SAMPLE PAYER CONTRACT LANGUAGE ANALYSIS

PHYSICIAN AGREEMENT

THIS AGREEMENT is entered into by and between _____, Inc., a _____ corporation, ("Network") and _____, M.D. ("Physician").

WHEREAS, the Network is developing a provider network consisting of physicians, institutional facilities, and providers of ancillary health; and

WHEREAS, Physician wishes to be a Participating Physician in Network.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree as follows:

- **Make sure the contract clearly describes what product line(s) this contract is for.**
- **When is the contract effective?**
- This Agreement applies only to Payer's Commercial HMO, but not to Payer's Medicare HMO.

DEFINITIONS

"Benefit Plan" means those health care services which are included as health care benefits pursuant to Members Benefit Plan.

- **Make sure that Benefit Plans are only in those Product lines you have agreed to contract.**
- **Benefit Plans will be limited to Commercial HMO, and not Medicare HMO.**

"Covered Services" means medical and other health care services that are covered under a Health Benefit Plan established by a Payer and which are deemed Medically Necessary by Payer or Network.

- **Who is the Payer? Look for a definition of Payer.**

"Emergency" means the sudden and unexpected onset of a condition or symptoms requiring medical or surgical care to screen and/or treat the Member, and which is secured immediately after the onset (or as soon thereafter as the care can be made available), and is of such immediate nature that the Member's life or health might be jeopardized if he or she is not treated as soon as possible.

"Fee Schedule" means the maximum amount which Network will pay for a specific service.

- **And what exactly is that?**

"Medically Necessary" or "Medical Necessity" means those services or supplies which, under the terms and conditions of this Agreement, are determined to be: appropriate and necessary for the symptoms, diagnosis or treatment of the medical conditions of the Member; provided for the diagnosis or direct care and treatment of the medical condition of the Member; within standards of medical practice within the community; and not primarily for the convenience of the Member, the Member's physician or another provider.

"Member" means any person eligible to receive Covered Services and whose Benefit Plan has access to the Network.

- **Make sure that Member is only in those Product lines you have agreed to contract.**
- Member will be limited to Commercial HMO, and not Medicare HMO.

"Participating Hospital" means a duly licensed hospital which has entered into an agreement with Network to provide Covered Services to Members.

"Participating Physician" means a physician who has entered into an agreement with Network to provide Covered Services to Members.

- **What Physicians and Hospitals are participating?**

"Payer" means an organization, firm, or governmental entity, including but not limited to a self-insured employer, employer coalition, health insurance purchasing cooperative, insurer, health maintenance organization or preferred provider organization, that has contracted with Network to arrange for the provision of health care services to its members.

- **The Payer and the Network you are contracting with are not necessarily the same. The Payer may pay the Network to access providers in the Network. In these situations, the Payer is obligated to pay the claim not the Network.**
- **Network warrants that its contracts with Payers require Payers to comply with all Payer requirements and responsibilities described in this Agreement, and that such contracts also require Payers to acknowledge that they will not be allowed to participate in the negotiated rates and other terms of this Agreement if they fail to comply with such requirements.**
- **Network agrees that each agreement with any Payer shall provide for a differential for in-network versus out-of-network coverage for Physician Services of at least 10 %. The foregoing discount shall also be applied to the Member's out-of-pocket costs, i.e. Copayments or Deductibles.**
- **Network agrees to provide a quarterly list of contracted Payers.**

"Primary Care Physician" means a Participating Physician who is designated by the Network as a provider of primary care services, and who is primarily responsible for managing and coordination the overall health care needs of the Member.

"Physician Manual" means the manual which has been prepared by Network and sets forth all policies and procedures governing Physician's participation in Network.

- **Make sure you get a copy of this and read it.**

"Specialty Care Physician" means a Participating Physician who is designated by the Network as a provider of specialty services other than primary care services.

"Utilization Review/Quality Assurance Plan" or "UR/QA Plan" means the program or programs adopted by the Network, and carried out by Participating Providers with Network which authorizes and monitors the utilization of Providers offered to Members.

- **Before executing the contract, obtain copies of the Payer's Provider Handbook/UR/UM Manuals and Protocols. Understand the Appeals, Grievance, UR/QA and Authorization Processes. Determine which services need preauthorization and notification and who can request authorizations – PCP, SCP or both.**
- **Are retro-authorizations considered for medical necessity?**

Additional Definitions to include:

- "Clean Claim" means a claim for payment for a Covered Service that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in Payer's claims processing system. It does not include a claim under review for medical necessity.
- "Claim" means a bill submitted by Physician to Network for Physician services provided to a Member using a billing form containing equivalent information.
- "Non-Covered Services" means services, supplies, products and accommodations that Network is not required to provide to Members pursuant to a Group Contract, including but not limited to services which are not authorized by Network as part of the Utilization Review program.

PHYSICIAN RESPONSIBILITIES

Physician agrees to provide to Members those Covered Services to the same extent and availability, and with the same degree of care, as Physician normally provides such services to the general community.

Physician shall maintain reasonable office hours in a location convenient to Members, and agrees to be accessible to Members either personally or by arranging for coverage by another Participating Physician or by another qualified physician approved by Network. Physician shall assist Network in ensuring that the covering physician complies with the UR/QA plans established by Network and by Payers, and that he complies with the compensation terms of this Agreement.

- **Make sure you can close practice to one product line and not another.**

If Physician arranges with either a participating or non-participating Physician to cover Members for him/her in his/her absence, it will be the Physician's responsibility to ascertain that the covering Physician will: (a) accept compensation from Network as full payment for covered services in accordance with the applicable Network compensation schedule (b) not bill the Member directly except for any applicable copayment, coinsurance, or deductibles; (c) obtain approval as designated by Network, prior to all non-emergency hospitalizations and non-emergency referrals of Members; and (d) comply with all Network rules, protocols, procedures, and programs.

- **This provision makes it the Physician's responsibly to educate non-participating covering physicians.**

Physician shall maintain adequate medical records for Members and shall retain and preserve such records fort he full period of time required by state and federal law. Physician and Network shall maintain the confidentiality of Members' medical records in accordance with all applicable laws and regulations. Subject to such requirements, the Physician will make the Member's medical records readily available to any Participating Physician or other health professional who needs the records in order to treat the Member, and upon reasonable request, shall make the records available for review by Network, Payer, or their designee for quality assurance/utilization purposes or for other reasonable and necessary purposes.

- Network will reimburse Physician the cost of preparing, copying, and delivering records**.**

Network or its designee shall have the right to inspect and audit, any of the Physician's accounting,administrative, medical records and operations.

- **This provision allows the Payer to inspect any of your financial records.**
- Any review will be limited to Members and Covered Services. Payer shall contact Physician at least fifteen (15) days in advance of any review to schedule a mutual agreeable time for the review.
- Network may not request or have any access to Physician's non-public financial data, records, or information, which they feel to be confidential.

Physician represents that the information provided in the network application is correct. In addition, Physician warrants that he is (a) licensed to practice medicine or osteopathy in the State(s) of Texas: (b) has met all qualifications and standards for appointment to the medical staff of at least one Participating; (c) will have and maintain, where appropriate, a current and unrestricted narcotics number issued the Drug Enforcement Administration ("DEA"); (d) has specialized training in the area in which he practices.

- **Watch the State location referenced in the contract.**

Physician shall report any reportable occurrences including, but are not limited to, any action, investigation, or proceeding initiated or taken by any professional society or organization, by any facility, by any medical group or practice, by any licensure or certification agency, by any reimbursement entity or managed care organization, or by any similar entity or organization, to revoke, suspend, restrict, or otherwise adversely affect his privileges, license, certification, or professional standing or membership. The Physician agrees to notify the Network immediately of any suspension, reduction, or termination of his liability insurance, or of any lawsuit filed against him alleging malpractice or negligence and requesting damages in excess of $5,000.00.

Physician, shall provide and maintain professional liability insurance, in amounts of $250,000 per claim and $750,000 annual aggregate during this Agreement.

- **Do you have this coverage?**

Physician agrees that Network shall not be responsible for any claims, actions, liability or damages arising out of the acts or omissions of Physician or the acts or omissions of any non-participating physician who covers Members for the Physician.

- **This provision only protects the Network.**
- Network agrees that Physician and Physician's employees, servants, directors, or officers shall not be liable or responsible for any and all acts or omissions of Network relating to (i) any and all determinations by Network of Medical Necessity; (ii) any and all determinations by the Network as to whether or not a treatment, service, or product is a Covered Service; and (iii) any and all determinations by Network as to whether or not any person is, or is not, a Member or Beneficiary. Network shall have the duty to make decisions at least according to industry standards and at least with due and appropriate care and diligence. Network shall indemnify and hold Physician and Physician's employees, servants, directors, and officers harmless against any and all claims, actions, proceedings, demands, settlements, liabilities, expenses, or damages asserted against Physician or Physician's agents, employees, and officers to the extent such things result from or arise out of any act or omission of Network; provided however, this indemnification shall not include any claims or harm resulting from, and to the extent of, any liability arising out of the provision of health care services by Physician or Physician's employees, servants, directors, and officers.

The Physician agrees to cooperate with marketing programs established or approved by Network, and agrees to allow the Network and Payers to list the Physician's name, specialty, address, telephone number, willingness to accept additional Members, and other relevant information in Participating Provider directories and similar informational materials.

- Network shall distribute identification cards identifying Network to all members; each card shall include a toll-free number that Physician may use during normal business hours to verify eligibility of coverage, to obtain general coverage information and to obtain authorizations. A copy of any card(s) of a design not previously seen by Physician shall be provided to Physician prior to distribution of cards to Members.

UTILIZATION REVIEW, QUALITY MANAGEMENT AND ADMINISTRATION

The Network will establish criteria and goals for establishing and monitoring the Medical Necessity, appropriateness, and quality of services provided by Participating Providers.

- **What are they?**

Physician agrees to cooperate with all Network rules, protocols, procedures, and programs in establishing its utilization review, quality management, benefit management, denials of admissions or continued stay, or other programs that may be established to manage the cost and utilization of medical services.

- Except for Emergency Services, Physician shall confirm Member status and secure prior authorization before rendering services. Upon the request for Member treatment by a participating physician, Physician shall contact Network to confirm Member status and to verify that the proposed treatment is approved as a Covered Service.
- Network shall provide the requested verifications within ___ hour(s) of Physician's initial request, unless Physician failed to provide information needed to make the eligibility determination. Upon such verification, Network shall give to Physician an authorization code indicating approval upon which Physician may conclusively rely for the delivery of authorized services to the Member. If Physician obtains such verification, Network shall not retroactively deny payment if Network later determines that Member is not eligible or that the service authorized and rendered is not a Covered Service.
- Network shall provide Physician with at least thirty (30) calendar days prior written notice of any modification or amendment of the Utilization Review program. If Physician objects to such modification or amendment, Physician may terminate this Agreement by providing notice to Network within such thirty (30) day period.

Physician agrees to refer Members to other Participating Providers when he/she is unable to provide the required services and when consistent with sound medical judgment.

- **Make sure you are provided with up-to-date Provider Directories.**
- Physician will use his/her best efforts to refer Members to other Participating Providers when he/she is unable to provide the required services and when consistent with sound medical judgment.

Physician agrees that failure to cooperate with Network rules, protocols, procedures, and programs may result in penalties as set forth by the Network and included in the Physicians' office manual.

- **PENALTIES**
- Review the Physicians Office Manual Carefully

Physician agrees to cooperate with any applicable Network grievance procedure and decisions. Physician shall comply with all determinations rendered by the UR/QA Plan program.

- Upon such verification, Network shall give to Physician an authorization code indicating approval upon which Physician may conclusively rely for the delivery of authorized services to the Member. If Hospital obtains such verification, Network shall not retroactively deny payment if Network later determines that Member is not eligible or that the service authorized and rendered is not a Covered Service.
- Nothing in this Agreement shall be construed to interfere with or affect in any way the exercise of the independent medical judgment of Physician or Physician's employees in rendering health care services to Members. Specifically, but not in limitation, the Physician or Physician's employees shall be permitted to communicate with Members concerning (i) all matters necessary or appropriate for the delivery of health care services, (ii) treatment alternatives regardless of the provisions or limitations of coverage, and (iii) the reimbursement arrangements under which the Physician is compensated.

COMPENSATION

For Covered Services provided to members, Physician shall be compensated in accordance with Exhibit A.

- **Is there an Exhibit A? Does is clearly describe reimbursement by product line?**

Physician agrees to look solely to Network for payment for Covered Services.

- Physician has the right to bill Member for all non-covered services. No contractual discount will apply.

Network may offset overpayments against future payments to Physician.

- Network agrees that recovery of over-payments will not be taken from future payments, but will be billed to Physician with appropriate documentation to substantiate the recovery.
- Network will notify Physician within fifteen (15) calendar days of receipt of claim, of any claim pended for review or audit.
- Network must notify the Physician of suspected over-payments no later than twelve (12) months from the date Health Plan made the payment to the Physician to be eligible to recover such amounts.

Under certain Health Benefit Plans no coverage is available if the Covered Service has not been preauthorized. Physician agrees to consult the Physician's office manual, Member services and other Network materials in order to determine if a Covered Service is covered, and if so, to obtain the necessary authorization(s) in order for the Covered Service to receive the maximum benefit.

If Physician bills Network, such bill must be submitted no later than ninety (90) days after the date of service. Network shall not be obligated to pay any such bills submitted after the ninety (90) day period.

- **Try to remove this provision.**
- Complete claims that are not paid within thirty days will be paid at Physician's billed charges.

Physician agrees to cooperate with Network COB requirements and in the recovery of claims from other insurers and third party payers.

- Physician will cooperate with Network in implementing Payer's coordination of benefits program. Where the Network is primary under applicable coordination of benefit rules, the Network shall pay the reimbursement rates due under this Agreement as provided in Attachment. If such payment does not cover all billed charges, Physician may submit claims to the secondary carrier.
- Where the Network is other than primary under coordination of benefit rules referred to above, the Network shall pay those amounts which, when added to amounts owed to the Physician from other sources, pursuant to the applicable coordination of benefit rules, shall not exceed one hundred percent (100%) of the amount billed. However, payment by Network to Physician shall not exceed one hundred percent (100%) of the rates set forth in this Agreement.
- If the primary carrier does not pay Physician within forty-five (45) calendar days of Physician's billing, then Network shall pay Physician at the rates set forth in this Agreement and seek reimbursement from the primary carrier. If Network so pays Physician, Physician shall promptly remit to Network such amount of any payment hereafter received from the primary carrier such that Network shall not have paid to Physician any more than it would have paid under this Agreement.
- The Physician should not agree to any provision that would limit its recovery of full charges if members subrogate their rights to the health plan.
- Network Member ineligibility determinations shall be limited to (30) thirty days after Member was considered eligible.

TERM AND TERMINATION

This Agreement shall be effective as of _____, 202___, and shall continue for a term of three (3) years from that date. Unless otherwise terminated as set forth below, the Agreement shall automatically be renewed for subsequent one-year terms. Renegotiations of Agreement shall only take place ninety days prior to the end of the term of the Agreement.

- **Watch the term of the contract and when you can renegotiate.**
- The term of this Agreement shall be ____ years, beginning as of _____ ___, ____ and ending at midnight on _____ ___, ____, subject to earlier termination by Network or Physician as hereafter provided. This term may be extended with the consent of both parties in writing.

Either party may terminate this Agreement, with or without cause, at any time upon one hundred and eighty (180) days' prior written notice to the other party.

- Carefully review the termination period.

Either party shall have the right to terminate this Agreement upon thirty (30) days' prior written notice to the other party if the party to whom such notice is given is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. If the breach is cured within the notice period, then the Agreement shall continue in effect for its remaining term, subject to any other provision of this Agreement.

- **Make sure the time frame for breech is understood.**

In addition, Network may terminate this Agreement immediately upon (i) the revocation, suspension, or restriction of Physician's license to practice medicine; (ii) the revocation, suspension, or restriction of Physician's license, certification, registration, permit or approval required for the lawful and reasonable conduct of his practice and the provision of Covered Services to Members; (iii) Physician's failure to maintain general and professional liability insurance as required under this Agreement; (iv) revocation, suspension, or restriction of Physician's medical staff appointment or the necessary clinical privileges required to provide Covered Services at a Participating Hospital or any other hospital; (v) Network's determination that any Member would be endangered or impaired by the continuation of this Agreement.

In the event of any material changes in laws affecting the structure of the Network, or affecting the provision or reimbursement of health care services similar to those provided hereunder, the parties agree to negotiate in good faith to amend this Agreement to conform with applicable law. In the event that such changes adversely affect either party, such party may terminate this Agreement upon sixty (60) days written notice if the parties are unable to renegotiate the Agreement on mutually agreeable terms within such 60-day period.

In the event of termination of this Agreement, Network and Physician shall use their best efforts to arrange for an orderly transition of patient care, consistent with appropriate medical standards, for Members who have been or are at the time under the care of Physician, to the care of another physician selected by Member or Payer, but for no longer than (1) one year. Such services shall be provided according to this Agreement.

- **This provision states that even though you have terminated the Agreement you may still be receiving the reimbursement for a year.**
- Upon termination of this Agreement Physician shall continue to provide Covered Services to Members then inpatients of the Physician and entitled to services pursuant to Health Benefit Plans until such Members are (i) discharged or transferred consistent with sound medical practice; or (ii) thirty (30) calendar days from the effective date of termination.

MISCELLANEOUS

All Network business, medical and other records and all information generated by or relating to Network. or its management information systems shall be and remain the sole property of Network. Physician agrees to keep such information strictly confidential.

The parties are independent contractors, and neither is or shall represent itself as the employer, employee, partner, agent, principal, or joint venture of the other. The Physician understands and agrees that in the provision of medical care services, the Physician acts as an independent entity and that the physician-patient relationship shall in no way be affected.

Any notice or communication required, permitted or desired to be given hereunder shall be deemed effectively given or mailed, addressed on the signature page.

- Preferred notice sent certified mail.

The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach hereof.

This Agreement shall be governed by and construed in accordance with the laws of the state of Texas.

- This Agreement has been executed and delivered, and shall be interpreted, construed and enforced in accordance with the laws of the State of Texas, without regard to any conflict of law provisions contained therein.

This Agreement may be amended by Network upon thirty (30) days written notice of such proposed amendment. Failure of Physician to provide written objection to such amendment within the thirty (30) day period shall constitute Physician's approval of such amendment.

- This Agreement, including all attachments, may not be amended or changed in any of its provisions except by a subsequent written agreement signed by duly authorized representatives of Network and Hospital.

The invalidity or unenforceability of any term or condition hereof shall in no way affect the validity or enforceability of any other term or provision.

Physician may not assign this Agreement without Network's prior written consent.

- This Agreement cannot be assigned without the written consent of the other party.

Network and Physician agree to submit to binding arbitration any dispute or claim arising out of the interpretation of or performance under this Agreement which cannot be settled by informal means.

- The parties shall attempt to resolve any dispute, controversy or claim arising out of or relating to this Agreement or the preparation of this Agreement, including but not limited to the payment or non-payment of a claim, the eligibility of a Member, the determination of Covered Services, or the determination of medically necessary procedures, by mutual cooperation. Nothing in this Agreement shall preclude Network or Physician from exercising, at any time, the right to seek resolution through legal remedies as the law may provide.
- If any judicial proceeding is necessary to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees, costs and expenses from the other party, in addition to any other relief to which such party is entitled. If the parties mutually agree to the use of arbitration, the decision of the arbitrator shall not be binding in a court of law.
- This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their successors and permitted assignees.
- This Agreement supersedes any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement. This Agreement may not be amended except in writing duly executed by both parties.
- Notwithstanding any provision of this Agreement to the contrary, the sections of this Agreement relating to payment, confidentiality, insurance, and records requirements shall survive any termination of this Agreement.
- The failure of Network or Physician to object to or to take affirmative action with respect to any conduct of the other which is a breach of this Agreement shall not be construed as a waiver of that breach or of any prior or future breaches of this Agreement.

Reimbursement Exhibit

Physician shall bill Network and Network shall pay for Medically necessary Covered Services provided by Physician to Member the lesser of (1) Network's Physician Fee Schedule minus applicable Copayments, Coinsurance, and Deductibles, or (2) usual and customary charges minus applicable Copayments, Coinsurance, and Deductibles.

- The rates provided for in this contract may be renegotiated by either party. If new rates have not been agreed to by the parties within thirty (30) days of the written request form the Physician then an automatic increase of ten percent (10%) or the change in the annual Physician and Medical Services Consumer Price Index, whichever is greater, shall be applied to the current rates.
- Strike "usual and customary charges" and replace with "Physician's Billed Charges."