How to prepare for the negotiations:

- **Step 1 – Create Your Fee Schedule List** Breakdown your annual productions into a specific subgroup of codes to target for raising fees in your specific office.

  Your goal is not to have an across the board increase but specific increases to your highest volume codes. This is your “Fee Schedule Hit List”. It’s typical that 30 codes make up 90% of a practice’s production.

- **Step 2 – Create Your Insurance Provider Call Sheet** Breakdown your annual production into different insurance providers so that you know the source of the majority of your production.

- **Step 3 – Familiarize Yourself with Your Direct Contracts, Shared Network Contracts, and Third Party Administrators** Analyze your direct contract rates for each insurance company versus the possible shared network contracts’ fee schedules.

  The Direct Contract takes place over the Shared Network Contracts if you have multiple in play. You want to make sure the Direct Contract is the highest fee so that you are paid your highest possible fee. For example, Connection Dental’s shared network contract fee schedule may or may not be a better fee schedule based on your “Fee Schedule Hit List” than the direct contract. Be sure to understand the intricacies of any third party administrators. It’s possible that what you originally agreed to may not be what you are receiving from your third party administrator. You can check your explanation of benefit statements to see if you are using a third party administrator/agreement.

- **Step 4 – Know Your Timeframes and What’s Allowed** A lot of insurance companies require a 24 month wait between contract changes.

  Certain insurance companies allow auto-increases and others allow you to use your “Fee Schedule Hit List” to really optimize your fee schedule and production.

  Quick tip: Set up calendar reminders to remind you when you can ask for increases.

- **Step 5 – Know Your State’s Laws** Find out if you are in a state that allows you to charge your full fee for non-covered services.
This is really important to know before going into negotiations so that you can make accurate decisions on what codes to focus negotiations on. For example, if you are in a state that allows you to charge your full fee on non-covered services and veneers are on your “Fee Schedule Hit List”, you don’t want to be negotiating veneers as they wouldn’t be covered anyways. If you are in a state that does not allow for the charging of your full fee for non-covered services you are still bound by the PPO fee even if the procedure is non-covered, so it’s worth it to keep it on your “Fee Schedule Hit List”.

Making the Phone Calls

- **Step 1** – Use Your Call List Take your list of insurance providers that do renegotiate and that are in the timeframe of being eligible to renegotiate.

- **Step 2** – Call the Provider Relations Line for the Insurance Provider Be prepared to have to dig through the company’s infrastructure to find the correct person and agent. Each insurance company will have different preferred methods of communication and procedures for starting the negotiations. This can sometimes take 5-10 phone calls. It’s important to take notes so that you’ll know the next time you contact the company; you’ll know precisely what to do.

- **Step 3** – You May Have to Wait Be prepared to wait an additional four to six weeks to be assigned an agent or rep if you’ve not been assigned one or don’t know who to contact directly.

- **Step 4** - Build a relationship with the agent. Remember, these agents are not customer service and are not connected to claims.

You're complaining about the way a claim was handled will not help your position. Over time you will learn the best way to speak and relate with each agent so that you can efficiently renegotiate and go through the hoops with the insurance company. It is very likely you will deal with the same agent/rep the next time you renegotiate with the practice.

- **Step 5** – Be prepared to wait. The process after the request has been made can take anywhere from a few weeks to a few months before knowing if the negotiations have come through.

- **Step 6** – Set calendar reminders It is very important to remember the next time you will be eligible for renegotiations.
Set as many reminders as possible to be sure to know the next time to contact the company for any contract changes. Any notes you have made about the process and or the agent you will want to save a copy of as well with the reminder so that you can skip some of the preparation the next time you contact the company.

- Step 7 – Rinse and Repeat Go back to step 1 and move onto the next insurance provider until you’ve finished your list.

**Deciding on Working with New Insurance Plans**

- Step 1 – Prepare a demographic report This is a snapshot to look at the major employers in your area and which insurance companies are tied to those employers.

- Step 2 – Prepare a write off comparison report Look at your insurance providers to see if any significant providers make up a significant amount of your production but have higher than average write off percentages.

- Step 3 – Look at alternatives Look at smaller alternative plans in your area that may have a lower write off production and see if you can possibly add multiple small plans to add to your patient base and start weeding out the plans that have the higher write offs.

- Step 4 – Prepare a Competition Report Look at how many other dental practices are in your area that are participating in any potential insurance plans so that you can see if the insurance provider may be saturated in your area.
Tracking Memos for Utilization Review/Case Management Department

Tracking memos should be used to follow up on requests that do not result in an immediate response. The tracking memos should provide the patient-specific information and date and time of the request, and should quote regulatory information regarding necessity of response. You may want to cite your state utilization review time frames in the tracking memos.
Attn: (Insurance Carrier)
A preservice health claim was filed with your company on: (date)

Patient:
ID:
Treatment Information:

Please be advised that ERISA requires the group health plan administrator to make a decision (adverse or not) involving a preservice health claim within a reasonable period of time, taking into account the particular medical circumstances, but no later than **15 days** after the receipt of the claim (**72 hours** for urgent care). The plan administrator may have a one-time extension (due to matters beyond the control of the plan) of up to 15 days, as long as the claimant is notified **prior** to the end of the initial 15-day period of the reason for the extension.

Further, group health plan administrators must advise either the provider or the beneficiary of an improperly filed preservice health claim within five days (**24 hours** for urgent care) of receipt of the preservice health claim.

For more information about the ERISA preservice response requirements, go to [www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html](http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html).

Please fax us a written response within 24 hours.

FOR INTERNAL USE ONLY:
DATE RESPONSE RECEIVED:
DISPOSITION:
Attn: (Insurance Carrier)

A concurrent health claim was filed with your company on: (date)

Patient: 
ID: 
Treatment Information: 

Please be advised that ERISA requires the group health plan administrator to provide notification of an adverse concurrent care decision “at a time sufficiently in advance of the reduction or termination.” If the concurrent care decision involves urgent care, the plan administrator must notify the claimant of the decision (adverse or not) within 24 hours after receiving the claim. In this case, the claim must have been made at least 24 hours before treatment was to end.

For more information about the ERISA concurrent care notification requirements, go to www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html.

Please fax us a written response within 24 hours.

FOR INTERNAL USE ONLY:
DATE RESPONSE RECEIVED: 
DISPOSITION:
Attn: (Insurance Carrier)

A preservice health claim adverse determination has been received related to the following request:

Patient:
ID:
Treatment Information:

Please be advised that ERISA benefits claim processing guidelines mandate that any decision to deny, reduce, terminate, or refuse payment for a benefit is an adverse benefit determination. This includes any decision on a preservice health claim or a denial because a benefit is found to be experimental or not medically necessary or appropriate. We wish to appeal this adverse determination based on the following medical criteria:

If the preservice claim remains denied, please furnish the name and credentials of the medical professional who reviewed the treatment records. This information is necessary to determine whether the medical professional maintains a medical license for this state in the same specialty as the treating provider. Also, please provide a detailed description of the medical criteria used to assess this request, an outline of the specific records reviewed, and a description of any records that would be necessary in order to approve the treatment. Further, we would appreciate copies of any expert medical opinions that have been secured by your company in regard to treatment of this nature and its efficacy so that the treating physician may respond to its applicability to this patient’s condition.

Group health plan administrators must advise either the provider or the beneficiary of any decision on a preservice health claim appeal within 30 days (72 hours for urgent care) of receipt of the preservice health claim. For more information about the ERISA preservice response requirements, go to www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html.

Please fax us a written response within the required time frame.

FOR INTERNAL USE ONLY:
DATE RESPONSE RECEIVED:
DISPOSITION:
Sample Letter for Requesting Managed Care Fee Schedule Renegotiation

Date

Attn: Provider Relations Representative
Insurance Carrier
Address

Re: Provider Name:
Provider Tax Identification Number:

Dear Provider Relations Representative,

This letter is to notify you that our contract with your company is nearing term or has expired. (Provider Name) has provided valuable medical services to your insured members during the term of the existing contract. According to our records, we have served approximately XX patients with (Insert Insurance Carrier Name) from (contract onset date) to (current date).

We would like to request a meeting to discuss fee schedule increases for the coming contractual term. As you are likely aware, a number of both commercial and governmental payers are increasing fee schedule allowances to offset medical organization operational costs.

Further, our office has implemented a number of quality improvement measures which we believe will result in improved care to your insured members:

- Clinical performance measurement implementation
- Patient Satisfaction Improvements (use of surveys, new locations, longer hours, organization of support groups)
- Staffing Improvements
- Technology Improvements

Please indicate your availability for this discussion. We look forward to renewing our contract with your company and providing uninterrupted high quality medical care through our partnership with your health plan.

Sincerely,

(Name)

Optional Request for Additional Disclosure

It appears that our office was not provided with the applicable fee schedule related to this contract or the applicable internal procedures for bundling, coding and outlier application which affect reimbursement. Therefore, we request that this additional reimbursement information be sent to us immediately. Disclosure of the information will allow us to more fully prepare for our upcoming discussion regarding this contract.