

10 Managed Care Best Practices for Bariatrics, General Surgery and Gynecology

By Susan Charkin

Contract negotiations adhere to a rule that 80 percent of time should be used to prepare for the negotiation and 20 percent to negotiate. To help be more effective in achieving results when you actually need to sit down at the negotiating table, here are 10 managed care contracting best practices for bariatrics, general surgery and gynecology, written in collaboration with Marty Winslow, director of reimbursement for Nueterra Healthcare and Gary Whiteaker, administrator for Apogee Outpatient Surgery Center in Redding, Calif.

1. Understand the effects of the Medicare system on commercial payers. ASCs are now faced with the challenge of a new payment system based upon the hospital outpatient department (HOPD) rates. The system uses ambulatory payment classifications (APCs) which categorize surgical and other outpatient procedures based on the relative use of resources to perform each procedure. Although already one year into the four-year transition to a fully-implemented APC-based Medicare payment system, most commercial payors still do not use a methodology consistent with this approach. The good news is you may be able to use this to your advantage. The oppor-

tunity lies in the ability to explain the new system and its relatively higher payments for certain specialties.

For general surgery and gynecology, the 2009 Medicare rates show an increase over 2008 rates for the most common procedures performed. If you can move from an ASC grouper-based system to an APC-based system, consistent with the new methodology, you might see a boost in rates as a result. As mentioned above, most payors are not prepared for such a change, so for now they likely will continue to use some derivative of the old Medicare grouper system. Even if a payer remains on a proprietary grouper-based system, you can use the newer, and in most cases, higher wage index-based rates to adjust the bar to raise rates to a higher level.

One critical element to success is to clearly define the payor's basis for its methodology. For example, is it based upon Medicare's prior nine groupers or an amended version/proprietary set of groupers used by several of the major national payors? Never assume it is based on a pure Medicare grouper system or you may have some surprises once the contract is in place. More often than not, payors have their own proprietary groupings that do not correspond to the old Medicare grouper-based

methodology. For instance, a laparoscopic cholecystectomy (lap chole) may be grouped in a category defined by the payor instead of falling outside the groupers as it did in the old Medicare system. One major national payor has actually rearranged many of the more prevalent codes like cataracts and, in this case, moved these procedures from a "Group 8" down to a "Group 3." Make sure to receive a breakdown of their groupings and focus on where your main procedures are grouped to maximize your reimbursement.

2. Develop policies and procedures for bariatric population. In bariatrics, ASCs are generally limited to performing lap-band procedures. Many of these procedures are not covered by insurance, so any lap-band program will see a great deal of self-pay patients, not unlike cosmetic surgery. As such, it is critical to develop processes and policies supportive and appropriate for this patient population.

It is also important to work with your bariatric surgeons to determine an appropriate and competitive market-based price for these procedures. The bands themselves are quite expensive, so make sure the price for the procedure takes into account not only your typical surgical costs but also the cost of the band.

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3. Pursue a BSCOE certification. Many centers pursue a Bariatric Surgery Center of Excellence (BSCOE) certification. This can benefit the center by demonstrating a high level of competency to the payors. In fact, some payors may require that bariatric procedures be performed in a center with BSCOE certification to be covered at the highest benefit level. More information on the program and its requirements is available at www.surgicalreview.org.

4. Include a stop-loss/outlier provision for bariatrics. For those ASCs that offer overnight stays and more complex bariatric surgical services such as gastric bypass, ensure that there is a stop-loss/outlier provision in your agreements to treat the potential catastrophic costs of clinically complex patients. A stop-loss simply protects the center in the case of excessive length of stay or use of resources on any given patient. Payors are usually comfortable seeing this type of language in hospital agreements, so asking for inclusion of it in your contracts should not come as a surprise.

Here is an example of how you may want to word this clause reading in your contract:

"If billed charges per patient case exceed \$25,000, payor agrees to reimburse provider at 80 percent of billed charges for all services including — but not limited to — facility charges, implants, devices, DME (durable medical equipment), surgical fees, laboratory, radiology, pathology and anesthesiology services;"

or

"In addition to contracted payment per patient case, payor agrees to reimburse facility at 80 percent of billed charges for all services that exceed the \$25,000 threshold, including but not limited to facility charges, implants, devices, DME, surgical fees, laboratory, radiology, pathology and anesthesiology services."

5. Carve out laparoscopic procedures. Carve-outs are procedures that you request higher reimbursement for than the across-the-board reimbursement for all other procedures in your agreement. Generally you will want to identify those procedures that are the most important to your ASC. This can be determined by CPT code by multiplying the amount a payor pays for a procedure time the frequency the CPT code is performed. Codes with the highest result are those that are critical to influencing your bottom line. For your general surgery cases, make sure you can carve out frequently performed procedures such as laparoscopic procedures, including lap choles and laparoscopic hernias, for higher reimbursement as the cost of performing these services is substantially higher than what most standard payor agreements allow.

6. Choose the right gynecology cases. Make sure your surgeons are very clear on which gynecology procedures they should bring to your center. Some procedures may have implants such as tension-free vaginal tape (TVTs) or conventional pubo-vaginal sling (PVS) procedures using polypropylene mesh and neuro-stimulators for incontinence. These implants are often high-cost items so you need to quantify these costs upfront. Other items such as disposable balloons used for endometrial ablation can carry a high price tag as well, so make sure your surgeons identify these procedures so that you can carve them out of any contracts.

7. Fight for gynecology carve outs. Payers often restrict services such as ultrasounds, mammograms and bone densitometry to other specialties potentially resulting in diagnosis and treatment delays. It is critical that you work with your payors to have these restrictions lifted for gynecology and then carve out these services by code in your payor agreements.

8. Ask for percentage of billed charges for implants. If possible, try to get your carve-outs at a higher base rate and implants reimbursed at least at cost or higher. Always work to have the implant paid as part of the claim and paid on a percentage of charges that is equivalent to your cost or greater. For instance, you may want to ask for implants and supplies described earlier to be reimbursed at cost, including shipping costs and taxes, plus 10 percent.

If possible, you should not readily agree to a contract which requires a copy of the invoice each time a claim is submitted when an implant is used. This will create additional work and paper shuffling for your staff. It will also increase the likelihood that the paperwork for the implant is not submitted, thus forcing you to bill those cases with implants on paper instead of electronically.

It is always preferable to bill electronically from a tracking and timeliness of payment perspective. The simplest method for reimbursement is to allow for payment at percentage of billed charges for any implants identified by the appropriate revenue code (usually 278). Try to stay away from thresholds whereby the implant is only paid if it is above a certain cost or charge. So, for example, on general surgery, you may often use mesh for the hernia repairs. You would not want a threshold of \$500 in cost because in most cases the cost to the mesh would be less and you would not receive separate payment for the implant.

Note: During this Medicare payment transition period, it is imperative that you continue to evaluate reimbursement for non-device-intensive multiple procedures. Reimbursement for many of these services is much lower during the first one to two years of the phase-in period. This is due to the fact that implants can no longer be billed separately and that the new payment combines reimbursement for both the implant and procedure.

9. Vigilantly monitor contract reimbursement. It is not only critical to negotiate a good contract, but then you must ensure the contract is paid based upon the correct rates and payment terms. Ongoing vigilance in comparing your reimbursement to the rates you agreed upon will pay big dividends. Often you may be able to receive carve-outs for higher cost cases such as TVTs or lap choles. However, if the payor does not pay the contract correctly on the carve-outs, it does not serve you well. Also, always monitor the payment on your implants as those often are reimbursed incorrectly.

10. Prepare for P4P. As with other specialties, bariatrics, general surgery and gynecology will at some point most likely be linked with pay-for-performance (P4P). P4P programs link physician adherence with recommended case management processes and protocols to financial incentives. Currently, CMS has chosen not to incorporate any P4P or additional quality criteria for ASCs in 2009. However, the managed care industry is actively working with CMS to help develop appropriate standards for future possible implementation.

Earlier we mentioned the Bariatric Surgery Center of Excellence (BSCOE) certification. Whether externally or internally, it is important to track and trend quality and cost areas for your center. As such, it is worthwhile to start preparing now for P4P by collaborating with your major payors in developing their P4P programs. These programs should be based upon key clinical indicators, use appropriate methodologies and use simple methods to administer and monitor them by both parties. ■

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