The Soft Ask

QUICK REFERENCE • Revisit vs. Renegotiate • The Two-Hour Grid • The Ask • Sizing the Win • Traps

Pediatric Management Institute
Helping Pediatricians Succeed
www.PediatricSupport.com

1 | TWO MENTALITIES | REVISIT VS. RENEGOTIATE

Getting a payer to market rate on your biggest codes without opening a full renegotiation

10 × 4–5	< 2 hours	$37 → $35	< 80%	80+%
codes × your largest commercial payers — one grid of last-EOB allowed amounts	to build that grid from EOBs the practice already has on file	illustrative — ask just under what the market already pays for the code	of your best commercial rate on a code is your strongest soft-ask line	of total rate opportunity sits in the top 10 codes

	THE SOFT ASK · REVISIT THE RATES	THE FULL RENEGOTIATION
Framing to the payer	"We don't want a total revamp — we just want an update to market rates on these codes."	"We are renegotiating the agreement." The whole fee schedule and the contract terms are on the table.
Scope	4–6 high-impact codes drawn from the 10-code grid: the sick-visit E&Ms, the well-visit bands, the first vaccine-admin code	Every code on the schedule, plus clauses — reference year, amendment rights, carve-outs, recoupment lookbacks
Evidence	Your own EOBs from your other major payers, in one internal grid	Payer transparency files: specialty-peer percentiles by code, volume-weighted, inside a six-component data package
The number you ask for	Just under the best rate already paid for that code — if you know that the payer is paying someone in town $37, ask for $35	Higher: the 75th percentile of the filtered specialty peer set, tiered aggressive / moderate / hold
Time to prepare	Under two hours	Weeks of analysis — the file opens 9–12 months before renewal
Who does it	Practice manager or owner, through the payer's provider relations contact	Manager runs the file · owner at chosen moments · if practice needs help, a consultant when the fee is a fraction of the modeled lift
Leverage it needs	Your annual volume with the payer, and being below market on the codes you name	A walk-away floor fixed before first contact, and a real willingness to walk
Typical outcome	The gap to market on your biggest codes — a few percent when the payer is close, much more when one payer trails everyone else	A larger lift after a longer, riskier fight
Use it when	First, any month of the year — payers change rates mid-term whenever they choose, so the request does not wait for a renewal window. Try it before paying anyone to negotiate on the practice's behalf.	The soft ask stalls · the grid shows the payer far below market across the board · a renewal window is already open

PMI'S RULE NUMBER ONE

"It depends on how hard you're willing to fight. It's not a negotiation if you're not willing to walk away."

- **That rule governs the full renegotiation.** The soft ask carries no termination notice — it gives the payer an easy way to say yes. The lowest payer's request can carry one more sentence: decline, and the practice will seek to renegotiate the full schedule.

WHY START WITH THE REVISIT

- **Two very different mentalities.** Revisiting asks to be brought to market. Renegotiating asks for more.
- **The payer already knows** what your other contracts pay. A grid of your own EOBs gives you the same view.
- **A full negotiation** means weeks of data work.
- **Try 'The Soft Ask' before paying someone** to do it for you.

ESCALATE TO A FULL RENEGOTIATION WHEN

- **The no holds.** After two or three rounds of follow-up the answer is still no and nothing has been offered.
- **The grid shows the payer far below market** across the board — code after code under 80% of your best rate.
- **A renewal or notice window is open.** Notice windows commonly run 30–90 days prior to renewal.
- **The payer is low-rate and high-friction.** Denials, payment lag and aged A/R act as a second price cut.

2 | THE TWO-HOUR GRID

10 codes × your 4–5 largest commercial plans, from your own EOBs · then let the grid tell you

BUILD IT · SIX STEPS

- **1. Pick 10 codes.** The two sick-visit E&M codes, the well-visit age bands and the admin codes — together they carry the overwhelming share of the rate increase opportunity.
- **2. Columns = your 4–5 largest commercial payers** — the target payer plus the plans you compare it with, such as Anthem/BCBS, Aetna, Cigna and United.
- **3. Each cell = the allowed amount on the last EOB** for that code from that payer.
- **4. Add trailing-12-month units** per code — the column that turns a rate gap into dollars.
- **5. Mark the best rate in each row** and where the target payer ranks.
- **6. Divide target by best.** Under 80% on a code is your strongest soft-ask line.

THE GRID · 10 CODES × YOUR TOP PAYERS

CODE	Anthem/BCBS	Aetna	UHC	Cigna
99213				
99214				
99391				
99392				
99393				
90460				
90461				
90471				
96110				
96127				

Each cell = the allowed amount on the last EOB from that payer. Swap in your own largest payers.

READING THE GRID

- **Second place or lower on a code = below market.** Make the case one code at a time.
- **It may not be across the board.** Ask only on the codes where the target payer trails.
- **The grid stays inside the practice.** The one-pager states the gap without quoting another payer's contract.
- **Under 80% of your best rate on one code** is your strongest soft-ask line; under 80% across most of the grid is the escalation trigger.
- **Physician-rendered claims only.** A growing share of contracts pay APP services at a discount, most commonly 85% of the physician rate; a mixed column understates the payer.
- **Same payer, same code, two providers more than 10% apart** — two products on different fee schedules, or a linkage or credentialing error; confirm which on the EOB before any ask. Providers credentialed under the group contract may not appear by name in payer data.
- **The sturdier version** uses the median payment across fully adjudicated lines, partials and denials excluded.
- **Public fee schedules are statewide** — too coarse for a code-level ask.

3 | THE ASK ITSELF

Just under market, on the codes that trail · through provider relations

TAILOR THE NUMBER

- **Two ways to set the number.** Just under your best payer's rate for the code (your best payer pays $37 for 90460; ask this one for $35), or just under what this payer pays other local pediatricians in its public transparency file. Say "below market" and leave which market unstated.
- **"We're not asking to be paid more than everybody else."** Give the payer an easy way to say 'YES'.
- **Only the codes that trail.** Where the payer already leads, treat the code as a hold. Skip any code where your ask would land above what the payer pays other practices in town — it stops being an easy yes.
- **Two tones.** Collegial for a payer that leads your grid but trails its peers; firm for the one at the bottom.

THE REQUEST, IN WRITING

- **The codes.** The 4–6 codes found below market, with the payer's current rate on each.
- **The number.** The requested rate per code — just under market, set as in the panel to the left.
- **The date.** An effective date about six weeks out, so the payer has time to load the schedule.
- **All products.** The new rates apply to every product under the agreement.
- **The window.** A response requested within a stated period — PMI uses 10 working days.

ROUTE AND WEIGHT

- **Go through provider relations.** The payer should already know who you are in the market.
- **Finding the rep:** the notice or contact clause in your contract · the provider-relations line on the payer's website · the appeals number your billing team already calls · a colleague in your IPA, PHO or network who has a name.
- **Direct or through an IPA?** The contract route decides who holds the rates and whose termination clock governs.
- **Know your weight.** The same letter gets a different answer from a six-location group than from a single site — which is why the soft ask, not a termination notice, is a small practice's first move. It does not always work; the cost of asking is one email.

AFTER YOU ASK

- **The first answer is no.** Ask what would support an increase and which codes have flexibility.
- **Get any counter in writing** and model it at full volume before replying.
- **Follow up every 2–3 weeks and log every contact** — unanswered correspondence is escalation material.

THE ONE PAGE THE REP CARRIES. The provider relations rep takes your request, so hand over a page: the codes you are asking on, the payer's current rate on each, your ask, trailing-12-month units and the annual dollars at your volume. **Add a short practice profile** — years in the community, clinicians and hours, the share of the payer's covered children in your care. The numbers show the rate is below market; the profile argues the practice is worth keeping.

4 | SIZING THE WIN

The unit that moves a payer is annual dollars · every dollar figure below is a worked example

(Your Ask – Current Rate) × Trailing-12-Month Units = Annual Dollars, Per Code

Run it for every code on the grid, then sum the rows. Worked example: 99392 paid at $128, ask $140, 1,850 units a year = **$22,200 a year from one code**.

THREE ILLUSTRATIVE ROWS

CODE	THE NUMBERS	WHAT IT MEANS
99392	$128 now · $140 ask · 1,850 units	$12 × 1,850 = $22,200 a year
90460	Market pays $37 · ask $35	Just under market — an easy yes
99213	$72 median vs. $95 at the best carrier	76% of best — the strongest line on the grid

WHICH PAYER TO ASK FIRST

- **Rank payers by revenue per wRVU.** Typical pediatric spread: $35–$60. A payer at $58 pays about 66% more than one at $35 for the same clinical work.
- **Ask the lowest payer and the next one up in the same week.** A yes from the better payer funds the hard choice on the worst one.

WHY SMALL PERCENTAGES ARE MATERIAL

- **Incremental increases on a high-volume code** are material.
- **The top 10 codes typically carry 80+%** of total opportunity, so the whole ask fits in a one-page table.
- **It cuts the other way too.** A payer trim to vaccine administration repeats on every shot visit, all year.
- **Illustrative settlement:** +6% on a payer paying $410,000 a year = +$24,600 a year, essentially all margin.
- **Price the friction too.** A low-rate payer with high denials, lag and aged A/R cuts price twice — its friction file becomes the dossier.

STATED VS. EFFECTIVE · CHECK BEFORE YOU ASK

Effective multiplier = actual average payment as a % of current Medicare, volume-weighted. Investigate any gap over 3 points against the contract's headline.

- **Count units, not claim lines** — a multi-unit line counted once overstates the multiplier. Confirm the export carries units before dividing.

GAP CAUSE	WHAT IT LOOKS LIKE
Carve-outs	Multiplier on E&M only; admin paid flat (e.g., $22), screens at 90% of Medicare
Frozen reference year	A stated 140% worth ~133% of current Medicare after four years
Down-coding, bundling	99214s paid at the 99213 allowable
Plain underpayment	Including one provider linked to the wrong fee schedule

5 | WHEN THE SOFT ASK ISN'T ENOUGH

PMI's rule: it's not a negotiation if you're not willing to walk away · set the floor before the first call

THE SIX-COMPONENT DATA PACKAGE

1	**Contract file**	Agreement, every amendment, operative fee schedule, renewal date, notice window
2	**Your numbers**	Trailing-12-month volume, revenue and wRVUs with this payer; effective vs. stated multiplier; denials, lag
3	**Quality story**	Well-visit, immunization and screening rates; after-hours access; the payer's own HEDIS-fed metrics
4	**Panel**	Patients by age, zip, language, employer concentration
5	**Market benchmark**	Transparency percentiles, code by code, volume-weighted
6	**Narrative**	One page a medical director can read in 3 minutes

The practice profile from section 3 goes on top. A payer that drops a practice caring for 4,000 of its members has a potential network-adequacy problem.

THE TIERED ASK

- **Anchor at the 75th percentile** of the filtered specialty peer set: groups of more than ~5 providers, deduplicated, your own rows excluded.

TIER	WHERE THE CODE SITS
Aggressive	Below the specialty-peer median
Moderate	Specialty median to overall 75th percentile
Hold	At or above the 75th — named and defended

- **Fix three numbers before first contact:** opening ask, settlement range, walk-away floor.

WHO	THEIR PART
Manager	Runs the file, the correspondence and the follow-up cadence
Owner	The medical-director conversation and the final session
Consultant	When the fee is a fraction of the modeled lift; the practice still owns its data

Without the volume model, a negotiator argues with adjectives.

THE CALENDAR · RENEWAL = T

WHEN	ACTION
T–12	Contract file read; renewal and notice dates confirmed
T–11/10	Transparency extract, peer percentiles, volume model
T–9	Data package; ask, range and floor set with the owners
T–8	Proposal through the payer's channel; contact log opened
T–7/6	Follow up every 2–3 weeks; counter requested in writing
T–5/4	Counters modeled at full volume; escalate
T–3	Settle inside the range, or run the walk-away analysis
Notice	Sign, or deliver notice — windows commonly 90–180 days
T+0	Load new rates; audit the first 90 days of remittances

Opening the file 60 days out means accepting the payer's terms. Stagger renewals.

THE WALK-AWAY FLOOR, BUILT FIRST

- **Start from contribution margin:** payments less the incremental cost of that payer's volume.
- **Model backfill scenarios.** Illustrative model, year-one net on a $410,000 payer:

Settle +6%	**+$24,600**
Exit, 65% backfill	**–$41,000**
Exit, 35% backfill	**–$128,000**

- **The math usually argues for patience.** Any settlement at or above current rates beats the best exit in that model; it flips for a practice at capacity with a 6-week new-patient wait.
- **Share the scenario table with the partners** before the campaign. It pre-authorizes the negotiator.
- **Leverage belongs to practices with waiting lists** — payers can see network utilization.
- **Escalation ladder:** rep → network manager → medical director → state insurance department where prompt-pay rules are broken.

6 | TRAPS | HOUSEKEEPING

A negotiated rate is money only once it is loaded into expected-pay tables and audited

TRAP · THE COUNTER-OFFER

- **Evaluate every counter across ALL code families** at actual volumes. The classic pediatric version: an attractive E&M increase paired with a vaccine-administration trim that nets negative.
- **Payers read counters as trades** and fund increases by trimming the codes a practice forgets to protect. Name your hold codes.
- **Distrust the headline.** A line-by-line schedule can pay 130% of Medicare on rarely billed codes and 105% on top preventive codes.

TRAP · NEVER COORDINATE RATES

- **Compare your own contracted rates across your own payers.**
- **Never share, compare or agree on rates with other practices.** Payer contracting is exactly where antitrust law is enforced.
- **Reading a payer's published rates is price-checking,** the way one restaurant knows what another charges. Agreeing on rates with another practice is the line.
- **What a practice may share depends on its state and its structure** — an independent practice, an IPA and a clinically integrated network each answer differently. Ask the practice's attorney before sharing anything; a question up front costs far less than a defense afterward.

CLAUSES THAT MOVE THE RATE

- **Frozen reference year** → "current year."
- **Unilateral amendment** → mutual consent. Until then, silence is signature.
- **Automatic renewal** → a fixed term. An evergreen clause rolls the schedule over untouched; a term that expires forces the payer back to the table before it does.
- **All-products** → product-by-product participation.
- **Lesser-of clause:** a charge set below an allowable caps your own payment.
- **Default rate** for unpriced codes (e.g., 80% of billed charges) governs every new code at launch.

HOUSEKEEPING

- **Get every offer in writing** and log every contact.
- **Load new rates into expected-pay tables** and audit the first 90 days of remittances line by line.
- **Amendment mail is a contract event** — read, price, accept or object within the window.
- **Contract inventory,** one row per agreement — dates, notice window, evergreen or fixed term, fee-schedule year, amendments; review quarterly.
- **Once a year, same month,** rebuild the grid and send the request to the lowest-paying contract. PMI does it in August.
- **Where the practice spends money to bring patients in,** start with the better-paying payer's members. The spread between payers on the same visit can run 30%.

RATE PANEL FAMILY	CODES	RATE PANEL FAMILY	CODES
THE ~40-CODE PEDIATRIC RATE PANEL · THE SAME CODES FOR EVERY PAYER, RECORDED AT SIGNING AND UPDATED AT EVERY AMENDMENT			
Office visits	99203 · 99204 · 99213 · 99214	**Preventive series**	99391–99395 · 99401
Vaccine administration	90460 · 90461 · 90471–90474	**Screens**	96110 · 96127 · 96160 · 96161
Newborn and hospital	99460 · 99462 · 99463 · 99238 · 99239	**Vaccines**	Representative products: MMR · HPV · IPV · a combination product such as Pentacel
In-office labs	36416 · 81002 · 85018 · 83655 · 87880 · 87804 · 99000 · occult blood · cholesterol · RSV antigen	**Why keep it**	At signing it makes the payer commit numbers in writing · in operation it seeds expected-pay tables · at renewal it is the payer-by-payer comparison on one page

Abstract every contract the same way — at signing (about an hour) and at every amendment (about 20 minutes): direct or IPA/CIN, which year's Medicare, line-by-line or blended, escalators, vaccine pricing formula and update frequency. **Credentialing runs 60–150 days:** start enrollment the day a clinician signs, and ask the payer to complete within 45 days or grant provisional status.