Generating Revenue
from Your Own Fee Schedule

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Though Medicare fees are set, you can, and should, make a difference in the revenue you generate through your commercial contracts. Here, we'll look at two basic components of payer contracts: the actual fees and the legal verbiage.

You can, and should, make a difference in the revenue you generate through your commercial contracts.

Getting Started

This should go without saying: Locate the contracts (including the fee schedules) and provider manuals for each payer. If you can't find them, call the commercial providers with which you do the greatest business and ask for their ophthalmology fees. (If you're multi-spec ophthalmology, most payers still look at ophthalmology in one lump; e.g., if you have retina, it's "ophthalmology.") Then:

- Check the contract expiration dates. Most contracts contain "evergreen" language.
- Put this aggregated information into easily identifiable and labeled folders in a central location.
- Build a spreadsheet and key in your allowable fees by payer by CPT, and Medicare allowables for each CPT.
- From your practice management (PM) system, gather your procedures by CPT by payer. This enables you to see the "work" performed for each payer. (Do you have allowables for each payer keyed into the PM system? If not, divine a method for your accounts receivable department to ensure full collections for each procedure for each carrier.)
- Analyze your commercial allowables as a percent of Medicare. Do this code by code and on the aggregate **(Figure 1)**.
- Armed with data, dip your feet in the water by trying a "low-value payer." That way the practice stands to lose only a small chunk of business if you (or the payer) walk away. You'll gain from the experience and you don't risk a large piece of your business. Decide your angle. Do you negotiate code by code or as an overall percent of Medicare? (See sidebar.)
- Determine your bottom line. That is, reach for the stars, but know the fees you'll settle for.

The Negotiation

Unless you are comfortable on your own, make sure you keep your physicians, or lead MD, up to date on negotiations. The last thing you want to do is cut a deal your boss does not like.

When you have your data:

- Remember that the fee schedule is only part of the battle.
- Understand your leverage. This is key. If you're the only ophthalmologist in town, you've got the ace in the hole. If you're one ophthalmologist among many, you have decidedly less leverage. If you have subspecialty in-house, you may have more latitude.
- Reach out to your first payer. Contact the local office and determine who on the staff can begin the negotiating process.
- If your payer's fees are below your expectations, send a letter to your local or regional contact requesting a change. State the timeframe in which you'd like a response. Create a tickler folder for follow up.
- If the payer submits a good offer, get the offer in writing. Sometimes simply asking to negotiate is all it takes to motivate some payers to offer you a better contract.
- If you don't come to an agreement, invoke a contingency plan notifying

CPT Code	Medicare Fee	Medicare Visits	Commercial Plan #1	Code by code Commercial as a % of Medicare	Commercial Visits	Medicare Based on Commercial	Commercial Revenue
92002	$ 60.00	1	$ 85.00	142%	0	$ -	$ -
92004	$ 110.00	2	$ 142.50	130%	1	$ 110.00	$ 142.50
99201	$ 45.00	1	$ 50.00	111%	0	$ -	$ -
99202	$ 55.00	2	$ 57.00	104%	1	$ 55.00	$ 57.00
99203	$ 85.00	3	$ 106.25	125%	2	$ 170.00	$ 212.50
					Total:	$ 335.00	$ 412.00
						Aggregated Services:	123%

Figure 1

	Medicare Fee	Medicare Visits	Commercial Plan #1 125% of M'care	Commercial Visits	Medicare Revenue	Commercial Revenue	
92002	$ 60.00	1	$ 75.00	0	$ 60.00	$ -	
92004	$ 110.00	2	$ 137.50	1	$ 220.00	$ 137.50	
99201	$ 45.00	1	$ 56.25	0	$ 45.00	$ -	
99202	$ 55.00	2	$ 68.75	1	$ 110.00	$ 68.75	
99203	$ 85.00	3	$ 106.25	2	$ 255.00	$ 212.50	
99204	$ 105.00	2	$ 131.25	1	$ 210.00	$ 131.25	
99205	$ 115.00	1	$ 143.75	0	$ 115.00	$ -	
99241	$ 105.00	1	$ 131.25	0	$ 105.00	$ -	
99242	$ 110.00	2	$ 137.50	1	$ 220.00	$ 137.50	
99243	$ 115.00	3	$ 143.75	2	$ 345.00	$ 287.50	
99244	$ 125.00	2	$ 156.25	1	$ 250.00	$ 156.25	
99245	$ 145.00	1	$ 181.25	0	$ 145.00	$ -	
				Total Revenues:	$ 2,080.00	$ 1,131.25	$ 3,211.25

Figure 2a: Original fee schedule

	Medicare Fee	Medicare Visits	Commercial Plan #1 125% of M'care	Commercial Visits	Medicare Revenue	Commercial Revenue	
92002	$ 54.00	1	$ 67.50	0	$ 54.00	$ -	
92004	$ 99.00	2	$ 123.75	1	$ 198.00	$ 123.75	
99201	$ 40.50	1	$ 50.63	0	$ 40.50	$ -	
99202	$ 49.50	2	$ 61.88	1	$ 99.00	$ 61.88	
99203	$ 76.50	3	$ 95.63	2	$ 229.50	$ 191.25	
99204	$ 94.50	2	$ 118.13	1	$ 189.00	$ 118.13	
99205	$ 103.50	1	$ 129.38	0	$ 103.50	$ -	
99241	$ 94.50	1	$ 118.13	0	$ 94.50	$ -	
99242	$ 99.00	2	$ 123.75	1	$ 198.00	$ 123.75	
99243	$ 103.50	3	$ 129.38	2	$ 310.50	$ 258.75	
99244	$ 112.50	2	$ 140.63	1	$ 225.00	$ 140.63	
99245	$ 130.50	1	$ 163.13	0	$ 130.50	$ -	
				Total Revenues:	$ 1,872.00	$ 1,018.13	$ 2,890.13
				Difference(s):	$ (208.00)	$ (113.13)	**$ (321.13)**

Figure 2b: Results if Medicare cuts 10% of fees

patients, referring doctors, affiliated hospitals, employers, and the press, if necessary, about your contract termination. Let people know that you could not come to terms with the insurance company. Do *not* besmirch the insurer in your correspondence and discussions; it can get you into hot water.

- If your contract is not complete but you're in negotiations, ask for a written agreement that ensures the old contract remains in effect until the new agreement is completed. But don't let the payer use this as a ploy to keep you on the hook. Get the deal done!
- Evaluate the results. A year down the road, pull two or three big dollar contracts and see how you did. Did you hit your goals?

Admittedly, this process could take a couple of months to iron out. If you have a contract nearing expiration, don't wait until the last minute. The payer may use a tight timeline to push you into an agreement you might not like.

"125% of Medicare"

This little caveat deserves its own treatment. You should avoid, where possible, accepting fee schedules that are "…X% of Medicare." **Figure 2a** displays how this approach can haunt us. As you can see in **Figure 2b**, Medicare has reduced its fee schedule amount 10%. If we have a commercial plan that pays a percent of Medicare, when the Medicare fees drop, our commercial fees adjust downward.

Two remedies for this: avoid tying your commercial fees to Medicare *or*, in lieu of contract language stating "…125% of Medicare," tie your fees to a select Medicare fee schedule that had some sort of static value. For instance, include language stating the fees will be "….125% of the 2005 Medicare fee schedule" as opposed to "…125% of Medicare." That way you

	Medicare Fee	Comm. Visits	Comm. fees @ 135% of MC	Negotiated as % of M'care	Final fees as negtiated	Commercial Revenue @ 135%	Commercial $$ code-by-code negotation
92002	$ 60.00	1	$ 81.00	120%	$ 72.00	$ 81.00	$ 72.00
92004	$ 110.00	2	$ 148.50	135%	$ 148.50	$ 297.00	$ 297.00
99201	$ 45.00	1	$ 60.75	120%	$ 54.00	$ 60.75	$ 54.00
99202	$ 55.00	2	$ 74.25	135%	$ 74.25	$ 148.50	$ 148.50
99203	$ 85.00	3	$ 114.75	145%	$ 123.25	$ 344.25	$ 369.75
						$ 931.50	$ 941.25
					Aggregated Services:	135%	136%
						8	9

Figure 3: Setting up your fee schedule

know that if the current Medicare fee schedule is reduced, which *just might happen,* your private pay schedule won't be cut in kind.

Charging Code by Code or Percent of Medicare?

Two likely fee options you'll want to consider: (1) as a percent of Medicare or (2) on a code by code basis. This is where your data come into play. In our overly simplistic example **(Figure 3),** we see how the practice can benefit from a code-by-code approach compared to a percentage of Medicare.

Remember, none of this is static. In other words, if you performed 99204s on 50 BC/BS patients this year, you may or may not perform 50 next year. Deploying your current numbers gives you an idea of how you might perform under the new contract based on your history.

What we've done is determined, based on history, that if we can negotiate based on our most utilized codes, we stand to generate more revenue than if we simply settle for 135% of Medicare. Based on our ability to negotiate, we received (in column 4), 145% of Medicare for one of the codes we use the most. On the aggregate and based on our history, this translates to136% of Medicare vs. 135% if we simply accept an across-the-board pricing solution.

The Language

Most payer contract language is fairly generic. Each payer will have its own contract language, which contains "boilerplate" and nuances that may be required by each state in which it does business.

The key with language is to make sure that the components are not too onerous on you. Can they change fees simply by sending you a notice? Normally when this happens, and it does, those notices tend to end up on the bottom of your "in" box while you've simultaneously taken a cut in your fees. Is the language too hard on your group? I've found that many payers are less inclined to give on language than they are on fees.

Remember, in theory this entire process is a negotiation. There *may* be language that can be changed but often payers are reluctant to do so. Their willingness is probably directly correlated with your leverage.

Summing Up

Here are the key things to consider when evaluating whether you can use your commercial contracts to generate additional revenue:

- Your leverage. Are you the dominant choice in the market? Do you offer something other practices don't (quality measures/outcomes, new cutting-edge services)?
- Your data. Do you know your allowables by payer? Do you know your CPTs frequencies by payer? Does staff know allowables?
- Your contract language. Some of it will make sense, some will not. Depending on the value of the contract (e.g., "big" vs. "small"), it may be worth contacting a contract expert.
- Often you'll be dealing with a local or regional rep. This is the starting point. You *can* get by them with some effort, if you feel you must. It is a process of give and take.
- As with any negotiations, know your starting point and where you feel you can settle. I.e., if you wanted $5,000 for a 99203, would you be willing to settle (and be more reasonable!) for $140 for a 99203?
- What you charge has little, if anything, to do with what you get paid. Some folks run two fee schedules (to reduce contracted adjustments) while others run one and pay no mind to write-offs. Either way works. Just realize that with one fee schedule, your adjustments will be inflated.
- Negotiation is an ongoing give and take. Can you call their bluff? *Re-evaluate your position annually.*
- Have the courage to walk away. AE

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