



CONTRACT REVIEW

2010 BLUE CROSS BLUE SHIELD OF MINNESOTA AWARE PROVIDER SERVICE AGREEMENT

In this document, we provide a summary of the changes made to the Blue Cross and Blue Shield of Minnesota (BCBS) 2010 Aware Provider Service Agreement (Agreement). Please note that this summary is not intended to be a comprehensive legal analysis, and it 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 alternate terms of the Agreement, you will need to contact your own attorney, accountant or consultant.

There are many clarifications and changes in the 2010 Agreement, and some are significant. We urge our members to review all of these changes carefully as some may merit contractual negotiations.

This Agreement will become effective when accepted and signed by Blue Cross. It will automatically renew for one-year terms commencing on July 1 for each subsequent renewal term. The Agreement incorporates the provisions of your original signed Agreement, all renewal amendments to date, and all other items that fall under the revised definition of “Agreement” in Article II. Providers are

encouraged to review that definition for a comprehensive list of what is included.

Either party may elect to terminate the Agreement without cause by providing written notice to the other party. The termination will become effective 130 days after the receipt of the written notice. (III. B. 1.)

Changes in the 2010 Agreement are as follows:

Definitions

The definition of “Agreement” was expanded to include signature pages; fee schedules as maintained by Blue Cross; the attached 2010 version of the Amendment to the Agreement on Medicare Programs; any and all existing Rules and Regulations previously issued by Blue Cross; any and all Exhibits to the Agreement issued by Blue Cross; the provisions of the Blue Cross and Blue Shield of Minnesota Credentialing Policy Manual Series 800; the Addendum for Recognizing Excellence Initiative; any other Addenda subsequently executed by the Parties. (II. B.)

The definition of “Blue Cross” was amended to include “one or more” of its Affiliates, and grants those Affiliates “entitle(ment) to receive and enjoy the

same rights and benefits that Blue Cross and Blue Shield of Minnesota receives and enjoys under this Agreement.” (II. C.)

The definition of “Concurrent Review” was added. (II. D.) This definition refers to “ongoing review” during an inpatient admission to ensure that the Subscriber’s care meets established medical criteria in a timely manner, and certifies the necessity, appropriateness and quality of services being provided.

The definition of “Health Care Professional” was revised to no longer include Providers (the term “Providers” now has its own definition). Health Care Professionals now are limited to employees or independent contractors of the Provider. Providers are encouraged to watch for areas within the Agreement that refer to Health Care Professionals but do not mention Providers because the applicability of those sections of the Agreement to Providers has now changed. (II. E.)

The definition of “Health Service” was expanded to include health care services, products, procedures, or items provided to a Subscriber even when they are not

covered under the Subscriber Contract. (II. F.)

The definition of “Minnesota Senior Health Options” now provides a statutory reference (Minn. Stat. § 256B.69, subd. 23) and states that, “MSHO includes Elderly Waiver services for enrollees who qualify, and one hundred eighty (180) days of nursing facility care.” (II. L.)

The definition of “Preferred Provider Benefit Plans” from the former Agreement was deleted. It referred to benefit plans under which Subscribers received higher levels of coverage for services received from preferred providers. (Formerly in II.O.)

The definition of “Pre-certification” was added. (II. O.) Pre-certification refers to a review that takes place in advance of a proposed facility admission, services or procedures. The review is used to determine whether the proposed care meets the Medical Necessity criteria for payment, and to ensure that the Subscriber receives maximum benefits available under his/her plan.

The definition of “Provider” was added (note that this term was formerly included under the definition of Health Care Professional). (II. Q.)

The definition of “Regular Billed Charges” was added. (II. R.) This definition says, “‘Regular Billed Charges’ means the schedule of regular billed charges of Provider for Health Services, provided that in no event shall Regular Billed Charges be higher than the charges for the same Health Services provided to any patient who is not a Subscriber.” This requirement appears to conflict with Minnesota Statute § 62A.64 (2) which says that, “An agreement between an

insurer and a health care provider may not...require ... the provider to accept a lower payment in the event the provider agrees to provide services to any other insurer or pay or at a lower price.”

As a result of MMA concerns as to the apparent illegality of this provision relative to Minnesota’s law prohibiting so-called “most-favored nation” clauses, BCBS has agreed not to enforce this provision as written. BCBS intends to clarify their specific intent, which is that physicians would charge Blue Cross no more than what private pay patients are charged, in an update to next year’s contract.

The definition of “Special Needs Basic Care” was revised to include a statutory reference (Minn. Stat. 256B.69, Subd. 28).

Authority and Covenants

Claim Submission. The time Providers must submit claims from the date of service has been reduced to six months (formerly, Providers had 12 months). (III. C.). This change is consistent with state law.

Blue Cross has stated that “Upon reasonable advance written notice to Provider, (It) may either prohibit submission of paper claims or Blue Cross may charge Provider for processing paper claims.” (III. C.) Minnesota state law currently requires electronic claims submission consistent with standards defined in the Minnesota Uniform Companion Guides (see: www.health.state.mn.us/auc for more information).

Additional Information. Providers are now required to furnish at their own expense any information needed by Blue Cross to perform Precertification re-

views, preadmission notification, prior authorizations, and Medical Necessity reviews as well as any authorization required to release such information as requested by Blue Cross. (III. D.)

Clinical Coding Requirements. In addition to the coding rules of CPT and ICD-9-CM, and HCPCS, the Agreement states that Providers are required to comply with the Clinical Coding Requirements of the Minnesota Department of Health Uniform Companion Guides, including any updates or changes to such coding rules and/or guides as applicable “and as interpreted by Blue Cross,” (vague terminology). (III. E.) The Uniform Companion Guides may be viewed at: <http://www.health.state.mn.us/auc/guides.htm>

Medical Records. Consistent with CMS requirements, the number of years that Providers are required to maintain Subscriber medical records was reduced from eleven to ten years. (III. F.)

Provider Bulletins. Policies, procedures and requirements relating to the Agreement will be communicated to Providers via Provider Bulletins. Blue Cross has clarified this section to say that it will provide Providers 90 days’ advance written notice from the date of publication on <http://www.bluecrossmn.com> of any new Provider Bulletins. (III. G.) Blue Cross has stated that the policies, procedures and requirements will become effective 90 days after the publication date, unless otherwise required by law.

Quality Improvement/Managed Care Requirements; Nondiscrimination. Blue Cross has added additional examples to this section of the types of quality improvement and care management requirements and procedures that Providers must comply with including the

completion of Pre-certification reviews and utilization reviews. (III. I.)

Blue Cross deleted the Patient Safety Policies section of its Agreement which talked about patient safety measures and standards that Providers were required to implement and follow. (Formerly, III. J.) Blue Cross has stated that the Patient Safety Policies section will be located in the Policy and Procedure Manual. No changes will be made to the content.

Provider Payment

Payment Amount. If Providers begin billing for a new Health Service (e.g., a newly accepted medical practice, new technology, or new services for practice), they must provide Blue Cross 90 days advance written notice prior to submitting claims or billing for any such new service. (IV. A.) This language is very broad. Providers are encouraged to seek clarification to better define the scope of these requirements. Blue Cross has stated that the Policy and Procedure Manual will provide greater guidance on new Health Services, too.

Negligence, Omission or Error. This section refers to times in which no payment shall be made by Blue Cross or the Subscriber. Note: the terms “Negligence, Omission and Error” are not defined in the Agreement and could be interpreted very broadly. Starting in 2008, The MMA, EMMS, WMMS, and MMGMA worked with Blue Cross to clarify this language. Although these terms were still not defined in the 2009 Agreement, Blue Cross stated that, “The National Quality Forum has defined certain events as serious preventable medical errors and these are the situations for which no payment shall be made by Blue Cross or the Subscriber. A listing of these events can be found at [\[tyforum.org\]\(http://www.quali-forum.org\). This listing will be updated periodically by the National Quality Forum.” \(Formerly, section IV. A.\) With this year’s Agreement, Blue Cross is supplying the list of situations in which no payment shall be made in its Provider Policy & Procedure Manual. \(IV. C.\) Blue Cross has said that although the Provider Policy & Procedure Manual has not yet been updated, it will include the National Quality Forum Never Events and refer to the Adverse Health Event Best Practices written by the Administrative Uniformity Committee. See: <http://www.health.state.mn.us/auc/bstprac06.pdf> Providers are strongly encouraged to review those lists.](http://www.quali-</p>
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Minnesota Health Care Programs. For health services provided to Minnesota Health Care Programs Subscribers, Blue Cross will pay Provider at the lesser of 90% of Provider’s Regular Billed Charge or 103% of the applicable public program fee schedules as published by the Minnesota Department of Human Services and as determined by Blue Cross (vague). (IV. D.) Note that this rate is unchanged from last year.

CPIU Payment Increase. The CPIU Maximum Increase is now the lesser of 3.0% (formerly, 3.5%), or the percent change between the June CPIU index level of the previous year’s data and the June CPIU index level of the current year’s data. (IV. E.) Note that in past years, the range of CPIU has been above 3.5% and below 0% (negative).

MinnesotaCare Tax. Blue Cross has provided clarification on how it will compensate Providers subject to the MinnesotaCare Tax. Blue Cross will add the amount representing the tax to services paid based upon a fixed fee method (e.g. BCBS fee schedule, per diem rates, and per case amounts). Blue Cross will not

increase its payment for amounts billed for services paid at Regular Billed Charge or a percentage of Regular Billed Charge amounts, as those amounts are already deemed to include the tax amount. (IV. F.)

Overpayments. Requests by Blue Cross or Provider for corrective adjustments due to overpayments must be made within 12 months (formerly, 15 months) from the date the claim for such services were paid or denied by Blue Cross. This change is consistent with a newly-enacted Minnesota law (MN Session Laws 2010, Chapter 331)

Blue Cross has also amended the Agreement to say that it may offset the claims for covered services by using a “statistically valid sample” (the source of which is not identified) when determining overpayment amounts, and that Provider cannot bill Subscriber for the balance on the claim amounts. (IV. I.) Blue Cross has stated that greater detail on the on the recovery and payment process can be found in the Policy and Procedure Manual, once it is updated. Providers are encouraged to seek up-front clarification on this.

Subscriber Hold Harmless. Under the Agreement, Providers may not bill, charge, collect a deposit from, seek remuneration from or have recourse against Subscribers for Health Services except for copayment amounts and applicable deductible and coinsurance amounts. (IV. L.)

A provision was also added that states that Providers may not charge Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC) Subscribers coinsurance or copayment

amounts that would exceed the amounts permitted under Medicaid. (IV. L.)

Applicability

Scope of the Agreement. A new provision was added whereby Health Services provided to Subscribers enrolled in benefit plans that are either underwritten or administered by other Blue Cross Plans are entitled to the rights and privileges of that agreement where applicable, except that this Agreement controls for Health Services that are provided to a Subscriber in MN or in a county of Iowa, ND, SD, or WI that is directly adjacent to MN. (V. A. 2.)

Blue Cross deleted the provision requiring it to provide Provider with 90 days' notice for modifications either in the reimbursement method or amount to be paid to the Provider, or other material impacts on the Provider's obligations under the Agreement, when Provider and a Blue Cross Affiliate enter into a separate agreement. (Formerly, V. A. 4.)

Provider Participation Requirements

Health Care Professionals Exempt from Credentialing. The Provider is now responsible for verification that Health Care Professionals hold and maintain minimum malpractice coverage appropriate to their scope of practice at least \$1 million per incident (formerly the requirement was limited to \$1 million per incident), except where the Health Care Professional is covered by a state or federal Tort Claim Liability statute. (VI. D.)

Termination. If Provider is determined by DHS to be out of compliance with Minnesota Statutes or laws, the Provider is required to notify Blue Cross immediately (presumably according to the notice requirements in X. I. D). The

Agreement now states that the termination shall be effective as of the first date of non-compliance. (VIII. B. 5.)

Notification Upon Termination. For MN Advantage Health Plan Subscribers, all the terms of the Agreement will continue until the end of the current calendar year (Note: not one year from the date the Agreement was signed) even if the Agreement terminates during the calendar year. (VIII. C.)

Arbitration. Blue Cross has added new terms to the arbitration clause. It states that, "Disputes or controversies related to the Agreement must be commenced within two years of the expiration or termination of the effective date of the Agreement, without regard to any other limitations period set forth by law or statute . . . Parties agree to exhaust all avenues of review and appeal prior to pursuing arbitration." (VIII. D.) It is not clear how a disputing party would begin the review process, or what avenues of appeal exist prior to commencing arbitration. This provision also waives parties' rights to having a longer period of time which they might otherwise be entitled to by law to resolve the matter either via arbitration or other means.

The Agreement requires the expenses and fees of the sole arbitrator and of the arbitration proceedings to be shared equally by each of the Parties. (VIII. D.) Formerly, Blue Cross agreed to pay all expenses and fees related to the arbitration if the Provider prevailed in the arbitration. (Formerly, VIII. D.)

Appeals decisions involving medical necessity or provider credentialing for which arbitration is pursued will be overturned or modified only if the arbitrator determines that the decision of the appeals panel or reviewer was "arbitrary

or capricious" (these terms are very narrow). This does not apply for medical necessity reviews as detailed in Minnesota's Utilization Review laws. (VIII. D.)

Parties do not have a right to arbitration where those rights have been waived or another review process has been agreed to (presumably, by signing a different Agreement). (VIII. D.)

Complaint and Inquiry Procedures

Provider's Responsibilities. Provider is now required to inform Blue Cross of all Subscriber complaints received by Provider immediately (the amount of time that Provider had to notify Blue Cross about complaints was not specified in previous Agreements). (IV. A.) Presumably, the type of notice required is as set forth in XI.D.

Confidentiality; Non-Interference

HIPAA Compliance. References to the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") were added to the Agreement. (X. C.)

Providers are required to notify Blue Cross of the discovery of disclosures of Protected Health Information ("PHI") within five days of the discovery. (Formerly, Providers were required to report disclosures "at least monthly"). (X. C. 6.)

Providers are required to cooperate with Blue Cross in investigating the disclosure and in meeting Blue Cross' obligations under HIPAA regulations and the HITECH Act. A list of the new items Providers are required to report in the event of a disclosure can be found on Page 24 of the Agreement. (X. C. 6.) The items in

the list are substantially similar to those listed in the federal laws.

Non-Interference. This clause was clarified to state that Providers may not disclose proprietary information such as specific financial or other terms of this Agreement “unless expressly authorized by Blue Cross in writing signed by an officer of Blue Cross,” or required by law. (X. E.)

Miscellaneous

Transplant Services. This new provision states that with the exception of kidney and cornea transplants, this Agreement does not apply to any transplant services unless a separate agreement is fully executed between Blue Cross and the Provider. (XI. A.)

Notices. Information on how Providers may update their contact information with Blue Cross was clarified. (XI. D.)

It is unclear when notices will be deemed effective. According to last year’s Agreement, they were effective on the third day following the date they were deposited in the mail or the date they were sent via email unless otherwise specified. (Formerly, XI. C.)

Force Majeure. In the event that pandemic influenza or other pandemic is declared by the U.S. Government or the World Health Organization, Blue Cross has the right to extend the term of the Agreement until 90 days after the pandemic has been declared over. Providers may no longer terminate the Agreement prior to the expiration of the 90-day period. (XI. I.) Note: depending on when the U.S. Government or the World Health Organization declared the pan-

demical over, this Agreement could extend a very long time.

Waiver. Waivers of or to the Agreement will only be deemed valid if in writing and signed by the Party to be charged with the waiver. (XI. J.)

The clauses titled, “Ambiguities,” “Survival,” “Cumulative Rights,” and “Headings” were added. (XI. J., K., L., M., and N.)

Note that clause K on Ambiguities states that, “Each Party has participated fully in the review and revision of this Agreement and has had the opportunity to review said Agreement with such Party’s legal counsel. Any rule of construction to the effect that ambiguities are to be resolved against the drafting Party shall not apply in interpreting this Agreement.” When interpreting ambiguous contractual language, courts typically favor the party that did not draft the contract. This provision waives that right. Providers are encouraged to have ambiguous contractual language clarified by counsel prior to signing the Agreement.

Provider Reimbursement

Implementation of the 2010 Relative Value Units. Blue Cross has stated that beginning July 1, 2010, it will be using the CMS 2010 Relative Value Units as the basis for allowance creation for professional based services. To see the final rule implemented by CMS regarding its payment policies under the physician fee schedule for CY 2010, go to: http://www.federalregister.gov/OFRUupload/OFRData/2010-10814_PI.pdf

Unlisted Injectable Drugs: Injectable drugs that are billed with an Unlisted Code (“Unclassified,” “NOC,” or “NOS”) must include an NDC number

and a description of the drug provided to the patient. Codes that are submitted with an unclassified code will be priced at a percentage of the AWP, as determined by the Blue Cross pricing source. If providers wish to appeal, the provider must submit the actual invoice for the drug that is being appealed (it is not clear how the appeals process works; what other documents would need to be submitted; within what timeframe; or to whom). Blue Cross has stated that submitting an invoice will not guarantee any adjustment or reimbursement.

Unlisted DME Services. DME items that are billed with an Unlisted DME Code, that do not include an invoice, will default to a percentage of the provider billed charges.

Medicare Programs Amendment to the Agreement

Providers are encouraged to read this year’s Medicare Programs Amendment very closely as many formatting and content changes have been made.

Definitions. The definitions section that was in former versions of the Amendment has been deleted. Capitalized terms used in the current version of the Amendment have the meanings assigned to them in the Agreement. (I. C.)

Delegated Activities. This article is new. (II.) It states that Blue Cross will delegate the authority to the Provider to provide services that support Blue Cross’ Minnesota Health Care Programs, MSHO, SNBC and Medicare Advantage products in a manner consistent with federal law requirements.

Accountability. Blue Cross has supplied a link to its website containing the policies and procedures that Providers must comply with:

medicaresolutions.com/for_providers/provider_guide.html (IV.) Providers are encouraged to visit the website to ensure their familiarity with these requirements.

Fraud and Abuse. Requires provider to implement and administer a compliance plan to detect, correct and prevent fraud, waste and abuse as required by federal law¹ and to present any material modifications to such plan to Blue Cross for its approval. (V.B.) Note that the reference to 42 C.F.R. §§ 422.504(b)(4)(vi) is an erroneous citation and it is therefore unclear what Blue Cross' expectations for Providers are.

Excluded Persons. Providers are expected to check the following databases at least monthly to determine whether any existing or prospective employee, director, Health Care professional, other provider, or Medicare and Medicaid subcontractor has been excluded from participation in the Medicare program or any other federal health care program: DHHS Office of Inspector General Exclusion List (<http://www.woig.hhs.gov/fraud/exclusions.html>), General Services Administrations Excluded Parties List System (<http://www.elps.gov/>), and the Healthcare Integrity and Protection Data Bank (<https://www.npdb-hipdb.com>). Providers must notify Blue Cross in writing immediately if participation from the Medicare program is or becomes compromised. (V.C.)

Confidentiality and Accuracy of Records. This article is new. (VI.) It requires provider to treat all health and

enrollment information of Subscribers as confidential and comply with all laws regarding the confidentiality and disclosure of that information. It also requires Provider to maintain the information in an accurate and timely manner, and to ensure timely access to it as stated in the Agreement.

Reporting to Blue Cross. This article is new. Note: it is unclear who (Provider or Blue Cross) would cover the cost of assembling the statistics and other information that Blue Cross requests. (VII.)

Inspection and Audit. Blue Cross has revised this section of the Amendment. Providers are no longer required to permit the National Committee for Quality Assurance ("NCQA") to inspect Providers records pertaining to transactions related to the Agreement. However, Providers are now required to permit direct access of Provider's books, contracts, medical records, patient care documentation, documents, papers and "other records pertaining to any transaction related to the Agreement" (very broad) to DHS, CMS, DHHS, the Comptroller General (formerly, GAO) or their designees. Providers are required to permit Blue Cross or their designees to inspect evaluate and audit the same items as mentioned above with the exception of contracts. Instead of contracts, the Amendment says Blue Cross and its designees shall be allowed to inspect Providers' contacts. Blue Cross has stated that it is a typographical error that will be

corrected in the next contract and possibly a Provider Bulletin as well. (IX.)

Training and Education. This article is new. (X.) Note that this provision requires Providers to have in place, update and administer a customized training and education program regarding compliance with all laws for which Provider has a compliance obligation. Providers must also establish and maintain "Blue Cross-specific training" where appropriate, and provide "attestations of training completion to Blue Cross" upon Blue Cross' request. These requirements are vague; Providers are encouraged to seek further specificity.

Communication with Blue Cross. This article is new. (XI.) Note that the provision requires Providers to communicate with Blue Cross' compliance office and Government Products management team "as reasonably required." It is unclear what information needs to be communicated or how often is "reasonable." This provision also requires that Provider "implement its own business compliance structure and communications process pertaining to the Health Services provided under this Amendment." It references 42 C.F.R. § 423.504(b)(vi)(D) as authority for this requirement, however, this is an invalid citation.

Contracts with Downstream Entities. This Article is new. Providers are encouraged to read it closely, as it details the contractual requirements that apply to Providers' delivery of Health Services. (XII.) Note that unlike last year's

1. Two federal laws are listed in the Amendment: First, 42 C.F.R. §§ 422.503(b)(4)(vi) states: A compliance plan that consists of the following: (A) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards. (B) The designation of a compliance officer and compliance committee that are accountable to senior management. (C) Effective training and education between the compliance officer and organization employees. (D) Effective lines of communication between the compliance officer and the organization's employees. (E) Enforcement of standards through well-publicized disciplinary guidelines. (F) Procedures for internal monitoring and auditing. (G) Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to the organization's MA contract. The second federal law listed in the Amendment is 42 C.F.R. § 422.504(b)(4)(vi): This is an erroneous citation.

Amendment, “First Tier” and “Related Entities” are not included in this provision with Downstream Entities (formerly, B. 12.)

Compensation. There are two new provisions in this section. For Government Subscribers enrolled in any Minnesota Health Care Program, Health Services covered by the applicable Minnesota Health Care Program will be reimbursed at the contracted rates for Minnesota Health Care Programs. (XIII. E.)

Blue Cross has also added that, unless a claim for payment is disputed (It) shall promptly make payment on or provide Provider notice of denial for each clean claim that is timely submitted by Provider for Health Services rendered to a Government subscriber pursuant to Minn. Stat. § 62Q.75 (XIII. G.)

Survival. Blue Cross has expanded its survival clause. Now, the Amendment will continue to apply after the termination of the Agreement “for so long as the Provider performs any Health Services or continuity of care.” (XVI.) Furthermore, Articles I, V, VI, VII, VIII, IX, XI

and XVIII of the Amendment will survive the expiration or the termination of the Agreement and Amendment indefinitely. (XVI.)

Termination. Blue Cross has divided the terms under which the contract may be terminated between Article XIV “Termination of Agreement for Breach” and XVII “Termination of CMS Contract.” It also deleted the former provision in its termination clause that allowed Provider or any of Provider’s Sub-contractors to voluntarily terminate the Amendment and participation in Blue Cross’ Medicare Benefit Program by providing 130 days prior written notice to Blue Cross. (Formerly, D. 1.)

Hold Harmless. Although the title of this article is new, a lot of the provisions in it existed in Section E of last year’s Amendment. New terms in this section provide that after the termination or expiration of this Amendment, Blue Cross will remain liable for payment of Health Services rendered by Provider to a Government Subscriber (other than for applicable co-insurance, deductibles or co-payments) who either retains eligibility or is under

the care of Provider at the time of termination, until the specific Health Services being rendered to the Government Subscriber by Provider are completed, “unless Blue Cross makes reasonable and medically appropriate provision for the assumption of such services by another participating provider” (unclear what criteria would be used to make this determination). (XVIII. C.) It also says that the Health Services and hold harmless obligation shall last throughout the period for which the Government Subscriber’s premium has been paid to Blue Cross by CMS, not to exceed a period of 30 days following termination or expiration of the Amendment (except for those Subscribers who are hospitalized on an inpatient basis). Providers are required to continue to arrange for Health Services to those Government Subscribers who are hospitalized on an inpatient basis “at the time this Amendment is no longer in effect” (unclear) until the applicable Government Agreement either terminates or the Government Subscriber is discharged from the hospital, whichever is earlier. (XVIII. C.)