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10 Managed Care Best Practices for Urology

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ASCs and their urologists can often feel intimidated and ill-equipped to deal with the negotiation process. They may accept what payors offer and begrudgingly sit tight year after year knowing that they should get

much more money from their payor agreements but aren't getting it. However, they often don't know the steps to take to obtain this incremental revenue. To be more effective in achieving results when you actually negotiate with payors, here are 10 ASC managed care best practices for urology. This article is written in collaboration with Deepak A. Kapoor, MD, chairman and CEO of Integrated Medical Professionals, a physician practice consisting of 90-plus physicians in the greater New York Metropolitan area, and a healthcare executive in the northeast market who wishes to remain anonymous.

1. Plan for the possible impact of changes by the Obama Administration to Medicare and to provider reimbursements. While the various proposals under consideration would likely retain the multiplicity of commercial health plans in play today, there is some speculation that the U.S. government may also create a governmentsponsored payor to compete with commercial payors. Such an outcome would further increase the pressures on ASCs and their physicians to perform services at lower reimbursement levels.

Early proposals suggest that Medicare reimbursements may decrease for clinical providers and facilities alike. Many payors follow Medicare guidelines for determining both charges and reimbursement. As such, urology providers and facilities are responding to these challenges by proactively drafting responses to Medicare to justify the cost of major urological episodes of care. "Cost" to a payor is not actually the physician cost of providing care, but rather a minimum fee set by the payor's actuarial department that, in many cases, is based upon market forces and not the actual cost of providing care.
Pick 10 of your primary cases and determine the cost of providing care for each. Unbundle CPT codes and account for all services including ancillary services such as anesthesia, lab, radiology, pathology, supplies, etc. Having this information can assist you in explaining the cost of providing your services and can be used to justify your requested increased reimbursements to payors during contract negotiations.

2. Prepare for 2010 Pay for Performance. It is important to track the trend of quality and costs since urologists' fees will, at some point, most likely be linked to P4P. P4P programs link physician adherence with recommended case management processes and protocols to financial incentives. These programs should be measurable and based upon key clinical indicators. The managed care industry is actively working with CMS to help develop appropriate standards for such future implementation.

The National Committee for Quality Assurance has been a central figure in the movement towards P4P. NCQA works with large employers, policymakers, doctors, patients and health plans to determine measurements and improvements in this arena. NCQA's Healthcare Effectiveness Data and Information Set tool is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

As such, it is worthwhile to start preparing now for P4P by collaborating with your major payors by reviewing ongoing efforts by NCQA in developing HEDIS standards and compliance goals, and knowing how/when these will impact your ASC. Also note that there should be simple methods to administer and monitor quality and cost so both you and the payor can easily understand your indicators. Toward this end, compliance protocols, policies and reimbursement methodologies should be spelled out in detail in the body of your payor agreements or as separate amendments.

3. Develop and monitor urological standard quality of care measures. Patient care is improved as a result of the sharing of "best practices" and creating aggressive quality management and utilization review programs. For example, it is recommended that ASCs go well above the Medicare baselines for chart review,

as well as maintaining detailed data and documentation on their hospital readmissions and infection rates. ASCs should also verify and document their continual compliance with internal group and ASC protocols.

Physicians should regularly exchange metrics, ideas and thoughts concerning patient care and practice efficiencies. Consider the institution of a monthly morbidity and mortality report, development of best practice models for operational efficiencies, institution of standardized protocols for commonly performed clinical conditions as well as standardized reporting for in-office surgery and diagnostic testing. Again, these practices will assist you in preparing your ASC for future payor reimbursement under any new P4P and/or Medicare reimbursement methodologies.

4. Form a urological "supergroup." Urologists first dipped their toes into collaborative ventures to enhance patient access to services and control quality via the formation of lithotripsy cooperatives. This was done under the auspices of an ASC in some instances, and, in others, urology participation in ASCs followed after physicians experienced the advantages of non-hospital based surgical sites.

Urologists' next logical step towards controlling their destiny is to fully integrate solo and small group practices into financially and clinically fullyintegrated group practices. These new entities have resulted in demonstrated improved efficiencies, including reduced treatment and non-treatment costs, improved outcomes, expanded patient access and improved healthcare services for both insured and non-insured patients alike. These group practices cannot exist in name only but need to satisfy the unified business test which implies a very high level of integration. It is also important to note that these entities are required to comply with both local state and federal guidelines. Any such structure should be developed with legal counsel that is familiar with both local state and federal guidelines regarding integrated practices.

5. Expansion into non-urological ancillary services. Additional advantages to the economies of scale offered by a large group practices are traditionally termed ancillary services. However, large group practices have introduced a new comprehensive urological care model enabling urologists and their ASCs to have some form of control over all the services that impact the patient, such as diagnostic radiology, laboratory and pathology services. However, before getting started, contact each of your contracting and non-contracting payors individually for their credentialing and payment protocols since each will have completely different policies and procedures relative to this issue.

If you build it doesn't necessarily mean the patients will have automatic access to your new services. This is as much as credentialing issue as a contracting issue. Assuming that these new services are covered under your existing tax ID number, you need to first determine if any of your physicians will be credentialed and can be reimbursed when providing both the professional and technical components of these new services. Also, determine if there are additional credentialing or accreditation requirements that the payor is going to require for these new services such as accreditation by the American College of Radiology.

Payors, regardless of your geographical presence or market power, may be unable to contract with you if they are already contracted either exclusively or via capitated rates for these ancillary services with another provider. Remember that payors often view physicians who provide both the professional and technical components of non-urological ancillary services much like having the fox running the hen-house; payors will look at your utilization of these services much more closely as overutilization becomes an increasing concern.

Also, Medicare is currently reviewing its rules relative to the relationship of specialists who provide ancillary

services, such as pathology, which may or may not change in 2010. Regardless, payors are constantly evaluating these issues. Just because they have given you the green light for reimbursement today doesn't preclude them from altering these policies and procedures in the future unless you get it in writing in your payor agreements.

6. Implement a common electronic health records platform. EHRs enable patient records to be easily exchanged between different physicians (either different specialties or within the same specialty). All laboratory, diagnostic studies and clinical information should be in a central repository, and should be updated on a real-time basis. Your EHR should be designed around evidence-based protocols, further guiding your physicians to improving clinical care. Leverage technology for electronic prescriptions (which will also virtually eliminates errors in transcription and side effects from unpredicted drug interactions), as well as electronic storage of media such as radiographs. These steps will reduced your infrastructure costs as well as provide you with documents needed in justifying fees to health plans for new and renegotiated agreements.

7. Provide new services, equipment and technology. A major advantage to both patients and third-party payors is the ability for patients to obtain highly specialized services from new, state-of-the-art treatments and equipment. Payors are now looking at contracting with ASCs whose physicians have advanced fellowship training in such areas as oncology, robotics, laparoscopy, impotence/infertility, neurology, female urology and stone disease as being the gold standard in urological training and care. New state-of-the-art equipment and technologies are not restricted to urological technology; they include non-urological technologies as well such as diagnostic radiology, pathology and radiation oncology. Examples of technological innovation in these areas include 64-slice CT scanners, microwave and laser units for the treatment of Benign Prostatic Hyperplasia (BPH) and image-guided radiation therapy (IGRT). The use of these technologies can improve outcome, increase throughput and reduce costs, both directly and by reducing patient morbidity.
It is essential to maintain complete cost and patient quality care records as you provide these services and use these pieces of equipment. Tracking the use of these advanced services and technologies will assist you in documenting a payor's cost per episode of care, and in turn can provide you with the compelling data and documented needed to justify your requested rate increases during payor contract negotiations.

8. Implement and document ongoing physician continuing education. Establish programs to ensure that your physicians are continuously receiving training so that patients receive the highest level of medical care. The most progressive ASCs and their urologists now provide their physicians with monthly scientific presentations either delivered or arranged by their chief medical officers, and organizations hold monthly morbidity and mortality conferences. Arrange to provide didactic and hands-on training for your physicians to ensure standardization of technique and reporting with respect to key services such as ultrasounds.

Furthermore, it is a good idea to conduct regular meetings, mandatory to all physicians, at which national thought leaders provide state-of-the-art lectures on various clinical subjects. In addition to clinical information, it is also imperative to update physicians regularly on healthcare policy and operational issues. To demonstrate your commitment to quality of care provided in your community, open your scientific meetings to both your member and non-member physicians alike without cost or obligation. In taking these extra steps, you will be able to demonstrate intent as a collaborating partner with both your community and your local health plans.

9. Implement aggressive procedure coding review. Ongoing statistical modeling regarding coding error rates and accuracy should be performed by your ASC. Physicians should be educated on correct coding initiatives on at least a quarterly basis. These initiatives ensure that each patient receives the correct treatment for the disease entity, and that the bills reflect the appropriate charges for the service. This will increase both patient quality of care as well as reduce the likelihood of audit retrospective review, denial of payment of past claims, and possible payor recoupment and recovery of money from future services.

10. Vigilantly monitor contract reimbursement. Last, but most definitely not least, it is critical that you gather your current contract fee schedules and ensure that your top codes reimbursements are maximized. There are several ways to do so. First, make sure you know the frequency that each service is performed per unit of time and that you also know the contracted rate and actual claims payments. Compare your contracted rates to local Resource-Based Relative Value Scale Medicare reimbursement and to other physicians in your locality, state and in the country. Make sure that your sample size is large enough to avoid any issues a payor may have with collusion. It is best to consult your legal council before implementing a rigorous reimbursement review and negotiation process.

For your review, deploy the "20/80 rule." This means you identify the 20 percent of your codes that drive 80 percent of the book of business into your organization. Weight your codes in descending order based upon the payment associated with each code (i.e., the payor contracted rate times volume). Such an approach will allow you to hone in on the services that most affect your payor reimbursement. Also, look for trends when grouping your top codes. For example, are urology surgical codes above standard benchmarks but your radiology codes far below standard benchmarks? This descending order weighting approach will help you determine which contracts and services to focus on and will result in maximizing revenues from commercial payor contracts.

It is not only critical to negotiate a good contract, but then you must ensure the contract is paid based upon the correct rates and payment terms. Ongoing vigilance in comparing your reimbursement to the rates you agreed upon will pay big dividends.

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