Participation in insurance plans requires diligence in analyzing the specific stipulations contained in contracts. When a surgeon signs a contract to participate in a particular health plan, he or she is bound to all of its conditions. It’s just like signing any type of contract, which is a legal obligation between two parties to abide by the conditions of that agreement.

**The good**

The good news is that plastic surgery remains a great specialty, with a broad spectrum of surgical procedures that help patients and are professionally satisfying. Though at times you may feel isolated, you are not alone. Other plastic surgeons, as well as surgeons in other specialties, struggle with the challenges of the current reimbursement milieu. Fortunately, our specialty is in a better position than most. The percentage of Medicare patients in a plastic surgery practice is far less than in many other specialties, such as general surgery, urology, ophthalmology or cardiovascular surgery.

We also have cosmetic surgery within the realm of our specialty, which can help subsidize our reconstructive work.

**The bad**

Unfortunately, the system is not always fair to physicians, and reimbursement is not necessarily a reflection of our skills, years of training or the amount of time and effort we put into doing what’s best for our patients.

When a physician participates with an insurance company, reimbursement is based upon what the contract states, which is generally what the insurance company feels is appropriate.

Reimbursement is often based on the Resource-Based Relative Value Scale (RBRVS). Unfortunately, in many cases, RBRVS is not based on resources nor relative values, and does not differentiate between differing extents of a given code (e.g., traditional free flap vs. perforator flap).

In a rush to be busy, surgeons often sign up for all insurance plans presented to them. But they neither read the provisions of the plans, nor analyze the fee schedules. If a surgeon has signed up for a plan without thorough analysis of the contract – and then is dissatisfied with payments for procedures performed, there is no recourse. By participating, the surgeon has agreed to the fee schedule as payment in full, as well as the payment provisions.

Very few physicians have someone qualified (e.g., an attorney or practice management consultant) to review contracts.

**The ugly**

Insurance companies and the general public don’t care about our plight. They want the medical care to be rendered, and they want to pay as little as possible for it.

It doesn’t matter that you have three Board certifications, have take subspecialty fellowships, teach, write and publish. Your reimbursement is based upon the conditions of the contract you’ve signed, and you are paid by CPT code. The dollar amount is not based upon your skill or the time involved in rendering specialized services. It’s based upon the value assigned the CPT code describing the procedure.

Whether a plastic surgeon comes to the Emergency Department at 2 a.m. to suture a 2.5 cm complex facial laceration, or a surgeon performs an elective 2 cm scar revision in the office, the CPT code is the same: 13131. There’s no provision for extra effort, time of day, inconvenience or differing skills. In fact, the office surgeon will be paid more, as the procedure has been performed in an office setting rather than in a facility.

**Some painful truths**

Signing a contract to participate with an insurance company obligates the surgeon to the rules of that contract. This is the milieu under which one then practices.

It’s vital to understand contractual adjustments – signing a contract binds the surgeon to the fee schedule determined by the insurance company. No matter what the surgeon charges, he/she is obligated to accept the contracted amount. The rest must be written off as a contractual adjustment. There’s nothing that can be done to increase the amount of reimbursement beyond the contracted amount, unless the contract is renegotiated.

Sending appeal letters protesting low allowable reimbursements is futile; it’s a waste of office staff and billing service time. Their time is better spent on fruitful endeavors (e.g.: Is the insurance company in fact paying the allowable? Are multiple procedure reductions applied correctly? Are add-ons not discounted below the allowable?). The contracted amount is just that. The surgeon is bound by the amount in the fee schedule and is obligated to write off the difference.
Here are some key points to keep in mind:

- When you sign a contract, unless you’ve successfully negotiated a carve-out for certain procedures, the provisions of the contract apply to all services (medical, surgical, elective, emergency, etc). Some surgeons wrongly assume a contract does not apply to emergency services.
- You cannot balance-bill the patient for the difference between your fee and what the insurance company allows. The difference must be written off as a contractual adjustment.
- Different payers use different software bundling edit packages. Some of these edits are much more aggressive than the Correct Coding Initiative (CCI), and some do not comply with AMA CPT rules. Although CCI is a public document, many bundling edits are proprietary, and payers will seldom divulge specifics. Modifier 59 sometimes works, but often it does not in these situations.
- Not only do some payers use different bundling rules than CCI, they may also use a different multiple procedure payment formula. Whereas Medicare reimburses 100 percent of the allowable for the primary procedure, then 50 percent for subsequent procedures, other payers may reimburse at 100 percent, 50 percent, 25 percent, 25 percent again and 10 percent. This is an important reimbursement provision that must be recognized before signing a contract.
- Watch for “Silent PPOs.” Payers will sometimes “share” names of contracted physicians with other payers. Even if you don’t have a contract with a particular PPO, your name may be accessed through other PPOs with which you participate, and your fees may be discounted on that basis. This practice is not uncommon. Careful study of Explanations of Benefits (EOBs) is mandatory. If you do not have a contract with an insurance company, you do not have to accept their discounted reimbursement rates.
- Even if you don’t participate with a particular insurance company, some payer contracts stipulate that as soon as you bill them, you “participate,” and are bound by their rules and fee schedules. This will be evident in your EOBs, which must be analyzed very carefully.

**Recommendations**

The milieu is not favorable to physicians, but you can help protect yourself by approaching contracts analytically. Here are some tips:

- Don’t sign every contract presented to you. Remember that they are written to the insurance company’s advantage.
- Have an attorney or practice management consultant review all contracts you sign – read the fine print.
- Don’t append modifier 22 on all your procedures. It’s uncommon for payers to pay for V50.1, but they sometimes will. With dummy CPT codes, payer computers will not pay for cosmetic procedures.
- Use dummy CPT codes for cosmetic procedures performed on your contracted patients. Don’t record these services into your practice management information system with the usual CPT codes. A patient may submit an invoice to the insurance company “just to see what happens.” If the insurance company then pays for the service, the physician is obligated to accept that amount as full fee and refund the cosmetic fee back to the patient. This is a mistake any practice will only make once. Also make sure to use ICD-9 code V50.1 (unacceptable cosmetic appearance) as your only diagnosis code for cosmetic procedures. It’s uncommon for payers to pay for V50.1, but they sometimes will.
- Don’t forget to collect co-pays. These add up to significant amounts of money. Do not waive them, as not only are you contractually bound to collect them, but the co-pay amount is factored into your total reimbursement for a service.
- Pre-authorize. If you perform a procedure that’s not covered in a patient’s contract, the money will sit in your Accounts Receivable forever. It’s not collectible, as you have performed a non-covered procedure.
Yes, the situation is daunting, and you may feel like the cards are stacked against you. Therefore, it’s critical in the current reimbursement milieu that you approach all contracts critically and analytically.

And please… don’t kill the messenger.

– Dr. Janevicius is the Society’s representative to the AMA CPT Advisory Committee.