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Lori Bielinski, Executive Director
Washington State Chiropractic Association
21400 International Blvd. Suite 207
SeaTac, Washington 98198

Dear Lori,

As requested, I have reviewed the PremeraFirst Provider Agreement [PCWPCORE (1/08)] and have made comments below. For the most part, the Premera Agreement closely follows Washington insurance regulations. Nevertheless, there are sections that should be discussed further as probable violations of state insurance rules.

Part I Definitions

These definitions must be carefully considered since they do more than describe terms; they include substantive requirements.

- 1.02 A “Claim” is not a “Claim” without “Complete and Accurate” information. This is later defined to include “other known insurance coverage” under the definition of “Complete and Accurate.” Thus, technically no claim has been made unless it contains “Complete and Accurate” information.
- 1.07 The definition of “Enrollee” includes not just Premera subscribers but also any person covered under any plan or network administered by Premera.
- 1.08 “Medical necessity” includes consideration of cost effectiveness. A proposed health care service is not “medically necessary” if the service is “more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results...”
- 1.11 “Plan” is defined as the carrier or other organization rather than the coverage agreement. It is important to remember this non-traditional use of the word since state regulations keyed to “plan” refer to the agreement and not to the organization.
- 1.15 “Subscriber Agreement” means any contract for health care services and thus, includes contract or insurance policy that provides for health care benefits.

Part 2 Obligations of Plan

- 2.01 “Claims Processing” provisions largely follow Washington State rules governing provider payment.
- 2.04 “Benefit and Eligibility Determinations” differ from state requirements by narrowing the insurance rule found at WAC 284-43-410(3) (h) & (i) although the rule

would “trump” the contract limitation in any dispute. The contract states that Premera will not “reverse any prior authorization of Covered Services for Medically Necessary [sic] unless Plan medical review determines that Plan authorized the services based upon materially incomplete or inaccurate information...” The state rule has two parts. The first in subsection (h) requires that a Plan: “Not retrospectively deny coverage for... care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a *material misrepresentation* by the provider.” That standard is distinctly narrower than a “material inaccuracy.” The second part in subsection (i) requires that a Plan: “Not retrospectively deny coverage or payment for care based upon standards or protocols not communicated to the provider or facility within a sufficient time period for the provider or facility to modify care in accordance with such standard or protocol.” Thus, a Plan may not retrospectively deny coverage based upon a UR standard not communicated by the Plan to the provider at the time of care.

- 2.05 “Network Tiering” creates three classes of providers in accordance with the current Attachment A Compensation Exhibit: Tier 1 - those providers without a contract; Tier 2 – those providers with a contract; Tier 3 – those providers who accept the Tier 3 fee schedule and who have admitting privileges. This is somewhat odd in that the contract creates a “network tier” (Tier 1) for providers who are not in the network.

Part 3 Obligations of Providers

Most of the provider obligations follow state regulatory standards with respect to licensure, non-discrimination, utilization management and billing.

Part 4 Payment and Billing

The Agreement shifts all responsibility to the provider for mistaken payments, enrollee misrepresentation, and other traditional carrier problems with collection from enrollees such as retroactive plan terminations.

- 4.01 (I.) Providers may seek payment from patients for care that the Plan denies on medical necessity grounds only if the patient has been informed and consented in advance to the service and the cost for the service. This restriction on advance notice of service and price would seem to require a prescience on the part of providers with respect to which service the Plan might refuse to pay on medical necessity grounds and violates RCW 48.43.085 as an indirect limit on the enrollee’s ability to contract for services on any terms and conditions when the Plan does not cover the service.
- 4.01 (J.) Participant assumes the liability for enrollee fraud or misrepresentation against a Plan that results in coverage where no coverage exists. This provision pushes Plan responsibility to the practitioner and violates RCW 48.43.410 governing retrospective denials of coverage when approved by the Plan. Fundamentally, the Plan has a cause of action against the enrollee when fraud is committed by the enrollee. The result of this clause is that when Premera is cheated by an enrollee, Premera will seek recovery of the payment from the practitioner who must pursue the patient. The clause is written so broadly as to suggest that if Premera determines that the enrollee application for insurance contained a material misrepresentation resulting in later cancellation of the

- 4.02 Similar to the “misrepresentation” issue noted above, if the Plan cancels coverage after care has been given, the provider is responsible for collecting the funds. This will also add to delays in payment as the provider seeks reimbursement and then is advised that the Plan has terminated the coverage. This will be particularly troublesome in those cases where the Plan gives an employer a 30 day grace period for non-payment of premium and later retroactively terminates coverage.
- 4.03 Providers are required to refund erroneous payments within 30 days of request and if not refunded within 60 days, the Plan may offset against future payments. This provision violates RCW 48.43.600 which permits the provider 30 days to contest and refund and that prohibits a Plan from making a “request that a contested refund be paid any sooner than six months after receipt of the request.”

Part 5 Records

- 5.02 Provider agrees to maintain patient records for at least 7 years. The Plan will pay Provider at the rate of \$.25 per page for medical record duplication requested in connection with utilization review.

Part 6 Termination

- 6.02 (A.) Either party may terminate the agreement without cause after 90 days prior written notice.
- (B.) Either party may terminate for contract default with a 30 day period for curing the default.
- (C.) The Plan may terminate immediately if the provider fails to meet credentialing standards or presents “significant adverse effect to the health and well-being of the Enrollee.”
- (D.) The Provider may terminate the contract with 30 day written notice when the Provider objects to a “material adverse” change to the contract. “Material adverse” change is not defined and provisions of Part 7 govern certain changes to the contract.

Part 7 Amendments

- 7.01 (A.) Amendments affecting compensation, existing products or treatment become effective after 90 days advance written notice to Participant.
- 7.01 (B.) Plan may modify fee schedules to ensure consistency with regulatory coding conventions.

Part 8 Dispute Resolution

Dispute resolution procedures including mediation generally follow state regulatory requirements. Binding arbitration is permitted only with mutual consent of the parties.

Part 9 General Provisions

- 9.07 This provider agreement (and many others like it) declare the terms and conditions of the agreement to be confidential despite the fact that such agreements are filed with the Insurance Commissioner and are publicly available documents except for compensation and similar exhibits.

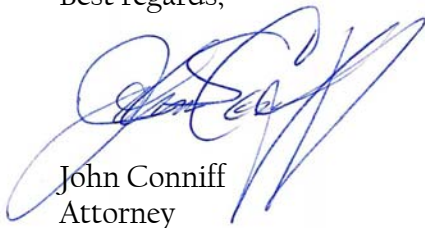
Other Issues

The Premera agreement carves out “affinity” plans (non-insurance programs offering provider discounts) for separate agreement or rejection by the provider.

Some chiropractic services may be considered medically unnecessary or investigational by the Plan. In either instance, state regulations require disclosure of the basis for such determinations. In the case of medical necessity, RCW 48.43.520 requires carriers to “make clinical protocols, medical management standards, and other review criteria available upon request to participating providers.” In the case of investigational treatments, WAC 284-43-043 requires “supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.”

Call me if you have any further questions or need broader explanations of the terms and conditions of the reviewed Agreement.

Best regards,



John Conniff
Attorney