

## **CONTRACT LANGUAGE - BEST OF THE WORST**

### **PROVISIONS TIED TO INFORMATION NOT INCLUDED WITH THE CONTRACT:**

1. The applicable participating entity will reimburse you for the services you deliver that your patient's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is **subject to our reimbursement (coding) policies and methodologies of us and the participating entities**. Our reimbursement policies and methodologies are updated periodically. **To request a copy of our reimbursement policies and methodologies, write to...** Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (all as described in the Administrative Guide). We recognized CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. **Following these guidelines does not imply a right to reimbursement for all services as coded or reported.**
2. The amount you receive will be based on the lesser of your billed charges or our fee schedule... and is **subject to the reimbursement (coding) policies and methodologies of us and the participating entities**...Our reimbursement policies and methodologies are updated periodically...
3. Language from actual Exhibit on Reimbursement "explaining" how physician will be paid: Physician Fee Schedule, Exhibit 2 – Lab/Pathology <Plan> Lab Schedule; Immunizations, Injectables/Other Drugs AWP; Durable Medical Equipment Supplies <Plan> DME Schedule; Radiology <Plan> Radiology Schedule
4. **Upon execution of the Agreement, <Plan> shall provide a Participating Provider a current list of Affiliates**. This list will be updated not less than quarterly and a copy will be provided to Participating Provider upon request.
5. Participating Provider agrees to abide by the terms of the Provider Manual...
6. Reimbursement will be made according to <Plan's> medical/reimbursement policies...
7. Provider agrees that XXX Fee Schedule contains proprietary and confidential information subject to the confidentiality provisions of this agreement. XXX will not make the entire XXX Fee Schedule available to Provider but will provide a sample listing of maximum allowable rates upon request by Provider...
8. The carrier shall reimburse the Participating Provider the lesser of billed charges or a percentage of the current Medicare RBRVS fee schedule that the carrier has implemented for covered services.
9. <Plan> Affiliate means any direct or indirect subsidiary of <Plan>, as designated by <Plan>.
10. Only those charges for Covered Services billed in accordance with <Plan>'s standard claim coding and bundling methodology will be payable.
11. The Program Attachments hereto are a part of this Agreement and their terms shall **supersede** those of other parts of this Agreement in the event of a conflict.

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12. This Agreement together with all Program Attachments contains all the terms and conditions agreed upon by the parties, and supersedes all other agreements, express or implied, regarding the subject matter.
13. <Plan>'s Maximum Fee Schedule means <Plan>'s customary fee schedule in effect at the time of service and applicable to Physician with respect to this Managed Care Program.
14. Only those charges for Covered Services billed in accordance with <Plan>'s standard claim coding and bundling methodology reflected in the applicable claim payment system will be payable.
15. ***This document highlights the essential features of <Plan>'s Managed Care Program Requirements for Participating Providers.*** For complete information, please refer to the Provider Reference Guide, if applicable, including any supplements to the Provider Reference Guide. These Program Requirements apply to services rendered to Participants in <Plan>'s Managed Care Programs which Programs cover various products as determined by <Plan>, including but not limited to, <Plan>'s or <Plan> Affiliate's HMO, POS, HMO Open Access, POS Open Access, Network, Network Open Access, Network POS, Network POS Open Access, Open Access Plus products, and such other future Managed Care Program products identified by <Plan>. Participating Providers must follow the Program Requirements in order to receive payment for Covered Services rendered to Participants. In the event of a conflict between these Program Requirements and a provision of the provider agreement or applicable law, such provision or applicable law will control.
16. Participating Provider shall pay PPO five percent (5%) of total allowable fees, based on Exhibit A, for those subscribers receiving services for an auto injury covered by an auto carrier holding a PPA [Payor Participation Agreement] with PPO. PPO shall bill Participating Provider for such fees. Payors listed on Exhibit B shall deduct five percent from the overall allowable fee and pay such amount directly to PPO. An initial membership fee in an amount to be determined by PPO shall be paid by Participating Provider at which time the initial credentialing application is submitted. Thereafter, an annual membership fee for Participating Provider will be assessed by PPO. (8/04 contract)

### **CHANGES TO CONTRACT PROVISIONS WITHOUT NOTICE:**

17. Tied to information not with the contract - The applicable participating entity will reimburse you for the services you deliver that your patient's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to our reimbursement (coding) policies and methodologies of us and the participating entities. ***Our reimbursement policies and methodologies are updated periodically.*** To request a copy of our reimbursement policies and methodologies, write to... Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (all as described in the Administrative Guide). We recognized CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

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18. The amount you receive will be based on the lesser of your billed charges or our fee schedule... and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities...***Our reimbursement policies and methodologies are updated periodically...***
19. Upon execution of the Agreement, <Plan> shall provide a Participating Provider a current list of Affiliates. ***This list will be updated not less than quarterly and a copy will be provided to Participating Provider upon request.***
20. Ordinarily, XXX's fee schedule is updated using similar methodologies for similar services. XXX will not generally attempt to communicate routine maintenance of this nature.
21. XXX will make its Payment Policies available to Medical Group on its website or upon request. XXX may change its Payment Policies from time to time.
22. Payment policies – These policies may be changed from time to time. XXX will make information available about the Payment Policies upon request or at a website identified by XXX.
23. ...Such policies and procedures and other documents may be amended by <Plan> from time to time....

### **PROVISIONS THAT DICTATE BUSINESS PRACTICES**

24. Provider shall not charge a Participant for non-covered services unless, in advance of providing the service, the Provider has notified the Participant that the particular service will not be covered and the Participant acknowledges in writing that he/she will be responsible for payment of such service. ***Unfair shifting of risk and responsibility.***
25. Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefit, and submitting you claim.
26. Physician shall maintain and furnish such records and documents as may be required by applicable laws, regulations and Program Requirements. All of such records shall be maintained for the period of time required by applicable law. Physician shall cooperate with <Plan> to facilitate the information and record exchanges necessary for Quality Management, Utilization Management, peer review, or other programs required for <Plan>'s operations. Physician agrees to provide copies of such ***records at no charge.***
27. Physician shall not charge a Participant for a service which is not a Covered Service unless, in advance of the provision of such service, the Participant has been notified by Physician that the particular service will not be covered and the Participant acknowledges in writing that he or she shall be responsible for payment of charges for such service. . ***Unfair shifting of risk and responsibility.***
28. In accordance with the terms of the Agreement, Physician shall accept all Participants who select Physician. Notwithstanding the foregoing, Physician may close Physician's panel to new Participants upon 30 days advance notice to <Plan> if Physician provides

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<Plan> with evidence that the number of Participants in Physician's patient panel exceeds the number of patients in Physician's panel who are members of any other single managed care organization or if Physician is closing Physician's panel to all new patients. Physician must reopen Physician's panel to new Participants if the acceptance of new patients causes the number of patients who are members of any other single managed care organization exceed the number of Participants in Physician's patient panel....

29. Provider shall accept any and all Members as patients, subject to Provider's capacity to provide Covered Services to such Members. In the event Provider plans to close or restrict availability to new Members, Provider shall use best efforts to provide Company with at least sixty (60) days prior written notice of such plans. Provider shall not close or restrict acceptance of Members as patients unless Provider closes or restricts acceptance of new patients for all health plans in which Provider participates. Provider shall provide notice to Company as soon as practicable if it re-opens or removes restrictions on acceptance of new patients.
30. Physician shall make appointments available to Participants on the same schedule and with the same frequency as provided to patients covered through other payment mechanisms.
31. Provider may bill or charge Members only in the following circumstances: for any applicable co-payment, deductible or coinsurance as specified in the Health Benefits Plan. Provider shall make reasonable efforts to collect all approved co-payments, deductibles and coinsurance. Provider shall not bill Members for deductibles or coinsurance prior to receipt of an explanation of benefits.... **Unfair shifting of risk**
32. ...Upon termination of this Agreement, Provider shall continue to treat Members until the earlier of: (i) the completion of their course of treatment; or (ii) <Plan> has made arrangements to have their treatment provided by another provider. In addition, Provider shall continue to treat Members, upon request of any Member or Payor, until the anniversary date of such Member or Payor's Health Benefits Plan or for one (1) calendar year, whichever is less....

### **UNILATERAL HEALTH PLAN DICTATES**

33. This Agreement excludes those Covered Services which <Plan> has elected to obtain through an arrangement between <Plan> or a(n) <Plan> Affiliate and a national or regional vendor or provider or a capitated provider, except as otherwise agreed by <Plan>. Physician shall not be reimbursed and shall not bill Participants for any such excluded services. If <Plan> notifies Physician that it no longer wishes to exclude such services from this Agreement, such Covered Services will be reimbursed as specified in Section II. Above.
34. No mention of any advanced notice or if review would be during normal business hours: ...shall allow <Plan> to conduct on-site review of Claims charges and related records.
35. When an overpayment is identified, the refund may, at the option of <Plan>, be recovered through a credit against future Claims payments.

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36. <Plan> may, however, assign this Agreement to any successor organization.
37. Provider agrees that the name, address, and phone number of Provider may be included in the provider directories for the applicable Plan. **The carrier will have no obligation to immediately correct, delete, or update such information.** The carrier will use reasonable efforts to make appropriate changes to Provider's listing in such directory.
38. Termination without cause: no termination shall be effective prior to the expiration of the Initial Term. **What is the initial term, 1 yr., 2 yrs., 3 yrs.?**
39. Consultant Provider further acknowledges and agrees that Consultant has not entered into this Agreement based upon representations by any person other than <Plan> and that no person, entity, or organization other than <Plan> or its assignee shall be held accountable or liable to Consultant for any of <Plan>'s obligations created under this Agreement. This provision shall not create any additional obligations whatsoever on the part of <Plan> or its assignee, other than those obligations created under other provisions of this Agreement. **MUMBO JUMBO**
40. Upon reasonable notice and during regular business hours, <Plan> or its designee shall have the right to inspect, review and make copies of, at <Plan>'s expense, all records maintained by Physician with respect to all payments received by Physician from all sources for Covered Services rendered to Participants during the term of this Agreement. <Plan> or its designee shall have the right to conduct periodic audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement....
41. Physician shall refund to <Plan> or the applicable <Plan> Affiliate any excess payment made by a Payor to Physician in the event Physician is paid for the same health care services or supplies more than once, is overpaid for particular health care services or otherwise received incorrect or inadvertent payment. <Plan> or the appropriate <Plan> Affiliate may, at its option, deduct said excess payments from other payments to Physician. <Plan> will notify Physician of any such deduction.
42. Physician shall cooperate with <Plan> in the development and maintenance of statistical data, records and procedures in support of Quality Management, Utilization Management and other applicable Program Requirements.
43. Statute allows reasonable charge - Physician agrees to cooperate in connection with any transfers of Participants' medical records required when Physician ceases rendering services to a Participant whether during the term of this Agreement or after termination of this Agreement. Physician agrees to provide copies of such records **at no charge.**
44. ...Physician shall be compensated for Covered Services provided to any such Participant after termination of this Agreement in accordance with the reasonable and customary charge for such services....
45. Neither <Plan> nor Physician may assign duties, rights or interests under this Agreement unless the other party shall so approve by written consent, provided, however, that any reference to <Plan> herein shall include any successor in interest and that <Plan> may assign its duties, rights and interests under this Agreement in whole or in part to a <Plan> Affiliate or may delegate any and all of its duties in the ordinary

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course of business.

46. Physician agrees to cooperate with any <Plan> Affiliate which provides disability coverage for a disabled Participant in the management of the disabling event.

### **MEDICAL PRACTICE ISSUES**

47. "Medically Necessary" or "Medical Necessity" means services or supplies received from a Participating Provider that Plan determines are medically appropriate.
48. ...<Plan> may also from time to time review a sample of medical records and provide performance feedback on past treatment.
49. Physician must notify <Plan> about any Participant who may benefit from case management or a disease management program such as diabetes, acute back pain or asthma.
50. With respect to OB/GYNs...If the Participant is assigned to a PCP, OB/GYNs must notify the Participant's PCP following an office visit to provide information about the care provided, the treatment plan and any other specialty care needed to facilitate continuity of care and must notify <Plan> when an office visit indicates an initial OB visit, a condition requiring long term treatment or a patient who may benefit from case management, a disease management program or the XXXXX XXXXX Program for expectant mothers.

### **ERISA**

51. You will look to the applicable entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.
52. In the case of a Member whose Membership Certificate is not underwritten by <Plan> or an Affiliate, Participating Provider's cause of action, if any, shall lie strictly with the Plan sponsor of said Member's Plan.
53. In the event the Colorado prompt payment legislation is not applicable, <Plan> shall require Plans or their designees to use best efforts to make payment or arrange for payment for all Clean Claims for Covered Services...within ninety (90) days of receipt...