

AMERICAN COLLEGE OF SURGEONS

# Resources for the Practicing Surgeon: **CONTRACTING WITH PRIVATE PAYORS**

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**100+** years

AMERICAN COLLEGE OF SURGEONS

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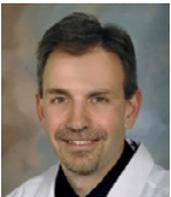
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**DISCLAIMER**

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# INTRODUCTION





## INTRODUCTION

The days when one could enter the practice of surgery with only a passing knowledge of the business climate and extensive regulations that come with running a surgical practice are long gone. To start and maintain a practice today as an independent entity—whether as part of a group, in solo practice, or through an employment contract—without learning the basics of these topics is hazardous to your economic health and personal well-being. Beyond the requirements of surgical knowledge and dedication to one’s patients, surgical practice today also requires allies in other disciplines and a strong commitment to managing one’s business. It is only in this way that one can reasonably expect consistent, predictable remuneration allowing the surgeon the ability to enjoy meaningful professional autonomy and financial security.

*ACS Resources for the Practicing Surgeon: Contracting with Private Payors* is intended to highlight some of the important principles of establishing and sustaining a surgical practice in today’s challenging health care environment. This primer begins with an explanation of the economics underlying health insurance markets, a basic understanding of which is essential for any surgeon entering into negotiating insurance contracts. The next section provides practical information for the surgeon in developing a productive relationship with payors, followed by guidance aimed at helping surgeons evaluate insurance contracts and improve their revenue cycle, including various templates for tracking payor policies, claims denials, and compliance plans, among other tools. The primer concludes with tips for strategic contract renewals, along with issues to consider when leaving an insurance network.

Whether starting a new practice or evaluating existing contractual relationships with private payors, surgeons and practice administrators should find a wealth of detailed information within this publication to assist in navigating the current landscape of health insurance plans and networks. Perhaps the most important takeaway message is that surgical practice today necessitates study and understanding of these concepts as well as the use of professional advisors who can assist surgeons to steer past the rocks and shoals inherent to the business and administrative aspects of surgery.



NAVIGATING HEALTH INSURANCE PLANS AND NETWORKS

# NAVIGATING HEALTH INSURANCE PLANS AND NETWORKS





## NAVIGATING HEALTH INSURANCE PLANS AND NETWORKS

### Identifying Payors and Understanding Your Market

#### Market Share

The first step to successful payor agreements is to have a good understanding of your local market. The relative value and leverage of any plan will be heavily influenced by its market share in the insurance products that cover significant portions of the population in the relevant region. Markets are characterized by two aspects: a **product market** and a **geographic market**.

- A **product market** is a product or group of products for which there are no adequate substitutes. In the health insurance industry, the main product types are:
  - **Preferred Provider Organization (PPO):** A health plan product that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Enrollees pay less if they use providers that belong to the plan’s network. Enrollees can use providers outside of the network for an additional cost.
  - **Health Maintenance Organization (HMO):** A health plan product that limits coverage to in-network providers; care from doctors who work for or contract with the HMO. It generally will not cover out-of-network care except in an emergency. An HMO may require enrollees to live or work in its service area to be eligible for coverage.
  - **Point of Service (POS):** A health plan product similar to an HMO that offers the lowest cost coverage with in-network providers, with a provision allowing for some higher cost out-of-network care. POS plans require enrollees to get a referral from their primary care doctor to see a specialist.<sup>1</sup>
- A **geographic market** requires a determination of the area in which there is effective competition for a given product. In determining the extent of the market for health insurance, distance is a critical consideration. Due to the local nature of health care delivery, geographic markets for insurance products are also often local—consumers typically buy coverage that serves them close to where they work and live.<sup>2</sup> For certain specialty services for which patients may be willing to travel long distances, however, the geographic market could be quite broad, particularly in rural areas.<sup>3</sup>



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In rural areas, “geographic market” can often be best thought of as “time to travel” rather than by using a strict measure of distance. For instance, two practices may be equidistant from a patient, but if travel one way is on level terrain, or can be reached by interstate highways, and the other practice lies on the other side of mountains or is accessible only by winding two-lane roads, then the “time to travel” may be the greater driver of where the patient will choose to go.

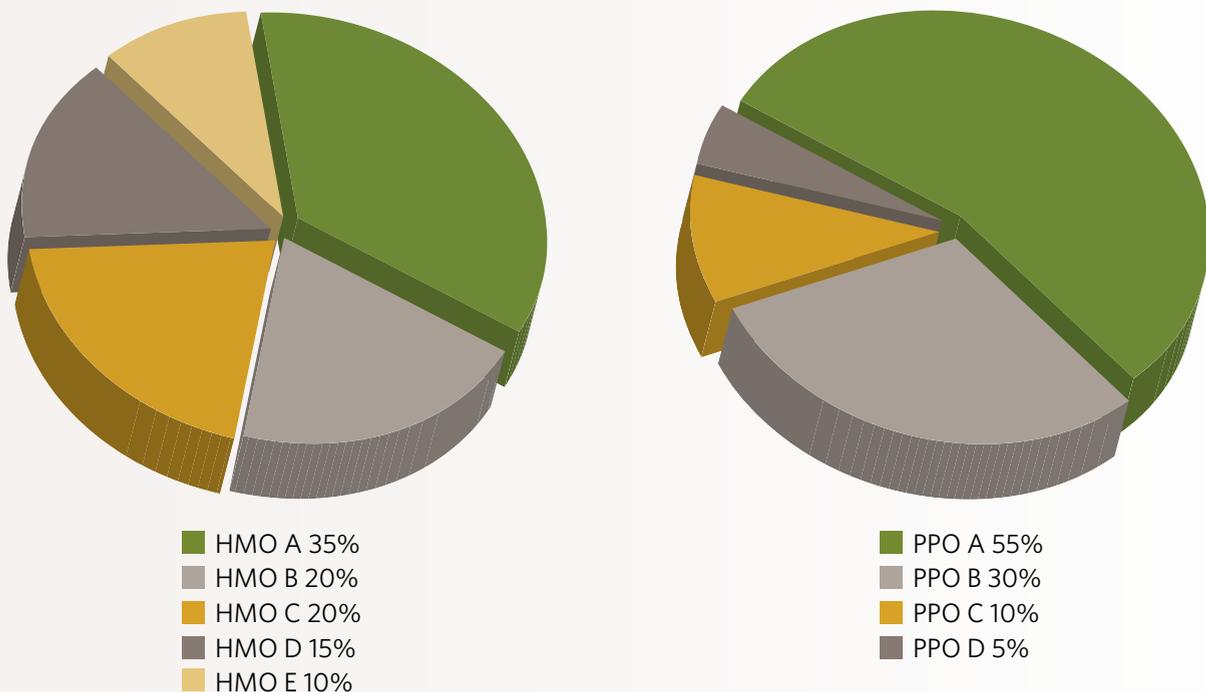


## NAVIGATING HEALTH INSURANCE PLANS AND NETWORKS

A payor's market share for a particular type of insurance product is the percentage of the population covered by the plan for that product. Chart 1 depicts a typical representation of market share for a region for both HMO and PPO insurance products.<sup>4</sup> For example, if the market share of a given payor's HMO is 30 percent of the HMO market, then the payor provides insurance coverage for 30 percent of the population that is currently covered by an HMO health insurance product. If only 20 percent of that total population has HMO insurance coverage, then only 6 percent (30 percent of 20 percent) of the region's population will be covered by that same payor's HMO. A payor may have little presence in the HMO market but may also be a dominant player in the PPO market or vice versa.

The annual American Medical Association (AMA) publication, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets," can assist in determining the market share of the various health plans in the area. In its 2020 report, the AMA determined that when using 2019 data on enrollment in HMOs, PPOs, and POS plans, the majority of health insurance markets in the United States are highly concentrated and that, on average, such markets have become significantly more concentrated over the past five years.<sup>2</sup> **The Kaiser Family Foundation has a helpful website listing state health facts but also the various competitive insurance products for a given area.<sup>5</sup> This website will allow you to look up your state and understand the various insurance products in the marketplace.**

**Chart 1.** Example HMO/PPO Regional Market Share





## NAVIGATING HEALTH INSURANCE PLANS AND NETWORKS

When a payor exercises market power in its **output** market—the sale of insurance coverage—premiums are higher than in a competitive market. When a payor exercises market power in its **input** market (e.g., physician services), payments to health care providers are below competitive levels. In both settings, the quantity of insurance coverage provided is lower than in a competitive market. In short, the exercise of market power adversely affects health insurance coverage and health care.

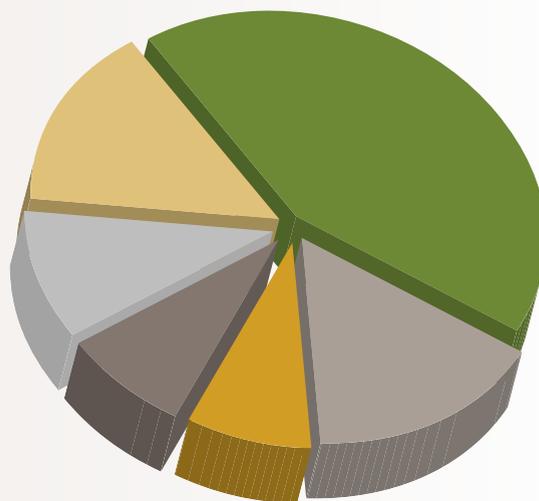
Research suggests that payors exercise market power and that competition among them lowers health plan premiums. When assessing whether payors charge higher premiums to employers that earn higher profits (i.e., whether they engage in direct price discrimination)—which would imply that insurers exercise market power—payor data indicates that they possess and exercise market power in an increasing number of geographic markets.<sup>6</sup> High barriers to entry into payor markets also enable payors to exercise market power. Such barriers include state regulatory requirements, the cost of developing a provider network, and the development of sufficient business to permit the spreading of risk.<sup>7</sup>

### Payor Mix

In preparing for negotiations with a payor, perhaps even more important than understanding the payor market share landscape is understanding the payor mix of a given physician practice. The payor mix is the percent by payor for a given metric. These contributions may be measured by a number of scales: number of patients seen, gross charges, total collections received, or total work relative value units (RVUs). **One of the most useful financial statistics for surgeons to know is the gross collection percentage (payment divided by charge) by payor, as it details for a given charge how much is typically paid.**

Examples of a payor mix analysis are shown in Charts 2 and 3 below. Chart 2 illustrates payor mix based on total RVUs for the health plan's members. Chart 3 represents payor mix based on collections from the payors. Note that for both Medicare and HMO B, the payor mix by RVUs is greater than the payor mix by revenue collected. This is because the compensation by these payors per RVU is lower than the other payors. For HMO B, a physician practice should consider negotiating reimbursement rates that are more consistent with the other payors in the payor mix. Alternatively, PPO A has a much higher payor mix based on collections compared to payor mix by RVUs, suggesting a relatively high fee schedule.<sup>4</sup>

**Chart 2.** Payor Mix (RVUs)

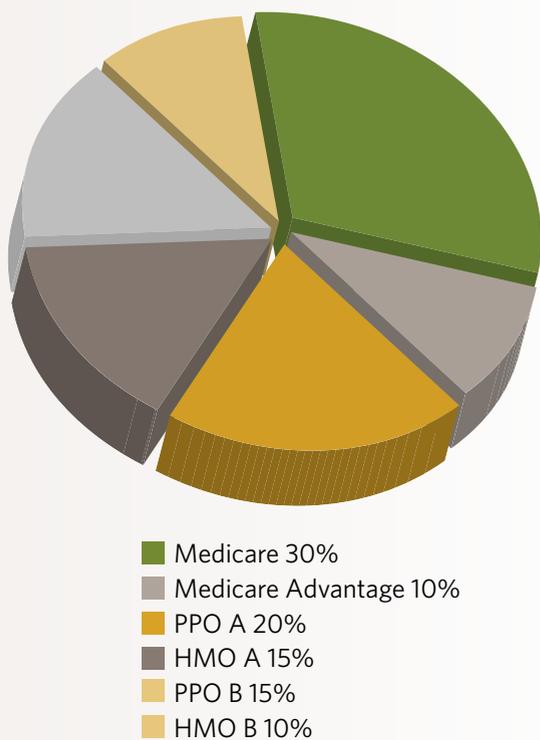


- Medicare 43%
- Medicare Advantage 16%
- PPO A 8%
- HMO A 8%
- PPO B 10%
- HMO B 15%



## NAVIGATING HEALTH INSURANCE PLANS AND NETWORKS

**Chart 3.** Payor Mix (Revenue)



It is important to follow trends in payor mix, as these will change over time based on the success of the payor in contracting with employers and with the participation of referring physicians within the plan's network. If a major employer switches insurance coverage for its employees from HMO A to PPO B, it will likely impact a practice's payor mix. If a large primary care group that refers to a surgical practice drops their participation in HMO B, there may be a decline in HMO B's payor mix. However, HMO B members may choose other primary care physicians who refer to the surgical practice, resulting in no change in the practice's payor mix.<sup>4</sup>

### *Assessing Potential for Revenue*

The first step for a physician practice that is beginning to build relationships with payors is to identify those with which the practice could enter into a new contract or renew an existing contract. The actions a practice takes will vary based on whether it is new to contracting with payors, expanding to add additional payors, or examining existing contracts to maximize reimbursement or other terms and conditions.

During the relationship-building process, practices should aim to establish that it is a "must-have" group that will better enable the payor to compete in its market. Payors succeed in a market by growing membership and controlling total health care costs. Practices should work to gather any information on what a payor's needs may be—such as geographic need (limited number of or access to providers in the practice's geography), a performance need (their performance is less than average on certain HEDIS benchmarks where your practice performs well), **an economic efficiency of the practice's outcomes**, or a need to have surgical specialists in their network—and utilize that information when approaching potential payor partners. Practices can prepare for an effective negotiation by knowing the answers to the following questions about both the payor and the practice itself:

- How many of the practice's **patients and potential referrals are covered** by the payor? While there is no specific number of patients enrolled in a given payor's plan a practice must serve in order to enter the payor's network, it is important to know how many patients in a physician practice are insured by a particular payor. Practices can analyze their payment data to determine payor mix.



## NAVIGATING HEALTH INSURANCE PLANS AND NETWORKS

- Is the payor **growing or declining** in membership?
- Do **high-volume referring physicians** participate with this payor?
- Does the payor make **timely and accurate payments** for billed services?
- What dollar amount is the practice currently being **paid by this payor**?
- What dollar amount is the practice currently being **paid by other major competitor payors** in the region?
- How do the **quality and cost profiles** of the practice group physicians compare to other competing physicians?
- What is the **practice's cost** for providing medical services?
- Is there a **reimbursement advantage** to changing the payor mix?
- What is the practice's **target revenue** payor mix? Due to reimbursement and other factors, some practices will limit their practice revenue to certain products (e.g., no more than 40% HMO).

Health benefits brokers can also be a valuable source of payor and market information. Brokers must have detailed information to sell their client payor's products, including market share, products, and provider networks. For example, commercial health benefit brokers will often know which payors are increasing membership and factors contributing to their growth. They often will also have information on underwriting and product pricing strategy, providing insights into employer group characteristics and population health.

Similarly, Medicare health benefit brokers will often have detailed knowledge of available products, including traditional Medicare and Medicare Advantage. While Medicare Advantage products tend to have limited variation within a given market, how the payors market their product, how they service their members and how operationally efficient they are with their providers can be significantly different. Advance preparation is critical to selecting one or more "partner" payors for a long-term relationship.

Health benefit brokers can be national, regional, or local in scope. Select one or more brokers capable of assessing your market(s) of interest. Provide them with the parameters of interest for your market. Typical payor parameters include membership, membership growth, products (lines-of-business), service area, provider network, customer service, claims payment timeliness and accuracy, and underwriting.

Additional payor information to consider could include ownership, financial strength, management stability, commitment to your market, and partnership philosophy. This information can be gathered from a variety of sources, including financial filings for public companies and health benefit brokers.

Profiling payors by physician in your service area is also valuable for understanding your market. This information is readily available for many markets from provider credentialing firms, often at no cost. Identify credentialing firms that work with providers in your service area and request a market analysis. Indicate select ZIP codes and medical specialties to use for the report. The analysis will provide a list of payors by physician in your market, providing valuable payor information.



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Practices should also leverage any existing relationships they may have (e.g., in-network status with other payors or partnerships with local community providers/primary care sites) and ask for tips from colleagues who have gone through the negotiation process with a given payor. Approach negotiations prepared with the knowledge of payor market share, practice payor mix, performance profiles, market rates, and an overall practice assessment to achieve the best results.<sup>4</sup>

### **Assessing Potential Payor Partners**

Entering into a contract necessitates a payor that is ready and willing to work within a partnership. When assessing payors in your market, you should first decide if you want to contract with all the payors in your area or a select few. Contracting with all of them may provide the opportunity to rapidly reach a threshold number of members. Many physician practices prefer to diversify their relationships and contract with any payor that offers a reasonable agreement. As a result, the disruption to their business is minimal should they decide to terminate a single payor agreement. One disadvantage to contracting with a broad range of payors is an increase in administrative costs related to multiple reporting criteria, multiple oversight audits, and multiple service relationships to manage.

An alternative approach is to contract with a few payors to have larger enrollment with each payor and ease your administrative burden. However, there are often many payors competing for membership and none of them individually may be able to build a large enough population with you to achieve revenue targets. The challenge then will be how to select the payors that will afford the greatest opportunity for you to succeed. A disadvantage to having just a few payor relationships with more members becomes evident during renegotiation time. If you are unable to reach an agreement with the payor for reasonable renewal terms, and they are willing and able to move their membership to other practices, the loss of so many members at one time could have significant financial implications to your practice.

Another consideration is that payors can attract different populations, depending on who they are enrolling and which employers use their services. One payor may have an older, sicker, or more service-intensive population. If you partner with one of these payors, you will be impacted by the demographics and acuity of these enrollees. Depending on your market, you may be best served by taking a middle ground by negotiating with enough payors to generate sufficient membership to establish leverage in the market.

### **Physician-Payor Relationships**

An important next step in successfully working with a payor is to establish a strong relationship with them. This relationship will be the foundation upon which a physician practice will engage with the payor and will be a major factor in a practice's continued viability. The relationship that a practice has with the payors it contracts with is critical to maintaining long-term financial stability, as such payors will likely be the source of a significant portion of revenue generated by the practice.<sup>8</sup>

Knowing whom to talk to at a payor, and what to say, can have a profound impact on patient care. Once payors of interest have been identified, physicians and their practice staff should determine the key contacts at those payors. Successful payor relationships depend on connecting with the right people, at the right time, with all the right information necessary to resolve an issue. Strong relationships should be established with provider relations or customer service representatives, physician network managers, and medical directors.



## NAVIGATING HEALTH INSURANCE PLANS AND NETWORKS

### Tips for Establishing Effective Communication with Payors

- Send marketing materials and/or an invitation for a meeting to establish a relationship with a payor before any specific issues arise.
- Try to learn generally about the payor team representatives in advance, as this will help create a more personal foundation for a long-term relationship. Create and continually update a document to help you collect and organize key contact information for the payors with which you contract. Such information may include names, titles and job responsibilities, phone numbers, e-mail and mailing addresses, websites, coverage policy databases, notes about any personal connections, subject matter experts, and any other relevant details.
- When initiating contact, be prepared to clearly and concisely articulate the types of services your practice offers, the total number of patients in your practice and the total number of patients enrolled with a given payor, the number/type of providers/sites and hours of operation of your practice. Share relevant information about patient demographics, HEDIS measures, quality initiatives, accreditations/credentialing information (e.g., licensing, Medicare/Medicaid certification), and any knowledge you may have gained about the payor's network needs. Matching the payor's expectations with your practice's goals and services increases the chances of a mutually beneficial relationship.

### Ongoing Sustainability: Maintaining the Relationship

Physician practices with standard processes in place to work with payors often find that issues are identified in a coordinated and consistent manner. Regular payor-physician interactions help payors recognize problems faced by surgeons and create opportunities for payors to correct and improve their policies and procedures. When surgeons understand and are able to positively influence payor decisions where appropriate, they are able to maximize time spent providing quality care to patients and reduce potential grievances with the payor.<sup>9</sup>

Once an initial relationship has been established and it has been decided that a given payor is a viable potential partner for your practice, it is important to nurture and continuously improve the relationship. Set a goal to meet in person or via video conference at least semi-annually with a medical director and/or other decision-makers from each payor with which you contract. Face-to-face discussion is paramount in establishing relationships with influential payor employees, enabling both parties to build



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Meeting with payors may change in the new dynamic of Zoom conferencing. Consider meeting 3-4 times a year with the payors that had a significant practice population (>20%) and 1-2 times a year with the others. A defined agenda with the financials is important as well as the opportunity for defining new procedures and services. Have updated outcomes. A mix of face-to face and virtual meetings will likely be the norm going forward.



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credibility and develop mutual trust. During in-person meetings, remind payors that you are available to help answer any questions that arise in their organizations about specific clinical topics within your area(s) of expertise. Video conferencing is also an acceptable (and sometimes a more convenient) way to communicate and nurture an established relationship, but the power of a face-to-face meeting and personal connection should not be underestimated. Physicians report having the best relationships with payors with which they have met face-to-face.<sup>9</sup>

To be adequately prepared for these discussions, practices should produce financial analytics to evaluate the past, current, and potential future of the payor's performance with regard to the practice. Even simple analyses such as the payor's initial denial rates, total practice charges and net patient revenue as a percentage of total, and/or practice volume as a percentage of total are valuable pieces of information that can lend a significant degree of context to these conversations. During such meetings, physicians and their practice management team should update payors on new programs, both clinical and financial/operational, that have been put in place to improve the quality and value of the practice. It is also advised that the practice offer the payor input and time by providing clinical data or serving on one of their internal committees. Physicians may consider asking payors questions such as:

- What could the practice do to strengthen its relationship with the payor?
- What are the qualities of the payor's "best in class" practice partners?
- What data analyses, both clinical and financial, would best assist the payor in providing the most favorable reimbursement to the practice?<sup>8</sup>

As a result of increased communication, organization and preparedness, and business acumen on the part of the practice, expectations will likely be more clearly defined and any potential confusion avoided or easily remedied.

Payor relationships require a two-way interaction—the practice is providing a valuable service, and the insurance company is providing the payment for that service. An ongoing positive physician-payor relationship will benefit both parties, as well as the patients that they serve.<sup>8</sup>

As mentioned above, regular physician-payor meetings are essential to good working relationships. Establishing a Joint Operations Committee (JOC) with your key payors is recommended to collaboratively identify issues and trends across the payor/provider delivery system that adversely impact quality, utilization, cost, and access, as well as to implement improvement strategies. Members of a JOC should include key decision-makers who can assign accountability within their organization. Participants from the payor may include regional contract directors, contract managers, directors/managers of provider relations, physician advocates, clinical management specialists, and encounter data specialists. Participants from the provider organization should include all staff directly or indirectly associated with the payor relationship.

JOC meetings can be considered to bridge the gap between payor policies and procedures and the actual delivery of health care. Payors are required to have extensive operational documentation, which providers incorporate into their practice, but there are certain to be unique circumstances that the JOC is designed to address. Providers should come prepared to discuss these unique circumstances and include a timeline for resolution, particularly if there are reoccurring issues. A JOC agenda often includes the following payor items: key contacts sheet update, utilization data, mass mailing review (e.g., any provider terminations), and clinical management. While it is common for payors to set the agenda, it is highly recommended that it be a mutual agenda, including items of importance to physicians and their practice.

Working together with a JOC can significantly build the payor relationship, maintain operational efficiency, and improve customer satisfaction. This arrangement can also be proactive and strategic, with a focus on the future and partnership.



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# UNDERSTANDING PAYOR CONTRACTS

Please note: The following material should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult your own lawyer on any specific legal questions you may have concerning your practice.



## UNDERSTANDING PAYOR CONTRACTS

### Preparation: Initial Review of Important Contract Components

As previously described, it is important to identify who the decision maker is at the payor. Once you identify the individual(s) (e.g., network manager, contract representative) at the payor with whom you will be negotiating, then establish rapport; however, there are other steps you must take before you are ready to begin negotiations.

#### *Financial and Administrative Expectations*

You must have a very clear and in-depth understanding of your current financial and administrative standing with regards to all payors, including Medicare, Medicaid, including Medicare, Medicaid, and other federal health care programs.

- **Fee schedules and payment rules:** Know your current fee schedules for all payors, which you should have in writing from each payor as a part of your contract. First, double check to make sure the payors are paying you the rate you agreed to in the contractual fee schedules. Next, identify your top 10 to 20 CPT codes billed by volume and by dollar amount. Rank the payors based on who pays more for these top codes. Include Medicare in this ranking and determine if your private payors are paying more or less than Medicare for those codes. Next, analyze each of your top 5–10 payor contracts for other rules or contractual provisions that impact payment. For example, does a schedule to the contract say the payor does not recognize incident-to billing? Pay particular attention to capitalized terms and their definitions. Review all definitions anytime you see a capitalized term. Identify any language that might allow the payor to adjust allowable amounts within a certain range of other payors, such as Medicare. One of the most important terms to identify (and never agree to) is a unilateral right of the payor to modify the fee

schedule or payment terms. Some payors try to do this by creating or modifying a policy and arguing that the policy change is not really a contract change. In contract law, terms cannot be modified without both parties' signatures, unless one party waives that in the contract. Does the contract give the payor the right to reduce your rates? Or is the rate based on Medicare, so that if Medicare reimbursement goes down, then this payor pays you less too?

- **Incentives and disincentives:** Identify incentives and disincentives from each payor. Incentives might include quality- or value-based metrics that pay more if you follow certain steps and provide certain data. A capitated payment may be an incentive or disincentive, depending on related terms and volume. A disincentive might be something like high deductible plans that could discourage patients from receiving treatment due to out-of-pocket costs. Foregoing treatment could exacerbate the patient's condition, which could cost the payor more in the long run, so perhaps you and the payor are aligned in the concern that high deductibles may need to be addressed, perhaps with a carve out for certain types of care.
- **Denials, adjustments, and other hurdles:** Payor contracting is about more than the reimbursement rates. Take time to interview your practice's team members (e.g., billing and collections staff) who interface with payors every day. Ask detailed questions about which payors are the best, the worst, and why. What difficulties do these team members face daily as they perform their jobs? What do they think would improve the process of billing and collecting for your practice? If they could change one thing about each payor with which they interact, what would it be? This subjective data will help you further rank each payor. It is wise to complete this step in the preparation process to identify what may be written rules, or that, upon



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investigation, may be artificially imposed rules that the payors apply in contravention of the contractual terms. These can take the form of multiple procedure reductions in payment, look-back periods, and carve outs. Be sure to interview these team members about what the team and practice does well. What sets this practice apart from other similar practices in ways that the payor might appreciate?

- **Termination:** While you are reviewing the contract for payment and related terms, outline for each of your top payors what their contract termination clause demands. How much notice do you have to give if you decide to terminate an in-network contract? Do you have to, or can you, mail notices to patients to inform them that you will no longer be in-network with the payor? Once patients get those letters, they may contact the payor and their employer benefits department and apply pressure to the payor to treat the physician group better. Do you have to continue to treat patients in the payor's network post-termination? Sometimes, giving notice to the payor that you intend to terminate the contract will prompt them to start to negotiate with you.

### **Knowing Your Goals and Highlighting Your Practice**

Once you have had the chance to thoroughly analyze the above information, ask yourself the following:

- What can you offer to the payor that could be a win-win?
- What rates do you really want? On which rates are you willing to settle?
- Are there any deal breakers for you? Is there anything that is non-negotiable?
- Are you willing to take more risk?

- Are you willing to be paid based on value to the payor and patient rather than volume and, if so, for what types of procedures and what might that include?

Next, create a "sales pitch" for your practice. Explain why your group is the best group for the payor to partner within the area for your specialty type. Do you have state of the art billing software? Are all your coders certified? Focus on administrative processes that impact the payor daily. Of course, also be persuasive about the medical aspects of the practice. Focus on ways your group provides the best, most efficient and effective care.

Think about how you will share this information with payors. This may be done in one-on-one meetings with payors, practitioner focus groups, or by serving on committees that payors may have in the medical community. Identify how your participation in the payor's network can yield results that are mutually beneficial and prepare ways to explain these benefits easily.

### **Contract Negotiation, Review, and Execution**

A typical negotiation process takes six months. Be reasonable in your expectations as to the timeframe. The better the relationship you have with the payor, the more direct your access to the decisionmaker, and the more definite the terms in the preliminary letter of intent or memorandum of understanding, the faster the contract process.

The common first step, perhaps after a meeting sharing the perspectives and goals of each party, is to aim to enter into a letter of intent or memorandum of understanding as to key terms of a potential contract. This might be as simple as several bullet points of key items to be included in the contract. Once there is a meeting of the minds as to those key points, the contract is drafted and shared. It is wise to have an experienced healthcare attorney review the contract. The attorney may take the lead in



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the negotiations or may be in the background providing guidance as the practice negotiates directly with the payor. Consider hiring not only an attorney to review the legal terms but also a reimbursement or revenue cycle expert who is more attuned to the financial aspects of reimbursement. A team approach can be best.

Your attorney should point out the following concepts in the agreement (or their absence):

- **Definitions of key terms, particularly of “clean claim” and “medical necessity”:** These terms typically define when a payor has to pay a claim (a claim that is clean is usually one that has all the criteria needed to process it) and the grounds on which it may be denied. It is important to define these according to any state laws that might protect physicians. Tailor them to your specialty as appropriate—what is medically necessary for one specialty might not be medically necessary for another.

Likewise, watch out for overly expansive definitions of “payor” that could make you have to follow the fee schedule of an affiliate of the payor. For example, language like “an insurance carrier or other entity that has contracted with the payor to pay the lesser of its or payor’s rates” allows the payor to contract with other insurance companies that have lower fee schedules and bind your company to follow those lower fee schedules. Be sure to limit the “payor” to the entity that is named in the first paragraph of the contract and on the signature line.

- **Timing:** Pay particular attention to timeframes. By what date do you have to submit a claim after a service is furnished? By what date does the payor have to pay or deny it? If they deny it, what is the timeframe by which you have to correct and resubmit it? What is the timeframe (i.e., the statute of limitations) by which the payor can audit and

recoup payments they allege were wrongly paid? This language may read, for example, “audits must begin within 90 days of the billing date of the claim” or “no claim paid hereunder can be recouped by the payor for any reason other than intentional fraud after one year from the date of service.”

- **Dispute resolution:** How will disputes between your practice and the payor be handled? Many payors have preliminary, internal processes that must be followed prior to the filing of an arbitration or lawsuit. Be wary of these, as they can be time intensive and financially exhaustive before the provider gets to a non-biased resolution setting. While some sort of negotiation as a prerequisite to arbitration or mediation is normal, requiring participation in an internal process that has no clear end is not fair.
- **Antitrust:** Antitrust laws prohibit entities from joining together to restrain trade and competition. One of the main antitrust cases is a 1982 lawsuit in which the State of Arizona sued the Maricopa County Medical Society, alleging that the society’s members agreed amongst themselves to set maximum fees that they would claim in full from insurance plans. The court held that this was an illegal restraint of trade in the form of price fixing. This is deemed “horizontal price fixing,” where competitors collaborate to impact the price of a good or service they provide. Some advisors take this decision to mean that physician groups should not share information about what payors are paying them. Be careful in the conversations you have with your competitors about rates that you will accept from payors.



# IMPROVING YOUR REVENUE CYCLE AND PRACTICE MANAGEMENT





## IMPROVING YOUR REVENUE CYCLE AND PRACTICE MANAGEMENT

A surgical practice, like any other business, will be successful if—and only if—its surgeons take interest in their business and help manage it. The most fatal mistake to make is assume that someone else will manage your business better than you. This does not mean that you have to be in the front office checking in patients, or in the billing/coding office licking stamps on envelopes, but it *does* mean that you have to be visible and show interest in how your practice is run.

The revenue cycle is the engine of any office that pays the bills for the practice and includes the work from charge entry to bill submission to follow up and collections. A surgeon can work day and night to provide the best care to their patients, but if the practice does not have an efficient revenue cycle, all of that hard work will be for naught in terms of appropriate reimbursement.

### Improving Revenue Cycle from the First Call

Does waiting until the patient arrives in your office to discover their insurance is expired make sense? No. Patients should all be preregistered with their health history and demographics submitted prior to their appointment—this is easily done by insisting on the use of your patient portal. Clipboards and pens are out! Insurance card data can easily be scanned and submitted via your secure portal.

Best practices call for patients to complete their paperwork at least two days prior to their appointment. Remember, patients who complete their paperwork are not likely to be no-shows.

Eligibility and benefit verification allow you to contact the patient in advance of their appointment and tell them what they will be asked to pay for the visit and any expenses to expect for necessary tests or surgical procedures.

**Key Step:** In the eligibility and benefit verification call, ask the patient how they plan to settle their account. Note this and advise check-in staff.

At check-in, collect the amount owed for that visit by the patient and ask if they would like to use the payment method discussed during the eligibility and benefit verification call. Patients appreciate the financial transparency—no one likes surprise bills.

Another policy that is growing more common requires the patient to sign an agreement with the practice that, after their insurance pays the allowed amount, any remaining balance less than \$200 can be automatically charged to the patient's credit card on file. Fitness centers, utilities, storage lockers, and all sorts of other service businesses that use this feature—there is nothing new or revolutionary about this process. Cash flow is improved, billing costs are saved, and there is a reduced need for collection calls and notices.

When a decision for surgery is made, another process begins. The surgeon creates an order in the EHR and provides the planned CPT and ICD-10 codes to be billed. By elevating the traditional “scheduler” position into someone who can capably discuss the cost of surgery, the requirements for a surgery scheduling deposit, as well as booking the case at the hospital or outpatient surgical department optimally means that accounts receivable problems are reduced, if not eliminated. There is software available through clearinghouses or practice management systems that allow staff to prepare an estimate of what the case will cost in terms of patient responsibility. Alternatively, staff can go directly to the payor's website and prepare the estimate. Most major payors today have a cost estimator feature.



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There is nothing intuitive about filing insurance, billing, coding, and appealing, but following best practices like the ones below can make these processes more efficient:

1. Have a budget for training business office staff on billing and coding tactics. Staff and surgeons should consider attending educational webinars, such as those offered for free by the ACS, along with office and surgical coding workshops that carry CME and CEU credits, such as those hosted by the ACS in collaboration with Karen Zupko & Associates, Inc. Hold staff accountable for writing up the “learnings” that apply to improving their performance or that of the practice.

In addition, assign one staffer the responsibility for reading payor newsletters, which often include updates on coding and billing guidelines, and sharing relevant items with the entire team. At least one surgeon should also be responsible for reading payor newsletters to serve as the practice’s payor relations expert. To stay up to-date on payor-specific coverage requirements, consider making a chart like the one below to keep track of common policies across payors.

**Payor Policy Tracker**

Policy	Medicare	BCBS TX	Aetna	Anthem**	Cigna	Humana	UHC
Bilateral Procedure Reporting	1 line 1 unit Double fee	1 line 1 unit Double fee		1 line 1 unit Double fee	1 line 1 unit Double fee	1 line 1 unit Double fee	1 line 1 unit Double fee Eff. 7/12/17
Bilateral Procedure Payment	150%	150%		150%	100% for the first surgical procedure and 50% of the fee schedule for second procedure	150%	One side reimbursed at 100% and the other side reimbursed at 50%
Multiple Procedure Discounting	50%	50%	50% (line 2) 25% (lines 3+)	50% (line 2) 25% (lines 3-5)	50%	50%	50%
Pays for Consults	No			Yes			Yes
Incident-to Billing	Yes	Yes		Required to direct report		Yes	Yes



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2. **Remember:** You cannot manage what you do not measure, and it is important to monitor a variety of revenue cycle pulse points to measure tangible improvement in cash flow. Pick two or three change initiatives to focus on for the next quarter. Determine your practice’s current baseline data and metrics and set a goal for specific results. Examples might include increasing over the counter collections or surgery scheduling deposits by 35 percent.

Below is a chart to help you quantify the volume and impact of denials each quarter. Note that both front end registration performance and coding accuracy are tracked.

### Running the Right Reports

To diagnose the strengths and weaknesses in your practice, initiate a revenue cycle analysis. The first and most important report is the **aged accounts receivable (A/R) report**. Many surgeons receive one version of this report with all patients listed in alphabetical order up until the 120-day mark. Typically, the report is the size of the local phone book, and it tells them nothing.

There is a more meaningful way to understand what your accounts receivable are and how to reduce the amounts owed. Start by asking if the A/R report is run by **date of service (DOS)** or **date of posting**. There can be a big difference if, for example, one of your partners

**Denials Impact Chart**

Denial Category	Sample Denial Reasons	\$ Value /Number of Denials
Eligibility or Registration Denials	<ul style="list-style-type: none"> <li>▪ Patient not eligible on date of service</li> <li>▪ Cannot identify patient</li> </ul>	
Referral or Pre-Certification Denials	<ul style="list-style-type: none"> <li>▪ No referral (office)</li> <li>▪ Not pre-certified</li> </ul>	
Coding Denials	<ul style="list-style-type: none"> <li>▪ Included in another CPT code (bundled)</li> <li>▪ Service during a global period</li> <li>▪ Missing modifier</li> <li>▪ Place of service discrepancy</li> </ul>	
Medical Necessity Denials	<ul style="list-style-type: none"> <li>▪ ICD-10 does not support service</li> </ul>	
Timely Filing and Appeal Deadlines	<ul style="list-style-type: none"> <li>▪ Service outside of timely filing period</li> <li>▪ Appeal outside of timely appeal period</li> </ul>	



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holds all surgery charges and submits them at the end of the month. In effect, this surgeon is giving all insurance companies an interest-free loan—thus some accounts in the “current” category are actually about 30 days old. Watch that your billing services enter data on a timely basis. Understanding the charge entry date is key. Best practices call for surgery to be billed no later than **72 hours after the case is done.**



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I often had little time to consume in detail all of the factors affecting how the practice was doing financially on a daily or weekly basis. Surgery tended to consume all my time, but if there were two numbers I needed to know to protect myself from coming up without income at the end of the month it was the accounts receivable and the amount of accounts receivable over 90 days old. These two numbers predicted my cash flow over the ensuing three months. If that number was less than my known overhead expectations, trouble was on the near horizon.

Examine the various amounts of charges for 60-90 and 90-120 days, as identifying and working on accounts in this time frame represents your best opportunity to collect that money. Next, to make the data more meaningful, age out beyond the usual 120 days for each of the categories included in the aged A/R report as shown in the chart below. Typically, a huge money bubble is in the 90- to 120-day-old category. The real eye opener will be seeing how old some of that money really is. Age the accounts out to 150 days, 180 days, 210 days, and so on. Your chance of being paid on these old accounts is slim—very slim. And beyond one year, the chance of being paid is almost nonexistent. The expense of sending and continuing to send statements cannot be ignored. At some point, practices should consider contracting with an ethical licensed collection agency unless the patient is making monthly payments.

Next, run the A/R report separating patient balances from insurance balances. Remember, the amounts owed by patients are actual dollars after insurance is paid. The dollar amounts on the insurance A/R are inflated by your fee schedule multiplier, often some percentage of Medicare 1.5, 2.0, or 2.5 times, which payors typically do not pay. This report illustrates why collecting patient balances is so important: the \$807,932 in the 151-day-old category is likely not collectable.

### Aged A/R Report

	0-30 Days	31-60 Days	61-90 Days	91-120 Days	121-150 Days	151+ Days	Total
Insurance	\$1,508,350	\$1,434,615	\$606,676	\$367,715	\$163,722	\$744,418	\$4,825,496
% of Ins	31%	30%	13%	8%	3%	15%	100%
Patient	\$7,679	\$44,352	\$68,463	\$47,685	\$34,736	\$807,932	\$1,010,848
% of Pt	1%	4%	7%	5%	3%	80%	100%
Total	\$1,516,029	\$1,478,967	\$675,139	\$415,400	\$198,458	\$1,552,350	\$5,836,344
% of Total	26%	25%	12%	7%	3%	27%	100%



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By running insurance A/R by payor, you will see notable trends in payment timelines. For example, Medicare contractually pays on a clean claim in 14 days. A plan like Blue Cross Blue Shield (BCBS), on the other hand, may have contract terms saying that they pay in 30 days.

High dollar amounts in categories beyond 30 days indicates that claims are likely not being run through a good clearinghouse with errors fixed before submission. When dollars are in the 60-, 90-, and 120-day columns, it suggests that appeals are not being made or made effectively. Practices should consider running the A/R by payor report for the top three or four payors they are contracted with.

Running A/R reports by payor will have added diagnostic value if they are run for each physician in the practice. If there are noticeable differences in the A/R aged reports between physicians, ask why. Is one doctor an egregious coding unbundler? Does one surgeon have a distinctly different payor mix or referral base? Is failing to get prior authorization before operating a problem? Are the staff not working claims for all doctors equally? These are among the questions to ask when there are remarkably different A/R patterns by surgeon.

### The following are other reports that have value when run per provider:

- **Charges, payments, and adjustments** by provider, by payor, and by location.
- **Credit balances:** This is money collected over the charged amount. You may be overpaid by insurance or have collected more from patients than they owed. Adjust credit balances monthly by making refunds. Unethical billing companies often hide credit balances from physician clients—watch for this.
- **CPT frequency reports:** Run a CPT frequency report for each surgeon quarterly. Separate the categories of office visits, hospital visits, surgery, and ancillaries. This helps assess appropriate code usage and volume of work.

- **Missing encounters:** Check on cases where a patient checked in for a visit, yet there are not any charges. Did the patient pay cash? Are staff late in posting visit charges?
- **Denial reports:** A very important diagnostic report that says why a service was not paid.
- **Unapplied payments:** This is money the practice has received and not applied to any patient account.
- **Adjustments by type:** Adjustment types include contractual, non-contractual, and other adjustments that are treated as contractual when calculating net collection percentage. If you want to improve your practice profitability, getting a granular understanding of what is being adjusted is key:
  - **Contractual adjustments:** The most common adjustment code you will see is CO-45 if you are contracted with a payor. This code describes why there is difference between what you charged and the allowed amount. You will also see expected adjustments because of -51 and -59 modifiers.
  - **Non-contractual adjustments:** You will find things like denials because of late filing, missed appeal deadlines, no referral authorization, preexisting conditions not covered, and lack of medical necessity. Note that these denial reasons can be controlled by better practice management procedures and policies, and your collections will increase if you eliminate or reduce these denial reasons. Other denials that are beyond control by practice management include patient bankruptcy, NSF checks, accounts turned over to collections, and deceased patients.
  - **Other adjustments:** Denials for bundling, appeals that are denied, charity care, professional courtesy, surgical assistants billed for but not covered, and financial hardship discounts that grew during the COVID-19 pandemic.



## IMPROVING YOUR REVENUE CYCLE AND PRACTICE MANAGEMENT

### Tackling Common Denials

#### Verifying Credentials

Some of the most common reasons for a surgeon being considered “non-participating” by a plan or seeing a reduction in benefits and denials include the following:

- Not being credentialed for a particular payor (*Oops! We forgot to sign up the new surgeon!*)
- Not being re-credentialed for a particular payor (it is like renewing your driver’s license—you are not one and done)
- Credentialed for a particular payor but not linked to a certain contract or payor’s product

Completing a uniform application for credentialing with multiple plans through the Council for Affordable Quality Healthcare (CAQH) is an essential first step in ensuring your eligibility for reimbursement by payors you contract with. The following what is required for credentialing:

1. An NPI number
2. Evidence that you have malpractice insurance
3. A completed CAQH application
4. Registration with Medicare
5. Licensure to practice medicine in a given state

Make sure all your location information is correct if you have multiple offices. Verify that providers’ names are spelled correctly and consistently along with their date of birth, national provider identifier, and Social Security number. Typos and other mistakes are costly. As an example, in one recent case, claims were denied because the provider was credentialed with a payor through the surgeon’s previous employer but not through the surgeon’s new practice.

The entire payor credentialing process is critically important and time consuming. When a credentialing mistake is made it typically has expensive consequences. Consider using a credentialing software that enables you to keep physician credential records electronically, or work with outsourced companies who handle the process for you. Ask other surgeons in your area for recommendations about credential management tools. Do not make your decision solely on price. Make sure you use a credentialing solution that will keep you in business.

#### Understanding Denial Codes

Below is a partial list of denial reason codes prepared by a revenue cycle director for a surgical group practice. The full list consisted of 69 detailed codes with the amounts listed for each, totaling \$238,984. **Failing to monitor denials can be an expensive revenue leak.** The reason codes shown below are for the largest dollar amounts denied.



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### Codes for Largest Denied Amounts

Denial Code	Reimbursement Comment	Count	Denial Amount
CO-B10	Allowed amount has been reduced because a part of code was paid	7	\$88,725.91
CO-97	The benefit for this service is included in the payment/allowance for another service	318	\$52,318.03
CO-59	Process based on multiple or current procedure rules	709	\$34,053.95
OA-23	Adjusted as may be covered by another payer per coordination of benefits	1	\$29,183.64
CO-29	The time limited for filing expired	150	\$26,782.75
OA-18	Duplicate claim	416	\$11,330.17
CO-131	Claim specific negotiated discount	80	\$10,713.93
CO-16	Claim/service lacks information which is needed for adjudication	78	\$8,291.00
CO-119	Benefit maximum for this time period has been reached	101	\$4,693.00
CO-96	Non-covered charges	39	\$3,669.00
CO-222	Exceeds the contracted maximum number of hours/days/units by this provider	24	\$3,523.87
CO-234	This procedure is not paid separately. At least one remark code must be provided	65	\$2,469.82
PR-54	Multiple physicians/assistants are not covered in this case	2	\$2,426.25
CO-55	Procedure/treatment is deemed experimental/investigational by payor	8	\$2,087.00
PR-19	This is a work related injury/liability of the workers comp	18	\$1,958.00
CO-183	The referring provider is not eligible to refer the service billed	4	\$1,824.00
CO-4	The procedure code is inconsistent with the modifier used or modifier is missing	132	\$720.00

The partners of the surgical group were shocked when they received this report. The challenge is keeping up with the ever-changing insurance company rules. Useful metrics for analyzing the problem of denials across payors in your practice include the following:

1. Evaluating the initial denial rate as a percentage of volume and dollars
2. Denial write-offs as percentage of net patient service revenue

3. The time from initial denial to appeal
4. Time from initial denial to claim resolution
5. Percentage of initial denials overturned

While it may not be possible to address every denial you receive, there are certain actions that can be taken to rectify the most common denials experienced by practices, as described in the following chart.



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### Codes for Largest Denied Amounts

Type of Denial	Methods to Appeal Denial	Methods for Avoiding Denial
CO-31: Patient cannot be identified as our insured	Correct insurance and resubmit to appropriate payor	Eligibility verification at time of appointment
CO-140: Patient/Insured health identification number and name do not match	Correct ID number and file corrected claim	Eligibility verification at time of appointment
N276: Missing/incomplete/invalid other payor referring provider identifier	Add referring physician and file corrected claim	Custom claims editing
CO-197: Precertification/ authorization absent	<ul style="list-style-type: none"> <li>Determine if all codes were pre-certified for the surgery</li> <li>Add prior authorization and file corrected claim</li> </ul>	<ul style="list-style-type: none"> <li>Custom claims editing</li> <li>Adopt an internal policy to compare pre-authorized surgery codes and the surgery codes actually performed immediately following the procedure. File an amended authorization with additional codes where necessary.</li> </ul>
CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing	Correct issue and file corrected claim.	Custom claims editing
CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	<p>If billed correctly, file an appeal.</p> <p>If not, reverse charges for incorrect codes.</p>	<ul style="list-style-type: none"> <li>If billed correctly: appeal</li> <li>If not billed correctly: custom claims editing may be possible to flag</li> </ul>
CO-50: These are non-covered services because this is not deemed a "medical necessity" by the payor	If billed correctly, file an appeal.	Determine if the practice documented according to payor guidelines. This may not stop the denial but will increase chances of successful first appeal.
PR-227: Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete	Change claim to patient responsibility and send to the patient	Instruct the patient to complete the payor COB form proactively
OA-18: Exact duplicate claim/service	Ensure it is a duplicate claim	<ul style="list-style-type: none"> <li>File corrected claims rather than resubmitting the original claim</li> <li>Change fee amount for assistant at surgery to a lesser amount in the fee schedule</li> </ul>
CO-16: Claim/service lacks information or has submission/billing error(s)	Review the claim for errors. Make corrections and file corrected claim.	Custom claims editing



## IMPROVING YOUR REVENUE CYCLE AND PRACTICE MANAGEMENT

### Compliance Programs: What Your Practice Needs to Know and Have in Place

Another important component of successful practice management is the establishment of a compliance program, which is a formal statement of a practice's coordinated, proactive efforts to prevent, detect, respond to, and report violations of law, government regulations, contractual obligations, and ethical rules related to coding and billing for professional services. When it comes to compliance issues, many physicians take a deep breath, close their eyes, and mentally prepare for unpleasantness. This topic is greeted much like an envelope from the Internal Revenue Service or a summons for jury duty. Fear not—this section will help your practice navigate the requirements relating to a compliance program.

#### Defining a Compliance Program

The compliance program sets forth proactive steps to help achieve its goals. Often there are supplemental policies or procedures to the compliance program.

Compliance programs are mandatory for all healthcare providers that submit charges to Medicare and Medicaid. The Patient Protection and Affordable Care Act (ACA) requires health care organizations to create and implement compliance programs as a condition to providing services under Medicare, Medicaid, and the Children's Health Insurance Program.<sup>1</sup> Because of this, many private payors are now also requiring providers to have a compliance program as a condition of participation.

You will not be surprised by the rationale behind compliance programs. The National Healthcare Anti-Fraud Association (NHCAA) reports financial losses due to fraud run in the tens of billions of dollars every year. The Department of Health and Human Services and the Department of Justice annually use the False Claims Act

to recover several billion dollars of over or inappropriate payments and penalties from healthcare providers.<sup>2</sup> The government and payors want to avoid the submission of fraudulent and defective claims. One way to do that is mandate those individuals submitting claims to have a compliance program aimed at legal and accurate claims being produced.

#### Elements of the Compliance Program

All this begs the question, "What goes into a compliance program?" First, a word of caution—there is no one-size-fits-all compliance program. The program must be customized to your practice's needs. With that said, there are seven core elements mandated for compliance programs.

#### 1. Written Policies, Procedures, and Standards of Conduct

Your practice's policies, procedures, and standards of conduct should cover the following points (note this is not an all-inclusive list):

- Name(s) and contact information for the compliance officer and compliance committee members
- Description of how and when employees will be trained
- Schedule for monitoring and auditing of coding and billing
- How investigations will be conducted
- State law requirements for working with overseeing physician assistants and/or nurse practitioners



## IMPROVING YOUR REVENUE CYCLE AND PRACTICE MANAGEMENT

### 2. Compliance Program Oversight

Your practice needs to establish who will oversee the compliance program. A compliance officer and/or a compliance committee should be put into place.

The compliance officer or chairperson of the compliance committee should report directly to the organization's board of directors or chief executive officer. However, the compliance officer or compliance committee needs to be solely responsible for the day-to-day workings of the compliance program.

### 3. Staff Training and Education

You need to provide training and education to staff, both for new employees and annually for existing employees. Employees should be instructed who the compliance officer is and how to report a potential issue. The most effective training uses actual compliance scenarios as examples. Finally, all training and education should be documented.

### 4. Opening Lines of Communication

Open the lines of communication regarding compliance issues. Employees should know it is their responsibility to raise compliance issues. The practice should offer anonymous reporting where possible. The practice may not retaliate or otherwise attempt to deter reporting of compliance issues by staff. Although not a legal requirement, many practices have found using a third-party service to be helpful in facilitating staff communication.

### 5. Auditing and Monitoring

A practice should have internal monitoring and audits, as well as external audits, as may be appropriate and feasible. First, monitoring encompasses regular reviews performed as part of standard operations to confirm ongoing compliance. Auditing is the formal review of compliance when measured against set standards. Audits should be designed to measure the practice's compliance with a range of statutory, contractual, and payor requirements. Auditing should be done on an annual basis.

Another key component of this element is a risk assessment. Risk assessments should include areas of concern identified by payors, patients, and providers. The risk assessment needs to categorize identified risks by level (e.g., high, medium, or low). Risk assessments should be performed annually.

### 6. Consistent Discipline

Your practice's written policies should mandate discipline for compliance failures. Predictable penalties to impose accountability are necessary. Additionally, discipline should be dealt with in a timely manner. It is never pleasant to discipline a staff member, but failure to do so is a violation of a proper compliance program.

### 7. Corrective Action

When a compliance issue is discovered, it must be corrected. When an audit reveals the practice has received overpayments, the excess funds must be repaid. Risk assessments are of little value if efforts are not made to remedy areas of high risk. As noncompliance is identified or alleged, action must be taken to address it.

### *Consequences of Inaction*

Some practices may ask, "So what? If we skip the compliance program, what is the worst that can happen?" There are unpleasant consequences for failure to have an active compliance program. A failure to implement a compliance program may result in increased violations of the law; undetected kickbacks and/or false claim submissions; being forced into a Corporate Integrity Agreement with the Office of the Inspector General; and/or assessment of monetary penalties. It may also result in the cancellation of private payor contracts or exclusion from participating in federal programs, such as Medicare and Medicaid.



## IMPROVING YOUR REVENUE CYCLE AND PRACTICE MANAGEMENT



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Corporate compliance plans always sounded like something a really big company needed to worry about. Wrong. Even the solo practitioner needs this in their office. Falling afoul of these laws is a highly negative experience.

Compliance programs are required by federal law. The seven elements listed above are not a checklist to be ticked off but rather a plan for behavior and activities to be performed routinely. As your practice develops its compliance program, decisions will need to be made to tailor the program. To that end, the templates included in the Appendix are meant as a framework to assist your practice in working to form or adjust your program. Ultimately, you need to create a compliance program that not only meets the seven elements previously described but also is practical and doable. With time and effort, your practice will be able to create and implement a usable compliance program.

### References

1. 42 U.S.C. §18001
2. 31 U.S.C. §3729-3733



# STRATEGIC CONTRACT RENEWALS





## STRATEGIC CONTRACT RENEWALS

### Do the Results Match the Terms of the Initial Contract?

The number of metrics that can be utilized to measure the value of a practice's payor contracts is endless. First, the practice should determine what a given payor is currently paying per CPT code or bundled care. **What does the fee schedule or formula attached to the contract say the payor is supposed to pay for a selection of codes representing the practice's top 10 codes billed in terms of revenue or volume?** Verify that by going back to EOBs and remittances and making sure that, indeed, the payor has been paying the contracted amount. Does your expected revenue match revenue actually generated? If it has not, refer to your contract's dispute resolution section. Do you have to sue the payor? Is arbitration the only option? Is mediation required?

The practice should then compare these findings—the contracted rates versus what was actually paid—with that given payor to all other payors the practice contracts with. Are any or all of these payors paying lower-than-contracted rates? Are some better than others at staying true to contract terms? Compare those payors to others with which the practice is not contracted.

#### Marginal Costs

Another method that can be used to evaluate the value of a payor relationship is the practice's marginal cost to treat each patient in the payor's network. **Does your marginal revenue from this payor exceed marginal cost? Marginal cost can typically be determined by dividing total company overhead and expenses costs per year by the number of patient encounters per year.** While this might be one of many good metrics to use for internal purposes, it is generally not very persuasive in court or payor negotiations absent putting forth justification of the practice's expenses—a discussion that many physician groups do not want to have. A frequent rebuttal from a payor is that their payment is not too low, but that the revenue generated from the payor does not cover the practice's marginal cost because of the practice's spending habits (e.g., physician and staff salaries, clinical or administrative equipment/technologies, office supplies).



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If a payor increases the administrative burden to the practice, this will also impact the practice's marginal cost. For instance, your practice expends resources when staff must spend one hour on hold or complete endless peer-to-peer requirements in order to obtain prior authorization for a medically necessary ultrasound so that the furnishing physician may bill and collect for the service.

#### Growth and Profitability

Practices may also find it beneficial to examine service line growth and profitability over the term of their contract with a payor. Is the practice better off than when it first signed the current contract? Dividing up the practice into different service lines and comparing them may provide some "aha!" moments. Sometimes, negotiating a lower percentage fee schedule for one service line in exchange for higher reimbursement for another service line can be mutually beneficial for the practice and the payor. For example, a payor may want to discourage the practice to perform certain procedures by paying less for those services, which might be acceptable to the practice if the payor in turn offers higher reimbursement for the procedures the practice performs most often. Look for other "win-wins" with payors—such as understanding which types of services the payor is trying to encourage and incorporating performance of those services into your negotiation strategy—may result in more fruitful fee schedules.

#### Operational and Administrative Burdens

Sometimes, a practice's problem is not with a payor's fee schedule but instead the hassle the practice must go through to actually receive payment for claims submitted to the payor.



## STRATEGIC CONTRACT RENEWALS

### *Consistency, Accuracy, and Timeliness of Payment*

If your practice is experiencing significant delays in receipt of payment from a payor, or if the payment is inconsistent in terms of timing, denials, or amounts paid, first make sure that you have followed all of the payor's billing guidelines. If you are properly following the payor's rules but are still experiencing delays and rigmarole to get paid, some will say that's "just how it is" with payors—however, practices can provide insights and try to make payment processes more effective and efficient through proactive communication with payors.

### *Frequency of Utilization Reviews and Denials*

As recommended in the revenue cycle and practice management section of this publication, **be sure to track claim denials**. If you are detecting a series of denials for the same services, or the payor is consistently denying services for one specific reason, and you believe the denials are unwarranted, implement the process your contract or state law might allow you to use to stop a payor recoupments. Many states have laws that put the burden on the payor to request and state the grounds for a recoupment rather than simply taking it out of future payments. Some laws allow the practice the right to deny the payor's request for a recoupment. Know these laws and use any time you receive a series of denials or a recoupment.

While utilization management techniques, such as prior authorization or step therapy, may be warranted for certain treatments, payors are increasingly using these tactics as a way to delay or deny payment for medically necessary and appropriate care. **If a payor is subjecting your practice to heavy-handed utilization management, try to find out why**. If this payor is simply one to excessively apply utilization reviews, audits, and denials, then perhaps it is not prudent to keep your contract with the payor unless they provide greater reimbursement to cover the time spent attending to such reviews, audits, and denials. The more time your practice spends complying with the payor's rules, the more it costs to do business with this payor and, therefore, the higher the payor's reimbursement must be to justify a continued relationship.

### **Leaving a Payor's Network—Is It Worth It?**

A practice should not take lightly a decision to terminate its existing contract with a payor. Leaving a payor's network to become a non-participating ("non-par") provider should be an option of last resort—consider first the potential implications of terminating the contract.

#### *Number of Covered Lives*

Knowing what percentage of your patients are covered by each payor is crucial—it is just as important as understanding each payor's fee schedule. If you achieve an increase of \$10 per procedure code from a payor that covers 60% of your practice's patients, that is a much bigger "bang for your buck" than getting an increase of \$15 per procedure code from a payor that represents only 10% of your patient population.

Put your negotiating capital to work to use your leverage within the community. If your practice employs 10 of the city's 15 specialists, make sure the payor knows that. If you go non-par, that payor's members will have a hard time getting an appointment with the five other specialists in town.

Alternatively, you may lose all of these patients if the payor successfully renavigates them to your competitor. Some patients are loyal to their physicians and may be willing to pay out-of-pocket rates for services while the practice and payor decide what reimbursement rate is fair. Other patients will view a non-par situation as akin to abandonment by their physician. Most patients cannot easily change their insurance provider to be able to stay with a physician who has left their network. Communications with patients is vital should your practice leave a payor's network. Explaining what to expect in terms of paying for care once the practice is no longer in network with the payor is important. Some plans make the patient pay a larger percentage of the costs of care if the patient sees an out-of-network provider as opposed to an in-network provider.



## STRATEGIC CONTRACT RENEWALS

### Fee Schedules

During the contract renewal process, payors may propose reductions in reimbursement to your practice. Common reasons given for such reductions include increasing overhead for the payor due to more regulations impacting the insurance industry—this is hardly an impactful or sympathetic explanation to give to practices and physicians, who are also subject to extensive regulatory burdens.

The best way to counter any argument that a payor gives to decrease a practice's reimbursement is to highlight how your practice succeeds at providing quality care to the payor's members at a fair, cost-effective rate. Show the payor how you are saving them money by keeping their members out of the emergency room and avoiding costly procedures at expensive sites of service. Explain how your billing staff efficiently submits clean claims and note the billing and compliance processes your practice has in place to make it easy for the payor to process and pay such claims accurately. **In other words, the best way to overcome reasons a payor will not pay what you want them to pay is to show the payor why they need you.** Any negotiation should start with a "sales pitch" by the practice, with the practice demonstrating with detail to the payor all the things the practice does to be a good partner for the payor.

**If you are unable to reach an agreement with a payor regarding payment rates and decide to terminate your contract, consult with an attorney about what price your practice should bill the payor once you go non-par, as you will no longer have a contractual fee schedule with that payor.** In most jurisdictions, understanding the law on this is not an easy task, particularly if you are a specialist other than an emergency or trauma physician, mainly because there is little precedent on the subject of non-emergency reimbursement from payors to non-par providers. Generally speaking, most courts analyze the question of what a payor should pay based on one of two inter-related lines of rationales:

1. The common law notion of **quantum meruit**, meaning a reasonable sum of money, determined by the court, in the absence of an agreed-upon price; and

2. Putting the quantum meruit rationale in action, the insurer should pay what is **"usual and customary"** or **"fair market value"** for an insurer to pay the physician for the service(s) rendered.



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Our ambulatory surgery center was unable to negotiate with our biggest payor: BCBS. They basically said: "here are our terms, take them or leave them; we are not going to talk." We chose to go out of network with them. It was hard. We did not hire a lawyer to determine fees, but we did get an outside consultant familiar with the process. We set fees higher than what our best contract paid, so to leave nothing on the table with our other payors but set them lower than the charges at the hospital. We had one employee who had to work with every single BCBS patient to explain the bill ahead of time and show them what they would be paying elsewhere compared to our charges; this person had unilateral authority to adjust charges downward to fairly bill the patient. We did this for about two years until BCBS came back to the table with a more reasonable fee schedule and we were able to get back in network. Lesson: you cannot negotiate with insurance companies unless they have something to lose. They can always afford more than what they offer, but they will not pay you more for just asking; you have to fight it out of them.

Both rationales are often difficult to put into motion in a meaningful way, particularly due to wide ranging and confidential reimbursement terms between payors and network providers.

The challenge in determining what is "usual and customary" is in comparing apples to apples within a practice's patient population and payor reimbursement rates. Should all patients be counted when establishing a usual and customary fee? Or should only in-network, contracted fee schedules count? One economic theory that seems to be taking hold in the courts is that of



## STRATEGIC CONTRACT RENEWALS

discounted contracted rates. This theory suggests that a payor brings a certain volume of patients to the practice, and in exchange for that flow of patients in the network, the practice in turn takes a discounted rate off its normal fee schedule to have the benefit of being able to participate in that network and see those patients. The complimentary theory, then, if an in-network, contracted rate is lower than normal, a non-contracted physician group should be paid more than what the payor paid when the payor and practice were parties to a contract.

Similarly, payors do not make its plan members pay as much of a co-pay or deductible if the provider/practice is in network. In exchange for that reduction in patient financial responsibility, practices are willing to accept

lower reimbursement rates in order to gain access to the payors' plan members (i.e., customers/patients for the practice). Accordingly, perhaps one of the best indicators of "usual and customary" is what other payors have paid to other practices with which the payor does not have a contract with.

Some jurisdictions have explored the fairness of relying on the Medicare Physician Fee Schedule (PFS) as the standard usual and customary rate. The Centers for Medicare and Medicaid Services publishes a PFS annually. Because the PFS sets Medicare payment rates per CPT code for physician services provided to Medicare patients, it could be an easy standard to use. But is the Medicare rate a barometer of a "usual and customary" rate?

One Florida appellate court found just that in its *BayCare v. AHCA* decision.<sup>1</sup> BayCare and Health Options were parties to a contract with a set fee schedule. The provider, BayCare, terminated the contract but continued to treat approximately 500 Health Options plan members for several months after the contract ended. BayCare asked the court to determine what amount Health Options owed them for that post-contract-termination care. While some claims fell under a Florida statute regarding emergency care payments and surprise billing, the remaining claims were a major big issue. BayCare asked Health Options to pay for the services at BayCare's customary fee schedule. Health Options paid much less than the billed amounts. Not terribly helpful, the court said that the rate must be a "reasonable rate," citing *Payne v. Humana Hosp.*<sup>2</sup>

BayCare contended that the billed amounts for the claims submitted were reasonable rates, saying it reflected the "usual and customary" amounts for the services rendered. Health Options instead moved to define "usual and customary" as 120% of the Medicare PFS, reasoning "it [being] well recognized in...medical circles that hospital billing fluctuates widely...and that hospitals' billed charges bear no resemblance to market realities."<sup>1</sup> An initial dispute resolver agreed with Health Options and its 120% argument, as did the second district court of appeals. In essence, the court indicated that the government-imposed, nonnegotiable Medicare PFS is a fair measure of arm's length negotiations and fair market value in the private commercial market. Ironically, in that there is no arm's length negotiations with CMS as to its fee schedule. Some states' courts have agreed with this court; others have differed.

Illustrating the divergent application of varying theories to these disputes, a subsequent Florida case was decided differently. The Florida First District Court of Appeal (DCA) specifically excluded Medicare rates from the consideration of what is "usual and customary."<sup>3</sup> This case discussed the state's emergency services/surprise billing law, which requires that payment be the lesser of (a) the provider's charges, (b) the "usual and customary provider charges for similar services in the community where the services were provided," or (c) the charge mutually agreed to by the payor and the provider. The provider group argued that its "charge master" (or fee schedule) billed charges were "usual and customary." The provider group noted that self-pay patients are billed that charge master rate, although the group did sometimes accept much less than that amount to satisfy patient debts.

Dispensing with the Medicare PFS, the Florida First DCA held that the focus must be on the "provider's charge, which means the amount billed by the provider." The court noted that a "usual and customary" charge might be what the practice charges uninsured patients, stating that "what is usual and customary physician group charges in statutes governing reimbursement by an HMO for services provided by a physician group with whom it does not have a contract is the fair market value of the services provided. Fair market value is the price that a willing buyer will pay and a willing seller will accept in an arms' length transaction." Unfortunately, the court offered little help on determining the applicable comparison or analytical spectrum. The court made no distinction between whether the willing buyer and willing seller would be negotiating in or outside of a contract.



## STRATEGIC CONTRACT RENEWALS

Any practice considering going non-par should first consult experienced counsel to determine state law in the practice's jurisdiction. Because of the development of statutes nationwide against surprise billing, some clarity is coming to this legal segment of payment rates for healthcare services. However, most prohibitions against surprise billing deal with emergent or urgent care, such as when a patient is rushed to an emergency room for surgery and the hospital, anesthesiologist, or surgeon does not have a contract with the patient's payor. More important for most practices considering going non-par is not emergency care but instead is planned, elective, or routine care.

Hashing this out in court can take years. If your practice decided to go non-par because the payor was not paying enough for you to cover the costs of treating your patients, how long can you go with the payor paying nothing or next to nothing at all?

### Tips for Proceeding with Renegotiation

Before entering contract renegotiation with payors, get your house in order. First, complete an extensive self-analysis as detailed above. Know what payors are supposed to pay you per your contractual fee schedule compared what they have actually paid you. Identify any types of services that are specifically excluded from a payor's fee schedule. Ask your team members who are on the front lines of billing and collecting about their experiences with each payor to understand your practice's position with these payors in terms of strengths, weaknesses, opportunities, and threats.

Search for patterns in terms of denials, recoupments, and utilization management. It may be helpful to hire a revenue cycle company that specializes in reimbursement to perform this assessment for you and document their findings with data points that will be persuasive to payors—validation by an independent and unbiased expert third party may be helpful in establishing rapport and trust with payors. In fact, payors may actually thank you for hiring a specialist to conduct such analyses, as it can be very helpful to the payor too. Again, acting like a partner with the payor is important.



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My experience demonstrated that the individual surgeon has little or no leverage in changing the conditions of a contract unless I was the only surgeon available to the payor or was part of a large enough group that the payor had to pay attention to us since we treated a large percentage of their potential policy holders. In this area there is strength in numbers. Try to find a way to align oneself with other surgeons or health facilities that can partner in these negotiations legally.

Second, study payors' payment initiatives and listen to their goals—what are they trying to target in terms of both clinical and financial outcomes? Gather information about a payor's needs during meetings with them, from their publications, from your colleagues, and any other sources available. Use these details to explain how your practice can complement the payor's goals and initiatives. Be a team player. If it is possible to serve on committees with the payor, volunteer to do so. Accentuate the things about your practice that makes it the best partner the payor can have.

Third, be creative. Do not be afraid to ask for something atypical. Sometimes payors have a hard time increasing all payment rates to a practice by 10 percent but could perhaps increase some by 12 percent, others by 8 percent, and maybe more by 15 percent if the practice can implement process measures and track outcomes for certain procedures. Can you do a full case, from initial evaluation to post-operative care, for one price instead of submitting a bunch of different codes and claims throughout the process? If so, present that.



## STRATEGIC CONTRACT RENEWALS

Contract termination is the nuclear option. Terminate only after all other forms of negotiation have failed. Do not terminate your contract without consulting with an experienced health care attorney. Timing is very important. You may have to notify your state's department of insurance of the contract termination at the same time you notify the payor. Identify how current patients covered by that payor must be handled according to your contract. Some contracts require the provider to continue to see patients for up to 180 days post-contract termination, even for non-acute ailments, under the contract's fee schedule. In addition, be sure that terminating the contract does not have a domino effect on your other contracts. Contracts may be linked such that if you go out of network for one plan, you automatically terminate other contracts too. Experienced counsel should guide you through the termination planning process six months in advance. You may also want to include a public relations consultant to help with messaging not only to your patients but also to referring providers and facilities at which you see patients. You will need to navigate the fallout of going non-par with hospital leaders as well as the providers who refer patients to you. Proceed carefully not only from a financial and legal standpoint but from a political one also.

### References

1. BayCare Health Sys. v. Agency for Health Care Admin., 940 So.2d 563, 565 (Fla. App. 2 Dist. 2006).
2. 661 So.2d 1239, 1241, Fla 1st DCA (1995).
3. Baker County Medical Services Inc. v. Aetna Health Management LLC, 31 So.3d 842 (Fla. App. 1 Dist. 2010)





# FINAL THOUGHTS: DON'T FEAR THE PAYOR CONTRACTING PROCESS





## FINAL THOUGHTS: DON'T FEAR THE PAYOR CONTRACTING PROCESS

Surgeons face many challenges in today's health care environment, particularly when navigating the insurance market and understanding the nuances associated with payor contracts and related reimbursement rules. Establishing successful and meaningful contractual relationships with private payors does not occur overnight; rather, it is a process that will require time and research about how your practice may or may not fit in to—and prosper from participation in—a payor's network.

The decision to enter into a contract with a payor is generally complex, intensive, and critically important to the financial stability of a surgical practice. While this publication addresses some of the key issues to consider when assessing your practice's payor contracts and revenue cycle processes, there are many other factors to keep in mind. However, if the concepts demonstrated above are learned and utilized, the ultimate outcome is likely to be a successful contract and revenue cycle review process that protects the surgeon and benefits both parties by creating a sustainable physician-payor relationship.



# ADDITIONAL RESOURCES





## ADDITIONAL RESOURCES

### APPENDIX

#### Compliance Plan Templates

Use these as a starting point to develop a compliance program for your practice.

#### **[PRACTICE NAME] COMPLIANCE PLAN**

[PRACTICE NAME] voluntarily implements a compliance program aimed at fraud, waste, and abuse prevention while at the same time advancing the mission of providing quality patient care. Our compliance efforts are aimed at prevention, detection, and resolution of variances.

The eight elements of [PRACTICE NAME] the Compliance Plan are:

- I. Commitment to Compliance
  - A. Standards of Conduct
  - B. Reasonable and Necessary Services
  - C. Coding, Billing, and Claims
  - D. Reliance on Standing Orders
  - E. Compliance with Applicable HHS Fraud Alerts
  - F. Marketing
  - G. Anti-Kick Back/Inducements
  - H. Retention of Records/Documentation
- II. Designation of a Compliance Officer/Committee
- III. Conducting Training and Education Programs
- IV. Communication
- V. Disciplinary Guidelines
- VI. Auditing and Monitoring
- VII. Corrective Action
- VIII. Response to a Government Investigator or Auditor

### I. COMMITMENT TO COMPLIANCE

#### A. Standards of Conduct

[PRACTICE NAME] promotes adherence to the Compliance Plan as a major element in the performance evaluation of all staff members.

[PRACTICE NAME] employees are bound to comply, in all official acts and duties, with all applicable laws, rules, regulations, standards of conduct, including, but not limited to laws, rules, regulations, and directives of the federal government and the State of [STATE], and rules, policies and procedures of [PRACTICE NAME]. These current and future standards of conduct are incorporated by reference in this Compliance Plan.

All candidates as a condition for employment shall undergo a reasonable and prudent background investigation, including a reference check. Due care will be used in the recruitment and hiring process to prevent the appointment to positions with substantial discretionary authority, persons whose record (professional licensure, credentials, prior employment, any criminal record) gives reasonable cause to believe the individual has a propensity to fail to adhere to applicable standards of conduct.

All new employees will receive orientation and training in compliance policies and procedures within sixty (60) days of the date they were employed. Participation in required training is a condition of employment. Failure to participate in required training may result in disciplinary actions, up to and including, termination of employment. Employees are expected to share [PRACTICE NAME]'s commitment to this Compliance Plan.

Every employee shall sign a statement certifying they have received, read, and understood the contents of this Compliance Plan.

Every employee will receive periodic training updates in compliance protocols as they relate to the employee's individual duties.

Noncompliance with the plan or violations will result in disciplining of the involved employee(s) up to, and including, termination of employment. Further, additional education may be required. [PRACTICE NAME] is committed to fully comply with all state and federal laws, rules, and regulations.

#### B. Reasonable and Necessary Services

Medicare and other government health benefit programs condition payment for many services on the treating physician's certification that they have reviewed the patient's condition and has determined that the service is reasonable and necessary. Medicare primarily relies on the professional judgment of the treating physician, so it is important that physicians provide complete and accurate information on any certifications they sign. Physician certification is obtained through a variety of forms, including prescriptions, orders and Certificates of Medical Necessity (CMN). By signing a CMN, a physician makes several representations, including: (1) he or she is the patient's treating physician; (2) the entire CMN was completed prior to the physician's signature; and (3) information relating to whether the service is reasonable and necessary is true, accurate, and complete to the best of the physician's knowledge. Physicians who sign CMNs either knowing they are false or disregarding whether they are true or false may be subjecting themselves and/or [PRACTICE NAME] to criminal, civil, and administrative penalties. Activities such as signing blank CMNs, signing a CMN without seeing the patient, or signing a CMN for a service that the physician knows is not reasonable and necessary are not permitted.



## ADDITIONAL RESOURCES

Advance Beneficiary Notices (ABN) are used when there is a likelihood that an ordered service will not be paid. The patient will be notified, in writing, of the likelihood that the service will not be paid before the service is provided. The ABN will only include those specific tests that do not meet Medicare criteria for medical necessity. Patients will never be offered blank ABNs to sign.

### C. Coding, Billing, and Claims

#### 1. Billing in General

Honesty and accuracy in billing and in the making of claims for payment by Medicare, Medicaid, or payment by any third-party payor, is vital. Each health care professional employed by [PRACTICE NAME] is expected to monitor compliance with applicable billing rules. No employee shall submit, authorize, or sign a false claim for reimbursement in violation of applicable laws and regulations.

#### 2. Billing and Coding

[PRACTICE NAME]'s employees will refrain from any of the following practices and work to identify and correct instances in which mistakes have occurred in the following areas:

- Billing for items or services not rendered or not provided as billed
- Submitting claims for equipment, medical supplies and services that are not reasonable and necessary
- Double billing resulting in duplicate payment
- Billing for non-covered services as if covered
- Knowingly misusing provider identification numbers, resulting in improper billing
- Unbundling (billing for each component of the service instead of billing or using an all-inclusive code)
- Failure to properly use coding modifiers
- Falsely indicating that a particular health care professional attended a procedure
- Clustering (billing all patients using a few middle levels of service codes, under the assumption that it will average out to the appropriate level of reimbursement)
- Failing to timely refund credit balances
- Upcoding the level of service provided



## ADDITIONAL RESOURCES

### 3. Billing to Receive Denial

[PRACTICE NAME] may bill Medicare to receive a denial for services, but only if the denial is needed for reimbursement from a secondary payor. The Medicare claim submission should indicate that the claim is being submitted for the purpose of receiving a denial to bill a secondary insurance carrier.

### 4. Waiver of Co-payments and Deductibles

[PRACTICE NAME] will not waive co-payments or deductibles except to the extent consistent with applicable laws, regulations and guidance issued by the Office of Inspector General. Permissible waivers may include, but are not necessarily limited to, waiver based on indigence and contractual write-offs and discounts. [PRACTICE NAME] has created a “Co-Payments or Deductible Reduction Waiver Policy” that is incorporated into the Plan by reference.

### 5. Notification and Refund of Overpayment

In the event [PRACTICE NAME] receives excessive payment/overpayment from Medicare, Medicaid, or any third-party payor, the excessive payment/overpayment shall be refunded within sixty (60) days of when [PRACTICE NAME] becomes aware of the excessive payment/overpayment.

### 6. Self-Disclosure Protocol for Improper Billing

In the event [PRACTICE NAME] believes after reasonable assessment, it or its agent(s) have violated a federal criminal, civil, or administrative law(s); [PRACTICE NAME] shall use the Office of Inspector General’s “Self-Disclosure Protocol” of April 17, 2013. Such “Self-Disclosure Protocol” shall be commenced within ninety (90) days of [PRACTICE NAME] forming the belief of said violation.

[PRACTICE NAME] currently utilizes (Nurse Practitioners and/or Physician Assistants) to provide services to its patients. Under the laws of [NAME OF STATE], (Nurse Practitioners or/and Physician Assistants) are required to have a certain amount of Physician oversight. More specifically, [SUPERVISION REQUIREMENT OF THE SPECIFIC STATE IS INSERTED HERE].

[NAME OF PROVIDER(S)] have exercised their right to opt out of being a Medicare Provider. The documentation associated with this opt-out is attached hereto as an exhibit to this Plan.

[NAME OF PROVIDER(S)] may not bill for services rendered to Medicare patients unless specific, narrow requirements are met. Every effort will be made to comply with the billing and coding requirements of opted-out providers.



## ADDITIONAL RESOURCES

### D. Reliance on Standing Orders

Standing orders will not be prohibited for an extended course of treatment. However, when standing orders are utilized, [PRACTICE NAME] should prescribe a fixed term of validity, must renew the order upon its expiration if continued treatment is indicated, and should periodically confirm in writing the need for continued treatment.

### E. Compliance with Applicable HHS Fraud Alerts

[PRACTICE NAME]'s Compliance Officer, [COMPLIANCE OFFICER NAME], will review the Medicare Fraud Alerts. They will also terminate any conduct criticized by the Fraud Alert immediately, implement corrective actions, and take reasonable actions to ensure that future violations do not occur.

### F. Marketing

[PRACTICE NAME] will utilize only honest, straight forward, fully informative, and non-deceptive marketing. All marketing efforts will comply with Federal Trade Commission regulations, state law, and rules of professional conduct of State Medical Boards.

### G. Anti-Kickback/Inducements and False Claims

[PRACTICE NAME] is committed to complying with the requirements of Federal and State law, including the Federal Deficit Reduction Act of 2005 and the Fraud Enforcement and Recovery Act of 2009, and to preventing any fraud, waste, or abuse in its organization in connection with government health care programs.

#### 1. Federal False Claims Act

Under the federal False Claims Act (FCA), any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government is liable for significant penalties and fines. The fines may include a penalty of up to three times the Government's damages plus civil penalties ranging from \$11,181.00 to \$22,363.00 per false claim, and the costs of the civil action against the entity that submitted the false claims. Generally, the FCA applies to any federally-funded program. The FCA applies, for example, to claims submitted by health care providers to Medicare or Medicaid (31 U.S.C. §§ 3729-3733).

A similar federal law is the Program Fraud Civil Remedies Act of 1986 (PFCRA). It establishes administrative remedies for knowingly submitting false claims and statements. A false claim or statement includes submitting a claim or making a written statement that is for services that were not provided, that asserts a material fact that is false, or omits a material fact. A violation of the PFCRA may result in a maximum civil penalty of \$11,001.00 per claim plus an assessment of up to twice the amount of each false or fraudulent claim (31 U.S.C. §§ 3801-3812).

Any employee involved in promoting or accepting kickbacks or offering inducements may be terminated immediately.



## ADDITIONAL RESOURCES

### 2. State Medicaid False Claims Act

[PRACTICE NAME] will comply with the [STATE] False Claims Act (FCA).

### H. Retention of Records/Documentation

[PRACTICE NAME] will ensure that all records required by federal and/or state law are created and maintained. All records will be maintained for a period of not less than seven years.

Documentation of compliance efforts will include staff meeting minutes, memoranda concerning compliance protocols, problems identified, and corrective actions taken, the results of any investigations, and documentation supportive of assessment findings, diagnoses, treatments, and plan of care.

[PRACTICE NAME] utilizes an electronic medical records (EMR) system. Efforts will be made to update the EMR system to the software specifications. Further, efforts will be made to not exceed the software license(s) associated with this EMR system. [PRACTICE NAME] acknowledges that it retains the legal, professional, and ethical duties associated with the creation, maintenance, and protection of its patients' medical records and billing information.

## II. DESIGNATION OF A COMPLIANCE OFFICER AND/OR A COMPLIANCE COMMITTEE

[PRACTICE NAME] designates [COMPLIANCE OFFICER NAME] to serve as the coordinator of all compliance activities.

### A. Compliance Officer:

The responsibilities of the Compliance Officer are:

- Overseeing and monitoring the implementation of the compliance program.
- Reporting (monthly/quarterly) to the Practice on the progress of implementation and assisting the Practice in establishing methods to improve efficiency and quality of services and to reduce the vulnerability to allegations of fraud, waste, and abuse.
- Developing and distributing all written compliance policies and procedures to all affected employees.
- Periodically revising the program in light of changes in the needs of the organization and in the law, as well as and changes in policies and procedures of government and private payor health plans.
- Developing, coordinating, and participating in a multifaceted educational and training program that focuses on the elements of the compliance program and seeks to ensure that all employees are knowledgeable of, and comply with, pertinent federal, state, and private payor standards.
- Ensuring that all physicians and health care providers are informed of compliance program standards with respect to coding, billing, documentation, and marketing, etc.
- Assisting in coordinating internal compliance review and monitoring activities, including annual or as needed reviews of policies.



## ADDITIONAL RESOURCES

- Independently investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations.
- Developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation.

The Compliance Officer has the authority to review all documents and other information relative to compliance activities, including, but not limited to, requisition forms, billing information, claims information, and records concerning marketing efforts and arrangements with third parties.

### **Compliance Committee:**

[PRACTICE NAME] will designate a compliance committee to advise the compliance officer and assist in the implementation of the compliance program as needed.

The functions of the compliance committee are:

- Analyzing the Practice’s regulatory environment, the legal requirements with which it must comply, and specific risk areas.
- Assessing existing policies and procedures that address risk areas for possible incorporation into the compliance program.
- Working within the Practice’s standards of conduct and policies and procedures to promote compliance.
- Recommending and monitoring the development of internal systems and controls to implement standards, policies, and procedures as part of the daily operations.
- Determining the appropriate strategy/approach to promote compliance with the program and detection of any potential problems or violations.
- Developing a system to solicit, evaluate, and respond to complaints and problems.

### **III. CONDUCTING EFFECTIVE TRAINING AND EDUCATION**

[PRACTICE NAME] requires all employees to attend specific training upon hire and on an annual and as needed basis thereafter. This will include training in federal and state statutes, regulations, program requirements, policies of private payors, and corporate ethics. The training will emphasize the Practice’s commitment to compliance with these legal requirements and policies.

The training programs will include sessions highlighting the Practice’s Compliance Program, patient privacy rights and protection, summaries of fraud and abuse laws, discussions of coding requirements, claim development, claim submission processes, and marketing practices that reflect current legal and professional standards.



## ADDITIONAL RESOURCES

The Compliance Officer/Designated Committee Member will document the attendees, the subjects covered, and any materials distributed at the training sessions.

Basic training will include:

- Government and private payor reimbursement principles
- General prohibitions on paying or receiving remuneration to induce referrals
- Proper translation of narrative diagnoses
- Duty to refund overpayments
- Only billing for services ordered, performed, and reported
- Duty to report misconduct
- Government privacy laws that apply to patients
- HIPAA and HITECH Act requirements

### IV. DEVELOPING EFFECTIVE LINES OF COMMUNICATION

[PRACTICE NAME] will protect employees that raise, report, or express legal or ethical issues relating to coding and billing from retaliation. Efforts to keep the employee's identity anonymous will be made. A newsletter or written memorandum will be used to communicate responses to anonymous inquiries or reports, as well as to communicate other information regarding compliance and compliance activities.

[PRACTICE NAME] will establish a procedure so that employees may seek clarification from the Compliance Officer/Designated Committee Member in the event of any confusion or questions regarding a policy or procedure.

Any potential problem or questionable practice which is, or is reasonably likely to be, in violation of or inconsistent with federal or state laws, rules, regulations, or directives or [PRACTICE NAME] rules or policies relative to the delivery of health care services, or the billing and collection of revenue derived from such services and any associated requirements regarding documentation, coding, supervision, and other professional or business practices **must** be reported to the Compliance Officer or the Compliance Committee.

Any person who has reason to believe that a potential problem or questionable Practice is or may be in existence should as soon as possible report the circumstance to the Compliance Officer or the Committee. Such reports may be made verbally or in writing, and may be made, to the extent possible, on an anonymous basis.

The Compliance Officer or the Committee will promptly document and investigate reported matters that suggest substantial violations of policies, regulations, statutes, or program requirements to determine their veracity. The Compliance Officer will maintain a log of such reports, including the nature of the investigation and its results.

The Compliance Officer or the Committee will work closely with legal counsel who can provide guidance regarding complex legal and management issues.



## ADDITIONAL RESOURCES

### V. DISCIPLINARY GUIDELINES

All employees of [PRACTICE NAME] will be held accountable for failing to comply with applicable standards, laws, and procedures. Supervisors and/or managers will be held accountable for the foreseeable compliance failures of their subordinates.

The supervisor or manager will be responsible for taking appropriate disciplinary actions in the event an employee fails to comply with applicable regulations or policies. The disciplinary process for violations of compliance programs will be administered according to Practice protocols (generally oral warning, written warning, suspension without leave, leading to termination) depending upon the seriousness of the violation. The Compliance Officer and/or the Committee, as well as legal counsel, may be consulted in determining the seriousness of the violation.

If the deviation occurred due to legitimate, explainable reasons, the Compliance Officer and supervisor/manager may want to limit disciplinary action or take no action. If the deviation occurred because of improper procedures, misunderstanding of rules, including systemic problems, the Practice will take immediate actions to correct the problem.

When disciplinary action is warranted, it should be prompt and imposed according to written standards of disciplinary action.

Within thirty (30) working days after receipt of an investigative report, the Supervisor and/or Practice Administrator of [PRACTICE NAME] shall determine the action to be taken upon the matter. The action may include, without limitation, one or more of the following:

- Dismissal of the matter
- Verbal counseling
- Issuing a warning, a letter of admonition, or a letter of reprimand
- Entering into and monitoring a corrective action plan. The corrective action plan may include requirements for individual or group remedial education and training, consultation, proctoring, and/or concurrent review
- Reduction, suspension, or revocation of clinical privileges
- Suspension or termination of employment
- Modification of assigned duties
- Reduction in the amount of salary compensation
- Notify law enforcement of potential criminal behavior

The Practice Administrator shall have the authority to, at any time, suspend summarily the involved provider's clinical privileges or to summarily impose consultation, concurrent review, proctoring, or other conditions or restrictions on the assigned clinical duties of the involved provider to reduce the substantial likelihood of violation of standards of conduct.



## ADDITIONAL RESOURCES

### VI. AUDITING AND MONITORING

[PRACTICE NAME] utilizes an Electronic Medical Records (EMR) system. The Compliance Officer shall use features of this system to monitor billing and coding compliance and monitor the confidentiality of patient's protected health information (PHI). The EMR system will be used to detect off hours access of PHI and irregularities in coding Practices.

[PRACTICE NAME] shall on an annual basis use the E/M analyzer for \_\_\_% of each provider's claims submitted in the last thirty (30) days. The results of this analysis shall be reviewed by and acted upon, if necessary, by the Compliance Officer. Results of the analysis shall be retained by the Compliance Officer.

[PRACTICE NAME] works to achieve accuracy and compliance of its coding and billing by routinely checking claims. The Compliance Officer from time to time shall randomly review claims files by the Practice. The Compliance Officer shall verify that the claim's coding and billing are supported by the patient's corresponding medical records. Claims will also be reviewed for timely submission to third-party payors. Denied/rejected claims are to be occasionally reviewed to determine if there is a systemic cause. The Compliance Officer shall make necessary steps via auditing and monitoring to promote accuracy and a culture of compliance for the Practice.

### VII. RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

Violations of [PRACTICE NAME]'s Compliance Plan, failure to comply with applicable state or federal law, and other requirements of government private health plans, and other types of misconduct may threaten the Practice's status as a reliable, honest, and trustworthy provider, capable of participating in federal healthcare programs. Detected but uncorrected misconduct may seriously endanger the mission, reputation, and legal status of the Practice. Consequently, upon reports or reasonable indications of suspected noncompliance, the Compliance Officer must initiate an investigation to determine whether a material violation of applicable laws or requirements has occurred.

The steps in the internal investigation may include interviews and a review of relevant documentation. Records of the investigation should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of witnesses interviewed, and the documents reviewed the results of the investigation and the corrective actions implemented.

If an investigation of an alleged violation is undertaken, and the Compliance Officer believes the integrity of the investigation may be hampered by the presence of employees under investigation, those employees should be removed from their current work activities pending completion of that portion of the investigation. These employees will be temporarily suspended with pay pending the outcome of the investigation.

Additionally, the Compliance Officer must take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

If the results of the internal investigation identify a problem, the response may be immediate referral to criminal and/or civil law enforcement authorities, development of a corrective action plan, a report to the government, and submission of any overpayments within sixty (60) days as prescribed by law, if applicable. If potential fraud or violations of the False Claims Act (FCA) are involved, the Compliance Officer should report the potential violation to the Office of the Inspector General or the Department of Justice.



## ADDITIONAL RESOURCES

When making a repayment for an overpayment, the Practice should inform the payor of the following: (1) the refund is being made pursuant to a voluntary compliance program; (2) a description of the complete circumstances prompting the overpayment; (3) the methodology by which the overpayment was determined; (4) any claim-specific information used to determine the overpayment; and (5) the amount of the overpayment.

The Compliance Officer of [PRACTICE NAME] shall have the authority and responsibility to direct repayment to payors and the reporting of misconduct to enforcement authorities as is determined, in consultation with legal counsel, to be appropriate or required by applicable laws and rules.

If the Compliance Officer of [PRACTICE NAME] discovers credible evidence of misconduct and has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the Compliance Officer will promptly report the matter to the appropriate government authority within a reasonable time frame, but not more than sixty (60) days after determining that there is credible evidence of a violation.

Office of Inspector General Hotline: 1-800-HHS-TIPS (1-800-447-8477)

When reporting misconduct to the government, the Compliance Officer should provide all evidence relevant to the potential violation of applicable federal or state laws and the potential cost impact.

### VIII. RESPONSE TO A GOVERNMENT INVESTIGATION OR AUDITOR

As government and public scrutiny increases, the possibility of a government investigator or auditor contacting a [PRACTICE NAME] employee at his/her home or place of work increases. The [PRACTICE NAME] encourages each employee contacted by a government investigator or auditor to cooperate fully and appropriately. If you receive such a visit or are contacted, you should follow the following steps:

- Ask the investigator or auditor for identification and verify it if possible.
- Make a copy of the identification or write down the information on the identification.
- Tell the investigator or auditor it is the [PRACTICE NAME]'s policy that you make two calls first.
- Call your supervisor. You may ask the investigator or auditor to talk to your supervisor.
- Call the Compliance Officer at [PHONE NUMBER]. You may ask the investigator or auditor to talk with the Compliance Officer.

You do not have to talk to the investigator or auditor if you do not want. [PRACTICE NAME] is not instructing you to refuse to talk to the investigator or auditor; however, you are not under any obligation to talk to them. Until it is determined who or what is the subject of the investigation or audit, as a matter of sound advice, it is usually not in an employee's best interest to talk with an investigator or auditor without an attorney present. Simply tell the investigator or auditor that you want the interview to be terminated until an attorney is present.



## ADDITIONAL RESOURCES

You are not authorized to give [PRACTICE NAME] documents (including documents you have prepared at work) to the government. Any request for documents should be reported to the Compliance Officer.

**Search Warrants:** If a government investigator presents a search warrant, you must allow the search to occur. However, you should follow the steps outlined above. To protect [PRACTICE NAME]'s interests, it is crucial that your supervisor and the Compliance Officer are notified immediately. Further, before any search occurs, ask the investigator to make a copy of the search warrant. Make a log of all documents taken and attempt to obtain the investigator's permission to copy the documents prior to their removal.

**Subpoenas:** If presented with a subpoena for documents, you do not have to provide the documents immediately. Give the subpoena to your supervisor who will coordinate with the Compliance Officer regarding the appropriate response to the subpoena.

This plan has attempted to provide the foundation for development of an effective and cost-efficient compliance program. This Compliance Plan may be altered or amended in writing only with the concurrence of the Compliance Officer of [PRACTICE NAME].

The adoption of this Compliance Plan has been approved and authorized as designated below, effective this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

[PRACTICE NAME]

By: \_\_\_\_\_

[COMPLIANCE OFFICER NAME]

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## ADDITIONAL RESOURCES

### BILLING AND CODING COMPLIANCE PLAN ACKNOWLEDGMENT

I, \_\_\_\_\_, am an employee of [PRACTICE NAME]. I have been given a current copy of [PRACTICE NAME]'s Billing and Coding Compliance Plan. I acknowledge the following:

- I have read [PRACTICE NAME]'s Billing and Coding Compliance Plan.
- I have been given an opportunity to ask for clarification of any portion(s) of the Plan that I did not fully understand.
- I will follow [PRACTICE NAME]'s Billing and Coding Compliance Plan to the best of my ability.
- I am aware of a hotline (xxx-xxx-xxxx) that is available so that employees may consult with the third-party agent of [PRACTICE NAME] regarding questions or to report possible violations.
- I am aware that [COMPLIANCE OFFICER] is the current Compliance Officer of [PRACTICE NAME].

So agreed and acknowledged this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

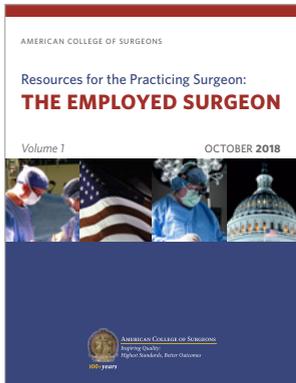
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Employee Signature

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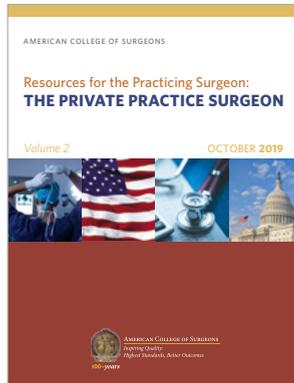
## ADDITIONAL RESOURCES

### Practice Management

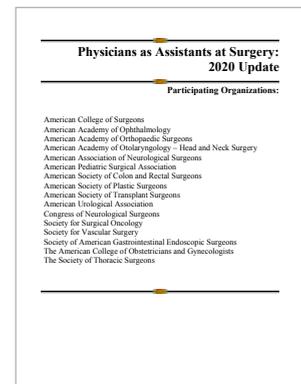
#### ACS Resources for the Practicing Surgeon, Volume I: The Employed Surgeon



#### ACS Resources for the Practicing Surgeon, Volume II: The Private Practice Surgeon



#### Physicians as Assistants at Surgery: 2020 Update



- **FACS Interview Series**
- **Resource Library**



- **Billing Compliance Plan**
- **HIPAA Compliance Plan**



- **On-Demand Coding Workshops**



## ADDITIONAL RESOURCES

### ACS Newsletters

#### Bulletin Brief

AMERICAN COLLEGE OF SURGEONS



### Bulletin Brief

The Bulletin Brief is a weekly newsletter that will deliver updates on important advances from the American College of Surgeons (ACS) and other organizations working to help you provide optimal care for the duration of the COVID-19 pandemic. It also will include the latest information on other ACS activities, programs, and news.

**Latest Issue: May 11, 2021**

**Print Issues:**  
 May 4, 2021  
 April 27, 2021  
 April 20, 2021  
 April 13, 2021  
 April 6, 2021  
 March 30, 2021  
 March 23, 2021  
 March 16, 2021  
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#### Bulletin Advocacy Brief

AMERICAN COLLEGE OF SURGEONS



### Bulletin Advocacy Brief

The Bulletin Advocacy Brief is a biweekly newsletter that covers the American College of Surgeons' efforts to advocate for you and your patients on the Hill. In this newsletter, you will also see updates from the Surgeon Care Coalition and other organizations.

**Latest Issue: May 6, 2021**

**Print Issues:**  
 April 23, 2021  
 April 6, 2021  
 March 23, 2021  
 March 16, 2021  
 February 26, 2021  
 February 19, 2021  
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