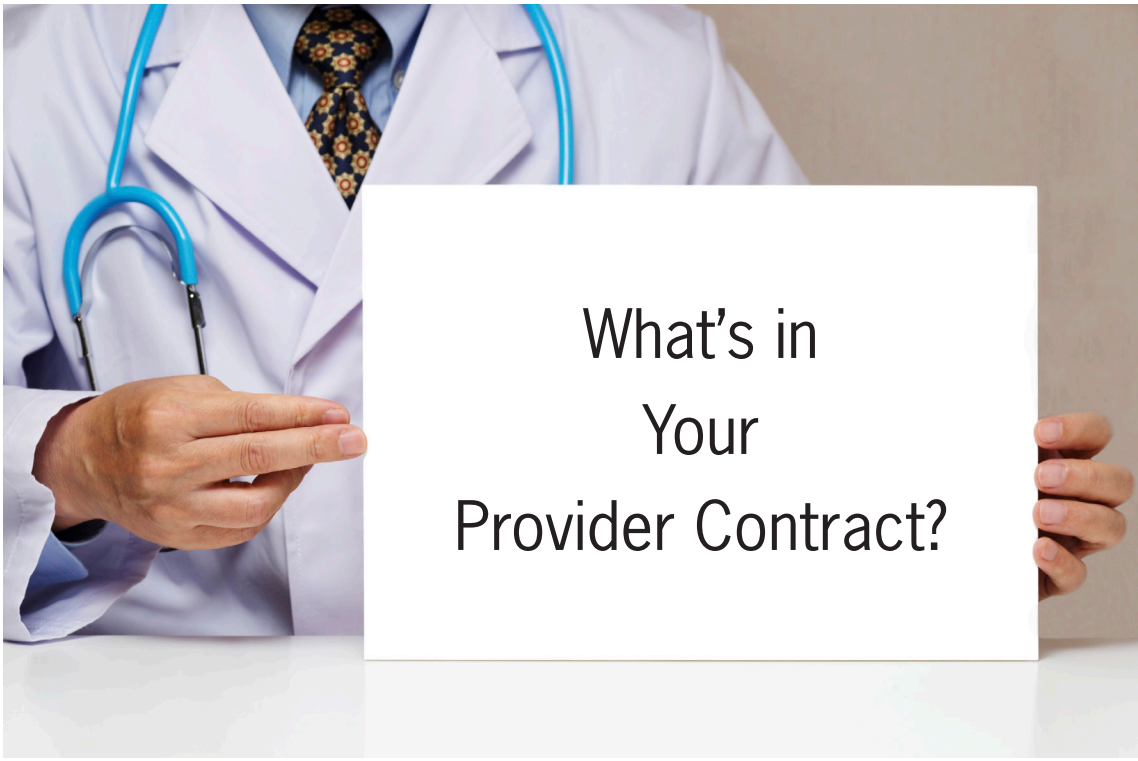

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Background

In the commercial health insurance market, payers and providers enter into contracts that govern the provision of and payment for health care services delivered by providers to members of commercial health insurance plans (hereinafter, "Contract"). Payers consist mainly of insurance companies or other third party administrators ("TPA") that manage health plans and reimburse providers for the care they provide to members.

Many health insurance plans offer incentives to their members, including lower co-payments for example, if they receive care from service providers in the plan's network. Provider networks are composed of contracted health care service providers and generally include licensed health care facilities, physicians and physician groups, specialists like radiologists, and suppliers such as durable medical equipment providers that provide services and supplies to members pursuant to the terms and conditions of their Contract.

For the most part, hospitals, provider associations and other large medical facilities leverage their size to their advantage when negotiating contracts with health insurance companies. On the other hand, individual providers and small health care practices do not have the clout or capacity and are typically at a disadvantage during the negotiation process. Regardless of the scale and leverage that a provider might have, it is critical to understand what is included within the terms of the standard Contract. Navigating this complex, yet essential area is not part of the medical school curriculum, which is why providers should always consult with a lawyer skilled in this area of the law before signing a contract.

Credentialing

One of the first steps in the contracting process is credentialing. Credentialing is used to uniformly gather specific information about providers to determine their eligibility to participate in the network. The process includes completion of an application by the provider and submission of additional information, such as licensure, verification of education, training and any prior sanctions, review of work history, verification of adequate malpractice insurance, and depending upon the provider's specialty, additional certificate or accreditation documentation that may be required.

Credentialing is an ongoing process, and it is the responsibility of the provider to update their information regularly to avoid possible termination of the Contract and/or removal from the network. Generally, the formal process of "re-credentialing" takes place every three years.

Plan Participation

It is also essential to understand what insurance plans the provider has agreed to accept within the context of the Contract. In the current environment, there is significant variation in plans offered to members, including high deductible plans, narrow network plans, and Medicare Advantage plans, all of which carry different administrative burdens for providers. It is critical for the provider and staff to understand which plans the provider has agreed to accept, because they are the responsible parties tasked with differentiating between the payment rules, coding edits, benefit designs and fee schedules of each plan.

Moreover, the provider must recognize what plans are included in the Contract at the time of execution, as well as whether the insurance company can add plans during the Contract term because the provider could be faced with changes in plan offerings without the ability to negotiate rates. Providers must also be cognizant of the expected patient volume, reimbursement provisions and rates for each plan from the commencement of the relationship in order to determine the Contract's value to the practice.

Utilization Review and Clinical Review Criteria

Providers are required to participate in a utilization review for certain services they provide, depending on the plan. The purpose of a utilization review is twofold: (1) to determine if the requested services are medically necessary, and (2) to assure that services meet quality and level of care standards (hereinafter referred to as "Clinical Review Criteria"). It is important to have a working knowledge of the definition of "Medically Necessary" and the Clinical Review Criteria used by the applicable insurance company, TPA or utilization review agent, because they may differ.

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While the definition of "Medically Necessary" is generally the same in all corners of the health care industry, when conducting a utilization review, insurance companies, TPAs and utilization review agents will rely on the definition found in the Contract. The following are two examples of definitions for "Medically Necessary," (emphasis added to point out discrepancies in the definition that could result in different decisions, even with the same facts presented):

"Medically Necessary" means that the health care services provided to treat the illness or injury, *upon review by the insurance company* are: (1) *appropriate and effective* for the diagnosis, treatment, or care of the condition, disease ailment or injury for which it is prescribed or performed; (2) appropriate with regard to generally accepted standards of medical practice within the medical community or scientific evidence; (3) not primarily for the convenience of the member, the member's family or provider of such member; AND (4) *the most appropriate* in terms of type, amount, frequency, setting, duration, supplies or level of service which can safely be provided to the member, i.e. *no less expensive professionally acceptable alternative is available.*

"Medically Necessary" or "Medical Necessity" shall mean health care services that a Physician, *exercising prudent clinical judgment*, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) in accordance with the generally accepted standards of medical practice; (2) *clinically appropriate,* in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient or Physician, or other Physician, and *not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results* as to the diagnosis or treatment of that patient's illness, injury or disease.

The same is true with regard to the Clinical Review Criteria. The applicable Clinical Review Criteria that are used to conduct utilization review vary and are often available in medical policies or online at the insurance company, TPA or utilization review agent's website. Providers do not negotiate the medical policies or the Clinical Review Criteria, but rather must accept those used by the insurance company, TPA or utilization review agent.

Contracts also include rules regarding when providers must submit requests for utilization review and when providers can expect to receive a decision, depending on the timing and type of service. For example, a provider could be required to submit a request for a non-urgent preadmission review at least three (3) working days prior to a scheduled inpatient admission, and can expect a decision within five (5) working days, as long as all information necessary to make the determination is properly submitted. Therefore, understanding what information is required and when it must be submitted is critical to avoid denials or delays in reimbursement. It is also important to note that a utilization review decision that a service is medically necessary IS NOT a guarantee of payment.

Claims processing is a separate step in addition to utilization review and a claim for a service that is deemed medically necessary could be denied (for example, if the member did not have coverage at the time of the service).

Provider Manual and Administrative Procedures

The Provider Manual and/or Administrative Procedures are documents that are usually separate from the Contract, but are generally incorporated into the Contract. These documents are developed by the insurer and included as part of the Contract. Providers do not have an opportunity to negotiate the Provider Manual or Administrative Procedures. Manuals and Administrative Procedures provide specifics on many important topics, including billing and reimbursement procedures, utilization review procedures, referral procedures, case management and quality improvement programs, credentialing, audit guidelines and dispute resolution procedures, among others. Providers and their staff must be aware of the various Manuals and Administrative Procedures that apply to their practices and ensure they follow the policies and procedures applicable to each member's specific plan. For example, the Administrative Procedures from one insurance company may require submission of different information at different times, for the same service, than another insurance company.

Compensation and Billing

In the world of high deductible health plans, understanding what is billable to the member is critical. As a general proposition, providers are required to accept in full, the payment from the insurance company and are not permitted to seek additional payment from the member outside of the member's cost share (i.e., co-payments, co-insurance and deductibles). However, with high-deductible health plans, many members are responsible for the first dollar payments up to a certain dollar maximum before the insurance company will pay. Knowing a patient's status relative to satisfying their deductible and other financial requirements under the plan is as essential as knowing who is the financially responsible party, if it is anyone other than the insurance company.

Billing the member incorrectly could result in termination of the Contract. In some cases, providers are permitted to bill the member for services that are determined to be medically unnecessary; but only if the member agrees in writing to be financially responsible for those services. The Contract must be explicit in addressing this issue to ensure proper billing and avoid loss of revenue.

Providers participating in a network are at an advantage over non-participating providers because they receive payment directly from the insurance company for the services they provide. Many insurance companies make payments to the member when the member receives services from a non-participating provider. The member is expected to pay the non-participating provider with the funds received from the insurance company and the member is responsible for the difference between what the non-participating provider charged and what the insurance company paid. As a result, non-participating providers do not have a guaranteed payment for approved services like they would under a Contract and therefore, must pursue members for payment.

Providers must generally file claims for the services provided within one-hundred and eighty days (180) of the date of service. Claims filed outside this time frame will be denied and the Provider will not be allowed to bill the member for those services. Insurance companies generally reserve the right to review substantiating documentation in connection with the claims for services, so providers should maintain records that adequately document and substantiate the services provided.

"Complete claims" must be processed within thirty (30) days of receipt by the insurance company or TPA. A "complete claim" is a claim that includes all of the required information before it will be accepted and reviewed. A claim that is deemed "incomplete" will be sent back to the provider for revisions or additional information and must be resubmitted.

Approved, denied and suspended claims will be presented to the provider on a "remittance advice." The remittance advice will provide a patient-by-patient detail of how the claims were adjudicated. Claims may be put in "suspended" status for a number of reasons. For example, a claim could be suspended if it was not "complete" and the insurance company needs additional information from the provider. Providers must be proactive about determining why a claim is "suspended" and what they can do to move it from "suspended" to "approved".

Most standard provider contracts also include a provision that the insurance company may unilaterally recover what it considers to be "overpayments" to providers. Insurance companies will deduct funds owed to the provider on future claims for funds that it alleges were an overpayment on prior claims. This is known as an "offset" or "recoupment," and standard contract language generally states that the insurer can offset for any reason. It is important that providers are aware of potential offsets or recoupments of overpayments and be diligent in addressing the issue on a current basis. Ideally, it is in the provider's best interest to include a time limit in the Contract on the reach back period for offset. For example, the ability to offset could be limited to 90 days, which means that claims that were paid more than 90 days prior may not be recouped; and it may make sense to reimburse the insurance company directly rather than allow an offset on future claims.

Appeals and Dispute Resolution

Providers are generally permitted to appeal claims or utilization review denials on their own behalf by following certain procedures outlined in the Contract. Provider appeals are dealt with differently from member appeals, which are governed by the Employee Retirement Income Security Act of 1974 ("ERISA") (i.e., adverse benefit determinations).

Providers will generally receive one level of appeal followed by a right to dispute within the context of the dispute resolution provision of the Contract, which generally requires arbitration. On the other hand, ERISA sets forth specific notice and appeal procedures governing member or "beneficiary" appeals and provides three levels of review for a medical denial, including a review by an external independent third party.

In several jurisdictions in the United States, an open question remains as to whether providers are "beneficiaries" under ERISA and should therefore be afforded the same notice and appeal rights as members. This question is especially important when dealing with "offsets" or "recoupments" and whether those constitute denials, subject to ERISA, that must be properly noticed and can be appealed by providers. At least one jurisdiction, the US District Court for the Northern District of Illinois, recently required an insurance company to modify its practices after determining that providers are "beneficiaries," and held that overpayments may not be simply unilaterally recovered from providers, but rather must be subject to appeal and other procedural protections.

Conclusion

This outline of common Contract provisions only touches the surface and is not intended to replace the assistance of knowledgeable counsel; however, it is an attempt to highlight some areas of concern for providers. It is imperative that providers have staff that is well trained in understanding and dealing with the complexity of the Contract including, the Provider Manual and Administrative Procedures, that governs the provider's provision of services to members. When it is possible to negotiate the terms of the Contract, the assistance of an expert in this field improves the provider's ability to be compliant and fully protected for the services they provide.

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