ISSUE BRIEF

V: Disclosure of payment-related information

I. What payment issues should you consider prior to signing a managed care agreement?

- Has the health insurer given you a complete and accurate fee schedule?
- Has a health insurer disclosed the payment rules, coding edits and modifiers that it will use to determine your reimbursement?
- If the health insurer calculates payments using a formula based on the Medicare Resource-Based Relative Value Scale (RBRVS) or a customized relative value unit (RVU) system (including any conversion factors), do you have enough information to figure out how much you will be paid under that system?
- If you will be participating in multiple products, plans, or networks, do you know how much you will be paid for treating patients through these products, plans or networks?
- Can the health insurer change your reimbursement after you have signed the agreement? If so, will you know beforehand? If you object, can you terminate the contract before these changes become effective?

II. Factors that health insurers use to calculate payments

Health insurers often use a combination of factors to determine payments. Such factors typically include:

- Fee schedules;
- Reimbursement methodologies, e.g., relative RVUs (which may or may not be identical to the relative value units used by the Medicare RBRVS) for specific services, multiplied by the health insurer's conversion factor(s);
- Coding edits, which are bundling algorithms programmed to deny payment for certain Current Procedural Terminology (CPT®) codes when they are included on a claim with certain other CPT codes, e.g., when a health insurer denies payment for a CPT code reported by a medical practice to indicate vaccine administration when the practice also bills a CPT code for the vaccine itself;
- Payment rules like a multiple surgery reduction rule, which, for example, may state that if a patient undergoes a surgery involving more than one surgical procedure, the "primary" surgical procedure will be reimbursed at 100% of the contracted rate but other surgical procedures performed during the surgery will be reimbursed at 50% or even less of the contracted rate

A. Fee schedules

Health insurers' failure disclose complete and accurate fee schedules has been a chronic problem. Some health insurers refuse to disclose complete fee schedules. Instead, they may give you a list of sample fees for the most commonly reported CPT codes for select medical specialties that may have

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little relation to the CPT codes that you typically report.

B. Reimbursement methodologies

Health insurers may fail to provide adequate information concerning the reimbursement methodologies they use to calculate physician payments. For example, some managed care agreements state that payment calculations will be based on the "Medicare RBRVS." References to the "Medicare RBRVS" may be misleading. The components of the health insurer's RVU system may not be identical to Medicare's, e.g., the insurer's RVU system might drop the medical liability RVU. Or, even if the insurer uses the same RVUs as Medicare, the insurer may not assign the same relative values to each RVU as the Medicare RBRVS does. Without specific information concerning the content, structure and application of the health insurer's reimbursement methodology, it may be difficult to determine what the health insurer will be paying you under the contract.

C. Coding edits

Health insurers often apply coding edits to claims on which two or more separate, distinct CPT codes are used to report separate procedures and services performed on a patient during a single visit. Coding edits are used to reduce payments for those separate services by bundling those services into a single service. Health insurers' undisclosed coding edits are frequently used to inappropriately bundle CPT codes. Code bundling has become particularly more widespread as health insurers have expanded their use of proprietary, i.e., "black box," code-editing software, and confusion is further increased when health insurers repeatedly modify that proprietary software to suit their individual corporate needs. Unless the health insurer discloses its coding edits to you, you may not be able to: (1) predict what you will be paid; or (2) perform adequate claims payment reconciliation.

D. Payment rules

Payment rules, e.g., multiple surgery reduction rules, global surgical periods, modifiers and site-of-service differentials, may influence payments. Although the Medicare program's payment rules are fully transparent, some health insurers do not use Medicare's payment rules, or if they do, they may use those rules differently than Medicare.

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III. State disclosure requirements and Advocacy Resource Center model legislation

Many states have recognized how problematic health insurers' failure to fully and accurately disclose payment-related information is for physicians and have enacted laws imposing disclosure requirements on insurers. All of these laws are grouped in the Database under the following categories: "Fee schedules," "Payment edits," and "Payment rules." The Advocacy Resource Center has also developed comprehensive physician payment disclosure model legislation entitled "Transparent Payment To Ensure Access To Care." You can access this model bill in the Database under the general category "ARC model legislation," under the categories: "Risk-physicians taking;" "Fee schedules;" "Payment edits;" or "Payment rules."

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