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The Health Insurance Portability and Accountability Act (HIPAA) of 1996; What it means for you and your business

What is HIPAA?

HIPAA (The Health Insurance Portability and Accountability Act of 1996) is the federal government's Act regarding specific PRIVACY, ELECTRONIC DATA INTERCHANGE (EDI), and SECURITY requirements for health care providers.

The PRIVACY requirements require "covered entities" (i.e.- those entities who provide health services to its patients) to protect privacy of individually identifiable Protected Health Information (PHI) which includes information about the patient including but not limited to Name, Address, Age, Social Security Number, Diagnosis, Medication, Medical History, Etc...contained in medical records. The effective date for HIPAA Privacy compliance is April 14, 2003.

EDI requirements impose standards for "covered entities" to transfer electronic information, such as claims and billing information. These standards for are for data interchange, code standards, and secure transmission. The effective date for EDI compliance has already passed and is October 16, 2002 unless a "covered entity" has filed for a one-year extension in which case the effective date is October 16, 2003.

The SECURITY requirements impose standards for "covered entities" to physically secure information contained in medical records. The effective date for to implement the Security Rule is April 18, 2005.

Who is Affected by HIPAA?

All "covered entities". The federal government defines "covered entities" who must comply with HIPAA as health care providers and clearinghouses who submit any health information in electronic form in connection with a transaction regarding a patient.

Why Do I Need to Comply?

There may be legal and financial impacts to you and your business. Penalties may apply to covered entities, as well as individuals within the covered entity. Civil, Non-Compliance penalties can amount to $100 per person, up to $25,000. In addition, penalties could range up to $250,000 and 10 years imprisonment per incident for those violations involving Criminal, Commercial Advantage or Personal Gain. Also, please note that EDI regulations require that effective October 16, 2002, Medicare pays all providers exclusively via standardized EDI transactions. As such, providers that do not comply with these EDI requirements will not receive payment from Medicare for services rendered to Medicare recipients. Finally, your organization could be sued by patients/personnel for HIPAA violations such as breaches to patient privacy rules if those requirements as outlined under the HIPAA Privacy rules are not followed.

Recommended HIPAA Compliance Plan

To make sure both you and your payers are ready to operate under HIPAA guidelines, you should examine every relationship which requires the exchange of private healthcare information and ask: What must we have in place to ensure that we are in compliance with HIPAA guidelines and to ensure that we can still get paid in a timely fashion? To answer this question, we recommend the following steps for achieving HIPAA Compliance:

1. Conduct a HIPAA Audit:

1. Develop a detailed checklist, which will clearly identify areas of compliance and areas of non-compliance and outline, step by step, tasks that will lead to achieving HIPAA full compliance.
2. *Using a template similar to this one, (see Sample HIPPA Tak Comliance Form on page 5)*
   a. *Outline the step-by-step tasks needed to achieve HIPAA compliance*
   b. *Identify and document those tasks that have been completed*
   c. *Identify and document those areas that currently comply with HIPAA guidelines.*

2. Identify Compliance Gaps: Required Areas of Review:

a. **Business Associates**
   1. Identify "Business Associates" (BAAs) for Provider to have signed agreements with BAAs to ensure the safekeeping of PHI.

b. **Document Storage**
   1. Review your documentation and file storage practices: *Fax machines, printers, files/records, server room access, drop box security, etc.*

c. **Communication of PHI**
   1. Review your communication practices: *Conversations, phones, radios, etc.*

d. **IT Procedures & System Controls**
   1. Review your policies and procedures to ensure computer systems/applications "time out"
   2. Review your procedures and policies to issue and enforce systems/applications passwords.
   3. Review your document data back-up, retention, and disaster recovery plans.

e. **Personnel Training - initial and ongoing**
   1. Review your employee Handbook and recommendations to amend employee handbook with HIPAA policies & procedures.
   2. Tasks to complete HIPAA training of current and new personnel as well as track training completion.

f. **Forms**
   1. Tasks needed to train personnel on the completion and storage of critical HIPAA forms

g. **Privacy Agreement for Personnel**
   1. Tasks needed for you to obtain signatures from all personnel stating

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they understand their responsibility to safeguard PHI.

h. Marketing and Fundraising

1. Tasks needed for you to comply with restrictions for using PHI in marketing and fundraising efforts.

i. PHI Policies Regarding Minors

1. Tasks needed for you to comply with PHI policies regarding individuals acting "in loco parentis" for a minor.

j. PHI Privacy Breaches

1. Tasks needed to formally handle an unauthorized disclosure of PHI
2. Tasks needed to write disciplinary policies & procedures to manage personnel who refuse to comply with HIPAA practices.

k. PHI and your Web Site

1. Tasks needed to ensure web site does not publish information that falls within the definition of PHI.

l. Recording, Changing, and Accessing PHI

1. Tasks needed for you to prepare to record PHI, and allow patients/personnel the ability to view and amend their PHI.
2. Tasks needed for you to produce a record of PHI disclosures to patients/personnel, as requested

In summary, it is important to begin the process of achieving HIPAA compliance as soon as possible since there are two very key dates, one in April of this year and another in October of last year, which require that Covered Entities, such as yourself, meet HIPAA Privacy and HIPAA EDI requirements. For additional information, go to www.cms.gov or call the HIPAA Hotline at 866/282-0659 for the most up-to-date information.

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Sample HIPAA Task Compliance Form:

HIPAA Task Compliance Form

Policies & Procedures xxx		Task xx xxx
1.	Organization Name	
2.	Organization Contact Name and Info	
3.	Individual Responsible for Task Completion	
4.	HIPAA Compliance Requirement	
5.	Reference Documentation	
6.	Current Practice / Policy / Procedure	
7.	Action Required for HIPAA Compliance	
8.	Completed by	Name:
		Date:
9.	Verified by Privacy Officer Name:	
	Signature:	Date:
10.	Verified by Security Officer	Name:
	Signature:	Date:

Money Matters

REIMBURSEMENT TIPS TO IMPROVE YOUR BOTTOM LINE

HIPAA & Managed Care Claims

For some time now, you've been hearing about the Health Insurance Portability and Accountability Act. Essentially, HIPAA seeks to improve efficiency of health-care payments by standardizing electronic data exchange while protecting the confidentiality and security of health-care data. HIPAA aims to accomplish this by enforcing strict standards for the electronic submission of patient information.

Those entities affected by the HIPAA regulations include health plans and health-care providers, including ambulance services, that transmit any health information in electronic form.

Covered entities should have been in compliance with the HIPAA Transaction and Code Set regulations by Oct. 16 (unless they filed in time to receive a one-year extension). Don't confuse this date with the HIPAA Privacy Rule compliance deadline of April 14, 2003—just five months from now.

To make sure both you and your payers are ready to operate under HIPAA guidelines, you should examine every relationship your service has with a health plan and ask: What must we have in place to ensure we are in compliance with HIPAA claims submission guidelines and continue to get paid in a timely fashion? To answer that question, we recommend you take the following steps.

Conduct due diligence

First, you must determine which health plans will require you to submit claims electronically. According to the Centers for Medicare and Medicaid Services, all private-sector health plans choosing to submit and receive claims electronically must use the HIPAA standards for electronic transactions developed by the American National Standards Institute.

All ambulance services and other health-care providers receiving Medicare reimbursement must file claims electronically beginning Oct. 16, 2003. However, the law includes an exception for "small providers of services," meaning those with fewer than 25 full-time equivalent employees or a physician, practitioner, facility or supplier (other than a service provider) with fewer than 10 FTE employees. Those that believe they're eligible for this exemption must file a waiver. If CMS approves that waiver, they won't have to comply with the HIPAA electronic transaction requirements. CMS will soon publish regulations detailing which entities will be eligible for this waiver.

Some of the health-care plans you work with may have applied for the one-year extension for compliance with the HIPAA transaction standards, giving them a bit more time to implement the new technologies. As part of your due diligence, you should communicate directly with each health plan to determine if this extension was filed.

If a plan has filed for an exemption, ambulance services may continue to submit claims via hard copy until the health plan is either equipped to receive claims electronically or until Oct. 16, 2003—whichever comes first.

HIPAA allows all covered entities, including ambulance providers, to perform these billing functions either directly or through a clearinghouse.

Prepare for electronic submissions

Once you determine which health plans will require electronic claims submission, you need to test your company's compatibility with the payer's billing software. Work with the health plan's information technology department to set up a time to test and verify the accurate submission of electronic claims. This testing process includes the following steps:

Standard Code Compliance. You should use the same format you currently use to submit your hard copy claims. *Example:* Are you using the most current ICD-9 (International Classification of Diseases, 9th Edition) and HCPCS (Health Care Financing Administration Common Procedure Coding System) codes? These familiar codes will continue to be a requirement, even for electronic submissions.

Important note: HIPAA requires health plans to accept the standard claim forms or to offer software that includes an electronic submission claim form.

Although HIPAA cannot prevent health plans from denying claims for such reasons as a lack of medical necessity, HIPAA states health plans must accept claims submitted in the standard formats.

Testing Schedule. Once the code sets are in place and you have verified compatibility, set up a schedule for testing all your electronic interfaces with those of the various payers. This includes internal and external interfaces to and from your payers, clearinghouses, claims processors, benefit managers and so on. The Administrative Simplification Compliance Act requires all HIPAA compliance entities, including ambulance services and health plans, to implement a testing phase beginning no later than April 16, 2003—provided you filed for the one-year extension by Oct. 15. (Again, do not confuse that April 16 testing deadline with the April 14, 2003, HIPAA Privacy Rule compliance deadline.) If you did not file for the extension, your compliance deadline was Oct. 16, and your testing and implementation should be well under way, if not completed.

Review contracts

Finally, initiate a discussion with your health-care partners about any modifications to existing contract language that must be included in an amended agreement, if applicable. Some of your newer contracts may already contain references to HIPAA compliance. However, older contracts may include only a reference to a unilateral amendment (no signature required) that can be sent to you to ensure your organization will be compliant with such programs as HIPAA. We recommend you consult with your legal counsel for additional information on this topic.

For the most up-to-date information on HIPAA, go to www.cms.gov or call the HIPAA Hotline at 866/282-0659.

The authors thank Doug Wolfberg of Page, Wolfberg & Wirth for his assistance with this article. Contact him at www.pwwemslaw.com.

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Money Matters

REIMBURSEMENT TIPS TO IMPROVE YOUR BOTTOM LINE

Effectively Market Your Services

Ensuring that local health-care facilities use your services takes more than simply giving them a good price. You also must know your market, know your community's needs and know your competition.

Before launching a successful marketing campaign, analyze your call volume reports to determine which hospitals and nursing homes generate the most calls and which should be targeted for additional marketing.

Begin by aiming your marketing efforts at the least productive facilities in your area to familiarize them with the services you offer. Make sure you have appropriate materials available to distribute, including company brochures, physician's certification statement forms, patient return envelopes and so on.

To determine the competitive environment and each facility's most critical issues, find out which ambulance providers they already use and what they think about the quality of those services. Ask specific questions about your competitors; include queries about their response times, their professionalism and their availability.

What factors does the facility review to determine which ambulance service to call first for a transport? What most influences those decisions: price, the quickest response times, the easiest PCS form to complete or crew attitudes?

Get in the Door

Making the initial contact poses the first challenge in any marketing campaign. The "front line" people—receptionists, admitting coordinators or nursing staff—may pose barriers hard to get through. When dealing with these gatekeepers, be persistent, but not pushy. Although these people may not be the ones you need to convince to use your services, they can point you in the right direction—or make it hard for you to reach the right people.

Seek out the case managers, social workers, discharge planners or transport coordinators who request patient transports. Also leave materials at the nursing stations for after-hours calls or for when case managers are not available to make the calls themselves. Pens and stickers with your 800 number may be low-tech, but they work. Busy nurses call the first number they see.

Encourage the nursing staff to contact your company for service and offer to make a return visit in a week or two to discuss their experiences. Without forcing them to call you, you are planting the seed of customer service by checking on their progress.

Secure a Contract

The second challenge: Many hospitals require you to have an executed contract with that facility before you can market your services within the hospital. This contract can be as simple as a one-page letter of agreement outlining such basic points as rates, payment and billing guidelines, procedures for terminating the agreement and the services provided. (For more information, see "Negotiate Winning Contracts" in the January *EMS Insider* and "A Managed Care Contract Negotiation Checklist" in the April issue.)

Health-care administrators must be cost-conscious, so you must demonstrate how your service can provide quality care and still offer competitive prices.

Remember: Your marketing efforts must comply in all respects with the federal anti-kickback statute, which prohibits giving money or items of value to facilities in return for transport referrals. Consult your legal counsel for questions on particular marketing practices.

Once you have such a signed contract, meet with the facility's case managers and ask them to introduce you to everyone responsible for ordering transports.

Important note: Make sure senior hospital administrators have recommended and authorized the use of your services before staff calls in the first transport.

Ensure Customer Service

The third challenge requires simultaneously addressing customer service issues while increasing awareness of your services. Callers must feel confidence in your company from the initial point of contact with dispatch through completion of the transport. Exhibit enthusiasm about your services and hand out business cards regularly. Offer to help by facilitating problem-solving or researching inquiries. Then follow up accordingly.

Ask about callers' experiences when calling for a transport. If you receive a negative response, always ask more questions to determine why the experience was not successful and to prevent a recurrence. Use this time to educate your audience about your company's internal guidelines, Medicare regulations and requirements and any other upcoming issues that may affect patient transports.

Maintain Relationships

The fourth and final challenge involves sustaining long-term business relationships. Treat your business colleagues as friends and as valued members of your community. Always be courteous, friendly and respectful of staff's time. *Example:* Plan to make your marketing calls in the afternoon to avoid the usual rigors of morning routine and unforeseen emergencies. Consistently revisit all local hospitals, not just those that give you less business. Remember, marketing involves both presenting the services you offer and ensuring the ongoing quality of services you provide.

Marketing ambulance services to local hospitals and skilled nursing facilities means more than simply selling a product: You must also offer reliability, integrity and honesty, along with consistent service at cost-effective rates. By understanding your market, knowing your community's needs and acknowledging your competition, you can develop a winning strategy for increasing your call volume and maximizing your revenue stream.

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Money Matters

REIMBURSEMENT TIPS TO IMPROVE YOUR BOTTOM LINE

Maximize Managed Care Reimbursement

The ability to effectively collect revenues can make or break an ambulance service, especially as revenue streams become more difficult to tap. The following steps can help significantly improve your managed care organization revenue:

1 Check the patient's insurance. Make sure it covers emergencies, and note if the policy requires an emergency provider to alert the MCO within 48 hours of the emergency transport.

2 Know relevant state laws and state MCO rules. State law may require MCOs to pay claims within a certain time period and may stipulate provisions for filing appeals or grievances over payment denials. Some state laws entitle non-contracted providers to payment of up to 100% of billed charges or for "reasonable costs" for emergency services rendered to commercial and non-Medicare Part C patients. Currently, 38 states have statutes restricting, limiting or otherwise prohibiting medical providers from billing HMO subscribers.

3 Review your Medicare HMO agreements carefully in light of the new Medicare fee schedule. As of April 1, ambulance services without contracts must accept assignment from Medicare HMOs. However, services with Medicare HMO contracts should continue receiving previously contracted rates—unless the contract incorporates the fee schedule provisions and rates.

4 Adjust your rates. Make sure to bill Medicare HMOs at least your Medicare-allowable base rate and mileage rate. Include any rural mileage adjustments the fee schedule permits in your area. Know the allowable emergency rates for the local EMS system if regulated, and bill MCOs at these rates for non-Medicare patients.

5 File electronic claims if you are a contracted provider. This may speed up processing and decrease errors, leading to fewer rejections. It may also allow you to check the status of your claim online, eliminating the need for numerous phone calls. Check the system requirements with the insurer's provider relations representative to ensure the MCO's ability to work with electronic claims.

The Health Insurance Portability and Accountability Act Transactions and Code Sets regulations will require most ambulance services to file all Medicare claims electronically after Oct. 15, 2003, and many private insurers may soon require electronic filing as well.

Filing electronic claims can prove impractical unless you provide services under a contract or perform a large volume of services for an insurer, however. If you file a paper claim, you may still be able to track the status of your claim online. Check the insurer's Web site to see if the MCO allows electronic follow-up.

6 Use your provider number on the claim. An HMO may assign even non-contracted providers a provider number. Check a recent explanation of benefits to obtain your provider number, or ask the HMO for that number.

7 Ensure the insurer has your current federal tax ID number and billing address. Insurers will reject claims or process them manually if the provider's address or tax ID number differs from what they have on file.

8 Complete run reports. Make sure field providers properly complete every patient care report. You may need to submit them to support any appeals, especially if the insurer questions medical necessity.

9 Obtain all appropriate signatures at the time of the call. If a patient can't sign the claim, ask a field provider to document why.

10 Never use highlighters or labels on paper claims. They interfere with prompt processing and payment.

11 Meet MCO timely filing deadlines. Know applicable state law that regulates MCO filing deadlines, and file claims within this period whenever possible. If a patient provides insurance information after the filing deadline has passed, still submit the claim. After the insurer rejects it, appeal the rejection with a routine letter outlining the circumstances. You may need to provide a copy of your billing log to demonstrate your attempts to gather the insurance information.

Providers with MCO contracts must take particular care to file claims before the timely filing deadline. Insurers typically reject appeals from contracted providers, forcing them to write off the claim. (If you obtain insurance information late, try an appeal anyway.)

12 Appeal rejected claims. Mail the rejected claim back to the MCO appeals department with a letter quoting any applicable state law; attach a copy of the relevant section of state law. You may also want to send a copy of the letter to the governing entity for health plans in your state. If the insurer still rejects the claim based on lack of medical necessity, you may need to write it off. An MCO typically has the right to make final determinations of medical necessity, subject to the patient's or the provider's appeal or grievance rights.

Batch rejected claims so you can address them in one phone call or appeals proceeding. Note, however, that many HMOs will discuss only three claims at a time.

If you can't resolve a claim in two phone calls, ask to speak to a supervisor or leave a message for the supervisor to call you back. Occasionally, a supervisor can override the MCO system and get the claim processed and paid.

13 Learn what each MCO requires. Besides the steps suggested here, you should prepare and submit claims following guidelines in the MCO's provider manual or in your contract with that MCO. Missing or altering a step in this process can result in denied claims.

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Money Matters

REIMBURSEMENT TIPS TO IMPROVE YOUR BOTTOM LINE

An MCO Contract Negotiation Checklist

Once you've determined you want to contract with a managed care organization, assess your strengths. The following factors can make a contract more desirable to the MCO and give your service more contractual leverage:

Geographic exclusivity. State law may require MCOs in a 9-1-1 franchise area to contract with a provider for emergency services or pay 100% of billed charges (except for the caveats mentioned below). The MCO can save money by contracting for these services, even at 100% of billed charges, by eliminating the need to process each claim manually.

Networks. MCOs look favorably on ancillary ambulance providers that have good relationships with other MCOs, physician groups and hospitals.

Onestop shopping/price sensitivity. MCOs often prefer to contract with providers that can provide lower-priced services for non-emergency business than competitors and/or an array of services such as emergency, non-emergency, wheelchair and air ambulance.

State and federal laws make certain contractual elements non-negotiable. However, the following items should be negotiated to everyone's satisfaction:

Timely payment. The contract should stipulate how long you have to submit a bill and when the MCO must pay that bill. It should also detail the process your service must follow to submit bills after the timely filing deadline and any timely filing procedures required by your state.

Clean claims requirements. Specify the MCO's claim requirements.

Billing manual. The MCO should provide you with a billing manual.

Written appeal and grievance policies. Agree on how to handle payment denials.

coming soon

- Could You Use a Blood-Gas Analyzer?
- Amiodarone & Lidocaine Compared
- Ambulance Service Hires Physician Assistants

Balance-billing stipulations. Spell out whether your service will be allowed to balance-bill patients if the MCO denies the bill for lack of coverage or the patient is ineligible for a service. Also stipulate whether your agency must give the patient advance notice of non-coverage, and if so, in what format. Because balance-billing provisions vary by state, consult your attorney before finalizing this provision.

Define Payment Rules

The contract should specify the following:

- Authorization of services by the MCO should guarantee payment.
- The MCO will not conduct concurrent or retrospective claim reviews (that is, the MCO may not deny payment for services previously authorized).
- Covered services must include emergency services.
- The definition of emergency services should include BLS-emergency, ALS, ALS-emergency, critical care transport and paramedic intercept.
- The MCO should pay a per-copy rate for copying all medical and administrative records.
- Services must be paid based on the predetermined rate schedule and not based on the lesser of the negotiated rate or the MCO's usual and customary rate or internal fee schedule.

Try to negotiate a provision that deems all 9-1-1 dispatches "emergencies" for payment purposes under the contract.

Strive to negotiate payment for 100% of billed charges for emergency services. Some states require MCOs to pay only "reasonable fees" or "reasonably necessary costs" for emergency services, but providers should take the position that "reasonable" means 100% of billed charges. MCOs may, of course, properly deny claims for a lack of medical necessity or patient ineligibility for services.

Get to know your MCO contacts. Agreements can be lost when providers don't have the right contacts within an MCO. Typically, an MCO's Provider Relations or Provider Contracting Department will handle contracting for ambulance services. They may assign this task to different people in the department for different geographic areas. Providers that cover multiple counties or townships should get the names of all their contact people. Then try to narrow the negotiating process to include just one MCO representative with the authority to negotiate one agreement for all locations, provided those locations are all in one state.

Follow through. Stay on top of the process. MCO officers often juggle myriad tasks and contracts. In this environment, they tend to first deal with the "sticky wheel," or the provider who is seen as the most vocal, the most prompt and the most visible. You can do this by asking your contracting hospital and/or medical groups to call and recommend your services. You may also want to ask the MCO to e-mail you a draft of the contract. (MCOs sometimes agree to e-mail draft agreements, as they consider drafts non-binding.) Contact the MCO contracting officer a few days after the arrival of the document to follow up and negotiate your rates.

Be persistent. While an MCO may not be interested in contracting initially, this can change for any number of reasons and at a moment's notice. To stay on top of the changes, stay in touch with the MCO's contracting personnel. Make a note to call them every couple of months and ask them when you should call back. Doing so can make all the difference.

Negotiating a successful contract takes knowledge, patience and an understanding of the MCO's need to ensure excellent service to patients at a reasonable cost. A successfully crafted contract can better meet the needs of the patient, the health plan and the ambulance provider.

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Money Matters

Negotiate Winning Contracts

As EMS administrators across the country struggle to gain financial and operations efficiencies without sacrificing quality of care, many are considering whether to contract with third-party payers. Managed care organizations (health maintenance organizations, preferred provider organizations and independent physician groups) have a vested interest in contracting with EMS providers that deliver high-quality service at competitive prices. Contracts with MCOs can also benefit both municipalities and EMS providers by:

- Increasing patient referrals;
- Increasing EMS reimbursement;
- Decreasing or eliminating the need for taxpayer subsidies;
- Improving EMS care;
- Allowing EMS providers to control nonemergency transports;
- Providing incentives to EMS systems to offer one-stop shopping for all transportation services; and
- Allowing the EMS agency to keep services in-house vs. outsourcing.

Before entering into contract negotiations, analyze your current system as well as the risks and benefits of such a contract. Consider the following:

What percentage of the region's population belongs to MCOs and to this MCO?

For what emergency medical services does the payer currently reimburse? (Because HMOs must pay 100% of billed charges for all emergency services, why contract for services for which the system is already being paid in full? Can you negotiate discounts for prompt payment or referrals for non-emergency business?)

What does you hope to accomplish by contracting with an MCO?

Does your organization have the excess capacity to provide additional services?

What new infrastructure would you need to support new services?

Does your agency receive a subsidy? If so, how would the contract impact it?

You should also examine the services you offer to determine if private payers will find them desirable. Typically, MCOs prefer to work with agencies that provide a full array of medical transport services. Such organizations have a much better bargaining position than those offering limited services. They'll also find it easier to obtain an exclusive or first-call contract than an organization that provides minimal services.

However, an organization offering only limited services can still bargain effectively with MCOs. A payer can gain significant economies of scale by contracting with large ambulance systems even at 100% of billed charges (*Examples:* reduced data-entry costs from fewer claims requiring manual processing and prompt-payment discounts offered by the providers).

Finally, contrary to popular opinion, HMOs consider much more than price when making contracting decisions. They also evaluate response times, quality of care and the providers' relationships with local hospitals and physicians.

Before negotiating a contract with an MCO, you should know exactly what state and federal laws and regulations require third-party payers to provide and how they must act. This knowledge can level the playing field and eliminate unnecessary discussions during contractual negotiations. *Some basics:*

Each state requires an MCO be licensed before it can conduct business in a particular geographic area. Before obtaining this license, the payer must demonstrate it has an adequate provider network in place to provide a predetermined menu of services—including EMS—in that area. Every state requires MCOs to either contract with EMS providers to provide those services or pay 100% of billed charges to providers without contracts.

State and federal laws require most MCOs to reimburse providers within 30 to 45 days after receipt of claims. If the MCO does not adjudicate a claim within that time period, the MCO must pay late fees to the EMS provider—even to a provider not under contract.

The Emergency Medical Treatment and Active Labor Act requires hospitals to contract with local EMS providers to ensure adequate access and transport for emergency services.

MCOs and their subcontracting providers may not balance-bill patients for rendered services, other than for copayments and deductibles. However, EMS providers currently aren't subject to these requirements unless they operate under contract with the MCO.

Recent changes in Medicare law have created confusion among payers and providers. Many MCOs now misinterpret Medicare Part C rules to mean they need pay only the Medicare-allowable charges and not 100% of billed charges for Medicare HMO patients. A provider that contracts now with an MCO will still get those contracted rates when the new Medicare fee schedule takes effect—even if those rates are higher than the fee schedule rates. Conversely, an EMS provider without a contract will be required to accept Medicare's rates by default.

The benefits of a good contract can be impressive, including increased revenue, improved patient care and long-term viability of the EMS system. ■

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Don't be afraid to re-negotiate insurance cc

Here's how to re-negotiate from a position of strength to be paid what you deserve

Today there is little connection between actual charges for medical services and reimbursement by third-party payers. Fee schedules are legacies of days gone by, often inflated to accommodate one or two contracts that are still based on billed charges. The consequences are that human or technical resources are required to make huge "adjustments" to charges, confusing financial statements, and unintended cost shifting to uninsured, underinsured, and indigent patients.

Insurance companies play by a different set of rules. Insulated from the same regulatory environment that limits collective bargaining by physicians, they are responsible first to shareholders, second to customers (who pay premiums), and last to contracted vendors. While appalling to physicians who compare their own value in the health care system to non-physicians, the salaries and bonuses paid to executives of these companies reflect the business values of a publicly held company.

What is the insurance companies' perspective of their physician contractual relationships today? Many feel that most doctors and office managers lack the skills to deal with insurance companies and negotiate rates. In order to receive t compensation that you deserve, you nc to periodically evaluate your contra and re-negotiate those contracts that performing poorly.

The consequences of not periodical evaluating contracts are serious. First, y can miss your deadline and be stuck wi your previous reimbursement for one ad tional year. Second, if the insurance cor pany owes you money, you can't retr

The Bottom Line

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Does this scenario sound familiar? You check a series of explanation of benefits forms and find that most of your payers are paying 50% of your billed charges. If you compare your biggest payers, you find that they are paying 85% to 90% of what Medicare reimburses you for your services. A typical small business response to this situation might be to call the insurance company and ask for a review of your fee schedule. They might throw you a bone consisting of a 3% increase over your previous payments. You thank them and hang up feeling like you have been taken advantage of.

If that scenario is all too close to home and it happens more often than you would like, this article is for you. To help you improve your contracts with your payers, we have interviewed Susan Charkin, president of Healthcents, Inc. (*www.healthcents.com*), a physician contracting, software, and consulting company with extensive experience in helping urologists and other specialists negotiate more profitable payer contracts. After reading this article, you should be able to evaluate your existing contracts, re-negotiate them from a position of strength, decide which contracts to drop, and collect the out-of-network fee from your patients for those dropped contracts.

spectively request review of money they owe you. Most contracts provide for the collection money for a specified time period, perhaps 90 days in arrears. Once you get past this window, a retrospective review of fees owed may not be possible. Finally, you can expect to be paid less than what you deserve and less than others who are proactive in their contract negotiations.

Evaluating a contract

Unless you have been a medical director of an insurance company or have an MBA, chances are that you have few skills in negotiating with insurance companies. The fact is that the insurance companies often need the physicians more than the physicians need the insurance companies. Insurance companies have licensure requirements and geographic coverage requirements to maintain their licenses. Also, providers who are the only urologists in the area often have great leverage.

If your book of business consists of $500,000 paid the past year and 1,000 patients, the payer will likely pay attention because they have to serve the employer groups and patients in their networks to maintain revenue flow and customer satisfaction. Too many of us are fearful of potentially irritating insurance companies. However, if you have urologic services for their insured customers, geographic advantage, and/or a large book of business, then these companies will want to do business with you.

You need to periodically evaluate your contracts and re-negotiate those contracts that are performing poorly.

With a regular review of your largest contracts and with a successful contract negotiation with the insurance company, it is not unreasonable for urologists to achieve a contract for 150%+ of Medicare for urologic procedures and 100%+ of Medicare for office visits. This, of course, is highly dependent on your Medicare locality, market position, geographic advantage, size of practice, book of business, number of patients, employer groups

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served, number of subspecialtics, etc.

Contract negotiations adhere to the 80% rule. In this case, 80% of the time should be used to prepare for the negotiation and 20% to negotiate. It is important, where possible, to benchmark your rates to local Medicare rates and to rates of other similar urologists in your region, state, and the rest of the country.

It is also important to model your practice to determine whether or not it's financially better off in the payer's network at a given level of reimbursement. This may surprise you, but, it is not unusual for a practice to be better off out-of-network if reimbursement is not high enough. Unfortunately, this kind of modeling may require a level of business analysis that many practices are unfamiliar with. A product such as Healthcents' Revolution Software can help you perform these benchmarks and quickly reach a decision on how much reimbursement you need to remain in a payer's network. At a minimum, you should benchmark your rates to Medicare and have knowledge of the key terms in your agreement.

Negotiating your payer contracts is a team sport. It involves your business manager, the doctor, and often an experienced negotiator with skills in this area. UT

Your Practice

Implementing Contract Negotiations

LAST OF THREE PARTS

BY SUSAN E. CHARKIN, MPH

In Part 1 (November issue), we began by offering a list of data to collect to give you a clearer overall perspective of the negotiating process, and thus a solid bargaining advantage. This is also the information that the payer would prefer that you ignore or overlook.

Part 2 (December issue) covered how to create a simple but substantive proposal letter that is sent to the payer's contracts manager. The letter introduces the practice, requests a rate increase and, most importantly, states the reasons for the proposed increase.

Part 3 discusses a strategy for implementing actual negotiations with third-party payers.

Negotiations with third-party payers can be tricky. Be sure to have command of all your facts and emphasize the overall advantages of contracting with your practice.

Promote the big picture

Payers who are evaluating your need for a new contract or for increased reimbursement may be striving to achieve their individual departmental goals rather than organizational goals. Don't hesitate to point out the advantages to their company in the overall, long-term scheme of things. Dollars and cents talk. If you have a large book of business and patient base, it is key that you remind the payer of what is at stake.

First- and second-level negotiations: As described in the last issue, prepare your proposal letter and send it to the payer's first-level contract negotiator, who can often be identified through a simple phone call asking for the contact person to whom your proposal should be addressed. It is tempting to find a way to leapfrog over first- and even second-level contacts, and go directly to the top-level contracting decision maker. Resist this temptation. While a first- or second-level negotiator has little decision-making authority, violating chain of command can be perceived as a serious offense by many payers which could lead them to ignore or resist your request.

The waiting game: In many cases your it may take several weeks for your proposal to be reviewed and analyzed by various internal payer departments, such as actuarial and sales, before a counterproposal is submitted back to you. Be patient but simultaneously remember the adage about the "squeaky wheel." Continue to follow up in a timely and courteous manner with your first-level negotiator, preferably by e-mail, so that you have written documentation should you need it when you progress in your negotiations with senior payer management. This can be useful if you are not getting return e-mails and other follow-up correspondence to show you acted in good faith and have not been receiving correspondence. First-level contracts personnel often send a quick e-mail but do not follow up via other methods of correspondence such as phone or U.S. mail.

Take it to the top: Once you go back and forth with your first-level negotiator and receive your last counterproposal, and assuming it is not what you need to close the deal, now is the time to bump it up the payer food chain. Let the first-level negotiator know that you are dissatisfied and that you will be contacting his/her manager or director to complete your negotiations, as they are individuals with the power and decision-making authority to understand your needs and how your business benefits their organization.

Good cop, bad cop: On the provider side, in many cases, it is advantageous to have your billing director or practice manager implement negotiations with the payer. As negotiations progress, and you are working with senior level management to finalize selections, it's a good idea to switch up and have your senior management work with their senior management. On your end, get a physician advocate involved who can strongly and clearly represent the practice's needs from a owner/shareholder perspective. In many cases, this person can help turn the tide in the practice's favor and close the deal. This is where teaming and leveraging the personnel in your practice helps.

Finalizing the contract

When the contract arrives for your signature, check to verify that it includes the reimbursement rates and terms you agreed to. Once you sign your agreement, send it return-receipt certified mail to ensure that the payer has received it.

Just because you have sent in your agreement doesn't guarantee that the payer will implement it. Staff changes, mergers, acquisitions or even a change of heart by someone in payer senior management (unfortunately, despite the ethical considerations on their part, this does happen occasionally) can sometimes allow your contract to fall into the payer's "black hole." To avoid this, have your staff follow up regularly with the payer to ensure that you receive a fully executed agreement (signed by both parties).

After a payer mails the fully executed agreement, the contract is sent to claims or provider services to load the new rates and terms. As such, after your receipt of the fully executed agreement, contact the general number for provider relations and verify that they have loaded your new contract with the correct rates into their systems. There is nothing worse that going through this entire process only to learn that they are still paying you under your old agreement and that now you not only have the problem of getting the contract loaded properly, but the headache of having to retrospectively collect money on incorrectly paid claims.

In summary, remember to:

1) Leverage the facts from your information gathering and proposal letter (as outlined in the first and second parts of this article series).
2) Send your proposal letter to the correct first-level contract negotiator.
3) Work through the payer's chain of command.
4) Leverage your personnel.
5) Don't take no for an answer. A "no" just means you just haven't spoken to someone that's going to tell you "yes." Always persevere. ■

Ms. Charkin is the president of Healthcents, Inc. of Salinas, Calif. (www.healthcents.com), a physician contracting and consulting firm.

Your Practice

Negotiating HMO and PPO Agreements

The many things payers don't want you to know, and how we can help you navigate the pitfalls

FIRST OF THREE PARTS

BY SUSAN E. CHARKIN, MPH

When it comes to negotiating a physician agreement with a third-party payer, knowledge is power. There is a direct correlation between your level of success and how well-informed you are about payers' needs, their knowledge, and their bargaining strategies.

Here is what to keep in mind when dealing with third-party payers, so you can leverage your power and increase your chances of entering into a productive provider contract.

Charge Master Analysis

The Charge Master Analysis is a spreadsheet that tracks all of your reimbursements in a variety of ways: by payer, procedure, timeliness of reimbursement, average reimbursement per payer, average reimbursement by procedure, and monthly, quarterly, or annual reimbursement per payer or procedure.

Such a spreadsheet can provide you (and the payer with whom you are negotiating) a clear and indisputable picture of where your reimbursement is coming from, which procedures are most profitable for you, and which reimbursement items must be improved to be acceptable. This information provides you with an invaluable bargaining tool to use during negotiations and can be quite convincing to a payer. It is essential, however, that every figure in your spreadsheet be documented and supported by evidence that you can produce on demand.

Third-party payer reimbursment

Payers profit by negotiating contracts favorable to them and by negotiating rates based on whatever the providers in a particular market will tolerate. Try to get a true picture of the reimbursement others are receiving in aggregate by product line. For PPO business in particular, we recommend that physicians try to benchmark reimbursement for their top 40 codes against what other similar providers are receiving, in the aggregate, in their Medicare locality for these same services. One product available is Healthcents' Revolution Software, an internet-based software tool, which can assist you in many of these decisions including obtaining this aggregated information and determining whether in-network or out of network payer participation is right for you.

When establishing your agreement structure with a third-party payer, it is important to be up-to-date about bargaining strategies and payer needs.

Medicare allowables

What can you do when a payer quotes you on the basis of apples and you've been charging by the orange? For example, you may currently be reimbursed at 140% of Local Medicare Locality rates. Yet, when you renegotiate your agreement, you find that this same payer now wants to reimburse you a percentage of their proprietary fee schedule.

Are you better off? Maybe, maybe not. Some codes may be higher and some lower than CMS allowables, depending on a unique blend of factors that impact the market rate in your area (at least from the perspective of the payer).In order to make this determination, you need to find out the specifics of what comprises the "local payer fee schedule."

Your best response is to choose your top 40 CPT codes (top 20 by volume, top 20 by reimbursement), and provide them to the payer with a request for their reimbursements on those codes. The key is to use the 90/10 rule. Choose the top codes that represent about 90% of your business and not the other several hundred that represent only 10%. Place the payer's proposed reimbursement for the top codes alongside Medicare's allowables and the reimbursement that you are currently receiving for them. You'll be able to make a more relevant, apples-to-apples comparison. Also, you will be placing the focus where it needs to be—on the codes that are driving the most revenue into your practice.

Assess geographic leverage

How close, geographically, are your neighboring urology/renal specialists? If you are one of only a few, are the only provider in your area, or you provide a service that others don't, you have additional bargaining power.

Reimbursement rates

If your reimbursements at the contracted in-network rate are not high enough to be viable, and there appears to be no room for negotiating a better rate, consider staying out of network and billing the patient for the balance of the unpaid charges. If you're debating the value of an existing contract, and considering renegotiating or terminating your agreement, weigh the pros and cons by anticipating your losses.

Determine the revenue you would lose if these patients are required to seek urology/renal service elsewhere, and compare this to the out-of-network revenue you might receive in its place. You also need to think about the effect on your practice of displacing (and annoying) patients.

Limit contracts

Accepting blanket reimbursement rates for all coded services can frequently result in significant and consistent losses when some of those codes reimbursed at below cost. In some cases, it may make sense to identify and request a higher rate for your high cost services. If the payer won't agree to pay the higher rate for these carve-outs without simultaneously accepting the standard reimbursement for the low-paying codes, it may be wise to cut your losses by terminating the agreement.

Gathering the information is the first step. Next month, we will discuss how to write your proposal letter and the actual negotiation process as you move forward. ■

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Your Practice

Writing an Effective Proposal Letter

For starters, avoid excessive explanation and detail as the main points in the letter might be lost

SECOND OF THREE PARTS

BY SUSAN E. CHARKIN, MPH

In Part I, we provided guidance on the kinds of data you need to gather prior to negotiating reimbursement rates with third-party payers. Now it is time to put this information to work by preparing a simple but substantive proposal letter that is sent to the payers' contracts manager that introduces the practice, the request for a rate increase and, most importantly, the reasons for the proposed increase.

To begin with, avoid over-explanation and unnecessary content. Sending a letter with too much detail may risk losing key aspects of the basic message. Letters that recount the qualifications of a single doctor in the practice, or even about the practice itself, lose their effectiveness quickly. Similarly, explaining the many subspecialties and educational background of each doctor can distract from the purpose, which is to get the payers attention to focus on who your practice is and why it should get an increase. An effective letter is no more than one to 1½ pages long. Remember that this letter is a sales pitch and attention getter, written from the perspective of payers explaining succinctly why they should increase your reimbursement. Payers need a good reason to give you more money.

PHOTOSTOCK

A solid proposal letter explains clearly and concisely why your reimbursement rate should be increased.

List the physicians in your practice, and their network affiliations.

To get payers' attention, consider the following structure of the letter:

- Start with the name of your practice, your book of business with the payer and the number of patients or cases you treat per year. The adage that "money talks" could not be more apropos here. Practices with large books of business and large patient loads have leverage. Payers want to maintain practices in their networks that keep their patients and large employer groups happy. This is where the payers get their business. To the payer, their most important customer is usually the large employer who brings in big premium dollars that can be invested to generate more profits.
- Next, talk about your geographic advantage, if there is one. For example, if you are the only full service urology practice between Phoenix and Tucson, you have some leverage. Payers will need to meet individual state licensure requirements to have a certain amount of specialty physician coverage within a specific geographical radius. It could be critical to a payer's coverage strategy to have you in its network.
- Talk about your specialties and qualifications, but be careful not to go overboard. We all are passionate about what we do and why we are deserving of recognition. In one to two paragraphs at most, describe the qualifications and specialties of your practice and what makes you different and unique from your competition if you have any.
- Explain that you cannot keep treating their patients at the current contracted reimbursement. Specifically, state that you have analyzed your current reimbursement levels and have determined that the rates in your current agreement are not competitive with your other payer agreements and you are losing money on many of the procedures you perform. As such, you have attached the following as a proposal for reimbursement.
- Provide a clear list of items that you are seeking. Keep it short. Depending on the structure of your agreement and your analysis, you may state that you are asking for a 30% increase in Payer X's current fee schedule for all of your codes. Or, you may state that you are asking for 200% of local Medicare rates for the following 40 codes, which represent your highest volume and highest priced procedures. You may also want to carve out CT and other radiology services as well as IMRT and pathology codes since many payer agreements either pay these at substantially lower rates or no rate at all. The key, as we explored in Part I, is make sure you have the data and the basis to ask for your increase, and that you know what you are asking for and why. You may also need these data later in the process to finalize your negotiations.
- List the physicians. If you have a large practice with prominent physicians, list who they are and mention if they have a longstanding relationship in the payer's network.
- Time is money. Remember to place a timetable when you expect to hear back. For example, "thank you for considering this proposal and we are expecting a reply back no later than XX/XX/XX." Three weeks is a good rule of thumb.
- Make sure the letter is directed to the correct person and department in a payer's organization. To determine this can take many calls to the payer and different parts of the organization. If this starts to be too drawn out, then call the corporate office or the president's office in the state you are in to find out where to direct a letter.

In summary, the proposal letter is the first correspondence with the payer which communicates your request for an increase and the reasons. Payers are business entities focused on generating profit. Many are publicly held corporations which trade stock. They need to understand the business value of why your practice needs more money and why they should give you that money to keep you in their network. ■

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