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Coming Next Month

Practice Governance

Appropriate Reimbursement: How to Compare Your Payer's Fee Schedules to Medicare's

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When trying to determine what level of payer reimbursement is appropriate, the right answer will differ for every practice. In some regions, Medicare payment rates are the minimum acceptable while other markets would be thrilled with any contract paying that much. The key benefit of comparing local payers with Medicare is to identify outliers—payers that perform significantly worse than others. These payers deserve special attention by the practice, whether by aggressive negotiation or possible termination. Here's how to accurately compare Medicare and payers in your market:

- Identify your top 20 procedure codes based on contribution to practice revenue. Review your records to determine which codes are financially most meaningful. These procedure codes should cover the vast majority of any plan's payments and will normally represent 60-80 percent of practice (fee-for-service) revenue. This information should be available from your data processing system.
- Identify the top 10 insurance plans. Use net collections by payer over the past 12-month period to pinpoint your most valuable plans.
- Obtain the payer's fee (reimbursement) for each of the identified 20 procedures under your current contract. This information is in the payer's explanation of benefits (EOBs) accompanying past payments to the practice. Alternately, you can request a list of fees from the payer. Generate a fee schedule request of the top 20 codes along with a cover letter for each of your top 10 payers.
- Review the current year Medicare allowable amounts for each of the 20 procedures. Your local Medicare carrier provides an annual report with this information.
- Compare the payer's fee with the Medicare fee, noting the dollar and percentage variations for each service. Simply create a table (usually in a spreadsheet program, such as Excel) that includes the selected procedure codes, descriptions, practice charge, Medicare allowable, and current payer reimbursement.
- Analyze data by totaling the reimbursements by payer and comparing these totals as a percentage of Medicare. Easily calculate information by inputting formulas in appropriate cells. (*See Exhibit 1.*)

Exhibit 1: Payer Reimbursement Comparison

CPT Code	Description	Our Fee	Medicare Fee	Payer 1	Payer 2	Payer 3	Payer 4	Avg.
99213	Est. Patient E&M	$70.00	$52.68	$50.05	$55.31	$63.22	$41.02	$52.40
66984	Cataract Extraction	$890.00	$684.05	$643.00	$711.41	$820.86	$520.40	$673.92
66821	Yag Laser	$325.00	$248.23	$235.82	$260.64	$297.86	$186.10	$245.11
99243	Office Consultation	$160.00	$122.79	$116.65	$128.93	$147.35	$126.40	$129.83
Total			$1,107.75	$1,045.52	$1,156.29	$1,329.29	$873.92	$1,101.26
% of Medicare			100%	94%	104%	120%	79%	99%

Since a significant percentage of most ophthalmology practice revenue is based on Medicare, this provides a reasonable method for determining financial performance of the contract.

About the author: *Bruce Maller is president and CEO of BSM Consulting, an internationally recognized health care consulting firm headquartered in Incline Village, Nevada and Scottsdale, Arizona. For more information about the author, BSM Consulting, or content/resources discussed in this article, please visit the* ***BSM Café*** *at* ***www.BSMCafe.com****.*

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Q&A: Marketing to Health Care Plans

Question: We are heavily weighted toward Medicare in terms of our collections by payer. We would like to achieve a higher percent of collections from third-party payers, especially those with higher fee allowances than Medicare. Can you suggest ways to increase our patient base in specific health plans? Can health plans assist us in reaching their enrollees, especially in light of the "federal do not call" list and other mechanisms to limit solicitations to individuals?

Answer: If the objective is to increase the number of plan members selecting or accessing your practice, it would be important to know how patients get to your practice in the first place. If, for example, patients are referred from primary care providers, I would place a greater emphasis on marketing and educating those doctors on the plan's panel. Oftentimes, ophthalmology practices do not dedicate adequate time in marketing to these professionals. This can range from simply providing them enhanced communication about the status of patients referred to your practice to providing a newsletter dedicated to referring doctors. You might also approach the health plan and identify areas of opportunity to educate their members. Joint sponsorship of eye screenings, health fairs, and support groups (for eye disease) are examples of programs that might be of interest to them and their members.

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