



Understanding Complex Out-of-Network Reimbursements



Frequently Asked Questions About Out-of-Network Reimbursements

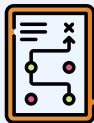
THE AGENDA



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OVERVIEW

Every year, the experts at Collect Rx talk to thousands of out-of-network providers, and every year, we hear new and even more challenging questions. We have been working with out-of-network providers since 2006 as the only company 100% focused on helping them maximize reimbursements on out-of-network bills.

We have helped almost 3,000 providers nationwide optimize their out-of-network reimbursements, across a variety of provider types including ambulatory surgery centers, hospitals, physician groups, labs, behavioral health facilities and others. Our team of experts formerly worked on the insurance company side so are uniquely equipped to level the playing field for providers fighting back against payors for what they deserve.

Definitions



Out-of-network: when providers have not negotiated a contract with the payor. It is not that they do not accept that insurance, but just that they do not have a defined contract for reimbursement.



Allowable: The amount determined by the insurance company that should be reimbursed on a given bill, not necessarily the payment. Allowable is calculated as the payment from the payor plus the patient responsibility, so the co-insurance, deductible, and any copays all equal the allowable on the individual claim.



Repricing: A payor reimburses lower than the provider's full billed charges



Vendors: Third parties that are used by insurance companies to outsource the reduction of bills. They negotiate high discounts, or just reprice claims at very low amounts.



Single case rate agreements or negotiations or letters of agreement: These are the settlement offers received either prior to a payment on a case or post payment on a case to negotiate a final rates for reimbursement.



Discounts: The amount off the billed charges that are provider and payor agree upon.



General Questions

What is the number one key for successful out-of-network negotiations?

Data. To combat what the payors or the vendors are attempting to do, having comparable data is critical. If you have tracked data over time, you can use it to say, "I had a case last week process at 80% or 90%, I need this one at 80% or 90%." The payors and the vendors track all of this data on their side, so it is critical to track on your side so you can have a leg to stand on.

If I am currently out-of-network and there is no third-party rental agreement, is there still a strategy to negotiate?

Yes. Absolutely negotiate or appeal on a case by case basis or a bill by bill basis. Vendors are going to attempt to minimize reimbursement by either one of these means. So you need to look at your individual cases one by one, to see this as an opportunity to negotiate or appeal.

What is the best way to negotiate with payors, phone, email, or fax?

Vendors will attempt to email and fax you offers, but the best way to interact is by phone. It is the most time consuming way to do so, but it has the best results. Faxes and emails can be ignored. If you get someone on the phone and you can really talk through offers, that is the absolute best way to negotiate.

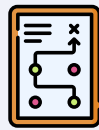
Is it worth the trouble negotiating if we do not see a lot of out-of-network?

Any case where you can potentially get additional dollars is worth negotiating. If you have in-network contracts, Medicare and Medicaid, there is no way to increase your reimbursements. But if you have an out-of-network case, there is no contract. That is your opportunity to drive additional reimbursements.



Why would I want to be out-of-network?

This is a complicated question, but the simple answer is more money. When you go in-network, you are really taking a volume discount to pay for the patient steerage. So you take a discount on your reimbursements. When you are out-of-network, there is no limit to how much you can get paid. It is more difficult, but there are certain situations where you absolutely want to be out-of-network because you can make more money doing so.



Payment Processing

How do payors determine what to pay?

Employer preference. When insurance companies sell to an employer group, the employer is the one who determines how to dial up or down the levels of benefits. They are the ones who determine if a provider is able to negotiate or if cases are going to be repriced, what the payor should do if a provider or a patient pushes back on a low payment, or how a payor should stand on data. They decide if they will or will not increase the payment, or if they will make fairly drastic concessions to eliminate any patient noise on their end.

From an insurance company perspective, their client is the patient or the employer group so they will do what that patient or employer group has paid for. If they are paying for a more expensive policy, there are more options to negotiate or appeal or get higher reimbursement for the provider. For this reason, it is critical to have supporting data even down to the employer level.

How can two patients with the same treatment and same insurance company have two different reimbursements?

The reimbursement levels are determined by the employer group. So what is really important to understand is that in each individual insurance company, there are numerous different plans. Inside the individual payor, the employer groups dial up and down not only the in-network benefits, but the out-of-network benefits specifically. That is how claims are priced or reimbursed differently.



...reimbursements are based on a percentage of Medicare, usually between 85% to 140% of Medicare...

My revenue cycle team insists that usual and customary is limited to 150% of Medicare. Is this correct?

People believe that usual and customary is a specific amount. Usual and customary or reasonable and customary is a general term used by the insurance company to not have to back up what they are paying. It is not Medicare, and it is more art than science. Payors often use terms "Fair Health" or "Comparable Data in the Area" which is a good indication that it is not necessarily a specific number. This is why it is very important to track insurance policies and collect data to fight back on these usual and customary plans.

How do you collect more than usual and customary?

Data, policies and expertise. Collect Rx does not collect more than usual and customary, rather, usual and customary is an undefined term. It means different things to different payors, and it is not set in stone. By using data, and understanding the patient's policy information, insurance companies will allow additional reimbursement on usual and customary plans.



Policies

What is a limited benefit policy?

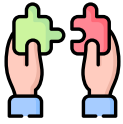
A limited benefit policy is one that puts restrictions on the calculations of reimbursement. So this could be a policy that has a fee schedule attached to it, one based on Medicare, or one with a daily cap on reimbursement. Anything that is not a usual and customary plan is a limited benefit policy plan.

So what are some examples of limited benefit policy plans?

UnitedHealthcare MNRP plan and the Cigna MRC plan. These plans are Medicare based plans. They are not Medicare plans, but the reimbursements are based on a percentage of Medicare, usually between 85% to 140% of Medicare. Call the insurance company to check benefits prior to this patient coming, to estimate what the reimbursement is. There is a possibility to negotiate higher if you receive a settlement offer.

How do I know if the patient has a limited benefit policy plan?

During benefit verification, specifically ask how the patient's policy reimburses, with specific questions such as if it is a Medicare based policy or if it is usual and customary based policy. You will need to ask until you get the answer at the detail level. Understand if it is a Medicare based policy and how the benefit is determined, i.e 110%? Is it 120%? If it is usual and customary understand the percentage of usual and customary. Continue to press until you are comfortable with the details you are provided.



Negotiating Settlement Offers

Given that there is no contract, what is the incentive to agree to any of these proposals when the provider is out-of-network with the payor?

For the provider, the biggest incentive is to maximize reimbursements.

- When you are negotiating, you are maintaining control of what could potentially happen on the case. By not negotiating, you give up any control.
- Faster payment
- Higher success rates

So why would I negotiate offers from companies like MultiPlan? I expect 100% of my charges.

More power to you, that is fantastic. But bill minimization tactics are designed to allow payors to reimburse at a fraction of what providers charge. Not to say you have to accept every offer. Look at the data, at how claims are processing when you do not negotiate and track that. We do not take the stance that providers should expect 100% of charges and to never negotiate.

Any tips for negotiating single case agreement?

Data. Track insurance policies, what you have done on negotiations previously (whether in the billing system, follow-up tool or even in a manual spreadsheet), and what is the result after you are accepted or not accepted. Understand that if you turned down an offer at 60% or 70%, what was it allowing on the backend.

Persistence. The other side wants to get a deal done, because that is also how the negotiators of the vendors get paid. Feel free to negotiate. This is not about hurting the payor's feelings. Get a rate that is comfortable. Obviously be respectful, but there is no reason just to give in.



What do you think of the strategy of never accepting more than 10% discount?

Generally, this is not a productive strategy. We do not adhere to any strategy that has a hard line in any direction, i.e. only accepting this, never accepting that, because every individual patient policy is different. For example, you may have a 30% offer that should be accepted because it is five times Medicare. If you do not accept it, it will process at 85% of Medicare. It is important to review each individual bill on a case by case basis. Most importantly, if you communicate this strategy to the payor, they will likely stop contacting you to negotiate these cases, and will likely just reprice these claims, which puts you in a situation where you then lose control and ultimately lose out on reimbursement.

Will negotiating aggressively ruin my relationship with the vendors?

Vendors are not your friend. Their whole job is to try to limit providers' reimbursements. They are not there to do a favor for you. At the same time, providers are trying to increase their reimbursements. You should not be trying to do them favors at the expense of your own revenue.

Are vendors allowed to give me less than a day to negotiate?

Unfortunately, the answer is yes. Again, this is not always bad from the provider side. Providers want to settle the claim quickly to get claims processed and paid. While the claims are sitting in negotiation, they are not going through processing. However, the payors are putting quick turnaround timelines on providers as a pressure technique to settle less than what you should.

Once we agree to a discount, can the payor change their mind?

Unfortunately, the answer is yes. There are times where the payor makes mistakes, their algorithm sends out a negotiation that wasn't supposed to get out, or they send a claim to be negotiated but once it is settled, the payor decides that is too high. The payor can determine not to accept that agreement at this point. Unfortunately, there is not very much to do in this case. Except, if the payor does not accept the agreement, you are then entitled to balance bill the patient because you are no longer held to that agreement either.



If we decline a single case agreement, can we bill a patient?

In this scenario, you can bill them the reminder of the charges after the claim processes. There are no restrictions.

On the opposite side, if you accept a single case agreement, can you bill the patient for the discounted amount?

Discounts work by ensuring that if you have a \$1,000 charge, and negotiated 90%, you cannot bill the patient for the \$100 that you signed off for. Still bill the patient for the patient responsibility, i.e. their co-insurance and deductible, but you can't bill them for the amount that you accepted underneath of the agreement.

Is it better to decline an agreement if we do not agree with the reimbursement amount?

Sometimes. It depends on the policy type and how it is going to reimburse otherwise without the agreement. Analyze your data to determine if it is a good deal. Whether it is a percentage of charges, a percentage of Medicare or compared to your cost, compare it to previous results where you have accepted or declined agreements. Also consider what will happen if you do decline and it is repriced.

Is it good to sign up with third-party portals?

Solidly, no. Third-party portals, with MultiPlan for example, will sign you up to do the negotiations there rather than fax or phone. The vendors use it because it is easier and more efficient for them. However, it is much harder to negotiate claims from the portal. Claims are not actually assigned to a negotiator on that side, so there is no one specifically to negotiate with since they do not take calls. It ultimately reduces successful results.

With regards to accepting deals where I do not agree with the reimbursement, is there any downside to signing those settlement offers?

That is a very complicated question. The provider's time is valuable, so you do not want to set a precedent of 60% of charges as "okay." But you have to be able to track your data to figure out what is going to happen if you do not accept a 60% offer. If you turn down 60%, is it going to allow at Medicare rates, 10% of charges, 20% of charges? You need to know what is the lowest evil in the situation.

What can I do if I do not see a lot of negotiations or letters of agreement. Is there a way to get more of them?

There is no way to generate a negotiation if a negotiation is not available. Often, providers will ask us to go get a negotiation for a claim, but it does not work that way. It is based on the employer group and how they ratchet up and down the benefits. However, some of the ways you can avoid NOT getting negotiations is by making sure the vendors do not believe that you will not accept negotiations, and not getting blacklisted. But you can't make cases available for negotiation if they are not there, because it is ultimately up to the employer group and the benefits that the individual patient has.

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Appealing Underpayments

What is the best way to successfully appeal underpaid bills?

The best way is to maintain a rigorous appeals process.

- **Step 1:** Initial intake of the documents. Ensure that you have all the documentation necessary to handle the claim. This includes the UB or the CMS 1500, the EOB, the assignment of benefits and any billing or collection notes you have.
- **Step 2:** Payor verification. Contact the payor to verify the patient and bill information and obtain a verbal explanation of the basis for how they price the claim. Call them and ask why the claim was processed in this way, and during that call, find out if anything is denied, if more documentation is required, if it is usual and customary and the patient's plan. This is when you get the reasoning from the payor on why they price it the way they do.
- **Step 3:** Strategy development. Devise the appropriate strategy for that claim based on all the information you received during the payor verification stage and your documentation. Add your data to figure out the best argument to make to the payor. We use our CRXIS business intelligence engine to assist in this process. If you are doing it yourself, find a way, even if it is manual, to make sure you are putting this data together.
- **Step 4:** Payor engagement. Engage the payor and present the relevant facts and arguments. To be successful with appeals, the key is persistence. This includes calling every day, writing letters, escalating when necessary, potentially even to the state insurance commission. Once you fully present the information to the payor, the payor is going to internally consider its decision, which will take weeks, oftentimes 30, 60 or even 90 days. It is critical to continue to follow up to make sure they are actually reviewing everything to process the claim.
- **Step 5:** Settlement agreement and post settlement follow-up. Unsurprisingly, payors frequently do not pay on time and in the correct amount. So when you are successful in coming to a settlement, you need to follow up. You must ensure you actually get paid and at the settlement you agreed to. Just because you have a signed agreement, does not mean you will be paid. You need to follow up with the insurance company to ensure that is actually paid per the agreement that you did sign.



What is an Assignment of Benefits?

The assignment of benefits very simply, ensures that you as a provider are paid. The first thing to remember is that the patient owns all of the benefits. They are the client of the insurance company. The benefits do not belong to the provider. What the assignment of benefits does is assigns their benefits that they have paid for to the provider. It allows the provider to send a claim on the patient's behalf to the insurance company and allows the payor to pay you directly. It also should allow the provider to appeal on the patient's behalf and be paid appropriately.

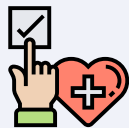
Any tips on the assignment of benefits?

- Explicitly assign the benefits and the rights to appeal and the right to receive documentation to you the provider.
- It has to refer to the provider as the patient's authorized representative.
- It should properly reference ERISA and a full and fair review of claims.

If your AOB is inadequate, it is another roadblock that payors will use to stop you from getting reimbursed on your out-of-network bills. There are individual payors that have specific patient authorization forms that you need your patients to sign in order to appeal. Ensure that this document is in your patient intake and that it is signed by the patient.

What about insurance companies paying initially, but then later recouping the money?

We do see this. Payors proactively do audits. If they do attempt to recoup, it is critical to appeal the refund request. Determine why and what their reasoning is for refunding the money. It can be a patient benefit dispute or it may be that they paid incorrectly. Use your data and retain all signed settlements to dispute.



Third-party Rental Agreements

What is a Silent PPO or third-party rental agreement?

A third-party rental agreement is an insurance company tactic to lower reimbursements by accessing discounted rates with another insurer, typically without the provider's knowledge. These are not signed with an individual payor, these are signed with companies like MultiPlan. It is actually simply a network that other insurance companies can access to drive reimbursements down. They sound easy and convenient, but they are very detrimental to out-of-network providers.

If you happen to have any third-party agreements or third-party contracts, Collect Rx offers a complimentary analysis of them. We can review them to see if they are a good deal or bad deal and how you can get out of them.

So how do I know when a third-party rental agreement is going to be applied?

Unfortunately, you do not. The payor is going to use a third-party rental agreement when it yields the lowest payment on the claim. Even if a patient has MultiPlan on their insurance card it is not certain that Multiplan is going to be applied, because if there is a way for them to access a lower contract, the payor will do so.

Why do so many providers contract with third-party rental agreements, Silent PPOs?

The main reason is because they are very easy. You receive an offer from a third-party company offering you a high percentage of charges. You are out-of-network, and it is much higher than in-network. It seems like a great deal.

As CFO, for example, you might dream of these consistent payments where you can track and everything seems great, getting everything under one contract, to deal with the complexity of out-of-network.

So why do the payors not always use my third-party contract?

The best way to describe a third-party contract is as a cap on reimbursement. Many providers think of them as floors of reimbursement, assuming that if they have an 80% contract, they will always receive 80%. Except that is not how it actually works in practice. For example, say you have a 70% contract, but the individual insurance policy actually reimburses at 40%, they will use the 40% rate because they are going to try to use whatever results in the lowest reimbursement to you. But if another employer group has a pretty generous plan with great out-of-network benefits that reimburses at 80%, they will use your 70% contract because it reduces the reimbursement.

Why does the EOB sometimes state the third-party contract was used, but the bill was not reimbursed according to that contract?

The main reason is that the vendors use tactics that result in different cuts. Many of them say a percentage of allowed charges instead of billed charges. They determine what is allowed. They might use the term “covered” versus “non-covered”. They also have different edits they can do for multiple procedure reductions and other code edits.

If you have an 80% contract, basically you are starting at 80% of your charges, and then they start applying cuts rather than starting at 100% of your charges and apply the cuts from there. So again, it is just a cap on your reimbursement.



So how do I track if my Third-Party Rental Agreements are being applied correctly?

The only way to know if your third-party contracts are being applied correctly is to check your EOB. Not your electronic remits, but your actual hard copy EOB's. On the EOB it will specifically state that a network agreement was used, whether it was Multiplan, GCS, or any of the other thousands of vendors. Then what you would do is to verify again that your contract was used and compare it against your contract to ensure you have received the rate you signed up for.

So why do I receive settlement offers when I have a contract?

The primary reason is that payors are trying to beat the contracted rates, so another tactic that insurance companies deploy is trying to beat a contract rate by negotiating a lower rate. For example, if you have a 70% contract, but this patient's plan is a limited benefit policy, it is an MRC plan. They are not going to pay the MRC plan, which is a 85% to 100% Medicare based plan, at 80% of charges.

They are going to try to negotiate a 30% rate or even a 20% rate. If you do not accept that rate, it may process even lower. It just may not process per your contract. Again, you need to review your claims on an individual basis to figure out should it be part of my contract. Ask yourself should it not be part of my contract, should I negotiate, should I not, and then at what levels.

Are you allowed terminate the third-party agreement at will?

There are some exceptions, but many of these contracts are subject to evergreen clauses. This means that once you sign them, they automatically renew and you have to catch the notice period in time to be able to terminate. However, for many of the contracts, the notice period to terminate is 180 days prior to the anniversary date.

Is it a good idea to go in-network with MultiPlan?

There is no such thing as being in-network with MultiPlan, just as there is no such thing as being in-network with any other third-party company. These third-party companies do not administer benefits, they do not pay claims, they do not have a network. These third-party companies, if you look on their websites, will tell you they are a cost containment vendor working on behalf of the insurance company. Their goal is to reduce reimbursements to providers. There is no patient steerage with MultiPlan like you would see in a regular network. All it is, is a way for the payor to access lower rates so they can drive down your reimbursements.



Conclusion

The out-of-network space has become more and more complex since 2006, when Collect Rx first began to work with providers to level the playing field with the payors. Payors face increasing pressure to reduce their medical loss ratios, the percent of their premiums that they collect that are paid to providers. Out-of-network is one more lever that they can use to reduce your reimbursements.

We know that as providers survey the landscape today, there really are not many opportunities to improve reimbursement rates. In-network contracts can be very difficult to obtain. Once you have them, they are almost impossible to change. Medicare and Medicaid rates are not going to be improving for the better anytime soon either. So out-of-network really does represent that last great opportunity for a provider to bring more dollars through the door and to ultimately improve the bottom line.



Collect Rx is the leading provider of solutions that help providers maximize reimbursements on out-of-network bills, reduce patient billings, and eliminate the hassle of dealing with the insurance companies. Utilizing its proprietary CRXIS™ business intelligence engine and subject matter expertise, Collect Rx has delivered proven results for more than 3,000 providers across the nation.

As an innovator in data-driven professional services for healthcare providers' most complex billing issues, Collect Rx is the only company in the country that is laser focused on maximizing out-of-network collections, serving a variety of different provider groups including hospitals, surgery centers, labs, physician groups and behavioral health centers, among others.

For more information, please visit us at www.CollectRx.com

