Withholds and reserves

Plain and simply **withholds** and **reserves** are annoying and complicating reimbursement problems when they're made part of physician and facility Provider Agreements. Typically you won't see these provisions when contracting directly with insurers.

But withholds and reserves should not be a complete surprise when a practice or facility has an agreement with an IPA, medical group, or other entity that acts as an intermediary and contracts on their behalf with payors. That intermediary acting as your "agent" can raise issues you might not otherwise encounter.

A withhold or reserve is some portion of reimbursements, a slice of the financial pie that an intermediary holds back and doesn't pay at the time it adjudicates a claim. Those funds are used to offset some of the intermediary's administrative costs and, more significantly, retained as a "bank" against high utilization by the combined provider panel.

If you don't count on getting a withhold or reserve returned in full then you'll never be disappointed. If you do get money back, consider yourself fortunate. That uncertainty is the crux of the issue when discussing withholds or reserves with an intermediary offering you access to a local patient population not otherwise accessible directly with a payor.

Here's sample language from an agreement.

> ***Compensation.****<Name of intermediary> agrees to compensate <name of physician group> for Covered Services rendered under this Agreement in accordance with the compensation schedule set forth in the attachments hereof. The attached compensation schedules specify the reimbursement for services provided by <name of physician group>. Except as otherwise set forth in the compensation schedule, <name of intermediary> will not deduct any withholds, hold backs, or risk amounts from the amount otherwise due <name of physician group>.*

The Issue: There you saw a representative statement that monies will not be held back from physician payments *"Except as otherwise set forth in the compensation schedule..."* View such words as a red flag warning – another heads-up.

When you flip to the relevant pages looking for specificity describing how that might play out, typically there is no specificity. An agreement might include a statement that "X%" of each claim will be held back with reconciliation not more than 60 days after the end of each quarter, or end of the calendar year. But there is no enlightening description of precise reconciliation mechanics. How much of the money will be returned under specific circumstances; will interest be paid; and exactly how is your share of the risk determined? So many questions should pop into mind, yet all too often there is precious little clarity in the writing.

Possible Solutions: Frankly I hate it when monies are kept back and not paid in full per the terms of the reimbursement schedule(s). But in order to participate in a master contract held by an intermediary you may have to grit your teeth and sign on to a deal that puts a big asterisk next to each line item on your reimbursement schedule. To preclude costly surprises I recommend trying to negotiate into the base agreement, or included in a collateral document **Incorporated by Reference**, some specific language stating exactly how, when, and under what conditions any such withholds, hold-backs, reserves, risk amounts or any other similar designation are to be distributed. Get the formula in writing and have it reviewed for validity by a healthcare-experienced financial analyst.

If it doesn't pass the "sniff test" with an analyst, be wary. Too many have waited in vain for return of that money. And when not received it means that the already discounted fees you had agreed to accept just took a further "hit."

Also, always be concerned and **get written confirmation that those monies are the total limit of your potential financial liability.** You do not want to be responsible for any more than those funds, for example through a surprise assessment, and certainly not on the hook as the result of the financial under-performance of others.

So if those funds held back at the time claims are paid are to be the sole risk for **your** under-performance, that's one thing. But if your practice is meeting all the targeted benchmarks you don't want to be at risk for the under-performance of other ophthalmology practices, and you sure as heck do not want to be at risk for making up the performance shortfalls of other medical specialties in the collective.

I recommend asking: *"If our practice meets the targeted benchmarks but ophthalmology as a whole fails to do so, will we still get the monies not paid with our claims? If ophthalmology as a whole does not meet the benchmarks are we subject to additional hits? If other medical specialties do not meet their targets but we meet ophthalmology's, will we be made whole?"*

Get the specifics in writing so that there are no surprises. In doing so it politely puts an intermediary on notice that you expect no financial shenanigans at reconciliation time.