Evaluating Insurance and Third-Party Payor Contracts

August 2024 Rebecca Wartman OD

One of the most important tasks a practice must undertake is the evaluation of insurance and third-party payor contracts. The impact of any specific contract on the practice should be carefully considered prior to entering into an agreement. The evaluation of a contract can be complicated and should include all aspects of the potential impact.

A doctor or practice administrator should review each and every contract in depth for the potential revenue that these patients might bring to the practice. Providers should ensure that the reimbursement per patient for well vision and medical services cover the cost of having a particular patient even enter your door. The per patient or per hour costs of maintaining the practice need to be known. This analysis should include cost calculations for items such as rent or mortgage, utilities, internet, equipment leases or purchases, building and equipment insurance, computer costs and any items that have a consist monthly cost. Once the fixed costs are known, employee costs must be considered. Employee costs go beyond the salaries for each person. Employee costs include insurances, workers compensation, unemployment insurance, retirement accounts and any bonus structure that might be in place in the practice. Doctor costs need to be included in this calculation. Once all the known costs are calculated, the provider should know how many patients can be seen in a day and for what examination types. These calculations will allow you to know how much revenue per person the practice needs to bring in order to keep the doors opened.

Once the known, fixed costs have been calculated, the practice should consider how far in advance the practice is currently booked with patients and if there is room to increase the number of patients without negatively impacting your current patient base. Questions such as: Would plan "X" push my appointment time out beyond what is comfortable for the practice or required by current third-party contracts? Would the new plan create an excessive strain on the current practice mode and resources? If so, can this strain be appropriately managed for the benefit of the patients and the practice? Current workflows should be reviewed to ensure efficiency of resource use. Would an increase in the number of patients be handled appropriately with appropriate adjustments in the workflows? An office might need to consider extending practice hours, cross-training employees to ensure efficiencies or even adding another part-time or full-time doctor.

The contract presented by any particular payor should be carefully reviewed to ensure an understanding of the contact terms and any restraints to your practice, including how to cancel the contract, how to bill for reimbursements, reimbursement timelines and policies, prior approval requirements and the prior approval process, the claims appeal process, coding directives for a particular plan, options for participation in only select or specific products from a particular insurance or third-party plan, and how often are fee schedules updated. Providers might consider negotiating the proposed fee schedule if the reimbursement does not meet the practice needs. When considering any contract, doctors need to consider the potential patient base in their geographic region. Sometimes a third-party payor does not yet have clients for the plan and are simply trying to create a provider base in order to secured clients for a proposed plan contract.

Providers should consider the coverage offered by a particular insurance or third-party plan. Doctors need to determine if well-vision care and/or medical eye care are subcontracted to another entity. At times, plans have been known to limit the care a practice can provide to only well vision care. Consideration should be given to how a plan handles materials for eyeglasses, contact lenses or low-vision aids. For instance, if there a requirement for a specific frame inventory the practice must purchase or is that inventory provided and maintained by the plan. Providers need to know if a plan requires the use specific branded lenses for progressives or anti-reflective coatings and, if required, the quality of that brand should meet the standards set for the practice. Plans often require the use of certain labs or contact lens manufacturers. Practices should determine if any required vendors are reliable and produce quality products delivered in a timely manner. Consideration should be given to the reimbursement structure for materials and the impact on practice revenue compared to the staff time costs required to complete the work under a specific plan.

The third-party plan marketing to patients is among other factors to be consider. Questions such as: does the plan encourage patients to seek care from specific types of providers or encourage on-line purchase of materials? How does their provider directory list your services - under Eyecare or in a separate listing at the end of their provider directory? How often are policies under specific plan altered and updated and how are any changes in contract or policy communicated to the providers?

The decision on whether a specific plan or product under a particular insurance is right for a practice is a complicated process that requires vigilance over the entire length of the contact. Providers should reconsider each contract on a yearly or bi-yearly basis to ensure any particular plan still meets the needs of a practice. Providers need to be aware of any new coverage that major employers in their area are implementing to ensure that the practice has considered any new insurances for the coming year.

Another important factor to keep in mind: Per antitrust laws, providers should NEVER discuss their fees and reimbursement from a particular plan with any provider(s) outside their own practice. The AOA has a good resource for contract evaluation here. The AOA also has a Center for Independent Practice. Happy Coding….