

Private Practice Toolkit

Examples of Significant Payor Unilateral Policy Changes



In addition to the formal contractual language described above, physicians should be aware of certain important policy changes made by payors in recent years. Policy changes are significant because, in many cases, payors may unilaterally make these changes by amending a manual or written procedure documents. Depending on the terms of the payor agreement, a physician may receive limited notice of these changes, and may not be able to effectively contest or reject the change. In some cases, a physician's only recourse is to terminate the agreement entirely due to such changes. However, other agreements may specify that changes to policies, procedures, or manuals may not take effect without the consent of the physician practice.

In some recent cases, unilateral policy changes have been associated with emerging payor practices that impact physician clinical decision-making in important ways. Some examples to be on the lookout for include:

1) Language Permitting Down coding

Certain payor agreements, policies, or manuals now contain language permitting the payor to override a service billed by a physician, and instead unilaterally pay the physician for a different service reimbursed at a lower rate. This may be true even if the physician has fully documented the medical necessity of the service, if the payor is using technology or a vendor to determine what the physician "should have" billed.

Examples of recent contractual language allowing this practice are as follows:

Example 1: *In an effort to reduce the administrative burden of requesting and submitting medical records for review, [Payor] will begin using [Proprietary Tool] which determines appropriate E/M professional coding levels based on data such as patient's age and conditions for the Medical Decision-Making key component. [Payor] will presume the provider meets the requirements of the E/M code level they have submitted related to the History and Exam key components for the initial adjudication of the claim.*

Example 2: *[Payor or affiliate of Payor] will review emergency services claims to determine appropriate use of emergency room and whether an emergency medical condition existed. At a minimum, both the facility and the physician will receive reimbursement for screening services:*

- 1) For physician services billed on a CMS-1500 claim: If a prudent layperson review determines that the service was not an

emergency, [Payor] is required to reimburse, at a minimum, for Current Procedural Terminology (CPT) code 99281, the Emergency Department Visit Level 1 screening fee.

- 2) For facility charges billed on a UB-04: If a prudent layperson review determines the service was not an emergency, [Payor] must reimburse for revenue code 451, EMTALA Emergency Medical Screening Services.

2) Language permitting or requiring bundling of distinct services

Some payors are adopting software solutions or using third-party vendors to group together physician services into bundled services. Often this is based on the payor's determination that reimbursement for distinct services is already reflected in payment for a single comprehensive code. In some cases, this means the payor may avoid separate payment for services performed and properly documented by a physician, based on software edits grouping the service into a bundled code. Physicians should understand how payors will apply these "bundling" policies and their rights to appeal or contest the decision to bundle services this way.

Example: Effective [Date], we will begin using [Software], a new clinical code editing software for medical and behavioral products. [Software] will facilitate accurate claim processing for medical and behavioral claims submitted on a CMS-1500 claim form. [Software] code auditing is based on assumptions regarding the most

common clinical scenarios for services performed by a health care professional for the same patient. [Software] logic is based upon a thorough review by physicians of current clinical practices, specialty society guidance, and industry standard coding. Services considered incidental or mutually exclusive to the primary service rendered, or as part of a global allowance, are not eligible for separate reimbursement. Patients covered under [Payor]-administered plans should not be balanced billed for clinically edited non-paid services. A procedure that is performed at the same time as a more complex primary procedure, requiring little additional physician resources and/or is clinically integral to the performance of the primary procedure, is considered incidental to the related primary procedure(s) on the same date of service and will not be separately reimbursed.

3) Language on payment options

Some payors are adopting electronic payment requirements through third parties that may impose additional costs on the physician. Physicians should understand all reimbursement options from the payor and any costs associated with each reimbursement option.

Example: [Third party vendor] offers the following payment options: (1) Electronic Funds Transfer (EFT) – EFT is a fast and reliable method to receive payments and is the preferred method for [Payor]. In order to register for [Payor] payments and choose EFT as your payment preference, visit [Third party vendor] registration page. (2) Virtual Card Payment – Standard credit card processing and transaction fees apply. Fees are based on your credit card processor's fees and your current banking rates. [Third party vendor] does not charge any additional fee for processing. For each payment transaction, a credit card number unique to that payment transaction is sent either by secure fax, or by mail. Processing these payments is similar to accepting and entering patient payments via credit card into your payment system. (3) Paper Check – If your office would prefer to receive check payments, please call [Third party support] at [customer support number].

4) Language for required use of specialty pharmacies

An increased number of payors are contracted with a third-party specialty pharmacy to lower up-front medication acquisition costs to physicians, integrate coordination of coverage between physician, patient, and payor, assure compliance with guidelines and standards, and others. Physicians should understand options for specialty pharmacies for each payor, required use of specialty pharmacies. It is important to note that some payors may have different requirements for each plan. Physicians should check specific plan requirements prior to medication administration.

Example: [Payor] contracts with select specialty pharmacies to obtain specialty medications for physician administration to our members. Specialty medication coverage is based on the member's benefit. Prior Authorization or Predetermination approval may still apply to specific specialty medications. In accordance with their benefits, some members may be required to use a specific preferred specialty pharmacy, or be subject to a split fill program, for benefits to apply. For more information about medical criteria, please refer to the Medical Policies. Note: Depending upon administration (physician-administered or self-administered), the member's plan will determine which benefit (medical coverage or pharmacy coverage) will cover the medication. Please call the number on the member's ID card to verify coverage, or for further assistance or clarification on your patient's benefits.

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