



Private Practice Toolkit

Payor Contract Review Checklist

This Checklist provides an overview of key terms and considerations when reviewing a payor contract as well as questions for physicians to ask when reviewing, understanding, and negotiating agreements.

- **Parties, Plans & Products** Does the contract clearly identify the parties to the contract? Does the contract specify plans and reimbursement methodologies covered under the contract? If the payor adds a plan to the contract, can the physician review and/or opt-out of on a plan-by-plan basis?
- **Physician Services** Does the contract clearly describe physician's services covered by the contract, along with any limitations or exclusions? Does the contract address medical necessity and coverage rules for physician's services? Does the payor have specific prior authorization policies (and transparency of policies) for services or prescriptions? What is the payor's PA process (manual vs. electronic) and are other third parties involved (benefit managers)?
- **Key Definitions** Are the key terms used in the contract clearly defined? Some examples of key terms include adverse change, affiliates, billed charges, clean claim, covered services, effective date, emergency care, enrollee/member/beneficiary, medical necessity, and payor.
- **Credentialing Requirements** Does the contract clearly indicate which party is responsible for credentialing? Are credentialing and corrective action procedures clearly described? Can physicians provide services and receive payment while their credentialing application is pending? Are payors required to notify the physician before actions disciplining or disqualifying a physician? Additional credentialing considerations include confidentiality of peer review documents, peer review organization state license requirements, and feasibility of meeting credentialing requirements (e.g., site visits, turn-around times, reporting, etc.).
- **Payment Provisions**

 - Late Payments or Non-Payment** What are the remedies or penalties for late payments (e.g., late fees, interest, etc.)? Can a physician easily identify nonpayment/underpayment? How can a physician directly enforce payment?
 - Payment methodology** Does the contract specify within how many days the payor must pay the physician? Does the

contract incorporate any state prompt-pay laws? What billing forms must be used? What constitutes a clean claim? Does the contract require physicians to accept electronic payments (vs. paper checks)? Does the contract require the provider to accept virtual credit cards for payment, or to contract with any third-party EFT payment processors? Are there fees associated with receiving payments through VCC or EFT?

Submission of claims Does the timeframe for submission of claims coincide with physician's billing cycles? Does the payor require electronic submission of claims? If so, are practices required to submit via a particular clearinghouse? What method does the payor require for submission of associated clinical data for claims (fax, portal, email, US mail, etc.)? Aside from payment, for what other purposes does the payor use claims data?

Enrollee Payments Is the physician allowed to bill enrollees for coinsurance, co-payments, and appropriate deductibles at the time of service? Is the physician allowed to bill enrollees usual and customary charges for non-covered services?

Overpayment/Offset How are overpayments to physician treated (e.g., will overpayments be offset from future payments; will the physician receive advanced notice of such offsets)?

Appeal Does physician have sufficient time to evaluate and appeal a denied claim? If overpayments may be offset, will offsets begin only after an appeal concludes?

Rates How are rates determined (e.g., fee schedule, percentage of Medicare, other calculation)? If rates are based on Medicare, are they based on the then-current Medicare fee schedule? Does the contract allow the payor to adjust rates, and can physician dispute the change or terminate the contract? Do rates increase annually (e.g., percentage over prior rates, linked to Consumer Price Index)? Are physicians required to offer payor the lowest rates it offers any other payor?

□ **Coordination of Benefits** Does the contract identify which party is responsible for coordination of benefits? Does the contract address whether recovery from all potential sources may exceed the contract price?

□ **Financial Data and Audits** Is the physician required to provide financial data to payor? Is the payor's right to financial data limited to specific, relevant information? Does the obligation to share financial data apply to both parties (particularly for capitated arrangements)? Are the notice and audit timeframes addressed in the contract, and are they reasonable?

□ **Policies, Procedures, Guidelines** Does the contract clearly identify all policies or procedures with which the physician must comply? Has the physician reviewed policies, procedures, or guidelines that are incorporated into the contract before signing the contract? If not, has the physician requested policies, procedures, and guidelines from the payor and reviewed these documents prior contracting? Does the contract require notice of changes to documents that are incorporated into the contract? Can a physician terminate the contract if the terms of updated documents are not acceptable?

□ **Utilization and Quality Review**

Utilization/Quality Review Structures Are utilization review (UR) and quality review structures reasonable and clearly defined? Are each party's roles and responsibilities clearly defined? Is the UR administrator who is responsible for UR determinations identified? Does physician have a right to independent external review? Does the contract require prior written notice for amendments to UR terms? Does the practice have the ability to terminate the contract if amended terms are not acceptable? If so, how burdensome is the process (e.g., simple notice vs. mandatory arbitration)?

Prior Authorization/Concurrent/Retrospective Review

Does the contract clearly identify (or point to specific, easily accessed electronic lists) services, drugs, or supplies that are subject to prior authorization? Are procedures clear, workable, and timely (i.e. specific prior authorization processing times; urgent prior authorization process and associated processing time)? Does the payor offer electronic prior authorization processing via standard electronic transactions integrated within practice management systems/electronic health records (vs. payor portals)? Does payment continue even if an enrollee loses eligibility during a course of treatment? Are there limitations on payor's ability to deny payment, particularly if its prior authorization or concurrent review process approved the care? What are the qualifications of the medical personnel reviewing prior authorizations (Are they guaranteed to be in the same medical specialty or subspecialty)? The AMA has prior authorization resources [available](#).

Appeals and Dispute Resolution Does the contract address physician's appeal rights? Does the contract address the process for grievance or dispute resolution regarding claims or denials based on UR?

□ **Term and Termination** How long is the initial term? Does the contract automatically renew? This can be problematic if payors are changing contract terms (especially rates) and changes are not transparent to the physician. Can the contract be terminated by either party without cause upon written notice (e.g., 30 to 90 days' prior written notice)? Can the contract be terminated immediately in certain circumstances (e.g., loss of license, insolvency, exclusion from federal health care programs; non-payment)? Do parties have an opportunity to cure a material breach after receiving notice of the breach? If so, how long is the cure period? Can the physician terminate on written notice for non-payment? If so, can the physician terminate the whole arrangement due to breach by a single plan? Or, can the physician terminate his or her participation in a single plan without terminating the whole arrangement? Can the physician terminate the agreement without penalties in response to a unilateral amendment or material policy change (note that some state laws require payors to offer this option)?

□ **Effect of Termination** Can the physician terminate the physician's participation in an individual plan(s) without terminating the entire contract? Which terms survive termination? Is the physician's obligation to continue to provide services time-limited, and is the payor obligated to pay the contract price during that time? Is a physician prohibited from rejoining the network after termination? What are the post-termination rates for the payor and plans that were covered by the contract?

□ **Amendment** Are all changes or amendments required to be in writing and signed by both parties or can a party propose amendments unilaterally? If the latter, can the other party object and dispute the amendment or terminate the agreement? Is the physician bound by any "click-through" provisions online?

□ **Assignment/Change of Control** Does the agreement terminate upon the change of control of either party? When is notice required for a change of control (e.g., new EIN/NPI, change in controlling interest)? Does the contract prohibit assignment, delegation, or subcontracting by either party without prior written notice and/or consent? Are there any exceptions?

□ **Indemnification** Do the indemnification terms apply to both parties? Do the protections include agents and employees? Do the indemnification terms jeopardize physician's liability insurance coverage? Do these terms survive the termination of the contract?

□ **Non-Solicitation** Does the agreement restrict the physician from contacting or otherwise soliciting his or

her patients after it is terminated? Does it limit physicians' communications with ongoing patients related to utilization of other providers within a network?

- **Dispute Resolution** How are costs allocated? How are the mediator(s) or arbitrator(s) selected? Where will mediation or arbitration occur? Is arbitration binding or non-binding? What types of disputes must be resolved through arbitration?
- **Operational Considerations** Can the payor outsource functions that may affect the speed or reliability of payment or communications? Does the payor require use of third parties for any functionalities (i.e. prior authorization for certain service types with a benefit manager, or contracting with a third-party company for electronic payments)? If a third party is involved, what is the turnaround time for requested information? Are there additional fees associated with these third parties (i.e. processing fees for electronic funds transfers, portal fees for electronic remittance advice). Does the payor require use of their proprietary portal for compliance or reporting? How does the payor use patient and physician data? Consider taking the following steps before agreeing to a payor contract: (1) review claims data for the payor (e.g., gross revenue and any recurring problems); (2) if applicable, ask different departments for their impressions of the payor (e.g., quality, finance, clinical staff); (3) consider the payor's market share and market focus; and (4) benchmark the payor against other payors.