The Hawthorn
CONNECTION

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Payer Contract Management

by Stan Hosler

Maybe I'm old-school, but I always thought you honor a contract. –Brett Favre

Like professional musicians, actors and athletes, health care professionals are paid according to contracts. Insurance companies pay claims based on contracts that include fee schedules and other provisions that are negotiated between the two parties. Some payer contracts tie reimbursements to the Medicare fee schedule, with payment amounts expressed as a percentage of the allowed Medicare fee.

Commercial payers follow a business model that is focused on maximizing revenue, increasing efficiency and reducing costs. This means that payers will reject or deny claims that do not meet the requirements of the contract. Claims may be rejected for missing CPT codes, incorrect patient information or failure to meet filing deadlines.

Payer-to-provider contracts include expiration dates or renewal dates, but evergreen contracts automatically renew unless one of the parties requests a change. From time to time payers may replace old contracts with new contracts that favor their business goals. Additionally, payers may amend contracts with notices that automatically go into effect unless they receive a response within 30 or 45 days. Payers may reduce fee schedules by sending notices that say the changes are required to streamline operations or improve competitive positioning.

It is the provider's responsibility to hold payers accountable for paying claims based on contracted payment amounts, and this function can only be fulfilled by paying close attention to the details. This means creating the right reports, analyzing results, auditing EOBs and appealing claims—services Hawthorn performs routinely in behalf of its clients.

The Healthcare Business Management Association (HBMA) recognizes that medical practices must remain diligent in managing their payer-to-provider contracts. HBMA shares current trends on its website (www.hbma.org) under the heading, Commercial Payor News. A recent HBMA article offered bullet points for understanding product lines, educating staff at the point of treatment, and using a third-party billing company to manage payer contracts.

- ✓ Most payers offer a variety of product lines to meet a range of consumer needs—Platinum, Gold, Silver, and Bronze, plus combinations of coverages. As a provider, you must understand these product lines and confirm each patient's eligibility and coverage.

- ✓ You should train your staff on how to qualify patients at the point of treatment: 1) note the deductible for each patient, 2) explain the deductible provisions for every patient encounter, 3) verify benefits and note the terms of coverage, 4) recognize the need for pre-authorization when required, and 5) collect correct co-pay amounts based on product line features.

- ✓ You can improve your results by using a third-party billing company to manage payer contracts, analyze your payer mix and product lines, pursue appeals for denied claims, and educate your practice team.

Hawthorn delivers the revenue cycle management functions described and recommended by HBMA. Hawthorn's services go beyond mere billing and collecting activities to deliver the promises of The Hawthorn Advantage. (Click on the Our Promises tab at www.hawthorngrp.com to review the Hawthorn value platforms for Professional Management and Professional Advocacy.)

PQRS – Physician Quality Reporting System Timeline

March 13, 2017- Last day to submit 2016 CQMs for dual participation in PQRS and Medicare EHR Incentive Program.

March 31, 2017- Last day to submit 2016 QCDRs (XML only) and registries to submit 2016 data.

December 31, 2017- PQRS program year ends for both group practices and individuals.

2017 Q1 Employee Service Awards

Shirley S. **15 year Anniversary**
Judi J. **15 year Anniversary**
Lucia K. **15 year Anniversary**

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