

Section 3 – Participating Provider Agreements

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Participating Provider Agreements

The final stage of becoming a participating provider with any payer, private or public is the agreement itself.

Key Concepts:

- Agreement types
 - Contract
 - Memorandum of Understanding
- Contract clauses
 - Medical necessity/policy
 - Prompt payment
 - Hold harmless
 - Liability insurance
 - Timely filing
 - Coding edits
 - Reimbursement
 - Coordination of Benefits (COB)
 - Renewal
 - Miscellaneous
 - Directory publication
 - Own use concept
 - Silent PPO concept

There are two basic types of agreements used by Wisconsin health insurers, contracts or Memorandums of Understanding (MOU).

Contract

Under Wisconsin contract law¹, legally binding contracts, whether oral or written, require three basic components:

- offer (one party offers to provide something of value to another);
- acceptance (the offer is accepted by the other party); and
- consideration (something of value exchanged that is mutually provided by both parties).

For example, an agreement whereby a party agrees to pay you \$1,000, without receiving anything in exchange, is by definition not a contract. Wisconsin contracts all come with an implied duty of "good faith and fair dealing" on the part of both parties to the contract. In other words, once an agreement has been reached, both parties have an obligation to make reasonable efforts to fulfill their respective obligations, and to avoid taking actions that would hinder the performance of the contract. Parties to contracts have the right to enforce them in courts of law.

Memorandum of Understanding

Contracts and MOUs² are alternative document forms; each is best suited for different situations. The purpose of a contract is to document each party's obligations and responsibilities, while also minimizing each party's risks during the performance of the agreement and providing for dispute resolution and laying out remedies if either party doesn't perform. A memorandum of understanding (see **Appendix 9**) plays a similar role in that an

¹ <http://ezinearticles.com/?Wisconsin-Contract-Law---What-Makes-a-Legally-Binding-Contract?&id=3373178>

² <http://benflavinlaw.com/law-blog/is-a-memorandum-of-understanding-a-contract/>

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MOU prevents misunderstandings and disputes by clarifying the expectations of the partners, but doesn't normally offer either party any protections.

A contract is almost always legally binding on the parties who sign it, while an MOU may or may not be legally binding. Usually, parties choose an MOU specifically when they do not want to be legally bound. Whether or not an MOU is legally binding depends on the language used in the document—if it contains many of the clauses that are present in standard contracts, it will most likely be considered enforceable by a court. Also, it is possible for certain provisions of an MOU to be legally binding, while others are not. This may be the case concerning a confidentiality or non-disclosure clause, which might contain language making it specifically legally binding.

Contract Clauses

Whichever agreement document is used, there are specific items that should be considered for inclusion in a health insurance agreement. See **Appendix 10** for an example of a standard contract format. Discussed below are items that should be carefully considered in a contract between an LHD and a commercial payer. Medicare and Medicaid don't generally allow for negotiations of contract terms.

Medical Necessity/Medical Policy

In all cases, the overriding decision of whether a service will be reimbursed depends on whether or not it is considered "medically necessary" according to the payer. Even services listed on fee schedules can be denied for this reason. This definition should be reviewed carefully. It is not always contained within the provider contract, as it may instead be part of the individual benefit plan, allowing it to vary from plan to plan. It can be a simple statement without definition to a very complex set of criteria.

Payers also have medical policies that serve to define medical necessity of specific procedures. Again, these may not be part of the provider contract, so you should ask if there are any policies that affect your services (e.g., immunizations or a particular vaccine), before you sign the contract.

Commercial

Every payer has their own definition of medical necessity and how they develop medical policies on specific services. **Figure 1** and **Figure 2** are examples:

Medical Policy Criteria

Medical necessity decision-making requires the consistent application of utilization criteria. Arise Health Plan uses both nationally published and locally developed criteria. Input from Arise Health Plan practitioners, including department chairs and other practitioners, is solicited. The Medical Policy Committee reviews criteria for appropriateness and makes recommendations for approval to the Quality Improvement Committee. The Quality Improvement Committee makes the final decision to approve criteria for use. Decision making criteria is reviewed and updated annually or more frequently if significant changes in standards of care are identified.

Criteria are applied consistently to medical necessity decisions, and in a manner that is responsive to individual member needs and the characteristics of the local delivery system. At least annually, Arise Health Plan evaluates the consistency with which Case Management Specialists and the Medical Director apply the criteria when making decisions. A corrective action plan is developed if significant variation is found.

The following criteria used by Arise Health Plan are, but not limited to:

- Milliman Care Guidelines, for Inpatient and Surgical Care, Ambulatory Care (Medical and Behavioral health and Chiropractic Care), General Recovery and Chronic Care
- Hayes Medical Technology Directory
- Mercy Conference Guidelines, Cochrane Collaborative Systemic Reviews and CCGPP for Low Back Pain (for Chiropractic Care)
- DSM-V Criteria (Behavioral Health)
- Medical Policy Committee Decisions (Coverage Policy Bulletins)
- Pharmacy Benefit Criteria (Includes clinical data, reference materials, expert physician opinion, FDA-approved labeling, and/or cost-benefit information)
- APTA Guide to Physical Therapy Practice
- Apollo Managed Care Guidelines

Figure 1 - Arise Medical Policy Criteria

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Medical Necessity definition from typical member policy:

Medically Necessary:

The treatment, services, or supplies provided by a hospital or Health Care Provider that are required to identify or treat a Member's illness or injury and which, as determined by our Medical Affairs Division, are: (a) consistent with the Member's illness or injury; (b) in accordance with generally accepted standards of medical practice; (c) not solely for the convenience of a Member, hospital, or other provider; and (d) the most appropriate supply or level of service that can be safely provided to the Member in the most cost effective manner.

Psychological reactions to appearance or fear of disease do not constitute a basis for medical/surgical necessity, other than for behavioral health services. Cosmetic services or plastic surgery are not a benefit unless representing a material and functional medical/surgical necessity, except as otherwise indicated in this Policy.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular illness or injury does not mean that it is

Medically Necessary as defined in this Certificate. The definition of Medically Necessary used in this Certificate relates only to this Policy and may differ from the way a physician engaged in the practice of medicine defines medically necessary.

Figure 2 - Example of Medically Necessary Definition

Medicare

Medicare defines medical necessity as services that:

- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

Medicaid

To determine if a requested service is medically necessary, ForwardHealth consultants obtain direction and/or guidance from multiple resources including:

- Federal and state statutes.
- Wisconsin Administrative Code.
- Prior Authorizations guidelines set forth by the DHS.
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Wisconsin Administrative Code DHS 101.03

(96m) "Medically necessary" means a medical assistance service under ch. DHS 107 that is:

Required to prevent, identify or treat a recipient's illness, injury or disability; and Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient?

Hold Harmless Provisions

Both by contract agreement and state statute, when a discounted payment is made to a provider, that amount must be considered payment in full, except for any cost-sharing amounts (deductible, coinsurance, copayments). The provider has agreed to not bill the insured for the difference between the submitted charge and the allowable charge. The Wisconsin statute applies to all payers including Medicare [609.91(1m)] and Medicaid [609.91 (1p)].

Wisconsin Statute

609.91 Restrictions on recovering health care costs.

IMMUNITY OF ENROLLEES AND POLICYHOLDERS. Except as provided in sub. (1m) or (1p), an enrollee or policyholder of a health maintenance organization insurer is not liable for health care costs that are incurred on or after January 1, 1990, and that are covered under a policy or certificate issued by the health maintenance organization insurer, if any of the following applies:

The liability is for the portion of health care costs that exceeds the amount that the health maintenance organization insurer has agreed, in a contract with the provider of the health care, to pay the provider for that health care.

(1m) **IMMUNITY OF MEDICAL ASSISTANCE RECIPIENTS.** An enrollee, policyholder or insured under a policy issued by an insurer to the department of health services under s. 49.45 (2) (b) 2, to provide prepaid health care to medical assistance recipients is not liable for health care costs that are covered under the policy.

IMMUNITY FOR CERTAIN MEDICARE RECIPIENTS. An enrollee, policyholder, or insured under a policy issued by an insurer under Part C of Medicare under 42 USC 1395w-21 to 1395w-28 or Part D of Medicare under 42 USC 1395w-101 to 1395w-152 to provide prepaid health care, fee-for-service health care, or drug benefits to enrollees of Part C or Part D of Medicare is not liable for health care costs that are covered under the policy.

PROHIBITED RECOVERY ATTEMPTS. No person may bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee, policyholder or insured, or any person acting on their behalf, for health care costs for which the enrollee, policyholder or insured, or person acting on their behalf, is not liable under sub. (1), (1m), or (1p).

DEDUCTIBLES, COPAYMENTS AND PREMIUMS. Subsections (1) to (2) do not affect the liability of an enrollee, policyholder or insured for any deductibles, copayments or premiums owed under the policy or certificate issued by the health maintenance organization insurer or by the insurer described in sub. (1m) or (1p).

Liability Insurance

Health insurance contracts will address liability coverage. In most cases, it is likely LHD coverage is through the city or county (**Appendix 11**). For most insurance companies, their limits are based on a physician's coverage – since that is whom they deal with the most. There is a statutory requirement⁴, which mandates coverage requirement of at least \$1 million per occurrence and \$3 million in the aggregate per year to be licensed in Wisconsin. This is what most insurers in this state will require of whatever policy is covering the LHD.

Timely Filing

All insurers have timely filing clauses that define how long a provider has to submit a claim for reimbursement. Some include the time period in their contract process and others publish it.

Commercial

Payers determine their own filing limits. (see **Appendix 12**)

Medicare

To be eligible for Medicare reimbursement⁵, providers must file claims within a qualifying time limit. On March 23, 2010, President Obama signed into law the Affordable Care Act (ACA), which amended the time for filing Medicare fee-for-service (FFS) claims. Under the new law, providers must file claims for services furnished on or after January 1, 2010, within one calendar year of the date of service.

⁴ WI Statute § 655.23

⁵ <http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol3/pdf/CFR-2009-title42-vol3-sec424-44.pdf>

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Medicaid

While ForwardHealth recommends that providers submit claims at least on a monthly basis, the following are the time limits posted on the website under Topic 547, Submission Deadline:

- Standard Claims - This deadline applies to claims, corrected claims, and adjustments to claims.
- Crossover Claims - Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received within 365 days of the DOS or within 90 days of the Medicare processing date, whichever is later. This deadline applies to all claims, corrected claims, and adjustments to claims.

Coding Edits

CMS developed the National Correct Coding Initiative (NCCI or CCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the *National Correct Coding Initiative Coding Policy Manual for Medicare Services* (Coding Policy Manual). The current manual states the following regarding immunizations:

Chapter XI - Medicine, Evaluation and Management Services (CPT Codes 90000 - 99999)

12. Administration of influenza virus vaccine, pneumococcal vaccine, or hepatitis B vaccine is reported with HCPCS codes G0008, G0009, or G0010 respectively. Administration of other immunization(s) not excluded by law is reported with CPT codes 90460-90461 or 90471-90474 depending upon the patient's age and physician counseling of the patient/family. Based on CPT instructions a physician should report administration of all immunizations other than influenza, pneumococcal, or hepatitis B vaccines on a single date of service from either of these two code ranges and should not report a combination of CPT codes from the two code ranges.

13. Similar to drug and chemotherapy administration CPT codes, CPT code 99211 (evaluation and management service, office or other outpatient visit, established patient, level I) is not separately reportable with vaccine administration HCPCS/CPT codes 90460-90474, G0008-G0010.

There are also commercial software applications available that apply the NCCI edits, as well as other standard coding rules.

Commercial

Commercial insurers tend to use commercial software packages for code editing. When negotiating your contract make sure any editing rules they apply are defined and should include the publisher, product, edition, and release number of any commercial source (book, file, or software application). Also, ask them to explain what specific edits they will be applying to immunization codes.

Medicare

Each Medicare carrier has installed set "edits" in their claims processing system to identify and eliminate the incorrect billing of medical services.

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Medicaid

ForwardHealth is required to implement the NCCI⁶ in order to monitor all professional claims submitted with CPT or HCPCS procedure codes for reimbursement under Wisconsin Medicaid and/or BadgerCare Plus. Compliance is reviewed for the following NCCI edits:

- Medically Unlikely Edits, or units-of-service detail edits.
- Procedure-to-procedure detail edits.

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by McKesson ClaimCheck[®] and in ForwardHealth interChange. (see Topic 11537 on ForwardHealth website)

Reimbursement

There are many different reimbursement methodologies used in healthcare payments. The most commonly used methods are defined below. In all cases, payment is always the lessor of the billed charge or the “allowed charge”.

Fee for Service (FFS)

The provider sets a fee (charge) for each service based on either a CPT or HCPCS code. The payer processes each service line on the claim and applies any deductible or other copayments prior to paying the service. Under this method, patients can pay the provider directly and submit the claim to their insurer for reimbursement. This is no longer a standard method since there was no way to cap payments as providers raised their fees.

Discounted Fee-for-Service

Works the same as FFS, but the payer does not usually pay the billed charge. Instead, a discount is taken, often based on a one of the following.

- Usual customary and reasonable charges (**UCR**): Calculated as the most common charge for a particular medical service when rendered in a particular geographic area. Based on retrospective review of all claims.
- Customary, prevailing and reasonable (**CPR**): Payment for a service is limited to the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge for the service (75 percent of other providers), or (3) the prevailing charge (lowest) for that service in the community—based on retrospective review of all claims. This was used by Medicare prior to 1997.
- Medicare Resource-Based Relative Value Scale (**RBRVS**): Enacted by Congress as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). The calculation is based on objective measures of a physician’s work:
 - 1) Physician Work
 - a) Time, technical skill and effort, mental effort and judgment, and stress to provide a service.
 - b) 48 percent of total
 - c) Updated annually
 - 2) Practice Expense
 - a) Non-physician clinical and nonclinical labor of the practice, as well as expenses for building space, equipment, and office supplies.
 - b) 48 percent of total
 - 3) Malpractice Expense
 - a) Cost of malpractice insurance premiums.
 - b) 4 percent of total

⁶ National Correct Coding Initiative <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>

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- 4) Geographic Practice Cost Indices (**GPCI**): Geographic Practice Cost Indices account for the geographic differences in the cost of practice across the country. CMS calculates an individual GPCI for each of the RVU components—physician work, practice expense and malpractice. GPICs are reviewed every three years.
- 5) Conversion Factor (**CF**): The conversion factor converts the relative value units into an actual dollar amount. The dollar multiplier (CF) is updated on an annual basis according to a formula specified by statute, but CMS has the authority to override it.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	
HCPCS CODE	SHORT DESCRIPTION	CARRIER LOCALITY - LEADING ZERO* DROPPED	LOCALITY TRANSLATED	NON FACILITY PRICE	CONVERSION FACTOR	GPCI WORK	GPCI Practice Expense	GPCI Malpractice	WORK RVU	FULLY IMPLEMENTED NON-FAC PE RVU	MP RVU	CALCD RVU	CALCD RVU * CONVERSION FACTOR	
2	99211	Office/outpatient visit est	95100	WI	\$19.70	34.023	1	0.96	0.547	0.18	0.41	0.01	0.57907	19.701699
3	99211	Office/outpatient visit est	95212	E. St. Louis	\$19.84	34.023	1	0.936	1.934	0.18	0.41	0.01	0.5831	19.838811
4	99211	Office/outpatient visit est	95215	Chic Suburbs	\$21.81	34.023	1.025	1.072	1.706	0.18	0.41	0.01	0.64108	21.811465
5	99211	Office/outpatient visit est	95216	Chicago	\$21.68	34.023	1.03	1.051	2.077	0.18	0.41	0.01	0.63708	21.675373
6	99211	Office/outpatient visit est	95299	rest of IL	\$19.26	34.023	1	0.909	1.336	0.18	0.41	0.01	0.56605	19.258719
7	99211	Office/outpatient visit est	110203	Napa	\$24.00	34.023	1.051	1.248	0.456	0.18	0.41	0.01	0.70542	24.000505
8	99211	Office/outpatient visit est	110205	San Fran	\$25.71	34.023	1.072	1.36	0.516	0.18	0.41	0.01	0.75572	25.711862
9	99211	Office/outpatient visit est	110206	San Mateo	\$25.63	34.023	1.072	1.354	0.516	0.18	0.41	0.01	0.75326	25.628165
10	99211	Office/outpatient visit est	110207	Oakland	\$24.15	34.023	1.058	1.254	0.516	0.18	0.41	0.01	0.70974	24.147484
11	99211	Office/outpatient visit est	110209	Santa Clara	\$25.42	34.023	1.077	1.337	0.516	0.18	0.41	0.01	0.74719	25.421645
12	99211	Office/outpatient visit est	110299	rest of CA	\$21.59	34.023	1.024	1.085	0.547	0.18	0.41	0.01	0.63464	21.592357
13	99211	Office/outpatient visit est	119217	Ventura	\$23.18	34.023	1.034	1.193	0.605	0.18	0.41	0.01	0.6813	23.17987
14	99211	Office/outpatient visit est	119218	Los Angeles	\$22.66	34.023	1.036	1.154	0.642	0.18	0.41	0.01	0.66604	22.660679
15	99211	Office/outpatient visit est	119226	Anaheim	\$23.61	34.023	1.044	1.218	0.676	0.18	0.41	0.01	0.69406	23.614003
16	99211	Office/outpatient visit est	119299	rest of CA	\$21.59	34.023	1.024	1.085	0.547	0.18	0.41	0.01	0.63464	21.592357
17	99211	Office/outpatient visit est	120201	Hawaii/Guam	\$22.46	34.023	1	1.154	0.7	0.18	0.41	0.01	0.66014	22.459943
18	99211	Office/outpatient visit est	130200	NV	\$21.30	34.023	1	1.058	1.232	0.18	0.41	0.01	0.6261	21.3018
19	99211	Office/outpatient visit est	210201	DE	\$24.30	34.023	1.5	1.067	0.661	0.18	0.41	0.01	0.71408	24.295144
20	99211	Office/outpatient visit est	310200	AZ	\$20.11	34.023	1	0.978	1.015	0.18	0.41	0.01	0.59113	20.112016
21	99211	Office/outpatient visit est	1010200	AL	\$18.53	34.023	1	0.878	0.474	0.18	0.41	0.01	0.54472	18.533009
22	99211	Office/outpatient visit est	1020201	GA	\$20.62	34.023	1.002	1.015	0.949	0.18	0.41	0.01	0.606	20.617938
23	99211	Office/outpatient visit est	1020299	GA	\$18.97	34.023	1	0.898	0.928	0.18	0.41	0.01	0.55746	18.966462
24	99211	Office/outpatient visit est	1030235	TN	\$18.83	34.023	1	0.898	0.523	0.18	0.41	0.01	0.55341	18.828668

Figure 3 - 2013 Sample of Medicare Fee Schedule

Fee Schedule

A fee schedule is a predetermined list of fees that the payer allows for payment for each healthcare service. The **allowable fee** represents the average or maximum amount the payer will reimburse providers for the service. Payers generally have limited sets of codes on a fee schedule. For instance, a cardiology specialty schedule will have all the cardiology codes along with some general evaluation and management (E&M) codes, as opposed to a PCP specialty that would have E&M codes and minor procedures done in an office setting. Any other codes will either fall to a percentage discount or are not covered. This should be clearly defined.

Capitation

This method reimburses providers a fixed, per capita amount for a period. “Per capita” means “per head” or “per person.” A common phrase in capitated contracts is “per member per month” (PMPM). The PMPM is the amount of money paid each month for each individual enrolled in the health insurance plan. There can also be outlier services that have been pre-determined to be paid outside of the capitation. This method requires patient enrollment with a specific PCP. Example: PCP with 100 members at \$20 PMPM would be paid \$2,000 per month in revenue whether they provide complex care or just give the patient an immunization.

Commercial

Most LHD’s will probably be offered a certain percentage off from billed charges or an RVU based fee schedule. A capitation would not likely be offered because the patient population of an LHD cannot easily be defined.

New Vaccines

Some managed care organizations pay for immunizations on a separate fee schedule.

Reimbursement should be at least at the level of practice costs. In situations where the price of the

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vaccine increases, or a new vaccine is introduced during the contract period, be sure the contract addresses how those services will be reimbursed.

Medicare

The general formula for calculating Medicare allowed amounts for 2013 (see **Figure 3** above) is expressed as:

$$\begin{aligned} & \text{Work RVU} \times \text{Work GPCI} \\ & + \text{Practice Expense RVU} \times \text{Practice Expense GPCI} \\ & + \text{Malpractice RVU} \times \text{Malpractice GPCI} \\ & = \text{Total RVU} \\ & \times \text{Conversion Factor (CY2013 = \$34.023)} \\ & = \text{Medicare Payment} \end{aligned}$$

Medicaid

States may develop their payment rates based on:

- The costs of providing the service
- A review of what commercial payers pay in the private market
- A percentage of what Medicare pays for equivalent services

Payment rates are often updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate.

In Wisconsin, per topic 517 on ForwardHealth, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-program patients. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

For services requiring a member copayment, providers should still indicate their usual and customary charge. The copayment amount collected from the member should not be deducted from the charge submitted. When applicable, ForwardHealth automatically deducts the copayment amount.

Coordination of Benefits (COB)

Coordination of benefits is a process that guarantees that when there are two *similar* (e.g., health) policies covering one person, the full payment does not exceed the billed charges. While the COB methodology can vary from payer to payer and can be very complex, (see **Appendix 13**). In its simplest form, the primary payer reimburses to the limits of the plan's coverage for a specific benefit, and then the secondary payer pays any remaining balance. Medicaid and TRICARE are always considered "payers of last resort" and will never be the primary payer. (See **Section 6 – Eligibility and Coverage**).

Commercial

Not all types of insurance plans are coordinated when paying benefits. The following types of plans are usually considered in the COB process:

- Group and non-group insurance contracts and subscriber contracts;
- Group-type contracts;
- Medical care components of long-term care contracts, such as skilled nursing care;
- Medicare or other governmental benefits, as permitted by law, and

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- The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts.

The following plan types are usually not coordinated with a health plan:

- Hospital indemnity coverage benefits or other fixed indemnity coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- School accident-type plans that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis;
- Benefits provided in long-term care insurance policies for non-medical services;
- Medicare supplement policies.

If children are covered under both parents’ separate policies, the most common industry standard is to apply the *Birthday Rule*.

Birthday Rule: According to the National Association of Insurance Commissioners (NAIC), the health plan of the parent whose birthday comes first in the calendar year is designated as the primary. The year of birth is not a factor. For instance, if your birthday is March 27, 1952, and your spouse’s is October 31, 1950, your health plan would be considered primary because your birthday is first in the calendar year. Exception: If both parents happen to have the same birthday, the plan that has covered a parent longer pays first.

Medicare

Medicare has developed the following chart to assist in COB with its plan.

If you have retiree insurance (insurance from former employment)...	Medicare pays first.
If you’re 65 or older, have group health plan coverage based on your or your spouse’s current employment, and the employer has 20 or more employees ...	Your group health plan pays first.
If you’re 65 or older, have group health plan coverage based on your or your spouse’s current employment, and the employer has less than 20 employees ...	Medicare pays first.
If you’re under 65 and disabled, have group health plan coverage based on you or a family member’s current employment, and the employer has 100 or more employees ...	Your group health plan pays first.
If you’re under 65 and disabled, have group health plan coverage based on you or a family member’s current employment, and the employer has less than 100 employees ...	Medicare pays first.
If you have Medicare because of End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)...	Your group health plan will pay first for the first 30 months after you become eligible to join Medicare. Medicare will pay first after this 30-month period.

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Medicaid

49.67, 6) COORDINATION OF BENEFITS.

(a) *May not exceed benefits under other plan.* The benefits covered under the plan under this section may not exceed the benefits covered under the health care benefit plan under s. 49.45 (23).

(b) *Coordination of benefits.*

1. Benefits under the plan under this section shall not include any charge for care for injury or disease for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, for which benefits are payable under a worker's compensation or similar law, or for which benefits are payable under another policy of health care coverage, Medicare, or any other governmental program, except as otherwise provided by law. If an individual who has coverage under the plan under this section also has coverage under the plan under subch. II of ch. 149, benefits under the plan under this section are secondary to the benefits provided under the plan under subch. II of ch. 149.

2. The department is subrogated to the rights of an individual with coverage under the plan under this section to recover special damages for illness or injury to the individual caused by the act of a 3rd person to the extent that benefits are provided under the plan.

Renewal Clause

The renewal clause should be reviewed to make sure it is specific or if the payer is using the “evergreen clause.” This type of clause states that the contract is automatically renewed at the end of the current term, unless the contract is terminated. This is not a favorable clause to providers as it precludes any ability to re-negotiate terms.

Miscellaneous

Directory Publication

Most payers will want to list their providers in a directory. They will have some sort of marketing clause that may read as follows:

Provider Listings: Plan **will list** LHD as provider. LHD **may/will list** Plan in listing of plans in which it participates. No other use of LHD name without LHD’s prior written consent.

Marketing Plan will **promote** LHD to the same extent it promotes other participating providers.

It is important for the LHD legal counsel to consider two other issues that might be in conflict with such a contractual item.

The LHD might avoid both of these issues if it requests that it **not** be listed in the directory.

Own Use⁷

The first is the concept of “own use.” If the LHD purchases vaccine from the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP), it is subject to the concept of “own use,” which essentially means you may not “compete” with other providers who are not able to obtain the same discounts on vaccine that a government entity will receive. MMCAP states the following:

“All items acquired by participating facilities under MMCAP must be purchased for consumption in traditional governmental functions and *not for the purpose of competing* against private enterprise. All purchases must comply with the requirements of **Portland and Jefferson** and **the applicable MMCAP contract.**”

⁷ <http://www.mmd.admin.state.mn.us/MMCAP/background/OwnUse.aspx>

Section 3 – Participating Provider Agreements

NCQA

The second area of potential conflict comes into play if the payer is NCQA accredited. NCQA only requires credentialing if the health plan is “directing” members to see providers (e.g., including a provider in the Provider Directory). If you request the payer not to include your LHD in their directory, that issue is resolved. Payers routinely honor requests to omit providers from directories, while still reimbursing those providers as in-network.

Silent PPO

A silent PPO describes an arrangement where one organization buys or uses a discounted rate for services from a health provider or practitioner without the provider’s authorization. The LHD signs a contract giving a discount to certain payers and suddenly additional payers, who were not intended recipients of the discount, are discounting their payments. Silent PPOs are not good for the LHD because there is no formal agreement with the other entity, and the LHD is not consulted on their participation in the other plan.

It is important to carefully review payer contracts to ensure there are no provisions that allow them to transfer or assign benefits to another health plan. Review explanation of benefits (EOB) to identify whether unapproved discounts have been taken by non-participating health plans.

Wisconsin Statute

INS 9.40 Required quality assurance and remedial action plans

(17) "Silent provider network" means one or more participating providers that provide services covered under a defined network plan where all of the following apply:

- (a) The insurer does not include any incentives or penalties in the defined network plan related to utilization or failure to utilize the provider.
- (b) The only direct or indirect compensation arrangement the insurer has with the provider provides for compensation that is:
 - 1. On a fee for service basis and not on a risk sharing basis, including, but not limited to, capitation, withholds, global budgets, or target expected expenses or claims;
 - 2. The compensation arrangement provides for compensation that is not less than 80% of the provider's usual fee or charge.
- (c) The insurer, in any arrangement described under par. (b), requires that the reduction in fees will be applied with respect to cost sharing portions of expenses incurred under the defined network plan to the extent the provider submits the claim directly to the insurer.
- (d) The provider is not directly or indirectly managed, owned, or employed by the insurer.
- (e) The insurer does not disclose, market, advertise, provide a telephone service or number relating to, or include in policyholder or enrollee material information relating to, the availability of the compensation arrangement described under par. (b), or the names or addresses of the provider or an entity that maintains a compensation arrangement described under par. (b), except to the extent required by law in processing of explanation of benefits. The insurer may not indirectly cause or permit a prohibited disclosure and may not make any such disclosure in the course of utilization review or pre-authorization functions.

