Provider Contract Analysis

Illustrative Sample

Sample Payer for Virginia Market

Commercial HMO

Pathway X Tiered Hospital HMO

Pathway Tiered Hospital HMO

Preferred Provider Organization Network(s) PPO

Medicare Advantage

Exclusive for Illustrative Sample
By: CodeToolz, LLC
May 2022

Credentialing Process

*You will receive a letter notifying you of your acceptance into the networks for which you agreed to participate on the Signature Page**. <u>You should not begin seeing Members until you are notified of your acceptance into our networks.</u>***

Provider warrants that he/she/it meets all applicable Plan credentialing requirements, standards of participation, and accreditation requirements for the Networks in which Provider participates. A description of the applicable credentialing requirements, standards of participation, and accreditation requirements, are set forth in the provider manual(s) and/or in the PCS. Provider acknowledges that until such time as Provider has been determined to have fully met Plan's credentialing requirements, standards of participation, and accreditation requirements, as applicable.

Contract Language Review

1. *Payer shall be <u>entitled to offset and recoup an amount equal to any overpayments or improper payments</u> made by Payer to Provider against any payments due and payable by Payer to Provider with respect to any Health Benefit Plan under this Agreement.*
2. *<u>Provider shall voluntarily refund</u> all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful.*
3. *Should Provider disagree with any determination by Plan that Provider has received an overpayment, <u>Provider shall have the right to appeal</u> such determination under Payer's procedures set forth in the provider manual, an such appeal shall not suspend Payer's right to recoup the overpayment amount during the appeal process unless suspension of the right to recoup is otherwise required by Regulatory Requirements.*
4. *Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member. Provider and its designees <u>shall comply with all applicable state and federal record keeping and retention requirements</u>, and, as set forth in the provider manual(s) and/or Participation Attachment.*
5. *Following a request<u>, Provider shall transfer a Member's medical records in a timely manner</u>, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a Member at no cost to Payer, Plan, the Member, or other treating health care providers.*

6. *This Agreement shall commence at 12:01 AM on the Effective Date and shall continue in effect until such time it is terminated as provided herein. Either party may terminate this Agreement or Provider's participation in a Network(s) without cause at any time by giving at least one hundred twenty (120) days prior written notice of termination to the other party.*
7. *Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within ninety (90) days from the date the Health Services are rendered, or Plan will refuse payment. If Plan is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.*
8. *Provider may refer or transfer a Commercial Business Member to a non-Participating Provider after obtaining a written acknowledgement (e.g. written waiver form) from the Commercial Business Member, prior to the provision of the service, indicating that: (1) the Commercial Business Member was advised that no coverage, or only out-of-network coverage would be available from Plan; and (2) the Commercial Business Member agreed to be financially responsible for additional costs related to such service.*
9. *Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable. In addition, upon termination of this Attachment but subject to the Continuation of Care provision(s) and applicable Regulatory Requirements, any references to services, reimbursement, or participation in Networks related to Commercial Business are hereby terminated in full and shall have no further force and effect.*
10. *Payer agrees to make best efforts to pay a majority of Clean Claims for MA Covered Services submitted by or on behalf of MA Members, within forty-five (45) days of receipt by Payer.*

Fee Schedule Language

For Covered Services provided by or on behalf of Provider to a Member who is enrolled in a product and/or program that is supported by a Network designated in this Agreement, Provider agrees to accept as the Payer Rate, the lesser of Eligible Charges or the compensation as set forth in fee schedule.

The non-facility rate is the payment rate for services performed in the office. This rate is higher because the physician practice has overhead expenses for performing that service. (Place of service 11).

Some codes may only be performed in one place or the other: for example, an initial hospital visit has only a facility fee, because it is never performed anywhere but a facility. Office visits, on the other hand, may be done in the office (non-facility) or in the outpatient department (facility.)

CODETOOLZ
Contract Analyzer

Fee Schedule

Plan Compensation Schedule (10/01/2021)

Provided by: Northern Region – Sample Payer

Payer For: Illustrative Sample

Code	PPO Office	PPO Facility	HMO Office	HMO Facility	Pathway Office	Pathway Facility
11406	$399.26	$312.10	$367.32	$287.13	$323.80	$253.80
11900	$68.67	$38.30	$63.18	$35.24	$55.69	$55.69
13121	$538.80	$330.15	$495.70	$303.74	$436.97	$436.97
14302	$277.77	$277.77	$255.55	$255.55	$225.27	$225.27
15771	$728.53	$728.53	$670.25	$557.26	$590.84	$590.84
15772	$229.78	$229.78	$211.40	$164.83	$186.35	$186.35
15860	$137.78	$137.78	$126.61	$126.76	$111.74	$111.74
19318	$1396.31	$1396.31	$1284.61	$1284.61	$1132.41	$132.41
19357	$1909.15	$1909.15	$1756.42	$1756.42	$1548.32	$1548.32
19361	$2001.15	$2001.15	$1841.06	$1841.06	$1622.93	$1622.93
19364	$3509.27	$3509.27	$3228.53	$3228.53	$2846.02	$2846.02
19380	$989.13	$98913	$910.00	$910.00	$802.18	$802.18
99202	$93.20	$61.95	$85.74	$56.99	$75.59	$50.24
99203	$132.38	$93.20	$121.79	$85.74	$107.36	$75.59
99204	$202.81	$160.11	$186.59	$147.30	$164.48	$129.85
99211	$27.61	$10.45	$25.40	$9.61	$23.39	$8.47
99213	$91.88	$62.83	$84.53	$57.80	$74.51	$50.96
99214	$133.70	$97.16	$123.00	$89.39	$108.43	$78.80
99221	$126.78	$236.78	$116.64	$116.64	$102.82	$102.82
99243	$132.38	$93.20	$121.79	$85.74	$107.36	$75.59

Fee Schedule Analysis

Using the CodeToolz Contract Analyzer

*Payer HMO – Office: Average Reimbursement offer is **113.54%** of Current 2022 Medicare*

*The average HMO in this region is **110%-120%***

*Payer Pathway HMO – Office: Average Reimbursement offer is **100.09%** of Current 2022 Medicare*

*The average HMO Select in this region is **100%-110%***

*Payer PPO – Office: Average Reimbursements offer is **123.41%** of Current 2022 Medicare*

*The Average PPO in this region is **120%-130%***

*Medicare Advantage – Office: Average Reimbursements offer is **100.00%** of Current 2022 Medicare*

*The Average Medicare Advantage in this region is **100%***

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