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MANAGED CARE Contracting & Reimbursement ADVISOR

Sometimes you just have to end it: How to terminate a contract that's not working

When you're scrambling for revenue anywhere you can find it, terminating a managed care contract may sound like the last thing you should do. But in fact, getting rid of a contract that is not working for you can actually make your practice more profitable.

Physician practices often hold on to contracts that are not profitable because they have had a relationship with that managed care provider for years and losing it would seem like a financial loss, says **John Schmitt,** a managed care expert with EthosPartners Healthcare Management Group, based in Suwanee, GA. However, a close analysis of the numbers may show that the contract is not producing any revenue for your practice—in fact, it may actually be costing you money, says Schmitt.

"We can be reluctant to let go. People often think anything is better than nothing, but with managed care contracts that's not always true," he explains. "If you have a bad contract or a bad business partner, it can be very resource-consuming for the practice because it will take a lot of time and require a lot of hassle."

A practice also may be reluctant to terminate a contract because a personal relationship has been established, Schmitt says.

"Often the payer is represented by a very cordial, nice person and you don't want to tell them no," he says. "So you renew the contract, and then months later you ask yourself why you ever signed this contract in the first place. You have to not make it personal and just say you don't want contracts that don't work for you."

> **"People often think anything is better than nothing, but with managed care contracts that's not always true."**
>
> *—John Schmitt*

Broken promises often the cause

Termination frequently is prompted by payers who have unreasonable fees or aren't responsive to problems such as claim denial rates and pre-authorization rates that are difficult to work with. Another common reason for terminating a contract is the payer not fulfilling promises it made when trying to get you on board, Schmitt says.

"It can be like a divorce: too many irreconcilable differences and you just can't work it out," he says. "Breaking up is not something you want to do, but you just can't go on like that."

Managed care contracting is becoming more complicated than in years past, Schmitt says, particularly with the growing popularity of incentive-based payer programs. These arrangements can hinge on promises that,

> continued on p. 2

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IN THIS ISSUE

p. 3 **Financial trouble for a payer can mean disaster for you**
Find out whether a payer is in trouble before signing the contract.

p. 5 **Develop a specific plan for addressing denied claims**
Be sure to capture data on denials so you can look at root causes.

p. 6 **Use this flow chart for tracking and appealing denials**
This step-by-step process can formalize your response.

p. 7 **AMA launches "Heal That Claim" campaign**
Too many claims are faulty; steps are needed to improve payments.

p. 8 **Checklist can help you optimize claims submissions**
Review the list to see whether there are ways you can improve.

Terminate a contract

< continued from p. 1

if unfulfilled, may form a reasonable basis for terminating the relationship, he says.

The incentive arrangements require a great deal of trust between the two parties, Schmitt says. If the managed care provider is not transparent, cooperative, and willing to resolve problems, the arrangement can fall apart.

Detecting a lack of trust should put you on the alert that this may not be a contract that is worth keeping, Schmitt says. Warning signs can be a pattern of delayed or denied claims that seem unreasonable, a failure to respond in good faith when the practice reports concerns about transactions, or overly burdensome requirements from the payer, he says.

"When there's no trust, the negotiations are slow, and because they're slow, you lose revenue you could have made in the meantime, and it's more costly in terms of the time it consumes," Schmitt says. "So it actually results in a trust tax, so to speak."

Not the time for emotion

So when it comes time to say goodbye, how do you do it? The first rule is to make the termination strictly factual and not emotional, Schmitt says. All communication should be respectful, and you should document why you have decided to end the relationship, he says.

"You should present it to them in a very clear way, saying, 'These were our expectations and these are what the results were. We expected these things and you did not deliver. You didn't keep your commitment to what you said you were going to do.' They deserve to know why you're terminating the contract, but this is not the time to get angry or tell them how frustrated you are. Simply state the facts calmly and leave it at that."

Although terminating a contract can be the right business decision, do not take the decision lightly, Schmitt says. Remember that terminating a contract will cause some headaches for you.

Not likely to come back

For starters, you must give notice to patients covered by that payer, and the patients will not be happy about the news, Schmitt says. Patients should be notified individually, and a notice should be posted in the lobby stating that you no longer accept the payer's coverage, but you will still see the patients if they wish to self-pay.

"The front office should be prepared to convey this information and discuss it in a caring way because this is a difficult issue for patients. They take it personally," he says. "You can't just say, 'Oh, we don't take that anymore.' "

Don't terminate or threaten to terminate a contract in hopes of getting a better offer from the payer, Schmitt says. If the payer were going to make you a better offer or provide better service, it already would have before

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you got to the point of termination. Likewise, don't expect the payer to court you in the future. The relationship will be strained at best, he says.

"Will they come back later and try to make it all better, change their ways and give you better rates?" Schmitt says. "Well, some divorced couples get back together. But don't count on it. Usually it takes a new era of management to come in at the payer and change things around, then they try to show you they don't have the same problems as before." ■

Protect against insolvency when negotiating contracts; look for warning signs

In a tough economy, it is important for providers to protect themselves as much as possible from the insolvency of payers. Savvy scrutiny of the payer's financial background and the contract terms can keep you from being left empty-handed in the event that someone else goes under.

Providers often don't worry about the possibility of a payer hitting hard times until it is too late, says **John Meyers, JD,** an attorney with Ervin Cohen & Jessup in Beverly Hills, CA. The financial stability of the company—whether it is a healthcare plan or a medical group that will be the intermediate payer—should be considered from the start and during the contract negotiations, he says.

It is important to know with whom you are negotiating, Meyers says. Most payers are publicly traded, so there are public filings that describe their holdings and give a clue as to solvency, he notes.

Don't be persuaded to contract with a company that is on thin ice financially just because it offers you a sweet deal in the contract, Meyers says. The terms of the contract won't mean much if it turns out that the company goes bankrupt, he says.

Some states, such as California, have clearinghouses where you can check on the financial status of a payer and whether it has a history of complaints regarding payment.

"The question is, what are the indicators that they won't be able to pay me?" Meyers says. "When will they be in trouble? It's not like this hasn't happened frequently."

Bankruptcy termination clause may not work

With a contract that provides for capitation by the payer, a bankruptcy can be particularly difficult on the providers, Meyers says. Despite any clause in the contract that says you can terminate if the payer goes bankrupt, you most likely will have to continue providing care through the bankruptcy, he says.

> **"The question is, what are the indicators that they won't be able to pay me?"**
>
> *—John Meyers, JD*

"You have to perform while the bankrupt party decides whether they want to affirm or reject your contract," he says. "The provision saying you can terminate is just not valid in the context of bankruptcy and many state receivership programs."

Meyers also cautions about a clause commonly found in contracts stating that a provider will look only to the payer in the immediate payment stream for its payment. The clause is usually required by state law and means that the provider will look only to the payer for reimbursement and will not go after the consumer, he says.

> *continued on p. 4*

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Insolvency

< continued from p. 3

"This is usually stated somewhat broader than it needs to be, and some payers are not entirely forthcoming about this clause," Meyers says. "They articulate it as a requirement of state law, saying it is a plan protection device, when actually it is a consumer protection device."

Reserve right to go to upstream payer

The clause is abused when a medical plan is at the top of the payment stream, capitating a large medical group underneath it, says Meyers. The medical group then pays a provider that is not within the medical group but is a contract provider within its network. The payer often tells the medical group that it must include the clause in its downstream agreements, trying to protect itself in the event of the medical group's failure.

> **"You can get locked in so that you have receivables that become worthless."**
>
> *—John Meyers, JD*

"If you can only look to the medical group for payment, you can't get to the plan," Meyers explains. "So if the medical group becomes insolvent, the plan uses this clause to say they paid the medical group and you risked the insolvency of the medical group."

Meyers says providers should reject an overly broad version of that clause and substitute wording to this effect: "If the medical group cannot pay us, we agree not to look to the consumer, but we reserve the right to look to any upstream payer," meaning the medical plan that capitates the medical group.

Get termination clause exceptions

Providers also should study the contract's termination clauses. Payers generally require a long notice period such as 180 days, but Meyers suggests negotiating for exceptions related to financial irregularities. For instance, the provider could push for a clause stating that if the payer does not provide the capitation payment on the agreed-upon date and then fails to do so within 48 hours of the provider demanding payment, the contract can be terminated regardless of the other clauses requiring a notice period.

"You can't be trapped in the agreement requiring 180 days' notice when you aren't getting paid," says Meyers. "The risk is that you can't get paid by the plan, you can't get anything from the medical group if there is one in between you and the plan because they aren't paying the group either, and you're prohibited from going to the patient for payment. You can get locked in so that you have receivables that become worthless."

Meyers says he has witnessed that situation countless times in California, with medical groups dissolving and the downstream providers left with no one to pay them. When they approach the plan, they often are offered some fraction of the money due, and the providers have little choice but to take it. The plan argues that it already paid the medical group and any effort to make the downstream providers whole is just an effort to continue a relationship in the future.

"The actuarial experience and knowledge really lies at the plan level, and these medical groups in the middle sometimes misestimate the actuarial performance," he says. "Usually they can't manage their expenses as well as they should, and then all of a sudden they realize that they are losing money. They're trapped by their contract with the payer, and then the downstream providers can end up taking a big hit." ■

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Mitigate revenue impact brought by denied claims

With about 10% of claims denied on average, a physician practice must have a specific plan in place to respond to denials. Otherwise, you are forfeiting a significant amount of revenue that is rightly yours, says **Brian Sanderson, JD,** a partner with Crowe Horwath, LLP, in Oakbrook, IL.

That 10% is the first-level denial rate, but then the second and final denial rate—after you have worked the claim but still have not received payment and now must write off the loss—is about 1%–3% of those initial denials, Sanderson says.

"Some organizations are proud of the fact that their initial denial rate is less than 1%, but if their second denial rate is 13% or 14%—and I've seen multiples of that—then the expense that is required to recapture that money also is a significant expense," explains Sanderson. "It puts a lot of pressure on the business office."

A physician practice must have a plan that dictates how a denied claim is addressed, Sanderson says. Rather than the business office simply taking a look at the claim and trying to figure out what the problem is, each denied claim should be routed through a process that captures the data and enables those employees most appropriate to that particular claim to study the reason for nonpayment, he says. (Sanderson provides a sample flow chart that can be tailored to your own practice. See the flow chart on p. 6.)

Reducing the denial rate should be a top priority. That starts with analyzing your denials, Sanderson says. Understand what types of denials you're getting. The denials can be broken down into broad categories such as administrative, which might include denials for incorrect insurance and not a covered patient, which are more related to registration and patient access.

Technical issues require digging

Another category might include problems that are more technical in nature, such as when a claim is denied for lack of medical necessity, lack of proper modifiers, or a CPT code not matching the demographics of the patient. An example would be the submittal of a CPT code for a prostate exam on a female patient.

"Those will vary by physician, by group, by specialty, because they are dependent on the performance of each organization," Sanderson says.

With claims related to technical issues, denials usually can be tied to the following three problems:

- **Quality issues in the charge capture process.** This can be a disconnect within the charging process of how a service gets put onto the charge ticket and then onto the bill. Sometimes there is a mix-up in that process and the resulting bill will have incorrect information. For instance, in surgery, the sequencing of CPT codes is very important.
- **Not following a payer's specific rules.** Some payers have specific rules regarding what can be charged or what can be bundled, for example, and not following those rules will result in a denied claim. Understanding the details of each managed care contract is key to avoiding this problem.
- **Breaking an unknown "rule" with the payer.** In some cases the denial seems arbitrary, when in fact the managed care payer is denying claims for a reason not clearly stated to providers. The denial code may seem unjustified. The true reason may be that the payer has deemed the procedure unnecessary but doesn't come right out and say so. Claims in which the reason for denial is unclear must be fought vigorously, Sanderson says.

Staff must have time to do the job right

With administrative denials, the first thing to consider is whether your staff has the time and resources necessary to produce quality patient data, Sanderson says.

"Some practices are extremely diligent with patient access and registration, but with others the front office

> *continued on p. 6*

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Mitigate impact

< *continued from p. 5*

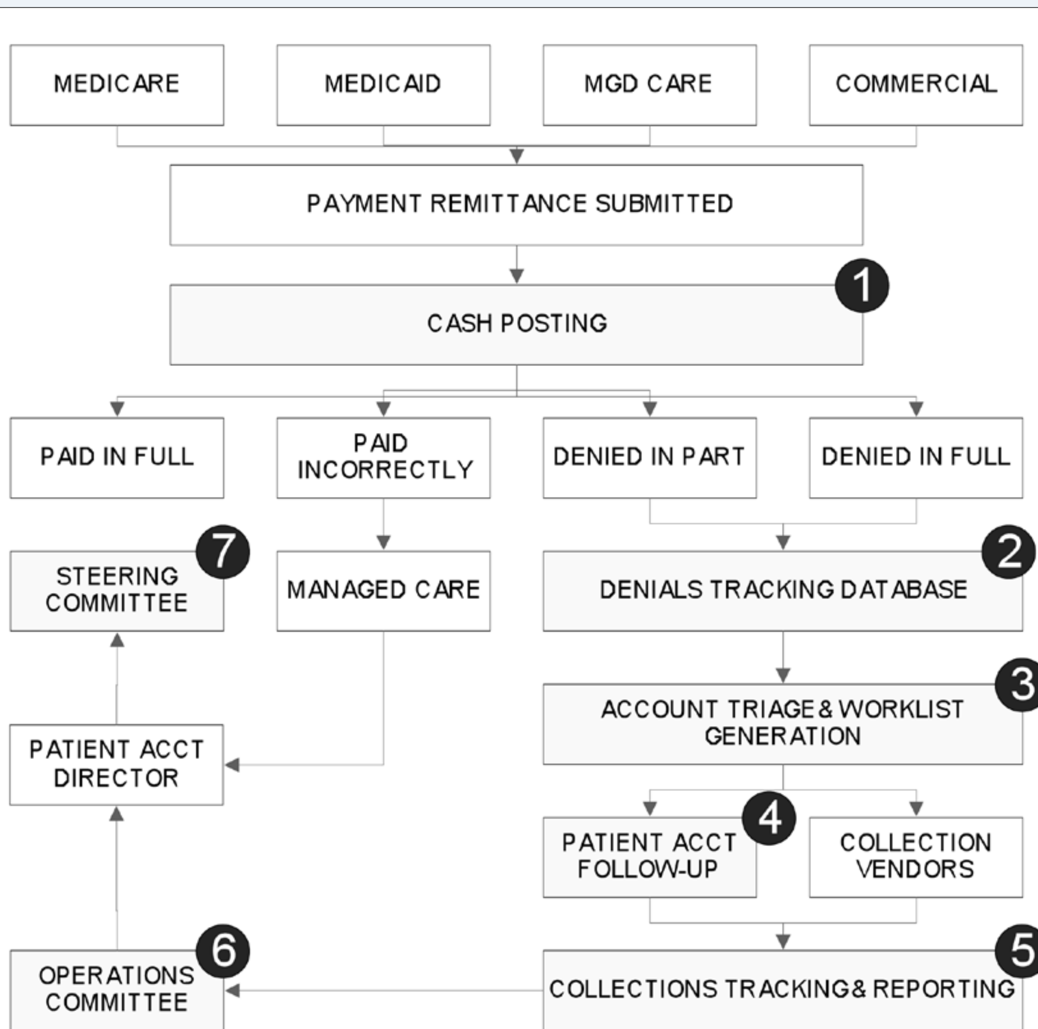
person is responsible for that task and four or five others. Then it becomes just a matter of throughput, getting the patient data through the system, rather than ensuring the quality of that data."

This means that reducing your denial rate sometimes requires assessing your staffing and task assignments for the front office, Sanderson says. The first question is whether you have enough staff. Then ask yourself whether those staff members have enough time to register patients efficiently and accurately.

This assessment can be a challenge, Sanderson says, because the practice needs staff to work at full capacity so you don't have too many staff members on the roster and you're not paying people to sit around with little to do. At the same time, you must not burden those staff members with so much work that they cannot properly perform their jobs.

"You have to find a balance. If you have coordination of benefits issues, it's largely a matter of whether those people have time to focus," he says. "It's tempting to

Flow chart for addressing denied claims



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pile on the work so that people are always working near their limits, but that can be one reason you get inaccurate or incomplete patient registration. You can be saving yourself pennies in the short run but costing yourself thousands of dollars later if that hurried work results in denied claims."

Discuss data with staff

Although education of staff also can be an issue, Sanderson says that generally takes a backseat to the administrative processes in place and the time staff have to work with patient data.

Tracking the reason for denials is the best way to discover where your shortcomings are, Sanderson says. Monthly data on denials should be posted in the office for all staff to see, and they should be discussed in staff meetings, he says.

"Sometimes simply giving them that information and discussing it openly can have a significant effect, even without making any process changes," Sanderson says. "Once they're aware of the rate of denials and the reasons, and they know that you're monitoring it, they pay more attention to what they're doing." ■

> **"Some practices are extremely diligent with patient access and registration, but with others the front office person is responsible for that task and four or five others."**
>
> *—Brian Sanderson, JD*

AMA urges providers to take action on inaccurate payments, says one in five are wrong

The AMA is urging physicians to take action against inaccurate payments from private health insurers. As part of the launch of its "Heal That Claim" campaign, the AMA is supplying physicians with tools to fight flawed and inefficient claims processing by health insurers.

One out of five medical claims is processed inaccurately by commercial health insurers, according to the AMA's National Health Insurer Report Card.

A 20% error rate represents an intolerable level of inefficiency that wastes an estimated $15.5 billion annually.

The administrative costs of ensuring proper insurance payments takes a heavy financial toll on physicians and can consume up to 14% of their earned revenue, says AMA president Cecil Wilson, MD.

"The AMA's goal is to significantly reduce the administrative costs of processing claims from 14% to 1% and allow doctors to focus on caring for patients instead of battling health insurers over delayed, denied, or short-changed medical claims," Wilson says.

Because health insurers often increase their rate of claim denials during the last quarter of the year, many more physicians may have just experienced such activity and will appreciate the reason for the campaign, Wilson says. He urges physician practices to take the initiative in improving the accuracy of claims, rather than waiting for insurers to do it.

The AMA is helping physicians overcome claims obstacles by offering online resources to help prepare, track, and appeal claims. These resources include template appeal letters, printable checklists, and logs that help physicians simplify their claims management system.

To learn more about how the AMA is helping physicians get paid accurately by health insurers, please visit the "Heal That Claim" campaign site at *www.ama-assn.org/ama1/pub/upload/mm/368/htc_general_flier.pdf*.

At the site, physicians can pledge support for the campaign, report any unfair health insurer practices, share successes, or sign up for the AMA's free e-mail alerts to help stay up to date on unfair payer practices. ■

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Use this checklist to see whether you're submitting claims efficiently

As part of its "Heal That Claim" initiative, the AMA suggests using the following checklist to determine whether your practice is submitting claims efficiently and accurately:

- Does your practice prepare and submit claims in a timely manner? Do you update and verify patient insurance coverage and eligibility information prior to each visit to make sure that you submit eligible claims to the correct health insurer?
- Do you have a practice staff member specifically responsible for reviewing health insurer payments for accuracy? When you receive EOBs and electronic remittance advice (ERA), do you address delays, denials, and reductions?
- Do you keep copies of your contracted fee schedules in order to verify accurate payment from health insurers? Does your practice management software allow you to store contracted fee schedules? Do you maintain all health insurer contracts in a central and easy-to-locate file cabinet or drive?
- Does your practice run a monthly collection report and review EOBs and ERAs for each claim?
- Do you identify the basis for health insurer payment adjustments? Do you understand the claims adjustment reason and remark codes reported on EOBs and ERAs to explain adjustments to payments and address them quickly and appropriately?
- Do you gather supporting documentation to respond to health insurers' claims adjustments and routinely submit appeal letters using easily accessible templates to streamline and standardize appeals for common denials?
- Does your practice maintain a follow-up log to monitor its communications with insurers regarding claims?
- Does your practice hold internal claims processing and review meetings to periodically evaluate your work flow for ways to improve efficiency?
- Do you persist in appealing your delayed, denied, or reduced payments until they are paid accurately?
- Do you have a plan for complying with the 5010 and ICD-10 mandated updates? The deadline for upgrading electronic transactions to the HIPAA-mandated 5010 version is January 1, 2012, and the deadline for reporting ICD-10 codes is October 1, 2013.

The AMA offers an interactive library of resources and tools for improving claims submission and efficiency at *www.ama-assn.org/go/pmc.* The tools are available free of charge.

Questions? Comments? Ideas?

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