Payment policies

Every payor will have its own set of payment policies. While they may be mentioned in the base agreement or in an appendix or exhibit, the specifics of those payment policies likely are spelled out in excruciating detail in a collateral document, typically the Provider Manual. As your claims will be processed and paid per those policies then prior to signatures and for every agreement it's necessary that practices and facilities have in hand and review those policies.

The Issue: As the guidelines used to determine your payments will vary from payor to payor be on the lookout for language along the lines of "…*<name of payor> or its designees' standard claim coding and bundling methodology and claims processing policies and procedures*."

Hmmm… **The payor's "…***standard claim coding and bundling methodology and claims processing policies and procedures?"* **Or its designees'** standard policies and procedures? What in the world could those be?

Are those "standard" policies and procedures congruent with the CCI (Correct Coding Initiative)? Do the payor and its designees use widely published standards known to the ophthalmology world, or are they using some sort of proprietary "mumbo-jumbo?"

What about this pulled from an actual Provider Agreement?

> *Reimbursement will be made according to <name of payor's> medical/reimbursement policies for Covered Services including, but not limited to, policies regarding multiple surgical procedures, surgical assistance, global surgical service, coding and unbundling, and other billing and reimbursement practices.*

And the payor's *"…other billing and reimbursement practices."* What?

The above paragraph includes potentially problematic, open-ended language – in this case allowing the payor to create and impose upon a practice or facility any proprietary billing and reimbursement practices it wishes. The payor is not obligated to use industry accepted billing and coding standards such as the AMA's CPT descriptors and modifiers. So at its own initiative and at its sole discretion the payor could decide that your claims are improperly coded. The payor could then downcode the claims and pay them at a lower level than submitted. And as you likely know by now these days fewer and fewer claims are actually processed by a human, and fewer still include medical records examination. Rather, most claims are processed by rules-based software.

In my opinion to reduce inefficiencies while coding, billing, and reconciling claims a payor and its designees should agree to use **only** the CCI. Otherwise if your CCI-based coding and bundling methodology differs from the proprietary or other methodology that a payor or a designee may be using, you're in trouble. That payor or its

designee could manipulate and massage the claims (delay, downcode, deny) as much as they want if you've granted them the right to do so.

Possible Solutions: Consider two possible ways to push-back. If a payor and/or its designees use CCI then this issue is moot. However, if not then I suggest presenting the following language to your attorney. With his/her approval submit this or something substantially similar to the payor and seek to have it included.

Note: This language limits a plan's ability to recode and reprice claims at its sole discretion and based upon self-defined guidelines. It obligates the plan to use only recognized coding guidelines, and to provide you with written notice/substantiation of any change to a claim.

Downcoding

1. Use of Recognized Guidelines – <Name of payor> shall utilize the then current CPT guidelines of the AMA's (American Medical Association) CPT descriptors and modifiers and the Correct Coding Initiative (CCI) in determining the compensation due to Physician for Covered Services. In no event shall <name of payor> utilize a different coding methodology to downcode claims submitted by Physician.

2. Notice and Justification Required – In the event <name of payor> downcodes any claim submitted by Physician, <name of payor> shall provide written notice to Physician of such downcoding, along with a reasonable justification, within the <insert number of days> days claims adjudication period set forth in this Agreement.

3. Original Claim Deemed Appropriate – <Name of payor>'s failure to provide both such notification and justification within the specified claims adjudication period shall be deemed an approval of Physician's claim at the rate payable for the CPT code specified by Physician in such claim.

4. No Waivers or Limits on Appeals – Physician's acceptance of compensation at a downcoded rate, or any other reduced rate, shall not constitute a waiver of, or otherwise limit, Physician's right to seek payment at the rate originally claimed by Physician through <name of payor>'s appeals process, or to pursue Physician's other available legal remedies.

5. Cooperation – <Name of payor> and Physician agree to review downcoding issues regularly and to confer regarding mutually acceptable parameters for appropriate CPT coding.

As with so many other matters in Managed Care will a payor accept such language the first time it's presented? Probably not, for this would seriously limit a payor's ability to process and pay claims as it sees fit. But this is one area where you just do not want to give a payor the rope to hang you. So push as hard as possible for something along the above.

Alternatively here's another approach.

If a payor insists on using proprietary rules and edits or standards alien to you and rejects the above then the alternative example language I present next may be acceptable. It allows the payor to use those non-CCI guidelines as the basis of payment policies, but also obligates the payor to make those guidelines known to you. Further, this language gives the physician the right to appeal the proprietary edits and any claims not settled to those proprietary guidelines or to the industry standard CCI.

Again I suggest asking your attorney to review and comment toward acceptable language built on these key points. Then discuss with the payor for merging into your agreement.

At the Provider Agreement's anniversary date and no less than annually, <name of payor> shall give to Physician a complete list of its coding edits that are not consistent with the then-current Correct Coding Initiative (CCI).

Physician has the right to appeal any edit or changes in edits, or any claim that is not processed in accordance with the most recent list of proprietary edits or the then-current CCI.

<Name of payor> must reply/respond to Physician's appeal, in writing, within thirty days.

<Name of payor> shall detail the issue and explain its rationale supporting the coding decision in question.

If <name of payor> fails to respond within 30 days, or if Physician is not satisfied with the response, then Physician has the right to submit the dispute to binding arbitration.