

Model Managed Care Contract

With annotations and supplemental discussion pieces

Fourth Edition 2005



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Table of Contents

Introduction	5
Model Managed Care Contract	7
Addendum – Physicians Beware of these Common Managed Care Contract Clauses.....	38
Supplement 1 – Medical Necessity	42
Supplement 2 – “All Products” Provisions	45
Supplement 3 – Fee-For-Service Payment Arrangements.....	47
Supplement 4 – Coordination of Benefits	51
Supplement 5 – Late Payment	55
Supplement 6 – Retrospective Audits	58
Supplement 7 – Subrogation	60
Supplement 8 – Termination “Without Cause”	62
Supplement 9 – Dispute Resolution: Litigation vs. Arbitration	64
Supplement 10 – Restrictions and Obligations Post-Termination	66

Introduction to the Fourth Edition

In late 1997, the American Medical Association (AMA) unveiled the first edition of the AMA Model Managed Care Contract. Since that time, 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 contract is designed to help physicians in their negotiations with a wide range of managed care organizations (MCOs), including HMOs, PPOs and other plans.

In many respects, managed care contracts exhibit the elements associated with “contracts of adhesion”—a standardized contract that gives the weaker party the opportunity to either adhere to the contract or reject it. Many MCOs make the material terms—such as the services and procedures 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. Still others give the MCO wide berth to “rent” the physician’s discount to unrelated third parties. 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 this fourth edition of the AMA Model Managed Care Contract, we have made revisions to the contract in recognition of new unfair contracting and business practices. For example, Section 3.6 “Coding for Bills Submitted,” has

been strengthened in light of the continuing misuse of American Medical Association Current Procedural Terminology (CPT[®]) codes, guidelines and conventions through bundling, downcoding and reassignment of CPT codes. Section 5.5, “Cooperation in Credentialing” addresses the issue of lengthy delays in credentialing physicians. It requires the MCO to credential a physician within 45 days or grant provisional credentialing. We have added to the Addendum an example of a “most favored nations” provision, which requires physicians to give the MCO the benefit of the lowest rate he or she negotiates with any other health insurer.

Section 5.8, “Quality Improvement,” provides that any quality improvement programs (including so-called “pay-for-performance” programs) undertaken by the MCO are evidence-based and that participating physicians have a mechanism for input into such programs. It also makes clear that participation in any initiatives that tie financial incentives to such programs must be voluntary. We have updated and revised the 10 Supplements.

It is imperative that physicians carefully review and understand any managed care contract they are considering signing. This is true whether the physician is signing the contract directly or indirectly through a physician network such as an independent practice association (IPA). It is not enough to review a summary of the contract terms. Provisions in the contract that are often glossed over at the time of signing can suddenly

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spring to life in new and often unpredictable ways when a controversy arises that requires interpretation or clarification.

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 these materials before signing.

Physicians also need to know their patient mix and understand the economic impact of any contract on their practice. You can say "no" to a contract, particularly if it constitutes a small percentage of your patient base. To assist in this evaluation process, the AMA has developed *15 Questions to Ask Before Signing a Managed Care Contract*.

The AMA continues to monitor new and potentially harmful trends in managed care and to battle aggressively against unfair MCO business practices, but we need your help. The AMA's Private Sector Advocacy unit is collecting physicians' concerns about unfair managed care practices through the AMA's Health Plan Complaint Form. The easy-to-use form can be accessed at <http://www.ama-assn.org/go/psa>. The AMA's Private Sector Advocacy unit also has developed a wide range of products to help physicians navigate an increasingly complex environment. These documents are available free of charge to AMA members and can be accessed at <http://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 *italics*) refer more informally to “physician,” which encompasses physician groups and physician networks. 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] Managed Care Organizations (“MCO”) (Medical Services Entity and MCO 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, MCO 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 the MCO.

WHEREAS, MCO 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 a contract. 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 “Payers” may allow unscrupulous MCOs to “rent” 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 MCO 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 procedures provided to Enrollee.

1.2 MCO Notice. A communication by MCO 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 MCO Compensation. The Total Compensation less that portion designated by the Plan as a Copayment, Deductible and/or Coinsurance.

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 Coinsurance. The percentage of the Total Compensation, per service or procedure, that is the responsibility of Enrollee.

1.6 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.

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

1.8 Deductible. The portion of an Enrollee's benefits that must be paid by the Enrollee before any insurance coverage applies.

1.9 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 1.9 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 that the treating physician had at the time a course of treatment was being decided.

1.10 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 Payer; (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.

1.11 Medically Necessary/Medical Necessity. Health care services or procedures 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 economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

*The definition of "medical necessity" in Section 1.11 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 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. For more information, see Supplement 1, **Medical Necessity and Due Process**.*

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

1.13 Payer. The entity or organization directly responsible for the payment of MCO 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 Payer 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 Payer shall be the insurance company or health maintenance organization, as the case may be. Under no conditions shall the parties interpret “Payer” to be, nor shall the negotiated rates herein described be assigned to or accessible to, any party other than MCO or an employer offering a self-funded product that contracted with MCO to administer such product.

*The definition of “Payer” in Section 1.13 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 payer. However, this definition makes clear that the MCO cannot “rent” or “lease” the terms of the agreement (including the physician’s discounted services) to other entities. For further information about “rental networks” see Supplement 3, **Fee-For-Service Arrangements**.*

1.14 Plan. An individual set of health service delivery and compensation procedures offered as a “managed care” product by MCO, or administered by MCO, on behalf of a Payer 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 MCO and Enrollees are subject. Nothing in this Agreement shall be construed to require physicians to participate in all of MCO’s Plans as a condition of participating in any individual plan or plans. Nothing in this Agreement shall be construed to require physicians to participate in future Plans introduced by MCO.

Section 1.14 makes clear that the contracting physician is not required to participate in all products offered by the MCO. It also makes it clear that the contract cannot require physicians to participate in future products or plans that the MCO may introduce. To provide administrative streamlining, the AMA Model Contract permits the MCO and the physician 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, it 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 and policies that require physicians to participate in all products as a condition of participating in any product. For more information on “all products” clauses, see Supplement 4.

1.15 Qualified Physician. A doctor of medicine or osteopathy licensed to practice medicine, who has agreed in writing, to provide Covered Services to Enrollees and who has been credentialed pursuant to the rules and procedures of the Plan by the MCO or a duly appointed and authorized agent to which such responsibility has been delegated.

1.16 Quality Improvement. The process designed to monitor and evaluate the quality and appropriateness of care and to improve care.

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

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 and procedures 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 and procedures as “not covered.” Similarly, some capitation agreements either fail to clearly and completely articulate the set of services and procedures to be performed—or may fail to provide the list altogether—which allows the MCO 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 and procedures are covered, the MCO is penalized and must reimburse the physician 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, **Medical Necessity and Due Process**.*

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 MCO 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 or 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, MCO shall pay Medical Services Entity the Qualified Physician's billed charge for each service and procedure performed by a Qualified Physician for the benefit of Enrollee.

The requirement in Section 2.4 that the MCO pay the physician's billed charge is a fair and reasonable way to ensure that physicians receive fair payment for services and procedures 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/Eligibility. Except in the case of emergency, Medical Services Entity shall use the mechanism, including identification card, MCO Web site, or telephone, chosen by MCO 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 MCO 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, MCO and Medical Services Entity agree to the following:

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

2.6(b) If Medical Services Entity, after following MCO 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 MCO 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 a good faith efforts to verify eligibility, and verification is not reasonably possible given time constraints caused by the MCO's action or inaction, and it is later determined that patient is not an Enrollee, then Medical Services Entity shall attempt to collect from patient the amount due, up to the billed charges fee of the Qualified Physician providing the service. If, after two billing cycles, Medical Services Entity or Qualified Physician has not received full payment, MCO will pay Medical Services Entity the Qualified

Physician's billed charges 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 fail to provide real-time Internet-based access, telephone access or other convenient and quick 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 MCO's plans and prevents the MCO from unilaterally changing those terms. It requires that such terms be attached as Exhibit B. Physicians around the country have discovered 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. This dynamic would not occur under Article III.

3.1 Compensation. Medical Services Entity or its designee shall accept from MCO or Payer 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 composed of separate schedules designated as B1, B2, etc., which shall identify separately the Total Compensation and related terms for each Payer and Plan.

3.3 Full Disclosure. The Total Compensation set forth on the Exhibit B schedule(s) shall specify for each Payer and Plan, the manner of payment (such as fee-for-service, capitation or risk withholds) for medical services and procedures 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 MCO 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:

3.3(a) 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 and procedure to be rendered pursuant to the agreement
- ii. Where compensation is based on a relative value unit (RVU system), such as the Medicare RBRVS, Exhibit B shall identify the specific RVU system, the conversion factors used, and shall provide a means to apply the formula or database to obtain rate information per CPT code
- iii. Where compensation is based on a “usual customary and reasonable” (UCR) system, Exhibit B shall identify the database use and the methodology applied to determine the fee schedule. The database and methodology must be statistically accurate, tied to physician charges, and based upon physicians of the same specialty in the same geographic area
- iv. A statement that the fee schedule cannot be changed without the consent of Medical Service Entity
- v. A provision stating the consequence for a Payer 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

Physicians continue to be extremely frustrated by the lack of fee schedule transparency in discounted fee-for-service arrangements. Some MCOs do not provide any fee schedule, others will provide a “sample” fee schedule that does not relate to the physician’s contract. Still others provide a “fee schedule” but do not disclose medical payment policy and other methodology that is applied to arrive at final reimbursement. This renders the fee schedule meaningless. Section 3.3(a) provides transparency and also eliminates the possibility of unilateral changes in the fee schedule. For more information on fee-for-service arrangements, see Supplement 3.

3.3(b) In the case of a capitation arrangement, Exhibit B shall contain the following:

- 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. Such assignment shall occur immediately upon enrollment, and the PCP shall receive monthly payment until or unless Enrollee designates another PCP
- iii. The date each month that the capitation payment is due

- iv. The manner by which MCO 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 MCO, 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 MCO
- vii. The fee-for-service schedule to which the parties will revert in the event that 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 that are 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 MCO or a Payer 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 MCO to enable the Medical Services Entity to manage effectively the risk it assumes under capitation arrangements. These reports will include membership information to allow monthly reconciliation by Medical Services Entity of capitation payments
- x. The information provided by the MCO that is current through the end of the previous month

3.3(c) In the case of a withhold or bonus, Exhibit B shall contain the following:

- 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 MCO 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 MCO 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

Sections 3.3 (b)–(c) require the MCO to provide the physician with data needed to evaluate and manage risk contracts. They provide a checklist of issues to be identified and resolved in negotiating two 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, section 3.4 establishes a penalty when the MCO fails to articulate the precise payment terms honestly and in sufficient detail. For more information on capitation and other risk arrangements, see the AMA/California Medical Association publication Benchmark Capitation Rates: The Physician’s How-To Guide for Calculating Fee-For-Service Equivalents at <http://www.ama-assn.org/go/psa> and click on “Prompt payment/Payment hassles.”

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 MCO shall pay Medical Services Entity the Qualified Physician’s billed charge for each service and procedure 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.

Allocating the administrative duty of providing information on compensation terms to the MCO is logical and fair, and reversion to billed charges in the absence of sufficiently defined compensation schedules 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 MCO. If payment is required under the terms of Exhibit B, MCO 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 MCO within six (6) months after the date services were rendered. Medical Services Entity shall submit such Claims electronically or on a CMS-1500 billing form.

3.6 Coding for Bills Submitted. MCO hereby agrees that Claims submitted for services and procedures rendered by Medical Services Entity shall be presumed to be coded correctly. MCO 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 MCO’s coding edits and medical payment policy. MCO shall adhere to CPT codes, guidelines and conventions including the use and recognition of modifiers. MCO shall

not automatically change CPT codes submitted by a Medical Services Entity. MCO must provide adequate notice if it wishes to change a code and must allow sufficient time for Medical Services Entity to submit additional documentation to support the CPT codes reported. Medical Services Entity shall have the right to appeal any adverse decision regarding the payment of Claims based upon the CPT codes reported. If MCO or a Payer 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 the billed charges for the claim.

Physicians should be paid for the services and procedures they provide. Section 3.6 prevents the practice of “bundling,” “downcoding,” and “reassignment” of CPT codes. These 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 that they are submitted to the MCO at one level of intensity but are reimbursed at a lower level reflecting a reduced intensity of service, or they are simply “reassigned” to a different code. This section is designed to require the MCO to set forth billing standards and policies to the physician. For more information about CPT codes, guidelines and conventions visit <http://www.ama-assn.org/go/cpt>.

3.7 Copayments to be Collected from Enrollees. Where the Plan requires Enrollees to make Copayments at the time of service, Medical Services Entity or one of its Qualified Physicians shall collect such Copayments accordingly. MCO shall educate Enrollees about their Copayment obligations. If Copayment is not remitted to Medical Services Entity in a timely fashion, MCO agrees that Medical Services Entity may discontinue seeing Enrollee, 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 Coinsurance and Deductibles to be Collected from Enrollees. Where the Plan requires Enrollees to pay Coinsurance and/or a Deductible, MCO shall educate Enrollees about these obligations. If Enrollee fails to remit in a timely fashion payment pursuant to Coinsurance or a Deductible, MCO agrees that the Medical Services Entity may discontinue seeing the Enrollee 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.

3.9 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, Payer will pay Medical Services Entity the Total Compensation 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 Payer is the Secondary Payer, the sum of such payments shall not be less than one hundred percent (100%) of the Medicare allowed fee schedule.

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

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

3.9(c) Payer shall be presumed to be the primary Payer and shall make payments in accordance with this Agreement, unless such Payer can document to the satisfaction of the Medical Services Entity that it is secondary under industry COB standards within fourteen (14) calendar days of receipt of a claim.

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

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

3.9(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.

3.9(g) Secondary payers shall not be relieved of their obligation to make full payment to Medical Services Entity in the event the primary payer fails to pay Medical Services Entity’s properly submitted Claims within one-hundred eighty (180) days of submission.

The coordination of benefits provision in Section 3.9 deals with the question of what entity will pay the physician 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 more information on coordination of benefits, see Supplement 4.

3.10 Promptness of Payment. Each Payer shall remit to Medical Services Entity the MCO Compensation within fourteen (14) calendar days of receipt of an electronic Claim and thirty (30) calendar days (or such shorter time as set by law) of receipt of a written Claim by Medical Services Entity that contains sufficient detail that Payer 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 MCO Compensation shall be remitted by the fifteenth (15th) day of the month covered by such payments.

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 Payer can reasonably determine what service and/or procedure was performed and how much should be paid. It also requires the Payer to pay interest on delayed payments.

The AMA has made prompt payment a major advocacy initiative and has worked with a number of state and county medical associations on legislative and other strategies to combat delayed payment. Forty-nine states and the District of Columbia now have prompt pay laws and/or regulations. In the past several years, a number of state insurance commissioners have become more aggressive in enforcing state prompt payment laws. For information on state prompt payment laws, and a summary of state insurance commissioner fines, visit <http://www.ama-assn.org/go/psa>. For answers to questions physicians frequently ask about late payment, see Supplement 5.

3.10(a) In the case of a written claim, Payer shall mail to Medical Services Entity written acknowledgment of receipt of a written Claim within three (3) business days of receipt. Payer shall acknowledge receipt of an electronic claim within twenty-four (24) hours of receiving that claim. When a 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 3.10(a) addresses the ongoing problem of 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 3.10(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. It also requires the MCO to acknowledge receipt of claims.

3.10(b) If additional information is needed by Payer to evaluate or validate any Claim for payment by Medical Services Entity, Payer shall request any additional information in writing within five (5) business days of receipt of an electronic claim and ten (10) business days of receipt of a paper claim. Payer shall affirm and pay all valid electronic claims within fourteen (14) calendar days of receipt of such additional information, and written claims within thirty (30) calendar days. Any undisputed portions of a Claim must be paid according to the time frame set forth in 3.10 while the remaining portion of the Claim is under review.

Under 3.10(b), the Payer must return claims lacking information or not “clean” enough for payment to the physician within 10 business days of receipt. The Payer must pay the claim within 14 calendar days of receipt of the

additional information requested, for an electronic claim, and within 30 calendar days for a paper claim. This prevents the MCO from “sitting” on unprocessed claims or delaying payment on claims the MCO arbitrarily determines are not “clean.”

3.10(c) If a Payer fails to make such payment in a timely fashion as specified herein, Payer shall be obligated for payment of such amounts plus interest accruing as follows:

- (i) For electronic claims: 1.5% from the 15th day through the 45th day; 2% per month from the 46th day through the 90th day; and 2.5% per month after the 90th day.
- (ii) For paper claims: 1.5% from the 31st day through the 60th day; 2% per month from the 61st day through the 90th day; and 2.5% per month after the 120th day.

3.10(d) All payments to Medical Services Entity will be considered final unless adjustments are requested in writing by Payer within one-hundred-eighty (180) days after receipt by Medical Service Entity of payment explanation from Payer.

Section 3.10(d) is designed to prevent MCOs from retrospectively auditing claims and reducing payment long after services were rendered. This is accomplished in Section 3.10(d) by making payments to physician final within 180 days after receipt by the physician. For answers to questions physicians frequently ask about retrospective audits, see Supplement 10.

3.11 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 that the Payer fails to make such payment, Medical Services Entity agrees to look solely to that Payer for payment of all Covered Services delivered during the term of the Agreement.

3.11(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.

3.11(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 Payer’s bankruptcy, insolvency, or failure to pay the Qualified Physician providing services.

3.11(c) Notwithstanding the foregoing, MCO shall cooperate in the processing of such claims against Payer 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
- iii. Services provided to any Enrollee after this Agreement is terminated

State law 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 Payer as a creditor. Section 3.11 satisfies the intent of most state statutes in protecting consumers and allows the physician to pursue other remedies under the law. Section 3.11 (c) also sets forth circumstances in which a physician 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 a MCO has declared bankruptcy, the physician has limited remedies for recovering payments due.

3.12 Administrative surcharge: Nothing in this contract shall affect the right of the Medical Services Entity to charge Enrollees a reasonable and otherwise legal surcharge for individual or aggregated administrative services. Medical Services Entity must fully inform Enrollees about the surcharge and the probability that the surcharge will not be reimbursed by the MCO unless such services are otherwise specifically identified and reimbursed in Exhibit B.

3.13 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:

3.13(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.

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

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

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

3.13(e) Upon receiving payment from the responsible party, Medical Services Entity will refund the amount of payment to Payer up to the amount paid by the Payer 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 Payer.

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 automobile 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 more information about subrogation, see Supplement 7.

IV. Medical Services Entity's Obligation

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 MCO 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 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.

4.5 Administrative Procedures. Medical Services Entity and each of its Qualified Physicians will comply with the policies and procedures established by MCO or any of its Plans to the extent that the Medical Services Entity has received notice 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 MCO or its various Payers. The policies and procedures in Exhibit D also must be available on MCO's Web site, and they may not be altered 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 4.5 prohibits such unilateral action and requires that all policies must be attached to the contract and must also be accessible at the MCO's Web site.

4.6 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 MCO. Medical Services Entity further agrees that it and its Qualified Physicians will abide by MCO'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.

4.7 Use of Names for Marketing. Medical Services Entity and each of its Qualified Physicians shall permit MCO 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. Such material shall be factually accurate and in compliance with applicable law and ethical standards.

4.8 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of MCO or any Payer to intervene in any manner in the methods or means by which Medical Services Entity and its Qualified Physicians render health care services or procedures 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 4.8 clearly establishes the physician's independent role in treating the patient. While other managed care contracts often include a provision similar to Section 4.8, 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 1.11), gives Section 4.8 force.

V. MCO'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 Payers. MCO shall include as part of Exhibit C a list of each Payer and shall promptly update Exhibit C upon the addition or deletion of Payers. The parties acknowledge that the intent of Sections 1.13, 3.1, and this Section 5.1 is to provide a mechanism for assuring that “rental networks” and similar arrangements 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 1.13, 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 “renting” of the physician’s discount to entities without the physician’s knowledge or approval. For more information about rental networks, see Supplement 3.

5.2 Adverse Medical Necessity or Coverage Decision. Medical Services Entity or Qualified Physician shall have a right to appeal any adverse medical necessity or coverage decision made by MCO. 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:

5.2(a) Unless existing MCO 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 MCO on behalf of Plan no more than ten (10) calendar days following the contested decision.

5.2(b) MCO 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 MCO 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.

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

Section 5.2 is designed to link existing MCO procedures with due process protections. Adverse decisions about medical necessity or coverage are subject to a due process review that is ultimately decided by independent peers, rather than by the MCO in its sole discretion. This process closely resembles the peer review process traditionally found in hospital medical staff bylaws. It also must be consistent with the laws of the states in which services are provided.

5.3 Administration. With respect to each Plan it offers or administers, MCO 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 Payment by Parties other than MCO. In the event MCO contemplates that payment for services or procedures provided hereunder is to be made by a Payer other than MCO, 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 3.10, MCO, within five (5) days of the receipt of written notice from Medical Services Entity, shall make a written demand to Payer on behalf of such Medical Services Entity for payment.

5.4(a) In the event a Payer fails to make payment within sixty (60) days after receipt of such notice, MCO shall either: (i) make such payment on behalf of the Payer; (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.

5.4(b) In the event of an occurrence described in Section 5.4, MCO shall tender to Medical Services Entity a copy of the agreement that governs the relationship between MCO and Payer. The Medical Services Entity may rely on this Agreement in prosecuting such action. MCO shall release Medical Services Entity, at Medical Services Entity's option, from any further obligation under this Agreement to provide services or procedures to Enrollees of Payer.

5.4(c) MCO shall notify Payer of the provisions of this contract and shall obligate Payer with respect to such provisions.

Section 5.4 protects the physician no matter who is obligated to pay. Many managed care contracts do not require the MCO to make payment. Instead, they require the payer (eg, an employer-funded plan) to make such payment. This 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 payer does not make payment. This provision is a businesslike approach to granting physician the right to pursue the appropriate party, if necessary, in court.

5.5 Cooperation in Credentialing. MCO and Medical Services Entity agree to cooperate in credentialing and re-credentialing Qualified Physicians in accordance with the process set forth on Exhibit D of this Agreement. MCO agrees to make final physician credentialing determinations within forty-five (45) calendar days of receipt of an application and to grant provisional credentialing pending a final decision if the credentialing process exceeds 45 calendar days. MCO also agrees to retroactively compensate physicians for services rendered from the date of their credentialing submission.

Exhibit D shall identify rights and obligations of MCO and the physicians during the credentialing process. By way of example, Exhibit D shall specify the following:

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

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

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

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

5.5(e) Identification of how and when physicians will be notified of credentialing decisions.

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

5.5(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 MCO to support its adverse decision
- (v) What individuals within the MCO 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 MCO must make a final decision following the appeal procedure and communicate the decision to the physician
- (vii) Provisions for notice and corrective action prior to an adverse credentialing decision becoming final

5.5 (h) In the credentialing of Qualified Physicians, MCO 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 MCO shall limit such request to that which is reasonable and necessary to achieving valid credentialing purposes.

Prolonged delays in credentialing have become an increasing problem around the country, particularly for young physicians entering practice. In addition to requiring that plans set forth the criteria for credentialing, Section 5.5 provides that credentialing must occur within the reasonable timeframe of 45 days and that payment will be retroactive to submission of the credentialing form. It also limits the extent of information the MCO can request to those items that are reasonable and necessary for the credentialing process.

5.6 Physician Grievances. MCO shall establish and maintain systems to process and resolve a grievance by a Qualified Physician toward MCO or a Payer. Such process shall be set forth in the procedures which are a part of Exhibit C and any MCO 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 MCO, MCO 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. The internal procedure for resolving such grievance will be presumed concluded in the event that 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 to resort to the dispute remedies of Article IX.

The type of grievance system outlined in Section 5.6 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 or other dispute resolution processes. 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. MCO 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 MCO or a Payer and Enrollees.

Section 5.7 places the responsibility to inform Enrollees of their benefits where it belongs: on the MCO. Often, MCOs fail to provide Enrollees adequate information about benefits. This can create confusion and place an added burden on the physician and his or her staff to at the time of a patient visit.

5.8 Quality Improvement. Medical Services Entity and MCO are both committed to quality improvement. Evidence-based clinical quality of care measures are the primary measures used, and outcome measures are subject to the best available risk-adjustment for patient demographics and severity of illness. Clinical performance measures are developed and maintained by appropriate professional medical organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession. Physician participation in financial incentive programs is voluntary. MCO has a mechanism to allow Qualified Physicians ongoing participation in the development,

assessment, and evaluation of quality management programs. MCO provides physicians the opportunity to review and appeal the accuracy of their personal data and data analysis.

Many MCO contracts include language requiring physicians to participate in and “cooperate” with quality initiatives. The AMA is very concerned that this vague language can be used by MCOs to mandate participation in pay-for-performance, profiling or other initiatives that are not quality-based and are in fact cost-cutting programs that may harm the patient-physician relationship. Some of these programs may be inappropriate for certain types of practice or physician specialties. Moreover, MCOs may establish programs that require significant financial investment in information technology and accompanying staff resources with little or no added compensation to the physician practice. Section 5.8 makes clear that any quality improvement program must be evidence-based and developed by physicians and that any participation in pay-for-performance programs must be voluntary. It also requires the MCO develop a mechanism for physician input into any quality improvement initiatives. The AMA has developed Principles and Guidelines for Pay-For-Performance that can be accessed at www.ama-assn.org/go/psa, click “Pay for Performance.”

5.9 Provider directories. MCO shall maintain a current provider directory available to enrollees on the MCO Web site and in hard copy. MCO shall include Medical Services Entity on all provider lists for plans set forth in Exhibit B.

5.10 Provision of Financial Information. MCO 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 MCO. 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 MCO; 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 MCO. 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 from financially troubled MCOs by granting physicians 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 when the Payer 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 3.11, 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, in the event of a MCO’s financial failure.

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 MCO. Any request by MCO for confidential medical records shall be limited to the minimum information necessary to accomplish the specific purpose for which MCO seeks the information. MCO 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 MCO seeks the information and must be in compliance with applicable state and federal laws.

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's Qualified Physicians 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. They are consistent with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which makes clear that MCOs cannot have unfettered access to a patient's medical record and that any requests for information must be the "minimum necessary" to accomplish the MCO's purpose. For more information about HIPAA visit the AMA Web site at <http://www.ama-assn.org/ama/pub/category/4234.html>.

6.3 Other Confidential Information. 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). 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.

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

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, 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.

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 or procedures 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 MCO by Medical Services Entity upon MCO’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—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 an 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 MCO from unilaterally changing reimbursement. Second, it also allows the physician to drop a single product or plan without terminating every product subject to the agreement by providing an administratively convenient method for the physician to end participation in one product while continuing the legal relationship with 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 who 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 must track contract renewal dates so that if he or she wants to negotiate, he or she 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) MCO 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, or a conviction of a felony, and upon notice to Medical Services Entity, Medical Services Entity fails to immediately terminate such Qualified Physician from the provision of services and procedures 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, 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 MCO to terminate the agreement upon ninety (90) days notice. The AMA Model Managed Care Contract rejects that approach. Instead, it separates terms related to the definition of covered services and fee schedules from all 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, can 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.

*In addition, Section 8.4 provides that either party must give one hundred twenty (120) days notice of termination. A party that wishes to terminate the agreement must state in writing the reason for the termination. The requirement of a written reason for termination 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 more information about "without cause" termination, see **Supplement 8**.*

8.5 Termination for Failure to Satisfy Financial Obligations. This Agreement may be terminated in its entirety or with respect to a Payer by either party upon five (5) days written notice if either party, or in the case of termination by Medical Services Entity, a Payer 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.

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 MCO 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 MCO to pay for Covered Services rendered pursuant to this Agreement is discharged. Payment for such services and procedures shall be made pursuant to the fee schedule contained on Exhibit B or, if Exhibit B does not contain a fee schedule, at the billed charges of the Qualified Physician performing the services or procedures.

IX. Dispute Resolution

The AMA recognizes that there can be multiple approaches to dispute resolution. 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. For example, in some cases, mediation can be an effective dispute resolution technique. However, often in the context of physician disputes with MCOs, mediation simply adds one more layer of process, cost, and delay. Likewise, arbitration, when done properly, can provide for a less costly, expedited, trial-like proceeding. However, the typical managed care contract provides for arbitration as the exclusive remedy, and MCOs attempt to use these arbitration provisions to limit physicians' ability to bring and participate in lawsuits challenging unfair business practices embodied in many managed care contracts.

Article IX includes arbitration as one dispute resolution mechanism. However, Article IX is in no way meant to promote arbitration to the exclusion of litigation. Under Article IX, if one party has already filed a lawsuit, arbitration is not an option and the lawsuit would be allowed to proceed. For more detailed information about dispute resolution, see Supplement 9.

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 or procedures 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, MCO 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.

Typically, in an arbitration, each party bears its own costs. However, in the case of a dispute resolution involving a Medical Services Entity and a MCO, the Medical Services Entity is alleging that it has rendered services and the MCO is holding the Medical Services Entity's money. Section 9.2 recognizes that 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 MCOs Entity.

10.4 Assignment. MCO may not assign this Agreement without Medical Services Entity’s prior written consent, except that MCO may assign this Agreement to an entity related to MCO 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 MCO’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 MCO’s prior written consent. Nothing in this provision shall be interpreted to permit renting or leasing of Medical Service Entity’s services or fee schedule to entities that are not owned or controlled or a successor in interest of the MCO.

Assignment provisions generally are designed to allow for a seamless administrative transition if one of the parties to the contract changes ownership or control through a merger or other business transaction. They allow for the rights and obligations to continue under the contract. The assignment provision in 10.4 is distinct from most managed care contracts, which limit the ability to assign upon change in ownership or control to the MCO. Section 10.4 permits either party to assign without consent under these limited circumstances. Section 10.4 also provides additional protection against “leased” or “rental” networks by making clear (consistent with the definition of Payer in Section 1.11) that the provision does not permit such activity.

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 MCO:

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.

This provision 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 Payer 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 provides 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 section 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 10.

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: _____

MCO

By: _____

Title: _____

Exhibits that must be attached to AMA Model 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 examples of some provisions that physicians often agree to that create unanticipated problems. Physicians should know how to recognize these provisions 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.

EXAMPLE 1: Payer. “Payer” 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 MCO to use MCO’s provider network.

CONCERN: *This definition of “Payer” is broad enough to allow the managed care organization (MCO) to “sell” or “rent” its provider network to third parties, thus creating, what is sometimes referred to as a “rental network.” This practice allows third parties to exploit the MCO’s negotiated discounts with physicians without the knowledge of those physicians. For more information about “rental networks,” see Supplement 3.*

EXAMPLE 2: All Products. MCO has and retains the right to designate Provider as a Participating Provider or non-participating provider in any specific Plan. MCO 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 MCO. 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.

CONCERN: *“All products” provisions force physicians to participate in all current (and sometimes future) products that 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. At least seven states have passed legislation limiting their use. The AMA is concerned that MCOs may use “all products” provisions to force physician participation in government programs, including the new Medicare Advantage plans. For more information about “all products” provisions, see Supplement 2.*

EXAMPLE 3: General Offsets and Adjustments. Provider agrees to authorize MCO to deduct monies that may otherwise be due and payable to Provider from any outstanding monies that Provider may, for any reason, owe to MCO. Provider agrees that MCO may make retroactive adjustments to the payment outlined in Exhibit B.

CONCERN: *This provision gives the MCO a free hand to do whatever accounting it desires and deduct monies from a physician in its sole discretion without a requirement to account to the physician 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 off-sets the overpayment from reimbursement otherwise due. For more information about retrospective audits, see Supplement 7.

EXAMPLE 4: Comparable Provider Rate.

If Provider, accepts at any time, payment from another Payer of like or lesser total reimbursement than provided in this Agreement, then the Provider agrees to give written notice of the new rate to MCO and to enter immediately into good faith negotiations with MCO regarding revision of MCO rate. If Provider fails to notify MCO of the fact that it accepted a lower rate, MCO may terminate the agreement, or MCO may deem any past savings amount that it would have realized had the new rate been timely disclosed to it as a recoverable amount to be repaid or require that the revised compensation reflect unrealized past savings.

***CONCERN:** This provision is an example of a most-favored nations (MFN) provision. A most-favored nations provision requires physicians to give the contracting insurer the benefit of the lowest rate he/she negotiates with any insurer. Most-favored nations provisions had virtually disappeared from physician contracts but they have started reappearing in the past few years. The AMA believes that most-favored nations provisions are anticompetitive, particularly when they are used by a health insurer with a significant market share. In a series of cases and enforcement actions, the federal antitrust enforcement agencies have recognized the potential for MFN clauses to deter competition. If you receive a contract that appears to have a most-favored nations provision, alert your state medical association and the AMA.*

EXAMPLE 5: CPT Codes. Provider agrees that if MCO reassigns or re-bundles CPT codes, it will accept the applicable MCO Compensation for these services or procedures as reassigned or rebundled by MCO as payment in full.

***CONCERN:** This provision gives the MCO complete discretion to arbitrarily downcode, reassign or bundle CPT codes reported on physician claims. These practices are widely employed throughout the industry and are used to save MCOs money while depriving physicians of payment for services and procedures they have provided. Physicians should be reimbursed for the services and procedures they provide. When physicians contract to permit these unfair practices, they have limited ability to challenge the practices.*

EXAMPLE 6: 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.

***CONCERN:** This provision is designed to further deter a physician from bringing a legal action to enforce his or her rights. Physicians are already deterred by the legal war chests MCOs have available to fight lawsuits. By requiring the physician to pay attorneys fees and other costs of litigation if the MCO prevails in the lawsuit, this provision attempts to intimidate physicians from initiating litigation.*

EXAMPLE 7: Noninterference with Members.

During the term of this Agreement, Provider and its Qualified Physician shall not advise or counsel an Enrollee to disenroll from MCO’s Plan and will not directly or indirectly solicit any Enrollee to enroll in any other health care service plan or insurance program.

CONCERN: *This provision has the potential to function as a “gag clause” and inhibit legitimate patient–physician communication. It 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 counsel that could cause the patient to disenroll from the MCO.*

EXAMPLE 8: 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 attorneys fees attributable to any and all acts and omissions of the Provider.

CONCERN: *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.*

EXAMPLE 9: 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 (120th) 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 MCO after the MCO receives Provider’s notice of termination. However, this Agreement will continue in effect with respect to Enrollees existing prior to the MCO’s receipt of such notice until the anniversary date of the MCO’s contract with the subscriber group or for one (1) year, whichever is earlier, unless otherwise agreed to by the MCO. If termination is by the MCO, the rights of each party will terminate on the effective date of termination.

CONCERN: *While this termination “without cause” provision theoretically allows either party to terminate with 120 days notice, upon close inspection it requires the physician to continue providing services for one year or more after giving notice. Any termination “without cause” provision should be truly mutual. For more information about terminations “without cause,” see Supplement 10.*

EXAMPLE 10: Liability. Notwithstanding anything herein to the contrary, MCO’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 MCO under this Agreement during the twelve (12) months immediately prior to the date the cause of action arose. The MCO 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 or disagreement or any action, inaction, alleged tortious conduct, or delay by MCO.

CONCERN: *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 of real remedies in litigation with the MCO. Given that litigating against a large MCO can cost significant sums, 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.*

EXAMPLE 11: 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.

CONCERN: *The statute of limitations for actions on contracts such as this varies 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 and Due Process

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, 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. This allows the medical director to 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.

Equally troubling is the fact that many MCOs factor cost criteria into the definition of medical necessity. It is the position of the AMA that cost containment has no place in medical necessity determinations.

Section 1.11 of the AMA Model Managed Care Contract defines medical necessity as:

Health care services or procedures 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 economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

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

“Covered services” refer to the medical services and procedures that the MCO has specifically stated that it will cover under the enrollee’s benefits package. MCOs have an obligation to clearly inform physicians in their contracts and consumers in their subscriber agreements about what services and procedures are “covered.” However, MCOs often use the terms “non-covered” and “not medically necessary” interchangeably, which is confusing to patients. A service or procedure may be “non-covered” or excluded from the MCO’s coverage, despite the fact that the service or procedure is determined to be medically necessary by the treating physician.

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

In addition to using the “prudent physician” standard to define medical necessity in Section 1.11, 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 his or her billed charge for the service or procedure performed.

What can be done if a MCO overrules a physician’s clinical judgment that a service or procedure is medically necessary?

Physicians play a critical role in helping their patients navigate the process of appealing a medical necessity denial. There are several important avenues of appeal available.

• United States Department of Labor (DOL) regulations

In 2000, the DOL issued regulations that provide important protections to patients who receive their health insurance through an Employee Retirement Income Security Act (ERISA) plan, whether fully-insured or self-insured. The “regulations require ERISA plans to process claims within a certain time period and also to make timely decisions when a claim for benefits that were denied is appealed. If state law provides more generous patient protections than the DOL regulations, then state law applies. Under the DOL regulations, the MCO is required to have procedures in place that adopt the following timelines:

- Urgent care claims must be decided by the MCO no later than 72 hours after receipt of the claim. Any appeals must also be decided within this period.
- Pre-service claims must be decided no later than 15 days after receipt of the claim. Appeals of pre-service claims must be decided within 15 days of the submission of appeal.
- Post-service claims must be decided not later than 30 days after receipt of the claim.

The regulations also require that if the claim for benefits is denied because the service or procedure was determined to be not medically necessary or was determined to be experimental treatment, the plan must disclose an explanation of the scientific or clinical judgment for the determination, applying the terms of the patient’s plan. Once the decision is rendered, the MCO cannot require more than two levels of internal appeal before the patient can go to court to challenge the benefit denial under ERISA. The MCO’s procedures also cannot include mandatory arbitration that would prevent the patient from filing a lawsuit.

The DOL has issued “frequently asked questions” (FAQs) about the regulations, which are available at http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg.html. The FAQs make clear that with respect to urgent care, a plan must permit a treating physician to act as an authorized representative of the patient. With respect to pre-service care, the claims procedure cannot preclude an authorized representative of a patient from acting on his or her behalf, but the plan can establish procedures for determining whether an individual has been authorized to act on the patient’s behalf.

Physicians should be aware of these regulations and be prepared to help their patients, especially in the case of urgent care situations.

- **Independent external appeal**

Forty-three states and the District of Columbia have enacted laws that require an independent external review process for appeals of adverse medical necessity decisions. It is critical that physicians and patients take advantage of these processes if a MCO has overruled a physician's medical necessity judgment. A significant number of external review decisions on medical necessity are in favor of patients. External appeals laws require that patients exhaust internal appeals processes before accessing the external appeals processes. To learn about your state's external review process, contact your state medical association.

In a victory for patients and physicians, in 2002, the U.S. Supreme Court in *Moran v. Rush Prudential HMO*, held that the Illinois HMO Act, which provides for external review of medical necessity decisions, was not preempted by ERISA. The AMA and the Illinois State Medical Society filed "friend of the court" briefs in support of the plaintiff, Debra Moran, in both the U.S. Court of Appeals and the U.S. Supreme Court. The *Moran* decision makes clear that external review laws applicable to fully-funded health plans, like the Illinois law, are not preempted by ERISA. However, the Supreme Court did not rule on whether the Illinois HMO Act applied to patients who receive their insurance through self-funded plans. This is another reason the DOL regulations are so important.

Does the AMA Model Managed Care Contract provide physicians a right to appeal adverse medical necessity or coverage decisions?

Yes. Section 5.2 of the AMA Model Managed Care Contract requires that adverse decisions relating to medical necessity or coverage are subject to a due process review that is ultimately decided by independent peers, rather than by the MCO in its sole discretion. This process closely resembles the peer review process traditionally found in hospital medical staff bylaws. It also must be consistent with the laws of the states in which services are provided, including any external appeals laws.

What is the AMA doing to address the continuing lack of accountability on the part of MCO's for their medical necessity decisionmaking?

The AMA continues to advocate that health plans be held responsible for their medical necessity decisions that harm patients. The AMA does not believe that when ERISA was passed in 1974, Congress envisioned managed care as it exists today or that ERISA would function as a barrier to accountability of health plans making medical treatment decisions. The AMA believes that Congress has the responsibility to determine what approach is most appropriate to protect Americans from medical necessity decisions that are made by health plans.

“All Products” Provisions

What is an “all products” provision?

“All products” provisions have evolved since they first started appearing in managed care contracts in the late-1990s. In general, an “all products” provision is a clause in a managed care organization (MCO) physician contract that requires physicians to participate in all of the MCO products, sometimes extending to future products.

In the late-1990s, “all products” provisions were used primarily to force physicians who wanted to participate in a MCO’s PPO product to participate in the MCO’s HMO product, a dramatically different product that often requires physicians to assume insurance risk. This forced participation was part of a strategy by employers and MCOs to increase employee enrollment in HMOs. Some MCOs were aggressive in enforcing “all products” provisions. A physician group or network would seek to terminate an HMO contract, and the MCO would respond by terminating the PPO contract, contending that the “all products” provisions allowed such action.

Thanks to aggressive advocacy efforts by the AMA and state medical associations, a number of MCOs pulled back on their insistence on mandatory participation in HMOs as a condition of participating in PPOs. In addition, as part of the settlements reached in class action lawsuits brought by physicians and a number of state and county medical associations, at least two MCOs have agreed that they will not condition participation in PPOs on participation in HMOs. To learn more about the class action settlements, visit <http://www.hmosettlements.com>.

The New “All Products” Problem

It is clear that “all products” provisions have not disappeared. Because of changes in the market, “all products” policies have changed as well. Generally, they no longer specifically tie PPO participation to HMO participation. Instead, these clauses are broader and often require physician participation in all of the plans offered by the MCO.

This is in part because of the backlash against HMOs in the past several years and the continuing patient demand for health insurance products that offer more choice. It is also in part because of the rapid evolution and proliferation of new products including consumer-directed products. According to a Kaiser Family Foundation Study, in 2004, 25% of commercially insured Americans were in HMOs, compared with 31% in 1996. By comparison, in 2004, 55% of commercially insured Americans were in PPOs, nearly doubling since 1996.

An example of a new generation of “all products” provision follows:

Physician agrees to participate in the plans and other health products as described in the Product Participation Schedule. MCO reserves the right to introduce, modify, and designate physician’s participation in plans and products during the term of the agreement.

This sample “all products” provision is problematic for two reasons. First, if the physician does not have the ability to affirmatively designate which

“products” are included on the Product Participation Schedule, this provision functions as an “all products” provision. Second, the provision requires physicians’ participation in any and all future products without any prior negotiation. This provision makes clear that once the physician has signed a contract, he or she has no ability to opt-out of products, even if participating in those products has an adverse impact on his or her ability to treat patients or to manage the practice. Even if a physician initially had some ability to negotiate product participation, that ability is rendered meaningless.

Why are non-negotiable “all products” provisions and policies objectionable?

In the current environment where new product and plan types are being developed and introduced at a rapid rate, physicians must retain the ability to select which products and plans in which to participate. Physicians must have the ability to review and assess the product, including the fee schedule, so they can make an informed business decision about participation. “All products” provisions coerce physicians into participating in products. This includes forced participation in future products with an unknown impact on patients and with unknown and unpredictable business risk.

What is the AMA doing to combat “all products” provisions?

The AMA has been aggressively fighting mandatory “all products” provisions and identifying new trends in this arena. The AMA has developed model state legislation to prohibit “all products” provisions or policies. Eight states (Alaska, Arkansas, Florida, Indiana, Kentucky, Maryland, Massachusetts, and Virginia) have

passed legislation to limit the use of “all products” provisions. While those laws were originally developed in the context of MCO’s tying PPO participation to HMO participation, most of them are broad enough to cover the new evolution of “all products” provisions.

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

Section 1.12 of the AMA Model Managed Care Contract 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 should develop separate business terms (including compensation) for each and every product, although all terms may be collected within a single contract. Under this provision, if the MCO introduces a new product, it could not unilaterally designate the physician as a participant. If the physician chooses to participate, the MCO would then have to reach an agreement with the physician with new business terms for the new product. In addition, either party may terminate plans or products individually.

Fee-For-Service Payment Systems

What is a fee-for-service payment system?

In a fee-for-service payment system, the physician files claims with the managed care organization (MCO) for all services and procedures performed and should receive payment for all medically necessary services and procedures performed as long as they are covered by the patient's insurance policy. Under fee-for-service payment systems, there is no assumption of financial or insurance risk by the physician.

Fee-for-service payment under managed care is different from fee-for-service under a traditional indemnity plan where a physician submits a claim and is paid fully for his or her billed charges. Fee-for-service payment systems now use several models that essentially operate to discount the physician's fees. Therefore, fee-for-service under managed care systems is commonly referred to as "discounted fee-for-service" payment.

This supplement provides basic information about fee-for-service payment systems and payment policy. It also alerts physicians to the existence of "rental network" PPOs.

What are the models for discounted fee-for-service payment?

There are three basic models for discounted fee-for-service payment.

- The reimbursement is a "percentage of Medicare." This is determined by relying on the Medicare Resource-Based Relative Value Scale (RBRVS) and Medicare conversion

factors and then determining a percentage of the Medicare fee schedule (e.g. 110% of Medicare).

- The reimbursement is determined based on relative value units (RVUs). Some use the Medicare RVU system and some use other systems. The MCO then assigns its own conversion factor, creating its own fee schedule.
- The fee schedule is a percentage discount (e.g. 20%) off of physician's billed charge.

It is important that physicians understand the payment methodology that underlies a fee schedule. Physicians need to understand whether the payment they receive is sufficient to cover expenses and to generate a reasonable income.

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

Some important questions to consider when negotiating a discounted fee arrangement include the following:

- Is a detailed description of a comprehensive fee schedule attached to the agreement? Is enough information provided so that the fee for each service and/or procedure 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 service or procedure code reported. MCOs sometimes provide a "sample" fee schedule with a contract that contains "sample" fees for the most commonly billed

Current Procedural Terminology™ (CPT) codes for each specialty. However, these rates may not be the same as those negotiated pursuant to the contract. Therefore, physician practices should prepare a list of all CPT codes used, submit it to the MCO, and insist that the MCO provide pertinent reimbursement rates specific to the practice.

- If payment is based on Medicare RBRVS or a customized RVU system, does the MCO provide physicians with a user-friendly means to apply the formula to obtain rate information per CPT code?
- Who has authority to change the fee schedule? Can the MCO change the fee schedule unilaterally?
- How much notice will physicians be provided before the fee schedule is changed, and if adequate notice is not given, does the physician have the right to terminate?
- Has the physician practice analyzed the fee schedule to take into account the frequency of utilization of specific CPT codes?

Physicians must keep in mind that overall reimbursement is determined by multiplying utilization rates by the reimbursement. 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 service and procedure CPT codes reported by the practice and insist that the MCO provide pertinent reimbursement rates.

How does a fee schedule relate to MCO's payment policy?

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Once a claim is submitted, it proceeds through the MCO's claims adjudication process. There are a number of steps to the claims adjudication process, including the application of the MCO's medical payment policy. This process is typically not transparent to the physician but impacts reimbursement.

The first step in claims adjudication is determining whether a patient is eligible for benefits and whether the service and/or procedure is covered under the patient's benefit plan. However, a primary reason for the discrepancy between a fee schedule and the final amount paid to the physician is the application of the MCO's proprietary and customized combination code edits. These combination code edits are typically applied automatically without reference to the specific claim, and they often result in decreased reimbursement to the physician. The MCO's medical payment policy is reflected in the code edits.

Physicians around the country are extremely frustrated by the lack of transparency in the claims adjudication and payment process, including the application of customized code edits that are inconsistent with CPT codes, guidelines and conventions.

However, there has been some progress in moving towards transparency in physician payment. Virginia recently enacted a law requiring health plans to disclose all of their downcoding and bundling edits and requires an appeal mechanism for physicians to contest the bundling and downcoding policies of the plan. The law goes into effect January 1, 2006.

In 2002, after a court victory in a case brought by the Medical Association of Georgia and supported by the AMA, Blue Cross and Blue Shield of

Georgia was ordered by the court to disclose its fee schedule and precise methodology used in payment. The Georgia Insurance Commissioner issued an order requiring all plans to disclose this information and to disclose coding edits on request.

In addition, as part of the settlement agreements reached in national class action lawsuits brought by physicians and state and county medical societies, at least three MCOs have agreed to significant changes that will result in more transparency and fairness in claims adjudication. For example, these MCOs have agreed to post on their Web sites fee schedules applicable to each physician and to provide a fee schedule to a physician for up to 50 CPT codes by e-mail or fax. The MCOs have agreed to disclose all proprietary and customized code edits and medical payment policy. They have also agreed to limits on automatic adjudication of claims. For more information on the settlements visit <http://www.bmosettlements.com>.

The AMA has a range of resources to help physicians navigate claims processing to increase the likelihood of full, prompt payment of claims. Those resources can be accessed at <http://www.ama-assn.org/go/psa>, under “Claims Processing.”

How does the AMA Model Managed Care Contract address the lack of transparency in claims processing?

Section 3.3. of the AMA Model Managed Care contract requires the MCO to attach the fee schedule and if the MCO fails to do so, payment reverts to billed charges. It also prohibits unilateral change in fee schedule. Section 3.3 (a) i-v provide for transparency under any discounted fee system.

Section 3.6 presents the practice of “bundling,” “downcoding” and “reassignment” of CPT codes. It requires the MCO to adhere to CPT codes, guidelines and conventions, including the use and recognition of modifiers. For more information about CPT codes, guidelines and conventions, visit <http://www.ama-assn.org/go/cpt>.

What is a “rental network” PPO?

Another cause of physician frustration with discounted fee-for-service arrangements is “rental network” PPOs. A physician practice will receive an explanation of benefits form (EOB) that lists payers that the staff has never heard of and rates that are either the lowest contracted rate or an even lower rate. This is typically the result of the use of “rental network” PPOs.

A “rental network” PPO is not really a managed care product. It is best described as a process. It is essentially a secondary market in physician discounted rates. The rental network PPO develops a physician panel and then leases its physician panel (and physician discounts) to payers, such as a third party administrator acting on behalf of a self-insured employer or MCO that does not have a physician network in a particular market. Some “rental network” PPOs are referred to as “silent PPOs” because the physician did not enter into any contract authorizing the leasing of such discounts.

The rental network PPO also may lease the network to non-payers, the so-called “network brokers” or “reprice.” Payers access these entities to obtain the deepest discount a physician has agreed to and then “reprice” the claim. In some cases, the claim is “re-priced” to a rate unrelated to any rate the physician has agreed to in a contract.

Physicians must be very careful about signing contracts that permit the sale or leasing of their discount. MCOs sometimes rent their PPO networks, and they justify this practice by invoking broad contractual definitions of “other payers” or “affiliates.” (See AMA Model Managed Care Contract Addendum, Example 1).

There are also many companies whose primary business is creating and renting PPO networks. They do not provide health benefit plans, administer plans, or provide health insurance. Physician contracts with these rental network PPO companies typically allow the PPO to lease the physician’s discounted rate to a very broad range of entities without prior approval from the physician and often without any notice to the physician. The PPO specifically states that it is not responsible for payment and can only make “best efforts” to assure that the entity responsible for payment pays according to the contract.

To further complicate matters and disadvantage physicians, the contracts do not require payers to apply a consistent payment methodology. Therefore, payers can “rent” the discount, apply their own payment methodology and the physician’s fee is subject to further unfair discounting. Moreover, when a physician sees a patient who is “out of network,” the patient’s MCO may also access the discount from the rental network PPO instead of reimbursing based on the physician’s billed charge. It is possible for a physician to sign a contract with a single rental network PPO that can allow dozens of payers access to the physician’s discount.

What is the AMA doing to address problems created by “rental networks?”

“Rental networks” are unfair to physicians, and unraveling them is challenging. The AMA has

developed detailed materials to help physicians identify and manage problems, including identifying the rental network PPO contracts that may be harming the practice. Those materials can be accessed at <http://www.ama-assn.org/go/psa> under “Prompt payment/Payment hassles.”

In addition, the AMA has developed model state legislation to address the issue of unfair renting of physician discounts. Six states currently have laws that place limits on PPO rental networks (California, Kentucky, Louisiana, North Carolina, Oklahoma, Texas).

In 2003, California passed what is currently the most expansive law protecting physicians from some of the worst abuses of rental network PPOs. The law requires that any MCO contracting with a physician must specifically indicate whether the MCO’s networks can be sold or rented and must provide a list of all payers eligible to access the physician’s discount. It requires that physicians have the opportunity to decline participating with any given payer. It also requires that on all explanation of benefit forms, every payer that has rented a physician’s discount must identify the plan or network with which the physician has a written contract. When a physician’s discount is rented or sold, the written contract between the physician and plan or network governs.

How does the AMA Model Managed Care Contract address the issue of “rental networks” and “silent PPOs?”

The AMA Model Managed Care Contract addresses this issue by defining “payer” in Section 1.13 in a manner that makes clear that the MCO cannot “sell” or “rent” the network to other entities, with the exception of a self-insured employer that has contracted with the MCO to administer the benefit plans.

Coordination of Benefits

What is “coordination of benefits?”

Coordination of benefits (COB) refers to a process and to standards advocated by the National Association of Insurance Commissioners to determine the obligations of payers 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 and/or procedure. 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 payer 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 health insurance industry are enormous. One leading consultant for the managed care industry estimated 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 managed care organization (MCO).

There has been a reluctance to acknowledge the potentially deceptive practice of payers receiving additional premiums from an employer and employee whose family has duplicative coverage without providing a corresponding additional benefit to the member. While physicians are often not allowed to retain reimbursement equal to 100% of their billed charges, payers may retain 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 payers engage in a practice known as “pursue and pay,” in which the payer makes no payment until it can verify that it is the primary payer. Other payers engage in a practice known as “pay and pursue,” in which the payer pays claims and then seeks out the primary payer, if any, for reimbursement. The experience of many physicians suggests that the majority of payers 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 payer, receives no reimbursement until the companies determine who has the primary obligation to pay.

The second set of concerns relates to attempts by some payers to use the COB system to pay less than they might otherwise owe for services.

A hypothetical situation illustrates these concerns:

Plan A contracts with physicians at a reimbursement rate equal to 120% of the resource-based relative value scale (RBRVS) used in the Medicare program. Plan B 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 health insurance industry standards, physicians receive payment from the primary payer in accordance with the terms of the physician's agreement with that payer, 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 payers would know which payer is primary at the time service is rendered.

The obligation of the secondary payer is far less clear. If the reimbursement for the service or procedure under the secondary payer's plan is less than that of the primary payer, 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 payer's plan is more than that of the primary payer, then the issue becomes whether the secondary payer owes nothing or owes the difference between the obligation of the primary payer and the secondary payer. In the 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 payer owes the physician.

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

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

The Medicare program presents a range of difficult issues involving primary and secondary payers. 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 payer, and the employer or its contracted agent would become the secondary payer. 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 payer.

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 employer health plans refuse to cover these co-payments in situations where the plan's contracted reimbursement rates are lower than Medicare allowed fees. Section 3.9 of the AMA's Model Managed Care Contract addresses this issue by providing that in the case of Medicare beneficiaries, where the payer 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 or procedures rendered under the Medicare program.

If the secondary payer continues to resist, the physician may decide to collect directly from the beneficiary. While a physician may be reluctant to do this, he or she is legally entitled to do so;

in fact Medicare laws and regulations prohibit physicians from routinely waiving copays and deductibles.

Section 3.11(c) of the AMA Model Managed Care Contract permits physicians to collect payments from individuals for certain services or procedures, provided that contract such collection efforts do not violate state or federal law. Physicians need to be cautious in signing managed 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 payer 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 3.9 of the AMA Model Managed Care Contract. This language prohibits payers 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 payers verify whether they are primary or secondary, in exchange for the payer's written agreement to first pay the physician, then pursue payment from potential secondary sources.

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

Section 3.9 of the AMA Model Managed Care Contract provides that physicians are entitled to an amount of reimbursement from both payers that does not exceed the maximum amount permitted by either payer. However, as noted, in the case where Medicare is primary, the total payments cannot be less than 100% of the Medicare allowed fee schedule.

Late Payment of Claims

Why is late payment of claims such a problem?

Late payment of claims by managed care organizations (MCOs) and other payers is 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 timely payments. It also creates a heavy administrative burden on physicians and their staff who often spend excessive time on the phone with MCOs pursuing unpaid and overdue claims. And when a MCO or other payer delays payment, it earns interest on the payment delayed while physicians lose the time value of that money.

Physicians are also frustrated with a claims processing system that can exacerbate the problem. It is not uncommon for a MCO to return a claim 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. The problem is particularly acute with paper claims, but it also exists with electronic claims.

Physicians need to be alert to the possibility that a MCO that is chronically late in paying claims may be in financial trouble. If it appears that a MCO is headed toward insolvency, a quick

termination of the contract offers the physician the greatest protection. Once a business declares bankruptcy, options for recovery become very limited. Physicians should, however, take care not to abandon, or give the appearance of abandoning, patients covered by that MCO.

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. MCOs have no incentive to include language that would force them to pay promptly.

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 MCOs and 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 Hassles Survey Support Package. Survey results have been used by state and county 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, 49 states and the District of Columbia, have laws and/or regulations requiring the timely payment of health insurance claims. The AMA has worked with over 30 states to pass laws specifically based on AMA model legislation. The AMA model legislation requires MCOs and other payers to pay claims within 14 calendar days of submission when filed electronically and within 30 calendar 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.

There continues to be significant activity at the state level. State medical associations are seeking to close loopholes in existing prompt pay legislation. Examples include efforts to amend current state law to provide a private right of action against MCOs that fail to comply with the law, redefining the term “clean claim,” and extending the reach of state law to the broad range of entities that function as “payers.”

On the regulatory front, a number of state regulators have become more aggressive in enforcing state prompt payment laws and are levying substantial fines against MCOs that violate the law. Since 1997, fourteen states have fined MCOs a total of over \$54 million in the aggregate for violations of state prompt pay laws. Regulators in California, Georgia, New York and Texas have been particularly active in enforcing state prompt pay laws. In addition to levying fines, the Texas Department of Insurance has ordered 47 MCOs to pay over \$64 million in restitution to physicians for violations of Texas prompt pay laws since 2001.

Late payment of claims has also been an important issue in such class action lawsuits brought by physicians and state and county medical societies challenging a range of unfair MCO business practices. In settlement agreements reached with three of the former defendants in the lawsuits, the MCOs have agreed to prompt payment time frames. They have also agreed to generate electronic acknowledgment of receipt of electronic claims and to date stamp paper claims upon receipt in the mailroom. If a physician lives in a state with a prompt pay law which provides more protection than that provided by the settlement, the state law applies. To learn more about the settlement provisions, go to <http://www.hmosettlements.com>.

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

Section 3.10 of the AMA Model Managed Care Contract is designed to provide a fair payment mechanism in which the MCO or other payer has a clearly defined obligation to pay claims within a reasonable period of time. The AMA Model Managed Care Contract requires the MCO or other payer to pay within 14 calendar days of receipt of a claim submitted electronically and within 30 calendar days of receipt of a claim submitted on paper, or such shorter time as is specified under state law.

The AMA Model Managed Care Contract does not use the term “clean claim.” Instead, the Section 3.10 provides that claims must be paid within the time frame if the claim “is sufficient in detail so that the MCO or other payer is able to reasonably determine the amount to be paid.” If a claim does not have sufficient detail, the MCO or payer 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 payer to either pay or request information within the time frame and is designed to prevent MCOs or other payers from manipulating the “clean claim” concept or otherwise sitting on claims.

Section 3.10(a) addresses the problem of MCOs and other payers “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 3.10(a) addresses this “resetting the clock” when a claim is “lost” by the MCO, but the physician has records of the date a claim was originally filed.

Section 3.10 (c) provides for interest penalties when MCOs or other payers fail to make payment in a timely manner. While these provisions do not guarantee that MCOs and other payers will improve their payment practices, this interest penalty serves as a strong incentive for payers to make payment to physicians in a reasonable and timely manner.

Retrospective Audits

What is a retrospective audit?

In a retrospective audit, managed care organizations (MCOs) review claims paid to a physician practice over a set period of time to determine whether there has been overpayments of claims. Retrospective audits are burdensome and add an administrative expense to the physician practice, particularly when they occur several years after a claim was paid. If a MCO determines through a retrospective audit that overpayments have been made, physicians may be asked to make repayments for services and procedures already provided or may be forced to accept automatic reductions or “offsets” to future reimbursements until the “overpayment” amount is satisfied.

In recent years, MCOs have become increasingly aggressive in using retrospective audits as a cost containment tool. Sometimes the MCO will request refunds from overpayments discovered in the audited claims only. However, MCOs also may extrapolate the findings from a sample review and apply them across all claims submitted during the time period of the audit, a practice that the American Medical Association (AMA) opposes. This can result in physician receiving a letter demanding repayment of significant sums of money in a short time frame.

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

Retrospective audits involve a multiphase process that will vary by MCO. The first phase is typically an internal audit of claims performed by the MCO. The audit looks for “red flags” that indicate an overpayment may have occurred. The MCO will provide written notice to the physician of the suspected overpayment. The notice usually includes the reason for the suspected overpayment and a request for medical records and other documentation to assist in performing the next phase of the audit. When a practice receives notice of an audit, it is important to be proactive in responding. In some cases, the MCO will refuse to pay pending claims until the audit is complete.

What are the reasons that MCOs audit?

There are a number of reasons that MCOs audit. In some cases, the MCO may “red flag” a physician practice because of high service volume that the MCO believes indicates overutilization of reimbursable health care services or procedures. In other cases, MCOs may “red flag” a practice that uses the same AMA Current Procedural Terminology (CPT®) code frequently. An audit may also be prompted by a practice’s reporting a high volume of certain CPT modifiers or for nonconformity with health plan coding guidelines. And, MCOs can simply conduct random audits.

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What should a practice do once it receive notice of an audit?

Quality medical record documentation is the key to successfully navigating a retrospective audit. For example, if the practice is audited because of high service volumes, the physician may substantiate high volume or frequency of services by providing documentation relating to the size, specialty, local disease prevalence, and other factors that affect the practices's service delivery and billing patterns. Likewise, if a practice is audited because of repeated use of the same E/M codes, the practice is much more likely to prevail in a retrospective audit if the medical record clearly supports the need for the level of service billed and the procedures or services required. It is critical that physicians bill each service or procedure case-by-case rather than employing "generic" billing practices. Without good documentation, it is very difficult to defend a retrospective audit.

Some physician practices perform an annual internal billing audits to assure that billing errors are not occurring and that billing is in compliance with CPT codes, guidelines and conventions, as well as billing guidelines MCOs provide to the practice. While this is a significant undertaking, it will typically yield improved claims management processes and cash flow and also will help the practice in the event of a retrospective audit.

Are there any legal limits to retrospective audits?

Physicians who receive notice of a retrospective audit should review their MCO contract to determine whether it addresses retrospective audits. Many MCO's include "offset" provisions in their contracts that are very broad and give the MCO wide berth to decrease future

reimbursement based on alleged overpayments. See **AMA Model Managed Care Contract Addendum, Section 3.0**

However, six states prohibit automatic "offset" or recoupment of payment and require notice and some due process (Alaska, California, Florida, Kentucky, Ohio). A number of states also limit the time period for retrospective audits.

In addition, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires that physicians may only release the "minimum necessary" information for the intended purpose of a request. Therefore, if a physician practice believes that release of some or all of the information requested as part of the audit goes beyond the "minimum necessary" standard, it should not release the information and should inform the MCO of its position.

Finally, if a physician practice believes it has been singled out for a retrospective audit because of patient advocacy or other protected activity, it should seek legal counsel.

How does the AMA Model Managed Care Contract protect physicians from retrospective audits?

The AMA Model Managed Care Contract Section 3.10(d) specifically provides that all payments to physicians and physician groups/networks will be final unless adjustments are requested in writing by the MCO within 180 days after receipt. It also requires the MCO to notify the physician within 15 days of a request for additional information if the claim is not considered "clean," and to provide the reason for the alleged deficiency. This eliminates the possibility of retrospective audits beyond the 180 day period.

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 payer “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 payers frequently do not cover services or procedures 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 payers 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 or procedures 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 and procedures; 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 and procedures should recover those costs from the liability insurer. In most cases, the party at risk is the MCO or other payer. However, when the physician has a capitation contract, then the party at risk may be the physician.

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 and procedures at 100% of the costs 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 does the AMA Model Managed Care Contract address subrogation?

Article III of the AMA Model Managed Care Contract requires MCOs and other payers to pay the physician in a timely manner and then pursue claims against third parties. The subrogation provision (Section 3.12) further calls for reimbursement of costs incurred by the MCO or other payer at risk in a subrogation action. Once actual costs are reimbursed, the AMA Model Managed Care Contract allows physicians to receive additional payments from the excess funds in an amount not to exceed 100% of billed charges.

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 a 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. For example, while the MCO may initially contract with a large panel of physicians to gain entry to a market and capture market share; they then 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.

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. Maine, Massachusetts, New Mexico and Texas all require insurers to provide a written reason to providers before any termination or nonrenewal. 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.”

State courts have historically enforced termination “without cause” provisions. However, two state courts have refused to enforce such terminations. In *Potvin v. Metropolitan Life Ins. Co*, 2000 Cal. Lexis 3717 (Ca. Sup. Ct. May 8, 2000), the California Supreme Court 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 take in 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 are 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 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 Managed Care Contract

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, a physician also has rights to dispute the MCO's decision.

Dispute Resolution: Litigation vs. Arbitration

The health care environment is becoming increasingly complex and adversarial. Physicians around the country complain about a wide range of managed care organizations (MCOs) business practices, many relating to payment of claims. When physicians come to an impasse over these 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.

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 a

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 <http://www.adr.org> or the American Health Lawyers Association Alternative Dispute Resolution Service at <http://www.healthlawyers.org/adr>.

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. Binding arbitration forecloses all opportunities for physicians to pursue any litigation against a MCO.

Moreover, physicians need to be aware that MCOs are beginning to insert provisions in contracts that prohibit a physician from consolidating his or 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?

Article IX of the AMA Model Managed Care Contract allows physicians to litigate disputes before a court of law, as long as there has been no request to arbitrate by the MCO before the lawsuit is filed. This is a critical distinction because most MCO contracts require arbitration to the exclusion of bringing a lawsuit. The AMA Model Managed Care Contract does not favor arbitration or any other dispute resolution process.

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 of the contract. 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 MCO’s receipt of notice of termination by the physician until the anniversary date of the MCO’s contract with the enrollee’s subscriber group or for

one (1) year, whichever is earlier, unless otherwise agreed to by the MCO.” 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 MCO 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 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 payer, 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 payer. 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.

How does the AMA Model Managed Care Contract address restrictions or obligations that continue after termination?

Section 8.6 of the AMA Model Managed Care Contract outlines clearly the effect of termination. It 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 billed charges of the physician. Under the AMA Model Managed Care Contract, 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.

