

Demystifying Provider Contracts

Here are some important items to understand and consider about these contracts.

When you sign a provider contract with an insurance or managed care company to deliver services to insurance plan subscribers, you agree to obligations that are enforceable by law. Some contract provisions can create difficulties and challenges for practitioners. Others are just important to be aware of to make your dealings with the company smoother.

This article begins with some general pointers for handling provider contracts, discusses how these contracts are organized, and then highlights several contract terms that may require particular attention.

Much of the advice in this article will apply to provider contracts with other entities, such as accountable care organizations or medical homes. And some of the material, particularly the general pointers, will be applicable to any contract you may sign in your practice — for example, a lease of office space, an employment contract or an independent contractor agreement.

General pointers

Consider the following general guidance:

Review the contract before you sign it. Do not assume that all provider contracts are alike. Make sure you know what the terms of a contract mean — and obligate you to do — and be certain you are willing and able to meet all of the obligations.

Reviewing provider contracts was easier decades ago when they tended to be only a few pages long. Many provider

contracts now exceed 20 pages. At a minimum, you should be sure to carefully review the key provisions described in the last section.

Psychologists sometimes wonder if there is any leeway to modify a contract provision that they find objectionable. Companies typically expect health care professionals to agree to a provider contract in its entirety. As such, you may find that you have limited opportunity to negotiate terms, though some psychologists have successfully negotiated reimbursement rates. You can always ask whether a particular company is willing to modify or delete a particular provision in the contract.

Consider having a knowledgeable attorney assist you as needed with contract review. This is particularly important if you are having trouble understanding what the contract says. Based on their own knowledge and experience, your professional colleagues as well as your state psychological association may be able to provide good leads on attorneys. (Some state associations, such as those in Florida and Texas, offer members free or discounted attorney consultations as a member benefit.) For law firms not recommended by colleagues or your state association, you can check the law firm's website to see if health care, health care contracts or provider contracts are identified as an area of expertise. If the firm's website has a long list of specialties relative to the number of attorneys, consider whether the firm actually has in-depth expertise relevant to reviewing provider contracts. For example, you might ask how many provider contracts the firm has reviewed in the last few years.

Keep a copy of your signed contracts readily accessible, whether electronically or a photocopy, including any amendments. You need to be able to readily refer to the contract if a disagreement or other conflict with the company arises. Also keep handy any amendments to the contract that you may receive from the company. A quick review of these documents may allow you to favorably resolve problems with the company.

Be aware of state governmental entities to which you can report unfair practices by the insurance or managed care company. Your state insurance commission, or similar state agency responsible for overseeing contracts issued by insurance or managed care companies, may address health professionals' complaints about their contracts and may be willing to help you resolve these conflicts. (Some insurance commissioners only respond to consumer/patient concerns.) When you send a complaint email or letter to the company, you might want to send a copy to the state insurance agency as well (See the "10 Tips" article in the Related Resources sidebar on page 9 for further information).

Components of your provider contract

Understanding the different pieces of the provider contract will make it easier for you to review it. The typical provider contract has four basic components. Together these make up the package to which you are agreeing.

The main contract. Most of the key provisions discussed in the next section will be found in the main body of the contract, which typically ends with the signature page. While this is typically the only document that you sign, it generally contains a provision saying that you are also agreeing to abide by the terms of the other components. (Sometimes the contract uses the legalese expression that the other components are "incorporated by reference," which means that they are considered part of the contract.)

Amendments. Often the provider contract will have amendments that change portions of the main contract. Some may only apply to particular programs, such as a Medicaid plan, while other amendments are designed to conform the contract to your state's law. Amendments may specify what happens if there is a conflict between a provision in the main contract and a provision in the appendix or amendment. Typically, the provision in the amendment takes precedence if there is a conflict.

Amendments are the most common way for the company to change the main provisions of the contract after you

have signed it. The less common alternative is for the company to send you a completely new contract to sign. Thus, in addition to any amendments that are attached to the original contract package, you may receive several amendments to the contract during its term.

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The fee schedule. The schedule of various reimbursement rates by procedure code is usually a separate document. Be sure that you have reviewed and understand this schedule before you sign the contract. For example, there may be different fee schedules for different programs and it may not be immediately clear which schedule or schedules apply to your practice.

Other provider guidance incorporated by reference into the contract. Provider contracts also often have you agree to follow policies or procedures contained in resources that are not part of the provider contract package that the company sends you. The most common such resource is the provider section of the insurance company website. That section often contains important information such as recordkeeping, pre-authorization and billing requirements, as well as services the insurer does not cover. (These provider website sections replace the printed Provider Manual from a decade or two ago.)

KEY CONTRACT PROVISIONS

- Term and termination
- Ability to assign you to different company networks or products
- Payment and recoupment
- Recordkeeping policies and procedures, and audits
- Changes to contract terms

You should review these sources before you sign the contract, but be aware that the company has flexibility to change this outside guidance without formally amending your contract. The main contract or state law may limit the extent to which the company can alter the contract without proper notice. See “Changes to contract terms” in the next section for additional information.

Key provisions

The following provisions are the ones most likely to be central to psychologists’ disputes with, or concerns about, a company. With the exception of the recordkeeping and billing procedures, all of these provisions should be in the main contract – but they may be altered by amendments to the contract.

Term and termination. These provisions, or at least the termination provision, are usually found near the end of the contract. Most provider contracts are now set up to renew annually until you or the company terminates the contract.

Termination provisions control the circumstances under which you or the company can terminate the contract, and the notice required before termination. Most contracts enumerate certain reasons that will allow the company to terminate the contract, such as alleged breaches of the contract that you do not fix after being notified by the company. Commonly, providers are allowed to terminate without giving reasons, but are often required to give 90-day notice to allow for transitioning the care of patients covered by the company. Contracts often have specific provisions regarding your obligations to provide care to these patients during the transition period.

Ability to assign you to different company networks or products. Some contracts give the insurance or managed care company leeway to send you patients affiliated with lower paying plans and networks also operated by the company. For example, you contract to provide services for a preferred provider organization (PPO), but the company is also able to send you patients affiliated with a health maintenance organization (HMO) that has lower reimbursement rates.

Relatedly, some provider contracts have a provision saying that if you sign up for one of the company’s plans or products, for example a higher paying PPO plan, you are automatically enrolling in all of the company’s plans. Virginia prohibits such “all products” clauses.



Contracts often address circumstances under which companies may demand repayment for services, also known as recoupment or claw back.

Payment and recoupment. The following are important aspects of the contract regarding payment provisions. The contract should define the “covered services” for which you will get paid. It should also state how promptly the company will pay you after you have submitted a clean claim – one that contains all of the information necessary for the company to process payment. Virtually all states require insurance and managed care companies to pay claims within a certain number of days after receiving clean claims – for example 15 days for electronically submitted claims and 30 days for paper claims. The company should follow whichever time period is shorter – the one specified by state law or the provider contract.

To make sure that you are filing clean claims that the company must promptly pay, you should familiarize yourself with the company’s pre-authorization requirements and billing procedures before you provide services. These are often found in the provider section of the company website.

Payment provisions also typically govern the extent to which you can bill patients/insureds for uncovered services or services that are deemed not medically necessary. For example, the company may determine that certain services are not medically necessary, or not covered for other reasons, but the contract still prohibits you from charging more than the reimbursement rate to which you agreed for providing these services. Or you may be required to have the patient sign a document acknowledging that the patient understands that the services will not be covered by the insurer.

Finally, contracts often address circumstances under which companies may demand repayment for services, also known as recoupment or claw back. For example, the company may discover after paying you that a beneficiary was no longer an employee when you provided services, and therefore not covered by its insurance. Many states have laws that limit how far back a company can go with recoupment. Two years is common, but a few states limit recoupment to 180 days.

Recordkeeping policies and procedures, and audits. Your contract may specify how many years you need to keep patient records. Regardless of what the contract does or doesn't say about the records retention period, a longer retention period may be required by your state's law or recommended by APA's recordkeeping guidelines.

continued on page 18

Help consumers find you.



The Psychologist Locator

A benefit of your APAPO membership dues

Create or update your listing at

psychologistlocator.org



RELATED RESOURCES FROM THE APA PRACTICE ORGANIZATION

Look for current issues regarding provider contracts, and dealing with insurance/managed care generally, in the Insurance and Managed Care section of the APA Practice Organization's Practice Central website at apapracticecentral.org/advocacy/managed/index.aspx

10 tips for resolving issues with insurance companies

Pointers to make the process of problem resolution with insurance companies less painful and more effective. apapracticecentral.org/update/2008/12-17/secure/resolving-insurance-issues.aspx

Update on risk adjustment audits

Recommendations and information for members who have received Inovalon audit requests for Anthem BCBS and other companies. apapracticecentral.org/update/2015/04-16/risk-adjustment-audits.aspx

Detailed or lean therapy records?

Helpful information in rethinking your approach to record-keeping in the wake of Risk Adjustment Audits under the Affordable Care Act. apapracticecentral.org/update/2014/12-18/detailed-lean-records.aspx

Dealing with managed care audits

Steps for psychologists to follow before and after receiving an audit notice. apapracticecentral.org/good-practice/secure/care-audits.pdf

Dealing with discount networks

A step-by-step guide for psychologists. apapracticecentral.org/good-practice/secure/discount-networks.pdf

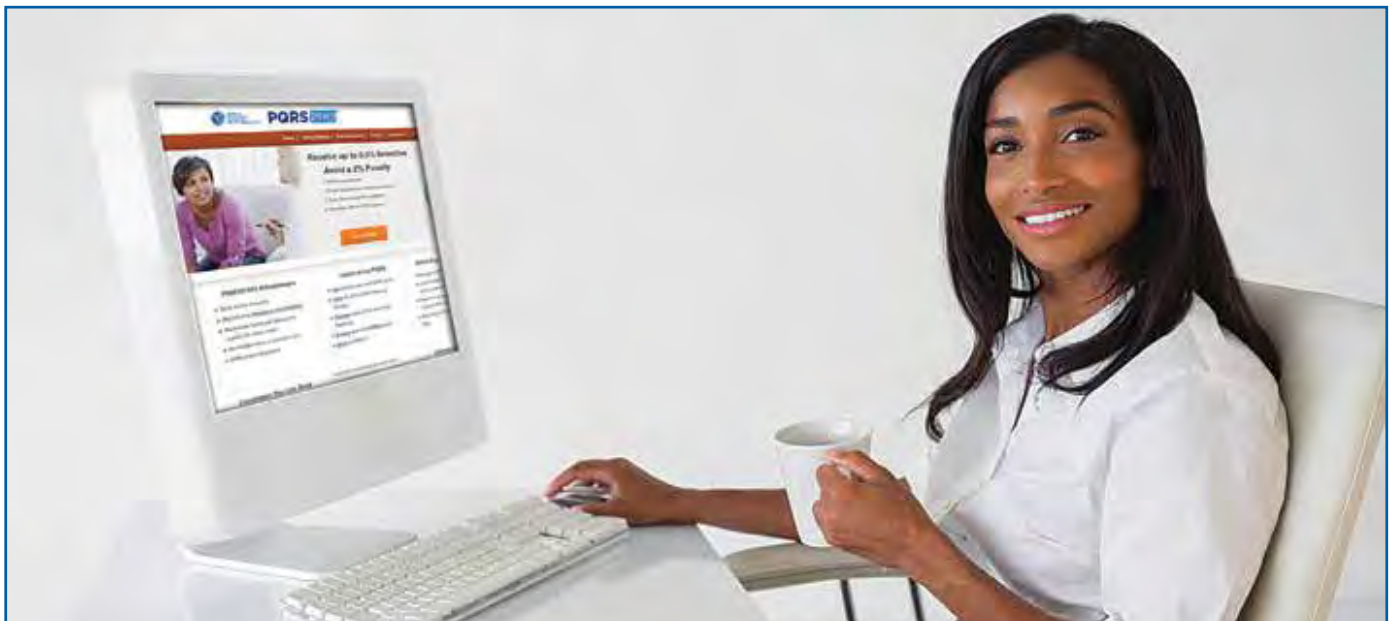
Demystifying Provider Contracts *continued from page 9*

The details of what content should be in your records is usually not covered in the provider contract, but more likely in the provider section of the company website. In some cases, the company's recordkeeping guidance is not well tailored to mental health recordkeeping. If so contact the company to clarify what recordkeeping it expects from you as a psychologist. Document your inquiry and any response.

The reason that companies may tell you how long and how to keep records is that most provider contracts give the company the right to audit your patient records. A company may conduct audits for a variety of reasons, including quality of care, medical necessity, quality of recordkeeping, fraud and abuse, and the annual Risk Adjustment Audits that started in 2015 as required by the Affordable Care Act. (See the sidebar on page 9 for articles on preparing for and responding to various insurance and managed care audits.)

Changes to contract terms. Most provider contracts have what might be called a "take it or get out" provision for contract changes. In other words, contracts often require the company to give you 60 days' notice of significant changes to the contract. But if you don't like the change, the only option the contract gives you is to terminate your contract. If you find yourself in this circumstance and you have bargaining power with the company, it may be worth asking whether the company will make an exception for your practice. ☺

Please note: *Legal issues are complex and highly fact-specific and require legal expertise that cannot be provided by any single article. In addition, laws change over time and vary by jurisdiction. The information in this article should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.*



It's not too late.

There's still time to report PQRs measures for 2015 if you register online by January 31, 2016.

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