Physician Fee Schedule Survey — 2007

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By Shirley Grace [2]

We hear you. Unfortunately, physician reimbursement continues to decline, according to the results of our exclusive 2007 Fee Schedule Survey. That’s the bad news. Now here’s the good news: Along with all the hard data, we arm you with the tools you need to fight back.

When we reported the results of the 2006 Fee Schedule Survey this time last year, we couldn’t think of an eloquent way to sugarcoat the dismal state of physician reimbursement in the United States. The numbers were simply bad: A 10 percent dip in E&M visit allowables from the year before, dropping below Medicare. Massive insurance industry consolidation. Frustrated, overworked physicians who felt powerless to negotiate a fair fee schedule.

Sorry, but the news is no better today. In fact, it’s disturbingly similar: Another sizeable drop in E&M visit reimbursement. Even more payer consolidation. And payer accessibility? “It’s like God,” says Arvind Cavale, a solo endocrinologist in the Philadelphia area. “You can’t ask them. Either you get ‘This is what we have’ or they just don’t answer.”

Are physicians so completely hogtied? Maybe. Insurance companies are notorious for ignoring meeting or information requests. They change their policies with little notice, posting bulletins of critical information on their Web sites, a dozen clicks deep. They bundle and unbundle codes with the speed of a curbside shell game.

How exhausting — and how time-consuming — is trying to hit this moving target? Well, Cavale, for one, has not tried to renegotiate his 20 or so payer contracts since 1999. “How much time do I have to go through a 28-page contract?”

Yet there are ways to improve your leverage with payers, and even see some success. Check out these survival tools we’ve collected for you. Learn them. Use them. Most importantly, share them. You may find yourself not only pushing through the once-impenetrable underbrush of fee schedule negotiation, but even blazing trails to better financial leverage for other physicians to follow.

The ungilded lily

First, the numbers: Average reimbursement for E&M allowables dropped to $73.48 — a 6.5 percent drop since 2006. Shocking? “Not really,” says Susanne Madden, founder of the Verden Group, a managed-care consulting company. “But it’s discouraging to see how much rates have moved down again.”

The biggest single-year step down was in the Mountain region, where the average E&M visit allowable fell 12.5 percent to $83. But worse than this is the Pacific region, which slipped more than 20 percent in 2006 and lost another 9 percent last year.

Two data slices are particularly disheartening: City docs will be unhappy to see that reimbursements in urban areas, which have historically outranked suburban and rural areas, fell to the lowest of all three area types for the first time. And no matter where you practice, the reimbursement gap hits primary care the hardest, when compared to medical and surgical specialists.

One bright spot: New England, whose average reimbursement had tumbled 27 percent in just 12 months during 2006, reclaimed nearly 11 percent of that deficit, and now stands at the above-average $84.
What you’re up against

It’s hardly surprising that physicians are feeling like 98-pound weaklings up against a sand-kicking bully at the beach these days. Health insurance is now all about survival-of-the-biggest, meaning in many cases a handful of companies hoarding the bulk of the market.

Why should payers worry about so-called “fair” negotiation? Is there even such a thing? Just four
insurance companies — UnitedHealth Group, WellPoint, Aetna, and Healthcare Service Corporation — occupy more than a third of the market (36.5%). Greg Mertz, president The Horizon Group, a healthcare consulting firm, says that the insurance behemoths don’t sit down at the table with anybody because they don’t need to. “They just can’t find the time to meet with you,” he says. “You ask for a meeting weeks in advance: Nope, not available.”

As physicians, of course, you know you cannot commiserate on your fees; but insurance companies can in fact collude with each other. “I never talked to a rep that didn't know what his competitors were paying,” says Mertz.

And yes, you’re trying to make a living, but your first priority is to your patients. Compare this with an insurance company, which must answer to its stockholders. Sound wrong? To many people it does, “unless you put your business hat on,” says Nick Fabrizio, a Medical Group Management Association senior consultant. “They’re taking advantage of the market.”
Juliet Breeze, a part-time family practitioner and CEO of Partners in Practice, a Richmond, Texas-based practice management consulting firm, concurs. She even admits a grudging respect: “Insurance companies are worthy adversaries. They have very good strategies.” Insurance companies employ many ways to increase their profit margins by playing around with operating income. They lower their “medical loss ratios” — industry-speak for what an insurance company pays out in reimbursements to physicians — bundle procedures, and put protocols in place as barriers to care (e.g., preauthorization). “If it takes 30 to 45 days for physicians to catch on, you’re saving millions,” says Madden, who even worked for UnitedHealth for nine months. It’s these
little erosions that add up to big, big losses for physicians, she says. “There are initiatives put into place that target small-dollar areas.”

**Whaddaya know?**

Prevailing foggy perceptions by physicians also frustrate Madden: “Most physicians are not business people. They want to take care of their patients. I can’t tell you how many ask why they need to know about [payers’] policy changes.” You do need to know about policy changes, and more, if you’re truly interested in bettering your situation. Specifically, you should know:

**Your data.** Pop quiz: Say you were promised $99 for a 99213 by a payer. Are you actually getting that? Fabrizio says that many physicians would have no idea if asked. Shaving just a couple dollars off this one very common code can cost you tens of thousands of dollars.

You should know your top 20 codes in this intimate fashion. Make yourself an Excel spreadsheet with one row for each payer and your top 20 codes across the top. Track timeliness, denial rate, and whatever else makes sense to you. “Trend each payer. When you do that you can really see what’s happening,” says Breeze. Leverage is being able to jab your finger at some indisputable facts and say, ‘Did you know you deny 20 percent more claims than other payers?’

Breeze also points out that, “A new trend with insurers is to pull out a ‘report card’ on you. ... If you know your own data, then if those report cards don’t seem accurate, you’ve got your own data to refute it — a little bit of turning the tables.”
## SURVEY STATS

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### Region
- Southeast/ South Central: 267 (35%)
- Middle Atlantic: 151 (20%)
- North Central: 135 (18%)
- Pacific: 76 (10%)
- Mountain: 68 (9%)
- New England: 27 (4%)

### Group Size
- Solo: 280 (37%)
- 2-10: 376 (49%)
- 11-50: 74 (10%)
- 51+: 30 (4%)

### Area Type
- Suburban: 341 (45%)
- Urban: 229 (30%)
- Rural: 133 (18%)

### Specialty
- Family/General practice: 121 (16%)
- Allergy: 109 (14%)
- Internal medicine: 69 (9%)
- Pediatrics: 58 (8%)
- Dermatology: 55 (7%)
- Gastroenterology: 50 (7%)
- OB/GYN: 37 (5%)
- Orthopedics: 30 (4%)
- Otolaryngology: 20 (3%)
- Surgery: 19 (3%)
- Endocrinology: 18 (2%)
- Psychiatry: 17 (2%)
- Neurology: 15 (2%)
- Ophthalmology: 14 (2%)
- Urology: 12 (2%)
- Other specialty: 116 (16%)

* Percentages may not equal 100 due to rounding and/or unreported data.

Survey distribution/advertisement via:
- Physicians Practice issues May to September, 2007
- Eight issues of PEARLS e-newsletter
- One issue of PEARLS on Coding e-newsletter

NOTE: We publish CPT code information reported by three or more respondents only.


Your costs. This is admittedly easier said than done. “There’s no real relation between reimbursements and cost of delivery of services,” says director of outreach programs for the American Academy of Professional Coders Barbara Cobuzzi. “If I were making widgets, I would know the cost.”  

Not so with medical practices; there are just too many variables. Costs include overhead, ancillary personnel, rent, and supplies, to name a few. Hence, the birth of the volume-based practice. “Physicians think they’ll make it up in volume,” she says. “But doing more just means it’s costing you more. You have to get a feel for your costs, even if you SWAG it (Scientific Wild-Ass Guess).”  

Who your payer reps are. It’s very important to know this, and to foster relationships with them. “The reason for building that rapport is because nine times out of 10, that’s the only person you’ll deal with,” says Jeff Milburn, during his workshop lecture “Managing Your Payer Contracts” at the 2007 Medical Group Management Association conference in October. And remember, justified or not, these reps take a lot of abuse from providers. “You have to be firm,” says Millburn. “But being nice doesn’t hurt.” Stay calm, politely state the facts, and let your data speak, rather than emotion. This will go much farther than impassioned pleas based on outrage.  

Where your contracts are. Administrative turnover can wreak havoc on document organization in a practice. Do you know where your contracts are? They are precious. Store them in one place, and have off-site backups like you would any valuable document. Make sure you have a current contract that is also signed by the payer. How can you dispute the terms if you can’t even prove it’s a ratified contract? And just as you do (or should do) with your insurance policies, archive the last one to two versions. If the payer ever decides to reevaluate your claims for possible revenue “take-back,” you can point to the clause in your old contracts that limits this activity.  

The important dates. When are your renewal dates for each of your contracts? What are the requirements for termination? Do you have any evergreen clauses? If so, get those renewal dates in particular into your Outlook calendar or other tickler software, and make sure it conks you in the head in plenty of time to contact the payer to renegotiate. (And make a note to yourself to excise those evergreen clauses for the following year.)  

What you want and why. When you were a kid and you asked mom for something you wanted, which got you more respect: Clearly outlining the benefits and costs of keeping the nifty turtle you just found in the back yard, or sputtering a pouty “’Cause I wanna turtle!”? Likewise for dealing with payers. What goals have you set for the following year? Five years? What will they cost? Why are they worthwhile to pursue? “This will go much farther than, ‘Hey, can you pay me more?’ They’ll say no,” says Breeze. “The next step is ‘Well, here’s why.’ By that you’ve set yourself apart from most other physicians. I’m not going to pretend that every carrier is just going to fall over when you present your numbers. But they’ll take you more seriously.”  

Know how to walk away. This idea can knot up the most placid physician tummy. “It’s very, very hard to walk away,” says Mertz, especially if it means your waiting room will become 20 percent emptier. But Madden maintains that it could be a step worth taking. “You never lose all of your patients when you drop a plan,” she says. Of course, you want to terminate in the right way. Send a letter to both the insurance company (and the potentially affected patients) that in 12 months you’ll terminate if they won’t raise your rates. Cobuzzi recommends including a sentence like “Your fee schedule is inconsistent with my cost structure.” “If enough physicians start dropping their [contracts] and the panels for these payers get small enough, even if the small doctors drop them — and it may take a year or two or three — the insurance companies will come knocking at the door and say ‘What can we do?’ because they won’t have any physicians to work with,” she says.  

Your most important to-do list  

There are a number of proactive tasks you should consider doing to put (and keep) yourself in the best possible bargaining position when it comes to negotiating with payers. Consider these suggestions:  

Follow up annually. The squeaky doc gets the grease — on your palm, that is. “Squeezing a couple percent out of a payer every year sometimes works better than asking for 10 to 15 percent every five years,” says Milburn. Alternatively, he suggests, you could agree on a two-year contract with a 2 percent escalation factor. And don’t be afraid to be a pest. “Physicians should insist on receiving a complete fee schedule and coding guidelines from a carrier before signing,” says Breeze. No, the carrier will not want to do this, but be persistent.
Read each contract carefully. This cannot be stressed enough. They are not all the same. Look for red flags such as the aforementioned “evergreen clauses,” meaning automatic renewal, or “market fee schedule” — an insidious reimbursement-sapper. A market fee schedule can be whatever a payer wants it to be, says Breeze. “They may say they’ll pay you 105 percent of their ‘market fee schedule.’ That’s great, but the next year, the market fee schedule can be anything.” What if it’s 10 percent lower than this year? “You just got a haircut you didn’t want on your charges,” she says.

Insist on including a clause requiring the insurance company to give you written notification of changes. “Not by fax. Not by e-mail. Not by any electronic means,” warns Breeze. “‘Electronic’ means to them that they can tell physicians about a fee schedule change, and it doesn’t have to be in a very obvious place.”

If at all possible, engage an attorney to read through the contracts. Yes, this can be pricey, and maybe infeasible for a small operation. But the investment might be well worth skimping elsewhere.

Tighten your operations. Consider that a faucet dripping once per second can fill your bathtub 55 times in one year. Yikes. Look around for such “leaks” in your practice. How’s your scheduling? Lots of no-shows? Perhaps an appointment reminder service is in order. Do you use your EMR and practice management software to their fullest capabilities? Try to understand “where you fall in terms of your colleagues,” says Breeze. “If you prescribe more expensive prescriptions, maybe you can explore a different formulary. It’s not only the insurance companies who need to save money.” Look at every operational aspect of your practice, especially your staff. “Getting paid fairly is important and you should do everything in your power to do so, but there is also pressure on you to make sure you don’t have employees who aren’t working the way they should,” says Breeze.

Code and bill properly. This is undoubtedly one of the most challenging aspects of the whole process of payment by insurance companies. “Even when a practice has a good coder, it’s difficult,” says Cobuzzi. “It’s not an exact science.”

Cobuzzi also points out that billers are not necessarily coders, or vice versa. Billers may not be certified in coding. This is a concern, she says, because such billers could have critical gaps in their knowledge. Worse, they may not be unaware of current protocols, which morph regularly. “A practice has ‘Darla,’ and she’s ‘wonderful,’” she says. “But Darla’s been doing the same thing for 15
Make sure someone in your practice is coding-certified. The American Academy of Professional Coders offers certification and continuing education — well worth the time and effort, not only because you’ll know how to code higher and collect more, but also because “you’re protecting your practice,” Cobuzzi says. “If you’re audited, you can show that you spent that extra effort. You can show you’re trying to do the right thing.”

As for billing, you certainly want to send out clean, complete claims. As complicated as claims are these days, claims scrubber software has pretty much become de rigueur.

Ramp up your patient collections. With more of the cost of healthcare resting on patients’ shoulders, you’ll want to shore up your collections practices. Simply put, collect while your patient is standing in front of you. Physicians should count on a 17 percent to 30 percent loss chasing patients’ money if they don’t collect up front, says Madden. “Obviously, if they’re chasing money it costs them.”

Breeze also notes that “it has become truly mandatory to know your allowables. That requires some work ahead of time. You need to make sure the patient actually has the benefits he says he has.”

If a patient truly has a financial difficulty, you can set up a payment plan. “In general, people want to pay for their services; they’re not trying to shirk,” says Breeze. Regardless, the more time you let go by, sending statement after statement, the more likely you’ll never see any of that money. So make it easier on everyone by considering these solutions:

- **Use the ACH debit system for patient accounts** on a payment plan. “We find they actually like it,” Breeze says. “Or we use their credit card. ... It takes it out of their hands.” And into yours.

- **Point patients toward healthcare-specific financing options**, such as CareCredit. This is similar to a regular consumer credit card, but with flexible no- or low-interest offerings to leverage a patient’s out-of-pocket costs. Once obtained, a patient can use his CareCredit card repeatedly, although he should be highly cognizant of honoring the terms, as a late payment could result in a jacked-up interest rate or some other penalty.

- **Verify, adjudicate, and collect all in one place.** Check out InstaMed, a Web-based outfit that offers real-time insurance verification to 430 payers, real-time claims adjudication, and electronic payment from both patients and payers. Bill Marvin, president of InstaMed, says the service brings the worlds of banking and healthcare costs together. It’s fully HIPAA-compliant, highly secure, and fast. “When you do an eligibility transaction, you’re going to get an answer 99 percent of the time, as the patient is sitting there.” Generally, says Marvin, you can expect to save $10,000 to $20,000 per physician, and a 200 percent increase in collections. “The biggest benefit comes in the reduction of staff time,” he adds.

**Speak up**

Mertz thinks that “there’s no national understanding of this whole reimbursement thing, on either the physician or the public side.” And truly, he says, payments are all over the map. Fabrizio has noticed most of his consulting practice shifting to integration — practices joining together, or getting bought by hospitals. “They’re [each] just one doctor,” he says. “They don’t have time. They can’t be politically active. Patients walk in the door morning, noon, and night.”

Breeze agrees. “Physicians are trying to be physicians, trying to take care of patients. To get their compensation, they need a JD or an MBA. ... As I’m seeing changes in healthcare, it’s becoming more and more difficult to sustain as a single practitioner.”

Joining together can be beneficial operationally, but be careful not to negate the power of one, says Madden. She strongly advocates writing letters of objection to payers, politicians, and anyone else who should be listening. It can be a standard “I disagree” letter, where you mail-merge your local, state, and national medical associations, governing state bodies, and the like. Don’t assume they’re already well-apprised of your issue. “I’m often surprised at political people,” says Madden. “They just don’t know.”

And don’t write one letter from your group; instead, have everyone in the group write one individually.

Is this worth the trouble? Absolutely.

“I know many physicians who say, ‘Oh, what’s the use?’ says Madden. “But it’s really important that
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physicians communicate with as many people as possible. Don't just let it be a small subset of rabble-rousers, or they get marked as such.”

And don’t discount the public. Even the supposedly politically shrewd physician organizations “grouse and lobby,” says Mertz, “but nobody goes to the public. Nobody says, ‘Hey, we’re going to have a 200,000-physician shortage. If you live in a rural area, you’re going to have no doctor.’”

One crowd that could potentially do some damage is the senior set. “They’ve got the time to understand the issues,” Mertz says. “They could have a gray army out there, pounding on the doors.”

Cavale notes the public’s employers need to listen up and take action, as “the consumer is not really the consumer of care. They’ve delegated that option to their employers. ... You must pay attention as an employer.”

This means performing due diligence when shopping for healthcare, says Madden, which she claims many employers don’t do. “You have a lot of employers just trying to keep costs low, and not really paying attention to quality of care. They leave it up to insurance companies. There needs to be a much bigger awareness of what are you buying and why you are buying it. It's not a valuable proposition just because you saved $10,000 on Aetna over Cigna. [With employers and employees] working together, you’d be surprised how effective it is with insurance companies. It really forces their hand.”

**How low will it go?**

If trends continue, reimbursements will theoretically hit bottom in a few years, akin to an asteroid striking Earth while the dinosaurs munched happily on flora, fauna, and each other. “We’re in a changing world right now,” says Breeze. A growing movement of physicians are soliciting large groups and hospitals, looking for a stress-relieving salary payment structure, for example. Something’s gotta give, and soon.

Will we move to a single-payer system? Hard to say, although even if we do, “the devil’s in the details,” says Fabrizio, and implementation would take years. He suggests that only a major political shift will cause any major change in the current reimbursement slide. “There has to be changes by all the constituents. Unfortunately, I don’t see any movements to have everyone talking at the same table — the AMA, physicians’ groups, no one.”

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