Several years ago, I was sitting in a café having an early breakfast in the heart of Wyoming’s deer hunting capital when a rather bleary-eyed hunter came through the front door. He spotted a friend of his sitting at the counter.

“Well, how did you do this morning?” the friend asked.

“Just a few sound shots,” he replied.

“Sound shots?” the man on the stool asked.

“Yeah, you know, when it’s dark out there, you hear something, and you shoot in that direction, then search to see if you got anything.”

I finished my coffee quickly, climbed into my car, and sped from town, watching for any unskilled hunters who might have heard my car making suspect sounds.

In my experience, hospital-based finance professionals who are responsible for negotiating payer fee schedules for medical group practices often conduct payer negotiations with a “sound shot” approach. In the dim light of practice reimbursement, medical group negotiators tend to respond to payer compensation proposals with a “hope we got something” attitude.

Such responses are understandable. Typically, payers address compensation provisions by giving medical groups a small sample of “representative” codes and fees. Sometimes, proposed compensation is stated as a percentage of a given year of Medicare’s relative value scale (RVS). Other proposals

AT A GLANCE

There are six questions negotiators for medical group practices should ask in trying to secure the right level of payer reimbursement:

- Which CPT codes characterize the practice?
- What codes are most valuable to the practice?
- What fees are acceptable to the practice?
- Which payers are paying acceptable fees?
- How can payer schedules be made more acceptable?
- What is the financial return from fee negotiations?

View the full spreadsheet created by the author to compare payer fee schedules at www.hfma.org/hfm.
cite a market fee schedule the group is not familiar with as the basis for compensation. Assessing the value of any of these proposals generally leaves the group negotiator making inappropriate fee schedule evaluations based on Medicare rates or the payer’s current fees.

A skilled hunter knows the prey he is seeking. He selects the right equipment for the hunt and uses a well-aimed shot to bag his prize. Likewise, hunters of reimbursement—in this instance, a hospital’s medical group negotiator—should use a skilled approach to negotiate payer fee schedules. Such an approach requires answering six questions about the medical group practice and converting those answers into a spreadsheet that the negotiator can use to begin a proactive, and specific, pursuit of the right level of payer reimbursements.


Every medical group’s business is characterized by CPT codes used by the group’s business office for patient billings. Because fees associated with CPT codes constitute the group’s revenue sources, they are the payers’ basis for fee schedule negotiations. Therefore, it is very important for the group’s negotiator to proactively offer payers the CPT codes characterizing the group’s particular mix of patient services. Often, groups mistakenly leave it up to payers to present a sample of codes and fees representing proposed fee schedules for the group’s specialty. This puts the group negotiator at a significant disadvantage, because the negotiator must then use sample fees to extrapolate the fees of real interest to the group. Erroneous assumptions about payer RVS will lead to erroneous extrapolations.

Further, payers tend to use different methodologies for determining fees for patient visits, ancillary services (e.g., lab, radiology, and physical therapy), and surgical procedures. For example, some payers use different multiples of Medicare’s RVS for each grouping of CPT codes. Unless CPT groupings are considered in fee schedule evaluation processes, a payer may raise its evaluation and management (E&M) rates by 28 percent, but lower lab rates to such an extent as to take it all back (Cook, R., “Build a Defensible Fee Schedule to Challenge Low-Ball Payer Contracts,” Managed Care Contracting & Reimbursement Advisor, November 2008). In any event, the group should provide payers with a sample of meaningful codes organized by CPT groupings specific to the group’s practice experience.

The number of codes in each CPT grouping will vary. Some sources advise providing payers with the group’s top 25 highest volume codes as a representative sample (Lowes, R., “You Can Negotiate with Health Plans,” Medical Economics, Jan. 4, 2008). Others suggest using those CPT codes that represent a majority of practice revenue. Another approach is to determine some minimal annual volume as a cutoff in each code grouping to ensure the sample submitted by the group is representative and reasonable. In any case, it may be necessary for the sample to include certain low-volume codes that characterize subspecialty practices within the group.

2. What Codes Are Most Valuable to Your Practice?

Not all codes used in practice billings are of equal value to the practice. High-volume office visit codes usually produce considerable revenue, as do lower-volume procedure codes. What is important in fee schedule negotiations is to determine which codes account for a majority of practice revenues. One way to determine the relative value of CPT codes used by the practice is to compute a weighted value for each code.

A CPT code’s weighted value is a measure of the relative value of a code to the practice in...
comparison with other codes. For example, CPT code 99213 (established outpatient meeting specific qualifications, physician time: 15 minutes) has a relative value nearly twice that of code 99203 (new outpatient meeting specific qualifications, physician time: 30 minutes).

Weighted values are determined using a three-step process. First, multiply the annual frequency each code is billed by the charge amount or average amount paid by payers for that code. Second, add all the computed weighted values to determine a total for all CPT-weighted value calculations. Third, divide each CPT’s weighted value by the total weighted value to yield a percentage value for each CPT code. All of the percentages for the relative values will add up to 100 percent. The weighted value process should be undertaken for each CPT grouping.

Computing a weighted value enables the practice to magnify and focus on specific target areas of a payer’s fee schedule. For example, a payer’s E&M fees may be acceptable, but certain surgery fees are not. Simply adjusting a Medicare multiplier may exceed the financial limits of the payer and not satisfy the specific concerns of the group.

3. What Fees Are Acceptable to Your Practice?

Once the practice’s most valuable CPT codes have been identified, attention should shift to the fees associated with those codes. It is easy to become overwhelmed trying to understand the different methodologies payers use to develop fee schedules. Many payers use some multiple or variation of the Medicare resource-based RVS (RBRVS) payment system. However, the major flaw in this approach is the assumption that a payer’s insured population is basically the same as the aged Medicare population. Recognizing this shortcoming, other payers have developed their own relative value system using internally derived multipliers to produce their company’s fee schedules. Still other payers, it seems, use methodologies only understood by their actuaries.

In the search for some methodology to compare and contrast different payer fee schedules, medical groups often use the Medicare fee schedule as a relative baseline. At this point, fee schedule negotiations become focused on trying to get an improved multiple of the Medicare rate, and the hunt for reimbursement too easily becomes a matter of “sound shots”—guesses that the hunter
hopes will yield something of value. It is important to include Medicare rates as a reference point, but not as the sole basis for fee negotiations.

A better approach is to determine what fees the market is actually paying for CPT codes of value to the practice. The group should determine what the payer market considers an “allowable” (i.e., acceptable) fee for each code. For example, one practice arrayed its top four payers and grouped the others to produce an average payment. The practice selected the highest fee paid by any one of its contracted payers as the “allowable fee.” The actual fee paid by a payer may vary depending on its volume of business in the market, its corporate limitations, or its negotiation skills. In any event, selecting an allowable fee sets aside all other considerations and simply holds to the fact that at least one payer is paying the practice this fee for a particular code. Using this approach, the practice can compare payer fees with allowable fees and initiate negotiations from a position of marketplace reality rather than a position based upon practice charges, payment history, Medicare multipliers, or payer methodology.

The process for determining allowable market-based fees can be likened to a hunter’s decision regarding where to conduct a hunt. Group negotiators hunting for the right level of reimbursement should set aside wishful thinking and conduct a practical search for fees based on market data.

4. Which Payers Are Paying Acceptable Fees?
The essence of effective practice reimbursement lies in selective negotiations. Once the practice determines its allowable fees, the next step is to compare how payers stack up with respect to those allowable fees.

The exhibit below is a snapshot of a spreadsheet that a medical group negotiator could create to build a better business case for improved reimbursement. In this exhibit, the practice’s payers are rank ordered by the percentage of business they represent. Payer 1 provides more practice revenue than the other payers. The number of payers displayed in the practice’s spreadsheet is a function of the business they represent up to some minimum cutoff (e.g., 5 percent). The residual payers are grouped into the “other” category, and their fees are averaged. Then, each payer’s fees are listed and presented as a percentage of the allowable fees.

<table>
<thead>
<tr>
<th>Payer 1 (% of Allowable Fees)</th>
<th>Payer 2 (% of Allowable Fees)</th>
<th>Payer 3 (% of Allowable Fees)</th>
<th>Payer 4 (% of Allowable Fees)</th>
<th>Other Plans (% of Allowable Fees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$70.00 (77%)</td>
<td>$80.85 (89%)</td>
<td>$90.55 (100%)</td>
<td>$77.06 (85%)</td>
<td>$74.30 (82%)</td>
</tr>
<tr>
<td>$116.00 (82%)</td>
<td>$126.97 (89%)</td>
<td>$142.19 (100%)</td>
<td>$140.21 (99%)</td>
<td>$135.20 (95%)</td>
</tr>
<tr>
<td>$106.00 (77%)</td>
<td>$122.61 (89%)</td>
<td>$137.32 (100%)</td>
<td>$119.87 (87%)</td>
<td>$115.59 (84%)</td>
</tr>
<tr>
<td>$47.00 (82%)</td>
<td>$50.89 (89%)</td>
<td>$56.99 (100%)</td>
<td>$54.92 (96%)</td>
<td>$52.96 (93%)</td>
</tr>
<tr>
<td>$175.00 (82%)</td>
<td>$191.11 (89%)</td>
<td>$214.04 (100%)</td>
<td>$198.93 (93%)</td>
<td>$191.82 (90%)</td>
</tr>
<tr>
<td>$154.00 (82%)</td>
<td>$168.72 (89%)</td>
<td>$188.95 (100%)</td>
<td>$176.23 (93%)</td>
<td>$169.94 (90%)</td>
</tr>
<tr>
<td>$224.00 (82%)</td>
<td>$245.39 (89%)</td>
<td>$274.83 (100%)</td>
<td>$249.84 (91%)</td>
<td>$240.92 (88%)</td>
</tr>
<tr>
<td>$219.00 (82%)</td>
<td>$239.27 (89%)</td>
<td>$267.98 (100%)</td>
<td>$253.12 (94%)</td>
<td>$244.08 (91%)</td>
</tr>
<tr>
<td>$78.00 (81%)</td>
<td>$85.46 (89%)</td>
<td>$95.71 (100%)</td>
<td>$94.51 (99%)</td>
<td>$91.14 (95%)</td>
</tr>
<tr>
<td>$152.00 (82%)</td>
<td>$165.97 (89%)</td>
<td>$185.87 (100%)</td>
<td>$175.55 (94%)</td>
<td>$169.28 (91%)</td>
</tr>
</tbody>
</table>
In the exhibit, the percentage totals are an average percentage of the allowable fees in each CPT code grouping. For example, careful review of the full spreadsheet will reveal that Payer 1’s fees average 81 percent of the allowable fees for E&M codes, 95 percent of procedure fees, 87 percent of allowable radiology fees, 82 percent of physical therapy (PT) and occupational therapy (OT) fees, and 97 percent of surgical fees. Once the practice is equipped with this information, it will be in a position to determine what is acceptable about Payer 1’s fee schedule and, more important, what is not acceptable. The same analysis, of course, should be applied to the practice’s other payer fee schedules. When this process is complete, the practice will have a comprehensive, market-based strategy with which to proceed with reimbursement negotiations.

If practices are going to make meaningful, reasonable, and successful improvements in reimbursement, there must be logic behind their negotiations. Securing an acceptable payer fee schedule is not a matter of mere chance, but of thoughtful assessment.

Looking through his scope, the hunter must make choices regarding what to target. So, too, the group negotiator must make reimbursement choices as the negotiator assesses each payer’s fee schedule. Sometimes, assessment results are quite surprising. For example, an analysis of Payer 1’s schedule will disclose that the practice’s largest payer has the most acceptable surgical fees. The focus of negotiations with Payer 1 should be on making competitive adjustments in E&M, radiology, PT, and certain office fees.

5. How Can Payer Schedules Be Made More Acceptable?

The results of the fee analysis identify what needs to be “fixed” in each payer’s fee schedule to be acceptable to the group practice. The exhibit shows a snapshot of fee comparisons for the practice’s four largest payers. A review of the full spreadsheet will reveal that fee schedule negotiations with Payer 1 should focus only on improving the fees mentioned earlier, whereas a review of Payer 2’s fee schedule will show that the payer is particularly deficient in procedure and surgical fees. A review of Payer 3’s fee schedule will show that the payer has excellent E&M fees and competitive surgical fees, but needs to improve its PT/OT fees. Meanwhile, the analysis will reveal that Payer 4 is paying roughly 90 percent or better of allowable fees for nearly all code groupings.

It is important to show payers the competitive weaknesses of their fee schedules compared with those of their marketplace competitors. These weaknesses may be presented in the context of the practice’s other payer fee schedules. For antitrust reasons, however, competitors’ names must be kept anonymous, so it is best to use a labeling system, such as “Payer 1” and “Payer 2.”

The group negotiators’ goal is to make a unique business case for each payer to adjust its fee schedule to be competitive. For example, it is reasonable to explain to a smaller payer like Payer 2 that unless it meets the higher fees of a larger payer, such as Payer 1, the practice is being counterproductive by giving a discount to the smaller payer. If such discounts are continued, the practice will be giving the smaller payer a competitive edge over the larger payer that is bringing the practice more, better-paying business. On the other hand, it is logical for a practice to choose to extend proportional discounts in the form of lower fees to larger payers based on the volume of business they are bringing the practice.

A skilled hunter assesses each target before taking a precise shot. If practices are going to make meaningful, reasonable, and successful
improvements in reimbursement, there must be logic behind their negotiations. Securing an acceptable payer fee schedule is not a matter of mere chance, but of thoughtful assessment.

6. What Is the Financial Return from Fee Negotiations?
The metric for successful reimbursement is the financial difference between previous fees and renegotiated fees multiplied by payer volume. Therefore, a practice’s reimbursement strategy should include a prioritization of payer negotiations based on the percentage of business that each payer represents. If a practice does not track revenue by CPT code by payer, the first order of business is to correct this deficiency.

For the practice whose payer fee schedules are featured in the exhibit, an analysis of the full spreadsheet will reveal that the average E&M fee is about one-tenth of the average surgical fee. The average PT/OT fee is about one-third of the average E&M fee. Therefore, the practice’s reimbursement strategy should base its priorities on weighted CPT values, CPT groupings, payer volume, and specific fee schedule deficiencies. It is assumed that government payers for this orthopedic practice represent 35 percent of payer revenue. In turn, Payer 1 represents 40 percent of the practice’s revenue. Payer 2 represents 10 percent, Payer 3 represents 5 percent, Payer 4 represents 4 percent, and all other payers together represent the remaining 6 percent of the practice’s revenue. If annual practice revenues are $250 million, and all payers agree to correct their fee schedules to meet the practice’s allowable, market-based fee schedule, the return from such negotiations would yield nearly $3 million in additional revenue. If negotiations also included a 3 percent cost-of-living adjustment, the return would be in the range of $7 million.

A Smarter Hunting Strategy
Medical group negotiators hunting for better reimbursement need a better strategy than reactive “sound shots.” By developing a spreadsheet of payer fee schedule comparisons based on actual, market-based fees, the practice can present a solid business case to each payer regarding the need to correct specific shortcomings in each payer fee schedule. Medical group negotiators who become proactive hunters of reimbursement by taking aim at specific fee schedule targets could bring home big rewards.

About the author
John P. Schmitt, PhD, is senior managed care consultant, EthosPartners, Atlanta, and associate faculty member, University of Phoenix (jschmitt@ethospartnershc.com).