Contract Clauses

- Do definitions matter?
- What is mutually promised?
- How important are payment terms?
- Should you review external policies and data issues?
- When should you call for help?

Do Definitions Matter?

- Read definitions carefully
- If language is unclear, clarify
- As much as possible, defer to statutory or regulatory language

Definitions "Covered Services"

Health Plan Friendly

Covered Services means those medically necessary services that are covered under the member's health benefit plan, are within the provider's license and scope of practice, and are provided in accordance with the terms of this agreement.

Provider Friendly

Covered Services means those services that are covered under the member's health benefit plan. Provider may provide Covered Services which it is licensed to provide, and there are no Covered Services carved out from this agreement.

Definitions “Medically Necessary”

Health Plan Friendly

Payor shall determine whether a service is Medically Necessary, and in the event payor makes a determination that the service is not Medically Necessary, the payor shall not be responsible for reimbursing provider for the service.

Provider Friendly

A determination by payor of whether a service is Medically Necessary shall be conducted by a licensed physician. Further, a payor may not retroactively deny payment for a Covered Service rendered by a provider who obtained prior authorization from payor to provide the service.

Definitions “Plans or Products”

Health Plan Friendly

Payor may add or remove plans or products at any time, and provider shall be required to participate in any new plan or product on the same terms and conditions of this agreement.

Provider Friendly

Plan or product means a health care benefit plan offered by payor as set forth in Exhibit A which may be amended only by mutual written consent of the parties.

What is mutually promised?

- Understand the provider's obligations
- Figure out what the payor is obligated to do (and not do)
- Compromise wisely

“Provision of Services”

Health Plan Friendly

Provider may provide Covered Services to members that are within the scope of the provider’s license and certification to practice and for which provider has been approved and credentialed by payor to provide.

Provider Friendly

Provider shall provide Covered Services to member that provider is licensed to provide and which are consistent with accepted standards of medical practice and the terms of this agreement.

“Payment”

Health Plan Friendly

Payor will pay provider for the provision of medically necessary covered services in accordance with the compensation terms in this agreement below and its polices and procedures for retrospective review and utilization management.

Provider Friendly

Payor shall pay provider for covered services in accordance with the compensation terms set forth in Exhibit A of this agreement.

“Credentialing”

Health Plan Friendly

Payor shall individually approve and credential the provider to determine eligibility to participate in payor’s network. Payor may amend its credentialing policies at any time with notice to provider.

Provider Friendly

Payor will credential provider according to its credentialing policies set forth in Exhibit D. Payor will complete its credentialing process within 30 days of a properly completed application.

How important are payment terms?

- Submitting claims
- Working toward timely payment
- Verifying payments

“Clean Claim”

Health Plan Friendly

A clean claim means a claim which: (a) contains appropriate and sufficient medical and patient data to allow payor to pay the claim; and (b) is submitted within the timeframes set forth herein.

Provider Friendly

A clean claim means a claim which: (a) contains all of the CMS 1500 data elements; and (b) is submitted within the timeframes set forth herein.

“Time Period for Claims”

Health Plan Friendly

Provider shall submit claims for billable Covered Services within 90 days from the date of service. Any claim submitted more than 90 days following the date of service will be denied.

Provider Friendly

Provider acknowledges that if provider fails to submit claims within 90 days from the date covered services are provided, the payor reserves the right to deny payment for such claims unless the provider demonstrates just cause for the delay.

“Time Period for Payment”

Health Plan Friendly

Payor shall use its reasonable efforts to process Clean Claims within thirty 30 days of receipt.

Provider Friendly

Payor shall reimburse provider for covered services furnished to enrollees within 30 days after provider’s submission of a Clean Claim.

Should you review policies and data issues?

- Be aware of references to external policies and procedures
- Be on guard for retrospective reviews
- Get access to meaningful data

“Policies and Procedures”

Health Plan Friendly

Provider agrees to be bound by all policies and procedures of payor. Payor may amend its policies and procedures at any time in its discretion with notice to the provider.

Provider Friendly

Provider agrees to comply with the policies and procedures of payor which are set forth in the Payor Manual. Payor shall give 90 days prior written notice of any material change to the Manual, and the provider shall have an opportunity to object to the change.

“Retrospective Review”

Health Plan Friendly

Payor may perform retrospective review of any claim, and may deny payment for claims that are not submitted in accordance with the payor’s utilization management policies.

Provider Friendly

If payor provides certification for cover services, payor shall not be permitted to retrospectively deny payment for covered services based on medical necessity. No claim may be retrospectively adjusted more than 180 days after it was paid.

“Use of Claims Data”

Health Plan Friendly

At all times during and after the term of this agreement, payor shall be the sole owner and have the exclusive right to use all claim data submitted by provider to payor.

Provider Friendly

Payor and provider shall have equal access to, and a non-exclusive license to use, all data submitted by provider to payor as part of any claim for reimbursement under this agreement.

“Audit of Financial Records”

Health Plan Friendly

Provider may request a summary of financial information related to claims paid by payor to provider.

Provider Friendly

Provider shall have the right to audit payor’s enrollment and financial records, proprietary or otherwise, as reasonably necessary to determine the accuracy of the compensation paid to provider under this agreement.

When should you call for help?

- Know the contract term
- Read the termination provisions
- Learn what rights you may have to dispute resolution

“Term”

Health Plan Friendly

The term of this contract shall be one (1) year, and shall automatically renew for successive one year terms.

Provider Friendly

The term of this contract shall be one (1) year, and the parties shall enter into good faith negotiations regarding renewal of the contract at least 60 days before the completion of the term.

“Termination”

Health Plan Friendly

Payor shall have the right to terminate this contract immediately upon written notice to provider in the event provider commits a material breach of this contract.

Provider Friendly

Either party shall have the right to terminate this agreement at any time without cause upon 60 days’ prior written notice to the other party.

“Dispute Resolution”

Health Plan Friendly

All disputes arising from this contract shall be settled by binding arbitration, and the parties shall be responsible for their own costs of arbitration including attorney fees.

Provider Friendly

Any dispute arising under this agreement shall first be submitted to the timely mediation procedures herein. If mediation is not successful, the matter shall be settled by binding arbitration. The parties will share the costs of arbitration, and the prevailing party may be entitled to an award of attorney fees.

Questions

- Questions or comments?
- A good legal resource (and reference for some of the definitions in this seminar) is the **Health Plans Contracting Handbook** from the American Health Lawyers Association (2008).