Getting Fee Schedules from Contracted Health Plans

Introduction

This is an issue that exists only in health care. In any other industry both parties to a contract have full access to and agreement on the basic contractual exchange; which is “I will do this if you do that”. However, in health care the physician (Provider) says I will provide these services but the purchaser (Payer) says I will decide later, and at my discretion, what I will pay for each service. This paper will focus on some strategies that a practice can use to close this imbalance.

The first lesson is realism. The fact remains that payers in health care have more leverage than providers. This is not universally true for all regions or specialties or services. Payers deal with a complex regulatory environment and a marketplace where only part of the cost of providing coverage, the price per unit, is under some control. For payers the open question of how many services must be paid for, makes it very difficult to predict costs and therefore insurance rates. Payers neither consume health care services nor control how and how many are consumed. From this perspective it might seem reasonable that a payer would try to exert control over the price per unit to gain control over costs. Never-the-less, many payers have used the need to exert control over cost as an excuse to withhold fee and pricing information entirely.

To narrow this question down let’s assume that we have a market place with a willing provider and a willing payer. We will focus on how a provider might get the necessary price/fee information to determine if the expected payment rates are adequate. The issue of leverage and payers that don’t want to contract is addressed in a separate Web Resource Document “Increasing your Leverage” and the issue of how to enforce contracted rates is addressed in the Web Resource Department “Silent PPOs and What You Can Do About Them”.

What Does State Law Provide?

Many state legislators have begun to recognize the marketplace imbalance and have created some relief.

Tennessee – TCA 56-7-1013 provides

Health insurance carriers shall provide or make available to a healthcare provider, when contracting or renewing an existing contract with such provider, the payment or fee schedules or other information sufficient

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1 A summary of these and other state laws affecting manage care activities is available in the Web Resource Document “Laws Governing Payer Contracts”.


to enable the healthcare provider to determine the manner and amount of payments under the contract for the healthcare provider's services prior to final execution or renewal of the contract. The payment or fee schedule or other information submitted to a healthcare provider pursuant to this section shall include a description of processes and factors that may be applicable and that may affect actual payment (e.g., co-payments, coinsurance, deductibles, risk sharing arrangements and liability of third parties). A health insurance carrier, upon request of a healthcare provider, shall make available to the healthcare provider examples of actual payment for procedures frequently performed by the provider that involve combinations of services or payment codes, if the actual payment for such procedures cannot be ascertained from the fee schedule or other information submitted to a healthcare provider pursuant to this section. The provisions of this subsection (b) requiring the submission of a fee schedule or other information upon renewal of an existing contract shall not be applicable to renewal of an existing contract when the payment or fee schedule previously provided to the healthcare provider has not changed.

**Virginia** – VCA 38.2-3407.15.8 provides

No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision B 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

**Kentucky** – KRS 304.17A-254(7) provides

(Health Insurers must) Include in any agreement it enters into with providers for the provision of health care services a clause stating that, upon request, the insurer shall provide the provider with specific fees for requested codes applicable to the compensation that the provider will receive under the contract with the insurer within thirty (30) days of the date of such request, and

**Georgia** – OCGA 33-20A-5(1)(D) provides

A managed care entity which negotiates with a primary care physician to become a health care provider under a managed care plan shall furnish that physician, beginning on and after January 1, 2001, with a schedule showing fees payable for common office based services provided by such physicians under the plan;

**Alabama, Arkansas, and Mississippi** do not appear to have similar statues that require plans to make contracted fees available to providers.

Even with these legal remedies it may be necessary to push plans to provide fee information in a usable format. Some plans may provide only a sample. Some may provide fee information only on paper, some only via the web, and some only a few codes at a time. To get the needed information providers will need to take the lead in communicating format and process for the exchange of fee information.

**How to Ask**

The most efficient way of communicating fee information is the use of a formula. The most common example is to establish allowed fees as a percentage of Medicare payment rates. Setting fees as a percent of Medicare can be precise and is efficient, but it requires some specification. When discussing fees as a percentage of the Medicare the following elements must be known to interpret a proposed fee schedule correctly:
• What year of Medicare fees,
• When will those fees be updated relative to Medicare’s changes,
• What geographic region (GPCI)
• Is the same percentage applied across all services (CPTs),
• How is a fee established if Medicare does not publish a fee,
• Is there a risk or withhold provision,
• What payment policy edits will be applied – Medicare’s CCI or another,
• Is the same percentage applied to all specialties,
• Is there any discount applied to physician extenders (NP & PAs)
• Will the sight of service differential be applied (Facility vs. Non-Facility)?

Knowing these elements will let the practice re-create the fee schedule that is intended by the payer. All of these elements are part of the definition of the fee schedule and should be specified in the contractual agreement. Samples of a “Good” and “Poor” fee specification are attached at the end of this paper. Even with this level of detail the best way for a practice to analyze a proposed fee schedule is to use these elements to actually create a fee for each service the practice will perform, so that a volume weighted analysis can be performed.

The next easiest way to communicate with a payer about the allowed fees is to use a comprehensive fee list. This is where the practice can help itself by offering a method. Most practice management systems can report the frequency of each service (CPT). A practice should run a CPT frequency report, including CPTs with modifiers and noting the place of service for each CPT. By exporting this report to Excel the practice can build and electronic file of fees that need to be priced. This file can be sent to payer representatives so they can specify fees. Some payer representatives will recognize this as a help and others will see it as more work.

The electronic file should contain the following:
• All CPTs used by the practice
• The frequency of each CPT/Modifiers/Sight of Service combination
• The current Medicare rate of each CPT

Note that the file list does not include the practice’s charge for each service. Some payers will ask for charge information. Generally, the reason for requesting charge information is so the payer can lower any fees to the practice charge if the charge is lower than what the payer would pay. You are under no obligation to provide this information. Simply reply that you will provide the charge when a claim is submitted.

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2 For more information about how to analyze a fee schedule see the Web Resource Document “Building a Fee Analyzer for Your Practice.”
Handling Resistance

Despite regulations and trends to the contrary some payers will resist providing fee information. Resistance can occur in many forms such as unexplained delays, providing information in obscure or unreadable formats, claiming the information is proprietary, ignoring requests, limiting how many fees can be accessed at a time, and outright rejection. When you encounter resistance the following arguments may help.

First use logic: The logic of having a contract where the primary terms (Services and fees) are known and/or changeable by only one party is ridiculous. Think of renting a home where the landlord could change the rent any time. Would the rent ever go down?

If the reply is “There is no point giving you the fees cause we change them from time to time so what we give you would not be accurate”, then counter by restating the obvious why would any two parties be in a contract where only one party knows the terms. Any change in fees must be agreed to in advance. If the payer will not move off this position 1) ask for fees anyway, and/or 2) consider not contracting.

If they reply is “We don’t pay claims our contracted payers do, and they set the fees”, then counter by replying with recommended language from the Web Resource Document Silent PPOs and What You Can Do About Them. Another alternative in this situation is to ask that contract language be amended to read “the allowed payment rate will be greater of (rather than the usual “lesser of”) the usual and customary rate or the billed charge.”

If the reply is “We don’t have time to respond to your fee request”, then counter with: 1) Sending and electronic file, 2) Ask for a formula that defines the fees and you will create a schedule for yourself, or 3) Ask for a complete fee schedule in any form and you will pick the fees out yourself.

If these tactics don’t work then quote the state laws where applicable. If necessary get an attorney to write a letter and insist on a deadline, with a threat to report the issue to the appropriate authority. Lastly, if you can’t get adequate information about how you will be paid you may want to consider not contracting with this payer.

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3 Contracted payers might be another network renting access to this contract or a third party administrator (TPA) or a self-insured employer
SAMPLE OF A POOR ALLOWED FEE SPECIFICATION

The maximum amount payable for covered services under this agreement will be the lesser of the Maximum Allowable Fee Schedule, as determined by and modified from time to time by the Plan, or the charge submitted by provider.

SAMPLE OF A GOOD ALLOWED FEE SPECIFICATION

The maximum amount payable for covered services under this agreement will be the lesser of the Maximum Allowable Fee Schedule, as specified below, or the charge submitted by the provider.

The basis of the fee schedule:
- CMS Medicare Fees for 2005
- Locally adjusted for: Tennessee

Each fee will be determined by multiplying the current Medicare fee by the percentage adjustment identified in the table below.

<table>
<thead>
<tr>
<th>CPT Group (Range)</th>
<th>Percent Adj.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical (10000 – 69999)</td>
<td>125%</td>
<td>Except as Noted</td>
</tr>
<tr>
<td>Radiological (70000 – 79999)</td>
<td>120%</td>
<td>In office services only</td>
</tr>
<tr>
<td>In Office Lab</td>
<td>115%</td>
<td>See attached list</td>
</tr>
<tr>
<td>Reference Lab</td>
<td>100%</td>
<td>Any 80000 range not on in-office list</td>
</tr>
<tr>
<td>Medicine &amp; therapies (90000 – 99100)</td>
<td>115%</td>
<td></td>
</tr>
<tr>
<td>E&amp;M (99201 – 99999)</td>
<td>118%</td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Office administered meds</td>
<td>90%</td>
<td>2005 AWP adjusted Qtrly</td>
</tr>
</tbody>
</table>

Sight of service differential is used for all services. Fees apply to all specialties within the practice.

Note: the percentages indicated above are for illustration purposes only. The correct percentages for your practice may need to be higher or lower.