

American Medical Association

Physicians dedicated to the health of America



Model Managed Care Contract

With annotations and supplemental
discussion pieces

Third Edition

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Table of Contents

Introduction	iii
Model Managed Care Contract	1
Addendum – Physicians Beware of these Common Managed Care Contract Clauses	36
Supplement 1 – Medical Necessity	39
Supplement 2 – Silent PPOs	41
Supplement 3 – “All Products” Provisions	44
Supplement 4 – Capitation and Risk	46
Supplement 5 – Discounted Fee-for-Service	53
Supplement 6 – Downcoding and Bundling of Claims	56
Supplement 7 – Coordination of Benefits	66
Supplement 8 – Late Payment	69
Supplement 9 – Retrospective Audits	72
Supplement 10 – Bankruptcy and Other Financial Failures	74
Supplement 11 – Subrogation	76
Supplement 12 – Credentialing	78
Supplement 13 – Patient Record Confidentiality	81
Supplement 14 – Termination “Without Cause”	84
Supplement 15 – Dispute Resolution: Arbitration vs. Litigation	86
Supplement 16 – Restrictions and Obligations Post-Termination	89

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GEB:02-442:2M:12/02

Introduction to the Third Edition

In late 1997, the American Medical Association (AMA) unveiled the first edition of the AMA Model Managed Care Contract. In the five years since the first edition was released, it has had a significant impact, both as an educational tool for physicians and as a tool for medical societies in work with regulators and legislatures. The genesis of the AMA Model Managed Care Contract was the increasingly onerous contracts that managed care organizations (MCOs) present to physicians on a take-it-or-leave-it basis. This practice has continued unabated.

In many respects, managed care contracts increasingly exhibit the elements associated with “contracts of adhesion”—a standardized contract that gives the weaker party only the opportunity to adhere to the contract or reject it. Many MCOs make the material terms—such as the services to be provided and the compensation to be paid—wholly illusory. Others inappropriately inject the MCO into clinical decisionmaking through their definitions of “medical necessity” and other terms. The AMA Model Managed Care Contract is designed to offer a reasonable alternative to these one-sided contracts. This approach balances the rights and obligations of both parties and protects the patient-physician relationship.

In 2000, the AMA released the second edition of the AMA Model Managed Care Contract, which was expanded to address important issues that emerged since 1997, including the increasing use of “all products” provisions by MCOs, the “renting” of physician discounts to third parties through “silent PPOs,” and the increased prevalence of “downcoding” and “bundling” of claims. The second edition included sixteen supplement-

tal pieces addressing these and a number of other important issues physicians must understand when signing a managed care contract, such as prompt payment of claims, capitation, and termination.

This, the third edition of the AMA Model Managed Care Contract, is very similar to the second edition. We have revised Article IX, Dispute Resolution, in response to gross mischaracterizations of the Model Managed Care Contract by health insurers that are defendants in class action lawsuits brought by physicians challenging abusive business practices. Those health insurers contend that the AMA Model Managed Care Contract “favors” arbitration, which is untrue. The AMA Model Managed Care Contract does not take a position on whether arbitration or litigation is a preferable dispute resolution mechanism and, in fact, permits both options. For the same reason, Supplement 15, “Mediation and Arbitration” has been substantially revised and retitled “Dispute Resolution: Arbitration v. Litigation.” Other supplements have been revised to reflect legal and other developments in the past two years.

The AMA strongly urges physicians to carefully review and understand any managed care contract they are considering signing. Provisions in the contract that are often glossed over at the time of signing suddenly spring to life in new and often unpredictable ways when a controversy arises that requires interpretation or clarification.

The AMA is very concerned that in response to growing criticism of their contracts, MCOs have “cleansed” their contracts by removing objectionable provisions and practices from the contract

and moving them into policy and procedure manuals that are “incorporated by reference” into the contract. Physicians should insist on obtaining copies of MCO policies and procedures and should review these policies and procedures as part of the contract review. These policies and procedures typically address a wide array of patient care and other important issues and may be considered part of the contract. If the MCO refers to materials available at the MCO’s Web site, the physician should request a password and review all of these materials before signing.

The AMA continues to monitor new and potentially harmful trends in managed care and to battle aggressively against abusive MCO business practices. In its ongoing efforts to help physicians level the playing field, the AMA will continue to bring physicians the most current information. The AMA’s Private Sector Advocacy unit is collecting physicians’ concerns about abusive managed care practices through the *AMA’s Health Plan Complaint Form*. The easy-to-use form can be accessed at www.ama-assn.org/go/psa.

American Medical Association Model Managed Care Contract

This contract is designed for the broadest possible application between physicians and managed care organizations (MCOs). It can be entered into by an individual physician, his or her professional corporation, a group practice, or physician network. As a result, the phrase "Medical Services Entity" stands for the physician entity (e.g., individual, corporation, group practice, network), while the phrase "Qualified Physician" refers to an individual physician within the entity. The annotations (in bold italics) refer more informally to "physician" or "physician group/network." Where the contract is with an unincorporated individual physician, that physician is both a Medical Services Entity and a Qualified Physician. This agreement is not intended for use between a physician group or network and an individual physician.

THIS AGREEMENT, made this ____ day of _____ 200_ and made effective on the ____ day of _____, 200_ ("Effective Date") by and between [a physician] [a medical group practice] [a physician joint venture, such as a Network or IPA] _____ ("Medical Services Entity"), and _____ a [state of incorporation] Corporation ("Company") (Medical Services Entity and Company jointly the "parties").

Witnesseth:

This section, known as the "recitals," will vary from arrangement-to-arrangement. The recitals describe the intentions of the parties in entering into the agreement. The recitals should be changed to fit the specific facts. Recitals generally are not an enforceable part of the contract, but they may be very important to a judge or arbitrator in interpreting the contract. Therefore, care should be taken that the recitals are set forth accurately and completely.

WHEREAS, Company offers or directly administers one or more health benefit products or plans and wishes to arrange for the provision of medical services to enrollees of such products or plans.

WHEREAS, Medical Services Entity is comprised of or contracts with one or more physicians capable of meeting the credentialing criteria of Company.

WHEREAS, Company desires to engage Medical Services Entity to deliver or arrange for the delivery of medical services to the Enrollees of its plans.

WHEREAS, Medical Services Entity is willing to deliver or arrange for the delivery of such services on the terms specified herein.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and other good and valuable consideration, the parties hereby agree as follows:

I. Definitions

Definitions matter. They are one of the most critical elements of the agreement. A right or responsibility may begin and end with the definition of a term. The difference between a liberal and narrow definition of “medically necessary” or “emergency services” could mean the difference between the MCO approving and paying for a patient’s procedure or refusing to pay. In addition, for example, an expansive definition of “Payors” may allow unscrupulous MCOs to create “silent PPOs” by “renting” discounted physician services to other entities not a party to the contract without the knowledge of physicians.

1.1 Claim. A statement of services submitted to Company by Medical Services Entity following the provision of Covered Services to an Enrollee that shall include diagnosis or diagnoses and an itemization of services and treatment provided to Enrollee.

1.2 Company Notice. A communication by Company to Medical Services Entity informing Medical Services Entity of the terms of one particular Plan, modifications to the Plan, and any other information relevant to the provision of Covered Services pursuant to this Agreement.

1.3 Company Compensation. The Total Compensation less that portion designated by the Plan as a Copayment.

1.4 Coordination of Benefits. The determination of whether Covered Services provided to an Enrollee shall be paid for, either in whole or in part, under any other private or government health benefit plan or any other legal or contractual entitlement, including, but not limited to, a private group indemnification or insurance program.

1.5 Copayment. A charge that may be collected directly by a Medical Services Entity or Medical Services Entity’s designee from an Enrollee in accordance with the Plan.

1.6 Covered Services. Health care services to be delivered by or through Medical Services Entity to Enrollees pursuant to this Agreement. A description of the medical services that are covered by the applicable products or plans is attached to this Agreement as Exhibit A.

1.7 Emergency Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention, to result in (a) placing the patient’s health in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part.

The definition of emergency medical condition in managed care agreements accounts for many payment disputes, and MCOs often have denied payment based on the fact that what appeared to be a medical emergency to all parties present, was not, in fact an emergency in the view of the MCO after the fact. The “prudent layperson” standard in Section 1.7 protects patients and physicians and prevents payment disputes by acknowledging the common sense of the prudent layperson in determining whether his or her condition requires immediate medical attention. An acceptable alternative to the “prudent layperson” standard is a “prudent physician” concept adopted by the American College of Emergency Physicians that defines “emergency medical condition.” The latter standard defines “emergency medical condition” as one that would be recognized as urgent in the judgment of a prudent physician who has the information the treating physician had at the time a course of treatment was being decided.

1.8 Enrollees. Any individual(s) entitled to health care benefits under a Plan who presents an identification card that contains the following information: (i) the name of the Payor; (ii) the Enrollee’s name; (iii) the logo of the plan or product; (iv) contact information for pre-authorization, if necessary; (v) the billing address; and (vi) the applicable Plan.

1.9 Medically Necessary/Medical Necessity. Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.

The definition of “medical necessity” in Section 1.9, which is AMA policy, relies on an objective “prudent physician” standard for medical necessity determinations and does not consider cost in making that determination. Generally, MCOs will not pay for care that is not “medically necessary.” However, many managed care contracts allow the MCO medical director to determine what is “medically necessary” according to vague standards that allow the medical director to override the physician’s clinical judgment. At the same time, the MCO disclaims any legal responsibility for these decisions. Many of these same agreements impose a “least cost” standard as well, thereby inappropriately interjecting financial considerations into a clinical decision. This definition relies on what would be believed necessary by the average, prudent physician faced with a diagnosis or condition. For answers to questions physicians frequently asked about medical necessity, see Supplement 1.

1.10 Non-Covered Services. Health care services that are not Covered Services as defined herein.

1.11 Payor. The entity or organization directly responsible for the payment of Company Compensation to the Medical Services Entity under a Plan. With respect to a self-funded Plan covering the employees of one or more employers, the Payor shall be the employer(s) and/or any funding mechanism used by the employer(s) to pay Plan benefits. With respect to an insured Plan or Plan providing benefits through a health maintenance organization, the Payor shall be the insurance company or health maintenance organization, as the case may be. Under no conditions shall the parties interpret “Payor” to be, nor shall the negotiated rates herein described be accessible to, any party other than Company or an employer offering a self-funded, non-indemnity product that contracted with Company to administer such product.

The definition of “Payor” in Section 1.1 provides a reasonable amount of flexibility consistent with the reality that in some cases, the MCO will be providing an insured product, and in other cases, the MCO will be administering a product for a self-funded employer plan. In the second case, the self-funded employer is actually the payor. However, this definition makes clear that the MCO cannot “sell” or “rent” the terms of the agreement (including the physician’s discounted services) to other entities—thus preventing the creation of “silent PPOs.” For answers to questions physicians frequently ask about silent PPOs, see Supplement 2.

1.12 Plan. An individual set of health service delivery and compensation procedures offered as a “managed care” product by Company, or administered by Company, on behalf of a Payor for the benefit of Enrollees, as it may be modified from time to time, and all the terms, conditions, limitations, exclusions, benefits, rights, and obligations thereof to which Company and Enrollees are subject. Nothing in this Agreement shall be construed to require physicians to participate in all of Company’s Plans as a condition of participating in any individual plan or plans.

Section 1.12 makes clear that the contracting physician is not required to participate in “all products” offered by the MCO. It does permit the MCO and the physician or physician group/network to enter into a single set of legal terms to govern their relationship that would apply to every product or plan included in the arrangement. However, the agreement also requires the parties to recognize separate business terms (including compensation) for each and every product and plan, which are attached as exhibits to the contract. By using this approach, the parties may terminate plans or products individually, without terminating the entire contract, by choosing to add or delete the plans or products described on Exhibit B. The AMA strongly opposes managed care contracts that require physicians to participate in “all products” as a condition of participating in any product. For answers to questions physicians frequently ask about “all products” clauses, see Supplement 3.

1.13 Qualified Physician. A doctor of medicine or osteopathy licensed to practice medicine, who has agreed in writing, either through this Agreement or through another written instrument, to provide Covered Services to Enrollees and who has been credentialed pursuant to the rules and procedures of the Plan by the Company or a duly appointed and authorized agent to which such responsibility has been delegated.

1.14 Quality Management. The process designed to monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve care, and resolve identified problems in the quality and delivery of care.

1.15 Total Compensation. The total amount payable by Payor and Enrollee for Covered Services furnished pursuant to this Agreement.

1.16 Utilization Review. The process by which Company, or a duly appointed and authorized entity (including Medical Services Entity) to which such responsibility has been delegated, determines on a prospective, concurrent, or retrospective basis the medical appropriateness of Covered Services furnished to Enrollees.

II. Delivery of Services

2.1 Covered Services. Medical Services Entity shall provide or, through its Qualified Physicians, arrange for the provision to Enrollees of those Covered Services that are identified in Exhibit A, attached hereto and made a part of this Agreement by this reference.

In many managed care contracts, the services to be covered by the MCO are either poorly defined or not defined at all. This works to the advantage of the MCO by giving it wide berth to deny requested services as “not covered.” Similarly, some capitation agreements either fail to clearly and completely articulate the set of services to be performed, or may fail to provide the list altogether, which allows the company to demand that the physician provide virtually open-ended services for the fixed capitation amount. Section 2.1 defines the “Covered Services” for each plan or product as those specifically set forth on one or more schedules attached as Exhibit A and places the responsibility for describing covered services where it belongs: on the MCO. If the MCO fails to fulfill this responsibility, or if its terms are so unclear that it is difficult to interpret which services are covered, the company is penalized and must reimburse the physician or physician group/network using a fee schedule similar to a standard private pay or indemnity arrangement. For an explanation of the relationship between “medical necessity” and “covered services,” see Supplement 1.

2.2 Full Description. Exhibit A shall be comprised of separate schedules designated as Exhibit A1, A2, etc., which shall either identify separately the Covered Services relating to each Company Plan or provide a fixed, readily available, location where the Medical Services Entity can conveniently find the complete list of covered services.

2.3 Full Disclosure. Where such schedule contemplates a global or capitated arrangement requiring Covered Services not normally provided by the Qualified Physicians of Medical Services Entity, such Covered Services shall be designated in bold type on Exhibit A, and a note shall be displayed prominently stating that payment for these Covered Services shall be the Medical Service Entity's responsibility.

2.4 Administrative Responsibility. If Exhibit A is not attached or in the event such exhibit contains descriptions of Covered Services that are so materially lacking in specificity that the purpose of this Agreement is defeated, Company shall pay Medical Services Entity the Qualified Physician's billed charge for each service performed by a Qualified Physician for the benefit of Enrollee.

The requirement in Section 2.4 that the company pay the physician's usual and customary charge is innovative. Although MCOs are likely to strongly resist this provision, it is a fair and reasonable way to ensure that physicians receive fair payment for services when the MCO neglects to include important terms in the contract to its own financial advantage.

2.5 Medical Responsibility. All Covered Services shall be provided in accordance with generally accepted clinical standards, consistent with medical ethics governing the Qualified Physician.

2.6 Verification of Enrollees. Except in the case of emergency, Medical Services Entity shall use the mechanism, including identification card, on-line service or telephone, chosen by Company or its agent designated for such purpose, to confirm an Enrollee's eligibility prior to rendering any Covered Service, in order to guarantee payment. If Company does not provide verification services on a twenty-four hour a day, seven-day per week basis, Medical Services Entity shall be entitled to rely on the information printed on the Enrollee's identification card as conclusive evidence of such Enrollee's eligibility. In addition, Company and Medical Services Entity agree to the following:

2.6(a) Company or Payor shall be bound by Company's confirmation of eligibility and coverage for the requested services and shall not retroactively deny payment for Covered Services rendered to individuals the Plan has confirmed as eligible using Company's designated verification mechanism.

2.6(b) If Medical Services Entity, after following Company procedure to the extent reasonably possible, is unable to verify the eligibility of a patient who holds him or herself out to be an Enrollee, Medical Services Entity shall render necessary care through its Qualified Physician, and Company shall pay for such care if the patient is an Enrollee.

2.6(c) In the event of an emergency, at the first available opportunity, Medical Services Entity shall attempt to verify eligibility. In the event Medical Services Entity makes all good faith efforts to verify eligibility, and verification is not reasonably possible given time constraints caused by the Company's action or inaction, and patient is not an Enrollee, Medical Services Entity shall attempt to collect from patient the amount due, up to the usual and customary fee of the Qualified Physician providing the service. If, after two billing cycles, Medical Services Entity or Qualified Physician has not received full payment, Company will pay Medical Services Entity the Qualified Physician's usual and customary fee, minus that which the Qualified Physician or Medical Services Entity has already collected from the patient, not to exceed the amount provided for as Total Compensation herein.

As every physician's office knows, verifying a patient's enrollment in a plan is not always an easy task, and the physician practice usually suffers for the MCO's administrative mistakes. For example, physicians sometimes are denied payment because MCOs make administrative errors in identifying Enrollees or failing to provide enough telephone access or other convenient means of communication for the physician to obtain verification in a timely fashion. Section 2.6 sets forth a reasonable procedure for ensuring that a physician can verify Enrollees and allows the physician to receive payment where the physician reasonably relies on these procedures.

III. Compensation and Related Terms

Article III provides a unique and sensible approach that allows the parties to negotiate separate business terms – including compensation – for each of the company's plans and prevents the MCO from unilaterally changing those terms. It simply requires that such terms be attached as Exhibit B. In the past several years, physicians around the country have made the unpleasant discovery that they thought they had agreed to a set compensation schedule for the term of the contract, when the MCO had, in fact, reserved the right to change that schedule unilaterally and at-will. That discovery typically occurs when the physician begins receiving reduced payment for services. That dynamic would not occur under Article III.

3.1 Compensation. Medical Services Entity, or its designee, shall accept, from Company or Payor, as full payment for the provision of Covered Services, the Total Compensation identified in Exhibit B, attached hereto and made a part hereof by this reference.

3.2 Full Description. Exhibit B shall be comprised of separate schedules designated as B1, B2, etc., which shall identify separately the Total Compensation and related terms for each Payor and Plan.

3.3 Full Disclosure. The Total Compensation set forth on the Exhibit B schedule(s) shall specify for each Payor and Plan, the manner of payment (such as fee-for-service, capitation, risk withholds, global payment, or bonus arrangement) for professional and diagnostic services rendered pursuant to the provision of Covered Services as set forth in the counterpart schedule of Exhibit A, and shall identify the portion of the Total Compensation that shall be the Company Compensation. Exhibit B shall also identify with specificity the additional business terms negotiated by the parties related to such Total Compensation. By way of example, and without limiting the requirements of this section, Exhibit B shall specify the following:

Sections 3.3 (a)-(c) require the MCO to provide the physician or physician group/network with data needed to evaluate and manage risk contracts. The agreement requires that any compensation exhibit beyond a standard fee-for-service schedule specify in detail the precise terms of payment. Subsections (a)-(c) provide a checklist of issues to be identified and resolved in negotiating three of the alternatives to a simple fee schedule. Note that separate Exhibit B schedules are required for each plan or product, so that they can be negotiated, renewed, or terminated individually. Finally, just as with the covered services on Exhibit A, this section establishes a penalty when the company fails to articulate the precise payment terms honestly and in sufficient detail.

3.3(a) In the case of a capitation arrangement,

- i. the amount to be paid per Enrollee, per month;
- ii. the mechanism by which Enrollees who do not designate a primary care physician (PCP) are assigned a PCP for purposes of capitation payment;
- iii. the date each month that the capitation payment is due;
- iv. the manner by which Company will determine and communicate to Medical Services Entity who is an Enrollee assigned to Medical Services Entity at the beginning of each month;
- v. the precise terms of the stop-loss arrangement offered to Medical Services Entity by Company, or a recital indicating that Medical Services Entity shall obtain stop-loss protection through other arrangements;
- vi. the boundaries of the service area in which treatment of Enrollees shall be arranged by Medical Services Entity and outside of which treatment provided to Enrollees shall become the financial obligation of Company;

- vii. the fee-for-service schedule to which the parties will revert in the event the number of Enrollees assigned to Medical Services Entity falls below a designated actuarial minimum, defeating the predictability of risk that both parties rely on in the arrangement;
- viii. the number of covered lives and the fee-for-service schedule upon which Medical Services Entity will be paid for those Covered Services provided to Enrollees not specifically made a part of the capitation arrangement on Exhibit A. In the case of a capitation arrangement, Medical Services Entity shall have the right to audit, at Medical Services Entity's expense, the books and records of Company or a Payor for purposes of determining the accuracy of any capitation payment and for the purposes of determining the number of Enrollees assigned to Medical Services Entity;
- ix. the description of reports and analyses to be supplied at least monthly by the Company to enable the Medical Services Entity to manage effectively the risk it assumes under capitation arrangements.
- x. the information provided by the MCO shall be current through the end of the previous month.

For answer to questions that physicians frequently ask about capitation arrangements, see Supplement 4.

3.3(b) In the case of hospital/Medical Services Entity or Payor/Medical Services Entity risk sharing on Non-Covered Services (ie, risk pools for hospital services),

- i. the amount allocated by a Payor for Non-Covered Services including the figure used for measuring hospital inpatient days per one thousand (1,000) Enrollees assigned to Medical Services Entity and applicable hospital per diem or capitation payment;
- ii. those services that will be charged against the hospital budget, such as hospital inpatient and outpatient care, ambulance service, home health services, durable medical equipment, and the capitation payment withhold, if any, of Medical Services Entity's contribution to the hospital budget;
- iii. the monthly date upon which Company will submit to Medical Services Entity a report regarding current charges made against the hospital budget;
- iv. the amount of the hospital budget surplus to which Medical Services Entity would be entitled in the event utilization of institutional services is favorable, and the degree and scope of risk to Medical Services Entity, if any, in the event utilization of institutional services is excessive.

For information about risk sharing, see Supplement 4.

- 3.3(c)** In the case of a withhold or bonus,
- i. the method by which the amount to be released or paid will be calculated and the date on which such calculation will be complete;
 - ii. the records or other information on which Company will rely to calculate the release of the withhold or the payment of the bonus;
 - iii. the date upon which Medical Services Entity will have access to such records or information relied on by Company in making such calculation for the purpose of verifying the accuracy thereof;
 - iv. the date upon which such payment or release, if any is finally due, shall be made.

For information about withholds, see Supplement 4.

- 3.3(d)** In the case of a discounted fee-for-service arrangement, Exhibit B shall contain the following:
- i. a comprehensive fee schedule that states clearly how much will be paid for each service to be rendered pursuant to the agreement or, as appropriate, sufficient information is provided to enable a fee for each service to be calculated accurately by each party;
 - ii. a statement that the fee schedule cannot be changed without the consent of Medical Service Entity;
 - iii. a provision stating the consequence for a Payor changing the terms of a fee schedule without consent of the Medical Service Entity, including the right to terminate the agreement and the right to recover billed charges.

For answers to questions that physicians frequently ask about discounted fees, see Supplement 5.

3.4 Administrative Responsibility. In the event Exhibit B is not attached or contains descriptions of compensation and related terms that are so materially lacking in specificity that the purpose of this Agreement is defeated, then Exhibit B shall be considered null and void and Company shall pay Medical Services Entity the Qualified Physician's billed charge for each service performed by a Qualified Physician hereunder. The Parties agree that the precise terms of Exhibit B, as opposed to the general description of the manner of payment, shall remain confidential between the parties and their respective attorneys.

Like Section 2.4, the concept in Section 3.4 of reverting to billed charges in the absence of sufficiently defined compensation schedules is innovative. However, allocating the administrative duty of providing information on compensation terms to the MCO is logical and fair, and reversion provides an incentive for the MCO to comply with the requirement.

3.5 Billing for Covered Services. Medical Services Entity shall submit a Claim to Company. If payment is required under the terms of Exhibit B, Company shall pay Medical Services Entity for Covered Services rendered to Enrollees in accordance with the terms of this Agreement. Medical Services Entity shall arrange for all Claims for Covered Services to be submitted to Company within six (6) months after the date services were rendered. Medical Services Entity shall submit such Claims electronically or on a HCFA-1500 billing form.

3.6 Coding for Bills Submitted. Company hereby agrees that Claims submitted for services rendered by Medical Services Entity shall be presumed to be coded correctly. Company or Payor may rebut such presumption with evidence that a claim fails to satisfy the standards set forth on Exhibit C. Exhibit C shall include a detailed description of Company's coding standards and requirements, including, but not limited to, the rules on modifiers, multiple surgeries, evaluation and management, and bundling policies such as edits, including correct coding initiatives. Company and Payor shall not adjust the billing codes submitted by Medical Services Entity on a claim without first requesting additional documentation to satisfy the coding standards described on Exhibit C. Company or Payor must provide adequate notice if it wishes to adjust a code and must allow sufficient time for Medical Services Entity to submit additional documentation or explanation. Medical Services Entity shall have the right to appeal any adverse decision regarding the payment of Claims based upon the level of coding with rights and duties as set forth in this Agreement. If Company or a Payor reduces payment of a claim in contravention of this section, such party shall be obligated to reimburse Medical Services Entity for the full amount of billed charges for the Claim.

Section 3.6 prevents the practice of "bundling" and "downcoding" which are practices often used by MCOs in which multiple procedures are sometimes "bundled" together and paid as a single procedure or claims are "downcoded," meaning they are submitted to the MCO at one level but are reimbursed at a separate lower level than what was actually billed. This section is designed to require the MCO to set forth billing standards and policies to the physician or physician group/network. For answers to questions physicians frequently ask about downcoding and bundling, see Supplement 6.

3.7 Copayments to be Collected from Enrollees. When the Plan requires Enrollees to make Copayments, Medical Services Entity or one of its Qualified Physicians shall collect such Copayments from the Enrollee at the time of service. Company shall require Enrollees to make Copayments at the time of service and educate Enrollees about their Copayment obligations. If Copayment is not remitted to Medical Services Entity in a timely fashion, Company agrees that Medical Services Entity may discontinue seeing patient, subject to its Qualified Physician's ethical duties, and that such action will not constitute a violation of Section 4.2 by Medical Services Entity.

3.8 Coordination of Benefits. When Enrollees are covered, either fully or partially, for services provided by a Qualified Physician under any contractual or legal entitlement other than this Agreement, including, but not limited to, a private group or indemnification program, Medical Services Entity shall be entitled to keep any sums it recovers from such primary source consistent with applicable federal and state law. Except as indicated in the following sentence, Payor will pay Medical Services Entity the usual and customary fee of the Qualified Physician providing service for Medical Services Entity, less that which is obtained from any primary source. If Exhibit B contemplates a fee-for-service compensation arrangement, the sum of such payments shall not exceed the Total Compensation set forth on Exhibit B; however, in the case of Medicare beneficiaries and where the Payor is the Secondary Payor, the sum of such payments shall not be less than one hundred percent (100%) of the Medicare allowed fee schedule.

3.8(a) If Payor is deemed “primary” in accordance with applicable industry coordination of benefits (“COB”) standards, the Payor shall pay Medical Services Entity in accordance with the terms of this Agreement with no delay, reduction, or offset.

3.8(b) If Payor is deemed “secondary” in accordance with applicable industry COB standards, Payor shall pay Medical Services Entity the difference between what Medical Services Entity received from the primary Payor and the amount Payor owes Medical Services Entity as Total Compensation under the terms of this Agreement.

3.8(c) Payor shall be presumed to be the primary Payor and shall make payments in accordance with this Agreement, unless such Payor can document to the satisfaction of the Medical Services Entity that it is secondary under industry COB standards within 72 hours of receipt of a claim.

3.8(d) If Payor pays a claim to Medical Services Entity in accordance with this Agreement, Medical Services Entity agrees to cooperate with the reasonable efforts of Payor to determine whether it is the primary or secondary Payor under industry COB standards.

3.8(e) If it is subsequently determined that a Payor should be considered secondary under industry COB standards, then Medical Services Entity will cooperate with that Payor’s reasonable efforts to seek reimbursement from the responsible primary payor.

3.8(f) If Exhibit B provides a fee-for-service schedule applicable to Enrollee’s Plan, Medical Services Entity shall not retain funds in excess of the Total Compensation fee schedule listed on Exhibit B, unless applicable state law regarding COB requires or imposes a different requirement.

3.8(g) Secondary payors shall not be relieved of their obligation to make full payment to Medical Services Entity in the event the primary payor fails to pay Medical Services Entity properly submitted Claims within 90 days of submission.

The coordination of benefits provision in Section 3.8 deals with the question of who will pay the physician or physician group/network and how much must be paid when a person is covered by more than one insurance plan. For example, a person may be covered by both his or her employer's plan and a spouse's plan. This provision ensures that the physician or group receives full compensation without placing the patient under inappropriate financial risk. For answers to questions physicians frequently ask about coordination of benefits, see Supplement 7.

3.9 Promptness of Payment. Each Payor shall remit to Medical Services Entity the Company Compensation within fourteen (14) days of receipt of an electronic Claim and thirty (30) days (or such shorter time as set by law) of receipt of a written Claim by Medical Services Entity that contains sufficient detail that Payor is able to reasonably determine the amount to be paid. In the case of Total Compensation described on Exhibit B that requires prepayment or lump sum payment for services, such as capitation, such Company Compensation shall be remitted by the fifteenth day of the month covered by such payments. In the case of a written Claim, Payor shall mail to Medical Services Entity written acknowledgment of receipt of Claim within three (3) business days of receipt.

Delayed payment of physicians is a chronic problem in parts of the country, and most managed care contracts are silent on the issue, giving the physician no rights and the MCO no responsibilities. This section gives the physician a contractual right to prompt payment of all claims clean enough that a Payor can reasonably determine what service was performed and how much should be paid. It also requires the Payor to pay interest on delayed payments. Whether the Payor is "reasonable" in making such a determination is a proper subject for arbitration (see Article IX).

The AMA has made prompt payment a major advocacy initiative and has worked with a number of state medical associations on legislative and other strategies to combat delayed payment. In the past several years, a number of state insurance commissioners have become more aggressive at enforcing state prompt payment laws. For information on state prompt payment laws, and a summary of state insurance commissioner fines, visit www.ama-assn.org/go/psa. For answers to questions physicians frequently ask about late payment, see Supplement 10.

3.9(a) Payor shall acknowledge receipt of an electronic claim within twenty-four (24) hours of receiving that claim. When an MCO claims that it has not received a written claim, and Medical Services Entity has a record of the original filing, the time for submission of claims will run from the time Medical Services Entity determines that the MCO did not receive the claim.

Section 3.9(a) is an addition to the 2002 edition of the AMA Model Managed Care Contract. It was added in response to ongoing problems with MCOs “losing” claims, particularly paper claims. Physicians around the country complain that they submit claims, never receive payment, and after contacting the MCO are informed that the claim was never “received.” The Medical Services Entity will submit a claim and assume that it is being processed; meanwhile the time for claims submission is tolling. Section 3.9(a) addresses this by “resetting the clock” when a claim is “lost” by the MCO but the Medical Services Entity has records of the date a claim was originally filed.

3.9(b) If additional information is needed by Payor to evaluate or validate any Claim for payment by Medical Services Entity, Payor shall request any additional information in writing within five (5) days of receipt of an electronic claim and ten (10) days of receipt of a paper claim. Payor shall affirm and pay all valid Claims within thirty (30) days of receipt of such additional information. Any undisputed portions of a Claim must be paid according to the time frame set forth in 3.9 while the remaining portion of the Claim is under review.

Under 3.9(b), the Payor must return claims lacking information or not “clean” enough for payment to the physician or physician group/network within ten (10) days of receipt. The Payor must pay the claim within fourteen (14) days of receipt of the additional information requested, if the claim is filed electronically, and within thirty (30) days for a written claim. This prevents the MCO from silently “sitting” on unprocessed claims or delaying payment on claims the company arbitrarily determines are not “clean.”

3.9(c) If a Payor fails to make such payment in a timely fashion as specified herein, Payor shall be obligated for payment of such amounts plus interest accruing at the annualized rate of the *Wall Street Journal* prime rate of interest on the first day of the month on which such amounts were due plus three percent (3%) or such greater rate of interest as provided for under state law in the event of late payment. All payments to Medical Services Entity will be considered final unless adjustments are requested in writing by Payor within ninety (90) days after receipt by Medical Service Entity of payment explanation from Payor.

Section 3.9(c) is designed to prevent MCOs from retrospectively auditing claims and reducing payment long after services were rendered based on the MCO’s determination that certain claims should not have been paid or should have been reimbursed at a lower level. This is accomplished in Section 3.9(c) by making payments to physician or physician groups/networks final within ninety (90) days after receipt by the physician. For answers to questions physicians frequently ask about retrospective audits, see Supplement 10.

3.10 Sole Source of Payment. Where Enrollee is enrolled in a Plan subject to state or federal legal requirements that prohibit a physician from billing patients for Covered Services in the event the Payor fails to make such payment, Medical Services Entity agrees to look solely to that Payor for payment of all Covered Services delivered during the term of the Agreement.

3.10(a) In such circumstances, Medical Services Entity shall make no charges or claims against Enrollees for Covered Services except for Copayments as authorized in the Plan covering Enrollee.

3.10(b) In such circumstances, Medical Services Entity expressly agrees that during the term of this Agreement it shall not charge, assess, or claim any fees for Covered Services rendered to Enrollees from such Enrollees under any circumstances, including, but not limited to, the event of Payor's bankruptcy, insolvency, or failure to pay the Qualified Physician providing services.

3.10(c) Notwithstanding the foregoing, Company shall cooperate in the processing of such claims against Payor to provide Medical Services Entity with its greatest chance to receive compensation for covered services provided. This provision shall permit Medical Services Entity to collect payment not prohibited under state or federal law, including, but not limited to:

- i. Covered Services delivered to an individual who is not an Enrollee at the time services were provided;
- ii. services provided to an Enrollee that are not Covered Services, provided that Medical Services Entity advises the Enrollee in advance that the services may not be Covered Services; or
- iii. services provided to any Enrollee after this Agreement is terminated.

State law strictly limits physicians' ability to charge patients for services delivered under a managed care contract, even when the MCO is in bankruptcy. However, some MCOs abuse this by effectively requiring physicians to continue to treat patients indefinitely and preventing them from making any claims against the MCO or Payor as a creditor. Section 3.10 satisfies the intent of most state statutes in protecting consumers and allows the physician or physician groups/network to pursue other remedies under the law. Section 3.10(c) also sets forth circumstances in which a physician or physician group/network can collect payment from individual patients. Non-payment of claims may be a sign of financial instability, and physicians should consider terminating in this event. Once an MCO has declared bankruptcy, the physician has limited remedies for payment. For answers to questions physicians frequently ask about bankruptcy, see Supplement 10.

3.11 Subrogation. In the event an Enrollee is injured by the act or omission of a third party, the right to pursue subrogation and the receipt of payments shall be as follows:

3.11(a) If Exhibit B provides for a capitation payment for the Enrollee, Medical Services Entity shall retain the right of subrogation to recover reimbursement from third parties, such as automobile insurance companies, for all Covered Services for which it is at risk to provide in exchange for the capitation paid hereunder.

3.11(b) If Exhibit B provides for a fee-for-service arrangement for the Enrollee, Medical Services Entity shall permit Payor to pursue all its rights to recover reimbursement from third party Payors to the extent Payor is at risk for the cost of care.

3.11(c) Payor shall pay claims submitted by Medical Services Entity in accordance with this Agreement, notwithstanding Payor's pursuit of subrogation rights against potentially responsible third parties who caused an injury by their act or omissions in accordance with section 3.11(b).

3.11(d) Medical Services Entity shall abide by any final determination of legal responsibility for the Enrollee's injuries.

3.11(e) Upon receiving payment from the responsible party, Medical Services Entity will refund the amount of payment to Payor up to the amount paid by the Payor for the services involved. Medical Services Entity shall be entitled to keep any payments received from third parties in excess of the amount paid to it by Payor.

Subrogation involves a third party's right to receive payment from a defendant in a negligence lawsuit by "stepping into the shoes" of the plaintiff. For example, if a patient is in a car accident and receives damages from the defendant or defendant's insurer, the party at risk for the medical care (the physician and/or MCO) should be afforded rights of subrogation for the cost of that care. For answers to questions physicians frequently ask about subrogation, see Supplement 11.

IV. Medical Services Entity's Obligation

Article IV sets forth the obligations of physicians or physician groups/networks that are reasonable and necessary in the managed care arrangement. They have been drafted to recognize the administrative realities that MCOs face in balancing the needs of their various Payors.

4.1 Licensed/Good Standing. Medical Services Entity represents that it, or each of its Qualified Physicians, is and shall remain licensed or registered to practice medicine and, if applicable, the legal entity is registered and in good standing with the state in which it is chartered and each state in which it is doing business.

4.2 Nondiscrimination. Medical Services Entity agrees that it, and each of its Qualified Physicians, shall not differentiate or discriminate in its provision of Covered Services to Enrollees because of race, color, ethnic origin, national origin, religion, sex, marital status, sexual orientation, income, disability, or age. Further, Medical Services Entity agrees that its Qualified Physicians shall render Covered Services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability as such services are offered to patients not associated with Company or any Plan, consistent with medical ethics and applicable legal requirements for providing continuity of care.

Section 4.2 is subject to state law, and the parties entitled to protection under Section 4.2 may be modified to be consistent with such law.

4.3 Standards. Covered Services provided by or arranged for by Medical Services Entity shall be delivered by professional personnel qualified by licensure, training, or experience to discharge their responsibilities and operate their facilities in a manner that complies with generally accepted standards in the industry.

4.4 Cooperation in Credentialing. Company and Medical Services Entity agree to cooperate in credentialing and re-credentialing Qualified Physicians in accordance with the process set forth on Exhibit D and consistent with Section 5.4 of this Agreement. Exhibit D shall identify with specificity the criteria for credentialing timelines and the rights and obligations of Company and the physicians during the credentialing process. By way of example, Exhibit D shall specify the following:

4.4(a) The criteria to be used by Company in its decision whether or not to credential or re-credential a physician.

4.4(b) Identification of the internal process that Company will use in making credentialing decisions.

4.4(c) Identification of the individual or committee that has authority to decide whether to grant or remove credentials.

4.4(d) Identification of the individual or committee to whom the initial decision maker is accountable.

4.4(e) Identification of how and when physicians will be notified of credentialing decisions, including a reasonable deadline by which Company must finalize credentialing decisions.

4.4(f) A requirement that an adverse decision state with specificity the reason for such decision.

4.4(g) A statement of the rights and duties of Medical Services Entity or a physician in an appeal of an adverse credentialing decision, including the following elements:

- (i) The deadline for filing an appeal;
- (ii) Whether the appeal will be in writing or a live hearing;
- (iii) What evidence the physician may introduce;
- (iv) The physician's right to review the material prepared by Company to support its adverse decision;
- (v) What individuals within the Company will review the appeal and have the final authority to make a decision and a statement of that person or committee's qualifications to make credentialing decisions;
- (vi) The deadline by which Company must make a final decision following the appeal procedure and communicate the decision to the physician; and
- (vii) Provisions for notice and corrective action prior to an adverse credentialing decision becoming final.

For answers to questions physicians frequently ask about credentialing, see Supplement 12.

4.5 Authority. Medical Services Entity represents and warrants that it has full legal power and authority to bind its Qualified Physicians to the provisions of this Agreement.

Physician groups/networks entering into this agreement on behalf of their physician members must have this authorization from their individual physicians under a physician agreement or employment agreement. Section 4.5 states that the authorization has been obtained. Without that authorization, the physician group/network can neither contract with a MCO nor make this representation.

4.6 Administrative Procedures. Medical Services Entity and each of its Qualified Physicians will comply with the policies and procedures established by Company or any of its Plans to the extent Medical Services Entity has received notice of same consistent with the terms of this Agreement. At the effective date of the Agreement, the policies, rules, and procedures applicable to Medical Services Entity are contained in those manuals and other writings attached hereto on Exhibit D and incorporated by this reference. Medical Services Entity shall rely on these policies and procedures as the sole material policies and procedures of Company or its various Payors until such time as Medical Services Entity receives a Company Notice or is notified otherwise consistent with this Agreement. Neither Company nor a Payor may modify these policies and procedures in a manner that would have a material adverse effect on Medical Services Entity without Medical Services Entity's prior written consent.

Many managed care contracts allow MCOs to change their administrative policies unilaterally at any time and do not require clear communication to physicians of these policies. Section 4.6 requires reasonable written notice of policy changes and recognizes that each MCO will have certain policies and procedures on minor administrative matters that should be followed by each physician or physician group/network. All policies must be attached to the contract. Where assurances can be made that they will not be altered, they can be provided at an electronic site. In either event, the policies cannot be changed until the MCO sends a "Company Notice" pursuant to Section 5.2 thirty (30) days in advance of the policy's implementation. Most importantly, this provision prohibits the MCO or any Payor from modifying the policies and procedures in a way that would have a material adverse effect on the contract without physician or physician group/network's written consent.

4.7 Assistance in Grievance Procedure. Medical Services Entity agrees to have each of its Qualified Physicians keep available for Enrollees explanations of the grievance procedures and grievance encounter forms relating to Plan, which shall be supplied by Company. Medical Services Entity further agrees that it and its Qualified Physicians will abide by Company's and or Plan's process for resolving Enrollee grievances, which procedures are a part of Exhibit C, consistent with this Agreement. Medical Services Entity also agrees to require each of its Qualified Physicians to participate in helping resolve the grievances described in Section 5.6 hereof.

4.8 Use of Names for Marketing. Medical Services Entity and each of its Qualified Physicians shall permit Company to include the name, address, and telephone number of it or its Qualified Physicians in its list of Medical Services Entities distributed to Enrollees; provided, however, that such rights shall not extend to the listing of such Qualified Physicians or Medical Services Entity in any newspaper, radio, or television advertising without the prior written consent of Medical Services Entity and that such material shall be factually accurate and in compliance with applicable law and ethical standards.

4.9 Provision of Covered Services. In the event Exhibit B contemplates the provision of the full range of full medical services that may be offered by a medical group on a capitated basis to a defined population of patients, Medical Services Entity agrees to provide or arrange for the provision of Covered Services on a 24 hour per day, 7 day per week, 365 day per year basis.

4.10 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of Company or any Payor to intervene in any manner in the methods or means by which Medical Services Entity and its Qualified Physicians render health care services or provide health care supplies to Enrollees. Nothing herein shall be construed to require Medical Services Entity or Qualified Physicians to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Enrollees.

Section 4.10 clearly establishes the physician's independent role in treating the patient. While other managed care contracts often include such a provision, it can be seriously diluted by an approach to "medical necessity" which allows the MCO to override the physician's decisionmaking while avoiding any legal responsibility. In contrast, the definition of "medical necessity" in this model contract (see Section 1.9), gives Section 4.10 force.

V. Company's Obligations

Article V sets forth a number of obligations that normally are, or should be, part of the obligations of the MCO. In some agreements these provisions are absent altogether. In others they are set forth in a way that either makes the obligations meaningless or subject to the MCO's sole interpretation.

5.1 List of Payors. Company shall include as part of Exhibit C a list of each Payor and shall promptly update Exhibit C upon the addition or deletion of Payors. The parties acknowledge that the intent of Sections 1.11, 3.1, and this Section 5.1 is to provide a mechanism for assuring that "networks," "silent PPOs," and similar arrangements between entities similar to Company and Payors do not accede to this Agreement or avail themselves of the discounts and arrangements established by the Parties through this Agreement.

Section 5.1, read in concert with Section 1.11, prevents MCOs from "renting" their physician networks to third parties who are not party to this agreement. It is designed to prevent the practice of "silent PPOs."

5.2 Deemed Notification. Company shall notify Medical Services Entity in writing of all policies, procedures, rules, regulations, schedules, in addition to those attached as Exhibit C, that Company considers material to the performance of this Agreement, as well as any amendments. Medical Services Entity shall be deemed notified of such policies, procedures, rules, or regulations, or any amendment, or any Company Notice ninety (90) days after receipt of written notice of same is delivered to Medical Services Entity consistent with the notice provisions of this Agreement. Neither Company nor a Payor may modify its policies and procedures in a manner that would have a material adverse effect on Medical Services Entity without Medical Services Entity's prior written consent.

The "deemed notification" provision in Section 5.2 sets forth a rational approach to the policy changes a MCO may make from time-to-time by requiring the MCO to provide the physician or physician group/network with written notice of changes in policies at least ninety (90) days in advance of the change. This requirement prohibits the MCO from making changes to policies or procedures that would have a material effect on the physician or physician group/network without its prior consent.

5.3 Adverse UR/QM Decisions. Notwithstanding anything to the contrary contained in the policies, procedures, rules, or regulations of Company, Company shall grant Medical Services Entity or Qualified Physician a right and a mechanism to appeal any Utilization Review or Quality Management decision made by Company on behalf of a Payor. Such appeal shall be coordinated with any related appeal by the Enrollee filed at or prior to the time of the Medical Services Entity appeal. The appeal procedure shall be as follows:

Section 5.3 is designed to link existing MCO procedures with due process protections. Adverse decisions on medical utilization review or medical quality matters are subject to a due process review that is ultimately decided by independent peers, rather than by the MCO in its sole discretion. The utilization review and quality management procedures in this agreement closely resemble the peer review process traditionally found in hospital medical staff rules and are supported by AMA policy. They also must be consistent with the laws of the states in which services are provided.

5.3(a) Unless existing Company policies provide for a more liberal rule, and except for utilization review decisions related to emergency care, which shall be expedited, written notice of such appeal shall be given by either the Medical Services Entity or Qualified Physician to Company on behalf of Plan no more than ten (10) calendar days following the contested decision.

5.3(b) Company shall have five (5) calendar days after receipt of such notice to appoint a licensed physician in the same or similar specialty not employed by Company to hear the appeal, which shall be heard within ten (10) days. A decision will be communicated to the parties no later than five (5) days after the hearing.

5.3(c) In any such appeal, a prior authorization for treatment granted by Company shall be conclusive in determining whether payment for services should be made.

5.4 Administration. With respect to each Plan it offers or administers, Company shall promptly and diligently perform all necessary administrative, accounting, enrollment, and other functions including, but not limited to, eligibility determination, claims review, data collection and evaluation and, if applicable, maintenance of medical, ancillary, and hospital group risk pools.

5.4(a) With respect to each Plan, Company shall issue a Company Notice to Medical Services Entity identifying the manner in which rules, regulations, or policies relating to a particular Plan are at variance with the general rules, regulations, or policies of the Company upon which Medical Services Entity generally relies.

5.4(b) In the credentialing of Qualified Physicians, Company agrees that neither it nor its agents shall request that Qualified Physicians sign an information release broader than necessary to obtain the specific credentialing information sought, and Company shall limit such request to that which is reasonable and necessary to achieving valid credentialing purposes.

Section 5.4 provides general, minimum administrative requirements. Depending on the needs of the physician or physician group/network, or its concerns about the MCO, this list could be significantly expanded. The administrative requirements in Section 5.4 go to the heart of what a MCO is in business to provide.

5.5 Payment by Parties other than Company. In the event Company contemplates that payment for services provided hereunder is to be made by a Payor other than Company, and in the event that such payment is not received by Medical Services Entity within the time and under the conditions set forth in Section 3.5, Company, within five (5) days of the receipt of written notice from Medical Services Entity, shall make a written demand to Payor on behalf of such Medical Services Entity for payment.

Section 5.5 protects the physician or physician group/network no matter who is obligated to pay. Many managed care contracts do not require the MCO to make payment. Instead, they require the payor, (who may be, for example, an employer under an employer-funded plan) to make such payment. While this is virtually unavoidable in the managed care arrangement, it presents a significant problem for physicians. Because there may be no direct relationship between the physician and the party who has the obligation to pay, the physician does not have a direct remedy in the event the payor does not make payment. This provision is a businesslike approach to granting physicians or physician groups/networks the right to pursue the appropriate party, if necessary, in court.

5.5(a) In the event a Payor fails to make payment within sixty (60) days after receipt of such notice, Company shall either: (i) make such payment on behalf of the Payor; (ii) initiate legal action to recover such payment on behalf of Medical Services Entity; or (iii) assign the right to initiate such action to Medical Services Entity.

5.5(b) In the event of an occurrence described in Section 5.5(a)(ii) or (iii) of this Section, Company shall tender to Medical Services Entity a copy of the agreement that governs the relationship between Company and Payor. The Medical Services Entity may rely on this Agreement in prosecuting such action. Company shall release Medical Services Entity, at Medical Services Entity's option, from any further obligation under this Agreement to provide services to Enrollees of Payor.

5.5(c) Company shall notify Payor of the provisions and obligate Payor with respect to such provisions.

5.6 Physician Grievances. Company shall establish and maintain systems to process and resolve a grievance by a Qualified Physician toward Company or a Payor. Such process shall be set forth in the procedures which are a part of Exhibit C and any Company Notice amending such process. In connection with such grievances, to the extent that confidential patient information is discussed or made part of the record, or confidential patient records are submitted to Company, Company shall either abstract such information or shall remove the name of the patient so that none of the information or records would allow a third party to identify the patient involved. Notwithstanding anything in Company's policies, procedures, or rules to the contrary, the internal procedure for resolving such grievance will be conclusively presumed concluded in the event such grievance is not resolved to the parties' satisfaction within forty-five (45) days of the submission of such grievance and will allow either party resort to the dispute remedies of Article IX.

The type of grievance system outlined in Section 5.6 is supported by AMA policy and should be an integral part of the managed care relationship. Each MCO should maintain a system to process and resolve grievances brought by both physicians and patients. This provision protects patients by limiting the use of patient record information and protects physicians by providing a clear point in time when the MCO's internal grievance procedures have been exhausted and the matter may be resolved by arbitration. Many managed care grievance procedures allow the MCO to delay resolving grievances, preventing physicians from taking up the matter in another forum.

5.7 Benefit Information. Company shall advise and counsel its Enrollees and Medical Services Entity on the type, scope, and duration of benefits and services to which Enrollees are entitled pursuant to the applicable agreement between Company or a Payor and Enrollees.

Section 5.7 places the responsibility to inform Enrollees of their benefits where it belongs: on the MCO. Often, the physician and his or her office staff are left to explain the details of MCO to patients. This provision makes such explanations the clear duty of the MCO.

5.8 Cooperation on Care Review and Management. If Medical Services Entity is responsible for utilization review and quality management activities, Company shall assist and cooperate with Medical Services Entity in the development and initial implementation of such activities that are necessary to carry out the terms of this Agreement. If that utilization review and quality management activities are the sole responsibility of Company, Company shall fully advise Medical Services Entity of the methods used and underlying information relied on to develop, implement, and manage or monitor utilization and quality on an ongoing basis, and shall develop a mechanism to allow Qualified Physicians to participate in the development of utilization review and quality management ongoing assessment and evaluation.

Many MCOs do not provide any mechanism for practicing physician input into utilization review and quality management programs, nor do they provide for adequate communications of these policies. Section 5.8 requires the MCO to actively assist or fully advise physicians on the “management” portion of managed care and most importantly, requires practicing physician input into the process.

5.9 Context of Company/Payor Obligations. If Company is also a Payor under this Agreement, it shall perform and satisfy all duties and obligations of the Payor under this Agreement. If Company is not a Payor under this Agreement, this Agreement shall be construed to require Company to use its best efforts to cause the Payor to perform and satisfy the Payor’s duties and obligations under this Agreement.

5.10 Provision of Financial Information. Company shall provide to Medical Services Entity, no less frequently than quarterly, a balance sheet and income statement (collectively, “Financial Statements”) accurately depicting the financial condition of Company. Such Financial Statements shall be prepared in accordance with generally accepted accounting principles and shall be provided on an audited basis to the extent available. Medical Services Entity acknowledges the confidentiality of such Financial Statements and shall not: (a) use such Financial Statements for any purpose other than evaluating the financial condition of Company; or (b) disclose the Financial Statements, or any non-public information contained therein, to any third party, other than Medical Services Entity’s attorneys or accountants, without the prior written consent of Company. The obligations of Medical Services Entity under the immediately preceding sentence shall survive termination of this Agreement.

Section 5.10 is important for protecting physicians and physician groups/networks from financially troubled MCOs by granting physicians and physician groups the right to review the MCO’s quarterly balance sheet and income statement. Physicians also might consider including an additional requirement that the MCO notify the physician or physician group/network when the Payor is unable to pay its debts as they come due or when it does not have capital sufficient to carry on its business. As noted in Section 3.9, there is suspicion that one reason some MCOs pay claims slowly or reject an excessive number of claims as not being “clean” is to improve their financial reporting when they are short on capital—a clear sign of financial instability. Physicians need to be alert to this possibility. Taken together with Section 8.5, Section 5.10 gives the physician the greatest protection possible, short of prepayment for services, in the event of a MCO’s financial failure. For answers to questions physicians frequently ask about bankruptcy, see Supplement 10.

VI. Records and Confidentiality

6.1 Confidential Medical Records. All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws. All medical records shall belong to Medical Services Entity's Qualified Physicians. The release, disclosure, removal, or transfer of such records shall be governed by state and federal law and by the Medical Services Entity's established policies and procedures. The cost associated with copying medical records or any other records referred to in this Article VI shall be paid by Company. Any request by Company for confidential medical records shall be limited to the minimum information necessary to accomplish the specific purpose for which Company seeks the information. Company shall counsel its employees, agents, and subcontractors on their obligations to ensure that such information remains confidential.

6.2 Access to Records. During normal business hours, each party shall have access to and the right to examine records of the other which relate to a Covered Service or payment provided for a Covered Service. However, any review of the medical record must be narrowly tailored to the specific purpose for which the Company seeks the information.

Sections 6.1 and 6.2 are designed to protect medical information from unauthorized use or disclosure. These provisions make clear that the medical record belongs to the Medical Services Entity and not the MCO. They are also designed to limit the MCO's access to medical records by requiring that any requests for medical records be narrowly tailored to the specific purpose for which the MCO seeks the information. The treatment of medical records will change dramatically with the implementation of the 1994 Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. This rule makes clear that MCOs cannot have unfettered access to a patient's medical records and that any requests for information must be the "minimum necessary" to accomplish the MCO's purpose. For more information about medical records and HIPAA, see Supplement 13.

6.3 Other Confidential Information. Generally, the parties agree that the sole items of information subject to confidentiality under this Agreement are: (i) medical information relating to individual Enrollees, so as to protect the patient's medical record as required by medical ethics and law; (ii) the precise schedule of compensation to be paid to Medical Services Entity pursuant to Exhibit B; and (iii) such other information set forth in sections 6.3(a) and (b). Otherwise, all other information, including the general manner by which Medical Services Entity is paid under this Agreement and the general terms and conditions of this Agreement, may be shared with non-parties in the reasonable and prudent judgment of the Parties to this Agreement or Qualified Physicians.

Section 6.3 protects patient–physician communication and clarifies that, except for a limited number of matters that are proprietary to both the MCO and physician or physician group/network, there are no inhibitions on free communication between the physician and the patient or any other parties. While some plans have eliminated so-called “gag clauses” from their contracts and a number of states have outlawed them, the AMA has found that some MCOs continue to find ways to constrain patient–physician communication through the contract. Section 6.3 eliminates this possibility.

6.3(a) Any financial or utilization information provided by Medical Services Entity to Company or a Payor (including the Compensation schedule(s) set forth in Exhibit B) shall be maintained in strict confidence by Company and each Payor and may not be disclosed by Company or Payor to any third party or used by Payor for any purpose, other than: (i) to satisfy mandatory governmental or regulatory reporting requirements; (ii) to compare cost, quality, and service among providers with whom Company has contracted; (iii) for premium setting purposes; (iv) for HEDIS reporting.

6.3(b) Notwithstanding the foregoing, Company shall be permitted to prepare and disclose to a third party a report of “Medical Services Entity Quality Data.” For purposes of this subsection, Medical Services Entity Quality Data shall be limited to: (i) utilization data of all contracted Medical Services Entities in the aggregate; (ii) HEDIS data production and performance evaluation; (iii) Enrollee satisfaction data; (iv) overall compliance with NCQA or other comparable quality standards; and (v) Payor disenrollment data; provided, however, that Medical Services Entity Quality Data shall not include any information that identifies an individual Enrollee or an individual Qualified Physician or information that is privileged or confidential under applicable peer review or patient confidentiality laws.

6.3(c) At least thirty (30) days prior to providing Medical Services Entity Quality Data to a third party, the third party shall provide such Medical Services Entity Quality Data to Medical Services Entity so that Medical Services Entity may confirm the accuracy, completeness, or validity of the data and prepare a written response to such data to the extent Medical Services Entity deems appropriate.

6.3(d) To the extent Medical Services Entity believes that all or any portion of the Medical Services Entity Quality Data is inaccurate or incomplete, Medical Services Entity and Company shall negotiate in good faith to correct such inaccuracies or to make such data complete prior to its submission to the third party. If such inaccuracies or deficiencies are not corrected to the satisfaction of Medical Services Entity, Company shall submit, at the time the Medical Services Entity Quality Data is provided to the third party, any written response to such Medical Services Entity Quality Data prepared by Medical Services Entity.

VII. Insurance

7.1 Medical Services Entity Insurance. Medical Services Entity shall require each Qualified Physician to maintain, at all times, in limits and amounts standard in the community, a professional liability insurance policy and other insurance as shall be necessary to insure such Qualified Physician against any claim for damages arising directly or indirectly in connection with the performance or non-performance of any services furnished to Enrollees by such Qualified Physician. In the event that Medical Services Entity discovers that such insurance coverage is not maintained, Medical Services Entity shall immediately upon making such discovery ensure that such Qualified Physician discontinues the delivery of Covered Services to Enrollees until such insurance is obtained. Evidence of such coverage shall be tendered to Company by Medical Services Entity upon Company's request.

VIII. Term and Termination

Article VIII avoids the yearly "renewal" approach in favor of a defined beginning and ending date based on an event (e.g., notice of termination). However, certain terms and provisions may be renegotiated at the initiative of either party on an annual basis (see Section 8.2). State law should be consulted to assure that a failure to state a term of years does not convert the agreement to be one terminable at-will.

8.1 Term. This Agreement shall commence on the Effective Date and extend until terminated pursuant to this Article VIII.

8.2 Negotiation of Renewal of Exhibits A and B. Not later than ninety (90) days prior to each anniversary of the Effective Date hereof, a Party wishing to revise Exhibits A or B or any of the schedules affixed thereto shall serve notice in writing of such intention to the other Party, along with the new terms proposed. Within sixty (60) days thereafter, the Parties shall agree to a new Exhibit A and Exhibit B. If the Parties are unable to come to such agreement, either Party may notify the other within ten (10) days following the deadline for such agreement that it intends to terminate the Agreement entirely or with respect to one or more specific Plans reflected on a schedule. In such event, this Agreement (in the case of termination of all Plans) or the Agreement with respect to a particular Plan or Plans, shall be terminated sixty (60) days after such notice.

Section 8.2 furthers two purposes. First, it allows either party to renegotiate the business terms of the contract (Exhibits A and B) annually, provided that the party gives notice 90 days before the anniversary. It prevents the company from unilaterally changing reimbursement. Second, it also allows physician or physician group/network to drop a single product or plan without terminating every product subject to the agreement by providing an administratively convenient method for the physician or group/network to end participation in one product while continuing the legal relationship on other products uninterrupted. Even when an agreement does not overtly require the physician to service “all products,” most managed care contracts effectively do just that by requiring the physician or physician group/network that wishes to discontinue only certain plans or products to terminate the entire contract and re-enter a new contract that excludes the product rejected. Under 8.2, the physician or group/network must track contract renewal dates so that if it wants to negotiate, it can give 90 days notice.

8.3 Termination for Cause. If either Party shall fail to keep, observe, or perform any covenant, term, or provision of this Agreement applicable to such Party, the other Party shall give the defaulting party notice that specifies the nature of such default. If the defaulting Party shall have failed to cure such default within thirty (30) days after the giving of such notice, the non-defaulting Party may terminate this Agreement upon five (5) days notice. However, it shall be grounds for immediate termination if (i) Company should lose its license to underwrite or administer Plans; or (ii) if any Qualified Physician suffers a loss or suspension of medical license, a final unappealable loss of hospital medical staff privileges for reasons that would require reporting to the National Practitioner Data Bank pursuant to the requirements of the Health Care Quality Improvement Act of 1986, a conviction of a felony, or a loss of credentials for stated quality reasons under a Plan, and upon notice to Medical Services Entity, Medical Services Entity fails to immediately terminate such Qualified Physician from the provision of services to Enrollees.

8.4 Voluntary Termination. Either Party may terminate this Agreement or Medical Services Entity participation in any Plan with or without cause upon one hundred twenty (120) days written notice to the other Party specifying whether the termination relates to a specific Plan or to the Agreement generally. The terminating Party shall state the reason for such termination. In the event of a voluntary termination hereunder, neither party shall be foreclosed from participation in the dispute resolution procedures described in Article IX.

Section 8.4 protects the integrity of the termination process for both parties. Many managed care agreements provide the illusion of running for a full year prior to renewal, when in fact, the termination clauses allow the company to terminate the agreement upon ninety (90) days notice. The AMA Model Managed Care Contract rejects that approach. Instead, it separates all terms unrelated to the definition of covered services and the fee schedules from other legal terms. The legal terms are binding throughout the relationship of the parties. The list of covered services and fee schedules for each plan or product, as set forth in Exhibits A and B, are to be renegotiated annually and renewed or rejected individually. However, under Section 8.3, either party may terminate the entire contract on thirty (30) days notice or less upon the occurrence of a default or breach under the contract.

Otherwise, Section 8.4 provides that either party must give one hundred twenty (120) days notice of termination. Most importantly, a party that wishes to terminate the agreement must state in writing the reason for the termination. Often, physicians are the subject of unfair discrimination when a MCO terminates a contract even though the initial termination may have been strictly for business or administrative reasons. Requiring the terminating party to state reasons for termination may provide the physician with increased ability to obtain and maintain relationships with other companies. The requirement of a written reason for termination also provides some protection for a physician who suspects that the termination is premised on violation of the MCO's informal "gag" policy or other illegal reasons. Finally, this provision allows the physician or MCO to ensure that terminations are not based on mistakes of fact. For answers to questions physicians frequently ask about "without cause" termination, see Supplement 14.

8.5 Termination for Failure to Satisfy Financial Obligations. This Agreement may be terminated in its entirety or with respect to a Payor by either party upon five (5) days written notice if either party, or in the case of termination by Medical Services Entity, a Payor is: (a) more than sixty (60) days behind its financial obligations to its creditors; (b) is declared insolvent; or (c) files in any court of competent jurisdiction: (i) a petition in bankruptcy; (ii) a petition for protection against creditors; or (iii) an assignment in favor of creditors or has such a petition filed against it that is not discharged within ninety (90) days.

For answers to questions physicians frequently ask about their rights and obligations in the event of a MCO bankruptcy, see Supplement 10.

8.6 Effect of Termination. This Agreement shall remain in full force and effect during the period between the date that notice of termination is given and the effective date of such termination. As of the date of termination of this Agreement, and except as provided by Section 10.14, this Agreement shall be of no further force and effect, and each of the Parties shall be discharged from all rights, duties, and obligations under this Agreement, except that Company shall remain liable for Covered Services then being rendered by Qualified Physicians to Enrollees who retain eligibility under the applicable Plan or by operation of law until the episode of illness then being treated is completed and the obligation of Company to pay for Covered Services rendered pursuant to this Agreement is discharged. Payment for such services shall be made pursuant to the fee schedule contained on Exhibit B or, if Exhibit B does not contain a fee schedule, at the usual and customary charge of the Qualified Physician performing the service.

IX. Dispute Resolution

The AMA has revised Article IX by eliminating mediation from the dispute resolution process. While mediation can assist two parties to settle their differences, in the context of physician disputes with MCOs, mediation simply adds one more layer of process, cost, and delay, which serves to the advantage of MCOs. If a dispute with an MCO is unresolved after exhausting internal administrative processes, it is highly unlikely to be resolved in mediation.

While Article IX includes arbitration as one dispute resolution mechanism, Article IX is in no way meant to promote arbitration to the exclusion of litigation. This is an extremely important point. A number of MCOs, which are defendants in class action lawsuits brought by physicians, have grossly mischaracterized Article IX to support their arguments that physicians' lawsuits should be dismissed because they are subject to binding arbitration. In fact, these class action lawsuits would be permitted to proceed under Article IX. Under Article IX, if one party has filed a lawsuit, arbitration is not an option and the lawsuit would be allowed to proceed.

In a typical managed care contract, where the MCO relies on disenfranchising physicians from legal rights in the text of the agreement, dispute resolution becomes particularly complex. On the one hand, in some cases arbitration, when done properly, can provide physicians with a less costly, expedited, trial-like proceeding. On the other hand, the typical managed care contract provides for arbitration as the exclusive remedy, and MCOs are attempting to use these arbitration provisions to prevent physicians from participating in lawsuits that are challenging the unfair business practices embodied in many of these contracts. For more detailed information about dispute resolution and arbitration, see Supplement 15.

9.1 Binding Arbitration. Unless one Party has previously filed suit in a court of competent jurisdiction regarding the same subject matter, either Party may submit any dispute arising out of this Agreement to final and binding arbitration. Any such arbitration shall be held in the state where the services at issue in the dispute were or are to be performed. Arbitration shall be conducted pursuant to either the rules of the American Arbitration Association or the American Health Lawyers Association Alternative Dispute Resolution Project. The arbitrator shall be selected on the mutual agreement of both Parties and shall be an attorney and member of the National Academy of Arbitrators or the American Health Lawyers Association.

9.2 Arbitration Expenses. If Medical Services Entity prevails in the arbitration, Company shall be responsible for Medical Services Entity's costs and expenses related to the arbitration, including attorneys' fees and Medical Services Entity's share of the arbitrator's fees.

Section 9.2 is an addition in the 2002 AMA Model Managed Care Contract. Typically, in an arbitration, each party bears its own costs. However, in the case of a dispute resolution involving a Medical Services Entity and an MCO, the Medical Services Entity is alleging that it has rendered services and the MCO is holding the Medical Services Entity's money. If the Medical Services Entity has to spend money to obtain funds that an arbitrator determines it is entitled to under the contract, it is legitimate to require the MCO to pay reasonable costs and attorneys' fees.

X. Additional Provisions as Required by State Law

State law may require specific language to be included in a medical services or "provider" agreement. State-specific requirements should be inserted here.

[RESERVED]

XI. Miscellaneous

10.1 Nature of Medical Services Entity. In the performance of the work, duties, and obligations of Medical Services Entity under this Agreement, it is mutually understood and agreed that Medical Services Entity and each of its Qualified Physicians are at all times acting and performing as independent contractors.

10.2 Additional Assurances. The provisions of this Agreement shall be self-operative and shall require no further agreement by the Parties except as may be specifically provided in this Agreement. However, at the request of either Party, the other Party shall execute such additional instruments and take such additional acts as may be reasonably requested in order to effectuate this Agreement.

10.3 Governing Law. This Agreement shall be governed by and construed in accordance with the applicable federal laws and regulations and the laws of the state in which the subject services are primarily performed by or through Medical Services Entity.

10.4 Assignment. This Agreement shall inure to the benefit of and be binding upon the Parties and their respective legal representatives, successors, and assigns. Company may not assign this Agreement without Medical Services Entity's prior written consent, except that Company may assign this Agreement to an entity related to Company by ownership or control or to any successor organization without Medical Services Entity's prior written consent. Medical Services Entity may not assign this Agreement without Company's prior written consent, except that Medical Services Entity may assign this Agreement to an entity related to Medical Services Entity by ownership or control or to any successor organization without Company's prior written consent.

The assignment provision in 10.4 is mutual, unlike many managed care contracts, which limit the right of assignment to the MCO. Section 10.4 allows the assignment of the contract only to closely connected entities without requiring the consent of the other party. The automatic assignment will assist the parties administratively in the event of a change in ownership or control.

10.5 Waiver. No waiver by either Party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions.

10.6 Force Majeure. Neither Party shall be liable for nor deemed to be in default for any delay or failure to perform under this Agreement deemed to result, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, failure of transportation, strikes or other work interruptions by either Party's employees, or any other cause beyond the reasonable control of either party.

10.7 Time is of the Essence. Time is of the essence in this Agreement. The Parties shall perform their obligations within the time specified.

10.8 Notices. Any notice, demand, or communication required, permitted, or desired to be given shall be deemed effectively given when personally delivered or sent by fax with a copy sent by overnight courier, addressed as follows:

If to Company:

If to Medical Services Entity:

or to such other address, and to the attention of such other person or officer as either Party may designate in writing.

10.9 Severability. In the event any portion of this Agreement is found to be void, illegal, or unenforceable, the validity or enforceability of any other portion shall not be affected.

10.10 Third-Party Rights. This Agreement is entered into by and between the Parties and for their benefit. There is no intent by either Party to create or establish a third-party beneficiary status or rights in a third party to this Agreement, except for Enrollees or as such rights are expressly created and as set forth in this Agreement. Except for such parties, no such third party shall have any right to enforce or any right to enjoy any benefit created or established under this Agreement.

Unlike virtually every managed care agreement, this contract recognizes that the patient may have a legally recognizable right to benefit from the relationship between the physician and the MCO entity.

10.11 Entire Agreement. This Agreement supersedes any prior agreements, promises, negotiation, or representations, either oral or written, relating to the subject matter of this Agreement.

10.12 Notification of Legal Matters. If any action is instituted against either Party relating to this Agreement or any services provided hereunder, or in the event such Party becomes aware of facts or circumstances which indicate a reasonable possibility of litigation with any Payor utilizing Medical Services Entity, any Enrollee, or any other third person or entity, relevant to the rights, obligations, responsibilities, or duties of the other Party under this Agreement, such Party shall provide timely notice to the other, and the other Party shall cooperate with the first Party in connection with the defense of any such action by furnishing such material or information as is in the possession and control of the other Party relevant to such action.

10.13 Amendment. This Agreement may not be modified without the express written approval of both parties.

Many managed care contracts allow the MCO to unilaterally amend most of the terms and provisions at any point during the life of the contract. Section 10.13 ensures that neither side can amend the agreement without authorization.

10.14 Survival. Notwithstanding any provisions contained herein to the contrary, the obligations of the Parties under Articles III, VI, and IX shall survive termination of this Agreement.

Even after the contract is terminated, this provision ensures that the compensation, confidentiality and dispute resolution provisions remain in effect. For answers to questions physicians frequently ask about survival of obligations post-termination, see Supplement 16.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

MEDICAL SERVICES ENTITY

By: _____

Title: _____

COMPANY

By: _____

Title: _____

Exhibits that must be attached to AMA Managed Care Contract

Exhibit A

Covered Services

Exhibit B

Fee Schedules/Capitation/Withhold Schedule

Exhibit C

Coding Standards and Requirements

Exhibit D

Credentialing Criteria and Process

Addendum – Physicians Beware of these Common Managed Care Contract Clauses

Many managed care agreements contain clauses that are harmful to physicians. Many of these are discussed in the AMA Model Managed Care Contract and the Supplements. The following nine provisions are a sampling of some provisions that physician often agree to that create unanticipated problems. Physicians should know how to spot them and understand the consequences of agreeing to them. The term “provider” is used in the addendum instead of “Medical Services Entity,” because that is the term typically found in these contracts.

1.0 “Payor” means an employer, trust fund, insurance carrier, health care service plan, trust, nonprofit hospital service plan, a governmental unit, any other entity which has an obligation to provide medical services or benefits for such services to Enrollees, or any other entity which has contracted with Company to use Company’s PPO Plan.

This definition of “Payor” is broad enough to allow the managed care organization (MCO) to “sell” or “rent” its provider network to third parties, thus creating a “silent PPO. The practice of silent PPOs allows third parties to have the advantage of the MCO’s negotiated discounts with physicians, without the knowledge of those physicians, and without providing any value to the physician. For questions physicians frequently ask about silent PPOs, see Supplement 2.

2.0 All Products. Company has and retains the right to designate Provider as a Participating Provider or non-participating provider in any specific Plan. Company reserves the right to introduce new Plans during the course of this Agreement. Provider agrees that Provider will provide Covered Services to Members of such

Plans under applicable compensation arrangements determined by Company. Provider shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, regardless of whether Provider is a Participating Provider in such Plan.

“All products” provisions are becoming increasingly common in managed care contracts. They essentially force physicians to participate in all current (and sometimes future) products the MCO offers, on the terms and conditions dictated by the MCO. “All products” provisions have become an increasingly contentious issue in contract negotiations with MCOs, and at least seven states have passed legislation limiting their use. For questions physicians frequently ask about “all products” provisions, see Supplement 3.

3.0 General Offsets and Adjustments. Provider agrees to authorize Company to deduct monies that may otherwise be due and payable to Provider from any outstanding monies that Provider may, for any reason, owe to Company. Provider agrees that Company may make retroactive adjustments to the payment outline in Exhibit B.

This provision gives the MCO a free hand to do whatever accounting it desires and deduct monies from a physician or physician group/network in its sole discretion without a requirement to account to the physician or physician group/network and explain such deductions. This provision also could be used to justify the practice of “retrospective audits,” in which the MCO conducts an audit – often several years after services were rendered – and determines there has been an “overpayment.” The MCO then unilaterally sets

off the overpayment from reimbursement otherwise due. For answers to questions physicians frequently ask about retrospective audits, see Supplement 9.

4.0 Litigation. In the event of any litigation between the parties arising out of or related to this Agreement, the prevailing party shall be entitled to recover from the other party its reasonable attorney's fees and cost of litigation, including, without limitation, any expert witness

This provision is designed to further deter a physician or physician group/network from bringing a legal action to enforce their rights. Physicians are already deterred by the legal war chests MCOs have available to fight lawsuits. This clause ups the ante significantly by requiring the physician or physician group/network to pay attorneys fees and other costs of litigation if the MCO prevails in the lawsuit.

5.0 Noninterference with Members. During the term of this Agreement, Provider and its Qualified Physician shall not advise or counsel an Enrollee to disenroll from Company's Plan and will not directly or indirectly solicit any Enrollee to enroll in any other HMO, PPO or similar health care service plan or insurance program.

This provision has the potential to function as a "gag clause" and inhibit legitimate patient-physician communication. While MCOs have legitimate business interests in limiting the ability of physicians to encourage patients to switch plans, this provision ignores the reality that patients frequently turn to their physician first to discuss health care coverage options. This is particularly the case when the patient learns that his or her current health plan coverage is limited, or that

a particular specialist is not in the network. Under this provision, any explanation or discussion of these important patient care issues could be deemed as advice or counseling that could cause the patient to disenroll from the MCO.

6.0 Indemnification and Hold Harmless.

Provider agrees to indemnify and hold harmless and defend MCO from and against any and all loss, damage, liability and expense, including reasonable attorney's fees attributable to any and all acts and omissions of the Provider.

This "hold harmless" clause means that if an action or investigation is commenced or any other claim is made against the physician that involves the MCO, the physician will have complete responsibility for any costs the MCO incurs, even if the physician is ultimately exonerated. These clauses are particularly dangerous because MCOs are being named in lawsuits with increasing frequency. Physicians must be aware that most professional liability policies will not defend or indemnify a person who is not a party to the contract, so the physician would most likely have to cover these costs personally. The AMA strongly opposes "hold harmless" provisions.

7.0 Termination Without Cause. This Agreement may be terminated without cause by either party by written notice given to the other party at least one hundred twenty (120) days in advance of such of termination. In such cases termination will occur on the last day of the month in which the one hundred and twentieth (120) day following such notice occurs. Upon said termination by Provider, the rights of each party hereunder will terminate with respect to subscriber groups enrolled by the Company after the Company receives Provider's notice of termination. However, this Agreement will continue in

effect with respect to Enrollees existing prior to the Company's receipt of such notice until the anniversary date of the Company's contract with the subscriber group or for one (1) year, whichever is earlier, unless otherwise agreed to by the Company. If termination is by the Company, the rights of each party will terminate on the effective date of termination.

While this termination "without cause" provision theoretically allows either party to terminate 120 days notice, upon close inspection it requires the physician or physician group/network to continue providing services for one year or more after the giving notice. Any termination "without cause" provision should be truly mutual. For answers to questions physicians frequently ask about terminations "without cause, see Supplement 14.

8.0 Liability. Notwithstanding anything herein to the contrary, Company's liability, if any, for damages to Provider for any cause whatsoever arising out of or related to this Agreement, regardless of the form of the action, shall be limited to Provider's actual damages, which shall not exceed the amount actually paid to Provider by Company under this Agreement during the twelve (12) month immediately prior to the date the cause of action arose. The Company shall not be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of disagreement or any action, inaction, alleged tortious conduct, or delay by Company.

Physicians should beware of clauses like this that limit the physician's damages in a lawsuit to the amount of payment received from the MCO in the previous year. This is another tactic designed to effectively strip the physician for physician

group/network of real remedies in litigation with the MCO. Given that litigating against a large MCO can easily run into six figures, this limitation is clearly designed to chill the physician from bringing any lawsuit. Also, there is no attempt to make the limitations on remedies mutual. There is no rational legal basis in the managed care relationship for this provision.

9.0 Limitation on Action. Notwithstanding anything herein to the contrary, no action, regardless of form, arising out of or relating to this agreement may be brought by Provider more than twelve (12) months after such cause of action has arisen.

The statute of limitations for actions on contracts such as this vary from state-to-state but generally extend for five (5) years. There is no rational reason why MCOs should seek special treatment not available to others in limiting such actions to a twelve (12) month period.

Medical Necessity

What is the significance of “medical necessity” in a managed care contract?

The standard for determining whether care is “medically necessary” in a managed care setting has become an issue of national importance. Generally speaking, managed care organizations (MCOs) will pay for “covered services” that are “medically necessary.” However, MCOs across the country have taken control of medical decisionmaking by blurring the definition of medical necessity—a clinical determination—with covered services—a business determination. At the same time, the MCOs specifically disclaim any responsibility for medical decisionmaking and seek to place all liability on physicians.

Some managed care contracts leave the determination of medical necessity squarely in the hands of the MCO medical director with no stated role for the treating physician. The medical director can therefore override the treating physician’s decision. A medical necessity definition without a clear role for the treating physician is harmful to patients and physicians operating in a managed care environment and is a key factor in the dynamic that is driving legislative efforts at the state and federal levels.

Equally troubling is the fact that many MCOs also define medical necessity according to their own arbitrary cost criteria. It is the position of the AMA that cost containment has no place in medical necessity determinations, but instead should be addressed through contractual language regarding covered services.

How does “medical necessity” relate to “covered services”?

“Covered services” refer to the medical services the MCO has specifically stated that it will cover. MCOs have an obligation to clearly inform consumers about what services are “covered.” However, MCOs often use the terms “non-covered” or “not medically necessary” interchangeably, which is confusing to patients. A service may be “non-covered” or excluded from the MCO’s coverage, despite the fact that the service is “medically necessary.” Alternatively, a service may be a “covered service” under the MCO’s coverage, but a patient may be denied coverage because it is not deemed “medically necessary” for that particular patient.

How does the AMA Model Managed Care Contract address “medical necessity” and “covered services”?

The AMA Model Managed Care Contract (AMA Model) uses a “prudent physician” standard in defining medical necessity. Section 1.9 defines “medically necessary/medical necessity” as “health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician or other health care provider.”

Section 2.4 provides that covered services provided through the agreement must be specifically described in an exhibit to the contract. If the MCO fails to do so or does so in a non-specific manner, the MCO is required to pay the physician or physician group/network its billed charge for the service performed.

By making a clear distinction between medical necessity and covered services, the AMA Model provides greater protection to patients, assures that they have clear information about what services are covered, and assures that the MCO will not override medical necessity decisions based on cost considerations.

What is being done on this issue to protect the patient-physician relationship?

Forty-one states have enacted laws that require an external review process for appeals of adverse medical necessity determinations. MCOs, which typically take the position that those laws are preempted by ERISA, were dealt a major blow by the U.S. Supreme Court in *Moran v. Rush Prudential HMO, Inc.*, (June 2002). In a major victory for patients, the Supreme Court held that the Illinois HMO Act, which provides for external review of medical necessity decisions, was not preempted by ERISA. The *Moran* decision was broad enough that MCOs will face an uphill battle should they try to challenge external appeal laws in other states, particularly to the extent that those laws are similar to the Illinois law. The AMA and the Illinois State Medical Society filed “friend of the court” briefs in support of Ms. Moran in both the U.S. Court of Appeals and the U.S. Supreme Court.

However, the Supreme Court also made clear that the Illinois HMO Act did not apply to patients who receive their insurance through self-funded plans. Over half of commercially insured Americans receive their insurance through self-funded plans, so that leaves a major gap in patient protections. The issue of medical necessity and the rights of patients and physicians to appeal medical necessity decisions was debated by the United States Congress for much of 2001, as the House and Senate each passed versions of a Patients’ Bill of Rights. However, over the summer of 2001, House and Senate conferees were unable to agree on final language.

The AMA will continue to advocate strongly that medical necessity decisions should be determined in accordance with generally accepted standards of medical practice, and not by MCOs, and that all patients should be entitled to an independent external review of medical necessity decisions.

Silent PPOs

What is a “silent PPO”?

A “silent PPO” refers to a situation where, unbeknownst to its contracting physicians, a managed care organization (MCO) “sells” or “rents” its Preferred Provider Organization (PPO) network of providers to a third party (typically a third party administrator, insurance broker, or smaller PPO) and that third party gets the advantage of whatever discount the MCO has negotiated with the physician. The physician becomes aware of this only after he or she provides services to a patient who is not covered by the PPO. After filing a claim for his or her services with the patient’s health plan or insurer, the physician receives less than full payment and an explanation of benefits (EOB) referencing the discount with the original MCO PPO. Both the “seller” and the “purchaser” of the discount rely heavily on the fact that a busy physician practice will have difficulty spotting this anomaly on an EOB.

Depending on the terms of the physician’s contract, silent PPO activity may constitute a breach of contract. The AMA also believes that silent PPO activity may be fraudulent. Because of the potentially significant sums of money involved, physicians should take special precautions to assure that their managed care agreements do not contain “all payor” clauses that allow the MCO to rent or lease its physicians’ services to non-contracted entities. Section 1.0 of the Addendum to the AMA Model Managed Care Contract includes an example of a contract definition of “payor” that could potentially allow the MCO to rent or sell the discount.

Why are silent PPOs harmful to physicians?

Silent PPOs are financially harmful to physicians (and hospitals), and they violate fundamental concepts of fair business dealing. The silent PPO takes discounts to which it is not entitled, without negotiation, and without the physician’s consent or knowledge. Silent PPOs cut out the main incentive that induces physicians to enter into managed care contracts – patients.

When contracting for a PPO product, physicians and the managed care company engage in a deal. The physician offers a negotiated fee discount in exchange for access to a base of patients, as well as other benefits that result from participation on a PPO panel, such as inclusion in the PPO’s physician directory. In return, the PPO agrees to direct and encourage its patients to visit participating network physicians in exchange for discounted rates.

In a silent PPO, the physician or physician group/network unknowingly gives up a valuable asset—the discount—but does not receive a patient base in return. Patients may also be harmed because they may be paying inflated or incorrect copayments.

How does a silent PPO operate?

The following example demonstrates how a physician may become a victim of a silent PPO.

- Dr. Y is an internist who is a member of ABC PPO’s network and has negotiated a 25% discount for services rendered to PPO patients.

- Patient X, who is covered by an indemnity plan (*not* ABC PPO), presents to Dr. Y for an office visit. Dr. Y treats the patient and presents a bill to the indemnity insurer for the reasonable and customary charge of \$100.
- The indemnity insurer, after receiving the bill, contacts a third party administrator, broker, or any PPO to determine whether Dr. Y is on a physician network with a negotiated discount.
- ABC PPO offers to allow the indemnity insurer to use its negotiated 25% discount, for a fee.
- Instead of reimbursing Dr. Y the indemnity fee he is entitled to, the indemnity insurer then remits its portion of the discounted fee negotiated by ABC PPO, with a EOB. Dr. Y is instructed to collect the copayment from the patient.

Dr. Y is unlikely to realize what has happened. Most physicians do not have the computer technology or personnel required to compare each EOB statement to the patient's insurance coverage.

This example illustrates one type of silent PPO scenario. It is important for physicians to be alert to other situations where payment received is less than payment negotiated in the contract.

What is the financial impact of silent PPOs?

Given the difficulty in detecting the use of silent PPOs, it is impossible to determine the amount of money physicians have lost due to this practice. However, it has been estimated that physicians and non-physician health care providers nation-

wide have lost between \$750 million and \$3 billion annually since the practice began in the early 1990s.

How can physicians recognize a silent PPO in a managed care contract?

Provisions for silent PPOs may appear in contracts in a variety of forms, or they may not be a part of the physician's contract at all. Physicians should first scrutinize their managed care contracts for "all payor" clauses. These clauses typically require the physician to accept the discounted rate as payment in full from any payor. This may permit "selling" or "renting" the negotiated discount. However, simply because a contract does not contain an obvious "all payor" clause does not provide full protection from silent PPO activity. Therefore, physicians should try to gather as much information from the PPO representative before signing a contract, including asking direct and pointed questions about the PPO's relationship with its payors.

The AMA offers several suggestions physicians can use to protect themselves from the unauthorized use of negotiated discounts by silent PPOs.

1. Ensure that all PPO patients eligible for discounts are steered toward using in-network physicians. For example, PPO patients commonly receive a financial incentive to use network physicians.
2. Extend discounts only to patients with PPO identification cards.
3. Require the PPO (within the physician contract) to provide timely notice of changes to the list of payors authorized to receive the network discount.

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4. Require the PPO to disclose any discounts applicable to a PPO patient at the time the physician verifies coverage.

How do “silent PPOs” relate to companies that “reprice” claims for insurance companies?

A number of large “repricing” companies have developed healthcare networks that allow them to offer “custom” networks to MCOs, at a significant discount. In a typical example, an MCO (or self-insured employer) seeks access to providers in an area where the MCO has a limited number of covered lives. Therefore, the MCO may not have the leverage to extract discounts from providers. Instead it “rents” the network of the “repricing” company.

The primary difference between silent PPOs and repricing arrangements is that physicians have actually entered into a contractual agreement with the “repricing” company and agreed to allow their services to be “rented” to the company’s clients. Physicians need to be aware of what it means to sign a contract with one of these entities and the impact the agreed-upon discounts will have on their practices.

How does the AMA Model Managed Care Contract deal with silent PPOs?

Section 1.11 of the AMA Model Managed Care Agreement specifically restricts MCOs from selling or renting their networks to others not entitled to the negotiated discounts and does not include an “all payors” clause.

What is being done to combat silent PPOs?

The American Medical Association (AMA) is attacking this practice on a number of levels. The AMA succeeded in getting silent PPOs banned from all Federal Employee Health Benefits Plan (FEHBP) contracts, which was an important victory in light of the federal government’s liberal use of silent PPOs as a cost savings mechanism in the FEHBP.

In addition, the AMA Litigation Center and the Medical Association of Georgia filed “friend of the court” briefs in *HCA Health Services of Georgia v. Employers Health Insurance, Co*, which involved a challenge by a medical center to a silent PPO arrangement whereby an insurance company reduced the plaintiff’s payment by 25%. In February 2001, the U.S. Court of Appeals for the Eleventh Circuit rejected the defendant’s arguments that the plaintiff did not have “standing” to sue the insurance plan and held that the defendant’s interpretation of the provider contract was arbitrary and capricious. The AMA Litigation Center continues to look for other possible legal challenges to silent PPO arrangements.

One state, North Carolina, has implemented a law specifically addressing silent PPOs. The North Carolina law (N.C. Gen. Stat. 58-63-700) makes it an “unfair trade practice” for insurers to make a “material misrepresentation to a health care physician to the effect that the insurer or service corporation is entitled to a certain preferred physician or other discount off the fees charged for medical services, procedures, or supplies provided by the health care physician, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the physician on those fees.”

“All Products” Provisions

What is an “all products” provision?

An “all products” provision is a clause in a managed care organization (MCO) physician contract that requires, as a condition of participating in any of the MCO products, that the physician participate in all of the MCO products, sometimes present or future. “All products” provisions are part of an ongoing trend among MCOs to draft more and more onerous contracts that they present to physicians on a “take-it-or-leave-it” basis.

Can physicians opt-out of the “all products”?

“All products” provisions are often mandatory. However, thanks to the relentless advocacy efforts by the AMA and state medical associations, a number of MCOs have at least partially pulled back on their insistence on mandatory participation in “all products.” However, the AMA continues to have concerns about these same MCOs “backdooring” the all products requirement.

For example, some of these insurers require participation in all products within a “product line.” Given the reality that product lines are blurring, and MCOs are increasingly offering hybrid products, there are ways MCOs can manipulate product line definitions to force physicians to participate in products. MCOs also reserve the right to create different fee schedules for those physicians who choose not to participate in all products. The AMA also is very concerned about the possibility of differential fee schedules that are so coercive (in the form of lower rates for physicians who do not participate in all products) that it is financially impossible for physicians to

truly opt-out. The AMA continues to be vigilant about identifying tactics that MCOs may use to “backdoor” all products requirements.

Why are “all products” clauses so objectionable?

There are a number of important reasons why non-negotiable “all products” clauses are unacceptable. MCO plan products differ substantially in operation. For example, a physician may feel comfortable participating in a PPO product, but may have very valid reasons for not wanting to participate in an HMO product, which is a dramatically different product and often requires physicians to assume insurance risk. A risk contract may not be a viable business option for smaller practices with smaller patient bases because of practice size, patient mix or other valid actuarial or business concerns. A large group may have valid concerns that the MCO does not have appropriate computer systems to provide the data needed to manage the insurance risk.

“All products” provisions coerce physicians into participating in products about which they have legitimate concerns. In addition, some all products clauses require physicians to accept future contracts with unknown and unpredictable business risk.

How do MCOs try and justify these clauses?

MCOs state that they want a uniform network across product lines and that the all products approach is intended to protect continuity of care. However, this assertion is illogical. For

example, if a physician who has been participating in a PPO refuses to sign an “all products” clause, a patient who has historically chosen to see that physician through the PPO will be unable to continue under the physician’s care.

What is being done to combat “all products” provisions?

The AMA is aggressively fighting mandatory “all products” provisions and some insurers have pulled-back on their use of “all products” provisions as a result.

At the state level, seven states (Arkansas, Florida, Indiana, Kentucky, Maryland, Massachusetts, and Virginia) have passed legislation to limit the use of “all products” provisions in those states. A number of other state medical associations are considering similar efforts. Other states are working with their insurance commissioners to determine whether “all products” policies violate state unfair trade practices acts. The Nevada insurance commissioner has ruled that “all products” policies violate Nevada’s unfair trade practices act.

The AMA brought the issue to the attention of the U.S. Department of Justice (DOJ) in its 1999 challenge to Aetna/U.S. Healthcare’s proposed acquisition of Prudential. Because of the strong advocacy efforts by the AMA and the Texas Medical Association, the DOJ forced Aetna to spin-off parts of its Texas business as a condition of approving the acquisition. For the first time, the DOJ based an enforcement action on a MCO’s power over the purchase of physician services.

The DOJ specifically acknowledged the potentially harmful impact of the “all products” provision where MCOs have significant market share. The DOJ noted that where an MCO has a large market share, an “all products” provision further limited a physician’s ability to walk away from a contract. Given the DOJ’s analysis, the AMA believes that successful challenges to “all products” provisions will occur in markets where a dominant insurer is insisting on physician participation in “all products.”

How does the AMA Model Managed Care Contract treat this issue?

Section 1.12 of the AMA Model Managed Care Contract (AMA Model) specifically states that the contract cannot be construed to require physicians to participate in all products as a condition of participating in any individual product. The MCO and physician can enter into a single set of legal terms to govern all products included in the agreement, but they must develop separate business terms (including compensation) for each and every product. Either party may terminate plans or products individually.

Capitation and Risk

What is capitation?

Capitation is a method of reimbursement that shifts the financial risk for provision of care from the managed care organization (MCO) or other payor to a physician or physician group/network by establishing a fixed amount to cover specific services for a defined patient population on a per member (ie, patient) per month (PMPM) basis. In the context of managed care, the term “risk” refers to the obligation to pay for covered services, without knowing in advance what services will be needed.

Capitation is a radical shift from a fee-for-service basis or a discounted fee-for-service arrangement. When reimbursement is based on a fee-for-service basis, the cost of care is the MCO’s responsibility. The physician provides medically necessary services and the MCO pays, though often at a negotiated discount.

By contrast, under a system of capitation, the physician assumes the financial risk of providing care for a population of patients. The amount of reimbursement is fixed, regardless of the number of services an individual patient may need. The theory behind capitation is that physicians will practice more “efficiently” when they are at-risk for utilization of services and will use less resources.

Capitation can be financially beneficial to a physician or physician group/network, and there are practices that have done well financially under capitation. However, it also can be highly risky, and there are physician groups/networks that have suffered severe financial loss under capitated agreements over the past few years. When

patients use fewer services than anticipated in setting the PMPM rate, the physician practice retains the unspent funds. Healthy patients obviously use less services. However, when patients use more services than anticipated in setting the PMPM rate (and remember, healthy patients get sick), the physician practice loses money.

Therefore, entering a capitation contract requires a different approach. The physician or physician group/network must evaluate, from an actuarial standpoint, whether or not the practice is in a position to assume financial risk under the contract. Because there is no way to predict in advance how much care each patient will require, the “risk” is that the healthy patients assigned to a physician practice will balance against the sicker patients who require more services for the same set payment amount.

This involves a number of factors, including the PMPM rate, the identification of covered services, size of the patient population, and actuarial projection of cost. The practice must have the capacity to track utilization of services under a capitated contract in order to manage the risk of financial loss. While the capitation rate itself is critical, the totality of the capitation arrangement in relationship to the individual practice must be evaluated. The AMA and the California Medical Association have jointly published *Benchmark Capitation Rates: The Physician’s How-to Guide for Calculating Fee-for-service Equivalent* which provides detailed guidance on assessing the financial viability of capitation rates proposed by MCOs. AMA members can obtain the guide free of charge by calling 800 262-4311.

How do physicians manage their practices on capitation payments?

The PMPM payment for defined covered services may seem inadequate for a physician or physician group/network to accept for an individual member. For example, a capitation of \$40 PMPM for the provision of all professional services translates to \$480 a year, an amount that could be exhausted overnight by an enrollee with serious medical problems. Yet, this same PMPM capitation rate may make more sense if a physician or physician group/network has 2,000 enrollees, which translates to an annual payment of \$960,000 per year. As the number of enrollees increases, the risk associated with capitation decreases.

Therefore, capitation is typically a better option for larger groups that have the infrastructure to manage the costs of health care for larger patient populations and a far riskier proposition for solo and small group practices. Regardless of the practice size, it is important to establish an actuarially sound minimum number of enrollees before the capitation rate becomes effective in order to limit risk.

It is impossible to recommend a minimum number of enrollees or appropriate capitation rates for an individual practice because every practice situation is unique. The AMA/CMA publication, *Benchmark Capitation Rates*, provides more detailed information on evaluating capitation rates.

What are the different types of capitation?

The different capitation arrangements relate primarily to the scope of defined services to be

included. The types of capitation arrangements from greatest risk to smallest risk are:

- Full-risk capitation (also known as global risk);
- Professional risk capitation (also known as multispecialty capitation);
- Primary care capitation; and
- Specialty capitation.

Full-risk or global capitation

In a full-risk capitation model, the physician or physician group/network must provide or arrange for all professional and institutional services for its assigned patients. Physicians and hospitals have shared financial incentives to control all medical utilization.

Physicians accepting full-risk capitation must have a substantial infrastructure and effective practice management. The physician group/network must make arrangements to provide all covered services either directly, or indirectly through relationships with hospitals, other physicians, and non-physician providers. Remember that in this type of agreement, the practice is responsible for all covered services. If the practice does not perform certain services, it will be responsible for paying someone else to perform them. Administering full-risk agreements also demands sophisticated financial management, information systems, and medical management to track member eligibility, oversee referrals, process claims, and prepare reports to enable physicians to make informed decisions on a timely basis.

Percentage of premium

Percentage of premium arrangements are substantially similar to full-risk capitation. The responsibilities and duties of the physician group/network to provide all professional and institutional services remain the same. The critical difference is how the capitation rates are structured.

Instead of setting the capitation rate at a fixed dollar amount PMPM, the MCO pays the physician or physician group/network a percentage of the premium rate the MCO receives from the employer. The perceived benefit to the physicians is that they receive their fair portion of the premium dollar. If the MCO increases the premium it charges employers, then the physician group/network will receive a larger reimbursement.

Percentage of premium entails greater risk for the physician or physician group/network. If the MCO does not perform underwriting properly or decides to expand market share by lowering its premiums, then the percentage of premium received by the physicians may be insufficient to cover the cost of service that must be provided.

Professional (multispecialty) capitation

In a professional capitation model, the physician or physician group/network receives a capitation payment and agrees to provide or arrange for all primary and specialty care physician services. This differs from full-risk capitation because the physicians are not responsible for hospital or institutional services. If the physicians cannot provide a particular service, they must enter into an arrangement to pay another physician

or non-physician provider to deliver the service. Because the physicians are not at risk for institutional services under a professional capitation arrangement, the MCO may structure a hospital bonus arrangement (sometimes in the form of a risk pool, discussed below) to incentivize the physicians to manage the MCO's costs for hospital utilization.

Primary care capitation

In a primary care capitation model, the physician group receives a capitation payment in exchange for the obligation to provide only primary care services for assigned patients. The specific services that are included in the primary capitation payment are defined in the contract and are frequently subject to negotiation. The physician group may also provide services not included in the capitation and receive reimbursement in accordance with a fee schedule. These services are known as "carve-outs" (see discussion below) because they are carved-out of the capitation reimbursement.

Specialty care capitation

In a specialty capitation model, the physician group receives a capitation payment in exchange for the obligation to provide specialty services for assigned patients. The specific services that are included in the specialty capitation are defined in the contract.

Physicians entering into specialty care capitation arrangements should take into account the frequency and the average cost of the service before agreeing to a specific capitation rate. The lower the frequency and the higher the cost, the larger

the group of patients must be before a specialty capitation is a financially viable alternative. For example, a specialty capitation might be a viable option for a physician practice because the practice has a higher frequency and lower average cost per service. A specialty capitation might not be a viable option for a physician practice that has a lower frequency and higher average cost per service.

What is sub-capitation?

Sub-capitation refers to arrangements in which a physician group accepts capitation, but then subcontracts out some of the risks and obligations to provide certain covered services for a defined population to another group of physicians or providers. For example, a group of primary care physicians may accept professional capitation and sub-capitate a group of cardiologists by paying them a fixed per member per month payment for the provision of cardiology-related services for the members assigned to those primary care physicians.

What is case rate reimbursement?

A case rate is the total reimbursement paid for one particular treatment or service (a “case”) with a limited duration. This term is used most often to cover all defined services related to a certain procedure, such as an outpatient surgery, maternity delivery, or organ transplant. Case rates may include the professional component only, facility component only, or both, depending on the agreement between the parties.

A case rate blends certain features of capitation and discounted fee-for-service reimbursement.

It places physicians at risk for the cost of the case, but it does not place physicians at risk for the full volume of patients who may need procedures covered under these case rates.

What is contact capitation?

While there are various models of contact capitation, in general, revenue is distributed among a panel of specialists according to “episodes” or “contacts.” The contact almost always begins with a patient referral. However, different models use different means of specifying the duration of the contact. The duration of the contact can be defined in terms of a specified number of months, the achievement of specific clinical endpoints, or the provision of specific services.

Regardless of the model, the specialist receives a fixed amount of revenue for treatment of the patient over the term of the contact, and the specialist is responsible for providing the majority of the care within the specialty. The implementation of contact capitation poses certain administrative challenges for physicians that are different from other forms of capitation, and physicians need to be careful before entering into such an arrangement.

What are “carve outs”?

Physicians may identify certain services offered by the MCO to patients that they wish to exclude from a capitation agreement, generally because they are very high cost services. These exclusions are sometimes referred to as “carve-outs” because they are “carved out” of the capitation reimbursement. Any carve-outs should be

listed in the contract by procedural code to avoid potential payment disputes.

The decision whether or not to carve out a service should be based on an analysis of the cost to provide or arrange for those services and the financial impact of potentially providing these services under a capitated payment system. Procedures that are very time consuming and expensive to perform should be carved out of the capitation rate. Examples of services commonly carved out may include pharmacy services, organ transplants, behavioral health services, and fertility services.

A physician can still perform a procedure that has been carved out of the capitation arrangement. The carve-out simply means that the MCO, rather than the physician group, is “at risk” to provide the service, and the physician will be reimbursed on a fee-for-service basis.

What is “stop-loss” insurance?

“Stop-loss” insurance limits the financial liability for physicians under capitation contracts. MCOs typically offer stop-loss insurance as part of the capitation agreement. Stop-loss essentially protects physician practices against the potentially devastating financial impact of a number of high cost patients not accounted for in the PMPM reimbursement methodology. There are two basic forms of stop-loss insurance. The first is specific stop-loss coverage, which bases a threshold (e.g., \$10,000) on an individual patient. The second is aggregate stop-loss coverage, which bases the threshold on the combined treatment costs of the entire capitated group (e.g., \$60,000). Once the threshold is exceeded, the MCO may pay all

costs in excess of the threshold, or a percentage (e.g., 80%).

Stop-loss insurance is important in helping physicians effectively manage risk in capitation arrangements. Physicians should carefully analyze the price, terms of coverage, financial benefits, and appropriateness of stop-loss protection to accompany their risk-based contracts.

What are “withholds”?

Withholds are an incentive arrangement under capitation. Under a typical “withhold,” MCOs will retain a certain percentage of capitation payment due physicians, and at the end of the year, return all, some, or none of it, depending on whether certain conditions relating to utilization of medical services have been met. Common conditions for receiving withhold funds at the end of the year include achieving goals related to hospital costs, specialty costs, pharmacy utilization, and patient satisfaction. Routinely, withholds may range from 10-20%.

It is critical that physicians understand, before signing a contract, that they may never receive a withhold payment. Therefore, it is risky to rely on that potential revenue in managing the business end of a practice. It is also critical that the practice have the ability to self-monitor progress toward meeting withhold requirements throughout the term of the contract and that the MCO provide regular status reports on progress toward reaching the targets. One alternative to withholds is for both parties to agree that a fixed reimbursement amount will be paid, plus incentive payments, if certain agreed upon goals are met. This approach allows the practice more predictability from a business perspective.

What are “risk pools”?

“Risk pools” are another financial incentive used in capitation contracts. A risk pool is a mechanism sometimes offered to physicians to participate in any cost savings the physicians create for the MCO. Under a risk pool arrangement, funds are withheld from the physician and typically, hospitals, to cover the costs of specific services, such as prescription drugs, hospital charges, laboratory, and pathology services. The MCO may also contribute to the risk pool.

While risk pools occur in many different scenarios, the result is the same. If certain specified goals are met (for example, coming in below budget for hospital or pharmacy services), the MCO and other participants (physicians and/or hospitals) agree to share a certain portion of the savings from the budgeted expenses.

The theoretical advantage of risk pools is that physicians have access to a larger percentage of the premium dollar. However, the physician group/network (as well as the hospital) must have an infrastructure that allows it to track utilization of these specific services in order to maximize the possibility of sharing the surplus.

What are the key issues that need to be considered before accepting a capitation agreement?

Paragraph 3.3(a) of the AMA Model Managed Care Contract sets forth key issues that need to be considered before accepting a capitation arrangement. As part of the contract analysis, the physician group/network should consider the following questions:

1. Are the services included in the capitation rate clearly identified and understood?
2. Are there any procedures that are so expensive and time-consuming to provide that they should be “carved out” of the capitation agreement? If so, these procedures should be identified by procedure code in the contract along with their rate of reimbursement.
3. Is the amount of capitation adequate, based upon sufficient financial and actuarial analysis of relevant data?
4. Is there a minimum number of enrollees established before the capitation rate becomes effective? Is that number actuarially sound?
5. Are agreements in place to manage the risk through such mechanisms as stop-loss insurance, carve-outs, and sub-capitation?
6. Is the MCO’s commitment clear regarding the provision of complete, accurate, and timely financial reports and analysis?
7. Is there a mechanism, if certain conditions are met, to switch prospectively to discounted fee-for-service payments during the term of the contract and, if so, what would those terms of payment include?
8. Has the physician compensation plan been fully discussed and understood among the pertinent physicians, including analysis of best and worst case scenarios for managing capitation?
9. How realistic are the key assumptions that must be satisfied in order for the capitation payment to be adequate?
10. Has the physician or physician group/network received the appropriate professional guidance in determining that the capitation rate offered will be sufficient not only to provide all covered services but also to meet overhead?

What are the key advantages of capitation?

The key advantages of capitation are:

- **Potential increased income:** Capitation allows physicians to essentially “control” a larger share of the premium dollar. In a best-case scenario, the physicians can therefore benefit financially from reducing utilization of their own services, and in some arrangements, from reducing use of hospital and ancillary services.
- **Potential improved cash flow:** Physicians receive a fixed payment each month; therefore, capitation can improve cash flow and reduce bad debt expenses.
- **Potential budgeting benefits:** The steady cash flow generated from capitation improves physicians’ ability to manage their practices by enabling them to use well-defined budgets.
- **Relief from external utilization review:** Because physicians are at risk for overutilization, there is no external review performed by the MCO.

It is important to remember that the benefits of capitation can be illusory for many physicians because assuming risk by definition requires very sophisticated and expensive information infrastructures beyond the reach of many physician practices. MCOs do not generally care or consider whether or not the physician or physician group/network has the capability to manage risk.

This is one reason that the AMA objects strenuously to the “all products” provisions in many managed care contracts because they can force physician practices that are not equipped to handle risk into capitation contracts, with potentially dire financial consequences. Physicians

and physician groups/networks should have the opportunity to review these potential advantages in the context of the realities of their practice.

What are the key disadvantages of capitation?

- **Need for complex, costly information infrastructure:** The physician or physician group/network must have in place an information infrastructure that enables tracking cost and utilization of services. It is important to remember that a number of large, sophisticated physician practice management companies have gone bankrupt because of an inability to manage risk contracts.
- **Inadequate capitation payments:** There are increasing concerns in parts of the country that MCOs are continuing to decrease capitation payments to a point that it threatens the stability of physician practices in those areas. Inadequate capitation has been cited as the primary reason for a rash of physician group practice bankruptcies in California and other parts of the country.
- **Financial risk:** No matter how careful a practice is and how carefully it manages the capitation contract, there is a possibility that the practice will lose money under a capitation contract.

Financial incentives in managed care contracts can raise complex ethical issues for physicians. For guidance, physicians can refer to AMA Council on Ethical and Judicial Affairs opinion E-8054 (available at the AMA web site <http://www.ama-assn.org>).

Discounted Fee-for-Service

What are the different types of discounted fee-for-service arrangements that MCOs use to pay physicians?

The term “discounted fee-for-service” refers to payment for each service rendered by a physician based on a discounted fee schedule. In discounted fee arrangements, the managed care organization (MCO) and physician or physician group/network negotiate a discounted fee schedule. Discounted fee schedules are by far the most common form of compensation in managed care agreements. In contrast to capitation arrangements, in discounted fee arrangements, the physician or physician group/network does not assume financial or insurance risk for the total cost of care for a patient population.

The major types of discounted fee models include fee schedules that rely upon the following: the Medicare Resource-Based Relative Value System (RBRVS) or some other relative value system, usual and customary physician charges, physician billed charges, or custom-designed fee schedules. MCOs usually construct fee schedules to achieve strategic objectives and address the MCO’s perception of the market for physician services.

What are the key issues in analyzing discounted fee-for-service compensation arrangements?

The temptation for some physicians is to rely on the MCO’s informal representations about the fee schedule in a discounted fee contract. Discounted fee arrangements sound simple and straightforward, but can be problematic for physicians. MCOs commonly fail to attach fee

schedules, fail to update physicians on changes to the schedule, and often refuse to tell a physician the rate of reimbursement before the contract is signed. And when MCOs provide fee schedules, they often insist on the right to unilaterally reduce the fee schedule without consultation and consent of physicians.

The key issues to address with discounted fee arrangements include the following:

- Is a detailed description of a comprehensive fee schedule attached to the agreement or is enough information provided that the fee for each service can be calculated accurately? MCOs often refuse to provide this information, arguing that it is too cumbersome to provide a list of fees for each procedural code used. *When that occurs, physicians should consider providing the MCO with a list identifying twenty to fifty of the most commonly billed procedures by CPT code and insist that the MCO provide the pertinent reimbursement rates.*
- Who has authority to change the fee schedule? Can the MCO change the fee schedule unilaterally or must it notify and obtain the consent of physicians?
- How much notice will physicians be provided before the fee schedule can be changed, and if adequate notice is not given, does the right to terminate apply?
- Have the fee schedules been analyzed in a manner to take into account the frequency of utilization of specific codes? Physicians need to make sure that they get paid fairly for the CPT codes they use most often. Some MCOs mislead physicians by presenting favorable

reimbursement terms for CPT codes rarely used. Again, physicians should consider presenting the MCO with a list of common procedural codes used by the practice and insist that the MCO provide pertinent reimbursement rates.

Why aren't MCOs required to provide fee schedules for discounted fee arrangements?

The AMA believes that MCOs should be required to provide fee schedules. MCOs typically claim that their fee schedules are “proprietary” and that they are not obligated to disclose them. Others argue that it is “too complex” to produce an accurate fee schedule. Given that the MCOs are able to determine payment when a claim is submitted, the MCO knows what its fee schedule is.

Thanks to efforts by organized medicine, in 2002 physicians have had their first major victories in combating the refusal of MCOs to disclose fee schedules. In *Stubbs v. Blue Cross Blue Shield of Georgia, Inc.*, (a case filed by the Medical Association of Georgia (MAG) and supported by the AMA), the Georgia Superior Court upheld a lower court order that requires Blue Cross and Blue Shield of Georgia (BCBSGA) to disclose its fee schedule and the precise methodology used in determining all payments. The AMA and MAG plan to aggressively work to assure that BCBSGA complies with the May 2002 decision.

In addition, at the instigation of the Texas Medical Association (TMA), in May 2002, the Texas Attorney General ruled that the Texas

Department of Insurance (TDI) has the authority to require health insurers to fully disclose their reimbursement practices to physicians and other providers, including fully disclosing practices such as downcoding and bundling of claims. TDI originally indicated it did not have the authority to issue these rules, but following the Attorney General's decision, TDI issued new rules requiring disclosure.

What are the advantages of discounted fee-for-service arrangements?

Discounted fee arrangements are safer for physicians and physician groups from a practice management perspective. Physicians receive payment for all individual procedures performed as opposed to a single “per member per month” payment covering all care rendered for a patient population. Discounted fee arrangements do not require a complex actuarial analysis to evaluate and do not require that the practice have a complex infrastructure to track utilization of patient populations. In addition, physicians who negotiate discounted fee arrangements are doing so as part of a MCO network (e.g., a PPO). By participating in a MCO network, the physicians expand their potential patient base.

As physicians continue to file claims under discounted fee contracts, the practice is able to gather and analyze information, such as utilization and outcomes measures. Such analyses can be used in a number of beneficial ways, including improving the clinical performance and business efficiency of the practice and determining whether the practice might be in a position to accept capitation contracts in the future.

What are the disadvantages of discounted fee-for-service?

Compared to non-discounted fee agreements, discounted fee agreements clearly provide less reimbursement for the same services. However, the greater concern with discounted fee arrangements is the control the MCO may retain over reimbursement. Many contracts allow the MCO to unilaterally change fee schedules at will, with no real recourse for physicians. Unless the contract contains adequate protections, MCOs can continue to ratchet down the fee schedule with little recourse for the physicians.

To the extent that capitation allows physicians to share in the potential “upside” of managing a patient population, discounted fee arrangements clearly do not offer that advantage. There are some group practices that prefer risk sharing to discounted fee arrangements.

How does the AMA Model Managed Care Contract protect physicians?

Article III of the AMA Model Managed Care Contract (AMA Model) requires the MCO to attach the fee schedules and if the MCO fails to do so, payment reverts to “usual and customary.” The AMA Model also prohibits the MCO from unilaterally reducing the fee schedule. Although the fee schedule can be renegotiated annually, the physician can terminate the contract if the fee schedule is unacceptable.

Downcoding and Bundling of Claims: What Physicians Need to Know About These Payment Problems

Introduction

Coding can be a confusing issue for a physician practice. If it isn't done properly, payment for services can be denied or significantly reduced. On the other hand, even though a physician practice often does everything correctly when it comes to coding, payments may still be denied, delayed, and/or significantly reduced by health insurers.

The bottom line is that physicians are entitled to be paid for the services they provide. The first step in assuring that this occurs is to make sure that each and every claim is submitted correctly. This means that the correct code is selected to describe the services rendered and that any other requirements of the insurer are met.

Even after jumping through the hoops, physicians cannot control what happens to the claims once those claims leave a physician's office. A whole slew of problems can occur and are responsible for millions of dollars in lost income annually. The purpose of this supplement is to explain the terminology used in coding and claims submission, help physicians understand the importance of coding correctly, alert physicians to some of the increasingly common health insurer tactics that undermine physicians' efforts to get fair compensation for services rendered, and propose possible solutions.

At the outset, it is important for physicians and their office staff to understand the difference between what they may perceive as a coding problem and what is, in fact, a payment policy problem. Health insurers are free to set their own

payment policies, which is why it is important for physicians to know fee schedule amounts.

This paper addresses problems relating to commercial insurance and does not address claims and coding issues in the Medicare program.

What is CPT?

Current Procedural Terminology (CPT®), a coding work, was developed by the American Medical Association (AMA) and organized medicine over 30 years ago and is the most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs. It is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. CPT currently includes over 7800 codes. The development of CPT continues to be driven by the need for accurately reporting medical services, which benefits patients, physicians, and payors alike.

How is CPT kept current?

CPT is kept current through the CPT Editorial Panel process. The CPT Editorial Panel is made up of 16 members, including 11 physicians nominated by the AMA, the chair of the Health Care Professionals Advisory Committee (HCPAC), and one physician representative each nominated by the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the American Hospital Association,

and the Centers for Medicare and Medicaid Services. The CPT Editorial Panel is supported in its efforts by the CPT Advisory Committee, which is made up of representatives of more than 100 national medical specialty societies and other health care professional organizations.

CPT is maintained and routinely revised, updated, and modified to address the often complex problems associated with new technologies, outdated medical procedures, and changes in medical care. The CPT Editorial Panel addresses over 60 major topics a year, which typically involve more than 3000 votes on individual items. The panel actions result in three outcomes:

- 1) add a new code or revise existing nomenclature;
- 2) table an item for further discussion;
- 3) reject an item.

The AMA implements the decisions and recommendations of the CPT Editorial Panel.

Are health insurers required to abide by the CPT guidelines and instructions?

The AMA holds a copyright to CPT codes and descriptions as well as its guidelines, notes, and instructions. Use or reprinting of CPT materials in any product or publication requires a license, unless the use is very limited and would be “fair use” as defined in the U.S. copyright laws. CPT is widely licensed to software developers, medical publishers, and others who are interested in using CPT codes or descriptions to describe medical procedures. The law does not permit the AMA to enforce certain payment policies based on a payors’ interpretation of CPT. In other words, the CPT Editorial Panel controls CPT issues,

while private health insurers largely control payment policy.

CPT is designed to be used in its entirety. The structure of the coding system provides precise definitions and instructed usage for each service or procedure subject to a separate code. The AMA also requires CPT licensees to use commercially reasonable steps to follow CPT guidelines, notes, and instructions for use of CPT (as included in the current CPT book) in the development and updating of their products.

The AMA succeeded in having CPT named as the code set for physician services in the Administrative Simplification Rules on Transactions and Code Sets promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This was a great success for physicians and means that by October 2003, all providers and insurers who transmit health care information must be able to read and accept CPT codes and modifiers. However, the AMA did not succeed in having the CPT guidelines named as the national standard. Had the AMA succeeded, this would have addressed the concerns of physicians about varying interpretations of CPT by insurers. The AMA needs the strong support of physicians and others to work towards the eventual adoption of the CPT guidelines as a standard under federal law.

Acceptance of CPT codes, guidelines, and conventions does not imply standardized payment for documented and reported services. However, the increasingly arbitrary, unilateral, and inconsistent application of CPT codes, guidelines and conventions has created confusion and uncertainty for physicians and made it difficult—if not impossible—to determine whether the health insurer has paid according to the contracted rate.

It is important for physicians to understand that nothing prevents the federal government or any private health insurer from choosing another code set over CPT in the future. This code set could be introduced by groups far removed from hands-on patient care.

Physicians should never take CPT for granted. The path the AMA chooses and the steps taken to enhance CPT will largely determine whether organized medicine is able to continue to lead in the development of medical service coding, not only for physicians, but for the entire health care industry.

Is CPT a reimbursement system?

No. The CPT process to develop codes and descriptions does not dictate the payment amount or whether or not a service is covered under any particular payment program. CPT merely represents a language or communication methodology for claims submission for services and procedures. However, increasingly, commercial insurance payment systems are based on a Medicare Resource-Based Relative Value System (RBRVS) or some other relative value system, which establishes physicians' work values for CPT codes based on their precise definitions and instructed usage.

When Medicare implemented the RBRVS in 1992, the CPT Editorial Panel (which includes representatives from the Blue Cross and Blue Shield Association and the Health Insurance Association of America) agreed with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) that modifiers were crucial in establishing a formalized structure and linkage between CPT coding and this new payment methodology. When health

insurers base payment on the Medicare RBRVS, it is particularly inappropriate for these health insurers to misapply CPT coding and justify denial of payment based on this misapplication.

How exactly does CPT coding relate to claims billing?

CPT is an integral part of claims billing. As noted, CPT provides a common "language" for physicians to submit claims to health insurers. Each claim submitted for services provided or procedures performed must include:

1. An ICD-9-CM diagnosis code to describe the diagnosis or symptoms for which a service or procedure was provided. A HCFA 1500 claim form typically allows multiple CPT codes to be linked to a single ICD-9-CM diagnosis code;
2. The correct CPT code(s) for each service and/or procedure provided;
3. With unlisted procedures, appropriate supporting documentation.

What are the keys to accurate documentation for claims submission?

It is AMA policy that the medical record is first and foremost a clinical record to support patient care. Nonetheless, accurate documentation plays a critical role in claims submission. Physicians should assure that the medical record supports the need for the level of service billed and the procedures or services provided. Accurate medical records should be maintained to reflect all pertinent information, including diagnoses, clinical findings, tests ordered, and procedures performed. Any consultations over the phone also must be documented.

The medical record comes into play in at least two situations relating to claims submission. First, if physicians believe claims were wrongly denied (or bundled/downcoded), accurate documentation in the medical record will be a key component to any appeal. Second, if physicians are retroactively audited by a health insurer or are accused of fraud, the medical record will be an important defense.

Some health insurers are following the example of the Medicare program and requiring supporting documentation for certain levels of evaluation and management (E/M) services. This will be touched on briefly in the “downcoding” section. All of this highlights the importance of accurate medical records documentation.

How does the managed care contract impact claims submission?

Contracts between physicians and health insurers set forth, or should set forth, detailed information on how claims should be submitted, including the following: the type of patient information required, the type of form to use (almost universally the HCFA 1500 form), the type of documentation required, and the place to send the information.

Physicians should beware of contract terms that state that CPT will be used for claims submission, but add a caveat such as “the Company reserves the right to rebundle to the primary procedure those services determined by the Company to be part of, incidental to, or inclusive of the primary service.” This type of provision is designed to permit the health insurer to engage in the objectionable practices described in this article.

What is “bundling” of claims?

In the broadest sense, “bundling” occurs when a physician submits a claim for two or more separate and distinct CPT services or procedures performed on a single patient during a single office visit and the insurer “bundles” them together and reimburses for just one of the services or procedures, typically the one of lowest cost. This happens in a variety of ways. The most common are through ignoring CPT modifiers and through the use of secret “black box” edits.

- **Ignoring modifiers**

One of the most common ways of bundling is for health insurers to ignore CPT modifiers.

A CPT modifier is an additional two-digit code reported together with a CPT code that indicates that the procedure or service was somehow modified. There are several modifiers whose purpose is to signal to the health insurer that two or more services or procedures submitted on a single claim and performed on the same day are, in fact, separate and distinct and separately reimbursable. The problem of claims “bundling” occurs when an insurer ignores the modifier, “bundles” the two reimbursable procedures together, and reimburses only for one. This results in an unfair devaluation of the physician’s services.

Physician complaints about health insurers ignoring modifiers and bundling separate procedures and services occur most frequently with modifier -25.¹ Modifier -25 is described in the CPT Manual as a “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.”

¹ The AMA also has received complaints about modifiers -51, -57, and -59 being inappropriately ignored, and separate procedures “bundled.”

In simpler terms, modifier -25 is used when a patient presents with one health care problem that a physician evaluates, manages, and treats, and during the same visit the patient also presents a second unrelated problem that the physician treats. Modifier -25 also can be used when the patient's condition required a significant, separately identifiable Evaluation and Management (E/M) service **above and beyond** the usual preoperative and postoperative care associated with the procedure that was performed. That work takes additional physician time and resources and should be reimbursed. However, health insurers frequently ignore modifier -25 and reimburse for just one service (the lowest cost). It is also important to note that the diagnosis reported with both the procedure/service and E/M service need not be different, if the same diagnosis accurately describes the reasons for the encounter and the procedure.

Health insurers ignore modifier -25 (and other modifiers) to save money. Because it is done automatically, there is no consideration of the actual clinical encounter between the patient and physician. This is directly contrary to published CPT instructions and violates principles of fundamental fairness. Physicians should not be penalized for providing all necessary care during a single office visit, and, instead, insurers should reward this efficiency and quality care.

- **“Black box” edits**

A second common form of bundling is through “black box” coding edits. “Black box” edits refer to claims editing software that health insurers purchase and then customize to automatically ignore certain modifiers or to group certain CPT codes together in a manner contrary to CPT instructions. The term black box comes from the fact that health insurers consider these

edits proprietary and keep them secret. The physician typically is reimbursed for just one procedure and receives no reimbursement for the second procedure.

Black box edits are very problematic because of the secretive nature of the edits. For example, some third-party vendors will customize surgical “packages” for health insurers’ billing purposes. What services or procedures are included in the package are often unknown and may not be consistent with CPT. Moreover, there are any number of idiosyncratic edits that are difficult to even decipher from an explanation of benefit (EOB) form. Sometimes physicians can figure out certain edits after getting numerous denials or lower reimbursement for the same service or procedure, but this is still difficult.

It is particularly troubling that commercial health insurers insist on using secret “black box” edits, in light of the Centers for Medicare and Medicaid Services’ (CMS) decision to eliminate black box edits in the Medicare program and make all coding edits public. While CMS’s approach to the issue of coding edits is not perfect, this new policy acknowledges and respects that physicians have a basic right to know coding policies and procedures before claims submission.

CMS also has solicited the AMA and national medical specialty societies for input into matters relating to coding edits through the Correct Coding Policy Committee. Through this process, the national medical specialty societies have reviewed and submitted comments on tens of thousands of proposed edits to CMS. CMS has reconsidered some proposed edits as part of this process. Commercial health insurers, in contrast, have shown little interest in eliminating “black box” edits or in seeking outside physician input

as to the clinical justification for these arbitrary edits.

How does a physician practice determine that bundling is occurring?

If a physician practice suspects that inappropriate bundling is occurring, office staff must pay close attention to EOB forms. The original claims submission must be compared to the EOB form. If the health insurer is ignoring modifier -25 (or other modifiers) and bundling the two claims or using a claims editing software to otherwise “bundle” the claims, the EOB form will not necessarily reflect this.

Instead, the EOB form typically will indicate that there was no payment for the initial office/outpatient visit and a payment for the separate, secondary procedure. In some cases, under the “adjustment code description” or the “remarks” section of the EOB, an ambiguous reason for non-payment will be given such as “when you report multiple related services on the same day for a patient, insurer bases benefit payment on the primary service,” or “denied; this procedure is included in the global services.”

Is “partial payment” of multiple claims a form of “bundling”?

No. What is referred to as “partial payment” of multiple claims occurs when a practice submits claims for multiple procedures. Rather than bundling the CPT codes, the health insurer will recognize all codes, pay 100% of the first claim, then progressively reduce amounts for the second and third claims, sometimes paying as little as 25% per claim. The insurer’s rationale is that the

second and third procedures are components of the first claim, and therefore should be reimbursed at a lower level. In some circumstances, Medicare also pays progressively less for these same “components,” but Medicare typically reimburses at a significantly higher level for the second and third claim.

While partial payment is another key reimbursement issue that the AMA Private Sector Advocacy Group is exploring, it is not explored in detail in this analysis because it is a separate and distinct problem from bundling and downcoding claims.

What is “downcoding” of claims?

“Downcoding” occurs when a health insurer unilaterally reduces an E/M service level. The typical scenario occurs when a practice submits a claim for a patient visit based on a CPT code definition (for example, new patient visit code 99204—a “level 4”) and the insurer automatically “downcodes” the claim to a lower level (for example, new patient visit code 99203—a “level 3”) and then reimburses at a lower rate. Typically, the physician receives no explanation for the change but simply receives lower reimbursement. Occasionally the EOB form might include an ambiguous explanation such as “level of service (or procedure) has been adjusted” but more typically the only way to detect that downcoding occurred is to be familiar with the fee schedule and compare that to the amount received on the EOB form.

Sometimes health insurers downcode based solely on the diagnosis code. In other words, the insurer assumes (most likely through a software system) that when a patient presents with certain

diagnoses, the clinical evaluation can never be more complicated than a certain E/M level, regardless of the specifics of the individual case. This assumption has no clinical basis. In order to appeal the decision, the practice is stuck with the administrative burden of having to submit additional justification for the level of service performed.

A new twist on downcoding involves additional documentation requirements for some E/M services. This has appeared in two forms, with some health insurers either: 1) adopting a policy that all level 4 and 5 claims will automatically be downcoded, and then physicians will have a window of time to submit additional documentation to support the claim; or 2) requiring substantial additional documentation for all level 4 and 5 claims initially. In addition to the administrative burden, these requirements can complicate physician efforts to file claims electronically.

Moreover, requiring all physicians to provide substantial additional documentation does not further the alleged goal of the health insurers, which is to identify physicians who overuse these codes without clinical justification. Instead, it penalizes physicians across the board, particularly those with a sicker, more complex patient mix, and seems designed to save money. The AMA has successfully worked with the Federation to advocate with some insurers that they pull back and place limits on these documentation requirements.

The practice of downcoding claims is another important reason for physicians to assure that the medical record supports the level of services reflected in the claim. Any appeal of a claim that has been downcoded will require submission of supporting documentation from the medical

record. CMS has developed detailed guidelines to provide physicians and claims reviewers with advice about preparing or reviewing documentation for E/M services in the Medicare program. While these guidelines are specific to Medicare, some private payors use them, and they are one resource for physician office staff. To the extent the medical record complies with these guidelines, it should be a very strong argument in support of the physician's position. Those guidelines are available on the Internet at <http://cms.hhs.gov>.

Why do insurers bundle and downcode?

Bundling and downcoding save money for health insurers, ultimately bolstering their bottom lines. However, the justifications actually used by insurers are questionable. For example, insurers may contend that these practices further their efforts to identify cases of fraud and abuse. The AMA is absolutely opposed to any true acts of fraud and abuse committed by physicians or other health care providers. However, automatically bundling and downcoding does nothing to further the elimination of fraud and abuse because it does not result in identifying or punishing true offenders. Instead, it penalizes all physicians.

Health insurers also contend that some of the software edits that bundle and downcode claims are due to the preferences and benefit packages developed for employers. This "passing the buck" makes it that much more difficult for physicians to get to the root of the problem.

Regardless of the justification, systematic bundling and downcoding of claims without reviewing supporting documentation goes against

the entire definitional structure of the CPT system, which provides precise definitions and instructed usage for each service or procedure subject to a separate code. With the increasing reliance on Medicare RBRVS-based payment systems, arbitrarily ignoring CPT instructions undermines the concepts of uniformity and fairness in payment systems.

Does the AMA have policy relating to bundling and downcoding of claims?

Yes. The AMA has policy strongly opposing these practices. These policies can be accessed at the AMA web site (<http://www.ama-assn.org>).

How can physicians work with the AMA Private Sector Advocacy (PSA) unit to fight bundling and downcoding?

The AMA's Private Sector Advocacy (PSA) unit stands ready to assist state and county medical associations and national medical specialty societies where patterns of inappropriate bundling and downcoding of claims are identified. There are two key components to building an argument that a health insurer is inappropriately bundling or downcoding.

1. **Documentation of a pattern in a particular locale with a particular health insurer:** PSA is working with medical societies to help them gather information to determine if the problem is widespread. This includes collecting the original claims submission, the explanation of benefits (EOB), and any appeals or other communication between the physician and the insurer. Effective advocacy will require collecting enough of these examples to show a

pattern. These examples must be reviewed for coding and other possible claims submission errors.

2. **Developing the clinical and policy-based reasons to counter the health insurer's justification for bundling or downcoding:** There are a number of ways to do this. Probably the most important is to explain why, from a clinical standpoint, one service or procedure should not be considered a component of another service or procedure. This requires a detailed explanation of the nature of the service or procedure. This is where the assistance of the appropriate national medical specialty societies is critical.

From a policy standpoint, there are several approaches that can bolster an argument that the bundling or downcoding is inappropriate. First, evidence that the health insurer does pay for each procedure when performed on separate visits should be gathered. Second, evidence that other insurers in the area do not bundle or downcode in this manner also should be gathered.

Once the information is gathered and arguments developed, the problem should be brought to the attention of the health insurer. As with all issues, in scheduling a meeting, it is important that the medical society insist that individuals with decisionmaking authority at the insurer or health plan attend, as well as the plan's regional medical director. If the insurer or health plan blames an employer, the medical society should indicate that it plans to follow-up with the employer, and should do so.

The AMA is willing to assist medical societies at any step in the process, including attending meetings with the health insurer.

What can individual medical practices do about the problems of bundling and downcoding?

By far the most important first step is to assure that the physician's office staff is coding claims correctly, including providing all supporting documentation. Physician office staff must have a clear understanding of and comply with the health insurer's claims submission process. This information should be set forth in the managed care contract or provider manual. If the information is not provided, physicians should be aggressive in requesting it.

There are a wide range of tools available to assist practices in coding correctly, including a number of publications and workshops available through the AMA at <http://webstore.ama-assn.org/index.jhtml>. For example, the AMA CPT Information Service (CPT-IS) is a coding help-line offered by the AMA. AMA members receive their first four CPT-IS inquiries each year free of charge. Specialists are available Monday through Friday, 9:00AM to 4:45PM CST, to handle inquiries ranging from simple interpretation of CPT guidelines to complete coding of the most complex operative reports.

In addition, a number of state medical associations have correct coding initiatives to educate physicians about coding claims correctly. If a physician believes that there may be problems with the way staff are coding claims, it may be worthwhile to bring in a consultant to review the process and educate the staff.

Physician practice staff also must be vigilant in reviewing insurer EOB forms to determine

whether bundling and/or downcoding are occurring. Payment received routinely should be compared to the fee schedule (if provided) to make sure correct payment has been provided.

If a claim is filed correctly and the health insurer inappropriately bundles or downcodes, the physician should attempt to appeal the claim, by putting in writing a clinical justification for the appeal. The practice should document all communication with the insurer. While appealing claims obviously adds another administrative burden to the practice, there is a large element of truth in the "squeaky wheel" theory: an individual physician who is persistent, has good documentation, and is logically persuasive stands a better chance at succeeding than a physician who does nothing.³

The physician also should notify the relevant state and county medical associations and the relevant national medical specialty society. Those entities can then determine how widespread the problem is, and, if it is widespread, work with the AMA to develop an advocacy strategy. Finally, physicians should complete the AMA Health Plan Complaint Form, which can be accessed at www.ama-assn.org/go/psa. That information will be used to determine prevalence of these practices.

A note on electronic filing of claims

One important step toward simplifying the claims submission process and reducing the possibility of error or delayed claims is establishing a system to file claims electronically. This should be a

³ In 2002, an Illinois physician settled a lawsuit with a large national insurer, which paid him \$145,000 for late claims as well as

downcoded claims. The physician kept impeccable claims records, which put him in a strong position in settlement negotiations.

top priority for physicians and their practice administrators for a number of reasons. Electronic claims generally are paid much quicker than paper claims, and, if there are problems with the claim, refiling is significantly easier. And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires electronic claims submission for most physicians as of October 2002, unless the physician or physician practice has filed for a one-year extension. The sooner physicians make this transition, the fewer headaches in the future.

Conclusion

Physicians face a wide array of problems getting paid for the services they provide their patients, from getting paid on time, to getting paid at all. The practices outlined here are just a few of the methods health insurers use to deprive physicians of full payment for services rendered. The AMA and its Private Sector Advocacy unit stand ready to combat abusive practices that no other legitimate business concerns would tolerate and that interfere in physicians' ability to provide quality patient care.

Coordination of Benefits

What is “coordination of benefits”?

Coordination of benefits (COB) refers to a process and standards advocated by the National Association of Insurance Commissioners to determine the obligations of payors when a patient is covered under two separate health care benefit policies. The goal of COB provisions is to avoid duplicate payments for a single service. This dual coverage situation occurs most frequently when married couples elect coverage for their dependents from their respective employers.

If there is duplicate coverage, a COB standard determines which payor is primary and which is secondary. The general rule is that the employer’s insurance coverage for the employee is primary, and duplicate coverage obtained through the health plan of a spouse’s employer is secondary. With respect to children of parents who have both elected dependent coverage, the insurance industry standard is that the parent whose birthday falls earlier in the year will have primary coverage for children under his or her policy. This is commonly referred to as the “birthday rule.”

The COB expectations of insurance companies become binding upon employees, dependents, physicians, and other health care providers because they are incorporated into the terms of coverage documents as well as provider contracts. For example, an employer-sponsored health plan may expressly state that the benefits for a dependent are reduced if the expenses are also covered by the plan of the spouse’s employer.

The financial stakes of COB programs for the insurance industry are enormous. One leading consultant for the managed care industry esti-

imated that a COB program can save or recover \$5 or more per member per month, which translates to an annualized recovery of \$6 million for every 100,000 enrollees of the MCO.

There has been a reluctance to acknowledge the potentially deceptive practice of payors receiving additional premiums from an employer and employee whose family has duplicative coverage without providing a corresponding additional benefit to the member. While often physicians are not permitted to retain reimbursement equal to 100% of their billed charges, payors may retain well over 100% of the appropriate premium for the collective level of benefits extended to enrollees when there is duplicate coverage.

How can coordination of benefits issues harm physicians?

The first set of problems physicians may experience with COB issues is the additional delay in receiving payment and the administrative costs of resubmitting bills. Some payors engage in a practice known as “pursue and pay,” in which the payor makes no payment until it can verify that it is the primary payor. Other payors engage in a practice known as “pay and pursue,” in which the payor pays claims and then seeks out the primary payor, if any, for reimbursement. The experience of many physicians suggests that the majority of payors engage in the practice of “pursue and pay” to the financial detriment of physicians. The physician, who should be able to receive payment from either payor, receives no reimbursement until the companies determine who has the primary obligation to pay.

The second set of concerns relates to attempts by some payors to use the COB system to pay less than they might otherwise owe for services. A hypothetical situation illustrates these concerns. Plan A dominates its market and contracts with physicians at a reimbursement rate equal to 120% of the resource-based relative value system (“RBRVS”) used in the Medicare program. Plan B is less established and contracts to pay physicians 150% of RBRVS. An employee pays her portion of the premium with Plan A for herself and her family. Meanwhile, her spouse arranges for a portion of his pay to be deducted for family coverage from Plan B.

When their child is hospitalized and receives medical care, the question becomes not only which health plan is obligated to pay but how much each health plan will pay. Should the physician receive 150% of RBRVS in total or 120% of RBRVS in total? Who decides? What are the expectations of the employers, patients, and physicians?

According to insurance industry standards, physicians receive payment from the primary payor in accordance with the terms of the physician’s agreement with that payor, whether it is 150% or 120% of RBRVS. In the hypothetical, the physician is highly unlikely to know the birthdays of the parents, so neither the physician nor the payors would know which payor is primary at the time service is rendered.

The obligation of the secondary payor is far less clear. If the reimbursement for the service under the secondary payor’s plan is less than that of the primary payor, then the secondary health plan would have no obligation to make payment because the physician has received full payment at the higher rate.

If the reimbursement rate under the secondary payor’s plan is more than that of the primary payor, then the issue becomes whether the secondary payor owes nothing or owes the difference between the obligation of the primary payor and the secondary payor. In our hypothetical, the difference would translate to 30% of RBRVS. The answer to this important question is not always easy to find. It may be addressed in the contract between the MCO and the physician, or it may depend upon state law in jurisdictions that mandate when and how much the secondary payor owes the physician.

A third set of concerns arises when the primary payor is having financial difficulties or files for bankruptcy. The issue in this situation is how much the secondary payor owes. Some secondary payors may take the position that the maximum amount owed to the physician is the difference between what the primary payor owes (as opposed to what the primary payor pays) and the contractual obligation of the secondary payor. In that case, if the primary payor pays nothing, then the physician is left with the difference between what the primary payor owed (e.g., 150% of RBRVS) and what the secondary payor would owe if primary (e.g., 120% of RBRVS), which equals just 30% of RBRVS for that service.

How do physicians make sure that employer-sponsored plans that are secondary payors make co-payments on behalf of their Medicare retirees?

The Medicare program presents a range of difficult issues involving primary and secondary payors. If an employer-sponsored health plan provides additional health care benefits for its retirees who receive benefits from the Medicare

program, Medicare would remain the primary payor, and the employer or its contracted agent would become the secondary payor. If the employer has chosen to provide health care benefits for its Medicare-eligible retirees, the physician is entitled to obtain co-payments from the secondary payor.

However, even if an employer has chosen to provide health care benefits for its Medicare-eligible retirees, physicians may find it difficult or impossible to obtain these co-payments. This is because some employers' health plans refuse to cover these co-payments in situations where the plan's contracted reimbursement rates are lower than Medicare allowed fees. Section 3.8 of the AMA's Model Managed Care Contract (AMA Model) addresses this issue by providing that in the case of Medicare beneficiaries, where the payor is secondary, the Medicare allowed fee serves as a minimum in determining the total amount that can be collected by the physician. This enhances the likelihood that the physician will receive full payment, from either the plan or beneficiary for services rendered under the Medicare program.

If the secondary payor continues to resist, the physician may decide to collect directly from the beneficiary. While this is an uncomfortable situation for the physician, he or she is legally entitled to do so; in fact Medicare laws and regulations prohibit physicians from routinely waiving copays and deductibles.

Section 3.10(c) of the AMA Model permits physicians to collect payments from individuals for certain services, provided that such collection efforts do not violate state or federal law. Physicians need to be cautious in signing man-

aged care contracts in which they may inadvertently give up their otherwise legal rights to collect monies owed from patients.

What can physicians do to further protect themselves?

Physicians may request the authority and responsibility to coordinate benefit payments by agreeing in writing to return payments to the secondary payor in excess of the total compensation that the physician is entitled to under both agreements. As a practical matter, unless the physician belongs to a sizable physician group/network, this request likely will be denied because it requires a sophisticated billing system to track.

At a minimum, physicians should insist upon the protections set forth in Section 3.8 of the AMA Model. This language prohibits payors from engaging in the practice of "pursue and pay," which results in substantial delays in payment. Instead, physicians offer to provide full assistance to help payors verify whether they are primary or secondary, in exchange for the payor's written agreement to first pay the physician, then pursue payment from potential secondary sources.

With respect to the amount of compensation owed the physician, the AMA Model provides that physicians are entitled to an amount of reimbursement from both payors that does not exceed the maximum amount permitted by either payor. Physicians should be careful not to accept standard COB provisions that do not address the issues of when payment will be made and how much will be owed.

Late Payment of Claims

Why has late payment become such a problem?

Late payment of claims by managed care organizations (MCOs) and other payors has become a common problem for many physicians in a wide range of practice settings, and combating this problem is a priority for the AMA. In some communities, it has become so chronic and widespread that it has created serious financial problems for physicians whose practices rely heavily on the delinquent payors. It also creates a heavy administrative burden on physicians and their staff who often spend hours on the phone with MCOs pursuing payment of unpaid, overdue claims.

MCOs have a range of responses to complaints from physicians who assert that claims are not being paid promptly, none of which provide a justification for holding funds and earning interest on them while the physician who has provided the service is deprived of payment. For example, some MCOs—especially those that have experienced major growth through mergers or other business strategies—attribute payment delays to problems associated with converting computer systems to accommodate growing beneficiary loads.

However, poor business planning does not justify MCOs enhancing their cash flow at the expense of physicians. When an MCO or other payor delays payment, it earns interest on the payment delayed while physicians lose the time value of that money. It is equivalent to the physicians floating a loan to the MCO.

The other common justification MCOs present for delay of payment is that the physician has submitted a claim that is not “clean.” While

MCOs can certainly require physicians to submit claims “clean” enough to make a payment decision, many MCOs manipulate the concept of clean claims in a manner that can allow them to delay payment for months.

For example, MCOs will return claims as not “clean,” but fail to indicate what is missing or incorrect, putting the burden on the physician practice to navigate the MCO bureaucracy. MCOs also will make multiple requests for additional information over an extended time period, which can easily push payment back six months or more. Some MCOs simply sit on unprocessed claims, “pending” them until a time uncertain or even throw them away. The problem is particularly acute with paper claims, but it also exists with electronic claims.

How do managed care contracts typically treat this issue?

Because MCOs draft most physician contracts, they are typically silent on the issue of prompt payment of claims. They have no incentive to include language that would force them to pay promptly or limit their ability to “game” the concept of “clean” claim to further delay payment. Physicians have no rights, and the MCO has no responsibilities.

What is the AMA doing to battle late payment of claims?

The AMA has made battling late payment of claims a top priority. The AMA’s Campaign to Promote Timely Payment has placed pressure on

local health insurers to pay physicians in a timely manner and has provided support for passage of state prompt payment laws and more aggressive enforcement of those laws. A growing number of state medical associations have initiated prompt payment surveys, using the AMA's Payment Timeliness Survey Support Package. Survey results have been used by state medical associations in a number of ways, including directly approaching poor performing MCOs and using the survey findings as an advocacy tool with legislators and regulators.

And the results are clear. Today, 47 states have laws and/or regulations requiring the timely payment of health insurance claims. The AMA has worked with 30 states to pass laws specifically based on AMA model legislation. The AMA model legislation requires MCOs and other payors to pay claims within 14 days of submission when filed electronically and within 30 days if submitted on paper. Such entities are required to pay interest on claims that are not paid within specified timeframes. The AMA model legislation also provides physicians a private right of action that allows them to sue the MCO for noncompliance.

In addition, a number of state legislators and regulators are evaluating the need for stricter enforcement of existing prompt payment laws, based in part on state medical association prompt payment survey findings. Many MCOs simply ignore the law, in part because some of the laws currently on the books provide no private right of action for physicians to enforce the law, and state department of insurance officials have not been aggressive in enforcing these laws.

However, times are changing, and a number of state regulators have become aggressive in

enforcing state prompt payment laws and are levying substantial fines against MCOs that violate the law. For example, the Georgia Insurance and Fire Safety Commissioner has levied multiple fines against a number of MCOs. In 2002, the Commissioner initiated a second round of fines against MCOs that continue to pay claims late despite previous fines. The Texas Department of Insurance also has been aggressive in levying fines and other penalties against MCOs that do not comply with the Texas prompt payment law, including requiring the MCOs to pay restitution to physicians.

The AMA is pursuing prompt payment violations in court. In January 2000, the AMA, along with the Medical Association of Georgia (MAG) and the AMA Litigation Center, filed a lawsuit against Aetna, Inc. in Georgia, alleging that Aetna is engaging in a systematic pattern of late payment in violation of Georgia law.

Late payment of claims also is a key allegation in the class action lawsuits brought in state and federal court by a number of state medical associations, including the California Medical Association, Connecticut State Medical Society, Florida Medical Association, Medical Association of Georgia, Hawaii Medical Association, Louisiana State Medical Society, Medical Society of New Jersey, Medical Society of the State of New York, South Carolina Medical Association, Texas Medical Association, and Tennessee Medical Association. The AMA/MAG case and nearly all of the state class actions have been consolidated into a single federal court proceeding in Florida. For more information about the AMA's battle against late payment, go to www.ama-assn.org/go/psa.

How does the AMA Model Managed Care Contract address this issue?

Section 3.9 of the AMA Model Managed Care Contract (AMA Model) is designed to provide a fair payment mechanism in which the MCO or other payor has a clearly defined obligation to pay claims within a reasonable period of time. The AMA Model requires the MCO or other payor to pay within 14 days of receipt of a claim submitted electronically and within 30 days of receipt of a claim submitted on paper, or such shorter time as is specified under state law.

The AMA Model does not use the term “clean claim.” Instead, the Section 3.9 provides that claims must be paid within the time frame if the claim “is sufficient in detail so that the MCO or other payor is able to reasonably determine the amount to be paid.” If a claim does not have sufficient detail, the MCO or payor must request additional information from the physician within five days of receipt of a claim submitted electronically and ten days of receipt of a paper claim.

This provision places a clear obligation on the payor to either pay or request information within the time frame and is designed to prevent MCOs or other payors from manipulating the “clean claim” concept or otherwise sitting on claims. The term “clean claim” and its definition have been the subject of much debate because of manipulation by MCOs and other payors.

A new provision, 3.9(a), addresses the problem of MCOs and other payors “losing” claims, especially paper claims. Physicians around the country complain that they submit claims, never receive payment, and after contacting the MCO

are informed that the claim was never “received.” A physician will submit a claim and assume that it is being processed; meanwhile the time for claims submission is tolling. Section 3.9(a) addresses this “resetting the clock” when a claim is “lost” by the MCO, but the Medical Services Entity has records of the date a claim was originally filed.

Section 3.9(c) provides that if a MCO or other payor fails to make payment in a timely manner as specified, the payor is obligated to pay interest at a rate of prime plus 3% on the claims that should have been promptly paid, or such other rate as is specified under state law, whichever is greater. While these provisions do not guarantee that MCOs and other payors will improve their payment practices, this interest penalty serves as a strong incentive for payors to make payment to physicians in a reasonable and timely manner.

Retrospective Audits

What is a retrospective audit?

A retrospective audit is a practice performed more and more often by managed care organizations (MCOs) that is causing increasing alarm among physicians around the country. In a retrospective audit, the MCO reviews claims paid to a physician or physician group/network over a set period of time, sometimes several years past. If the MCO determines that it has paid the physicians more than it should have, the MCO may issue a letter asking for repayment of those amounts. Alternatively, the MCO may attempt to offset such alleged “overpayments” by reducing from future reimbursement until the “overpayment” amount is satisfied.

How will I know if the MCO is performing a retrospective audit?

Physicians may receive a letter or other statement from an MCO, stating that the MCO has determined that it overpaid physician by a certain sum. The MCO will generally provide a reason for the overpayment; perhaps it determined that the claim was incomplete or coded incorrectly, or the MCO paid a claim for a service that later was determined not to be covered. In other cases, the MCO requests a certain number of charts to audit the type of services performed and will ask for money back due to alleged utilization discrepancies. In these cases, the MCO will often refuse to pay any pending claims until the audit is complete. This puts additional pressure on the physician.

Sometimes no actual “audit” is done. Instead, the MCO uses a formula and arbitrarily compares

the physician’s utilization with whatever standards the MCO is using to determine if the physician is giving appropriate care. This practice can be especially problematic because no actual charts are reviewed. However, the physician is still asked to return the funds. While the MCO sometimes asks the physician or physician group/network to return a certain amount of money, at other times physicians begin experiencing an unexplained decrease in reimbursement amounts for services rendered.

How do retrospective audits harm physicians?

In the event of a retrospective claims review audit, many physicians are at a distinct disadvantage compared to MCOs, because MCOs usually have more advanced and sophisticated information databases to perform retrospective audits. In contrast, many physicians do not have the information or personnel to perform similar reviews. In addition, key information, such as the terms of a beneficiary’s contract, may be in the sole possession of the MCO and not available to the provider. Therefore, physicians often have difficulty in disputing a finding of an overpayment.

When faced with a mandate from a MCO for an audit, many physicians may be unwilling to dispute an overpayment finding for fear of losing their patient base. Because the MCO controls information and patients, it is in a stronger position to assert its will through findings of overpayments. Because audit reports are unlikely to detail specific reasons for retrospective denials in individual cases, physicians are less likely to spend their resources to dispute arguable cases. Often the request for repayment by the MCO

is threatening and aggressive, sometimes demanding enormous sums of money back within a very short time frame (e.g., 10 days) or threatening arbitration or legal action. Also, supporting documentation rarely is attached to the letters, thus creating fear and frustration for the practice receiving the letter.

However, physicians should not simply back down in the face of a retrospective audit. Physicians should immediately contact the MCO and demand detailed information on the reasons for the audit. This will be critical in determining an appropriate response to the audit. While it may require time on the part of the physician's administrative staff, that time expenditure is well worth it to effectively respond to (and potentially challenge) a retrospective audit.

Are retrospective audits legal?

Whether a MCO legally is entitled to reduce future payments or perform retrospective audits depends on the terms of the managed care agreement. Many agreements proposed by MCOs have "offset" provisions which specifically allow MCOs to decrease future reimbursement, meaning a monthly capitation check could potentially have a large sum of money suddenly missing with very little explanation or documentation. The AMA Model Managed Care Contract, Addendum, Section 3.0, provides an example of such an offset provision.

If the agreement is silent and does not specifically allow offsets, the question is one of general contract law. A managed care agreement generally is a contract for services. In the simplest terms, the

provider is under a duty to perform services, and the MCO is obligated to reimburse for those services. Physicians who have provided medically necessary covered services should not be required to return funds long after a claim was paid.

However, MCOs often use their power to circumvent legal principles and processes and simply impose their will upon providers. Thus far, there have not been any litigated cases involving retrospective audit, but there may be in the future given its increased prevalence. In any retrospective audit situation, physicians should seek legal counsel to determine their best options and contact their state or local medical society to determine whether the MCO may be engaging in a pattern of abusive audits.

How does the AMA Model Managed Care Contract deal with retrospective audits?

The AMA Model Managed Care Contract specifically precludes MCOs from offsetting future payments or from demanding overpayment reimbursement. Section 3.9 requires the MCO to notify the physician within 15 days to request additional information if claim is not considered "clean," and to provide the reason for the claimed deficiency. Section 3.9(b) also specifically states that all payments to physicians and physician groups/networks will be final unless adjustments are requested in writing by the MCO within 90 days after receipt.

Bankruptcy and Other Financial Failures

What rights do physicians have in the event of an MCO or other payor's financial failure?

Over the past two years, the financial failures of a number of managed care organizations (MCOs) and physician practice management companies (PPMCs) around the country have been a rude awakening to many physicians who had provided services to enrollees of those entities with the logical expectation that they would be paid. These bankruptcies can wreak financial havoc on physician practices and disrupt patient/physician relationships. Unfortunately, a physician or physician group/network has limited options in the event of financial failure because bankruptcy laws offer little protection.

A financial failure generally results in the business entity either declaring “bankruptcy” under federal law; or being declared “insolvent” under state law and placed in receivership. In a majority of states, HMOs that fail financially must submit to state receivership proceedings. However, other business entities that are not regulated by a state's department of insurance always have the option of filing for federal bankruptcy, as do HMOs themselves in certain states.

As a practical matter, whatever rights the physician group may have under either procedure are highly unlikely to return the physician group to the position it was in prior to the financial failure. In the event of federal bankruptcy, for example, physicians generally will be considered “unsecured” creditors. Unsecured credits have lowest priority to receive the already limited funds being fought over by those higher on the priority scale—the secured creditors.

If the entity is in state receivership, the contracting physician “creditor” stands in line with others to receive monies from the entity and possibly funds from a state insurance guarantee fund. However, in most states physicians will be lower on the priority list of creditors.

Is there any good news in this scenario?

In several states, state medical societies have aggressively stepped in to advocate on behalf of physicians and patients, and the results have to some extent cushioned the blow. In California, when a large PPMC declared bankruptcy, the California Medical Association took quick action and was extremely involved in the actions of the state to assure that physicians got a reasonable portion of the reimbursement owed. Likewise, the Medical Society of New Jersey advocated aggressively on behalf of its physicians and their patients when an HMO declared bankruptcy in 1998. By working closely with the state insurance commissioner, MSNJ was able to play a role in assuring that physicians received 75% of normal reimbursement before the HMO dissolved.

How can physicians best protect themselves?

Diligence is the key to providing any protection in the event of the possible financial failure of a MCO or other entity. To the extent possible, physicians need to get a reasonable idea of the financial stability of the MCO before signing a contract and be aware of possible signs of financial instability during the life of the contract

term. If there are clear signs of instability—such as chronic late payment—physicians should terminate as early as possible. Once it becomes clear that a company is technically insolvent or is nearing that point and unable to pay the physicians in a timely fashion, a quick termination (if possible) offers the physician group its greatest protection.

How does the AMA Model Managed Care Contract protect physicians?

The AMA Model Managed Care Contract builds in the three protections needed in the event of a financial failure: access to financial data (Section 5.10); requirement for timely payment (Section 3.9); and immediate termination rights in the event of problems with the first two (Section 8.4). No language, however, will be effective in allowing physicians to recoup accounts receivable built up over a period of time from a company protected from creditors in bankruptcy or receivership. Only alert action following warning signs can shield physicians from greater financial harm.

Subrogation

What is “subrogation” in the context of health care?

The issue of subrogation is an insurance concept that arises when an enrollee of a health plan is injured by the negligence of a third party such as an automobile driver. In the context of health care, subrogation refers to a managed care organization (MCO) or other payor “stepping into the shoes” of an enrollee to pursue the enrollee’s legal rights for damages against negligent third parties and their liability insurance companies. The purpose of subrogation is to recoup the cost of providing medical care that resulted from the negligent action.

The money involved in subrogation can be substantial. Liability insurance companies do not receive discounts from physicians as MCOs do, and therefore may be required to pay 100% of billed charges. Because medical care related to injuries caused by negligence, such as automobile accidents, tends to be expensive, the reward for pursuing subrogation may be significant. The economic consequences of subrogation can be so important that MCOs and other payors frequently do not cover services that are medically necessary when they are the result of the negligence of a third party, unless the MCO is subrogated to the MCO enrollee’s rights of recovery.

Who is entitled to funds obtained through subrogation?

There can be disagreement about who is entitled to subrogation funds and how those funds are divided. MCOs and other payors believe that they are entitled to payment from liability insurance companies as reimbursement for the costs

they incurred in paying the physician, hospital, and other health care providers. These entities believe that they are entitled to such payment as reimbursement for their billed charges for services rendered.

The resolution to this disagreement may be a matter of contract and may depend on the language of agreements between MCOs and physicians. For example, in some agreements, MCOs may require physicians to assign all of their rights to subrogation. This tactic eliminates any debate about who will receive payment from the liability insurance company and creates a case for the MCO to recover even more than the amount it paid to physicians and other health care providers.

Who should benefit from subrogation?

Who benefits from subrogation depends on a number of factors including the following: who is at risk for paying the cost of medical services; how much money is recovered from the liability insurer; what role the billed charges played in the damage award; and fundamental principles of fairness.

As a general principle, the party at risk for the cost of medical services should recover those costs from the liability insurer. In most cases, the party at risk is the MCO or other payor. However, when the physician has a capitation contract, then the party at risk may be the physician or physician group/network.

Many MCOs are reluctant to recognize that physicians should have the right to subrogation when they are at risk pursuant to capitation

contracts. Instead, MCOs present agreements to physicians that assign the physicians' subrogation rights to the MCO. This results in the potential for an unwarranted financial windfall for the MCO and inadequate capitation reimbursement for physicians who incur substantial costs caring for injured enrollees. To achieve a fair result, it is incumbent upon physicians and their advisors to make sure the managed care contract does not give up physicians' right to subrogation if they are at risk through capitation.

How should funds obtained through subrogation be divided?

To answer this question, it is important to note that plaintiffs in a lawsuit are entitled to claim as damages all bills they incur for medical care resulting from the negligence of defendant. The fact that the physician accepted a negotiated discount does not preclude the plaintiff from introducing billed charges as part of a claim for damages.

As part of a settlement of a negligence action, parties may agree that the defendant reimburse the party at risk for the cost of medical services 100% of the costs they actually incurred. However, in situations in which the party at risk is the MCO, and the amount of payment from the liability insurance company exceeds the MCO's actual costs because it is based on billed charges, the physician should be entitled to a portion of the funds obtained from subrogation up to and including 100% of the billed charges.

Fundamental principles of fairness dictate that MCOs should not retain subrogation funds in excess of their costs. Instead, these excess funds, which directly relate to billed charges of physicians, should be paid to the physicians who rendered care.

How can physicians make sure they get paid in a manner that is timely and fair under the circumstances?

Article III of the AMA Model Managed Care Contract requires MCOs and other payors to pay the physician or physician group/network in a timely manner and then pursue claims against third parties. The subrogation provision (Section 3.11) further calls for reimbursement of costs incurred by the MCO or other payor at risk in a subrogation action. Once actual costs are reimbursed, the AMA Model allows physicians to receive additional payments from the excess funds in an amount not to exceed 100% of billed charges.

Credentialing

What does it mean to be credentialed by a managed care organization?

“Credentialing” refers to the process used by managed care organizations (MCOs) to accept, evaluate, and act upon applications from physicians to be deemed eligible to render medical care to MCO enrollees. Often physician participation in an MCO is contingent on the credentialing process being completed. The process often is cumbersome and time consuming, especially when a physician seeks to be credentialed by multiple MCOs which demand to review identical information in different formats.

In the credentialing process, the physician completes a lengthy application and presents documents including state medical license, Drug Enforcement Agency certificates, professional liability insurance coverage, and board certification. The MCO also may perform an on-site review of the physician’s office. The MCO reviews and verifies the information received. When a physician is recertified, the MCO also may take into account information related to compliance with the MCOs protocols and procedures.

Is credentialing by an MCO similar to credentialing by a hospital?

Yes and no. Some of the issues related to credentialing by MCOs are similar to those relating to hospital medical staff credentialing. Like hospital medical staff credentialing, a MCO expects physicians to demonstrate their qualifications by producing evidence that their training, education, and experience meet the standards of the MCO. Like hospitals, MCOs also are concerned about

their potential liability for negligence if there is a failure to exercise reasonable care in selecting, retaining, and evaluating the performance of physicians in their networks. Hospitals and MCOs both use the credentialing process to enhance their reputation for quality care.

However, there are two key differences: there is no medical staff, and there are no medical staff by-laws. MCOs have the authority to grant and withdraw credentials without participation of elected medical staff physician leaders and without protections afforded by medical staff bylaws as mandated by state laws and the Joint Commission for Accreditation of Healthcare Organizations. The physician who is denied participation by the MCO does not have rights to the extensive due process or appeals protections provided in the hospital medical staff setting.

This latitude enables MCOs to interject criteria into the credentialing process that may go beyond the quality, training, and expertise of physician applicants. This can result in blocking the participation of qualified physicians. This can be a particular problem for young physicians just starting out in practice who do not yet have an established patient base.

It also enables MCOs to make credentialing decisions based upon factors not fully disclosed or understood such as economics, physician participation with competing plans, or physician advocacy for patients that is viewed as inappropriate by the MCO. A physician who is not credentialed by an MCO typically has few or none of the rights expected in a fair appeals process such as sufficient notice, opportunity to respond, or appeal to an impartial and knowledgeable group of individuals.

What happens when the credentialing process is handled poorly or unfairly?

The credentialing process should promote quality care for the MCO. When handled poorly or unfairly, it denies choice to patients by excluding qualified physicians from participating in MCO networks and limits fair competition. It can also penalize young physicians and physicians with a sicker-than-average patient base.

Moreover, failure to obtain credentials or removal of credentials can have serious legal and business ramifications for a physician. For example, if a physician's credentials are not renewed, it can adversely impact credentialing and recredentialing applications with hospitals and other MCOs. Applications commonly ask whether a physician has had his or her credentials modified or rescinded by any organization. If the decision is based on "quality" reasons, it can result in reporting to the National Practitioner Data Bank (although the physician would legally be entitled to due process in that event). Physicians may also be required to disclose adverse credentialing decisions during the renewal process for professional liability insurance, which may result in higher premiums.

Because of these serious consequences, it is essential to move towards a MCO credentialing model—similar to the medical staff model—that assures accountability, fairness, and due process.

What does "delegated credentialing" mean?

All MCOs have a responsibility to perform credentialing, and the National Committee for Quality Assurance requires a credentialing process for an MCO to receive accreditation.

However, some MCOs delegate the function to a "downstream" entity such as a physician network or IPA. The physician network or IPA performs the credentialing, subject to the MCO's criteria and supervision.

"Delegated credentialing" is a mixed-bag for the "delegated" entity. Sometimes the delegation is forced on the entity, as yet another example of the MCO pushing more and more insurance and administrative functions down to their contracting entities. Credentialing is resource intensive, and, delegated credentialing imposes the MCO's standards on yet another aspect of administrative functioning.

On the other hand, some IPAs and networks prefer delegated credentialing because it decreases the burden on their physician members. The physician completes one credentialing application for the IPA or network, and the IPA or network submits the information to all pertinent MCOs.

What is being done to streamline the credentialing process?

If there is one area where physicians and MCOs agree, it is that the current credentialing process is burdensome on physicians and inefficient. In some markets, physicians have contracts with over 20 MCOs and must go through 20 different credentialing processes. A number of efforts are underway to streamline the process.

The Coalition for Affordable Quality Healthcare (CAQH), a coalition of 24 of America's largest health plans and networks, has developed a Single Application Credentialing initiative to reduce these burdens. All of CAQH's members, which include Aetna, CIGNA, Anthem, and WellPoint, among others, have jointly developed and agreed

to accept a single credentialing form. A demonstration project was rolled out in Colorado and Virginia in early 2002, and CAQH plans to expand it nationally. While the CAQH initiative is a step in the right direction, it does not yet include all health plans and networks, and it is unclear what physicians in the demonstration states think about this credentialing initiative.

In addition to voluntary efforts by the industry, a number of state medical associations are seeking legislative solutions that would require health plans and networks to use and accept a uniform credentialing form. Seven states have passed laws that require uniform credentialing (IL, MD, NE, NM, OR, TX, WV), and two (IL and OK) specify a time frame in which the credentialing verification process must be completed. The AMA has model legislation requiring uniform, prompt credentialing.

How is credentialing handled in managed care contracts and in the AMA Model Managed Care Contract?

Some managed care contracts do not specify the criteria and process for credentialing. If they are not specified, the physician should assume that the MCO will provide minimal rights and protections in the credentialing process. The physician will be subjected to whatever criteria the MCO uses, which may be burdensome or even prevent the physician from ultimately getting approved to the MCO physician panel. Physicians should pay careful attention to provisions in form agreements that permit the MCO to make adverse credentialing decisions without disclosing its reasons or create a forum for hearings that give only the illusion of fair deliberations.

In contrast, the AMA Model Managed Care Contract (AMA Model) attempts to make the credentialing process fair, complete, accurate, and quick for the MCO and the physician. Under Section 4.4 of the AMA Model, each party's expectations are reasonable and clearly stated in the agreement. The AMA Model also contains fair and uniform criteria for decision-making.

Patient Record Confidentiality and HIPAA

How has technology changed medical record confidentiality?

In the health care field, technology has changed not only the ability to perform new and innovative medical procedures, but it has also changed the way physicians communicate with their patients, other physicians, non-physician health care providers, and payors. Medical records, once kept by hand and locked in physician offices, are increasingly committed to electronic rather than paper records and stored in one or more computer databases. In addition, managed care organizations (MCOs) have been a driving force in the formation of computerized health care information networks to assist them in their payment and utilization review activities.

Electronic medical data has many advantages for both patient and physician. It allows information to follow a patient as he or she visits primary care physicians and specialists, it provides easy, quick access, and it has the potential to save lives in emergencies. In addition, electronic claims are typically paid faster than paper claims. However, with the advantages come risks and responsibilities. Chief among them are the physician's ethical and legal duty to maintain confidentiality of patients' medical information, and the risk that electronic data, difficult to secure and easy to transmit, may be put to unauthorized uses by authorized persons or disclosed to unauthorized persons. Electronic medical records are more susceptible to forwarding, printing, and other means of quick and easy distribution that may violate patient's rights than traditional paper medical records.

Physicians have always had an ethical and legal duty to maintain a confidential relationship with

their patients, including a duty to maintain confidentiality of patients' health information. In the past, state laws typically have governed medical record confidentiality. However, these laws by and large applied to physicians and not to MCOs and other payors that require individually identifiable medical information for medical necessity determinations and claims review activities.

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is the first comprehensive federal law addressing patients' privacy rights in their medical records. HIPAA is primarily focused on portability of health care benefits when an individual changes insurance or employers. However, HIPAA also includes an "administrative simplification" section that is designed to facilitate uniform transaction standards for the electronic transmission of medical information relating to health claims. Under these "transaction standards," most physician practices will be *required* to submit electronic claims and other transactions in standard format, using standard code sets by October 2002, unless they filed for a one year extension before that time. A separate law requires electronic submission of Medicare claims by October 2003.

Physicians need to become fully informed about all of the HIPAA administration simplification requirements. For more information on HIPAA requirements visit www.ama-assn.org/go/hipaa.

Congress also recognized the risks inherent in electronic communications of medical records. Therefore, HIPAA mandated the development

of standards to protect the confidentiality and security of patient medical records and individually identifiable health care information. The security standards are still under development, but compliance with the privacy standards (discussed below) is required by early 2003.

HIPAA is considered a “floor” of privacy protection for patients. If existing state laws are more stringent than HIPAA (ie, provide more protections), they apply and not the federal law. The privacy standards apply to physicians, other health care providers, health plans, and health care clearinghouses.

What is the HIPAA “Privacy Rule?”

Pursuant to HIPAA, the Department of Health and Human Services (HHS) developed “Standards for Privacy of Individually Identifiable Health Information.” (Privacy Rule). The Privacy Rule was initially issued in December 2000 and will take effect in April 2003. The Rule elucidates a series of duties that covered entities (which include physicians and other health care providers, health plans, and health care clearinghouses) have to safeguard “protected health care information” from unauthorized use and disclosure. The Rule also creates patients’ rights with respect to their health information, and requires physician practices to develop certain policies and procedures to protect these rights, including the appointment of a privacy officer.

However, the initial Rule was heavily criticized by various interests in the health care industry. The AMA’s concerns with the initial Rule were that it unfairly placed much of the burden on

physicians, who already have legal and ethical obligations to protect patient confidentiality, while leaving gaps in important areas, particularly in the use of individually identifiable health information by companies for marketing. A summary of the AMA’s concerns about the initial Rule is available at www.ama-assn.org/go/hipaa.

In response to this criticism, in March 2002, HHS issued a proposed Rule to modify certain aspects of the Privacy Rule which was final August 13, 2002. While the AMA will continue to lobby for improvements to the Rule, all physician practices will have to be in compliance with the Privacy Rule by April 14, 2003, including assuring that handling of protected health information is in compliance with HIPAA.

To further complicate matters, HIPAA provides that where an existing state law is more stringent than HIPAA, the state law governs. The Privacy Rule is complex, and a full discussion of the requirements is beyond the scope of this discussion. However, the AMA has developed a number of tools to assist physicians in complying with HIPAA. These can be accessed at www.ama-assn.org/go/hipaa.

How does the HIPAA Privacy Rule impact managed care contracts?

Managed care relationships also will have to be in compliance with the Privacy Rule. HIPAA requires that physicians may only release the “minimum necessary” information for the intended purpose of a request. It also requires that entities requesting patient information may only request the “minimum necessary” information to accomplish the intended purpose.

The AMA is concerned that MCOs will use HIPAA to justify onerous contract provisions that go beyond those required by the Privacy Rule. Health insurers have shown no reluctance to push more administrative work and cost onto physicians. The AMA will be vigilant in reviewing health insurer contracts to determine whether such practices are occurring.

How does the AMA Model Managed Care Contract protect confidentiality?

Article VI of the AMA Model Managed Care Contract (AMA Model) reflects the increased use of electronic data and the special concerns raised. It applies the base protections provided for electronic records in the HIPAA regulations to both paper and electronic data. These confidentiality provisions are consistent with physicians' ethical duties to their patients, and the patients' rights to privacy. The AMA Model also requires MCOs to narrowly tailor consent to the release of medical information for specific purposes. This approach attempts to balance the physicians' duties, the patients' rights, and the MCO's need for information to process claims.

Termination “Without Cause”

What is termination “for cause” and “without cause”?

Provisions in managed care contracts providing for termination “for cause” allow either party to end the relationship for certain clearly stated reasons. These provisions commonly allow for either immediate termination or termination in specified time frame (ie, 30 days). These provisions are generally regarded as valid and necessary to protect the ability of each party to terminate the relationship.

An example of grounds for a physician terminating a managed care contract “for cause” include the managed care organization’s (MCO’s) loss of its license to underwrite or administer health plans. Examples of grounds for a MCO terminating “for cause” include loss or suspension of a physician’s medical license or a final loss of medical staff privileges. Termination “for cause” also may result when one party fails to perform its obligations under the agreement and fails to cure its default after notice from the other party.

The more controversial provision in managed care contracts is the termination “without cause” provision that typically allows either party to terminate the agreement “without cause” upon giving a certain number of days notice. Some MCOs have exploited these provisions. While the MCOs initially contract with a large panel of physicians to gain entry in a market, after capturing market share, they narrow the panel by invoking termination “without cause” provisions. This results in disruption of patient care and loss of a potentially significant patient base. There have also been concerns that termination “without cause” provisions permit MCOs to disguise the underlying—and potentially illegal—reason

for removing a physician from a panel, such as having a sicker-than-average patient base. Moreover, there is a stigma attached when a physician is terminated from a MCO panel, regardless of the circumstances.

How have state legislatures and courts addressed termination “without cause” provisions?

There has not been a great deal of state legislative activity on this issue. However, two states have enacted legislation that requires insurers to provide written reasons to providers before any termination. Texas law requires that preferred provider benefit plans provide in writing the reasons for any termination prior to the termination (Tex. Ins. Code 3.70-3C sec. 3 (1999)). The Texas law also requires MCOs to conduct a reasonable review of the physician prior to termination. Likewise, Maine law requires any carrier offering a managed care plan to provide a written explanation of the reasons for the termination of a physician contract termination or nonrenewal in advance of such action (Me. Rev. Stat. tit. 24-A sec. 44503 (1999)). The Maine statute specifically states that “the existence of a termination without cause provision in a carrier’s contract with a provider does not supersede the requirements of this section.” The Maine law also gives the physician the right to a review of hearing on the termination.

Although courts have historically enforced termination “without cause” provisions, two state court opinions in recent years may indicate a shift in thinking. These cases recognize that terminating a physician “without cause” in an

era of managed care has social and policy ramifications. These two cases have been the subject of much discussion in the legal community.

In *Potvin v. Metropolitan Life Ins. Co.*, 2000 Cal. Lexis 3717 (Ca. Sup. Ct. May 8, 2000), the California Supreme Court recently held that a physician terminated “without cause” was entitled to fair procedure when an insurer possessed market power so substantial that removal impaired the physician’s ability to practice, thereby affecting a substantial economic interest, even when the physician’s contract included a termination “without cause” provision.

In *Harper v. Healthsource*, 674 A.2d 962 (N.H. 1996), the Supreme Court of New Hampshire held that a HMO’s decision to terminate its relationship with a physician must comport with the covenant of good faith and fair dealing and thus must not be made for a reason that is contrary to public policy. The court held that a physician terminated “without cause” was entitled to review of the HMO’s decision when he or she believed that the decision was made in bad faith or in a manner that was contrary to public policy.

While Potvin and Harper generated significant discussion at the time of the decisions, they are not binding beyond California and New Hampshire respectively. At least two state courts (Ohio and Colorado) have declined to follow their lead. It is difficult to predict the direction that courts will proceed on future cases challenging terminations “without cause.” The most likely chance of success is where a physician can demonstrate that the “without cause” termination was a subterfuge and was in fact based on reasons that are illegal or against public policy.

How does the AMA Model Managed Care Contract treat terminations “without cause”?

The AMA approach reflects a recognition of the substantial economic impact that termination may have on a physician’s practice and on his or her patients. In contrast to most managed care agreements, the AMA Model Managed Care Contract (AMA Model) mandates that the party wishing to terminate the agreement must provide reasons for the termination in writing. Providing a reason for termination does not change the termination to a “for cause” termination. For example, a typical reason may be that the MCO is narrowing its physician panel for strictly business reasons. The AMA Model requirement is designed to protect providers from terminations that are illegal, potentially discriminatory, or for other reasons that are contrary to public policy. Under Article IX of the AMA Model, a physician also has rights to dispute the MCO’s decision through mediation and arbitration.

Dispute Resolution: Litigation vs. Arbitration

The health care environment is becoming increasingly complex and adversarial. Physicians around the country complain about managed care organizations (MCOs) refusing to pay at the contracted rates by downcoding or bundling claims, paying claims late, “losing” claims and then attempting to deny payment of a claim because the claim was filed late, and other such practices. When physicians come to an impasse over these other issues relating to the contract, they are faced with the choice of accepting payment lower than provided in the contract, seeking relief through the courts, or seeking relief through “alternative dispute resolution.” The terms of the managed care contract often control whether physicians can seek relief in the courts or through alternative dispute resolution.

What is alternative dispute resolution?

Alternative dispute resolution generally refers to any process other than litigation, designed to resolve a conflict. Mediation and arbitration are the two most common forms of alternative dispute resolution.

What is mediation?

In mediation, a neutral third party facilitates a mutually agreeable resolution for both parties. The primary responsibility for resolution remains with the parties, and the mediator has no binding authority.

Is there a benefit to mediation in the managed care setting?

While mediation can be a very effective dispute resolution mechanism in some settings, such as labor relations’ disputes, it is of very little practical utility with respect to disputes involving physicians because it is non-binding. If a physician cannot resolve the dispute informally or through an MCO’s internal procedure, mediation will not help. Instead, mediation will only embroil the physician in a proceeding that consumes valuable time and expense and that will not create a binding result.

What is arbitration?

Arbitration is a process whereby the parties select a neutral person or persons who are empowered to receive evidence and render a binding decision on the parties. Where parties have agreed to submit their disputes to arbitration, the process begins when one party notifies the other of its intent to arbitrate and also sends a notice to an arbitration service. While there is not a formal “discovery” process as in a lawsuit, there is an informal process by which the arbitrator gathers and hears evidence. An arbitrator can hear any evidence that might be relevant to the dispute, and the arbitrator’s decision is binding on all parties.

To understand more about the special rules of arbitration, go to the American Arbitration Association at www.adr.org and the American Health Lawyers Association Alternative Dispute Resolution Service at www.healthlawyers.org/adr/.

Is there a benefit to arbitration in the managed care setting?

In theory, arbitration could be beneficial in the managed care setting because it can offer a potentially faster and less confrontational mechanism for resolving disputes, particularly if the physician wants to maintain a relationship with the MCO. However, because most managed care contracts are drafted so heavily in favor of the MCO, the MCO may be able to manipulate the process to the detriment of physicians. For example, many managed care contracts include provisions that require physicians to arbitrate any dispute with the MCO. MCOs around the country are using arbitration clauses as a mechanism to block physician attempts to hold MCOs accountable before courts of law. In addition, MCOs have proven adept at using delay tactics to undermine any efficiencies of arbitration.

What are the potential advantages of arbitration?

Economy. Arbitration can be a less expensive alternative to litigation. According to the American Arbitration Association, an arbitration is typically completed within a few months of filing, as opposed to litigation, which can stretch for years.

However, arbitration is not cost-free. Arbitration involves greater upfront costs than litigation, but theoretically costs less over the long-haul because of the shorter time frame. The party seeking the arbitration must pay a substantial filing fee at the outset. In arbitration, the initial filing fees are significantly more expensive than the fees

associated with filing a lawsuit, which are kept low to provide access to the courts. Further, the parties have to pay for the arbitrator as well as the administrative expenses of the arbitration association. While these expenses are shared by the parties, they usually have to be paid in advance of the arbitration hearing. In addition, the parties will need legal representation, which is an additional cost but less than in a drawn-out litigation.

Speed. As noted, arbitration is usually faster than a lawsuit. This is particularly true in major metropolitan areas and the more populous states, because courts in these locations often have very crowded dockets. However, state courts in some parts of the country can offer relatively fast and expeditious case handling, so this is a determination that a physician will need to make with legal counsel.

What are the potential disadvantages of arbitration in a managed care setting?

The primary disadvantage is that arbitration forecloses the option of taking a dispute to court. The arbitrator's decision is final. Depending on the nature of the dispute, there may be reasons a physician wishes to bring a lawsuit in court. For example, in a lawsuit, a court has broader authority than an arbitrator to compel the MCO to produce documents and witnesses that may be helpful to the physician's case. Also there can be advantages to having a case heard by a jury.

In addition, there are currently a number of class action lawsuits that have been brought against MCOs by physicians and physician groups

alleging a range of abusive and unfair business practices relating to payment of claims and other contractual issues. MCOs are using the existence of arbitration clauses in managed care contracts to argue for dismissal of at least some of the class action plaintiffs on the grounds that the physicians who have signed contracts with mandatory arbitration clauses are obligated to arbitrate and foreclosed from participating in the class action lawsuits. Physicians who sign contracts with mandatory arbitration clauses need to be aware of this tactic on the part of MCOs.

Moreover, physicians need to be aware that MCOs are beginning to insert provisions in contracts that prohibit a physician from consolidating his/her arbitration claim with other physicians who may have similar claims. This is another attempt to limit a physician's ability to participate in class action lawsuits.

Do small claims courts offer a viable option for dispute resolution?

If the dispute involves a relatively small amount of money, a small claims court action may be a viable option. Small claims courts exist in every state in the United States. These courts permit any citizen to sue for under \$2,500 for the payment of less than \$200 in filing and other administrative fees. In some circumstances, small claims courts offer physicians a swift and informal procedure for resolving reimbursement claims. Physicians considering this option will need to determine whether they can aggregate multiple reimbursement claims up to the filing limit under one filing fee.

How does the AMA Model Managed Care Contract address dispute resolution?

The AMA Model Managed Care Contract allows physicians to litigate disputes before a court of law, as long there has been no request to arbitrate by the MCO before the lawsuit is filed. This is a critical distinction because most MCOs foreclose any opportunity to bring a lawsuit. The AMA Model Managed Care Contract does not favor arbitration or any other dispute resolution process. In contrast, it seeks to provide various approaches to dispute resolution.

Restrictions and Obligations Post-Termination

Why do certain aspects of a managed care agreement continue even after termination?

Restrictions and obligations that survive termination serve various purposes. Many protect the business interests of the managed care organization (MCO). Such clauses may provide for confidentiality of proprietary information or the nonsolicitation of MCO enrollees treated by the contracting physician. Other restrictions and obligations are designed to protect the best interests of patients or enrollees of managed care plans. These clauses may contain provisions governing the confidentiality of medical records or may ensure some continuity of care despite termination of a particular physician from a managed care plan. Some of these restrictions are commercially reasonable. Others are not.

Why are continuing obligations to managed care enrollees included?

Physicians should keep a careful eye out for provisions obligating them to continue to provide care to managed care plan enrollees post-termination. Medical ethics and state laws prohibit physicians from abandoning patients in the middle of a course of treatment. However, that has little to do with the managed care contract. Using that ethical and legal obligation as the basis for their continuing restrictions, some contracts include clauses such as: “this Agreement will continue in effect with respect to enrollees existing prior to the Company’s receipt of notice of termination by the physician until the anniversary date of the Company’s contract with the enrollee’s subscriber group or for one (1) year,

whichever is earlier, unless otherwise agreed to by the Company.” With this type of provision, physicians are potentially obligated to provide care for up to an entire year, whether or not the enrollees are currently under a course of treatment. Moreover, such managed care contracts often do not address how, or if, the physician will be compensated for such services.

This obligation is even more problematic where the MCO’s financial condition is unstable or where the company has filed bankruptcy. Although the physician may be obligated to continue to provide care to enrollees of the insolvent MCO for a certain amount of time, payment to the physician for services rendered is very uncertain at best.

Do some of these restrictions restrict physicians from communicating with patients?

Many contracts provide for the MCO (often alone and sometimes in conjunction with the physician) to notify enrollees when their physician is no longer a participating physician under a plan. Moreover, nonsolicitation clauses often restrict physicians from advising patients of their options to switch plans in order to remain with their current physician. Such restrictions function as a “gag” clause, effectively prohibiting a physician from communicating on one of the most fundamental components of the patient/physician relationship—its possible termination.

Some contracts require the physician to give immediate notice to patients/enrollees that the physician is no longer a participating MCO

physician. Contracts may include financial penalties if the patient is not informed and he or she incurs costs for seeing the physician out-of-network. Some also require physicians to refer patients/enrollees to another participating MCO physician.

What are the common restrictions on confidentiality?

Most managed care contracts contain provisions that provide for confidentiality of proprietary information that typically survives termination. Proprietary information of the MCO or payor, such as mailing lists, enrollee lists, employer lists, payment rates and procedures, utilization review procedures, physician contract terms, and other documents concerning the MCO's systems and operations, is deemed the exclusive property of the MCO or payor. The physician must maintain the confidentiality of this information and not improperly disclose it to third parties. The physician may even be required to return any copies of proprietary information in the physician's possession at termination.

Similarly, most managed care contracts contain provisions addressing the confidentiality of medical records that survive termination. Typically, these records are to be maintained and treated as confidential as required by state and federal laws. The MCO is given the authority to access or obtain copies of these records from the physician with a written release from the patient. The physician is required to make records available to the MCO for legitimate purposes such as audits, medical necessity determinations, and utilization review. Many contracts provide that the provision requiring access to data and information survives

the termination of the contract either indefinitely or for a period of years specified in the contract.

Which restrictions or obligations continue after termination in the AMA Model Managed Care Contract?

Section 8.6 of the AMA Model Managed Care Contract (AMA Model) outlines clearly the effect of termination. The AMA Model provides that as of the effective date of termination, the Agreement is no longer in force and that each party is discharged from all rights, duties, and obligations under the Agreement. However, Section 8.6 also explicitly states that the obligations of the parties under the sections governing Compensation, Confidentiality and Records, and Dispute Resolution survive the termination of the Agreement.

For example, the MCO remains liable for covered services and retains the obligation to pay the physician for any covered services rendered by the physician to enrollees who the physician is obligated to continue treating by law until the treatment for an episode of illness is completed. The payment for such services rendered after termination must be made according to the fee schedule for that plan attached to the contract, or if no schedule is attached, according to the usual and customary charges of the physician. Under the AMA Model, the MCO also must maintain confidentiality of medical records after the termination of the contract, and the physician must maintain the confidentiality of any financial, utilization, or compensation information obtained during the life of the contract.

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