



Managed Care Contracting

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Contents

Preface	1
Joining a Managed CARE Plan: Doing the Math.....	2
Calculate Your Costs	2
Developing Fee Schedules	2
Identifying Your Target Patient Populations.....	4
Payment Methodologies: Advantages and Disadvantages for Practice.....	5
Keeping Track of Your Contracts.....	11
What To Do if the Payer Does Not Pay According to Contract.....	11
Silent PPOs.....	11
A Provider Contracting Checklist.....	13
Getting to “Yes”: Securing Managed Care Contracts	17
A Managed Care Plan’s Perspective.....	17
Tactics for Success	17
Down to Business: Negotiating the Contract	19
When Should I Walk Away?.....	22
Conclusion	22
Glossary 1. Financial Terms.....	23
Glossary 2. Health Insurance Terms	24
Glossary 3. Contracting Terms.....	29
Additional Resources	30

Managed Care Contracting



Preface

To ensure adequate coverage of their enrollees, managed care plans frequently reach out to providers to join their networks.

Government plans provide clear enrollment criteria and fee schedules and generally are open to any provider meeting those criteria, regardless of geographic competition. These plans don't allow for any negotiating of contract terms, provisions, or fee schedules. That may not be the case with some private insurance plans, of which there are several hundred. Because so many patients are enrolled in health plans, you might assume that by not contracting, your practice will exclude many potential consumers in your market. While most physical therapists do consider joining a provider network at some point, the decision should be based on sound business strategy.

There are several details to consider before contracting with payers, whether private or public. It's imperative to review each contract in its entirety with professional advice before signing. Terms or provisions in contracts that are often overlooked at the time of signing could significantly impact your practice in the long run.

APTA staff liaises with private payers, utilization review vendors, employer stakeholders, and employer group health and workers' compensation plans. We offer help to members of APTA specialty sections and state chapters, and work with payers and purchasers to expand coverage of physical therapist services and resolve access issues. Contact us at advocacy@apta.org or 800/999-2782 ext. 8511.

DISCLAIMER: The information in Managing Care Contracting is offered for general informational purposes only. It is not specific to the facts and circumstances of any person, organization, or practice. The information is not intended to provide legal advice or opinion. You are advised to seek counsel from experienced attorneys and accountants for assistance with your particular provider contracts.

Joining a Managed CARE Plan: Doing the Math

If you've never gone through the process of joining a managed care plan, the financial considerations can be daunting. This chapter will help you “do the math” to decide what fee schedules, patient populations, and payment methodologies are best suited to your practice.

Calculate Your Costs

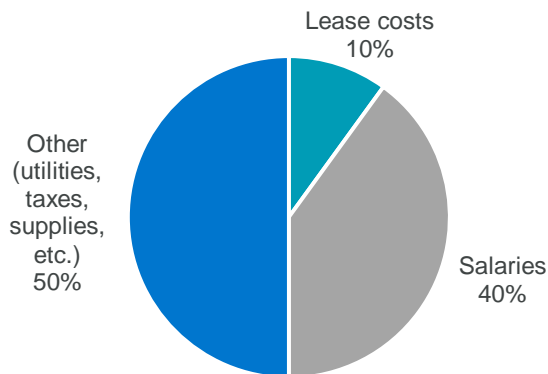
The crucial first step is to define your costs of providing services. Knowing your costs will help determine whether a contract is financially feasible for your practice.

For a simple analysis, use the table below to fill in your overall cost of business. Once you have added up your costs, divide the total by either 12 or 52 to get your monthly or weekly overall costs.

Knowing how much to charge for your services, or whether a contract offered by a payer is fiscally acceptable, depends on an understanding of your costs. There are two types of costs: direct and indirect. Direct costs are the expenses for clinical services, such as salaries, equipment, supplies, etc. Indirect costs are often referred to as overhead costs, that is, nonclinical expenses, such as rent or mortgage payments, electricity, heating and cooling, and janitorial services.

Some costs, such as the rent or mortgage, are fixed. This means that your practice will incur the same cost whether you treat 10 patients or 200 patients. Other costs like staff salaries or utilities are semi-fixed. If your staff must work overtime, then salary costs increase. Variable costs include items like disposable supplies. These costs can increase depending on patient volume.

Benchmark Expense Breakdown



All costs, including fixed costs, need to be reevaluated at least annually. Lease agreements generally have an annual fixed rate increase that has to be accounted for when calculating expenses and forecasting budgets. Lease costs should not exceed about 10% of your overall budget.

Labor costs are a key area for a service business like physical therapy and can make or break your practice. The key is combining appropriate wages with adequate productivity. Labor costs should also include owner or key employee benefits and outsourced service costs. It is recommended that labor costs for PTs should equal between 28% and 40% of their gross collections. Higher salaries are usually awarded to more productive staff with fewer cancellations, better patient retention, higher outcomes scores, and the best customer service scores.

Developing Fee Schedules

Now that you know your costs of care, you can look at each insurance fee schedule and see how many patients you will need to treat in that time frame to produce a profit. To be realistic, don't count on more than a 90% collection rate, depending on your market, allowing a margin of error for uncollectible or delayed payments. Also, remember to always maintain about three months of operational cash flow, or at least allow 90 days in the billing cycle to receive all payments that were billed.

The next step is to estimate the annual gross total income you need to make a profit. Gross income includes all payments received, before taxes and expenses are deducted, such as insurance reimbursement, self-pay and copay, as well as income from other services like fitness, massage, functional capacity evaluations, etc. Your gross total income must exceed your calculated expenses in order for the business to remain profitable. The difference is called net ordinary income.

Net Ordinary Income = Gross Total Income –Total Expenses

Divide your net ordinary income by weekly, monthly, or annual hourly net income (before interest, taxes, depreciation, and amortization) to assess your potential income based on the above assumptions and numbers. A reasonable starting target profit margin would be 10%. As growth and efficiencies develop, that can increase. For example, if you add a staff PT, the fixed costs such as rent are now spread among two

Expenses	Amount
Payroll	
PTs	
PTAs	
Other personnel	
Owner's standard salary	
Payroll taxes	
Company incentives (bonuses, continuing education, etc)	
Per diem labor (vacation and holiday laborers, etc.)	
Insurance (health, dental, etc.)	
Retirement plan	
Billing services fee	
Other employee benefits	
Variable expenses	
Advertising, business promo, marketing, professional services	
Education and travel	
Postage/ shipping	
Services (consulting, practice management, computer, laundry, payroll service, etc.)	
Clinical supplies	
Office supplies	
Repairs and maintenance	
Fixed Expenses	
Bank charges	
Dues, subscriptions, licenses, permits, etc.	
Equipment rental and purchases	
Facility (rent, utilities, janitorial, etc.)	
Liability insurance	
Workers compensation, liability, professional services insurance	
Accounting and legal services	
Communication (phones, cell phones, internet service, pagers, etc.)	
Other expenses	
Depreciation and amortization	
Interest	
Taxes and fees	
Other	
Total	

Identifying Your Target Patient Populations

What happens if you specialize in a unique niche, provide care in an underserved area, or provide a valuable service? (Remember, it's not your perception of value that counts, but the payer's (either insurer or employer) and patient's. What will entice the payer to contract with you for that specialization? If your facility treats more patients in a specific segment of the population, will this increase or decrease your overall costs of care?

One approach to fine-tune your cost by segments is to identify the types of conditions treated, or the 10 most frequently used diagnoses (ICD-10 codes) by staff member or clinic:

	Diagnosis Code	M47.814
A	CPT codes used	97110 97112 97140
B	Total billed time	45 minutes
C	Payroll cost	\$35
D	Extra staff cost	\$10 (aide)
E	Cost of necessary equipment	\$10 (night-time cervical roll)
F	Other expenses related to this specific diagnosis	Examples [add dollar amounts]: Cleaning traction table \$ Special supplies \$
G	Variable, fixed, and other expenses related to this code	\$11

- How many and what CPT procedure codes do you typically use when providing treatment for these diagnoses? In other words, what is the value of each code in terms of time spent?
- What is the typical number of treatment sessions per diagnostic code or condition?
- What are the staff needs for these diagnoses, such as supplies, space, support staff, and equipment?

Example (the following numbers are arbitrary and do not represent actual costs, actual diagnosis codes, or complete costs):

For treating a patient with diagnosis code M47.814 using CPT codes 97110, 97112, and 97140 in the above example:

Cost per minute of care = (C+D+E+F+G) ÷ 45 minutes

The reimbursement received from the patient or payer must exceed the cost of care for the diagnosis. If your payment for 45 minutes of care equals your costs, you may consider negotiating with your insurance company using your statistics.

You can position your argument and negotiate better payment if you can demonstrate that your practice offers better value in the form of fewer visits per patient and better outcomes compared with other health plan beneficiaries, fewer recurrences of reinjury, and/or fewer downstream costs, such as lower utilization of diagnostic tests, medications, specialists, surgeries, and injections. Share your cost of care with the insurer and see if you can identify a price point that gives you appropriate profits for the care you are providing.

There are additional steps you can take to successfully negotiate with a payer. For example, check to see what types of patients an insurer targets and the payment fee schedule. Is the insurer paying a flat rate, a capitated rate, or a fee for service? Also check the insurer's authorization process to find out if you will incur additional costs, such as staff time and applicable systems, to comply. You must add all of these to the cost calculation (see page 5) in setting a forward-looking budget and projecting profit and loss potential.

Note: If you decide to accept a new patient demographic and/or new diagnosis, you may incur additional expenses, such as staff training, lower initial productivity of staff during the learning curve, and purchasing specialized equipment.

Gather as much intelligence as you can on the managed care organization. The best places to look for this type of information would include industry and association publications, general-interest publications such as consumer magazines and newspapers, and various online resources such as the America's Health Insurance Plans website.

Payment Methodologies: Advantages and Disadvantages for Practice

Most physical therapists today receive a salary for the services they deliver. But the revenue to pay those salaries has to originate somewhere, and third-party insurance continues to be the most common source, regardless of type of facility or practice setting.

Following are some common methodologies that third-party payers use to pay for physical therapist services. No one methodology is inherently good or bad; all have advantages and disadvantages, and each has the potential to pay you fairly or poorly. When evaluating payer contracts, select those that make the most sense for your practice setting. Fee for service payment remains the most common payment methodology. However, there is a growing shift to value-based payment which necessitate providers meet specific quality and efficiency criteria for participation.

Value-based payment

Value based payment is a preferred and evolving payment model for outpatient physical therapy services. Health care stakeholders are looking to maximize value in terms of outcomes and cost. The provider is paid based on a desired outcome and may be asked to assume a level of financial risk tied to specific performance metrics. The methodology is best suited to providers that are data savvy and currently using clinical outcomes to improve practice.

Common payment methods are:

- **Episodic care or bundled payments.** A provider or a group of providers receives a single payment that covers an array of services needed to manage a specific condition.
- **Global Capitation Model.** The payer makes a single, comprehensive payment to cover an individual over a defined period of time. Risks: Not being able to manage costs and missing the savings opportunity/being penalized and the severity of the patients' conditions.
- **Partial or Blended Capitation.** Certain types or categories of services are paid on a capitated basis, while other services are paid on a fee-for-service basis.
- **Shared savings.** Providers receive a portion of the cost savings associated with managing a condition and achieving a desired outcome.

Pros and Cons

Advantages include the ability of the physical therapist to be paid based on their true value to the patient and their contribution in reducing overall health care costs. In these types of models, savings to the health care system due to reduced downstream spending resulting from physical therapy interventions, such as hospital readmissions, imaging, x-rays, prescription medications, urgent care visits, emergency room visits, etc. may be calculated and rewarded. The specialized skills of the physical therapist are of paramount importance as stakeholders seek to partner with providers that collect data, reduce spending, and contribute to optimal clinical outcomes.

Disadvantages primarily affect providers who do not collect data or do not have demonstrated clinical outcomes. They may find it difficult to successfully participate in these models. Participation will also require the practice to be knowledgeable about its risk tolerance and finances.

The pressure on providers to reduce costs and improve quality and outcomes will only continue to grow. Determining which value-based model is the right one will require physical therapists to understand how the various models work, including their incentives, risks, and potential financial impacts. Hospitals and health systems, among other providers, are looking for partners and suppliers that can offer lower prices, reduce spending, and contribute to better quality scores and outcome measures. If a provider can demonstrate this, they will be viewed as a preferred partner relative to others. **Check out the [APTA APM Contracting Guide](#) for more information.**

Fee-for-Service Payment

Fee-for-service payment is the most common type of payment methodology for outpatient physical therapist services. The provider reports each service delivered by the physical therapist, along with the fee for each service. For payment purposes, each service has a distinct code that is reported on either the Center for Medicare & Medicaid Services' CMS-1500 paper claim form or on the electronic 837P form. The American Medical Association's Current Procedural Terminology — referred to as CPT — coding structure is most often used. (This payment methodology also is known as line-item coding, as each service is coded into a line item on the claim form.) The payer reimburses the physical therapist based on the fee schedule. Discounted FFS is similar, except the physical therapist and the payer agree up front on rates that are discounted from the Medicare fee schedule. This rate may be a fixed amount per service or a percentage discount.

In a fee-for-service scenario, if a patient visits the physical therapist and receives 15 minutes of therapeutic exercise and 30 minutes of manual therapy, the claim form will include one unit of 97110, which represents 15 minutes of therapeutic exercise, and two units of code 97140, which represents manual therapy.

Pros and Cons

The advantages of fee-for-service include the ability to best describe the services that are delivered and to bill for those specific services. By recognizing each service, fee-for-service is the least “bundled” of all payment types and arguably is the the most equitable payment method currently available for the services delivered. In addition, in a Resource-Based Relative-Value Scale payment methodology such as Medicare, fee-for-service rates typically apply to all providers who bill the service. If a payer wants to reduce payment for a given service, the reduction would affect not only physical therapists, but also physicians, osteopathic physicians, podiatrists, and all other providers who deliver that service. Thus, the potential for outcry is much greater when a payer considers adjusting fee-for-service rates.

One potential disadvantage to fee-for-service payment is that it may provide an incentive to overutilize care and deliver as many services as possible, whether or not they are necessary — the more you do, the more you are paid. Payer response to this behavior has been to increasingly restrict payment policies. There is provider disincentive for the efficient use of services.

If you do report services to a payer using a fee-for-service payment methodology, be sure to include every service along with all of the applicable diagnostic codes. Insurers have been known to justify their denial of coverage on the grounds that no one is furnishing a given service. This is based on their analysis of submitted claims. Neglecting to bill for a service just because the insurer may deny it only contributes to this continuing cycle.

Per-Visit or Per-Diem Payment

In a per-visit scenario, insurers make one lump-sum payment to providers for each patient or client visit, with little regard for the services that were delivered. In this case, providing more services does not result in higher payment rates. Historically, per-visit payment has not addressed the situation of few (or too few) services being provided, thus creating an incentive for providers to deliver fewer services per visit and more visits per episode. Some insurers have developed strategies to address this situation, such as switching to a per-episode payment methodology (see page 8). Other payers have required CPT codes to be listed even though the payment is not dependent on those codes. A third approach, which has become more widespread, is to require the line-item CPT codes to be listed and to pay the lesser of either the line item total amount or the per-visit amount. This leads to the same net result as fee-for-service payment, but it caps the total amount paid per visit. By doing this, the payers assume less risk.

In the previous example of the patient who receives 15 minutes of therapeutic exercise and 30 minutes of manual therapy, the physical therapist would receive a flat payment for the visit, assuming that the billed line items do not total less than the given visit payment. If the physical therapist provided 45 minutes of therapeutic exercise and 30 minutes of manual therapy, the payment would still be the same. Once the payment level exceeds the line-item total, the payment amount remains the same no matter how much work is performed by the physical therapist. This is an example of a “bundled” payment: All services are bundled into a single payment amount.

Pros and Cons

One advantage of the per-visit payment methodology over fee-for-service arrangements is that it may reduce the incentive for providing unnecessary care. It also avoids dealing with some of the edits that payers build into fee-for-service payments. Edits are put in place to promote correct coding and prevent improper payments. For example, some payers may edit for ultrasound and electric stimulation at the same visit or for aquatic and land-based therapy at the same visit. These edits generally are not applied to per-visit payment scenarios.

A disadvantage may be the lack of payment for necessary services when the cost of these services exceeds a cap. There is also a certain amount of “singling out” that takes place with per-visit payment arrangements. This means that PTs billing for physical therapist services can be targeted for certain payer strategies, such as reduced caps. Since only specific providers are involved, there is less negative feedback from the overall health care provider community to the insurer when they implement these strategies.

Another negative aspect that has recently come to the forefront is that the per-diem or /per-visit rate may become more inclusive. For example, the lump-sum payment may include items such as orthotics and other durable medical supplies, when previously these items were carved out from the per diem rate and reimbursed as fee-for-service. This may cause a financial hardship on physical therapist practices that specialize in areas such as hand rehabilitation. Consequently, any review of per-diem or per-visit contracts should include a thorough examination of the services that are included in the lump-sum payment and should be compared with the resources the provider may need to treat a specific population of patients.

Per-Episode Payment

Per-episode payments include in a single payment all services that are delivered to a patient or client for a given episode of care. Payments are based on a predetermined, fixed amount, rather than on per-service charges.

Our example of the patient who receives 15 minutes of therapeutic exercise and 30 minutes of manual therapy is difficult to expand to this payment methodology, since neither the services nor the visit itself would be separately billable. Typically, the PT who accepts a contract for this type of payment would describe the patient's condition at the initial evaluation, and payment would be based on that condition.

Pros and Cons

Per-episode billing may reduce claims paperwork for both the payer and the provider, and typically gives providers the freedom to deliver the services they believe are necessary, without having to justify each service to the payer. This is one of the most bundled payment methodologies, with a single payment accounting for all services. The single payment also may allow the PT to manage a patient for a longer period of time without objection from the payer.

The disadvantages of this methodology may be significant. If there is a denial, everything may be denied, not just a single line item or visit. Because so much of the payment may be based on the diagnosis code given, PTs must become skilled in diagnosis coding, identifying as many diagnosis codes as possible.

Another difficulty with per-episode payments may be determining when one episode ends and a new episode begins. If a patient is being treated for a shoulder fracture and then sustains a leg fracture, there clearly are two episodes of care. However, a patient whose main complaint is cervical pain might not have a new episode if he or she voices a new complaint of thoracic pain. Similarly, a patient who is having difficulty walking may or may not have a new episode if he or she experiences low back pain.

A key item to look for in any contract that calls for per-episode payments is the management of outliers — patients whose complaints and/or presentation are atypical. A patient who has been in a serious car accident may have multiple injuries and complaints that can be helped by physical therapy, as compared with a typical patient with a single diagnosis. Additionally, comorbidities, age, gender, prior conditions, psychosocial factors, and other issues can have a dramatic impact on the severity of the case and the potential outcome.

Capitation

Capitation is the most bundled payment methodology of all. The physical therapist receives a lump-sum payment each month for all the covered subscribers for which he or she is responsible. The payment is the same regardless of the number of interventions that any of the patients receive or the volume of patients that are seen.

One way to determine capitation amounts is to allocate a given patient or client population to the physical therapist by zip code. The physical therapist is paid a capitated amount for each health plan member who resides within the specified zip codes. The amount may vary each month, as members move in and out of the health plan or the zip codes. For example, a payer may contract to pay the physical therapist \$0.50 for each member within a set of zip codes. If there are 1,000 members in those zip codes, the physical therapist would receive a check for \$500 each month, regardless of the number of plan members seen, the length of each visit, or what services were provided.

Cons (and no Pros)

While health plans that still use this methodology do require some notification that services are being delivered, the paperwork requirement is still typically far less than for the other payment structures. However, this payment mechanism transfers the insurance risk from the health plan to the provider. In other words, if the utilization of services is higher than expected, the additional cost to provide these additional services does not affect the profitability of the health plan. In our example, the payer will pay \$500 per month, regardless of services provided. Therefore, capitation is a guaranteed monthly payment for the provider. Unfortunately, it is the physical therapist who faces the risk — and the costs — of providing a higher-than-expected volume of services.

While the PT can use some general rules of thumb to calculate an appropriate capitation rate, the health plan has a wealth of information, placing it at a clear advantage in this calculation.

There is also a certain referral source risk for the PT. Patients who request more services than are appropriate to their needs pose a particular dilemma under capitation, and a physician who is under a capitation contract has an incentive to move the patient to another setting. Unfortunately, this may mean sending the patient to receive more physical therapy, thus increasing costs for the physical therapist. Consequently, any review of capitated contracts should include data analysis and an examination of the referral process so that the PTs is not penalized for making a determination that, based on sound clinical findings, a patient may need services other than physical therapy.

For those who wish to delve into the utilization trends and risk analyses that are inherent in capitation, this payment methodology may be appropriate. However, for the typical physical therapist who is more interested in clinical outcomes than accounting and spreadsheets, capitation is usually a poor choice and should be avoided. The percentage of capitation contracts available has shrunk dramatically, and it has fallen out of favor as a payment methodology.

Multiple Procedure Payment or “Cascade” Payment

A common form of provider payment is a multiple-procedure reduction model, which can come in several forms. In January 2011, CMS implemented a policy calling for multiple procedure payment reduction to “always therapy” services. Under this policy, the procedure with the highest practice expense value that day is paid at 100%, and the practice expense values for subsequent codes are reduced when multiple therapy services are billed to the same patient on the same date. The work and malpractice components of the therapy service payment are not reduced. From Jan. 1, 2011, to March 31, 2013, the MPPR included a 20% reduction on the practice expense for nonfacility providers and a 25% reduction for facility providers. The MPPR increased to 50% for providers in all settings on April 1, 2013. For Medicare beneficiaries, the reduction is 50% for providers in all outpatient settings. For other payers, the amount of the reduction varies by payer and by insurance plan. Because clinicians who deliver physical therapist services typically deliver a variety of services as represented by the CPT codes, there are numerous potential code combinations that, when executed, determine the total payment for services in a given day.

Alternatively, a multiple procedure reduction model may include a tiered approach that reimburses the highest-valued service at 100% and subsequent services at a lower percentage than the highest valued service. Using our example, if a patient visits the physical therapist and receives 15 minutes of therapeutic exercise and 30 minutes of manual therapy, the therapist would report one unit of 97110 and two units of 97140. Therapeutic exercise is the highest-valued procedure; therefore, 97110 will be paid at 100% of the allowable charge. Manual therapy will be paid at a reduced rate, such as 75% of the allowable charge. Another trend in MPPR is for the payer to reduce payment by the number of units billed. Using the scenario above, the payment for the first unit of manual therapy is reduced and the second unit is reduced even further. Therefore, the payer will pay 75% for the initial unit (following 100% of the highest-valued service, therapeutic exercise) and 50% for the second unit of manual therapy. As with most payment policy changes implemented by CMS, some variation of MPPR is now used by commercial payers and some workers’ compensation payment policies. The discounts applied by these payers may be significantly higher than that for Medicare.

Cons (and no Pros)

This is not an advantageous method of payment. The reduction of payment by the number of units billed is problematic for the physical therapist. The value of each procedure and the work required to provide those services are not reduced simply because multiple services are delivered on the same date of service.

Patient Payment (Self-Pay)

The terms patient payment or self-pay speaks for itself: reimbursement for professional services that comes directly from the patient, usually on the day of treatment. This type of payment usually occurs if the physical therapist does not have a participating agreement with the patient's or client's insurer, the existing benefits have been exhausted, or the service is not part of the benefit package. On the day of service, the patient is provided an invoice (or superbill) or claim outlining the professional services provided. If the service is covered in part or full, the patient may file the claim with their insurance company for reimbursement. Some practices operate on a cash-only basis. This is becoming an increasingly popular method of payment and does not require a contractual agreement with a payer.

Pros and Cons

An advantage to collecting from the patient is that payment is received at the time of the visit, providing a steady cash flow into the practice. It also eliminates the need and cost for the facility to file a claim form and subsequently wait for payment. The minimal paperwork involved lessens the administrative burden of filing claims and obtaining precertifications or preauthorizations for services.

Believe it or not, there can be disadvantages to patient payment. Primarily, the patient or client may not have the ability to pay for services at the time of treatment. In addition, there may be reluctance from the physical therapist's office to pursue patients who are delinquent in paying. It is imperative that the facility has a written policy outlining the responsibilities of a self-pay patient. In addition, providing formal, structured training of all staff regarding collection policies and procedures will result in an increased comfort level when communicating with patients and clients about their financial responsibilities.

Determining What Is Best for Your Practice

There are advantages and disadvantages to the common payment methodologies; know the differences and how they might affect your practice as you review and negotiate your contracts. As important as the methodology is the terms and adequacy of payment. Fair payment rates are possible with each methodology, but inadequate payment rates exist in each as well.

Keeping Track of Your Contracts

As confusing and tedious as contracting can be, you can't sign an insurer contract and place it in file cabinet without continuous review. If your office staff does not keep a close eye on payments, they will never know which insurers are not reimbursing according to contract, resulting in lost income for your practice. Additionally, it is important to monitor payer websites for policy updates.

While keeping your contracts in a secured location is a precautionary tactic, your office should conduct a regular audit — at least annually — of charges and payments, especially after signing a new contract. Insurers typically will pay the lesser of the charged amount or contracted rate. Consider investing in practice management software that allows you to load the various contracted fee schedules into your system and can help identify any discrepancies in payment.

What To Do if the Payer Does Not Pay According to Contract

It isn't uncommon for insurers to delay or deny payment for services. The most common reason for denying a claim is an assertion that there is a lack of medical necessity, which you can successfully counter with proper documentation. Delays and underpayments of claims by payers greatly affect a practice's cash flow, forcing you to spend more hours or personnel to pursue reimbursement through resubmission of claims and contacting the insurer's claims processing division.

An effective strategy for resolving these disputes is to read and thoroughly understand your contract — that includes managers and care providers, as well as administrative employees. Contracts usually contain language detailing how to settle claims disputes. Most contracts will require you to submit a written appeal of the denied claim, with specified time frames and required information. Occasionally a contract will refer you to policy manuals, contract addendums, exhibits, or attachments for additional information. Be sure you have all documents that are required under your contract. The contract will likely include more than one level of appeal. If you have the required documentation, you should continue to appeal at all levels to ensure adequate and appropriate payment of services.

In addition to direct agreements with providers, payers in many states are subject to "prompt payment" laws requiring them to pay "clean" claims within a mandated time frame. Under such laws, if an insurer does not reimburse a provider within the law's time frame, it could face penalties and fines. Usually prompt payment laws allow for payment within 30 days for electronic claims and 45 days for paper claims. Penalties for unpaid claims can range from a fine of a set amount to the maximum allowable state interest rate. Review your state law with counsel to determine what laws apply.

In addition to appeals, determine if your contract has an alternative dispute resolution provision. Through this process, the involved parties agree to shift future legal disputes away from costly litigation and instead use a mediator or arbitrator to help resolve the dispute in a timely fashion whenever possible. This process may be fairer, less expensive, and potentially as efficient.

Silent PPOs

In the typical preferred provider organization arrangement, the physical therapist has a written agreement to offer discounted fees to the PPO in exchange for identification as a network provider and increased number of referrals. The understanding is that the discount is offered only to the contracting PPO, not to the PPO's subsidiaries. A silent PPO is an unauthorized use or sale of a PPO network listing and its accompanying negotiated discounted fees to a third party. That third party typically takes advantage of the PPO providers' fee discounts but does not offer those providers any of the contract advantages. This usually happens without the provider's prior knowledge or permission.

Silent PPOs have been around for a number of years due to insurer consolidation and corporate pressure to reduce rising health care costs. Silent PPOs rent or buy multiple provider networks and can then load the provider contracts with discounted rates into its claims system. When claims are submitted, the system searches for the lowest contracted rate to reimburse the provider.

What To Consider Before Signing a PPO Contract

Before signing a PPO contract:

1. Check to see if the PPO includes a list of their subsidiaries or clients in the contract. If not, request a complete list of all subsidiaries and clients with whom the PPO contracts.
2. Reexamine the client list periodically, preferably every quarter, to track any updates or trends.
3. Ask if you can opt out of the discount on a payer-by-payer basis.
4. Confirm whether the patient' or client's health insurance card identifies the reimbursing PPO by name and provides a phone number to verify eligibility and benefits.
5. Understand how the contract defines "payer" or "affiliate." If the contract does not include an "all-payer clause," beware of language defining a payer as "any other entity that has contracted with the company to use the company's provider network."
6. Find out whether the PPO informs you before entering into a silent agreement.

What You Can Do To Protect Your Practice

Silent PPOs place an unreasonable financial risk on your practice if you do not know to whom or when the discounted fee will be applied. Such discounting practices can strain staff resources in collection efforts and time-consuming audits to identify which of the PPO's subsidiaries applied the discounts. The patient or client may be required to pay a higher percentage of the provider's full-billed charges if the lowest payment rate — the highest discounted rate — is applied to the patient's claim when submitted by an out-of-network provider.

Keep a watchful eye on your insurance payments. Be sure your front-office staff is trained in deciphering health insurance cards with PPO logos. The office should carefully review all explanation of benefits notices to identify discounts. Beware of "cold calls" and invitations from PPOs to join their networks. There is a possibility the PPO is a rental PPO that is attempting to increase their provider network.

Before signing a PPO agreement, review the contract thoroughly and exercise caution. Gather a clear understanding of all contract provisions and their implications for your practice.

Fortunately, some states have legislation that requires greater transparency from the insurer to the provider, such as making it an unfair trade practice for insurers to intentionally misrepresent themselves to a health care provider in order to get preferred provider or other discounts they aren't entitled to.

A Provider Contracting Checklist

This basic list of common issues and concerns related to contractual agreements is not a substitute for legal advice. Although contracts are entered into at a point in time, they should still be thought of as dynamic documents. Changes in the business goals, growth, or vision, as well as occasional contract updates, may make a once-compatible contractual arrangement now obsolete. Review contract terms initially, then periodically, to ensure that they fulfill your needs and to assess your clinic's and the payer's compliance. You should have your legal advisors review any information that is unclear.

Is a New (or Existing) Contract Right for You?

There are several steps you can take and questions you can ask before deciding whether a particular contract meets your business needs.

- Perform an external assessment. Will the contract help you remain competitive? Does the payer have a significant market share in your region?
- Perform an internal assessment. Do you have the resources to manage this contract — from pretreatment benefit and authorization review to claim submission and collections?
- Is there a provider representative or provider relationships manager available to speak with if you have questions or issues with the contract, now or in the future?
- Will the provider representative visit your practice? (This is a positive if you have a great practice environment that is a model of professionalism.)
- Assess contract terms and payments relative to your costs and resources.
- Negotiate the contract. (Read more about negotiation on page XX.)
- Sign (or cancel existing) contract.
- Identify the insurer's specific credentialing process if you agree to sign. Get all the necessary forms and documents before signing any part of a contract. If you are terminating a contract, obtain a letter of acknowledgement from the payer that your termination has been accepted and will be effective on a specific date. Make sure you complete your obligations under the contract terms.
- Educate your staff on processing contract terms, executing contract and internally required systems, and managing patients who are no longer covered.
- Monitor accounts receivable of payer and internal collections process for errors.
- Gather statistics on the value proposition of your practice relative to benchmarks. Does your clinic offer better clinical outcomes, specific services unavailable in your geographical area, or any other item that will make your clinic more valuable to the insurer? The longer you've had these practices in place, the better.

Once a provider determines that a contract may be financially and administratively acceptable, there are several other factors to consider.

Administrative Factors

- Does the contract have an "evergreen clause"—does it automatically renew? (This typically occurs annually.)
- Is an administrative fee or surcharge required during the life of the contract?
- Are the credentialing and recredentialing processes simple and timely?
- What are the malpractice and liability insurance requirements, such as group vs. individual policies and the respective dollar amounts?
- Reassignment of a contract: When a practice is acquired, can it transfer the contract to a new owner?

Terms of Contract

Every contract defines the terms it uses. Unfortunately, the insurer usually makes unilateral decisions — as in, they aren't required to inform you — when making modifications.

While this is especially true when it comes to payment terms, that section of the contract should not be the sole focus of a careful review, as other contract terms can influence the provider's net profits:

- Are the definitions clear?
- Are the definitions consistent throughout the contract?
- How is "medical necessity" defined?
- How is "covered services" defined?
- Is there a clear and concise list of services that are considered "covered" by the plan?

Claims Requirements

- Is "timely filing" defined in the agreement? (Timely filing is the duration of time allowed to submit a claim to the insurer. Usually, the longer the duration, the less risk that a claim will not have the opportunity to be resubmitted if it gets lost or delayed in sending to the insurer.)
- What is the expected turnaround time for payment of a clean claim?
- What is your state's prompt payment law?
- Is your state's prompt payment law reflected in the contract?
- Are you permitted to apply interest charges if claims are not paid in the agreed-upon time? This is dictated by federal and state laws and can often also be determined or changed by the state commissioner of insurance.
- How does the plan handle coordination of benefits?

The Appeals Process

- Are the appeal policies clearly defined?
- What is the filing deadline?
- Where and to whom should the appeals be submitted? Many insurance plans have several plan options and claims addresses that can act as processing centers.
- What are the levels of appeals?
- How are retroactive denials handled?

Compensation

- Does the contract include a comprehensive fee schedule? If so, compare this with the conditions you most commonly treat.
- Which payment method is used under this agreement? Discounted fee-for-service, per diem or per visit, capitation, per episode, or something else?
- Are you permitted to bill the patient if payer does not pay the claim?
- Are you permitted to charge for no-shows and/or cancellations?
- Are you permitted to bill for services not covered under this plan, such as durable medical equipment and certain modalities?
- How do you verify benefits, such as electronically, by phone, or by fax?
- How long does it take to verify benefits?
- How often does the insurer update member benefits?

- How do you obtain prior authorizations, such as electronically, by phone, or by fax?
- What is the process for checking on submitted claims?
- Does the payer require electronic submission of claims and electronic receipt of payments?
- Are payments modified based on an annual cost-of-living allowance? Try to get a COLA clause in the contract when first negotiating. COLA is usually tied to the Consumer Price Index.

Prior Authorization/Utilization Management

- Are prior authorizations required?
- Are prior authorizations processed internally or by an external vendor?
- What are the specific standards for utilization management determinations and are they available to you?
- What is required of you to participate in the prior authorization program?
- Is the utilization management program tiered?
- Do you receive incentives, such as additional visits for patients without prior authorization, for favorable participation in the utilization management program?
- How are audits performed? What is the limitation or retroactive date from the date of service? How are refunds requested?

Rental Networks (Silent PPOs)

- Is there an “all-payer” clause in the agreement? If so, this will enable the payer to rent or lease its provider network to other payers. You will lose any control and independence if assigning the rights for the payer to lease or rent the contract.
- Are you charged an administrative fee for participating with the network? Are you permitted to opt out on a payer-by-payer basis?
- Who are the payers covered under this arrangement? Obtain a list of payers.
- Will the insurer notify you when a payer is added to the payer/client list?
- What method is used to identify that a patient belongs to a rental PPO? Is it identified on the patient's health insurance card?

Amendments

- Is there an opt-out option if an amendment is not agreeable?
- How long will you have to review an amendment before accepting or rejecting it?

Dispute Resolution

- Appeal process: If a claim is denied, what is the mechanism for appealing to reverse the denial and get paid for services rendered? What methods of appeal are available?
- Internal vs. external: Most insurers have at least one mechanism for internal appeal, by which you can speak with an insurance representative to reverse a denied claim. There also usually is at least one external appeal — similar to an arbitrator, an independent party that will hear both sides and decide on whether a claim should be denied or paid.
- Arbitration: Under arbitration, two parties agree to provide testimony to an officer of the court who judges a disputed claim.

- Mediation: Under mediation, two disputing parties present their case to an officer of the court in the hopes of finding resolution without litigation. In nonbinding mediation, either party can leave the process at any time without coming to a resolution. In binding mediation, a mediator is appointed who is responsible for attempting to get the parties to voluntarily settle their dispute.
- Litigation: If all other avenues are exhausted, the parties bring a dispute to court.

Termination

- For cause: You may have specific reasons to terminate a contract due to a breach of a term or a change in terms that you may deem unfavorable or unjust.
- Without cause: Some states allow termination of contract without specific cause but may require a contractually or a state-mandated notice period.
- What are your obligations to continue care after termination? If you terminate a contract, do you have to maintain medical records for a period of time, continue treatment until the patient discharges, or accept patients for a period of time after you have given notice of contract termination?
- Does the provider have the right to immediately terminate the agreement if payer becomes insolvent?

Other Payer Obligations

- The payer must provide you with the plan's administrative/policies and procedures manual.
- The payer should clearly identify and list the enrollment/credentialing process.
- The payer should explain requirements for the precertification process. Some insurers may require a site visits before accepting you into a network.
- The payer must establish a procedure for verification of patient eligibility.
- The payer should clearly state coding and billing guidelines.
- If the plan is a PPO, the payer should provide a list of payers covered under the plan.
- The payer should frequently update its provider directory in electronic and hard copy form. The more often, the better.

Getting to “Yes”: Securing Managed Care Contracts

Many managed care plans decline to contract with some or all private-practice physical therapists despite a generally competitive service price and a record of quality outcomes. Such refusals, legal in most states, are often cited by the insurance company as legitimate due to the relatively high administrative costs of signing new providers and a saturated network. One of the real reasons, however, is that physical therapists may not adequately differentiate themselves from one another in terms of quality and value for the payer. Understanding the managed care plan’s vantage point can help you obtain a valuable contract.

A Managed Care Plan’s Perspective

Negotiating and administering a contract are fixed expenses for a managed care plan, regardless of the provider’s volume of business; thus, the cost per patient is far lower for a large hospital than for a small private practice. Such costs may well be higher than any savings in service prices. Further, administrative costs are the sole basis of profit or loss for managed care plans’ self-insured products.

Administrative costs are also particularly important when a managed care plan has legally achieved its obligation or believes it has achieved its own goal of sufficient provider representation in its network. In that case, the marginal administrative costs of including physical therapy as one of many services in a hospital contract are very low. In contrast, if a mature network contracts with a private PT practice, it incurs relatively high initial costs, which can only be offset by reducing patient services or decreasing provider payment well into the contract’s run (if at all).

Another likely impediment to contracting with private practices is that to do so would weaken a plan’s fiscal leverage with hospitals and physicians. A managed care plan must have some hospitals and physicians in its network. Yet hospitals and doctors may offer lower overall fee discounts on other services and products if physical therapy or physical medicine is excluded from their contracts.

Finally, although private practices’ nominal fees per service and per visit typically are highly competitive — about 10% below those of physicians and 60% below those of hospitals — the lower total per-episode fee comparisons have not been identified or accepted by insurance companies. Insurers might be concerned that private practices may offset lower prices per unit with longer episode durations.

Tactics for Success

Achieve Economies of Scale

Physical therapy independent practice associations and preferred provider organizations, amalgams of multiple private practices, are operating in several states. This one-stop contracting obviously reduces managed care plans’ administrative costs. Key elements include the number of practices involved and their geographic and specialty coverage relative to those needed by the plan. Some PT provider networks also have internal quality and utilization management mechanisms that add to their attractiveness.

Service diversification is another way to achieve economies of scale. Of course, each type of service has a critical minimum volume it needs to remain profitable — it is inefficient to have specialized staff and equipment merely to treat one pediatric patient per month. However, once a break-even level of volume is achieved, service diversification offers managed care plans a greater degree of one-stop shopping.

Offer Niche Services

Managed care plans may be willing to carve out highly specialized services. This can occur in either of two instances: if a practice offers services that are truly unique in the local market — such as pediatric physical therapy in a smaller community; or if it offers quality specialty services — such as functional capacity evaluations — at a relatively high volume. If the plan considers these services essential and there is enough market demand, you are in a good bargaining position.

Document Your Practice's Clinical and Fiscal Success

Providing the payer with data on your practice's outcomes including cost and quality will help in your negotiations. Be as specific as possible: For example, show an 86% rate of return to work within one month for carpal tunnel patients, or an episode duration of three visits or less for 92% of sprain or strain patients. You also can use research articles to support the value of specialized training; for example, research shows that PTs with ABPTS certification, such as a cardiovascular/pulmonary or sports specialty, are more knowledgeable than their noncertified peers. Childs JD, Whitman JM, Sizer PS, Pugia ML, Flynn TW, Delitto A. A description of physical therapists' knowledge in managing musculoskeletal conditions. *BMC Musculoskeletal Disord.* 2005;6:32. <http://www.biomedcentral.com/1471-2474/6/32>. Accessed May 1, 2012.

Ask Others To “Carry Your Water”

If any of your primary referring physicians are affiliated with the network with which you seek to contract, ask them to contact the plan to request your involvement. Similar letters from employer health plans and patients with the network's coverage also may help.

Be Flexible on Payment and Structural Issues

Some providers accept capitation as the basis of payment, offer to accept preset per-episode fees, or offer various guarantees, such as per-episode costs no greater than a set amount or returning patients to work within a set number of weeks. Such flexibility in payment mechanisms and prices is a key consideration for many managed care plans. Similarly, offering evening and/or weekend hours may set you apart from other clinics.

Some managed care plans want your practice to agree to participate in either all its products (PPO, POS, and HMO) in order to participate at all. A particular contract may appear unprofitable compared with your average costs but may be profitable under your generally lower marginal costs. In addition, the administrative costs of multiple contracts with a plan are only slightly higher than for a single contract, yet potential business volume is multiplied. Finally, unless you are willing to sue the plan by claiming an unlawful “tying arrangement,” your only practical choices may be signing all contracts or no contracts. Some plans may ask you to assign them the rights to negotiate for you with other plans or to negotiate the payment amount for you. These tying arrangements are highly discouraged, because you would lose any power in identifying which contracts fit your individual needs.

Facilitate Ongoing Administration

This means doing any of the following if requested by the plan: Use HCFA-1500 claim format and CPT service coding, bill electronically, and submit requested clinical records in a timely manner in the desired format, such as electronically, or via fax or mail.

Leverage Affiliations With Competing Managed Care Plans

If you have contracts with other managed care plans, you may be able to use this as leverage: “Your competitors know something you don't.”

Down to Business: Negotiating the Contract

You might be inexperienced or uncomfortable with negotiating techniques. Now that you have established your leverage, here are some tips for improving your negotiation skills.

Establish Relationships

It is beneficial to establish relationships with plan representatives from the very beginning, even before beginning negotiations.

Prepare, Prepare, Prepare

Learn as much as you can about the organization, the company structure, the decision makers, the history of the issue, and any other pertinent information. Negotiating is a process, not an event.

Organize a Team of Experts

Negotiations with insurance companies are difficult and frustrating. The burn-out rate of health care negotiators is high, and PTs have limited time to devote to negotiations, so a team approach is essential. Your team should consist of at least three negotiators, with a designated leader. Your team must be committed to the process and a good outcome, and be willing to invest time in the negotiations. Around the core negotiating team should be numerous advisors with different backgrounds and personalities to ensure diverse input and feedback. Be careful of people who have exhibited strong uncontrolled emotions or have had previous negative communication or negotiating experiences with the insurance company. Such experiences could hinder open communication, healthy relationships, and fruitful discussions, and could doom your outcome before the negotiations have even started.

Include APTA Staff as Part of Your Advisory Group

APTA's experienced and knowledgeable staff are readily available to members. (Contact advocacy@apta.org.)

Now that you have a negotiating team, continue your preparation. Make sure everyone is aware of the who, what, where, when, why, what-ifs, how much, and why not. Set the goals and objectives for the negotiations and make sure everyone on your team can define these goals clearly and concisely. Have a general information meeting to explain the negotiating process and how it relates to the main problem, the objectives, and the goals.

Negotiation is not about being right or wrong, but about finding mutual ground for a win-win solution. For example, help the insurance company improve the quality of physical therapist services provided to its subscribers in return for fairer reimbursement and achieving direct access to physical therapy care, or help the insurance company set the boundaries to avoid overutilization of rehabilitation services. The goal is to create an alignment of benefits for both parties.

The next step is to practice the negotiations. Explore as a team all the counterarguments that the other side will present. Have clear answers to all the questions, concerns, and arguments. Have multiple people role-play the negotiations and defend different positions. All team members should be able to clearly and effectively state their positions. Pay attention to the delivery as much as the message, as negotiations can fail based on nonverbal communication cues regardless of how well you are able to verbalize your position. Simple things such as individually acknowledging and introducing yourself to everyone at the table, maintaining eye contact, listening actively by leaning forward, nodding to show you are listening, smiling, adopting good posture, and remaining calm are skills you can practice to become a better communicator.

Other items to prepare prior to the negotiations are the meeting place, the agenda, the attendance list, and a debriefing meeting. Most meetings with insurance companies will take place on their territory, often in one of their meeting rooms with the two groups on opposite sides of the table. Your lead negotiator should be in the middle of your delegation and facing the person you believe is the key decision-maker.

Prepare the agenda and send it to the insurance company at least a week in advance. Include a letter thanking them for their willingness to meet with you. If the other side has topics to discuss, combine them with yours ahead of time and create a balanced agenda. Try to control the topics being discussed, give the other side a “heads-up” about your topics so they can prepare their position, and limit the topics to a maximum of three. Too many topics will distract from your goal and allows the other side to jump to the next item before satisfactorily discussing the previous item.

Prior to the meeting, obtain the names of attendees. Because your time is valuable, make sure the decision makers and people from the correct departments are across the table to make your negotiations productive and efficient.

For example, if you want to improve clinical guidelines, include the medical director. As well, do not attempt to negotiate increased reimbursement with only the clinical review nurse and legal counsel. Sometimes this situation occurs because the company doesn't understand the problems PTs face as clinicians, sees the problem differently from how PTs do, or simply don't have a full understanding of what PTs do. Unfortunately, sometimes it is also part of their negotiating tactics.

It is common for PTs to back off in contract negotiations once they have agreed on the payment rates. However, this can be problematic for a practice, as there are many contingencies in contracts that can be damaging if not properly addressed in the negotiation process.

During the negotiations:

- Arrive early. This will give you time to acclimate to the surroundings, prepare mentally, and to informally meet the other negotiators. The more you learn early about the other side, the better — it might be useful later.
- Keep the discussions on target. Discussions and negotiations may get off track for a variety of reasons, such as to pacify the opponent. Bring the other side back to your main issue and restate the problem. Remain calm, polite, but firm. Avoid emotional outbursts.
- Avoid overloading the discussion. Remain on target to achieve your primary objective. Only move to the next agenda item if you are satisfied with the outcome of the previous item and have a plan to implement the changes, or when you feel the negotiations are stalling and you are stuck on the subject.
- Move on if everything seems to be said, there does not seem to be common ground, participants start repeating their positions, or you feel that spending more time on the topic will not lead to a positive outcome. One option is to table the item but state that you would like to continue the discussion on this topic, keeping the door open for a renewed effort or changed strategy.
- When the meeting is coming to an end, restate the agreed actions or solutions. Make sure everyone hears what has been agreed on and who will take what action in what time frame. Clarity is key. Thank the other party for taking the time to meet with you and reiterate that you look forward to the implementation of the agreed points or to the next meeting to continue the positive dialogue.

After the negotiations:

- Immediately after the negotiations, regroup privately and evaluate the meeting. What went right? What went wrong? What has been accomplished? How do these accomplishments relate to the main goals? Who will write the summary of the meeting? What are the next steps?
- Assign someone to provide a summary of the meeting to all team members and possibly chapter members or committees. Identify next steps and action items. Send a copy to the insurance company for review. It is crucial to maintain a paper record of your negotiations.
- Pinpoint those on the other side who seem to be most receptive to your problems and possible solutions. Determine options to pursue during the next meeting, as well as options that need further exploration. Preparation for the next meeting should begin immediately after the last meeting.
- Relax and step away from the problem for a couple of days. Clear your mind so you can tackle the issue with renewed energy and clear vision.

A Few More Negotiating Tips

- **Show respect.** Treat others the way you would like to be treated. Be sensitive to culture, environment, and events affecting your negotiations.
- **Listen.** Actively listen, ask questions, and watch for opportunities for mutual gains. This shows you are trying to understand the other side's points of view and situation.
- **Maintain good communication at all times.** Assume the best and stay positive.
- **Be honest.** Have your facts straight. Never lie or be deceitful, or you will lose credibility and bargaining power.
- **Look for the win-win.** Seek solutions or compromise on both sides to come up with a solution that both sides can sell to their constituents, bosses, membership, or others as a positive outcome.
- **Be confident.** Good negotiators have high self-esteem and feel passionate about their cause.
- **Speak in order.** Only one person should speak at a time. Do not try to battle by raising your voice or interrupting people.
- **Provide contact information.** Provide the other side with your delegation's business cards so they can easily contact you and maintain open lines of communication.
- **Avoid irritation.** Do not let the other side "get under your skin." Remain calm and separate the people from the problem.
- **Keep sight of the big picture.** Look at your objectives and focus on your goals.
- **Do not look or act needy.** If you are needy, you lose control and may make poor decisions. Look for the needs of the other side.
- **Use "we," not "you."** Start sentences with "we" or "I." For example, don't say: "You have underpaid us for years and you don't seem to care." Instead say: "We believe we have not been fairly compensated for our services especially if you compare your reimbursement rate to Medicare. I believe that there is not much interest from your company's point of view to change this problem."
- **Put the agreement in writing.** Ensure that the other party is fully authorized to close the deal. Record all finalized agreements in detail at the conclusion of the negotiations. Verify that everyone agrees with the final written document and make sure it is clear, well defined, and complete. If you are not satisfied with the deal, do not sign it.

When Should I Walk Away?

This is probably one of the most difficult decisions to make. Sometimes it does not make sense to continue negotiations. For example, you may have covered the same issues repeatedly and the other side is not willing to negotiate, or the other party is not showing the respect you feel you deserve. Walking away from the negotiating table sometimes is inevitable when the decision makers are not willing to meet with you, but instead send representatives who have no decision-making power.

If you cannot get the other side to focus on your main objective, or they have demonstrated that they do not want to negotiate, you are faced with the option to stop negotiating. Walk away, because you may be wasting your valuable time. Discuss this with your team of negotiators. If you all agree, end the current discussions. Inform the other side that you do not see enough improvement to warrant time away from your patients. Never burn any bridges because you very likely will have to deal with the same people or organization at some point in your career.

Another option may be the use of a mediator. This could be a neutral health care attorney who has experience in health care negotiation or someone from your state insurance commissioner's office or department of insurance.

Conclusion

Although the other side of the bargaining table is often more skilled in negotiating than you are, no one knows more about physical therapy than your team. Mastering these negotiating techniques and becoming comfortable with your personal style of negotiating will take time, effort, and practice. Good negotiators can call on a range of negotiating styles to use in different situations. Developing multiple styles of negotiating makes you more flexible and adaptable to all different situations during the negotiating process.

Learn from the people who have done it before. Talk to people who negotiate for a living. Read about techniques, tactics, and skill development. Practice your skills. Remember: Everything in life is a negotiation. Every relationship is full of negotiating experiences. Practice does make perfect. Physical therapists should view negotiation as a skill of every effective leader in the current and future health care environment.

Glossary 1. Financial Terms

90-day average: Ratio of payments and adjustments to charges; in other words, the collection rate — how well you are collecting actual collectible dollars.

Administrative costs as % of net revenue: Administrative overhead ÷ net revenue.

Direct costs: Costs that are directly related to producing the goods or services, such as salaries and durable medical equipment.

EBITDA: Earnings before interest, taxes, depreciation, and amortization. (Similar to a cash-based accounting system in which only the incoming and outgoing cash that has traded hands is calculated.)

EBITDA as % of net revenue: Clinic-level EBITDA ÷ net revenue.

Economies of scale: Lowering the average cost of services or goods produced by sharing fixed costs, such as using one advertising person for multiple clinics and sharing office space with other clinicians.

Fixed costs: Costs that do not change and are predictable, such as rent, office cleaning, and insurance.

Gross collection rate: Net receipts ÷ gross charges — what you collect on each billed dollar.

Gross total income: Total amount of money collected for goods or services sold. If accounting is done on a cash basis, only the cash collected for the financial period is counted and without outstanding accounts receivables.

Indirect costs: Costs that may not be directly attributed to producing a good or service, such as phones and advertising. These are referred to as overhead or burden costs.

Net ordinary income: Profits from the business operations. This value is usually matched on a tax return.

Net receipts: Gross profit minus any refunds (cash in –cash out).

Net profit: Gross profit minus all liabilities and overhead costs — the income left after all expenses are paid.

Net collection rate: (All payments minus patient refunds) ÷ (All charges minus write-offs or adjustments). Can also be calculated as net receipts ÷ net charges. Your ratio should be above 90%. (Note: Write-offs should be identified, such as contractual or bad debt.)

Labor cost per visit: Clinic salaries, wages, and benefits ÷ total number of actual visits. Should be differentiated into professional and support staff.

Ratio of labor cost to total cost: Salaries, wages, and benefits ÷ total clinic expenses.

Units per visit: Total number of billed units ÷ total number of patient visits.

Variable costs: Costs that tend to change because of volume, season, or other easily modified factors.

Glossary 2. Health Insurance Terms

General

Administrative services only: An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing. The employer bears the risk for claims. This is common in self-insured health care plans.

Association health plans: This term is sometimes used loosely to refer to any health plan sponsored by an association. It also has a precise definition under the Health Insurance Portability and Accountability Act of 1996 that exempts from certain requirements insurers that sell insurance to small employers only through association health plans that meet the definition.

Coinsurance: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the payment for covered benefits up to allowed charges: The individual could also be responsible for any charges in excess of what the insurer determines to be “usual, customary, and reasonable.” Coinsurance rates may differ if services are received from an approved provider (ie, a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list. In addition to overall coinsurance rates, rates may also differ for different types of services.

Copayment: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. There may be separate copayments for different services. Some plans require that a deductible first be met for some specific services before a copayment applies.

Deductible: A fixed dollar amount during the benefit period, usually a year, that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.

Flexible spending accounts or arrangements: Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee’s share of insurance premiums or medical expenses not covered by the employer’s health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Flexible benefits plan (also called cafeteria plan and IRS 125 Plan): A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

Fully insured plan: A plan under which the employer contracts with another organization to assume financial responsibility for the enrollees’ medical claims and for all incurred administrative costs.

Gatekeeper: Under some health insurance arrangements, a gatekeeper is responsible for the administration of the patient's treatment; the gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals, and hospitalizations.

Group purchasing arrangement: Any of a wide array of arrangements in which two or more small employers purchase health insurance collectively, often through a common intermediary who acts on their collective behalf. Such arrangements may go by many different names, including cooperatives, alliances, or business groups on health. They differ from one another by governance, functions, status, and other dimensions under federal and state laws. Some are set up or chartered by states, while others are entirely private enterprises. Some centralize more of the purchasing functions than others, including functions such as risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks. Depending on their functions, they may be subject to different state and/or federal rules. For example, they may be regulated as multiple employer welfare arrangements.

Health Care Plans and Systems

Conventional indemnity plan: An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.

Exclusive provider organization plan: An EPO is a restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

Health maintenance organization: An HMO is a health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.

- **Group model HMO:** An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.
- **Staff model HMO:** A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.
- **Network model HMO:** An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single-specialty and multi-specialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.
- **Individual practice association HMO:** A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

Indemnity Plan: A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

Point-of-service plan: A POS plan is an HMO/PPO hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed similar to conventional indemnity plans, such as provider reimbursement based on a fee schedule or usual, customary, and reasonable charges.

Preferred Provider organization plan: An indemnity plan which provides coverage to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

Claims Payment for Services

Fee for service: CPT codes, published by the American Medical Association, are listed for specific services in the contract with assigned dollar value. This is the maximum amount a payer will pay for services rendered. The provider is paid based on how many CPT codes and time he or she has billed the insurer.

Capitated plan: Capitation is commonly used for HMO plans, self-insured employer plans, independent physician associations, and physician hospital organizations. Providers are paid a fixed amount, usually on a monthly basis, for each patient enrolled in the plan. The provider is obligated to provide the necessary care under this arrangement.

Discounted arrangements: The provider is paid through a third party that usually discounts the provider's fees to the payer.

Per diem rates: The provider is paid a fixed fee per visit regardless of the duration, frequency, or complexity of care provided. These are most common in hospital payments.

Pay for performance or value-based care: This model surfaced over the years as health care stakeholders have looked to maximize value in terms of outcomes and cost. The provider is paid based on a metric of desired outcome and may assume risk. Common payment methods are:

- **Episodic care of payments:** Payment is assigned based on resolution of a specific condition.
- **Bundled payment:** Provider or a group of providers receives a single payment that covers an array of services needed to manage a specific condition.
- **Shared savings:** Providers receive a portion of the cost savings associated with managing a condition and achieving a desired outcome.

Balance billing: Billing a patient for the difference between what was billed to the insurance company and what the provider was paid from the insurer. Most state provider contracts prohibit this.

Physician-hospital organization: A PHO is an alliance between physicians and hospitals to help providers attain market share, improve bargaining power, and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

Managed care plans: Managed care plans generally provide comprehensive health services to their members and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include:

- Health maintenance organization
- Preferred provider organization
- Exclusive provider organization
- Point of service plan

Managed care provisions: Features within health plans that provide insurers with a way to manage the cost, use, and quality of health care services received by group members. Examples of managed care provisions include:

- **Pre-admission certification:** An authorization for hospital admission given by a health care provider to a group member prior to their hospitalization. Failure to obtain a pre-admission certification in nonemergency situations reduces or eliminates the health care provider's obligation to pay for services rendered.
- **Utilization management/review:** The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.
- **Preadmission testing:** A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
- **Nonemergency weekend admission restriction:** A requirement that imposes limits on reimbursement to patients for nonemergency weekend hospital admissions.
- **Second surgical opinion:** A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.
- **Maximum plan dollar limit:** The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan. Plans can have a yearly and/or a lifetime maximum dollar limit. The most typical maximum is a lifetime amount of \$1 million per individual.

Maximum out-of-pocket expense: The maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum. (See Maximum plan dollar limit.)

Medical Savings accounts: MSAs are accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a flexible spending account and an MSA is the ability under an MSA to carry over unused funds to a future year, instead of losing unused funds at the end of the year. Also unlike FSAs, most MSAs are combined with a high-deductible or catastrophic health insurance plan.

Minimum premium plan: A plan under which the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

Multiple employer welfare arrangement: MEWA is a technical term under federal law that encompasses essentially any arrangement not maintained pursuant to a collective bargaining agreement (other than a state-licensed insurance company or HMO) that provides health insurance benefits to the employees of two or more private employers.

Some MEWAs are sponsored by associations that are local, specific to a trade or industry, and exist for business purposes other than providing health insurance. Such MEWAs most often are regulated as employee health benefit plans under the Employee Retirement Income Security Act of 1974, although states generally also retain the right to regulate them, much the way states regulate insurance companies. They can be funded through tax-exempt trusts known as voluntary employees beneficiary associations and they can and often do use these trusts to self-insure rather than to purchase insurance policies.

Other MEWAs are sponsored by Chambers of Commerce or similar organizations of relatively unrelated employers. These MEWAs are not considered to be health plans under ERISA. Instead, each participating employer's plan is regulated separately under ERISA. States are free to regulate the MEWAs themselves.

These MEWAs tend to serve as vehicles for participating employers to buy insurance policies from state-licensed insurance companies or HMOs. They do not tend to self-insure.

Multi-employer health plan: Generally, an employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers. These plans are also known as Taft-Hartley plans or jointly administered plans. They are subject to federal but not state law, although states may regulate any insurance policies that they buy. They often self-insure.

Premium: Agreed-upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured individual and the plan sponsor.

Premium equivalent: For self-insured plans, the cost per covered employee, or the amount the firm would expect to reflect the cost of claims paid, administrative costs, and stop-loss premiums.

Primary care physician: A PCP serves as a group member's primary contact within the health plan. In a managed care plan, the primary care physician provides basic medical services, coordinates, and, if required by the plan, authorizes referrals to specialists and hospitals.

Reinsurance: The acceptance by one or more insurers, called reinsurers or assuming companies, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage.

Self-insured plan: A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third-party administrators for claims processing and other administrative services; other self-insured plans are self-administered. Minimum premium plans are included in the self-insured health plan category. All types of plans (conventional indemnity, PPO, EPO, HMO, POS, and PHO) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.

Stop-loss coverage: A form of reinsurance for self-insured employers that limits the amount employers must pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Third-party administrator: An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

Types of health care provider arrangements:

- **Exclusive providers:** Enrollees must go to providers associated with the plan for all nonemergency care for the costs to be covered.
- **Any providers:** Enrollees may go to providers of their choice with no cost incentives to use a designated subset of providers.
- **Mix of providers:** Enrollees may go to any provider but there is a cost incentive to use a designated subset of providers.

Usual, customary, and reasonable charges: Conventional indemnity plans operate based on UCR charges, meaning that the charge is the provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount.

Glossary 3. Contracting Terms

Covered services: Benefits to which plan members are entitled under the terms of an applicable insurer contract.

Hold harmless clause: A provision in an agreement under which one or both parties agree not to hold the other party responsible for any loss, damage, or legal liability.

Managed care organization: Any organization that uses managed care techniques in providing health services. Some are independent organizations, while others may be division of other corporations such as insurance companies.

Medically necessary: Describes medical procedures or care that may be justified as reasonable, necessary, and/or appropriate based on evidence-based clinical standards of care.

Member: Includes both a subscriber and his or her eligible family members for whom premium payment has been made. This term is synonymous with enrollee.

Participating provider: A physician, hospital, skilled nursing facility, home health agency, or any other duly licensed institution or health care professional under contract with an insurer to provide professional services to members.

Payer: The party that makes payment for services under the insurance coverage policy. Most often the payer is the same as the insurer. In the case of very large self-insured employer, the payer is a separate entity under contract to handle the administration of the insurance policy.

Preferred provider organization: An insurance plan that contracts with providers at a discounted rate and an insurer that in return grants those providers preferred status.

Referral: A medical professional's recommendation for a patient or client to consult another medical professional either for specialized services or a second opinion.

Subscriber: An individual who has contracted, or on whose behalf a contract has been entered into, with an insurer for health care services.

Third party: A person or organization ancillary to the doctor-patient relationship that participates in the services rendered by reviewing, processing, and/or paying the claims for health services provided.

Utilization management/review: The critical examination by a health care professional of health care services provided to patients, especially for the purpose of controlling costs, by identifying unnecessary medical procedures, and monitoring the quality of care.

Additional Resources

[America's Health Insurance Plans](#): National association of providers of coverage for health care and health-related services.

[American Health Law Association](#): Nonprofit, nonpartisan educational organization devoted to legal issues in the health care field.