



With the right data and a reasonable approach, you can overcome some inequities in payers' fee schedules.

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Can You Negotiate Better Reimbursement?

It has been more than a decade since increases in fees have resulted in increases in income. The introduction of the Resource Based Relative Value Scale (RBRVS) and the adoption of a national fee schedule by Medicare virtually eliminated a practice's ability to generate more income from insurance plans by increasing what it charges for services.

Today, most health plans operate with fixed fee schedules. Often these schedules have little in common with the RBRVS, and while some are roughly based on a percentage of what Medicare pays, they may be tied to payment levels that are three or more years old. Most physicians who question this

methodology for paying for professional services are told to take it or leave it.

Some practices are finding, however, that negotiating with payers for fairer payments is possible. This does not mean payers are willing to grant large increases just because you ask. But with the right data and a reasonable approach, you may be able to overcome some inequities in existing fee schedules.

Do your homework

Solid data and a well-reasoned approach are key to negotiating better reimbursement rates. Most of the data you will need are readily available, particularly if your practice uses a computer-based billing system. ►

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To gather the data needed for negotiation, first determine the most commonly used CPT codes in your practice.



A basic spreadsheet will help you compare a payer's reimbursement rates per CPT code against Medicare's rates and your actual charges.



It may be useful to standardize all of your fees at some percentage of Medicare, perhaps 125 percent.

Step 1: Determine your most common CPT codes. Most primary care practices derive the bulk of their revenue from office-visit, hospital and preventive-medicine codes, so the number of codes you will need to study may be limited. Be sure the codes on your list account for at least 75 percent of total practice charges. Next to each CPT code, record its frequency, that is, the number of times you provided the service over a 12-month period. Be sure to include some lab charges or procedures to see whether different payers have different reimbursement schemes for these services.

If your practice uses billing software, you should easily be able to generate reports on your CPT codes and their frequency. If your practice generates invoices manually, have your billing staff keep tallies of the CPT codes you have included on your superbills. Three months of data should be sufficient. If you use this manual method, pick three of your busiest months.

Step 2: Determine your top payers. Again, if you have an automated billing system, you can likely run a report on your top payers. Since Medicare and Medicaid use established fee schedules and do not negotiate, focus on the three to four other payers that make up the bulk of your reimbursement.

Step 3: Determine your reimbursement for each code. Review the Explanation of Benefits statements you receive from each of the payers you selected and note how much they allow for each code on your list. Be sure to use the "allowed" amount, not the "paid" amount. The paid amount is the allowed amount minus any co-payments or deductibles the patient pays to the practice.

In addition, calculate each payers' reimbursement rates as a percentage of Medicare's reimbursement rates. For example, a health plan may pay 110 percent of Medicare's rate for code 99214. You can find Medicare's current rates for your geographic area through the "Medicare Physician Fee Schedule Look-Up" tool at <http://www.cms.hhs.gov/physicians/mpfsapp/step0.asp>. There, you can also find the current relative value units (RVUs) Medicare assigns to each code.

Because more and more health plans are beginning to use RVUs, it is important

KEY POINTS

- A simple analysis of your fees and your health plans' reimbursement rates can help you reveal and overcome payment inequities.
- Make sure you review your fees annually and set them reasonably (for example, at 130 percent of Medicare's rates).
- Negotiating even small increases for a few codes can generate valuable income for your practice.

to understand how they work. Under the Medicare RBRVS, each service is assigned RVUs based on the physician effort, practice expenses and malpractice risk involved. For example, the total RVUs for a 99214 office visit are 2.2. To calculate the payment for this service, you simply multiply its total RVUs by the annual conversion factor. Medicare's conversion factor for 2004 is \$37.34; therefore, its rate for a 99214 office visit is \$82.15 (plus or minus geographical adjustments).

Step 4: Review your fees for each code. Note your current fees for each CPT code on your list, and calculate your fees as a percentage of Medicare's rates. If you find that an insurance company is reimbursing some of your charges in full, this may mean your fees are too low and the insurance company may be willing to pay more. Consider raising those fees or, better yet, standardize all of your fees at some percentage of Medicare,

perhaps 125 percent. If your payers seem to pay more for procedures or diagnostic studies, establish a tiered fee schedule that sets evaluation and management services

at 125 percent of Medicare while charging 150 percent of Medicare for other services. Whatever method you choose, be sure to update your fee schedule annually based on changes to the Medicare fee schedule.

Step 5: Organize and analyze the data. Once you have gathered the above data, organize it onto a spreadsheet or chart, such as the one shown on page 33. This will help you identify which codes or health plans should be targeted for improvement.

In general, focus first on the codes with the highest volume and dollar value, as they will yield the most return for your effort. In addition, if one health plan's rates are clearly

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lower or if one code is paid at a much lower percentage of Medicare than the others, this may be a likely target for negotiation. For example, if you find that one of your health plans pays 99 percent of Medicare for preventive services and 150 percent of Medicare for lab services, you could use that as a negotiating point, as most health plans are committed to preventing disease and should provide proper incentives to do so. What's more, some insurers pay specialists at a higher rate than primary care physicians. This is a remnant of the days when Medicare had two conversion factors (one for surgeons and one for "cognitive" specialists). If you can demonstrate this inequity, you may secure better reimbursement rates.

After you weigh these kinds of issues, establish target reimbursement rates for your negotiations, say 120 percent of Medicare for

most services. A sample is shown in the far right column of the table below. To determine the impact these target rates would have on your practice, multiply them by the frequency for each code. The table below reflects this analysis. It shows a potential 8 percent increase in revenue for the codes targeted.

Don't threaten to drop out of a plan unless you intend to follow through.

Take action

Once you have completed the fee analysis, you should act on what you have learned. These are some of your options:

Negotiate individual fees. Unless you

dominate your market, payers are unlikely to grant sweeping fee increases. However, you may be able to negotiate increases for individual services if you can demonstrate inequities using your data analysis (from step 5, above).

Typically, your first contact in the negotiation process should be the health plan's

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Before entering a negotiation, establish target reimbursement rates and calculate the financial impact these target rates would have on your practice.

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TWO HELPFUL SPREADSHEETS

A fee-analysis spreadsheet, such as the one shown here, can help you identify which reimbursement rates should be negotiated with payers. In this example, code 45330 is the easiest target, as the health plan's reimbursement rate as a percentage of Medicare is much lower for this service. (It appears the practice has set its current fee too low.) In addition, the group could set a negotiation target of 120 percent of Medicare for most services.



Compiling a fee-analysis spreadsheet for each of your major health plans will help you compare their reimbursement rates and highlight inequities.

FEE ANALYSIS:

CPT Code	Description	Frequency	Medicare Allowed Amount*	Your Current Fee	Your Fee as a % of Medicare	Health Plan Payment Rate	Health Plan Payment as a % of Medicare	Target Payment Rate	Target as a % of Medicare
99203	Level 3 office visit, new	385	\$94.18	\$115	122%	\$105	111%	\$113	120%
99213	Level 3 office visit, est	2269	\$51.63	\$65	126%	\$58	112%	\$62	120%
99232	Subsequent hospital care	596	\$54.27	\$65	120%	\$60	111%	\$65	120%
99214	Level 4 office visit, est	1977	\$80.65	\$100	124%	\$90	112%	\$97	120%
45330	Sigmoidoscopy	112	\$117.28	\$125	107%	\$125	107%	\$141	120%
93000	Electrocardiogram	198	\$25.76	\$50	194%	\$45	175%	\$45	175%
99396	Preventive visit, est.	211	\$104.27	\$130	125%	\$105	101%	\$117	112%
81002	Urinalysis	588	\$0.00	\$12		\$5		\$5	

REVENUE ANALYSIS:

CPT Code	Frequency	Health Plan Payment	Current Revenue	Target Payment Rate	Projected Revenue	% Increase
99203	385	\$105	\$40,425	\$113	\$43,505	8%
99213	2269	\$58	\$131,602	\$62	\$140,678	7%
99232	596	\$60	\$35,760	\$65	\$38,740	8%
99214	1977	\$90	\$177,930	\$97	\$191,769	8%
45330	112	\$125	\$14,000	\$141	\$15,792	13%
93000	198	\$45	\$8,910	\$45	\$8,910	0%
99396	211	\$105	\$22,155	\$117	\$24,687	11%
81002	588	\$5	\$2,940	\$5	\$2,940	0%
Summary			\$433,722		\$467,021	8%

A revenue-analysis spreadsheet, such as the one shown here, can help you assess how much you stand to gain should the health plan accept your target rate. In this example, the practice would gain more than \$30,000.

Download both spreadsheets in a Microsoft Excel file by visiting this article online at <http://www.aafp.org/fpm/20041000/31cany.html>.



Your first contact in the negotiation process should be the health plan's provider relations representative, not the medical director.



If a health plan's rates are extremely low, consider whether you should drop the plan completely or stop accepting new patients covered by the plan.



Comparing a health plan's payment rate to that of its closest competitor can be an effective negotiating strategy.



As the pressure to contain health care costs continues, it will be crucial that physicians negotiate fairer reimbursement rates, rather than simply accepting whatever is paid.

provider relations representative. If your argument to this individual is compelling, the discussion will move up to the contracting manager or network manager. The medical director essentially has no role in the business side of the plan. If you are performing a procedure that is new or not well defined, the medical director might be able to support your argument for a higher payment for that specific code or a specific case, but negotiating rates is generally not within the medical director's scope. (For a real-life negotiation example, see below.)

Drop the plan. If a health plan's payment levels are extremely low, you may be tempted to bypass negotiations and simply no longer accept patients from that plan. Whether this is a sound strategy depends on your local market. For example, if you practice in a highly competitive market, those patients will easily find another physician and you will simply lose market share. However, in less competitive markets, patients may complain to their employers that the loss of your practice has created a hardship and they may pressure the insurance company to return to the bargaining table. Whatever your situation, don't threaten to drop out of a plan

AN EXAMPLE FROM THE REAL WORLD

Recently, our firm worked with a hospital-based group of physicians in Virginia who had never negotiated any of their reimbursement rates with health plans; they simply accepted whatever was paid. After studying the reimbursement patterns of the group's various payers and targeting the four largest, we contacted one of the plan representatives assigned to the group's geographic market and presented our analysis. Key points involved explaining how the group's reimbursement targets were set (they used a resource-based relative value formula tied to 2004 Medicare levels with a target of 130 percent of current Medicare allowed amounts) and demonstrating that the health plan's payments varied between 100 percent and nearly 180 percent of current Medicare rates.

The health plan representative agreed to take the information to the contract manager for analysis. After two weeks, the group received an offer via e-mail of 120 percent of current Medicare rates, which was roughly 8 percent above the current average level of payment. It was an improvement, but given that the closest market competitor was reimbursing at 130 percent of Medicare's allowable amounts, we asked the contract manager to match that rate. The contract manager eventually counter offered with 128 percent of Medicare's rates but sweetened the deal by allowing automatic annual increases of 3 percent over the next four years. This would exceed projected Medicare increases and guarantee payment rates of 144 percent of Medicare's rates by the end of the term.

FPM ARTICLES ON NEGOTIATION

To brush up on your negotiation skills, read the following articles from the *FPM* archives. Both are available free online at <http://www.aafp.org/fpm>.

"You Can't Always Get What You Want ... But Sometimes You Can." Giovino JM. November/December 1999:24-27.

"Negotiation Gambits." Giovino JM. January 2000:60-61.

unless you intend to follow through. Most plans will call your bluff.

Close to new patients. While you may not want to drop a health plan completely, you may wish to stop accepting new patients covered by the plan. Over time, your number of patients covered by the plan will decrease as they switch to different plans or leave the practice and are replaced by new patients with better reimbursement.

What's ahead

Dramatic annual increases in the overall cost of health care are beginning to meet resistance from employers and government, who pay most of the bills. While physician

cost increases lag behind those in the hospital and pharmacy sectors, the pressure to contain overall costs will depress future reimbursement. Practices should assume that any annual adjustments will not be sufficient to keep pace with labor, malpractice and supply-cost increases and plan accordingly.

This means that, unless physicians want to work harder, they will need to generate more revenue for the work they now do. While accurate coding and complete charge capturing can play a key role, physicians should not hesitate to negotiate with health plans for fairer reimbursement. Practices that present a well-documented argument may be rewarded with a positive payer response. **FPM**

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