

GUIDE TO BCBS-TN, INC. PROFESSIONAL AGREEMENT

In response to members and practices contacting the Tennessee Medical Association (TMA) legal department with questions about terms in their BlueCross BlueShield of Tennessee, Inc. Professional Agreement (Agreement or Contract), the Agreement was reviewed and this summary and guide resource was developed. The version we reviewed is referred to on the footer of the Agreement as “Professional Provider Core Template 10.27.14 FINAL”.

This TMA resource provides you with an executive summary of the provisions of the Agreement, an analysis of some of the terms, and a discussion of pitfalls that you might want to pay close attention to when reviewing this or any managed care contract. TMA strongly urges its members to review the contract and its ancillary resources prior to signing it and to obtain competent legal representation in the review and negotiation processes. This resource should not substitute for actually reading the document or obtaining legal advice and representation in contract and fee schedule negotiations. This resource does not identify all pitfalls found in the Agreement as pitfalls can vary from physician to physician depending on circumstances. No fee schedule or rates were reviewed by TMA in the formulation of this resource.

DISCLAIMER: This correspondence and discussion of this issue should not be construed as legal advice or representation by the TMA. It does not constitute an attorney-client relationship between you or any TMA employee. This unwarranted material is provided only for informational purposes. Should you require legal advice or representation, you should contact your personal attorney.

PREPARATION AND CONTRACT REVIEW

1. Read the entire Professional Agreement thoroughly and make sure that you fully understand its terms. Yes, it is long but it creates several obligations on your part.
2. The Agreement is replete with references to “the Provider Manual”. You should access the current version and familiarize yourself with its provisions. Understand that the manual is subject to unilateral revision by BCBS-TN at any time.
3. You should retain an experienced competent health care lawyer to provide legal advice and representation in both the review and negotiation processes. If you would like recommendations for health care lawyers with experience in representing physicians in managed care contract review/negotiations, please contact the TMA Legal Department for a list, info@tnmed.org.
4. Make certain the “Anniversary Date” blank is filled in. This is found in Section 2 within the definition of “Anniversary Date”.
5. Retain a signed copy of your contract once it is signed by the parties. If you do not receive a copy with both parties’ signatures from BCBS-TN, you should follow-up promptly with BCBS-TN to obtain one. This is a legally binding document that you should have easily accessible throughout its term and thereafter. From time to time, you may need to refer to it such as when amendment proposals are sent to you.

PREAMBLE

This section, found on page 1 of 28, recites the parties to the agreement and establishes the effective date which is either the date the last party on the signature page (page 25 of 28) signs it or the date the “Professional Provider” (Provider) becomes credentialed by BCBS-TN. This should not be confused with the Anniversary Date which is defined and discussed in Section 2.

I. Recitals

This short section, found on page 1 of 28, sets out the desire that the parties intend to contract. The Provider is agreeing to provide healthcare services for individuals referred to as “Members” who are eligible to receive covered healthcare services under a BlueCross Benefit Plan.

II. Definitions

This section, beginning on page 1 of 28, defines several terms found in the contract. It is important to read and understand this section because many of the terms defined are found throughout the contract. Some of the terms may not comport to your common understanding and use of them, although most definitions are straightforward. Keep in mind that these definitions apply throughout the contract.

III. Relationship Between the Parties

Section III reiterates the independence of the parties. It also establishes that the healthcare professionals entering into the agreement may be a group practice or other entity.

IV. Services and Responsibilities

Section 4.1(a) on page 4 of 28 states that BCBS-TN does not necessarily agree to let providers participate in any particular network. There is no “any willing provider” law in Tennessee. Thus, BCBS-TN does not have to allow you into every network you wish to join.

4.1(b) limits services to those for which Provider is licensed to perform, credentialed and qualified to provide, and which are medically necessary. It further states that determinations made by BCBS-TN are benefits and not treatment determinations. This is important to note because health plans are often criticized by irate physicians as “practicing medicine” when they refuse to pre-authorize or pay for a service. By signing on to the agreement, you are agreeing that the plan is not practicing medicine when these types of decisions are made.

4.1(b) reminds the provider that some eligibility and coverage determinations are governed by the Early Retirement Income Security Act (ERISA) plans and not BCBS-TN. Such determinations are benefit determinations and not treatment decisions. BCBS-TN acts as a third party administrator for some ERISA plans.

4.2(a) is the nondiscrimination clause. Agreeing to this contract means you should be prepared to treat the plan’s Members. It does allow you to refuse to treat a Member for appropriate medical and professional reasons but not for reasons that would be considered discriminatory.

4.2(e) merits some comment. It says that BCBS-TN may assist Members “in maximizing their benefits”. One of the examples it lists is through the use of “transparency tools”. There is no definition of this or further explanation in the contract. However, we believe that it refers at least in part to BCBS-TN’s physician rating tool for quality and cost. BCBS-TN is not as aggressive as some of the national plans in terms of marketing its rating and tiering system to Members. However, it does have a rating system on its website for use by Members. Tennessee has laws addressing physicians’ rights with regard to rating and tiering. More information on this is available on the “Additional Resources” list at the end of this guide.

4.3 addresses prior authorization. You agree that BCBS-TN can retroactively deny and recoup payments if it is later determined, for example, that the Member was not covered on the date of service, or for other reasons. It is noteworthy that state law governs some recoupments by commercial health plans not acting as ERISA plan administrators. There is more information on recoupments as well as on internal and external appeals listed in the “Additional Resources” section at the end of this guide.

4.6(a) references “Network Participation Criteria” with respect to your insurance requirements in order to participate. These can be found in the Provider Manual.

4.7 requires you, your physician assistants, and nurse practitioners to be credentialed with BCBS-TN.

4.8 allows BCBS-TN to verify information that you provided in your application for participation as a network provider.

4.9 requires you to “immediately” notify BCBS-TN if certain things happen.

4.12 requires you to accept assignments for the payment of services provided to Members and keep evidence thereof. TMA has developed a model assignment of benefit form. More information is included in the “Additional Resources” section at the end of this guide.

4.13 contains standard language requiring you to refer patients only to other in-network providers.

4.15 requires your office to verify the identity of BCBS-TN identification card-holders by checking patient’s IDs when they show up for their appointments.

V. Compensation

5.1(a), on page 8 of 28, requires you to accept payment from BCBS-TN via electronic funds transfer (EFT) or possibly have the Agreement terminated. It references Section 11.4 which is the immediate termination clause.

Section 5.1(d) prohibits balance billing a Member for Covered Services.

Section 5.2 does not allow you to waive any “applicable Member Obligation without BCBST’s prior written approval”. Those refer to copays, deductibles, and co-insurance amounts owed by the Member pursuant to Member’s Benefit Plan.

You have 180 days from the date of service to submit a claim according to Section 5.5(a). If BCBS-TN is secondary, claims must be submitted within 60 days from the date indicated on the primary’s remittance advice or EOB. You are bound by BCBS-TN’s standards of coding and BCBS-TN reserves the right to rebundle, down code, or otherwise “correct” Provider’s coding.

According to Section 5.5(c), BCBS-TN’s coding edits and reimbursement rules are transparent. It does not indicate where such edits and rules are located or how it will notify you of changes to them.

Section 5.5(d) prohibits pass-through billing, like client-billing, for lab work. More information about client billing is available in the “Additional Resources” section at the end of this guide.

Section 5.6 raises an obligation of Provider to notify BCBS-TN upon discovery that Member is eligible for other coverage.

BCBS-TN has the right in 5.7(a) to recover amounts paid to Provider for treatment of Member for illness or injury caused by the Member or a third party. Per 5.7(c), Provider must notify BCBS-TN within 14 days.

VI. Quality Improvement and Utilization Management

Section 6.1 requires you to comply with BCBS-TN Quality Improvement and Utilization Management programs. You should understand what these are. They include BCBS-TN’s rating and tiering program. They are described in the Provider Manual.

VII. Resolution of Disputes

Section 7.3 addresses grievances raised by Members or other Network Providers. You must notify BCBS-TN “promptly” if a Member or other Network Provider files a grievance with you regarding your services. You are obligated to notify BCBS-TN and cooperate to resolve the grievance.

Section 7.4 says rate/fee negotiations, network participation, “and other terms of this Agreement” are not subject to the dispute resolution process found in the Provider Manual.

VIII. Use of Names

By agreeing to Section 8.1, you are allowing BCBS-TN to use your name in its provider directory. It is unclear but this broad provision, along with 8.2 and 9.5, probably permits BCBS-TN to use your name and claims data information for its rating and tiering program which provides information to patients and potential patients. Many plans are starting to post information about cost and rates for various procedures. Arguably, this provision gives it permission to do so.

Section 8.3 prohibits you from using BCBS-TN's name or logo in connection with any of your advertising without its permission. TMA takes the position that this provision would not prohibit you from listing BCBS-TN as a plan in which you are in-network on the State of Tennessee's online Consumer Right to Know professional profile.

IX. Records, Access, Inspection and Confidentiality

Section 9.1 requires you to submit all claims electronically to BCBS-TN.

By agreeing to Section 9.3, you are subjecting yourself to audits and inspections by BCBS-TN employees. This will likely require the production of documents such as medical records to BCBS-TN employees or contractors. You are not allowed to charge these entities for any copying costs or labor for cooperating with the audit or inspection. See "Pitfalls" below for more information. The provision makes it clear that the audits and inspections are "healthcare operations," so under HIPAA individual patient consent is not required to produce these records to auditors and inspectors. You have the right to verify the identity and purpose of business of anyone claiming to be a plan auditor or contracted auditor.

Section 9.4 requires you to make copies of medical records available to other healthcare professionals treating Members at no charge to BCBS-TN or Members. If a patient is "transferred" to the care of another Provider, dis-enrolls, or if you are no longer in-network, you must provide records at no cost to BCBS-TN, the Member, and the new physician. See "Pitfalls" below for more information.

Under 9.5, you agree not to reveal any financial information "or other terms and conditions of this Agreement" to any other person except as required by law, court order, or agreement of the parties. 9.5 also permits BCBS-TN to use your name and claims data information for its rating and tiering program which provides information to patients and potential patients. Many plans are starting to post information about cost and rates for various procedures. Arguably, this provision gives it permission to do so.

X. Liability and Indemnification

Section 10.2 contains a mutual hold harmless and indemnification clause. You should consult your personal lawyer for guidance as to its applicability.

XI. Term and Termination

There are many important provisions in this section. The contract includes provisions for termination without cause, termination for cause, and causes for immediate termination. Each has different notice provisions.

Section 11.1 of the agreement we reviewed provided for an initial three (3) year contract. But the contract was evergreen meaning that it automatically renews each year for successive periods of one year unless terminated. Your contract terms may be different, so pay attention to both the initial term period and any renewal periods.

Section 11.2 prohibits you from terminating the agreement during the "Fixed Period" which is defined in 11.1 as the first three years of the contract. After that, either party wishing to terminate the contract "without cause" may do so by giving written notice by certified mail or courier "no later than 120 days prior to the Anniversary Date". So, if you give notice of termination within the 120 day period, BCBS-TN does not have to let you out of the contract. The "Anniversary Date" is indicated in Section 1 within the definition of "Anniversary Date". Make sure that blank is filled in prior to signing.

Section 11.3 addresses termination for cause referred to as “Material Breach”. This requires notice by certified mail or courier but only requires 30 days’ notice. The reasons for termination must be spelled out in the notice. The non-noticing party has 30 days to remedy the breach to the satisfaction of the noticing party. If not, the contract terminates at the end of the 30 day period. There is a one-sided provision allowing BCBS-TN to terminate the contract “immediately” if there is a pattern of multiple material breaches.

Section 11.4 sets forth a list of things that, if they occur, terminates the contract immediately upon notice by BCBS-TN. Most are straightforward. For example, if your medical license is suspended, put on probation, or revoked, the contract may end. However, it may also terminate if one of your “Associated Professional’s” license is disciplined. For example, under a strict reading of the contract, if one of your employee nurse’s license is revoked, then the BCBS-TN can terminate your agreement. On this list, be cognizant that a judgment or settlement in a medical malpractice case(s) “of sufficient number or seriousness to suggest deficiencies in patient care” may be grounds for BCBS-TN to terminate. Pay close attention to 11.4(g) which essentially gives BCBS-TN broad authority to terminate.

Under Section 11.7, you must understand that termination does not mean you no longer care for members or have a relationship with BCBS-TN. You must care for patients until the patient is transferred to another Network Provider. BCBS-TN still has access to Member records for 5 years. It can still come after you for fraud and abuse for 5 years after termination.

Upon exclusion by BCBS-TN of an Associated Professional from participation for cause, Section 11.8 places the onus and expense of notifying Members on the Provider. The submission of claims indicating that services were performed by a Provider when they were actually performed by an excluded Associated Professional is grounds for BCBS-TN to terminate the contract.

Section 11.9 prohibits you from discouraging any person from doing business with BCBS-TN upon termination. Both parties are prohibited from making disparaging or critical remarks about the other to employees, the news media, or any other person.

XII. Unforeseen Circumstances

Section 12.1 excuses Provider from performance under the agreement under certain circumstances beyond the Provider’s control. However, Section 12.2 allows BCBS-TN to terminate the contract if Provider cannot deliver services for 60 days because of the unforeseen circumstances listed in 12.1.

XIII. General Provisions

Section 13.1 and 13.2 address one of the biggest complaints about providers that we get from the health insurance industry. The provision requires you to notify BCBS-TN in the event of a “change of control” affecting Provider. This can be a purchase of the practice, a merger, a physician leaving the practice, or many other situations affecting the ownership of the practice or the Provider’s status under the contract. As serious a problem as it is maintained by the plans, BCBS-TN does not tell you in the contract who to contact. You may assume that the notice goes to the BCBS-TN contact in Section 13.5.

Section 13.3 prohibits you from subcontracting any portion of the agreement, but BCBS-TN can.

Section 13.4 is boilerplate legalese. It means that if one of the parties decides not to enforce any of the provisions of the agreement, it does not mean that it cannot enforce any similar subsequent breach. For example, assume that Doctor’s medical license is placed on probation for a minor offense. BCBS-TN exercises its discretion and decides not to enforce

Section 11.4(a). If Doctor’s medical license is later placed on probation again by the licensing authority, just because BCBS-TN did not enforce 11.4(a) the last time, does not mean it cannot do so the second time.

Section 13.5 directs you how to give notice as required to BCBS-TN.

Severability is addressed in Section 13.6. This is boilerplate legalese meaning that if a court of law declares that a particular term of the agreement is invalid or not enforceable, then the rest of the contract remains intact.

According to Section 13.7, the Agreement, Provider Manual, and other manuals, including those on the BCBS-TN website, fee schedule attachments, and other addendum are the entire agreement. Understand that you will receive from time to time amendments to the contract which are incorporated into the Agreement if agreed upon by the parties.

Section 13.9 is boilerplate legalese. It means that headings in the contract are for reference only and not part of the Agreement.

Section 13.10 establishes Tennessee as the law of choice to apply if a court has to interpret the contract.

Section 13.11 is boilerplate legalese. Each party warrants that the person signing the Agreement has authority to bind that party.

Section 13.12 is boilerplate legalese. It states the ways in which the contract may be signed by the parties. It says it can be signed in one or more counterparts, each of which is considered an original, and scanned signatures are as good as originals.

XIV. Reserved

Section 14 of the contract we reviewed was designated “reserved” and had no provisions.

XV. and XVI. Network Participation

In the Agreement we reviewed, Sections 15 and 16 addressed participation in Network P and Network S. They set forth the terms of participation; referenced fee schedules (which were not submitted to or reviewed by TMA); and addressed term and termination which referenced Section 11.2.

PITFALLS

1. Generally, much of the information referenced in the agreement may be found in BCBS-TN’s Provider Manual. Be very familiar with this before you sign the agreement. Understand that entries in the Provider Manual may be unilaterally changed by BCBS-TN at any time. So, you are actually agreeing to terms that may not even be in place yet. You should consult the Provider Manual on a regular basis and not rely on your memory of its terms because terms may have changed since you consulted the Manual last.
2. The term “Blue Cross Benefit Plan” is used in several places. It is defined in section 2. More than likely, you will not know what is in a Member’s (patient’s) benefit plan. So, for instance, you will not know what Covered Services are available under the terms of the Member’s Benefit Plan. The pitfall here is that you may unwittingly provide a service you believe is, or should be, covered (paid for) when in fact such service is NOT available under the Member’s Benefit Plan.

3. As to section 4.4, you are agreeing that BCBS-TN may enter into agreements with other providers on an exclusive or preferential basis. So, BCBS-TN may from time to time require you to refer Members to specific providers. This is important because we have seen BCBS-TN in its TennCare line of business require you to submit lab work to Quest instead of a local provider with whom you have a relationship. We have also seen issues with other plans steering imaging services to providers which the plans want Members to go to because the services are cheaper.
4. Section 4.10 requires you to “be available to provide Covered Services to Members at all appropriate times in accordance with the applicable “Member Policy” section of the Provider Manual. You should read and understand this provision. TMA is aware that BCBS-TN audits various aspects of Provider practices. We know that it monitors after-hours voice mail messages and that it has selectively enforced prohibitions on Provider recordings that merely direct callers to the emergency room.
5. Section 5.1(a) requires you to accept payment from BCBS-TN via electronic funds transfer (EFT). Be clear as to what this means. Some health plans pay reimbursements via virtual credit cards. These virtual credit cards actually charge the practice either a percentage of the claim or another fee thus reducing reimbursement. Physicians have certain rights. If this looks problematic, contact the TMA legal department.
6. Be careful with your referrals. Section 5.1(b) requires you to accept 98% of billed charges for services provided to out of network Members and prohibits balanced billing in that situation.
7. Another recoupment pitfall is outlined in Section 5.1(c); in fact, it is quicksand. This provision requires that you obtain a signed advanced notice from the Member if you perform a service that is either not Medically Necessary or not a Covered Service. A sample notice is included in the Provider Manual. Understand that you might not get paid for services requested by the Member that are not Medically Necessary or Covered Services if you do not specifically follow the instructions in 5.1(c), including the use of the form in the Provider Manual. The plan may audit your records for compliance with this provision so save the signed form or risk recoupment of payment for these services.
8. Another recoupment pitfall is found in 5.1(e). If a Member is later determined to have been ineligible on the date of service, BCBS-TN can recoup payments made within ninety days prior to the date that BCBS-TN becomes aware that the Member was ineligible. State law prohibits a plan from recouping based on ineligibility after six months from the date of payment. However, for ERISA plans with different retroactive termination clauses, the ERISA plan provision shall apply. The TMA has an ERISA Toolkit to help members negotiate the oft misunderstood rights physicians have under ERISA. See the “Additional Resources” section at the end of this guide.
9. In Section 5.1(g), you are agreeing that payment and dispute resolutions be resolved pursuant to the terms of the Agreement and Provider Manual. That can be read to mean that there is no recourse to file a lawsuit to attempt to get paid by BCBS-TN. Also, the arbitration provisions can be cumbersome and expensive.
10. In Section 5.3, BCBS-TN reserves the right to deduct any Member Obligations from the Provider’s payment.
11. Section 5.4(b) provides that BCBS-TN can offset overpayments from pending claims or demand direct payment. Offsetting from pending claims can be an accounting nightmare for practices.

12. The BCBS-TN Dispute Resolution Process is referenced in Section 7.2 on page 13 of 28. The process is set out in the Provider Agreement. The first step is an internal dispute resolution process where BCBS-TN employees make the decision regarding any dispute. After that, there is an external arbitration process. Understand that this can be expensive and cumbersome. You may have to go to Chattanooga for the arbitration and you could have to pay for a panel of arbitrators.
13. By agreeing to Section 9.4, you are waiving the option under Tennessee law to charge for the copying of medical records under certain circumstances. This could get very expensive for your office should you, for instance, go out-of-network with BCBS-TN and patients transfer their care to another physician.
14. Under the terms of Section 11.1, if you terminate the Agreement, participation in all networks pursuant to the Agreement terminate. If you wish to terminate participation in a specific network but remain in other BCBS-TN networks, you should not terminate the Agreement but just notify BCBS-TN of termination in a network.
15. Section 13.8(a) expresses that the Provider Manual trumps the Agreement if there is a conflict. In this provision, BCBS-TN reminds you that it can change the terms of the Provider Manual any time it wants with 30 days' notice to Provider. 13(b) allows BCBS-TN to modify the terms of any BCBS-TN Benefit Plan without Provider approval at any time.
16. Amendments have been shown to be a huge pitfall in managed care contracting. How this occurs is outlined in Sections 13.8(d) and (e). BCBS-TN can amend using the procedure described in these sections. Become familiar with this section. Doing nothing with an amendment equals agreeing to the amendment. You have to respond by certified mail if you want to turn down an amendment. Be advised that if you do reject an amendment, BCBS-TN reserves the right to terminate the entire Agreement with only 15 days' notice or just keep the Agreement in place.

UPON TERMINATION OF THE AGREEMENT

1. Make sure BCBS-TN removes your name from its provider directory.
2. Understand your continuing responsibilities under Sections 11.7 and 11.10.
3. Do not throw away your contract. Again, some provisions survive the termination of it.

ADDITIONAL RESOURCES

TMA has several related resources to help members navigate through the labyrinth of managed care and managed care contracting. Below is a list of topics and tool kits that may assist members in understanding their rights vis-à-vis health plans and health plan contracts. To access these documents, go to www.tnmed.org. Under "Member Resources", click on "Legal Resources". Choose the "Law Guide" (or "ERISA Toolkit") button.

1. **ERISA Physician Tool Kit.** TMA's Employment Retirement Income Security Act Toolkit is full of sample letters for filing appeals, claims, and complaints. It also gives resource descriptions to help you with what you need.
2. TMA Law Guide topic on "Assignment of Benefits". Our **Assignment of Benefits** guide is a comprehensive guide detailing the 2010 state law amendments, including definitions and policies.

3. TMA online Law Guide topic on **Credentialing for Physicians – Commercial Insurance Plans** is an informative document that details the laws regarding health insurers' requirements in credentialing of a physician in the state of Tennessee.
4. The **Insurance – Health Carrier Internal and External Review** law guide topic by the Tennessee Medical Association is a very detailed and comprehensive discussion of the definitions, reviews, policies, and procedures regarding the requirement of health carriers to establish and maintain standards for resolution of grievances.
5. The **Interest Charges, Patient Billing** law guide topic by the Tennessee Medical Association provides members a detailed guide on physician's offices charging patients interest on outstanding bills. Included in this document is a TMA practice guide as well as discussions on federal laws and ethical considerations surrounding charging interest charges to patients.
6. The **Pay for Performance** guide by the Tennessee Medical Association details the existing pay for performance regulations, and includes a summary of new additions to the law.
7. The **Prompt Pay** guide by the Tennessee Medical Association defines specific prompt pay laws such as the Commercial, TennCare and Insurance Prompt Pay laws. The **Prompt Pay Sample Letters** guide by the Tennessee Medical Association shows physicians sample prompt pay letters suggested by the Advocacy Resource Center of the American Medical Association to use for their medical practice.
8. The **Recoupment** guide by the Tennessee Medical Association is a very comprehensive document outlining the recoupment laws (and TennCare policies) in Tennessee. Included in this document are summaries, explanations, definitions, pointers, and recoupment examples for medical practices.
9. The **Tiering by Insurance Plans- How to Challenge Profile or Placement** guide is document that provides physicians a to-do list on challenging their current network profile or network placement.
10. The American Medical Association has an excellent resource for its members, National Managed Care Contract, which contains suggested best practice language or managed care contracts. It can be found online at <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/admin-simp-fair-contracting/national-managed-care-contract-overview.page>.