



## **Cultivating Payer Relationships that Pay off!**

“Don’t bite the hand that feeds you!” This phrase may sound cliché but it is truly an important concept when it comes to building a team relationship with your current or potential reimbursement sources. Consider that your organization has both the opportunity and the obligation to educate, communicate and advocate for reimbursement for rehab services. Your willingness and ability to capitalize on this opportunity affects your patient’s access to necessary care, as well as your bottom line. A strategic approach to understanding and cultivating payer relationships is the key to your success.

### **Understanding the payer perspective:**

Any good relationship begins with understanding the background and the perspective of the other party. The payer is clearly a member of the healthcare team in our third-party reimbursement climate. The role of the payer is first to judiciously select and contract with qualified providers. The payer then offers their product and provider panel to employers purchasing coverage. Finally, they must process and pay for claims for plan enrollees. In making payment decisions, they must consider the individual contracts they hold with employers. Coverage for medical services under each contract is prescribed in the plan Certificate of Benefit (COB). Each COB can be unique. (Many are available for review through the payer’s website.)

Payers are NOT in the role of deciding what services may or may not be appropriate for a client, but instead what services are appropriate for reimbursement under a given contract. It is important that you understand that payers are under constant pressure to control spending. They face expanding plan enrollments, growing requests for expenditures and must compensate for escalating premiums that lead to loss of enrollees. Contracting strategies, plan language and medical review policies are constantly evolving to deal with these challenges. These strategies are NOT always favorable to the rehab provider.

### **How can you be a part of the solution?**

#### **Initiating a relationship:**

Contracting with third-party payers can provide your patients with the access they need to utilize your services. Many therapy providers mistakenly assume that payers wish to have all providers on their panel (*panel: contracted providers*). When payers contract they expend resources in the process. The ideal scenario is for payers to contract with high quality, self-monitoring providers that expertly manage the claims process and deliver cost-effective services. They are looking for partners in delivering cost-effective care NOT adversaries!

If you wish to be a preferred provider for a payer in your service area, you must market to them! Begin by researching payers that are in your area for contracting opportunities. You might want to approach key referral sources to determine which payer plans are most important to your referral sources. Or consider searching your State Commissioner of Insurance website for licensed insurers and their numbers in your service area.

Prioritize the payers that you wish to become a provider for. Contact their Provider Relations department to become a provider. If they are interested, immediately request a provider application, their provider agreement and their fees. Carefully review the contracting opportunity and the reimbursement. Not all contracts are good contracts! If you decide that the provider agreement and reimbursement are favorable have legal review of the contract before signing. Once in the panel, consider approaching the payer annually or at least every 2-3 years to renegotiate your fees. Many providers allow a contract to age without managing it or revisiting the fee schedule.

If a payer says that their panel is closed or filled. Consider asking them the following questions:

- When does your plan open its panel?
- What is your fiscal year?
- What are your current challenges with managing rehab services?
- Are there any specialty services or locations you are looking for?
- When can I follow up with you on opportunities to become a provider?

Armed with responses to these questions, contact the payer periodically, every 3-6 months either by phone or formal letter. Consider dropping off information about your therapy services.

**Key Follow up Information to Provide to Provider Relations Contacts:**

Specialty services	Recommendations from contracted employers
Clinical outcomes	Recommendations from contracted MDs
Patient satisfaction	

Realize that you may need a level of persistence to be considered. Inquire about the opportunity to contract through a therapy provider network or group. Once contracted you must further cultivate the strength of your relationship through ongoing strategies.

**Educating the payer:**

The rehabilitation industry continues to grow and evolve in both the interventions we offer and the types of patients that can benefit from our services. Third-Party payers often base their benefits policies off of previous benefits policies. Their medical review policies may or may not be updated, as new technologies are available to rehab providers. As clinicians and advocates for our profession, consider you are in the professional role of educating payers about appropriate rehab services.

Capitalize upon one or more of the following opportunities to educate:

- Attach evidence-based literature to documentation when a payer requests medical review of a new treatment strategy or application. When a clinician from your practice attends a continuing education course or when your practice secures new rehab equipment, insist that the presenter or vendor provide the most recent evidence-based references or articles. Review the evidence carefully and highlight the lines (I usually recommend 10 or less) that best describe the efficacy of the intervention. Forward this literature to the reviewer and offer to answer any follow up questions.

- If you are introducing a new treatment consider contacting your primary payers with a formal letter and literature describing the care. Direct correspondence to both the Plan's Medical Director and the Supervisor of the Utilization Review Department. Offer to answer additional questions by phone or in person.
- Offer to in-service case managers or utilization review staff at local payers on treatment strategies. Provide a simple handout with references.

### **Communicating with the payer:**

Realize that your most common form of communications with your payers is through the claims you submit and the documentation you provide to support them. The accuracy, neatness and completeness of your claims are a reflection on your operation. Consider submitting all claims electronically. Utilize practice management software that "front end" edits your claims for simple errors.

Understand that many third-party payers have claims management systems and processes that automatically flag your claims for review after a certain number of visits. For example: a payer may flag all claims for back pain after the sixth visit. At that time a request for documentation is sent. That request reflects their responsibility to determine if services are medically necessary and meet the contract language. Be certain that these requests are responded to promptly, within 10-14 days, and specifically.

In preparing your response, have the evaluation, plan of care, prescription (if needed) and daily notes pulled from the patient's chart. Have the treating therapist review this documentation to be certain of completeness. It may be helpful to highlight key information in the documentation.

Important information to highlight might include:

- The patient's functional deficit and goals.
- Baseline status on functional tests and assessments.
- Measurable progress that the patient has made or an explanation regarding limited progress.
- Residual problems that warrant additional intervention.
- Your plan for additional intervention or projected discharge.

If the therapist finds that there may be additional supporting information he/she can provide after reviewing the documentation, have the therapist write a concise cover letter that frames the documentation and fills in any additional information.

If the request arrives with specific questions from a reviewer, answer each question specifically. Do NOT refer globally "See attached."

### **Advocating for your patients:**

If you are in a position where care that you feel is medically necessary is reduced or denied, consider advocating with the patient through the appeal process. Payers are aware of those providers that will make the extra effort to appeal versus those providers who accept reductions or denials without question. Your "reputation" with them may be

that you are either an “easy mark” or a “challenge” when they are considering denying rehab services.

Follow these steps for an effective appeal:

- Request information regarding the specific reason for denial.
- Review the patient’s plan language for coverage and definitions of medical necessity as they pertain to the services you are considering appealing.
- Call the reviewer involved and ask: “What additional information do you need to help understand how the care I am requesting meets your plan coverage criteria?” Treat the reviewer as a colleague NOT an adversary!
- Appeal only those services that you have a strong and legitimate case to appeal. This will insure your credibility.
- Enlist the patient in contacting the insurer to question the denial. The patient is the payer’s real customer. A call from a patient advocating for his/her own care may be enough to turn the denial around. The patient may also discuss a denial for services with his/her employee benefits specialist. The benefits specialist will have knowledge of the plan and a contact person at the payer’s office. Their clout with the payer is important.
- Prepare a concise cover letter referencing the “plan language” and referring to your documentation as it supports the billable services.
- Ask the patient’s prescribing physician (if appropriate) to do the same.
- Do NOT assume that “more is better”. The quality of the information you provide is much more important than the quantity.
- Contact your state or national professional association reimbursement department for assistance if a problem persists. They have both the experience and references to support you.

Your practice can succeed in the challenging third-party payer climate by understanding and respecting the payer perspective and committing to a positive ongoing relationship. You can make a difference through your willingness to educate, communicate, advocate and cooperate with your third-party payer partners. The future of our professions rests on our ability to provide cost-effective, evidenced-based services and convince payers of their value!

*BIO:*

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