

FIVE TIPS FOR THIRD-PARTY PAYER CONTRACTING



These best practices can help you strategize negotiations and maximize your leverage.

BY ASHLEY R. GEARY, ESQ

As Medicare and commercial payer reimbursement rates continue to trend downward and the US population continues to age, physicians across the country are facing financial challenges. Between high-deductible plans, prior authorization requirements, and an endless cycle of audits and payer compliance programs, physician practices are under significant stress that has nothing to do with patient care. In a medical specialty that is heavily reliant on Medicare reimbursement, including Medicare Advantage reimbursement, opting out or terminating a payer contract is rarely feasible. As a result, physicians feel they have little (if any) leverage in negotiating with payers and are forced to accept whatever is offered.

With years of negotiating payer contracts under my belt, I can tell you that it is possible to get improved reimbursement from payers, but doing so takes time, effort, and the dedication of resources. Based on my experience, herein are five key strategies to keep in mind when negotiating with payers.

NO. 1: DO YOUR HOMEWORK

To start, assign someone in your practice the responsibility of maintaining your payer contracts. Not only keep copies of all payer contracts in an easily accessible location but also track the renewal dates of each payer contract and the notice periods necessary to terminate them. This is key in deciding when to reach out to each payer. If you have a 3-year contract with a payer and are only 18 months into that contract term, that payer should not be your top priority. On the other hand, if a payer contract is coming up on its renewal date and the contract requires 90 days' notice of termination to avoid renewal, make sure you start communicating with that payer before the notice deadline. Otherwise, the payer will likely reject any rate proposal because your contract is set to renew at the current rates. Usually, the payer will tell you to reach back out when your next renewal date approaches, leaving you stuck with the current rate.

Before communicating with a payer, first compile reimbursement data so

you are prepared to request changes. I recommend a comparative analysis of your top 25 codes across your top five to 10 payers. I generally advise clients to use Medicare rates as their benchmark and compare the other payer reimbursement with those rates. This will give you an idea of which payers are having the most significant effect on your bottom line.

For example, say Payer A reimburses well for procedure codes but poorly for evaluation and management (E&M) codes. Although a single procedure code reimburses much higher than a single E&M code, E&M codes are billed far more frequently. As a result, you may be surprised to find Payer A's procedure code reimbursement is not sufficient to offset their poor E&M code reimbursement. Although you might not have initially intended to pursue improved reimbursement from Payer A, the decision to do so may change once you complete your analysis.

NO. 2: PREPARE REALISTIC REQUESTS

Once you have done your homework and determined which payers you want to contact, prepare your requests—and be realistic. A payer is not going to agree to give your practice an across-the-board increase of 30%. The narrower you can make your requests and the more you can justify those requests based on actual numbers and costs, the more likely you are to achieve success with the payer. Going back to Payer A, if their procedure code reimbursement is satisfactory, focus on their E&M reimbursement. If they are reimbursing under Medicare rates, look to achieve at least 100% of Medicare.

Consider asking for carveouts for certain codes. For example, if you have an ambulatory surgery center

AT A GLANCE

- Keep copies of all payer contracts in an easily accessible location and track the renewal dates of each payer contract and the notice periods necessary to terminate them.
- When preparing a requested change to your payer contract, be realistic. A narrow and easily justifiable request has a higher chance of success.
- Once you make contact with the payer with your request, be prepared for a delayed response; you will likely be passed around to multiple representatives and get vague assurances that they "will be in touch shortly."

and your procedures are reimbursed through “Grouper” categories (ie, payer-stratified groups of Current Procedural Terminology codes used to assign reimbursement), you will have a greater chance of carving certain codes out of a specific Grouper than you will negotiating an increase for all the codes within that Grouper.

As an example, say that your practice performs a procedure listed in Grouper 3, which is reimbursed at \$500, but the actual costs put it more in line with the reimbursement for Grouper 6 at \$1,500. In this scenario, it would make sense to ask the payer to either move the code to Grouper 6 or carve it out of Grouper 3 with a special reimbursement rate—either option could lead to better reimbursement for that procedure. If you ask to increase the Grouper 3 reimbursement to \$1,500, you can expect a denial from the payer.

NO. 3: PREPARE TO DISTINGUISH YOURSELF

Payers are not going to increase your reimbursement rates simply because you asked. You need to sell yourself and your practice to them. Prove that you provide a benefit to the payer and its beneficiaries. If you are the only glaucoma specialist in the area, make sure they know that. If you have contracted with the payer for 25 years and never had a single negative audit result, make sure they know that, too.

Do not assume the payer is familiar with your practice’s background information; the department that handles contract negotiations does not necessarily talk to the department that tracks quality scores or audit results. Lay everything out for them and make it difficult for them to say no. It may not be financially feasible to terminate your contract if the payer is not willing to work with you, but you may have to stop accepting new patients or stop performing certain procedures on their beneficiaries because the payer’s reimbursement does not cover the cost. Whatever the case may be, distinguish yourself from the thousands of other

practices that they contract with and justify why they should pay you more.

NO. 4: MAKE CONTACT

Despite its apparent simplicity, making contact is often the most difficult task in the negotiation process. It can be challenging to get your proposal in front of a payer representative who has the time and authority to handle the negotiation and is willing to dedicate their time and effort to working with your practice to achieve a mutually acceptable resolution. Many payers do not provide a direct point-of-contact for their participating providers. Instead, when a practice has questions about claims or contract terms, the practice manager must use the general “Provider Services” contact. Based on my experience, you are unlikely to have success at this level. Thus, I often recommend practices direct their request, in writing, to a member of the payer’s leadership team. This may be the chief medical officer, vice president of network contracting, general counsel, or another executive-level individual.

Some payers have a dedicated department tasked with responding to inquiries received by the leadership team. Although you will not be negotiating with these executives, they have the authority to assign someone to work with your practice.

Regardless of the person you initially reach out to, be prepared for a delayed response; you will likely be passed around to multiple representatives and get vague assurances that they “will be in touch shortly.” Ensure that the team member tasked with negotiating your payer contracts takes the time to check in periodically to ensure your negotiation progresses as quickly as possible.

NO. 5: REVIEW THE PROPOSAL CLOSELY

Once you finally receive a counterproposal from the payer, make sure that you review it closely. Check the attached fee schedules and make sure they apply to the correct geographic region and place of service (ie, facility

vs nonfacility). If the rates are based on Medicare reimbursement, check which Medicare fee schedule is applicable. Although practices might expect the most current fee schedule to provide the highest rate of reimbursement, that is not necessarily true. Although Medicare’s E&M reimbursement has generally increased over the years, their procedure reimbursement has not. In some cases, the 2019 Medicare fee schedule may be preferable to the 2024 Medicare fee schedule.

It is possible that, as part of the fee schedule negotiation, the payer expects you to enter into a new contract with them. This new contract may contain new terms that negatively affect your practice. For example, payers may impose certain requirements related to their ability to conduct audits, give themselves broad rights to recoup overpayments, and tie your practice into a lengthy term. Before signing any new payer contract, it is important to review not only the fee schedule but also the contract terms that apply to your practice going forward.

NEGOTIATE WITH CONFIDENCE

Payer contract negotiations are just one more operational task that ophthalmology practices must tackle to ensure they remain financially sound. Practices that simply accept what is offered without a careful review of each contract or periodic assessment of the reimbursement may find themselves facing financial difficulties and tough decisions regarding closing, merging with a larger practice, or selling.

To maintain your autonomy and ensure your practice’s continued success, you must dedicate time and attention to your payer contracts and make sure you receive adequate reimbursement for your services. ■

ASHLEY R. GEARY, ESQ

- Partner, Wade, Goldstein, Landau & Abruzzo, Berwyn, Pennsylvania
- ageary@wadegold.com
- Financial disclosure: Consultant (AAO)