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**HFMA NORTHERN CALIFORNIA  
SPRING CONFERENCE**

**SACRAMENTO MARRIOTT HOTEL  
RANCHO CORDOVA, CALIFORNIA**

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**CONTRACTING FROM THE LEGAL PERSPECTIVE  
“GETTING THE CONTRACT RIGHT”**

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## OUTLINE

### What is in the Contract?

- Basic Rules of Contract Interpretation
- Incorporation of Manuals and Other Documents
- Discretion – Whose it it?
- Changes in Law – Regulations and Statutes, how do they affect the contract?

### Reimbursement Reduction

- Disallowed Charges
- Stop Loss Calculation
- Level of Care
- ER/Trauma
- Authorization/Verification Process

### Dispute Resolution Process

- Appeal Denied Claims – “Deadlines”
- Meet and Confer Obligation
- Mediation
- Arbitration or Court Process
- Legal Fees/Costs

### Other Important Issues

- Billing Responsibility (When, Where, What, How)
- Third Party Liability and Workers’ Compensation Exclusions
- Pre-existing conditions and other coverage issues
- Network Contracts and Silent PPO’s
- Change of Coverage, New Coverage, Termination of Coverage

### Attachments

- Pre-Contract Questionnaire
- Managed Care Operational Team
- Basic Rules of Contract Interpretation

Pre-Contract Questionnaire

*FACILITY NAME*

**PRE-CONTRACT QUESTIONNAIRE**

**GENERAL INFORMATION:**

Plan Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Contact/Title: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Web Address \_\_\_\_\_

Parent Co. Name: \_\_\_\_\_ Managed by? \_\_\_\_\_ Owned \_\_\_\_\_

Parent Co. Address: \_\_\_\_\_

<b>MANAGEMENT STAFF:</b>	<b>Name</b>	<b>Title</b>	<b>Phone Number</b>	<b>Email</b>
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CEO: \_\_\_\_\_

Medical Director: \_\_\_\_\_

Marketing Director: \_\_\_\_\_

Utilization Mgmt: \_\_\_\_\_

Provider Relations: \_\_\_\_\_

Provider Contracts: \_\_\_\_\_

Claims Manager: \_\_\_\_\_

Member Services: \_\_\_\_\_

Plan Type (please check all that apply):

	HMO	PPO	POS	PHO	MSO	Self Ins.	Risk Share
Current:	___	___	___	___	___	___	___

Planned (in the next Yr):	___	___	___	___	___	___	___
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Is Plan a subcontractor for specific services? Yes \_\_\_ No \_\_\_ (if Yes, please answer below)

Subcontractor Services: \_\_\_\_\_

Subcontractor Plan Names: \_\_\_\_\_

Does Plan subcontract out for major services? Yes \_\_\_ No \_\_\_ (if Yes, please answer below)

Subcontracted Services: \_\_\_\_\_

Subcontractor Names: \_\_\_\_\_

Subcontractor Address: \_\_\_\_\_

Subcontractor Phone Number: \_\_\_\_\_

Other names under which you're Plan may be marketed:

\_\_\_\_\_

Who is your prescription card processor or manager? \_\_\_\_\_

**MEMBERSHIP/LIVES:**

Total Members "Your Market Area": \_\_\_\_\_ County: \_\_\_\_\_ Adjacent County: \_\_\_\_\_

Estimated member numbers by county: "County": \_\_\_\_\_ Adjacent County: \_\_\_\_\_ Adjacent County: \_\_\_\_\_ Adjacent County: \_\_\_\_\_

Estimated member numbers by product line:

	COMM	MA	MED	FED EMP	WORK COMP	SELF INS	STATE EMP
HMO	_____	_____	_____	_____	_____	_____	_____
PHO	_____	_____	_____	_____	_____	_____	_____
POS	_____	_____	_____	_____	_____	_____	_____
PHO	_____	_____	_____	_____	_____	_____	_____

Model Type: \_\_\_% IPA \_\_\_% Network \_\_\_% Group \_\_\_% Staff \_\_\_% Owned

Are there any new geographical regions slated for expansion over the next six months? Where?

\_\_\_\_\_

\_\_\_\_\_

**PLAN SPECIFIC**

For PPO/POS products, are there incentives to steer members to contracted providers? Explain:

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Do you allow out-of-Plan (authorized) services (other than emergencies or not available Plan)?

If so, explain

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**PROVIDER CONTRACTING:**

Do you have relationships with other providers that prohibit or limit your ability to use/contract with any "Facility Name" facilities/services? If yes, please list those facilities and/or services below:

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Do you have standard strategies or financial arrangements with hospitals and/or physicians (i.e., risk sharing, capitated, etc.)? If yes, please explain:

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Do you have standard contracting strategy for network development (i.e., exclusive arrangements, partnerships, etc.)? If so, please explain:

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Plan participating hospitals in the "County" and "Adjacent Counties" (list or attach list):

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Are there providers/facilities owned by Plan in the "County" and "Adjacent County" area? If yes, please list:

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Do you have contracts with other specialists in "Your" County? If so, please provide a directory of "Your" County participating physicians.

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Other information that you would like to add:

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**MEDICAL OFFICE OPERATIONS**

1. What is your organization's process for obtaining referral authorization? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. How is eligibility verified? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. How are benefits verified? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. How long does it take for new members to receive their identification cards? \_\_\_\_\_

\_\_\_\_\_

5. Does your organization issue temporary ID cards? \_\_\_\_\_

6. Does your organization provide in-services or other orientation programs prior to the start (effective) date of the Agreement? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

8. What are the procedures for answering questions after normal business hours?

\_\_\_\_\_

8. Does your organization provide quick reference guides with important information for front office staff?

\_\_\_\_\_

If yes, please attach a sample of such guides.

**PATIENT SCHEDULING AND REGISTRATION**

1. Does your organization provide examples of identification cards given to members? \_\_\_\_\_

2. Does the identification card have a billing address for claims submission and a phone number for eligibility verification on it? \_\_\_\_\_

3. Does the identification card indicate the name, address, and phone number of the third party administrator, payer, or other contracted entity? \_\_\_\_\_

4. If your organization utilizes gatekeepers or Primary Care Physicians, does the identification card indicate the gatekeeper or PCP? \_\_\_\_\_

5. Are co-pays and after hour charges indicated on the identification card? \_\_\_\_\_

6. Does your organization have any access/availability requirements for participating providers?

If yes, please list them in the space provided or attach separately. \_\_\_\_\_

7. Please list the providers you are contracted with for the following services:

Lab: \_\_\_\_\_

Diagnostic Imaging: \_\_\_\_\_

Physical Therapy: \_\_\_\_\_

Durable Medical Equipment: \_\_\_\_\_

IV/PTN: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Home Care: \_\_\_\_\_

Behavioral Health: \_\_\_\_\_

Other: \_\_\_\_\_

8. Please provide a list of the members in your specialist panel or network in "Your" and "Adjacent" County.

**BILLING AND CLAIMS SUBMISSION**

1. Does your organization accept the HCFA 1500 and Standard UB-~~9~~? \_\_\_\_\_

2. Does your organization utilize current CPT-4 and ICD-9 codes? \_\_\_\_\_

3. Which procedures require an attached Medical Records report for payment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Does your organization have the capability to accept claims or/ or encounters electronically or via tape?  
\_\_\_\_\_

If yes, what (if any) procedures or services are excluded from electronic/tape billing and must be submitted via paper?  
\_\_\_\_\_  
\_\_\_\_\_

5. What procedures require pre-authorization for payment? \_\_\_\_\_  
\_\_\_\_\_

6. Is a hard copy of referral/authorization required for claim payment? \_\_\_\_\_

If so, is a copy of the referral/authorization sent to the Business Office for billing purposes? \_\_\_\_\_  
\_\_\_\_\_

7. Does your organization have a time requirement for claims submission? \_\_\_\_\_

8. Are there any special billing requirements for PA's or CRNP's.? \_\_\_\_\_  
\_\_\_\_\_

**CLAIMS PAYMENT**

1. Does your organization guarantee payment within 30 days? \_\_\_\_\_

2. If payment is not made within 30 days, does your organization send correspondence stating why payment has not been made? \_\_\_\_\_

3. Does an Explanation of Benefits (EOB) accompany every payment? (not sent under separate cover)  
\_\_\_\_\_

4. Does the EOB clearly state Billed amount, Allowed amount, Paid amount, and our patient account number as listed in box 26 of HCFA 1500 or box 3 of UB-92? \_\_\_\_\_

(Please attach a sample EOB for review)

5. What is the time frame for submission of claims after services have been performed? \_\_\_\_\_

6. What is your organization's policy for reconciling overpayment? (Do you request a refund or do you reduce future payments?) \_\_\_\_\_  
\_\_\_\_\_

8. What is your organization's policy of payment if you are secondary payer? \_\_\_\_\_  
\_\_\_\_\_

9. Do you have a stop-loss clause for high dollar outliers? \_\_\_\_\_

10. If so, what is the stop-loss clause? \_\_\_\_\_  
\_\_\_\_\_

**CREDENTIALING**

1. Does your organization delegate credentialing to qualified IDS's? \_\_\_\_\_

2. What paperwork and information is required to credential a provider? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Will your organization accept the *Pennsylvania (or other State) Medical Society Standard Credentialing Application*? \_\_\_\_\_

4. What guidelines do you follow for credentialing, if any (i.e., NCQA, etc.) \_\_\_\_\_  
\_\_\_\_\_

4. Do you require credentialing of Nurse Midwives, Nurse Practitioners, and Physician's Assistants? \_\_\_\_\_  
\_\_\_\_\_

5. Once the paperwork for credentialing has been submitted, how long does it take your company to credential a provider? \_\_\_\_\_

6. Once credentialing has been completed, how long does it take your company to enter the provider into your database? \_\_\_\_\_

7. Are provider numbers issued for each physician? \_\_\_\_\_

8. Are provider numbers all issued at the same time? \_\_\_\_\_

9. What are your requirements for recredentialing? \_\_\_\_\_  
\_\_\_\_\_

10. How often do you recredential providers? \_\_\_\_\_

11. How often do you update provider manuals? \_\_\_\_\_

12. Malpractice policies for "*Facility*" organization run from (*facility dates*)). When adding new physicians process prior to receiving a revised malpractice policy, will your organization accept a copy of the policy currently in effect until a new policy is established with the agreement? \_\_\_\_\_

13. If you are not able to delegate credentialing, are you willing to authorize and pay claims for physicians until such time as the physician is credentialed? \_\_\_\_\_

14. How often are site visits conducted? Is a site visit required with addition of new physician? \_\_\_\_\_  
\_\_\_\_\_

(Please attach policies and procedures for credentialing and recredentialing.)

**UTILIZATION MANAGEMENT**

1. Does your organization delegate Utilization Management? \_\_\_\_\_

If yes, what are the criteria for achieving delegated UM? \_\_\_\_\_

\_\_\_\_\_

2. What utilization management data/information is provided, and how often is it provided? \_\_\_\_\_

\_\_\_\_\_

3. Please list all UM reports required by your organization for groups with delegated status. \_\_\_\_\_

\_\_\_\_\_

4. Please describe the catastrophic case management process and attach all required reporting tools.

\_\_\_\_\_

\_\_\_\_\_

5. Is pre-certification required for hospital services? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

6. What is the pre-certification appeal process? \_\_\_\_\_

\_\_\_\_\_

7. Please list the benefits, which are carved out. (i.e., vision or mental health)

\_\_\_\_\_

8. Please describe the UM audit process and the frequency of such reviews. \_\_\_\_\_

\_\_\_\_\_

9. Do you utilize a mandatory pay list for Emergency Room Services? If so, please provide a copy.

\_\_\_\_\_

10. Is Urgent Care Services a covered benefit?

\_\_\_\_\_

11. Do you cover the screening portion of the Emergency Department visit if the diagnosis is not a covered Emergency Service?

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12. For concurrent authorization, does your organization conduct on-site reviews or telephonic reviews?

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13. Please describe your organization's member grievance and appeals process. What is the time frame required for resolution of member complaints? What requirements are there for reporting member complaints?

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(Please attach your standard QM audit form.)

**QUALITY MANAGEMENT** (if applicable)

1. Please describe your organization's quality management audit process (include any information from Primary Medical Group).

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2. How many records will be reviewed per audit indicator? \_\_\_\_\_

3. How frequently will these audits be conducted? \_\_\_\_\_

4. Does your staff conduct the audits or will our staff perform our own internal QM audits? \_\_\_\_\_

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5. What is the time frame within which we will be required to complete the audit? \_\_\_\_\_

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6. What are your expectations regarding follow-up on any issues identified through the audit process?

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7. What Quality Management data/information is provided, and how often? \_\_\_\_\_

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**MANAGED CARE** (if applicable)

1. Does your organization have a provider services department? \_\_\_\_\_

If yes, please provide the phone number and mailing address. \_\_\_\_\_

What is your provider services department's normal hours of operation? \_\_\_\_\_

If no, where are provider questions directed and during what hours can they be reached? \_\_\_\_\_

2. How often can a member change his/her Primary Care Physician? \_\_\_\_\_

3. How does a member change their PCP? \_\_\_\_\_

Person completing this questionnaire:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

**DOCUMENTS:**

Please attach the following:

- ◇ Major client/employer list with lives in the "Facility Market" and "Adjacent Market" area
- ◇ ID card (or cards if you use a different format). Please include a sample of each card if there are multiple formats by payor or employer.
- ◇ Sample marketing literature
- ◇ Provider manual (for physicians/hospitals)
- ◇ Utilization management procedures and criteria (if not included in provider manual)
- ◇ Quality management requirements (for physicians and hospitals)
- ◇ Sample (each) of physician (PCP) and hospital standard contract
- ◇ Current Provider Directory (physician and hospital)

Managed Care Operational Team  
Chairperson's Responsibilities

**Managed Care Operational Team  
Chairperson's Responsibilities**

**Pre-Contract**

1. Update Managed Care Operational Team with status of current negotiations, re-negotiations and contract termination on a quarterly basis.
2. Submit completed pre-contract questionnaires to Managed Care Operational Team.
3. Review potential contract terms with Managed Care Operational Team.
4. Solicit input from entities during re-negotiations for contract compliance issues.
5. Identify method of claims submission (EDI). No hard copy documentation should be required if submitting via EDI. UB92 or 1500 form accepted medium if not EDI.

***Timeline once Contract Signed by Senior VP of Finance and CFO***

**Must be completed within 30 days**

1. Provide copies of Contracts/Addendum's/Attachments to Managed Care Operational Team.
2. Provide current provider directory and claims/utilization review policies.
3. Allow for Managed Care Operational Team to review "*Facility Name*" directory information prior to printing by payer.
4. Schedule meeting with Managed Care Operational Team and provider representative within 30 days after contract finalized.

**Within 45 days**

1. Ensure orientation to entities within 45 days after contract finalized.
2. Review open/closed status in Contracts to ensure compliance with "*Facility name*" policies.
3. Encourage usage of a standard referral form by payer.
4. Define CPT code, procedures or services requiring pre-authorization.
5. Identify ability to provide eligibility/enrollment information electronically. Additions/Deletions list required monthly.
6. Provide fee schedules (electronic) for primary and specialty practices, at minimum, annually.
7. List specialty fees by CPT codes.
8. List capitated services by CPT codes.
9. List of CPT codes identifying those services for which we can collect co-payments.
10. Provide copies of dated formularies on routine basis and update any changes.
11. Allow for unlimited inquiries for claims follow up.

*Facility Name*  
**Managed Care Contracting Guidelines**

**General Issues:**

- ✦ Obtain the name and address of contracting party;
- ✦ Obtain a list of corporate officers and organization chart of key management;
- ✦ Obtain a description of products offered and covered lives in each product (HMO, PPO, POS, Network, Fully Insured Indemnity, etc.);
- ✦ Obtain an expected term of the contract (1 yr., 3 yr., evergreen, etc.);
- ✦ Request description of the nature of provider panels (exclusive vs. non-exclusive);
- ✦ Obtain a copy of the most recent quarterly filing with the State Department of Insurance;
- ✦ Request a list of major customer / employer groups;
- ✦ Request copies of typical benefit design and plan description materials;
- ✦ Obtain a list of any benefits / services commonly excluded from coverage;
- ✦ Specify contract termination provisions (with or without cause, reciprocity of provisions, period of notice, ability to cure breach, etc.);
- ✦ Specify payment provision for inpatient services (discount off charges, case rates, DRGs, per diems, primary care capitation, global capitation, etc.);
- ✦ Specify payment provision for outpatient services (discount off charges, case rates, ASC grouping category rates, fee schedule, etc.);
- ✦ Specify payment provision for Physician services (hospital-based physicians, primary care physicians, specialty care physicians, etc.) as well method of payment (discount off charges, fee schedule, RBRVS, RVU's, percent of Medicare, etc.);
- ✦ Specify participation terms when patient is referred to a non-participating provider. If a patient is referred by a participating physician to a non-participating physician, will health plan consider the entire continuum of care to be non-participating;
- ✦ Specify payment terms for observation and SNF;
- ✦ Specify payment for Preventative Medicine;
- ✦ Does Payor compensate for Complimentary Medicine;
- ✦ Under Act 68, in an emergency setting, a provider cannot make inquiries regarding a Patient's ability to pay prior to receiving medical services. Specify a health assessment fee to offset the cost of screening the patient in the event the service is deemed non-emergent and the health plan will not pay for the services rendered;
- ✦ Specify that health plan should adhere to government regulations. Health plan cannot deny payment for specific hospital inpatient days due to provider's inability to discharge a patient due to government regulations. (i.e. inability to discharge a psych patient without proper forms.);

- ✦ Do not accept assignment of contract to another insurer or other insurance products of the insurer without “*Facility Name*” written acceptance;
- ✦ Evaluate overall cost to administer contract;
- ✦ Allow 60-90 days to implement contracts;
- ✦ Allow 60-90 days to terminate the contract;
- ✦ Allow 30 days to respond to any contract changes initiated by Insurer. All changes must be accepted by “*Facility Name*” in writing with authorized signature;
- ✦ Operational issues completed prior to implementation of contract;
- ✦ Coordinate administrative functions with other areas of organization (utilization review, discharge planning, admissions and registration, physician credentialing, etc.);
- ✦ Request copies of delegated credentialing contracts for review against CCT policy;

**Claim Submission:**

- ✦ Allow for claim submission up to 180 days, 30 days after primary payment received;
- ✦ Payment of clean claims in 30 days;
- ✦ Allow for interim billing of inpatient accounts when charges or days are beyond average;
- ✦ Impose financial penalty for late payments;
- ✦ Identify Coordination of Benefits payments policy;
- ✦ Contract should be specific on balance billing patient for non-covered services;
- ✦ Identify system for eligibility determination and verification of benefits;
- ✦ Contract must specify appeal procedures for denied claims;
- ✦ Contract should stipulate acceptance of standard electronic billing protocols;
- ✦ Do not allow bundling of codes;
- ✦ For PPO’s who act as a middleman between provider and third-party payor – add clause stating if the payor doesn’t pay, the plan will either pay; file a lawsuit against the payor; or allow Provider to sue payor on its behalf;

**Credentialing:**

- ✦ Credential “*facility name*” in its entirety; not site by site (if applicable);
- ✦ Utilize *State’s* Medical Society Standard credentialing Application;
- ✦ Grant temporary billing privileges to providers if contract is initiated prior to completion of credentialing by payer;

- ✦ Propose that re-credentialing requirements allow require submission of changes to original credentialing application;
- ✦ Identify if credentialing of Nurse Midwife/Physician Assistance/Nurse Practitioner is required;

**Physician Practices:**

- ✦ Identify if Open/Closed status for new patients is deemed by "Facility Name" as a whole site by site;
- ✦ Provide language allowing referrals to specialty physicians with which payer has no network if no other specialist available;
- ✦ Credentialing of non-physician providers (nurse practitioners and physician assistants);

**Utilization Review:**

- ✦ Obtain a copy of utilization review and quality improvement requirements (pre-admission certification, concurrent review, discharge planning, retrospective review, requirements for copies of medical records, etc.);
- ✦ Contract or Payor Policies should state when pre-admission is required as well as specific time limits;
- ✦ Contract should state if hospital or an outside entity is responsible for ongoing review of case;
- ✦ Contract or Payor Policies should state how a hospital could obtain a retroactive authorization if one was not obtained prior to admission and appeal processes should be clearly defined;
- ✦ ED authorization and referral process should be clearly defined;

**Medical Records:**

- ✦ Cost of Medical Records should be paid by Insurance;
- ✦ Ensure contract follows state and federal guidelines regarding patient confidentiality;