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# CONTRACT REVIEW

## OF 2011 BCBS 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) 2011 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 you will need to contact your own attorney, accountant or consultant. Blue Cross has indicated that this is a standard provider contract and it will generally not alter it based on provider negotiations.

There are many clarifications and changes in the 2011 Agreement. We urge our members to review them carefully.

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 and all renewal amendments to date. Reviews

of prior years' amendments are available on the MMA website at: <http://www.mnmed.org/KeyIssues/LegalAdvocacy/tabid/2205/Default.aspx>

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. (VIII. B. 1.)

Changes and clarifications in the 2011 Agreement are as follows:

### Definitions

The definition of "Concurrent Review" was expanded to include review of the Subscriber's care of both inpatient and outpatient Health Services. (II. D.) Formerly, it was limited to "inpatient admission" only.

The definition of "Primary Coverage Responsibility" is new and includes all coverage under Blue Cross Subscriber Contracts that are not secondary pursuant to any coordination of benefits, auto

insurance or similar types of provisions. (II.P.)

The definition of "Regular Billed Charges" was amended to say that in no event will Regular Billed Charges be higher than the charges for the same Health Services provided to a private pay patient, to the extent allowed by applicable law." (II. S.) Note: Although the contract was approved by state regulators, The MMA remains concerned about this definition in that it appears to conflict with the requirements of Minnesota Statute § 62A.64 (1) and (2)<sup>1</sup>. Providers are encouraged to consult with their legal counsel and Blue Cross about this provision to ensure compliance.

The definition of "Relative Value Units" (RVUs) is new. RVUs have three components: work expense, practice expense and malpractice expense. They are determined by the resource costs needed to provide the services which is based on

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1. Minnesota Statute Section 62A.64 states in pertinent part:  
HEALTH INSURANCE; PROHIBITED AGREEMENTS.

An agreement between an insurer and a health care provider may not:

1. prohibit, or grant the insurer an option to prohibit, the provider from contracting with other insurers or payors to provide services at a lower price than the payment specified in the contract;
2. require, or grant the insurer an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other insurer or payor at a lower price;

the Resource-Based Relative Value Scale (RBRVS) established by CMS. (II. T.)

The definition of “Utilization Review Process” was revised in 2011 to say that “a person or entity other than the attending Health Care Professional” would evaluate and determine the necessity, appropriateness and efficacy of the provision of Health Services and use of facilities. This amendment was language that had been used in the 2009 BCBS Aware Provider Service Agreement but deleted from the 2010 Agreement. (II. X.)

### Authority and Covenants

**Scope of Health Services.** Providers must now provide “or arrange for the provision of Health Services to Subscribers subject to the terms and conditions of the Subscriber Contract.” (III. A.)

**Verification of Eligibility.** Blue Cross will not pay for Health Services provided to any person who is not a Blue Cross Subscriber “at the time the Health Service was rendered.” (III. B.) This language further clarifies Blue Cross’ prior requirement that Providers verify Subscriber’s eligibility prior to providing Health Services.

**Claim Submission.** The last two sentences of this provision are new. Summarized, they state that once a Provider submits a claim, he/she waives the right to collect for charges not included in that claim as submitted. Further, he/she agrees not to bill Blue Cross for any omitted services, claims or late charges. Note: Providers have 6 months from the adjudication of the original claim to send a replacement claim which would

include any omitted service from that original submission.

Further, Provider may not submit a replacement claim (i.e., a claim with no data changes) in order to extend the 90 days allowed from process date of the claim to the appeal. (III. C.)

**Clinical Coding Requirements.** New language states that the Provider is responsible for obtaining any authorization required to release any information relating to claims submitted for Health Services to Blue Cross and/or the Plan Sponsor. (III. E.)

**Provider Bulletins.** When Blue Cross implements certain policies, procedures and requirements relating to the Agreement, it issues them via Provider Bulletins. **Blue Cross is reducing by half (from 90 to 45 days from the date of publication) the amount of time given to Providers for advance written notice of any changes unless such changes were issued to otherwise comply with a state or federal requirement.** (III. G.) This is consistent with the minimum notice requirement in state law<sup>2</sup>. The written notice will be published at: [http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc\\_bluecrossmn/documents/public/mbc1\\_provider\\_nl.hcst?provider=bull\\_prov&SortField=xgblDate1&SortOrder=desc](http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/mbc1_provider_nl.hcst?provider=bull_prov&SortField=xgblDate1&SortOrder=desc).

**Access to Records.** In addition to allowing Blue Cross to access the treatment and billing records of Subscribers to verify claims information during Provider’s regular business hours, Blue Cross has broadened their scope of access by stat-

ing that it may also access “any aspect of services performed.” (III. H.)

Providers are required to allow other entities access to records, books, documents and papers related to the Agreement. Blue Cross has clarified that state or federal regulatory or governmental agencies include but are not limited to “the State of Minnesota, CMS or the Comptroller General, or their designees.” (III. H.)

**Advance Directives.** This provision is new and may aid in the completion of advance directives by more patients. **Providers must for the first time make information available to Subscribers to aid them in completing an advance directive. Information includes but is not limited to helping Subscribers understand medical terminology, medical care options, and referring Subscribers to appropriate resources such as the Minnesota Department of Health website. Providers must maintain a copy of a Subscriber’s advance directive in the medical record maintained by Provider at the request of the Subscriber.** (III. O.)

### Provider Payment

**Payment Amount.** Providers may request a list of applicable fee schedule allowances up to twice annually. Requests most now be made via e-mail to the following address: [Fee\\_Schedule-Allowance\\_Request@bluecrossmn.com](mailto:Fee_Schedule-Allowance_Request@bluecrossmn.com). (IV. A.)

**Payment Dispute.** If a Provider has a dispute regarding payment by Blue Cross, it must now bring it to Blue Cross’ attention within ninety (90) days of receiving notification of the benefit determination by Blue Cross in order for Blue Cross to

2. Minn. Stat. 62Q.735, Subd. 2(a).

agree to further review of the case. (IV. D.)

**Minnesota Health Care Programs.** Payments for Health Services provided to Subscribers of the Minnesota Health Care Programs must be consistent with Provider's licensure as reported to Blue Cross and as verified with the applicable licensing board. (IV. E.) Blue Cross has stated that this language was added as a clarification on its existing credentialing process.

**Overpayments.** Providers are responsible for promptly reporting and returning overpayments of any kind to Blue Cross. Where overpayments are a result of data incorrectly submitted on a claim for Health Services, Provider must promptly send a replacement claim correcting the data and allowing Blue Cross to recoup the overpayment. (IV. J.) Note: Blue Cross has said that submission of replacement claims is limited to twelve (12) months from last adjudication.

**Quality Care Delivery.** This provision is new. **Providers are required to cooperate with Blue Cross to assure the delivery of quality, medically necessary care to subscribers. They must also assure that no compensation or other incentives exist for the purpose of limiting care delivery.** (IV. K) Note: The MMA is somewhat concerned about the breadth of this language given the new payment models that may shift the risk to physicians and other providers such as Total Cost of Care Agreements. Blue Cross has acknowledged that the language in this

provision may need to evolve as payment models expand.

Provider and Blue Cross decision makers must encourage appropriate utilization, assure measures to prevent under-utilization and overutilization, and discourage inappropriate denials.

Consistent with state law prohibiting financial-based utilization review incentives, the Agreement notes that "no compensation is made for denials of coverage or Health Services." (IV. K.)

**Subscriber Liability.** New language states that Providers must abide by all applicable statutes and requirements including Minn. Stat. 62Q.751<sup>3</sup>. Providers must refrain from charging MSHO (Minnesota Senior Health Options) Subscribers coinsurance or copayment amounts that would exceed amounts permitted under Medicaid. Blue Cross deleted former language that required Providers to refrain from charging individual Subscribers for Health Services prior to submitting the claim to Blue Cross for processing and waiting for Blue Cross to notify the Provider of the appropriate Subscriber liability amount. (IV. M.)

#### **Provider Participation Requirements**

**Excluded Health Care Professionals.** When a Health Care Professional is excluded from participation with Blue Cross, either the affected Health Care Professional or the Provider on behalf of the Health Care Professional, may appeal the exclusion. The appeal process is set forth in the Blue Cross Credentialing Policy manual at: [\[bluecrossmn.com/bc/wcs/groups/bcb-smn/@mbc\\\_bluecrossmn/documents/public/mbc1\\\_credentiaing\\\_policy\\\_manu.pdf\]\(http://www.bluecrossmn.com/bc/wcs/groups/bcb-smn/@mbc\_bluecrossmn/documents/public/mbc1\_credentiaing\_policy\_manu.pdf\). \(VI. C.\)](http://www.</a></p>
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**Participating Provider Availability.** Providers are now required to "ensure that all Health Services provided to Subscribers are furnished by Health Care Professionals participating fully with Blue Cross at the time such Health Services are rendered." (VI. F.) Blue Cross has stated that "fully participating" means that the practitioner performing the service is credentialed and effective under the provider contract. The provider will be able to "ensure" that the practitioner is fully participating when it receives notification from Blue Cross that the practitioner has been added and accepted into the network.

#### **Term; Amendment and Termination; Arbitration**

**Term; Amendments.** **If Blue Cross modifies or amends the Agreement, it will now provide 45 days (formerly 90 days) prior written notice to the Provider.** (VIII. A.) Blue Cross has stated that the notice will be provided either in the Provider Bulletin on the Blue Cross website, or by written document sent to the provider.

**Termination.** New language states that in the event of an uncured material breach, either party may terminate the Agreement. Termination will become effective 130 days after receipt of written notice. The Agreement further states that material failure "may include the Provider not meeting utilization, quality of care, enrollment or other standards established by Blue Cross." This language is very broad. Alternatively, Blue Cross

3. Minn. Stat. 62Q.751 states: A health plan company shall not prohibit providers from collecting deductibles and coinsurance from patients at or prior to the time of service. Providers may not withhold a service to a health plan company enrollee based on a patient's failure to pay a deductible or coinsurance at or prior to the time of service. Overpayments by patients to providers must be returned to the patient by the provider by check or electronic payment within 30 days of the date in which the claim adjudication is received by the provider

has reserved the option to “freeze the enrollment” of the Provider if it is deemed by Blue Cross to be in either its best interests or its Subscriber’s best interest. In determining whether to terminate the Agreement or freeze the enrollment of the Provider, Blue Cross may consider recommendations of the Provider and other appropriate review organizations. (VIII. B. 2.) Blue Cross has indicated that it would only freeze the enrollment of the Provider in very rare circumstances.

**Arbitration.** Any disputes relating to this Agreement must be subject to binding arbitration. Disputes or controversies related to payment for Health Services must begin no later than two years from the date that Provider provided the Health Services (formerly, this was 2 years from the expiration or termination of the date of the Agreement). This time limit does not apply to circumstances where claims adjustments are not limited to 12 months. Note: it is not clear which services are therefore excluded. A list of those claims may be found in the Policy and Procedure Manual: [http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc\\_bluecrossmn/documents/public/post71a\\_082625.pdf](http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/post71a_082625.pdf) . If the source of a dispute or controversy does not involve a payment for a Health Service, then the action must begin within two years of the date on which the Provider’s claim arose. (VIII. D.)

## Miscellaneous

**Provider Acquisitions.** This provision is new. If a Provider acquires, is acquired by or merges into or with a third party health care provider that has partici-

pating provider agreement with Blue Cross at the time of the acquisition or merger, then Blue Cross will determine whether the Agreement and/or the participating provider agreement of such third party health care provider will be applicable, control and/or be effective. (XI. O.) Blue Cross has stated that it makes these determinations on a case by case basis, however the criteria it uses remains unclear.

### Medicare Programs Amendment to the Agreement

Note: The Medicare Programs Amendment is sent to all participating providers regardless of whether they participate in government programs. Signing the Agreement does not create a presumption or otherwise obligate clinics to participate in government programs.

**Medicare Benefit Program.** The provision titled, “Medicare Benefit Program” is new. It is described as a program to provide services to Medicare beneficiaries under a contract with CMS, including the Medicare Advantage program, the Medicare Prescription Drug Improvement and Modernization Act, Medicare Cost Contract program, Tax Equity and Fiscal Responsibility Act and other programs designed to provide services to Medicare beneficiaries. (Art. I. D.)

**Article IV. Accountability.** New language states that Provider is required to comply with the policies and procedures set forth in the Blue Cross Provider Policy and Procedure manual ([http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc\\_bluecrossmn/docu-](http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/docu-)

[ments/public/post71a\\_082625.pdf](http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/post71a_082625.pdf)) and the Blue Plus Manual ([http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc\\_bluecrossmn/documents/public/post71a\\_023249.pdf](http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/post71a_023249.pdf)). Providers using the MedicareBlue PPO must also comply with the policies and procedures set forth at: [www.yourmedicareolutions.com/for\\_providers/provider\\_guide.html](http://www.yourmedicareolutions.com/for_providers/provider_guide.html).

**Article XIII. Compensation.** This provision was amended to state that for Government Subscribers enrolled in a Minnesota Health Care Program, Provider will be reimbursed at the contracted rates for Minnesota Health Care Programs “as detailed in the Agreement” (i.e., section IV(E) of the Agreement) for services not covered under Medicare.

**Article XIX. Effective Date; Previous Amendments; Termination.** The provision titled, “Termination” is new. It states that this Medicare Amendment may be terminated by Blue Cross with or without cause upon prior written notice. The termination will take effect 130 days after Provider’s receipt of the notice *or earlier if there is a specified date in the notice*. The Agreement will remain in full effect even if the Amendment is terminated. The Medicare Amendment will automatically terminate if the Agreement either terminates or expires, or if the Provider terminates his/her participation with Government Products under the Agreement. Note: It is unclear whether Provider should provide notice to BCBS if it terminates its participation with Government Products.