Jodi Black

From: Rosen, Andrea [RosenA@insurance.ca.gov]
Sent: Thursday, October 26, 2006 2:06 PM
To: Aileen Wetzel; Hoge, Nettie; Whitfield, Jerry
Cc: Catherine Hanson; Jodi Black; Frank Navarro
Subject: RE: PacifiCare/United Healthcare Physician Contract

Thank you Aileen.

We appreciated the opportunity to meet all of you and learn about your concerns. We will review your materials and follow up accordingly.

Andrea G. Rosen
Staff Counsel
Enforcement Bureau- Health Insurance
California Department of Insurance
916 492-3508/ FAX 916 324-1883
rosena@insurance.ca.gov
Sacramento Office

-----Original Message-----
From: Aileen Wetzel [mailto:awetzel@cmanet.org]
Sent: Thursday, October 26, 2006 1:48 PM
To: Rosen, Andrea
Cc: Catherine Hanson; Jodi Black; Frank Navarro
Subject: PacifiCare/United Healthcare Physician Contract

Andrea and Nettie:

Thank you for taking time yesterday to meet with CMA and for your interest in our concerns regarding PacifiCare/United Healthcare. Per your request, attached please find a copy of PacifiCare's physician contract. I am also forwarding an electronic copy of CMA's analysis of the contract.

If you have any questions regarding these documents, please don't hesitate to let me know. On behalf of CMA, we look forward to working with you on these issues.

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<<Alert Pacificare analysis updated 092106.pdf>> <<PC-UHC Final Contract DMHC approved 08-06.doc>>

Jodi Black

From: Aileen Wetzel
Sent: Thursday, October 26, 2006 1:48 PM
To: 'rosena@insurance.ca.gov'
Cc: Catherine Hanson; Jodi Black; Frank Navarro
Subject: PacifiCare/United Healthcare Physician Contract

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PacifiCare/United Contract Analysis (Updated 9/18/06)

The Department of Managed Health Care (DMHC) approved a revised PacifiCare contract on August 3, 2006. An analysis of the revised contract is provided below. It should be noted that PacifiCare did not make any changes to the underlying Physician Agreement. Rather, revisions have been made to the California Regulatory Requirements Appendix, which is incorporated as part of the agreement. The cover page of the agreement states that if there is any inconsistency between California Regulatory Appendix and any term or condition contained in the agreement, the terms of the appendix will control. Physicians should note that the lack of a crosswalk between the two documents creates significant confusion on provisions. Few practices have the resources to fully understand their rights under these agreements.

ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
OBTAIN AND REVIEW ALL REFERENCED DOCUMENTS	"Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix." (Introduction) "Additionally, for customers enrolled in benefit plans issued or administered by a subsidiary of either PacifiCare Health Plan Administrators, Inc. or PacifiCare Health Systems, LLC (these customers are referred to as ("PacifiCare Customers"), you will be subject to requirements described in or made available to you through the PacifiCare Provider Policy and Procedure Manual ("PacifiCare Manual"). When this agreement refers to the Administrative Guide, it is also referring to the PacifiCare Manual. The PacifiCare Manual will be made available to you on line or upon request. In the event of any conflict between this Physician Contract or the "UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide" or other UnitedHealthcare administrative protocols, and the PacifiCare Manual, in connection with any matter pertaining to a PacifiCare Customer, the PacifiCare Manual will govern, unless applicable statutes and regulations dictate otherwise. (Appendix 1)	This issue is not addressed in the California Regulatory Appendix.	Physicians are advised to obtain and review all referenced appendices, Administrative manuals, policy and procedure manuals, fee schedules and payment rule information prior to signing a contract. Different Administrative and policy and procedure manuals apply, depending on whether the patient is insured by PacifiCare Health Plan Administrators, PacifiCare Health Systems, or United Healthcare. It is not clear to physicians which policies and procedures apply to which patients.

ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
CONTRACT APPLIES TO ALL PRACTICE SETTINGS	"This agreement applies to you and the services you provide in all of your practice arrangements and for all of your tax identification numbers."	This issue is not addressed in the California Regulatory Appendix.	**This provision is in violation of the requirement that all plan contracts with physicians be fair and reasonable. (Health & Safety Code §1367, Insurance Code §10133.5.)** Physicians should be aware that this provision authorizes PacifiCare to apply the terms of the contract, including the discounted rates, to all of the physician's practice settings (e.g. private practice, group practice, academic) and locations, not just to the tax ID number under which the contract is signed. This may have implications for physicians who contract with multiple provider groups.
NOTIFICATION REQUIREMENTS	"You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide, **if you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer."** (What You Will Do)	This issue is not addressed in the California Regulatory Appendix.	**Violation of the requirement that all plan contracts with physicians be fair and reasonable. (Health & Safety Code §1367, Insurance Code §10133.5.)** This requirement is unreasonable in that it requires physicians to notify PacifiCare of all services the physician provides, including new services. If PacifiCare does not receive notification of a new service, the physician will not be paid. Physicians will need to ensure that all services are listed and incorporated as part of the contract. If new services are added, the office will need to have a process in place to immediately notify PacifiCare or the services will not be reimbursed.

ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
ELECTRONIC CLAIMS SUBMISSION	"***Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis*** to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefits, and submitting your claim." (What you will do, paragraph 3)	**California Regulatory Appendix** ***Provision applicable to products regulated by DMHC[1]:*** "Termination for Cause. As directed by the DMHC, in the event we seek to terminate this agreement for cause on the basis of your material breach of the requirement to conduct business with us entirely on an electronic basis within one year of the effective date of the agreement, we shall provide you with 180 days prior written notice and you shall have 180 days from the receipt of such notice to cure the deficiency in order to avoid termination." The California Regulatory Appendix, updated by PacifiCare and approved by DMHC on August 3, 2006, authorizes PacifiCare to terminate the physician **for cause for material breach of contract** if the physician is unable to comply with this requirement within 180 days notice of breach of contract from the plan. ***Provision applicable to products regulated by DOI:[2]*** This issue is not addressed in the California Regulatory Appendix as it pertains to DOI regulated products. Therefore, the terms of the underlying contract apply.	**This provision is in violation of the requirement that all plan contracts with physicians be fair and reasonable. (Health & Safety Code §1367, Insurance Code §10133.5.)** This provision would require that physicians conduct certain business with PacifiCare, including claims submission, on an electronic basis. This provision exceeds the requirements of other health plan agreements. If a physician's practice is not set up to verify eligibility or submit claims electronically, the physician will not be able to meet the contract requirements may be terminated for breach of contract. It is noteworthy that the contract does not require PacifiCare to be able to perform all required HIPAA transactions.

[1]Products regulated by the Department of Managed Health Care include PacifiCare HMO.
[2] Products regulated by the Department of Insurance include PacifiCare PPO, United Healthcare PPO and "other payors" accessing the PacifiCare network, with the exception of self-funded plans.

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ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
CLAIMS FILING DEADLINES	"You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. ***If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer."*** (What you will do, paragraph 4)	**California Regulatory Appendix** ***Provision applicable to products regulated by DMHC:*** 15(a) "...in the event a claim is denied because it was filed beyond the claim filing deadline, we will, upon your submission of a provider dispute and the demonstration of good cause for the delay, accept and adjudicate the claim in accordance with Health & Safety Code §§1371 or 1371.35, as amended, whichever is applicable..." ***Provision applicable to products regulated by DOI:*** Section 7(a), Payment of Claims "...in the event a claim is denied because it was filed beyond the claim filing deadline, we will, upon demonstration by you of good cause for the delay, accept and adjudicate the claim in accordance with Insurance Code §§10123.13 or 10123.147, as amended, whichever is applicable." For products regulated by both DMHC and DOI, deadlines may not be imposed for the receipt of a claim from a physician that is less than 90 days for contracted providers and 180 days for non-contracted providers, after the date of service (28 C.C.R. §1300.71(b)(1), Insurance Code §10133.66)). Furthermore, a plan must, upon the physician's demonstration of good cause for the delay, accept and adjudicate the claim (28 C.C.R. §1300.71(b)(4)).	The California Regulatory Appendix has been revised to be consistent with 28 C.C.R. §1300.71(b)(4) and Insurance Code §10133.66; However, it is not clear which provisions in the underlying contract are superseded by the terms of the regulatory appendix.
TIMELY PAYMENT & INTEREST ON LATE PAYMENT	"We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are	**California Regulatory Appendix** ***Provision applicable to products regulated by DMHC:*** Section 15(b) states that "for each Complete	Although the regulatory appendix appears to have been updated to be consistent with the requirement that plans pay claims within 30 days (45 days for HMOs) after receipt of the claim. (Health & Safety Code §§1371, Insurance Code §10123.13), the regulatory appendix

ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
	not complete, • You may be asked for additional information so that your claim may be adjudicated; or • Your claim may be denied and you will be notified of the denial and the reason for it; or • We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have. If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, ***if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide."*** (What we will do, paragraph 1)	Claim, as defined in Title 28 of the California Code of Regulations §1300.71(a)(2), as amended, submitted by you which we or the participating entity does not deny or contest, we or the participating entity will pay the amount due to you within 45 working days following our receipt of the Complete Claim. In the event it is determined that a claim is not a Complete Claim, we will, within the timeframe set forth above for the payment of a Complete Claim, advise you of the basis upon which a claim is not eligible for payment and specify any additional information required for us or the participating entity to pay the amount due with respect to the applicable claim. Additional information regarding this process is included in the PacifiCare Manual. This provision specifically supersedes any conflicting requirements in (1) the fourth, sixth and seventh paragraphs in the section of this agreement entitled "What you will do"; (2) the first and second paragraphs in the section of this agreement entitled "What we will do"; and (3) section 2.1 in Appendix 3 of this agreement." ***Provision applicable to products regulated by DOI:*** Section 7(b), Payment of Claims, "...for any claim or portion of any claim submitted by you that is not contested or denied by us or the participating entity, we or the participating entity will pay the amount due to you within 30 working days following our receipt of the claim. In the event that a claim is contested or denied by us or the participating entity, we will, within the timeframe set forth above, furnish you the information required by Insurance Code §§10123.13 or 10123.147, as amended, as applicable. If a claim or portion thereof is contested on the basis that we have not received information reasonably necessary to determine	does not address the requirement that interest be paid on late payment in accordance with 28 C.C.R. 1300.71(i) and Insurance Code §10123.13. For DMHC regulated products, the regulatory appendix states that Section 15(b) "specifically supersedes any conflicting requirements" in the first and second paragraphs of the agreement entitled "What we will do;" However, it is not clear if the provision in the underlying agreement that inappropriately relieves PacifiCare of their obligation to pay interest and penalties on claims that are not paid in a timely manner in the event PacifiCare "completed a claim that was not complete." For DOI regulated products, the regulatory appendix does not specify which provision in the underlying contract is superseded by the provision set forth in the regulatory appendix.

ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
		our or the participating entity's liability for the claim or portion thereof, then we will have 30 working days after receipt of this additional information to complete reconsideration of the claim; and (c) "Complete Claim" as used in the Agreement will have the meaning set forth in Insurance Code §10123.147(c), as amended.	
REQUIREMENT TO REFER TO CONTRACTING PHYSICIANS	"You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity." (What you will do, paragraph 10)	This issue is not addressed in the California Regulatory Appendix.	Physicians are advised to determine if their practice can comply with this provision. Do you know which physicians in your community participate with PacifiCare? Do you have a process in place to ensure that patients are referred to participating physicians?
FEE SCHEDULE DISCLOSURE	"The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. "Ordinarily, fee amounts listed in Appendix 3 are based upon primary fee sources. We reserve the right to use gap-fill fee sources where primary fee sources are not available." (What we will do, paragraph 4) "Unless specifically indicated otherwise, amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate modifier (for example, professional and technical modifiers). Any co-payment, deductible or coinsurance that the customer is responsible to pay under the customer's benefit contract will be	This issue is not addressed in the California Regulatory Appendix, despite the fact that California law requires plans to disclose all fee schedules, payment policies and payment methodologies to contracting physicians. The disclosure must include the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service and must be disclosed on the internet or on written request to the plan. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract must incorporate that fee schedule by reference, including the year of the schedule. For any proprietary fee schedule, the contract must include sufficient detail that payment amounts related to that fee schedule can be accurately predicted. (28 C.C.R. §1300.71(o), Business & Professions Code §511.4, Insurance Code §10133.6)). Detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims must be disclosed and shall:	**This provision is in violation of the requirement that plans disclose all fee schedules and payment methodologies (28 C.C.R. §1300.71(o), §1300.75.4; Business & Professions Code §511.4; Insurance Code §10133.6).** Neither the contract nor the regulatory appendix include a definition of "primary fee source" or "gap fill" fee source. Neither document discloses which methodologies will apply or how fee schedules are calculated. CMA's analysis of PacifiCare's fee schedule reveals that the fee schedule varies significantly from code to code. Physicians are advised to obtain a complete fee schedule for each and every service to be provided pursuant to the contract as well as a copy of all payment rules.

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ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
	subtracted from the listed amount in determining the amount to be paid by the payer. The actual payment amount is also subject to matters described in this agreement, such as the reimbursement policies." (Appendix 3, Page 12)	1) when available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies and major credentialing organizations; 2) clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and 3) at a minimum, clearly and accurately state the policies regarding the following: • consolidation of multiple services or charges, and payment adjustments due to coding changes; • reimbursement for multiple procedures; • reimbursement for assistant surgeons; • reimbursement for the administration of immunizations and injectable medications; • recognition of CPT modifiers.	
UNILATERAL CHANGES PROHIBITED	"We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicaid and Medicare Services (for example HCPCS, etc.). Ordinarily, our fee schedule is updated using similar	**California Regulatory Appendix** ***Provision applicable to products regulated by DMHC:*** Any amendment proposed by us to change a material term of the agreement between you and us must be negotiated and agreed to by you. However, if the change is not material or is made to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization, we may amend this agreement without your consent. If we make a change to a material term of our agreement we will provide at least 45	The California Regulatory Appendix appears to have been revised to be consistent with Health & Safety Code §1375.7 and Insurance Code §10133.65; however, it is not clear which "conflicting requirements" of the underlying contract are superseded by the terms of the regulatory appendix.

ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
	methodologies for similar services. ***We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.***" (What we will do, paragraph 5). We may make changes to the Administrative Guide or PacifiCare Manual or other Administrative Guide or PacifiCare Policy and Procedures or other administrative protocols upon 30 days' electronic or written notice to you." (Appendix 1)	business days' notice to you, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization require a shorter timeframe for compliance. If we amend a manual, policy, or procedure document referenced in the agreement, we will provide at least 45 business days' notice to you and you have the right to negotiate and agree to the change. If you and we cannot agree to the change to a manual, policy, or procedure document, you have the right to terminate the agreement prior to the implementation of the change. The 45 business days' notice requirements set forth in this section may be waived if you and we mutually agree, on a case by case basis. Except for changes that are not material or are made to comply with state or federal law or regulations or accreditation requirements, you have the right to negotiate and agree to any proposed change on a case-by-case basis at any time after you have received notice of the proposed change. For purposes of this section only, the term "material," means a change to which a reasonable person would attach importance in determining the action to be taken upon the provision. This provision specifically supersedes any conflicting requirements in (1) the third, fourth, fifth and sixth paragraphs in the section of this agreement entitled "What we will do"; (2) the second paragraph in the section of this agreement entitled "How long our agreement lasts, how it gets amended and how it can end"; (3) the "Administrative Guide" section in Appendix 1 of this agreement; and (4) section 3 in Appendix 3 of this agreement. ***Provision applicable to products regulated by DOI:*** Section 3, Amendment and Termination Due to	

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		Amendment. "We may amend the agreement. If our proposed amendment involves a material change to the agreement or to our quality improvement or utilization management programs, we will provide at least 45 business days' notice to you and you may terminate the agreement by providing written notice to us of your intent to terminate this agreement, as further described in the agreement. Nothing in this section limits the ability of you and we to mutually agree to the proposed material change at any time after you have received notice of the proposed material change. For purposes of this section only, the term "material" means a change to which a reasonable person would attach importance in determining the action to be taken upon the provision.	
RESCISSION OR MODIFICATION OF AUTHORIZATION OR ELIGIBLITY PROHIBITED	"***Your reimbursement is also subject to our rules concerning retroactive eligibility***, subrogation and coordination of benefits (as described in the Administrative Guide)." (What we will do, paragraph 3)	This issue is not addressed in the California Regulatory Appendix, despite the fact that California law provides that attempts to rescind or modify an authorization or verification of eligibility for health care services after the provider renders the service in good faith and pursuant to the authorization are prohibited. (Health & Safety Code §1371.8; 28 C.C.R. §1300.71(a)(8)(T) and Insurance Code §796.04)).	Violation of Health & Safety Code §1371.8; 28 C.C.R. §1300.71(a)(8)(T) and Insurance Code §796.04, which states that attempts to rescind or modify an authorization or verification of eligibility for health care services after the provider renders the service in good faith and pursuant to the authorization are prohibited.
UNAUTHORIZED OFFSETS PROHIBITED	"In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment." (What we will do, paragraph 7)	**California Regulatory Appendix** ***Provision applicable to products regulated by DMHC:*** Section 8, Authorization of Our Right to Offset any Uncontested Notice of Overpayment. In the event of an overpayment and prior to any adjustment we make in future claims payments to you, we will provide you with a separate written notice of the overpayment of a claim or claims which clearly identifies the overpaid claim or claims, enrollee's name and dates of	The California Regulatory Appendix appears to be in compliance with 28 C.C.R. §1300.71(d)(3), (4), and (6). Insurance Code §§10133.66, 10123.145, 10 C.C.R. §2695.11. However, it is not clear which "conflicting requirements" of the underlying contract are superseded by the terms of the regulatory appendix.

ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
		service and explains the basis of our request for reimbursement of the overpayment. We will furnish such notice of overpayment to you within 365 calendar days after the date of the overpayment, unless the overpayment was caused in whole or in part by fraud or misrepresentation by you. If you intend to contest our notice, you must send written notice of your intent to contest within 30 business days of your receipt of our notice. If we do not receive a notice of intent to contest our notice of the overpayment of a claim or claims or the requested reimbursement from you within the above timeframes, you authorize us to offset the requested reimbursement amount from our current claims payments to you. Additional information regarding this process is included in the PacifiCare Manual. This provision specifically supersedes any conflicting requirements in the seventh paragraph in the section of this agreement entitled "What we will do". ***Provision applicable to products regulated by DOI:*** Section 8, Reimbursement Requests for the Overpayment of a Claim. "We will not request reimbursement for the overpayment of a claim unless we send you a written request for reimbursement within 365 days of the date of payment of the overpaid claim. The written notice will clearly identify the claim, the name of the patient, and the date of service, and will include a clear explanation of the basis upon which it is believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The 365-day time limit will not apply if the overpayment was caused in whole or in part by your fraud or misrepresentation. "	

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DISCLOSURE OF DISPUTE RESOLUTION PROCESS REQUIRED	"If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide." (What you will do, paragraph 7)	**California Regulatory Appendix** ***Provision applicable to products regulated by DMHC:*** Section 9, Submission of a Provider Dispute. You may obtain specific information regarding our provider dispute resolution mechanism in the PacifiCare Manual. You may submit information to us regarding provider disputes by writing us or calling us at the location and telephone number listed on the cover page of the agreement. We will inform you of any changes to our provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. You will receive the rights listed in California Health & Safety Code §1375.7, as amended, if we make any changes to our provider dispute resolution mechanism. This provision specifically supersedes any conflicting requirements in the first paragraph in the section of this agreement entitled "What if we do not agree". Section 5, Dispute Procedure. We will inform you of any changes to our provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. ***Provision applicable to products regulated by DOI:*** Provider dispute resolution is not addressed in the California Regulatory Appendix as it applies to products regulated by DOI. It is therefore not clear if PacifiCare's process is consistent with the requirement that payors	Neither the agreement nor the regulatory appendix include a description of the dispute resolution process and instead refer to PacifiCare's Administrative Guide. It is not clear if PacifiCare has complied with the requirement that payors establish a free, optional, fair, fast and cost-effective dispute resolution mechanism to process physician disputes. (28C.C.R. 1300.71.38 and Insurance Code §10123.137)). Physicians are advised to obtain a copy of PacifiCare's Administrative Guide in order to review the dispute resolution process and to ensure if your practice can administer its requirements.

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ISSUE	CONTRACTUAL PROVISION	REGULATORY ISSUES	CONCERN
		establish a free, optional, fair, fast and cost-effective dispute resolution mechanism to process physician disputes. (Insurance Code §10123.137).	
INAPPROPRIATE REQUESTS FOR ADDITIONAL INFORMATION	"You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies." (What you will do, paragraph 10)	This issue is not addressed in the California Regulatory Appendix. For DMHC regulated products, physicians are only required to provide the plan with "reasonably relevant information," which means the minimum amount of itemized, accurate and material information generated by or in the possession of a provider related to the billed services that enables a claims adjudicator with appropriate training, experience, competence, and timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with any governmental information requests. (28 C.C.R. §1300.71(a)(10).) A payor that requests information that is not reasonably relevant or that is in excess of the information necessary to determine payor liability but ultimately pays the claim in whole or in part, must pay interest. Where it fails to do so automatically, it must also pay a penalty in the same manner as is required for the late payment of claims beginning the first calendar day after the expiration of the time for reimbursement (thirty days for PPOs, forty-five days for HMOs). (28 C.C.R. §1300.71 (k).)	This provision may be in violation of 28 C.C.R. §1300.71(a)(10) and 28 C.C.R. §1300.71 (k), which limit the amount and type of information that a payor can request from a physician.
OTHER PAYORS	The following entities have access to our agreement: • United HealthCare Insurance Company ***and its affiliates*** • Groups receiving administrative services from United HealthCare Insurance Company or its affiliates or that have arranged	**California Regulatory Appendix** ***Provision applicable to products regulated by DMHC:*** Section 2, Network Participation. Upon our receipt of your signed copy of this agreement and upon any renewal of this agreement, we will provide you with the disclosures described in California Health & Safety Code §1395.6, as	The regulatory appendix appears to be consistent with Health & Safety Code §1395.6 (b), Business & Professions Code §511.1, and Insurance Code §10178.3. However, the appendix does not expressly require PacifiCare to disclose a summary of all payors (including name and plan type) currently eligible to claim a physician's contracted rate, within 30 calendar days of receipt of a written request from a physician.

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	for network access through an entity that has contracted with United HealthCare Insurance Company or one of its affiliates. **Products or services.** We may include you in networks where your patients are enrolled in benefit contracts of the types generally described below: • Benefit contracts where individuals are offered a network of participating physicians and other health care professionals and must select a primary care physician, who in some cases must approve any care provided by other health care providers. An option for this benefit contract allows individuals to receive health services from non-participating physicians. • Benefit contracts where individuals are offered a network of participating physicians and other health care providers but are not required to select a primary care physician An option for this benefit contract allows individuals to receive health services from non-participating physicians. • Benefit contracts where individuals ate not offered a network of participating physicians and other health care providers. (Appendix 2)	amended and as applicable, and will otherwise comply with the requirements of this law with respect to the sale, leasing or transfer of this agreement to a payor other than us. ***Provision applicable to products regulated by DOI:*** Section 2, Network Participation. Upon our receipt of your signed copy of this agreement and upon any renewal of this agreement, we will provide you with the disclosures described in California Business & Professions Code §511.1 or California Insurance Code §10178.3, as amended and as applicable, and will otherwise comply with the requirements of these laws, as applicable, with respect to the sale, leasing or transfer of this agreement to a payor other than us. California law requires plans that that sell or otherwise convey their lists of contracted health care providers and reimbursement rates to a payor or another contracting agent must meet specified requirements each time they enter or renew a provider contract. These requirements include all of the following: • Disclosure of whether the list may be sold or otherwise conveyed, and specification of whether workers' compensation insurers or automobile insurers may be the recipients; • Disclosure of whether future payors may be permitted to pay a physician's contracted rate without actively encouraging enrollers to use contracted providers (see discussion below); • Upon the signing of a contract, and within 30 calendar days of receipt of a written request from a physician, disclosure of a summary of all payors	

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		(including name and plan type) currently eligible to claim a physician's contracted rate; and • The opportunity to decline to be included on any list conveyed to payors that do not "actively encourage" their beneficiaries to use the list. This opportunity must be provided not only upon initial signing and renewal of the contract, but also upon each amendment. Providers who so decline may not, for that reason, be excluded from any list with respect to payors that do "actively encourage" list use. (Health & Safety Code §1395.6 (b).) Contracting agents must also disclose what specific practices, if any, the other payors utilize to encourage enrollees to use the contracted providers. A payor "actively encourages" its subscribers to use the contracted providers if one of the following occurs: • The payor offers its enrollees direct financial incentives to use the contracted providers, e.g., reduced copayments or deductibles, premium discounts, or the imposition of financial penalties for the non-use of a contracted physician. (Health & Safety Code §1395.6(b)(2)(A); Business & Professions Code §511.1(b)(2)(A); Insurance Code §10178.3(b)(2)(A)). • The payor provides to enrollees provider directories, toll-free telephone numbers, or internet web sites that supply the names, addresses, and telephone numbers of contracted physicians in advance of their selection of a physician. With respect	

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		to workers' compensation cases, the payor need only provide this information to employees during the period the employer has medical control, or in advance of a workplace injury or upon notice of an inquiry or claim by an employee, and may provide that information by means of wall cards that direct employees to a readily accessible listing of the contracted physicians or a toll-free number or internet website address. However, Internet web site addresses alone are not sufficient. Contracting agents or payors need only provide listings of providers located within a reasonable geographic range of the enrollee, and need not "actively encourage" list use with respect to emergency care. (Health & Safety Code §1395.6(b)(2)(B).)	
REPORTING OF ANY AMOUNTS COLLECTED FROM PATIENTS, INCLUDING CO-PAYMENTS		**California Regulatory Appendix** ***Provision applicable to products regulated by DMHC:*** Section 7, Reporting or Surcharges and Co-Payments. You will report to us all surcharge and co-payment moneys paid by subscribers and enrollees directly to you. ***Provision applicable to products regulated by DOI:*** This issue is not addressed in the California Regulatory Appendix as it pertains to DOI regulated products.	**Violation of the requirement that plan contracts with physicians be fair and reasonable (Health & Safety Code §1367(h)(1)).** This provision is unreasonable in that it requires physicians to document and report to PacifiCare any and all surcharges **and co-payments** collected from enrollees. This places an unnecessary burden on the physician practice and is neither fair nor reasonable. Physicians are advised to carefully consider the impact this provision may have on the practice prior to signing the agreement.
OFFICE HOURS MUST BE APPROVED BY AND		***Provision applicable to products regulated by DMHC:*** Section 7, Access to Services. Your hours of operation and provision for after-hour services	**Violation of the requirement that contracts be fair and reasonable (Health & Safety Code §1367(h)(1)).** This provision requires physicians to have "reasonable"

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WILL BE MONITORED BY PACIFICARE		will be reasonable. We will have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which will include, but is not limited to, waiting times and appointments. In addition, you will provide or arrange for the provision of emergency health care services 24 hours a day, 7 days a week. ***Provision applicable to products regulated by DOI:*** This issue is not addressed in the California Regulatory Appendix as it pertains to DOI regulated products.	office hours and after-hour services. It is not clear what PacifiCare considers to be "reasonable" office hours. It is also unclear how PacifiCare intends to monitor waiting times and appointments and what they will do with this information.
TERMINATION OF AGREEMENT	"...either you or we can terminate this agreement, effective on an anniversary of the date this agreement begins, by providing at least 90 days' prior written or electronic notice." (How long our agreement lasts; how it gets amended; and how it can end)	This issue is not addressed in the California Regulatory Appendix.	Physicians are advised that the contract can be terminated only once a year, upon 90 days prior written notice, the end of which must coincide with the contract effective date. This provision, to the extent that it permits termination of the contract via "electronic notice" conflicts with the provision in the same section that requires physicians to send the termination notice via Certified Mail, Return Receipt.
MEDICAL STAFF PRIVILEGES AT A PARTICIPATING HOSPITAL REQUIRED	"...we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you, if you no longer have your license to practice medicine, ***if you no longer have hospital admitting privileges in any participating hospital***, or in accordance with the terms of our Credentialing Plan." (How long our agreement lasts; how it gets amended; and how it can end, paragraph 5).	This issue is not addressed in the California Regulatory Appendix.	Physicians should be aware that this provision allows PacifiCare to immediately terminate a physician from the network in the event the physician does not have admitting privileges at a participating hospital.
ARBITRATION MUST BE CONDUCTED IN	"Arbitration will be conducted in Los Angeles County, California." (What if we do not agree, paragraph 2)	This issue is not addressed in the California Regulatory Appendix.	**Violation of the requirement that plan contracts with physicians be fair and reasonable (Health & Safety Code §1367(h)(1) and Insurance Code §10133.5)).**

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LOS ANGELES			The requirement that arbitration will be conducted in Los Angeles County is not fair or reasonable for physicians who practice in other parts of the state. Furthermore, this may act as a deterrent to physicians who are not able to take time away from their practice to travel to Los Angeles.
CAPITATION FROM DATE OF ENROLLMENT	"Retroactive Additions. A member added retroactively on the 14th of the month would generate a capitation payment for the entire month. However, a Member added on the 16th or later would not generate a capitation payment, even though the Member would be considered eligible for services."	This issue is not addressed in the California Regulatory Appendix.	**Violation of the requirement that contracts be fair and reasonable (Health & Safety Code §1367(h)(1)).** This provision requires the physician to provide services as soon as the member is eligible; however, if the member is added after the 16th of the month, the physician will not be paid and capitation is not retroactive to the date of enrollment. This places unreasonable financial risk on the physician. Furthermore, reference is made to when a member is added, not when they are eligible. It is also not clear if retroactive capitation reductions will work in the same manner.

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