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CONTRACT NEGOTIATION

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Contract Renegotiation

Healthcare providers consistently decry the managed care industry's unwillingness to negotiate contract terms. Instead, managed care contracts are routinely presented on a take-it-or-leave-it basis. Without a doubt, facing the insurance carrier's size, bureaucracy, and routine contracts can be daunting. Yet, many providers have, with persistence, won important concessions through the negotiation process.
The following quote by Attorney Neil Caesar, president of The Health Law Center (*www.healthlawcenter.com*), perfectly illustrates the contrast between action and inaction on the contract negotiation:

> If you cannot differentiate yourself by virtue of risk-taking, scope of services, better outcomes, enhanced patient satisfaction or some other means, then you will be relegated to the bottom of the deep, deep pool of fungible, good-quality caregivers who are told what they will be paid, what services are included in that payment and what administrative and reporting quotas they must satisfy. Conversely, careful negotiation can help you establish working relationships that will make you valuable to managed care companies by offering them enhanced services, prompt availability, a minimum of problems in the relationship and/or higher patient satisfaction. Clear, practical managed care contracts can help you build valuable partnerships with managed care companies.
> (Source: What You Should Know When You Negotiate a Managed Care Contract
> *Managed Care Magazine*, January, 1998
> *www.managedcaremag.com/archives/9801/9801.legal.shtml*)

The economic implications of inequitable negotiation can be very damaging to the medical community. Ultimately, healthcare providers must seriously look at the effect on quality of care and the effect of being denied basic, necessary protections which ensure quality medical decision-making by payers. With so much at stake, managed care negotiators must prepare for negotiations and anticipate how to respond to a carrier's refusal to enhance the contract protections related to the decision-making process.

Nurse and author, Phyllis Beck Kritek, has excellent recommendations to prepare negotiators for such a process in her book, *Negotiating at an Uneven Table: Developing Moral Courage in Resolving Our*

Conflicts. As indicated by the title, Kritek speaks at length to the fact that one party hold the upper hand in almost all negotiations. Disadvantaged negotiators find themselves in a number of compromising situations in which they may not be adequately prepared. Kritek suggests "ten ways of being" to help those in such positions to stay at the table and better represent their interests. The introduction serves as a reminder of how important the task is, even, and perhaps especially, to parties at an extreme negotiating disadvantage:

> The most compelling premise of this book is that the resolution of human conflicts is a moral enterprise that is the responsibility of every human being. To not pursue the creative and constructive resolution of human conflict is to knowingly and deliberately further divisiveness and the harms such divisiveness creates."
> (Source: *Negotiating at an Uneven Table: Developing Moral Courage in Resolving Our Conflicts* [Jossey-Bass, 2002], p 17)

Most commonly overlooked managed care contract issues

Denials can be controlled through better contract language regarding claim processing. State and federal guidelines now provide a number of important protections related to claim processing; however, these protections apply to only certain types of claims. Furthermore, violations can often be pursued only by the policyholder or by state regulatory agencies; therefore, these important mandates do not always extend to protecting doctors and hospital financial interests in an effective manner. The following suggestions are meant to guide providers into negotiating for contract protections which mimic certain consumer protections so that they will be as fully protected as the policyholder.

1. Incorporating prompt payment penalties and protections

The carrier may stipulate that claims will be paid within a specified time frame, but clean claim definitions and penalties for failure to promptly pay may not be included. Many providers feel that this omission is not damaging because state laws may regulate these details. However, many major carriers process both self-funded and fully insured health benefit plans. Self-funded plans are exempt from a number of state mandates and federal protections, while providing some guidance ensuring prompt payment may not be as detailed as the state regulation. Negotiation to include all the state-mandated prompt payment details into the contract ensures that all of your claims with the carrier will fall under the same requirements.

Suggested contract wording:
(This is an amended version of the American Medical Association [AMA] Model Managed Care Contract; for the complete contract, go to http://www.ama-assn.org/ama1/pub/upload/mm/368/mmcc_4th_ed.pdf

(a) In the case of a written claim, Payer shall mail to Medical Services Entity written acknowledgment of receipt of a written Claim within three (3) business days of receipt. Payer shall acknowledge receipt of an electronic claim within twenty-four (24) hours of receiving that claim. When an MCO claims that it has not received a written claim, and Medical Services Entity has a record of the original filing, the time for submission of claims will run from the time Medical Services Entity determines that the MCO did not receive the claim.
(b) If additional information is needed by Payer to evaluate or validate any Claim for payment by Medical Services Entity, Payer shall request any additional information in writing within five (5) business days of receipt of an electronic claim and ten (10) business days of receipt of a paper claim. Payer shall affirm and pay all valid electronic claims within fourteen (14) calendar days of receipt of such additional information, and written claims within thirty (30) calendar days. Any undisputed portions of a Claim must be paid according to the time frame set forth in this clause while the remaining portion of the Claim is under review.
(c) If Payer fails to make such payment in a timely fashion as specified herein, Payer shall be obligated for payment of such amounts plus interest accruing as follows: (i) For electronic claims: 1.5% from the 15th day through the 45th day; 2% per month from the 46th day through the 90th day; and 2.5% per month after the 90th day. (ii) For paper claims: 1.5% from the 31st day through the 60th day; 2% per month from the 61st day through the 90th day; and 2.5% per month after the 120th day.
(d) All payments to Medical Services Entity will be considered final unless adjustments are requested in writing by Payer within one-hundred-eighty (180) days after receipt by Medical Services Entity of payment explanation from Payer.

The following is a suggested addition:
In the event of a discrepancy on the initial filing day, Payer will accept Medical Services Entity's computer-generated billing notes as proof of the initial date of filing. If billing notes are deemed unclear by Payer, Payer will alternatively accept a signed affidavit from the billing representative to establish the initial filing date.

2. Negotiating verification of benefit protections and penalties

Carriers have a duty to provide detailed information to their policyholders regarding coverage. When providers seek information regarding coverage, however, carriers routinely warn that verifications are not a promise of payment and that benefits will be determined only after a provider renders care and files a claim. Negotiating some basic verification of benefit protections can extend the right to receive accurate information to the provider.

Contracts should clearly state that carriers have the duty to provide accurate coverage information prior to treatment when requested by the provider. Carriers routinely record verification and this information should be used to determine the accuracy of the information provided. Therefore, the contract should specify that the provider has the right to request a transcript of the recording if the accuracy of the verification of benefits is questioned. This will force the carrier to review its records and assess the accuracy of the verification. Finally, the contract should stipulate that claims will be processed in accordance with the information cited. Protections related to any breach of contract, such as failure to provide correct benefit information, should result in a contractually agreed upon penalty, such as full payment of billed charges.

Suggested contract wording (patterned after Texas Verification Mandate):

A **verification** is a guarantee of payment. A provider may request verification by telephone, in writing, or through other means of communication, including the Internet, as agreed by the provider and the carrier. Carriers may, within one (1) day of receiving a request for verification, request additional information from the provider. Carriers may make only one request for additional information. A carrier must issue either verification or declination no later than five (5) days after the date of the receipt of the request for verification. For concurrent hospitalizations, verification or declination must be issued within twenty-four (24) hours, and for post-stabilization care or a life-threatening condition, verification or declination must be issued within one (1) hour. Carriers must issue verification in writing, but may also issue verbal verification as long as written verification is sent to the provider within three (3) calendar days of the verbal reply. Verification is valid for at least thirty (30) days.

See AMA Model Verification Language at ***www.ama-assn.org/ama1/pub/upload/mm/368/mmcc_4th_ed.pdf*** for alternative contract language.

Negotiating medical necessity contractual protections

Managed care contracts should specifically address clinical care guidelines that will be used in both utilization review and medical necessity decision-making. In addition, care should be taken to insert language stating that the clinical care guidelines will be waived when they conflict with the medical necessity definitions or situations in which a patient presents a unique combination of illnesses or suffers from treatment-resistant illnesses.

According to a 2003 study conducted by the Utilization Review Accreditation Commission, most insurers use an externally developed medical review guideline, with the most widely used standard being Milliman & Robertson. One Kansas hospital successfully explained in court that Milliman & Robertson guidelines reflect "optimal efficiencies" not attainable in rural hospitals. The Milliman Web site states that its guidelines will soon affect the care of 100 million Americans; however, the Kansas hospital just referenced was able to negotiate terms prohibiting the use of these guidelines for its own claims.

An interview between the Kansas Department of Insurance and a hospital negotiator discusses the hospital's successful efforts to specify that its managed care organization contract uses InterQual instead of Milliman & Robertson because the Milliman & Robertson guidelines are based on "optimal efficiencies," which some rural hospitals cannot reach. You can read the interview at *www.ksinsurance.org/about/archive/bcbs/public_testimony/intervenors/kms/statement_Fairbank.pdf*.

You can appeal applications of the clinical guidelines that do not seem appropriate for the patient's condition on a case-by-case basis, but these appeals may be more effectively argued if certain protections are negotiated into the contract.

Prior to negotiating terms, it is helpful to review your medical necessity denials with that carrier to determine whether the carrier is using a clinical guideline that is frequently at odds with your own quality care guidelines. If there is a more generous or widely followed industry standard at odds with the carrier's clinical guideline, bring that information to the table to demonstrate the problem and explain how it affects your organization.

If such managed care review protections are agreed to in the contract, these protections should be cited in medical necessity and prior authorization appeals to ensure compliance. If the exact guidelines

cannot be agreed upon between parties, the following protections at least give you more ammunition for overturning medical necessity denials on a case-by-case basis.

Defining medical necessity broadly to allow the physician decision-making authority

As discussed, the policy/plan definition of medical necessity is typically very broad and may even reference medical necessity to be care and treatment recognized by the *carrier* as most appropriate for the patient.

The American Medical Association Model Managed Care Contract medical necessity definition, a more provider-friendly definition, reads:

> Carrier agrees to provide payment for medically necessary treatment. For both utilization review and claim processing, medical necessity is defined as follows: Health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider.

You can expand on this definition by addressing disclosure and industry standards with the following text:

> Upon request, the carrier shall provide the clinical rationale used to make an adverse determination, both utilization review and benefit determination, in writing to the provider or facility rendering the service. The clinical rationale used by the carrier should conform to industry standards for quality healthcare such as (insert favorable care standards, such as InterQual, American Cardiology Care Guidelines, American College of Physician Guidelines, etc.).