BCBS

- Retroactive relief settled (Submit claim for by October 19th), Prospective relief still in mediation. Per Carol Scheele, more to come in early 2008.

- Complaints of unfair and deceptive practices include:

    - Bundling, downcoding, failure to recognize modifiers, unjustifiably refusing to pay

    - Denying for medically necessary claims with no clinical review

    - Inefficient administrative system designed to frustrate payment, redundant and excessive requests for medical recrods, failure to explain payment denials

    - Refuses to honor eligibility verifications

    - Time consuming appeals process that discourages legitimate appeals

    - All products clause

    - Etc, etc. etc.

Aetna

- By signing an agreement inconsistent with the terms of the settlement agreement, you may be waiving the protections you are entitled to. This applies to all settlement agreements. In the packet is some suggested language to add to your contracts.

- Quite a few coding rules are required

- Physician fee schedules shall be made available via the Internet and can only be changed once a year

- Physicians shall receive 90 days' advanced written notice of material adverse changes

- Payment policies will be consistent across all products and claim systems

- Copies of contracts will be provided to physician upon written request

- Clean electronic claims shall be paid within 15 days and 30 days if they are paper claims. Interest will be prime or 8%

- Retroactive recoupment is limited to 24 months and there shall be 30 days' notice.

- Arbitration fees are capped at $1000 for small groups or solos.

- New physicians shall be credentialed within 90 days.

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CIGNA

- Settlement agreement ended September 4!
- The Physicians Advocacy Institute is trying to persuade CIGNA to continue to abide by the terms.
- CIGNA will still provide fee schedules, pay reasonable fees for vaccines (?!), and not downcode E&M
- CIGNA could reinstate all products clause, could change the fee schcedule more frequently, reinstate silent PPOs, and recoup further back.
- Suggestion: negotiate for the settlement terms that impact your practice

Health Net

- Coding rules
- Copies of contracts (with attachments!!) will be provided within 30 days or as soon as practical.
- Health Net shall provide its formulas or database used to construct fee schedules
- Healthnet will respond wtihin 10 days to e-mailed inquiries requesting ffs dollar amount allowable for those codes that specialty reaaonably uses up to twice a year.
- Physicians can opt out of products.
- Claims must be processed within 30 days, 15 for electronic.
- There will be no retroactive retraction of a pre-certified medically necessary determination.
- Credentialing applications can be submitted prior to new employment and will be processed within 90 days.

Humana

- Starting this week, claims must be paid within 15 days. Interest will be 6% per year.
- Retro recoupment is limited to 18 months.
- See coding rules
- No retro retraction of a pre-certified medically necessary determination

Remedies: File a compliance dispute – it is free!

More Info: www.hmosettlements.com

http://www.ncmedsoc.org/members/pages/payor_issues/hmo_lawsuits.html

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www.doctorslawyer.com

April 2007

Dear Medical Group Administrator:

Have you experienced any of the following reimbursement issues with your health plan payers: bundling, downcoding, refusal to recognize modifiers, delays in payment, retrospective refund requests, failure to pay in accordance with your contract with a health plan payer? If so, you will be interested to learn that the protections provided in the multi-district litigation (MDL) settlements can help. The American Medical Association (AMA), the American Medical Group Association (AMGA) and the Medical Group Management Association (MGMA) want you to know that **Aetna Inc., CIGNA Corp., Health Net Inc., Humana Inc., and WellPoint Inc. (Anthem) MDL lawsuit settlements are *all* effective**. As a result of these settlements, the unfair practices mentioned above are *prohibited*.

The true value of these settlements is found in such protections going forward and can be achieved through the compliance dispute process, which allows physicians to have a neutral mediator resolve disputes with the settling health plans. You are encouraged to stay vigilant in reviewing, auditing and tracking claim payments from the settling health plans to make sure each health plan processes and pays your claims according to its settlement agreements. If you are not being paid appropriately under the health plan payer's settlement terms, you are encouraged to file a compliance dispute. A compliance dispute that was recently filed by physicians resulted in more than **$12.5 million dollars being refunded to physicians**. Did you submit your eligible claims by the deadline to receive your refund? Visit ***www.ama-assn.org/go/settlements*** or ***www.amga.org*** or ***www.mgma.com*** for more information regarding the compliance dispute process. These organizations are working with the MDL compliance dispute facilitators who can assist you in filing compliance disputes free of charge.

The AMA has created informational fliers to assist you in understanding the MDL settlement and the key provisions of each individual settlement. To learn what protections these settlements provide your practice, visit *www.ama-assn.org/go/settlements* or *www.hmosettlements.org* or *www.amga.org* or *www.mgma.com* to download these complimentary fliers.

Sincerely,

American Medical Association
American Medical Group Association
Medical Group Management Association

Fact Sheet: Blue Cross Blue Shield Lawsuit Settlement Documents

What is this settlement? The North Carolina Medical Society, in conjunction with 19 other state medical societies, have agreed to a settlement with Blue Cross and Blue Shield Association (BCBSA) and over 80 Blue Cross Plans and subsidiaries, including Blue Cross and Blue Shield of North Carolina. BCBSA, the named Blue Cross plans and their subsidiaries were named as defendants in the class action suit pending in the federal court for the Southern District of Florida (*Love et al .v. Blue Cross Blue Shield Association, et. al.)* and were also named in dozens of state court actions. Wellpoint/Anthem (a company owning numerous for-profit Blue Cross plans) settled similar lawsuits in January, 2006. These settlement agreements now cover over 90% of Blues plans nationwide.

What are monetary damages? The settlement includes substantial prospective relief (changes in Blue Cross business practices) as well as a cash payment of more than $131 million to physicians who qualify and file a claim. Physicians are entitled to file Claim Forms which will result in payments based on their active status, value of claims and the number of physicians who file. In North Carolina: $6.2 million will be contributed by BCBSNC toward the settlement.

When were the Documents Mailed? Mailed Notice, Claim Forms and Claim Form Instructions were mailed to physicians on July 27, 2007. Physicians should have received a plain white envelope with a return address referencing the settlement administrators: Blue Parties' Settlement Administrator, PO Box 2876, Portland, Oregon. If you did not receive the documents, simply download them at www.hmosettlements.com.

What is the Deadline? You must return the completed and signed claim form no later than October 19, 2007. There will be no extensions. Physicians who want to opt out of the settlement must do so by September 14.

Are the documents physician-specific or practice-specific? Physician groups or physician organizations may file one claim form and attach a list of all active physicians to which the claim form applies. If a physician has left the practice, the physician (not the practice) is entitled to file his/her own form. Retired physicians and estates of retired physicians have separate rules and should file on their own behalf.

How are payment shares or categories defined? Active physicians receive payment shares or categories based the physician's certification regarding their level of gross receipts with Blue Cross for 2004, 2005 and 2006 at: (1) less than $5000 (1 Share), (2) between $5,000 to $50,000 (5 Shares), or (3) $50,000 or greater (10 Shares). Physicians may use a different three-year time period between 1997 and 2006 if he/she files "proof of receipt." Retired physicians, and legal heirs or representatives of deceased physicians may elect to receive an amount calculated in part based on the number of Retired Physicians filing claims. Physicians may contribute their shares directly to the NCMS Foundation, Inc. Monetary payments will not be available to physicians against whom Blue Cross has obtained a final finding of fraud and abuse through a judicial, arbitral or administrative proceeding.

More information about the Blue Cross settlement and other settlements with the other health plans named in the lawsuit can be found at www.hmosettlements.com, by calling Carol Scheele or Susie Cunningham at NCMS (919-833-3836), or the Blue Cross settlement administrator at (877) 893-2643.

Fact Sheet: Blue Cross Blue Shield Lawsuit Settlement Documents

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What are monetary damages? The settlement includes substantial prospective relief (changes in Blue Cross business practices) as well as a cash payment of more than $131 million to physicians who qualify and file a claim. Physicians are entitled to file Claim Forms which will result in payments based on their active status, value of claims and the number of physicians who file. In North Carolina: $6.2 million will be contributed by BCBSNC toward the settlement.

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Are the documents physician-specific or practice-specific? Physician groups or physician organizations may file one claim form and attach a list of all active physicians to which the claim form applies. If a physician has left the practice, the physician (not the practice) is entitled to file his/her own form. Retired physicians and estates of retired physicians have separate rules and should file on their own behalf.

How are payment shares or categories defined? Active physicians receive payment shares or categories based the physician's certification regarding their level of gross receipts with Blue Cross for 2004, 2005 and 2006 at: (1) less than $5000 (1 Share), (2) between $5,000 to $50,000 (5 Shares), or (3) $50,000 or greater (10 Shares). Physicians may use a different three-year time period between 1997 and 2006 if he/she files "proof of receipt." Retired physicians, and legal heirs or representatives of deceased physicians may elect to receive an amount calculated in part based on the number of Retired Physicians filing claims. Physicians may contribute their shares directly to the NCMS Foundation, Inc. Monetary payments will not be available to physicians against whom Blue Cross has obtained a final finding of fraud and abuse through a judicial, arbitral or administrative proceeding.

More information about the Blue Cross settlement and other settlements with the other health plans named in the lawsuit can be found at www.hmosettlements.com, by calling Carol Scheele or Susie Cunningham at NCMS (919-833-3836), or the Blue Cross settlement administrator at (877) 893-2643.

How the Aetna Settlement Agreement helps the physician practice

The Aetna Settlement Agreement ("Settlement") benefits physicians in a number of ways including reducing administrative burdens and simplifying claims submission and processing. Physicians and their staff can register referrals, pre-certify procedures, submit claims for covered services, check plan member eligibility for covered services, and check the status of claims for covered services at Aetna's Web site ***www.aetna.com***.

Contracts provided by Aetna to physicians in its provider network must conform to the Settlement. **Physicians should review all future Aetna contracts to make sure that they include a clear written representation that the proposed contract does not waive or conflict with any of the business practice initiatives Aetna has agreed to implement under the Settlement.** An example of such language would be:

> Aetna represents that nothing in this contract waives or conflicts with any of the business practice initiatives it has agreed to undertake pursuant to the Settlement Agreement dated as of May 21, 2003, in the In Re: Managed Care Litigation, Master File No.: 00-1334-MD-MORENO.

Under the Settlement, certain business practices are prohibited, such as those reflected in "gag" clauses, "all products" clauses, and restrictions on stop-loss coverage from other insurers. However, it must be underscored that physicians can waive the protections that are contained in the Settlement. **If the physician receives a contract with terms that are inconsistent with the Settlement and signs the contract then the Settlement protections may be waived.** Physicians should consult with their attorney before agreeing to waive any protections provided in the Settlement. Physicians should consider asking Aetna to separately identify and explain in writing each provision in the physician's contract that is inconsistent with the Settlement and that could result in a waiver by the physician of the protections provided to the physician in the Settlement.

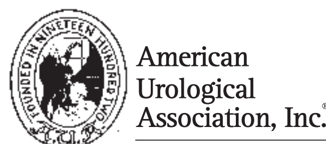
Physicians should review **all** contracts from every payer before signing any contract to understand the implications of the contract on their practices. The American Medical Association (AMA) provides several useful tools to educate physicians on managed care contracts. The AMA *Model Managed Care Contract* contains sample contract language designed to assist physicians in avoiding common contracting pitfalls. The "15 Questions to Ask Before Signing a Managed Care Contract" flyer is designed to complement the AMA *Model Managed Care Contract* and provides a roadmap to help physicians evaluate whether to sign a managed care contract. This material is available on the AMA Web site at *www.ama-assn.org/go/psa*.

Physicians should note that the Settlement provides that if state law offers more protection than the Settlement, then state law applies. Physicians need to be aware of relevant state laws and regulations, particularly in the area of prompt payment of claims to ensure that they are receiving available protections.

A summary of the "key" business practices mandated in the Settlement can be found on the reverse side of this flyer. This flyer does **not** summarize or identify all of the protections provided in the Settlement. Physicians are encouraged to download the Settlement from ***www.hmosettlements.com*** or obtain additional information, including compliance dispute processes, from the AMA Web site at ***www.ama-assn.org/go/settlements***. Physicians may consider filing a compliance dispute if prohibited clauses are contained in a contract submitted by Aetna.

For additional information, go to the AMA Private Sector Advocacy Web site at ***www.ama-assn.org/go/psa***. You may also visit the American Urological Association's Web site at ***www.auanet.org***.

This informational flyer was developed through a cooperative effort between the American Medical Association and the American Urological Association.



Summary of "Key" Aetna Settlement Provisions

Coding Rules

- Aetna shall comply with most American Medical Association (AMA) Current Procedural Terminology (CPT®)* codes, guidelines and conventions.
- No automatic downcoding of any evaluation and management (E/M) CPT code for covered services.
- If a bill contains a CPT code for the performance of an E/M CPT code appended with a modifier 25 and a CPT code for the performance of a non-E/M service procedure code, both codes will be recognized and eligible for payment.
- A CPT code appended with a CPT modifier 59 will be recognized and separately eligible for payment to the extent that they designate a distinct or independent procedure performed on the same day by the same physician.
- No CPT modifier 51 exempt CPT codes are subject to the multiple procedure reduction logic or rule.
- Supervision and interpretation CPT codes are separately identifiable and payable.
- "Add-on" codes, as designated by CPT, will be recognized and eligible for payment as separate codes and shall not be subject to the multiple procedure logic or rule.
- A CPT code will not be automatically changed to a CPT code reflecting a reduced intensity of the service when such CPT code is one among a series that differentiates among simple, intermediate and complex.
- Recommended vaccines and injectibles, as well as the administration of these vaccines and injectibles, will be reimbursed as appropriate.
- No global period for surgical procedures will be longer than any period designated on a national basis by the Centers for Medicare and Medicaid Services (CMS) for such surgical procedures.

Disclosure of Fee Schedule Information, Claim Coding and Payment Policies

- Physician fee schedules shall be made available to all contracted physicians through the Internet and can be changed only once a year.
- Physicians will be provided with 90 days advance notice of all planned Material Adverse Changes to Aetna's policies and procedures affecting performance under contracts with participating physicians.
- Payment policies will be consistent across all of Aetna's products and claim systems.
- A pre-adjudication tool on Aetna's Web site provides informational edits on CPT code combinations so that physicians can obtain Aetna's allowable amount in advance of the actual payment.
- Certain medical payment policies, code editing policy and claims adjudication logic will be disclosed to physicians through Aetna's Web site.

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- Copies of contracts will be provided to physicians upon written request.
- Capitation fees will be paid retroactive to the date of enrollment, when a patient chooses a primary care physician (PCP) or is assigned to the PCP.

Prompt Payment Requirements

- Generally, Aetna is required to issue a check or electronic funds transfer within 15 calendar days of the receipt of clean electronic claims and within 30 calendar days of the receipt of clean paper claims.
- Interest will be paid at the lesser of prime rate or 8% on delayed claims.
- Paper claims will be date stamped upon receipt in the mailroom and an electronic acknowledgment will be generated when an electronic claim is received.

Overpayment Recovery

- Overpayment recovery efforts will not be initiated more than 24 months after the original payment. A 30-day written notice will be provided to the physician prior to initiating an overpayment recovery effort (other than for recovery of duplicate payments).

Medically Necessary or Medical Necessity Definition

- Aetna accepts the following definition of medical necessity.

> "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Arbitration

- Arbitration fees for solo and small group physicians are capped at $1,000.

New Physician Credentialing

- New physician group members will be credentialed within 90 days of the receipt of the application. Physicians also can submit an application prior to their employment.

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GEA:06-0083:2.5M:12/06

Review your CIGNA contract - before September 4!

The CIGNA multi-district litigation (MDL) class action settlement agreement protections **END September 4, 2007**. The termination of the CIGNA settlement agreement means that **CIGNA no longer has to comply with its settlement terms**. However, the termination of the CIGNA settlement does not affect CIGNA's obligation to pay physicians who submitted valid claims for damages from the Claim Distribution Fund and have not yet been paid.

All contracted physicians with CIGNA are encouraged to review their contracts and contact their provider representatives to determine how termination of the MDL settlement will affect their business relationship with CIGNA. The reverse side of this flyer is a checklist that contains a number of key settlement terms. Physicians are encouraged to download the entire settlement document from ***www.hmosettlements.com*** to view all of the settlement provisions.

Aetna, Health Net, Humana and WellPoint (Anthem) settlements remain in effect.

The AMA encourages all physicians to learn about the protections offered physicians through the Aetna, Health Net, Humana and WellPoint (Anthem) settlements that remain in effect. Physicians may consider filing a compliance dispute, (a free, simple enforcement process) if prohibited clauses are contained in a contract submitted by the settling health insurer or the settling health insurer fails to adhere to the terms of its settlement. Physicians are encouraged to hold the settling health plans accountable to their respective settlements. The Blue Cross Blue Shield settlement is anticipated to be effective by the end of 2007. Visit the AMA Web site at ***www.ama-assn.org/go/settlements*** for additional information on these settlements, including the compliance dispute process.

CIGNA's good faith continuation of business practices

The Physicians Advocacy Institute (PAI) is working with CIGNA in an effort to persuade CIGNA to voluntarily continue most of its business practices required by the settlement in an effort to foster continued communication with physicians and transparency of the payment process. As a result of these discussions, PAI has informed the AMA that CIGNA has indicated the following:

Business practices which will remain in effect:

- Adherence to AMA Current Procedural Terminology (CPT®)* codes, guidelines and conventions
- Availability of fee schedules
- No downcoding of CPT codes for evaluation and management (E&M) services
- Payment of reasonable fees for vaccines and injectibles
- 180 day timely filing requirements on claim submissions

Business practice, which may change:

- Clinically-based medical necessity definition, as defined in the settlement
- Reinstatement of all-products clauses
- Increased frequency of fee schedule changes

Business practice that will change:

- Overpayment recovery period will be extended
- No late payment interest on self-funded business
- Reserve right to contract with rental network PPOs
- Compliance dispute process terminated

The AMA commends the PAI for its efforts on behalf of physicians along with CIGNA for its willingness to continue many of its settlement provisions. The AMA urges CIGNA to continue its commitment to disclose certain business practices and provide physicians with greater transparency in its claims processing and payment practices.

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Visit the AMA PSA Web site at ***www.ama-assn.org/go/settlements*** for more information on the MDL and Blue Cross Blue Shield parties' settlements.

Summary of "key" CIGNA MDL settlement provisions effective through September 4

This checklist does not summarize or identify all of the protections provided in the Settlement. Physicians are encouraged to download the Settlement from ***www.hmosettlements.com*** to obtain a complete list of the provisions CIGNA agreed to under the settlement.

Business practices

□ Prohibited "gag clauses"

□ Prohibited "all products clauses"

□ Restrictions on balance billing

□ Termination of contract without cause.

Coding rules

□ CIGNA shall comply with most AMA Current Procedural Terminology (CPT®)* codes, guidelines and conventions, unless otherwise identified on CIGNA's physician Web site.

□ No automatic downcoding of any evaluation and management (E/M) CPT code for covered services.

□ If a bill contains a CPT code for the performance of an E/M CPT code appended with an appropriate modifier (e.g., modifier 25 and 57) and a CPT code for the performance of a non-E/M service procedure code, both codes will be recognized and eligible for payment.

□ A CPT code will not be automatically changed to another CPT code reflecting a reduced intensity of the service when such CPT code is one of a series of codes that differentiates among simple, intermediate and complex.

□ A CPT code appended with a CPT modifier 59 will be recognized and separately eligible for payment to the extent that it designates a distinct or independent procedure performed on the same day by the same physician.

□ No CPT modifier 51 exempt CPT codes are subject to multiple procedure reduction logic or rule.

□ Supervision and interpretation CPT codes are separately identifiable and eligible for payment.

□ "Add-on" codes, as designated by CPT, will be recognized and eligible for payment as separate codes and shall not be subject to multiple procedure logic or rule.

□ Recommended vaccines and injectibles, as well as the administration of these vaccines and injectibles, will be reimbursed.

□ No global period for surgical procedures will be longer than any period designated on a national basis by the Centers for Medicare and Medicaid Services (CMS) for such surgical procedures.

Disclosure of fee schedule information, claim coding and payment policies

□ Physician fee schedules must be made available to all contracted physicians upon request of specific CPT codes via email and can be changed only once a year by CIGNA.

□ CIGNA will not rent its physician networks to any other managed care company or health insurer that is not a subsidiary, for the purpose of providing health care services or supplies to any person who is not a plan member.

□ Physicians will be given 90 days advance notice of all planned Material Adverse Changes to CIGNA's policies and procedures affecting performance under contracts with participating physicians.

□ CIGNA will respond within 10 days to inquiries regarding fee schedule, claim coding and bundling edits, covered services and clinical guideline information that are sent to the established electronic mail address.

□ "Payment in full" or other restrictive endorsement on a payment by CIGNA is not binding and can be appealed.

□ Copies of contracts will be provided to physicians upon written request.

□ Capitation fees will be paid retroactive to the date of enrollment, when a patient chooses a primary care physician (PCP) or is assigned to a PCP.

□ CIGNA shall provide physicians who are paid on a capitation basis with monthly reports within 10 business days after the beginning of each month. These reports will include membership information to allow reconciliation of capitation payments.

Prompt payment requirements

□ CIGNA must process and finalize payment for manually submitted claims within 30 calendar days and 15 business days for electronically submitted claims following the submission of all necessary information.

□ Interest will be paid at 6 percent on late payments.

Overpayment recovery

□ Overpayment recovery efforts will not be initiated more than 12 months after the original payment. A 30 day written notice will be provided to the physician prior to initiating an overpayment recovery effort (other than for recovery of duplicate payments).

Medically necessary or medical necessity definition

□ No retroactive retraction of a pre-certified medically necessary determination.

□ Clinically-based medically necessity definition

Arbitration

□ Arbitration fees for solo and small group physician practices are capped at $1,000.

New physician credentialing

□ New physician group members will be credentialed within 90 days of the receipt of the application. Physicians also can submit an application prior to their employment.

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Visit the AMA PSA Web site at ***www.ama-assn.org/go/settlements*** for more information on the MDL and Blue Cross Blue Shield parties' settlements.

How the Health Net Settlement Agreement helps the physician practice

The Health Net, Inc. (Health Net) Settlement Agreement ("Settlement") provides for greater transparency in Health Net's claims processing and payment practices. Through this Settlement, Health Net has agreed to update and increase the efficiency of its administrative and claims processing systems by improving the speed and accuracy of current information about its plan members' eligibility. Health Net will lessen physicians' administrative burden by reducing the number of procedures requiring precertification and by reducing the number of services requiring submission of clinical information for precertification. In addition, Health Net has committed to disclose certain business practices and provide contracts to physicians in its provider network that conform to the Settlement.

Physicians should review all future Health Net contracts to make sure they include a clear written representation that the proposed contract does not waive or conflict with any of the business practice initiatives that Health Net has agreed to implement under the Settlement. An example of such language is:

> Health Net represents that nothing in this contract waives or conflicts with any of the business practice initiatives it has agreed to undertake pursuant to the Settlement Agreement dated as of May 2, 2005, in the In Re: Managed Care Litigation, MDL No.: 00-1334-MD-MORENO.

Under the Settlement, certain business practices are prohibited, such as: the inclusion of "gag" clauses in provider contracts as well as "most favored nations" clauses, "all products" clauses, and no "withholds" or "risk pools" to capitation payments. The Settlement also provides certain protections against "rental network" relationships with entities other than Health Net affiliates. However, it must be underscored that physicians can waive the protections that are contained in the Settlement.

If a physician receives and signs a contract with terms that are inconsistent with the Settlement, the Settlement protections may be waived. Physicians should consult with their attorney before agreeing to waive any protections provided in the Settlement. Physicians should consider asking Health Net to identify and to explain in writing, each provision in the physician's contract that is inconsistent with the Settlement. Signing a contract that is inconsistent with the Settlement could result in a waiver by the physician of the protections provided to the physician in the Settlement.

Physicians should note that the Settlement provides that if state law offers more protection than the Settlement, then state law applies. Physicians need to be aware of relevant state laws and regulations, particularly in the area of prompt payment of claims, to ensure they receive all available protections.

Physicians should review **all** contracts from every payer to understand the implications of the contract on their practices before signing any contract. The American Medical Association (AMA) *Model Managed Care Contract* contains sample contract language designed to assist physicians in avoiding common contracting pitfalls. Visit *www.ama-assn.org/go/psa* where this material is available to AMA members at no cost.

This flyer does **not** summarize or identify all of the protections provided in the Settlement. If you believe Health Net is not complying with any of the Settlement provisions listed below, you may initiate a compliance dispute by filing a compliance claim form. This form is available at ***www.hmosettlements.com*** and at ***www.npmlaw.com***. For more information concerning the compliance dispute process, visit the AMA Web site at ***www.ama-assn.org/go/settlements*** or contact the Health Net Compliance Dispute Facilitator, Cameron C. Staples, at ***ccs@npmlaw.com***. The compliance dispute process is available to you at no cost and may be an effective way to ensure that Health Net honors its commitments under the Settlement.

Summary of "key" Health Net settlement provisions

Coding rules

- Health Net shall comply with most AMA Current Procedural Terminology (CPT®)* codes, guidelines and conventions, unless otherwise identified on Health Net's physician Web site.
- Health Net will not automatically reduce the code level or reassign the category (e.g., changing a consultation to an office visit) of an evaluation and management (E/M) CPT code for a covered service ("downcoding").
- If a bill appropriately contains a CPT code for the performance of an E/M service appended with a CPT modifier 25 and a CPT code for the performance of a non-E/M service procedure code, both codes will be recognized and eligible for payment.
- If a bill appropriately contains a CPT code for the performance of a preventive medicine E/M service and a CPT code for the performance of a problem focused E/M service appended with a CPT modifier 25, both codes will be recognized and eligible for payment.

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- A CPT code will not be automatically changed to another CPT code reflecting a reduced intensity of the service when such CPT code is one among or across a series that includes, without limitation, codes that differentiate among simple, intermediate and complex, complete or limited and/or size.
- A CPT code appended with a CPT modifier 59 will be recognized and separately eligible for payment to the extent that it designates a distinct or independent procedure performed on the same day by the same physician.
- No CPT modifier 51 exempt CPT codes are subject to the multiple procedure reduction logic or rule.
- Supervision and interpretation CPT codes are separately identifiable and eligible for payment.
- "Add-on" codes, as designated by CPT, will be recognized and eligible for payment as separate codes and shall not be subject to the multiple procedure logic or rule.
- Recommended vaccines and injectibles, as well as the administration of these vaccines and injectibles, will be reimbursed.
- No global period for surgical procedures will be longer than any period designated by the Centers for Medicare and Medicaid Services for such surgical procedures.

Disclosure of fee schedule information, claim coding and payment policies

- Health Net will reference the applicable formula or database used to create its fee schedule and provide, either directly or through its Web site, a means to apply the formula or database to obtain rate information per CPT code.
- Health Net will respond within 10 days to e-mailed inquiries requesting the fee-for-service dollar amount allowable for each CPT code for those CPT codes that a physician in the same specialty reasonably uses in providing covered services. Physicians are allowed up to two inquires per year.
- Physicians can "opt-out" of products through which Health Net offers its provider network for use by entities other than Health Net, its affiliates or its self-funded plan customers.
- Physicians will be given 90 days' advance notice of all planned Material Adverse Changes to Health Net's policies and procedures affecting performance under contracts with participating physicians.
- "Payment in full" or other restrictive endorsement on a payment by Health Net is not binding and can be appealed.
- Copies of contracts along with all attachments will be provided to physicians upon request within 30 days or as soon as practical.
- Capitation fees will be paid retroactive to the date of enrollment, when a patient chooses a primary care physician (PCP) or is assigned to a PCP.
- Health Net shall provide physicians who are paid on a capitation basis with monthly reports. These reports will include membership information to allow reconciliation of capitation payments.

Prompt payment requirements

- Health Net is required to process and finalize payment for claims within 30 calendar days following the submission of all necessary information. Health Net is required to process and finalize payment of claims within 15 business days following the submission of all necessary information for claims submitted electronically.
- Interest will be paid at 6 percent on delayed claims.

Overpayment recovery

- Overpayment recovery efforts will not be initiated more than 12 months after the original payment. A 30 day written notice will be provided to the physician prior to initiating an overpayment recovery effort (other than for recovery of duplicate payments).
- Health Net will reimburse physicians for the reasonable cost of copying medical records that are required for the purpose of postpayment audit. No determination of recoupment, denial or overpayment recovery shall be based on extrapolation or statistical sampling.

Medically necessary or medical necessity definition

- No retroactive retraction of a pre-certified medically necessary determination.
- Health Net accepts the following definition of medical necessity for clinical conditions and mental health care, including treatment for psychiatric illness and substance abuse:

> "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Arbitration

Arbitration fees for solo and small group physician practices are capped at $1,000.

New physician credentialing

New physician group members will be credentialed within 90 days of the receipt of the application. Physicians also can submit an application prior to their employment.

For additional information, visit the AMA Private Sector Advocacy (PSA) Web site at ***www.ama-assn.org/go/psa*** or call (800) 262-3211 and ask for PSA.

GEA:06-1182:2.5M:12/06

How the Humana Inc. Settlement Agreement helps the physician practice

The Humana Inc. ("Humana") Settlement Agreement ("Settlement") provides for greater transparency in Humana's claims processing and payment practices. Through this Settlement, Humana implemented a series of initiatives to improve its relationships with physicians, including but not limited to: reduced pre-certification requirements; greater notice of policy and procedure changes; reduced claim resubmissions; and improved accuracy of information about eligibility of plan members. Humana, via the Internet or clearinghouses, also has given physicians access to register referrals, pre-certify procedures, submit claims for covered services, check plan member eligibility for covered services and check the status of claims for covered services.

In addition, Humana has committed to disclose certain business practices and provide contracts to physicians in its provider network that conform to the Settlement.

Physicians should review all future Humana contracts to ensure they do not contain any provisions that are inconsistent with any of the business practice initiatives that Humana has agreed to implement under the Settlement. An example of such language is:

> Humana represents that nothing in this contract is inconsistent with any of the business practice initiatives it has agreed to undertake pursuant to the Settlement Agreement dated as of October 17, 2005, in the In Re: Managed Care Litigation, MDL No.: 00-1334-MD-MORENO.

Under the Settlement, certain business practices are prohibited or restricted, such as: the inclusion of "gag" clauses in provider contracts as well as "all products" clauses; ability of physicians to obtain stop-loss coverage from other insurers; and the use of pharmacy risk pools.

Physicians should note that the Settlement provides that if state law offers more protection than the Settlement, then state law applies. Physicians need to be aware of relevant state laws and regulations, particularly in the area of prompt payment of claims, to ensure they receive all available protections.

Physicians should review **all** contracts from every payer to understand the implications of the contract on their practices before signing any contract. The American Medical Association (AMA) *Model Managed Care Contract* contains sample contract language designed to assist physicians in avoiding common contracting pitfalls. Visit ***www.ama-assn.org/go/psa*** where this material is available to AMA members at no cost.

This handout does **not** summarize or identify all of the protections provided in the Settlement. If you believe Humana is not complying with any of the Settlement provisions listed below, you may initiate a compliance dispute by filing a compliance claim form (available at ***www.hmosettlements.com***). Visit the AMA Web site at ***www.ama-assn.org/go/settlements*** for more information concerning the compliance dispute process, or contact the Humana compliance dispute facilitator, Carol Scheele, at *cscheele@ncmedsoc.org* or (919) 833-3836. The compliance dispute claim process is available to you at no cost and may be an effective way to ensure that Humana honors its commitments under the Settlement.

Summary of "key" Humana Settlement provisions

Coding rules

- Humana shall comply with most AMA Current Procedural Terminology (CPT®)* codes, guidelines and conventions.
- Humana will not automatically downcode or reduce the code level of any evaluation and management (E/M) CPT code for covered services, except to reassign a new patient to an established patient based on AMA CPT codes, guidelines and conventions.
- If a bill contains a CPT code for the performance of an E/M service appended with a CPT modifier 25 and a CPT code for performance of a non-E/M service, both codes shall be recognized and separately eligible for payment, unless Humana disclosed on its physician Web site that the code combination was not appropriately reported under its policy.
- If a bill appropriately contains a CPT code for the performance of a preventive medicine E/M service and a CPT code for the performance of a problem-focused E/M service appended with a CPT modifier 25, both codes will be recognized and eligible for payment.

*CPT is a registered trademark of the American Medical Association.

Summary of "key" Humana Settlement provisions

Coding rules (continued)

- No CPT modifier 51 exempt CPT codes are subject to the multiple procedure reduction logic or rule.
- "Add-on" codes, as designated by CPT, will be recognized and eligible for payment as separate codes and shall not be subject to the multiple procedure logic or rule.
- Supervision and interpretation of radiologic guidance (e.g., fluoroscopic, ultrasound or mammographic) CPT codes are separately identifiable and eligible for payment.
- A CPT code appended with a CPT modifier 59 will be recognized and separately eligible for payment to the extent that it designates a distinct or independent procedure performed on the same day by the same physician and that there is not a more appropriate CPT recognized modifier to append to the code(s).
- No global period for surgical procedures will be longer than the period designated by the Centers for Medicare & Medicaid Services.
- Humana shall not automatically change a code to one reflecting a reduced intensity of service when such CPT code is one among or across a series that includes, without limitation, codes that differentiate among simple, intermediate and complex, complete or limited, and/or size.
- Humana has agreed to pay a fee for the administration of vaccines and injectibles by a physician.
- Humana will pay for newly recommended vaccines as of the effective date of a recommendation made by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.

Prompt payment requirements

- Beginning one year following the "effective date of September 28, 2006" of the Settlement, "complete claims" for covered services submitted electronically must be paid (mail a check or make an electronic funds transfer) within 15 calendar days of receipt.
- Interest will be paid at 6 percent per annum on delayed claims.

Disclosure of fee schedule information, claim coding and payment policies

- The complete fee information showing the applicable fee schedule amount shall be made available to all contracted physicians via hard copy, CD-ROM or electronically.
- Copies of contracts will be provided to physicians upon written request.
- "Payment in full" or other restrictive endorsement on a payment by Humana is not binding and can be appealed.
- Humana will disclose the identities of those entities that are not subsidiaries to which it provides access to its network of participating physicians. Humana may or may not adjudicate the claims for the entities, but Humana does not provide the explanation of benefits or remittance advice.

Overpayment recovery

- Overpayment recovery efforts will not be initiated by Humana more than 18 months from the date original payment was received by the physician.
- A 30-day written notice will be provided to the physician prior to initiating an overpayment recovery effort.

Medically necessary or medical necessity definition

- No retroactive retraction of a pre-certified medically necessary determination shall occur.
- Humana accepts the following definition of medical necessity or comparable term:

"Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

New physician credentialing

- New physician group members will be credentialed (including, as relevant, licensure and hospital privilege) within 90 days of receipt of the application. Physicians also can submit an application prior to their employment.
- Humana will only require previously credentialed physicians to submit additional information based upon a change in employment or location.

For more information and resources, there are three easy ways to contact the AMA Private Sector Advocacy (PSA) unit:

- Call (800) 262-3211 and ask for AMA-PSA.
- Fax information to (312) 464-5541.
- Visit ***www.ama-assn.org/go/psa*** to access the AMA-PSA Web site.

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