MMA MINNESOTA MEDICAL ASSOCIATION MEDICINE'S VOICE IN MINNESOTA
CONTRACTING RESOURCES
CONTRACT REVIEW
MINNESOTA MEDICAL GROUP MANAGEMENT ASSOCIATION
HMS HENNEPIN ANOKA CARVER SCOTT W. DAKOTA Hennepin Medical Society
RAMSEY MEDICAL SOCIETY

2003 Renewal Amendment to the Blue Cross Blue Shield of Minnesota Aware Professional Provider Service Agreement

New Addition/Change Differs from AMA/MMA Model Contract

In this document, we provide a brief overview of some of the key provisions in the 2003 Renewal Amendment to the Blue Cross Blue Shield of Minnesota (Blue Cross) Aware Professional Provider Service 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 negotiating or determining the specific application of this Agreement to your practice, please contact your own attorneys, accountants and consultants.

Executive Summary

The changes to the 2003 Aware Agreement are the result of a lengthy, comprehensive process to update and improve the Agreement. Blue Cross involved many different stakeholders in the rewriting process, including representatives of the Minnesota Medical Group Management Association (MMGMA) and the Minnesota Medical Association (MMA). Although there are many changes, most of them involve reorganizing and consolidating existing provisions. Physicians should note that the Agreement will renew automatically effective July 1, 2003 unless either party gives notice of termination by May 1, 2003.

- **Scope of Agreement - Related Documents.** The Agreement has been revised to reflect the fact that attachments referenced throughout the Agreement, such as the Provider Policy and Procedure Manual, are available on the Blue Cross Web site - bluecrossmn.com. (Article II, Section B)
- **Clinical Coding Requirements.** The Agreement has been modified slightly to eliminate the vague language that required compliance with coding guidelines "as interpreted by Blue Cross" and instead references coding guidelines that are set forth in the Provider Policy and Procedure Manual. (Article III, Section E)
- **Advance Notice for Provider Bulletins/Rules and Regulations.** Blue Cross will now provide 90-days advance written notice of new Provider Bulletins/Rules and Regulations unless they are issued to address regulatory or accreditation requirements, or involve minor clarifications, in which case Blue Cross will provide as much notice as reasonably possible. (Article III, Section G)
- **Claims Adjustments/Overpayments.** A significant, positive change to the Agreement is the adoption of a 15-month timeline for claims adjustments. With certain limited exceptions, Blue Cross may make corrective claims adjustments only within 15 months of the date a claim was paid or denied. (Article IV, Section F)
- **Reimbursement.** According to Blue Cross, an aggregate increase of 6 percent is provided for in 2003. Effective July 1, 2003, Blue Cross will implement the 2003 Centers for Medicare and Medicaid Services (CMS) relative value units (RVUs). Blue Cross will continue to use the higher practice expense RVUs and will continue to exclude the geographic practice cost indices. (Article IV & fee schedule)
- **Plan Sponsor Insolvency.** If a plan sponsor (not Blue Cross) fails or does not meet its financial obligations, a provider may bill the subscriber directly and may exercise all lawful remedies against the plan sponsor. (Article IV, Section G)
- **Credentialing.** The Agreement now allows physicians to appeal initial credentialing decisions. Although the Agreement does state that providers may only bill for health services personally performed by health care professional *employees* who meet Blue Cross eligibility criteria, Blue Cross has indicated that the intent is to continue the current practice of requiring both employees and independent contractors to be credentialed prior to treating Blue Cross enrollees. Recredentialing will occur no less frequently than every three years (changed from every two years). (Article VI, Sections A & B)
- **Indemnification.** Although providers are still required to indemnify Blue Cross from claims resulting from acts and omissions of providers, their employees and agents, the same requirements now apply to Blue Cross as well. Previously Blue Cross was only required to indemnify providers from claims involving denials of coverage. (Article VII, Section B)
- **HIPAA.** The Agreement contains new terms relating to implementation of HIPAA. The provisions are written in an overly broad way in that they appear to apply to all patients and not just Blue Cross subscribers. Blue Cross has indicated, however, that the intent is to apply the requirements to Blue Cross enrollees only. (Article X, Section C)
- **Remote Access Services.** The Agreement has been updated to incorporate a 6-page agreement for the use of Blue Cross' accessBlue system. (Article XI)
- **Miscellaneous.** New Force Majeure and Waiver provisions have been added. (Article XII, Sections H & I)

MMA
MINNESOTA MEDICAL ASSOCIATION
MEDICINE'S VOICE IN MINNESOTA
CONTRACTING RESOURCES
CONTRACT REVIEW
2003 BCBS Aware Agreement, Pg 2

MINNESOTA MEDICAL GROUP MANAGEMENT ASSOCIATION

New Addition/Change Differs from AMA/MMA Model Contract

Article I - Purpose

No changes were made to this article, which simply outlines the intent of the Agreement.

Article II - Definitions

This article contains definitions for 13 terms used throughout the Agreement. Three terms have been deleted in their entirety. Joint Venture Company and Medicare Select have been deleted as they are not used anywhere else in the Agreement. The definition for Rules and Regulations has also been deleted, but relevant language has been incorporated elsewhere. Some of the key definitions are listed below.

Affiliate and Blue Cross. The Agreement is entered into between the provider and Blue Cross, which is defined to include Blue Cross affiliates - those entities that, directly or indirectly, control or are controlled by Blue Cross. This year for the first time, Blue Cross will be providing, under separate cover, a listing of current affiliates. (Article II, Sections A & C)

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. The Agreement has been revised, however, to reflect the fact that attachments referenced in the document are available on the Blue Cross Web site. (Article II, Section B)

Medically Necessary/Medical Necessity. The Agreement continues to define "medically necessary" or "medical necessity" as "health services which are medically appropriate as defined in the Subscriber Contract." The ability to identify services that are not medically necessary is important for determining potential patient liability and for ensuring that determinations of medical necessity are separate from determinations of covered services. (Article II, Section F)

- The incorporation of a "prudent physician" standard for the definition of medical necessity in a managed care contract is part of the Model Managed Care Contract-Minnesota Edition (AMA/MMA, 2002) (Model Contract). Blue Cross has indicated that the adoption of a single medical necessity definition is not possible due to the variations in their self-insured contracts. Copies of medical policies are, however, posted on the Blue Cross Web site.

Rules and Regulations. The Agreement no longer includes a definition for "Rules and Regulations." Current Rules and Regulations have been incorporated into the Agreement or will be incorporated into the Provider Policy and Procedure Manual. Blue Cross does not intend to issue any new Rules and Regulations. See related information, however, in Article III, Section G.

Article III - Authority and Covenants

Although this article appears to have been dramatically modified, the vast majority of the changes are the result of moving provisions, consolidating provisions, and adding clarification by eliminating vague references. The most significant change is found in the Provider Bulletins/Rules and Regulations section (G).

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. Although the Agreement continues to allow Blue Cross to assess a charge for processing paper claims, new language has been added that would first require Blue Cross to provide "reasonable advance written notice." (Article III, Section C)

Additional Information. The Agreement continues to state 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 D)

Clinical Coding Requirements. The Agreement has been modified slightly to eliminate the vague language that required compliance with coding guidelines "as interpreted by Blue Cross." The Agreement now references coding guidelines that are set forth in the Provider Policy and Procedure Manual (Article III, Section E).

Provider Bulletins/Rules and Regulations. A fairly significant change in the Agreement now provides for 90-days advance written notification before Blue Cross issues Provider Bulletins/Rules and Regulations. The 90-day notice requirement may not apply, however, if bulletins or Rules and Regulations are issued for regulatory or accreditation purposes or if they address "only minor administrative or operational clarifications." The Agreement has also been changed to clarify that a new Provider Bulletin/Rule and Regulation that has a material effect on the provider would not be applied to that provider if the provider terminates the Agreement (upon 130 days written notice). (Article III, Section G)

- These changes are fairly consistent with language in the Model Contract. The model language recognizes the need for health plans to issue policies, procedures, rules, and regulations, and establishes a 90-day written notice of such changes in advance of implementation. The Blue Cross Agreement, however, varies from the model language that would prohibit the issuance

★ New Addition/Change ⊘ Differs from AMA/MMA Model Contract

of policies, procedures, rules and regulations that have a materially adverse effect on the provider unless the provider has given prior consent.

★ **Referrals.** The Agreement has been improved to eliminate the vague reference to "referral policy guidelines issued by Blue Cross." Instead, a specific reference to the referral requirements as outlined in the Provider Policy and Procedure Manual is established. (Article III, Section J)

★ **Coordination of Benefits.** New language has been added to clarify current Blue Cross practice for COB when Blue Cross is the secondary payer. (Article III, Section L)

Article IV - Provider Reimbursement

This article outlines the basic payment provisions of the Agreement, much of which is unchanged. A welcome and significant change, however, is the establishment of a specific policy regarding claims adjustments and overpayments (section F).

Blue Cross has not made any real changes to its physician reimbursement methodology since 2002. According to Blue Cross, an aggregate increase of 6 percent is provided for in 2003 (based on both RVU and conversion factor changes). Attached to the Agreement is a sample fee schedule that should represent approximately 80 percent of the payment received for the clinic-specific specialty. Any questions or concerns should be directed to Blue Cross.

RVUs and Conversion Factors. Effective July 1, 2003, Blue Cross will implement the 2003 CMS 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). Blue Cross also continues to implement the RVUs without the geographic practice cost indices (GPCIs), which would otherwise reduce payment by 3 percent.

Payment Amount. Except as otherwise provided in the Agreement, payment is the lesser of regular billed charges or the Blue Cross fee schedule allowance, minus subscriber or other party liabilities. If treatment is deemed by Blue Cross to be unusually complex or to involve unusual clinical circumstances, Blue Cross may allow a higher fee. The Agreement continues to allow Blue Cross to make any material modifications to the fee schedule following a 90-day advance notice, but historically that provision has rarely been used. New language has been added to allow Blue Cross to correct errors or omissions or to reflect regulatory requirements without the 90-day notification. (Article IV, Section A)

★ **Minnesota Health Care Programs Fee Schedule.** For payments to physicians for services provided to enrollees in Minnesota health care programs (e.g., Medical Assistance, 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. Language that allowed Blue Cross to substitute an actuarially equivalent fee schedule upon 90-days advance written notice has been deleted from the Agreement. (Article IV, Section C)

- Physicians should note that current legislative budget proposals could change the base fee-for-service Medical Assistance fee schedule published by the Department of Human Services. If passed, such changes could impact reimbursement received under this provision of the Agreement.

★ **Claims Adjustments/Overpayments.** A significant, positive change to the Agreement is the adoption of a specific timeline and language for claims adjustments. The Agreement previously allowed Blue Cross very broad discretion to "deduct overpayments of any type from future payments owed to the provider" and was silent on physicians' ability to request adjustments for underpayments. The new language grants providers the explicit right to request corrective adjustments to any previous payment, so long as such requests are made within 15 months of the date the claim was paid or denied. Likewise, the new language grants Blue Cross the right to make corrective adjustments to any previous payment within 15 months of the date the claim was paid or denied by Blue Cross. Payments subject to COB recovery, subrogation recovery, and "certain other payments as set forth in the provider policy and procedure manual" are exempt from the 15-month time limit. (Article IV, Section F)

★ **Insolvency.** The Agreement has been changed to clarify that in the event a plan sponsor (not Blue Cross) fails or is unable to meet its financial obligations, the provider may bill the subscribers (patients). Previously, the Agreement held subscribers, both those of Blue Cross and plan sponsors, harmless from liability in the event of insolvency. (Article IV, Section G)

Subscriber Hold Harmless. Numerous existing subscriber hold-harmless provisions, most of which are required under Minnesota law, have been consolidated into a single provision. (Article IV, Section I).

Article V - Applicability

★ **Use of Agreement.** New language has been added that requires Blue Cross to provide 90-days advance written notice if application of the Agreement to other entities changes the reimbursement method or amount paid or otherwise has a material impact. Although the physician may terminate the agreement (without cause upon 130-days advance notice), Blue Cross has indicated that this section would not apply to that provider for the 40-day difference between notification and termination, even though that is not explicitly stated. (Article V, Section A)

★ New Addition/Change — Differs from AMA/MMA Model Contract

Article VI - 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. New language has been added to reference the credentialing requirements that are available on the Blue Cross Web site. The provision has also been changed to eliminate the requirement that clinics provide Blue Cross with a listing of the licenses and certificates held by the clinic's providers. (Article VI, Section A)

Recredentialing; Appeals. The Agreement has been changed to reflect that Blue Cross recredentials every three years, not every two years, although more frequent recredentialing could occur if necessary. Prior to changes made this year, the Agreement precluded appeals of initial credentialing decisions. That restriction has now been eliminated and all termination or adverse credentialing or recredentialing decisions can be appealed through Blue Cross' established appeal process. (Article VI, Section B)

Article VII - Insurance & Indemnification

Indemnification. The Agreement has been modified in a positive way to provide for mutual indemnification, so that now Blue Cross and the provider agree to hold the other harmless from any and all claims, damages, and expenses of all kinds (including reasonable attorneys' fees) by reason of any act or omission caused by, or alleged to have been caused by, the other. (Article VII, Section B).

Article VIII - Amendment & Termination; Arbitration

Agreement Term & Amendments. The Agreement continues to have an initial term of one year, and then automatically renews unless either party terminates. Amendments or modifications to the agreement may be made with at least 90-days written notice to the provider. New language clarifies that if a provider gives Blue Cross notice of termination within 30 days of the issuance of such changes or amendments, those changes will not be applied to the provider for the balance of the time before the termination takes effect. (Article VIII, Section A)

- It is worth noting that the Model Contract, which supports the ability of either party to terminate the Agreement without cause, would, however, require the terminating party to state the reason for the termination. The Blue Cross Agreement does not require the reason for termination to be provided.

Termination. The Agreement continues to outline a variety of termination provisions. Note that Minnesota HMO law requires that providers seeking to terminate a contract without cause must give the HMO 120-days advance notice.

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

2. Breach of contract: Available to either party upon written notice if failure is not corrected within 30 days (previously required 130 days notice). (Article VIII, Section B(2))

3. 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 submission, health care professional eligibility, or the delivery of care. (Article VIII, Section B(3))

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 by any review organization. (Article VIII, Section B(4))

5. 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 and rules, which require providers to serve a minimum defined percentage of public health care program enrollees as a condition of participation in other state programs. (Article VIII, Section B(5))

Arbitration. Existing arbitration language has been moved to this article. New language clarifies that arbitration applies only to disputes arising on or after the effective date of the Agreement. Language that limited damages that could be awarded in arbitration has been deleted. (Article VIII, Section C)

- Use of arbitration as the sole method of dispute resolution is not recommended by the Model Contract. The model contract suggests that arbitration is appropriate in the event that neither party has brought forth a lawsuit in a court of competent jurisdiction to address the same matter.

Article IX - 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. It further states that the provider and subscriber have the right to appeal all utilization review decisions through the Blue Cross utilization review process. (Article IX)

New Addition/Change Differs from AMA/MMA Model Contract

Article X - Confidentiality; Non-Interference

Confidentiality Requirements of Provider. Language in this section is unchanged. It 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. 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. Note that benefit coverage determinations are governed by the terms in the subscriber's contract with Blue Cross. (Article X, Section A)

- The confidentiality provisions contained in this section are significantly broader than those recommended by the Model 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 Requirements of Blue Cross. This section continues to address 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, language in the Agreement was modified to state that Blue Cross is permitted to release a broad range of provider-specific health care data for relative comparison, including: provider demographic information, utilization information, quality of care measures and initiatives, service volumes, small area analysis, credentialing data, outcome data, patient satisfaction results, costs and similar health data. The new language in this section also outlines the process Blue Cross will use when a provider submits a written request for specific information regarding how Blue Cross intends to use a particular category of data. Although Blue Cross is required to make a good faith effort to resolve the provider's concerns about the release of inaccurate data, the Agreement states that Blue Cross has the sole discretion over the content, dissemination and release of such data. (Article X, Section B)

- The Model 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.

HIPAA Compliance. This section adds new language to ensure compliance with federal Health Insurance Portability and Accountability Act (HIPAA) privacy requirements that take effect April 14, 2003. The Agreement states that providers shall be compliant with the privacy regulations and not disclose protected health information (PHI) 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 PHI are compliant with the law. It also requires that the provider report at least monthly to Blue Cross any disclosures of PHI except disclosures for which consent or authorization is not required, including: disclosures required by law; disclosures for public health activities; disclosures about victims of abuse, neglect or domestic violence; uses for health oversight activities; disclosures for judicial and administrative proceedings; and, disclosures for law enforcement purposes. This requirement is consistent with HIPAA law regarding accounting of disclosures of PHI. 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 X, Section C)

Non-interference. The Agreement continues to state that neither the provider nor Blue Cross will interfere with each other's business relationships. Providers are prohibited from disclosing proprietary information such as financial information or other terms of the Agreement. (Article X, Section D)

Article XI - Remote Access Services

This article has been added to the Agreement to incorporate a 6-page agreement for the use of Blue Cross' access-Blue system, which provides for the verification of insurance coverage benefits; verification of claims status; verification of cases; creation and update of referrals and prior authorizations; and creation and update of admission notifications. Physicians should note the disclaimer language, which although standard, nevertheless indicates that Blue Cross makes no guarantee that the information is, or will be, accurate. The Agreement also provides for the ability to impose service fees, upon 90-days advance written notice. (Article XI, Sections C & D)

Article XII - Miscellaneous

This article contains a number of standard or "boilerplate" provisions contained in most contracts. It is helpful to understand each of these sections, since they do create obligations and place certain limitations on the rights of the parties.

Family Members. The Agreement strikes language that prohibited providers from billing Blue Cross for any services provided to immediate family members. Blue Cross intends, however, to incorporate this requirement in its Provider Policy and Procedure Manual, so its elimination from the Agreement does not change the effect of the prohibition.

MMA

MINNESOTA MEDICAL ASSOCIATION
MEDICINE'S VOICE IN MINNESOTA

CONTRACT REVIEW

2003 BCBS Aware Agreement, Pg 6

★ New Addition/Change — Differs from AMA/MMA Model Contract

Assignment. The Agreement continues to contain an assignment clause that states that Blue Cross may assign or transfer the Agreement to another company. The provider is prohibited from doing so unless the provider obtains the written consent of Blue Cross. New language does state that Blue Cross' consent will not be unreasonably withheld. 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). (Article XII, Section A)

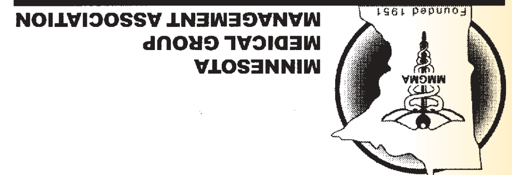
- It is notable that the Model Contract recommends a mutual assignment provision, allowing either party to assign or transfer the contract without the consent of the other party. This is recommended to assist the parties admistratively in the case of a change in ownership or control.

Notices. This section provides the Blue Cross address to be used to send notices, reports, and records and states that notices shall be deemed effective on the third day following the date they are deposited in the mail, a change from previous language stating that notices are effective when received by the party. (Article XII, Section C)

Invalid Provisions. This section provides that the remainder of the Agreement will still be valid in the event one or more sections are invalidated. (Article XII, Section F)

Force Majeure. New language has been added to state that neither party has liability under the Agreement for delay, failure to perform or damages due to acts of nature, war, terrorism, or any other causes beyond reasonable control. (Article XII, Section H)

Waiver. New language states that a waiver of a breach of the Agreement is not to be interpreted as a waiver of a subsequent breach of the same or any other provision of the Agreement. (Article XII, Section I)



3433 Broadway St. NE, Suite 300
Minneapolis, MN 55413

MMA
MINNESOTA MEDICAL ASSOCIATION
MEDICINE'S VOICE IN MINNESOTA