SILENT PPOS  
(NON-CONTRACTED PAYERS)  
And  
WHAT YOU CAN DO ABOUT IT

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Summary
Claim payment and processing is incredibly complex and getting more so every year. Payers are finding increasingly innovative ways to deliver provider panels to their customers and reduce the cost of claims. These market pressures have created an environment where the accuracy of contract administration has gone by the way side. Physicians must enforce contract terms on payers or be subject to the occasionally malicious and usually inattentive failure to live by the terms of contracts with physicians. There are strategies a practice can use to enforce contract performance.

This paper focuses on the universal problem of payers that take unauthorized discounts, often described as “Silent PPOs.” This article will describe the issue then offer some strategies that a practice can use to combat the problem. Throughout this paper we will use the term “Plan” to identify the entity with financial responsibility for payment of a claim and the term “Payer” to identify the entity holding a contract with the physician.

Discussion
Preferred Provider Organizations (PPOs) were originally created as a response to market pressure to reduce cost. The basic economic model is to trade volume for a price discount. The result of this discounting was a smaller physician panel. The payer offers to steer patients to this smaller panel of physicians by offering better benefits in exchange for the physician agreeing to a discounted fee schedule. Over time the discipline of this arrangement has gone away. Fee schedules are proposed by payers without any commitment to steerage or volume. Discounting fees has simply become a matter of course.

Payers must create a network of participating physicians in the areas they serve. It is an expensive undertaking to contract with the many physicians and hospitals necessary to build a comprehensive network. One way the payer can get a return on this effort is to lease access to those provider contracts to other payers that do not have a network in the area. Some companies have specialized in leasing access from existing networks of physicians rather than building their own. Physicians rarely know that additional payers have leased access to the networks they have joined.
These leased contracts can cause physicians several problems. The first is that the basic economic model evaporates. Services are discounted without the physician’s knowledge and without any hope of additional volume in exchange for the discount. However, this has become such an industry standard there is little hope of enforcing the economic model of PPO contracting. Additionally, practices operating at capacity cannot benefit from additional volume, so any discounting for volume is just lost revenue.\(^1\)

The second difficulty is more pervasive and more problematic. In each contract between a payer and a physician there should be a specification of the rates (fee schedule) that will be paid. As layer upon layer of these leased-access Silent PPO networks is created the correct application of the contracted fee schedule becomes less and less probable.

This complexity has become a problem for the payers as well. Many simply elect to establish their own payment rates and pay claims according to that fee schedule, which of course the physician has not agreed to accept. Limiting payment rates in this way falls under the euphemism of “limited by usual and customary rates (UCR).” The reason that payers can get away with this is because of the small differences between the correct and incorrect fees and the high number of times this occurs. Payers specializing in this kind of network access have learned that most Physicians will not challenge the payment accuracy.

An additional condition has developed in recent years. Because of the proliferation of “Silent PPOs” the number of contract routes between a specific plan and provider can now be duplicated many times. These different routes are priced at different levels. The effect of this condition is that a plan may have access to several different rates, contracted (Meaning agreed to by the provider) and not contracted, from which to pay. The most sophisticated of these payers have software that searches for the lowest rate.

There is no real prospect for legislative or industrial relief on this issue. It is important to remember that this situation is partially created by Physicians that have not chosen to enforce contract provisions. There are strategies that a practice can use to combat the problem. The strategies discussed below can be fit in two functional areas; payer contracting activity and collections activity.

**Payer Contracting Strategies**

1. All payer contracts have a section(s) that deals with defining and identifying the payer. The language to watch out for is how “Affiliates” are defined. If an affiliate is a company controlling, controlled by or under common control with the payer you are contracting with the concern is reduced. If an affiliate is any entity that simply has a contract with the payer you are contracting with, the door is open for leasing access.

   Another way a contract may address this is in the definition of a “Payer” where the “Payer” is the company financially responsible for payment of a claim, whether they process the claim or not. Payer in this context is often an employer self-insuring its

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\(^1\) For a better understanding of how capacity and demand interact to form the basis of a practice’s leverage see the Web Resource Document “Managing Capacity: Your Secret Weapon”
health coverage program and contracting with a Third Party Administrator (TPA) to administer, among other things, provider payments. Very few TPAs go to the trouble of building their own provider networks so they contract for network access.

- To address this vagueness ask for greater specification. If the payer won’t modify language record what you were told verbally in a written memo/letter to your contact stressing that this is your understanding of the contract and the payer’s intent.

- Ask the payer to provide a list of plans and entities currently contracted to access the network. Use this list to look for payers with which you already have a contract. There will probably be duplicates. Examine the fee schedules for each duplicate contract route to identify which pays best overall. If the fees in your current agreement are better ask that this particular plan be eliminated from this contract. Add a schedule or exhibit, and related language to the agreement that lists excluded plans and stipulate that you have the right to modify that exhibit with 30 days prior notice. In the case of a duplicate fee schedule where the proposed fees are better than the current fees go back to the older agreement and cancel that plan, using the exhibit and language you added to that agreement.

2. In an ideal world every patient would present for care with a valid ID card that would tell you all that you need to know to determine benefits, eligibility and how to file a claim. It is not a perfect world so we must rely on payers and plans to verify that information at the time of service. Review with the contact person what the contract says and the payer’s procedures for eligibility verification. Every payer and plan should provide no less than:

- An ID card for each family member or a card that identifies all covered family members
- A toll free number and / or website for verifying eligibility and benefits
- The physician should be able to rely on the information provided by the plan. This is a significant bone of contention for payers since sometimes employers do not notify them of dis-enrolled persons until after the fact. The best that you can hope for is that procedures used by the payer/plan to reverse payments will not unduly burden the practice, and that the practice is free to pursue payment from the patient after a reversal.

If the contract language is not strong enough consider adding the following language:

Payer (use the term the rest of the contract uses to refer to the entity you are contracting with) will maintain a process, either via the internet or by toll free number that physician (use the term the rest of the contract uses to refer to you) can use to verify the eligibility, benefits, patient’s responsibility portion, referral procedures and any special claim filing procedures for a

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2 For information on how to conduct a volume weighted Fee Schedule Analysis see the Web Resource Document “Building a Fee Schedule Analyzer for Your Practice”
patient presenting for treatment. Payer agrees to respond to eligibility inquiries in a prompt manner. Further, provider may rely on payer’s representation of eligibility as correct and valid, except when payer is notified retroactively of dis-enrollment of a member.

3. Perhaps the most critical contract addition is that dealing with accuracy of payments. To begin let’s assume that the payer you are negotiating with has provided a fee schedule that you have analyzed. You want to be able to rely on the payer to ensure the known fee schedule is used at all times, by all downstream plans. Talk with your contact about how they communicate the allowed rates to networks that will access this contract. Most payers will be reluctant to take any responsibility for how correctly other payers will apply the fee schedule. Get your contact to agree that this is a problem for physicians, and then propose the following language be added.

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\text{Payer (use the term the rest of the contract uses to refer to the entity you are contracting with)}\] agrees to make all reasonable efforts and take necessary steps to ensure that the fee schedule agreed to in this agreement is used by any plans or payers that lease or otherwise gain access to these contract rates. If a claim is paid using a fee other than that specified in this agreement physician (use the term the rest of the contract uses to refer to you) will notify the plan (use the term the rest of the contract uses to identify the entity financially responsible for payment) of the error and resubmit the claim to plan. In this event, and for the incorrect claim only, the allowed rate will automatically be established at 100\% of the billed charge, as submitted on the original claim. If plan fails to correct the claim payment, this will be grounds for termination of that plan as described elsewhere in this agreement.

4. As payments are posted you will need to be able to rely on the ID card, as discussed above, and the explanation of benefits (EOB) to identify the source of the discount taken. We will discuss invalid contracts below. For now let’s assume a known plan-payer combination. Like specifying a logo or other message on the ID card we want to insist that the payer, with whom we have this contract, will be identified on each EOB from another plan leasing access to this contract. If the contracted payer is identified on each EOB the practice will have the needed information to enforce the correct fee schedule.

Talk with your contact about this issue and ask what procedures are used. Get your contact to acknowledge that this is a problem for physicians and then suggest the following language be added to the agreement.

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\text{Payer (use the term the rest of the contract uses to identify the party you are contracting with)}\] agrees that all claim payments, from payer or any plan (use the term the rest of the contract uses to identify the entity financially responsible for payment) are correct and valid, except when payer is notified retroactively of dis-enrollment of a member.

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3 For more information on how to obtain a fee schedule from payers see the Web Resource Document “Obtaining Fees from Healthplans.”
responsible for payment) gaining access to this agreement, will be accompanied by an Explanation of Benefits (EOB). The EOB will include at least the following information:

- The total allowed rate due from the payer and patient
- The portion due from the patient
- The name of (The entity you are contracting with) represented as the source of any discounts taken
- The amount of any reduction or denial of payment for any portion of the claim, along with a reason for the denial or reduction

Payer, and all plans accessing this agreement, further agree that if a claim payment is returned without an EOB or an EOB is returned without this minimal information then the claim will have deemed to be paid in error and the allowed rate for this claim only will revert to the billed charge submitted on the original claim. If payer fails to correct the payment this will be grounds for termination of that payer as described elsewhere in this agreement.

You may get a significant push back on strategies 3 and 4. When this happens, use the following argument to make your point.

- Get your contact to agree that this is a problem for physicians.
- Ask your contact if she/he has concerns that his company cannot pay its own claims correctly. If the answer is “Yes” then don’t contract. If the answer is “No” then remind your contact that the economic affect of this provision will not impact his/her company but only those that cannot administer claim payments correctly.
- Some may reply that fee schedules are not fixed and may change from time to time in which case you reply that this is an unacceptable condition and it is unrealistic to ask any party to agree to major contract terms which can be unilaterally changed by the other party. You will not contract where you cannot verify the correctness of payments.
- Insist that some accommodation must be made and ask your contact for alternative language that addresses your concern.
- In many cases you will get a reply back that the contract cannot be changed, because of state law/regulations, corporate management will not allow it, or the deal is simply a take-it-or-leave-it offer. If the discussion degrades to this point you may want to consider this as a reason to not contract.

Collection Strategies

1. In many cases the contract, upon which a plan is relying to take a discount, is either non-existent or no longer valid. When you discover that payment rates are too low you can exploit this fact. You can ask the payer to prove that a contract exists. If they can not provide you with a copy of a signed agreement, and the intermediate routes to a signed agreement, then there is no legitimate agreement. If there is no
legitimate agreement then the rules limiting collection from the patients also do not exist.

To have good contract enforcement the following things are required:
- A good Payer Contract Inventory
- A fee analysis system to compare payment rates
- A Pricing Policy with a Cost Analysis

The first thing to have in mind is a threshold, above which, the discount taken on an invalid contract is too small to justify the effort to enforce better collections. This threshold should not apply in the situation of known valid contracts where the claim has been paid in error and as a result the allowed rate reverts to the billed charge, (see above.) The threshold is best established as a percentage of charge. The threshold for most practices will fall in between 70% and 90% of practice charges.

When should you challenge the payment of a claim? When:
- The payer is not recognized, that is to say not on the practice’s Payer Contract Inventory,
- The member ID card or the EOB does not specify a known payer as the source of the discount, and
- The paid amount is below the practice’s threshold.

Challenge these claims by sending a form letter to the entity that processed the claim stating that you do not recognize a contract, a discount was taken that has not been authorized, and that you expect payment in full. See the sample letter. The implicit threat is that if the contract is invalid you are free to bill the patient. You may or may not decide to actually bill the patient for the amount due. The decision to bill patients will require a second and lower payment threshold. The key issue is to respond promptly and forcefully to invalid discounts.

2. Strong patient registration and eligibility verification procedures can reduce payment enforcement problems. When eligibility is being verified have staff take an extra moment to confirm that the contract route is known. Requiring that the source payer contract is identified on the member ID card will make it possible for staff to examine an unfamiliar ID card and compare it to the Payer Contract Inventory. If the payer contract route is unknown then discuss the issue with the patient before the visit is concluded. The patient and the practice are allies in trying to find a valid contract route. This also keeps the patient in the communication loop if later the payment has to be challenged by billing the patient. Some practices will find it helpful to develop a form letter or instruction sheet for patients to educate them on this issue.

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4 For more information on creating a payer inventory see the Web Resource Document “Developing a Payer Contract Inventory”.
5 For information on how to conduct a volume weighted Fee Schedule Analysis see the Web Resource Document “Building a Fee Schedule Analyzer for Your Practice”
6 For more information on creating a Pricing Policy see the Web Resource Document “How to set your price”
3. Modify the payer account codes in your billing system to track contract routes. Record in the system the following elements for each patient / payer relationship.
   - Employer, this may or may not be the financially responsible party
   - Plan, the entity financially responsible for paying the claim
   - Administrator, the entity that will process provider payments
   - Payer or Contracting entity, this may be an IPA, PHO or other network or another payer or administrator. This is the entity that has a contract with you to provide services at a known rate.
A SAMPLE LANGUAGE FOR A PAYER TERMINATION EXHIBIT

Payer (Use the term the rest of the contract uses to refer to the entity you are contracting with) acknowledges Physician (Use the term the rest of the contract uses to refer to you) has the right to terminate a specific Plan (Use the term the rest of the contract uses to refer to the entity financially responsible for payment) for causes specified elsewhere in this agreement and for no cause. Provider will give 30 days written notice to Payer of its intent to terminate a specific Plan. Payer agrees to notify Plan of the termination. When a Plan is terminated the Plan's name will be added to Exhibit (X) and made part of this agreement. No acknowledgement or agreement is required by Payer or Plan for Physician to terminate with regard to a specific Plan.

SAMPLE EXHIBIT FOR PAYER/PLAN TERMINATION

<table>
<thead>
<tr>
<th>Plan/Payer Name</th>
<th>Account/Group/Other Identification</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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B SAMPLE INVALID CONTRACT CHALLENGE LETTER

To: The entity processing the payment (This may or may not be the plan or payer responsible for payment)
CC: The Plan or Payer responsible for payment of the claim (This may be an employer)
Re: Invalid Discount Taken

To Whom It May Concern:

The claim for medical services, as referenced on the attached EOB, has been paid in error. A contractual discount was taken (You may also want to include any payment reductions for policy issues. Do not include in this reference any reductions as a result of services not being covered) on this claim. We have examined our inventory of payer contracts and found we do not have a contract with your organization that allows a discount to be taken. All of our contracts with payers and plans that lease access to other payers and plans contain a provision requiring that the original payer's Identification (thus identification of the applicable contract route) must be provided on both the member’s ID card and the EOB.

Given these conditions one of two circumstances has occurred. 1) We do not have a contract with your organization – in which case the discount is invalid. In this event you need to correct your reimbursement to the billed charge less applicable patient co pays. 2) There is a valid contract with your organization but you have failed to provide the contractually obligated notice to us and therefore the claim has been paid in error. Claims paid in error automatically revert to billed charges. In this event you need to correct your reimbursement to the billed charge less applicable patient co pays.

We will wait 45 days from the date of this letter for you to contact us or make the corrected payment. If we do not hear from you by that time we will assume that you acknowledge the discount taken was invalid and that there is no contract between our organizations. Based on this conclusion we will bill the patient for the difference between what you paid and our full charge amount.

If you have any questions please feel free to contact our practice at:
Contact name
Address
Telephone
E-mail