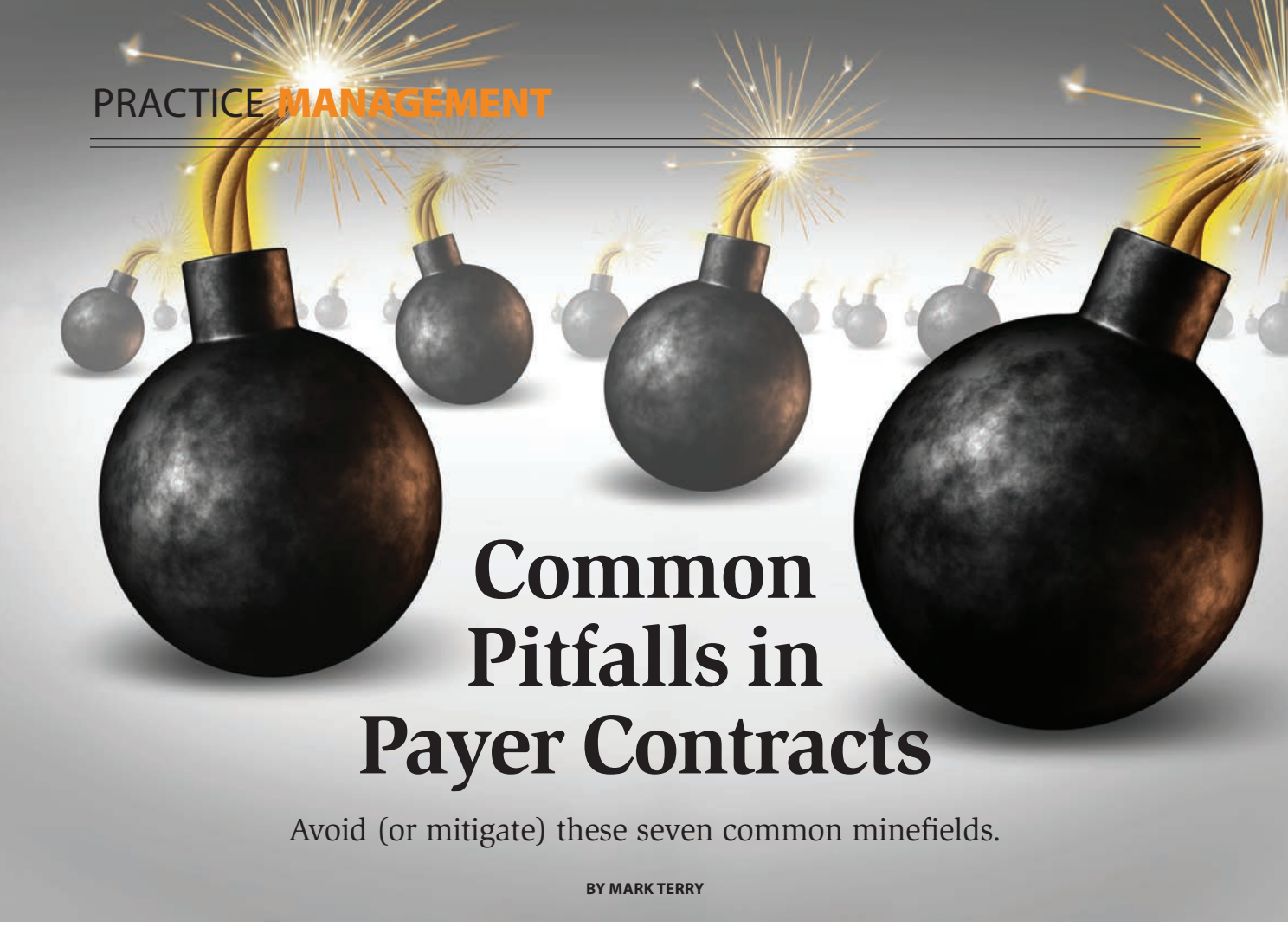

Common Pitfalls in Payer Contracts

Avoid (or mitigate) these seven common minefields.

BY MARK TERRY

Do you know what's in your payer contracts? You really should. Before signing, read and understand them, and beware of common pitfalls. Not every aspect of a payer contract can be negotiated, but many can. Understanding the problems can allow you to develop workflows and processes to navigate these traps. Here are seven of the top problem areas to look out for.

John W. Leardi

1) Overpayment Recoupment: This particular contract provision allows payers to recoup overpayments from the practice. And typically, if unmodified, the clause will not have a time limit.

"This is a little-known piece, or at least a greatly misunderstood piece," says John W. Leardi, a health law attorney with Buttaci Leardi & Werner (Princeton, NJ and Tarrytown, NY). "Just about every provider agreement that any physician or physician practice will have in place will have comprehensive provisions about the payer's rights concerning recouping overpayments. And they're not always in line with state law."

Physicians typically have a concept of when they will get paid, but there are any number of reasons why mistakes happen and payments are delayed or overpaid. Much of it has to do with a lack of human involvement in the claims and claims adjudication processes. As a result, down the road, the payer may review records and find new data or a complaint will get filed and the payer will decide they overpaid and want their money back.

Leardi notes that almost every state has passed legislation regarding overpayment, but by signing the provider contract, "you may be giving up some of those rights. They're not constitutional. You can waive them. There may be language in the contracts that if the payer decides you've been overpaid, they reserve the right to take it out of your current claim submissions."

"There may be language in the contracts that if the payer decides you've been overpaid, they reserve the right to take it out of your current claim submissions."—Leardi

These can be very difficult to understand or negotiate around. "With these provisions," Leardi says, "the most important piece is understanding they exist and trying to implement workflows to deal with the

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mayhem they can visit upon your office in terms of even just reconciling a patient account."

Be aware of timelines regarding this issue. Often, there is a set of timelines in which you can challenge an unpaid claim or raise a dispute with the payer over anything, but there will be a separate timeline in which you can challenge an overpayment.

2) Time Limit on Claims: This is somewhat related to the timelines issue in the previous section. As mentioned above, different parts of the contract may have different and separate timelines.

Leardi says, "A provider agreement can have a more truncated timeline. Because this is a voluntary agreement between two sophisticated parties, the expectation is that if you agree to something in your provider agreement, you know what you're agreeing to."

Although laws or even expectations may indicate a one-year timeline, the agreement might indicate 60 or 90 days. So, if there's a mistake or issue and a corrected claim needs to be filed, if you try to correct it after that deadline, you're out of luck.

"Obviously," Leardi says, "we'd love to be able to negotiate these things away, but even if we can't, understanding them and knowing that you have to have workflows built around that limitation is critically important."

3) Prior Authorization Protection: Typical payer contracts require physicians to follow authorization procedures. These are almost always in favor of the payer. When negotiating, try to get contract language that requires medical necessity standards for authorization and appeal decisions, and which allows the provider to request a peer-to-peer review of authorization denials.

In terms of information or claims vetting processes, confirming the patient has benefits and the service in question is covered is not the same thing as confirming prior authorization. Leardi says, "That's not really pre-authorization of the service. That's just an inquiry. Ultimately, if you decide to go forward with the course of care, it's something that's covered under the plan. But there's not much in the way of protection for you if on the back end the payer decides that it wasn't a necessary procedure or a necessary service. That means the initial inquiry is academic."

The following are objective data that are benefit verification, but not a review of whether a procedure is appropriate in specific situations:

- Finding out if the patients had added network benefits;
- Determining if the out-of-network benefits cover the procedure; and
- Identifying the financial ramifications of a procedure.

Typically, the payer will place some type of objective measure on the practice's performance. Physicians should know what those measures are.

Leardi says, "Something to check for in your provider agreement and in the written communication back and forth during the pre-authorization process is whether or not they try to slap on disposition disclaimers."

If the payer has the chart note and your clinical rationale for ordering a surgical procedure, for example, that should be enough to determine if the procedure is necessary. "And if they need more, they can ask for it," Leardi says. "But the payer may look at that note and then send you something that says, 'Yes, it's pre-certified,' but then slap a disclaimer on it arguing pre-certification or pre-authorization does not necessarily guarantee coverage or payment, that's obviously very concerning."

Basically, Leardi says, "Familiarize yourself with the coverage policy that payers are going to ultimately point to if they try to reverse course. Knowing that the payers have these rights can help you, not by being able to get rid of the pitfall, but how to navigate it."

4) Financial Penalties and Fines: For the most part, this applies to risk-sharing contracts or shared savings plans, where the payer is dealing with managing a population or they are being held accountable by self-insured employers or governmental payers. Typically, the payer will place some type of objective measure on the practice's performance. Physicians should know what those measures are. They need to understand what the financial downside would be if, for example, a fine is imposed on the payer and the payer then wants to pass that along to the providers participating in that shared savings or shared risk pool.

Leardi says, "You should understand what your metrics are, how you have to meet them, and how reasonable it is for you to meet them. But also understand that you may do everything right, but somebody else within the risk pool or in the shared savings universe might not. And that may ultimately fall back on you."

5) Unilateral Contract Amendments: Payer contracts may try to slip in a clause that allows payers to change the terms of the contract at any time. That, of course, doesn't go both ways—you won't be able to amend the contract when you want to. A typical contract outside of the payer-physician universe with "parties of equal footing" requires both parties to agree to any contract amendment; not so for many payer contracts.

Those payer agreements essentially include a provision that says they have the right to amend the contract upon X number of days' written notice. It will often state that as long as the payer sends the notice to the physician, if the physician continues to bill the payer under the contract or doesn't send a letter objecting to the amendment, it's going to be binding and effective on such-and-such a date. "This happens all the time," Leardi says. "They often do it because no one's challenging them."

As noted earlier, the contracts

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are based on an agreement between "two sophisticated parties," but in reality, there's very little equivalence between a physician's practice and a payer in terms of negotiating power.

"It's permitted unless it is completely unconscionable," Leardi says. "If the parties agreed that the contract can be amended by one side merely by sending a letter 30 days before it takes effect, and that the only way to have it not take effect is to either stop billing under that contract or to send in a termination letter, the law is going to recognize that as enforceable."

Some states and regulatory agencies have tried to make more sense of this process, but usually, those have affected the amount of time the payer must give you and how detailed the notice should be. Unless there is specific legislation, the law will recognize it as a valid contractual term.

6) Long Contract Duration: This can be a bit tricky. Most payer contracts are perpetual, which means that they will have a one-year term, but an evergreen provision will automatically renew unless one side or the other provides written notice of termination, usually 30 or 60 days. Leardi says that setting that aside, "there's always a provision that gives the payer the ability to terminate for cause or without cause. And in a 'without cause' scenario, it just requires notice. There is often an opportunity to object or appeal."

Physicians need to understand the process to challenge the renewal. What can be a trap is often a provision in these contracts that requires the provider to agree to continue to treat the payer's members on an in-network basis through the next anniversary of their individual contract. Why is that tricky? Because it's almost impossible to determine when those patients' contracts renew. It could be January 1, but it could be any other date. And that's information that physicians typically don't have access to.

7) Managed Care Entities: An example would be understanding if

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Understanding Your Breakeven Point and Considering Options

Legally, negotiating contracts can be a very peculiar situation. For example, try to negotiate a contract with a rental car company. Some contracts aren't negotiable. For medical practices, even larger practices, there's a power dynamic at play in trying to negotiate with payers—physicians are at a clear disadvantage.

Dr. Guiliana

John Guiliana, DPM, Medical Director–Podiatry for Modernizing Medicine (Boca Raton, Fl), notes that there's a tendency to think you have two choices—participate or become a concierge practice. "Those are not the only two choices here. What we have to do is become analytical and look at individual carriers for what they bring to the practice's margin."

Of course, that means the physician has to understand what their margin is based on their variable cost per patient; that is to say, the direct cost associated with treating a single patient. Variable costs are derived from your profit and loss statement, while the number of patients can be derived from your practice management software. Your variable costs over the year are divided by your total patient visits. That number is the breakeven point.

"Once you know your variable cost per patient, you can then look at this carrier that you're trying to negotiate with and say, based on my variable cost per patient, which is essentially your breakeven point, this carrier is providing me with—and I'm just going to be hypothetical—a 15% margin. Well, my target and my average margin is 30%. That's a problem. We can't be afraid to deselect carriers."

If you're not meeting your variable cost per patient, you're losing money every time that patient comes in. Guiliana says, "I would propose that most carriers at least meet that number, but it depends upon how much variability there is. That's the contribution margin. It varies across all of your payers. But as physicians, you need to decide, what's the opportunity cost?" The opportunity cost is what you give up when choosing one thing over another.

Negative externalities include things like the proportion of patients this carrier makes up in your practice. What will happen if you lose 30% of your practice's revenue stream, for example? Can you reduce costs by that amount to maintain profitability? And even if that carrier is a smaller percentage of your practice, how will losing it impact your referral base of primary care physicians?

Guiliana says, "You have to think all this through and perhaps communicate with your primary care physicians and let them know the reason you're deselecting, but you are there for those who accept other carriers. And there's nothing wrong with even saying, for those patients who are part of Acme Insurance Company, "we have a concierge program." You could be very transparent about the pricing, etc., and you could actually make more money by doing that. I just want to make sure that my colleagues know they're not at the mercy of these low-payers. There are options." **PM**

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you, as a provider, are signing up with a managed care entity to service their PPO population. Are you also agreeing to treat all their HMO patients? Are you agreeing to treat their managed Medicaid patients, for whom you would be paid much less than for their PPO patients?

So, understand if you are making a contract for one plan or all the plans that the payer has in place," Leardi says. "I can't tell you how often clients will come to me and don't understand that by signing a commercial agreement, they've agreed to take on Medicaid patients. And that can cause a nightmare."

Utilization Management

So what should you know or do? Utilization management, Leardi notes, is basically how you keep an eye on what you're doing and whether it complies with what you believe is medically or clinically appropriate. It ties back into the earlier discussion of pre-authorization.

The first point is that every payer "has exhaustive clinical policy bulletins that they expected to be followed, and they incorporate those by reference into your contract," Leardi says. "This idea that you think something is appropriate and you think it's necessary and therefore is enough to have it considered medically necessary is not at all the case."

The payer will have policies in place. For example, before you recommend a specific surgical procedure, you must attempt conservative therapy for a specific period. Medicare does the same thing with local coverage determinations, but Leardi says there's a sense that just following the LCD is going to be good enough across the board. But when it comes to payer contracts, it's not. "Private payers have their own rules. And much like Medicare, they're going to want to see that language regurgitated back to them in a note."

So it's important to understand utilization management in terms of what the payer policies and standards are. Understand your rights as described in the contract, determine whether a procedure is necessary and what your obligations are like, with supporting documentation. And as is the case with signing any contract, understand what you're signing. **PM**

Mark Terry is a freelance writer, editor, author and ghostwriter specializing in healthcare, medicine and biotechnology. He has written over 700 magazine and trade journal articles, 20 books, and dozens of white papers, market research reports and other materials. For more information, visit his websites: www.markterrywriter.com and www.markterrybooks.com.