

# MEDICAL/LEGAL NEWSLETTER



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## PAYER CONTRACTS: KNOW THY RIGHTS — AND OBLIGATIONS

We all know that it is very, very difficult – often impossible unless you are a dominant medical practice – to negotiate better reimbursement rates from third-party payers. But that doesn't mean you shouldn't carefully manage your payer contracts. Knowing your rights under the contract and the law can spare you serious legal problems and save you big money along the way.

In order to understand and manage your payer contract, you have to know what the "contract" is. It isn't just the ten page document that you sign with the provider relations representative. A typical payer contract will incorporate by reference the provider manual, bulletins and announcements, and all of the payer's policies and procedures. You are bound by them even if you don't have a copy in the office.

The office manager should maintain a "tickler" file to remind the practice that a contract is coming up for renewal. Some contracts have renewal dates tied to the anniversary of the signing date, but we recommend having all contracts on a calendar year basis (Jan. 1 to Dec. 31)

The provider contract will contain provisions which allow the payer to amend the contract. Sometimes the payer will have the right to change provisions unilaterally; other times the provider will be given 30 days in which to reject the amendment. Unfortunately if the amendment is rejected the only recourse for the provider is to terminate the contract and that is not usually desirable.

Providers need to be alert to the fact that although amendments to the contract must go through a notification process, changes in the payer's policies and procedures don't. The fundamental relationship between payer and provider can be altered significantly by amendments to policies and procedures that can be implemented without notice to the provider because they don't literally amend the "contract".

Even if you can't negotiate better reimbursement rates, there are tips for making sure you get everything you are entitled to under the contract. Almost all contracts provide that the physician will be paid the lesser of the payer's fee schedule or the physician's usual and cus-

tomary charge. If your charge for a service is \$80 and the fee schedule amount is \$100, the payer will only reimburse you the lower \$80 amount. Many physicians fail to regularly update their schedule of charges and end up leaving money on the table.

Beware of silent PPOs, those payers who attempt to piggyback on your current payer contract by taking advantage of the discounted rates that you may have agreed to. You need to be sure that a payer with whom you do not participate reimburses at the usual and customary rate. The State is considering legislation to prohibit the "renting" of a provider network without the provider's consent.

Physicians generally must submit their claims to the payer within 60 or 90 days after the date of service, failing which the claims will be denied as untimely. If a clean claim isn't paid within 45 days, the physician is entitled to interest at 12% per annum. Chronic late payments should be reported to the State Insurance Department because they are the watchdog and they have the power to levy fines against delinquent insurers (and they do).

When can you charge the patient directly if you are a participating provider? Under New York law, physicians cannot charge patients for "covered services" except for allowed deductibles and co-payments, even if the payer becomes bankrupt. This is known as the prohibition against balance billing. However, if the service is not considered a covered service, the physician may usually charge the patient so long as before receiving the service the patient signs a written acknowledgment of responsibility.

As a participating provider, you cannot charge concierge or boutique practice fees (i.e., membership fees), nor can you generally charge for filling out forms except in limited circumstances. It is permissible, how-

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## TIPS TO BETTER MANAGE YOUR THIRD PARTY CONTRACTS

### By George W. Chapman

It is not unusual for busy practices to lose track of their several agreements with third party payers. Consequently, most of these agreements automatically renew without any review or input by the practice. Physicians must take an organized, deliberate and business like approach to managing their third party payer contracts in order to protect resources, maximize income and provide better services. If you don't know where you stand with your agreements, I suggest meeting with your practice manager to find out and develop a plan of attack.

First, determine who you do business with, ranked in order by total charges for a year. The list will be long, but most likely the top 4 or 5 payers will be around 80% of your commercial (non Medicare) business. Start with them.

Second, create and organize files for these top 4-5 payers. They should contain the original signed agreement, amendments, correspondences, meeting notes, audits, contacts, staff notes, patient complaints, phone call records and anything else related to the payer. You will want to consider everything in the file when you consider renewing.

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Third, determine who you want to par with. Most likely, after the top 4-5 payers, most of the rest will be less than 1% of your volume. Do you have signed agreements with all of them, or are you unintentionally participating by default? In other words, there may have never been a signed agreement, but you are cashing their checks. Is it worth participating with a payer for a few visits a year? Is it worth the administrative hassle? Where do you draw the line in the sand when it comes to participating? It will be better financially to non-par with low volume payers which means you can balance bill the patient. If you do decide to par, get a signed agreement.

Fourth, determine your top procedures by charges. For most practices, 10 to 15 procedures comprise 90% of their business. You want to be sure exactly what you are going to be paid, to the specific penny, for at least your key procedures. Do not accept agreements that

refer to rates from a previous agreement, or site a percentage of the 2006 (or whatever) Medicare rates, or that allow the carrier to adjust the fees during the term of the agreement. Attach the specific fee schedule to the contract. When you sign an agreement, fees should not change over the term of the agreement unless both parties agree.

Fifth, review your files annually. It doesn't take long. There may be an disproportionate amount of problems relative to the volume of business you have with a particular carrier. While some carriers might pay relatively well, it could be a nightmare doing business with them. Bring this up when you meet with them. This is why you need to maintain a file. You may want to reconsider renewing unless the carrier can resolve the administrative problems or improve certain fees. Most agreements automatically renew if a practice doesn't notify the payer by a certain deadline. Don't let any agreement, especially a high volume one, automatically renew without reviewing it first.

Sixth, communicate with your staff. Everyone needs to know what carriers are "in" and what carriers are "out". Billing clerks need to know what patients should be balance billed because the practice does not have an agreement with their carrier. Receptionists need to know what plans require their members to make a co-pay at the time of service. Schedulers need to inform new patients whether or not their plan is accepted and how payment will work.

Seventh, review your internal billing process. Audit one or two days of business at random. Any copays should be collected the day of service. You should be paid within 45 days according to the fee schedule attached to the agreement. Check for denial patterns which are often stalling tactics. If you don't par, those patients must be balanced billed the difference between your charge and the carrier payment. Basically, are you and the payer living up to the agreement?

Eighth, keep your fee schedule realistic. It should make sense relative to what the carriers (the market) are paying you. All payers reimburse you the lower of your charge or their fee. You want a fee schedule that's high enough to capture 100% of third party reimbursement, but low enough so it's affordable to your underinsured or non-par patients. I suggest you base your fees on RVUs times a common multiplier. Having different charges depending on the patient's financial status is dangerous. Charge everyone the same and then make the appropriate third party contractual adjustments or discounts for the individual.

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ever, to charge for missed appointments and this also applies to Medicare patients.

**As a participating provider, you cannot charge concierge or boutique practice fees (i.e., membership fees), nor can you generally charge for filling out forms except in limited circumstances.**

Physicians are frequently asked or expected to give discounts or to waive co-payments for patients, especially during difficult economic times and rising unemployment. What may be viewed by the physician as a good-hearted accommodation can pose some legal risks however. The federal anti-kickback law makes it a crime to offer, give, or receive any kind of remuneration as an inducement or reward for referrals. Financial breaks for the indigent or unemployed may be acceptable under the anti-kickback statute, but giving those same benefits to other physicians who refer patients to you is another matter.

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A medical practice that routinely gives payment discounts may unintentionally lower its average charge, thereby bringing it below the payer's fee schedule amount. It may also create a risk of insurance fraud. Here's how that can happen: let's say the patient has a policy which reimburses the patient for 80% of the physician's usual and customary charge and that charge in this case is \$100. The insurer should pay 80% of the bill (\$80) with the patient responsible for the balance of \$20. But if the physician waives the coinsurance amount, the insurer should only pay 80% of \$80, or \$64.

In that scenario, the State Insurance Department says that if the patient submits the bill to the insurer knowing that the physician has waived the coinsurance amount, the patient is guilty of insurance fraud, and if the physician submits the bill directly the physician would similarly be guilty of insurance fraud.

What about accepting "insurance only" for patients who are out-of-network? Since patients usually bear a higher personal cost if the physician is out-of-network, it is tempting for the physician to waive the coinsurance amount in order to remain competitive and retain the patient. Again, if the insured is paying based on a percentage of UCR or charges, this could constitute insurance fraud. On the other hand, if the out-of-network reimbursement is a fixed amount, then it would be difficult for an insurer to claim that it had been misled by the physician. When in doubt, the Insurance Department advises physicians to inform the insurer that the coinsurance has been waived.

Insurers often conduct in-office chart audits and then seek to recover alleged overpayment amounts from the provider. Fortunately, physicians now have more rights than they had in the past. First, until recently the insurer could look back up to six years when seeking overpayment recovery. The Excellus/MSSNY class action settlement agreement limits that period to 12 months (originally 24 months under the settlement agreement) except for fraudulent or abusive billing. A New York statute limits the recovery period to claims paid within two years (not applicable to self-insured ERISA plans).

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Since 1999, all provider contracts entered into with commercial payers are supposed to contain provisions describing the methods for calculated payment adjustments, the time periods within which such calculations will be completed and adjustments made, a description of the records or information relied upon for the calculations and how the provider can access those, a process for resolving disputes related to these matters and the right to seek arbitration. In the author's experience, most provider contracts still lack these provisions. It remains to be seen how the courts will rule on payment disputes involving contracts that are not in compliance with the statute.

## TIPS TO BETTER MANAGE YOUR THIRD PARTY CONTRACTS

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Practice managers are busy, but it is critical to get your contracts under control. You may want to engage an independent advisor to assist you with getting organized and expediting the process. It is very cost effective; especially considering how much cash is at stake. An experienced advisor will pinpoint "leaks", offer recommendations to close them and act as a confidential sounding board to your practice when it comes to contract renewals.

*This is a summary of a presentation given to the Onondaga County Medical Society in April, 2009.*

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It is important for physicians to periodically review EOBs from the payer to see whether the correct amount of reimbursement is paid. Payers have to process millions of claims each year and often do not keep the claims processing software up to date which can result in significant underpayments to the physician.

If your practice is accredited to perform office-based procedures, you should ask your payers about an enhanced reimbursement for any procedure that can be performed as safely in the office as in the hospital setting. It's obviously more convenient for the physician to perform procedures in the office, but it also spares the payer the cost of a facility fee and some of that savings should be passed along to the private practitioner. There is no legal obligation for payers to pay you more just because you have been accredited for office-based surgeries. Whether you will be successful in negotiating a higher rate of reimbursement for these procedures will

depend on many factors, including your volume, overall cost savings to the payer, type of procedure, size of the medical practice, and political factors (e.g., hospital-payer relationship).

The downward trend in reimbursements is causing many practices to become more selective in deciding which payers to participate with. Government payers are often the first to be jettisoned.

Medicaid participation is not mandatory. Physicians can opt-out on thirty days notice. After the date of termination, you are prohibited from billing your current Medicaid patients; however, for new patients accepted by the practice after the effective date of disenrollment the prohibition does not apply.

More frequently physicians are electing to opt-out of Medicare, and if the fee schedule keeps decreasing – as much as 21% under the proposed Senate health reform bill – the pace is bound to accelerate. The decision is not to be undertaken lightly. Once the physician opts out of Medicare, he cannot re-enroll for a period of two years. The physician can treat Medicare patients (who must pay out-of-pocket), but only pursuant to a private contract that meets the standards set by CMS.

Physicians who have issues with their carriers should make sure they (or at least their attorney) understand their rights under the provider contract and the applicable statutes. For serious payment problems, the Insurance Department or the Health Care Bureau of the New York State Attorney General can be very helpful.

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