Ambulatory surgery centers (ASCs) must be patient, persistent, clear about their costs, and confident about their value when entering into negotiations with managed care organizations.

Industry experts and ASC managers skilled at negotiating say the bargaining climate is growing more challenging. Commercial insurers are either basing their payments on an increasingly outdated Medicare fee schedule or simply paying a capitated flat rate that does not include implants or multiple processes within a procedure that previously could be coded and billed separately. Contracts are complicated and full of legalese that can span 20 to 40 pages.

Kermit Knight, CASC, administrator of HealthPark Surgery Center in Venice, Fla, says maximizing reimbursement from managed care companies through determined negotiating is critical.

“Seventy percent of our business is Medicare,” he says. “We have to get the most out of our managed care contracts to cover the losses we incur with Medicare and can do nothing about.”

Using experts

How are ASCs negotiating profitably?

Knight and co-administrator Terri Lopez, CASC, get professional help. They hire an attorney to review the language in their contracts.

“It’s very difficult even for administrators to interpret managed care contracts,” Knight says. “You can avoid pitfalls by getting a legal review of your contracts. Our attorney went through each managed care contract and gave us a list of what needed to be changed. His services were invaluable.”

With a few managed care companies, Knight and Lopez brought their attorney to the negotiating table.

“The insurance company kept trying to ignore our attorney and address us, but he just stayed the course.”

Mary McLelland, NMCC, president of US Billing and Contracting, LLC, in Oklahoma City, Okla, recommends outsourcing contract negotiations and reviews if an ASC does not have the expertise or personnel to handle prolonged negotiations.

“Your contract can determine whether your facility makes it or not,” McLelland says. “The managed care arena is tough, and you want somebody who has experience and your best interests at heart to work over your contracts.”

McLelland also cautions ASCs to sign only contracts in the facility’s best interest.

“Don’t sign every contract just because an insurer will cover your patients,” she says. “It’s tempting for centers to sign on to any plan that will take them, but a bad contract can cost you a lot more than you’d ever make from it.”

Negotiating strategies

ASC administrators and industry experts say the following negotiating strategies work:

Have a game plan

ASCs rarely get everything they want in negotiations. You have to give on one side to get on the other, says Knight. Going into negotiations, Knight and Lopez plan their strategy. They identify their high-volume procedures where they need to make a prof-
it and their low-volume procedures where they can afford to break even or take a loss, if necessary.

**Know your high-revenue groupers**

“Sometimes it’s beneficial to take a lower reimbursement in one group to allow a higher reimbursement in another group or groups that most of your cases fall into,” says Dawn Gray, CPC, manager, Serbin Surgery Center Billing in Ft Myers, Fla.

**Find strength in numbers**

“Management companies that represent several surgery centers usually do better at negotiations than stand-alone ASCs because they have strength in numbers,” McLelland says.

Conversely, an ASC that is one of a kind in a rural area, has specialized equipment, or performs procedures not commonly available in a region also will be more appealing and wield more power during negotiations, McLelland says.

**Document costs**

“The rule of thumb is always know your costs and document them for the payer,” says Cathy Head, RN, BS, MHA, CASC, administrator of Evansville Surgery Center in Evansville, Ind. “Nothing will assist you more in negotiating than having a clear understanding of your costs. How else will the managed care organization understand that a procedure costs you more than the grouper rate pays?”

McLelland performs a thorough case-cost analysis for a center’s top 25 procedures that includes direct and indirect costs, including staffing, supplies, electricity, cleaning, equipment amortization, and taxes. During negotiations, she presents the case-cost analysis to the managed care organization and says, “We determined what it costs. We can’t do it for that amount, and I can prove it.”

**Prove value**

In addition to costs, ASCs should demonstrate their value as a safe, high-quality alternative to hospital-based outpatient surgery departments.

“Negotiating for an ASC is 90% education,” says Julie Greene, MBA, executive director of Grand Valley Surgical Center in Grand Rapids, Mich.

“I recommend negotiating from the standpoint of value even more than costs, because costs can change quickly. I try to be the absolute best value in the market—high quality, high patient satisfaction, high physician satisfaction—at a great price.”

Lisa Spoden, MHA, PhD, senior partner of Strategic HealthCare, Inc, and executive director of the Ohio and Kentucky ASC associations, says her members’ discussions with managed care organizations often begin with a PowerPoint presentation of ASC attributes, including requirements for licensing, accreditation, and Medicare certification; quality benchmarks; and low infection rates.

“I’m always surprised at how little insurers know about ASCs,” Spoden says. “We establish credibility.”

**Request parity**

An effective tactic for Greene is comparing insurance payments between ASCs and hospitals. “We are more than happy to be below hospital rates, but we need fair reimbursement of our costs,” she says.

“I tell the company, ‘If you can come back and tell me that I cost more than the hospital with my level of efficiency, patient satisfaction, and outcomes, than I will agree to your price. But I know that the reimbursement we are requesting from you is actually costing you less.’”

**Counter offer**

Always submit a counter proposal, Gray says. “Start high with the hope of coming in around your projected required amount,” she says.

**Be patient**

Knight says it took 8 months to come to terms with one large payer, but it was worth it.

“In the end, we got what we wanted,” he says. “We just kept coming back with the same message. We outlasted them.”
Find the right person and establish rapport

It can take time to find the right person with whom to negotiate, especially with large managed care organizations. “With the biggest insurer, we were assigned a negotiator who ignored us,” Knight says. “Finally, after 3 months, the head of the company’s Florida contract division assigned us to the right person. Establishing rapport and one-on-one communication is key. The negotiator gets to know you and your needs.”

Knight says applying his Cajun charm also helps.

“Some ASCs go into negotiations with their guns out and demand what they want,” he says. “I don’t think that’s effective. The insurer will just put you at the bottom of the basket, and by the time you get back up your contract is outdated.

“We need each other, but let’s face it. Insurance companies make more money than we do, and they’ve been at this business a lot longer. The advantage is usually theirs.”

Escalate discussions

Spoden encourages ASCs to escalate the discussions to negotiators at a higher management level if the ASC is not getting what it needs.

“In some instances, you need to go right to the medical advisory committee,” she says. “When it becomes a quality of care issue, they are more willing to listen.”

Spoden adds that one insurance executive told her, “Don’t be afraid to escalate the conversation to someone who is willing to listen and looks at the bigger picture because we’re never done negotiating.”

—Leslie Flowers

Leslie Flowers is a freelance writer in Indianapolis.

Contract language must-haves

In managed care contracts, “the devil is in the details,” says Cathy Head, RN, BS, MHA, CASC, administrator of Evansville Surgery Center in Evansville, Ind. Head designed a managed care contract language check-off list that includes the following:

Specific reimbursement methodology. Specifies rates for each procedure the ASC performs and either specifies reimbursement for each carve-out or includes carve-outs in the overall procedure rate.

Escalation clauses or cost-of-living increases. Provides automatic annual increases in reimbursement based on an agreed-upon percentage.

Technology reopener language. Allows the ASC to renegotiate pricing based on a new technology, such as equipment or instrumentation.

Additional codes during term of agreement. Allows the ASC to add procedure codes and negotiate payment terms for those codes.

Multiples. Ensures the ASC is reimbursed for multiple procedures within one grouper. For example, an arthroscopic rotator cuff repair (CPT 29827) and a distal claviculectomy (CPT 29824) are consistently performed together. Both codes should be billed to the payer.

Forbid blind contracts. Blind contracts are when Company A, with whom you have an agreement, sells its network to Company B, which then expects to reimburse the ASC at the same rate as Company A, even though the ASC did not make an agreement with Company B.

Unlisted procedures. Specifies payment for procedures that are not listed on the Medicare groupers. Some insurers will deny payment if a procedure is not listed.

Other criteria and language:

• Length of contract.
• Number of days payer has to remit payments, as stipulated by state law for electronic and paper claims.
• “Clean claim” clearly defined as a claim that has no defect or impropriety and is submitted with all required documentation.
• Provision for payment of clean claims guaranteed, meeting or exceeding state law requirements.
• Reasonable time limit following service date for claims submission (180-day minimum). Exceptions included for delays beyond the ASC’s control.
• Specific provisions for emergency services regardless of whether payer is notified.
• Specific remedies for untimely payments, such as interest or late fees.
• Provisions to terminate the contract for slow or delinquent payments.
• Defined settlement and appeals processes, including time limits.
• Defined time limits to recoup money for overpayments.
• Defined limits of secondary payors.
• Automatic renewal clause—if inflation index is included.
• Termination “without cause” clause, including number of days required for advance written notification.
• Medical necessity defined clearly.
• Preadmission and postadmission authorization defined.
• Requirement that reassignment of codes or changes in groups are communicated by written notice, in advance. Provider must have the option to discuss and analyze the effect of the change.
• Statement that information in the contract, including fee schedules, is proprietary and will not be shared.

This list is suggestive only. Please obtain professional counsel for specific contract language. Head’s complete check-off list is available in the OR Manager Toolbox at ormanager.com.

**Negotiating carve-outs**

Carve-outs are specific procedures and/or implants that must be negotiated separately for reimbursement because the typical payment rate does not cover them. Examples are laparoscopic vaginal hysterectomy, anterior cruciate ligament repair, shoulder arthroscopy, and lumbar laminectomy.

“If we were paid for these procedures on a case rate or group rate methodology, we would not even recoup our costs,” says Cathy Head, RN, BS, MHA, CASC, administrator of Evansville Surgery Center in Evansville, Ind.

Experts say negotiating reimbursement for carve-outs is getting tougher. As part of your negotiating strategy, pick your battles carefully, advises Stephanie Ellis, RN, CPC, president of Ellis Medical Consulting in Brentwood, Tenn.

“Understand that when you go to the mat on negotiations, you’re not going to get everything you want, but you should try to get coverage on those high-volume procedures that are really important,” Ellis says.

For example, if an ASC performs a large number of pain management cases, and the managed care contract states it won’t pay for X-ray, try to negotiate coverage for fluoroscopy. Or if an ASC uses implants, request a carve-out payment for 1 or 2 of the most commonly used implants.

“This way, you’re not taking such a big bath when you accept the managed care contract,” Ellis says.

Increasingly, payors are moving toward flat rates for procedures, implants, and multiple procedures within a code.

“The days of carve-outs are disappearing” says Mary McLelland, NMCC, president of US Billing and Contracting LLC in Oklahoma City. “Major carriers are only giving fixed amounts. However, you can request that they increase the fixed amount to cover your costs.”
The key to success, as with all managed care negotiations, is for an ASC to know its costs so it can recoup them.

“Our philosophy is that we just want to be covered for the implant and the administrative costs to receive it,” says Kermit Knight, CASC, administrator of HealthPark Surgery Center in Venice, Fla. “We usually request the invoice price plus 30% for administrative costs. The insurer usually negotiates down to the invoice price plus 15%.”