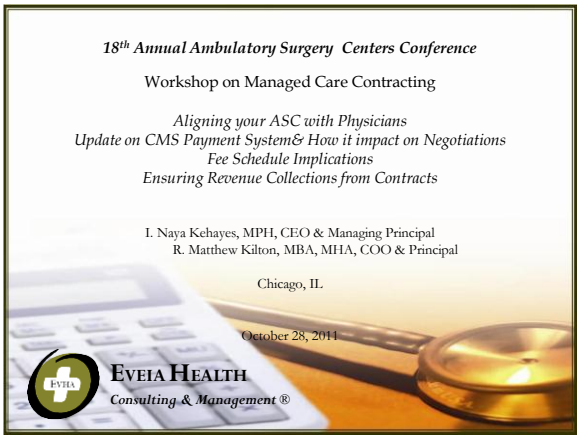

Managed Care Strategy &
Aligning your ASC with Physicians

Managed care contracts are the single most important factor in determining top-line and ultimately bottom-line success

Managed Care Strategy

How do you Partner with your Physicians for Success in Contracting?

- Alignment of ASC and Professional contract...

Why is this so important?

- In network continuity across all providers
- Motivates payors to consider contracting with the ASC

Managed Care Strategy

What about Anesthesiologists?

- Payors do not want "hidden" providers servicing members
- Increased requirements for Anesthesiologist to be contracted with Payors under agreement with the ASC
- ASC contract may have penalties or be subject to termination if Anesthesiologist is not contracted with Payor

Managed Care Strategy

Identifying the needs of the Partner Physicians

- What is the strategy for dealing with small volume payors?
- How does this impact contracting when a Physician partner requests a contract to bring certain cases?

Remain mindful of Rates, Terms and Value of contract

- How do you define value?
- Access to volume can impact rate & future negotiations
- Smaller payors may be vulnerable to acquisition by larger payor

How Physician Partners can Positively Influence ASC Contracting

Gather and summarize contract list of all physician partners and users of ASC…

- Which Payors are common to all parties?
- Which Payors are unique or do not have contracts with all parties?
- Which Payors are most important to shift patients to the ASC?

Physician Involvement

Why and when is Physician Partner Involvement Useful?

- Expansion of services requiring restructure of contracts
- New services not approved by payor; need physician team leader to meet with Payor Medical Director
- Provide payor with coordinated outcomes data
- Confirm volumes that will move out of hospital setting
- Assist ASC with obtaining a contract when payor is non responsive
- Use the leverage of the group, if evident, to motivate the payor to conduct business with the ASC

Physician Involvement

What to communicate when Payor is Unresponsive...

- Outline the professional history and relationships of physicians using the ASC
- Highlight physicians' services and involvement in the local medical community
- Opportunity for volume shift from hospital thru global case rates or other solutions that may not be common in the market

Physician Involvement

Steps to actively and positively participate in the process...

- Identify physician leaders
- Utilize physician data to create a business case
- ASC may wish to provide sample dialogue / scripts for physicians to use in communication with payors

Changing Payment Systems & Their Impact on Negotiations

Changing Payor Environment

National Observations

- Payors are aggressive and making changes
- Payment system modifications by CMS create opportunities for commercial payors
- Commercial payors seek to control and reduce cost through payment system changes
- Payors are removing incremental reimbursement for implants by transitioning to APC based methodologies
- Payors seeking transparency on rates with respect to cost structure

Payment System Review

APCs

- Modified version of APGs - enhanced classification of codes based upon cost
- APC is the system used to compensate HOPDs otherwise known as the Outpatient Prospective Payment System (OPPS)
- Implants are included in payment weight and rate
- Device intensive codes include allocation for device; these are based upon HOPD cost reporting to CMS

Standard Methodology Rate Calculation:
(APC weight * Area Adjustment) * (CF) = Reimbursement Rate

Payment System Review

APCs

- APC rates transitioned over four year period: 2008 - 2011
- January 2011- Fully transitioned payment rates in effect for ASCs
- Create opportunity for commercial payors to change payment systems
- What's good for CMS is good for the commercial payor!
- What's good for CMS may or may not be good for your ASC!

ASC Medicare Rate Change Over Time 2007-2011

Comparison of ASC Medicare 2007, 2010, and 2011 ASC National Payment Rates

CPT / HCPCS Code	Description	2007 Group	2007 Medicare Group Rate	2010 National Rate	2011 National Rate	Payment Increase / (Decrease) (2007-2011)	Percent of Change	Payment Increase / (Decrease) (2010-2011)	Percent of Change
29881	Knee arthroscopy/surgery	4	$ 630.00	$ 1,048.41	$ 1,161.03	$ 531.03	84.3%	$ 112.62	10.7%
29888	ACL	3	$ 510.00	$ 2,782.32	$ 3,447.64	$ 2,937.64	576.0%	$ 665.32	23.9%
29807	Shoulder Arthroscopy	3	$ 510.00	$ 1,586.87	$ 1,876.83	$ 1,366.83	268.0%	$ 289.96	18.3%
29827	Arthroscopic rotator cuff repr	5	$ 717.00	$ 1,636.33	$ 1,876.83	$ 1,159.83	161.8%	$ 240.50	14.7%
29892	Ankle arthroscopy/surgery	3	$ 510.00	$ 2,782.32	$ 3,447.64	$ 2,937.64	576.0%	$ 665.32	23.9%
30520	Repair of nasal septum	4	$ 630.00	$ 899.68	$ 993.66	$ 363.66	57.7%	$ 93.98	10.4%
31255	Removal of ethmoid sinus	5	$ 717.00	$ 1,049.75	$ 1,198.96	$ 481.96	67.2%	$ 149.21	14.2%
42830	Removal of adenoids	4	$ 630.00	$ 899.68	$ 993.66	$ 363.66	57.7%	$ 93.98	10.4%
49505	Repair initial inguinal hernia	4	$ 630.00	$ 1,109.88	$ 1,281.59	$ 651.59	103.4%	$ 171.71	15.5%
49585	Repair umbilical hernia	4	$ 630.00	$ 1,109.88	$ 1,281.59	$ 651.59	103.4%	$ 171.71	15.5%
52005	Cystoscopy & ureter catheter	2	$ 446.00	$ 872.49	$ 1,020.24	$ 574.24	128.8%	$ 147.75	16.9%
52204	Cystoscopy w/biopsy(s)	2	$ 446.00	$ 872.49	$ 1,020.24	$ 574.24	128.8%	$ 147.75	16.9%
52290	Cystoscopy and treatment	2	$ 446.00	$ 872.49	$ 1,020.24	$ 574.24	128.8%	$ 147.75	16.9%
57288	Repair bladder defect	5	$ 717.00	$ 1,521.44	$ 1,758.70	$ 1,041.70	145.3%	$ 237.26	15.6%
58550	Laparo-asst vag hysterectomy	9	$ 1,339.00	$ 2,509.39	$ 2,754.57	$ 1,415.57	105.7%	$ 245.18	9.8%
64721	Carpal tunnel surgery	2	$ 446.00	$ 668.34	$ 741.26	$ 295.26	66.2%	$ 72.92	10.9%
69436	Create eardrum opening	3	$ 510.00	$ 637.65	$ 671.76	$ 161.76	31.7%	$ 34.11	5.3%

ASC Medicare Rate Changes 2011 - 2012

Comparison of ASC Medicare 2011 and Proposed 2012 ASC National Payment Rates

CPT / HCPCS Code	Short Descriptor	Eveia Procedure Category	2011 National ASC Rate	Proposed 2012 National ASC Rate	Payment Increase / (Decrease) (2011-2012)	Percent of Change
30520	Repair of nasal septum	ENT	$ 993.66	$ 997.35	$ 3.69	0.4%
31255	Removal of ethmoid sinus	ENT	$ 1,198.96	$ 1,199.07	$ 0.11	0.0%
42826	Removal of tonsils	ENT	$ 993.66	$ 997.35	$ 3.69	0.4%
69714	Implant temple bone w/stimul	ENT - Cochlear/Baha Devices	$ 7,068.23	$ 7,498.30	$ 430.07	6.1%
49505	Prp i/hern init reduc >5 yr	General Surg - Hernia Repair	$ 1,281.59	$ 1,308.26	$ 26.67	2.1%
47562	Laparoscopic cholecystectomy	General Surg - Lap Chole	$ 1,853.68	$ 1,893.15	$ 39.47	2.1%
43239	Upper gi endoscopy biopsy	GI/Colo-Rectal	$ 344.10	$ 332.43	$ (11.67)	-3.4%
45378	Diagnostic colonoscopy	GI/Colo-Rectal	$ 361.93	$ 369.70	$ 7.77	2.1%
45380	Colonoscopy and biopsy	GI/Colo-Rectal	$ 361.93	$ 369.70	$ 7.77	2.1%
29888	Knee arthroscopy/surgery	Ortho - ACL/PCL	$ 3,447.64	$ 3,474.22	$ 26.58	0.8%
29881	Knee arthroscopy/surgery	Ortho - Arthros	$ 1,161.03	$ 1,167.37	$ 6.34	0.5%
29827	Arthroscop rotator cuff repr	Ortho - Arthros	$ 1,876.83	$ 1,922.43	$ 45.60	2.4%
64483	Inj foramen epidural l/s	Pain Management	$ 294.00	$ 299.46	$ 5.46	1.9%
62311	Inject spine l/s (cd)	Pain Management	$ 294.00	$ 299.46	$ 5.46	1.9%
57288	Repair bladder defect	Urology - Sling Procs	$ 1,758.70	$ 1,808.45	$ 49.75	2.8%

Implant Methodology Review

Implant Reimbursement Methodologies

1) Payment equal to invoice cost

2) Payment equal to invoice cost + x %

3) Payment equal to x % of billed charges equivalent to cost

4) Payment equal to x % of billed charges equivalent to cost + x %

5) Payment equal to x % of billed charges

6) Carve out for implant associated with specified CPT codes at % of billed charge up to a cap or at cost

Implant Methodology Review

Implant Reimbursement Methodologies

7) Implants paid at cost up to threshold of xxx $$

8) Implants with cost above xxx threshold of x $ paid separately

9) Aggregate implants with cost of x paid at cost or at cost + x %

10) Payment rates for surgery all inclusive at % of charge up to a cap of x $$ (surgery and implants are included in cap)

9) Implants will be paid by third party vendor designated by payor

10) Global flat rate with implants included in payment rate

Have you mastered the plan yet?

Payor Modifications to Payment Systems

Elements to watch when payor shifts over to APC's and away from reimbursing implants incrementally...

- Transitional APC payments vs. Fully Implemented Payments
- Impact of Weights on Global Payment
- Value of surgery rates with and without implants
- Impact on percent of APC rate or CF needed to cover the cost of implants rolled into the surgery rate
- Which APC year is the payor proposing?
- Is Payor using area adjustments?
- When will Payor move to 2011? 2012?

Shifting Methodologies - APCs without Implants

ACL Example (29888):

Current Methodology

	Volume	Surgery Rate - Carve Out	Implant Cost with Screws / Hardware	Allograft w/ Hardware	Total Projected Revenue	Avg NR / Case	
	20	$3,200	$800		$80,000	$4,000	
	50	$3,200		$2,500.0	$285,000	$5,700	
Totals	**70**				**$365,000**	**$5,214**	

APC Proposal = 160% of ASC APC Rate

2010 Wgt	Volume	100% of ASC	160% of ASC Rate		Total Projected Revenue	Avg NR / Case	% of Change
	70	$2,782	$4,451		$311,584	$4,451	
Projected Gain (Loss)					*($53,416)*	*($763)*	-15%
2011 Wgt	**Volume**	**100% of ASC**	**150% of ASC Rate**		**Total Projected Revenue**	**Avg NR / Case**	**% of Change**
	70	$3,448	$5,517		$386,176	$5,517	6%

Shifting Methodologies - APCs without Implants

ACL Example (29888):			
Financial Impact	**Gain (Loss) Total Revenue**	**Gain (Loss) NR/Case**	**% of Change**
Projected Gain (Loss) All Volume	$21,176	$303	6%
Projected Gain (Loss) Implant with Screw / Hardware	$30,336	$1,517	38%
Projected Gain (Loss) Implant with Allograft / Hardware	($9,160)	($183)	-3%

What is the strategy for optimizing success in this situation?

Contracting Strategy

- Present payor with cost data demonstrating savings

Will surgeons take cases to the hospital if ASC is unable to reach agreement with Payor to reconcile payment?

What will the hospital be paid at 100% of Medicare?

29888	$6,129
29881	$2,064 x .50
Total =	*$7,161*

How does HOPD rate compare to ASC rate?

Contracting Strategy

- Does payor have flexibility with respect to which APC year it can use?
- Understand the variance between transitional and fully implemented weights; may there is opportunity here....
- Show payor variance between ASC methodologies and HOPD rates when advantageous
- Provide physician utilization information ASC vs. Hospital when meaningful savings is evident

2011 ASC vs. HOPD Medicare Rates- Examples

2011 ASC vs. HOPD Medicare Rate Comparison

CPT/ HCPCS Code	Short Descriptor	2011 National ASC Rate	2011 National HOPD Rate	Variance	Percent of Change
29881	Knee arthroscopy/surgery	$ 1,161.03	$ 2,064.02	$ 902.99	78%
29827	Arthroscop rotator cuff repr	$ 1,876.83	$ 3,336.55	$ 1,459.72	78%
29888	Knee arthroscopy/surgery	$ 3,447.64	$ 6,129.06	$ 2,681.42	78%
30520	Repair of nasal septum	$ 993.66	$ 1,766.48	$ 772.82	78%
31255	Removal of ethmoid sinus	$ 1,198.96	$ 2,131.46	$ 932.50	78%
31256	Exploration maxillary sinus	$ 1,198.96	$ 2,131.46	$ 932.50	78%
69714	Implant temple bone w/stimul	$ 7,068.23	$ 8,596.24	$ 1,528.01	22%
64483	Inj foramen epidural l/s	$ 294.00	$ 522.67	$ 228.67	78%
62311	Inject spine l/s (cd)	$ 294.00	$ 522.67	$ 228.67	78%
57288	Repair bladder defect	$ 1,758.70	$ 3,126.54	$ 1,367.84	78%
49505	Prp i/hern init reduc >5 yr	$ 1,281.59	$ 2,278.36	$ 996.77	78%
47562	Laparoscopic cholecystectomy	$ 1,853.68	$ 3,295.39	$ 1,441.71	78%
42826	Removal of tonsils	$ 993.66	$ 1,766.48	$ 772.82	78%
43239	Upper gi endoscopy biopsy	$ 344.10	$ 611.73	$ 267.63	78%
45378	Diagnostic colonoscopy	$ 361.93	$ 643.41	$ 281.48	78%
45380	Colonoscopy and biopsy	$ 361.93	$ 643.41	$ 281.48	78%

Payor Modifications to Payment Systems

What else do you need to know?

- Multiple procedure logic

  Is the Payor following Medicare on an APC system?

- Prosthetic and implant payment changes
  - *Does payor adhere to Medicare policy changes?*
  - *Does payor follow policy regarding device intensive codes?*

Device Intensive Codes

Overview:

- CMS assembles cost data from HOPDs annually
- If the cost of a device is greater than 50%; CPT code is classified as "device intensive"
- Percent of total cost attributed to device = APC Device Dependent APC Offset Percentage
- CMS allocates 100% of HOPD allowed cost for device to ASC which is designated as "device related" portion of rate

Device Intensive Code Examples – ASC Changes

Device Intensive Codes and Cost Allocation
Nationwide (Unadjusted)

ASC COVERED SURGICAL PROCEDURES DESIGNATED AS DEVICE-INTENSIVE FOR CY 2011 EXAMPLES

					2011 Q1 Rates		
CY 2011 CPT Code	CY 2011 Short Descriptor	Final CY 2011 Device-Dependent APC Offset Percentage	Subject To Multiple Procedure Discounting	CY2007 National ASC Rate	2011 Q1 National ASC Rate	2011 Q1 Device-Related Portion	2011 Q1 Procedure-Related Portion
24361	Reconstruct elbow joint	59.37%	YES	$717.00	$7,068.23	$5,103.59	$1,964.64
24366	Reconstruct head of radius	59.37%	YES	$717.00	$7,068.23	$5,103.59	$1,964.64
25441	Reconstruct wrist joint	59.37%	YES	$717.00	$7,068.23	$5,103.59	$1,964.64
27446	Revision of knee joint	59.37%	YES	N/A	$7,068.23	$5,103.59	$1,964.64
33212	Insertion of pulse generator	72.92%	YES	$510.00	$5,803.96	$4,801.04	$1,002.92
54400	Insert semi-rigid prosthesis	61.03%	NO	$510.00	$5,852.95	$4,306.23	$1,546.72
54401	Insert self-contd prosthesis	71.49%	NO	$510.00	$10,175.11	$8,310.78	$1,864.33
55873	Cryoablate prostate	58.46%	YES	$1,339.00	$6,561.39	$4,687.71	$1,873.68
63650	Implant neuroelectrodes	57.55%	NO	$446.00	$3,707.45	$2,620.26	$1,087.19
63655	Implant neuroelectrodes	63.95%	NO	N/A	$5,223.67	$3,966.04	$1,257.63
63685	Insrt/redo spine n generator	85.62%	NO	$446.00	$13,816.04	$12,623.45	$1,192.59
64581	Implant neuroelectrodes	63.95%	NO	$510.00	$5,223.67	$3,966.04	$1,257.63
64590	Insrt/redo pn/gastr stimul	85.62%	NO	$446.00	$13,816.04	$12,623.45	$1,192.59
69714	Implant temple bone w/stimul	59.37%	YES	$1,339.00	$7,068.23	$5,103.59	$1,964.64
69930	Implant cochlear device	85.25%	YES	$995.00	$29,056.15	$26,479.07	$2,577.08

Device Intensive Code - Rate Change Example

Current Contract Structure 63685 with 63650 x 2
(Insertion of Spine Generator with Neurostimulator electrodes)

- Current Methodology – Carve outs with implants paid at cost; multiple procedures paid at 100/50+++
- Current Contract Rates:
  63685 $2,800
  63650 $2,000
- Costs:
  Spine Generator $19,500
  Neurostimulator electrodes $1,200 per lead

Device Intensive Code - Rate Change Example

Proposed Contract Structure:

- 100% of National Medicare ASC Rates
- Multiple procedure logic to follow Medicare
- Device intensive procedure logic in accordance with Medicare

2011 Medicare ASC National Payment Rates

63685 $13,816
Device related portion: $12,623

63650 $3,707
Device related portion: $2,620

Device Intensive Code - Rate Change Example

Neurostim / Generator 63685 w/ 63650 x 2

Current Methodology

	Volume	Surgery Rate - Carve Out	Multiple Procedure Discount 50%	Implants	Total Projected Revenue / Case
63685	1	$2,800	$2,800	$19,500	
63650	1	$2,000	$1,000	$1,200	
63650	1	$2,000	$1,000	$1,200	
Totals	**2**		**$4,800**	**$21,900**	**$26,700**

APC Rates at 100% of 2011 Medicare ASC (National Rates)

2011 Wgt	Volume	100% of ASC	Multiple Procedures at 100%	Implants	Total Projected Revenue	Projected Gain (Loss)	% of Change	Rate Required for Revenue Neutrality based upon 2011 ASC Medicare
63685	1	$13,816	$13,816	$0	$0	-$5,684		
63650	2	$3,707	$7,414			$3,014		
Total			$17,523		$17,523	-$2,670	-34%	*152%*

Device Intensive Code - Rate Change Example

How much will this case pay in the HOPD under the APC Methodology?

Neurostim / Generator 63685 w/ 63650 x 2 ASC vs. HOPD

Current Methodology

	Volume	Surgery Rate - Carve Out	Multiple Procedure Discount 50%	Implants	Total Projected Revenue / Case
63685	1	$2,800	$2,800	$19,500	
63650	1	$2,000	$1,000	$1,200	
63650	1	$2,000	$1,000	$1,200	
Totals	**2**		**$4,800**	**$21,900**	**$26,700**

APC Rates at 100% of 2011 Medicare HOPD (National Rates)

2011 Wgt	Volume	100% of HOPD	Multiple Procedures at 100%	Implants	Total Projected Revenue	Projected Gain (Loss)	% of Change	Rate Required for Revenue Neutrality based upon 2011 HOPD Medicare
63685	1	$14,744	$14,744	$0	$0	-$4,756		
63650	2	$4,553	$9,106			$4,706		
Total			$19,297		$19,297	-$50	-28%	*138%*

Contracting Strategy

Challenges:

- HOPD rate below current contract ASC rate
- Device cost allocation used by CMS equitable for ASC vs. hospital
- ASC cost for device greater than device cost allocation
- Commercial payors expecting reductions from ASC due to change in methodology

Contracting Strategy

Strategies to Implement;

- Focus on maintaining current methodology
- Show payor invoices for implants
- Propose a threshold on the implants

Alternatives:

- Can you carve out the entire case?
- Can the payor have multiple percentages for varied APC groups?

All Inclusive Payment on Implants

When is an all inclusive payment rate be in the best interest of the ASC?

- When ASC has very competitive cost
- Margins can increase substantially when ASC cost structure is below allowed amounts

Negotiation Strategy

- Identify highest cost cases – this is the risk you must cover!
- Obtain EOBs showing hospital cost is greater to the payor
- Show payors invoice cost and units used for most expensive cases

All Inclusive Payment on Implants

Example – ACL 29888 with Meniscectomy 29881

- Case cost with screws & hardware = $800
- Case cost with allograft & hardware = $2,500
- Weighted Average Implant Cost =

  (20*800) + (50*2500) / 70 = $2014

All Inclusive Payment on Implants

What should your minimum targeted rate be?

$2,500 + Cost of Case at $2,000 = $4,500

Remember: HOPD Medicare = $7,161

Rate Target at x% Savings to Hospital Medicare:

Savings	NR/ Case	Operating Margin*
✓ 10%	$6445	30%
✓ 20%	$5156	15%

* Operating margin on highest case cost scenario

All Inclusive Payment on Implants

What should your targeted rate be?

$2,500 + Cost of Case at $2,000 = $4,500

Hospital EOBs show ACL average reimbursement at $11,500

Rate Target at x% Savings to Hospital Payor Rate:

Savings	NR/ Case	Operating Margin*
✓ 40%	$6,900	35%
✓ 30%	$8,050	44%
✓ 20%	$9,200	51%

* Operating margin on highest case cost scenario

Opportunities for ASCs

How is understanding the changes in the APC methodology important in contract negotiations?

- Payors are noted for using Medicare as their baseline for argument
- Avoid potential losses on implants
- May present opportunity to restructure contract
- Understand which specific APC year Payor is using and time period for migration
- APCs may present opportunity for lowering vendor cost and increasing margins!

Fee Schedule Implications & Review

Fee Schedule Implications

- Fee schedules are outdated based upon historical payment systems
- Every payor uses a different payment system
- Fee schedules must represent a margin above maximum contract rate
- Payor looks at charges as an indication of rate of payment
- Payor measures savings based upon discount percentages, aka contractual write offs

Fee Schedule Implications

Fee Schedule Analysis

- Commercial payor contracts and Medicare rules specify payment to be lesser of negotiated rate or 100% of billed charge
- Some payors will assess total billed charges on a claim vs. billed charge at CPT level
- Evaluation of reimbursement methodologies to identify fees falling below maximum reimbursement rate
- CPT by volume by payor as well as multiple procedure logic should be accounted in the evaluation to determine impact

Fee Schedule Implications

Fee Schedule Analysis findings

- Most centers have opportunity to optimize revenue

Why?

- Fee schedules are often set below new Medicare APC rates as well as commercial payor rates
- Many ASC have not consistently reviewed their fee schedules

Fee Schedule Implications

Why is this occurring?

- Historical fee schedules based upon multiple of grouper based methodology
- Lack of annual adjustments
- Changing payment systems
- Center Administrator or owners reluctance to modify fee schedule

Fee Schedule Objectives

- Ensure Center does not have fees that fall below negotiated rates
- Optimize opportunity with revenue resulting from changing payment systems
- Ensure every CPT code that is ASC eligible is evaluated against contract rates and cost
- Consider market conditions in the analysis including HOPD considerations
- Ensure payor recognizes a "discount" off of charges through claims data – critical to negotiations moving forward

Fee Schedule Review Example

CPT	CPT Description	All Payor Procedure	Existing Fees as of 5/26/11	Max Contract Rate	Variance vs Existing Fee	Payor with Max Fee
19342	DLYD INS BREAST PROSTHESIS	9.00	6,435.00	6,729.21	($294)	Commercial Payor 1 - Effective 4/15/2011 Rate
19357	BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDING SUBSEQUENT EXPANSION	18.00	6,440.00	6,729.21	($289)	Commercial Payor 1 - Effective 4/15/2011 Rate
25365	Revise tibia & ulna	1.00	5,100.00	9,357.74	($4,258)	Commercial Payor 1 - Effective 4/15/2011 Rate
29879	SCP KNEE--ABRASION ARTHROPLASTY	16.00	2,750.00	3,151.32	($401)	Commercial Payor 1 - Effective 4/15/2011 Rate
29882	SCP KNEE--MENISCUS REPAIR MED OR LAT	10.00	2,750.00	3,151.32	($401)	Commercial Payor 1 - Effective 4/15/2011 Rate
29895	SCP ANKLE--SYNOVECTOMY	2.00	2,750.00	3,151.32	($401)	Commercial Payor 1 - Effective 4/15/2011 Rate
29897	SCP ANKLE--DEBRIDEMENT	2.00	2,750.00	3,151.32	($401)	Commercial Payor 1 - Effective 4/15/2011 Rate
29898	SCP ANKLE--DEBRIDEMENT EXTENSIVE	2.00	2,750.00	3,151.32	($401)	Commercial Payor 1 - Effective 4/15/2011 Rate
44180	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)	2.00	4,125.00	5,145.00	($1,020)	Commercial Payor 4- Effective 9/15/2010 Rate
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh ins	1.00	6,010.00	8,305.13	($2,295)	Commercial Payor 2- Effective 6/1/2011 Rate
63030	Laminotomy with decompression of nerve root	38.00	6,435.00	7,471.50	($1,037)	Commercial Payor 3 - Proposal 05/2011
63047	LAMINECTOMY LUMBAR	5.00	6,435.00	9,000.00	($2,565)	Commercial Payor 3 - Proposal 05/2011
63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, EPIDURAL	10.00	6,585.00	10,062.92	(3,478)	Commercial Payor 1 - Effective 4/15/2011 Rate

Ensuring Revenue Collection from Contracts

It Pays to Understand Your Contracts

Contract Compliance

Understanding your contracts and payment provisions are critical to your success!

- Payors are minimizing rate increases; some are moving to reduce rates
- Patient responsibility portion is increasing
- Payors trying to lower premiums for employer groups
- Collecting every dollar allowed by the contract requires increasing expertise

Contract Compliance

Contract compliance is essential throughout the Revenue Cycle:

- Accurate up-front collections from patients is crucial
- Pre-price claims and capture estimates of revenue due based upon contract rates

Up-front collections are critical to your success

- Higher deductibles and co-insurance amounts mean an increasing emphasis on collecting from patients
- Opportunity for success drops as soon as patient leaves the facility
- Most providers do not have the tools to pre price a claim

Understanding Payment Exhibits

Review every agreement and ask...

- How is the payor's methodology unique?
- Do I have the mappings to groupers when applicable?
- How will I get paid on implants?
- How will I get paid on multiple procedures?
- What additional documentation is needed to clarify reimbursement?
- Annual updates?

Compliance Tools

- Accurately determine the expected reimbursement amounts from payors and patients
- Determine whether your billing system has pricing functionality
- Create internal pricing tools for the entire staff to use

✓ Schedulers

✓ Insurance Verifiers

✓ Billers

✓ Collectors

Compliance Tools

Critical Information to Capture:

- Summarize reimbursement terms for each contracted payor by product
- Worksheets with allowed amount by CPT code
- Multiple procedure reductions – highest allowed amount vs. 1st position
- Patient responsibility
- Prosthetic and implant terms

Ensure implant & prosthetic mark ups are high enough to capture allowed amount from contract

Things to Remember…

- Align with physician partners to ensure continuity in contracting
- Educate the payor with the help of your physicians
- CMS changes carry over to commercial payors
- Changes in payment methodologies may impact fee schedules
- Product designs shift greater responsibility to patients & increased need for up front collections
- Educate your business office and provide them with the tools to maximize revenue from all payors

Q & A