WHITEPAPER

Healthcare Contract Management and Payer Negotiations

Knowing What You Are Owed, and Being Able to Prove It

Most practices cannot state what they are contracted to be paid for their highest volume procedures. This guide covers building a contract inventory, verifying payment against it, and negotiating from evidence rather than from frustration.

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1. Executive Summary

Ask most practice owners what they are contracted to be paid for their highest volume procedure by their largest payer, and the answer is an estimate. Ask whether they are actually being paid that amount, and the answer is usually that they assume so.

That gap is where a substantial amount of revenue sits. Not in denials, which are visible and worked, but in payments that arrive looking correct and are not, and in rates that have not been examined since they were agreed.

The core finding

A practice cannot detect an underpayment it has no basis to measure against, and cannot negotiate a rate it cannot evidence.

Contract management is not a legal exercise. It is the operational discipline of knowing what you are owed, verifying that you received it, and being able to demonstrate your value when the terms are revisited.

2. Why Contract Management Is Usually Absent

- **Contracts are signed and filed.** The executed agreement goes into a drawer or a folder and is not referenced again until a dispute arises.
- **Fee schedules are separate from the agreement** and frequently updated independently, so the version on file is not the version in force.
- **Nobody owns it.** It sits between the practice owner, the administrator and the billing team, and defaults to nobody.
- **Renewals happen automatically.** Evergreen terms roll forward without review, sometimes for years.
- **The information required to negotiate is not assembled.** Volume, case mix, payer mix and quality data exist in separate systems and have never been brought together.
- **Practices assume they have no leverage.** Frequently untrue, and almost never tested.

Rarely reviewed
Most contracts roll forward unexamined

Silent loss
Underpayments arrive looking like payments

Untested leverage
Most practices never assemble their own data

3. Building the Contract Inventory

This is the prerequisite. Everything else depends on it, and most practices have never done it.

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For every payer, record	Why
Executed agreement and date	The governing document, and whether it is current
Current fee schedule and effective date	Frequently updated separately from the agreement
Term length and renewal mechanism	Whether it renews automatically and when it can be changed
Notice period for termination or renegotiation	Determines when you must act to have any leverage
Escalator provisions and effective dates	Annual increases frequently go unapplied by the payer
Carve outs and separately negotiated rates	Where they exist, they are often not being paid
Timely filing and appeal windows	Procedural deadlines that void otherwise valid claims
Claim volume and revenue by payer	Your actual position, and the basis for any negotiation
Denial rate by payer	Whether this payer costs more to work than others

Start with the top five payers by revenue

A complete inventory across twenty payers is a project most practices never finish. The top five by revenue usually account for the large majority of income and almost all of the negotiating opportunity.

Build those five properly, then extend. A partial inventory that exists is worth considerably more than a complete one that does not.

4. The Terms That Determine What You Are Paid

Rate is the term everyone examines. Several others affect net revenue as much or more.

- **The fee schedule basis.** A percentage of a published schedule behaves differently from fixed dollar amounts, particularly when the underlying schedule changes.
- **Escalators.** Annual increases with a defined effective date. Payers frequently fail to implement these on time, and the practice continues receiving prior year rates without noticing.
- **Carve outs.** Separately negotiated rates for specific procedures, implants or high cost items. Commonly agreed and commonly not paid.
- **Payment timeframes.** Clean claim payment obligations and what constitutes a clean claim under the agreement.
- **Timely filing.** A short window voids otherwise valid claims and is entirely procedural.
- **Appeal rights and windows.** Including whether internal appeal is required before external review.

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- **Policy precedence.** Whether payer medical and payment policies can override specific contract terms, which is a frequently overlooked provision.
- **Audit and recoupment rights.** The lookback period and the process by which the payer may reclaim paid amounts.
- **Termination provisions.** Notice period, and whether termination is available without cause.

The provision most worth reading carefully

Whether payer policy can override contract terms. Some agreements permit the payer to apply internal payment policies that conflict with specifically negotiated provisions.

Where that provision exists, a carve out you negotiated may be unenforceable in practice. This is a point for counsel before execution, not after a dispute.

Do You Know What You Are Actually Being Paid?

Our free RCM audit compares your payments against your contracted rates, identifies variances by payer and procedure, and shows you where revenue is being lost silently.

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5. Verifying Payment Against Contract

An underpayment is harder to detect than a denial because it arrives as a payment. The claim is marked resolved and leaves the active queue. Nothing flags it.

Cause	What happens
Fee schedule not updated after renegotiation	Payer continues paying prior rates. Very common after contract renewal
Escalator not applied	Annual increase agreed and never implemented by the payer's system
Carve out paid at standard rate	Separately negotiated procedure reimbursed at the general rate
Incorrect bundling	Separately payable services combined into one payment
Downcoding	Submitted code internally reduced without clinical basis
Duplicate adjustment codes	Multiple reductions applied to a single claim
Policy applied over contract	Payer policy overriding a negotiated term

Verification method

- Load current contracted fee schedules for your top payers into whatever system performs the comparison
- Compare each payment line from the remittance against the applicable contracted rate
- Flag variances above a set threshold for review, prioritised by dollar value
- Look for patterns. A systemic error affecting hundreds of claims is worth far more than an individual variance
- Dispute inside the contractual window, which is commonly ninety to one hundred and eighty days
- Include the remittance, the contract provision and the fee schedule in the dispute

6. Preparing for a Negotiation

Preparation determines the outcome more than the conversation does. A practice that arrives with assembled evidence is negotiating. One that arrives with a request is asking.

Assemble	Why it matters to the payer
Volume by procedure and by payer	Establishes your actual significance to them
Case mix and complexity	Distinguishes you from a lower acuity provider
Geographic position and access	Network adequacy is a genuine payer obligation

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Assemble	Why it matters to the payer
Quality and outcome data where available	Directly relevant under value based arrangements
Cost of care comparisons where favourable	Particularly potent for ASCs against hospital outpatient
Patient satisfaction data	Supports network value beyond price
Your current rates against benchmarks	Establishes whether the ask is reasonable
Denial and administrative burden data	Administrative cost is a legitimate negotiating point

The argument payers respond to

Network adequacy. A payer must maintain sufficient providers in each specialty and geography to meet its obligations.

If your departure would create an access problem, that is leverage, and it is measurable rather than rhetorical. Establish it with data on geography, specialty availability and patient volume before the conversation.

7. What Is Actually Negotiable

Term	Negotiability	Note
Overall rate	Moderate	The hardest single ask. Often better approached selectively
Rates on specific high volume procedures	Higher	A narrower ask is more achievable than a general increase
Carve outs for implants and high cost items	Higher	Frequently agreed where cost evidence is presented
Annual escalators	Moderate to high	Often conceded when a general increase is not
Timely filing window	Moderate	Procedural and lower cost to the payer
Appeal windows and process	Moderate	Administrative, and often negotiable
Payment timeframes	Moderate	Cash flow relevant and sometimes overlooked
Policy precedence provisions	Low to moderate	Worth attempting. Significant if achieved
Audit lookback period	Low	Rarely moved but worth understanding

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The second and third rows are where most practices should concentrate. A general rate increase is the hardest thing to obtain. A rate adjustment on three specific high volume procedures, supported by cost and volume evidence, is a different and far more achievable conversation.

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8. Conducting the Negotiation

- **Start early.** Notice periods determine when you have leverage. A conversation opened thirty days before automatic renewal has none.
- **Lead with evidence, not frustration.** Volume, quality and access data. Payer representatives respond to a business case and disregard a complaint.
- **Be specific.** Name the procedures, the current rates and the requested rates. A general request for better terms produces a general refusal.
- **Ask for something the payer can give.** A representative who cannot authorise a rate increase may be able to authorise an escalator or a carve out.
- **Know your position if they decline.** Understand what leaving the network would cost you and what it would cost them, before you need to.
- **Get everything in writing**, including the effective date, and verify implementation in the first remittances after it takes effect.
- **Expect it to take months.** Payer contracting moves slowly. Build that into the timeline.

The step most practices omit

Verifying that an agreed change was actually implemented.

Fee schedule updates lag renegotiation routinely. A practice that negotiates an increase and does not check the next remittance may continue receiving old rates for months, having done all the work of the negotiation and captured none of the benefit.

9. Evaluating a Contract You Are Offered

- **Model the rates against your actual case mix**, not against the procedures highlighted in the offer. A favourable rate on a procedure you rarely perform is worth nothing.
- **Identify what is packaged.** Items you assumed separately billable and are not represent absorbed cost on every case.
- **Check whether implant or high cost item terms exist** if your case mix includes them.
- **Read the policy precedence provision** before anything else in the fine print.
- **Note the administrative burden.** A payer with a high authorisation requirement and a high denial rate costs more to serve than the rate alone suggests.
- **Understand termination and notice terms** before signing, not when you want to exit.
- **Have counsel review it.** The operational analysis here is not a substitute for legal review.

10. Ongoing Contract Governance

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Activity	Frequency	Owner
Verify payments against contracted rates	Monthly	Billing or RCM partner
Review variance patterns by payer	Monthly	Practice administrator
Check escalators took effect	At each effective date	Practice administrator
Review notice periods and renewal dates	Quarterly	Practice administrator
Update fee schedules on file	On every change	Billing or RCM partner
Review payer performance scorecards	Quarterly	Practice owner
Full contract review	Annually	Practice owner with counsel

A payer performance scorecard tracking rate position, denial rate, payment accuracy and days to payment turns contract management from an occasional event into an ongoing discipline, and it produces exactly the evidence a renegotiation requires.

11. Self Assessment

Inventory

- ☐ We hold the executed agreement and current fee schedule for our top five payers
- ☐ We know the renewal date and notice period for each
- ☐ We know which contracts contain escalators and when they take effect
- ☐ We know which contracts contain carve outs
- ☐ A named person owns contract management

Verification

- ☐ Payments are compared against contracted rates systematically
- ☐ Variances above a threshold are reviewed and disputed
- ☐ We check that escalators were actually implemented
- ☐ Disputes are filed within the contractual window

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Negotiation readiness

- [ ] We can produce volume by procedure and by payer on request
- [ ] We know our rate position relative to available benchmarks
- [ ] We have assessed our network adequacy position
- [ ] We track denial rate and administrative burden by payer

Governance

- [ ] Renewal dates are calendared with notice periods flagged
- [ ] Fee schedules on file are updated whenever they change
- [ ] A payer performance scorecard is reviewed quarterly
- [ ] Contracts are reviewed by counsel before execution

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12. Frequently Asked Questions

How do we know whether we are being underpaid?

By comparing each payment received against the contracted rate for that procedure and modifier combination, and investigating variances above a set threshold. Underpayments arrive as payments, so the claim is marked resolved and leaves the active queue. Without systematic contract to payment comparison there is no mechanism to detect insufficiency, which is why this loss persists in practices that manage denials well.

Do small practices have any negotiating leverage?

More often than they assume, though it is rarely the leverage they expect. A small practice is unlikely to move a payer on a general rate increase. It may well move them on a specific procedure where it holds meaningful local volume, on an escalator, on a carve out for a high cost item, or on network adequacy grounds where its specialty and geography make it difficult to replace. The narrower and better evidenced the ask, the higher the success rate.

When should we start a renegotiation?

Well before the notice period expires, which usually means starting six to nine months ahead of the renewal date. Payer contracting moves slowly and a conversation opened thirty days before automatic renewal has no leverage at all. Knowing your notice periods and calendaring them is the practical prerequisite, and it is the step most commonly missed.

What is the most overlooked contract provision?

Whether payer medical and payment policies can override specific contract terms. Some agreements permit it, which can render a negotiated carve out unenforceable in practice. It is a point for counsel before execution rather than a discovery made during a dispute. Timely filing windows run a close second, because they are purely procedural and they void otherwise valid claims.

Should we hire counsel for payer contracts?

For review before execution, yes. The operational analysis described here identifies whether the commercial terms work for your case mix. It does not substitute for legal review of enforceability, termination rights, indemnity, audit and recoupment provisions. The cost of review is small relative to the cost of a provision that turns out to be unfavourable across a multi year term.

13. How StafGo Health Helps

StafGo Health is a USA physician-owned revenue cycle management company working with medical and dental practices nationwide. Contract management connects directly to payment integrity, which is why we treat them as one function rather than two.

- **Contract inventory development.** Assembling agreements, fee schedules, renewal dates, notice periods and escalators into a usable register.

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- **Payment to contract verification.** Automated comparison of every payment against contracted rates, with variances flagged and prioritised by value.
- **Underpayment recovery.** Dispute preparation, filing within contractual windows, follow up and resolution tracking.
- **Negotiation preparation.** Assembling volume, case mix, denial burden and rate position data into the evidence a negotiation requires.
- **Payer performance scorecards.** Rate position, payment accuracy, denial rate and days to payment tracked by payer.
- **Fee schedule maintenance.** Keeping loaded schedules current so verification stays accurate.

Know What You Are Owed, and Prove It

In 30 minutes we will review your payment accuracy against contracted rates and show you where revenue is being lost without anyone noticing.

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