

## PHYSICIAN PRACTICES

## POSSIBILITIES



inside

## Managing Managed Care Contracts

### OVERVIEW

Most physician practices struggle with decisions about whether or not to participate in third-party payer contracts. This article discusses a methodology for evaluating the business and operational aspects of payer contracts.

Whether large or small, new or mature, providing general or specialty care—most physician practices are struggling with decisions about whether or not to participate in third-party payer contracts. Understanding, negotiating, implementing and managing third-party payer contracts requires time and planning. But, meeting the needs of your practice and getting a fair and understandable contract can make that effort a good investment.

The methodology discussed in this article can be used to assess a new contract or to perform a retrospective examination of an existing contract, allowing you to rank all your payer contracts. This will help you make decisions as to which have better terms and improved patient demographics.

### Assessing Practice Profile and Capacity

Three key elements should be reviewed during the practice assessment: Patient demographics, practice statistics and practice capacity.

#### Patient Demographics

Knowledge of age distribution and overall socioeconomic characteristics of active patients is important in order to compare the characteristics of your practice to the employee groups being enrolled or targeted by a particular payer. An understanding of patients' employers will enable you to assess areas, such as whether the payer is, or might be, focusing on key employer groups served by the practice and the impact on utilization. Employment information is important in determining the likelihood of existing patients

migrating to those plans offered by their employers, and those patients who could potentially be lost through non-participation with a particular plan.

In addition, understanding the types of medical procedures commonly performed by CPT code by payer mix for each physician in the practice will serve as the starting point for fee impact and treatment plan analyses. Minimally, the top 10 to 20 CPT codes by the number of patients seen, gross charges generated and payments received should be listed and analyzed. Most of the data should be available from your computerized practice management system, but can be obtained from a sampling of your appointment books, day sheets and accounts receivable records.

#### Practice Statistics

Understanding your historical utilization and financial trends will make it possible to broadly estimate the expansion capabilities of the practice and the effect on practice income of patients gained or lost through third-party payer contracting. In addition, knowledge of referral patterns (both

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*Contracts—from page 1*

to and from), allows comparison of the payer’s existing physician panel and your active physician referral network. As the administrative procedures of the payer contract are reviewed, a physician, particularly a specialist, may find that the referral and reimbursement procedures interrupt patient care and trust, as well as his/her income. The following information should be analyzed, minimally, for a three-year period:

- Average visits per active patient per year
- Average charge per active patient visit
- Average number of new patients per year
- Number of referrals to/from your practice
- Specialty services you most frequently refer
- Top sources of referrals to your practice
- Average referral income per patient per year



*Contracting objectives should be clearly defined and understood by the evaluation and negotiation teams. The evaluation team should not only consist of the physician(s) and the office manager, but also other key practice personnel and the practice’s outside advisors (i.e., attorney, business advisor).*

Some payers require specific treatment and/or diagnostic procedures be provided by a specific provider/vendor. As a result, the practice may find that it can no longer provide the service in-house and has to deal with multiple vendors at a cost of money and time. In addition, payers may include certain tests and procedures in their reimbursement rates, possibly creating a reduction in practice income. Therefore, an understanding of your ancillary services—what is performed in-house versus by an outside vendor, number of units for each procedure separately charged and the gross charges and payments—is essential.

### **Practice Capacity**

Knowing your willingness and ability to see more patients is important when considering participating in a payer contract. Understanding where your time is spent—direct patient contact, dictation, administration—is crucial. In addition, knowing the number and reasons for losing patients is important in estimating the impact of plans with which you are not affiliated. The following information should be analyzed, minimally, for a three-year period:

- Average number of patients seen per week
- Average number of days office is open for patient visits
- Number of requests for patient record transfers by reason for request

## **Evaluating the Payer Contract**

The decision to participate in a third-party payer contract is a difficult one, and is largely dependent upon the objectives of the individual practice. Contracting objectives should be clearly defined and understood by the evaluation and negotiation teams. The evaluation team should not only consist of the physician(s) and the office manager, but also other key practice personnel and the practice’s outside advisors (e.g., attorney, business advisor). Successful managed care contracting starts with a thorough and critical review of the agreement, utilizing a systematic, consistent process. There are six key areas of review:

- Plan background
- Overall key contract terms
- Eligibility/authorizations
- Utilization review
- Compensation and reimbursement
- Risk management

For each key area, the following are fundamental questions and items to consider during your review process. The items presented, while not all inclusive, are designed to help you evaluate the contract terms.

### **Plan Background**

- Which employers use the plan(s)?
- How many covered lives are in each plan and how many subscribers are located in each zip code?
- Request a current copy of the medical director’s curriculum vitae.
- Request a current copy of various directories (e.g., participating physicians, vendors).
- Request current copies of all handbooks, policies/procedures manuals, exhibits, etc.
- What types of plans are included under the contract?
- Will you be expected to treat patients covered under plans offered by affiliates of the plan? Under which terms will you be expected to participate?

### **Overall Key Contract Terms**

#### *Administration*

- Are the definitions of key words or phrases written so there is only one interpretation?

- Is the contract assignable and is the written consent of both parties required?
- Can the contract be amended and is the written consent of both parties required?

### *Term and Termination*

- Is the term of the contract multi-year?
- Does the termination provision allow either party to terminate the contract with cause on short notice?
- Are termination for cause reasons clearly defined?
- Does the termination provision allow either party to terminate the contract without cause and with a specified notice period?
- Is there an acceptable cure period?
- Does the contract provide that, upon termination, patients being treated at that time be reimbursed at the contracted rate?
- Does the contract allow the physician to continue patient treatment after termination of contract?
- Does the contract require continuation of treatment through a specified time period after contract termination and is reimbursement/payment clearly discussed?
- Does the contract contain notice provision and guarantee of payment if an employer fails to contribute to a self-funded plan?

### *Renewal Terms*

- Are renewal terms clearly stated?
- If the contract automatically renews, is there a provision for rate increases?

### *Resolution of Disputes*

- Does the contract address the appeals process for questions regarding appropriateness of treatment?
- Is there an appeals process for resolving payment/coverage disputes?

## **Eligibility and Authorization**

### *Member Eligibility*

- Does the contract provide for some form of member eligibility verification and the timing of such?
- Does the payer bear the risk of erroneous or late verification?

- Is there an appeals process for retroactive denial?

### *Eligible Services*

- Does the contract clearly define covered and non-covered services?
- Are contract services not routinely covered addressed?
- Does the contract state situations where a service may or may not be a covered benefit?

### *Pre-Authorization*

- Does the contract clearly specify pre-authorization procedures including contacts?
- Does the contract address evening/weekend procedures?
- Are the consequences of failing to obtain pre-authorization stated in the contract?
- Are emergent and non-emergent cases clearly defined?

### *Member Liability*

- Are co-payment responsibilities clearly stated?
- Is the member liable for payment of non-covered services?
- Do discounts apply to non-covered services?

## **Utilization Review**

### *Utilization Review*

- Is there a utilization review process and are contacts clearly identified?
- Do changes to the UR plan require prior notice and written consent?

### *Medical Records and Data Requirements*

- Does the payer pay for copying charges?
- Is written patient consent required prior to releasing medical records? Who is required to obtain consent?
- Does the contract require additional data/financial reporting and is it reasonable?

## **Compensation and Reimbursement Issues**

### *Compensation*

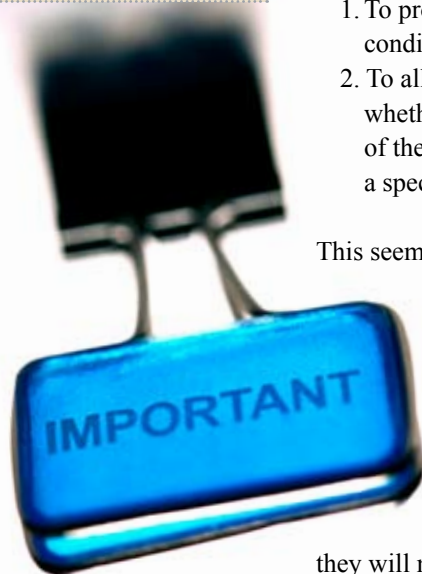
- How will the provider be compensated? Does it vary from plan to plan?



## 2010 CPT Coding Update

### OVERVIEW

This year CPT has added 226 codes, deleted 77 codes and revised 169 codes. The biggest impact to your practice will come in the form of consultation codes.



While there were no changes to the actual “consultation” codes listed within your 2010 CPT book, the introductory notes under the Evaluation and Management (E/M) subheading “Consultations” has been majorly revised. According to the introductory notes, consultation codes should be reported in only two circumstances:

1. To provide advice/opinion for a specific condition or problem.
2. To allow a determination to be made on whether to accept the ongoing management of the patient’s entire care or for the care of a specific condition.

This seems to clear up any past confusion regarding consultations, however, the Centers for Medicare and Medicaid Services (CMS) did not believe that physicians and coders were able to distinguish between an actual consultation and a transfer of care. To solve this problem, CMS has decided as of January 1, 2010, they will no longer accept claims containing consultation codes 99241-99245 (outpatient) and 99251-99255 (inpatient). The codes will be rejected by CMS with a statement clarifying “these codes are not recognized for payment.”

Does this mean your practice may no longer bill for consultations? Absolutely not. What this does mean is that CMS will require physicians to use different code sets to describe consultative services. In the inpatient setting, physicians will utilize the Initial Hospital Codes (99221-99223), and in the outpatient setting, physicians will utilize either the New Patient Codes (99201-99205) or the Established Patient Codes (99211-99215).

To distinguish between the Admitting Physician and any consulting physicians, modifier – AI has been created to append to the Admitting Physicians codes (99221-99223). It is important to note that this only applies to Medicare and Medicaid patients; you will need to contact all other payers for their recommendations on consultation coding.

### Telehealth Consultation Codes

By law, CMS must retain telehealth consultation codes. CMS has established the following three “G” codes to describe initial inpatient consultations for telehealth:

- G0425: Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth
- G0426: Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth
- G0427: Initial inpatient telehealth consultation, typically 70 minutes or more communicating with the patient via telehealth

### Resequenced Codes

Another significant change to the CPT 2010 book is the addition of the # symbol to signify a “resequenced code.” CPT has decided that the # symbol was created to be used when:

- The meaning and/or intent of a code changes
- Large groups of new concepts are added

As a result, it won’t be uncommon to see a code sequence such as:

- 21555: Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm
- 21552: 3 cm or greater
- 21556: Excision, tumor, soft tissue of neck or anterior thorax, subfascial; less than 5 cm
- 21554: 5 cm or greater

Please refer to Appendix N of the CPT Manual for all 27 resequenced codes.

### Musculoskeletal Coding

Extensive changes were made to the soft tissue tumor and bone tumor section of the musculoskeletal section of CPT 2010. This section also has the largest number of resequenced codes. These codes will need to be monitored carefully for changes.

CPT has cited three reasons for the vast number of changes:

- Significant advancements made in the treatment of bone and soft tissue tumor during the past 10 years
- To achieve greater granularity, consistency and standardization when reporting services
- Address rank-order valuation anomalies

Due to the fact that excision size was not accurately reflected and malignant skin tumors were mistakenly confused with radical soft tissue excisions, CPT made the decision to expand the musculoskeletal section.

**CODING TIP:** Radical Resection of Soft Tissue Tumor Codes generally apply to malignant soft tissue sarcomas and do NOT usually include malignant skin tumors, such as basal cell carcinoma and squamous cell carcinomas. The radical codes do NOT use depth as a coding determinant (all lesions require fascial resection).

### Interventional Radiology Coding

For interventional radiology coders, there is one major code change with the deletion of 36145, introduction of needle or intracatheter; arteriovenous shunt created for dialysis. CPT has added code 36147, introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava). Code 36147 INCLUDES radiological supervision and interpretation otherwise known as S & I codes. Do not report 75791 with code 36147. Code 36148, additional access for therapeutic intervention, was created to be an add-on code for CPT code 36147.

### Paravertebral Spinal Nerve and Branch Coding

New guidelines were established for paravertebral spinal nerve and branch coding. Image guidance includes only Fluoroscopy and Computerized Tomography (CT), and is an inclusive component of codes 64490-64495. Imaging guidance and localization are required for the performance of paravertebral facet joint injections described by codes 64490-64495.

If imaging guidance is not used, CPT directs you to use codes 20550-20553. If ultrasound guidance is used, report codes 0213T-0218T. Please note that this is an error in your CPT 2010 book. On page 314 it states to use CPT code 64999 for ultrasound guidance when it should state 0213T-0218T. Codes 0213T-0128T, facet injections with ultrasound guidance cervical/thoracic and lumbar/sacral will be implemented on January 1, 2010, but will not appear in the CPT book until 2011.

This article represents only a brief overview of the 2010 CPT changes. Please refer to your 2010 CPT book, Appendix B, for an entire listing of additions, deletions and revisions. Also, to ensure timely reimbursement for services rendered, monitor payment bulletins, newsletters and other carrier specific policies. ■



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*Due to the fact that excision size was not accurately reflected and malignant skin tumors were mistakenly confused with radical soft tissue excisions, CPT made the decision to expand the musculoskeletal section.*

## ■ Recession Response

# How is Your Practice Preparing for an Upturn?

### OVERVIEW

Over the past year, the nation grappled with a severe economic downturn. A “perfect storm” left many organizations vulnerable as they struggled with the evaporation of the capital markets, loss of consumer spending and a changing regulatory environment. We are optimistic, though, that the economy will regain its strength as organizations continue to adjust. This article discusses opportunities in anticipation of an economic up-turn.



*Identify your “rising stars” and challenge them to reenergize your teams, improve operating efficiencies, and drive change in your practice. Use tools to identify the real issues with your teams and improve upon those areas.*

Although business fundamentals are still critical for many organizations, we have begun to focus strategic direction on capitalizing on the opportunities available during a recession recovery.

We know this may be difficult for organizations that are still in “survival mode.” However, it is important to look past the uncertainties and prepare for the future. We know what lies ahead will not be business as usual, as there will be significantly less financial leverage in the system, long-term adjustments in household spending, and we may never return to our pre-crisis economic state.

What is certain are the opportunities that exist in a recession recovery. At Eide Bailly, we are taking a proactive approach by working with our clients to position their organizations to emerge as winners in the marketplace. At the same time, we are keeping an eye on the possible challenges that still lie ahead. Namely:

- The expectations of rising interest rates and taxes,
- The effects of a continued rise in unemployment in the short-term with slow recovery,
- The pressure on declining business valuations and multiples, and
- The impact of unprecedented budget deficits, both at the state and federal levels.

Most leaders have refined their operations over the past twelve months. Many organizations, however, are finding they cannot just “cut” their way out of this economic environment. Therefore, it’s important to focus on growth and new ways to meet the needs of the public. Looking forward, ask yourself, how will your organization adapt to the current marketplace?

The following are some of the key strategic areas of focus:

- Re-evaluate your value to the public. The marketplace is shifting, and what sustained you for a long time may not help you create long-term sustainability.
- Use your team to re-evaluate your growth strategies and service offerings, which may include transitioning existing products and services into current or new markets or creating new products and services for current and new markets.
- Leaders are back on the front lines. They are problem solvers and quick decision-makers.
- Client and patient relationships are key to success; thoroughly understand the public’s needs and demands.
- For peak performance, hire your people for their core values, but look to coach, mentor and train them to strengthen their personal and technical skills.
- Identify your “rising stars” and challenge them to reenergize your teams, improve operating efficiencies, and drive change in your practice. Use tools to identify the real issues with your teams and improve upon those areas.

Perhaps this economic crisis will turn around with less negative impact than many expect. If you apply the “perfect storm” fundamentals to your organization and go after opportunities in a disciplined, strategic way, the worst that may happen is that you emerge as a stronger leader in your community. ■



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## Tax Planning in 2010

Now is a good time to begin thinking about tax planning for 2010 and beyond. “Unknown” is probably the best way to describe the future of tax policy. Due to increases in government spending, many experts predict we will be paying higher taxes sometime in the future.

First, two changes to be aware of for 2010:

- Standard mileage rates have been reduced to 50 cents from 55 cents.
- For businesses that have been taking advantage of the increased first year write-offs for the purchase of capital assets: the Section 179 deduction is decreased for 2010 to \$134,000, down from \$250,000.

### Roth IRA Conversions

In 2010, the \$100,000 Adjusted Gross Income limitation is being lifted so that anyone with money in an IRA can convert to a Roth IRA. The difference between a traditional IRA and a Roth IRA is that a traditional IRA is subject to Required Minimum Distributions and a Roth IRA is not. Also, the distributions from a traditional IRA are taxable, while the distributions from a Roth IRA are not.

There are many reasons for someone to make this conversion and pay the taxes now, rather than at some future date. There are very sophisticated projections that can be done by your CPA or financial advisor. As with all tax planning strategies, you should consult your CPA to make sure that it is right for you.

### 401(k) Deferrals and IRA Contributions

While many things are changing for 2010, something that did not change is the deferral amount for retirement plans. Your 401(k) deferral is still \$16,500 with a maximum contribution limit of \$49,000 to include matching and profit sharing. The IRA contribution is still limited to \$5,000.

Another item that did not change was the Social Security (or Self-Employed Tax) maximum earnings, which stayed at \$106,800.

### Cash Flow and Tax Rates

Cash flow is something on the minds of many taxpayers, especially those in the medical field. With the two-month delay of the 21.2 percent Medicare cut, there are many great unknowns—tax rates included. With the Bush Administration’s tax cuts scheduled to expire January 1, 2011, we could soon be subject to tax rates not seen since 2000.

The top income tax rate is scheduled to increase to 39.6 percent, along with the removal of the 10 percent tax bracket. The long-term capital gains rate is scheduled to return to 20 percent from 15 percent. For 2011, the Section 179 deduction is scheduled to return to \$25,000 per year, down from \$134,000 in 2010. While tax policy can often be changed in the final hour, I have heard many people whom I trust and respect estimate higher taxes, and have yet to hear anyone estimate lower future taxes.

While the unknown can create fear, the assistance of a CPA can help guide you through this tough economic time. Your CPA can help you plan for a changing cash flow and provide you multiple scenarios, so you can be prepared for whatever might come. ■

### OVERVIEW

It's that time of year when we are all thinking about taxes. Whether it is the 1099 that you receive from your brokerage firm, or the W-2 that you receive from your employer, taxes are at the forefront of our minds. While you're focusing on paying taxes or receiving refunds for 2009, now is a good time to begin thinking about tax planning for 2010 and beyond.



*In 2010, the \$100,000 Adjusted Gross Income limitation is being lifted so that anyone with money in an IRA can convert to a Roth IRA. There are many reasons for someone to make this conversion and pay the taxes now, rather than at some future date. As with all tax planning strategies, you should consult your CPA to make sure that it is right for you.*



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### *Contracts—from page 3*

- How does contract compensation compare to provider's usual and customary fees and to other payer contracts?
- What is the payment for non-covered services?
- What is the payment for ancillary services?
- What is the process for the payer to recoup overpayments?
- Is there hold harmless clause included in the contract and will provider's malpractice carrier allow such clauses?
- Is there a sole responsibility clause that shifts liability from payer to provider?

### *Contract Terms*

- Does the contract address how notices should be given?
- Is there a provision which addresses payer insolvency?
- Is appropriate assignment of contractual obligations (e.g., change of ownership) and transferability addressed?
- Does the contract identify the responsible party for provider credentialing issues?
- Does the contract include non-performance, non-breach, due to unavoidable causes clauses?

### *Claims Processing*

- Is there a time period for the submission of claims and is it realistic?
- Is additional documentation or special forms required for certain claims?
- Are there electronic billing requirements?
- Is incomplete or inaccurate claim information addressed?

### *Time Payment Schedule*

- Is the payer required to make payment within a specified time period?
- Is there a penalty for delay in receipt of payment?

### **Risk Management**

#### *Insurance*

- Is evidence of insurance required and mutual?
- Is a minimum amount of general and liability insurance required of the provider?
- Is notice of cancellation or changes required

As you've read, successful contracting is a multi-step process beginning with your internal data review and culminating in the negotiation process. Then the real work begins. Practices that are able to manage their contracts on a consistent basis will be able to evaluate the success of their earlier efforts. ■



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