How Health Insurance Administrators Limit Professional Fees

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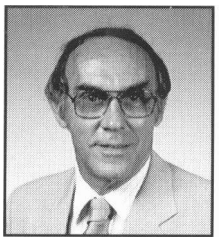
If I could pick just one topic in the health insurance spectrum on which to communicate understanding to auditors, it would be Reasonable and Customary (R&C). What we are talking about here is the predominant methodology used to control payments to professional providers. R&C normally has a greater impact on your company's cost than any other area of reimbursement. The paradox here is that concepts and related details surrounding R&C are not really that complicated yet, only a few auditors understand how it works and the cost implications that differences in methodology among health insurance administrators can mean.



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Why is R&C of great importance? It is because fee allowances can and do vary significantly between administrators for the same procedures performed on the same day by the same doctor. There are three reasons why R&C payments vary widely among administrators:

- Varying development criteria,
- Non-use of R&C for some medical services,
- Differing application to provider invoice methodology.

R&C Background

R&C limits payments to professional providers to the average of charges by all physicians during a prior historical period for each individual type of service as defined by the American Medical Association in their manual titled ***Cur-rent Procedural Terminology, 4th edition,*** or ***CPT-4.*** What this means is that this average is thk "customary" fee limit portion of R&C. Special extenuating circumstances that could lead to extra payment are the "reasonable" part of R&C. Some Blue Cross/Blue Shield Plans (Blue) also track individual doctors. The result of this tracking is referred to as "usual" and is reported by them as a UCR allowance. Some administrators employ the term "prevailing fee," which is merely another term for customary.

R&C is the successor methodology to the relative value system (RVS) approach, under which each medical service is assigned a point level to be multiplied by an area dollar value. RVS currently is the accepted methodology for determining anesthesia levels. Also, Medicare is using a version of RVS called Resource Based Relative Value System (RBRVS) to determine professional provider fee limits, which may presage a return to RVS for private business down the road. Many administrators now use RVS when they have insufficient occurrences to set R&C levels. An ongoing concern is that RVS dollar allowances often tend to be set high enough so as to pay provider charges in full.

Many of the larger administrators as well as most Blues develop their own R&C data, although data from other sources is available in the market place. Other administrators acquire data from outside agencies such as the Health Insurance Association of America (HIAA), which is a consortium of approximately 270 members active in the health insurance field. We believe administrative oversight of R&C from internally generated data is better, although we have seen instances where administrative control using outside source data was effective.

R&C Development

Administrators who develop their own data normally require 10 occurrences to justify development of an R&C level. Generally, they use the (statistical) mode and not the arithmetic mean or median to set R&C levels at the 100th percentile and then back off that number for the 90th, 80th and lower percentiles. This methodology leads to an interesting phenomenon in that clients that change from 100 percent of R&C to 90 percent of R&C do not reduce payment by 10 percent. The reason is that it is not uncommon for the 100th and the 90th percentile to be the same dollar level as illustrated in the following example:

Inpatient Hospital Visit
(charge per visit by 10 doctors)
$45-50-55-60-70-75-75-75-75-75

As you can see, reducing the percentile allowance from 100 percent to 90 percent does not change the mode fee limit of $75 for inpatient hospital visits. Physician payments will go down on an overall basis, but not by 10 percent.

Updating R&C Fee Limits

Use of different timing criteria to update R&C allowances can cause substantial differences in client costs. Some administrators update every six months, some every 12 months, and one administrator updates on an 18-month cycle. Obviously, those administrators updating every six months will have a greater payout on average since they are using more current provider charges.

Similarly, the quantity of data comprehended in an update will impact directly on allowance levels. While many administrators use the prior 12 months of history, others use 6 or 18 previous months.

Administrators that update every six months based on the most recent six months of history essentially are paying billed charges in full. We have measured differences in R&C levels of 15 percent between administrators for the same services.

Figure 1

Doctor Bill

CPT-4 Code	Service	Unit Charge	Number Services	Total Bill
11421	Lesions	$146	One	$146
11401	Lesions	$85	TWO	$170
			Total Bill	$316

Make no mistake about it. Establishing R&C dollar allowances is not a hit-or-miss proposition for many administrators. They can forecast the resultant percent payout in advance within a deviation of 0.5 percent. Our experience is that many administrators set dollar allowances for the 90th percentile so that the annual payout to professional providers approximates 93 percent of billed charges.

Paying Professional Providers

Different methodologies can be used to apply R&C to provider claims. Consider the different approaches used by administrators in paying the claim submitted by a professional provider. (see Figure 1). Note the difference in payment amounts although the same R&C allowances are used.

Some administrators "rebundle" or add up R&C levels for all reported services and allow payment in full if the sum of R&C allowances for covered services exceed total claim costs. In so doing, non-allowable services (not displayed here) often are rolled-in to the total payment (Figure 2).

Administrators using this approach would pay the above doctor bill of $3 16 in full because the sum of the R&Cs is $340. Contrast that method to the practice followed by other administrators who compare R&C to charges on a claim line-by-line basis, and only allow the lower of the two for each individual service and completely disallow non-covered services.

In Figure 3, a fee reduction is realized because the sum of the line-by-line comparisons of $296 is $20 less the doctor's bill of $3 16.

Both of the methodologies illustrated below are considered acceptable by the insurance industry. Companies that wish to minimize cost to employees should choose "rebundling" or totaling R&C allowances. Companies that wish to minimize corporate costs should opt for line-by-line comparisons.

Conclusion

Administrators more often than not do not communicate details of their R&C methodology to clients. It is important that you and your company make informed decisions about this vital area of your health insurance.

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Figure 2

Rebundling R&Cs Method
Payment Calculation

CPT-4 Code	Doctor Charge	R&C	Pay Up To	Payment
11421	$146	$190		
11401	$170	$150 (75x2)		
	$316	$340	$340	$316

Figure 3

Claim Line-By-Line Adjudication
Payment Calculation

CPT-4 Code	Doctor Charge	R&C	Allowance	Fee Reduction
11421	$146	$190	$146	
11401	$170	$150	$150	
	$316	$340	$296	***$20***