

INTERPRETING THE LANGUAGE IN YOUR PAYOR CONTRACTS

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Role of your attorney and contract review

- Primarily to review the documents and inform you what the documents mean.
- Rarely on any meaningful point, is there any effective discussions with the third party payor.

Contract Management

- What is the contract?
- Who keeps track of contracts?
- Who keeps track of contract amendments and notices?
- Who tracks compliance with a contract by the payor?

Renegotiating Contract Terms

- Only through the role of DOBI and the various professional societies can clauses be changed.

Who are you dealing with?

- Insurer/HMO or affiliate and explain difference.
- Be alert for references to “our affiliates” or other ways that they subcontract risk.
- Antitrust issues – avoid sharing pricing information with competitors.

Contract v. Regulatory Requirements

- Some payors provide an amendment incorporating New Jersey requirements.
- Amendment may be different from terms of main contract – need to review both.

Policies & Procedures

- Policies by incorporation – must obtain and review.
- Sample Clause: “You will comply with our policies and procedures. Some or all policies and procedures may be communicated in the form of a provider reference manual, and other written materials distributed by the payor to you and/or at a website identified by the payor. The policies and procedures may change from time to time. We will give you advance notice of materials changes to policies and procedures.”
- Contracts often provide for the right to amend contract or change policies unilaterally without notice or on short notice.

Polices & Procedures

- Amendments may be automatic unless you negotiate language in the contract which allows the provider to object to amendments and to terminate the agreement if it objects to an amendment.
- In some cases, there may be no advance notice – for example, some providers were in for an unwelcome surprise when we had the issues with reduction of Medicare reimbursement last year, as other third party payors' rates adjusted automatically per contract if they followed the Medicare fee schedule.
- The notice period for termination should be longer than the time period allowed to review and object to an amendment to the agreement, or policies or procedures.

Utilization Management

- NJ Health Care Quality Act imposes utilization management requirements mandating that utilization management determinations are based on written clinical protocols developed with involvement from practicing physicians and other health care providers and based on generally accepted medical standards.
- Some carriers have moved towards utilization management outsourcing (i.e. Magellan for Behavioral Health, Care Core National for cardiac imaging services).
- Know who you are dealing with.

Payment Issues

- New Jersey Prompt Payment Regulations – Supersedes contract – requires payment of claims filed electronically within 30 calendar days of receipt unless missing information or documentation; then, deadline extended until 30 days after electronic receipt of missing information (40 in case of paper claims); if not met, provider is owed interest.
- Are you restricted from billing a patient for no show charges?

Audits

- You are subject to audit at any time – be prepared.
- Sample Clause: “Upon reasonable notice and during regular business hours, the payor or its designee will have the right to review and make copies of all records maintained by you with respect to all payments received by you from all sources for covered services provided to plan participants. The payor or its designee will have the right to conduct audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement. Any amounts determined to be due and owing as a result of such audits must be promptly paid or, at the option of the party to whom such amounts are owed, offset against amounts due and owing by such party hereunder.”

Contract Controls Over Policies

- But who decides if conflict?
- See if there are any conflict resolution procedures in the agreement.

Contract Controls Over Policies

- May provide for mediation or arbitration.
- Sample Clause: “Disputes that might arise between us regarding the performance or interpretation of our agreement must first be resolved through the applicable dispute resolution process outlined in our policies and procedures. In the event the dispute is not resolved through that process, either of us can request in writing that we attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the within matter is not resolved within 60 days of such a request, either of us may initiate arbitration by providing written notice to the other.”

Coverage

- Do I, as a physician, need to arrange for an in-network provider.
- What about referrals to labs – are they in-network only?
- Sample Clause: “All laboratory services not performed as part of a physician’s office laboratory shall be referred to the payor’s participating laboratory providers, and plan participants may not be billed for such services.”

Scope of Services Covered

- Location Limitations – Are all of your offices covered?
- Definition of Covered Services
- Limitations on in-office laboratory or radiology services (exclusive vendor agreements; CLIA certification required)
- “Medically necessary” services – medical necessity determined by payor.

What Payor Plans Are Covered?

- A payor may have different types of plans such as PPO, POS, and the contract may cover some or all of these plans.
- Other payors may be covered by the contract resulting in your obligation to accept payments under this contract from other payors, but leaving you with no contractual right against such other payors if they do not pay.
- Sample Provision: “Plan may allow Payors to access Physician’s services under this Agreement for the Plan types described in Appendix 1.” “Payor” is defined as any payor authorized by the Plan to access the Physician’s services under the Agreement.

Obligation to Comply with Payor Policies and Protocols

- Credentialing Procedures.
- Utilization Review – payment may be denied with no recourse against the patient.
- Peer review.
- Patient grievances.
- Concurrent/retrospective reviews.
- These policies and protocols may have a tremendous impact on your practice operations and payment received under the contract.
- It is critical that you review them and follow them, and that you review all amendments.

Physician Responsible for All Medical Decisions

- Sample Provision: “Physician acknowledges that he/she is solely responsible for all decisions regarding the medical care and treatment of patients. Any determination by Plan denying approval for a particular service shall not relieve the Physician from providing or recommending such service if he/she deems it appropriate.”
- Under case law, the Payor may be responsible for denials of care based on medical necessity.
- These clauses are designed to shift the responsibility for the medical impacts of payment decisions from the payor to the physician.

Physician Responsibility (Continued):

- The physician must discuss the need for care with the patient and document this discussion with the patient.
- Physician may be prohibited from billing the patient for the services if the plan has deemed them not medically necessary.
- Physician may need to pursue all appeals available under the plan documents.
- Physician may need to continue treating the patient without payment if the risks of nontreatment are too high.

Patient Nonliability

- Sample Provision: “Physician agrees that in no event, including but not limited to, nonpayment by Plan or Plan insolvency or breach of this Agreement, shall Physician bill, charge, or seek reimbursement from or have any recourse against any patient or persons other than Plan for services rendered by Physician pursuant to this Agreement. This provision shall not prohibit collection of copayments and deductibles from patients.”
- This is a requirement under New Jersey law for HMOs, but may not apply to other payors; however, it is a common provision found in all payor contracts.
- Impact of the bankruptcy of payors on physicians and other providers.

Look Back Provisions

- Payors may have an unlimited right to recoup payments from physicians that the plan determines were made in error. However, physician's ability to seek corrections in payments may be time limited.
- Retroactive chart reviews going back 5-6 years with extrapolation and payors claiming physicians owed large amounts.

Limited Time Period to File Claims

- Contract may require that all claims be filed within 90-180 days after services provided (except for coordination of benefit cases).
- Payment may be denied if a claim is not timely filed.

Copies of Medical Records

- Contract may require the physician to provide copies of medical records free of charge.
- Retrospective medical record audits can result in medical record copying costs adding up quickly.

Term & Termination

- Many contracts have a 1 year term with indefinite automatic renewals.
- Contract may not contain the right to terminate without cause during the term, with termination only upon annual renewal dates.
- Policies can be revised or fee schedules changed without the right to terminate.
- Where there is a right to terminate upon a change of policy, there may be a very tight time frame in which to give notice of termination.
- Plan may have the right to terminate on notice without cause even if physician does not.
- Contract may terminate if hospital privileges are suspended even if only for medical records.
- Following termination, physician may be obligated to continue to provide services for a specified time period. Issue may arise as to right to get paid for these services.

Appeal Process

- HMOs are required to provide an internal and external appeal process upon termination – stage 1 (informal), stage 2 (formal) and external.
- Other payors may include appeal processes within the contract or within their policies.

Patient Grievances

- Sample Provision: “If complaints are received by Physician from patients concerning services provided under this Agreement, Physician shall notify Plan promptly. Physician shall fully cooperate and comply with Plan in the investigation and resolution of any complaint from a patient concerning services provided by Physician.”
- Note obligation to provide notice of a complaint.
- Note obligation to “fully cooperate and comply” – physician may not be happy with the plan’s resolution.
- Possible impact if malpractice action filed

Dispute Resolution Provisions

- The contract may contain a dispute resolution provision providing for mediation or binding arbitration for disputes between physician and plan.
- Contracts usually contain a shortened statute of limitations such as one year (breach of contract claims would normally be a 6 year statute of limitations).
- Often must exhaust all administrative appeals before invoking the right to arbitration.

QA Activities

- Physician may have the obligation to conduct QA activities within the practice and report data to the payor.
- Can the payor then publish the information or provide it to patients or others?
- Is this discoverable in a malpractice case?

Out of Network Referrals

- Contract may limit referrals only to network providers.
- In some cases, payors are terminating physicians without cause for using out-of-network providers such as ambulatory surgery centers.
- Physician may have no appeal rights in this circumstance.