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You Want Me to Sign **What?**

A Florida Dentist's Handbook on Managed-care Contracts

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THE FLORIDA DENTAL ASSOCIATION'S OFFICIAL PUBLICATION ON HEALTH LAW

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Chapter 1
The Basics: Types of Health Care Delivery Systems

Introduction

Florida dentists must distinguish between insurance and managed care based on four factors:

- Does the doctor sign a contract with the payor? If yes, then it is **managed care**, not insurance.
- Is the doctor contractually limited in advance to charge less than their normal fees? If yes, then it is **managed care**, not insurance. If fees are fixed in advance of care being provided, then it is **managed care**, not insurance.
- Are patients under financial incentives to seek care from in-network doctors (managed care) or do they have "freedom of choice" to be treated by any licensed dentist (insurance)?
- Is the doctor assuming some or all of the insurance risk (the financial cost of providing covered services)? If yes, then it is **managed care**, not insurance.

Definitions

Insurance

Insurance involves a risk of loss (reimbursement) conditioned on an uncertain event (need for dental care) being transferred from one party (the insured patient) to another party (insurer) in return for a set consideration (the premium).[1] There is no contract between the insurer and the doctor. The doctor is free to charge whatever he or she normally does, and the policyholder has freedom of choice to be treated by any licensed dentist. There is no prepayment or agreed fee schedule for professional services, and the doctor is reimbursed after the service is provided. The doctor gets paid based on the value or volume of services provided (fee-for-service) and never underwrites insurance risk (i.e., financial risk based on the value or volume of services provided). What the dentist isn't paid via insurance is balance billed to the patient. The patient (after they sign a personal financial responsibility and assignment of benefits form) is financially liable, typically for 20 percent of the doctor's full charges as compared to the plan's usual, customary and reasonable (UCR) charge for the service.

Managed Care

Financing and delivery of care are separate with insurance; with managed-care organizations (MCOs) they are combined. MCOs sell plans to enrolled individuals and negotiate arrangements with selected providers. They have formal quality assurance and utilization review. They build in financial incentives so that enrollees use the program's providers (steerage), who are watched to keep costs under control. MCOs include arrangements in which providers receive prepaid compensation (i.e., payment agreed to in advance of providing care) to deliver health care services to enrollees. In Florida, MCOs that dentists will encounter include health maintenance organizations (HMOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), prepaid limited health services organization (PLHSOs) and Medicaid prepaid health plans.[2]

Insurance vs. Managed Care

Unlike insurance, with MCOs:

- The payor actively manages how care is provided and the doctor enters into a contract with the MCO. Compared to insurance, managed care is more proactive and the emphasis is on oversight, accountability and cost containment of the dentist through various forms of utilization management.

- There is either a fee schedule agreed to before services are provided or prepayment is made to doctors in exchange for them providing services as set forth in the participating plan agreement.

- Enrollees usually have limited freedom of choice of doctor as there are financial incentives for them to use in-network doctors. But the ability of MCOs to "steer" patients to your practice varies dramatically based on the type of MCO involved.

- The doctor, via the participating provider agreement, assumes some or all of the insurance risk (the financial cost of providing covered services). The doctor can be at either partial or full risk. Partial risk exists when the MCO agrees to pay the dentist a discounted fee-for-service (FFS) payment using either a percentage discount off of a UCR or based on a predetermined discounted fee schedule using a specific fee for a specific code (a table of allowances). With discounted FFS, the doctor subsidizes some of the health care costs. Full risk exists when the MCO agrees to pay the dentist a capitated rate (a dollar amount per enrollee per month) in advance of treatment regardless of the volume or value of health care services utilized by plan enrollees. Full risk means the dentist has signed a legally binding participating provider agreement to provide covered services without further MCO payment. Also, depending on the type of MCO involved, the doctor may be prohibited from balance billing the patient.

Criticisms of Managed Care

Managed care, rather than insurance, now is more common for Florida's dentists, despite some dentists not liking to do business with them because they:

- cut reimbursement rates.

- don't increase reimbursement rates when they increase insurance premiums, and this is true even though the network doctors supported the plan by previously accepting lower reimbursement.

- increase the "red tape" and administrative inefficiency and make it harder to run a profitable dental practice through complicated plan limitations and exclusions (e.g., in-network requirements, medically necessary provisions and annual plan maximums) that interfere with the dentist's autonomy and negatively impact the doctor/patient relationship.

- force dentists to lower overhead to remain profitable.

- don't pay claims on a timely basis even though they require doctors to submit on a timely basis.

- deny claims unfairly.

- use long and complicated contracts written in language unfamiliar to most doctors that are usually one-sided in their favor.

- use capitation, which makes doctors underwrite the full financial risk of utilization of covered services (insurance risk).

Advantages of Managed Care (Steerage and Exclusivity)

MCOs exist to reduce compensation paid to doctors (also known as health care providers or HCPs), but why would dentists voluntarily lower their fees? From your perspective, it only makes financial sense to accept reduced reimbursement based on how effectively patients are locked in to using your services (steerage and exclusivity).

Steerage is achieved by MCOs placing financial incentives on patients to go in-network. Exclusivity (i.e., you are the only dentist in the MCO network) will never occur because both federal and Florida law mandate that closed-panel networks be large enough (both geographically and specialty-wise) to provide essential health benefits (EHBs) to enrollees. So, you need to understand that steerage is undercut based on inclusivity (the number of other dentists in the network). Your practice will never be the only in-network provider, but don't join "over-inclusive" networks that are already packed with in-network dentists because steerage to you will be almost nonexistent. If the network has too many dentists in it already, you will not see an increase in patient recruitment and retention, so why discount your fees? MCOs vary significantly based on how well they steer patients to your practice,

in addition to how they pay participating and non-participating doctors, so Florida dentists should understand the various types of MCOs they will encounter. For example, not all MCOs encourage enrolled patients to obtain care from participating providers and some place you at full risk.[3]

Chapter 2
The Basics: Types of MCO Models

Health Maintenance Organizations (HMOs)

HMOs[4] are regulated by Florida's Department of Financial Services (DFS), formerly known as the Department of Insurance, as well as the Agency for Health Care Administration (AHCA)[5] and have been around since 1973. But now, HMOs often include dental benefits as a supplement to the basic services (e.g., in-patient and out-patient hospital care, medical visits, lab and diagnostic testing, etc.) required by law (aka the EHBs) under the Patient Protection and Affordable Care Act (ACA). Due to ACA's marketplaces or exchanges, dental care is now embedded in many HMO plans.

HMOs require enrollees to use designated service providers (aka in-network) with specialty care accessible only through a referral by the enrollee's primary care physician (PCP), aka the "gatekeeper."[6] HMOs do not cover non-emergency services provided by doctors outside the plan's network of providers. Out-of-network care is unreimbursed. Therefore, HMOs feature high steerage.

HMO networks come in three models:

1. **Staff Model:** the HMO directly employs the HCPs and often locks them in through restrictive covenants. Florida dentists are unlikely to see staff model HMOs due to Florida's proprietorship by non-dentists prohibition,[7] but there are ways around this statute.

2. **Group Model:** the HMO contracts exclusively with a single group of HCPs. This model is common among physicians providing primary or specialty care (e.g., orthopedics, cardiology, radiology) and who have incorporated themselves into a clinically and financially integrated business entity (PA, LLC, etc.). Florida dentists are unlikely to see group HMO models because most dentists practice alone.

3. **Network Model**: what Florida dentists see, which is where the HMO contracts via a "participating provider agreement" with an individual doctor or their practice.

Prepaid Limited Health Service Organizations (PLHSOs)

PLHSOs are regulated by DFS[8] and are stand-alone dental-only plans. In the vernacular, PLHSOS are sometimes referred to as dental maintenance organizations (DMOs) or capitation plans. The error is understandable because these entities act like HMOs but for dental coverage only. However, both terms are misnomers. Capitation refers to a method of reimbursement, not a plan design, and DMO is a registered service mark of The Prudential Insurance Company of America that refers only to its specific product.

In Florida, so-called DMOs are regulated as PLHSOs. Examples of dental PLHSOS include: Oral Health Services, American Dental Plan and International Dental Plan. They provide limited health services to enrollees through exclusive provider panels. Limited health services include ambulance, dental, vision, mental health, substance abuse and chiropractic services. PLHSOs exclude coverage for in-patient, hospital surgical or emergency services unless provided incident to a limited health service. PLHSOs are therefore different than HMOs, self-funded plans or insurers because PLHSOs are authorized to indemnify only for limited health care services.[9]

Preferred Provider Organizations (PPOs)

PPOs are regulated by DFS.[10] They are network products offered by health insurers or HMOs that condition full payment of benefits on the use of network providers. Network doctors offer discounted fees in exchange for prompt payment and a certain expectation of increased patient volume. It is easier for PPO enrollees to access care out-of-network than under an HMO, so the guarantee of steerage is less than an HMO. Cost-sharing by the patient will be a coinsurance percentage amount rather than a dollar-specific copayment as in HMOs. With a PPO compared to an HMO, the dentist is looking to the patient for a larger part of reimbursement. Coinsurance means the patient is financially responsible for a percentage of the charges. Copayment means the patient is financially responsible to pay a stated dollar amount (e.g., $25) each time health care services are accessed. Additionally, the patient may be responsible for deductible amounts before HMO or PPO coverage applies.

PPOs and PLHSOs are the most common type of MCOs seen by Florida dentists. PPOs cover out-of-network services but pay a smaller percentage of the charges to out-of-network doctors compared to in-network doctors (e.g., 70 percent of UCR for

non-participating providers versus 80 percent of UCR for participating providers). PPO out-of-network services also have higher deductibles and coinsurance amounts for patients.

Discount Medical Plan Organizations (DMPOs)

DMPOs or discount plans are regulated by DFS[11] and are becoming common in Florida for dental care. A DMPO may be sold by an insurance company or an MCO, or it can be free-standing and unaffiliated with either insurers or MCOs.

DMPOs are unlike PLHSOs or any other MCO. Discount plans are not insurance and they do not pay for services. DMPOs enter into contracts where, in exchange for fees or dues paid by someone (often not even the patient), they provide access (but not payment) to HCPs for plan members and the right to receive medical services from those HCPs under contract at a discount negotiated between the doctor and the DMPO.

Exclusive Provider Organizations (EPOs)

EPOs are regulated by DFS and are occasionally seen in dentistry.[12] Like PPOs, EPOs are managed-care products offered by health insurance companies (traditional indemnity insurers). EPOs only pay when in-network doctors are used. In effect, they operate as a mini-HMO but for a narrower scope of services. Unlike PPOs, which pay reduced compensation for enrollees using out-of-network care, EPOs pay for no out-of-network care. Thus, EPOs more effectively steer patients to panel providers than PPOs do.

Carve-out Plans

These exist when a public (e.g., Medicaid) or private payor (e.g., an HMO) provides specialized services like dentistry through separate plans and reimbursement policies. Common services provided via carve-outs are prescription drug coverage, behavioral health services, vision care and dentistry. The concept behind a carve-out plan is that actuarial risk and financial risk of over-utilization can be better handled and predicted by a specialized entity providing a narrow scope of services. Dental utilization, for example, is much more actuarially predictable than medical utilization. The latter is catastrophic (meaning it is far less predictable and you never know when it will occur); usually much more involved (meaning it can be multi-specialty or multi-provider); and therefore, significantly more expensive. Dentistry is not catastrophic coverage and is actuarially quite predictable with a large enough enrollee population.

Point of Service Plans (POS)

POS plans allow enrollees to decide, at the time services are obtained, whether to use participating providers or obtain services from doctors outside the network in exchange for reduced reimbursement and perhaps increased premiums. They are hybrids between insurance and MCOs, and feature elements of both financing and delivery systems. Covered persons (i.e., subscribers and dependents) with POS options have freedom of choice to seek care from any licensed dentist without going through the gatekeeper physician.[13]

Workers' Compensation Managed-care Arrangements (WCMCAs)

WCMCAs feature cost-containment features similar to other MCOs. Dentists, especially oral and maxillofacial surgeons, will see both workers' compensation and personal injury protection (PIP) patients. Workers' compensation and PIP are regulated differently than insurance or managed care, but include managed-care cost-containment features. For example, WCMCAs include utilization review/quality assurance,[14] practice parameters,[15] aggressive coordination of care[16] and risk-based provider compensation, such as capitation[17] or fee withholds/risk pools.[18] Their plans of operation must be approved by AHCA.[19] Participating network providers must be certified, meaning that they have completed a minimum five-hour course on the cost-containment mechanisms, utilization review, ergonomics and practice parameters used by the WCMCA.[20]

Personal Injury Protection (PIP)

When dealing with automobile accident patients, PIP coverage is primary[21] (unless workers' comp or Medicaid is involved), so before billing the patient or the dental plan, the doctor must first bill the PIP carrier. Admittedly, PIP coverage is not what it used to be, so it pays for little dentistry. PIP law changed in 2012. Under the old PIP law, Florida was a no-fault state and all drivers had $10,000 in coverage regardless of who caused the accident, and there were no parameters on the type of treatment covered.

Under the new PIP law, the $10,000 personal injury benefits are restricted to emergency care within 14 days from the date of the accident. Also, they require a finding by an allopathic or osteopathic physician, dentist, physician's assistant or registered nurse practitioner (no chiropractors) that the auto accident injuries constitute an emergency medical condition, such that absence of medical care would result in: serious jeopardy to health, serious impairment of bodily functions or serious dysfunction of

bodily organ or parts. Moreover, this finding of emergency medical condition must be made within 14 days of the accident. If no finding of emergency medical condition is made during the 14 days after a car crash, then PIP benefits are restricted to $2,500. If no treatment is received within 14 days, then no PIP benefits are paid. Under the new PIP law, Florida dentists can still get paid up to $10,000, but it's harder to get payment. Chiropractors are capped at $2,500, and acupuncturists and massage therapists are excluded totally.

Under Florida law, there is a prompt payment rule for PIP benefits. They must be paid within "30 days after written notice (the claim form) is furnished to the insurer."[22] DFS, Office of Insurance Regulation (OIR) may order the PIP insurer to pay restitution to a "medical provider … including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law (and) restitution is in addition to any other penalties allowed by law."[23] The interest rate for late payment of PIP benefits varies year by year and is typically lower than prompt payment penalties for other types of MCOs.

If PIP does not pay and there is no other coverage, then the doctor can bill the patient directly. Most doctors have the patient sign and date a form in the intake process whereby they agree to be personally financially responsible in the event insurance doesn't pay.[24] Importantly, the PIP statute[25]is different than normal assignment of benefits. When PIP benefits are at issue, the dentist can bill the injured party only if "the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. However, such a charge may not exceed the amount the person or institution customarily charges for like services or supplies." In addition to the normal assignment of benefits protocols, the patient must personally countersign the bill and state that the services have been actually provided (i.e., the doctor must follow more anti-fraud provisions than assignment of benefits associated with non-PIP coverage).

Independent Practice Associations (IPAs)

IPAs, sometimes referred to as "practice without walls" are uncommon in dentistry. To pass antitrust muster, each independent practice in the IPA must be financially responsible for over-utilization by other practices as well as clinically integrated with those practices. Florida dentists typically are solo practitioners.

Provider Service Network (PSN)

Also known as a provider sponsored network or PSN, it is a network reimbursed on a prepaid basis, operated by a health care provider or group of affiliated health care providers that directly provides health care services under a Medicare, Medicaid or Healthy Kids contract.[26]It is like an IPA for public health care programs. A PSN that is approved by AHCA may obtain a certificate of authority to operate an HMO,[27] but PSNs are not seen in dentistry.

Accountable Care Organizations (ACOs)

As the ACA takes effect, reimbursement methodologies will change to incorporate quality assessments, patient outcomes and a single global capitation payment for all health care services delivered. ACOs exist for hospital and medical services, but Florida dentists will not encounter ACOs for many years.

Which MCOs Provide Strong Steerage?

PLHSOs, HMOs and EPOs provide steerage because if enrollees go to doctors outside the network, no payment will be made. In contrast, PPOs and POS plans provide less steerage because they will pay, although at a reduced rate, for out-of-network services. DMPOs provide strong steerage but do not pay for services provided by doctors under contract; rather, the doctor must give a discount to the patient and collect payment from the patient, not the DMPO.

Chapter 3

The Basics: Types of Reimbursement Methods

Full FFS vs. Managed Care

A simple way to differentiate between full FFS and managed care is to look at when the payment occurs or is agreed to. Full FFS is the traditional model where insurance pays the dentist directly for covered services at the dentist's usual rate and payment is made *after* the care is rendered. Payment also can be concurrent with date of service but it is never paid in advance of the service. In MCOs, the rate of payment (a discounted FFS schedule), a percentage discount off UCR fees or a capitation rate is agreed to *before* the care is rendered.

Some MCO reimbursement methods shift financial risk for paying for covered services from the MCO to network providers. In dentistry, risk-based compensation primarily takes the form of capitation reimbursement.[28] Risk-based compensation means the doctors' earnings depend on their success at either limiting the volume or value of services provided, or increasing practice efficiency. Full or discounted FFS means the more services doctors provide, the *more* money they make. Risk-based compensation like capitation means the more services doctors provide, the *less* money they make.

Discounted FFS

Discounted FFS typically is paid by PPOs. It exists when the HCP agrees to a fee schedule set in advance of treatment for covered services. It caps the maximum fee to be reimbursed for any procedure.

There are two types of discounted FFS (different than capitation): either a "table of allowances"[29] where the doctor will be paid a different fee for each service based on diagnostic codes, or a "UCR discount" where the doctor agrees to discount their charges by a certain predetermined percentage. Discounts vary between 10 and 30 percent depending on competitiveness of the market, the MCO's ability to steer patients to your practice, whether the services are preventive, diagnostic or restorative, and whether a specialist or a general practitioner does the work. Where discounted FFS is partial-risk reimbursement for dentists because they receive discounted rather than their full fees, capitation is known as full-risk.

Capitation

Capitation typically is paid by PLHSOs and HMOs rather than PPOs. Contracted providers receive as payment in full a predetermined amount per plan member, usually paid per month. Capitation reimbursement sometimes is referred to as "PMPM" (per member/per month), prepaid compensation or full-risk compensation to distinguish it from FFS and discounted FFS reimbursement. The capitation payment is not based on the amount, type, intensity or frequency of services (if any) provided to plan enrollees. Thus, the providers are underwriting insurance risk.

Capitation and Balance Billing

When accepting capitation, the participating dentist needs to know that the PMPM fee is basically all they will receive from the payor for covered services. The doctor may be able to bill the patient for a copayment, coinsurance or deductible, but otherwise balance billing is prohibited.

Copayment means a specific dollar amount the subscriber must pay upon receipt of covered health care services.[30] Coinsurance is a percentage amount rather than a specific dollar figure. Balance billing refers to the difference between the doctor's usual fees and the reimbursement actually received from the payor that is collected from the patient as their part of cost-sharing.

MCOs, unlike insurance and PPOs, prohibit balance billing. Under Florida law, any dentist who provides services covered by an HMO or PLHSO — not just those who sign participating provider agreements — is prohibited from balance billing HMO or PLHSO enrollees for covered services.[31]

Capitation and "Pacing"

Capitation pressures participating dentists to limit care and provide it with maximum efficiency. Only by doing so will they remain profitable. Importantly, the American Dental Association (ADA) has indicated that providing slower or cheaper care for patients with risk-based reimbursement than that given to FFS patients is unethical.[32] It also can constitute breach of contract, as most MCO contracts require the dentist to provide managed-care patients the same level of care as FFS patients receive.

Providing slower or less expensive care to MCO patients than fully insured patients also may result in malpractice and disciplinary liability. Participating dentists risk malpractice liability if, to reduce overhead, they refuse to provide needed care to plan enrollees,[33] delay it unreasonably[34] or provide it below the prevailing professional standard.[35] They also risk disciplinary liability if, to increase efficiency, they delegate tasks to ancillary personnel who are unqualified or improperly supervised.[36]

Fee Withholds and Risk Pools

Like capitation, fee withholds (or risk pools) are another form of risk-based compensation. Under this method of reimbursement, network providers are paid predetermined percentages of billing for covered services at the time of service. The remaining amounts are placed into risk pools retained by the MCO. The withheld compensation is paid to providers as a bonus typically at the end of the plan year and only if they have achieved predetermined cost-containment, access and quality of care goals established by the plan. Not often seen in dentistry, but common in primary care medicine and hospital services, penalties are as-

sessed rather than bonuses being awarded, which puts the provider's reimbursement at much higher risk. Risk pools obviously involve a lot of money, so ensure that interest earnings on the reserves are used to enhance the risk pool and not taken as profit for the MCO.

Advantages and Disadvantages of Discounted FFS

Currently, Florida dentists accepting managed care will encounter either discounted FFS, which comes in two different models based on percentage discounts or stated code-based fees, or capitation. The main advantage of discounted FFS payment is predictability, maybe decreased administrative hassle, and higher patient volume. The doctor will never incur a financial loss regardless of utilization unless the MCO goes bankrupt. Disadvantages of discounted FFS payment include claims submission process (e.g., prior authorization), payment disputes (e.g., the MCO asserts that the claim submitted is not a "clean claim"), and HCP responsibilities relating to coordination of benefits when more than one payor is involved.

Predictability of discounted FFS payments is not what it used to be. In the past, most MCO contracts used CDT codes to distinguish between covered and non-covered services, and to set forth specific payment amounts for specific procedures. Now, MCO contracts typically say orthodontic services are excluded as non-covered services (NCS) and periodontal care is covered at a certain percentage. Doctors are left to read the fine print in manuals to decode what they will be paid. Complicating matters further, CDT codes now change every year, but MCO contracts are for multi-year terms. So, policy and procedures manuals now control what the contract used to make explicit.

For example, common exclusions found in policy manuals but not explicit in the contract include the following as NCS: ceramic bridges on posterior teeth; surgical extractions for deciduous teeth; replacement of fillings within 24 months; more than one prophylaxis every six months; scaling and root planning on patients under 30; etc.

Advantages and Disadvantages of Capitation

Advantages of capitation are that disputes over payment are less likely to arise than under discounted FFS. Provided the PMPM fee is high enough, capitation can be a viable business model for Florida dentists.

Disadvantages of capitation are first, unpredictability. The doctor never knows whether the PMPM fees received will adequately compensate for services provided. The number of enrollees in the provider's panel, rather than their actual utilization of services, dictates payment. Second, who will receive the PMPM payment for enrollees who have not been assigned to an in-network dentist? Usually, patients select a dentist only when they need to access services. If the dentist is not getting compensated for enrollees that have not designated the dentist as their provider, then the dentist does not get the benefit of receiving the PMPM payment while those enrollees were healthy and not utilizing care. One fix for this problem is to include a lookback provision in the contract that captures all PMPM payments not previously allocated to network providers once the enrollee selects a network provider.

Future Reimbursement Methods/Shift to Value-based Payment

As the ACA continues implementation, expect to see additional reimbursement methods focusing on quality assessment and improvement. As government payors go, so do commercial payors. The government wants to pay based on value and outcomes, not volume. The government believes that FFS encourages overuse of health care services and fails to hold doctors accountable for whether patients get better. Future reimbursement models will place demands on doctors to not only control costs, but also to increase quality. Even worse, the ability of the individual HCP to gain access to and participate in the provider network becomes paramount.

Currently, we have medical loss ratios (MLRs), which are government regulations restricting how much profit and administrative expenses can go to the MCO versus being paid out to doctors to provide care. Currently, MLRs require a minimum of 85 percent of premiums to go to care, not profit or administrative expenses. At first glance, MLRs appear provider friendly, but as health plan margins decrease, MCOs seek to lower provider reimbursement levels.

Other at-risk reimbursement models are present in hospital and medical care, and eventually will reach dental care. Case rates are common for hospital contracts where the rate for the surgical procedure includes hospital charges, the surgeon and the anesthesiologist's charges, pathology and lab testing, as well as all pre- and post-operative care. Global capitation covers professional, hospital and ancillary services. Medicare has long used resource-based relative value scales (RBRVS) to set maximum fees. In theory, the reimbursement is based on the complexity of the procedure multiplied by a price per unit of complexity.

Since the ACA became law in 2010, the government is shifting reimbursement to ACOs. ACOs are groups of providers that share in the savings — and losses — based on how successful they are at providing access and quality of care, while also managing patients on a budget. This will force individual providers to clinically and financially integrate with other doctors because, in order to underwrite insurance risk, an ACO will need to be sufficiently large to have the capital and to operate on economies of scale.

Chapter 4
MCOs and Other Types of Risk

Underwriting or Insurance Risk

Underwriting or insurance risk occurs when a demographically unfavorable population with significant medical needs is enrolled in the MCO and the cost of providing covered services shifts from the MCO to the HCP. This especially is true among dental MCOS where "adverse selection" commonly occurs. In other words, dental coverage is not mandatory under the ACA, so those who purchase it fully intend to use it, meaning dentists will see higher utilization rates because only dentally needy patients enroll. Also, as the ACA marketplace or exchange becomes crowded with MCOs, competitors may set premium rates artificially low in order to increase market share knowing that the providers bear the financial risk.

Contract defenses against insurance risk include:

- re-opener clauses that allow renegotiation of the fee schedule if there are material shifts in member demographics or other costs.
- utilization corridors that are a specific dollar maximum on the provider's financial exposure to utilization risk before it transfers back to the MCO.
- stop-loss coverage that is a specific dollar maximum on the provider's financial risk before insurance coverage kicks in to reimburse the doctor.

In addition to insurance risk, dentists need to understand other fundamental risk issues when doing business with MCOs.

Price Level or Inflation Risk

Price level or inflation risk occurs when the doctor accepts a fixed payment for services for a fixed period of time and then has to deal with increasing costs due to changes in subcontracted fees or escalation of non-negotiable costs of providing care. The longer the MCO contract term, the more price level or inflation risk the doctor assumes. For example, staff costs, malpractice premiums, increase in rent, and higher cost of supplies and services like biomedical waste disposal all represent price level risk. If the contract is for a one-year term, price-level risk becomes less important.

Contract defenses against inflation risk include:

- an escalator clause in the contract. This means if your operating costs go up, so does the PMPM payment. If using an escalator clause, tie it to the Medical Consumer Price Index, not the CPI for All Urban Consumers (CPI-U). Medical inflation is always higher than CPI.
- a re-opener clause, which means you will have the right to renegotiate PMPM payments if your operating costs increase. It's not as good as an escalator clause that automatically increases because if the MCO is unwilling to renegotiate, your only option may be termination.
- an early termination or escape clause that allows you to cancel the MCO contract without the MCO's approval if price inflation occurs.

Rate Risk

Rate risk occurs when the HCP accepts a percentage of premium reimbursement schedules. Not often seen in dental MCO contracting but possible as ACOs come online, it puts the HCP at risk because whenever the MCO lowers its premiums to gain or protect market share, provider payments are proportionately reduced.

Contract defenses against rate risk include:

- a specified minimum dollar payment that is guaranteed regardless of the amount of premiums collected.
- being wary of contracts that use percentage of premium reimbursement based on proposed rates filed with OIR because MCOs can deviate from these rates.

Leakage

Leakage is present when the patients you think you are going to receive under the MCO arrangement go to another doctor. It is the flip-side of steerage. MCO plans other than HMOs, PLHSOs or EPOs do not restrict members to using only network providers, so you have risk of leakage with these managed-care products.

Contract defense against leakage is to require the MCO to have a significant copayment or deductible difference for in-network and out-of-network care. However, the government regulates how big the spread can be.

Environmental and Legal Risks

Environmental and legal risks occur when governmental regulations change; mandated benefits get added or subtracted; the workforce changes as older dentists leave practice or new dentists come into your geographical or specialty area; there are changes in the businesses with which the MCO contracts as employers come and go; there are lawsuits regarding patient quality of care and outcomes; or the MCO is expanding rapidly and overloading its management infrastructure so HCP payments are significantly slowed, creating cash flow problems.

Contract defenses for environmental risks include:

- calculating the financial and operational impact on your practice before you sign the participating provider agreement. You will see increased operating costs due to higher patient volume (phone calls, appointment requests and follow-ups). You also may see hidden higher costs due to administrative burdens imposed by the MCO contract (think chart reviews and on-site visits, precertification and preauthorization, verification of coverage, clawback provisions, etc.).

- being wary of MCO contracts with evergreen clauses, no escape clause for the doctor and unilateral right to change terms on the doctor (discussed below).

- listing the specific day of each month when PMPM payments will be made and including penalties for late PMPM payments (if capitation).

- ensuring the prompt pay, clean claim and interest penalties conform to statutory requirement (if discounted FFS).

- making chronic late payments grounds for termination with cause by the HCP.

Fraud and Abuse Risk

If the dentist only treats cash patients, there is little risk of fraud and abuse. But it is an "unfair claim settlement practice" for any dentist or their "agent or representative" (i.e., your billing staff) to cause "to be presented to any HMO a false claim for payment knowing the same to be false."[37] The same applies to PLHSOs.[38]

HCP fraud reported by MCOs is investigated by the DFS and OIR,[39] and governmental prosecution does not prevent the MCO from suing the doctor under "general civil and common law" because litigation damages are cumulative remedies to OIR fines.[40]

Both state and federal law have False Claims Acts (FCA) that encourage reporting of provider fraud by qui tam or whistleblower employees because whistleblowers get up to 30 percent of the recovery. In 2014, over 700 qui tam lawsuits were filed with the U.S. Department of Justice, and health care fraud resulted in the recovery of $2.3 billion out of the $3 billion collected. Most FCA cases relate to Medicare and Medicaid, and involve pharmaceutical claims and medical supplies, but doctor services are rapidly gaining. Here are a few examples of FCA violations:

- knowingly presenting (or causing to be presented) a false or fraudulent claim (e.g., falsification of patients and misrepresentation of the number or value of services provided)

- knowingly using (or causing to be used) a false record or statement (e.g., billing under the National Provider Identifier (NPI) of credentialed or enrolled providers when services are, in fact, being done by ancillary staff, or saying a specialist did the care when a general practitioner did) to get higher reimbursement

- conspiring with others (e.g., doctors and billing staff) to get a false or fraudulent claim paid

- knowingly using (or causing to be used) a false record or statement to conceal, avoid or decrease an obligation to repay false claims (e.g., if a Recovery Audit Contractor does an audit and you lie)

- routinely waiving copayments and deductibles to induce patients to use your practice is common with out-of-network billing, but it is improper

- giving professional courtesy discounts in exchange for patient referrals

- up-coding by billing separately for ancillary services (e.g., imaging or dental lab work) or by billing a facility charge, infection control charge or patient cancellation fee because it is already included in the code or description of services used

- if you operate practices in two different locations and accept different MCO plans at each location, submitting claims with the wrong tax identification number (i.e., the number for the other location where you do not participate in-network and get higher reimbursement) because the other location is in a more affluent ZIP code

Chapter 5

How to Negotiate with MCOs Step by Step

Introduction

The primary product sold by MCOs to employers is its provider network quality and accessibility. When you sign a participating provider agreement, you increase the payor's ability to attract business from employers. Saying "yes" to a sub-standard contract only increases a payor's market share so "just say no" to bad contracts. The quality of your payor agreements is far more important than the quantity. Even one bad contract could cause you to fail in your business.

Step 1: Assess Your Negotiating Leverage

Every dentist has been offered MCO contracts on a take-it-or-leave-it basis. But if you have negotiating leverage, everything is negotiable. Walking away from bad contracts (e.g., those that reimburse at less than it costs you to provide care) is the start of negotiating leverage.

Any Willing Provider (AWP) legislation is designed to level the playing field when individual doctors negotiate with MCOs because it requires the MCO to accept any licensed provider willing to accept the MCO's terms and conditions. But Florida does not have any willing provider legislation, and MCOs can accept and terminate providers as they see fit.

SWOT Analysis to Determine Negotiating Leverage

Your practice leverage can be determined with a standard Strength, Weakness, Opportunity and Threat (SWOT) analysis. For example:

- Does your practice provide unique services or amenities that are necessary or marketable for the payor when negotiating with employers?

- Does your practice see most of the employees from a particular employer that is meaningful to the MCO?

- Is the MCO establishing a new product or provider network that requires regulatory approval of network adequacy?

- Is the MCO facing deadlines in order to enter the market by a certain date?

- Is this a one-time deal or is it the start of a profitable long-term relationship?

- Does state insurance law require your provider type to be included in the network? For example, Medicaid mandates pediatric dental benefits and requires that the network be as accessible as a commercial one.

A sample SWOT analysis looks like:

Strength	Weakness
▶ Large market share ▶ Financially sound	▶ No specialists in network ▶ Plan known as having higher than normal administrative burdens
Opportunity	**Threat**
▶ The plan just signed up a major employer in your area.	▶ Other dentists are entering your market.

When You Have Leverage

You may compete on value based against what other dentists are doing. For example, do you treat foster children or other high need/difficult to treat patients that other dentists do not see? Are you willing to measure outcomes and costs for MCO patients, move to bundled payments or expand services into new geographic markets? Can you document reduction in ER visits or preventable hospitalizations? Are you willing to participate in "health fairs" that market the plan's services to prospective customers?

Typically, specialists have more leverage because there are fewer of them and the plans need them in-network to meet regulatory requirements. If you are a specialist, try to participate in the same networks as your referral sources. Participation in networks that do not match those of your referral sources will decrease your patient flow and increase overhead.

When You Don't

Evaluate the payor mix in your practice (i.e., what percentage of revenue comes from cash or self-pay versus insurance billing versus managed care versus Medicaid). If 100 percent of revenue comes from Medicaid, you have no leverage. Likewise, if 35 percent of revenue comes from a single MCO, you have little leverage over negotiations with that particular MCO.

Step 2: Homework Dos and Don'ts

There is plenty of information that the dentist can acquire before contracting to help decide if they want to be under contract and in-network.

- Each subscriber must be given the HMO contract and a member handbook,[41] so review that to determine coverage and exclusions.
- OIR approves rates and filings by MCOs and information about inconsistencies (e.g., a dental service is covered but also excluded), ambiguities (the line between covered and NCS is unclear) or misleading forms is available.[42]
- Review the identification card and ensure it has, at a minimum, an identification number, the MCO's logo and plan name (so you know if you are under contract with that particular plan), and the phone number or email address for prior authorization, benefits verification and patient financial responsibility estimates.[43]
- OIR also has publicly available information about the MCO's financial stability and ability to pay claims as well as their actual medical loss ratio (MLR), which will help you know how much money goes to paying claims versus profit-taking by the MCO.[44]

To prepare to negotiate, dentists should:

- obtain and actually read your managed-care contracts-before signing them.
- make it part of your regular business practice to ask patients for copies of their insurance policy or MCO member handbooks, not just their insurance or enrollment cards. While the participating provider agreement you sign with the MCO will control most of the relationship, the plan documents themselves often address details not found in the contract.
- always keep a fully executed copy (i.e., signed by both parties and contains an effective date). Contracts get modified frequently, so also maintain copies of modifications and their effective dates.
- factor in the amount of time it takes you and your staff to do paperwork. Feeling overwhelmed and burnt out by not having enough time to interact with patients can become a problem if you sign every MCO contract offer.
- research the MCO:
  - Know market shares, service areas, stability, solvency and reputation. A high rate of reimbursement is no good if claims are constantly denied or paid late. An early symptom that an MCO is in financial difficulty is failure to pay claims timely. Or, the MCO may cut the check within the "prompt-payment" statutory timeframe, but not release the check until days later. If an MCO routinely tells providers there is "no claim on file" that also is an indication of financial problems. If you think the MCO is in distress, consider immediately limiting or closing your practice to new patients from that payor.

- Visit each payor's website. Are plan coverage and exclusions clear and concise? Verify the plan hasn't had a high number of employer groups recently dis-enroll. See if a dentist serves on the board of directors or the credentialing and UR/QA committees.

- Look up the provider directory and call a few of them — especially those from your own specialty. Checking the provider list can reveal doctors who are no longer in-network but are still listed, doctors who work only limited hours but are listed as full time, whether deceased doctors are still listed and whether listed doctors have relocated out of the service area. You can search participating providers by specialty or ZIP code. If you're a specialist, find out if your referral sources are participating. If you find a particular MCO's network is very narrow, then anticipate higher utilization, which can be good if the plan is FFS or bad if the plan is capitation. Also, if there is a gap in the network's coverage, you have more leverage if you're in a position to plug the gap.

- Identify what products the MCO offers. It is common for one entity to offer HMO, PPO, Medicaid, workers' compensation, and self-funded Administrative Services Only (ASO) contracts (described below). Which ones are you interested in? Be careful you don't sign up for all of them.

- Ask for the number of enrollees in each plan and the payor's market share in your area to determine steerage. In other words, what major employers in your area have signed up with the MCO and how many patients will you realistically get? Also, compare the enrollee populations against the number of other dentists in the network (both primary and specialists).

- Ask your colleagues about complaints and turnaround time on payment. But realize that they may be contractually obligated not to disclose this information. Confidentiality and trade secret provisions are becoming common and may preclude sharing of proprietary rate schedules with non-contracted parties.

- Find out if the MCO is selling its products on a large group basis or on an individual-issue basis. It dramatically affects the number of individuals in the risk pool and controls whether you will have higher than expected utilization rates due to adverse selection. Individual issue coverage is purchased only because the patient intends to use it immediately and frequently.

- Research whether the MCO leases their networks to self-funded businesses. These contracts are known as ASOs and may have higher than anticipated utilization rates because the employer is self-funding. Also, ASO contracts are regulated under the federal Employee Retirement Income Security Act (ERISA) law, not Florida law. Compared to Florida law on MCOs, there is very little protection for HCPs under federal law.

- If considering capitation, think whether you want the PMPM to be age- and sex-adjusted. If the capitation rate is not severity-adjusted to control against insurance risk, think about negotiating a "risk corridor." This is accomplished by limiting your risk to a pre-specified dollar amount per member for the contract year or by negotiating the exclusion of expensive services beyond your control. If copayment and coinsurance amounts change, how will this affect the capitation rates? Are there incentives if you reach quality benchmarks? Did dentists have input into the clinical benchmarks? Are they realistic and attainable?

- Verify financial solvency via regulatory agency websites. OIR rate filings will provide information on historic and projected medical expenses as well as administrative expenses and profit. Rate filings relate to the premiums the MCO charges consumers, not what it pays providers, but the information can be useful.

- Visit sunbiz.org for corporate status, annual financial reports and board of directors. If you accept Medicaid patients, contact AHCA for the master contract between Florida and the MCO.

- When negotiating, dentists **should:**

  - respond to contract offers with questions rather than statements.

  - ask open-ended questions.

  - base all provisions on written, objective, readily defined standards.

- When negotiating, dentists **should not:**

  - get blinded to the details by looking only at the reimbursement rates.

  - get frustrated and emotional when negotiating; rather, objectify the data so you can make sound business decisions.

- make the mistake of accepting all contract offers regardless of terms just so you can gain market share or avoid losing patients. If the contract doesn't allow you to make money, it is better not to have it.

- evaluate contracts as one-time deals but view them as the start of a hopefully long-term business relationship and a part of your overall diversity of payors and how that stabilizes your practice.

- allow one payor to dominate your practice model.

Step 3: *Prepare a Contract Management Sheet*

MCO contracts are for a stated term. While you can renegotiate at any time, doing so at renewal dates when you have the right to terminate gets better results. MCOs typically use "evergreen" clauses, meaning the contracts renew automatically and in perpetuity unless the doctor gives notice of non-renewal a certain period of time before the anniversary date. Keep track of the anniversary date (when the contract was first signed) because minimum required notice is usually tied to X days before the anniversary date. Rarely is it tied to a simple calendar year date. If you miss the minimum notice period, you are trapped into a contract that may no longer fit your practice. Note in your contract management sheet who the provider relations person is and their name, email and phone number; each plan's unique or unusual claims procedures; the appeal timeframe and where to submit appeals for each level of dispute.

A contract management sheet looks like this:

Payor	Effective Date	Termination Provision	Notice of Non-renewal Date	Date to Start Contract Review
PPO A	June 13, 2014	90 days w/o cause	Flexible	
HMO B	July 15, 2015	180 days prior to second anniversary date	Jan. 15, 2017	Oct. 15, 2016
PLHSO C	Sept. 1, 2012	90 days prior to anniversary date	June 1 annually	March 1 annually

Step 4: *Obtain Current and Complete Fee Schedules*

Make sure you have sufficient detail to know what is payable and what is excluded. A common practice when negotiating is to determine the fee schedule for the top 20 CDT codes your practice submits for reimbursement in terms of both volume and value. It is misleading to look at fee schedules unless you know what you'll get paid across the board. Often, reimbursement rates look good for preventive care but not so good for restorative care. Also, ensure you get all the attachments (especially the payor's provider manual) referred to in the contract. You will want to understand payment rules on timely claims submission, reductions for multiple surgeries, what are non-covered services, prior authorization requirements, claim submission address, appeals process and use of code modifiers. This level of detail often is found in policy manuals, not the actual contract. Having this in a spreadsheet made available to billing staff will increase efficiency compared to reviewing the contract each time a question arises. Don't make the mistake of looking only at the fee schedule. If a procedure you perform routinely is labeled as investigational/experimental, and therefore, not covered, the reimbursement for the service doesn't matter. Likewise, confirm that the services you are obligated to provide are in fact covered. Don't assume the MCO is familiar with your scope of services. If you are a specialist, make sure specialty care is covered. If you're a general practitioner, don't obligate yourself to provide specialty care with which you are uncomfortable. Beware of payors that only give you a sample fee schedule — get a complete list of actual reimbursement rates. The contracted fee schedule is the start of the analysis; it ends only when you have factored in actual payment, timeliness of payment and staff time to obtain payment for each payor.

Update your fee schedule regularly. Don't make the mistake of not updating because reimbursement rates are outlined in contracts. A common provision is "lesser of billed charges or contracted fee schedule," so if you don't regularly update your fee schedule, you may be leaving money on the table. Compare the proposed fee schedule to other payors you have contracted with to see if it is high or low. Note if the contract uses a standard fee schedule or if it is individually negotiated. If you have multiple office locations, determine whether the fee schedule is based on a geographic (ZIP code) qualifier and see if you will get the highest reimbursement. Determine if the fee schedule will be increased or decreased, and if so, when: annually, at time of renewal, at any time unilaterally.

Step 5:
Terms and Conditions are Important!

MCO contracts are always written to favor the MCO. An easy way to analyze them is to break them down into five broad categories: definitions, MCO obligations, HCP obligations, term and termination, and miscellaneous provisions. Never make the mistake of ignoring the terms and conditions of a contract because you fixate on the fee schedule only. With contracts, "the devil is in the details."

1) Definitions

Definitions should be clear, precise and exact. Avoid vagueness and weasel words like "reasonable" or "including but not limited to." Understand key terms like parties, covered person, covered services, emergency condition and medically necessary. Definitions are subtle but make a huge impact. By defining parties to include "other payors" or "all products," the MCO may try to apply the discounted rate to affiliate or subsidiary companies, resulting in discounted rates for far more patients than you thought.

A. Silent PPOs and All Products

A silent PPO is when a payor claims a discount on fees that it is not entitled to under the contract. In effect, it changes your UCR billing schedule and extends discounts to plans that may not be referring you patients. The term also refers to a forced "all products" clause, when one plan with multiple product lines offers one rate for your services provided under all plans. For example, if the plan provides workers' compensation care, PIP benefits and a PPO rate, make sure that each category of service has a different rate. Why would you want to extend the PPO discount for PIP coverage?

Contract defenses include:

- identifying who the parties to the contract are (e.g., does it include other payors).
- knowing all the MCO's products.
- comparing them against the ones for which you are under contract.

B. Leased Networks and Other Payors

Your services can be leased out by the MCO if you see a clause that says:

> "Provider acknowledges that MCO's arrangements for access to the discounted rate (or Fee Schedule) may be deemed to be network "rental," "lease" or "sale" arrangements under some state or federal laws, and that some state or federal laws require specific disclosure of such arrangements. Accordingly, to the extent that the terms "rent," "lease" or "sale" apply to the arrangements contemplated under this Agreement, MCO and Provider agree that MCO may lease, sell, rent or otherwise grant access to Provider's rate discount (or Fee Schedule) to third parties, including other preferred provider organizations."

Provider networks can be leased and you may have signed a participating provider agreement that allows the plan (especially PPOs) to sell its network to other payors and obligates you to provide discounts to these other payors. This is known as an "other payors" clause and is similar to a silent PPO or all products provision. The MCO leasing its network will be paid, so determine if you will as well.

Contract defenses include:

- prohibit leasing.
- requiring advance written notice and your signed consent before the MCO can lease its network.
- requiring the plan logo on membership or enrollee cards so you know exactly what plan is involved.
- making sure that any other MCO to whom your services are leased is obligated to pay you at the same fee schedule — insert language that says:

> "In order to access Provider's discounted rate (or Fee Schedule) through this Agreement, each plan will be obligated to comply with all applicable terms and conditions of this Agreement."

C. TPAs and ASOs

If a TPA is among the contracting parties, your reimbursement is at higher risk. There usually is no contractual provision in the agreement between the health plan and the TPA mandating that the employer whose plan the TPA is administering will pay providers. Many self-funded plans use TPAs and are regulated not under state law but federal ERISA law that gives no protection to HCPs. The TPA is not a payor and provides "administrative services only."

Contract defenses include:

- being on the lookout for ASO contracts.
- list your practice as a third-party beneficiary named in the contract between the employer and the TPA.
- requiring the TPA to cooperate and assist you with pursuing claims against the employer.

D. Covered Persons

The term will be defined to include dependents such as spouse or children based on age. Also, some contracts require notification of the plan as well as plan enrollees if you are no longer accepting new patients; otherwise, they are covered persons entitled to discounted services. Others may require you to accept all patients under the plan and have appointments established for them within a short period of time.

Contract defenses include:

- understanding age limitations for purposes of coordination of benefits.
- negotiating a "cap" on the number of patients you are required to treat as covered persons.
- making it the basis for renegotiation if the number of covered persons exceeds the cap.
- avoiding time limitations for care that your practice cannot realistically meet.
- requiring the MCO name and logo to appear on identification cards so you can identify quickly whether negotiated discounts apply.

E. Covered Services vs. Health Care Services

Be wary of contracts that use both terms, as ambiguity will be used against you. For example, if you accept the applicable fee schedule as "payment in full" for "health care services," you will be required to write-off the difference between your billed charge and the health plan's allowed amount.

Contract defenses include:

- accepting the discount only for clearly defined covered services.
- avoiding the discount for health care services.
- using a CDT-based schedule explicitly listing payment by code.
- including language that allows you to transfer enrollees to other HCPs if needed health care services are beyond the scope of your resources and capabilities.

F. Denied or Referred Services

Some MCO contracts make network HCPs responsible for paying for health care services if the claim is denied as covered services (e.g., not medically necessary or no prior authorization) or if referred out-of-network.

Contract defenses include:

- accepting these clauses only if there are no competing plans offering better terms.
- explicitly stating that the plan, not the referring provider, is responsible for payment for referred care.

G. Clean Claim

A typical MCO definition says:

> "Clean Claim means a properly completed standard billing form that contains all required information needed for processing and has no defect, impropriety or particular circumstance requiring special treatment that prevents timely payment from being made."

Contract defenses include:

- knowing this definition is crucial because MCO prompt-payment obligations do not start to run until a clean claim is submitted.
- knowing that "clean claim" is a term defined in the MCO contract, not Florida law.

H. Effective Date

The effective date usually is found in the preamble (also known as "recitals") or on a signature page that refers to the "date first above agreed to." However, the two dates may differ, and sometimes recitals are not incorporated as part of the contract. Termination and renegotiation is keyed to the effective date.

Contract defenses include:

- knowing which effective date applies.
- monitoring it through your contract management sheet.
- understanding that if you mark up a contract, it is viewed only as an offer to the MCO and the contract takes effect only when the MCO signs it and initials the changes.
- if the network charges a monthly fee to belong that starts immediately upon the effective date, rejecting that term or including language that you are not obligated to pay until you actually bill the plan and the plan steers patients to your practice.

2) MCO Rights and Duties

Your biggest challenge when reading MCO contracts is to understand each plan's unique claims adjudication procedures (e.g., what is each MCO's policy on bundling, multiple procedure reductions, modifiers, preauthorization, claims submission deadline, where and how to transmit, which services require medical notes or radiographs, etc.). While it would be great if MCO contracts were standardized,[45] they are not, so "if you've read one participating provider agreement, then you've read one participating provider agreement."

A. Get and Actually Read All UM/QA Attachments

A typical MCO clause will say:

> "Provider shall submit each Claim to the applicable Plan no later than ninety (90) days after the date of service. Provider acknowledges that the Claim must be a Clean Claim in order to be processed by the Plan. Provider shall not submit Claims to the Plan for Excluded Services."

Utilization management (UM), quality assurance (QA) and claims processing procedures often are excluded from the participating provider agreement and buried in attached provider relations, policies and procedures, claims submission, utilization review or quality assurance manuals.

Contract defenses include:

- not signing until after you get and actually read written copies of all attachments.
- understanding which document controls in the event of a conflict between the participating provider agreement and the policies.
- making the effective date conditional upon your receipt and signed acknowledgement of policy manuals.
- negotiating unfair or inefficient policies before signing the contract.
- reserving the right to terminate if the policies change.
- requiring that qualified dentists be part of the UM review process.
- verifying how to appeal adverse UM decisions.
- understanding the administrative burden to your practice before signing.
- getting input from your front office staff before signing.

Know what type of UM you will encounter. It will either be prior to, concurrent with, or retroactive to claim submission. Prior-to review is preauthorization and precertification requirements. Precertification means clinical review and approval by the plan's medical director before payment. Prior authorization means written approval by a claims adjuster before payment. Both strategies

save money for MCOs by shifting cost to doctors via paperwork, faxing and hanging on the phone, waiting for approval, negotiating on behalf of patients and hiring staff to do that.

Contract defenses include:

- understanding exactly what procedures (usually the expensive ones) require precertification or prior written authorization.
- understanding the time frames for you to submit and for the payor to respond.
- getting a provision that you are entitled to relies on the plan's enrollment or member card, as well as telephone representations of coverage as a material part of the contract.
- including language that precertification will be revoked only if provider fraud or abuse occurs or the provider has intentionally misled.

Concurrent review is common with electronic claims billing, but most MCOs still retain the right to do post-claim or retroactive reviews. A common example is the patient was an enrollee at the time the preauthorization was obtained, but coverage lapsed before treatment began or was completed (see treatment date below).

Retroactive review may be either randomly selected chart reviews or audits. MCOs use statistically-based software to spot "outliers" or claims that seem unusually high or unusually frequent when compared to other dentists. These claims are then selected for intensive review. You may never know the post-utilization review is occurring until you get a letter saying you owe the plan X amount of money.

Contract defenses include:

- having a written records management policy (including but not limited to your diagnosis and treatment plan, case or progress notes, radiographs and maybe even photographs to justify medical necessity).
- keeping records as long as the contract requires or, if unspecified, through the MCO look-back period or the five-year statute of limitations.
- getting the statistical review to be ZIP code specific so the socioeconomic characteristics of your practice are accounted for (dentistry in Miami is more expensive than in North Florida).
- getting adjustments based on your years of practice or whether you are board certified.
- requiring advance minimum notice from the MCO before records will be produced.
- requiring on-site reviews to be during your normal business hours and pursuant to appointment.
- having a staff person there to limit scope of review.
- identifying exactly what records are to be examined.
- prohibiting post-claim statistical analysis or extrapolation of claims data.
- keeping information provided to the HIPAA required "minimum necessary."
- having internal grievance procedures that provide for a qualified independent third party to make the final decision.

B. Uneven Claims Payment

The primary complaint of doctors because a small number of CDT codes account for the majority of a practice's income. If these codes are paid slowly, it does not matter how quickly the plan reimburses for other codes.

Contract defenses include (although most doctors file claims daily for cash flow reasons):

- ensuring that you have enough time to identify overlooked claims and submit them later on for payment or amend them (longer is better).
- seeking mutually reciprocal time frames. MCOs will strictly limit the amount of time in which you can submit or amend claims, but few will limit the amount of time in which they can review paid claims. This is one of the most important terms to consider because if you face retroactive adjustment with respect to claims paid five years ago (the statute of limitations to enforce written contracts), you may have disposed of medical records two years after the treatment and have nothing with which to contest the clawback, which may bankrupt your practice (discussed next).

C. Clawback/Offset

Retroactive UM depends on the time the MCO has to bill you for overpaid claims or to offset future payments to recoup the overpayment. You are not made aware of the impending cash flow crisis until it hits and you have no control over how much the offset will be. The first clue you get will be an explanation of benefits (EOB) that shows fee-for-services provided and an offset taken against that amount.

Contract defenses include:

- negotiating for reasonable advance notice of a proposed adjustment as well as the right to contest it.
- prohibiting debiting overpayments for one patient from other patients covered by the same MCO.
- getting reciprocity (make the clawback provision coincide with the timeframe to submit claims after services are provided — e.g., if the plan can retroactively review your claims reimbursements for one year, but you only have 30 days in which to amend the claim, is this fair?).
- not signing if clawbacks will present you with cash flow problems.
- limiting clawbacks only to overpayment caused due to the HCP's "fault or fraud" of the provider.

D. Not Medically Necessary

Denials based on lack of medical necessity, downcoding and bundling are the bread and butter of slow payment strategies. Since only medically necessary services are reimbursed, ensure unilateral authority to decide what is medically necessary is not vested in the plan, as that will interfere with your autonomy.

Contract defenses include:

- stating that the HCP exclusively determines medical necessity.
- basing it on "community standards."
- having relevant scientific articles proving safety and efficacy.
- speaking directly with the dental director, not claims staff.
- submitting exhaustive diagnostic notes.
- citing to other patients with the same diagnosis who received the same treatment.
- determining if utilization review is outsourced because that leads to fragmented communications.

E. Downcoding

This is when MCOs pay at a lower rate for a less complex procedure than what you actually did. For example, posterior composite restorations become simple amalgam restorations. You get lower than expected reimbursement and cannot utilize non-covered services as a defense so you can charge your usual and customary fees. Since the plan has paid for an amalgam restoration, it's not a non-covered service. Even worse, patients often misconstrue EOB language regarding downcoding as a finding that you have over-billed them by doing more complex procedures than necessary.

Contract defenses include:

- Dentists have rights under Florida law to pursue internal grievances and even outside review under the Unfair Claims Settlement Practices Act (UCSPA). Usually, the dollar amount at stake does not justify these remedies, so front office staff negotiates on a case-by-case basis.

F. Bundling

This is when MCOs purposefully and routinely combine distinct dental services, even those that must be done on different days, into one diagnostic code that pays at a lower rate. For example, combining panoramic image and bitewing radiographs into a "full-mouth series," which then excludes coverage because the plan only pays for one full-mouth series of radiographs every five years; combining a mesial, occlusal and a single-surface buccal restoration into a three-surface restoration.

Downcoding and bundling are uniquely challenging for dentists. The typical contract defense used by hospital and medical providers is to require MCOs to follow the rules and procedures for Medicare billing. Because dentistry has no similar uniform billing standard, there is no effective contractual remedy to prevent downcoding and bundling.

Contract defenses include:

- Dentists have rights under Florida law to pursue internal grievances and even outside review under the UCSPA. Usually, the dollar amount at stake does not justify these remedies, so front office staff negotiates on a case-by-case basis.

- Combine your claims and use Florida's UCSPA and the Subscriber and Provider Dispute Resolution Program/ MAXIMUS.

G. Date of Service

When you do a crown, you send the initial impression to the dental lab (along with payment), but the MCO pays only according to "date of service." If the date of service is defined as "final placement," this pressures your front office to have patients keep appointments and interrupts cash flow on high-dollar services.

Contract defenses include:

- refraining from being stuck with the lab bill by patients who do not return for permanent placement ("snowbirds" who leave Florida in temporaries and never come back).

- understanding whether the date of service is final placement, try-in or prep date.

- trying to get all the plans you do business with to use the same date of service so there is less front office confusion.

- comparing the contract against ADA policy that the date of service for claims payment for fixed prosthetics is the preparation date and is the final impression date for removable prosthetics.

H. Assignment of Benefits

This is when the patient/enrollee tells the MCO to pay the dentist directly for covered services. Some plans disregard the patient's instructions and only will pay in-network providers directly, forcing out-of-network doctors to join the network in order to operate efficiently. Also, when the patient gets the payment instead of the doctor, the patient is likely to want to keep the money forcing the doctor to go to collections.

Contract defenses include:

- knowing Florida's "direct payment" law.[46]

- trying to get paid by the patient at the time of service.

- having financial responsibility forms signed before you submit claims. Most dentists do this routinely when a patient comes into the practice by requiring them to agree that "in the event the dental insurance/plan does not pay for services provided, then the patient is personally responsible." But balance billing the patient is not an option with PLHSOs and HMOs.

I. LEAT Clause

MCOs may exclude coverage for treatment you actually did because there is a "less expensive alternative treatment" (LEAT), even though your standards and the patient's best interests called for a higher level of care (e.g., you recommend a fixed bridge but the plan only pays for a removable partial denture). LEAT is like downcoding, but stronger.

Contract defenses include:

- before commencing treatment, have the patient understand the coverage exclusion so the patient either accepts the partial or makes up the difference between what the plan pays for the partial compared to your UCR for a fixed bridge.

J. Step Therapy and Formularies

Step therapy is when MCOs deny coverage for expensive medication or medical devices (sleep apnea) until a cheaper treatment or medicine fails. Similar, a formulary is when MCOs cover drugs only if doctors first prescribe what's on the plan's preferred drug list. If the first pill doesn't work, they're supposed to try another from the formulary. If there are no appropriate drugs on the formulary, then the doctor must get prior authorization. Payors and providers debate whether the formulary is too narrow or the step therapy too restricted (i.e., is there medical justification or just cost savings for the plan?). Cheaper drugs are usually older off-patent ones that may carry side effects or not work as well as newer brand name drugs. Another problem is MCOs change formularies frequently, forcing patients to change drugs (which may be dangerous) or pay unexpectedly higher coinsurance.

Contract defenses include:

- having medical decisions be the exclusive jurisdiction of the doctor.
- justifying it as safe and clinically effective with independent scientific evidence.
- negotiating that the plan (rather than the doctor) is liable if patients are harmed by unjustified limitations on access to care.
- negotiating to let new members remain on the drugs they are already taking at least until the appeals process concludes.
- grandfathering in medications, devices and therapies if the plan unilaterally changes their prior authorization or formulary list.

K. Cross Coding/Medical vs. Dental Claims

Some MCOs base level of reimbursement on whether services are dental in nature (DIN) or medical in nature (MIN), paying higher for MIN services. This causes doctors to cross code (i.e., use medical codes rather than dental codes because the medical codes pay more). If you are an oral and maxillofacial surgeon (OMS), you may participate in the dental plan, the medical plan or both. If you are in-network for the dental plan, you get paid according to the dental plan rate. If you are in-network for both plans, you get paid the dental plan rate for DIN services and the medical plan rate for MIN services. There is a specific list of DIN versus MIN procedures (almost like a formulary but based on code rather than medication) and precertification (clinical review prior to treatment by the plan's OMS) is required for some procedures.

Contract defenses include:

- understanding exactly what procedures are DIN versus MIN.
- realizing the plan may "reserve the right to change or update this information without notice."

L. Referrals

Some plans limit referrals to specialists to only those who are in-network and may even charge the cost of the referral back to the referring doctor if it is out-of-network.

Contract defenses include:

- inserting a clause that says:

  "Provider shall render only those services that Provider is professionally educated, trained and qualified to perform in accordance with his/her/its license, prevailing local standards of care, and the principles and ethics of the American Dental Association. In the event a Participant is in need of a specialty dentist, Provider shall promptly refer such Covered Person to MCO to make such referral."

- obtain transaction numbers so you can track the claims process.
- using electronic referrals to save on front office time setting up appointments and faxing records.

M. Pre-existing Condition Exclusion

The broadest exclusion commonly used, a typical clause states:

> a "pre-existing condition is any illness that existed before the policy was issued" or "any condition that manifested itself prior to the effective date of coverage."

Contract defenses include:

- arguing the ambiguity. An illness is deemed to have manifested itself only when it is diagnosable.[47]Otherwise, it "is manifest when the insured knew or should have known of the existence of his illness because he was experiencing symptoms that would lead a reasonable person to seek a medical diagnosis."[48]
- regardless of the policy language, whether an injury is manifest such that it is a pre-existing condition is a question of fact.[49]

N. Prompt Payment

The MCO's obligation of timely payment does not start until the HCP submits a clean claim containing "all mandatory entries." Plans will accept ADA claim forms and CDT codes, but they may use unusual coding practices that will increase the administrative burden and result in unintentional errors. Time frames vary based on type of MCO with PIP and workers' compensation using different times.

Florida prompt-payment laws apply to HMOs,[50] insurance, EPOs and PPOS,[51] but not DMPOs or PLHSOS. DMPOs are not payors and PLHSOs are prepaid (either capitation or prepaid aggregate amount).

Contract defenses include:

- knowing Florida law on prompt payment of claims.[52]
- avoiding signing the contract if it doesn't conform to these standards.
- there is a common misperception that a claim that has not been paid or denied cannot be appealed. If an MCO hasn't paid promptly, you can and should at least consider appealing based on lack of timely payment.
- knowing the following: the number of days you have to submit a claim after performing the service; the documentation you must submit with the claim; the number of days the plan has to remit payment upon receipt of a clean claim; the amount of interest, if any, the plan will pay if remittance of payments are late; the amount of time the plan has to claw-back overpayments; and, how the plan limits visits (by annual number, frequency or diagnosis).

3) HCP Rights and Duties

When negotiating, keep operational efficiency in mind and determine whether your contractual obligations are consistent with your own internal procedures and community standards. To maximize your efficiency, try to get standardized procedures and billing across all the MCOs with whom you contract.

A. Balance Billing and Direct Billing

A typical clause says:

> "Provider agrees that he/she/it will bill the Participant only for (i) any applicable copayments, coinsurance payments and deductibles, and (ii) cosmetic services and those dental services that are provided after the Participant has reached his/her maximum benefit available under the MCO."

Contract defenses include:

- knowing Florida law on whether you can directly bill the patient, depending on what type of MCO you are under contract with.

B. Credentialing

A typical clause says:

> "Provider agrees to provide MCO such information as necessary to properly credential Provider, including without limitation, Provider's dental license, evidence of professional liability coverage and the liability limits of such professional coverage, DEA certificate (if applicable), and authorization for MCO to obtain primary source information regarding Provider's education, post-graduation educational program related to dentistry, and any other primary source information necessary for MCO to conduct a proper credentialing program. Provider also agrees to notify MCO promptly and in writing of any pending investigation, action or sanction against Provider, or any agent or employee of Provider, which may affect Provider's ability to perform any obligation under this Agreement."

Contract defenses include:

- knowing what will be considered and when re-credentialing will occur.
- knowing whether you are under an on-going obligation to disclose information affirmatively.
- realizing that extensively long credentialing periods undercut steerage.
- realizing that procedures for ancillary staff and associate dentists compared to owner dentists may be different.

C. Non-discrimination

MCOs prohibit HCP discrimination based on age, race, sex, national origin or religion; some may prohibit discrimination based on medical condition or health status, obligating you to treat all MCO enrollees. This clause says:

> "Provider further agrees that treatment for any Covered Person shall be in a timely manner, without discrimination, and on the same basis as Provider makes available his/her/its services to other patients of Provider."

Contract defenses include:

- making sure you will not be forced to provide care outside your specialty or competency.

- if accepting capitation, ask for a provision capping the maximum number of patients you will be required to see.

- making sure you have authority to change your participation status (i.e., new patients, established patients only, no new patients).

- ensure changes to your participation status are defined to not be discrimination based on health status.

- keeping an eye on your income and guard against capitation becoming a disproportionate part because you lose negotiating leverage.

D. Dental Service and Emergency Care

Some MCO contracts require you to provide evening and weekend coverage or to be on-call for emergency services. This clause says:

> "Provider hereby agrees to provide or arrange for the provision of dental services to covered persons during regular business hours, by appointment and in the event of emergencies. Provider agrees to arrange for a substitute provider within the Network, if appropriate, if Provider is unavailable or absent."

Contract defenses include:

- defining "emergency" to include the "prudent layperson" standard. This protects against retrospective payment denials by defining an emergency as

> "a condition that a prudent layperson with an average knowledge of health care would reasonably interpret to be an emergency requiring immediate medical attention."

- knowing that PLHSOs are required to pay for emergency services — as defined by the PLHSO — when they are provided by doctors outside the participating provider panel, even if they are done without prior notification and approval of the PLHSO.[53]

- knowing EPOs may not restrict payment for covered services provided by nonexclusive providers if the services are for symptoms requiring emergency services and a panel provider is not reasonably accessible.[54]

- knowing that no emergency care payment is required with respect to PPOs.[55]

E. Standard of Care

This clause says:

> "Provider represents that he/she/it is duly qualified and licensed to perform dental services in the State of Florida. Also, Provider represents that all facts set forth on any application or other written documents submitted to MCO in connection with this Agreement are true and correct as of the date hereof, and Provider acknowledges that such facts are material to MCO's entering into this Agreement. Provider warrants that the representations herein shall remain true throughout the term of this Agreement unless Provider notifies MCO in writing of any change in such matters immediately upon the occurrence of such change."

Because the managed-care contract may list the enrollee as a named third-party beneficiary, HCPs should pay attention to the standard of care provision.

Contract defenses include:

- avoiding contracts that require you to provide "highest" or "best" standard of care.

- ensuring the standard is no higher than "the prevailing professional standard of care" used in medical malpractice claims or "that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar HCPs."[56]

F. Audits

All MCO contracts reserve the right to audit you. The typical provision says:

> "Provider agrees to notify and cooperate with MCO in the investigation of any enrollee or subscriber complaint, controversy or claim. Provider agrees to allow inspection by MCO or its agent, of all financial and dental records maintained by Provider specific to the enrollee or subscriber filing the complaint or claim, or identifying a controversy. MCO or its agent shall be allowed to make duplicate copies of relevant dental records upon reasonable notice and during regular working hours at no cost to MCO. Provider shall also permit MCO to access and review its files as necessary for MCO to meet its accreditation requirements."

Contract defenses include:

- clarifying that audits are at the MCO's plan expense.
- occurring only during your normal business hours with your staff present.
- narrowly defining documents subject to audit.
- making the contract comply with HIPAA and Florida records confidentiality law (e.g., the MCO may need to get a patient's signed authorization to release HIV records).
- requiring a stated period of advance written notice describing what they are looking for.
- imposing a specific look-back period beyond which the MCO can no longer audit.
- clarifying whether the audit is on-site or chart review only.
- making it mutually reciprocal, meaning if the MCO can audit you, then you can audit the MCO records and data relative to reimbursement — how else do you know if you are receiving all PMPM or discounted FFS payments to which you are entitled?

G. Gag Clauses/Confidentiality

MCOs often try to restrict open communication between the dentist and his/her patients. When alternative treatment options are discussed they don't want you criticizing the plan's coverage and exclusions. So, they may contractually prohibit you from disclosing "proprietary information," defined to include plan rates and design.

Contract defenses include:

- knowing that under Florida law, the contract cannot prohibit the doctor from discussing the MCO's denial of care and "care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient."[57]

H. Non-solicitation

Provider agreements often prohibit doctors from "soliciting" plan enrollees to terminate with the plan and enroll in a different plan. This clause applies when doctors terminate relationships with the plan and tell plan enrollees that they are joining another plan to comply with "patient abandonment" responsibilities. Depending on how the contract is worded, litigation may ensue if the doctor-patient communication goes beyond notifying them of practice relocation or unavailability to treat.

Contract defenses include:

- being alert that contractual duties do not interfere with your ethical and legal duties.
- narrowly defining what is "proprietary" or "confidential." For example, a contract that prohibits disclosure of "trade secrets" should specify what this information actually is (e.g., the MCO's rate of payment, enrollee lists, other confidential information that would assist a competing health plan) so that you don't have access to the information in the first place. Using enrollee information to notify patients of a doctor's departure is permissible but misappropriation of other confidential information may be actionable.

I. Records Maintenance

Different retention periods in different contracts make it almost impossible for you to have a uniform records retention policy but Florida law[58] requires you to maintain a written records policy. Also, a basic principle of risk management is to keep the rule as uniform as possible, with few or no exceptions, to make it simple to follow.

Contract defenses include:

- using your written records retention policy and attaching it to the contract.
- tying the minimum period to that set forth in statute and BOD rule.
- ensuring that the scope of records to be kept is consistent with your office policy.
- tying it to Florida's records owner laws[59] or HIPAA's "minimum necessary" standard.

J. Financial Responsibility

A typical clause says:

> "Provider shall obtain and maintain during the term of this Agreement professional liability insurance insuring Provider against claims arising out of the dental care services to be performed in connection with this Agreement, in the amount required by MCO, but in no event less than the greater of (i) the amount required by state or federal law; or (b) Three Hundred Thousand Dollars ($300,000.00) per occurrence and One Million Dollars ($1,000,000.00) annual aggregate. Such policy shall be issued by a company authorized to transact business in the State of Florida. In addition, Provider shall maintain comprehensive liability insurance in a reasonable amount that is consistent with similarly situated professional health care providers. Such insurance policies shall be at sole cost and expense of Provider."

MCOs typically do not allow HCPs to self-insure through a line of credit or a self-insurance trust fund[60] against malpractice claims; although, it is permissible under Florida law for a dentist to do so.[61] Also, note that the MCO contract may obligate you to pay for far more coverage than what the Board of Dentistry requires: $100,000 per claim and $300,000 annual aggregate.[62]

Contract defenses include:

- Negotiating against indemnifying the MCO because Florida law states that insurance, PPOs, EPOs, HMOs and PLHSOs:

  > "shall not be liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract in any amount greater than the amount of damages that may be imposed by law directly upon the health care provider."[63]

- Thus, if you have malpractice coverage, the MCO does not need to be indemnified for malpractice liability.

- making sure the coverage required is consistent with what you already have.

- making sure the insurance obligation is mutually reciprocal. On the plan's side it's not for medical malpractice coverage, but rather for commercial general liability (CGL) and errors and omissions ("E and O"), especially if the indemnification and hold harmless provisions are mutual.

K. Coordination of Benefits (COB)

HCPs are entitled to get paid 100 percent of the value of the claim but cannot get paid more than 100 percent. So, MCO contracts make you responsible for COB when one patient has two or more plans providing coverage. If the doctor gets it wrong, claims are denied. It is becoming an increasing problem because the ACA has resulted in more patients buying dental coverage that is "embedded" in their medical plans. But COB issues also arise when there are two separate dental plans. An on-the-job car accident with facial trauma may require COB among a dental plan, a medical plan, workers' compensation, PIP benefits and COBRA.

Contract defenses include:

- having contract language that obligates secondary payors to accept the precertification/preauthorization decision of the primary plan.

- specifying that the HCP (not the MCO) will receive the difference if one payor subrogates claims against another payor and recovers more than it paid you.

- counseling your patients to determine which coverage (including PIP or WC) pays the most and is most likely to pay the dental claim, and file with that coverage first.

COB provisions in MCO contracts and Florida law prohibit you from submitting duplicate claims.[64] Usually, if both plans have COB provisions (as is likely to be the case) the plan that the patient is enrolled in as an employee will be the primary payor. When a dependent is involved, the plan where they are a dependent will be secondary to the plan where they are the primary named insured.

But COB is highly regulated under Florida law.[65] Group health insurance as well as MCO plans "must contain a provision for coordinating its benefits with any similar benefits provided" by any other group health insurance or MCO plan "for the same loss."[66] The health insurer or MCO may "reduce or refuse to pay benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under" another health insurance plan or MCO "that provides protection or insurance against the expense" only if the insurers and MCOs "together pay 100 percent of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment."[67] For example, if the patient elects not to submit a claim to the primary insurer, then the secondary insurer is responsible for 100 percent of the claim.

To simplify, if both plans have COB provisions, the policy or plan that covers the person as an employee, member or subscriber is primary before those of the policy or plan that covers the person as a dependent.[68] In this context, "dependent" means natural born children as well as adopted children.[69] Typically, under ACA the age at which an individual is no longer a dependent is 26 years old. However, if the purported dependent, regardless of age, is incapable of self-sustaining employment due to physical or intellectual disability and is chiefly dependent on the primary subscriber for support and maintenance, then the MCO cannot exclude coverage based on the dependent's age.[70]

If two or more policies or plans cover the same child as a dependent of different parents, then the plan covering the parent with the earliest birthday in the year is primary.[71] If both parents have the same birthday, the plan that covered the parent for the longest period of time is primary.[72] Some states require that the dependent coverage of the father is primary and the coverage of the dependent's mother is secondary. If that is the case, then the COB provisions of the out-of-state policy or plan determine the order of benefits.[73]

If the dependent is a child of divorced or separated parents, then the policy or plan of the parent with custody of the child is primary; then the policy or plan of the spouse of the parent with custody of the child; then the policy or plan of the parent not having custody of the child.[74] However, if a court decree states that one of the parents is responsible for the health care expenses of the child and the HCP or the patient puts that policy or plan on actual notice of the court order, then that plan is primary.[75]

If none of the previous rules resolve the COB, then benefits of the policy or plan which has covered the patient for a longer period of time is primary.[76] If COBRA benefits[77] are involved, the plan covering the person as an employee, or as the employee's dependent, is primary and the COBRA coverage as a former employee or the dependent of a former employee is secondary.[78] If available, Medicare and Medicaid will always be secondary or tertiary payors.[79]

4) Term and Termination

Plan your exit strategy before you need it and account for factors outside your control that may force you to terminate MCO arrangements earlier than you planned. MCO plans often have multi-year initial terms combined with a clause that does not allow termination within the initial term, and further allows termination without cause only by the plan. Essentially, this locks the dentist into a multi-year term. If contract reimbursement is at risk, a long term effectively shifts price and inflation risk, as well as insurance risk and environmental/legal risks from the payor unto the doctor.

A. With or Without Cause

Without cause means any party can terminate for any reason or no reason at all upon giving notice to the other party.

Contract defenses include:

- avoiding termination at the "sole discretion" of the plan.
- negotiating for termination "only if the provider's participation jeopardizes enrollees' health or safety."

With cause means there must be a material breach of a provision before the contract can be cancelled. MCO contracts will define "cause" to include your failure to meet credentialing standards; suspension or revocation of license; settlement or judgment of medical malpractice; failure to maintain acceptable standards of care set forth in the contract; etc. But they do not make as explicit when the dentist will have cause.

Contract defenses include:

- specifically defining what constitutes material breach by the MCO, e.g., slow or inaccurate claims payment; changes in rates; failure to pay interest on untimely claims; breach of unfair claim settlement practices; failure to publish your name in the provider directory; bankruptcy filing; etc.

Termination with cause is usually tied to a "time to cure," meaning that once the breaching party is put on notice of the breach, they then have a contractually specified period of time in which to cure the breach. Only if the breach is not cured within that time is the contract canceled for cause.

Contract defenses include:

- getting a clear time frame in which you can cure the default.
- knowing when Florida law preempts termination clauses in MCO contract.

Florida Law Pre-empting Termination Clauses

There is no Florida law preempting the contract's termination clause for health insurance, PPOs and EPOs. However, there is for PLHSOs and HMOs.

PLHSO

HCPs must give "no less than 90 days' advance written notice to the PLHSO before canceling the contract … for any reason.[80] Florida dentists also should be aware that "nonpayment for goods or services rendered by the provider to the PLHSO shall not be a valid reason for avoiding the 90-day advance notice of cancellation."[81] The PLHSO may, if the HCP asks, "terminate the contract in less than 90 days if the PLHSO is not financially impaired or insolvent."[82]

Likewise, PLHSOs must give at least "90 days' advance written notice to the provider before canceling, without cause, the contract with the provider, except where a patient's health is subject to imminent danger or a provider's ability to practice is effectively impaired by an action by the Board of Dentistry or another governmental agency."[83] Note the 90-day warning does not apply when the PLHSO is terminating the HCP for cause.

HMO

HCPs must give "60 days' advance written notice to the HMO … before canceling the contract with the HMO for any reason.[84] Florida dentists also should be aware that "nonpayment for goods or services rendered by the provider to the HMO is not a valid reason for avoiding the 60-day advance notice of cancellation."[85] The HMO may, if the HCP asks, "terminate the contract in less than 60 days if the health maintenance organization is not financially impaired or insolvent."[86]

Likewise, HMOs must give "60 days' advance written notice to the provider … before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action" by the Board of Dentistry or other governmental agency.[87] Note the 60-day warning does not apply when the HMO is terminating the HCP for cause.

B. Evergreen Clauses

MCO contracts provide for automatic extension of the contract for specified periods beyond the initial term unless either party specifically elects to terminate the contract by giving the required notice prior to an anniversary of the "effective date." Common in MCO contracts, they will say:

> "Thereafter, this agreement will automatically continue for successive one-year renewal terms unless you or the MCO give written notice of cancellation to the other at least 60 days before the initial or renewal term ends."

They are legal and enforceable in Florida provided they are reduced to writing and signed by both the MCO and the HCP. Evergreen clauses can trap you into providing discounted services for a much longer period of time than you intended. For example, if you missed the two months immediately preceding the anniversary of the effective date, you are stuck for another 10 months.

Contract defenses include:

- looking carefully for evergreen clauses.
- if it is a multi-year term, negotiate for an accelerator or escalator clause that guarantees fee schedule increases each year of the multi-year term, typically stated as a percentage amount per year or tied to an objective published economic indicator like the Medical Consumer Price Index.
- if it is a full-risk capitation contract, consider using a "utilization corridor."

C. Statute of Frauds

Contracts that violate the statute of frauds are unenforceable in Florida. Because most MCO contracts are longer than one year, they must be reduced to writing and signed by both parties before they are enforceable as contracts. Florida's statute of frauds[88] applies to "any agreement that is not to be performed within the space of one year from the making thereof." As an aside, the statute of frauds also applies to a HCP's "guarantee, warranty or assurance as to the results of any medical, surgical or diagnostic procedure."

Contract defenses include:

- never agreeing to handshake deals on MCOs.
- realizing that Florida law mandates that MCO contracts be in writing for you to get reimbursed.

D. Work in Progress/Continuation of Care

A typical MCO clause says:

> "If this Agreement is terminated, other than for cause, while Provider is providing dental care services to any enrollee/subscriber, Provider shall continue to provide such services to such personas shall be required by applicable law, until the completion of any episode of care that may be underway at the time. In such instances, Provider shall continue to accept the discounted rate as payment in full for any claim submitted in connection with such services."

Or, it might say:

> "In the event of termination, dentist shall complete all work in progress."

Such clauses require you to continue delivering care to MCO enrollees after the contract has been terminated, meaning you may be obligated to provide the care but will not be reimbursed for it.

Contract defenses include:

- ensuring that the MCO's obligation to pay for work in progress survives termination of the contract.
- stating clearly that payments for a work in progress are at the same rate.
- stating that the prompt-payment provisions as existed before termination continue to apply.

5) Miscellaneous

MCO contracts may contain anything that is not inconsistent with Florida law.[89] Your defense is to avoid language that is one-sided in favor of the MCO.

A. Severability

A clause saying:

> "if any provision of the agreement is held to be unenforceable or otherwise contrary to any applicable laws, regulations or rules, such provision shall have no effect and shall be severable without affecting the validity or enforceability of the remaining provisions of this agreement."

It is required under Florida law for PLHSOs[90] and will typically be included in other MCO arrangements.

Contract defenses include:

- negotiating to get "inconsistent with professional ethics" added after "contrary to applicable law …"

B. Disclaimer or Limitation of Warranties

A typical MCO clause says:

> "IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR CLAIMS (WHETHER BASED ON A BREACH OF AN EXPRESS OR IMPLIED WARRANTY, NEGLIGENCE OR OTHERWISE) FOR ANY INDIRECT, CONSEQUENTIAL, EXEMPLARY OR PUNITIVE DAMAGES, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT OR OTHERWISE, EVEN IF SUCH PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THIS LIMITATION ON LIABILITY SHALL NOT APPLY TO ANY BREACH OF THE CONFIDENTIALITY PROVISIONS OF THIS AGREEMENT."

Contract defenses include:

- realizing the limitations of such disclaimers. They may not give you the protection you seek against malpractice liability. This type of disclaimer is not necessarily applicable to services but rather only goods under the Uniform Commercial Code.
- nevertheless, it serves to protect the doctor as well as the MCO so it does not need to be negotiated out of the contract.

C. Amendments

This clause says:

> "Provider agrees to accept as full payment for any Claim, an amount equal to the (discounted fee) applicable to such Claim. Provider agrees that MCO shall have the right to amend the rates by written notice to Provider. The amended rates will take effect as of the date set forth in such notice."

Contract defenses include:

- knowing Florida law. For example, HMOs are required under Florida law to give HCPs at least 30 days' advance written notice of changes regarding fee schedules, electronic and mailing addresses for claims submission, and telephone numbers to contact regarding claims.[91]

- other than that, MCOs may reserve the right to make unilateral changes "at their sole discretion" without the dentist's prior written consent. Unilateral amendments mean you have no leverage other than to cancel the contract.

- identifying clauses that allow MCOs to change contract terms in the future.

- negotiating for enough advance written notice to give you time to consider the implications on your business.

- determining if you are deemed to accept unilateral MCO changes if you continue billing or if you don't affirmatively opt out.

- looking for parity — if the MCO can implement mid-year changes, ask why you are not given the same right.

- requiring the actual fee schedule to be signed by both parties and dated in order for it to take effect.

D. Zipper or Merger Clause

A typical MCO clause says:

> "This Agreement, along with any Addenda hereto, includes the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior discussions, negotiations and agreements between the parties. This Agreement may not be amended or modified unless done so in a written instrument signed by both parties."

Contract defenses include:

- understanding that no matter what the MCO represents verbally, in cover letters, or in emails, if it is not written down and found in the four square corners of the agreement, it is unenforceable.

- checking to see if the zipper clause is internally inconsistent with other contract provisions that allow unilateral amendment by the MCO of fee schedules or UM procedures.

E. Waiver

A typical clause says:

> "No waiver of any breach or condition of this Agreement shall be deemed to be a waiver of any subsequent breach or condition, whether of like or different nature."

Contract defenses include:

- understanding that this may limit your ability to claim for reimbursement based on promissory estoppel or reasonable reliance (e.g., to avoid preauthorization or precertification requirements because the MCO previously paid for the same expensive procedure for another of your patients with the same diagnosis).

F. Hold Harmless and Indemnification

A typical clause will say:

> "Each party (the "Indemnifying Party") shall indemnify, defend and hold harmless the other party, including its officers, directors, employees, agents, successors and assigns (the "Indemnified Party") from and against all claims, demands, actions, proceedings, liabilities, damages, losses, fines, costs (including court costs and attorneys' fees), which may be recovered by or paid to any third party, and which arise out of or result from the breach of this Agreement or negligent act or omission of the Indemnifying Party, or any of its employees and/or agents, in connection with the performance of its duties or obligations under this Agreement. Any claim for indemnification with respect to such third party claim shall be made within the thirty (30) day period following the Indemnified Party's receipt of a complaint or other demand from the third party. In no event shall either party make a claim for indemnification hereunder more than two (2) years after the expiration or termination of this Agreement. In the event of a claim for indemnification hereunder, the Indemnified Party shall: (i) promptly furnish the Indemnifying Party with a copy of each communication, notice or other action relating to said claim; (ii) give the Indemnifying Party sole authority to conduct the trial, settlement or other proceedings related to such claim or any negotiations relating thereto at the Indemnifying Party's expense; and (iii) provide reasonable information and assistance requested by the Indemnifying Party in connection with

such claim or suit. Notwithstanding the foregoing, the Indemnifying Party shall obtain the Indemnified Party's consent to any settlement that creates any ongoing obligation for the Indemnified Party."

The most important clause of the contract, indemnification and hold harmless are actually two different provisions. An indemnification provision protects one party to a contract from any liability arising from the acts or omissions of the other party when performing contractual duties. A hold harmless clause means once you're put on notice of the claim, you will hire an attorney and defend the claim as well as pay for a settlement or judgment.

Independent liability against MCOs is starting to become a recognized legal theory. You want to be held harmless against any claims filed against the MCO just as much as the MCO wants to be held harmless against any claims filed against the HCP. But MCOs always include language saying the provider, not the MCO, is responsible if care is withheld (or provided) and harm to an enrollee occurs as a result. That's why you get malpractice insurance.

Contract defenses include:

- knowing these provisions apply even if the MCO refuses to pay the HCP delivering the care.
- knowing that all liability for patient care has been shifted to the doctor even if the MCO through plan design "interferes" with your treatment plan.
- negotiating for mutually reciprocal terms, meaning that you are responsible for your actions, but the MCO is responsible for its actions.
- if you can't get mutually reciprocal clauses, deleting the indemnification provision entirely means common law will control liability.
- realizing that you have professional liability coverage to guard against claims but you do not have insurance to guard against contract risk to which you have intentionally agreed.
- agreeing only to indemnify for damages arising from your own actions/inactions and those of individuals you employee or engage to provide services under the contract (e.g., if you prescribe pharmaceuticals paid for under the contract, why would you agree to indemnify the plan for improper manufacture of drugs?).

G. Change in Law

Health care is highly regulated and laws change frequently. There should be a fair process to amend the contract should "material changes" in the law occur that threaten the economic viability of the contract. Health insurance policies and most MCOs will say:

> "Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes."[92]

Contract defenses include:

- making sure either party has the right to request amendment.
- stating that the HCP may terminate without penalty if the amendment is unacceptable.
- requiring that such negotiations be conducted in "good faith" with "cooperation."

H. Independent Contractor

A typical clause says:

> "The relationship between the parties is solely that of independent contractors, and nothing in this Agreement shall be construed or deemed to create any other relationship between the parties, including one of employment, general agency or joint venture. As such, neither party shall be responsible for the acts or omissions of the other party."

Contract defenses include:

- verifying the relationship between parties is contractually defined as this protects both parties.
- having your dental practice defined as an independent contractor means you do not assume business liabilities of the MCO.

I. Assumption/Assignability

A typical clause says:

> "Except as otherwise permitted herein, neither party shall have the right to assign, delegate, or otherwise transfer any or all of its rights and/or obligations un-

der this Agreement to any third party without the prior written consent of the other party hereto. The foregoing notwithstanding, MCO may assign, delegate or otherwise transfer any or all of its rights and/or obligations under this Agreement to any parent, subsidiary, or affiliate of MCO, or to any entity that is a successor-in-interest to its business. This Agreement shall be binding upon and inure to the benefit of the successors and permitted assigns of the parties."

This clause applies when the MCO merges or is acquired by another MCO, which is common. Often, the contract will allow the MCO's contractual duties to be assigned to another entity without the HCP's consent, meaning that you will be held vulnerable to the reimbursement provisions of the "post-acquisition" MCO. This could be disastrous if the MCOs go from a discounted FFS to a capitated reimbursement. Also, when MCOs merge they usually say that the lower of the two reimbursement rates apply to all of the subscribers of the newly merged MCO.

Contract defenses include:

- having the contract say that the provider must consent in writing for assumption/assignment to occur by another MCO.
- having the contract say that all terms continue unchanged despite assignment of the contract.

J. Notice

A typical clause says:

> "All notices required or permitted under this Agreement shall be given in writing, signed by the party giving notice, and delivered by hand, by first-class registered mail with postage prepaid, by certified mail, return receipt requested, with postage prepaid, or by overnight delivery service, to the other party at the address set forth in the introductory paragraph to this Agreement."

Contract Defenses include:

- exempting this from applying to claims and notices of loss because it undercuts electronic claims submission, one of your practice efficiencies needed to make money under managed care.

K. Governing Law/Venue

A typical clause says:

> "This Agreement, its terms and the adjudication of all claims or controversies arising hereunder, shall be governed by, and construed and enforced in accordance with, the laws of the State of Florida, without regard to its conflicts of laws principles. In the event of a dispute between the parties, such dispute shall be submitted to a court of competent jurisdiction in Leon County, Florida."

Contract defenses include:

- being wary if governing law is anything other than Florida.
- negotiating to have venue in the county where you practice.

L. Restrictive Covenants

These are also known as non-compete clauses. They restrict dentists from competing in geographic areas during the term of the MCO contract and for a limited time thereafter.

Contract Defenses include:

- knowing Florida law, which says a contract between a HMO and a HCP cannot contain any provision that in any way prohibits or restricts the HCP from entering into commercial contracts with other HMOs.[93] Likewise, the HCP cannot restrict the HMO from entering into commercial contract with any other health care provider.
- knowing that other state's laws may not be similar.
- knowing Florida law also applies to PLHSOs and prohibits such a plan from restricting the HCP from contracting with another PLHSO.[94]

M. Litigation/Arbitration/Attorneys' Fees

Participating provider agreements rarely include arbitration clauses but often include "attorney's fees" clauses. A typical attorney's fees clause says:

> "If either party brings an action to enforce any of the terms or provisions of this Agreement, then the prevailing party shall be entitled to recover from the non-

prevailing party all costs and expenses of such action, including, but not limited to, reasonable attorneys' fees."

Contract defenses include:

- avoiding one-sided clauses that obligate only you to pay legal fees.
- avoiding intimidation against pursuing claims thinking that only you are at risk of legal costs.
- negotiating that legal fees will be awarded to whichever "prevailing party" wins or will be "shared equally."
- negotiating for the arbitration/litigation to occur in your area, rather than the plan's corporate offices.
- verifying whether you must first exhaust any internal appeal processes before initiating arbitration and what the time frames are for filing appeals.
- determining whether the arbitration is binding and legally enforceable in a court of law.
- knowing whether the arbitrator can award punitive or other damages, or only the value of the claim.
- knowing whether the contract prohibits you from pursuing or participating in class action lawsuits.

N. Most Favored Nation/Exclusivity

This clause requires you to offer the health plan the lowest, or most favorable, rates you have negotiated with any other provider network or payor.

Contract defenses include:

- keeping your contracted rates with other payors confidential and proprietary.
- avoiding language that says you will be a provider "exclusively" for one plan.
- knowing that Florida law makes such provisions voidable for PLHSOs[95] and HMOs.[96]
- adding a clause that says:

  "This Agreement is not exclusive in any respect. MCO is entitled to and may enter into similar agreements with other providers, and Provider is free to enter into similar agreements with other parties and to maintain Provider's private practice for patients who are not MCO enrollees/subscribers."

Step 6: Know Your Mix

Conduct an internal analysis of your practice's mix of payors, utilization by payor, accounts receivable by payor and how the fee schedule compares to your existing fee schedule. You want to understand who your major payors are. For example, if 100 percent of your practice is Medicaid, you have no leverage over that individual payor. Identify the problem payors for the last six months. If a MCO has a high rate of adjustments or a high number of days in accounts receivable, think about renegotiation. Also, verify if they are automatically including penalties for overdue claims.

Step 7: Efficiency

Focus on expense management and clinical efficiency to maximize profit. Efficiency is different than cutting expenses. Sometimes, it makes good business sense to spend more on management software or staff in order to streamline efficiency and timely payment. High patient turnover, distracted staff, and long patient wait times are a sign that you may need to scale back your MCO arrangements or optimize efficiency.

Step 8: Plan for the Future

Each MCO contract should go into one of three categories: terminate, renegotiate or continue with the same terms. If you terminate a plan, send a letter to all covered patients and also post a notice that as of a certain date, you will no longer be an in-network provider for that plan. If you decide to start terminating contracts, it is usually best to start with payors who represent only a small portion of your practice and then focus on how to work through going out-of-network with that payor.

At least monthly, reconcile payments posted against negotiated reimbursements. See if your practice management system can compare reimbursement on a plan by plan basis. If not, select random EOBs from each MCO and compare anticipated payment against actual reimbursement to prepare to renegotiate when the plan comes up for review. A great reimbursement rate doesn't mean you actually receive that. Efficiency is the key, so also select a dollar or percent range for which to ignore variances.

Focus on the big ticket reimbursements and include modifiers. If you see egregious, routine, significant disparities between contracted rates and amounts actually paid and prompt-payment violations, consider breach of contract or reporting to the Office of Insurance Regulation as bad faith claims practices.

When going through the steps, especially the ones concerning fee reimbursement, be aware of antitrust law. Each individual practice must act independently. Don't confer with competing practices on what their fee schedules are under one or more MCO contracts; on what patients you're willing to serve or where to locate your offices; or on what contracts or patients will be rejected.

The Future of Dental MCOs

The ACA establishes a national standard for network adequacy. It requires networks to be "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[97] This is sometimes referred to as "parity" legislation. But MCOs will have discretion as to what "sufficient" and "unreasonable" mean. It would be preferable if the law included objective minimum enrollee to provider ratios, wait times and maximum travel distance, but it does not.

Any Willing Provider (AWP)

Florida does not have AWP or "freedom of choice" legislation. AWP laws require MCOs to open their networks to any provider willing to accept the network's terms and conditions, including their reduced rates of payment. Freedom of choice legislation looks at the network from the patient's perspective (i.e., consumer protection) and guarantees enrollees' ability to receive care from any qualified dentist. Such statutes have little practical effect because they lack meaningful penalties and don't change the underlying differences in negotiating leverage between a plan and individual providers.

Narrow Networks

The ACA also promotes narrow networks for plans sold on state and federal exchanges, which means that commercial plans will eventually do so as well. Narrow networks offer smaller networks with lower premiums. They are similar to HMOs in that they do not pay for out-of-network care, effectively leaving the patient uninsured (and emphasizing the need for AWP legislation). But narrow networks place a greater focus on meeting established quality indicia and promoting high-value care through reimbursement mechanisms, such as bundled payments, and outcome driven payment, such as pay-for-performance. Proponents of narrow networks say they improve quality, standardize care and minimize unnecessary care by establishing "high performance provider networks." In other words, lower premiums through better controlling the cost of services by allowing only low-cost providers into the network.

Living Outside the Network

Some dentists are able to opt out of network participation by refusing to accept MCOs. Their assumption is that they can achieve a high enough reimbursement level without entering into an MCO contract. If the contracted in-network rate won't support your costs and allow you to make a profit, stay out-of-network and bill the patient for the balance of the unpaid charges. Just don't forget to factor in patient dissatisfaction levels.

Most dentists routinely require patients to agree to be personally responsible for balances left unpaid by MCOs. These claims often don't translate into much actual collections and are likely to trigger allegations of malpractice as defenses for non-payment. Florida law dictates who is responsible for paying providers and how much providers can receive for out-of-network services. In Florida, the patient is obligated to pay the doctor under various equitable theories, such as quantum meruit, detrimental reliance, promissory estoppel, unjust enrichment and contracts-in-fact. Florida also recognizes a right for such payments from MCOs in emergency services.

PLHSOs, HMOs and EPOs will not reimburse providers who are out-of-network (except for emergency services). Insurance and PPOs will pay out-of-network providers at the UCR rate or the prevailing charge. Make sure you understand the formula for how the UCR fee is calculated. Plans will use their own proprietary data (e.g., they pay according to their own fee schedule), not yours.

Most plans purchase data from FAIR Health Inc., a non-profit independent of any one payor. FAIR Health Inc. uses a nationwide database of claims for each ZIP code that includes the date and place of service, the procedure code and the average doctor's charge. That doesn't mean you will get the UCR fee from the plan, you will usually get only 80 percent, meaning that 80 percent of charges in your ZIP code are the same or less for the particular code in question. The MCO pays at 80 percent of the prevailing rate; then you balance-bill the patient's deductible and coinsurance if what you were paid by the MCO is less than you normally charge.

In that situation, the patient is required to pay the difference, even if the patient has reached the plan's annual maximum. For example, if you are out-of-network and routinely charge $120 for a service, that does not mean the plan will pay you $120. If the plan's coverage pays at 70 percent of UCR and UCR according to their data is $100, then you will get paid by the plan only 70 percent of $100 or $70. If the patient hasn't yet met their deductible, the patient is solely responsible and the plan pays nothing. If the deductible has been met, then you bill the patient for the difference between your usual charge and the plan's actual reimbursement. In this case you would bill the patient for $50 because your usual charge of $120 minus actual reimbursement received from the MCO of $70 equals $50.

Don't make the mistake of using the plan's UCR schedule if you are not contractually obligated to do so. For example, if you used the plan's UCR of $100, you would bill the patient $30, instead of $50, and you have discounted your fees when you are not contractually obligated to do so. Again, you are allowed to bill the full difference between your normal charge and what the plan actually pays if you are not a participating provider.

Chapter 6

Your Rights under Florida DMPO Contracts

Introduction

Timely and accurate reimbursement is the most important consideration for dentists doing business with MCOs. In a practice that accepts no dental plans, collections is simple — get paid upfront by the patient for the full value of your professional services and get unpaid balances caught up before you provide more care. But when dealing with MCOs, the dentist will need to determine and keep track of the volume and dollar amount of unpaid claims by individual payor and factor this into decisions to renew or terminate contracts early.

Insurance plans and managed-care plans are both regulated by Florida law and give dentists specific legal protections. But the regulations differ dramatically based on what type of MCO is involved. For example, the laws regarding balance billing are very different and depend on the type of payor involved. Non-contracted dentists are free to balance bill patients who belong to a PPO, but most PPO contracts state that dentists who are in-network must accept the amount received from the PPO as payment in full. Balance billing also is prohibited in workers' compensation, Medicaid and Medicare programs.

Health insurance companies are regulated under Chapter 627, Fla. Stats. If an MCO is involved, there are only four types in Florida:

- **DMPO** under Chapter 636, Part II, Fla. Stats.
- **PPO** under chapter 627, Fla. Stats.
- **HMO** under chapter 641, Fla. Stats.
- **PLHSO** under chapter 636, Part I, Fla. Stats.

It is easy to identify what type of MCO you are doing business with based on the plan documents. Under Florida law, each regulated entity must identify whether it is an EPO, PPO, HMO, DMPO or PLHSO. Likewise, if it is managed care, the entity cannot use the word "insurance" in its plan documents.

DMPO Rules

Since 2004, Florida has allowed discount medical plan organizations to contract with dentists. A DMPO is not insurance. It provides discounts at certain health care providers for medical services. It is not a payor as it does not make payments directly to the providers of medical services. The plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization.[98]

"Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. Dental care services and durable medical equipment (DME) like sleep apnea devices can be included in a DMPO but pharmaceutical supplies or prescription medications are excluded.[99] The term "discount medical plan" excludes any product regulated as insurance, a PPO, an EPO, an HMO or a PLHSO.[100]

DMPOs must be licensed in Florida by the Office of Insurance Regulation.[101] Do not sign a contract with an unlicensed DMPO. Licensed DMPOs must establish and maintain subscriber complaint procedures.[102] If they don't, HCPs should report them to OIR which has jurisdiction to investigate and revoke licensure.[103] Importantly, a HCP may operate an in-office DMPO for her patients only without obtaining OIR licensure.[104]

DMPOs are prohibited from:

- using the terms "insurance,"[105] "health plan," "coverage," "copay," "copayments," "pre-existing conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization,"[106] in contracts or marketing.
- imposing restrictions on freedom of choice of HCPs, including waiting periods before accessing care.[107]
- paying providers any fees for medical services.[108]

DMPOs and Provider Contracts

Provider agreements must be in writing.[109] The contract must include:

- a list of the services and products to be provided at a discount.
- the amount(s) of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates.
- a contractual obligation that the provider will not charge members more than the discounted rates.
- Each DMPO must file annual reports with the OIR that include information helpful to doctors when negotiating:[110]
- audited financial statements
- the names and residence addresses of all persons responsible for the conduct of the organization's affairs (are they dentists?)
- the number of discount medical plan members in the state, an up-to-date list of the names and addresses of the providers with which it has contracted, and a website page.[111]

NCS and Balance Billing

A DMPO is allowed to sell discounts together with any other insurance product[112] and this is one way for MCOs to avoid NCS legislation. The MCO also may charge members a fee for the discount plan in addition to the fees for the underlying coverage. A provider may bill her normal rates for non-discounted services unless the discount plan is coupled with an HMO or a PLHSO.

In-office DMPOs

Dentists may, without obtaining a certificate of authority from the OIR, operate a DMPO for their patients only.[113] The statute is unclear, but appears to prohibit a dentist from publicly marketing the plan. It allows a monthly fee to be paid by patients before dental services are provided. The fee is paid in advance for the promise of a discount at time of service. What makes this a DMPO rather than a PLHSO is that the prepaid fee is paid in exchange for a discount rather than the dental service itself.

If the doctor intends to market the discount plan directly to the public, then a DMPO certificate of authority is required. Most individual dental practices can meet the OIR requirements to set up a DMPO that will be marketed publicly. The process is time-consuming, but comparatively inexpensive to obtaining any other certificate of authority. For example, the DMPO need only have a net worth of at least $150,000[114] and the initial and annual application fee is only $50.[115]

Chapter 7

Your Rights under Florida Health Insurance and PPO Contracts

Introduction

"Any person (including HCPs) who has been damaged by an insurer" (including EPOs and PPOs offered by insurers) due to "unfair claim settlement practices" has the legal right in Florida to pursue civil damages against the plan.[116]As a condition precedent to suing, the department and the insurer must have been given 60 days' written notice of the violation.[117]

One advantage of filing civil suit is that civil damages do not preempt any other remedy or cause of action and may include an award or judgment in an amount that exceeds the policy limits. You have rights under either the common law remedy of bad faith or the statutory remedy, but you cannot obtain judgment under both remedies.

It is important that dentists who routinely receive improper claims denials or late payments put the department on notice; otherwise, there is no way to prove that the insurer is doing it with such frequency to indicate a general business practice. Unfair claim settlement practices[118] relevant to dental claims include insurers who:

- make material misrepresentation to any person having an interest in the proceeds payable (i.e., HCPs that accept assignment) with the intent of effecting settlement of such claim on less favorable terms than those provided by contract or policy.

- don't attempt in good faith to settle claims when, under all the circumstances, it could and should have done so with due regard for the insured.

- fail to promptly settle claims under one portion of the insurance policy coverage in order to influence settlements under other portions of the policy coverage.

Other unfair claim settlement practices occur only if done with such frequency as to indicate "a general business practice":

- not having standards to properly investigate claims.

- misrepresenting pertinent facts or insurance policy provisions relating to coverage.

- failing to acknowledge and act promptly upon communications with respect to claims.

- denying claims without conducting reasonable investigations based upon available information.

- failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof of loss statements have been completed.

- failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement.

- failing to promptly notify the insured of any additional information necessary for the processing of a claim.

- failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

Mandated Benefits

Insurance, EPOs and PPOs must provide anesthesia and cleft lip/palette benefits similar to HMOs (discussed below)[119] and direct payment for hospital based claims.[120]

How to File Administrative Complaints

The Department of Financial Services, Division of Consumer Services can assist you with insurance questions and open a formal complaint. There are helplines that will contact the insurance company on your behalf. You can submit complaints online at https://apps.fldfs.com/ESERVICE/Default.aspx or by telephone at 877.MY.FL.CFO (877.693.5236). Consumer Services sometimes processes complaints better if they come directly from the insured rather than the HCP.

Not all complaints fall under Consumer Services jurisdiction. The trick is for the dentist to determine the appropriate regulatory entity to address the claim payment concern: DFS reviews health claim payment **delays** relating to insurers, PPOs, EPOs and HMOs.[121] You need to submit written proof that the claims in question have been received by the insurance plan.

But claims that involve a dispute regarding **whether payment should be made, or the amount of a payment**, should be referred to the Statewide Provider and Health Plan Claim Dispute Resolution Program (MAXIMUS) instead of the OIR.[122] This program is run by AHCA, not DFS. Currently, AHCA has contracted with MAXIMUS to administer this program. Contact MAXIMUS by calling 866.763.6395, Option 5.

Further DFS does not have authority over:

- PLHSOs.

- contracts purchased outside of Florida. Contact the other state's Department of Insurance. You can get their contact information at the National Association of Insurance Commissioner (NAIC) website: www.naic.org/state_web_map.htm.

- self-insured employer plans under ERISA.

- Federal Employee Health Plans. Contact the Federal Employee Health Plans, U.S. Office of Personnel Management, Federal Employee Health Benefits Programs, Insurance Review Division, #1, 1900 E. Street NW, Washington, DC 20415-3500. Telephone: 202.606.0727.

- U.S. Military Plans. Contact Palmetto Government Benefits Administration, Tricare Claims Department, P.O. Box 7031, Camden, SC 29020-7031. Telephone: 800.403.3950.

- DFS can't help doctors or patients with disputes about pre-existing conditions, "medical-only" exclusions, or policy interpretation under a legal doctrine known as "separation of powers."[123]

Chapter 8
Your Rights under Florida HMO Contracts

Introduction

Where the OIR regulates insurance, EPOs, PPOs and DMPOs, both OIR and AHCA regulate HMOs.[124] HMOs are exempt from provisions of the Florida Insurance Code (chapter 627) regulating insurance companies.[125] HMOs must get "certificated" by AHCA as a "health care provider."[126] In order to be certificated, the HMO must meet certain network requirements regarding geographic capacity, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs.[127] The HMO legally is required to provide treatment authorization 24 hours a day, seven days a week. Requests for treatment authorization may not be held pending unless the requesting provider contractually agrees to take a pending or tracking number.

Right to Second Opinion from Medical Director

HMOs must ensure that "the health care services provided to subscribers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community."[128] If an HMO denies a dentist's claim based on "reasonableness or necessity of surgical procedures" or if the claim denial could "subject (the subscriber) to a serious injury or illness," then your patient has the right to a second medical opinion by a physician chosen by the subscriber — not the HMO's medical director.[129]

Claim Forms

HMOs typically accept the ADA claim form for dental services but are not required to do so.[130]

Emergency Services

Under Florida law, even if there was no prior notification to the HMO or prior authorization by the HMO, it must reimburse for emergency services performed by doctors outside the network when participating providers were not available at the time services were obtained.[131] This law requires "no less than 75 percent of reasonable charges for covered services" to be paid by the HMO "up to subscriber contract benefit limits."[132] Note, however, that emergency services will be defined by the HMO in its contract, certificate or member handbook, and may not conform to the definition of emergency services in statute.

Prompt Payment of HMO Claims

Claims include any paper or electronic billing instrument[133] submitted to the HMO's designated location. Claims for payment or overpayment:

- are considered received on the date the HMO actually receives it (not the date it was sent in).

- must be sent to primary payor within six months after the date of service and to the secondary payor within 90 days after final determination by the primary MCO.

- must not duplicate previously submitted claims unless it is determined that the original claim was not received or is otherwise lost.

- must not retroactively deny a claim based on subscriber ineligibility more than one year after paying the claim.[134] In other words, dentists have 12 months from claims submission to pursue the HMO for a claim of underpayment.[135] If more than 12 months go by, the claim for underpayment is deemed waived.

For electronic claims, the HMO must[136]:

- provide electronic acknowledgment within 24 hours after the beginning of the next business day after receipt of the claim.

- either pay or provide the HCP with electronic notice that the claim is contested or denied within 20 days after receipt of the claim. The HMO's action on the claim is considered to be made on the date mailed or electronically transferred.

- include an itemized list of additional information necessary to process the claim.

- pay or deny electronic claims within 90 days after receipt. Failure to pay or deny a claim within 120 days after receipt creates an uncontestable obligation to pay the claim.

For paper claims, the HMO must[137]:

- provide acknowledgment of receipt of the claim or give the HCP electronic access regarding the claim's status within 15 days (not 24 hours cf. electronic claims) after receipt.

- either pay or provide the HCP with notice that the claim is contested or denied within 40 days after receipt.

- include an itemized list of additional information necessary to process the claim. Note the HMO is barred from requesting duplicate documents.

- pay or deny claims within 120 days (not 90 days cf. electronic claims) after receipt. Failure to pay or deny a claim within 140 (120 days cf. electronic claims) after receipt creates an uncontestable obligation to pay the claim.

An overdue payment of an HMO claim bears simple interest at the rate of 12 percent per year and begins to accrue when the claim should have been paid, denied or contested. The interest is payable with the payment of the claim.

HMO Clawback or Offset for Claims Overpayment

The HMO may not reduce payment to the provider for other services (i.e., no offset allowed) unless the provider agrees to the reduction in writing or fails to respond to the HMO's overpayment claim in a timely manner. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred.

If the HMO overpays it must:

- make a claim for overpayment to the provider's designated location, identify the specific claims involved and state the basis for the overpayment within 30 months after it receives the claim, unless provider fraud is involved, in which case the time frame is extended. However, the rule for dentists (as opposed to other types of HCPs) is the overpayment claim must be submitted to the provider within 12 months after the HMO's payment of the claim.[138] In other words, the look-back period is significantly shorter.

- submit documentation requested by the HCP within 35 days.

The HCP must:

- pay, deny or contest the HMO's claim for overpayment within 40 days after the receipt. All contested claims for overpayment must be paid or denied within 120 days. Failure to pay or deny overpayment within 140 days after receipt creates an uncontestable obligation to pay the claim.

- notify the HMO in writing within 35 days after the provider receives the claim whether it is contested or denied. The notice that the claim for overpayment is denied or contested must identify the specific claims involved, state why it is contested, and request additional information if needed. If the HCP requests additional information, the HMO has 35 days to provide it and then the HCP must pay or deny within 45 days of receipt of the additional information.

Internal Grievance Procedure[139]

Under Florida law,[140] a subscriber[141] has a right to file a written grievance at any time. Unless it is being actively reviewed by a mediator, arbitrator or third-party dispute entity,[142] the HMO must conclude its internal resolution process within 60 days after the receipt of the provider's request for review or appeal.

Grievances typically concern standard of care or exclusions, so dentists should know what Florida law requires of HMOs: HMOs must ensure that the health care services conform to reasonable standards of quality of care[143] which are, at a minimum, consistent with the prevailing standards of medical practice in the community.[144] An HMO must give a "clear and understandable statement of any limitations on the services or kinds of services to be provided;"[145] however, that information is given to the subscriber, not the participating HCP. Likewise, an HMO must give a "clear and understandable description … to resolving subscriber grievances;"[146] but again, that information is given to the subscriber, not the HCP.

Expedited Review

Expedited review procedures shall be available to a subscriber and to the provider acting on behalf of a subscriber. In an expedited review, the HMO must make a decision within 72 hours after receipt of the request.

Administrative Remedies under Ombudsman Program[147]

AHCA operates a Statewide Managed-Care Ombudsman Committee that acts as a consumer protection and advocacy organization on behalf of all health care consumers receiving services through MCOs. It does not protect HCPs; rather, it protects HMO enrollees (your patients) to ensure they receive "covered medical services" they have contracted for under a managed-care program. The ombudsman committee is comprised of volunteers who work closely with AHCA to protect the public health, safety and welfare of enrollees. The ombudsman committee has authority to:

- receive complaints regarding quality of care from AHCA.
- assist AHCA with investigation and resolution of complaints against HMOs.
- review managed-care quality assurance programs and make recommendations as to how the rights of managed-care enrollees are affected.
- report to the Legislature regarding complaints received about HMOs.

Administrative Remedies under Subscriber Assistance Program Panel

Under Florida law, "every HMO must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances."[148] After the internal grievance procedure is completed, the subscriber has one year from the date of service to submit an appeal for review to the Subscriber Assistance Program panel.[149] HMOs must maintain records of all grievances and report to AHCA "the total number of grievances handled, a categorization of the cases underlying the grievances and the final disposition of the grievances."[150]

Allowable Claims Error Rate

A permissible error ratio of 5 percent is allowed for HMO claims payment violations.[151] An error ratio more than 5 percent also can be used to challenge an HMO's clawback claim. If the ratio exceeds 5 percent, then a fine may be assessed for those claims payment violations that exceed the error ratio.[152]

Pre-existing Condition Exclusion

An HMO is not required to exclude coverage for pre-existing conditions, but most do.[153] Check the subscriber handbook to determine if pre-existing conditions are excluded. They are only if the plan documents make it explicit that coverage pertains only to injuries caused by accidents after the effective date of coverage or illnesses that first manifest themselves after the effective date of coverage.[154] In addition, an HMO offering group coverage may impose a pre-existing condition exclusion only if:[155]

- medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date for the physical or mental condition.
- such exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.
- the period of any such pre-existing condition exclusion is reduced by periods of creditable coverage (i.e., coverage that the patient had before purchasing the HMO coverage).

Preauthorization

If the dentist has followed the HMO's authorization procedures and obtained authorization for covered services for an eligible subscriber, then the HMO cannot later deny the claim based on a failure of preauthorization.[156] If the HMO improperly authorized it, they must live by that decision, unless they prove that the dentist submitted the request with information with willful intent to misinform the HMO.

Attorney's Fees and Court Costs

In any civil action brought by a dentist to enforce the terms and conditions of an HMO contract, the prevailing party is entitled to recover reasonable attorney fees and court costs,[157] including payment of the claim as well as interest penalties.

Waiting Periods and Affiliation Periods

Group HMOs may impose waiting periods.[158] A "waiting period" means the period of time that must pass before the individual is eligible to be covered for benefits under the terms of the contract. In lieu of a waiting period, any HMO may use an "affiliation period" to guard against adverse selection.[159]

An affiliation period[160] is different than a waiting period, but has similar effect. With an affiliation period, no premiums are collected; with a waiting period, premiums are still collected. An affiliation period means a period of time that, under the HMO contract, must expire before the coverage becomes effective. The organization is not required to provide health care services or benefits during such period, and no premium may be charged during the period. The affiliation period begins on the enrollment date and runs concurrently with any waiting period under the plan. The affiliation period must be applied uniformly and, in general, cannot exceed two months. In contrast, a waiting period is whatever the contract says it is.

Mandated Benefits

There are several dental benefits that must be covered by HMOs under Florida law:

1. **If Untreated, will Result in Medical Condition:** dental treatment or surgery cannot be excluded based on lack of medical necessity if the "dental condition is likely to result in a medical condition if left untreated."[161]

2. **Coverage for Emergency Dental Care Done by Out-of-network Provider:** Dentists are entitled to HMO payment for care for "emergency medical conditions" even if they are out-of-network and did not obtain prior approval from the HMO.[162] However, the HMO is only obligated to pay 75 percent of the "reasonable charges for covered services,"[163] up to the subscriber's benefit limit. Emergency medical conditions[164] include some dental services, and are defined as: A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: serious jeopardy to the health of a patient, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

3. **General Anesthesia and Hospitalization:** If the HMO covers general anesthesia and hospitalization services, then it also must cover general anesthesia and hospitalization for children who are "under 8 years of age" when the physician and the dentist agree that such services are necessary "due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective"[165] or if the covered person, regardless of age, "has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center."[166] The mandated benefit for in-patient care and general anesthesia does not waive the requirement for prior authorization if it is otherwise required by the HMO. Most surgeries and hospital stays do require prior authorization or else the HMO may deny coverage.[167]

4. **Cleft Lip and Palate:** The HMO (assuming it provides coverage for children otherwise) must provide coverage "for treatment of cleft lip and cleft palate for" children under 18 years of age.[168] It will probably require, however, that the gatekeeper primary care physician prescribes or certifies that such services are medically necessary and consequent to treatment of the cleft lip or cleft palate. Like hospital care for dental conditions, coverage for cleft lip or palate dental treatment typically requires preauthorization.

5. **TMJ Coverage[169]:** If the HMO contract covers any diagnostic or surgical procedure involving bones or joints of the skeleton, it also must cover similar diagnostic or surgical procedures involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease or injury. The HMO may encourage "appropriate nonsurgical procedures" in the treatment of a bone or joint of the jaw and facial region and is not, under this statute, required to cover care or treatment of the teeth or gums, for intraoral prosthetic devices or for surgical procedures for cosmetic purposes.

6. **Domestic Violence:** An HMO cannot refuse to provide services solely because they are sought for injuries resulting from an assault, battery, sexual assault, sexual battery or any other offense by a family or household member,[170] or by another who is or was residing in the same dwelling unit.[171]

7. **Handicapped Children:** A PLHSO must continue to provide coverage to "handicapped children who are incapable of self-sustaining employment by reason of mental or physical handicap, and substantially dependent upon the enrollee for support and maintenance.[172]

Assignment of Benefits/Direct Payment Required

If the subscriber/patient, in the claim form, specifically authorizes payment of benefits directly to any contracted dentist, then the HMO must make payment to the designated provider of such services if any benefits are due.[173] The HMO contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed dentist for covered services provided. The attestation of assignment of benefits may be in written or electronic form. Payment to the provider from the HMO may not be more than the amount that the insurer would otherwise have paid without the assignment. This requirement does not affect the applicability of the provider billing prohibition and the mandated benefits for emergency services regardless of whether prior authorization was received.[174]

Coordination of Benefits (COB)

An HMO is entitled to coordinate benefits on the same basis as an insurer.[175] The insurance COB rules are set forth in section 627.4235, Fla. Stats., and Chapter 5 of this handbook.

Required Participating Provider Agreement Terms and Conditions

Each contract between an HMO and a dentist must[176]:

- be in writing.
- establish written procedures for a HCP to request and the HMO to grant authorization for utilization of health care services.[177] The HMO must give written notice to the provider before changing these procedures. The HMO is liable for services rendered to an eligible subscriber by a provider only if the provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber.[178] If the HCP obtains authorization pursuant to a "willful intention to misinform" the HMO, then the HMO is not liable.[179]
- contain a provision that the subscriber is not liable to the provider for any services in which the HMO is liable.
- require the HCP to give 60 days' advance written notice to the HMO before canceling for any reason. If requested by the HCP, the HMO may terminate the contract in less than 60 days. If either the HMO or the HCP terminate a contract, both must provide a written reason for the contract termination.[180] An acceptable reason includes termination "for business reasons."
- provide that nonpayment for goods or services rendered by the HCP to the HMO is not a valid reason for avoiding the 60-day advance notice of cancellation.
- require the HMO to give 60 days' advance written notice to the HCP before canceling, without cause, the contract with the provider except when a patient's health is subject to imminent danger or a HCP's ability to practice medicine is effectively impaired by a governmental agency.
- disclose to the HCP information about claims processing: the mailing or electronic address where claims should be sent for processing; the telephone number that a provider may call to have questions and concerns regarding claims addressed; the address of any separate claims processing centers for specific types of services.
- disclose to the HCP information about payment: the complete schedule of reimbursements for all the services and any changes in or deviations from the contracted schedule of reimbursements must be provided electronically or in writing if requested by the dentist. This information is subject to the nondisclosure provisions of the contract, and the HCP must keep it confidential.
- Require the HMO to provide contracted HCPs with no less than 30 calendar days' prior written notice of any changes to reimbursement or other required contract terms.

No "Silent MCOs"

An HMO cannot require a HCP to accept the terms of other MCOs or insurance under the HMO's common management and control.[181] Any contract provision that violates this section is void.

No Gag Clauses

A contract between a HMO and a HCP cannot contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.[182]

HMOs and Non-covered Services

Note that some HMO coverage may, in fact, be limited in that high-deductible contracts are allowed in connection with medical savings accounts.[183] A contract between a HMO and a Florida dentist cannot contain a provision that requires the dentist to provide services to the HMO subscriber at a fee set by the HMO unless such services are covered services under the applicable contract.[184] In this context, "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments or any other limitation.

Dentist Billing Prohibited

If an HMO is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the HMO and the HCP, then the HMO is exclusively liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider.[185] The law further states[186] that a provider or any representative of a provider, regardless of whether the provider is under contract with the HMO, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition also applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place.

This subsection does not prohibit collection by the provider of copayments, coinsurance or deductible amounts due the provider.[187] If the dentist in good faith knows (or should know) the HMO is liable, then neither the dentist nor her representatives, regardless of whether the dentist is under contract with the HMO, can:

- collect or attempt to collect money from a subscriber.
- maintain any action at law against a subscriber.
- report a subscriber to a credit agency.

The HMO is required to report suspected violations of the balance billing prohibition by a dentist to the Florida Department of Health, which may result in licensure discipline.[188] The dentist is presumed not to know the HMO is liable unless:

- the HMO tells the dentist that it accepts liability.
- a court determines the HMO is liable.
- the OIR or AHCA make a final determination that the HMO is liable subsequent to a recommendation made by the Subscriber Assistance Panel.[189]
- AHCA issues a final order that the HMO is required to pay subsequent to a recommendation made by a resolution organization.[190]

This prohibition applies while the claim is pending with the HMO or undergoing legal or dispute resolution proceedings to determine if the HMO is liable if the dentist is informed that such proceedings are taking place.

The following are examples of how the billing prohibition applies:

- An HMO patient, in a non-emergency situation, knowingly goes out of network to a non-contracted dentist for services that are covered by the HMO, and the dentist is neither authorized by the HMO nor referred by the HMO, the dentist may bill the patient directly for all charges.
- An HMO patient, in a non-emergency situation, knowingly goes out of network to a non-contracted dentist for services that are **not** covered by the HMO, and the dentist is neither authorized by the HMO nor referred by the HMO, the dentist may bill the patient directly for all charges.
- If an HMO, in a non-emergency situation, denies authorization for a service on the grounds that it is not medically necessary, then the treatment is not considered a covered service, and a contracted or non-contracted dentist may bill the patient directly for all charges.

- If an HMO, in a non-emergency situation, denies authorization for a service on the grounds that it is not a covered service, a contracted or non-contracted dentist may bill the patient directly for all charges.

- If a non-contracted dentist does not seek authorization from the HMO for a service, and is not authorized or referred by the HMO, the dentist may bill the patient for all charges.

- If a non-contracted dentist contacts the HMO and receives authorization for a covered service for an eligible subscriber the dentist may **not** bill the patient and must accept whatever the HMO pays as payment in full (minus any applicable copayment).

Chapter 9
Your Rights under PLHSO Contracts

Introduction

PLHSOs in Florida do not pay discounted FFS reimbursement like most PPOs do. Nevertheless, they are common in dentistry. PLHSOs pay full-risk reimbursement, meaning that they pay only capitation (PMPM) or a prepaid aggregate fixed sum.[191] PLHSOS also use only exclusive panels (meaning no reimbursement for out-of-network care), so patient steerage is comparable to that of HMO coverage.[192] PLHSOs are exempt from the Florida Insurance Code applicable to insurance, PPOs and EPOs,[193] the law for discount medical plans[194] and the HMO Act.[195] Subscriber contracts, marketing materials and premiums must all go through the OIR "rates and filings."[196] All PLHSO contracts must provide internal grievance procedures and are subject to DFS/OIR regulatory and investigative authority.[197] Providers have a statutory right to use the internal grievance system[198] as well as filing complaints with DFS or OIR.

No "Balance or Direct Billing" of Patients

Providers under contract with PLHSOs are prohibited from billing or attempting to collect payment from patients for services covered by the PLHSO — only the PLHSO can be billed.[199] The prohibition does not apply to non-covered services, deductibles or copayment amounts.[200]

Cancellation of Contracts

Unlike HMOs where a 60-day advance notice of cancellation by the plan or the provider is required, under PLHSOs 90 days' advance written notice is required.[201] The dentist is required to give 90 days' advance written notice to the PLHSO before canceling for any reason. If requested by the HCP, the PLHSO may terminate the contract in less than 90 days. Nonpayment by the PLHSO for goods or services rendered by the HCP to enrollees is not a valid reason for avoiding the 90-day advance notice of cancellation. The PLHSO is required to give the HCP 90 days' prior notice if termination is "without cause" and may further avoid the 90-days requirement if "imminent danger" to a patient is involved or the provider's ability to practice is "impaired by an action by the Board of Dentistry."[202]

No Gag Clauses

A contract between a PLHSO and a HCP may not restrict the HCP's ability to communicate information to patients regarding care or treatment options "when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient."[203]

No "Silent MCOs"

A PLHSO cannot require a HCP to accept the terms of other MCOs or insurance under common management and control.[204] Any contract provision that violates this section is void.

Non-covered Services

Like HMOs and insurance products, a contract between a PLHSO and a dentist may not contain a provision that requires the dentist to provide services to the PLHSO subscriber at a fee set by the PLHSO unless such services are covered services under the applicable contract. The term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments or any other limitation.[205]

Administrative Fines and Civil Lawsuits

In addition to fines and administrative action by DFS/OIR, any person (subscriber or HCP) may bring a civil lawsuit to enforce the terms and conditions of a PLHSO contract.[206] The "prevailing party" (either PLHSO or HCP) is entitled to attorneys' fees and court costs for civil actions[207] and the statutory cause of action is "cumulative to rights under the general civil and common law" regardless of action taken by DFS/OIR.[208]

Unfair Claim Settlement Practices

The Unfair Claim Settlement Practices Act applies to HMOs,[209]insurance, EPOS and PPOS,[210] and PLHSOs.[211]

Chapter 10
Fighting Back

Introduction

If dentists know that the MCO has violated the "rules of the road," consider reporting violations to the OIR and AHCA. AHCA monitors issues related to quality of care and the OIR monitors financial and contractual issues. Some violations are misdemeanors,[212] while others are subject to fines by governmental regulators. For example, the MCO may be liable for defamation (a type of unfair claim settlement practice) when its EOB forms routinely contain derogatory comments about providers that are false or maliciously critical of the dentist and calculated to injure the dentist (e.g., reputation and ability to retain and attract new patients).[213] For example, an EOB stating, "Root Canal fill appears inadequate on X-ray," sent to the patient may be defamation. This language in the EOB forms also may rise to the level of being an unfair claims settlement practice if it is committed "with such frequency as to indicate a general business practice" of "misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue."[214]

Unfair Claims Settlement Practices

MCOs violate Florida law if they commit or perform with such frequency as to indicate a general business practice any of the following[215]:

- failing to adopt and implement standards for the proper investigation of claims
- misrepresenting pertinent facts or contract provisions relating to coverage at issue
- failing to acknowledge and act promptly upon communications with respect to claims
- denying of claims without conducting reasonable investigations based upon available information
- failing to affirm or deny coverage of claims upon written request of the subscriber within a reasonable time not to exceed 30 days after a claim or proof of loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the MCO
- failing to promptly provide a reasonable explanation in writing to the subscriber of the basis in the health maintenance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement
- failing to provide any subscriber with services, care or treatment contracted for pursuant to any MCO contract without a reasonable basis to believe that a legitimate defense exists for not providing such services, care or treatment
- systematic downcoding with the intent to deny reimbursement otherwise due
- knowingly misleading potential enrollees as to the availability of providers
- failing to have in place an internal grievance system or complaint-handling procedure

Prompt Payment

Florida law[216] requires insurance to pay claims within 45 days of receipt and HMOs to pay claims within 35 days of receipt, but in no event, later than 120 days from receiving the claim. After 120 days, the HMO loses the right to protest payment for any reason. There is no similar prompt-payment requirement for PLHSOs, as reimbursement is either prepaid capitation or prepaid aggregate sum.

HCP Causes of Action under Florida Law

There are at least three different legal theories under which a dentist can sue an MCO for late or non-payment:

1. Claims reimbursement issues typically implicate contract language. Thus, the insured patient — or the doctor who has accepted assignment of the patient's rights under the policy — can sue for breach of contract.

2. By statute[217] "(a)ny person may bring a civil action against an insurer when such person is damaged" by unfair claims-settlement practices.

3. Under common-law causes of action[218] for unfair claims-settlement practices.[219] For example, an insured can sue for common-law fraud and deceit if the insurance company or its agents made false statements to support a bad faith settlement.[220] Slander and libel also have been upheld as common-law theories.[221]

Interestingly, under the statutory (but not the common law) cause of action, there is a procedural requirement that the insured notify the insurer of the bad faith claim.[222] The statute gives insurers 60 days from this notice to cure any bad faith on their part.[223]

Under Florida law, there is a common-law duty of good faith on the part of the insurer in negotiating settlements with third-party claimants (i.e., HCPs under assignment of benefits).[224] The common-law rule is that a third-party beneficiary who is not a formal party to the contract may sue for damages sustained as a result of one of the parties to the contract.[225] This is known as a third-party claim of bad faith. In 1982, Florida codified third-party bad faith claims into statute.[226]

Civil Remedy Notice

Before filing suit, HCPs must serve a Civil Remedy Notice on the MCO as a condition precedent to filing suit.[227] The notice must be served on both the MCO and DFS at least 60 days prior to bringing an action. DFS does not involve itself in the pre-suit negotiations or communications related to notices, as such actions are not within the scope of its statutory authority, but HCPs must do so to preserve their rights to civil remedies. To file a Civil Remedy Notice, go to: http://bit.ly/1EXMYsn.

Service of Process

When a party reaches the point of filing legal actions or proceedings against an MCO, they must proceed pursuant to a statutory procedure.[228] Under Florida Law, the Chief Financial Officer is designated to receive service of all legal process issued against a licensed insurer for any civil action or legal proceeding in the state. Service of process upon the Chief Financial Officer as the insurer's attorney pursuant to such an appointment shall be the sole method of service of process upon an authorized domestic, foreign or alien insurer in this state.

Administrative Remedies under Subscriber and Provider Assistance Program Panel

Under Florida law every HMO and PLHSO must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances."[229] After the internal grievance procedure is completed, the subscriber has one year from the date of service to submit an appeal for review to the Subscriber Assistance Program panel.[230] The subscriber must complete the entire appeal process and receive a final disposition from Florida MCOs before pursuing review by the Subscriber Assistance Program. The Subscriber Assistance Program will only accept appeals, it will not accept grievances. HMOs must maintain records of all grievances and report to AHCA "the total number of grievances handled, a categorization of the cases underlying the grievances and the final disposition of the grievances."[231]

Submit an appeal to:

Agency for Health Care Administration (AHCA)
Subscriber Assistance Program
2727 Mahan Dr., Building 1, Mail Stop #26
Tallahassee, FL 32308

or call 888.419.3456 or 850.412.5402.

Subscriber and Provider Assistance Program (SPAP) Procedures

Providers, defined as "a licensed practitioner" as well as charitable organizations, county public health departments, etc., may file an appeal with the SPAP.[232] All MCOs are subject to SPAP, including prepaid plans, HMOS, prepaid Medicaid plan, PPOs, EPOs and insurance products. The panel shall hear every grievance filed by subscribers or HCPs on behalf of subscribers, unless the grievance:

- relates to a managed-care entity's refusal to accept a provider into its network of providers.

- is part of an internal grievance in a Medicare managed-care entity or a reconsideration appeal through the Medicare appeals process that does not involve a quality of care issue.

- is related to a health plan not regulated by the state such as an administrative services organization, third-party administrator or federal employee health benefit program.

- is related to appeals by in-plan suppliers and providers, unless related to quality of care provided by the plan.

- is part of a civil lawsuit pending in state or federal court.

- is related to an appeal by non-participating providers, unless related to the quality of care provided to a subscriber by the managed-care entity and the provider is involved in the care provided to the subscriber.

- was filed before the subscriber completed the entire internal grievance procedure of the managed-care entity.

- has been resolved to the satisfaction of the subscriber who filed the grievance, unless the managed-care entity's initial action is egregious or may be indicative of a pattern of inappropriate behavior.

- is limited to seeking damages for pain and suffering, lost wages or other incidental expenses, including accrued interest on unpaid balances, court costs and transportation costs associated with a grievance procedure.

- is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed-care entity, which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the agency, office or department has reported these grievances to the appropriate professional licensing board or to the health facility regulation section of the agency for possible investigation.

- is withdrawn by the subscriber. Failure of the subscriber to attend the hearing shall be considered a withdrawal of the grievance.

AHCA's Commercial Managed Care Unit (CMCU) conducts regulatory oversight and issues Health Care Provider Certificates for commercial HMOs, and approves operational plans of EPOs, and WCMCAs. It also operates the Statewide Provider and Health Plan Claim Dispute Resolution Program via a contract with MAXIMUS.

MAXIMUS

Maximus is an independent dispute resolution organization that resolves claim disputes between HCPs and MCOs. Claim disputes must be submitted by the provider or the health plan and they must have been denied in full or in part, underpaid or overpaid. Complaints about late payments should be addressed to the DFS rather than MAXIMUS. Application forms and instructions on how to file claims are available from MAXIMUS directly at 866.763.6395, Option 5. Ask for the Florida Provider Appeals Process.

Eligible Claims

Dentists can submit claims against HMOs, PLHSOs and EPOs for:

- claim disputes related to payment amounts only (e.g., provider disputes payment amount received or HMO disputes payback amount). Claim disputes related exclusively to late payment and interest payment for violating prompt-pay statutes are not eligible.

- Dentists are required to aggregate claims (for one or more patients involving the same payor) by type of service to meet a minimum threshold of $500 in dispute.

Fees and Costs

The full review costs charged by MAXIMUS are paid by the non-prevailing party. If both parties prevail in part, the review cost will be apportioned based on the disputed claim amount. If the non-prevailing party or parties fail(s) to pay the ordered review costs within 35 days after the Agency's final order, the non-paying party or parties are subject to a fine of $500 per day. Entities filing a claim that is settled prior to any decision rendered by MAXIMUS pay the full review costs.

Since each claim dispute is different and of varying complexity, MAXIMUS does not estimate the full cost in advance but has agreed by contract with AHCA to the following fee schedule:

- Expert Review: $215/hr
- Coding Expert: $125/hr
- Legal Expert: $175hr
- Initial Review Fee to Determine Eligibility: $75 flat fee
- MAXIMUS will provide a review cost estimate in advance, if requested, at no additional charge beyond the initial review fee. However, review costs based on the final order from AHCA must be paid directly to MAXIMUS.

Timeframes

MAXIMUS, through AHCA, must review all grievances within 60 days after receipt and make a determination whether the grievance shall be heard. Once the agency notifies the MCO, the panel shall hear the grievance no later than 120 days after the date the grievance was filed. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. The panel shall issue a written recommendation, supported by findings of fact, to the subscriber or subscriber's representative, to the MCO and to the agency or the office no later than 15 working days after hearing the grievance.

If, upon receiving a proper patient authorization along with a properly filed grievance, the agency requests records from a HCP or an MCO, there is 10 days to provide records. Records include medical records, communication logs associated with the grievance both to and from the subscriber, and contracts. Failure to provide requested records may result in the imposition of a fine of up to $500. Each day that records are not produced is considered a separate violation.

Expedited Review

If the appeal poses an "immediate and serious threat" to a subscriber's health, there is an expedited review of 45 (cf. 60) from filing and the final order must be issued within 10 days after hearing the expedited grievance. If the appeal involves care that places "the life of a subscriber in imminent and emergent jeopardy" the panel has 24 hours to hear the appeal and 24 hours to issue the ruling.

An MCO, subscriber or HCP affected by a panel recommendation may within 10 days after receipt of the panel's recommendation, or 72 hours after receipt of a recommendation in an expedited grievance, furnish to the agency or office written evidence in opposition to the recommendation or findings of fact of the panel.

The panel can order the MCO to take any action necessary to address the grievance. It also can fine the MCO and fines are likely based on the actual or potential harm to the patient's health or safety, what the MCO did to resolve or remedy quality-of-care grievances and previous incidents of noncompliance by the MCO.

The panel consists of the Insurance Consumer Advocate, two AHCA representatives, two DFS representatives, a consumer appointed by the governor, a physician appointed by the governor and a medical director of an HMO. If special expertise is needed, the panel can retain experts.

ERISA: An MCO's Best Friend

The Employee Retirement Income Security Act (ERISA) of 1974,[233] applies to all insurance and managed-care organizations obtained through an employer that provide dental coverage for small and large group health plans. ERISA is "designed to have a sweeping pre-emptive effect in the employee benefit plan field and the various exceptions to pre-emption are meant to be narrow."[234] ERISA's broad pre-emption clause provides that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan."[235] Thus, ERISA pre-emption presents a real obstacle to enforcing Florida law because employers provide most health benefit plans.

ERISA is intended to provide uniform national standards for employee benefits. Thus, under section 514(a),[236] Florida insurance law is pre-empted if the benefits at issue are part of an employer-sponsored health plan. Under ERISA, the payor's only obligation is to pay the amount of the claim at issue. ERISA pre-emption is thus a significant roadblock for doctors recovering worthwhile damages for late or non-paid claims. ERISA pre-emption also means litigation will occur in federal court (where the civil docket is dramatically slower). Under ERISA (like state law), courts may award attorneys' fees (in addition to the amount of the claim in dispute) to the insured if he or she prevails.[237] So, if ERISA applies, it is a real obstacle to doctors' recovery of late or non-paid claims. The U.S. Supreme Court case of *Pegram v. Herdrich*,[238] identifies two types of coverage decisions made by managed-care organizations. "Eligibility decisions" determine whether a given condition is covered by the plan. "Treatment decisions" involve

diagnosing the insured's condition and deciding how to manage it. The Court reasoned that most managed-care decisions are "mixed eligibility and treatment decisions" and therefore, are not eligible for review in federal court under ERISA.

Contract Review Checklist

Evaluate agreements based on the following:

✓ Are all policy and procedure manuals referred to in the agreement present? If procedure manuals change at any time without the dentist's assent — how and when will you be told? Will you be able to opt out or are you only limited to terminating?

✓ Is there a complete fee schedule for each and every service to be provided under the contract? Do you have the right one for your geographic location? Do you have an understanding of billing procedures (claim submission deadlines and requirements, can they unbundle, deny if incorrect modifier used, etc.)? Do you know what utilization review (UR) and quality assurance (QA) procedures will be used against you and who is actually making these decisions (a dentist, an out-of-state dentist, a physician, a software program)? Do you know what services are covered versus NCS? How will this impact your collections?

✓ Has the MCO disclosed all the affiliates who are parties to the agreement? What type of entity is it: PPO, EPO, HMO, PLHSO, DMPO? Is it an ASO with a TPA administering ERISA benefits?

✓ Do you understand "usual" fee is your individual practice's "normal" or "regular" charge, but UCR is determined by the plan itself? What does normal or regular mean in this context: is the fee you charge 20 percent of your patients or 100 percent? What impact will other discount plans have on your regular fee? Do you understand the UCR's applicable geographic area and what percentile of UCR you will be paid?

✓ Are you prohibited from charging enrollees surcharges for infection control? For cancelled appointments without appropriate notice? Is the reduced fee enough to cover this overhead and still allow you to make profit?

✓ What are the referral authorization requirements? Are you limited to referring to only in-network specialists? If so, is who you normally refer to in-network?

✓ Do you understand precertification versus prior authorization versus case management reviews and other requirements for payment? Precertification means the MCO will confirm in writing (includes fax or email) what will be paid. Can you rely on the card or electronic verification? Can it be subsequently denied after you rely on it? Preauthorization just means they have coverage on the date you called but they can lose their job or cancel their coverage the next day.

✓ Do the fees offered cover your costs, including administrative expenses and how much malpractice you must carry? Do you know what the "local dental community standard" for financial responsibility actually means?

✓ What is your standard of care obligation? If it is "professional standards," do you know what that means? Will this clause be used against you by a patient in a malpractice lawsuit? Does it include "ethical standards?" Does it obligate you to provide specialty care or services beyond your skill level? With all the preauthorization, UR and exclusions can you really treat patients "in the same manner as dentist treats dentist's other patients?

✓ Does the MCO require you to look solely to the plan for reimbursement, such that you cannot direct or balance bill an enrollee? If the plan downcodes or bundles, are you still prohibited from balance billing the enrollee or does the contract clearly state you can bill the patient for the difference between the contract fee and the MCO's actual reimbursement? Even if they've signed a financial responsibility form agreeing to pay what their plan does not? Are exceptions for coinsurance, copayment, deductibles, policy limits, NCS clearly stated so you can bill the patient in these circumstances? Do you know what the deductible and plan annual maximums are? How will you be kept informed? Are you still obligated to applicable contract rates or the plan's discounted fee schedule if the services are not covered due to annual maximums being exceeded?

✓ Is there a continuing care obligation even if the plan doesn't pay you? How will you get paid for services post-termination by the MCO? Make sure you are not obligated to provide care for MCO patients longer than Florida law requires.

✓ Are carve-outs or individually negotiated service rates for specialty care specified clearly?

✓ Do you understand the appeal/provider dispute resolution process and deadlines? Can you be represented by an attorney? Who pays? Do you have malpractice coverage if the grievance goes against you and your care is not "medically necessary?" Are you locked into arbitration (given up your administrative and legal remedies under UCSPA?) Can you join a class action?

✓ Do you have a list of names and contact information for the payor's provider relations department, the contract manager, the medical/dental director?

✓ If you are under a "no discrimination" clause that includes subscribers' "health status," are you obligated to provide services beyond your normal practice or ability to care for them?

✓ Are you comfortable with the dental service and emergency care clause? If you can use a temporary substitute to meet these obligations, will you be liable for their work? Will your malpractice carrier cover their work? Do you need a separate contract with them?

✓ Watch effective dates and evergreen clauses. Most MCO contracts are not effective until countersigned by corporate headquarters. If you assume the contract is effective upon your signature and see patients before receiving the countersigned contract, you may not get reimbursed.

✓ Are you comfortable with the records retention requirement? Is it the same as your written office policy? Is it the same as the other MCOs you do business with? What about notice before inspection, what records are included, when do you have to do it, can you have a legal or other representative present, is it in person and on-site, or chart review only, does it require you to violate Florida records confidentiality, records owner law or HIPAA?

✓ Are you an independent contractor? Can you really control your work with the UR/QA imposed by the MCO — is your treatment plan interfered with?

✓ Assignment and amendment provision fair, reasonable and mutually reciprocal?

✓ What is for cause versus without cause in the termination section? If you have a claims dispute regarding fees being reimbursed properly, is that "for cause" termination by the MCO but not by you? Are non-solicitation, restrictive covenants or confidentiality clauses going to impair you regarding patient abandonment, filing of complaints with administrative agencies, litigation?

✓ Designate one person to open all payor-related mail. That way you ensure reimbursement is accurate and that person can share modifications to contracts as they come in. That person also should be monitoring claims payment (timeliness and accuracy) as well as logging phone conversations with the MCO. Claims can get pended or denied for inserting information in the wrong box or for not following prior authorization requirements. Someone needs to keep track of each MCO's particular rules. That person also should copy into a file for renegotiations instances of inappropriate denial, lower than expected reimbursement and other hassles. Review EOBs for accuracy. Check for coding changes and a clear description of why the claim was adjusted or denied, also check for interest payments on late payment. Contact the MCO if you don't understand a description code or the explanation of benefits.

✓ Confirm you can bill the patient directly for NCS.

✓ Check with other dentists about the MCO's reputation.

✓ If there is a fee withhold or a bonus calculation, do you understand it?

✓ Do you want to indemnify and hold the payor harmless for services provided or not provided? Is it indemnification or hold harmless, or both? Is it mutually reciprocal? Do you have enough malpractice coverage?

✓ Can you challenge credentialing denials, is this information going to be kept confidential by the MCO; if reported out will it affect hospital privileges, other MCO contracts, malpractice premiums, board recertification, etc., have you released the MCO from any liability associated with credentialing decisions?

✓ Can you limit the number of patients or close your practice to new patients on capitation contracts?

✓ Did you do your homework: Adverse selection? The lower the risk pool of enrollees, the higher utilization; the lower the copayment or deductible, the higher utilization will be. Does the plan pay on time? Does the plan provide assistance to train front office staff? Is there a merger in the works? What do other doctors think of the plan regarding levels of responsiveness and claims payment? Is there pending litigation between the plan and other providers? Will the plan be able to use your name in advertising? If it is ERISA, is the employer financially stable? Keep your practice diversified when it comes to payor mix.

Basic Claims Tips

▶ Submit electronically and accept electronic deposit, it's faster and fewer rejections. Include the treating dentist's NPI and the billing dentist's NPI if different.

▶ Determine what must be attached. Initial office visit and prophy usually don't require attachments. Submit attachments rather than wait for the payor to ask for them. It triggers the prompt

payment provisions earlier. Use an electronic vendor rather than scanning and attaching. It works better for X-rays, perio-charting, EOBs (for coordination of benefits), etc. Use current radiographs, label left and right on the panorex.

▶ Send only one claim. Duplicate claims usually get rejected by the software and slow down claims payment. At worse, it could be construed as fraud. Routinely check on status of claims at their due date.

▶ Predetermination may not be required but it is always a good idea as it helps the patient understand their financial responsibility before the treatment begins. Some plans do not require you to submit a final claim if the services provided match those authorized on the predetermination.

▶ Double-check all information is included and accurate. Don't use old codes.

▶ Include tooth numbers. Include date of extractions and missing teeth when submitting prosthodontic claims. Periodontal procedures must include quadrant ID. If it's not a full quadrant, identify affected teeth by number. Include prior periodontal history for patients with new coverage.

▶ Include full-time student verification. The plan will need it if the student is the beneficiary to determine eligibility based on age and status.

▶ Use box 35 to explain why fees charged are reasonable even though they may exceed the plan's UCR data. For example, a combative patient may explain why there are no radiographs.

▶ If billing a secondary payor, submit the claim only after the primary payor has processed it and issued the EOB. Include all information about the other plan.

Contract Summary Form

Name of Payor	Contract Effective Date	Date Last Updated

Provider Relations Representative	Medical Director
Name:	Name:
Address:	Address:
Ph. Number:	Ph. Number:
Email:	Email:

Products Contracted
☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ Workers' Comp ☐ Medicaid ☐ Other

Termination Provision
☐ With-cause only on ____ days prior notice ☐ Without cause on ____ days prior notice ☐ Evergreen clause based on calendar year _____ or effective date _____ (indicate date) ☐ Special provisions or restrictions (describe; e.g., CMRRR, copy to General Counsel, etc.)

Utilization Management
Eligibility verification phone number or website address:
Precertification phone number or website address:
Precertification requirements:

Claims Submission
Must submit claims within ____ days of service to be considered timely ☐ temp ☐ permanent placement Address and Instructions for Claims Submission:

Provider Dispute Process

Name and address to file an internal appeal:

Reimbursement

- ☐ FFS via:
  - ☐ Table of allowances
  - ☐ UCR discount
- ☐ Capitation with:
  - ☐ fee withhold
  - ☐ bonus
  - ☐ stop-loss
  - ☐ carve-out for services

References

1. The legal definition is section 624.02, Fla. Stats., which says "insurance is a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies."

2. Section 641.60(1)(f), Fla. Stats.

3. Participating providers is a managed care term used to describe doctors who have signed contracts with managed care payors. Participating providers are also sometimes referred to as preferred providers or in-network doctors. While the term "preferred provider" may connote superiority in the minds of some plan enrollees, it does not necessarily denote superior credentials or specialty certification. Managed care plans credential participating providers, provide quality assurance / utilization review oversight, and receive accreditation based partially on the quality of network doctors. However, the term "preferred" as used here denotes financial incentives placed on plan enrollees to use services of participating providers rather than doctors who have not signed contracts with plan.

4. HMOs are regulated by Chapter 641, Part 1, Fla. Stats. They provide comprehensive health services (cf. "limited health services" provided by PLHSOs) to enrollees through exclusive provider panels. HMOs provide emergency, inpatient hospital, physician, ambulatory, diagnostic, treatment and preventive health care services on a prepaid basis pursuant to contracts with participating providers. Gatekeepers include osteopathic or allopathic physicians, chiropractors, podiatrists or obstetrician/gynecologists (if female enrollees so elect) but not dentists. See §641.19, Fla. Stats.

5. Chapter 641, Fla. Stats.

6. Gatekeepers include osteopathic or allopathic physicians, chiropractors, podiatrists or obstetrician/gynecologists (if female enrollees so elect) but not dentists. See section 641.19, Fla. Stats.

7. Section 466.0285, Fla. Stats.

8. Chapter 636,Part I, Fla. Stats.

9. Section 636.003, Fla. Stats.

10. Section 627.6471, Fla. Stats.

11. Chapter 636, Part II, Fla. Stats.

12. Section 627.6472, Fla. Stats.

13. Section 641.31(38(a), Fla. Stats.

14. Section 440.13(6), Fla. Stats.

15. Section 440.13(15), Fla. Stats.

16. Section 440.134(6)(c)8, Fla. Stats.

17. Section 440.134(3), Fla. Stats.

18. Section 440.134(6)(c)5, Fla. Stats.

19. Section 440.134(4), Fla. Stats.

20. Section 440.13(3)(a), Fla. Stats.

21. Section 627.736, Fla. Stats.

22. Section 627.736(4)(b), Fla. Stats.

23. Section 627.736(4)(d), Fla. Stats.

24. Line 36 of the ADA claim form uses language to like effect.

25. See section 627.736(5), Fla. Stats.

26. Section 409.912(4)(d), Fla. Stats.

27. Section 641.2019, Fla. Stats.

28. To a lesser extent, dentists may also encounter risk-based compensation such as fee withholds, global fixed sum arrangements and percentage of collected premium arrangements.

29. As regards HMOs, rather than a table of allowances, a "schedule of reimbursements" is used. It means a schedule of fees to be paid by a HMO to a HCP for reimbursement for specific services pursuant to the terms of a contract. The physician provider's net reimbursement may vary after consideration of other factors, including, but not limited to, bundling codes together into another code and member cost-sharing responsibility, as long as these factors are disclosed and included in the terms of the contract between the HMO and provider. The reimbursement schedule may be stated using codes or any other method agreed upon by the parties. Section 641.3154(16), Fla. Stats.

30. Section 641.19(5), Fla. Stats.

31. See sections 641.315 and 636.035(2), Fla. Stats., respectively.

32. "The same ethical considerations apply whether the dentist engages in fee for service, managed care or some other practice arrangement… [and] contract obligations do not excuse dentists from their ethical duty to put the patient's welfare first." Section 3, Principles of Ethics and Code of Professional Conduct, ADA (January 2014).

33. Patient abandonment is a type of malpractice suit.

34. "Pacing" if it results in injury may rise to the level of patient abandonment, one type of malpractice liability.

35. Section 766.102(2), Fla. Stats.

36. Section 466.028(1)(z), Fla. Stats. See also, section 466.018(1): "The dentist of record shall remain primarily responsible for all dental treatment on such patient, regardless of whether the treatment is rendered by the dentist himself or by another dentist, dental hygienist, or dental assistant.…"

37. Section 641.3903(11), Fla. Stats.

38. Section 636.059, Fla. Stats., applies the unfair claims settlement act provisions in section 641.3903, Fla. Stats., to PLHSOs.

39. Sections 636.058 (PLHSOs) and 641.3907, 641.3909 and 641.3913 (HMOs).

40. See, e.g., section 636.063, Fla. Stats. (civil liability for false claims against PLHSO).

41. Section 641.31(1), Fla. Stats.

42. Section 641.31(3)(c)(2), Fla. Stats.

43. Sections 641.31(42)(a) – (g), Fla. Stats.

44. Section 641.23, Fla. Stats.

45. Colorado introduced legislation requiring standardized contracts but it failed.

46. Section 627.638 (2), Fla. Stats. (insurance); section 627.6471(1)(b), Fla. Stats. (PPO).

47. Preferred Risk Life Insurance v. Sande, 421 So.2d 566 (Fla. 5th DCA 1982) ("a majority of the cases recognize that a sickness should be deemed to have its inception at the time it first manifested itself or became active, or where there is a distinct symptom or condition from which one learned in medicine can with reasonable accuracy diagnose the illness."), 94 A.L.R. 3rd 990, 998 (1979).

48. American Sun Life Insurance Company v. Remig, 482 So.2d 435 (Fla. 5th DCA 1985). See also section 627.6045, Fla. Stats.

49. Daniel v. Orange Life Insurance Company, 403 So.2d 438 (Fla. 2nd DCA 1981) (issue of when the illness manifested itself was one for the jury in light of all the circumstances of the case).

50. Section 641.3155, Fla. Stats.

51. Section 627.6131, Fla. Stats.

52. See, e.g., sections 627.6131, Fla. Stats. (insurance) and 641.3155, Fla. Stats. (HMO).

53. Section 636.016(8), Fla. Stats.

54. Section 627.6472(8), Fla. Stats.

55. Section 627.6471, Fla. Stats.

56. Section 766.102(1), Fla. Stats.

57. Section 636.035(10), Fla. Stats (PLHSOs); section 641.315(5), Fla. Stats.(HMOs).

58. Section 456.057(10), Fla. Stats.

59. Section 456.057, Fla. Stats.

60. Section 627.357, Fla.Stats.

61. Section 456.048, Fla. Stats.

62. BOD Rule 64B5-17.011, Fla. Admin.Code.

63. Section 766.2021, Fla. Stats.

64. Section 627.6131(3)(c), Fla. Stats. (Insurance, PPO and EPO).

65. Section 627.4235, Fla. Stats.

66. Section 627.4235(1), Fla. Stats.

67. Section 627.4235(2), Fla. Stats.

68. Section 627.4235(4)(a)1., Fla. Stats.

69. See, e.g., section 641.31(17), Fla Stats.regarding HMO coverage.

70. Sections 641.31(29(a) and (b), Fla. Stats.

71. Section 627.4235(4)(b)1., Fla. Stats.

72. Section 627.4235(4)(b)2., Fla. Stats.

73. Id.

74. Section 627.4235(4)(c)1. – 3., Fla. Stats.

75. Section 627.4235(4)(c)3., Fla. Stats.

76. Section 627.4235(4)(e), Fla. Stats.

77. The Consolidation Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 99-272).

78. Section 627.4235(6), Fla. Stats.

79. See, e.g., sections 641.31(13) and (14), respectively, regarding HMO coverage, and section 627.4235(4)(a)2.c., Fla. Stats., regarding insurance.

80. Section 636.035(6)(a), Fla. Stats.

81. Section 636.035(6)(b), Fla. Stats.

82. Section 636.035(7), Fla. Stats.

83. Section 636.035(8), Fla. Stats.

84. Section 641.315(2)(a)1., Fla. Stats.

85. Section 641.315(2)(a)2., Fla. Stats.

86. Section 641.315(3), Fla. Stats.

87. Section 641.315(2)(b), Fla. Stats.

88. Section 725.01, Fla. Stats.

89. See, e.g., section 636.019 (PLHSO).

90. Section 636.035(9), Fla. Stats.

91. Section 641.315(4), Fla. Stats.

92. Section 627.627, Fla. Stats.

93. Section 641.315(6), Fla. Stats.

94. 636.05(11), Fla. Stats.

95. Section 636.035(11), Fla. Stats.states: A contract between a prepaid limited health service organization and a provider of limited health services may not contain any provision that in any way prohibits or restricts the limited health service provider from entering into or renewing a contract with any other prepaid limited health service organization. This subsection applies to all contracts entered into or renewed on or after July 1, 2009.

96. Sections 641.315(6)(a) and (b). The HCP cannot prohibit the HMO from contracting with other HCPS and the HMO cannot prohibit the HCP from contracting with other HMOs.

97. 45 C.F.R. s. 156.230(a)(1).

98. Section 636.212, Fla. Stats.

99. Section 636.202(4), Fla. Stats.

100. Section 636.202(1), Fla. Stats.

101. Section 636.204(1), Fla. Stats.

102. Section 636.204(2)(k), Fla. Stats.

103. Section 636.206(1), Fla. Stats.

104. Section 636.204(6), Fla. Stats.

105. Section 636.210(1)(a), Fla. Stats.

106. Section 636.210(1)(b), Fla. Stats.

107. Section 636.210(1)(c), Fla. Stats.

108. Section 636.210(1)(d), Fla. Stats.

109. Section 636.214(1), Fla. Stats.

110. Section 636.218(1), Fla. Stats.

111. Section 636.226, Fla. Stats.

112. Section 636.230, Fla. Stats.

113. Section 636.204(6), Fla. Stats.

114. Section 636.220(2), Fla. Stats.

115. Sections 636.204(2)(l) and 636.204(5), Fla. Stats.

116. Section 641.155(1)(a)(i), Fla. Stats.

117. Section 626.9541(3)(a), Fla. Stats.

118. Section 626.9541(1)(i), Fla. Stats.

119. Sections 627.65755, Fla. Stats. (anesthesia) and 627.66911, Fla. Stats. (cleft lip and palette).

120. Sections 627.638, Fla. Stats. (insurance) and 627.6471(1)(b), Fla. Stats. (PPO).

121. Sections 627.6131 and 641.3155, Fla. Stats

122. Section 408.7057, Fla. Stats.

123. DOI lacks jurisdiction to enforce or interpret insurance-policy language. This function is exclusively within the province of courts. Hughes v. Professional Insurance Corp., 140 So.2d 340 (Fla. 1st DCA 1962).cert. denied 146 So.2d 377.

124. Section 641.19 (2), Fla. Stats.

125. With one exception pursuant to section 641.30(5), Fla. Stats., which states that an HMO must not discriminate based on genetic information as set forth in section 627.4301, Fla. Stats.

126. Section 641.49(1), Fla. Stats.

127. Section 641.495, Fla., Stats.

128. Section 641.51(1), Fla. Stats.

129. Section 641.51(5)(a), Fla. Stats.

130. Section 641.30(1), Fla. Stats. The statute refers to s. 641.3155, Fla. Stats., which requires the HCFA 1500 data set for medical claims and the UB-92 data set developed by the National Uniform Billing Company for institutional claims.

131. Section 641.31(12), Fla. Stats

132. Id.

133. Section 641.3155(1), Fla. Stats.

134. Section 641.3155(10), Fla. Stats.

135. Section 641.3155(17), Fla. Stats.

136. Section 641.3155(3), Fla. Stats.

137. Section 641.3155(4), Fla. Stats.

138. Section 641.3155(16), Fla. Stats.

139. Section 641.3155(7)(a), Fla. Stats.

140. Section 641.511(2), Fla. Stats.

141. Section 641.511(6)(a), Fla. Stats.: For purposes of this subsection, "subscriber" includes the legal representative of a subscriber, which can be a HCP.

142. There is a statewide provider and health plan claim dispute resolution program under section 408.7057, Fla. Stats.

143. Section 641.185(1)(a), Fla. Stats.

144. Sections 641.495(1) and 641.51, Fla. Stats.

145. Section 641.31(4), Fla. Stats.

146. Section 641.31(5), Fla. Stats.

147. Sections 641.60-641.75, Fla. Stats.

148. Section 641.511(1), Fla. Stats.

149. Section 408.7056, Fla. Stats.

150. Section 641.511(1), Fla. Stats.

151. Section 641.3155(12), Fla. Stats.

152. Section 624.4211, Fla. Stats.

153. Section 641.31(16), Fla. Stats.

154. Section 641.31(16), Fla. Stats.

155. Section 641.3107(2), Fla. Stats.

156. Section 3156(2), Fla. Stats.

157. Section 641.28, Fla. Stats.

158. Sections 641.31071(1)(c)

159. Sections 641.31071(9)(a) – (c), Fla. Stats.

160. Section 641.31079(b), Fla. Stats.

161. Section 641.31(34), Fla. Stats.

162. Section 641.31(12), Fla. Stats.

163. Section 641.31(12), Fla. Stats.

164. Section 641.19(6)(a) and (b), Fla. Stats.

165. Section 641.31(34)(a), Fla. Stats.

166. Section 641.31(34)(b), Fla. Stats.

167. Section 641.31(34), Fla. Stats.

168. Section 641.31(35), Fla. Stats.

169. Section 641.31094, Fla. Stats.

170. Defined in section 741.28, Fla. Stats.

171. Section 641.3903(12)(b), Fla. Stats.

172. Section 636.022, Fla Stats.(PLHSOs).

173. Section 641.31(43), Fla. Stats.

174. See, respectively, sections 641.3154 (billing prohibition) and 641.513, Fla. Stats. (emergency services as mandated benefit).

175. Section 641.31(7), Fla. Stats.(i.e., as set forth in Section 627.4235, Fla. Stats.).

176. Section 641.315, Fla. Stats.

177. Section 641.315(8), Fla. Stats.

178. Section 641.3154(2), Fla. Stats.

179. Section 641.3154(2), Fla. Stats.

180. Section 641.315(7), Fla. Stats.

181. Section 641.315(10), Fla. Stats.

182. Section 641.315(5), Fla. Stats. See also, section 641.3903(14), Fla. Stats., which makes it an actionable unfair claims settlement practice to take adverse action against a provider based on medical discussions deemed in the patient's best interest.

183. Section 641.20185, Fla. Stats.

184. Section 641.315(11), Fla. Stats.

185. Section 641.3154, Fla. Stats., and section 641.3155(8), Fla. Stats.

186. Section 641.3154(4), Fla. Stats.

187. Section 641.3155(8), Fla. Stats.

188. Section 641.3154, Fla. Stats.

189. See section 408.7056, Fla. Stats.

190. See section 408.7056, Fla. Stats.

191. Sections 636.003(1) and (6), Fla. Stats.

192. Section 636.003(7), Fla. Stats.

193. Section 636.004, Fla. Stats.

194. Chapter 636, Part II, Fla. Stats.

195. Chapter 641, Fla. Stats.

196. Section 636.008, Fla. Stats.

197. Section 636.029(3), Fla. Stats.

198. Section 636.038(1), Fla. Stats.

199. Sections 636.035(1) – (4), Fla. Stats.

200. Sections 636.035(5), Fla. Stats.

201. Section 636.035(6), Fla. Stats.

202. Section 636.035(9), Fla. Stats.

203. Section 636.035(11), Fla. Stats.

204. Section 636.035(12), Fla. Stats.

205. Section 636.035(13), Fla. Stats.

206. Section 636.052, Fla. Stats.

207. Id.

208. Section 636.063, Fla. Stats.

209. Section 641.3903, Fla. Stats.

210. Section 626.9541(1)(i), Fla. Stats.

211. Section 636.059, Fla. Stats.

212. Section 641.37, Fl Section 636.035(6), Fla. Stats.a. Stats.

213. Sections 641.3903(3), Fla. Stats. (HMOs) and 626.9541(1)(i)3.b., Fla. Stats. (insurance, EPO, PPO).

214. Id.

215. Section 641.3903, Fla. Stats. (HMOs), section 636.059 (PLHSOs) and section 626.9541 (insurance, PPOs and EPOs).

216. Sections 627.613 (indemnity) and 641.3155 (HMO), Fla. Stats.

217. Sections 624.155(1)(b)1 (insurance), and 641.3903(3) and (5) (HMO), Fla. Stats. See also, Jones v. Continental Insurance Company, 670 F.Supp. 937 (S.D.Fla 1987) (statute not unconstitutionally vague); State Farm Mutual Auto Insurance Company v. Laforet, 658 So.2d 55 (1995) (statute within legislature's right to modify common law definition of damages and allow recovery for amounts not proximately caused by insurer's bad faith); Thomas v. Lumberman Mutual Casualty Company, 424 So.2d 36 (Fla. 3rd DCA 1983); Opperman v. Nationwide Mutual Fire Insurance Company, 515 So.2d 263 (Fla. 5th DCA 1987).

218. "Common law," also known as "case law," means law created through judicial decisions, as opposed to statutes created by the legislature or rules created by administrative agencies. "Causes of action" means that the law recognizes a basis for a lawsuit to be filed and for damages to be awarded if the underlying facts are proven.

219. McLeod v. Continental Insurance Company, 591 So.2d 621 (1992).

220. Escambia Treating Company v. Aetna Casualty & Surety Company, 421 F.Supp. 1367 (D.C. Fla. 1976) (insured's representatives knew that insurer's agents lacked authority to bind company, thus allegedly false statements by insurer's agents would not support cause of action for common-law fraud and deceit pertaining to misrepresentation in claims adjustment).

221. See, e.g., T.D.S. Inc. v. Shelby Mart Insurance Company, 760 F.2d 1520 (11th Cir. 1985).

222. Section 624.155(2)(a), Fla. Stats. See also, Hollar v. International Bankers Insurance Company, 572 So.2d 937 (3rd DCA 1990).

223. Section 624.155(2), Fla. Stats.

224. Auto. Mut.Indem. Co. v. Shaw, 184 So. 852 (Fla. 1938)

225. Thompson v. Commercial Union Insurance Co., 250 So.2d 259 (Fla. 1971).

226. Section 624.155, Fla. Stats. (insurance).

227. Section 624.155, Fla. Sttas.

228. Section 624.422, Fla. Stats.

229. Section 641.511(1), Fla. Stats.

230. Section 408.7056, Fla. Stats.

231. Section 641.511(1), Fla. Stats.

232. Section 408.7056, Fla. Stats.

233. 29 C.F.R. s. 2560.503-1

234. American Progressive Life and Health Insurance Company of New York v. Corcoran, 715 F.2d 784, 786 (2d.Cir. 1983) citing Delta Air Lines, Inc. v. Kramarsky, 650 F.2d 1287, 1304 (2d.Cir. 1981).

235. 29 U.S.C. §1144(a). Further, it is a "familiar and well-established principle that the Supremacy Clause (U.S. Const., Art. VI, cl. 2) invalidates state laws that 'interfere with, or are contrary to,' state law." Hillsborough County, Fla. v. Automated Med. Lab., Inc., 471 U.S. 707, 712 (1985) quoting Gibbons v. Ogden, 9 Wheat.1, 211 (1824).

236. 29 U.S.C. § 1144(a).

237. 29 U.S.C §1132(6), ERISA § 502(g).

238. Pegram v. Herdrich, 530 U.S. 1, 120 S.Ct. 1942, 147 L.Ed.2d 1 (2000).