

Managed Care Administrative CUTTING

Your job is difficult enough without the barriers of managed care. Are you doing what you can to reduce the hassles?

Mara Reichman

With all the challenges managed care throws your way, you might think there's little you can do to alleviate the situation. You and your staff likely spend countless hours on the phone verifying patients' eligibility, requesting prior authorizations and checking the status of claims – time that could be better spent with patients. Or, like Andrew Merritt, MD, a family physician in Marcellus, N.Y., your primary frustration with health plans might be simply getting a live person to answer your phone calls: "Our biggest hassle is that when we have a problem, we can't just pick up the phone, talk to a person, discuss the problem and get a 'yes' or 'no' answer."

Though improving health plans' phone skills might be beyond your control, you can take steps to minimize managed care administrative hassles. Here are some ways to begin.

Navigating health plan contracts

If you're new to practice, or even if you've been practicing for several years, it's important to understand that the best way to avoid health plan hassles is to avoid bad contracts. Before you sign on the dotted line, take the time to read and understand the contract or, better yet, have it reviewed by a health care attorney. (For help in finding an attorney, visit the AAFP's online listing at <http://www.aafp.org/online/en/home/practicemgt/fpassist.html>.)



Family physician Kenneth Olds, MD, of Greeley, Colo., has been negotiating contracts for his 19-physician practice since 1979 and strongly recommends that physicians take the time to decipher what they're signing. "You need to actually sit down, read through the contract and try to understand it. Try to understand what that two-page-long sentence actually means," said Olds.

Because contracts are often arduous and confusing, the AAFP has published a "Contracting 101" primer to help you navigate a health plan contract and determine whether it makes sense for you. The primer, which is available online at <http://www.aafp.org/privatesector>, suggests you start by clarifying your goals, asking questions such as: Am I trying to protect or increase revenue? Am I hoping to align with other providers in the market who contract with this plan? Am I trying to grow my patient panel? If you answered "yes" to these questions, make sure that signing the contract will help you achieve these goals.

Tasks:

THE RED TAPE

“Contracting 101” also suggests compiling a list of more specific questions to ask the health plan’s representative. The more familiar you are with the health plan’s policies, the better equipped you will be to do business with the organization. For example, consider asking questions about formularies, requirements for prior authorization and termination policies.

Of course, the dollars and cents will likely be your deciding factor. Request a copy of the health plan’s fee schedule and ask how its fees are set. Merritt, who is a member of the AAFP’s Commission on Practice Enhancement, warns that this is where physicians should be most careful. “The most important issue is not to enter into a contract that pays below-market fees. If you start at market levels, you have a better chance of maintaining market rates for your services.”

You should also identify the CPT combinations and modifiers you bill most frequently and ask whether the health plan bundles those codes. If you won’t be paid for some of your common services, reconsider the contract or try to negotiate with the payer. Finally, find out whether the plan employs a pay-for-performance program and, if so, whether it provides true bonuses based on performance measures that make sense for your practice.

The AMA offers two valuable contracting resources: a list of 15 questions to ask before signing a managed care contract and a Model Managed Care Contract to help physicians familiarize themselves with the structure and language of a fair contract. (Both are available at <http://www.aafp.org/privatesector>.) The 15 recommended questions, which cover

everything from term definitions to payment policies, include questions such as the following: How does the contract define “medically necessary” care? What are your rights to appeal a reimbursement decision? Does the managed care organization have an obligation to pay you promptly?

The AMA’s Model Managed Care Contract was created to counter the typical managed care contract, which casts the physician as the weaker party. Olds encourages family physicians to read the Model Contract before tackling their own to get a sense of how a fair contract should be structured. The Model suggests acceptable contract wording on a range of subjects, including these:

- Section 3.6, “Coding for Bills Submitted,” tackles the misuse of CPT coding rules by payers, including bundling and downcoding.
- Section 5.5, “Cooperation in Credentialing,” addresses the issue of credentialing physicians in a timely manner (within 45 days).
- Section 5.8, “Quality Improvement,” outlines acceptable guidelines for quality improvement programs, which should be voluntary when tied to financial incentives.

Can you negotiate?

If you haven’t conducted a fee analysis of your current payers, it’s time to start. This is especially important when signing a new contract. A simple spreadsheet and some data gathering are all that’s needed for a basic fee analysis. List your most common CPT codes in a single column in a spreadsheet. In the next column, record your fees for each code. Then, list your reimbursement for each code from each health plan. Finally, calculate each health plan’s payment rate as a percentage of your fee. For example, if you charge \$50 for a 99212 office visit and Health Plan X pays you \$40, its reimbursement rate for that code is 80 percent of your actual fee. (For

■ Avoiding bad contracts is the first step in reducing your managed care hassles.

■ Several resources are available to help you know what questions to ask before you sign a health plan contract.

■ By reading your contracts carefully, you can identify unfavorable provisions and suggest changes to make them reasonable and understandable.

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another approach to fee analysis, see “Can You Negotiate Better Reimbursement?” *FPM*, October 2004, and download the accompanying spreadsheet, which allows you to replace sample data with your own.)

Once you have the numbers in front of you, you can see how your health plans compare to one another and identify points you can use in negotiation. Merritt, for example, negotiated successfully with a PPO that did not have a high number of participating family physicians. “Because the PPO had not raised their rates regularly, their fees had fallen behind the market. We contacted them and told them that we would no longer be able to provide services as participating physicians unless there was an adjustment to our most frequently billed codes. We were successful in obtaining a 15-percent increase,” he said.

Of course, not all practices have enough leverage to negotiate this way. Olds admits that negotiations are easier for bigger practices like his. Even so, it’s always worth a try, he says.

Olds has found that many physicians simply retain the same contracts year after year. “Managed care companies contract with a family doctor and then hope the family doctor never asks for a raise,” said Olds. “Unless you ask for a raise, they won’t give you one, and you’ll be working under the same contract you signed in 1977.”

Sometimes even asking for a raise yields disappointing results, but physicians shouldn’t give up – and may need to get tough. “In the last three years, we haven’t been able to get a raise from any managed care company without first resigning from that group to get their attention,” said Olds. “Once we do that, they will usually negotiate with us.”

Olds advises physicians that everything is negotiable. “Many times I have been told that something in a contract could not be changed because it was ‘corporate policy,’” he said. “Surprisingly, they will often change their corporate policy when I demand it.”

After years of reading contracts, Olds understands their nuances and has developed several negotiation strategies:

Suggest changes and add provisions. “If the wording is confusing,” said Olds, “cross it out and put it in words that you understand.” Olds also inserts provisions into his contracts. For example, he adds a 90-day “out” that says

if he is unhappy with the plan for any reason, he can resign within 90 days of giving notice. He writes this provision onto the contract, initials it and faxes it back to the health plan for approval. This often prompts several back-and-forth proposals until both parties reach an agreement.

Stress your range of skills. Remind the health plan that, as a family physician, you can care for the majority of patients’ concerns in your own office without referring to another physician or facility. This offers convenience to their members as well as decreased costs.

Diversify your plans. Don’t let one particular plan comprise too much of your total patient panel. Try to keep each plan to no more than 15 percent to 20 percent of your practice. In order to negotiate, you must be able to drop a plan without it disrupting your business.

Curbing credentialing chaos

After the contracting process, the next challenge is credentialing. This was once a more onerous task that involved submitting a different form for each health plan you contract with, but the process has been simplified considerably thanks to the Council for Affordable Quality Healthcare (CAQH), a nonprofit collaboration between health plans, networks and trade associations. CAQH has created a universal credentialing application, which more than 100 health plans now accept.

If even some of your plans participate in the Universal Credentialing DataSource program, you can save time by completing your credentialing on this site. To find out whether your plans participate, visit http://www.caqh.org/ucd_health_participating.html. If one of your plans doesn’t participate, contact them and encourage them to do so.

Next, you’ll need to obtain your CAQH Provider ID number by contacting your health plan or by calling the CAQH help desk at 888-599-1771. Once you have your Provider ID number, you are ready to register online at <https://caqh.geoaccess.com/oas/>, after which you can log in and input your credentialing data at any time. You need to enter your data only once, and your information will be stored securely on the site and sent to all the health plans you select. The information

■
When you negotiate with a health plan for better reimbursement, use a fee analysis to illustrate why an increase is needed.

■
Health plans rarely raise rates unless you ask; be prepared to argue your case when you make your request.

■
CAQH’s DataSource program has significantly improved the credentialing process by enabling you to use one online form for multiple health plans.

you provide fulfills the requirements for all participating health plans. You also have the option of saving your work and finishing it later or printing out blank forms, completing them and faxing or mailing them in.

For physicians, the DataSource improves on the old process. “There’s no contest,” said Merritt. “The initial data entry was slightly cumbersome, but the ability to have the information sent to insurers we participate with and any new plans that we wish to contract with saves a tremendous amount of time.”

Coping with prior authorization

Prior authorization for certain diagnostic tests, procedures and prescription drugs continues to be a source of frustration. In fact, it’s the biggest hassle facing family physicians who contract with HMOs, especially where imaging is concerned, according to Trevor Stone, one of the AAFP’s private sector advocacy specialists. “We’re seeing more and more health plans instituting radiology/imaging management programs because of the exorbitant amount of money spent on imaging, especially high-tech imaging such as MRIs, CT scans and PET scans,” said Stone. “Because so much money is spent on these tests, and because some do not meet the necessary criteria, health plans use prior authorization as a stop-gap.”

Merritt admits his practice suffers fewer headaches due to prior authorization because they are thorough. “We minimize the number

of initial rejections by making sure that we have complied with the plan’s requirements,” he said. “We are up front with the patient in explaining the plan’s rules and will not attempt to obtain prior authorization unless the patient agrees to pay the cost of the procedure if the prior authorization is rejected. In addition, we make sure that our request is as detailed as possible. The key is knowing your insurance company’s rules.”

The hassles of prior authorization are not likely to dissipate any time soon, said Stone. This month, UnitedHealthcare is introducing a prenotification pilot program in six states (Arizona, Colorado, New Mexico, Oklahoma, South Carolina and Utah) that will require participating physicians to notify United in advance of performing any outpatient imaging procedures. If United does not receive a prenotification request for the service, it will deny the claim, making prenotification as burdensome as prior authorization. The silver lining, if there is one, is that physicians who earn United’s quality and efficiency designations will be exempt from the program. This type of exemption, also known as “gold-carding,” can eliminate a significant amount of administrative work.

Electrifying your practice

Using technology wisely in your office can significantly cut down on hassles associated with health plans. It can also save you money. According to estimates by Milliman Inc., electronic transactions can save a practice

■ Prior authorization is often the biggest hassle for physicians who contract with HMOs and order many imaging tests.

■ Certain health plans are testing “gold-carding” programs, which allow physicians who achieve quality and efficiency standards to bypass the prior authorization process.

■ Several national organizations are working to reduce health plan hassles.

ADVOCATING FOR YOU

Here are some of the ways organizations are tackling the issue of health plan hassles:

- **Council for Affordable Quality Health Care (<http://www.caqh.org>).** In addition to creating the Universal Credentialing DataSource, CAQH has established the Committee on Operating Rules for Information Exchange (CORE), which aims to give physicians and other providers access to patients’ eligibility and benefits at the time of service using the EHR of their choice.
- **AAFP Private Sector Advocacy Division (<http://www.aafp.org/privatesector>).** The Web site offers updates on the AAFP’s advocacy efforts and links to the AAFP Health Plan Complaint Form, which AAFP members can use to report concerns about insurers and read complaints other members have submitted. The AAFP and state chapters use this data to identify trends, develop policy and advocate for fairer health plan practices.
- **Healthcare Administrative Simplification Coalition (HASC).** Made up of such groups as the AAFP, the American Health Information Management Association (AHIMA) and the Medical Group Management Association (MGMA), HASC’s goal is to reduce the administrative costs and the complexity of health care, primarily by eliminating waste from process redundancy. The coalition endorses the work of the CAQH, as well as the Patient Friendly Billing initiative (<http://www.patientfriendlybilling.org>), which strives for concise and easy-to-read health care financial communication among insurers, providers and patients.

approximately \$42,000 annually per physician.¹ That's more than pocket change to most practices.

Investing in a personal digital assistant (PDA) is a good start. For example, remembering the details of each health plan's formulary is an impossible task without an electronic tool such as Epocrates (<http://www.epocrates.com>). By downloading Epocrates' free software, you can have multiple health plan formularies, including Medicare Part D, at your fingertips in the exam room. This will help reduce the number of calls from the pharmacy asking you to choose a different drug for your patient because the one you prescribed was not on the formulary.

Physicians like Easton Jackson, MD, of Delta, Utah, find Epocrates to be "absolutely indispensable." Jackson has used Epocrates since his fourth year of medical school and continues to rely on it in his third year of practice. "I check Epocrates 10 to 30 times a day in clinic and the hospital," said Jackson. "Along with formularies, the drug interaction MultiCheck feature is very helpful. I've found a number of possible interactions that I never would have thought about if I hadn't checked. Patients have also been impressed when I've looked up their medications and told them that I was checking for interactions."

PDAs also can be used to simplify other tedious processes. Tony Witte, MD, of Danville, N.Y., appreciates the drug formulary database but also relies on his PDA for other time-saving chores. "Back in the dark ages (about five years ago), it was the potential for formularies on a handheld that convinced me to get my first PDA," said Witte. Now he also uses two programs to check medical necessity compliance: One is for a local insurer's requirements for CT and MRI compliance, and the other is for Medicare's National Coverage Determination database for lab tests.

Karen Smith, MD, of Raeford, N.C., credits her practice's electronic processes for bringing organization to her practice, especially in the claims submission process. Her practice's electronic health record system makes her documentation of services more complete. Following each visit, her office staff uses an electronic system to check claims for errors and then submits them electronically. This decreases the risk of denials and lost charges, and it

improves the turnaround time for payments.

Smith, who is also a member of the AAFP's Commission on Practice Enhancement, said that when carriers offer online eligibility verification, it helps her practice run more smoothly. "We can identify co-pays 48 hours in advance of the visit, and we instruct patients to present with the payment prior to the visit," said Smith. "In addition, the patient and I have an opportunity to know what is a 'covered service' and what is not prior to the visit if we review plan policies electronically. Then, theoretically, there is a decrease in the number of statements required to collect payment from the patient."

Smith's experiences are echoed by the Milliman survey, which found that electronic claims submission "reduces claim rejections and the need to resubmit claims multiple times" as well as "improves cash flow and reduces accounts receivable days because claims are paid more quickly."¹ The survey also found that electronic eligibility verification reduces collection and billing costs by quickly identifying which services are covered by patients' insurance.

Taking small steps

Health plan hassles aren't going to be resolved overnight; however, the ideas presented here are steps in the right direction. Additionally, national organizations are on your side, pushing for new ways to help you turn your attention from paperwork to patients. (See "Advocating for you," on page 35.)

Your patients can do their part, too. Encourage them to arrive at their visits prepared, with their insurance cards and co-pays in hand. Stress to them the importance of knowing as much as they can about their health plan benefits. This will instill a greater sense of responsibility for their health care and ease some of the administrative burdens for you.

Together, these small changes can make a difference in your practice and help loosen the red tape that binds you. **FPM**

Send comments to fpmedit@aafp.org.

1. Phelan J, Naugle A. *Electronic Transaction Savings Opportunities for Physician Practices*. Milliman Inc; January 2006. Available at: [http://www.emdeon.com/pdfs/Milliman-EDI%20Benefits\(r011806\).pdf](http://www.emdeon.com/pdfs/Milliman-EDI%20Benefits(r011806).pdf). Accessed Sept. 21, 2006.

Switching from manual to electronic processes can save practices time, money and headaches.

Some PDA programs offer health plan formularies and drug interaction information at your fingertips, which makes it easy to look up important information.

Electronic eligibility verification can help you quickly identify patient co-pays and covered services.