



*MMA's review of the Blue Cross Aware Agreement is the first in a new series of MMA contract reviews that physicians and clinic managers will be able to use to evaluate health plan contracts. These contract reviews are part of the MMA's Contracting Initiative, which will also include a Minnesota-specific model contract, and a "Quick Reference Guide," which will summarize the major provisions of Minnesota health plan contracts.*

In this document, the Minnesota Medical Association provides a brief overview of some of the key provisions in the 2002 Amendment to the Blue Cross Blue Shield of Minnesota (Blue Cross) Aware Agreement (Agreement). Please note that this review is not a comprehensive analysis and the information provided in this document is not a substitute for legal and accounting advice. If you are interested in determining the specific application of this Agreement to your practice, or in negotiating the terms of the Agreement, please discuss the matter with your own attorneys, accountants and consultants.

### General Information

The cover letter to the 2002 Aware Agreement indicates that the Agreement will renew automatically effective July 1, 2002 unless either party gives notice of termination by June 1, 2002.

Although there are only about one dozen changes to the Agreement for 2002, the MMA has provided a summary of many key provisions including some that have been part of the Agreement for years. If you are interested only in the new language, please see the Change Summary provided by Blue Cross.

The MMA would draw your particular attention to the following changes in the Agreement for 2002:

- Protected Health Information (see HIPAA section on page 5 of MMA Review)
- Submission of Information for Administrative Processes (see page 2 of MMA Review)
- Provider Not to Charge Due to Lack of Timely Filing (see Claims Filing section on page 2 of MMA Review)
- Term & Amendment (see page 3 of MMA Review)

The Aware Agreement is the contract used by Blue Cross for its broadest network of providers. Since the network is not limited to any particular product, it includes many different provisions. For example, although not all of the Aware providers serve Blue Cross' HMO enrollees, many HMO legal and regulatory requirements are incorporated in the contract because Aware providers may see Blue Cross HMO enrollees on a referral basis. This is an important point to remember when reviewing the contract.

### Payment Policy

The 2002 Agreement incorporates some simple, but significant changes in reimbursement for physician services. According to Blue Cross, 34 physician specialty types were analyzed and all specialties are expected to see no less than a 5 percent increase in payment over last year's figures (based on both Relative Value Unit (RVU) and conversion factor changes). Physicians should carefully analyze the fee schedule provided with the Agreement to understand the impact of the changes on their particular practice. Any questions or concerns should be directed to Blue Cross. Although the Agreement continues to allow Blue Cross to make any material modifications to the fee schedule with only a 90-day advance notice, historically that provision has rarely been used. (Article VI, Section A)

**RVUs and Conversion Factors.** Effective July 1, 2002, Blue Cross will implement the 2002 Centers for Medicare & Medicaid Services (CMS) Relative Value Units (RVUs). Physicians interested in knowing the conversion factor applicable to their practice should refer to the fee schedule provided by Blue Cross as part of the Agreement mailing. Blue Cross is maintaining its previous policy of using the higher practice expense RVUs (either facility or non-facility), which means that there is no site-of-service differential applied by Blue Cross. Blue Cross also continues to implement the RVUs without the geographic practice cost indices (GPCIs), which are Minnesota-specific geographic adjustment factors and which could otherwise reduce payment by 3 percent.

**Minnesota Health Care Programs Fee Schedule.** For payments to physicians for services provided to enrollees in Minnesota health care programs (e.g., Medical Assistance [MA], MinnesotaCare, General Assistance Medical Care) covered under a Blue Cross plan, the Agreement makes no changes in payment policy. For specific payment levels, physicians should refer directly to the Agreement. (Article III, Section M, (2))

**Modifier -57.** As part of the Agreement mailing, Blue Cross indicated that several other key payment policies are being revised. One of the most significant changes for physicians is Blue Cross' decision to recognize (effective July 1, 2002) modifier -57, which allows for separate payment for an evaluation and management (E/M) service that resulted in the initial decision to perform the surgery when the procedure is performed on the same day.

### **Article I - Purpose**

This article outlines the intent of the Agreement, which is to “promote the practice of medicine and to assure quality care for Subscribers” of Blue Cross and its affiliates.

### **Article II - Definitions**

This article contains definitions for sixteen terms used throughout the Agreement. Some of the key definitions are as follows:

**Agreement.** The “Agreement” continues to be broadly defined to include the actual document, as well as any attachments and amendments including, but not limited to, Rules and Regulations, Provider Bulletins, and provisions of the Provider Policy and Procedure Manual. (Article II, Section B)

**Medically Necessary/Medical Necessity.** The Agreement defines “medically necessary” or “medical necessity” as “Health Services which are medically appropriate as defined in the Subscriber Contract.” But since the subscriber contract is not included, physicians will have difficulty knowing if a service will be considered medically necessary. The ability to identify services that are not medically necessary is important for determining potential subscriber (patient) liability. (Article II, Section G)

•It should be noted that although Minnesota HMO rules (M.R., Part 4685.0100, Subp. 9b) provide a definition of medically necessary care as it relates to HMO enrollees, the Agreement is not clear as to whether the HMO definition is used consistently throughout Blue Cross subscriber contracts.

**Protected Health Information.** A new term and definition is added for “Protected Health Information” as it relates to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (Article II, Section L)

**Rules and Regulations.** The Agreement continues to define “Rules and Regulations” as those procedures and requirements adopted “from time to time” by Blue Cross that, upon notification, providers are required to follow. (Article II, Section M)

**Utilization Review Process.** The term and definition for “Peer Review Process” is replaced with a new term and definition for “Utilization Review Process.”

### **Article III - Authority and Covenants**

This article outlines many of the logistical requirements of the contract related to issues such as claims submission, charges, overpayments, quality assurance, MinnesotaCare tax, and coordination of benefits. Some of the key provisions are as follows:

**Claims Filing.** Blue Cross continues to require that providers submit claims within three months of the date of service, but in no event later than 15 months from the date of service. This timeline, particularly the 15-month limit, is quite generous compared to industry averages and is helpful to physicians who sometimes encounter difficulty submitting complex claims. (Article III, Section B)

A new provision, however, explicitly prohibits a provider from billing an enrollee for the cost of services if Blue Cross denied payment due to lack of timely claims submission on the part of the provider. (Article III, Section H)

**Submission of Additional Information.** The Agreement has been modestly amended to specify that providers are responsible for furnishing additional information requested by Blue Cross (or the plan sponsor) to respond to claims, utilization review, coordination of benefits, other quality and care management reviews, and medical abstract reviews. The provider is responsible for the costs incurred in providing such information as well as for obtaining any authorization necessary to release the information. (Article III, Section B)

**Overpayments/Recoupment.** The Agreement continues to give Blue Cross very broad authority to deduct overpayments “of any type” from future provider payments without any explicit time limitations, advance notification, or appeal opportunities. (Article III, Section F)

**Rules & Regulations.** The agreement is amended to clarify Blue Cross’ broad discretion to modify operational processes or procedures related to the Agreement. New language states that Blue Cross may issue Rules and Resolutions “at any time” to implement aspects of the Agreement. For those Rules and Regulations that “materially affect the responsibilities or rights” of providers, providers have the right to terminate the Agreement, so long as they provide Blue Cross with 130-days prior written notice, AND so long as the notice is received by Blue Cross within 30 days after the issuance of the Rules and Regulations. The Agreement does not provide for a minimum notification period by Blue Cross before any Rules and Regulations take effect. (Article III, Section I)

•This provision is in stark contrast to the language included in the AMA Model Managed Care Contract (American Medical Association, 2000). Although the model language recognizes the need for health plans to issue policies, procedures, rules, and regulations, the model language would require that providers receive a 90-day written notice of such changes in advance of implementation. Furthermore, the model language would prohibit changes in such policies, procedures, rules and regulations that would have a materially adverse effect on the provider unless the provider has given prior consent.

**Referrals.** The Agreement continues to require providers to adhere to the “referral policy guidelines” of Blue Cross. This document is not included with the Agreement and attachments so the burden has been placed on providers to be able to access and understand the guidelines. (Article III, Section L)

**Preferred Provider Plans.** The Agreement continues to specify that payment for “Preferred Provider Benefit Plans” (such as Aware Gold) shall be the lesser of the billed charge or the amount shown on the “Preferred Provider Benefit Plan Fee Schedule.” If physicians are part of a Preferred Provider Plan, they should ensure that a copy of that fee schedule is included with the Agreement. For services not listed on that fee schedule, the payment rate will be 90 percent of the allowance defined elsewhere in the contract. (NOTE: the contract erroneously references Sections F and V, but the first reference should be to Section E). (Article III, Section M(1))

**Provider Recourse Against Subscribers.** For services provided under the Agreement, a provider is prohibited from billing, charging, collecting a deposit from, seeking remuneration from, or having any recourse against a subscriber in the event of, but not limited to, nonpayment or breach of the Agreement. The language in this entire section is mandated to be included in all HMO contracts under Minnesota HMO law (M.S. §62D.123). As previously noted, however, the Aware Agreement is not limited to providers serving only HMO enrollees. (Article III, Section N).

### *Article IV - Applicability*

**Use of Agreement.** The Agreement continues to have broad applicability by allowing other Blue Cross plans to use the Agreement, unless a provider has a separate agreement with a Blue Cross plan in

an adjoining territory. The Agreement further allows Blue Cross to permit affiliates and joint venture companies to use this Agreement and its reimbursement rates. (Article IV, Section A)

### *Article V - Provider Participation Requirements*

**Participation Requirements.** The Agreement continues to specify that only those providers who have successfully completed the credentialing process may treat Blue Cross enrollees. This provision, although often burdensome to physicians and patients, is currently a National Committee for Quality Assurance (NCQA) requirement for health plan accreditation. (Article V, Section B)

**Credentialing Exemptions.** The Agreement still includes a provision added last year that exempts certain providers (i.e., physical therapists, occupational therapists, speech and language pathologists, audiologists and certified registered nurse anesthetists) from the credentialing and re-credentialing process unless a potential quality-of-care issue arises. The responsibility for verifying credentials and appropriate malpractice coverage is delegated to clinics. (Article V, Section F)

### *Article VI - Amendment & Termination*

**Agreement Term & Amendments.** New language clarifies that the Agreement has an initial term of one year, and then automatically renews unless either party terminates. (The reference to a July 1 effective date and April 1 notification date have been removed from the Agreement). New language is added that allows amendments or modifications to the agreement to be made with at least 90-days written notice to the provider. (Article VI, Section A)

•This new language effectively shortens Blue Cross’ notification requirement for amendments or modifications that are not part of the annual changes. Previously, all amendments or modifications made by Blue Cross that were not part of the Agreement’s annual changes required 130-days advance written notice to providers. (2001 Agreement, Article VI, Section 3 has been deleted). That language has been replaced with a blanket 90-day notification period for all changes, whether part of the annual modifications or part of any changes that Blue Cross wants to make during the rest of the Agreement term. The Agreement fails to define how the new notification period (90 days) is reconciled

with the provider's termination requirements (see below), which generally require 130-days written notice. It is not at all clear which provisions of the Agreement (old or new) would apply for the 40-day difference.

**Termination.** The Agreement continues to outline a variety of termination provisions. It is important to note that Minnesota HMO law (M.S. §62D.123, Subd. 3) requires that providers seeking to terminate a contract without cause must give the HMO 120-days advance notice. As previously noted, the Agreement applies to providers serving many Blue Cross products, not just Blue Cross HMO products. Therefore, the notification that is required by law for HMO network physicians is broadly applied in the Agreement to all Aware network providers.

**1. Termination without cause:** Available to either party upon 130-days prior written notice. (Article VI, Section B(1))

**2. Breach of contract:** Available to either party upon 130-days prior written notice. (Article VI, Section B(2))

**3. Rules & Regulations:** Available to the provider for those Rules and Regulations that "materially affect the responsibility or rights of the provider" upon 130-days prior written notice. (Article VI, Section B(3), referencing Article III, Section I [the reference in the Agreement to Section J appears to be inaccurate]) (See also Article III, Rules & Regulations, on page 2 of MMA Review).

**4. Credentialing Process/Sanctions.** Available to Blue Cross upon 30-days prior written notice. This provision applies if a provider does not successfully complete the credentialing or re-credentialing process, or if a provider (or a provider's health care professional employee) has been sanctioned or reprimanded for quality of care "or similar issues" by any review organization, such as a plan, hospital medical staff, peer review organization, or state licensing board. This is the only termination provision for which it is explicitly indicated that providers may appeal. (Article VI, Section B(3), referencing Article V, Section B; and Article VI, Section B(5))

**5. Patient Harm/Fraud.** Available to Blue Cross immediately upon written notice to provider if Blue Cross has "evidence of the potential for significant patient harm or of fraudulent or illegal conduct" with regard to the practice of medicine, claim sub-

mission, health care professional eligibility, or the delivery of care. (Article VI, Section B(4))

**6. Public Program Participation.** Available to Blue Cross (no notification timeline identified) as it affects provider's participation in select benefit plans administered by Blue Cross (e.g., the Minnesota Comprehensive Health Association, state employees' plan, workers compensation). This requirement, commonly known as Rule 101, refers to state law (M.S. §256B.0644) and rule (M.S., Part 9505.5220), which requires providers to serve a minimum defined percentage of public health care program enrollees as a condition of participation in other state products. (Article VI, Section B(6))

**7. Credentialing Failure.** Available to Blue Cross immediately upon written notice to provider if provider fails to meet Blue Cross' credentialing requirements. This provision appears to be inconsistent with language in a previous section (Article V, Section B) that requires Blue Cross to give 30-days advance written notice if a provider does not successfully complete the credentialing or re-credentialing process. (Article VI, Section B(7))

### *Article VII - Complaint & Inquiry Procedures*

**Patient/Subscriber Complaints.** The Agreement continues to require that providers address subscriber/enrollee "complaints, inquiries and opinions" regarding the provider's operations and policies and to report all complaints to Blue Cross. (Article VII, Sections A & B)

### *Article VIII - Miscellaneous*

This article contains a number of standard or "boilerplate" provisions contained in most contracts and includes general information about the obligations of each party, their business relationship and other general provisions dealing with liability and immunity. Although this language is often standard, it is helpful to review and understand each of these sections, since they do create obligations and place certain limitations on the rights of the parties.

**Assignment.** The Agreement continues to contain a unilateral assignment clause which means that Blue Cross may assign or transfer the Agreement to another company. The provider, however, is prohibited from doing so unless the provider obtains the



written consent of Blue Cross. The Agreement also stipulates that the provider agrees that the payment terms in the Agreement may be assigned to a plan sponsor (employer or other third party administrator). It is notable that the AMA Model Managed Care Contract recommends a mutual assignment provision, allowing either party to assign or transfer the contract without the consent of the other party. This is recommended to assist the parties administratively in the case of a change in ownership or control. (Article VIII, Section A)

**Confidentiality: Provider Obligations.** This section outlines the confidentiality obligations of the provider and requires the provider to keep confidential all identifiable subscriber information (including medical records) except as authorized or required by law; all quality assurance/utilization review information; all financial/proprietary information in the Agreement except as authorized or required by law. In case of a breach of any of these provisions, this section states that Blue Cross is entitled to injunctive relief and attorneys' fees. It is notable that this section also states that the intent is not to interfere with the physician-patient relationship or limit communication between the physician and patient regarding treatment options. Also note that benefit coverage determinations are governed by the terms in the subscriber's contract with Blue Cross. (Article VIII, Section B)

•The confidentiality provisions contained in this Agreement are significantly broader than those recommended by the AMA Model Managed Care Contract. The model language suggests that except for patient medical information and the specific fee schedule to be paid by the plan, all other general terms and conditions in the contract, including the manner in which the physician is paid, may be shared with third parties if it is considered reasonable by the parties.

**Confidentiality: Blue Cross Obligations.** This section addresses the confidentiality obligations of Blue Cross and states that the company has an obligation to maintain the confidentiality of subscriber information and financial information relating to the Agreement, except as required or authorized by law. However, the section further states that Blue Cross is permitted to release a broad range of health care data (in accordance with applicable laws) including: claims data, provider demographic information, utilization information, quality initiatives, service volumes, small area analysis, credentialing data, outcomes measures and similar health data. Blue Cross is also permitted to release provider information for

the purposes of allowing subscribers, plan sponsors and others to compare the level and quality of care provided by competing providers. The contract does not, however, give providers the opportunity to review or dispute such comparative data. The AMA Model Managed Care Contract suggests that providers have 30 days to review such data before it is submitted to any third party so that the accuracy, completeness and validity of the data can be confirmed. (Article VIII, Section C)

**Family Members.** Physicians should take note of this continued provision which prohibits the provider from billing Blue Cross for any service provided to immediate family members (defined as the provider's spouse, children, parents or other members of the provider's family.) It should be noted that this section does not allow for any billing for treatment of family members, even in the case of an emergency or other unusual circumstances. (Article VIII, Section L)

**Insolvency.** The Agreement states that in the event that Blue Cross or the plan sponsor is insolvent or unable to meet its financial obligations, the provider agrees to hold subscribers (patients) harmless from liability for health services provided by the provider prior to the time of insolvency. (The physician would probably have some recourse against the plan if the plan files for bankruptcy or is placed in receivership.) (Article VIII, Section M)

**Hold Harmless.** The Agreement continues to require that the provider hold Blue Cross harmless from liability in the event of any claim for damages against the provider for any act or omission alleged to be caused by the provider. (Article VIII, Section N)

The Agreement also continues to state that Blue Cross shall hold the provider harmless for any claims, demands or expenses involving a denial-of-coverage decision made by Blue Cross as a result of any act or omission allegedly caused by Blue Cross. (Article VIII, Section O)

**HIPAA.** The Agreement is amended to incorporate the new federal Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, which are scheduled to take effect in April 2003. The Agreement broadly states that providers shall be compliant with the privacy regulations and not disclose protected health information in any manner that would violate the new federal law. The Agreement also extends responsibility to providers to ensure that any agents or subcontractors with whom



they share protected health information are compliant with the law. If the provider breaches any of these provisions, Blue Cross has the option of terminating the Agreement or reporting the breach to the federal government. (Article VIII, Section P)

**Transfer of Substantial Risk.** The Agreement is amended to incorporate federal regulations regarding physicians' transfer of substantial financial risk to its member physicians or employees. The federal requirement applies to physician financial incentive arrangements by managed care organizations contracting with Medicare and Medicaid. The regulations state that a managed care organization, which bases compensation on the use or cost of services furnished to Medicare or Medicaid recipients, may operate a physician incentive plan only if no specific payment is made directly or indirectly to a physi-

cian or physician group as an inducement to reduce or limit medically necessary services to an individual enrollee. It is not clear why this provision is being added to the contract at this time, because the federal requirements took effect January 1, 1997. (Article VIII, Section Q)

**Physicians should note that Blue Cross is undertaking a comprehensive analysis and rewrite of the Aware Agreement. The MMA is participating in that process and a variety of changes in the Agreement are expected in 2003.**

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