
BUSINESS SERIES FOR PROVIDERS
ROUNDTABLE DISCUSSION
Navigating Contract
Terms and Negotiations
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ABABILLING.NET
Behavioral Health Center of
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ABA THERAPY BILLING
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Roundtable Discussion

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General Disclaimer

- The following presentation is intended as a discussion from four industry professionals providing a view into Navigating Contract Terms and Negotiations.
- This presentation reflects our best understanding of the processes.
- Providers are encouraged to confirm all information presented by reviewing their own independent contracts, business practices and in payor relations with provider representatives.
- This presentation does not reflect opinions of any organization outside of those represented as roundtable presenters.

Get to Know Your Contracts

There's more to it than rates!

Presented By: Emily Roche

Careful Consideration and Big Decisions

- Is accepting insurance right for you business?
- What are the ABA guidelines from the payor?
  - Are they sustainable for your business?
- The contract is legally binding for your business, and many of the terms favor the insurance company or the member.
  - And, the burden is on you to process all authorizations and claims.
- Don't always follow what other companies are doing….
  - You don't know if what another company is doing has been financial sustainable, has the same terms, etc.

Contract Terms to Review

- "Boilerplate" Contracts: not made specifically for ABA providers
  - Know your state laws that apply

- Read your whole contract!
  - And, ask for ABA specific guidelines
- Know where to find your provider manual
  - These terms are considered binding along with the contract
- Notice of Material Change or Amendment****
  - How do you receive notice of a material change?
  - How can you dispute a material change?

Contract Terms to Review - continued

- Timely Filing Deadline
- How are claims submitted
  - Electronic, through a portal, paper claims, etc.
- Deadline for Appeals
- Term of the contract
  - How long you are locked into the contract?
- Period for timely payments
  - How long can insurance take to pay you?
- Interest on late payments

What Does the Contract Cover?

- Covered Products: PPO, EPO, HMO, etc.
- Does the HMO have additional requirements?

- Medicaid and CHP+
  - Do you have to accept Medicaid or CHP+ members covered by the payor?
- Group vs. Individual Contracts
  - If you plan to grow, attempt to get group contracts
- Who handles ABA authorizations?

Fee Schedules

- Be sure to ALWAYS have the fee schedule before signing a contract.
- Before negotiating rates….

- Know how to calculate your profit margins
- If using a "tiered" model….
  - Rates on behavior technician services supply the profit margin
  - Do not think a high BCBA rate can compensate for a low RBT/BT rate
  - Calculate how much profit is made on each rate
  - Then, calculate how many billable hours you provide of each service!
    - Technician: $25 profit per hour x 400 hours per week x 48 weeks = $480,000
    - BCBA: $25 profit per hour x 45 billable hours per week x 48 weeks = $54,000

Reimbursement Rates: Sharing the Value of Your Organization

Presented by: Sara Gershfeld Litvak, MA, BCBA

Readiness is Everything

- Understand the market and strengths of your own practice
  - SWOT Analysis
  - Utilization
  - Number of new patient referrals per month
  - Know your market share
  - Survey patient satisfaction (BHCOE offers this)
  - Benchmark aspects of your quality & efficiency
- Before meeting with representatives of healthcare plans, find out how significant your referral sources and footprint is in their network

Analyze the Fee Schedule

- "Quick and Dirty Approach":
  - Create a spreadsheet with every CPT code and the number of times it was billed for that payer
  - Multiply the use of each code by the proposed payment of the payer.
  - Add together all of these products and divide by the total frequency of all codes to determine the weighted average payment for that payer.
- By repeating this process for each payer, you can compare the overall weighted averages of all of your health care plans.

Next…

- Determine the break-even point for your practice by adding:
  - Overhead expenses
  - Compensation
  - Dividing this sum by total frequency of all codes for all payers
- This will give you the weighted average of your costs, your break-even point, and compare it with weighted average reimbursement for each contract.
- You can also do this analysis by service line – some service lines are more profitable than others
- You can also compare this as a % compared to Medicaid rates

Monitor Your Contracts

- Most contracts are evergreen and automatically renew unless modification is proposed
- As the date approaches, analyze the contract and determine changes

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- It is not advisable to allow contracts to go unchanged for many years.
  - It's easier to ask for a 1-3% increase every few years than a 10% increase all at once.

- Channel all contact with a healthcare plan through only one person. This person also communicates changes to clinical staff.

- Clinicians should not sign paperwork addressing rates, reimbursement, etc. Be careful with this. Do not sign "membership confirmation" letters.

Determine Your Position

- Set a bargaining range that includes optimum, minimum and target goal.
  - Optimum: starting point
  - Minimum: needed for you to sign
  - Target: point at which you would like to end up after negotiation
- BATNA: Best Alternative to a Negotiated Agreement
  - Go into negotiations knowing your alternatives
  - BATNA: option you take if no agreement is met
- Your position is weaker if you are primarily servicing one payer.
  - It's important to monitor your payer mix annually.

When Should You Walk Away?

- Decide on your bottom line ahead of time

- Do not accept truly poor contract terms just because it would cause disruption of ongoing care, decrease in new patients or loss of income.
- Case study: One business walked away from a poorly written contract that resulted in displacing more than 200 patients. They stuck to their guns, and it was well worth it. Eight month later, the plan said "We want you back in our network."

Negotiating the Contract

- Common Response to Clinicians: "This is what we pay in your market, and you're simply going to have to accept it."

- Contact the plan representative to set a date for a face-to-face meeting at your office.
- At the meeting, present well-organized, clear data. Many providers use the BHCOE Accreditation Results for this process.
- Make it plain that you have a thorough understanding of the finances of your practice.
- Present your requests for changes—asking for your optimum objective—before new terms are offered.
- Listen carefully to what they have to say, and do not interrupt.
- A basic negotiating principle is to remember that you are negotiating a relationship, not a transaction.[5]

Negotiating the Contract

- Find out the goals of the other party
- Find out the biggest issues the payer has and try to address them

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- Payers want cost control, predictable cost and progress. Show them you can provide that.
- Be prepared to share the following:
  - Practice data – Outcome Data
  - Patient Satisfaction Data
  - Staff Turnover & Staff Satisfaction (Happy Staff = Happy Patients)
- If you can, negotiate a multi-year contract with escalation of fees every year. This is less burdensome for payers, but ends up at the desired rate.

What else to negotiate?

- Authorization process

- Period specified for submitting claims (try pushing to 120 vs. 90 days)
- Period allowed to appeal a denied claim
- Requirements regarding assessments used
- Time specified for timely payments, and interest paid for late payment
- Period required for providing notice of modifications
- Cancellation clause, including advanced notice required

Preparing for Rate Negotiations

Presented by: Diana Wolf MA, BCBA, LBA

Pre-requisites of Rate Negotiations

- Have a full understanding of the new CPT codes

- Know what is in your contracts
- Know your numbers... Your needs
- Know the people who will listen and help

CPT codes

- What is the intended use of the codes?
  - APBA webinars
  - https://www.apbahome.net/store/ListProducts.aspx?catid=694517&ftr
  - BHCOE webinar
  - https://bhcoe.org/behavioral-health-virtual-academy/
  - ABA Therapy Billing and Insurance Services
  - https://www.ababilling.net/blog/
- How are they different from CPT III codes?
- What does the CPT manual say?
- What does the CPT Assistant article say?

Contracts – Not knowing can cost you!

- Medical Necessity provision
- Billing outside of an authorization

- Balance billing
- Timely filing provision
- How long insurance companies have to pay you
- Fee schedule alterations
- Clauses to hold members harmless
- Adjustments to payment – overpaid/underpaid
- Clause about ineligible members
- Notices
- Termination
- AND MORE! (All are payer specific… know what you're signing!)

Know your numbers

- Get an accountant
- Run an analysis of your organization
  - What exactly is involved in pre-service per code
  - What exactly is involved in post-service per code
  - How much time spent for each activity
  - What are our disposable and non-disposable supplies used
- Find out what your company rates are (per code) when they're "bundled" vs. if you had a separate indirect service code to use

Codes	Activities Before	Amount of time for each activity	Direct Services	Activities After	Amount of time for each activity	Disposable and non-disposable supplies	Cost per 15 min
97151			Behavior identification assessment, administered by a physician or other qualified healthcare professional,each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan				
97152			Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes				
0362T			Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: - administered by the physician or other qualified healthcare professional who is on site; - with the assistance of two or more technicians; - for a patient who exhibits destructive behavior; - completed in an environment that is customized to the patient's behavior.				
97153			Adaptive behavior treatment by protocol, administered by technicianunder the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes				
97155			Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes				

Who do you contact?

- Important to build relationships with people on the insurance side
  - Start with provider relations
    - Do you have a specific contact?
    - Do you have a contact through authorization department?
      - Can they lead you to the right person?
- If your contract amendments for new codes are not reflecting a number that would work with your calculations, send a counter-offer with a rationale.
  - Use your resources
    - AMA CPT Manual/Assistant article
    - Webinars and presentations by members of steering committee
    - Practice Guidelines for Health Funders from the BACB
    - White Paper explaining effectiveness of ABA from APBA

Show your worth

- Explain why you need what you need and why their proposed rates won't cut it
- Show the number of their members your organization is providing services for
- Show outcome measures
- If accredited, list accreditations and what they mean
- Survey your clients – client satisfaction scores go a long way

Don’t Back Down

- Most insurance companies know very little about ABA and how the therapy works
- Educate your payers
- You got this!

Understanding Intent and Implementation

Presented by: Michele Silcox, CMRS

Remember your WHY

- WHY do I need to review my contracts?

- WHY do I need to know the intent of the codes?
- WHY do I need to understand implementation of the codes?
- WHY do I need to understand that the full ABA program costs cover all services, overhead and expenses?
- WHY do I need a voluntary internal compliance program?

Intent vs Implementation

- Intent of Category I codes has been covered by the presentations from Gina Green, APBA and Jenna Minton, Minton Healthcare Strategies from the Steering Committee for the New CPT Codes for Adaptive Behavior Services
  - Grounding yourself in the Intent will give you an advantage in your payor relation contract and authorization conversations
- Implementation of Category I codes is at 100% discretion of the Payor. Having as much knowledge as possible about the codes and your organization will set you up for success in making business decisions and reviewing your contracts

Example of Implementation for Category III Codes
The View in Billing Code Format - BEFORE

TRICARE only- Supervised Fieldwork/ Protocol Modification

0360T/0361T

Supervised Fieldwork

- (used in a non Standard way by TRICARE only)
- Allowed to be conducted using telehealth

0368T/0369T

Protocol Modification

- Possible "underused" by providers while performing these activities naturally during a supervision session

Other Health Plans - Supervision/Protocol Modification

0368T/0369T

Supervision/Protocol Modification

- Does not require technician be present
- Not designed for some non face-to-face supervisory activities not involved in individualized clinical treatment

All Health Plans Indirect Services/Treatment Planning

Stand-alone codes such as: H0031, H0032, G9012 were present in some payor contracts for case management

TRICARE: 0368T/0369T for treatment team meetings defined in the TOM

- Did not require beneficiary be present

Some payors allowed 0368T/0369T for other non face-to-face uses such as team meetings or treatment planning

Example of Implementation for Category I Codes
The View in Billing Code Format - AFTER

TRICARE only –

Protocol Modification

Supervised Fieldwork

- No longer required or reimbursed

97155

Adaptive behavior treatment with protocol modification which may include simultaneous direction of technician

- Direction allowed only on-site during protocol modification
- Meeting TRICARE definition of protocol modification (refer to updated TOM and DHA documentation of changes
- Actively engaged with the client

Other Health Plans Supervision/Protocol Modification

97155

Adaptive behavior treatment with protocol modification which may include simultaneous direction of technician

- Does not require technician be present
- Not designed for some non face-to-face supervisory activities not involved in individualized clinical treatment
- Actively engaged with the client

All Health Plans Indirect Services/Treatment Planning

Category I codes do not allow for non face-to-face activities with the exception of 97151 Behavior Identification Assessment

Stand-alone codes such as: H0031, H0032, G9012 may be present in your contract fee schedule with some payors and could be defined as used for treatment planning

Let's Do The Math

TRICARE through 12/31/18 (face-to-face)

**using TRICARE standard published rates as a mathematical example*

0360T/0361T or 0368T/0369T

1 hour BCBA = $125 per hour

0364T/0365T

1 hour RBT = $50 per hour

Billable:

$125 per hour

TRICARE as of 1/1/19 – Protocol Modification (face-to-face)

**using TRICARE standard published rates as a mathematical example*

97155

1 hour BCBA = $125 per hour

97153

1 hour RBT = $50 per hour

Billable:

$125 per hour

TRICARE as of 1/1/19 – Supervised Fieldwork (face-to-face)

**using TRICARE standard published rates as a mathematical example*

No Code

1 hour BCBA = $0 per hour

97153

1 hour RBT = $50 per hour

Billable:

$50 per hour

Net change ($75.00) per hour

**when choosing to do Supervised Fieldwork activities that are not covered with 97155 Protocol Modification*

Unanswered Questions

- Different Interpretation of Codes = Difficult Implementation
  - With Payors being allowed to interpret the codes for implementation based on individual payor policy, you will need a master grid of information for crosswalking and moving forward in your business
  - Category I codes do not cover indirect services (non face-to face) with the exception of 97151
    - There is not a direct crosswalk for treatment planning from Category III to Category I codes
    - Some Payor were using Category III codes in a non standard way
    - Seek to obtain a stand-alone code
  - Things to watch for:
    - Concurrent billing
    - Different use of 97155
    - Treatment by Protocol by QHP (97153 or 97155?) – defined by Payor
    - Primary/Secondary use of different codes and differing use of same code

Advocacy

- Use all available resources to discuss the intent of the codes with Payors
  - Payor provider reps and claims specialists are learning the codes too
  - If the Payor Policy is not documented and published, don't take the guidance in a phone call that is misaligned with the intent without seeking to speak to a decision maker with the health plan and ask for information in writing
  - Rather than seeking for what you "can do" in writing (eg concurrent billing); utilize the intent and guidance from AMA and the Steering Committee
- Advocate for your Business!
- Participate in your state ABA Chapter
  - Become a leader in advocating for the industry

Voluntary Internal Compliance Program

- Seven components that provide a solid basis upon which a physician practice can create a voluntary compliance program:

1. Conducting internal monitoring and auditing;
2. Implementing compliance and practice standards;
3. Designating a compliance officer or contact;
4. Conducting appropriate training and education;
5. Responding appropriately to detected offenses and developing corrective action;
6. Developing open lines of communication; and
7. Enforcing disciplinary standards through well-publicized guidelines.

https://oig.hhs.gov/authorities/docs/physician.pdf

Questions?