day notice is contractually required.
Now Let’s Determine Who’s Robbing You Most

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Mod Description</th>
<th>Units</th>
<th>Medicare</th>
<th>AmeraCare (NF)</th>
<th>Great Bear Healthcare (NF)</th>
<th>Green Cross HMO (NF)</th>
<th>Green Cross PPO (NF)</th>
<th>Intell Healthcare (NF)</th>
<th>Union Healthcare (NF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>NF - Office/outpatient visit, est</td>
<td>16,923</td>
<td>$69.11</td>
<td>$86,84</td>
<td>$75.37</td>
<td>$64.99</td>
<td>$68.39</td>
<td>$59.63</td>
<td>$54.29</td>
</tr>
<tr>
<td>99214</td>
<td>NF - Office/outpatient visit, est</td>
<td>9,866</td>
<td>$102.49</td>
<td>$130,89</td>
<td>$113.02</td>
<td>$97.61</td>
<td>$102.71</td>
<td>$88.00</td>
<td>$85.37</td>
</tr>
<tr>
<td>36413</td>
<td>NF - Drawing blood</td>
<td>8,677</td>
<td>$3.00</td>
<td>$4.20</td>
<td>$3.90</td>
<td>$3.00</td>
<td>$3.00</td>
<td>$3.00</td>
<td>$5.00</td>
</tr>
<tr>
<td>81003</td>
<td>NF - Ulnar, auto, w/o scope</td>
<td>6,530</td>
<td>$3.16</td>
<td>$4.92</td>
<td>$2.98</td>
<td>$3.22</td>
<td>$3.22</td>
<td>$1.82</td>
<td>$1.82</td>
</tr>
<tr>
<td>96372</td>
<td>NF -</td>
<td>3,739</td>
<td>$23.20</td>
<td>$28.77</td>
<td>$18.22</td>
<td>$20.05</td>
<td>$21.43</td>
<td>$20.80</td>
<td>$18.15</td>
</tr>
<tr>
<td>85205</td>
<td>NF - Automated hemogram</td>
<td>4,538</td>
<td>$10.94</td>
<td>$17.03</td>
<td>$10.32</td>
<td>$11.14</td>
<td>$11.14</td>
<td>$5.39</td>
<td>$6.52</td>
</tr>
<tr>
<td>80061</td>
<td>NF - Lipid panel</td>
<td>3,908</td>
<td>$18.85</td>
<td>$17.19</td>
<td>$17.19</td>
<td>$17.19</td>
<td>$17.19</td>
<td>$17.19</td>
<td>$17.19</td>
</tr>
<tr>
<td>91040</td>
<td>NF - Methylprednisolone 80 MG inj</td>
<td>3,705</td>
<td>$7.27</td>
<td>$5.24</td>
<td>$5.24</td>
<td>$8.67</td>
<td>$6.64</td>
<td>$11.23</td>
<td>$11.23</td>
</tr>
<tr>
<td>36416</td>
<td>NF - Capillary blood draw</td>
<td>3,357</td>
<td>$5.24</td>
<td>$7.27</td>
<td>$9.00</td>
<td>$7.27</td>
<td>$4.00</td>
<td>$5.00</td>
<td>$5.00</td>
</tr>
<tr>
<td>71020</td>
<td>NF - Chest x-ray</td>
<td>2,220</td>
<td>$31.37</td>
<td>$42.89</td>
<td>$27.16</td>
<td>$28.41</td>
<td>$30.40</td>
<td>$39.62</td>
<td>$35.77</td>
</tr>
<tr>
<td>90471</td>
<td>NF - Immunization admin</td>
<td>2,195</td>
<td>$23.20</td>
<td>$28.77</td>
<td>$19.18</td>
<td>$21.05</td>
<td>$21.45</td>
<td>$18.74</td>
<td>$18.15</td>
</tr>
<tr>
<td>93000</td>
<td>NF - Electrocardiogram, complete</td>
<td>2,095</td>
<td>$19.75</td>
<td>$28.46</td>
<td>$22.76</td>
<td>$18.50</td>
<td>$19.90</td>
<td>$23.00</td>
<td>$25.77</td>
</tr>
<tr>
<td>70696</td>
<td>NF - Ceftriax sodium injection</td>
<td>1,847</td>
<td>$1.05</td>
<td>$1.93</td>
<td>$1.93</td>
<td>$1.93</td>
<td>$1.93</td>
<td>$1.93</td>
<td>$1.93</td>
</tr>
<tr>
<td>87880</td>
<td>NF - Strep a assay w/optic</td>
<td>1,764</td>
<td>$16.88</td>
<td>$25.10</td>
<td>$15.21</td>
<td>$16.41</td>
<td>$16.41</td>
<td>$8.25</td>
<td>$9.61</td>
</tr>
<tr>
<td>80050</td>
<td>NF - General health panel</td>
<td>1,615</td>
<td>$7.34</td>
<td>$37.82</td>
<td>$7.47</td>
<td>$7.47</td>
<td>$7.47</td>
<td>$4.38</td>
<td>$4.38</td>
</tr>
<tr>
<td>80003</td>
<td>NF - Allergen specific IgE</td>
<td>1,615</td>
<td>$7.34</td>
<td>$7.47</td>
<td>$7.47</td>
<td>$7.47</td>
<td>$7.47</td>
<td>$4.38</td>
<td>$4.38</td>
</tr>
<tr>
<td>87804</td>
<td>NF - Influenza assay w/optic</td>
<td>1,512</td>
<td>$16.88</td>
<td>$25.10</td>
<td>$13.21</td>
<td>$16.41</td>
<td>$16.41</td>
<td>$8.25</td>
<td>$14.00</td>
</tr>
<tr>
<td>80070</td>
<td>NF - Hepatic function panel</td>
<td>1,597</td>
<td>$11.49</td>
<td>$9.98</td>
<td>$9.98</td>
<td>$9.98</td>
<td>$9.98</td>
<td>$3.78</td>
<td>$3.78</td>
</tr>
<tr>
<td>80053</td>
<td>NF - ComprehMetabolic panel</td>
<td>1,502</td>
<td>$14.87</td>
<td>$7.53</td>
<td>$12.35</td>
<td>$12.35</td>
<td>$12.35</td>
<td>$7.23</td>
<td>$7.23</td>
</tr>
<tr>
<td>99396</td>
<td>NF - Prev visit, est, age 40-64</td>
<td>1,278</td>
<td>$7.53</td>
<td>$117.98</td>
<td>$101.45</td>
<td>$106.75</td>
<td>$108.54</td>
<td>$111.77</td>
<td>$111.77</td>
</tr>
<tr>
<td>71885</td>
<td>NF - Ketorolac tromethamine inj</td>
<td>1,100</td>
<td>$1.49</td>
<td>$1.49</td>
<td>$1.49</td>
<td>$1.49</td>
<td>$1.49</td>
<td>$0.23</td>
<td>$0.23</td>
</tr>
<tr>
<td>84443</td>
<td>NF - Assay thyroid stim hormone</td>
<td>1,066</td>
<td>$23.64</td>
<td>$36.80</td>
<td>$14.72</td>
<td>$24.06</td>
<td>$24.06</td>
<td>$5.78</td>
<td>$5.78</td>
</tr>
<tr>
<td>80048</td>
<td>NF - Basic Metabolic panel</td>
<td>997</td>
<td>$11.91</td>
<td>$9.88</td>
<td>$9.88</td>
<td>$9.88</td>
<td>$9.88</td>
<td>$5.78</td>
<td>$5.78</td>
</tr>
<tr>
<td>84153</td>
<td>NF - Assay of psa, total</td>
<td>898</td>
<td>$25.89</td>
<td>$26.34</td>
<td>$26.34</td>
<td>$26.34</td>
<td>$26.34</td>
<td>$5.78</td>
<td>$5.78</td>
</tr>
<tr>
<td>99202</td>
<td>NF - Office/outpatient visit, new</td>
<td>833</td>
<td>$71.16</td>
<td>$89.18</td>
<td>$77.31</td>
<td>$66.46</td>
<td>$69.93</td>
<td>$66.24</td>
<td>$67.31</td>
</tr>
<tr>
<td>90715</td>
<td>NF - Tdap vaccine &gt;7 im</td>
<td>830</td>
<td>$33.66</td>
<td>$7.41</td>
<td>$7.41</td>
<td>$7.41</td>
<td>$7.41</td>
<td>$41.92</td>
<td>$44.54</td>
</tr>
<tr>
<td>82570</td>
<td>NF - Assay of urine creatinine</td>
<td>810</td>
<td>$7.28</td>
<td>$3.46</td>
<td>$7.41</td>
<td>$3.46</td>
<td>$7.41</td>
<td>$3.46</td>
<td>$3.46</td>
</tr>
</tbody>
</table>
Payer Fee Schedule Comparison

All Bands – What If

Total Utilization X Each FS

What if all utilization used each fee schedule. Only procedure codes that were on all fee schedules were included.
Evaluation & Management – What If

What if all utilization used each fee schedule. Only procedure codes that were on all fee schedules were included.

E&M (99201-99215)
What if all utilization used each fee schedule. Only procedure codes that were on all fee schedules were included.
Do “What If” Analysis for All Major Bands

- E&M
- Surgical
- Medicine
- Lab
- Radiology

Injectible Challenges – especially JCodes & Immunizations

Sometimes use Specialty Band Subset – Examples:

- Peds- subset analysis Preventive Visits, Immunization Admin
- Derm – subset analysis of dermatopathology or Mohs
- Rad – subset analysis of high tech MRI & CT
- Oncology/Urology – Cull Radiation treatment out of rad band
Getting the Notice and Negotiation Started

- Find notice terms and termination provisions – these drive when and how notice is to be sent

- Decide upon the payer or network with which to negotiate based on…
  1) notice dates and
  2) financial impact on practice of payer rates (both strength of schedule and % market share of payer)

- You will be inclined to want to negotiate the whole darn bunch of them but generally don’t tackle more than two major negotiations at one time
Challenges & Tips Regarding Renegotiation Notice

- Know #days notice required & if tied to anniversary
- Rarely a “renegotiation” clause – Use Term & Termination provision as the driver
- If Individual vs Group Agreement - all providers sign
- Info to include covered later in session
- Send w signature receipt required & SAVE proof
- Plan to follow up – you drive the timeline

Without Termination Date on Table – Payer is rarely in any hurry
## Inventory of Your Agreements

Know Notice Due Dates and if Tied to Anniversary & Send to Rep and Notice Address

<table>
<thead>
<tr>
<th>Contract Name</th>
<th>Original Eff. Date</th>
<th>Original Date</th>
<th>Anniversary Date</th>
<th>Days to Anniv.</th>
<th>Term (Years)</th>
<th>Tied to Anniv.?</th>
<th>Notice Days</th>
<th>Notice Due Date</th>
<th>Notice Notes</th>
<th>Reimbursement Rates</th>
<th>Rep Contact Info</th>
<th>Notice Address</th>
<th>Termination Date</th>
<th>Contract Link</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Health - Group Agreement</td>
<td>05/05/08</td>
<td>05/05/11</td>
<td>253</td>
<td>1</td>
<td>No</td>
<td>60</td>
<td>3/5/2012</td>
<td></td>
<td></td>
<td>See attached reimbursement tab: &quot;Red Health FS eff 05/1510&quot;</td>
<td>Jane Doe Contract Manager 414-555-5555; Fax 888-888-8888. <a href="mailto:jDoe@redhealthc.com">jDoe@redhealthc.com</a> 101 Red Parkway Redview, ZZ 55446</td>
<td>Red Health 6600 Campus Circle Drive E Irving, TX 75063 Attn: AVP of Provider Contracting</td>
<td></td>
<td>Red Health Group Agmt eff 05/05/2008 fully executed</td>
<td></td>
</tr>
<tr>
<td>Yellow Healthcare</td>
<td>07/15/01</td>
<td>07/15/11</td>
<td>324</td>
<td>1</td>
<td>No</td>
<td>90</td>
<td>4/15/2012</td>
<td></td>
<td></td>
<td>90 day termination notice See attached tab &quot;Yellow FS&quot;</td>
<td>Jane Doe Contract Manager 414-555-5555; Fax 888-888-8888. <a href="mailto:jDoe@yellowhealthcare.com">jDoe@yellowhealthcare.com</a> 101 Yellow Parkway Yellowview, ZZ 55446</td>
<td>Yellow Healthcare 101 Yellow Parkway Yellowview, ZZ 55446</td>
<td></td>
<td>Yellow Healthcare Agreement Dated 05/14/2008 - fully executed</td>
<td></td>
</tr>
<tr>
<td>Green PPO Physician Group Agreement</td>
<td>09/01/08</td>
<td>09/01/11</td>
<td>6</td>
<td>1</td>
<td>Yes</td>
<td>180</td>
<td>3/1/2011</td>
<td></td>
<td></td>
<td>180 days prior to anniversary; 60 day breach See attached reimbursement tab: &quot;Green FS eff 040110 &amp; Green Rmbrsmt Contrct Provisions&quot;</td>
<td>Jane Doe Contract Manager 414-555-5555; Fax 888-888-8888. <a href="mailto:jDoe@greenppo.com">jDoe@greenppo.com</a> 101 Green Parkway Greenview, ZZ 55446</td>
<td>Green PPO, Inc. Provider Contract Management Network Operations S.W. Region101 Green Parkway Greenview, ZZ 55446</td>
<td></td>
<td>Green Group PPO Agreement eff 09/01/2008 fully executed</td>
<td></td>
</tr>
</tbody>
</table>
Let’s write your notice to Renegotiate/Terminate
Send w Proof of delivery to Contract Notice Address and to Rep

- Practice name
- Practice TIN & Locations
- Physicians and Midlevels w practice
- If Individual Agreements – signature of each provider
- **Intent to renegotiate but with termination date** if terms not agreed upon by given date
- Date by which you request a response
- On Letterhead
- Keep the delivery receipt until negotiations are done
What if you are leaving IPA or PHO and Negotiating a Direct Agreement

- Add this information to the Notice Letter to Payer
- Review your IPA or PHO agreement to determine if any notice to the IPA or PHO is required and how much notice is required
- Remember that your credentialing may be “delegated” through the IPA/PHO and you will need to credential directly – ask payer about how to make this transition without a non-par gap.
Have a decent rep?

- There are some very professional reps out there – wish it was the majority
- Some Payers and Networks have gone to a no-assigned rep approach – Ex: Aetna
- Give the rep a ring or email with a heads up to advise you are sending formal notice per the contract terms and advise you wanted to give a courtesy heads-up and not blind-side him/her.
What if you ask nicely without term notice?

- Sometimes the payer will come to the table in good faith and negotiate without the threat of termination - rarely, but if paper is old they want to get a compliant agreement done too.

- Agreements lack a “re-negotiation” clause so often termination is the only contractual mechanism to use

- Unfortunately, without term notice, there is no hurry on the payer’s or network’s part and so expect LONG delays in responses

- If termination is tied to anniversary and you try w/out termination, and then get frustrated with the negotiation, you may have to wait a year to get tougher because you just missed the notice period
Prepare List of Things That Set You Apart for Negotiating Leverage

- Primary Care – many markets have a shortage and members are very loyal to PCPs

- Specialists – unique procedures, highly trained, shortage in market, certain govt plans require access to members, etc

- Put yourself in their shoes – they want to keep costs down
  - Extended Hours – reduces payers’ cost for the very expensive ER visits these extra hours avoid
  - Willingness to hear what your practice can do to change utilization/referral patterns or facility use or improve their Members’ experience
  - Happy to consider performance based programs – most today are for PCPs
  - Payers are looking to keep their customers, mostly employers, happy

- Employers with which you have a very good working relationship – keep them informed
Quick Wrap Up on Initial Steps:

- Figure out which contracts to negotiate
- Know if Notice is Tied to Anniversary
- Get a Proper Timely Notice Out According to Contract Terms
- Don’t tackle too many at one time
- Create realistic expectations for yourself and your physicians
As you send notices....Ask yourself this serious question

Are you ready to walk out on the contract and actually terminate if the network will not present the rates and terms that you require?
Expected responses to your notice

- Due to reform we are not able to entertain any rate increases at this time. Our CEO needs to continue her $24mil base salary and if we give you an increase, she won’t meet her bonus goals.

- You are asking for a 23% increase all at one time – we can’t do that. It is not our fault that you did not complain the last ten years as we kept lowering your rates.

- We cannot provide an increase at this time but we can consider your eligibility for our P4P program that pays a pittance and it will be paid a year & a half after the period for which you are being reviewed.

- You are at market schedule and other providers accept these rates- So What! So they haven’t evaluated their contract either.

- Now some actual examples....
Hello,

I do apologize regarding the delay in presenting fee schedule for the group to review. Due to policy changes, I had to present a copy of the contract along with the confidentiality agreement for our VP to review. Unfortunately, the contract was located offsite and retrieving the correct information to order to contract has taken sometime. The contract has been requested, I hope to receive it by the end of the year. At which time I will present it to the VP for review.

Again, I do apologize for the inconvenience.

Warm Regards,
Response...re: End of Year...

I assume you made a typo in your previous email on Jan 9\textsuperscript{th}. Surely you meant the end of the WEEK and not the end of the YEAR given it is January 😊
“The Reimbursement Committee met this afternoon and they did not approve your final counter proposal. I know this is not the outcome you were hoping for, however, the Committee determined that our last offer was above the market standard fee schedule.”
Response to Reimbursement Committee Decision

“We appreciate your presenting our reasonable offer to your reimbursement committee to which you have denied us direct access to discuss the reimbursement.

We are not privy to what you pay others in the market and do not find their acceptance of your substandard rates to be a valid argument. If they want to do business at a loss they can.

We have advised you of the specialty surgical procedures that we perform in an office setting that save your plan tens of thousands each year. No other provider for 70 miles is trained to perform this lifesaving procedures. It is too bad that your members will not have access to these services as of ___date___ - after the termination of our contract.”
Objection re: ABC Primary Care that has a termination on the table

"We are unable to grant your request for an increase in reimbursement for ABC Primary Care. Your proposed rates represent a significant increase and according to our information, ABC is currently receiving market rates for their contracted specialties in Anywhere County. Therefore, at this time, we have decided to continue our relationship with ABC under the existing reimbursement terms."
“While we appreciate that you notified us that your company has “decided to continue the relationship with ABC under the existing reimbursement terms,” you have failed to recognize the termination notice that is on the table. Since you have made the decision not to negotiate in good faith, please advise us when you will drop letters to your insured members so that we can anticipate the call volume and advise your members, our patients, what their options are after our termination.”
If You Do Walk…

- Ask payer if and when member letters will drop in the mail (Know your state’s law, if any, re member notices)
- Request copy of Letter in advance from payer and list of members to whom they will send
- Notify Patients with your own notice – make it about the patient as much as possible
- Ask payer how Continuity of Care in your agreement & members certificate will be administered (Know your state’s law re Continuity of Care)
- Educate Schedulers and Billing Staff
- Establish Policy if Payer direct pays to patients
- Educate Employers & Patients w/o sharing confidential info
If negotiations are going OK but need more time

- If termination date is approaching and law or payer guidelines require member notices soon, put an extension on the table to postpone notices.

- Ask payer if email extension is adequate or does it need to be on letterhead.

- Typically 15 to 30 day extension is adequate to wrap up; keeps all parties focused on new deadline.

- Payers often ask practice to “rescind” vs extend – in most cases don’t take potential term off table, just extend deadline and/or term date.
Let’s Walk Through Modeling and Testing Offer Impact

- Typically Start Off Using All Payer Utilization if the payer or network is small to medium size…incorporates all codes in the analysis in case payer uses in future
- Looking for the best aggregate improvement so some codes or bands may take a hit
- If docs are paid based on “eat what they kill” …aka collections on their services, do you need to balance the final rates to improve all providers?
If the payer says... what do you have in mind?

- Qualify if they are asking for a % increase
- If they want you to model a specific offer first, ask what basis can be administered by payer:
  - Specific year and locality of Mcr RBRVS
  - Payer’s proprietary schedule - examples:
    - CIGNA RBRVS
    - Aetna Market Fee Schedule (AMFS
    - Humana 6 digit schedule name
  - % Charges (rare except as default)
## Testing the Impact of an Offer

**Using All Payer Util or Payer Specific Util**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>17110__</td>
<td>27</td>
<td>0</td>
<td>131.26</td>
<td>3544.02</td>
<td>135.36</td>
<td>3654.72</td>
<td>4.1</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>17250__</td>
<td>74</td>
<td>8</td>
<td>88.94</td>
<td>6581.56</td>
<td>96.89</td>
<td>7169.86</td>
<td>7.95</td>
<td>775.12</td>
</tr>
<tr>
<td>16</td>
<td>24640__</td>
<td>5</td>
<td>0</td>
<td>136.42</td>
<td>682.1</td>
<td>163.66</td>
<td>818.3</td>
<td>27.24</td>
<td>0</td>
</tr>
<tr>
<td>17</td>
<td>69200__</td>
<td>12</td>
<td>2</td>
<td>146.64</td>
<td>1759.68</td>
<td>121.66</td>
<td>1459.92</td>
<td>-24.98</td>
<td>243.32</td>
</tr>
<tr>
<td>18</td>
<td>69210__</td>
<td>80</td>
<td>1</td>
<td>58.43</td>
<td>4674.54</td>
<td>58.95</td>
<td>4716</td>
<td>0.52</td>
<td>58.95</td>
</tr>
<tr>
<td>19</td>
<td>81002__</td>
<td>2591</td>
<td>201</td>
<td>2.24</td>
<td>5803.84</td>
<td>2.3</td>
<td>5959.3</td>
<td>0.06</td>
<td>462.3</td>
</tr>
<tr>
<td>20</td>
<td>82962__</td>
<td>6</td>
<td>0</td>
<td>2.05</td>
<td>12.3</td>
<td>2.11</td>
<td>12.66</td>
<td>0.06</td>
<td>0</td>
</tr>
<tr>
<td>21</td>
<td>87880__</td>
<td>2173</td>
<td>158</td>
<td>9.65</td>
<td>20969.45</td>
<td>9.89</td>
<td>21490.97</td>
<td>0.24</td>
<td>1562.62</td>
</tr>
<tr>
<td>22</td>
<td>90460__</td>
<td>14958</td>
<td>1051</td>
<td>30.2</td>
<td>451731.6</td>
<td>30.91</td>
<td>462351.78</td>
<td>0.71</td>
<td>32486.41</td>
</tr>
<tr>
<td>23</td>
<td>90461__</td>
<td>13172</td>
<td>916</td>
<td>14.64</td>
<td>192838.1</td>
<td>14.87</td>
<td>195867.64</td>
<td>0.23</td>
<td>13620.92</td>
</tr>
<tr>
<td>24</td>
<td>90649__</td>
<td>670</td>
<td>47</td>
<td>176.99</td>
<td>118583.3</td>
<td>185.8</td>
<td>124486</td>
<td>8.81</td>
<td>8732.6</td>
</tr>
<tr>
<td>25</td>
<td>99212__</td>
<td>778</td>
<td>67</td>
<td>44.38</td>
<td>34527.64</td>
<td>44.34</td>
<td>34496.52</td>
<td>-0.04</td>
<td>2970.78</td>
</tr>
<tr>
<td>26</td>
<td>99213__</td>
<td>12878</td>
<td>895</td>
<td>72.24</td>
<td>930306.7</td>
<td>73.71</td>
<td>949237.38</td>
<td>1.47</td>
<td>65970.45</td>
</tr>
<tr>
<td>27</td>
<td>99214__</td>
<td>1415</td>
<td>95</td>
<td>108.54</td>
<td>153584.1</td>
<td>108.23</td>
<td>153145.45</td>
<td>-0.31</td>
<td>10281.85</td>
</tr>
<tr>
<td>28</td>
<td>99215__</td>
<td>119</td>
<td>7</td>
<td>146.08</td>
<td>17383.52</td>
<td>145.47</td>
<td>17310.93</td>
<td>-0.61</td>
<td>1018.29</td>
</tr>
</tbody>
</table>
Summary of Offer Impact – 3 year deal with 3% Escalation Clause Yr 2 & 3 on payer representing 7% of payer mix

<table>
<thead>
<tr>
<th></th>
<th>Current ABC- All Commercials Util</th>
<th>Proposed ABC Yr 1</th>
<th>Current at ABC Only Util.</th>
<th>Proposed at ABC Only Util.</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surg</td>
<td>$19,571.91</td>
<td>$20,042.27</td>
<td>$1,244.87</td>
<td>$1,209.04</td>
<td>-2.9%</td>
</tr>
<tr>
<td>Labs</td>
<td>$27,734.03</td>
<td>$28,598.30</td>
<td>$2,060.83</td>
<td>$2,128.32</td>
<td>3.3%</td>
</tr>
<tr>
<td>Immun Adm</td>
<td>$651,717.30</td>
<td>$667,001.67</td>
<td>$45,856.68</td>
<td>$46,964.62</td>
<td>2.4%</td>
</tr>
<tr>
<td>Immun</td>
<td>$1,372,650.20</td>
<td>$1,354,157.86</td>
<td>$96,843.81</td>
<td>$95,529.51</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Medicine</td>
<td>$54,733.04</td>
<td>$54,788.22</td>
<td>$3,988.46</td>
<td>$4,039.60</td>
<td>1.3%</td>
</tr>
<tr>
<td>E&amp;M</td>
<td>$2,273,581.58</td>
<td>$2,383,614.00</td>
<td>$163,489.74</td>
<td>$171,398.96</td>
<td>4.8%</td>
</tr>
<tr>
<td>Total</td>
<td>$4,399,988.28</td>
<td>$4,508,202.60</td>
<td>$313,484.61</td>
<td>$321,270.33</td>
<td>2.5%</td>
</tr>
<tr>
<td>w/o Imm</td>
<td>$3,027,338.08</td>
<td>$3,154,044.74</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>3% Escalator Y2 &amp; 3</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$7,785.72</td>
<td>$17,423.83</td>
</tr>
<tr>
<td>Year 2</td>
<td>$330,908.4399</td>
<td>$340,835.6931</td>
</tr>
<tr>
<td>Year 3</td>
<td>$27,351.08</td>
<td>$52,560.63</td>
</tr>
</tbody>
</table>
Why Year & Locality of Medicare and RBRVS are Important

- Walk through Analysis to illustrate year, locality, carve-out and default if no Mcr value to get $80K annual improvement that practice desires

- Why “RBRVS” vs reference to Medicare Amount Payable?
  - RBRVS does not imply 2% Sequestration Reduction
  - Amount Paid by Medicare implies 2% reduction
100% 2011 Medicare w 40% BC Default

$34k improvement on $293K = 11.6%

<table>
<thead>
<tr>
<th>Contract (fee schedule)</th>
<th>% of Medicare</th>
<th>Medicare RVU</th>
<th>2011</th>
<th>100%</th>
<th>% Charges</th>
<th>Non-Medicare</th>
<th>Sort</th>
<th>$ Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inteli Healthcare E&amp;M/surgical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Weighted Net Gain = $34,314.64**

Sample PCP
8/1/2010-7/31/2011

<table>
<thead>
<tr>
<th>CPT</th>
<th>MOD DESCRIPTION</th>
<th>Units</th>
<th>Total Charges</th>
<th>Total Payments</th>
<th>Current Contract Fees</th>
<th>2011 Medicare*</th>
<th>Proposed 100% of Medicare*</th>
<th>Potential Loss</th>
<th>Potential Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>NF - Office/outpatient visit, est</td>
<td>2081</td>
<td>$166,480.00</td>
<td>$114,807.19</td>
<td>$59.63</td>
<td>$69.11</td>
<td>$69.11</td>
<td>$0.00</td>
<td>$19,727.88</td>
</tr>
<tr>
<td>99214</td>
<td>NF - Office/outpatient visit, est</td>
<td>1307</td>
<td>$154,226.00</td>
<td>$109,807.99</td>
<td>$88.00</td>
<td>$102.49</td>
<td>$102.49</td>
<td>$0.00</td>
<td>$18,938.43</td>
</tr>
<tr>
<td>99396</td>
<td>NF - Prev visit, est, age 40-64</td>
<td>157</td>
<td>$27,475.00</td>
<td>$17,040.78</td>
<td>$108.54</td>
<td>$70.00</td>
<td>$70.00</td>
<td>$6,050.78</td>
<td>$0.00</td>
</tr>
<tr>
<td>99395</td>
<td>NF - Prev visit, est, age 18-39</td>
<td>40</td>
<td>$6,360.00</td>
<td>$3,944.41</td>
<td>$98.00</td>
<td>$63.60</td>
<td>$63.60</td>
<td>$1,376.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>99215</td>
<td>NF - Office/outpatient visit, est</td>
<td>73</td>
<td>$13,359.00</td>
<td>$8,964.70</td>
<td>$114.36</td>
<td>$137.88</td>
<td>$137.88</td>
<td>$0.00</td>
<td>$1,716.96</td>
</tr>
<tr>
<td>99394</td>
<td>NF - Prev visit, est, age 12-17</td>
<td>25</td>
<td>$3,200.00</td>
<td>$2,578.16</td>
<td>$102.09</td>
<td>$51.20</td>
<td>$51.20</td>
<td>$1,272.25</td>
<td>$0.00</td>
</tr>
<tr>
<td>17000</td>
<td>NF - Destroy benign/premalign les</td>
<td>24</td>
<td>$3,000.00</td>
<td>$1,376.06</td>
<td>$57.34</td>
<td>$79.67</td>
<td>$79.67</td>
<td>$0.00</td>
<td>$536.02</td>
</tr>
<tr>
<td>99203</td>
<td>NF - Office/outpatient visit, new</td>
<td>94</td>
<td>$12,784.00</td>
<td>$9,067.20</td>
<td>$93.00</td>
<td>$103.01</td>
<td>$103.01</td>
<td>$0.00</td>
<td>$940.94</td>
</tr>
<tr>
<td>10060</td>
<td>NF - Drainage of skin abscess</td>
<td>14</td>
<td>$2,786.00</td>
<td>$1,507.96</td>
<td>$107.71</td>
<td>$108.90</td>
<td>$108.90</td>
<td>$0.00</td>
<td>$16.64</td>
</tr>
<tr>
<td>36416</td>
<td>NF - Capillary blood draw</td>
<td>482</td>
<td>$4,820.00</td>
<td>$2,005.34</td>
<td>$3.00</td>
<td>$4.00</td>
<td>$4.00</td>
<td>$0.00</td>
<td>$482.00</td>
</tr>
<tr>
<td>17110</td>
<td>NF - Destruct lesion, 1-14</td>
<td>11</td>
<td>$1,430.00</td>
<td>$828.16</td>
<td>$75.29</td>
<td>$108.72</td>
<td>$108.72</td>
<td>$0.00</td>
<td>$367.76</td>
</tr>
<tr>
<td>11301</td>
<td>NF - Shave skin lesion</td>
<td>10</td>
<td>$1,520.00</td>
<td>$505.22</td>
<td>$50.52</td>
<td>$91.85</td>
<td>$91.85</td>
<td>$0.00</td>
<td>$413.28</td>
</tr>
<tr>
<td>99393</td>
<td>NF - Prev visit, est, age 5-11</td>
<td>11</td>
<td>$1,287.00</td>
<td>$1,002.76</td>
<td>$91.16</td>
<td>$46.80</td>
<td>$46.80</td>
<td>$0.00</td>
<td>$487.96</td>
</tr>
<tr>
<td>99202</td>
<td>NF - Office/outpatient visit, new</td>
<td>81</td>
<td>$8,019.00</td>
<td>$5,222.33</td>
<td>$66.24</td>
<td>$71.16</td>
<td>$71.16</td>
<td>$0.00</td>
<td>$398.52</td>
</tr>
<tr>
<td>99392</td>
<td>NF - Prev visit, est, age 1-4</td>
<td>7</td>
<td>$770.00</td>
<td>$640.78</td>
<td>$91.54</td>
<td>$44.00</td>
<td>$44.00</td>
<td>$0.00</td>
<td>$332.78</td>
</tr>
<tr>
<td>58100</td>
<td>NF - Biopsy of uterus lining</td>
<td>5</td>
<td>$1,325.00</td>
<td>$552.31</td>
<td>$110.46</td>
<td>$110.06</td>
<td>$110.06</td>
<td>$2.01</td>
<td>$0.00</td>
</tr>
<tr>
<td>11100</td>
<td>NF - Biopsy, skin lesion</td>
<td>5</td>
<td>$845.00</td>
<td>$386.14</td>
<td>$77.23</td>
<td>$102.45</td>
<td>$102.45</td>
<td>$0.00</td>
<td>$126.11</td>
</tr>
</tbody>
</table>
Increase Percent of 2011 Medicare from their initial offer of 100% to 110%

<table>
<thead>
<tr>
<th>CPT</th>
<th>MOD</th>
<th>DESCRIPTION</th>
<th>Units</th>
<th>Total Charges</th>
<th>Total Payments</th>
<th>Current Medicare</th>
<th>Proposed Medicare</th>
<th>Potential Loss</th>
<th>Potential Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>99223</td>
<td>NF</td>
<td>Office/outpatient visit, c</td>
<td>2081</td>
<td>$166,480.00</td>
<td>$114,807.19</td>
<td>$59.63</td>
<td>$69.11</td>
<td>$76.02</td>
<td>$34,107.59</td>
</tr>
<tr>
<td>99242</td>
<td>NF</td>
<td>Office/outpatient visit, c</td>
<td>1307</td>
<td>$154,226.00</td>
<td>$109,807.99</td>
<td>$88.00</td>
<td>$102.49</td>
<td>$112.74</td>
<td>$32,335.18</td>
</tr>
<tr>
<td>99291</td>
<td>NF</td>
<td>Prev visit, est, age 40-64</td>
<td>157</td>
<td>$27,475.00</td>
<td>$17,040.78</td>
<td>$108.54</td>
<td>$70.00</td>
<td>$70.00</td>
<td>$6,050.78</td>
</tr>
<tr>
<td>99295</td>
<td>NF</td>
<td>Prev visit, est, age 18-39</td>
<td>40</td>
<td>$6,360.00</td>
<td>$3,944.41</td>
<td>$98.00</td>
<td>$63.60</td>
<td>$63.60</td>
<td>$1,376.00</td>
</tr>
<tr>
<td>99215</td>
<td>NF</td>
<td>Office/outpatient visit, est</td>
<td>73</td>
<td>$13,359.00</td>
<td>$8,946.70</td>
<td>$114.36</td>
<td>$137.88</td>
<td>$151.67</td>
<td>$0.00</td>
</tr>
<tr>
<td>99294</td>
<td>NF</td>
<td>Prev visit, est, age 12-17</td>
<td>25</td>
<td>$3,200.00</td>
<td>$2,578.16</td>
<td>$102.09</td>
<td>$51.20</td>
<td>$51.20</td>
<td>$1,272.25</td>
</tr>
<tr>
<td>17000</td>
<td>NF</td>
<td>Destroy benign/premg lesion</td>
<td>24</td>
<td>$3,000.00</td>
<td>$1,376.06</td>
<td>$57.34</td>
<td>$79.67</td>
<td>$87.64</td>
<td>$0.00</td>
</tr>
<tr>
<td>99203</td>
<td>NF</td>
<td>Office/outpatient visit, new</td>
<td>94</td>
<td>$12,784.00</td>
<td>$9,067.20</td>
<td>$93.00</td>
<td>$103.01</td>
<td>$113.31</td>
<td>$0.00</td>
</tr>
<tr>
<td>10060</td>
<td>NF</td>
<td>Drainage of skin abscess</td>
<td>14</td>
<td>$2,786.00</td>
<td>$1,507.96</td>
<td>$107.71</td>
<td>$108.90</td>
<td>$119.79</td>
<td>$0.00</td>
</tr>
<tr>
<td>36416</td>
<td>NF</td>
<td>Capillary blood draw</td>
<td>482</td>
<td>$4,820.00</td>
<td>$2,005.34</td>
<td>$3.00</td>
<td>$4.00</td>
<td>$4.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>17110</td>
<td>NF</td>
<td>Destruct lesion, 1-14</td>
<td>11</td>
<td>$1,430.00</td>
<td>$828.16</td>
<td>$75.29</td>
<td>$108.72</td>
<td>$119.49</td>
<td>$0.00</td>
</tr>
<tr>
<td>11301</td>
<td>NF</td>
<td>Shave skin lesion</td>
<td>10</td>
<td>$1,520.00</td>
<td>$505.22</td>
<td>$50.52</td>
<td>$91.85</td>
<td>$101.94</td>
<td>$0.00</td>
</tr>
<tr>
<td>99393</td>
<td>NF</td>
<td>Prev visit, est, age 5-11</td>
<td>11</td>
<td>$1,287.00</td>
<td>$1,002.76</td>
<td>$91.16</td>
<td>$46.80</td>
<td>$46.80</td>
<td>$487.96</td>
</tr>
<tr>
<td>99202</td>
<td>NF</td>
<td>Office/outpatient visit, new</td>
<td>81</td>
<td>$8,019.00</td>
<td>$5,222.33</td>
<td>$66.24</td>
<td>$71.16</td>
<td>$78.28</td>
<td>$0.00</td>
</tr>
<tr>
<td>99392</td>
<td>NF</td>
<td>Prev visit, est, age 1-4</td>
<td>7</td>
<td>$770.00</td>
<td>$640.78</td>
<td>$91.54</td>
<td>$44.00</td>
<td>$44.00</td>
<td>$332.78</td>
</tr>
<tr>
<td>58100</td>
<td>NF</td>
<td>Biopsy of uterus lining</td>
<td>5</td>
<td>$1,325.00</td>
<td>$552.31</td>
<td>$110.46</td>
<td>$110.06</td>
<td>$121.07</td>
<td>$0.00</td>
</tr>
<tr>
<td>11100</td>
<td>NF</td>
<td>Biopsy, skin lesion</td>
<td>5</td>
<td>$845.00</td>
<td>$386.14</td>
<td>$77.23</td>
<td>$102.45</td>
<td>$112.70</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Weighted Net Gain= $66,418.57
Change Default if No Mcr Value from 40% of charges to 50%
## Add Carve-Out – Bingo $80K

### Medicare Yr. % of Medicare
- 2011
- 110%

### Non-Medicare
- % Charges
- 50%
- $ Change

### Weighted Net Gain = $80,428.05

### Sample PCP
8/1/2010-7/31/2011

### Inteli Healthcare E&M/surgical

<table>
<thead>
<tr>
<th>CPT</th>
<th>MOD</th>
<th>DESCRIPTION</th>
<th>Units</th>
<th>Total Charges</th>
<th>Total Payments</th>
<th>Contract Fees</th>
<th>Medicare*</th>
<th>Medicare*</th>
<th>Proposed</th>
<th>Potential</th>
<th>Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td></td>
<td>NF - Office/outpatient visit, d</td>
<td>2081</td>
<td>$166,480.00</td>
<td>$114,807.19</td>
<td>$59.63</td>
<td>$69.11</td>
<td>$80.50</td>
<td>$0.00</td>
<td>$434,340.47</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td></td>
<td>NF - Office/outpatient visit, d</td>
<td>1307</td>
<td>$154,226.00</td>
<td>$109,807.99</td>
<td>$88.00</td>
<td>$102.49</td>
<td>$112.74</td>
<td>$0.00</td>
<td>$322,335.18</td>
<td></td>
</tr>
<tr>
<td>99396</td>
<td></td>
<td>NF - Prev visit, est, age 40-64</td>
<td>157</td>
<td>$27,475.00</td>
<td>$17,040.78</td>
<td>$108.54</td>
<td>$87.50</td>
<td>$87.50</td>
<td>$3,303.28</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>99395</td>
<td></td>
<td>NF - Prev visit, est, age 18-39</td>
<td>40</td>
<td>$6,360.00</td>
<td>$3,944.41</td>
<td>$98.00</td>
<td>$79.50</td>
<td>$79.50</td>
<td>$740.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>NF - Office/outpatient visit, d</td>
<td>73</td>
<td>$13,359.00</td>
<td>$8,946.70</td>
<td>$114.36</td>
<td>$137.88</td>
<td>$151.67</td>
<td>$0.00</td>
<td>$2,723.63</td>
<td></td>
</tr>
<tr>
<td>99394</td>
<td></td>
<td>NF - Prev visit, est, age 12-17</td>
<td>25</td>
<td>$3,200.00</td>
<td>$2,578.16</td>
<td>$102.09</td>
<td>$64.00</td>
<td>$64.00</td>
<td>$952.25</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>17000</td>
<td></td>
<td>NF - Destroy benign/prenegl lesion</td>
<td>24</td>
<td>$3,000.00</td>
<td>$1,376.06</td>
<td>$57.34</td>
<td>$79.67</td>
<td>$87.64</td>
<td>$0.00</td>
<td>$727.30</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td></td>
<td>NF - Office/outpatient visit, d</td>
<td>94</td>
<td>$12,784.00</td>
<td>$9,067.20</td>
<td>$93.00</td>
<td>$103.01</td>
<td>$113.31</td>
<td>$0.00</td>
<td>$1,909.14</td>
<td></td>
</tr>
<tr>
<td>10060</td>
<td></td>
<td>NF - Drainage of skin abscess</td>
<td>14</td>
<td>$2,786.00</td>
<td>$1,507.96</td>
<td>$107.71</td>
<td>$108.90</td>
<td>$119.79</td>
<td>$0.00</td>
<td>$169.10</td>
<td></td>
</tr>
<tr>
<td>36416</td>
<td></td>
<td>NF - Capillary blood draw</td>
<td>482</td>
<td>$4,820.00</td>
<td>$2,005.34</td>
<td>$3.00</td>
<td>$5.00</td>
<td>$5.00</td>
<td>$0.00</td>
<td>$964.00</td>
<td></td>
</tr>
<tr>
<td>17110</td>
<td></td>
<td>NF - Destruct lesion, 1-14</td>
<td>11</td>
<td>$1,430.00</td>
<td>$828.16</td>
<td>$75.29</td>
<td>$108.72</td>
<td>$119.59</td>
<td>$0.00</td>
<td>$487.33</td>
<td></td>
</tr>
<tr>
<td>11301</td>
<td></td>
<td>NF - Shave skin lesion</td>
<td>10</td>
<td>$1,520.00</td>
<td>$505.22</td>
<td>$50.52</td>
<td>$91.85</td>
<td>$101.04</td>
<td>$0.00</td>
<td>$505.18</td>
<td></td>
</tr>
<tr>
<td>99393</td>
<td></td>
<td>NF - Prev visit, est, age 5-11</td>
<td>11</td>
<td>$1,287.00</td>
<td>$1,002.76</td>
<td>$91.16</td>
<td>$58.50</td>
<td>$58.50</td>
<td>$359.26</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td></td>
<td>NF - Office/outpatient visit, d</td>
<td>81</td>
<td>$8,019.00</td>
<td>$5,222.33</td>
<td>$66.24</td>
<td>$71.16</td>
<td>$78.28</td>
<td>$0.00</td>
<td>$975.24</td>
<td></td>
</tr>
<tr>
<td>99392</td>
<td></td>
<td>NF - Prev visit, est, age 1-4</td>
<td>7</td>
<td>$770.00</td>
<td>$640.78</td>
<td>$91.54</td>
<td>$55.00</td>
<td>$55.00</td>
<td>$255.78</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>58100</td>
<td></td>
<td>NF - Biopsy of uterus lining</td>
<td>5</td>
<td>$1,325.00</td>
<td>$552.31</td>
<td>$110.46</td>
<td>$110.06</td>
<td>$121.07</td>
<td>$0.00</td>
<td>$53.04</td>
<td></td>
</tr>
<tr>
<td>11100</td>
<td></td>
<td>NF - Biopsy, skin lesion</td>
<td>5</td>
<td>$845.00</td>
<td>$386.14</td>
<td>$77.23</td>
<td>$102.45</td>
<td>$112.70</td>
<td>$0.00</td>
<td>$177.36</td>
<td></td>
</tr>
</tbody>
</table>

### Inteli Healthcare E&M/surgical Totals:
- 4,805
- $292,705

### Weighted Net Gain = $80,428.05
Payer Says OK but Base on 2009 Instead

Lost 18K with year change

Sample PCP
8/1/2010-7/31/2011

Intelli Healthcare E&M/surgical

<table>
<thead>
<tr>
<th>CPT/ MOD DESCRIPTION</th>
<th>Units</th>
<th>Total Charges</th>
<th>Total Payments</th>
<th>Current Contract Fees</th>
<th>Medicare*</th>
<th>Proposed 110% of Medicare*</th>
<th>Potential Loss</th>
<th>Potential Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214 ___ NF - Office/outpatient visit, e</td>
<td>1307</td>
<td>$154,226.00</td>
<td>$109,807.99</td>
<td>$88.00</td>
<td>$93.05</td>
<td>$102.36</td>
<td>$0.00</td>
<td>$18,768.52</td>
</tr>
<tr>
<td>99213 ___ NF - Office/outpatient visit, e</td>
<td>2081</td>
<td>$166,480.00</td>
<td>$114,807.19</td>
<td>$59.63</td>
<td>$61.81</td>
<td>$80.50</td>
<td>$0.00</td>
<td>$43,430.47</td>
</tr>
<tr>
<td>99396 ___ NF - Prev visit, est, age 40-64</td>
<td>157</td>
<td>$27,475.00</td>
<td>$17,040.78</td>
<td>$108.54</td>
<td>$87.50</td>
<td>$87.50</td>
<td>$3,303.28</td>
<td>$0.00</td>
</tr>
<tr>
<td>99395 ___ NF - Prev visit, est, age 18-39</td>
<td>40</td>
<td>$6,360.00</td>
<td>$3,944.41</td>
<td>$98.00</td>
<td>$79.50</td>
<td>$79.50</td>
<td>$740.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>99394 ___ NF - Prev visit, est, age 12-17</td>
<td>25</td>
<td>$3,200.00</td>
<td>$2,578.16</td>
<td>$102.09</td>
<td>$64.00</td>
<td>$64.00</td>
<td>$952.25</td>
<td>$0.00</td>
</tr>
<tr>
<td>17000 ___ NF - Destroy benign/premalign les</td>
<td>24</td>
<td>$3,000.00</td>
<td>$1,376.06</td>
<td>$57.34</td>
<td>$70.64</td>
<td>$77.70</td>
<td>$0.00</td>
<td>$488.74</td>
</tr>
<tr>
<td>99215 ___ NF - Office/outpatient visit, est</td>
<td>73</td>
<td>$13,359.00</td>
<td>$8,946.70</td>
<td>$114.36</td>
<td>$125.66</td>
<td>$138.23</td>
<td>$0.00</td>
<td>$1,742.51</td>
</tr>
<tr>
<td>10060 ___ NF - Drainage of skin abscess</td>
<td>14</td>
<td>$2,786.00</td>
<td>$1,507.96</td>
<td>$107.71</td>
<td>$98.49</td>
<td>$108.34</td>
<td>$0.00</td>
<td>$8.80</td>
</tr>
<tr>
<td>36416 ___ NF - Capillary blood draw</td>
<td>482</td>
<td>$4,820.00</td>
<td>$2,055.34</td>
<td>$3.00</td>
<td>$5.00</td>
<td>$5.00</td>
<td>$0.00</td>
<td>$964.00</td>
</tr>
<tr>
<td>17110 ___ NF - Destruct lesion, 1-14</td>
<td>11</td>
<td>$1,430.00</td>
<td>$828.16</td>
<td>$75.29</td>
<td>$98.30</td>
<td>$108.13</td>
<td>$0.00</td>
<td>$361.27</td>
</tr>
<tr>
<td>99933 ___ NF - Prev visit, est, age 5-11</td>
<td>11</td>
<td>$1,287.00</td>
<td>$1,002.76</td>
<td>$91.16</td>
<td>$58.50</td>
<td>$58.50</td>
<td>$0.00</td>
<td>$395.26</td>
</tr>
<tr>
<td>11301 ___ NF - Shave skin lesion</td>
<td>10</td>
<td>$1,520.00</td>
<td>$505.22</td>
<td>$50.52</td>
<td>$83.34</td>
<td>$91.67</td>
<td>$0.00</td>
<td>$411.48</td>
</tr>
<tr>
<td>99203 ___ NF - Office/outpatient visit, new</td>
<td>94</td>
<td>$12,784.00</td>
<td>$9,067.20</td>
<td>$93.00</td>
<td>$92.44</td>
<td>$101.68</td>
<td>$0.00</td>
<td>$815.92</td>
</tr>
<tr>
<td>99392 ___ NF - Prev visit, est, age 1-4</td>
<td>7</td>
<td>$770.00</td>
<td>$640.78</td>
<td>$91.54</td>
<td>$55.00</td>
<td>$55.00</td>
<td>$0.00</td>
<td>$255.78</td>
</tr>
<tr>
<td>58100 ___ NF - Biopsy of uterus benign</td>
<td>5</td>
<td>$1,325.00</td>
<td>$552.31</td>
<td>$110.46</td>
<td>$104.99</td>
<td>$115.49</td>
<td>$0.00</td>
<td>$25.14</td>
</tr>
<tr>
<td>11100 ___ NF - Biopsy, skin lesion</td>
<td>5</td>
<td>$845.00</td>
<td>$366.14</td>
<td>$77.23</td>
<td>$92.92</td>
<td>$102.21</td>
<td>$0.00</td>
<td>$124.91</td>
</tr>
<tr>
<td>99385 ___ NF - Prev visit, new, age 18-39</td>
<td>4</td>
<td>$780.00</td>
<td>$479.40</td>
<td>$119.85</td>
<td>$97.50</td>
<td>$97.50</td>
<td>$89.40</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
What if not on **Percent of Medicare**
but based on **Conversion Factor &**
Don’t Forget **Site of Service Differential**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Non-Facility</th>
<th>Facility</th>
<th>RBRVS</th>
<th>RBRVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>358</td>
<td></td>
<td>Office/outpatient visit, est</td>
<td>$40.09</td>
<td>$25.14</td>
<td>$36.95</td>
<td>$23.16</td>
</tr>
<tr>
<td>359</td>
<td></td>
<td>Office/outpatient visit, est</td>
<td>$67.17</td>
<td>$49.59</td>
<td>$61.89</td>
<td>$45.70</td>
</tr>
<tr>
<td>360</td>
<td></td>
<td>Office/outpatient visit, est</td>
<td>$100.59</td>
<td>$78.29</td>
<td>$92.69</td>
<td>$70.29</td>
</tr>
<tr>
<td>361</td>
<td></td>
<td>Office/outpatient visit, est</td>
<td>$135.80</td>
<td>$107.76</td>
<td>$125.13</td>
<td>$99.29</td>
</tr>
<tr>
<td>362</td>
<td></td>
<td>Subsequent hospital care</td>
<td>$38.86</td>
<td>$38.86</td>
<td>$35.80</td>
<td>$35.80</td>
</tr>
<tr>
<td>363</td>
<td></td>
<td>Office consultation</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$46.10</td>
<td>$31.63</td>
</tr>
<tr>
<td>364</td>
<td></td>
<td>Office consultation</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$86.68</td>
<td>$66.35</td>
</tr>
<tr>
<td>365</td>
<td></td>
<td>Office consultation</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$118.44</td>
<td>$92.60</td>
</tr>
<tr>
<td>366</td>
<td></td>
<td>Office consultation</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$175.60</td>
<td>$147.35</td>
</tr>
<tr>
<td>367</td>
<td></td>
<td>Office consultation</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$214.45</td>
<td>$182.75</td>
</tr>
</tbody>
</table>

*Note: Medicare Rates not available for selected year.*
Deal Breakers in Contract & Amendment Language

- Identify provisions in a payer/network agreement or amendments that need your attention
- Determine how to manage provisions that payers refuse to change
- Propose more favorable alternative language to the payers/networks
When you get an agreement...

The quick look...

- Rate Exhibit
- Products and Programs
- Amendments
- Term & Termination
And then a whole lot more fine print...

Fine Print

This managed wireless device will only work if you sign a contract with your communications service provider who will:

* not answer your calls,
* generally have no staff available to deal with your trivial problems,
* tell you that you caused the problem,
* send your call to a foreign country, and
* will charge you exhorbitant amounts of money for pretty much nothing.
But before we head into these provisions

Let’s go over some baseline information about

- Who is accessing the Agreements
- Laws that help or hurt you
- What plans these laws apply to
Baseline Knowledge

Critical to understanding provisions or lack thereof

- Who is using the Agreement & For What Products
  - Fully Insured HMOs and Health Benefit Plans
    - (Including Government Replacement Plans)
  - Self-Funded ERISA plans
  - Discount Programs
  - Insured or self-funded Workers’ Comp, Auto, General Liability

- Leased vs Insurance Co Owned Networks

- State Law Cheat Sheet
  - What does your state require of fully insured plans?

- Impact of CIOs, ACOs and Exchanges
Self-Funded ERISA* Plans

- Self-Funded Employer /Union/Association takes the financial risk, not an insurance company

- Third Party Administrator (TPA) administers Plan claims on Administrative Services Only (ASO) basis for employer, etc.

- Large health insurers like BCBS, UHC, Aetna, CIGNA, Humana sell their TPA functions on ASO basis to employers - often 60 to 85% of their business in a market is self-funded

- ERISA Plans Regulated by Dept of Labor, not State Insurance Dept -DOL has few if any rules that help providers - Examples: No timely payment requirement & no time restriction on recouping overpayments

*Employee Retirement Income Security Act
Leased Networks vs Insurer Owned

- Leased Plans do not take risk for claims—they rent their networks to other parties taking the financial risk
  - Know how they make their $$$$%

- Insurance Company Owned – use for their insured products but also for their self-funded business for which they may simply be the third party administrator (TPA)
State Law Cheat Sheet

- Use to set guidelines for certain provisions as pertains to self-funded requirements that are most often absent in the agreement
- Laws often favorable to practice but not always
- Laws vary considerably from state to state
- Often the law is silent on issues
<table>
<thead>
<tr>
<th>STATE</th>
<th>TIMELY FILING</th>
<th>TIMELY PAYMENT</th>
<th>PATIENT HOLD HARMLESS</th>
<th>MEDICAL NECESSITY DEFINITION</th>
<th>LOOK BACK PERIOD FOR UNDER/OVERPAYMENTS - PAYER &amp; PROVIDER</th>
<th>OFFSETS</th>
<th>MALPRACTICE REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louisiana</td>
<td>Title 22 §1832. Standards for receipt and processing of nonelectronic claims</td>
<td>Title 22 §1188.1 Prompt Payment of Clean Claims</td>
<td></td>
<td></td>
<td>Title 22 §1838. Recoupment of health insurance claims payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. (1) Any nonelectronic claim by a health care provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider or its agent within forty-five days of the date of service, or date of discharge from a health care facility or institution, shall be paid, denied, or pend not more than forty-five days from the date upon which a nonelectronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of health insurance coverage or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard. (2) Any nonelectronic claim by a health care provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider or its agent more than forty-five days after the date of service, or date of discharge from a health care facility or institution, or</td>
<td>B. Within thirty business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay such claim if it is a clean claim or send a written notice acknowledging the date of receipt of the claim and either of the following: (1) That the insurer is declining to pay all or part of the claim and the specific reason or reasons for denial. (2) That additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary. C. Within thirty business days after receipt of all requested additional information pursuant to Paragraph (B)(2) of this Section, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim or send a written notice that the insurer is declining to pay all or part of the claim and the specific reason or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Revised Statutes**

A. An MNRO shall implement a written medical necessity determination program that describes all review activities performed for one or more health benefit plans. The program shall include the following: (1) Methodology to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services. (2) Data sources and clinical review of criteria used in decision-making. (3) The process for conducting appeals of adverse determinations. (4) Mechanisms to ensure consistent application of review criteria and compatible decisions. (5) B. Prior to any recoupment unrelated to a claim for payment of medical services provided by a health care provider or any other amount owed by a health insurance issuer to a health care provider, the health insurance issuer shall provide the health care provider written notification that includes the name of the patient, the date, or dates of health care services rendered, and an explanation of the reason for recoupment. A health care provider shall be allowed thirty days from receipt of written notification of recoupment to appeal the health insurance issuer's action and to provide the health insurance issuer the | | | |

C. (1) When a health care provider fails to respond timely and in writing to a health insurance issuer's written notification of recoupment, the health insurance issuer may consider the recoupment accepted. (2) If a recoupment is accepted, the health care provider may remit the agreed amount to the health insurance issuer at the time of any written notification of acceptance or may permit the health insurance issuer to deduct the agreed amount from future payments due to the health care provider.
# State Law Cheat Sheet

<table>
<thead>
<tr>
<th>State</th>
<th>Timely Filing</th>
<th>Timely Payment</th>
<th>Patient Hold Harmless</th>
<th>Medical Necessity Definition</th>
<th>Under/Overpayments - Payer &amp; Provider</th>
<th>Offsets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>§ 83-9-5 Policy provisions</td>
<td>§ 83-9-5 Policy provisions</td>
<td>§ 83-41-325 Minimum net worth requirement; deposits generally; computation of liabilities; contracts between HMOs and participating</td>
<td>§ 83-41-303 Definitions</td>
<td>§ 83-41-219 Reciprocal time limitations on health insurance claim filing &amp; claim audits; applicability</td>
<td>No statute found</td>
</tr>
</tbody>
</table>

**Mississippi Code of 1972 Unannotated Chapter 9 - Accident, Health & Medicare Supplement Insurance Article 1 - Hospital &..." Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient & outpatient hospital & physician care, diagnostic & therapeutic radiological services & includes but is not limited to mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehab treatment for the purpose of preventing, alleviating, curing or healing human illness or physical disability.**

If any health insurance issuer or other health insurance benefit payer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer or other health insurance benefit payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.
Research Your State Laws
These apply to insured plans but you can make them apply to self-funded

- Among laws that usually work for you in negotiations
  …if they exist
  - Timely Payment
  - Timely Filing
  - Medical Necessity
  - Material Change/Amendment
  - Over/Underpayment & Offsets
  - Credentialing Timeframes
  - Any Willing Provider
  - Fee Schedule Disclosure
  - Assignment of Benefits upon Termination
State Laws Working Against you

Among laws that can work AGAINST you in negotiations…if a law exist…and these do exist in most states…

- Patient Hold Harmless*
- Continuity of Care Upon Termination
- Offsets

* Most states require reserves for HMOs and insured plans but DOL does not require reserves of self-funded plans. If insolvent the insured plan has funds to pay run out claims as the plan phases out.
Clinically Integrated Network or Accountable Care Organization contracts may supersede your direct agreement with a payer or network – IF ACA is repealed CINs and ACOs may not continue to grow.

Look for provisions that allow these entities the right to negotiate on your behalf.

Payers that contract with ACO/CIN to build new plans want to know that the CIN has authority to contract on behalf of all par providers.

IPAs & PHOs can reduce cred and contracting efforts but are “messenger” models with limited ability to negotiate on behalf member providers.
CIN Authority to Negotiate on Practice Behalf

- Extreme:
  Medical Group hereby gives CIN the exclusive right to negotiate and enter into risk and non-risk Payer Contracts on behalf of Medical Group and its physicians

- More Favorable:
  CIN has the right to negotiate Payer Contracts on behalf of Medical Group and its physicians only when such contracts provide economic benefit over existing contracts between Medical Group or Physicians and the Payer
Some negotiate FFS and Value Based

Some rely on your FFS agreements to be in place and add the Value Based Programs over your FFS

- If you already have a value based program directly, payers will not pay double… which prevails?
- If through ACO/CIN, will value based bonuses come from payer or from ACO/CIN?
- Be on committees that allocate Value Based funds
Value Based At a Glance

- Three Basic Types Typical—ask for payouts to be sooner on all Quality Measures
  - Shared Savings
  - Shared Risk

- For Quality Measures – PCP Oriented
- Understand “Attribution” of Members Assigned
- Make Sure Your Practice Can Verify the Report Card from Payer upon which bonus is paid
- Interim Reports well in advance of final report card so providers w Poor performance can change/catch up

- For Shared Savings*
  Need control over the vast majority of services –
  HMO vs PPO – Benefit Design keeps members in-network w HMO, Less w PPO
  Are All Services Contracted/In-Network

- Shared Risk *
  What services/charges are subject to the targets – make sure clearly defined
  Require ability to audit payer data (tricky due to confidentiality for agreements that are not yours)
  Consider Re-Insurance depending on risk
  Understand Upside/Downside, Specific/Aggregate Stop-Loss, IBNR, RunOut, Withholds, Risk concepts

Ask for greater percent of upside

- Some of these Value based programs may be direct with your practice and some through an overlay negotiated by CIN/ACO
**Shared Savings & Shared Risk**

- **BIG DIFFERENCE**

- **Shared Savings** – Upside only with no risk except you may not meet the claims cost reduction goals and get nothing Extra.

- If base rate is reasonable and other PMPM bonuses are achievable – worth trying… BUT…

- Easier to validate measures of your achieved PMPM bonus. On the Shared Savings goal side, if tied to claims other than just your practice, hard to know if the Payer’s report card is accurate.
Shared Savings & Shared Risk
More PCP vs Specialty Oriented for Now

- With either, understand the ATTRIBUTION Model – which members are tied to your shared or risk based program
- With Shared Savings, if they offer 25%, ask for 50% +
- With Shared Savings or Risk – What is included?
  - Your Services
  - Other Specialists
  - Hospital
  - Rx and Other
- With Shared Risk – Do you need to buy some Reinsurance? – Maybe if hospital and Rx included
- With Shared Savings or Risk - Reserve the right to audit them – you won’t have claims info, other than what you provided to reconcile payer report card
Bundled Payments

- Consider being Convener/Bundler for certain procedures or diagnosis
- Fixed Price to Payer for Full Spectrum of Related Services
- Example: Joint Replacements
- Spectrum Includes: Diagnostics, Pre-Surg Screening, Surgeon, Anesthesia, Implants, Facility, Rehab/PT, Rx, Follow Up, Readmission, etc. for specified Period

- Challenges include:
  - How to submit claims/split up payment among numerous TINs;
  - How to keep patients in the spectrum;
  - How to Assess and Fund Risk … becoming an underwriter;
  - How to case manage to ensure efficacy and quality
With the foundation built... and some unique CIN/Exchange/Shared Savings & Risk Issues Covered


While many provisions are important, be sure to focus a lot of attention on:

- Rate Exhibit
- Amendment Provision
- Product Inclusion
Rate Exhibit

- Look for fee schedules that apply to each product (HMO, PPO, POS, Med Adv, Private Medicaid, Exchange, WC, Auto, Discount Plans & Gen Liab)

- Sometimes language here describes how rates can be amended. Most times in Amendment section.

- Unlikely to include dollar amounts by procedure
Rate Exhibit Description

- Percent or Conversion Factor (CF) of Medicare Resource Based Relative Value System (RBRVS) By Bands (E&M, Surg, Lab, etc)
- Payer/Network’s Proprietary RBRVS OR Standard Market Schedule By Bands
- Relative Value Unit (RVU) Conversion Factor (CF) of Proprietary Schedule by Bands
- Carve-outs on a small number of codes
- % “of” or “off of” Charges OR State Schedules like WC & Medicaid
- Capitation – pmpm – mostly PCP
- % Premium on Med Adv
- Shared Savings – mostly PCP – tied to “attributed” members
- Shared Risk
- Case Management Fee per “attributed” member per month

CIN/ACO – ask any that you have joined for baseline and value based details
Reimbursement Exhibit
Does it reflect the terms you negotiated?

- **Verify the Medicare year and locality** (or “national”)
  Beware of future unknown “Then Current” or “Prevailing” Year
  If based on 2010 or 2015, be sure to distinguish “a” or “b” in exhibit
  If based on 2007 or 2008 Conversion Factor, is BNA included

- **Gap Fill or Defaults**…for codes not in the base fee schedule
  EXAMPLES: 1974 CRVS, St Anthony’s, Ingenix (Now OptumInsight) &
  Other Sources
  Research who owns or funds these sources
  Don’t accept vague language like “industry accepted” or “at payer’s
discretion”
  May be best to seek % of billed charges – but expect 35-50% of charges

- **Site of service Differential** – Facility/Non-Facility
  Of particular importance to surgical specialist doing procedures at both
  office and ASC/Hospital
Reimbursement Exhibit

Does it reflect the terms you negotiated? ...continued

- **Exclusion of**, or very low paying, Labs, DME & Diagnostics
- **Banding**: Different % or CF by service type – Does agreement specify code ranges as defined by CMS
- **Carve-outs** - are they spelled out and any expiration on them?
- **Escalators** in multi-year agreements – are percentages & eff dates correct and who needs to initiate?
If “Prevailing Year” Medicare Basis is Basis

- Medicare Advantage - get at least 100% CY Mcr on all bands – watch out for labs, rad & DME being <\%100

- Commercial plans may be based on “Current/Prevailing YR

- Verify that SEQUESTRATION DOES NOT APPLY; and the payer says it does, ask where in the agreement this is explicitly stated
Verify the entire schedule in dollars & cents for ALL practice codes with rep

- Network will not likely include a full list of codes and rates in the agreement – instead a narrative description will be in rate exhibit
- Verify dollar and cent reimbursement for ALL codes
- Be sure contract is clear as to which fee schedules map to each product/plan. If not, get in writing prior to signing
- Make sure contracts do not allow new products and rates without your written consent
Deal Breaker Provisions Beyond Rate Exhibit

- Some can/will be changed, but many will not be negotiable

- You can manage some unfavorable provisions if you understand your agreement terms
What are YOUR Deal Breakers?

- The list may vary by practice but certain provisions are key to any practice.

- What would cause variation:
  - Are you hospital based?
  - Are you considering merger, acquisition or change of ownership?
  - Do you have an ASC, Sleep Ctr, Lab, DME, etc?
  - Are you a solo practitioner or a **Group**?
  - Other factors
Deal Breakers Common to Any Practice

- Rate Exhibit & Disclosure of Full Fee Schedule
- Amendment Provision
- Products or Plan Types Included – All Products
- Timely Payment & Filing
- Patient/Member Hold Harmless
- Which contract prevails
- Overpayment/Underpayment –
  - Timeframe & Offsets
  - Retro-Eligibility Denials
- Term & Termination & Continuity of Care after Termination
- Definition of Medical Necessity
- Affiliates and Assignment
- Favored Nation Clauses or Parity
- Mergers & Acquisitions
Provisions to Look For and Manage
May not be Deal Breakers

- Confidentiality
- Joint development of agreement — delete
- Equipment Standards
- Provider leaves your practice
- Escalators for multi-year contract WATCH FOR REQUIRED NOTICE
- Appeals Process
- Clinical & Administrative Edits — Bundling, etc
- Evergreen — Automatic Renewal
- “Payment Policies” — ever-changing
- Binding Arbitration — Ask your attorney
- Budget Neutrality Adjustor
- Malpractice requirements
- Merger & Acquisition/Change in Ownership
- Credentialing
None of the examples of contract language in this presentation represents an exact provision from an actual agreement. Confidentiality agreements prohibit the use of actual provisions. The examples are composites of generally used contractual language known in the industry and are intended to illustrate the types of provisions that may not be in the Provider’s best interest and should be addressed in any agreement with a payer or network.
Unacceptable Contract Provisions: Timely Filing

Group shall submit claims to ______ or Payor using HIPAA compliant 837 electronic format, or a CMS 1500 and/or UB-92, or their successors, within ninety (90) days from the later of: (i) the date of service; or (ii) the date of Physician's receipt of the explanation of benefits from the primary payor when ______ is the secondary payor; provided, however, **all claims under self-funded plans must be submitted within sixty (60) days** of the date of service. Notwithstanding the foregoing, self-funded plans may specify a shorter period of time in which claims must be submitted. Payor may deny payment for any claim(s) received by Payor after the later of the dates specified above. **Group further acknowledges and agrees that Covered Person shall not be responsible** for any payments to Group except for applicable Copayments and non-covered services provided to such Covered Person.
Timely Filing Issues & Alternatives

- Ask for the longer of at least 180 days or what your state minimally requires for insured business for any party that accesses your agreement.
- Do not agree that self-funded clients of the network can dictate a time period different than your contracted time period.
- Exceptions can be hidden in provisions that indicate in the event the Health Benefit Plan (HBP) and your contract conflict, the HBP trumps your agreement – Do not agree to such terms.
Unacceptable Contract Provisions: Timely Payment

Plans shall make payment for all Clean Claims for Covered Services submitted by Provider within the time frames established by State Law Cited, or other applicable state or federal statute or regulation. For Claims that are not subject to such statute or regulation, Plan shall make a good faith effort to make payment or arrange for payment for all such Clean Claims for Covered Services submitted by Provider within ninety (90) days*, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, or the extent of Plan’s payment liability, if any, related to coordination of benefits, subrogation or verification of benefits or eligibility.

*More often the timely payment provision is silent with regard to self-funded
Timely Payment Issues

- Provision often applies only to insured plans.
- State laws vary – most requiring 15 to 45 days for insured plans to pay and interest can be applied – electronic submissions sometimes shorter.
- Example gives self-funded VERY long 90 days to pay but…
- More often the agreement is absent of language re: self-funded – implying no timeframe – be sure it is stated specifically for self-funded.
- Network/TPA agreement with self-funded employers and unions may allow longer than state law allows for insured plans, creating inconsistency in agreements.
More Acceptable Alternative Language: Timely Payment

Plans and Payers shall make payment for all Clean Claims for Covered Services submitted by Provider within the time frames established by _XX_State Law_ xxxx, regardless of whether the plan is insured or self-funded. If such payment is not made within these timeframes, Plan or Payer must provide a written update within these timeframes or Provider shall assume the services are non-covered services for which Provider may bill full charges to the Member.
Contract Provisions: Hold Harmless

Provider agrees that in no event, including, but not limited to, nonpayment by Plan or a Payor, Plan or a Payor insolvency or breach of the Agreement, and Plan determination that services are not Medically Necessary, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or persons other than Plan or a Payor acting on their behalf, for Covered Services rendered under the Agreement. This section shall not prohibit collection of copayments, coinsurance, or deductibles in accordance with the Covered Person’s Contract.
Hold Harmless Issues & Alternative

- State laws usually protect patient/member for insured and HMO products requiring reserves DOL & State Laws don’t require self-funded reserves
- Add “Only as required by applicable law” in front of the provision to be compliant for insured plans
- Stipulate that insolvency, breach, or determination that service is not Medically Necessary by a self-funded payer allows practice to bill patient
- Offer to have a patient waiver signed indicating patient agrees to pay in these very specific circumstances
- Ensure that practice patient responsibility/waiver includes consistent language with your agreements*
Undesireable Contract Provision: Amendments

Plan can amend this agreement on 60 days’ written or electronic notice by sending Provider a copy of the amendment. **Provider signature is not required** to make the amendment effective. Provider’s written objection to such amendment must be received by Plan within 30 days of the date of Plan’s notice. Plan reserves the right to reject Provider’s objection and to terminate the agreement on the date the amendment would have been in effect. **If Provider does not send a written objection, the amendment shall be assumed to be in effect on the date indicated in the Plan’s amendment.**
Amendment Provision Alternatives

- Any non-regulatory amendment of this Agreement requires the prior written consent of both parties.

- You may agree to regulatory amendments needing 60-120 days written notice and have the option to terminate should the regulation change make the contract not worthwhile.

- Caution: written consent accompanied by “except as otherwise indicated herein” can mean there is an exception in, say, the rate exhibit or payments section – where payer/network can change WITHOUT written consent.

- Make sure the NOTICE section requires delivery receipt and alert your mail receiver to send anything from payers and networks to you. Set up Admin@ email address that can be forwarded to several practice staff.
Unacceptable Provisions: Medical Necessity

"Medically Necessary" means, unless otherwise defined under state law or by Health Benefit Plan, the provision of services by a Participating Provider which are:

a) consistent with the symptoms, diagnosis and treatment of a Covered Person's illness, disease or medical condition/problem;

b) commonly and customarily recognized in the Participating Provider's profession or area of health care services as appropriate in the treatment of a Covered Person's diagnosed illness, injury or condition; and

c) not primarily for the convenience of the Covered Person or the Participating Provider.
Contract Provisions: Medical Necessity Issues

Know your state’s Medical Necessity definition

- Medical Necessity       Meets clinical standards - ok
  Not experimental - ok
  Not for Patient Convenience - ok

Sounds good till…“unless defined otherwise by the Health Benefit Plan”

YOU WILL NOT LIKLEY GET CHANGED BUT ADVISE NETWORK:

The Health Benefit Plan should call a service an “exclusion” instead of “not Medically Necessary” if it meets the state definition or clinical guidelines of the specialty.

Hold Harmless provisions may prohibit you from billing patient for non-Medically Necessary service, as determined by the health benefit plan even if patient agrees to pay unless this language is fixed in the agreement.
Contract Provisions: Payment Policies

- Most agreements bind you to Payment Policies that are subject to change at any time.

Multiple Procedure and other Bundling rules are proprietary and vary by “payer” that is accessing the Agreement.

Require Network/Payer to post to Website and update 60-90 days prior to changes.

Understand complexities and variations in policies by payers accessing Leased Networks.

Consider use of outside vendors to monitor adherence to payer policies.
Contract Provisions:

- **Definition of “Affiliate”**
  - Did you ask for a list and require that these be listed on Website and in Agreement?

- **Assignment of Agreement**
  - Any affiliate “Assigned” must identify Contract on ID Card and on EOB or contract terms do not apply.
  - Any party “Assigned” must adhere to the terms of the Contract or breach can be cause for termination of entire contract or for that Assign.
  - If terms of agreement between Network and the Assigned party do not concur with your contract with the Network, your contract provisions prevail.
Under/Overpayment Resolution:

Contract often silent & “payment policies” of payer apply.

- Resolution of Payment Errors Checklist for Under/Overpayments to add to agreement
  - Provider has X months after paid date to request correction
  - Insurer has X days from DOS or receipt of request to correct – Remember: state law does not apply to self-funded
  - If request for refund is rec’d either refund or “dispute” in writing within 30 days (mirror applicable state law)
  - If “disputed” resort to Dispute Resolution/Arbitration rather than the one-sided “payment policies” of payer
  - Know your state law on insured plans and if favorable, mirror it

Extreme Example:

HRI targeted self-insured employers such as Georgia Pacific for claims as old as 4 years old for initial incorrect bundling
Contract Provisions:

- **Retro-Eligibility Denials after Verified on DOS**
  - Insurer has how long to retro deny, unless fraud
  - Require Payor to give written notice re: basis for retro-denial
  - If for COB, insurer must specify name/address of responsible entity & provider has x time from denial date to submit
  - Insurance Law does not usually address payer specifically verifying eligibility and later denying for lack of eligibility

See case law in CA, NE, MS

- If provider does not mislead payer in claim submission & payer pays, provider is not required to return funds
- “Disputes” go to arbitration which payer not likely to pursue
Contract Provisions: All Products

Did you appropriately exclude or qualify…

- Automobile Insurance Plans? – rarely include
- Exchanges/Medicaid/Medicare - require prior written consent and verify fee schedule is adequate
- Workers’ Comp
- Plans that don’t list provider in a directory
- Specialty Programs that exclude provider
- Plans that do not provide financial incentive to seek care from participating providers
- Plans that do not display payer/network on ID card & EOB
- Discount cards or Silent PPOs
Amending a current agreement
You just re-negotiated your rates and received the amendment

Provisions unrelated to the new rates might be in there, so read it carefully.

- **Examples:**
  - Favored Nation Clauses promising no other payer gets a better rate
  - Waive your right to terminate without cause in future
  - Termination date of the newly negotiated rates, reverting back to standard market schedule at end of term.
What’s New in Agreements

- Merger Language in Most now
- Shared Savings and other Value-Based (More for PCPs than Specialists)
- Penalties and Withholds if Terminating
- Penalties for Using/Referring to non-par providers
- Penalties for not timely updating credentialing info
- Payer/Network “First Right of Refusal” to buy practices
Do you need to be in every network?

NO

Certain Specialties can survive more easily than others without payer and network agreements.
After the Clean Up
Manage the Agreements and Notices

- Maintain your Inventory of Agreements – Check Monthly to see if an anniversary, initial term, escalation date, or notice period is approaching.

- Import all schedules to your PMS so that you can validate accurate “allowables” are used by payers as claims payments are posted & to calc patient responsibility.

- Do an annual chargemaster analysis and update.

- As you receive payer notices, especially related to rates and products, assume a response is time sensitive, failure to object likely means acceptance.
In Conclusion

- Start by gathering your agreements and rates for all codes or you will not know your Starting point.
- Use All codes and Weight by All Payer Utilization to compare fee schedules apples to apples; calculate actual improvement using payer specific.
- Know When and How to initiate a negotiation and manage the timeline using contractual terms.
- Look for best aggregate improvement, not just certain codes.
- Validate Value Based report card.
- Negotiate/Manage other Deal Breaker Provisions.