AMERICAN COLLEGE OF SURGEONS

MAY **2021**

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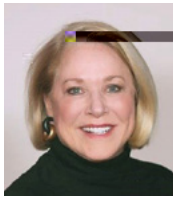

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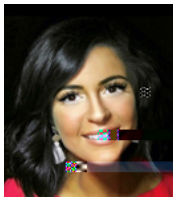

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PPC Membe

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INTRODUCTION



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 **d c ma ke** and a **ge g a hic ma ke** .

A **d c ma ke** is a product or group of products for which there are no adequate substitutes. In the health insurance industry, the main product types are:

P efe ed P ide O ga i a i (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.

Heal h Mai e a ce O ga i a i (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.

P i f Se ice (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.[1]

P ide a eal a e e ial c m e f he d c ma ke . Using an ideal situation, if there is only one general surgery practice in a market, then the health plan must have that provider to have a product.

A **ge g a hic ma ke** requires a determination of the area in which there is effective competition for

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.[4] 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

When a payor exercises market power in its market—the sale of insurance coverage—premiums are higher than in a competitive market. When a payor exercises market power in its **i** 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.[6] High barriers to entry into payor markets also enable payors to exercise market power. Such barriers inclos (. e (y)14 4 rrier)9.1 (s t)4 (o en whetherase marmaren whetqui)13 (y)1 (e e of m)15.1 (est)]TJ(s (. e (y)14 4 dttings, the)]o pr e oe martalmelln)hics 18 (e)

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



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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.[9]

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.

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

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5. Kaiser Family Foundation State Health Facts Health Insurance &

UNDERSTANDING GS



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 appreciatica?

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.

At check-in, collect the amount owed for that visit
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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.

P lic	Medica e	BCBS TX	Ae a	A hem**	Cig a	H ma a	UHC
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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. Under1s1.3 Td su1n1WWatch that.1 (18 da(er datavingk)16.2eh thay)4tha. B (-0 -1.3 Td[(basis.pe actuly es ent)4.csur)(ect, t
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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 f ll i g a e he e ha ha e al e he e ide :

Cha ge , a me , a d adj me by provider, by payor, and by location.

C edi bala ce : 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 f e e c e : 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.

Mi i g e c e : 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?

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!*

C de f La ge De ied Am

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.

C de f La ge De ied Am



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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

Do the Results Match the Terms of the Initial Contract?

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 e ack claim de ial** . 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]TJ0 -1ma 5he -1..15 Td(claim de)ses h pres fhe

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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?

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?

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)

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

ADDITIONAL RESOURCES



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.

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 Claim

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 followingareas:

   - 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

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.
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- 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/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 **m** 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.

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]

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 Of (v8Ot/estt of)]TJ0.846 0.636 0.15 rg/GS0 gs[

Practice Management

OCTOBER **2018**

ADDITIONAL RESOURCE

ACS Newsletters

Bulletin Brief

Bulletin Advocacy Brief

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