



Medical
Association
of Georgia

Building a Better State of Health Since 1849



Medical Group
Management
Association

MGMA[™]

Georgia
A State Affiliate

present

Georgia Model Managed Care Contract

2009

© Medical Association of Georgia
Georgia Medical Group Management Association

A GEORGIA MODEL MANAGED CARE CONTRACT - 2009

Acknowledgements

This Model Managed Care Contract was prepared by MAG's Office of the General Counsel and GMGMA's Third Party Payer Committee. The following individuals were instrumental in its development.

Medical Association of Georgia

Donald J. Palmisano, Jr., General Counsel
Cam Grayson, Director, Third Party Payer Advocacy
Tom L. Kornegay, Jr., Director of Communications
Brian W. Looby, Associate General Counsel
Angela Boltz, Communications Coordinator/Webmaster
Elizabeth Bullock, Administrative Assistant

A special thanks to Arnall Golden Gregory's Healthcare Practice Group and Sidney Welch for its editorial contributions.

Georgia Medical Group Management Association Third Party Payer Committee Members:

Michelle Albers, MBA, MHA
Nancy Babbitt, FACMPE
Cindy Barge
Sheila Coffee, FACMPE
Lauri Gebhart
Brynne Goncher, JD, MPH
J. Dale Hawkins
Deborah Hill, MBA, CMPE, CPC
Peggy Lamee, CPAM
Linda Leeson, RRT, MBA
Wade McKenzie
Linda Moore, RHIT, CMPE
Thomas O'Brian, JD
Linda Rickey, COE, FACMPE
Lamar Sims, FACMPE
Marilyn Smolinski
Linda Swadener, FACMPE
Ashley Tagtachian, MBA, CPA

Keener Lynn, Genesis Physicians Group
Pamela Miller, IMPACT

1849 The Exchange
Suite 200
Atlanta, GA 30339
678.303.9290
800.282.0224
Fax 678.303.3732
www.mag.org



Medical
Association
of Georgia

Building a Better State of Health Since 1849

December 11, 2008

Dear Members,

The Medical Association of Georgia is dedicated to improving the practice environment for Georgia physicians through strong legislative, legal and third party payer advocacy. In addition, MAG continuously strives to provide you, the practicing physician, with the tools you need to be successful in today's challenging environment.

The Georgia *Model Managed Care Contract* is the latest in a series of useful tools for the practicing physician. We are proud to have partnered with the Georgia Medical Group Management Association to bring you this product which will help you navigate the complexities of contracting in today's world of managed care.

The *Model Managed Care Contract* will help you recognize common contract provisions that often present problems for physicians. This resource will provide you with recommended alternative language that will benefit you and your practice and is recognized under Georgia law. We truly hope that this resource will ease the administrative burdens on your practice.

I want to thank Mr. Lamar Sims of GMGMA and Mr. Donald J. Palmisano, Jr., and Ms. Cam Grayson of the MAG staff who made this resource possible. I hope that you find this tool useful and as always, I appreciate your feedback.

Sincerely,

David A. Cook
Executive Director/CEO



December 11, 2008

The Georgia Medical Group Management Association, (GMGMA) is pleased to have partnered with the Medical Association of Georgia to present this Model Managed Care Contract.

GMGMA has always provided its membership with educational programs and other literature to improve their skills as Medical Practice Administrators. This Model Managed Care Contract is another example of this education process.

The objective of this education tool is to provide the Administrator with the information that is necessary to identify contract language which should be excluded from a Managed Care Agreement, and replace it with language that better meets the needs of the Medical Practice.

I would like to thank the members of the GMGMA Third Party Payer Committee for the work they have done to produce this Model Contract, the GMGMA Board of Directors for their support of the efforts of the Committee, and MAG Staff members Donald J. Palmisano, Jr., and Cam Grayson.

Third Party Payer Committee Members:

Nancy Babbitt, FACMPE	Wade McKenzie
Cindy Barge	Linda Moore, RHIT, CMPE
Sheila Coffee, FACMPE	Thomas O'Brian, JD
Lauri Gebhart	Linda Rickey, COE, FACMPE
Brynne Goncher, JD, MPH	Lamar Sims, FACMPE
J. Dale Hawkins	Marilyn Smolinski
Deborah Hill, MBA, CMPE, CPC	Linda Swadener, FACMPE
Peggy Lamee, CPAM	Ashley Tagtachian, MBA, CPA
Linda Leeson, RRT, MBA	

Respectfully Submitted:

Cecilia (Cissy) Bowden, FACMPE, GMGMA President
A. Lamar Sims, FACMPE, Chairman, Third Party Payer Committee

PREFACE

The Insurance Commissioner of the State of Georgia, John W. Oxendine, has exclusive authority to enforce the Insurance Code in the State of Georgia.¹ The Commissioner has investigative and enforcement power and has the authority, if he deems it to be appropriate in the public interest or for protection of policyholders, to issue an order prohibiting persons from engaging in an act, practice or transaction prohibited under the Insurance Code.² The Commissioner may issue a Cease and Desist Order, may fine licensed agents and companies, may place any insurer, agent, broker, or adjuster on probation, or may suspend or revoke the person or entity's license to do business.³ To report a concern or violation of the Insurance Code, physicians should contact the Insurance Commissioner's Office at (404) 656-2070.

While this *Georgia Model Managed Care Contract* is intended to address a number of issues, it is not intended to cover a number of specific types of insurance products, including the following:

- Provisions that you might find in a contract between a Medicaid Care Management Organization (Medicaid CMO) and a Participating Physician, as these organizations are subject to a number of requirements beyond the scope of the traditional managed care arrangement, including an agreement between the organization and the Department of Community Health. For additional information on Medicare Care Management Organizations, please visit O.C.G.A. 33-21A-1, et al., as well as the websites of the Georgia Medicaid CMOs, located at: <http://www.amerigroupcorp.com/Pages/Home.aspx>, <https://www.pshpgeorgia.com/pshp/> and <http://georgia.wellcare.com/>.
- The role in managed care contracts of Third Party Administrators (TPAs), which under Georgia law would include any business entity that, directly or indirectly, collects charges, fees, or premiums; adjusts or settles claims, including investigating or examining claims or receiving, disbursing, handling, or otherwise being responsible for claim funds; and provides underwriting or precertification and preauthorization of hospitalizations or medical treatments for residents of the state of Georgia for or on behalf of any insurer, including business entities that act on behalf of multiple employer self-insurance health plans, and self-insured municipalities or other political subdivisions. O.C.G.A. § 33-23-100(a)(1). While many major health plans act as TPAs, that role is beyond the scope of this model agreement. For more information on the regulation of TPAs in Georgia, see O.C.G.A. § 33-23-100, et al.
- Payments to nonparticipating physicians or nonpreferred physicians, except in the context of the "consumer choice option."⁴ If you practice medicine as an out-of-network physician for any plan, you can obtain more information about your right to payment for these services at O.C.G.A. § 33-24-54.
- Preferred Provider Arrangements, which Georgia law defines as contracts between or on behalf of a health care insurer and a "preferred provider" – a health care provider or

¹ O.C.G.A. § 33-2-1.

² O.C.G.A. § 33-2-24(a).

³ O.C.G.A. § 33-2-24.

⁴ O.C.G.A. § 33-20A-9.1(c).

group of providers who have contracted to provide specified covered services.⁵ For more information about statutorily permitted limits on payments to noncontracting providers associated with these arrangements, as well as limits to payments for emergency care provided under these arrangements, see O.C.G.A. § 33-30-23 and O.C.G.A. § 33-30-24, respectively.

A final word of caution: Georgia law generally governs *fully insured* Plans, but may not govern all products offered by a Payer and/or self-insured Plans. In these instances, the agreement signed by a Participating Provider should incorporate as many provisions as possible that are consistent with Georgia law beneficial to physicians. Because these statutes do not apply to self-insured plans, Participating Physicians involved in such products or Plans should not rely on statute or regulation for enforcement; rather, they should make the obligations of Payers contractually binding by ensuring necessary language is in the agreement ultimately signed by the parties.

⁵ O.C.G.A. § 33-30-20, et al.

**GETTING STARTED:
INSTRUCTIONS FOR USING THE GEORGIA MODEL MANAGED CARE
CONTRACT**

-  Review the information contained in the *Georgia Model Managed Care Contract* generally. For ease of reference, we have provided a Table of Contents that address specific provisions; comments regarding various provisions of the contract highlighted in gold text boxes; cautions regarding common potentially problematic language reflected in red text and marked by a red stop sign; and sample model language marked by a green light.

-  Because the *Georgia Model Managed Care Contract* is provided for the information and education of Georgia physicians and should not be construed as legal advice or recommendations, physicians are encouraged to consult with an independent health care attorney when considering, drafting, negotiating, or entering a managed care contract. No physician or practice should consider the *Georgia Model Managed Care Contract* as definitive for its adoption or use as actual contract provisions negotiated and agreed upon may differ. The language contained in the *Georgia Model Managed Care Contract* is information, and does not constitute recommendations.

-  This *Georgia Model Managed Care Contract* references the “HMO Settlements” globally or, where appropriate, the individual settlements with Wellpoint, Aetna, and others. Many of the obligations in these agreements have expired or will expire shortly. Therefore, the Payers may no longer have an obligation to include these terms; however, Participating Physicians may benefit from their inclusion.

- Review the *Georgia Model Managed Care Contract* offered to you or your practice by a Payer for pitfall language or language and concepts that may be omitted. Refer to the Georgia Model Managed Care Contract, using the Table of Contents to locate these particular provisions.
- Do not sign the contract if you do not understand any portion of the agreement. Get information from the Payer and your independent healthcare attorney.
- Make a list of priority items to negotiate with the Payer. *To avoid potential violations of the federal antitrust laws, each physician and/or practice that is a party to a managed care contract must make its own independent decision, upon consultation with its legal counsel, as to participate or not participate in a contract and the specific terms of the contract, including price.*
- Before signing a contract, make sure it contains all the terms that are important to you and/or to which you have agreed with the Payer. Note: any discussions, emails, or letters between you and any representatives of the Payers, which are not included in the contract, will NOT be contractually binding.
- Obtain a signed and dated copy of all Payer contracts.
- Make sure all exhibits, addenda, etc. are attached to the contract, including fee schedules and Payer policies and procedures, as applicable.
- Keep the executed contracts in one central location.
- Make a master list of all agreements that includes the date(s) that the contracts terminate or come up for renewal.
- Evaluate what's working and what's not on a routine basis to prioritize contracts that you want to renew or terminate.

- Budget enough time to allow important agreements to be renegotiated and signed.
- Maintain a list of key contact names and telephone numbers for each Payer representative assigned to you.
- Set up a system for 1) tracking whether you are getting paid on time including whether all codes and modifiers are being recognized and whether you are being paid the correct amount for each of these and 2) reporting any untimely payments to the Insurance Commissioner's Office and the Medical Association of Georgia's Department of Third Party Payer Advocacy.
- Remain current on Payer practices or managed care contracting issues by visiting www.mag.org and www.gmgma.com on a regular basis.

TABLE OF CONTENTS

ARTICLE	PAGE NUMBER	DESCRIPTION									
Preamble	1	Parties to and date of the agreement and general description of the agreement									
1. Definitions	3	A description of defined terms used throughout the agreement									
2. Delivery of Services	12	Provisions regarding determination of covered services and verification of enrollees' eligibility									
3. Compensation and Related Terms	15	Provisions regarding compensation for covered services, including: <ul style="list-style-type: none"> • Billing for covered services • Coding for bills submitted • Co-payments • Coordination of benefits • Prompt payment 									
4. Participating Physician's Obligations	32	Provisions regarding participating physician's obligations under the agreement, including: <ul style="list-style-type: none"> • License/Good Standing • Nondiscrimination • Assistance in grievance procedures • Noninterference with medical care 									
5. MCO's Obligations	35	Provisions regarding MCO's obligations under the agreement, including: <ul style="list-style-type: none"> • Adverse decisions about medical necessity or coverage and appeal thereof • Payment by parties other than MCO • Cooperation in credentialing • Physician grievances • Benefit information • Quality improvement 									
6. Records and Confidentiality	48	Provisions regarding confidential medical records, access to such records, and other confidential information									
7. Insurance	52	Provisions obligating participating physician to ensure each physician maintains adequate insurance									
8. Term and Termination	52	Provisions regarding the initial term of the agreement, automatic renewal, termination, and effect of termination									
9. Dispute Resolution	57	Provisions regarding binding arbitration and the payment of expenses related thereto									
10. Miscellaneous	58	Miscellaneous but important provisions, including: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">• Governing Law</td> <td style="width: 33%;">• Indemnification</td> <td style="width: 33%;">• Notice</td> </tr> <tr> <td>• Assignment</td> <td>• Change in Law</td> <td>• Exhibits</td> </tr> <tr> <td>• Amendment</td> <td>• Non-Compete</td> <td></td> </tr> </table>	• Governing Law	• Indemnification	• Notice	• Assignment	• Change in Law	• Exhibits	• Amendment	• Non-Compete	
• Governing Law	• Indemnification	• Notice									
• Assignment	• Change in Law	• Exhibits									
• Amendment	• Non-Compete										

Preamble Notes:

Parties to the Agreement.

This model contract is designed to be as flexible as possible for agreements between Physicians and managed care organizations (MCOs); however, it is not intended to serve as a contract between a Physician/physician group and a network, or a Physician and a physician group.

The Parties to these agreements will generally be the “Participating Physician⁶,” meaning an individual Physician (preferably only if he/she does not belong to any entity, as discussed herein), his or her professional corporation, a group practice, or physician network, that arranges for the provision of the medical services and the MCO that arranges for payment of those services. Although an individual Physician should not be a party or signatory to the contract, an individual Physician providing services through the corporation, group practice or network may be referred to as “Physician” in the document. Sometimes you may see contracts that attempt to bind the Physician to their terms by including them in the defined Parties, as a signatory to the contract, or in references to the Physician’s obligations throughout the contract. In all circumstances except where the individual Physician does not belong to an entity, the individual Physician should not be contractually bound to the contract.

Where a Physician does not practice in a corporate entity, he or she will be both the Participating Physician and the Physician. Generally, in contracts from the Payer, the contract will refer to the Participating Physician and the Physician collectively as the “Provider.”

Because the state in which the MCO is legally organized may have relevance in any disputes or litigation that arise from the contract, the Parties should identify the type of entity and the state in which the entity is organized in this section of the contract.

Date of the Agreement. *The contract may be dated as of the date it is signed by all Parties. However, if the date the contract is to be effective (i.e., the date the Parties intended for one or both of them to have enforceable obligations under the contract, such as an obligation to provide services or an obligation to make payment for services) is later than the date the agreement is signed, it should be set out differently and referred to as the “Effective Date.” Oftentimes, a contract will be presented for signature without the date(s) of the contract being filled in by the Parties. It is extremely important that this date be completed to avoid any dispute over the Effective Date of the obligations in the future.*

⁶ Agreements also often will refer to the physician/physician group party as the “Participating Provider.”



PREAMBLE

THIS AGREEMENT, made this ____ day of _____, 20__ and made effective on the ____ day of _____, 200_ (“Effective Date”) by and between _____, a [insert state of formation and type of legal entity (e.g., a Georgia professional corporation) if any] (“Participating Physician”), and _____, a [insert state of formation and type of legal entity (e.g., a Georgia professional corporation) if any] (“MCO”) (Participating Physician and MCO herein referred to from time to time collectively as the “Parties”).

WHEREAS, MCO offers or directly administers one or more health benefit products or plans and wishes to arrange for the provision of medical services to Enrollees of such products or plans; and

WHEREAS, Participating Physician is comprised of or contracts with one or more Physicians capable of providing medical services to Enrollees; and

Notes: Georgia law does not permit corporations to engage in the practice of medicine. Sherrer v. Hale, 248 Ga. 793 (1982) holds that “a business corporation cannot lawfully practice one of the so-called ‘learned professions.’” Professional corporations are enabled under O.C.G.A. §§ 14-7-2 and 14-7-3 and allow the practice of a profession, which includes medicine and surgery, as a professional corporation. Also, O.C.G.A. § 43-1-24 recognizes that a person licensed by a professional licensing board and who practices a profession may render services or practice as a professional corporation. Accordingly, the Participating Physician should typically “arrange for the provision” of such medical services rather than directly “provide” the services.

The extent to which the state regulates the corporate practice of medicine is unclear and there seems to be little enforcement activity of the corporate practice of medicine. However, in 2004 the court in Clower v. Orthoalliance, Inc. 37 F. Supp. 2d 1322, 1330 (N.D. Ga. 2004), noted that Georgia has formally prohibited corporations from employing such licensed practitioners as orthodontists under a corporate practice of medicine or dentistry doctrine. The court noted that “the continued health of the corporate practice of medicine in general is in doubt,” but the court did not question its applicability in the Clower case. Thus, recent case law suggests that a corporation that employs a Physician to provide medical services where it is not a professional corporation may experience problems where the arrangement is based solely on employment.

WHEREAS, MCO desires to engage Participating Physician to deliver or arrange for the delivery of medical services to the Enrollees of its plans; and

WHEREAS, Participating Physician is willing to deliver or arrange for the delivery of such services on the terms and conditions specified herein.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties hereby agree as follows:

Article 1 Notes: Definitions are absolutely critical to any managed care contract because they can make a significant difference in the interpretation of later substantive provisions. By way of example, if “Medically Necessary” is defined as being determined in the MCO’s discretion rather than by an objective medical standard, this definition could impact the MCO’s obligation to pay for a service rendered by the Participating Physician; “Payer” could be defined broadly enough to allow MCOs to rent discounted Participating Physician services to other entities not a party to the contract. Because of their significant implications, the definitions should NOT be glossed over but rather carefully reviewed and revised to make sure that they are as precise as they can be since rights and obligations of a party – whether the Participating Physician or the MCO – may turn on how a term included in that right or obligation is defined.

This Article contains definitions for the terms capitalized throughout the Agreement, as well as definitions for a number terms found in Georgia Code provisions related to managed care contracts that a Participating Physician might see included in such a contracts.¹ If you are dealing with another type of health care contract (e.g., HMO, PPO, PPA), the definitions for the same term used in a managed care contract may differ slightly. Consult O.C.G.A Title 33 (the Georgia Insurance Code) for the definitions of terms associated with health care plans other than managed care plans that have been adopted by Georgia.



1. DEFINITIONS

1.1 Affiliate. A person or entity who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person or entity.

1.2 Carrier means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.⁷

1.3 Claim. A statement of services submitted to MCO by Participating Physician following the provision of Covered Services to an Enrollee that shall include diagnosis or diagnoses and an itemization of services and procedures provided to Enrollee.

⁷ O.C.G.A. § 33-20A-60(2).

1.4 Claimant means any provider, facility, or individual making a claim under a health benefit plan on behalf of an Enrollee.⁸

Section 1.5 Notes: As we will see later in Section 3.11, the concept of “Clean Claim” is particularly important with respect to timing of payment, since it is the submission of a “Clean Claim” that starts the clock running on payment obligation timing of fifteen (15) days under Georgia’s Prompt Payment Statute. See O.C.G.A. § 33-24-59.5. The Georgia statute does not define “Clean Claim.” Accordingly, sample language below defines “Clean Claim” to give uniformity, to prevent avoiding prompt payment obligations by claiming immaterial deficiencies, and to require Notice of any deficiency.

1.5 Clean Claim. A Claim submitted via a properly completed billing form UB-92 or CMS 1500, or an equivalent paper or electronic form, (i) that has no material defect or impropriety which substantially prevents timely payment from being made on the Claim or (ii) with respect to which MCO has failed timely to notify Participating Physician of any such defect or impropriety in accordance with this Agreement.

1.6 Coinsurance. The percentage of the Total Compensation, per service or procedure, that is the responsibility of Enrollee.

1.7 Coordination of Benefits. The determination of whether Covered Services provided to an Enrollee shall be paid for, either in whole or in part, under any other private or government health benefit plan or any other legal or contractual entitlement, including, but not limited to, a private group indemnification or insurance program.

1.8 Copayment. A charge that may be collected directly by a Participating Physician or Participating Physician’s designee from an Enrollee in accordance with the Plan.

Section 1.9 Notes: This definition requires that a list of services covered by the Plan is attached to the contract as Exhibit “A.” Physicians ought to be aware that, as of the publication of this document, Georgia law required Plans to cover (or offer coverage for) thirty-two (32) separate benefits. For a full list of Georgia’s mandated benefits and the Georgia Code references to their coverage requirements, please refer to Exhibit “F” of this document.

1.9 Covered Services. Health care services and procedures to be delivered by or through Participating Physician to Enrollees pursuant to this Agreement. A description of the medical services and procedures listed by the American Medical Association’s Current Procedural Terminology Codes in effect at the time services are rendered to an Enrollee (“AMA CPT Codes”) that are covered by the applicable Plans is delineated by product and attached to this Agreement as Exhibit A.

⁸ O.C.G.A. § 33-20A-60(3).

1.10 Deductible. The portion of an Enrollee's benefits that must be paid by the Enrollee before insurance coverage applies to specific categories of Covered Services for which a Deductible must be met.

Section 1.11 Notes: The definition of emergency medical condition in managed care agreements accounts for many payment disputes. MCOs have often denied payment based on the interpretation of the definition of "medical emergency" after the fact. The "prudent layperson" standard in Section 1.11 protects patients and physicians and prevents payment disputes by acknowledging the common sense of the prudent layperson in determining whether his or her condition requires immediate medical attention. This standard was adopted by the Georgia Legislature in the Georgia Insurance Code.

1.11 Emergency Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (which may or may not include severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention, to result in (a) placing the patient's [or unborn child's] health in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part⁹ [or (d) other serious medical consequences].¹⁰

Section 1.12 Notes: The language below is also required by the Georgia Code, O.C.G.A. § 31-11-81(3), which helps further clarify requirements to receive payment for Emergency Services. O.C.G.A. § 33-20a-3(2) also defines Emergency Services for Managed Health Care Plans, but the definition is narrower and has not been included here.

1.12 Emergency Services. Emergency medical transportation or health care services provided in a hospital emergency facility to evaluate and treat any Emergency Condition.¹¹

Section 1.13 Notes: The language below is designed to give the Participating Physician the ability to decline new Enrollees during the Term of the Agreement. O.C.G.A. § 33-20A-3(3) also defines Enrollees for Managed Care Plans. Because O.C.G.A. § 33-20A-3(3) is not as thorough as the language included here, the model language does not include that definition.

1.13 Enrollees. Any individual(s) entitled to health care benefits under a Plan who presents an identification card that contains the following information: (i) the name of the Payer; (ii) the Enrollee's name; (iii) the logo of the Plan or product; (iv) contact information for pre-authorization, if necessary; (v) the billing address; and

⁹ O.C.G.A. § 31-11-81(1).

¹⁰ This additional language, "[or (d) other serious medical consequences]" as well as "[or unborn child]" above is not required by O.C.G.A. § 31-11-81(1).

¹¹ O.C.G.A. § 31-11-81(3).

(vi) the applicable Plan.¹² Participating Physician may decline to accept additional Enrollees as patients, if Participating Physician notifies MCO thirty (30) days prior to the date that Participating Physician will decline to accept additional Enrollees as patients. Participating Physician may likewise decline to continue treating an Enrollee for good cause, as may be determined in the reasonable judgment of Participating Physician.

1.14 Facility means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution for examination, diagnosis, treatment, surgery, or maternity care but does not include physicians' or dentists' private offices and treatment rooms in which such physicians or dentists primarily see, consult with, and treat patients.¹³

1.15 Managed Care Contractor means a person who:

- (a) Establishes, operates, or maintains a network of participating physicians and/or providers;
- (b) Conducts or arranges for utilization review activities; and
- (c) Contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.¹⁴

1.16 Managed Care Entity includes an insurance company, hospital or medical service plan, hospital, health care provider network, physician hospital organization, health care provider, health maintenance organization, health care corporation, employer or employee organization, or managed care contract that offers a managed care plan.¹⁵

1.17 Managed Care Plan means a major medical, hospitalization, or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

- (a) Arrangements with selected providers to furnish health care services;
- (b) Explicit standards for the selection of participating physicians; and
- (c) Cost savings for persons enrolled in the plan who uses the participating physicians and procedures provided by the plan.¹⁶

1.18 MCO Compensation. The Total Compensation less that portion designated by the Plan as a Copayment, Deductible and/or Coinsurance.

¹² O.C.G.A. § 33-24-57.1(b) requires Georgia insurance identification cards to include specific information, including the subscriber's name and identification number; the group number, if applicable; the effective date of coverage; the name of the subscriber's primary care physician, if applicable; the name of the subscriber's insurer, the name of the health plan, and the plan type or product name, if applicable; the address of the office where claims are to be filed; the insurer's contact phone numbers and the phone number for coverage confirmation and preauthorization, if applicable; the policy's requirements as to copayments, coinsurance payments, or deductibles, as applicable; and either the name of the primary hospital and of the laboratory and radiology services to be used or a toll-free or local telephone number for contacting the health plan and obtaining such information.

¹³ O.C.G.A. § 33-20A-3(4).

¹⁴ O.C.G.A. § 33-20A-3(9).

¹⁵ O.C.G.A. § 33-20A-3(10).

¹⁶ O.C.G.A. § 33-20A-3(11).

Section 1.19 Notes: As a practical matter, Payers have been known to give “Notice” of certain changes, updates, and relevant information by a variety of mechanisms. This mechanism can be as little as posting Notice on the Payer’s web site in an unidentified spot. This sample language is intended to make the Notice process consistent and effective for the Participating Physician without unduly burdening the MCO.

1.19 MCO Notice or Notice. A communication by MCO to Participating Physician that complies with Section 10.7 herein and is required to inform Participating Physician of any information relevant to the provision of Covered Services pursuant to this Agreement.

*Section 1.20 Notes: “Medical necessity” can be the lynchpin in determining whether a Payer will pay for a service. This seemingly clinical decision may be converted to a business decision with the Payer or its Medical Director making the decision using cost factors and with the MCO disclaiming liability for the determination. Such language usually appears along the lines of the following: **“Medically Necessary shall mean those services, supplies, equipment and facility charges that are not expressly excluded under the Plan and determined by the Payer to be medically appropriate ... necessary to meet the health needs of the Covered Services, ... Rendered in the most cost efficient manner ... not experimental or investigational ... as determined by the Payer ...”** Often the Payer’s Medical Director will make this decision and the Payer will use this physician to qualify as a “physician” making the determination. The definition of “medical necessity” provided in the sample language below relies on an objective “prudent physician” standard for medical necessity determinations and does not consider cost in making that determination.*

*Also be wary of language which may limit the definition of medical necessity like this: **“Medical Necessity shall mean X, unless otherwise defined in the Plan documents or Enrollee contracts, in which case the definition therein shall control.”** This type of language should be stricken and/or replaced with the following sample language: **“Notwithstanding any definition in the Plan documents or Enrollee contracts to the contrary, the following definition of Medical Necessity shall apply to all Covered Services provided by Participating Physician.”** The sample language below relies on what would be believed Medically Necessary by the average, prudent physician. The Alternative Definition is taken from the HMO Settlements and also uses this same reasonably prudent physician standard.*

Georgia law forbids any managed care plan from using a financial incentive or disincentive program that directly or indirectly compensates a health care provider or hospital for ordering or providing less than medically necessary and appropriate care to his or her patients or for denying, reducing, limiting, or delaying such care. (O.C.G.A. § 33-20A-6(a)). The Georgia Code defines "Medical Necessity," "medically necessary care," or "medically necessary and appropriate" as “care based upon generally accepted medical practices in light of conditions at the time of treatment which is: (A) Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition; (B) Compatible with the standards of acceptable medical practice in the United States; (C) Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms; (D) Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and (E) Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence. O.C.G.A. § 33-20-31(7). The sample language below is more expansive.

1.20 Medically Necessary/Medical Necessity. For purposes of this Agreement and for all internal decisions by a Payer determining whether a service is a Covered Service, health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

1.21 Medically Necessary/Medical Necessity (Alternative Definition).¹⁷ For purposes of this Agreement and all internal decisions by MCO, a Plan or a Payer regarding determination of Covered Services, the term “Medically Necessary” or “Medical Necessity” shall mean health care services or procedures that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally acceptable standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or that are otherwise consistent with Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors. MCO shall be required to disclose an annual rate of denials for Medical Necessity for all Claims on MCO’s web site or other comparable electronic medium. “Physician Specialty Society” means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.¹⁸

1.22 Non-Covered Services. Health care services that are not Covered Services as defined herein. For a list of Covered Services, please see Exhibit A.

1.23 Notice. Notice provided pursuant to Section 10.7 herein.

¹⁷ See, e.g., Section 7.16(a)(ii) of that certain Settlement Agreement dated as of May 21, 2003, by and among Aetna, Inc. and Certain Representative Plaintiffs, Signatory Medical Societies and Class Counsel (the “Aetna Settlement”), www.hmosettlements.com. See also “Future Consideration by Company of an Administrative Exemption Program, § 7.16(c) of Aetna Settlement. The Georgia Insurance Code also defines “Medical Necessity” at O.C.G.A. § 33-20A-31, but the definitions above both encompass the elements required by Georgia law and define the term in a manner that emphasizes the “prudent physician” standard.

¹⁸ Settlement agreements also talk about the requirement of an annual Medical Necessity Denial Rate disclosure on the Provider web site or other comparable electronic medium (see § 7.16(a)(ii) of Aetna Settlement). See also “Future Consideration by Company of an Administrative Exemption Program” (§7.16(c)).

1.24 Out of Network or Point of Service refers to healthcare items or services provided to an enrollee by physicians who do not belong to the provider network of the managed care plan.¹⁹

1.25 Participating Physician means that Participating Physician identified in the Preamble.



Section 1.26 Notes: Typically, managed care contracts will define Payer very broadly, which allows for unfavorable practices known as “rental networks” and “silent PPOs” described herein. For example, “Payer” might be defined as follows: “an employer, trust fund, insurance carrier, health care service plan, trust, nonprofit hospital service plan, a governmental unit, any other entity which has an obligation to provide medical services or benefits for such services to Enrollees, or any other entity which has contracted with MCO to use MCO’s provider network.” While this language is broad enough to allow for problematic “rental networks” or “silent PPOs,” rental networks and silent PPOs are created by the MCOs providing information regarding the Participating Physician and other providers to develop a provider network that offers the network to Payers at the discounted rate the Participating Physician and other providers offer to the MCO. Consequently, the Participating Physician and the other providers will receive Explanation of Benefits terms that reflect Payers they have not contracted with at rates for which they have not contracted. The rental network may also be referred to as a “silent PPO” because of the absence of the contract between the Participating Physician and the Payer and the fact that the Participating Physician may accept the noncontracted for discounted rate from the Payer without realizing no contract exists. By tightening the definition of Payer in Section 1.31 and the Confidentiality provisions in Section 6.3, this model contract language attempts to minimize the payment issues created by rental networks and silent PPOs.

The definition of “Payer” in Section 1.26 provides a reasonable amount of flexibility consistent with the reality that in some cases the MCO will be providing an insured product, while in other cases the MCO will be administering a product for a self-funded employer plan. In the second case, the self-funded employer is actually the Payer. However, this definition makes clear that the MCO cannot “rent” or “lease” the terms of the agreement (including the Physician’s discounted services) to other entities. Most MCO agreements include the word “affiliate” which is sometimes undefined. If the word affiliate is capitalized it is likely defined, and Providers should find the definition in the definition section to be sure it does not include more Payers than intended (i.e., allow for silent PPOs – the aforementioned problem.)

1.26 Payer. The entity or organization directly responsible for the payment of MCO Compensation to the Participating Physician under a Plan. With respect to a self-funded Plan covering the employees of one or more employers, the Payer shall be the employer(s) and/or any funding mechanism used by the employer(s) to pay Plan benefits. With respect to an insured Plan or Plan providing benefits through a health maintenance organization, the Payer shall be the insurance company or health maintenance organization, as the case may be. Under no conditions shall the Parties interpret “Payer” to be, nor shall the negotiated rates herein described be assigned to or accessible to, any party other than MCO or an employer offering a self-funded product that contracted with MCO to administer such product, and Payer shall have an affirmative obligation to assist Participating Physician in the recovery of payment from any such non-community Payer.

¹⁹ O.C.G.A. § 33-20A-3(13).



Section 1.27 Notes: Some managed care contracts require the Participating Physician to notify the MCO if an unapproved provider is rendering Emergency Services. “Provider shall notify MCO, Plan or employer if Provider has knowledge that an unapproved provider is rendering Emergency Services to an Enrollee” The language below eliminates that obligation.

According to Georgia law, every managed care plan offered by a managed care entity shall offer a separate “consumer choice option” to enrollees at least annually. O.C.G.A. § 33-20A-9.1(c). A consumer choice option is a plan for health care delivery that grants enrollees a right to receive covered services outside of any plan provider panel and under the terms and conditions of the plan. O.C.G.A. § 33-20A-9.1(c). Under the statute, every enrollee of a managed care plan shall have the right to nominate one or more out of network health care providers or hospitals for use by that enrollee and his/her eligible dependents as long as the provider meets the criteria detailed in the statute. Physicians should be familiar with these requirements as well as the remainder of O.C.G.A. § 33-20A-9.1 so that they are prepared in the event an enrollee of a particular plan nominates them to receive payment as though they belonged to the managed care plan’s provider network.

If Participating Physician employs both Primary Care and Specialty Physicians, definitions for both of these (with the specialties listed) should be added to avoid any ambiguity during the claims submission process. For example, some Plans classify OB/GYNs as Primary Care Physicians and pay them as such. Similarly, if Participating Physician employs mid-level and/or limited license professionals, definitions should be added to avoid any ambiguity during the claims submission process. Compensation for these services should be clearly delineated in Exhibit B.

1.27 Physician. A doctor of medicine or osteopathy licensed to practice medicine, who has agreed to provide Covered Services to Enrollees and who has been credentialed pursuant to the rules and procedures of the Plan by the MCO or a duly appointed and authorized agent to which such credentialing responsibility has been delegated; provided, however, nothing herein shall obligate Participating Physician to notify MCO or Plan in the event Participating Physician may be aware that a physician who is not credentialed pursuant to the rules and procedures of the Plan is rendering Emergency Services to an Enrollee.

1.28 Physician Contract means any contract between a Physician and a carrier or a carrier’s network, physician panel, intermediary, or representative providing the terms under which the Physician agrees to provide health care services to an enrollee pursuant to a health benefit plan.²⁰

Section 1.29 Notes: If a Participating Physician does not want to be contractually obligated to accept all present and future products, Section 1.30 would explicitly prevent this obligation.

This model contract permits the MCO and the Physician to enter into a single set of legal terms to govern their relationship that would apply to every product or plan included in the arrangement as a way to streamline the process. However, separate business terms for each product would be required to be reflected as Exhibits to the contract. This approach would also allow the Parties to terminate plans or products individually, without terminating the entire contract.

²⁰ O.C.G.A. § 33-20A-60(7).



This definition of “Plan” is drafted to prevent situations where a Medical Services Entity is required to participate in present and/or future products of a MCO and could be expansive enough to require participation in government programs, including, but not limited to Medicare Advantage Plans. This requirement is known as an “All Products” provision and may read as follows: “MCO has and retains the right to designate Provider as a Participating Physician or non-participating physician in any specific Plan. MCO reserves the right to introduce new Plans during the course of this Agreement. Provider agrees that Provider will provide Covered Services to Members of such Plans under applicable compensation arrangements determined by MCO. Provider shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, regardless of whether Provider is a Participating Physician in such Plan.”



A Payer may attempt to incorporate language like the following about the Plan: “Company and Payer reserve the right to introduce new products in addition to the current products while this Agreement is in effect and to designate Provider as participating or non-participating in any such new product. To the extent that the specific terms for the provision of Covered Services in new products are not included herein, they shall be agreed to pursuant to Section XX of this Agreement if Company or a Payer offers participation in these programs to Provider. Provider understands and agrees that Provider's participation in a current or future product does not mean that Provider shall be permitted to participate with each and every Payer for that product. From time to time Payers may select only certain Participating Physicians to take part in a Payer's provider delivery network. However, the terms of this Agreement, including payment, do not apply to any product or Payer for which Provider is not included.” These “silent PPO provisions” allow a Payer to pay Participating Physicians at a discounted rate for services for a Plan in which the Participating Provider is not participating. Alternatively, model language is included in Section 3.1.

1.29 Plan. An individual set of health service delivery and compensation procedures offered as a “managed care” product by MCO, or administered by MCO, on behalf of a Payer for the benefit of Enrollees, as it may be modified from time-to-time, and all the terms, conditions, limitations, exclusions, benefits, rights, and obligations thereof to which MCO and Enrollees are subject. Nothing in this Agreement shall be construed to require Physicians to participate in all of MCO's Plans as a condition of participating in any individual plan or plans. Nothing in this Agreement shall be construed to require Physicians to participate in future Plans introduced by MCO.

Section 1.30 Notes: As addressed in Section 5.8, Quality Improvement is particularly important to both the Participating Physician and the MCO. Any quality improvement program must be evidence based and developed by physicians, and any participation in pay for performance programs must be voluntary.

1.30 Quality Improvement. The process designed to monitor and evaluate the quality and appropriateness of care and to improve care, which, if maintained by MCO shall require Physician input.

1.31 Total Compensation. The total amount payable by Payer and Enrollee for Covered Services furnished pursuant to this Agreement.

Article 2 Notes: This Article outlines the Covered Services and the terms of their delivery, which are often poorly defined or not defined at all, allowing the MCO to deny services as “non-covered.” Section 2.1 defines the “Covered Services” for each plan or product as those specifically set forth on one or more schedules attached as Exhibit A and places the responsibility for specifying Covered Services on the MCO. By requiring these services to be listed on Exhibit A, Participating Physicians will have a means of keeping track of the services.



2. Delivery of Services

*Section 2.1 Notes: Many contracts will have language that requires a physician covering for another physician to be in-network and accept the contract provisions and associated payment. This requirement is unreasonable. The following is language a Payer might use: **“Covering Physicians. Physician shall make Covered Services available and accessible to Members, including telephone access to Physician, on a twenty-four (24) hour, seven (7) day per week basis. Notwithstanding the foregoing, in the event that Physician cannot provide such coverage, Physician may arrange for a physician, who is a Participating Physician, to furnish coverage on Physician's behalf (a "Covering Physician") so long as Physician retains primary responsibility for Members' care. For services rendered by any Covering Physician on behalf of Physician, including Emergency Medical Services, it shall be Physician's sole responsibility to make suitable arrangements with the Covering Physician regarding the manner in which said Covering Physician will be paid or otherwise compensated; provided, however, that Physician shall assure that the Covering Physician will not, under any circumstances, bill a Member for Covered Services (except as permitted in this Agreement), and Physician hereby agrees to indemnify and hold harmless Members and Health Plan against charges for Covered Services rendered by Covering Physicians.”** The existence of this provision in the agreement could prove detrimental, as well as onerous to a Participating Physician. If it is not possible to have this language removed, a Participating Physician may consider amending such language to acknowledge that the Physician will have proper coverage after hours, but there is no obligation for the Covering Physician to be in-network or to accept contract rates.*

Also, the provision below is designed to have the Covered Services specifically identified on an Exhibit A, which would give the Participating Physician the ability to refrain from providing all services he or she normally offers patients, such as laboratory or imaging services, to a particular Payer or for a particular Plan or Product. Participating Physician may want to use Exhibit A to expand upon the range of services provided by each Physician associated with the practice (if there is more than one). This would protect each individual Physician's range of services, and could allow for lab and diagnostic services to be performed in the office setting.

2.1 Covered Services. The Participating Physician shall arrange for the provision to Enrollees of those Covered Services that are identified in Exhibit A, attached hereto and made a part of this Agreement by this reference.

Section 2.2 Notes: Participating Physicians should be wary of and try to avoid any language that

allows a Payer to leverage one product against another. For example, some Payers do not allow Participating Physicians to participate in Medicare replacement products unless they also participate in the Payer's commercial products.

2.2 Full Description. Exhibit A shall be comprised of separate schedules designated as Exhibit A1, A2, etc., which shall either identify separately the Covered Services relating to each MCO Plan or provide a fixed, readily available location where the Participating Physician can conveniently find the complete list of Covered Services.²¹

2.3 Full Disclosure. Where such schedule contemplates a global or capitated arrangement requiring Covered Services not normally provided by the Physician or Participating Physician, such Covered Services shall be designated in bold type on Exhibit A, and a note shall be prominently displayed stating that payment for these Covered Services shall be the Participating Physician's responsibility.

Section 2.4 Notes: The sample language in Section 2.4 provides an immediate financial penalty in the event the MCO fails to include Exhibit A to the contract, rather than allowing the absence of the Exhibit to work to the detriment of the Participating Physician.

2.4 Administrative Responsibility. If Exhibit A is not attached or in the event such exhibit contains descriptions of Covered Services that are so materially lacking in specificity that the purpose of this Agreement is defeated, MCO shall pay Participating Physician the Physician's billed charge for each service and procedure performed by a Physician for the benefit of Enrollee.

*Section 2.5 Notes: Participating Physicians need to check the language of their managed care contract to make sure that they are not obligated to provide services in accordance with a standard of care that is not the applicable standard of care in Georgia, which is "the standard of care which is ordinarily employed by the medical profession generally under similar conditions and like circumstances." It is not uncommon to see language such as "**the generally accepted medical practices as recognized within the community in which the Physicians practice.**" This language does not accurately reflect the standard of care for physicians practicing in the State of Georgia, which is the standard of care which is ordinarily employed by the medical profession generally under similar conditions and like circumstances.*

2.5 Medical Responsibility. All Covered Services shall be provided in accordance with the standard of care which is ordinarily employed by the medical profession generally under similar conditions and like circumstances,²² and consistent with The American Medical Association's Code of Medical Ethics in effect as of the date of service.

Section 2.6 Notes: Participating Physicians are often denied payment because MCOs make

²² Johnson v. Riverdale Anesthesia Associates, P.C., 583 S.E.2d 431, 433 (Ga. 2002).

administrative errors in identifying Enrollees or fail to provide real-time Internet-based access, telephone access, or other convenient and quick means of communication for the Physician to obtain verification of an Enrollee in a timely fashion. Section 2.6 sets forth a reasonable procedure for ensuring that a Participating Physician can verify Enrollees and allows the Participating Physician to receive payment where the Participating Physician reasonably relies on these procedures. The Participating Physician should document the mechanism that they used to verify enrollment or eligibility for their records.

2.6 Verification of Enrollees/Eligibility/Covered Services.²³ Except in the case of Emergency Services, Participating Physician shall use, and shall be entitled to conclusively rely on, the mechanism, including identification card, MCO web site, or telephone, chosen by MCO or its agent designated for such purpose, to confirm an Enrollee's status as an Enrollee, eligibility and applicable Covered Services ("MCO's Designated Verification Mechanism") prior to rendering any such services, in order to guarantee payment. Participating Physician shall be entitled to rely on the information provided by MCO web site or telephone or, in the event MCO doesn't provide web site or telephone basis on a 24 hour a day, 7 days per week basis, then on the information printed on the Enrollee's identification card as conclusive evidence of such Enrollee's eligibility. In addition, MCO and Participating Physician agree to the following:

2.6(a) MCO or Payer shall be bound by MCO's confirmation of eligibility and coverage for the requested services and procedures and shall not retroactively deny payment for Covered Services rendered to individuals the Plan has confirmed as eligible for Covered Services using MCO's Designated Verification Mechanism.

2.6(b) If Participating Physician, after following MCO's Designated Verification Mechanism to the extent reasonably possible, is unable to verify the eligibility or Covered Services of a patient who holds himself or herself out to be an Enrollee, Participating Physician shall render necessary care and MCO shall pay for such care.

2.6(c) In the event Emergency Services are needed,²⁴ at the first available opportunity, Participating Physician shall attempt to verify eligibility and applicable Covered Services. In the event Participating Physician makes a good faith effort to verify eligibility and Covered Services, and such verification is not reasonably possible given time

²³ O.C.G.A. § 33-20A-7.1 sets forth an MCO's verification of benefits obligations and obligations when pre-certification is required.

²⁴ O.C.G.A. § 33-20A-9(A)(1) requires every managed care plan to include provisions that in the event that a patient seeks emergency services and if necessary in the opinion of the emergency provider responsible for the patient's emergency care and treatment and warranted by his or her evaluation, such emergency provider may initiate the care necessary to stabilize the condition of the patient without seeking or receiving prospective authorization by the managed care entity or managed care plan. The Georgia Code further provides that no managed care entity or private health benefit plan may subsequently deny payment for an evaluation, diagnostic testing, or treatment provided as part of such intervention for an emergency condition. In addition, no managed care entity or private health benefit plan which has given prospective authorization after the stabilization of a person's condition for an evaluation, diagnostic testing, or treatment may subsequently deny payment for the provision of such evaluation, diagnostic testing, or treatment. O.C.G.A. 33-30A-9(B). See also O.C.G.A. § 33-21-18.1 (requiring health maintenance organizations to contain similar provisions).

constraints caused by the MCO's action or inaction, and it is later determined that patient is not an Enrollee and/or is not entitled to certain Covered Services, then Participating Physician shall attempt to collect from patient the amount due, up to the billed charges fee of the Physician providing the service. If, after two billing cycles, Participating Physician has not received full payment, MCO will pay Participating Physician the billed charges fee, minus that which the Participating Physician has already collected from the patient, not to exceed the amount provided for as Total Compensation herein.

Article 3 Notes: This Article offers the Parties the ability to negotiate separate business terms for each of the MCO's Plans or products, and it requires that such terms be attached as Exhibit B for ease of reference. However, Participating Physicians must be sure to collaborate with Payers on exhibits and refrain from signing the agreement with the MCO until all exhibits are presented in final form. (See instructions referenced in "Instructions for Using the Georgia Model Managed Care Contract.") Furthermore, if an agreement contains more than one fee schedule for multiple products, the Participating Physician should insert a provision that allows each fee schedule to "stand alone" so that the MCO cannot try to limit access to a higher schedule to Participating Physicians who agree to participate in all plans (or more specifically, in HMO products). In addition, if a Participating Physician provides services at multiple facilities, the Participating Physician should review the contract closely to ensure that the MCO does not attempt to insert a provision indicating that different fee schedules will apply in different locations.



3. Compensation and Related Terms

3.1 Compensation. MCO shall have an obligation to pay Participating Physician the compensation designated on Exhibit B, attached hereto, for the Covered Services provided by Physicians hereunder. Participating Physician or its designee shall accept from MCO or Payer as full payment for the provision of Covered Services, the Total Compensation identified in Exhibit B, attached hereto and made a part hereof by this reference. Participating Physician shall not be obligated to accept these rates for any Plan outside of those designated on Exhibit B.

3.1(a) MCO shall develop and implement a plan reasonably designed to permit the Participating Physician, in each case, to view, on the MCO web site, on a confidential basis, the complete fee schedule applicable to such Participating Physician pursuant to that Participating Physician's direct written agreement with MCO. Each such fee schedule shall state the dollar amount allowable for each AMA CPT Code for Covered Services rendered by such Participating Physician's office.²⁵ MCO shall provide Participating

²⁵ See Medical Association of Georgia et al. v. Blue Cross & Blue Shield of Georgia, Inc. 536 S.E. 2d 184, 186 (Ct. App. Ga., 2000) (providing that Blue Cross's refusal to provide participating physicians with a fee schedule or the precise methodology used to determine the "usual, customary, and reasonable" fees for services rendered was

Physician the fee schedule for the AMA CPT Codes specified by such Participating Physician.²⁶

Section 3.2 Notes: Payment rules should be consistent across all of MCO's products. The HMO settlement agreements require the Plans to obtain assistance from software companies to develop "ClaimCheck" software (that provides information to Participating Physicians regarding how the Plan's claim system adjudicates invoices for specific AMA CPT codes/combinations). Moreover, most payment edits and claims adjudication logic now has to be disclosed pursuant to the HMO settlement agreements.

With respect to the fees themselves, Participating Physicians should be aware of and understand the consequences of the MCOs' using the term "usual, customary and reasonable" in determining the amount of compensation to be paid for Covered Services. Such language may state as follows: "Usual, customary, and reasonable charges shall mean the normal and necessary charges made for similar services by the providers of medical services who are practicing in the same geographic area or the actual charge, whichever is less. Determination of whether or not a charge is UCR shall be made by the Plan based on nationally obtained and recognized survey data or on data received from an insurance company which, as a major portion of its business, is involved with the adjudication of health care claims." This language should be avoided and supplemented with language referring to the market rate charged by the particular Participating Physician.

If UCR cannot be avoided, avoid the use of the phrase "usual, customary and reasonable FEE" as apposed to "usual, customary and reasonable CHARGE." A usual, customary and reasonable fee may be interpreted as what the Payer typically pays in the relevant market, and that is generally less than what is typically charged. To avoid a compensation reduction caused by such an interpretation, confirm that any use of the term "usual, customary and reasonable" is related to usual, customary and reasonable charges.

Alternatively, consider the following definition of UCR, which puts control in the hands of the Participating Physician: "Usual, customary and reasonable charges shall mean the normal, actual charges made for similar services by Participating Physician or the amounts identified on the fee schedules attached hereto as Exhibit B, whichever is less."

Additionally, the fee schedule, compensation, and related terms are one of several areas where the MCO should be required to provide basic training and educational information to Participating Physicians rather than being allowed to create a haze of confusion for Participating Physicians trying to understand these terms.

Finally, this language supplements Section 10.12 by confirming that these fee schedules may not be amended without the Parties' mutual written consent. If the Parties have agreed to a two year term without amendment, they may want to consider including an inflation or escalation factor to allow for an increase each year.

3.2 Full Description and Education. Exhibit B shall be composed of separate schedules designated as B1, B2, etc., which shall identify separately the Total Compensation and related terms for each Payer and Plan, all of which are subject

improper). The HMO settlements only require the MCO to provide "up to 50 AMA CPT Codes" and "upon written request from a Participating Physician." This language has been drafted more broadly.

²⁶ See Wellpoint Settlement, Section 7.3.

to the amendment provisions of Section 10.12 of this Agreement. MCO and/or its Plans shall provide to Participating Physician and its Physicians educational information and training reasonably sufficient to allow Participating Physician and its Physicians to understand the differences in Total Compensation and related terms for each Payer and Plan.

3.3 Full Disclosure. The Total Compensation set forth on the Exhibit B schedule(s) shall specify for each Payer and Plan, the manner of payment (such as fee-for-service, capitation or risk withholds) for medical services and procedures rendered pursuant to the provision of Covered Services as set forth in the counterpart schedule of Exhibit A, and shall identify the portion of the Total Compensation that shall be the MCO Compensation. Exhibit B shall also identify with specificity the additional business terms negotiated by the Parties related to such Total Compensation. By way of example, and without limiting the requirements of this section, Exhibit B shall specify the following:

Section 3.3(a) Notes: Most managed care contracts will include a provision that states that the Participating Physician agrees to adhere to all Policies and Procedures of the Payer. These types of provisions, that require Participating Physicians to abide by any Policies and Procedures the Payer chooses to implement, often without notice, are dangerous because they have the potential to allow Payers to contract around the agreement by adding requirements and/or obligations that Providers must meet in order to avoid breaching their obligation to follow the Policies and Procedures. In the event the Payer refuses to delete this type of provision, Physician's counsel may add language similar to the following so that the Provider at least has adequate advanced notice to decide whether he or she can abide by the change proposed or would rather terminate the contract (generally without cause) prior to its implementation:

"Payer shall provide Participating Physician with ninety (90) days advanced Notice of all planned Material Adverse Changes to the Payer's policies and procedures affecting performance under contracts with Participating Physicians, except to the extent that a shorter Notice period is required to comply with changes in applicable law. For purposes of this Section 3.3(a)(v), Material Adverse Change shall mean any change in policies and procedures that could reasonably be expected to have a material adverse impact on (i) the aggregate level of payment by the Payer to Participating Physician for Covered Services, or (ii) administration by Participating Physicians of their practices."

3.3(a) In the case of a discounted fee-for-service arrangement, Exhibit B shall contain the following:

- i. A comprehensive fee schedule that states clearly how much will be paid for each service and procedure to be rendered pursuant to the Agreement.

Section 3.3(a)(ii) Notes: Groupers, J-codes, pediatric codes, new procedures, and procedures not recognized by CMS are among those that may be left off the list in Exhibit B, inadvertently or otherwise. A billing specialist should review Exhibit B carefully for the Participating Physician to ensure all applicable information is listed on Exhibit B.

- ii. Where compensation is based on a relative value unit (RVU system), such as the Medicare RBRVS, Exhibit B shall identify the specific RVU system (including the year), the conversion factors used, and shall provide a means to apply the formula or database to obtain rate information per AMA CPT Code.
- iii. Where compensation is based on a “usual customary and reasonable” (UCR) system, Exhibit B shall identify the database used and the methodology applied to determine the fee schedule. The database and methodology must be based upon the current year, statistically accurate, tied to physician charges, and based upon physicians of the same specialty in the same geographic area.
- iv. A statement that the fee schedule cannot be changed without the consent of Participating Physician.
- v. A provision stating the consequence for a Payer changing the terms of a fee schedule without consent of the Participating Physician, including the right to terminate the agreement and the right to recover billed charges.

Sections 3.3 (b)-(c) Notes: These sections require the MCO to provide the Participating Physician with data needed to evaluate and manage risk contracts. They provide a checklist of issues to be identified and resolved in negotiating two of the alternatives to a simple fee schedule. Note that separate Exhibit B schedules are required for each Plan or product, so that they can be negotiated, renewed, or terminated individually.

3.3(b) In the case of a capitation arrangement, Exhibit B shall contain the following:

- i. The amount to be paid per Enrollee, per month.
- ii. The mechanism by which Enrollees who do not designate a primary care physician (PCP) are assigned a PCP (the MCO should use an Enrollee’s home address zip code to assign PCPs randomly or another reasonable method) for purposes of capitation payment. Such assignment shall occur immediately upon enrollment, and the PCP shall receive monthly payment until or unless Enrollee designates another PCP.
- iii. The date each month that the capitation payment is due.
- iv. The manner by which MCO will determine and communicate to Participating Physician who is an Enrollee assigned to Participating Physician at the beginning of each month.

- v. The precise terms of the stop-loss arrangement offered to Participating Physician by MCO, or a recital indicating that Participating Physician shall obtain stop-loss protection through other arrangements.
- vi. The boundaries of the service area in which treatment of Enrollees shall be arranged by Participating Physician and outside of which treatment provided to Enrollees shall become the financial obligation of MCO.
- vii. The fee-for-service schedule to which the Parties will revert in the event that the number of Enrollees assigned to Participating Physician falls below a designated actuarial minimum, defeating the predictability of risk that both Parties rely on in the arrangement.
- viii. The number of covered lives and the fee-for-service schedule upon which Participating Physician will be paid for those Covered Services provided to Enrollees that are not specifically made a part of the capitation arrangement on Exhibit A. In the case of a capitation arrangement, Participating Physician shall have the right to audit, at Participating Physician's expense, the books and records of MCO or a Payer for purposes of determining the accuracy of any capitation payment and for the purposes of determining the number of Enrollees assigned to Participating Physician.
- ix. The description of reports and analyses to be supplied at least monthly by the MCO to enable the Participating Physician to manage effectively the risk it assumes under capitation arrangements. These reports will include membership information to allow monthly reconciliation by Participating Physician of capitation payments, including, without limitation, Enrollee identification number or the equivalent name, age, gender, medical group/physician organization number, co-payment, monthly capitation amount, primary care physician, provider effective date, and in the monthly report following an applicable change (e.g., selection of a new primary care physician) a report of such change, as well as an explanation of any deductions.²⁷
- x. The information provided by the MCO that is current through the end of the previous month.

3.3(c) In the case of a withhold or bonus, Exhibit B shall contain the following:

²⁷ See, e.g., Aetna Settlement, Section 7.28(a).

- i. The method by which the amount to be released or paid will be calculated and the date on which such calculation will be complete.
- ii. The records or other information on which MCO will rely to calculate the release of the withhold or the payment of the bonus.
- iii. The date upon which Participating Physician will have access to such records or information relied on by MCO in making such calculation for the purpose of verifying the accuracy thereof.
- iv. The date upon which such payment or release, if any is finally due, shall be made.

Section 3.4 Note: See discussion of “All Products” clauses in Section 1.30 above. This language simply highlights the concept in the context of decisions to accept or reject capitated products.²⁸

3.4 Capitated Arrangements. Notwithstanding the provisions of Section 3.3(b) above, MCO shall not require Participating Physician to participate in capitated fee arrangements in order to participate in products in which Participating Physician is compensated on a fee for service basis. In the event that a Participating Physician chooses not to participate in all MCO products, or terminates participating in some MCO products, the fee-for-service rate schedule offered to or applied by MCO to such Participating Physician shall not be lower than MCO’s standard fee-for-service rate schedule for the geographic market in which such Participating Physician practices. Nothing in this Section is intended or shall be construed to prohibit MCO from offering a higher fee-for-service rate schedule, or other incentive, to any Participating Physician who elects to participate (or continue participation) in all of MCO’s products. Nothing contained herein shall restrict in any way MCO’s contracting practices with respect to hospitals.²⁹

Section 3.5 Notes: Just as with Covered Services on Exhibit A, Section 3.5 establishes a penalty when the MCO fails to articulate the precise payment terms honestly and in sufficient detail giving the MCO an immediate incentive to comply with these requirements.

3.5 Administrative Responsibility. In the event Exhibit B is not attached or contains descriptions of compensation and related terms that are so materially lacking in specificity that the purpose of this Agreement is defeated, then Exhibit B shall be considered null and void, and MCO shall pay Participating Physician the Physician’s billed charge for each service and procedure performed by a Physician hereunder. The Parties agree that the precise terms of Exhibit B, as opposed to

²⁸ See also, e.g., HMO Settlement, Section 7.13(b), which prohibited or significantly reduced the use of “All Products” clauses.

²⁹ See, e.g., Aetna Settlement, Section 7.13(b).

the general description of the manner of payment, shall remain confidential between the Parties and their respective attorneys.

3.6 Billing for Covered Services. Participating Physician shall submit a Claim to MCO. If payment is required under the terms of this Agreement, MCO shall pay Participating Physician for Covered Services rendered to Enrollees in accordance with the terms of this Agreement.

Section 3.6(a) Notes: The language in Section 3.6(a) addresses the concern that patients often do not provide enough information to submit a clean claim which results in delay of bill submission.

3.6(a) Time Period for Submission of Bills for Services Rendered.

MCO shall not contest the timeliness of bills for Covered Services if such bills are received within 180 days after the later of: (i) the date of service; (ii) the date the patient provides accurate and adequate information to submit a Clean Claim, and (iii) the date of the Participating Physician's receipt of an EOB from the primary Payer, when MCO is the secondary Payer. MCO shall waive the above requirement for a reasonable period in the event that Participating Physician provides Notice to MCO, along with appropriate evidence, of extraordinary circumstances that resulted in the delayed submission.³⁰

3.6(b) Claims Submission.

MCO agrees to accept both properly completed paper Claims submitted on Form CMS-1500, UB-92 or the equivalent, and also electronic Claims populated with similar information in HIPAA-compliant format or fields. MCO may continue to require submission of additional information in connection with review of specific Claims and as contemplated elsewhere in this Agreement; provided that nothing in this sentence is intended to or shall be construed to alter or limit any restrictions set forth elsewhere in this Agreement concerning MCO's ability to make requests for medical records in connection with adjudication of Claims. MCO shall disclose on its Provider web site and its public web site its policies and procedures regarding the appropriate format for Claims submissions and requests for additional information.³¹

Section 3.7 Notes: Physicians should be paid for the services and procedures that they provide. Section 3.7 prevents the practice of "bundling," "downcoding," and "reassignment" of AMA CPT codes. Oftentimes, MCOs will take multiple procedures and "bundle" them together and pay them as a single procedure; "downcode" claims, meaning that they are submitted to the MCO at one level of intensity but are paid at a lower level reflecting a reduced intensity of service; or "reassign" claims to a different code than the code billed by the Participating Physician. In the case of multiple surgical procedures, the first surgical procedure may be paid first, however payment on additional procedures may be denied or payment may be drastically reduced when rules are used that are far less attractive than CMS. This practice is often coupled with contract language giving them the right to engage in these practices. For example, such language might state: "Provider agrees that if MCO reassigns or re-bundles AMA

³⁰ See, e.g., Wellpoint Settlement, Section 7.17(a).

³¹ See, e.g., Aetna Settlement, Section 7.17.



CPT codes, it will accept the applicable MCO Compensation for these services or procedures as reassigned or re-bundled by MCO as payment in full.” This section is designed to require the MCO to set forth billing standards and policies to the Participating Physician. If a Participating Physician is unable to get such language removed, the Participating Physician may want to add a provision that allows the MCO to follow the Correct Coding Initiative (“CCI”) adopted by CMS. Another problem experienced by Participating Physicians and addressed in this Section 3.7 language is the MCO’s practice of applying proprietary and customized combination AMA CPT Code edits, reflecting the MCO’s payment policy and resulting in decreased payment to the Participating Physician. These proprietary edits are often referred to as “black box edits.” The HMO Settlements (see, e.g., Aetna Settlement, Section 7.8) and a number of state legislative efforts require the MCOs to disclose all proprietary and customized code edits and medical payment policy. The language here goes a step further to prohibit these edits altogether.

3.7 Coding for Bills Submitted. MCO hereby agrees that Claims submitted for services and procedures rendered by Participating Physician shall be presumed to be coded correctly. MCO may rebut such presumption with evidence that a Claim fails to satisfy the standards set forth on AMA CPT Codes. MCO shall adhere to AMA CPT Codes, including the use and recognition of modifiers. MCO shall not automatically change AMA CPT codes submitted by a Participating Physician. MCO must provide adequate Notice if it wishes to change a code and must allow sufficient time for, and shall only change a code to comply with a change to the AMA CPT Codes as adopted by the AMA. Participating Physician shall have the right to appeal any adverse decision regarding the payment of Claims based upon the AMA CPT Codes reported. If MCO or a Payer reduces payment of a Claim in contravention of this section, such party shall be obligated to pay Participating Physician for the full amount of the billed charges for the Claim, plus interest from the time from which the payment should have been made. All AMA CPT Codes will be updated annually in accordance with the most recent edition of the AMA CPT.

3.7(a) As of the Effective Date of this Agreement, MCO shall not automatically reduce the code level of evaluation and management codes billed for Covered Services (“Downcode”).

3.8 Copayments to be Collected from Enrollees. Where the Plan requires Enrollees to make Copayments at the time of service, Participating Physician shall collect such Copayments accordingly. MCO shall educate Enrollees about their Copayment obligations. If Copayment is not remitted to Participating Physician in a timely fashion, MCO agrees that Participating Physician may discontinue seeing Enrollee, subject to its Physician’s ethical duties, and that such action will not constitute a violation of Section 4.2 by Participating Physician.



Section 3.9 Notes: Many contract sections on Coinsurance and Deductibles will include language that forbids the Participating Physician from collecting Coinsurance and/or a Deductible prior to the provision of services. Section 3.9 of this Agreement contains language that would allow the Physician to decide when to bill for Coinsurance and Deductibles.

3.9 Coinsurance and Deductibles to be Collected from Enrollees. Where the Plan requires Enrollees to pay Coinsurance and/or a Deductible, MCO shall educate Enrollees about these obligations. Nothing shall prohibit Participating Physician from collecting such Coinsurance and/or Deductibles prior to the provision of services. If Enrollee fails to remit in a timely fashion payment pursuant to Coinsurance or a Deductible, MCO agrees that the Participating Physician may discontinue seeing the Enrollee subject to its Physician's ethical duties, and that such action will not constitute a violation of Section 4.2 by Participating Physician.

Section 3.10 Notes: Coordination of Benefits is generally described as the process of determining the obligations of various Payers when an Enrollee is covered by multiple policies. This process is geared toward avoiding duplicate payment. However, potential problems may arise when Payers retain over one hundred percent of premiums for the collective benefits in the case of duplicate coverage. Coordination of Benefits issues may result in (i) delay in payment while the benefits are coordinated; (ii) recoupment of the benefits paid and a Coordination of Benefits determination later made; and (iii) payment of less than the amount owed the Participating Physician.

The Coordination of Benefits provision in Section 3.10 deals with the question of how much must be paid when a person is covered by more than one insurance plan. This provision imposes limitations on the Payer in making Coordination of Benefits determinations or making payments and receiving full compensation without placing the patient under inappropriate financial risk.

3.10 Coordination of Benefits. When Enrollees are covered, either fully or partially, for services provided by a Physician under any contractual or legal entitlement other than this Agreement, including, but not limited to, a private group or indemnification program, Participating Physician shall be entitled to keep any sums it recovers from such primary source consistent with applicable federal and state law. Except as indicated in the following sentence, Payer will pay Participating Physician the Total Compensation of the Physician providing service for Participating Physician, less that which is obtained from any primary source. If Exhibit B contemplates a fee-for-service compensation arrangement, the sum of such payments shall not exceed the Total Compensation set forth on Exhibit B; however, in the case of Medicare beneficiaries and where the Payer is the Secondary Payer, the sum of such payments shall not be less than one hundred percent (100%) of the Medicare allowed fee schedule.

3.10(a) If Payer is deemed "primary" in accordance with applicable industry Coordination of Benefits ("COB") standards, the Payer shall pay Participating Physician in accordance with the terms of this Agreement with no delay, reduction, or offset.

3.10(b) If Payer is deemed "secondary" in accordance with applicable industry COB standards, Payer shall pay Participating Physician the difference between what Participating Physician received from the primary Payer and the amount Payer owes Participating Physician as Total Compensation under the terms of this Agreement.

3.10(c) Payer shall be presumed to be the primary Payer and shall make payments in accordance with this Agreement, unless such Payer can

document to the satisfaction of the Participating Physician that Payer is secondary under industry COB standards within fourteen (14) calendar days of receipt of a Claim.



Section 3.10(d) is designed to prevent MCOs from retrospectively auditing claims and reducing payment long after services are rendered. Be wary of language indicating that preauthorization or verification is not a guarantee of payment. The Participating Physician should also watch for language that gives the MCO the right to offset, deduct or recoup monies that allegedly are owed to the MCO. For example, “Provider agrees to authorize MCO to deduct monies that may otherwise be due and payable to Provider from any outstanding monies that Provider may, for any reason, owe to MCO. Provider agrees that MCO may make retroactive adjustments to the payment outlined in Exhibit B.” Not only does this type of language give the MCO the ability to deduct monies from a Physician in its sole discretion without a requirement to account to the Physician and explain such deductions, it also gives the MCO the right to do so at any point in time regardless of the date of service. In any event, Participating Physician should create an aggressive strategy to address requests for recoupment, applying contractual or regulated time frames, sending timely dispute notices, etc.

O.C.G.A. § 33-21A-9 states that if a Provider submits a claim to a responsible health organization for services rendered within 72 hours after the Provider verifies eligibility of the patient with that responsible health organization, the responsible health organization shall pay the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the responsible health organization made payment for a patient for whom it was not responsible, then the responsible health organization may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.

3.10(d) If Payer pays a Claim to Participating Physician in accordance with this Agreement, Participating Physician agrees to cooperate with the reasonable efforts of Payer to determine whether it is the primary or secondary Payer under industry COB standards. If it is subsequently determined that a Payer should be considered secondary under industry COB standards, then Participating Physician will cooperate with that Payer's reasonable efforts to seek payment from the responsible primary Payer.

3.10(e) If Exhibit B provides a fee-for-service schedule applicable to Enrollee's Plan, Participating Physician shall not retain funds in excess of the Total Compensation fee schedule listed on Exhibit B, unless applicable state law regarding COB requires or imposes a different requirement.

3.10(f) Secondary Payers shall not be relieved of their obligation to make full payment to Participating Physician in the event the primary Payer fails to pay Participating Physician's properly submitted Claims within one hundred eighty (180) days of submission.

Section 3.11 Notes: Delayed payment by MCOs is a chronic problem for Participating Physicians. The delay in payment may be under the guise or reality that the MCO doesn't have sufficient information to

process the claim. The MCO may not always give the Participating Physician Notice of the deficiency. The Georgia Legislature, however, has passed a "Prompt Payment" Statute, which can be found at O.C.G.A. § 33-24-59.5. With the exception of the provisions contained in Section 3.11(a) regarding documentation of receipt and Notice of Claim deficiency, and Section 3.11(e) below regarding acknowledgement of receipt of a Claim within three (3) business days or twenty-four (24) hours, as applicable, the text of this Section 3.11 is derived directly from O.C.G.A. § 33-24-59.5. Under 3.11(a), the Payer must return claims lacking information or not "clean" enough for payment to the Physician within 15 business days of receipt and to identify what additional documentation or information is required to process the Claim. Under 3.11(c), the Payer must pay the claim within fifteen (15) calendar days of receipt of the additional documentation and/or information it requested. This prevents the MCO from "sitting" on unprocessed Claims or delaying payment on claims the MCO arbitrarily determines are not "clean." However, Participating Physicians must take advantage of this legislation and implement processes to track and report these untimely payments and obtain the interest owed them under Georgia law.

Self-insured health benefit plans not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., are likewise subject to these rules. O.C.G.A. § 33-24-59.5(a)(3).

Some managed care contracts will contain provisions that allow Payers to retrospectively audit claims that have been paid to Participating Physicians, and in some cases, deduct funds they deem recoverable automatically from subsequent payments to the Participating Physicians. This provision will read something like:

"General Offsets and Adjustments. Provider agrees to authorize MCO to deduct monies that may otherwise be due and payable to Provider from any outstanding monies that Provider may, for any reason, owe to MCO. Provider agrees that MCO may make retroactive adjustments to the payment outlined in Exhibit ___."

Participating Physicians may want to consider removing such provisions from their contracts as they give the MCO a free hand to do whatever accounting it desires and deduct monies from a Physician in its sole discretion without a requirement to account to the Physician and explain such deductions. They also justify the practice of "retrospective audits," in which the MCO conducts an audit – often several years after services were rendered – and determines there has been an "Overpayment." The MCO then unilaterally offsets the overpayment from the payment otherwise due. In the event the Payer will not agree to a deletion of this type of provision, Participating Physicians should ensure that any provision allowing this practice includes language that includes a requirement of advanced written notice of a reasonable time period for any adjustments to claims payments, a full and detailed accounting of the monies deducted and an explanation for each deduction/adjustment.

3.11 Promptness of Payment.

3.11(a) Within fifteen (15) business days of receipt of a Claim for payment of Covered Services, which MCO shall acknowledge receipt as provided herein, Payer shall (i) if the Claim constitutes a Clean Claim, direct the issuance of a check to Participating Physician, or initiate an electronic wire transfer of immediately available funds to an account designated by Participating Physician for the full payment of such Clean Claim, or (ii) if Payer believes the Claim fails to constitute a Clean Claim, shall give Participating Physician a Notice stating the reasons the Payer may have for

failing to pay the Claim, either in whole or in part and also giving the Participating Physician a written itemization of any documents or other information needed to process the Claim or any portions thereof which are not being paid (a "Notice of Deficiency").

3.11(b) In the event Payer disputes a portion of a Claim submitted by Participating Physician for payment, any undisputed portion of the Claim shall be paid by Payer in accordance with this Section 3.11.

3.11(c) Where Payer provides a Notice of Deficiency pursuant to Section 3.11(a) in respect to a particular Claim, Payer shall have fifteen (15) business days from receipt from Participating Physician of all the documents or other information listed in such Notice as being required by MCO to process such Claim within which to process the Claim and either (i) mail or wire transfer payment in full for the Claim to Participating Physician, or (ii) send a letter or Notice to Participating Physician denying such Claim, in whole or in part and giving Participating Physician the reason(s), with reasonable specificity, for such denial.

3.11(d) Receipt of any proof, Claim, or documentation by an entity which administers or processes Claims on behalf of MCO shall be deemed receipt of the same by MCO for purposes of this Section 3.11.

Section 3.11(e) addresses the ongoing problem of MCOs "losing" Claims, particularly paper Claims. Physicians across the country complain that they submit Claims, never receive payment and are told that the Claim was never "received." The Participating Physician will submit a Claim and assume that it is being processed by the MCO; however, if it is not, the claims submission clock continues to run. Section 3.11(a) addresses this by "resetting the clock" when a Claim is "lost" by the MCO but the Participating Physician has records that demonstrate when a Claim was originally filed. It also requires the MCO to acknowledge receipt of Claims.

3.11(e) MCO shall incorporate into its interactive voice response telephone system sufficient functionality to permit Participating Physician to determine the date on which a submitted Claim was determined by MCO to constitute a Clean Claim. MCO shall date stamp written Claims for Covered Services upon receipt in its mailroom and shall generate an electronic acknowledgement of receipt of electronic Claims for Covered Services when received by the applicable MCO computer system. Further, in the case of a written Claim, Payer shall mail to Participating Physician written acknowledgement of receipt of a written Claim within three (3) business days of receipt. Payer shall acknowledge receipt of an electronic Claim within twenty-four (24) hours of receiving such Claim. When MCO Claims that it has not received a written Claim, and Participating Physician has a record of the original filing, the time for submission of such Claim will not commence running until the time Participating Physician receives Notice from the MCO that the MCO did not receive such Claim.



Section 3.11(f) Notes: Participating Physician may want to avoid provisions that require them to bill the Payer for interest, such as the following: “MCO shall, upon receipt of an invoice noting such interest due, shall pay Participating Physician interest at the rate of ___% per annum for failure to make prompt payment.”

3.11(f) MCO shall pay to Participating Physician interest equal to eighteen percent (18%) per annum on the proceeds or benefits due under a Claim for failure to comply with this Section 3.11. Notwithstanding the foregoing, MCO shall have no obligation to make any interest payment (i) with respect to any Clean Claim if, within thirty (30) days of the submission of an original Claim, a duplicate Claim is submitted while adjudication of the original Claim is still in process; (ii) to any Participating Physician who balance bills a Plan Member in violation of this Agreement; or (iii) with respect to any time period during which Force Majeure, as defined in Section 10.5 of this Agreement, prevents adjudication of Claims.



Section 3.11 (g) Notes: This Section is designed to prevent MCOs from retrospectively auditing claims and reducing payment long after services were rendered. Be wary of language indicating that “preauthorization or verification is not a guarantee of payment.” Also, a Participating Physician should watch for language that gives the MCO the right to offset, deduct, or recoup money that allegedly is owed to the MCO. For example: “Provider agrees to authorize MCO to deduct monies that may otherwise be due and payable to Provider from any outstanding monies that Provider may, for any reason, owe to MCO. Provider agrees that MCO may make retroactive adjustments to the payments outlined in Exhibit B.” Not only does this type of language give the MCO the ability to deduct monies from a Physician in its sole discretion without a requirement to account to the Physician and explain such deductions, it also gives the MCO the right to do so at any point in time regardless of the date of service. The MCOs can also extrapolate a sample “overpayment” over a large population of claims, making the recoupment significant in size and incredibly damaging to the Participating Physician. These issues are addressed by language in Section 3.11(g) that makes payments to a Participating Physician final within one hundred eighty (180) days after receipt by the Participating Physician.

3.11(g) All payments to Participating Physician will be considered final unless adjustments are requested in writing by Payer within one hundred eighty (180) days after receipt by Participating Physician of payment explanation from Payer; provided, however, that where payment for services is a partial payment of allowable charges, a Participating Physician may negotiate a check with “Payment in Full” or other restrictive endorsement without waiving the right to pursue the remedies available under this Agreement.

3.11(h) No Payer may conduct a post payment audit or impose a retroactive denial of payment on any Claim by any Claimant relating to the provision of health care services that was submitted within ninety (90) days of the last date of service or discharge covered by such Claim unless:³²

³² O.C.G.A. § 33-20A-62(a).

- (i) The Payer has provided to the claimant in writing Notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such Claim or any part thereof and has provided in such Notice the specific Claim and the specific reason for the audit or retroactive denial of payment;
- (ii) Not more than twelve (12) months have elapsed since the last date of service or discharge covered by the Claim prior to the delivery to the claimant of such written Notice; and
- (iii) Any such audit or retroactive denial of payment must be completed and Notice provided to the claimant of any payment or refund due within eighteen (18) months of the last date of service or discharge covered by such Claim.

3.11(i) No Payer may conduct a post payment audit or impose a retroactive denial of payment on any Claim by any Claimant relating to the provision of health care services that was submitted more than ninety (90) days after the last date of service or discharge covered by such Claim unless:³³

- (i) The Payer has provided to the claimant in writing Notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such Claim or any part thereof and has provided in such Notice the specific Claim and the specific reason for the audit or retroactive denial of payment;
- (ii) Not more than twelve (12) months have elapsed since such Claim was initially submitted by the claimant prior to the delivery to the claimant of such written Notice; and
- (iii) Any such audit or retroactive denial of payment must be completed and Notice provided to the claimant of any payment or refund due within the sooner of 18 months after the claimant's initial submission of such a Claim or twenty-four (24) months after the date of service.

3.11(j) No Payer shall be required to respond to a Participating Physician's request for additional payment or to adjust any previously paid Participating Physician's Claim or any part thereof following a final payment unless:³⁴

- (i) The Participating Physician makes a request in writing to the Payer specifically identifying the previously paid Claim or any part thereof and provides the specific reason for additional payment; and

³³ O.C.G.A. § 33-20A-62(b).

³⁴ O.C.G.A. § 33-20A-62(c).

- (ii) If the Participating Physician's Claim was submitted within ninety (90) days of the last date of service or discharge covered by such Claim, the written request for additional payment or adjustment must be submitted within the earlier of twelve (12) months of the date both the Participating Physician and the Payer agree that all payments relative to the Claim have been made and all appeals of such determinations have been made or waived by the Participating Physician or twenty-four (24) months have elapsed from the date of service or discharge.

3.11(k) No Payer shall be required to respond to a Participating Physician's request for additional payment or to adjust any previously paid Services Entity's Claim or any part thereof following a final payment unless:³⁵

- (i) The Participating Physician makes a request in writing to the Payer specifically identifying the previously paid Claim or any part thereof and provides the specific reason for additional payment; and
- (ii) If the Participating Physician's claim was submitted more than ninety (90) days after the last date of service or discharge covered by such Claim, the written request for additional payment or adjustment must be submitted within the earlier of six (6) months of the date both the Participating Physician and the Payer agree that all payments relative to the Claim have been made and all appeals of such determinations have been made or waived by the Participating Physician or twenty-four (24) months have elapsed from the date of service or discharge.

3.11(l) Notwithstanding any other provision in this Article to the contrary, when precertification has been obtained for a service, the Payer shall be prohibited from contesting, requesting payment, or reopening such Claim or any portion thereof at any time following precertification except to the extent the insurer is not liable for the payment³⁶ where the Enrollee is no longer covered under the Plan at the time the services are received by the Enrollee, benefits under the contract or Plan have been exhausted, or there exists substantiation of fraud by the Enrollee, provider, or facility.³⁷

3.12 Sole Source of Payment. Where Enrollee is enrolled in a Plan, Participating Physician agrees to look solely to that Payer for payment of all Covered Services delivered during the term of the Agreement.³⁸

³⁵ O.C.G.A. § 33-20A-62(d).

³⁶ O.C.G.A. § 33-20A-62(f).

³⁷ O.C.G.A. § 33-20A-7.1.

³⁸ But Georgia law does not prohibit balance billing. "Balance billing" is a matter of contract; Enrollees may be subject to balance billing if seen by an out-of-network provider. See, e.g., Mitchell v. Georgia Department of Community Health, 281 Ga. App. 174 (2006).

3.12(a) In such circumstances, Participating Physician shall make no charges or Claims against Enrollees for Covered Services except for Copayments, Coinsurance, or Deductible as authorized in the Plan covering Enrollee.

Section 3.12(b) Notes: Pursuant to Georgia law, Physicians participating in a managed care plan may not charge patients for Covered Services, even in the event of Payer's bankruptcy, insolvency, or failure to pay the Physician who provided the services. O.C.G.A. § 33-20A-9.1(c)(2). Every Payer doing business in Georgia must join the Georgia Life & Health Insurance Guarantee Association (O.C.G.A. § 33-38-5), which was implemented to assist impaired and insolvent Payers in conducting business (i.e. paying claims) in case of financial troubles. For information on what your rights are should a Payer fail to pay you due to financial problems, please visit: www.gaiga.org.

3.12(b) In such circumstances, Participating Physician expressly agrees that during the term of this Agreement it shall not charge, assess, or claim any fees for Covered Services rendered to Enrollees from such Enrollees under any circumstances, including, but not limited to, the event of Payer's bankruptcy, insolvency, or failure to pay the Physician providing services.

3.12(c) Notwithstanding the foregoing, MCO shall cooperate in the processing of such Claims against Payer to provide Participating Physician with its greatest chance to receive compensation for Covered Services provided. This provision shall permit Participating Physician to collect payment not prohibited under state or federal law, including, but not limited to:

- i. Covered Services delivered to an individual who is not an Enrollee at the time services were provided.
- ii. Services provided to an Enrollee that are not Covered Services, provided that Participating Physician advises the Enrollee in advance that the services may not be Covered Services.³⁹
- iii. Services provided to any Enrollee after this Agreement is terminated except as otherwise specifically provided in Section 8.6.

Section 3.13 Notes: This Section 3.13 makes it clear that Participating Physicians have the right to charge Enrollees fees for completing forms, charging for no-shows, and other administrative services.

3.13 Administrative Surcharge. Nothing in this contract shall affect the right of the Participating Physician to charge Enrollees a reasonable and otherwise legal

³⁹ Advanced notification from the Physician for Enrollee responsibility of payment for non-covered services likely could be satisfied by requiring the Enrollee to sign a one-time notice during his/her initial visit.

surcharge for individual or aggregated administrative services, including, but not limited to, fees for records in accordance with Georgia law⁴⁰ and no-show charges for missed appointments. Participating Physician must fully inform Enrollees about the surcharge and the probability that the surcharge will not be paid by the MCO unless such services are otherwise specifically identified and paid in Exhibit B.

Section 3.14 Notes: Payment issues can arise when an Enrollee has incurred medical expenses as a result of the negligence of a third party, such as an automobile driver. The negligent third party and the liability insurer would generally be responsible for the medical expenses in the situations, and the MCO may seek payment through the liability insurer. If, however, the Participating Physician has rendered these medical services to the Enrollee and been paid on a discounted or capitated basis, the MCO should not realize a windfall from its payment arrangement with the Participating Physician. Therefore, the language below requires timely payment, rather than waiting for pursuit of payment by the MCO from the liability insurer, and gives the Participating Physician the right to additional payments up to the billed charges once the MCO's actual costs are paid.

3.14 Subrogation. In the event an Enrollee is injured by the act or omission of a third party, the right to pursue subrogation and the receipt of payments shall be as follows:

3.14(a) If Exhibit B provides for a capitation payment for the Enrollee, Participating Physician shall retain the right of subrogation to recover payment from third Parties, such as automobile insurance companies, for all Covered Services for which it is at risk to provide in exchange for the capitation paid hereunder.

3.14(b) If Exhibit B provides for a fee-for-service arrangement for the Enrollee, Participating Physician shall permit Payer to pursue all its rights to recover payment from third party Payers to the extent Payer is at risk for the cost of care.

3.14(c) Payer shall pay Claims submitted by Participating Physician in accordance with this Agreement, notwithstanding Payer's pursuit of subrogation rights against potentially responsible third parties who caused an injury by their acts or omissions, in accordance with Section 3.11(b).

3.14(d) Participating Physician shall abide by any final determination of legal responsibility for the Enrollee's injuries.

3.14(e) Upon receiving payment from the responsible party, Participating Physician will refund the amount of payment to Payer up to the amount paid by the Payer for the services involved. Participating Physician shall be entitled to keep any payments received from third Parties in excess of the amount paid to it by Payer.

⁴⁰ O.C.G.A. § 31-33-3. For a list of the current allowable copying fees, see <http://www.opb.state.ga.us/publications/policies/state-policies.aspx>.

3.15 Ability of Physicians to Obtain “Stop Loss” Coverage from Insurers Other Than MCO. MCO shall not restrict Physicians from purchasing stop loss coverage from insurers other than MCO.⁴¹



4. Participating Physician’s Obligations

4.1 Licensed/Good Standing. Participating Physician represents that it, or each of its Physicians, is and shall remain licensed or registered to practice medicine and, if applicable, the legal entity is registered and in good standing with the State of Georgia.

*Section 4.2 Notes: In addition to preventing a Participating Physician from discriminating against Enrollees for illegal reasons, such as race or religion, managed care contracts often prohibit discrimination in the rendering of Covered Services to Enrollees on the basis of “**race, color, ethnic origin, national origin, religion, sex, marital status, sexual orientation, income, disability or age.**” Neither Georgia or federal law (and possibly municipality law depending on the municipality) recognize marital status, sexual orientation, or income as protected classes. Therefore, language that includes classes other than those listed in the sample language would create an obligation on the Participating Physician that does not exist by law.*

Contracts often require that the Participating Physician treat all Enrollees alike, and that they receive the same services as any other patient of Participating Physician. This language precludes a Physician from using his knowledge of a particular Plan’s payment history when deciding the course of treatment for a patient. Therefore, in the sample language below, the obligation is to treat Enrollees in “substantially the same manner.”

4.2 Nondiscrimination. Participating Physician agrees that it, and each of its Physicians, shall not differentiate or discriminate in its provision of Covered Services to Enrollees because of race, color, ethnic origin, national origin, religion, sex, disability, or age. Further, Participating Physician agrees that its Physicians shall render Covered Services to Enrollees in substantially the same manner and in accordance with the same applicable standards as such services are offered to patients not associated with MCO or any Plan, consistent with medical ethics and applicable legal requirements for providing continuity of care.

4.3 Standards. Covered Services provided by or arranged for by Participating Physician shall be delivered by professional personnel qualified by licensure, training, or experience to discharge their responsibilities and operate their facilities in a manner that complies with generally accepted standards in the industry.

⁴¹ See, e.g., Wellpoint Settlement, Section 7.29(h).



*Section 4.4 Notes: The MCO will likely seek language similar to that found in Section 4.4 but which more directly binds the Physicians to the Agreement, which could be interpreted as making the Physicians Parties to the Agreement. For example, the contract may state that **“Participating Physician represents and warrants that it has full power and authority to bind Physicians to the provisions of this Agreement”** The Physicians are not Parties to the Agreement and should not be individually liable to the MCO.*

4.4 Authority. Participating Physician will make all Physicians aware of the terms of this Agreement and shall provide support to such Physicians in their efforts to enable Participating Physician’s compliance with the terms of this Agreement.

Section 4.5 Notes: Many managed care contracts allow MCOs to change their administrative policies unilaterally at any time and do not require clear communication to Physicians of these policies. Section 4.5 prohibits such unilateral action and requires that all policies must be attached to the contract and must also be accessible on the MCO’s web site. However, many MCOs will not agree to a provision whereby the Participating Physician must consent to a change in the MCO’s policies and procedures. Instead, they follow a “take it or leave it” approach. In that case, the following alternative final sentence would allow the Participating Physician to “leave it”:

“Participating Physician must receive at least ninety (90) days advance Notice of any changes to the policies and procedures in Exhibit E; if Participating Physician does not agree to such changes, then, notwithstanding anything to the contrary in this Agreement, Participating Physician may terminate this Agreement or its participation in any particular Plan, with the effective date of such termination being the effective date of any such changes to the policies and procedures (Participating Physician shall effectuate such termination through the provision of a written Notice to MCO).”

If this alternate language or similar language is used, the Participating Physician should ensure that the time period with this section and the termination provisions are coordinated so the Participating Physician is not stuck under the new policies and procedures for any period of time.

4.5 Administrative Procedures. Participating Physician and each of its Physicians will comply with the policies and procedures established by MCO or any of its Plans to the extent that the Participating Physician has received Notice consistent with the terms of this Agreement. At the Effective Date of the Agreement, the policies, rules, and procedures applicable to Participating Physician are contained in those manuals and other writings attached hereto on Exhibit E and incorporated by this reference. Participating Physician shall rely on these policies and procedures as the sole material policies and procedures of MCO or its various Payers. The policies and procedures in Exhibit E also must be available on MCO’s web site. The policies and procedures in Exhibit E may not be altered without Participating Physician’s prior written consent in accordance with Section 10.12 of this Agreement.

Section 4.6 Notes: Participating Physician should carefully review the grievance procedures applicable to Enrollees, as participation in such grievance procedures is usually mandatory. While the MCO may be resistant to change, Participating Physicians may seek to modify the procedures if they are unreasonable (for example, if they require participation in telephone appeal proceedings, as opposed to allowing Physicians to simply present written information).

4.6 Assistance in Grievance Procedure. Participating Physician agrees to keep available for Enrollees explanations of the grievance procedures and grievance encounter forms relating to Plan, which shall be supplied by MCO. Participating Physician also agrees to participate in helping resolve the grievances described in Section 5.6.

4.7 Use of Names for Marketing. MCO shall permit Participating Physician and each of its Physicians to use MCO's name, address, telephone number, and any logo in its list of Payers with which Participating Physician participates. Participating Physician and each of its Physicians shall permit MCO to include the name, address, and telephone number of it or its Physicians in its list of Participating Physicians distributed to Enrollees solely for those Plans and Products in which Participating Physician participates; provided, however, that such rights shall not extend to the listing of such Physicians or Participating Physician in any newspaper, radio, or television advertising without the prior written consent of Participating Physician. Such material shall be factually accurate and in compliance with applicable law and ethical standards.

Section 4.8 Notes: This Section clearly establishes the Physician's independent role in treating the patient. While other managed care contracts often include a provision similar to Section 4.8, it can be seriously diluted by an approach to "medical necessity" which allows the MCO to override the Physician's decision making while avoiding any legal responsibility as discussed in the Notes to Section 1.20. Additionally, this type of language can be one of the ways to avoid the problems of gag clauses discussed in greater detail in the Notes to Section 6.3.

4.8 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of MCO or any Payer to intervene in any manner in the methods or means by which Participating Physician and its Physicians render health care services or procedures to Enrollees. Nothing herein shall be construed to require Participating Physician or Physicians to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Enrollees. Under no circumstances shall MCO or any Payer limit the free, open and unrestricted exchange of information between Participating Physician and/or its Physicians and Enrollees regarding the nature of the Enrollee's medical conditions or treatment and provider options and the relative risks and benefits and costs to the Enrollee of such options, whether or not such treatment is covered under the Enrollee's Plan, and any right to appeal any adverse decision by MCO or any Payer regarding coverage of treatment that has been recommended or rendered. MCO and all Payers agree not to penalize or sanction Participating Physician or its Physicians in any way for engaging in any free, open and unrestricted communication with an

Enrollee with respect to the foregoing subjects or for advocating for any service on behalf of an Enrollee.⁴²

Article 5 Notes: This Article sets forth a number of obligations that should be part of the obligations of the MCO. In some agreements, these provisions are absent altogether; in others, they are set forth in a way that either makes the obligations meaningless or subject to the MCO's sole interpretation.



5. MCO's Obligations

Section 5.1 Notes: Section 5.1 addresses the MCO's obligations. Read in concert with Section 1.31, Section 5.1 prevents MCOs from "renting" their physician networks to third Parties who are not a party to this agreement. It is designed to prevent the practice of "renting" the Physician's discount to entities without the Physician's knowledge or approval. Under such a practice, the MCO will for a fee allow unaffiliated Payers the ability to access the MCO's network of Physicians and take advantage of the rates negotiated by the MCO. As a result, the Participating Physician ends up providing services to more patients than contemplated at the MCO's rates.

The State of Arkansas has passed a law, that prohibits rental networks. At the time of publication, Georgia law contains no such provision. However, Participating Physicians can use the following language from the Arkansas statute to create contractual language:

No contracting agent shall sell, lease, assign, convey, or otherwise grant access to the contracting agent's panel of contracted health care providers or the contracting agent's contracted payment rates to another entity unless authorized in an agreement between the contracting agent and the Provider. At least annually and upon written request of a contracted Provider, a contracting agent shall disclose in writing or electronically to its providers all Payers and other entities to which the contracting agent has sold, leased, assigned, conveyed, or otherwise granted access to the contracting agent's panel of contracted health care providers and the contracting agent's payment rates.

A subscriber identification card shall state in a clear and legible manner the network applicable to provider claims arising under the subscriber identification card. A provider network's contractual discounts or other alternative rates of payments shall be enforceable and binding on all parties only with respect to the network identified under subdivision (c)(1) of this section.

A "contracting agent" means an entity while engaged in selling, leasing, assigning, conveying, or otherwise, grants access to the entity's panel of contracted health care providers and the entity's contracted payment rates to another entity.

Ark. Code. Ann. 23-63-113.

Georgia does not have statutory language that addresses rental networks.

⁴² See also, Wellpoint Settlement, Section 7.29(a).

5.1 List of Payers. MCO shall include as part of Exhibit C a list of each Payer and shall promptly update Exhibit C upon the addition or deletion of Payers. The Parties acknowledge that the intent of Sections 1.24, 3.1, and this Section 5.1 is to provide a mechanism for assuring that “rental networks” and similar arrangements do not accede to this Agreement or avail themselves of the discounts and arrangements established by the Parties through this Agreement.

Section 5.2 Notes: This Section is designed to link existing MCO procedures with due process protections. Adverse decisions about medical necessity or coverage are subject to a due process review that is ultimately decided by independent peers rather than the MCO at its sole discretion. (This process is similar to but not necessarily related to the peer review process traditionally found in hospital medical staff bylaws.) See O.C.G.A. § 31-7-130, et seq. (Georgia peer review laws provide a procedure by which professional health care providers evaluate the quality and efficiency of services ordered by or performed by other health care providers.) Also, Georgia provides that the proceedings and records of review organizations, including managed care organizations, shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action. See O.G.C.A. § 31-7-133.

The language below deliberately is more specific with regard to the timing of the process than is set forth in the Blue Cross/Blue Shield of Georgia settlement agreement process description (see Blue Cross/Blue Shield of Georgia Medical Necessity External Review Process set forth as a part of July 11, 2005 Settlement Agreement by WellPoint, Inc. and its identified subsidiaries including Blue Cross and Blue Shield of Georgia, Inc.) The Blue Cross/ Blue Shield of Georgia process provides for pre-service and post-service appeals and allows the Participating Physician to appeal on the Enrollee’s behalf.

5.2 Appeals of Adverse Decisions. Participating Physician shall have a right to appeal any adverse medical necessity, billing procedure, or coverage decision made by MCO. Such appeal shall be coordinated with any related appeal by the Enrollee filed at or prior to the time of the Participating Physician appeal. The appeal procedure shall be as follows:

5.2(a) Unless existing MCO policies provide for a more liberal rule, and except for utilization review decisions related to emergency care, which shall be expedited, written Notice of such appeal shall be given by either the Participating Physician to MCO on behalf of Plan no more than ten (10) calendar days following the contested decision.

5.2(b) MCO shall have five (5) calendar days after receipt of such Notice to appoint a licensed physician in the same or similar specialty not employed by MCO to hear the appeal, which shall be heard within ten (10) days. A decision will be communicated to the Parties no later than five (5) days after the hearing.

5.2(c) In any such appeal, a prior authorization for treatment granted by MCO shall be conclusive in determining whether payment for services or procedures should be made.

Section 5.2.1 Notes: Section 5.2.1 would create a streamlined, external review system that would enable Participating Physicians to dispute the MCO’s decisions on billing or medical records requests through a

Billing Dispute External Review Board if they do not receive acceptable resolution through the appeals process. To utilize this process, the Participating Physician often is required to pay a refundable filing fee. If included, such fee should be reasonable. As indicated in the model language below, decisions should be rendered within a month of receipt of all requisite documentation.

5.2.1 Adverse Billing Dispute Decision Post-Appeal Review⁴³

5.2.1(a) MCO shall establish an independent Billing Dispute External Review Board or Boards (the “Billing Dispute External Review Board”) for resolving disputes with Participating Physicians concerning (i) application of Payer’s coding and payment rules and methodologies to patient-specific factual situations, including without limitation the appropriate payment when two or more AMA CPT codes are billed together, or whether a payment-enhancing modifier is appropriate, or (ii) concerning whether Payer has complied with the provisions of this Agreement in requiring that the Participating Physician submit records, either prior to or after payment, in connection with Payer’s adjudication of such Participating Physician’s Claims for payments, or (iii) any Claim which was the subject of an appeal pursuant to Section 5.2 herein for which Participating Physician denies an additional review by the Billing Dispute External Review Board, provided that (x) such Claim is forwarded to the Billing Dispute External Review Board within ninety (90) days of Participating Physician’s receipt of the decision contemplated in Section 5.2; and (y) the appeal of such Claim is not based on the medical necessities of any services covered by such Claim (in which case the review procedure in Section 5.2.2 here are instead applicable). Each such matter shall be a “Billing Dispute.” The Billing Dispute External Review Boards shall not have jurisdiction over any other disputes, including without limitation those disputes that fall within the scope of the Medical Necessity External Review Process set forth in Section 5.2.2 of this Agreement, compliance disputes, and disputes concerning the scope of Covered Services.

5.2.1(b) Any Participating Physician may submit Billing Disputes to the Billing Dispute External Review Board upon payment of a filing fee calculated as set forth in Section 5.2.1(e) and in accordance with the provision of this Section 5.2.1(b)(iv), after the Participating Physician exhausts MCO’s internal appeals process, when the amount in dispute (either a single Claim for Covered Services or multiple Claims involving similar issues) exceeds \$500. MCO shall post a description of its provider internal appeals process on the Provider web site.

- i. Notwithstanding the foregoing, a Participating Physician may submit a Billing Dispute if less than \$500 is at issue and if such Participating Physician intends to submit additional Billing Disputes during the one (1) year period following the submission of the original Billing Dispute which involve issues that are similar to those of the original Billing Dispute,

⁴³ See also, Wellpoint Settlement, Section 7.10. The Billing Dispute External Review Board first appeared in the HMO Settlements and is currently applicable to the following settlements: Blue Cross Blue Shield, Healthnet, Highmark, Humana, and Wellpoint. Prior to June 2006, the Billing Dispute External Review Board was applicable to Aetna and CIGNA. However, the Aetna and CIGNA Settlements have expired.

in which event the Billing Dispute External Review Board will, at the request of such Participating Physician, defer consideration of such Billing Dispute while the Participating Physician accumulates such additional Billing Disputes. In the event that a Billing Dispute is deferred pursuant to the preceding sentence and, as of the Termination Date, the Participating Physician has not accumulated the requisite amount of Billing Disputes and MCO has chosen not to continue the Billing Dispute process following the Termination Date, then any rights the Participating Physician had as to such Billing Disputes, including rights to arbitration, shall be tolled from the date the Billing Dispute was submitted to the Billing Dispute External Review Board through and including the Termination Date.

- ii. In any event, a Participating Physician will have one (1) year from the date of submission of the original Billing Dispute and notifies the Billing Dispute External Review Board that consideration of such Billing Dispute should be deferred to submit additional Billing Disputes involving issues that are similar to those of the original Billing Dispute and amounts in dispute that in aggregate exceed \$500. In the event such additional Billing Disputes are not so submitted pursuant to the preceding sentence, the Billing Dispute External Review Board shall dismiss the original Billing Dispute and any such additional Billing Disputes and, in that event, the filing fee will be refunded by MCO to the Participating Physician.
- iii. The filing fee shall be payable upon the submission of the original Billing Dispute and shall apply to all subsequent Billing Disputes submitted pursuant to the first sentence of Section 5.2.1(b)(ii) until the aggregate amount at issue exceeds \$1,000 at which time additional filing fees will be payable in accordance with Section 5.2.1(e). The Participating Physician may withdraw the Billing Disputes at any time before the aggregate amount in dispute reaches \$500 and, in that event, the filing fee will be refunded by MCO to the Participating Physician.
- iv. The Participating Physician must exhaust MCO's internal appeals process before submitting a Billing Dispute to the Billing Dispute External Review Board; provided that a Participating Physician shall be deemed to have satisfied this requirement if MCO does not communicate Notice of a decision resulting from such internal appeals process within 45 days of receipt of all documentation reasonably needed to decide the internal appeal. In the event MCO and a Participating Physician disagree as to whether the requirements of the preceding sentence have been satisfied, such disagreement shall be resolved by the Billing Dispute External Review Board. Except as otherwise provided in

Section 5.2.1(a), all Billing Disputes must be submitted to the Billing Dispute External Review Board no more than 90 days after a Participating Physician exhausts MCO's internal appeals process and the Billing Dispute External Review Board shall not hear or decide any Billing Dispute submitted more than ninety (90) days after MCO's internal appeals process has been exhausted. MCO shall supply documentation to the Billing Dispute External Review Board not later than 30 days after request by the Billing Dispute External Review Board, which request shall not be made, if Billing Disputes are submitted pursuant to Section 5.2.1(b)(ii), until Billing Disputes have been submitted involving amounts in dispute that in aggregate exceed \$500.

- (v) A Participating Physician submitting a Billing Dispute to the Billing Dispute External Review Board shall state in the documents submitted to the Billing Dispute External Review Board the amount in dispute. The Billing Dispute External Review Board shall not be permitted to issue an award based on an amount that exceeds the amount stated by such Participating Physician in the documents submitted to the Billing Dispute External Review Board.

5.2.1(c) Any Participating Physician who contests the appropriateness of MCO's requirement that such Participating Physician submit records, either prior to or after payment, in connection with MCO's adjudication of such Participating Physician's Claims for payments may elect not to utilize the internal review process and request that the Billing Dispute External Review Board grant expedited review of the MCO's requirement, if the Participating Physician demonstrates to the Billing Dispute External Review Board that MCO's requirement has a significant adverse economic effect on the Participating Physician which justifies expedited review. In the event that the Billing Dispute External Review Board determines that such Participating Physician has not so demonstrated the Billing Dispute External Review Board shall dismiss such Claim without prejudice, pending the exhaustion by such Participating Physician of MCO's internal appeals process.

5.2.1(d) MCO shall select the organization(s) that shall constitute the Billing Dispute External Review Board. The MCO's choice must, at a minimum, include (i) a certified coder, (ii) a physician who is board certified in the specialty at issue, and (iii) an attorney knowledgeable in contractual and health care matters, none of whom have any type of financial relationship with MCO. With respect to Billing Disputes brought by Participating Physicians, the members of the Billing Dispute External Review Board shall be bound by the terms of the applicable agreement between the Participating Physician and MCO and the provisions of this Agreement. Otherwise, the Billing Dispute External Review Board shall resolve Billing Disputes based on generally accepted medical billing standards.

5.2.1(e) MCO's contract(s) with the Billing Dispute External Review Board or with members of the Billing Dispute External Review Board shall require decisions to be rendered not later than thirty (30) days after receipt of the documents necessary for the review and to provide Notice of such decision to the Parties promptly thereafter.

5.2.1(f) In the event that the Billing Dispute External Review Board issues a decision requiring payment by MCO, MCO shall make such payment within fifteen (15) days after MCO receives Notice of such decision.

5.2.1(g) MCO agrees to record in writing a summary of the results of the review proceedings conducted by the Billing Dispute External Review Board, including without limitation the issues presented.

5.2.1(h) If such Participating Physician elects to utilize this process, then any decision by the Billing Dispute External Review Board shall be binding on MCO and the Participating Physician.

Section 5.2.2 Notes: Section 5.2.2 creates a streamlined, external review system that would enable Participating Physicians to dispute the health plan's decisions on medical necessity through a Medical Necessity External Review Process if they do not receive acceptable resolution through the appeals process. This Process entails the use of an "Independent Review Organization" to provide an objective, independent review of the appeal.

O.C.G.A. § 33-20A-40 directs the expert reviewer of the Independent Review Organization to use the definition of medically necessary provided in O.C.G.A. 33-20A-31 to make a determination as to whether treatment is medically necessary and appropriate. In making such determination, the expert reviewer shall apply prudent professional practices and shall assure that at least two documents of medical and scientific evidence support the decision.

5.2.2 Adverse Medical Necessity Decision Post-Appeal Review

5.2.2(a) Except as otherwise required by state law, MCO shall maintain a nationwide process permitting Participating Physicians to seek independent external review of MCO's determination that certain services or supplies are not Covered Services because they are not Medically Necessary or are experimental and investigational in nature. "Medical Necessity External Review Process" means any such process maintained by MCO (or afforded by O.C.G.A. § 33-20A-30,)⁴⁴ as described in the preceding two sentences.

⁴⁴ In Georgia, the Patient's Right to Independent Review covers the "Enrollee." O.C.G.A. §33-20A-30. Under O.C.G.A. § 33-20A-32, an eligible enrollee is entitled to appeal to an independent review organization when: (1) the enrollee has received notice of an adverse outcome pursuant to a grievance procedure or the managed care entity has not complied with the standards of certification; or (2) a managed care entity determines that a proposed treatment is excluded as experimental under the managed care plan and the eligible enrollee meets certain criteria set forth in O.C.G.A. §33-20A-32(2)(A)-(E).

An eligible enrollee must submit a written request for independent review to a planning agency, which certifies independent review organizations. See O.C.G.A. § 33-20A-35(b); O.C.G.A. § 33-20A-39. Upon assigning a request for independent review to an independent review organization, the planning agency shall provide written notification of the name and address of the assigned organization to both the requesting eligible enrollee and the managed care

MCO shall make arrangements to enable Participating Physicians to access each Medical Necessity External Review Process in circumstances in which a Plan Member could access that process under MCO's policy or applicable law. The terms on which Participating Physicians may access such process shall be identical to those applicable to Plan Members, except to the extent provided below in this Section 5.2.2.

5.2.2(b) Notwithstanding the provisions of Section 5.2.2(a), Participating Physicians may not seek review of any Claim for which the Plan Member (or his or her representative) seeks review through the Medical Necessity External Review Process. In the event that both Plan Member (or his or her representative) and Participating Physician seek review, the Plan Member's Claim shall go forward and the Participating Physician's Claim shall be dismissed and may not be brought by or on behalf of the Participating Physician in any forum.

5.2.2(c) Notwithstanding the provisions of Section 5.2.2(a), Participating Physicians may not seek review of any Claim for which the Plan Member (or his or her representative) has filed suit under § 502(a) of ERISA. In that event, or if such a suit is subsequently initiated, the Plan Member's lawsuit shall go forward and the Participating Physician's Claims shall be dismissed and may not be brought by or on behalf of the Participating Physician in any forum; provided that such dismissal shall be without prejudice to any Participating Physician seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Participating Physician and not to such Plan Member.

5.2.2(d) Nothing contained in this Section 5.2.2 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any person under § 502(a) of ERISA or to supersede in any respect the Claims procedures under § 503 of ERISA.

Section 5.2.2(e) Notes: The Blue Cross/Blue Shield of Georgia Settlement Agreement procedure provides that MCO and Participating Physician may agree to forego the internal appeals process and proceed directly to External Review. The Parties may also bypass internal appeals process if the MCO is unable to provide a qualified reviewer for internal appeal.

5.2.2(e) MCO shall maintain an internal appeals process for medical necessity denials and shall disclose such process on a public web site. MCO shall adjudicate all such appeals of medical necessity denials on the timeframes that are applicable to Plans subject to ERISA, regardless of whether such Plans are actually subject to ERISA. Upon the express request of a Participating Physician pursuing through such internal appeals process MCO's denial of coverage for that Participating Physician's service on the ground that such service is or was not Medically Necessary, before

entity. A decision of the independent review organization in favor of the eligible enrollee is final and binding on the managed care entity and the appropriate relief will be provided without delay. O.C.G.A. § 33-20A-37(a).

deciding such appeal, MCO shall consult with a specialist in the same specialty (or, in MCO's sole and absolute discretion, the same sub-specialty) as the Participating Physician appealing such decision. Participating Physician may access the Medical Necessity External Review Process only after exhausting any applicable MCO or Plan Sponsor internal appeals process.

5.2.2(f) Participating Physician shall initiate the Medical Necessity External Review Process by submitting to MCO a request for external review. That request shall be deemed timely if submitted by Participating Physician within the time frame specified in the communication from MCO to Plan Member advising of the adverse coverage determination. MCO shall forward timely requests to the applicable Medical Necessity Independent Review Organization. MCO shall make external review request forms available on a public web site.

5.2.2(g) To access the Medical Necessity External Review Process, Participating Physician shall pay a filing fee of \$50; provided that if the matter involves services or supplies for which MCO requires pre-certification (other than pre-certification required for registration purposes only), then the filing fee shall be the lesser of \$250 or 50% of the Billing Dispute External Review Board's fees.

5.2.2(h) In the event the Medical Necessity External Review Process is initiated by a Participating Physician, the Medical Necessity Independent Review Organization shall request documentation from MCO promptly but in any event no later than five (5) Business Days after the Participating Physician pays the filing fee and MCO shall provide such requested documentation within ten (10) Business Days. The Medical Necessity Independent Review Organization shall provide a decision within thirty (30) days of MCO's submission of all necessary information.

5.2.2(i) MCO shall cause its contracts with each Medical Necessity Independent Review Organization to be consistent with the terms of this Section 5.2.2.

5.2.2(j) If the Participating Physician elects to utilize the Medical Necessity External Review Procedure, then any decision by the Medical Necessity Independent Review Organization shall be binding on both the MCO and the Participating Physician.

5.3 Administration. With respect to each Plan it offers or administers, MCO shall promptly and diligently perform all necessary administrative, accounting, enrollment, and other functions including, but not limited to, eligibility determination, claims review, data collection and evaluation and, if applicable, maintenance of medical, ancillary, and hospital group risk pools.

Section 5.4 Notes: This Section protects Participating Physician no matter who is obligated to pay a particular Claim. Many managed care contracts do not require the MCO to make payment. Instead, they require the Payer (e.g., an employer-funded plan) to make such payment, which presents a significant problem for the Participating Physician. Because there may be no direct relationship between the Participating Physician and the party who has the obligation to pay, Participating Physician does not have a direct remedy in the event the Payer does not make payment. This provision gives the Participating Physician the right to pursue the appropriate party, if necessary, in court.

5.4 Payment by Parties other than MCO. In the event MCO contemplates that payment for services or procedures provided hereunder is to be made by a Payer other than MCO, and in the event that such payment is not received by Participating Physician within the time and under the conditions set forth in Section 3.10, MCO, within five (5) days of the receipt of written Notice from Participating Physician, shall make a written demand for payment to Payer on behalf of such Participating Physician.

5.4(a) In the event a Payer fails to make payment within thirty (30) days after receipt of such Notice, MCO shall either: (i) make such payment on behalf of the Payer; or (ii) initiate legal action to recover such payment on behalf of Participating Physician. Alternatively, at Participating Physician's request, MCO will assign to Participating Physician the right to initiate a legal action against Payer to recover such payment.

5.4(b) In the event of an occurrence described in Section 5.4, MCO shall tender to Participating Physician a copy of the Agreement that governs the relationship between MCO and Payer. The Participating Physician may rely on this Agreement in prosecuting an action to recover payment against Payer if Participating Physician elects to initiate such an action. MCO shall release Participating Physician, at Participating Physician's option, from any further obligation under this Agreement to provide services or procedures to Enrollees of Payer.

5.4(c) MCO shall notify Payer of the provisions of this Agreement and shall obligate Payer with respect to such provisions.

Section 5.5 Notes: Prolonged delays in credentialing have become increasingly common, particularly for young physicians entering practice. In addition to requiring that Plans set forth the criteria for credentialing, Section 5.5 provides that credentialing must occur within the reasonable timeframe of thirty (30) days and that payment be retroactive to submission of the credentialing form. See, e.g., Aetna Settlement, Section 7.13.

5.5 Cooperation in Credentialing.⁴⁵ MCO and Participating Physician agree to cooperate in credentialing and re-credentialing Physicians in accordance with the process set forth on Exhibit D of this Agreement. Notwithstanding the

⁴⁵ See also, Wellpoint Settlement, Section 7.13(a). A recent trend has been for Plans to charge for credentialing services. Any charge for such services should be eliminated or limited.

foregoing, MCO and Payer agree that Participating Physician shall not be charged or assessed any amount associated with the credentialing and recredentialing Physicians. MCO shall permit Physicians to submit applications prior to the time when the Physician(s) becomes actively employed or engaged by a participating physician group. MCO agrees to make final physician credentialing determinations within thirty (30) calendar days of receipt of an application and to grant provisional credentialing pending a final decision if the credentialing process exceeds thirty (30) calendar days. If a Physician is successfully credentialed, MCO shall retroactively compensate such Physician for services rendered from the date of his/her credentialing submission.

Exhibit D shall identify rights and obligations of MCO and the Physicians during the credentialing process. By way of example, Exhibit D shall specify the following:

5.5(a) The criteria to be used by MCO in its decision whether or not to credential or re-credential a Physician.

5.5(b) Identification of the internal process that MCO will use in making credentialing decisions.

5.5(c) Identification of the individual or committee that has authority to decide whether to grant or remove credentials.

5.5(d) Identification of the individual or committee to whom the initial decision maker is accountable.

5.5(e) Identification of how and when Physicians will be notified of credentialing decisions.

5.5(f) A requirement that an adverse decision state with specificity the reason for such decision.

5.5(g) A statement of the rights and duties of Participating Physician or a Physician in an appeal of an adverse credentialing decision, including the following elements:

- i. The deadline for filing an appeal.
- ii. Whether the appeal will be in writing or a live hearing.
- iii. What evidence the Physician and MCO may introduce.
- iv. The Physician's right to review the material prepared by MCO to support its adverse decision.
- v. What individuals within the MCO will review the appeal and have the final authority to make a decision and a statement of that person or committee's qualifications to make credentialing decisions.

- vi. The deadline by which MCO must make a final decision following the appeal procedure and communicate the decision to the Physician.
- viii. Provisions for Notice and corrective action prior to an adverse credentialing decision becoming final.

5.5(h) In the credentialing of Physicians, MCO agrees that neither it nor its agents shall request that Physicians sign an information release broader than necessary to obtain the specific credentialing information sought, and MCO shall limit such request to that which is reasonable and necessary to achieving valid credentialing purposes.

Section 5.6 Notes: The type of grievance system outlined in Section 5.6 should be an integral part of the managed care relationship. Each MCO should maintain a system to process and resolve grievances brought by both Physicians and patients. This provision protects Enrollees by limiting the use of patient record information and protects the Participating Physician by providing a clear point in time when the MCO's internal grievance procedures have been exhausted and the matter may be resolved by arbitration or other dispute resolution processes. Many managed care grievance procedures allow the MCO to delay the resolution of grievances, preventing the Participating Physician from taking up the matter in another forum.

5.6 Physician Grievances. MCO shall establish and maintain systems to process and resolve a grievance by a Physician toward MCO or a Payer. Such process shall be set forth in the procedures which are a part of Exhibit G. Any modification to the process or procedures set forth at Exhibit G requires the prior written consent of Participating Physician. In connection with such grievances, to the extent that confidential patient information is discussed or made part of the record, or confidential patient records are submitted to MCO, MCO shall either abstract such information or shall remove the name of the patient so that none of the information or records would allow a third party to identify the patient involved. The internal procedure for resolving such grievance will be presumed concluded in the event that such grievance is not resolved to the Parties' satisfaction within forty-five (45) days of the submission of such grievance and will allow either party to resort to the dispute remedies of Article 9.

Section 5.7 Notes: This Section places the responsibility to inform Enrollees of their benefits on the MCO. Often, MCOs fail to provide Enrollees adequate information about benefits. This failure can create confusion and place an added burden on the Participating Physician and its staff at the time of a patient visit.

5.7 Benefit Information. MCO shall advise and counsel its Enrollees and Participating Physician on the type, scope, and duration of benefits and services to which Enrollees are entitled pursuant to the applicable agreement between MCO or a Payer and Enrollees. Explanation of benefits ("EOB") forms for MCO's traditional products shall contain at least: the name of and a number identifying the Plan Member, the date of service, the amount of payment per line item, any

adjustment to the invoice submitted and a generic explanation of any such adjustment, and an address and phone number for questions regarding the Claim described on such EOB. Each EOB shall indicate the amount for which the Physician may bill the Enrollee and state "Physician may bill you" such amount, or contain language to substantially similar effect, and shall not characterize disallowed amounts as unreasonable. The explanation of payment or similar forms that MCO sends to the Physicians communicating the results of Claims adjudications shall contain at least: the name of and a number identifying the Plan Member, the date of service, the amount of payment per line item, the procedure code(s), the amount of payment, any adjustment to the invoice submitted and generic explanation therefore, as well as any adjustment or change in any code on a line by line basis, and shall specify an address and phone number for questions by the Physician regarding the Claim described on such explanation of payment or comparable form. The foregoing sentence is not intended and shall not be construed to limit MCO's right to replace the communications referred to in the preceding sentence (i.e., communications to Participating Physician) with electronic remittance advices or the equivalent, to the extent such electronic remittances or the equivalent provide similar information and are consistent with legal requirements.

Section 5.8 Notes: Many MCO contracts include language requiring Physicians to participate in and "cooperate" with quality initiatives. This vague language can be used by MCOs to mandate participation in pay for performance, profiling or other initiatives that are not quality-based and are in fact cost-cutting programs that may harm the patient/physician relationship. Some of these programs may be inappropriate for certain types of practices or physician specialties. Moreover, MCOs may establish programs that require significant financial investment in information technology and accompanying staff resources with little or no added compensation to the physician practice. Section 5.8 makes clear that any quality improvement program must be evidence-based and developed by physicians and that any participation in pay for performance programs must be voluntary. It also requires the MCO develop a mechanism for physician input into any quality improvement initiatives.

5.8 Quality Improvement. Participating Physician and MCO are both committed to quality improvement. Evidence-based clinical quality of care measures are the primary measures used, and outcome measures are subject to the best available risk-adjustment for patient demographics and severity of illness. Clinical performance measures are developed and maintained by appropriate professional medical organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession. Physician participation in financial incentive programs is voluntary. MCO has a mechanism to allow Physicians ongoing participation in the development, assessment, and evaluation of quality management programs. MCO provides Physicians the opportunity to review and appeal the accuracy of their personal data and data analysis. MCO's current Quality Improvement Initiatives are listed on Exhibit H. In the event any of these initiatives require Participating Physician to submit data, MCO agrees to provide Participating Physician with at least ninety (90) days advance written notice of all information that must be submitted, including any deadlines.

5.9 Provider Directories. MCO shall maintain a current provider directory available to Enrollees on the MCO web site and in hard copy. MCO shall include Participating Physician on all provider lists for plans set forth in Exhibit B.

Section 5.10 Notes: This Section is important for protecting Physicians from financially troubled MCOs by granting Physicians the right to review the MCO's quarterly balance sheet and income statement. Physicians should also consider including an additional requirement that the MCO notify the Physician when the Payer is unable to pay its debts as they come due or when it does not have capital sufficient to carry on its business. As noted in Section 3.11, one reason some MCOs pay claims slowly or reject an excessive number of claims as not being "clean" is to improve their financial reporting when they are short on capital – a clear sign of financial instability. Physicians need to be alert to this possibility. Along with Section 8.5, Section 5.10 gives the physician the greatest protection possible in the event of a MCO's financial failure. To the extent a Participating Physician's patients may be covered by self-insured parties, it may also be necessary to require the MCO to notify the Participating Physician of its own or any Payer's insolvency or bankruptcy filing within a very short time of the event. In such event, Participating Physician should be allowed to immediately terminate the Agreement in total or the access to the specified Payer.

5.10 Provision of Financial Information. MCO shall provide to Participating Physician, no less frequently than quarterly, a balance sheet and income statement (collectively, "Financial Statements") accurately depicting the financial condition of MCO. Such Financial Statements shall be prepared in accordance with generally accepted accounting principles and shall be provided on an audited basis to the extent available. Participating Physician acknowledges the confidentiality of such Financial Statements and shall not: (a) use such Financial Statements for any purpose other than evaluating the financial condition of MCO; or (b) disclose the Financial Statements, or any non-public information contained therein, to any third party, other than Participating Physician's attorneys or accountants, without the prior written consent of MCO. The obligations of Participating Physician under the immediately preceding sentence shall survive termination of this Agreement.

5.11 Licensure and Registration. MCO represents that it is and shall remain licensed and in good standing with the State of Georgia Department of Insurance and is registered and in good standing with the state in which it is chartered and each state in which it is doing business, including the State of Georgia.

Section 5.12 Notes: In an effort to encourage clear communication and exchange of information regarding the Parties' obligations hereunder, which is often a chief frustration of managed care contracts, Section 5.12 provides language to promote education, exchange of information, and communication.

5.12 Education, Information, and Communication. MCO shall provide information, education, training, and assistance in plain English to Participating Physician to assist in understanding the terms and obligations of the Parties hereunder, including, but not limited to, the operation and administration of the Plan(s) and any product(s), any fee schedule or exhibits to this Agreement, Covered Services, utilization and quality reports, software, edits, and financial reports. MCO will designate a provider relations specialist to assist Participating

Physician with any issues hereunder. Contact information for such provider relationship specialist will be provided to Participating Physician as of the Effective Date. The provider relations specialist will be knowledgeable about this Agreement, the operations of MCO, and its policies and procedures and will assist in resolution of any issues in the implementation of this Agreement. MCO will notify Participating Physician pursuant to the provisions of Section 10.7 herein of any change in the identity or contact information of the provider relations specialist.

Section 5.13 Notes: Payers will often put a number of obligations in documents outside of the contract with the Participating Provider, including, but not limited to, policies and procedures. The language below clarifies that the Agreement will govern the relationship between the Payer and the Participating Provider in the event of any conflicts with any such outside documents.

5.13 Conflicts. In the event of a conflict between the provisions of this Agreement and the agreement between MCO and Plan or Payer or any other policy, procedure, or document of the Plan or Payer, the provisions of this Agreement will govern.



6. Records and Confidentiality

Sections 6.1 and 6.2 Notes: These Sections are designed to protect medical information from unauthorized use or disclosure. These provisions make clear that the medical record belongs to the Participating Physician's Physicians and not the MCO. They are also designed to limit the MCO's access to medical records by requiring that any requests for medical records be narrowly tailored to the specific purpose for which the MCO seeks the information. They are consistent with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which makes clear that MCOs cannot have unfettered access to a patient's medical record and that any requests for information must be the "minimum necessary" to accomplish the MCO's purpose.

Section 6.1 Notes specific to HMOs: Georgia law mandates that any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from the person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes Georgia law; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery of evidence; or in the event of claim or litigation between the person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

6.1 Confidential Medical Records. All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws.⁴⁶

⁴⁶ O.C.G.A. § 33-20A-8.

All medical records shall belong to Participating Physician.⁴⁷ The release, disclosure, removal, or transfer of such records shall be governed by state and federal law and by the Participating Physician's established policies and procedures. The cost associated with copying medical records or any other records referred to in this Article VI shall be paid by MCO in accordance with the fees specified by O.C.G.A. §31-33-3.⁴⁸ Any request by MCO for confidential medical records shall be limited to the minimum information necessary to accomplish the specific purpose for which MCO seeks the information. MCO may request access to each patient's medical records no more than once a month, absent extraordinary circumstances, the reasonableness of which shall be determined in Participating Physician's sole discretion. MCO shall counsel its employees, agents, and subcontractors on their obligations to ensure that such information remains confidential. Nothing herein shall be construed as granting to MCO any right of ownership in medical records of Enrollees.⁴⁹

Section 6.2 Notes: In an effort to prevent MCOs from showing up at Participating Physicians office without notice, the following provision requires that the MCO make a written request for access to medical records.

6.2 Access to Records. MCO must make a written request for medical records and allow for ten (10) business days to receive such records. However, any review of the medical record by MCO must be narrowly tailored to the specific purpose for which the MCO seeks the information and must be in compliance with applicable state and federal laws, including but not limited to the federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996.

*Section 6.3 Notes: The HMO Settlement Agreements require that MCOs omit from their contracts with Participating Physicians any provision limiting the free, open, and unrestricted exchange of information between Participating Physicians and Enrollees or penalizing them for the same. O.C.G.A. § 33-20A-7(a) specifies that no health care provider may be penalized for considering, studying, or discussing Medically Necessary or appropriate care with or on behalf of his or her patient. Because the language from the HMO Settlement is more beneficial to Physicians, this language is included below. Section 6.3 protects patient/Physician communication and clarifies that, except for a limited number of matters that are proprietary to both the MCO and Physician, there are no inhibitions on free communication between the Physician and the patient or any other Parties. Payers have included so-called "gag clauses" in these contracts. Such language might include the following, by way of example: **"During the term of this Agreement, Provider and its Physician shall not advise or counsel an Enrollee to disenroll from MCO's Plan and will not directly or indirectly solicit any Enrollee to enroll in any other health care service plan or insurance program."** Section 6.3 eliminates the possibility of constraining patient/Physician communication through the contract even though a MCO may have eliminated "gag clauses" from its contracts.*

⁴⁷ In Georgia, a provider having custody and control of any evaluation, diagnosis, prognosis, laboratory report, or biopsy slid in a patient's record shall retain such item for a period of not less than ten years from the date such item was created. O.C.G.A § 31-33-2.

⁴⁸ These expenses are published annually by the Georgia Office of Planning and Budget at www.opb.state.ga.us.

⁴⁹ O.C.G.A. § 31-33-3(b).

6.3 Other Confidential Information. The Parties agree that the sole items of information subject to confidentiality under this Agreement are: (i) medical information relating to individual Enrollees, so as to protect the patient's medical record as required by medical ethics and applicable federal and state law; (ii) the precise schedule of compensation to be paid to Participating Physician pursuant to Exhibit B; and (iii) such other information set forth in sections 6.3(a). Otherwise, all other information, including the general manner by which Participating Physician is paid under this Agreement and the general terms and conditions of this Agreement, may be shared with non-parties in the reasonable and prudent judgment of the Parties to this Agreement or Physicians.

6.3(a) Any financial or utilization information provided by Participating Physician to MCO or a Payer (including the Compensation schedule(s) set forth in Exhibit B) shall be maintained in strict confidence by MCO and each Payer and may not be disclosed by MCO or Payer to any third party or used by Payer for any purpose, other than: (i) to satisfy mandatory governmental or regulatory reporting requirements; (ii) for premium setting purposes; (iii) for Healthcare Effectiveness Data and Information Set ("HEDIS") reporting.

6.3(b) Nothing contained herein shall limit the free, open, and unrestricted exchange of information between Participating Physician and Enrollees regarding the nature of the Enrollee's medical conditions or treatment and provider options and the relative risks and benefit of such options, whether or not such treatment is covered under the Plan, and any right to appeal any adverse decision by MCO regarding coverage of treatment that has been recommended or rendered. MCO agrees not to penalize or sanction Participating Physician in any way for engaging in any free, open and unrestricted communication with an Enrollee or for advocating for any service on behalf of an Enrollee.⁵⁰

Section 6.4 Notes: MCOs are engaging in a rapidly expanding practice of assigning "designations" in the form of grades, stars, ratings, profiles, or tiers as a representation of quality, cost, or some other measure of the performance of the Physician, as determined by the MCO. This practice led to lawsuits in a number of jurisdictions, most notably New York, alleging that these practices violated state laws, including the Unfair Business or Deceptive Trade Practices Acts. The New York Attorney General proposed a model establishing certain requirements for any such designation programs, and a number of insurers involved in the litigation agreed to the proposal, some nationally and some just locally. These settlements spurred the development of programs to comply with the proposed program, such as Aetna Aexcel, United Health Care Premium Designation Program, and Blue Precision. The elements of the national model are (1) ensuring that rankings are based not solely on cost and clearly identify the degree to which any ranking is based on cost; (2) using established national standards to measure quality and cost efficiency, including measures endorsed by the National Quality Forums and other generally accepted national standards; (3) employing several measures to foster more accurate physician comparisons, including risk adjustment and valid sampling; (4) disclosing to consumers how the program is designed and how doctors are ranked, and providing a process for consumers to register complaints about the system; (5) disclosing to Physicians how the rankings are designed and provide a process to

⁵⁰ See Aetna Settlement, Section 7.29. This language also prohibits the "gag clauses" discussed in Section 6.3.

appeal disputed ratings; (6) nominating and paying for the Ratings Examiner, which must be a “national standard organization” and a 501(c)(3), subject to Attorney General approval, to oversee compliance with all aspects of the new rating model and report to the Attorney General’s office every six months. For more information on this topic, MAG has published a white paper that is available to its members at: http://www.mag.org/pdfs/physician_tiering_issuebrief_011408.pdf. Additionally, Colorado has passed legislation incorporating these concepts (See Colo. Rev. Stat. § 25-38-101 et seq.), and some of this language is incorporated in the sample language below in Section 6.4. **Finally, MAG is fundamentally opposed to these programs and has serious concerns about whether these programs can reliably and accurately measure quality or costs. Even if a Participating Physician is successful in having the model language below placed in their contract, MAG does not and will not endorse these programs.**

6.4 Designation Programs. Any Designation of Physician or Participating Physician shall include, at a minimum: (1) a quality of care component and a representation of the weight given to such quality of care factor; (2) accurate, valid, and reliable statistical analyses to adjust for statistical anomalies; (3) a statistically significant period of assessment of data updated at appropriate intervals; (4) if data from Claims are used, accurate data appropriately attributed to the Physician or Participating Physician; (5) evidence and consensus-based practice performance measures that account for factors such as practice, location, and patient population; and (6) any other relevant information contributed by the Physician and/or Participating Physician with respect to these or other measures. Such designations shall be accompanied by a disclaimer in bold-faced, all capitals, large font type that states that the designation is intended only as a guide to choosing a Physician, contain a risk of error, should not be used as the sole factor in choosing a Physician, and should be discussed with the Physician before making any decisions. If the MCO uses a Designation Program, it shall disclose to Physician and/or Participating Physician a detailed written description of the methodology upon which the Designation is based and all data used in arriving at the Designation. Such information shall be provided in plain language and MCO shall provide any education necessary to explain such data or the methodology. Participating Physician shall have the right to appeal any such Designation pursuant to the provisions of Section 10.19 herein. In the event of violation of this Section 6.4, MCO acknowledges and agrees that such violation shall constitute deceptive trade practice, and Participating Physician may bring suit against MCO for the same, notwithstanding the provisions of Article 9 herein. O.C.G.A. § 10-1-370, *et seq.* For purposes of this Section 6.4, Designation shall mean an award, assignment, characterization, or representation of the cost efficiency, quality, or other assessment or measurement of the care or clinical performance of any Physician or Participating Physician that is disclosed or intended for disclosure to the public or Enrollees by use of a grade, star, tier, rating, profile, or any other form of designation.

Article 7 Notes: MCOs will generally require that a Participating Physician maintain professional liability insurance. It is important to review the amounts and limits required by the MCO to confirm that the Participating Physician already possesses such insurance. The Participating Physician should not be required to increase its insurance levels simply to comply with an MCO agreement. To avoid this, Section 7.1 states that the Participating Physician will maintain insurance “in limits and amounts standard in the community.”



7. Insurance

7.1 Participating Physician Insurance. Participating Physician shall require each Physician to maintain, at all times, in limits and amounts standard in the community, a professional liability insurance policy and other insurance as shall be necessary to insure such Physician against any claim for damages arising directly or indirectly in connection with the performance or non-performance of any services or procedures furnished to Enrollees by such Physician. In the event that Participating Physician discovers that such insurance coverage is not maintained, Participating Physician shall immediately upon making such discovery ensure that such Physician discontinues the delivery of Covered Services to Enrollees until such insurance is obtained. Evidence of such coverage shall be tendered to MCO by Participating Physician upon MCO's request.

Article 8 Notes: Article VIII provides for an initial term of twenty-four (24) months and provides for successive twelve (12) month automatic renewal terms unless the Agreement is sooner terminated pursuant to the provisions of this Article VIII. Certain terms and provisions may be renegotiated at the initiative of either Party on an annual basis (see Section 8.2). Under Georgia law, an agreement without a fixed term or duration is terminable at the will of either contracting party. Atakpa v. Perimeter OB-GYN Associates, P.C., 912 F.Supp. 1566 (N.D. Ga. 1994); Coffee v. General Motors Acceptance Corp., 5 F.Supp.2d 1365 (S.D. Ga. 1998). Accordingly, it may be prudent to provide for a definitive term without any renewal provisions.



8. Term and Termination

Section 8.1 Notes: If the agreement calls for automatic renewal terms, the contract is considered to be "evergreen", that is, without a definitive ending point absent either party's termination of the agreement. If the Parties elect an evergreen clause, the Participating Physician will need to review the fee schedules on a regular basis. As an alternative, but to avoid the contract being viewed as terminable at will (see the Article 8 Notes), the Participating Physician may seek a definitive end point rather than having unlimited renewal periods. For example, Section 8.1 could be revised to state that the Agreement shall automatically renew for two (2) additional twelve (12) month periods

8.1 Term. This Agreement shall commence on the Effective Date and, unless earlier terminated or amended pursuant to the provisions hereof, shall continue in full force and effect for a period of twenty-four (24) months therefrom ("Initial Term"). Thereafter, this Agreement shall automatically renew for successive twelve (12) month periods unless MCO or Participating Physician provides the

other with written Notice of its intent to terminate not later than sixty (60) calendar days prior to a respective twelve (12) month anniversary of the Effective Date.

Section 8.2 Notes: This Section has two purposes. First, it allows either Party to renegotiate the business terms of the contract (Exhibits A and B) annually, provided that the Party gives Notice ninety (90) days before the anniversary, which prevents the MCO from unilaterally changing payment. Second, it also allows the Participating Physician to drop a single product or Plan without terminating every product that's subject to the agreement. Even when an agreement does not overtly require a Participating Physician to service all products, most managed care contracts effectively do that by requiring a Participating Physician who wishes to discontinue only certain Plans or products to terminate the entire contract and re-enter a new contract that excludes the product rejected. Under Section 8.2, a Participating Physician must track contract renewal dates so that if it wants to negotiate, the Participating Physician can give ninety (90) days Notice.

8.2 Negotiation of Renewal of Exhibits A and B. Not later than ninety (90) days prior to each twelve (12) month anniversary of the Effective Date, a Party wishing to revise Exhibit A and/or Exhibit B or any of the schedules affixed thereto shall provide Notice in writing of such desire to the other Party, along with the new terms proposed. Within sixty (60) days thereafter, the Parties shall mutually agree to a new Exhibit A and/or Exhibit B, as applicable. If the Parties are unable to come to such mutual agreement, either Party may notify the other within ten (10) days following the deadline for such agreement that it intends to terminate this Agreement in its entirety or with respect to one or more specific Plans reflected on a schedule. In such event, this Agreement (in the case of termination of all Plans) or the Agreement with respect to a particular Plan or Plans, shall be terminated sixty (60) days after such Notice of intent to terminate. Notwithstanding any provision contained in this Agreement to the contrary, Exhibits A and B hereto shall not be amended, revised, or otherwise altered in any way during the term of this Agreement, except as provided in this Section 8.2, or except as otherwise agreed in a writing signed by both Parties.

Section 8.3 Notes: Physicians should be wary of any termination for cause Notice period that is longer than thirty (30) or sixty (60) days. Thirty (30) days is a sufficient amount of time for either Party to cure a default that is indeed curable. Further, physicians should review in detail the list of causes for immediate termination; some MCOs are known to omit serious issues that should be cause for immediate termination of the Agreement, including, but not limited to, failure to make payment for certain successive periods and/or insolvency.

8.3 Termination for Cause. If either Party shall fail to keep, observe, or perform any covenant, term, or provision of this Agreement applicable to such Party, the other Party shall give the defaulting Party Notice that specifies the nature of such default. If the defaulting Party shall have failed to cure such default within thirty (30) days after the giving of such Notice, the non-defaulting Party may terminate this Agreement upon five (5) days Notice. However, it shall be grounds for immediate termination if: (i) MCO should lose its license to underwrite or administer Plans; (ii) any Physician suffers a loss or suspension of medical license, a final unappealable loss of hospital medical staff privileges for reasons that would

require reporting to the National Practitioner Data Bank pursuant to the requirements of the Health Care Quality Improvement Act of 1986, or a conviction of a felony, and upon Notice to Participating Physician, Participating Physician fails to immediately remove such Physician from the provision of services and procedures to Enrollees hereunder; (iii) MCO fails to pay Claims within thirty (30) days; or (iv) MCO files for bankruptcy.

Section 8.4 Notes: This Section protects the integrity of the termination process for both Parties. Many managed care contracts provide the illusion of running for a full year prior to renewal, when in fact, the termination clauses allow the MCO to terminate the Agreement upon ninety (90) days Notice. Section 8.4 rejects that approach. Instead, it separates terms related to the definition of Covered Services and fee schedules from all other legal terms. The legal terms are binding throughout the relationship of the Parties. The list of Covered Services and fee schedules for each Plan or product, as set forth in Exhibits A and B, can be renegotiated annually and renewed or rejected individually. However, under Section 8.3, either Party may terminate the entire contract on thirty (30) days Notice or less upon the occurrence of a default or breach under the contract.

In addition, Section 8.4 provides that either Party must give one hundred twenty (120) days Notice of voluntary termination. A Party that wishes to terminate the Agreement must state in writing the reason for the termination. The requirement of a written reason for termination provides some protection for a Participating Physician who suspects that the termination is premised on violation of the MCO's informal "gag" policy or other illegal reasons. Finally, this provision allows the Participating Physician or MCO to ensure that terminations are not based on mistakes of fact.

Finally, if the Payer accepts all of the other terms of the model contract, the Parties should agree that the contract not be terminated for two (2) years.

8.4 Voluntary Termination. Either Party may terminate this Agreement or Participating Physician participation in any Plan with cause, pursuant to this Agreement, or without cause, at any time after the Initial Term, upon one hundred twenty (120) days written Notice to the other Party specifying whether the termination relates to a specific Plan or to the Agreement generally. The terminating Party shall state the reason for such termination. In the event of a without cause termination, neither Party shall be foreclosed from participation in the dispute resolution procedures described in Article IX.

8.5 Termination for Failure to Satisfy Financial Obligations. This Agreement may be terminated in its entirety or with respect to a Payer by either party upon five (5) days written Notice if either Party, or in the case of termination by Participating Physician, a Payer is: (a) more than sixty (60) days behind its financial obligations to its creditors; (b) is declared insolvent; (c) files in any court of competent jurisdiction: (i) a petition in bankruptcy; (ii) a petition for protection against creditors; (iii) an assignment in favor of creditors or has such a petition filed against it that is not discharged within ninety (90) days; or (d) fails to pay Claims on time.



Section 8.6 Notes Some Payers will try to obligate providers to provide services for a transition period or defer termination in a way that may not be acceptable. For example: ***“This Agreement will continue in effect with respect to Enrollees existing prior to the MCO’s receipt of such Notice until the anniversary date of the MCO’s contract with the subscriber group or for one (1) year, whichever is earlier, unless otherwise agreed to by the MCO. If termination is by the MCO, the rights of each party will terminate on the effective date of termination.”*** Section 8.6 contains reasonable procedures for continuing to provide services to Enrollees and receive payment for those services after termination of this Agreement. This process avoids an abrupt end of the physician-patient relationship when the Agreement is terminated without binding the Participating Physician to an unduly lengthy obligation to continue to provide services.

8.6 Effect of Termination. This Agreement shall remain in full force and effect during the period between the date that Notice of termination is given and the effective date of such termination. As of the date of termination of this Agreement, except as provided by Section 10.13, this Agreement shall be of no further force and effect, and each of the Parties shall be discharged from all rights, duties, and obligations under this Agreement, except that MCO shall remain liable for Covered Services then being rendered by Physicians to Enrollees who retain eligibility under the applicable Plan or by operation of law until the episode of illness then being treated is completed and the obligation of MCO to pay for Covered Services rendered pursuant to this Agreement is discharged. However, any Enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from Participating Physician for a period of up to sixty (60) days from the date of the termination of this Agreement. In addition, any Enrollee who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of this Agreement shall have the right to continue receiving health care services from Participating Physician throughout the remainder of that pregnancy, including six (6) weeks' post delivery care.⁵¹ During such continuation of coverage period, Participating Physician shall continue providing such services in accordance with the terms of this Agreement, and the MCO, and all agents thereof shall continue to meet all obligations of this Agreement. The Enrollee shall not have the right to the continuation provisions provided in this Section 8.6 if the Agreement is terminated because of the suspension or revocation of Physician's license (in accordance with Section 8.3) or if the MCO reasonably determines that Physician poses a threat to the health, safety, or welfare of Enrollees. Payment for such services and procedures shall be made pursuant to the fee schedule contained on Exhibit B or, if Exhibit B does not contain a fee schedule, at the billed charges of the Physician performing the services or procedures.

Section 8.7 Notes: Managed care contracts often give the MCO, instead of the Participating Physician, an ability to terminate a Physician, which ought to be reserved for the Participating Physician. The model language below appropriately preserves that right for the Participating Physician, assuming it cures the breach or removes the Physician from the provision of Covered Services hereunder.

⁵¹ O.C.G.A. § 33-20A-61.

8.7 Removal of Physician. If any Physician ceases to be credentialed by the MCO or causes Participating Physician to be in breach of this Agreement, MCO shall give Participating Physician written notice specifying such breach and requesting cure of such breach or removal of Physician as a Physician for purposes of the provision of Covered Services hereunder. Participating Physician shall have thirty (30) days from receipt of such notice to either cure such breach or remove Physician as a Physician for purposes of the provision of Covered Services hereunder. In the event that Participating Physician does not cure such breach or remove such Physician, MCO may terminate this Agreement.

Article 9 Notes: There are multiple dispute resolution options that are available to physicians. In some cases, mediation can be an effective dispute resolution technique. However, often in the context of physician disputes with MCOs, mediation simply adds one more layer of process, cost, and delay. Likewise, arbitration, when done properly, can provide for a less costly, expedited, trial-like proceeding. However, the typical managed care contract provides for arbitration as the exclusive remedy, and MCOs attempt to use these arbitration provisions to limit Physicians' ability to bring and participate in lawsuits, including class action lawsuits, challenging unfair business practices embodied in many managed care contracts. The HMO Settlement Agreements have prohibited these kinds of overreaching arbitration provisions.

*Contractual agreements to arbitrate are generally enforceable under the Georgia Arbitration Code ("GAC"). See O.C.G.A. § 9-9-1, et seq. The GAC applies "to all disputes in which the parties thereto have agreed in writing to arbitrate and shall provide the exclusive means by which agreements to arbitrate disputes can be enforced." See *id.* Certain disputes are not subject to arbitration, including medical malpractice claims and disputes involving contracts of "insurance" (other than contracts between insurance companies). "Insurance" is defined as a "contract which is an integral part of a plan for distributing individual losses whereby one undertakes to indemnify another or to pay a specified amount of benefits upon determinable contingencies." See O.C.G.A. § 9-9-2(c)(3) (incorporating definition of "Insurance" found in O.C.G.A. § 33-1-2). Georgia cases have not yet addressed the question of whether a Managed Care Contract is a "contract of insurance" that is not subject to arbitration under the GAC.*

*For those contracts involving commerce between different states or parties from different states, the arbitration clause will be governed by the Federal Arbitration Act (the "Act"), 9 U.S.C. § 1, et seq. The Act states that arbitration agreements "shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." See *id.*, § 2. The Supreme Court has recognized that the Act creates a strong federal policy favoring arbitration, see, e.g., *Southland v. Keating*, 465 U.S. 1, 10, 104 S. Ct. 852, 858 (1984); *Mitsubishi Motors v. Solar Chrysler-Plymouth*, 473 U.S. 614, 625, 105 S. Ct. 3346, 3353 (1985); and accordingly has instructed the federal courts to "rigorously enforce agreements to arbitrate." *Dean Witter Reynolds v. Byrd*, 470 U.S. 213, 221, 105 S. Ct. 1238, 1242 (1985).*

Article 9 includes arbitration as one dispute resolution mechanism. However, Article 9 is in no way meant to promote arbitration to the exclusion of litigation. Under Article 9, if one party has already filed a lawsuit, arbitration is not an option and the lawsuit would be allowed to proceed. This provision is denoted in bold and brackets in the sample language in Section 9.1 as it is not clear whether this language would be enforced by Georgia courts.

*Additionally, Participating Physicians may see language in a contract that allow the "prevailing party" to recover attorneys' fees and the cost of litigation **from bringing a legal action to enforce his or her***

rights.” This language could have the effect of deterring a Participating Physician from bringing a legal action to enforce his or her rights under the contract. However, it also may give the Physician the ability to recover such fees and expenses in the event the physician is the prevailing party. In contract actions brought under Georgia law, attorneys’ fees may be recovered as part of damages where the defendant has acted in bad faith, has been stubbornly litigious, or has caused the plaintiff unnecessary trouble and expense. O.C.G.A. § 13-6-11. This language would enable physicians to avoid having to meet this high standard.

MCOs may also include the following kind of language to limit damages: *“Notwithstanding anything herein to the contrary, MCO’s liability, if any, for damages to Participating Physician for any cause whatsoever arising out of or related to this Agreement, regardless of the form of the action, shall be limited to Participating Physician’s actual damages, which shall not exceed the amount actually paid to Participating Physician by MCO under this Agreement during the twelve (12) months immediately prior to the date the cause of action arose. The MCO shall not be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach or disagreement or any action, inaction, alleged tortious conduct, or delay by MCO.”* This language would effectively strip the Participating Physician of real remedies in litigation with the MCO and would only limit the Participating Physician’s damages, not the MCO’s. Finally, the contract may contain a provision that limits the time period in which a Participating Physician can bring suit: *“Notwithstanding anything herein to the contrary, no action, regardless of form, arising out of or relating to his agreement may be brought by Provider more than twelve (12) months after such cause of action has arisen.”* Under Georgia law, the statute of limitations for contract claims is six years. O.C.G.A. § 9-3-24. This provision would limit that time period significantly.



9. Dispute Resolution.

9.1 Binding Arbitration. [Unless one Party has previously filed suit in a court of competent jurisdiction regarding the same disputed issue,] either Party may submit any dispute arising out of this Agreement to final and binding arbitration, and in that event arbitration shall be the sole and exclusive remedy for such dispute. Any such arbitration shall be held in the state where the services or procedures at issue in the dispute were or are to be performed. Arbitration shall be conducted pursuant to either the rules of the American Arbitration Association or the American Health Lawyers Association Alternative Dispute Resolution Center. The arbitrator shall be selected on the mutual agreement of both Parties and shall be an attorney and member of the National Academy of Arbitrators or the American Health Lawyers Association. If the Parties cannot agree on an arbitrator, an arbitrator shall be appointed by the American Health Lawyers Association Alternative Dispute Resolution Center.

9.2 Non-Binding Arbitration⁵². [Unless one Party has previously filed suit in a court of competent jurisdiction regarding the same disputed issue,] either Party may submit any dispute arising out of this Agreement to non-binding

⁵² Non-binding Arbitration is merely an advisory opinion.

arbitration. Any such arbitration shall be held in the state where the services or procedures at issue in the dispute were or are to be performed. Arbitration shall be conducted pursuant to either the rules of the American Arbitration Association or the American Health Lawyers Association Alternative Dispute Resolution Center. The arbitrator shall be selected on the mutual agreement of both Parties and shall be an attorney and member of the National Academy of Arbitrators or the American Health Lawyers Association. If the Parties cannot agree on an arbitrator, an arbitrator shall be appointed by the American Health Lawyers Association Alternative Dispute Resolution Center.

Section 9.3 Notes: In an arbitration, each Party typically bears its own costs. However, in the case of a dispute resolution involving a Participating Physician and a MCO, the Participating Physician is alleging that it has rendered services and the MCO is holding the Participating Physician's money. Section 9.2 recognizes that if the Participating Physician has to spend money to obtain funds that an arbitrator determines it is entitled to under the contract, it is legitimate to require the MCO to pay reasonable costs and attorneys' fees.

9.3 Arbitration Expenses. If Participating Physician prevails in the arbitration, MCO shall be responsible for Participating Physician's costs and expenses related to the arbitration, including its expenses and attorneys' fees and also 100% of the administrative fees and expenses of the arbitration and arbitrator's fees. In any arbitration between an MCO and a Physician who practices individually or in a Participating Physician of less than five physicians, the maximum amount of the arbitration administrative fees and expenses and arbitrator's fee payable by such Physician shall be the lesser of (i) fifty percent (50%) of the total of such expenses and fees or (ii) One Thousand Dollars (\$1000), and the remainder of the arbitration administrative fees and expenses and arbitrator's fee shall be payable by the MCO.

Article 10 Notes: The Miscellaneous Article of any contract contains provisions governing certain administrative matters, such as how to provide Notice to the other Party and which state's laws control the contract. While it is tempting to simply "skim" these provisions, important matters are usually contained therein. Each section should be reviewed carefully.



10. Miscellaneous

10.1 Nature of Relationship with Participating Physician. In the performance of the work, duties, and obligations of Participating Physician under this Agreement, it is mutually understood and agreed that Participating Physician and each of its Physicians are at all times acting and performing as independent contractors.

Section 10.2 Notes: The Participating Physician should identify its home county for purposes of limiting the forum of any lawsuit. This provision will provide convenience and a possible “home field” advantage for the Participating Physician.

10.2 Governing Law and Jurisdiction. This Agreement shall be governed by and construed in accordance with the applicable federal laws and regulations and the laws of the State of Georgia, including but not limited to the “any willing provider” provisions of Georgia law (O.C.G.A. § 33-18-18, § 33-19-13, § 33-20-16, § 33-20-31, § 33-20B-3, § 33-30-25.) Except as provided in Article 9 above, any and all disagreements shall be subject to exclusive jurisdiction in the Court in _____ County, Georgia. The Parties waive any objection as to venue, forum, or jurisdiction. Nothing contained in this Agreement is intended to, or shall, in any way reduce, eliminate or supersede any Party’s existing obligation to comply with applicable provisions of relevant state and federal law and regulations, and MCO shall comply with state and federal law and regulations. Nothing herein shall waive Participating Provider’s rights to participate in any class action lawsuit.

Section 10.3 Notes: Assignment provisions are generally designed to allow for a seamless administrative transition if one of the Parties to the contract changes ownership or control through a merger or other business transaction. They allow for the rights and obligations to continue under the contract. The assignment provision in Section 10.3 is distinct from most managed care contracts, which generally limit the ability to assign change in ownership or control just to the MCO. Section 10.3 permits either Party to assign their obligations under the Agreement only when it has the other’s prior written consent or if assignment is to a common entity in existence at the Effective Date of the Agreement without consent under these limited circumstances. Section 10.3 also provides additional protection (in addition to Section 5.1) against “leased” or “rental” networks by making clear that the provision does not permit such activity.

10.3 Assignment. MCO may not assign this Agreement without Participating Physician’s prior written consent, except that MCO may assign this Agreement to an entity related to MCO by ownership or control as of the Effective Date; provided, however, MCO must notify Participating Physician at least one hundred and twenty (120) days in advance of such assignment. Participating Physician may not assign this Agreement without MCO’s prior written consent, except that Participating Physician may assign this Agreement to an entity related to Participating Physician by ownership or control or to any successor organization without MCO’s prior written consent. Nothing in this provision shall be interpreted to permit renting or leasing of Participating Physician’s services or fee schedule to entities that are not owned or controlled or a successor in interest of the MCO. MCO shall recognize all valid assignments by Enrollees of Plan benefits to Physicians.

10.4 Waiver. No waiver by either Party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions.

Section 10.5 Notes: Carefully review the specific events listed as examples of force majeure (which literally means, "greater force"). These events excuse a Party's performance under the Agreement. The MCO may try to include events that are not truly of an emergency or critical nature, such as a failure of transportation. For example, in the Atlanta area, a MARTA failure should not stand as a reason to delay performance of the contract.

10.5 Force Majeure. Performance of obligations hereunder shall be excused to the extent delay or failure is caused by an event of "force majeure," such as from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work interruptions by either Party's employees, or any other cause beyond the reasonable control of either party; provided the affected Party gives written Notice of the delay to the other Party and uses reasonable best efforts to cure such failure or delay.

10.6 Time is of the Essence. Time is of the essence in this Agreement. The Parties shall perform their obligations within the time specified.

Section 10.7 Note: When providing Notice to the MCO, it is important to adhere to the requirements in the "Notice" section in a precise way; failure to do so may void the Notice. The following model language provides consistency for the notice process.

10.7 Notices. Any Notice required to be provided to any Party to this Agreement shall be in writing and shall be considered effective as of the date of deposit with the United States Postal Service by certified or registered mail, postage prepaid, return receipt and addressed to the Parties as set forth below:

If to MCO:

If to Participating Physician:

or to such other address, and to the attention of such other person or officer as either Party may designate in writing.

10.8 Severability. In the event any portion of this Agreement is found to be void, illegal, or unenforceable, the validity or enforceability of any other portion shall not be affected.

Section 10.9 Notes: This provision recognizes that the Enrollee may have a legally recognizable right to benefit from certain aspects of the relationship between the Physician and the MCO entity.

10.9 Third-Party Rights. This Agreement is entered into by and between the Parties and for their benefit. There is no intent by either Party to create or establish a third-party beneficiary status or rights in a third party to this Agreement, except for Enrollees or as such rights are expressly created and as set forth in this Agreement. Except for such Parties, no such third party shall have any right to enforce or any right to enjoy any benefit created or established under this Agreement.

Section 10.10 Notes: This sample language can provide considerable protection for Participating Physicians because it preserves the integrity of the negotiated contract as the document governing the Parties' obligations to one another.

10.10 Entire Agreement. This Agreement and its Exhibits incorporate completely all of the terms of the arrangement between MCO and Participating Physician, and there are no others in addition to those stated herein. This Agreement supersedes any prior agreements, promises, negotiation, or representations, either oral or written, relating to the subject matter of this Agreement. Any manual, policies, procedures, or guidelines of MCO not attached as Exhibits hereto are outside of the scope of this Agreement and shall not modify or otherwise affect the terms of this Agreement.

10.11 Notification of Legal Matters. If any action is instituted against either Party relating to this Agreement or any services provided hereunder, or in the event such Party becomes aware of facts or circumstances which indicate a reasonable possibility of litigation with any Payer utilizing Participating Physician, any Enrollee, or any other third person or entity, relevant to the rights, obligations, responsibilities, or duties of the other Party under this Agreement, such Party shall provide timely Notice to the other, and the other Party shall reasonably cooperate with the first Party in connection with the defense of any such action by furnishing such material or information as is in the possession and control of the other Party relevant to such action.

Section 10.12 Notes: Many managed care contracts allow the MCO to unilaterally amend most of the terms and provisions at any point during the life of the contract. Section 10.12 provides that neither side can amend the Agreement without authorization. Sometimes the contract calls for unilateral amendment by the MCO for "amendments required by regulatory authorities or federal or state law." To address regulatory changes, a Change in Law provision is included as shown in Section 10.17 below.

10.12 Amendment. This Agreement may not be modified without the express written approval of both Parties.

Section 10.13 Notes: Even after the contract is terminated, Section 10.13 ensures that the compensation, confidentiality and dispute resolution provisions remain in effect.

10.13 Survival. Notwithstanding any provisions contained herein to the contrary, the obligations of the Parties under Articles III, VI, and IX shall survive termination of this Agreement.

Note for Section 10.14: Many crucial business terms such as “payment rates” and “MCO policies” are found in exhibits. It is important to state within the contract that the Exhibits may be changed only upon the mutual, written agreement of the Parties.

10.14 Exhibits. All Exhibits are incorporated by reference into this Agreement and shall be attached to this Agreement at the time of execution. Exhibits may be modified or amended only upon the mutual, written agreement of both Parties; any modification to an Exhibit or the information, policies or procedures contained therein without the written consent of both Parties shall be null and void.

10.15 Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same document.

*Note for Section 10.16: The MCO may include a provision requiring the Participating Physician to indemnify and hold harmless the MCO against claims based on the MCO’s decision not to cover certain services. For example, an Enrollee who was denied coverage for a diagnostic procedure, and thus did not receive it from his provider, may sue the MCO if he later develops a disease that would have been identified by the procedure. Indemnification provisions commonly proposed by managed care companies would hold a Participating Physician liable to the MCO, through indemnification or otherwise, for the MCO’s decisions. Such problematic language may state: **“Participating Physician shall indemnify and hold MCO and Payers and employees harmless from any and all claims, lawsuits, settlements and liabilities incurred as a result of professional services provided or not provided by Provider with respect to any Enrollee, whether based on actions taken or not taken by the MCO in the administration of this Agreement or otherwise.”** If you encounter such a clause in your contract, delete it and attempt to replace it with the following model language, which confirms that no such indemnification requirement exists.*

10.16 Indemnification. MCO shall not require Participating Physician to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorney’s fees, court costs and any associated charges, incurred in connection with any Claim or action brought against MCO based on MCO’s management decisions, utilization review provisions or other policies, guidelines or actions.

Note for Section 10.17: Many contracts contain a provision allowing one or both Parties to modify the Agreement if a change in relevant law or regulations renders part of the agreement improper, illegal or no longer financially feasible for the parties. While such provisions are a good idea, it is important to include a statement that any such change must receive the prior written consent of the other Party, and that the suggested change should be supported by a reasonable legal opinion from the attorney of the Party

suggesting the change. If the other Party disagrees in good faith and does not think that the change in law requires a contract revision, and will not consent to the modification, that Party should have the option of terminating the contract without penalty. Model language to this effect is included below.

10.17 Change in Law. In the event of a change in federal, state or local law, any of which could, in either Party's reasonable judgment and as supported by a written legal opinion of that party's attorney, materially and adversely affect the manner in which either Party may perform services under this Agreement, the Parties shall work in good faith to promptly amend this Agreement to comply with the law, regulation, or policy and approximate as closely as possible the arrangements set forth in this Agreement as it existed immediately prior to the change in law, regulation or policy. Any such amendment requires the written consent of both parties. If, however, one party disagrees in good faith and, in that Party's reasonable judgment as supported by a written legal opinion of that Party's attorney, does not believe that an amendment is warranted, then, notwithstanding anything to the contrary in the Agreement, this Agreement may be terminated without penalty upon the provision of a five (5) day written Notice to the other Party.

Note for Section 10.18: The MCO may seek to limit the Participating Physician's ability to enter into additional contracts with any Payer that is participating in the MCO's network. For example, if Employer ABC is a Payer under MCO's plan, MCO may try to prohibit the Participating Physician from entering into a contract to provide services directly with Employer ABC or any other managed care company that also includes Employer ABC in its network. Such problematic language could include: "During the term of this Agreement and for one (1) year after the termination of this Agreement, Participating Physician shall not be a party to or execute a contract to serve as a provider for any Payer that is under contract with MCO." These covenants not to compete or "noncompetition" clauses should be avoided for three reasons: one, they hamper the Participating Physician's ability to freely contract in furtherance of its business mission; two, Participating Physician often may not know that a particular Payer participates in another managed care plan until after signing a contract with that managed care company; and three, that Payer may join another managed care plan after the Participating Physician has already signed a contract, in which case the Participating Physician is in the position of either terminating that contract or breaching the noncompetition clause in the MCO agreement. For these reasons, a covenant not to compete section should be refused and could be replaced with the following model language. In the event a Participating Physician does agree to a noncompete provision, Georgia law requires that the provision be reasonable in geographic scope and duration in order to be enforceable. Johnson v. Lee, 257 S.E.2d 273 (Ga. 1979).

10.18 No Covenant Not to Compete. Nothing herein shall limit Participating Physician's ability to negotiate or execute an agreement to serve as a provider of services for any other Payer, managed care company or employer, whether during the life of this Agreement or at any point thereafter.

Notes for Section 10.19: This provision would standardize the appeals process for any due process needs under the managed care contract rather than having various processes throughout the Agreement or a reference to the MCO's appeals processes generally.

10.19 Standard Appeals Process. For any appeal to which Participating Physician is entitled for which a specific appeals process is not otherwise provided in this Agreement, at a minimum, such appeal shall include the following three stages. First, Participating Physician shall have the right to appeal to the Payer Representative, in writing. The Payer Representative shall make good faith efforts to resolve the issue being appealed and provide the Participating Physician with a written response to the issue within ten (10) business days of receipt of the same. If Participating Physician is not satisfied with the outcome of the Payer Representative's good faith efforts to resolve the issue being appealed, Participating Physician shall have the right to appeal, in person at Participating Physician's election, to a panel constituted by the Payer to hear the appeal. Such appearance shall be scheduled within thirty (30) days of such request, if an in-person appearance is requested by Participating Physician. Such panel shall consist of members appointed by the Payer, but, at a minimum, where clinical issues are involved, shall include a physician who is currently practicing medicine and is board certified in the specialty at issue in the appeal. Such panel shall provide Participating Physician Notice of its decision within ten (10) business days of such appeal – either the date of Participating Physician's appearance or receipt of the written appeal. Finally, if the outcome of such appeal is unsatisfactory to Participating Physician, the Participating Physician shall have the right to appeal to the Executive Board of the Payer, which shall render its decision, in writing, and provide Notice of same to Participating Physician, within ten (10) business days of such appeal – either the date of Participating Physician's appearance or receipt of the written appeal.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

PARTICIPATING PHYSICIAN

By: _____

Title: _____

MCO

By: _____

Title: _____

EXHIBITS

Note for Exhibits: We recommend including a space for the initials of each Party at the bottom of each Exhibit.

- Exhibit A – Covered Services
- Exhibit B – Fee Schedules
- Exhibit C – List of Payers
- Exhibit D – Credentialing Criteria and Process
- Exhibit E – Payer Policies and Procedures
- Exhibit F – Georgia Code Mandated Covered Services
- Exhibit G – Physician Grievances
- Exhibit H – Quality Improvement Initiatives

Exhibit F

Georgia Code Mandated Covered Services

Alcoholism (33-24-28.3)
Ambulatory Surgery for Dental Care (33-24-28.4)
Autism (33-24-59.10)
Bone Marrow Transplants for the treatment of Breast Cancer (33-29-3.3 & 33-30-4.4)
Bone Mass Measurement (31-15A-1)
Breast Reconstruction (33-24-70, et al.)
Cervical Cancer/HPV Screening (proposed in 2006, but has yet to be acted upon at 33-24-56.5)
Chlamydia (31-17-4.1)
Clinical Trials (for children with cancer) (33-24-59.1)
Colorectal Cancer Screening (33-24-56.3)
Contraceptives (33-24-59.6)
Dental Anesthesia (33-24-28.4)
Dependent Children with Cancer (33-24-59.1)
Diabetes Self-Management (33-24-59.2)
Diabetic Supplies (33-24-59.2)
Emergency Services (33-20A-9)
Mammogram (33-30-4.2)
Mastectomy (33-24-72)
Mastectomy Stay (33-24-72)
Maternity (33-24-58 & 59)
Maternity Stay (33-24-58 & 59)
Mental Health General (33-24-28.1 & 29)
Mental Health Parity (33-24-28.1 & 29)
Morbid Obesity Treatment (33-24-59.7)
Newly Born or Adopted Child Care (33-24-22)
Off-Label Drug Use (33-24-59.11)
Ovarian Cancer Screening (33-24-56.2)
Pap Smear (33-30-4.2)
Prescription Inhalers (33-24-59.8)
Prostate Cancer Screening (33-30-4.2)
Telemedicine (33-24-56.4)
TMJ Disorders (33-30-14)
Vision Care Services (33-24-59.12)

ACKNOWLEDGMENTS:

This Georgia Model Managed Care Contract contains sample language drafted by the Medical Association of Georgia and its counsel in response to old and new managed care contract issues, as well as original commentary and sample cautionary language that should be part of any Physician's evaluation of a proposed managed care contract and is derived from various managed care contracts. It also notes and includes language from the various HMO Settlements and the Georgia Insurance Code, as applicable. The Georgia Model Managed Care Contract also incorporates a number of the example provisions of the Fourth Edition of the American Medical Association's Model Managed Care Contract, as revised in 2005. (See <http://.ama-assn.org/ama/pub/category/9559.html>.) Permission was granted by the American Medical Association.

GEORGIA MODEL MANAGED CARE CONTRACT

THIS AGREEMENT, made this ____ day of _____, 20__ and made effective on the ____ day of _____, 200_ (“Effective Date”) by and between _____, a [insert state of formation and type of legal entity (e.g., a Georgia professional corporation) if any] (“Participating Physician”), and _____, a [insert state of formation and type of legal entity (e.g., a Georgia professional corporation) if any] (“MCO”) (Participating Physician and MCO herein referred to from time to time collectively as the “Parties”).

WHEREAS, MCO offers or directly administers one or more health benefit products or plans and wishes to arrange for the provision of medical services to Enrollees of such products or plans; and

WHEREAS, Participating Physician is comprised of or contracts with one or more Physicians capable of providing medical services to Enrollees; and

WHEREAS, MCO desires to engage Participating Physician to deliver or arrange for the delivery of medical services to the Enrollees of its plans; and

WHEREAS, Participating Physician is willing to deliver or arrange for the delivery of such services on the terms and conditions specified herein.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties hereby agree as follows:

1. DEFINITIONS

1.1 Affiliate. A person or entity who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person or entity.

1.2 Carrier means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

1.3 Claim. A statement of services submitted to MCO by Participating Physician following the provision of Covered Services to an Enrollee that shall include diagnosis or diagnoses and an itemization of services and procedures provided to Enrollee.

1.4 Claimant means any provider, facility, or individual making a claim under a health benefit plan on behalf of an Enrollee.

1.5 Clean Claim. A Claim submitted via a properly completed billing form UB-92 or CMS 1500, or an equivalent paper or electronic form, (i) that has no material defect or impropriety which substantially prevents timely payment from being made on the Claim or (ii) with respect to which MCO has failed timely to notify Participating Physician of any such defect or impropriety in accordance with this Agreement.

1.6 Coinsurance. The percentage of the Total Compensation, per service or procedure, that is the responsibility of Enrollee.

1.7 Coordination of Benefits. The determination of whether Covered Services provided to an Enrollee shall be paid for, either in whole or in part, under any other private or government health benefit plan or any other legal or contractual entitlement, including, but not limited to, a private group indemnification or insurance program.

1.8 Copayment. A charge that may be collected directly by a Participating Physician or Participating Physician's designee from an Enrollee in accordance with the Plan.

1.9 Covered Services. Health care services and procedures to be delivered by or through Participating Physician to Enrollees pursuant to this Agreement. A description of the medical services and procedures listed by the American Medical Association's Current Procedural Terminology Codes in effect at the time services are rendered to an Enrollee ("AMA CPT Codes") that are covered by the applicable Plans is delineated by product and attached to this Agreement as Exhibit A.

1.10 Deductible. The portion of an Enrollee's benefits that must be paid by the Enrollee before insurance coverage applies to specific categories of Covered Services for which a Deductible must be met.

1.11 Emergency Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (which may or may not include severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention, to result in (a) placing the patient's [or unborn child's] health in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part [or (d) other serious medical consequences].

1.12 Emergency Services. Emergency medical transportation or health care services provided in a hospital emergency facility to evaluate and treat any Emergency Condition.

1.13 Enrollees. Any individual(s) entitled to health care benefits under a Plan who presents an identification card that contains the following information: (i) the name of the Payer; (ii) the Enrollee's name; (iii) the logo of the Plan or product; (iv) contact information for pre-authorization, if necessary; (v) the billing address; and (vi) the applicable Plan. Participating Physician may decline to accept additional Enrollees as patients, if Participating Physician notifies MCO thirty (30) days prior to the date that Participating Physician will decline to accept additional Enrollees as patients. Participating Physician may likewise decline to continue treating an Enrollee for good cause, as may be determined by the reasonable judgment of Participating Physician.

1.14 Facility means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution for examination, diagnosis,

treatment, surgery, or maternity care but does not include physicians' or dentists' private offices and treatment rooms in which such physicians or dentists primarily see, consult with, and treat patients.

1.15 Managed Care Contractor means a person who:

- (a) Establishes, operates, or maintains a network of participating physicians and/or providers;
- (b) Conducts or arranges for utilization review activities; and
- (c) Contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

1.16 Managed Care Entity includes an insurance company, hospital or medical service plan, hospital, health care provider network, physician hospital organization, health care provider, health maintenance organization, health care corporation, employer or employee organization, or managed care contract that offers a managed care plan.

1.17 Managed Care Plan means a major medical, hospitalization, or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

- (a) Arrangements with selected providers to furnish health care services;
- (b) Explicit standards for the selection of participating physicians; and
- (c) Cost savings for persons enrolled in the plan who use the participating physicians and procedures provided by the plan.

1.18 MCO Compensation. The Total Compensation less that portion designated by the Plan as a Copayment, Deductible and/or Coinsurance.

1.19 MCO Notice or Notice. A communication by MCO to Participating Physician that complies with Section 10.7 herein and is required to inform Participating Physician of any information relevant to the provision of Covered Services pursuant to this Agreement.

1.20 Medically Necessary/Medical Necessity. For purposes of this Agreement and for all internal decisions by a Payer determining whether a service is a Covered Service, health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

1.21 Medically Necessary/Medical Necessity (Alternative Definition). For purposes of this Agreement and all internal decisions by MCO, a Plan or a Payer regarding determination of Covered Services, the term "Medically Necessary" or "Medical Necessity" shall mean health care services or procedures that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce

equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally acceptable standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or that are otherwise consistent with Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors. MCO shall be required to disclose an annual rate of denials for Medical Necessity for all Claims on MCO's web site or other comparable electronic medium. "Physician Specialty Society" means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

1.22 Non-Covered Services. Health care services that are not Covered Services as defined herein. For a list of Covered Services, please see Exhibit A.

1.23 Notice. Notice provided pursuant to Section 10.7 herein.

1.24 Out of Network or Point of Service refers to healthcare items or services provided to an enrollee by physicians who do not belong to the provider network of the managed care plan.

1.25 Participating Physician means that Participating Physician identified in the Preamble.

1.26 Payer. The entity or organization directly responsible for the payment of MCO Compensation to the Participating Physician under a Plan. With respect to a self-funded Plan covering the employees of one or more employers, the Payer shall be the employer(s) and/or any funding mechanism used by the employer(s) to pay Plan benefits. With respect to an insured Plan or Plan providing benefits through a health maintenance organization, the Payer shall be the insurance company or health maintenance organization, as the case may be. Under no conditions shall the Parties interpret "Payer" to be, nor shall the negotiated rates herein described be assigned to or accessible to, any party other than MCO or an employer offering a self-funded product that contracted with MCO to administer such product, and Payer shall have an affirmative obligation to assist Participating Physician in the recovery of payment from any such non-community Payer.

1.27 Physician. A doctor of medicine or osteopathy licensed to practice medicine, who has agreed to provide Covered Services to Enrollees and who has been credentialed pursuant to the rules and procedures of the Plan by the MCO or a duly appointed and authorized agent to which such credentialing responsibility has been delegated; provided, however, nothing herein shall obligate Participating Physician to notify MCO or Plan in the event Participating Physician may be aware that a physician who is not credentialed pursuant to the rules and procedures of the Plan is rendering Emergency Services to an Enrollee.

1.28 Physician Contract means any contract between a Physician and a carrier or a carrier's network, physician panel, intermediary, or representative providing the terms under which the Physician agrees to provide health care services to an enrollee pursuant to a health benefit plan.

1.29 Plan. An individual set of health service delivery and compensation procedures offered as a "managed care" product by MCO, or administered by MCO, on behalf of a Payer for the benefit of Enrollees, as it may be modified from time-to-time, and all the terms, conditions, limitations, exclusions, benefits, rights, and obligations thereof to which MCO and Enrollees are subject. Nothing in this Agreement shall be construed to require Physicians to participate in all

of MCO's Plans as a condition of participating in any individual plan or plans. Nothing in this Agreement shall be construed to require Physicians to participate in future Plans introduced by MCO.

1.30 Quality Improvement. The process designed to monitor and evaluate the quality and appropriateness of care and to improve care, which, if maintained by MCO shall require Physician input.

1.31 Total Compensation. The total amount payable by Payer and Enrollee for Covered Services furnished pursuant to this Agreement.

2. Delivery of Services

2.1 Covered Services. The Participating Physician shall arrange for the provision to Enrollees of those Covered Services that are identified in Exhibit A, attached hereto and made a part of this Agreement by this reference.

2.2 Full Description. Exhibit A shall be comprised of separate schedules designated as Exhibit A1, A2, etc., which shall either identify separately the Covered Services relating to each MCO Plan or provide a fixed, readily available, location where the Participating Physician can conveniently find the complete list of Covered Services.

2.3 Full Disclosure. Where such schedule contemplates a global or capitated arrangement requiring Covered Services not normally provided by the Physician or Participating Physician, such Covered Services shall be designated in bold type on Exhibit A, and a note shall be displayed prominently stating that payment for these Covered Services shall be the Participating Physician's responsibility.

2.4 Administrative Responsibility. If Exhibit A is not attached or in the event such exhibit contains descriptions of Covered Services that are so materially lacking in specificity that the purpose of this Agreement is defeated, MCO shall pay Participating Physician the Physician's billed charge for each service and procedure performed by a Physician for the benefit of Enrollee.

2.5 Medical Responsibility. All Covered Services shall be provided in accordance with the standard of care which is ordinarily employed by the medical profession generally under similar conditions and like circumstances, and consistent with The American Medical Association's Code of Medical Ethics in effect as of the date of service.

2.6 Verification of Enrollees/Eligibility/Covered Services. Except in the case of Emergency Services, Participating Physician shall use, and shall be entitled to conclusively rely on, the mechanism, including identification card, MCO web site, or telephone, chosen by MCO or its agent designated for such purpose, to confirm an Enrollee's status as an Enrollee, eligibility and applicable Covered Services ("MCO's Designated Verification Mechanism") prior to rendering any such services, in order to guarantee payment. Participating Physician shall be entitled to rely on the information provided by MCO web site or telephone or, in the event MCO doesn't provide web site or telephone basis on a 24 hour a day, 7 days per week basis, then on the information printed on the Enrollee's identification card as conclusive evidence of such Enrollee's eligibility. In addition, MCO and Participating Physician agree to the following:

2.6(a) MCO or Payer shall be bound by MCO's confirmation of eligibility and coverage for the requested services and procedures and shall not retroactively deny payment for Covered Services rendered to individuals the Plan has confirmed as eligible, or Covered Services using MCO's Designated Verification Mechanism.

2.6(b) If Participating Physician, after following MCO's Designated Verification Mechanism to the extent reasonably possible, is unable to verify the eligibility or Covered Services of a patient who holds himself or herself out to be an Enrollee, Participating Physician shall render necessary care and MCO shall pay for such care.

2.6(c) In the event Emergency Services are needed, at the first available opportunity, Participating Physician shall attempt to verify eligibility and applicable Covered Services. In the event Participating Physician makes a good faith effort to verify eligibility and Covered Services, and such verification is not reasonably possible given time constraints caused by the MCO's action or inaction, and it is later determined that patient is not an Enrollee and/or is not entitled to certain Covered Services, then Participating Physician shall attempt to collect from patient the amount due, up to the billed charges fee of the Physician providing the service. If, after two billing cycles, Participating Physician has not received full payment, MCO will pay Participating Physician the billed charges fee, minus that which the Participating Physician has already collected from the patient, not to exceed the amount provided for as Total Compensation herein.

3. Compensation and Related Terms

3.1 Compensation. MCO shall have an obligation to pay Participating Physician the compensation designated on Exhibit B, attached hereto, for the Covered Services provided by Physicians hereunder. Participating Physician or its designee shall accept from MCO or Payer as full payment for the provision of Covered Services, the Total Compensation identified in Exhibit B, attached hereto and made a part hereof by this reference.

3.1(a) MCO shall develop and implement a plan reasonably designed to permit the Participating Physician, in each case, to view, on the MCO web site, on a confidential basis, the complete fee schedule applicable to such Participating Physician pursuant to that Participating Physician's direct written agreement with MCO. Each such fee schedule shall state the dollar amount allowable for each AMA CPT Code for Covered Services rendered by such Participating Physician's office. MCO shall provide Participating Physician the fee schedule for the AMA CPT Codes specified by such Participating Physician.

3.2 Full Description and Education. Exhibit B shall be composed of separate schedules designated as B1, B2, etc., which shall identify separately the Total Compensation and related terms for each Payer and Plan, all of which are subject to the amendment provisions of Section 10.12 of this Agreement. MCO and/or its Plans shall provide to Participating Physician and its Physicians educational information and training reasonably sufficient to allow Participating Physician and its Physicians to understand the differences in Total Compensation and related terms for each Payer and Plan.

3.3 Full Disclosure. The Total Compensation set forth on the Exhibit B schedule(s) shall specify for each Payer and Plan, the manner of payment (such as fee-for-service, capitation or risk withholds) for medical services and procedures rendered pursuant to the provision of Covered Services as set forth in the counterpart schedule of Exhibit A, and shall identify the portion of the Total Compensation that shall be the MCO Compensation. Exhibit B shall also identify with specificity the additional business terms negotiated by the Parties related to such Total Compensation. By way of example, and without limiting the requirements of this section, Exhibit B shall specify the following:

3.3(a) In the case of a discounted fee-for-service arrangement, Exhibit B shall contain the following:

- i. A comprehensive fee schedule that states clearly how much will be paid for each service and procedure to be rendered pursuant to the Agreement.
- ii. Where compensation is based on a relative value unit (RVU system), such as the Medicare RBRVS, Exhibit B shall identify the specific RVU system (including the year), the conversion factors used, and shall provide a means to apply the formula or database to obtain rate information per AMA CPT Code.
- iii. Where compensation is based on a “usual customary and reasonable” (UCR) system, Exhibit B shall identify the database used and the methodology applied to determine the fee schedule. The database and methodology must be based upon the current year, statistically accurate, tied to physician charges, and based upon physicians of the same specialty in the same geographic area.
- iv. A statement that the fee schedule cannot be changed without the consent of Participating Physician.
- v. A provision stating the consequence for a Payer changing the terms of a fee schedule without consent of the Participating Physician, including the right to terminate the agreement and the right to recover billed charges.

3.3(b) In the case of a capitation arrangement, Exhibit B shall contain the following:

- i. The amount to be paid per Enrollee, per month.
- ii. The mechanism by which Enrollees who do not designate a primary care physician (PCP) are assigned a PCP (the MCO should use an Enrollee’s home address zip code to assign PCPs randomly or another reasonable method) for purposes of capitation payment. Such assignment shall occur immediately upon enrollment, and the PCP shall receive monthly payment until or unless Enrollee designates another PCP.
- iii. The date each month that the capitation payment is due.
- iv. The manner by which MCO will determine and communicate to Participating Physician who is an Enrollee assigned to Participating Physician at the beginning of each month.

- v. The precise terms of the stop-loss arrangement offered to Participating Physician by MCO, or a recital indicating that Participating Physician shall obtain stop-loss protection through other arrangements.
- vi. The boundaries of the service area in which treatment of Enrollees shall be arranged by Participating Physician and outside of which treatment provided to Enrollees shall become the financial obligation of MCO.
- vii. The fee-for-service schedule to which the Parties will revert in the event that the number of Enrollees assigned to Participating Physician falls below a designated actuarial minimum, defeating the predictability of risk that both Parties rely on in the arrangement.
- viii. The number of covered lives and the fee-for-service schedule upon which Participating Physician will be paid for those Covered Services provided to Enrollees that are not specifically made a part of the capitation arrangement on Exhibit A. In the case of a capitation arrangement, Participating Physician shall have the right to audit, at Participating Physician's expense, the books and records of MCO or a Payer for purposes of determining the accuracy of any capitation payment and for the purposes of determining the number of Enrollees assigned to Participating Physician.
- ix. The description of reports and analyses to be supplied at least monthly by the MCO to enable the Participating Physician to manage effectively the risk it assumes under capitation arrangements. These reports will include membership information to allow monthly reconciliation by Participating Physician of capitation payments, including, without limitation, Enrollee identification number or the equivalent name, age, gender, medical group/physician organization number, co-payment, monthly capitation amount, primary care physician, provider effective date, and in the monthly report following an applicable change (e.g., selection of a new primary care physician) a report of such change, as well as an explanation of any deductions.
- x. The information provided by the MCO that is current through the end of the previous month.

3.3(c) In the case of a withhold or bonus, Exhibit B shall contain the following:

- i. The method by which the amount to be released or paid will be calculated and the date on which such calculation will be complete.
- ii. The records or other information on which MCO will rely to calculate the release of the withhold or the payment of the bonus.
- iii. The date upon which Participating Physician will have access to such records or information relied on by MCO in making such calculation for the purpose of verifying the accuracy thereof.

- iv. The date upon which such payment or release, if any is finally due, shall be made.

3.4 Capitated Arrangements. Notwithstanding the provisions of Section 3.3(b) above, MCO shall not require Participating Physician to participate in capitated fee arrangements in order to participate in products in which Participating Physician is compensated on a fee for service basis. In the event that a Participating Physician chooses not to participate in all MCO products, or terminates participating in some MCO products, the fee-for-service rate schedule offered to or applied by MCO to such Participating Physician shall not be lower than MCO's standard fee-for-service rate schedule for the geographic market in which such Participating Physician practices. Nothing in this Section is intended or shall be construed to prohibit MCO from offering a higher fee-for-service rate schedule, or other incentive, to any Participating Physician who elects to participate (or continue participation in) all of MCO's products. Nothing contained herein shall restrict in any way MCO's contracting practices with respect to hospitals.

3.5 Administrative Responsibility. In the event Exhibit B is not attached or contains descriptions of compensation and related terms that are so materially lacking in specificity that the purpose of this Agreement is defeated, then Exhibit B shall be considered null and void, and MCO shall pay Participating Physician the Physician's billed charge for each service and procedure performed by a Physician hereunder. The Parties agree that the precise terms of Exhibit B, as opposed to the general description of the manner of payment, shall remain confidential between the Parties and their respective attorneys.

3.6 Billing for Covered Services. Participating Physician shall submit a Claim to MCO. If payment is required under the terms of this Agreement, MCO shall pay Participating Physician for Covered Services rendered to Enrollees in accordance with the terms of this Agreement.

3.6(a) Time Period for Submission of Bills for Services Rendered. MCO shall not contest the timeliness of bills for Covered Services if such bills are received within 180 days after the later of: (i) the date of service; (ii) the date the patient provides accurate and adequate information to submit a Clean Claim, and (iii) the date of the Participating Physician's receipt of an EOB from the primary Payer, when MCO is the secondary Payer. MCO shall waive the above requirement for a reasonable period in the event that Participating Physician provides Notice to MCO, along with appropriate evidence, of extraordinary circumstances that resulted in the delayed submission.

3.6(b) Claims Submission. MCO agrees to accept both properly completed paper Claims submitted on Form CMS-1500, UB-92 or the equivalent, and also electronic Claims populated with similar information in HIPAA-compliant format or fields. MCO may continue to require submission of additional information in connection with review of specific Claims and as contemplated elsewhere in this Agreement; provided that nothing in this sentence is intended to or shall be construed to alter or limit any restrictions set forth elsewhere in this Agreement concerning MCO's ability to make requests for medical records in connection with adjudication of Claims. MCO shall disclose on its Provider web site and its public web site its policies and procedures regarding the appropriate format for Claims submissions and requests for additional information.

3.7 Coding for Bills Submitted. MCO hereby agrees that Claims submitted for services and procedures rendered by Participating Physician shall be presumed to be coded correctly. MCO may rebut such presumption with evidence that a Claim fails to satisfy the standards set forth on AMA CPT Codes. MCO shall adhere to AMA CPT Codes, including the use and

recognition of modifiers. MCO shall not automatically change AMA CPT codes submitted by a Participating Physician. MCO must provide adequate Notice if it wishes to change a code and must allow sufficient time for, and shall only change a code to comply with a change to, the AMA CPT Codes, as adopted by the AMA, and Notice of such change. Participating Physician shall have the right to appeal any adverse decision regarding the payment of Claims based upon the AMA CPT Codes reported. If MCO or a Payer reduces payment of a Claim in contravention of this section, such party shall be obligated to pay Participating Physician for the full amount of the billed charges for the Claim, plus interest from the time from which the payment should have been made. All AMA CPT Codes will be updated annually.

3.7(a) As of the Effective Date of this Agreement, MCO shall not automatically reduce the code level of evaluation and management codes billed for Covered Services ("Downcode").

3.8 Copayments to be Collected from Enrollees. Where the Plan requires Enrollees to make Copayments at the time of service, Participating Physician shall collect such Copayments accordingly. MCO shall educate Enrollees about their Copayment obligations. If Copayment is not remitted to Participating Physician in a timely fashion, MCO agrees that Participating Physician may discontinue seeing Enrollee, subject to its Physician's ethical duties, and that such action will not constitute a violation of Section 4.2 by Participating Physician.

3.9 Coinsurance and Deductibles to be Collected from Enrollees. Where the Plan requires Enrollees to pay Coinsurance and/or a Deductible, MCO shall educate Enrollees about these obligations. Nothing shall prohibit Participating Physician from collecting such Coinsurance and/or Deductibles prior to the provision of services. If Enrollee fails to remit in a timely fashion payment pursuant to Coinsurance or a Deductible, MCO agrees that the Participating Physician may discontinue seeing the Enrollee subject to its Physician's ethical duties, and that such action will not constitute a violation of Section 4.2 by Participating Physician.

3.10 Coordination of Benefits. When Enrollees are covered, either fully or partially, for services provided by a Physician under any contractual or legal entitlement other than this Agreement, including, but not limited to, a private group or indemnification program, Participating Physician shall be entitled to keep any sums it recovers from such primary source consistent with applicable federal and state law. Except as indicated in the following sentence, Payer will pay Participating Physician the Total Compensation of the Physician providing service for Participating Physician, less that which is obtained from any primary source. If Exhibit B contemplates a fee-for-service compensation arrangement, the sum of such payments shall not exceed the Total Compensation set forth on Exhibit B; however, in the case of Medicare beneficiaries and where the Payer is the Secondary Payer, the sum of such payments shall not be less than one hundred percent (100%) of the Medicare allowed fee schedule.

3.10(a) If Payer is deemed "primary" in accordance with applicable industry Coordination of Benefits ("COB") standards, the Payer shall pay Participating Physician in accordance with the terms of this Agreement with no delay, reduction, or offset.

3.10(b) If Payer is deemed "secondary" in accordance with applicable industry COB standards, Payer shall pay Participating Physician the difference between what Participating Physician received from the primary Payer and the amount Payer owes Participating Physician as Total Compensation under the terms of this Agreement.

3.10(c) Payer shall be presumed to be the primary Payer and shall make payments in accordance with this Agreement, unless such Payer can document to the satisfaction of the Participating Physician that Payer is secondary under industry COB standards within fourteen (14) calendar days of receipt of a Claim.

3.10(d) If Payer pays a Claim to Participating Physician in accordance with this Agreement, Participating Physician agrees to cooperate with the reasonable efforts of Payer to determine whether it is the primary or secondary Payer under industry COB standards. If it is subsequently determined that a Payer should be considered secondary under industry COB standards, then Participating Physician will cooperate with that Payer's reasonable efforts to seek payment from the responsible primary Payer.

3.10(e) If Exhibit B provides a fee-for-service schedule applicable to Enrollee's Plan, Participating Physician shall not retain funds in excess of the Total Compensation fee schedule listed on Exhibit B, unless applicable state law regarding COB requires or imposes a different requirement.

3.10(f) Secondary Payers shall not be relieved of their obligation to make full payment to Participating Physician in the event the primary Payer fails to pay Participating Physician's properly submitted Claims within one hundred eighty (180) days of submission.

3.11 Promptness of Payment.

3.11(a) Within fifteen (15) business days of receipt of a Claim for payment of Covered Services, which MCO shall acknowledge receipt as provided herein, Payer shall (i) if the Claim constitutes a Clean Claim, direct the issuance of a check to Participating Physician, or initiate an electronic wire transfer of immediately available funds to an account designated by Participating Physician for the full payment of such Clean Claim, or (ii) if Payer believes the Claim fails to constitute a Clean Claim, shall give Participating Physician a Notice stating the reasons the Payer may have for failing to pay the Claim, either in whole or in part and also giving the Participating Physician a written itemization of any documents or other information needed to process the Claim or any portions thereof which are not being paid (a "Notice of Deficiency").

3.11(b) In the event Payer disputes a portion of a Claim submitted by Participating Physician for payment, any undisputed portion of the Claim shall be paid by Payer in accordance with this Section 3.11.

3.11(c) Where Payer provides a Notice of Deficiency pursuant to Section 3.11(a) in respect to a particular Claim, Payer shall have fifteen (15) business days from receipt from Participating Physician of all the documents or other information listed in such Notice as being required by MCO to process such Claim within which to process the Claim and either (i) mail or wire transfer payment in full for the Claim to Participating Physician, or (ii) send a letter or Notice to Participating Physician denying such Claim, in whole or in part and giving Participating Physician the reason(s), with reasonable specificity, for such denial.

3.11(d) Receipt of any proof, Claim, or documentation by an entity which administers or processes Claims on behalf of MCO shall be deemed receipt of the same by MCO for purposes of this Section 3.11.

3.11(e) MCO shall incorporate into its interactive voice response telephone system sufficient functionality to permit Participating Physician to determine the date on which a submitted Claim was determined by MCO to constitute a Clean Claim. MCO shall date stamp written Claims for Covered Services upon receipt in its mailroom and shall generate an electronic acknowledgement of receipt of electronic Claims for Covered Services when received by the applicable MCO computer system. Further, in the case of a written Claim, Payer shall mail to Participating Physician written acknowledgement of receipt of a written Claim within three (3) business days of receipt. Payer shall acknowledge receipt of an electronic Claim within twenty-four (24) hours of receiving such Claim. When MCO Claims that it has not received a written Claim, and Participating Physician has a record of the original filing, the time for submission of such Claim will not commence running until the time Participating Physician receives Notice from the MCO that the MCO did not receive such Claim.

3.11(f) MCO shall pay to Participating Physician interest equal to eighteen percent (18%) per annum on the proceeds or benefits due under a Claim for failure to comply with this Section 3.11. Notwithstanding the foregoing, MCO shall have no obligation to make any interest payment (i) with respect to any Clean Claim if, within thirty (30) days of the submission of an original Claim, a duplicate Claim is submitted while adjudication of the original Claim is still in process; (ii) to any Participating Physician who balance bills a Plan Member in violation of this Agreement; or (iii) with respect to any time period during which Force Majeure, as defined in Section 10.5 of this Agreement, prevents adjudication of Claims.

3.11(g) All payments to Participating Physician will be considered final unless adjustments are requested in writing by Payer within one hundred eighty (180) days after receipt by Participating Physician of payment explanation from Payer; provided, however, that where payment for services is a partial payment of allowable charges, a Participating Physician may negotiate a check with "Payment in Full" or other restrictive endorsement without waiving the right to pursue the remedies available under this Agreement.

3.11(h) No Payer may conduct a post payment audit or impose a retroactive denial of payment on any Claim by any Claimant relating to the provision of health care services that was submitted within ninety (90) days of the last date of service or discharge covered by such Claim unless:

- (i) The Payer has provided to the claimant in writing Notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such Claim or any part thereof and has provided in such Notice the specific Claim and the specific reason for the audit or retroactive denial of payment;
- (ii) Not more than twelve (12) months have elapsed since the last date of service or discharge covered by the Claim prior to the delivery to the claimant of such written Notice; and

- (iii) Any such audit or retroactive denial of payment must be completed and Notice provided to the claimant of any payment or refund due within eighteen (18) months of the last date of service or discharge covered by such Claim.

3.11(i) No Payer may conduct a post payment audit or impose a retroactive denial of payment on any Claim by any Claimant relating to the provision of health care services that was submitted more than ninety (90) days after the last date of service or discharge covered by such Claim unless:

- (i) The Payer has provided to the claimant in writing Notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such Claim or any part thereof and has provided in such Notice the specific Claim and the specific reason for the audit or retroactive denial of payment;
- (ii) Not more than twelve (12) months have elapsed since such Claim was initially submitted by the claimant prior to the delivery to the claimant of such written Notice; and
- (iii) Any such audit or retroactive denial of payment must be completed and Notice provided to the claimant of any payment or refund due within the sooner of 18 months after the claimant's initial submission of such a Claim or twenty-four (24) months after the date of service.

3.11(j) No Payer shall be required to respond to a Participating Physician's request for additional payment or to adjust any previously paid Participating Physician's Claim or any part thereof following a final payment unless:

- (i) The Participating Physician makes a request in writing to the Payer specifically identifying the previously paid Claim or any part thereof and provides the specific reason for additional payment; and
- (ii) If the Participating Physician's Claim was submitted within ninety (90) days of the last date of service or discharge covered by such Claim, the written request for additional payment or adjustment must be submitted within the earlier of twelve (12) months of the date both the Participating Physician and the Payer agree that all payments relative to the Claim have been made and all appeals of such determinations have been made or waived by the Participating Physician or twenty-four (24) months have elapsed from the date of service or discharge.

3.11(k) No Payer shall be required to respond to a Participating Physician's request for additional payment or to adjust any previously paid Services Entity's Claim or any part thereof following a final payment unless:

- (i) The Participating Physician makes a request in writing to the Payer specifically identifying the previously paid Claim or any part thereof and provides the specific reason for additional payment; and

- (ii) If the Participating Physician's claim was submitted more than ninety (90) days after the last date of service or discharge covered by such Claim, the written request for additional payment or adjustment must be submitted within the earlier of six (6) months of the date both the Participating Physician and the Payer agree that all payments relative to the Claim have been made and all appeals of such determinations have been made or waived by the Participating Physician or twenty-four (24) months have elapsed from the date of service or discharge.

3.11(I) Notwithstanding any other provision in this Article to the contrary, when precertification has been obtained for a service, the Payer shall be prohibited from contesting, requesting payment, or reopening such Claim or any portion thereof at any time following precertification except to the extent the insurer is not liable for the payment where the Enrollee is no longer covered under the Plan at the time the services are received by the Enrollee, benefits under the contract or Plan have been exhausted, or there exists substantiation of fraud by the Enrollee, provider, or facility.

3.12 Sole Source of Payment. Where Enrollee is enrolled in a Plan, Participating Physician agrees to look solely to that Payer for payment of all Covered Services delivered during the term of the Agreement.

3.12(a) In such circumstances, Participating Physician shall make no charges or Claims against Enrollees for Covered Services except for Copayments, Coinsurance or Deductible, as authorized in the Plan covering Enrollee.

3.12(b) In such circumstances, Participating Physician expressly agrees that during the term of this Agreement it shall not charge, assess, or claim any fees for Covered Services rendered to Enrollees from such Enrollees under any circumstances, including, but not limited to, the event of Payer's bankruptcy, insolvency, or failure to pay the Physician providing services.

3.12(c) Notwithstanding the foregoing, MCO shall cooperate in the processing of such Claims against Payer to provide Participating Physician with its greatest chance to receive compensation for Covered Services provided. This provision shall permit Participating Physician to collect payment not prohibited under state or federal law, including, but not limited to:

- i. Covered Services delivered to an individual who is not an Enrollee at the time services were provided.
- ii. Services provided to an Enrollee that are not Covered Services, provided that Participating Physician advises the Enrollee in advance that the services may not be Covered Services.
- iii. Services provided to any Enrollee after this Agreement is terminated except as otherwise specifically provided in Section 8.6.

3.13 Administrative Surcharge. Nothing in this contract shall affect the right of the Participating Physician to charge Enrollees a reasonable and otherwise legal surcharge for individual or aggregated administrative services, including, but not limited to, fees for records in accordance with Georgia law and no-show charges for missed appointments. Participating

Physician must fully inform Enrollees about the surcharge and the probability that the surcharge will not be paid by the MCO unless such services are otherwise specifically identified and paid in Exhibit B.

3.14 Subrogation. In the event an Enrollee is injured by the act or omission of a third party, the right to pursue subrogation and the receipt of payments shall be as follows:

3.14(a) If Exhibit B provides for a capitation payment for the Enrollee, Participating Physician shall retain the right of subrogation to recover payment from third Parties, such as automobile insurance companies, for all Covered Services for which it is at risk to provide in exchange for the capitation paid hereunder.

3.14(b) If Exhibit B provides for a fee-for-service arrangement for the Enrollee, Participating Physician shall permit Payer to pursue all its rights to recover payment from third party Payers to the extent Payer is at risk for the cost of care.

3.14(c) Payer shall pay Claims submitted by Participating Physician in accordance with this Agreement, notwithstanding Payer's pursuit of subrogation rights against potentially responsible third parties who caused an injury by their acts or omissions, in accordance with Section 3.11(b).

3.14(d) Participating Physician shall abide by any final determination of legal responsibility for the Enrollee's injuries.

3.14(e) Upon receiving payment from the responsible party, Participating Physician will refund the amount of payment to Payer up to the amount paid by the Payer for the services involved. Participating Physician shall be entitled to keep any payments received from third Parties in excess of the amount paid to it by Payer.

3.15 Ability of Physicians to Obtain "Stop Loss" Coverage from Insurers Other Than MCO. MCO shall not restrict Physicians from purchasing stop loss coverage from insurers other than MCO.

4. Participating Physician's Obligations

4.1 Licensed/Good Standing. Participating Physician represents that it, or each of its Physicians, is and shall remain licensed or registered to practice medicine and, if applicable, the legal entity is registered and in good standing with the State of Georgia.

4.2 Nondiscrimination. Participating Physician agrees that it, and each of its Physicians, shall not differentiate or discriminate in its provision of Covered Services to Enrollees because of race, color, ethnic origin, national origin, religion, sex, disability, or age. Further, Participating Physician agrees that its Physicians shall render Covered Services to Enrollees in substantially the same manner and in accordance with the same applicable standards as such services are offered to patients not associated with MCO or any Plan, consistent with medical ethics and applicable legal requirements for providing continuity of care.

4.3 Standards. Covered Services provided by or arranged for by Participating Physician shall be delivered by professional personnel qualified by licensure, training, or experience to

discharge their responsibilities and operate their facilities in a manner that complies with generally accepted standards in the industry.

4.4 Authority. Participating Physician will make all Physicians aware of the terms of this Agreement and shall provide support to such Physicians in their efforts to enable Participating Physician's compliance with the terms of this Agreement.

4.5 Administrative Procedures. Participating Physician and each of its Physicians will comply with the policies and procedures established by MCO or any of its Plans to the extent that the Participating Physician has received Notice consistent with the terms of this Agreement. At the Effective Date of the Agreement, the policies, rules, and procedures applicable to Participating Physician are contained in those manuals and other writings attached hereto on Exhibit E and incorporated by this reference. Participating Physician shall rely on these policies and procedures as the sole material policies and procedures of MCO or its various Payers. The policies and procedures in Exhibit E also must be available on MCO's web site. The policies and procedures in Exhibit E may not be altered without Participating Physician's prior written consent in accordance with Section 10.12 of this Agreement.

4.6 Assistance in Grievance Procedure. Participating Physician agrees to keep available for Enrollees explanations of the grievance procedures and grievance encounter forms relating to Plan, which shall be supplied by MCO. Participating Physician also agrees to participate in helping resolve the grievances described in Section 5.6.

4.7 Use of Names for Marketing. MCO shall permit Participating Physician and each of its Physicians to use MCO's name, address, telephone number, and any logo in its list of Payers with which Participating Physician participates. Participating Physician and each of its Physicians shall permit MCO to include the name, address, and telephone number of it or its Physicians in its list of Participating Physicians distributed to Enrollees; provided, however, that such rights shall not extend to the listing of such Physicians or Participating Physician in any newspaper, radio, or television advertising without the prior written consent of Participating Physician. Such material shall be factually accurate and in compliance with applicable law and ethical standards.

4.8 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of MCO or any Payer to intervene in any manner in the methods or means by which Participating Physician and its Physicians render health care services or procedures to Enrollees. Nothing herein shall be construed to require Participating Physician or Physicians to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Enrollees. Under no circumstances shall MCO or any Payer limit the free, open and unrestricted exchange of information between Participating Physician and/or its Physicians and Enrollees regarding the nature of the Enrollee's medical conditions or treatment and provider options and the relative risks and benefits and costs to the Enrollee of such options, whether or not such treatment is covered under the Enrollee's Plan, and any right to appeal any adverse decision by MCO or any Payer regarding coverage of treatment that has been recommended or rendered. MCO and all Payers agree not to penalize or sanction Participating Physician or its Physicians in any way for engaging in any free, open and unrestricted communication with an Enrollee with respect to the foregoing subjects or for advocating for any service on behalf of an Enrollee.

5. MCO's Obligations

5.1 List of Payers. MCO shall include as part of Exhibit C a list of each Payer and shall promptly update Exhibit C upon the addition or deletion of Payers. The Parties acknowledge that the intent of Sections 1.24, 3.1, and this Section 5.1 is to provide a mechanism for assuring that “rental networks” and similar arrangements do not accede to this Agreement or avail themselves of the discounts and arrangements established by the Parties through this Agreement.

5.2 Appeals of Adverse Decisions. Participating Physician shall have a right to appeal any adverse medical necessity, billing procedure, or coverage decision made by MCO. Such appeal shall be coordinated with any related appeal by the Enrollee filed at or prior to the time of the Participating Physician appeal. The appeal procedure shall be as follows:

5.2(a) Unless existing MCO policies provide for a more liberal rule, and except for utilization review decisions related to emergency care, which shall be expedited, written Notice of such appeal shall be given by either the Participating Physician to MCO on behalf of Plan no more than ten (10) calendar days following the contested decision.

5.2(b) MCO shall have five (5) calendar days after receipt of such Notice to appoint a licensed physician in the same or similar specialty not employed by MCO to hear the appeal, which shall be heard within ten (10) days. A decision will be communicated to the Parties no later than five (5) days after the hearing.

5.2(c) In any such appeal, a prior authorization for treatment granted by MCO shall be conclusive in determining whether payment for services or procedures should be made.

5.2.1 Adverse Billing Dispute Decision Post-Appeal Review

5.2.1(a) MCO shall establish an independent Billing Dispute External Review Board or Boards (the “Billing Dispute External Review Board”) for resolving disputes with Participating Physicians concerning (i) application of Payer’s coding and payment rules and methodologies to patient-specific factual situations, including without limitation the appropriate payment when two or more AMA CPT codes are billed together, or whether a payment-enhancing modifier is appropriate, or (ii) concerning whether Payer has complied with the provisions of this Agreement in requiring that the Participating Physician submit records, either prior to or after payment, in connection with Payer’s adjudication of such Participating Physician’s Claims for payments, or (iii) any Claim which was the subject of an appeal pursuant to Section 5.2 herein for which Participating Physician denies an additional review by the Billing Dispute External Review Board, provided that (x) such Claim is forwarded to the Billing Dispute External Review Board within ninety (90) days of Participating Physician’s receipt of the decision contemplated in Section 5.2; and (y) the appeal of such Claim is not based on the medical necessities of any services covered by such Claim (in which case the review procedure in Section 5.2.2 here are instead applicable). Each such matter shall be a “Billing Dispute.” The Billing Dispute External Review

Boards shall not have jurisdiction over any other disputes, including without limitation those disputes that fall within the scope of the Medical Necessity External Review Process set forth in Section 5.2.2 of this Agreement, compliance disputes, and disputes concerning the scope of Covered Services.

5.2.1(b) Any Participating Physician may submit Billing Disputes to the Billing Dispute External Review Board upon payment of a filing fee calculated as set forth in Section 5.2.1(e) and in accordance with the provision of this Section 5.2.1(b)(iv), after the Participating Physician exhausts MCO's internal appeals process, when the amount in dispute (either a single Claim for Covered Services or multiple Claims involving similar issues) exceeds \$500. MCO shall post a description of its provider internal appeals process on the Provider web site.

- i. Notwithstanding the foregoing, a Participating Physician may submit a Billing Dispute if less than \$500 is at issue and if such Participating Physician intends to submit additional Billing Disputes during the one (1) year period following the submission of the original Billing Dispute which involve issues that are similar to those of the original Billing Dispute, in which event the Billing Dispute External Review Board will, at the request of such Participating Physician, defer consideration of such Billing Dispute while the Participating Physician accumulates such additional Billing Disputes. In the event that a Billing Dispute is deferred pursuant to the preceding sentence and, as of the Termination Date, the Participating Physician has not accumulated the requisite amount of Billing Disputes and MCO has chosen not to continue the Billing Dispute process following the Termination Date, then any rights the Participating Physician had as to such Billing Disputes, including rights to arbitration, shall be tolled from the date the Billing Dispute was submitted to the Billing Dispute External Review Board through and including the Termination Date.
- ii. In any event, a Participating Physician will have one (1) year from the date of submission of the original Billing Dispute and notifies the Billing Dispute External Review Board that consideration of such Billing Dispute should be deferred to submit additional Billing Disputes involving issues that are similar to those of the original Billing Dispute and amounts in dispute that in aggregate exceed \$500. In the event such additional Billing Disputes are not so submitted pursuant to the preceding sentence, the Billing Dispute External Review Board shall dismiss the original Billing Dispute and any such additional Billing Disputes and, in that event, the filing fee will be refunded by MCO to the Participating Physician.
- iii. The filing fee shall be payable upon the submission of the original Billing Dispute and shall apply to all subsequent Billing Disputes submitted pursuant to the first sentence of Section 5.2.1(b)(ii) until the aggregate amount at issue exceeds \$1,000 at which time

additional filing fees will be payable in accordance with Section 5.2.1(e). The Participating Physician may withdraw the Billing Disputes at any time before the aggregate amount in dispute reaches \$500 and, in that event, the filing fee will be refunded by MCO to the Participating Physician.

- iv. The Participating Physician must exhaust MCO's internal appeals process before submitting a Billing Dispute to the Billing Dispute External Review Board; provided that a Participating Physician shall be deemed to have satisfied this requirement if MCO does not communicate Notice of a decision resulting from such internal appeals process within 45 days of receipt of all documentation reasonably needed to decide the internal appeal. In the event MCO and a Participating Physician disagree as to whether the requirements of the preceding sentence have been satisfied, such disagreement shall be resolved by the Billing Dispute External Review Board. Except as otherwise provided in Section 5.2.1(a), all Billing Disputes must be submitted to the Billing Dispute External Review Board no more than 90 days after a Participating Physician exhausts MCO's internal appeals process and the Billing Dispute External Review Board shall not hear or decide any Billing Dispute submitted more than ninety (90) days after MCO's internal appeals process has been exhausted. MCO shall supply documentation to the Billing Dispute External Review Board not later than 30 days after request by the Billing Dispute External Review Board, which request shall not be made, if Billing Disputes are submitted pursuant to Section 5.2.1(b)(ii), until Billing Disputes have been submitted involving amounts in dispute that in aggregate exceed \$500.
- (v) A Participating Physician submitting a Billing Dispute to the Billing Dispute External Review Board shall state in the documents submitted to the Billing Dispute External Review Board the amount in dispute. The Billing Dispute External Review Board shall not be permitted to issue an award based on an amount that exceeds the amount stated by such Participating Physician in the documents submitted to the Billing Dispute External Review Board to be in dispute.

5.2.1(c) Any Participating Physician who contests the appropriateness of MCO's requirement that such Participating Physician submit records, either prior to or after payment, in connection with MCO's adjudication of such Participating Physician's Claims for payments may elect not to utilize the internal review process and request that the Billing Dispute External Review Board grant expedited review of the MCO's requirement, if the Participating Physician demonstrates to the Billing Dispute External Review Board that MCO's requirement has a significant adverse economic effect on the Participating Physician which justifies expedited review. In the event that the Billing Dispute External Review Board determines that such Participating Physician has not so demonstrated the Billing Dispute External Review Board shall dismiss

such Claim without prejudice, pending the exhaustion by such Participating Physician of MCO's internal appeals process.

5.2.1(d) MCO shall select the organization(s) that shall constitute the Billing Dispute External Review Board. The MCO's choice must, at a minimum, include (i) a certified coder, (ii) a clinician, and (iii) an attorney knowledgeable in contractual and health care matter, none of whom have any type of financial relationship with MCO. With respect to Billing Disputes brought by Participating Physicians, the members of the Billing Dispute External Review Board shall be bound by the terms of the applicable agreement between the Participating Physician and MCO and the provisions of this Agreement. Otherwise, the Billing Dispute External Review Board shall resolve Billing Disputes based on generally accepted medical billing standards.

5.2.1(e) MCO's contract(s) with the Billing Dispute External Review Board or with members of the Billing Dispute External Review Board shall require decisions to be rendered not later than thirty (30) days after receipt of the documents necessary for the review and to provide Notice of such decision to the Parties promptly thereafter.

5.2.1(f) In the event that the Billing Dispute External Review Board issues a decision requiring payment by MCO, MCO shall make such payment within fifteen (15) days after MCO receives Notice of such decision.

5.2.1(g) MCO agrees to record in writing a summary of the results of the review proceedings conducted by the Billing Dispute External Review Board, including without limitation the issues presented.

5.2.1(h) If such Participating Physician elects to utilize this process, then any decision by the Billing Dispute External Review Board shall be binding on MCO and the Participating Physician.

5.2.2 Adverse Medical Necessity Decision Post-Appeal Review

5.2.2(a) Except as otherwise required by state law, MCO shall maintain a nationwide process permitting Participating Physicians to seek independent external review of MCO's determination that certain services or supplies are not Covered Services because they are not Medically Necessary or are experimental and investigational in nature. "Medical Necessity External Review Process" means any such process maintained by MCO (or afforded by O.C.G.A. § 33-20A-30) in each case as described in the preceding two sentences. MCO shall make arrangements to enable Participating Physicians to access each Medical Necessity External Review Process in circumstances in which a Plan Member could access that process under MCO's policy or applicable law. The terms on which Participating Physicians may access such process shall be identical to those applicable to Plan Members, except to the extent provided below in this Section 5.2.2.

5.2.2(b) Notwithstanding the provisions of Section 5.2.2(a), Participating Physicians may not seek review of any Claim for which the Plan Member (or his or her representative) seeks review through the Medical Necessity External Review Process. In the event that both Plan Member (or his or her representative) and Participating Physician seek review, the Plan Member's Claim shall go forward and the Participating Physician's Claim shall be dismissed and may not be brought by or on behalf of the Participating Physician in any forum.

5.2.2(c) Notwithstanding the provisions of Section 5.2.2(a), Participating Physicians may not seek review of any Claim for which the Plan Member (or his or her representative) has filed suit under § 502(a) of ERISA. In that event, or if such a suit is subsequently initiated, the Plan Member's lawsuit shall go forward and the Participating Physician's Claims shall be dismissed and may not be brought by or on behalf of the Participating Physician in any forum; provided that such dismissal shall be without prejudice to any Participating Physician seeking to establish that the rights sought to be vindicated in such lawsuit belong to such Participating Physician and not to such Plan Member.

5.2.2(d) Nothing contained in this Section 5.2.2 is intended, or shall be construed, to supersede, alter or limit the rights or remedies otherwise available to any person under § 502(a) of ERISA or to supersede in any respect the Claims procedures under § 503 of ERISA.

5.2.2(e) MCO shall maintain an internal appeals process for medical necessity denials and shall disclose such process on a public web site. MCO shall adjudicate all such appeals of medical necessity denials in the timeframes that are applicable to Plans subject to ERISA, regardless of whether such Plans are actually subject to ERISA. Upon the express request of a Participating Physician pursuing through such internal appeals process MCO's denial of coverage for that Participating Physician's service on the ground that such service is or was not Medically Necessary, before deciding such appeal, MCO shall consult with a specialist in the same specialty (or, in MCO's sole and absolute discretion, the same sub-specialty) as the Participating Physician appealing such decision. Participating Physician may access the Medical Necessity External Review Process only after exhausting any applicable MCO or Plan Sponsor internal appeals process.

5.2.2(f) Participating Physician shall initiate the Medical Necessity External Review Process by submitting to MCO a request for external review. That request shall be deemed timely if submitted by Participating Physician within the time frame specified in the communication from MCO to Plan Member advising of the adverse coverage determination. MCO shall forward timely requests to the applicable Medical Necessity Independent Review Organization. MCO shall make external review request forms available on a public web site.

5.2.2(g) To access the Medical Necessity External Review Process, Participating Physician shall pay a filing fee of \$50; provided that

if the matter involves services or supplies for which MCO requires pre-certification (other than pre-certification required for registration purposes only), then the filing fee shall be the lesser of \$250 or 50% of the Billing Dispute External Review Board's fees.

5.2.2(h) In the event the Medical Necessity External Review Process is initiated by a Participating Physician, the Medical Necessity Independent Review Organization shall request documentation from MCO promptly but in any event no later than five (5) Business Days after the Participating Physician pays the filing fee and MCO shall provide such requested documentation within ten (10) Business Days. The Medical Necessity Independent Review Organization shall provide a decision within thirty (30) days of MCO's submission of all necessary information.

5.2.2(i) MCO shall cause its contracts with each Medical Necessity Independent Review Organization to be consistent with the terms of this Section 5.2.2.

5.2.2(j) If the Participating Physician elects to utilize the Medical Necessity External Review Procedure, then any decision by the Medical Necessity Independent Review Organization shall be binding on both the MCO and the Participating Physician.

5.3 Administration. With respect to each Plan it offers or administers, MCO shall promptly and diligently perform all necessary administrative, accounting, enrollment, and other functions including, but not limited to, eligibility determination, claims review, data collection and evaluation and, if applicable, maintenance of medical, ancillary, and hospital group risk pools.

5.4 Payment by Parties other than MCO. In the event MCO contemplates that payment for services or procedures provided hereunder is to be made by a Payer other than MCO, and in the event that such payment is not received by Participating Physician within the time and under the conditions set forth in Section 3.10, MCO, within five (5) days of the receipt of written Notice from Participating Physician, shall make a written demand for payment to Payer on behalf of such Participating Physician.

5.4(a) In the event a Payer fails to make payment within thirty (30) days after receipt of such Notice, MCO shall either: (i) make such payment on behalf of the Payer; or (ii) initiate legal action to recover such payment on behalf of Participating Physician. Alternatively, at Participating Physician's request, MCO will assign to Participating Physician the right to initiate a legal action against Payer to recover such payment.

5.4(b) In the event of an occurrence described in Section 5.4, MCO shall tender to Participating Physician a copy of the Agreement that governs the relationship between MCO and Payer. The Participating Physician may rely on this Agreement in prosecuting an action to recover payment against Payer if Participating Physician elects to initiate such an action. MCO shall release Participating Physician, at Participating Physician's option, from any further obligation under this Agreement to provide services or procedures to Enrollees of Payer.

5.4(c) MCO shall notify Payer of the provisions of this Agreement and shall obligate Payer with respect to such provisions.

5.5 Cooperation in Credentialing. MCO and Participating Physician agree to cooperate in credentialing and re-credentialing Physicians in accordance with the process set forth on Exhibit D of this Agreement. MCO shall permit Physicians to submit applications prior to the time when the Physician(s) becomes actively employed or engaged by a participating physician group. MCO agrees to make final physician credentialing determinations within thirty (30) calendar days of receipt of an application and to grant provisional credentialing pending a final decision if the credentialing process exceeds thirty (30) calendar days. If a Physician is successfully credentialed, MCO shall retroactively compensate such Physician for services rendered from the date of his/her credentialing submission.

Exhibit D shall identify rights and obligations of MCO and the Physicians during the credentialing process. By way of example, Exhibit D shall specify the following:

5.5(a) The criteria to be used by MCO in its decision whether or not to credential or re-credential a Physician.

5.5(b) Identification of the internal process that MCO will use in making credentialing decisions.

5.5(c) Identification of the individual or committee that has authority to decide whether to grant or remove credentials.

5.5(d) Identification of the individual or committee to whom the initial decision maker is accountable.

5.5(e) Identification of how and when Physicians will be notified of credentialing decisions.

5.5(f) A requirement that an adverse decision state with specificity the reason for such decision.

5.5(g) A statement of the rights and duties of Participating Physician or a Physician in an appeal of an adverse credentialing decision, including the following elements:

- i. The deadline for filing an appeal.
- ii. Whether the appeal will be in writing or a live hearing.
- iii. What evidence the Physician and MCO may introduce.
- iv. The Physician's right to review the material prepared by MCO to support its adverse decision.
- v. What individuals within the MCO will review the appeal and have the final authority to make a decision and a statement of that person or, committee's qualifications to make credentialing decisions.
- vi. The deadline by which MCO must make a final decision following the appeal procedure and communicate the decision to the Physician.

- viii. Provisions for Notice and corrective action prior to an adverse credentialing decision becoming final.

5.5(h) In the credentialing of Physicians, MCO agrees that neither it nor its agents shall request that Physicians sign an information release broader than necessary to obtain the specific credentialing information sought, and MCO shall limit such request to that which is reasonable and necessary to achieving valid credentialing purposes.

5.6 Physician Grievances. MCO shall establish and maintain systems to process and resolve a grievance by a Physician toward MCO or a Payer. Such process shall be set forth in the procedures which are a part of Exhibit G. Any modification to the process or procedures set forth at Exhibit G requires the prior written consent of Participating Physician. In connection with such grievances, to the extent that confidential patient information is discussed or made part of the record, or confidential patient records are submitted to MCO, MCO shall either abstract such information or shall remove the name of the patient so that none of the information or records would allow a third party to identify the patient involved. The internal procedure for resolving such grievance will be presumed concluded in the event that such grievance is not resolved to the Parties' satisfaction within forty-five (45) days of the submission of such grievance and will allow either party to resort to the dispute remedies of Article 9.

5.7 Benefit Information. MCO shall advise and counsel its Enrollees and Participating Physician on the type, scope, and duration of benefits and services to which Enrollees are entitled pursuant to the applicable agreement between MCO or a Payer and Enrollees. Explanation of benefits ("EOB") forms for MCO's traditional products shall contain at least: the name of and a number identifying the Plan Member, the date of service, the amount of payment per line item, any adjustment to the invoice submitted and generic explanation of any such adjustment, and an address and phone number for questions regarding the Claim described on such EOB. Each EOB shall indicate the amount for which the Physician may bill the Enrollee and state "Physician may bill you" such amount, or contain language to substantially similar effect, and shall not characterize disallowed amounts as unreasonable. The explanation of payment or similar forms that MCO sends to the Physicians communicating the results of Claims adjudications shall contain at least: the name of and a number identifying the Plan Member, the date of service, the amount of payment per line item, the procedure code(s), the amount of payment, any adjustment to the invoice submitted and generic explanation therefore, as well as any adjustment or change in any code on a line by line basis, and shall specify an address and phone number for questions by the Physician regarding the Claim described on such explanation of payment or comparable form. The foregoing sentence is not intended and shall not be construed to limit MCO's right to replace the communications referred to in the preceding sentence (i.e., communications to Participating Physician) with electronic remittance advices or the equivalent, to the extent such electronic remittances or the equivalent provide similar information and are consistent with legal requirements.

5.8 Quality Improvement. Participating Physician and MCO are both committed to quality improvement. Evidence-based clinical quality of care measures are the primary measures used, and outcome measures are subject to the best available risk-adjustment for patient demographics and severity of illness. Clinical performance measures are developed and maintained by appropriate professional medical organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession. Physician participation in financial incentive programs is voluntary. MCO has a mechanism to allow Physicians ongoing participation in the development, assessment, and evaluation of quality management programs. MCO provides Physicians the opportunity to

review and appeal the accuracy of their personal data and data analysis. MCO's current Quality Improvement Initiatives are listed on Exhibit H. In the event any of these initiatives require Participating Physician to submit data, MCO agrees to provide Participating Physician with at least ninety (90) days advance written notice of all information that must be submitted, including any deadlines.

5.9 Provider Directories. MCO shall maintain a current provider directory available to Enrollees on the MCO web site and in hard copy. MCO shall include Participating Physician on all provider lists for plans set forth in Exhibit B.

5.10 Provision of Financial Information. MCO shall provide to Participating Physician, no less frequently than quarterly, a balance sheet and income statement (collectively, "Financial Statements") accurately depicting the financial condition of MCO. Such Financial Statements shall be prepared in accordance with generally accepted accounting principles and shall be provided on an audited basis to the extent available. Participating Physician acknowledges the confidentiality of such Financial Statements and shall not: (a) use such Financial Statements for any purpose other than evaluating the financial condition of MCO; or (b) disclose the Financial Statements, or any non-public information contained therein, to any third party, other than Participating Physician's attorneys or accountants, without the prior written consent of MCO. The obligations of Participating Physician under the immediately preceding sentence shall survive termination of this Agreement.

5.11 Licensure and Registration. MCO represents that it is and shall remain licensed and in good standing with the State of Georgia Department of Insurance and is registered and in good standing with the state in which it is chartered and each state in which it is doing business, including the State of Georgia.

5.12 Education, Information, and Communication. MCO shall provide information, education, training, and assistance in plain English to Participating Physician to assist in understanding the terms and obligations of the Parties hereunder, including, but not limited to, the operation and administration of the Plan(s) and any product(s), any fee schedule or exhibits to this Agreement, Covered Services, utilization and quality reports, software, edits, and financial reports. MCO will designate a provider relations specialist to assist Participating Physician with any issues hereunder. Contact information for such provider relationship specialist will be provided to Participating Physician as of the Effective Date. The provider relations specialist will be knowledgeable about this Agreement, the operations of MCO, and its policies and procedures and will assist in resolution of any issues in the implementation of this Agreement. MCO will notify Participating Physician pursuant to the provisions of Section 10.7 herein of any change in the identity or contact information of the provider relations specialist.

5.13 Conflicts. In the event of a conflict between the provisions of this Agreement and the agreement between MCO and Plan or Payer or any other policy, procedure, or document of the Plan or Payer, the provisions of this Agreement will govern.

6. Records and Confidentiality

6.1 Confidential Medical Records. All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws. All medical records shall

belong to Participating Physician. The release, disclosure, removal, or transfer of such records shall be governed by state and federal law and by the Participating Physician's established policies and procedures. The cost associated with copying medical records or any other records referred to in this Article VI shall be paid by MCO in accordance with the fees specified by O.C.G.A. §31-33-3. Any request by MCO for confidential medical records shall be limited to the minimum information necessary to accomplish the specific purpose for which MCO seeks the information. MCO may request access to each patient's medical records no more than once a month, absent extraordinary circumstances, the reasonableness of which shall be determined in Participating Physician's sole discretion. MCO shall counsel its employees, agents, and subcontractors on their obligations to ensure that such information remains confidential. Nothing herein shall be construed as granting to MCO any right of ownership in medical records of Enrollees.

6.2 Access to Records. MCO must make a written request for medical records and allow for ten (10) business days to receive such records. However, any review of the medical record by MCO must be narrowly tailored to the specific purpose for which the MCO seeks the information and must be in compliance with applicable state and federal laws, including but not limited to the federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996.

6.3 Other Confidential Information. The Parties agree that the sole items of information subject to confidentiality under this Agreement are: (i) medical information relating to individual Enrollees, so as to protect the patient's medical record as required by medical ethics and applicable federal and state law; (ii) the precise schedule of compensation to be paid to Participating Physician pursuant to Exhibit B; and (iii) such other information set forth in sections 6.3(a). Otherwise, all other information, including the general manner by which Participating Physician is paid under this Agreement and the general terms and conditions of this Agreement, may be shared with non-parties in the reasonable and prudent judgment of the Parties to this Agreement or Physicians.

6.3(a) Any financial or utilization information provided by Participating Physician to MCO or a Payer (including the Compensation schedule(s) set forth in Exhibit B) shall be maintained in strict confidence by MCO and each Payer and may not be disclosed by MCO or Payer to any third party or used by Payer for any purpose, other than: (i) to satisfy mandatory governmental or regulatory reporting requirements; (ii) for premium setting purposes; (iii) for Healthcare Effectiveness Data and Information Set ("HEDIS") reporting.

6.3(b) Nothing contained herein shall limit the free, open, and unrestricted exchange of information between Participating Physician and Enrollees regarding the nature of the Enrollee's medical conditions or treatment and provider options and the relative risks and benefit of such options, whether or not such treatment is covered under the Plan, and any right to appeal any adverse decision by MCO regarding coverage of treatment that has been recommended or rendered. MCO agrees not to penalize or sanction Participating Physician in any way for engaging in any free, open and unrestricted communication with an Enrollee or for advocating for any service on behalf of an Enrollee.

6.4 Designation Programs. Any Designation of Physician or Participating Physician shall include, at a minimum: (1) a quality of care component and a representation of the weight given to such quality of care factor; (2) accurate, valid, and reliable statistical analyses to adjust for

statistical anomalies; (3) a statistically significant period of assessment of data updated at appropriate intervals; (4) if data from Claims are used, accurate data appropriately attributed to the Physician or Participating Physician; (5) evidence and consensus-based practice performance measures that account for factors such as practice, location, and patient population; and (6) any other relevant information contributed by the Physician and/or Participating Physician with respect to these or other measures. Such designations shall be accompanied by a disclaimer in bold-faced, all capitals, large font type that states that the designation is intended only as a guide to choosing a Physician, contain a risk of error, should not be used as the sole factor in choosing a Physician, and should be discussed with the Physician before making any decisions. If the MCO uses a Designation Program, it shall disclose to Physician and/or Participating Physician a detailed written description of the methodology upon which the Designation is based and all data used in arriving at the Designation. Such information shall be provided in plain language and MCO shall provide any education necessary to explain such data or the methodology. Participating Physician shall have the right to appeal any such Designation pursuant to the provisions of Section 10.19 herein. In the event of violation of this Section 6.4, MCO acknowledges and agrees that such violation shall constitute deceptive trade practice, and Participating Physician may bring suit against MCO for the same, notwithstanding the provisions of Article 9 herein. O.C.G.A. § 10-1-370, *et seq.* For purposes of this Section 6.4, Designation shall mean an award, assignment, characterization, or representation of the cost efficiency, quality, or other assessment or measurement of the care or clinical performance of any Physician or Participating Physician that is disclosed or intended for disclosure to the public or Enrollees by use of a grade, star, tier, rating, profile, or any other form of designation.

7. Insurance

7.1 Participating Physician Insurance. Participating Physician shall require each Physician to maintain, at all times, in limits and amounts standard in the community, a professional liability insurance policy and other insurance as shall be necessary to insure such Physician against any claim for damages arising directly or indirectly in connection with the performance or non-performance of any services or procedures furnished to Enrollees by such Physician. In the event that Participating Physician discovers that such insurance coverage is not maintained, Participating Physician shall immediately upon making such discovery ensure that such Physician discontinues the delivery of Covered Services to Enrollees until such insurance is obtained. Evidence of such coverage shall be tendered to MCO by Participating Physician upon MCO's request.

8. Term and Termination

8.1 Term. This Agreement shall commence on the Effective Date and, unless earlier terminated or amended pursuant to the provisions hereof, shall continue in full force and effect for a period of twenty-four (24) months therefrom. Thereafter, this Agreement shall automatically renew for successive twelve (12) month periods unless MCO or Participating Physician provides the other with written Notice of its intent to terminate not later than sixty (60) calendar days prior to a respective twelve (12) month anniversary of the Effective Date.

8.2 Negotiation of Renewal of Exhibits A and B. Not later than ninety (90) days prior to each twelve (12) month anniversary of the Effective Date, a Party wishing to revise Exhibit A and/or Exhibit B or any of the schedules affixed thereto shall provide Notice in writing of such desire to the other Party, along with the new terms proposed. Within sixty (60) days thereafter, the Parties shall mutually agree to a new Exhibit A and/or Exhibit B, as applicable. If the Parties are unable to come to such mutual agreement, either Party may notify the other within ten (10) days following the deadline for such agreement that it intends to terminate this Agreement in its entirety or with respect to one or more specific Plans reflected on a schedule. In such event, this Agreement (in the case of termination of all Plans) or the Agreement with respect to a particular Plan or Plans, shall be terminated sixty (60) days after such Notice of intent to terminate. Notwithstanding any provision contained in this Agreement to the contrary, Exhibits A and B hereto shall not be amended, revised, or otherwise altered in any way during the term of this Agreement, except as provided in this Section 8.2, or except as otherwise agreed in a writing signed by both Parties.

8.3 Termination for Cause. If either Party shall fail to keep, observe, or perform any covenant, term, or provision of this Agreement applicable to such Party, the other Party shall give the defaulting Party Notice that specifies the nature of such default. If the defaulting Party shall have failed to cure such default within thirty (30) days after the giving of such Notice, the non-defaulting Party may terminate this Agreement upon five (5) days Notice. However, it shall be grounds for immediate termination if: (i) MCO should lose its license to underwrite or administer Plans; (ii) any Physician suffers a loss or suspension of medical license, a final unappealable loss of hospital medical staff privileges for reasons that would require reporting to the National Practitioner Data Bank pursuant to the requirements of the Health Care Quality Improvement Act of 1986, or a conviction of a felony, and upon Notice to Participating Physician, Participating Physician fails to immediately remove such Physician from the provision of services and procedures to Enrollees hereunder; (iii) MCO fails to pay Claims within thirty (30) days; or (iv) MCO files for bankruptcy.

8.4 Voluntary Termination. Either Party may terminate this Agreement or Participating Physician participation in any Plan with or without cause upon one hundred twenty (120) days written Notice to the other Party specifying whether the termination relates to a specific Plan or to the Agreement generally. The terminating Party shall state the reason for such termination. In the event of a voluntary termination, neither Party shall be foreclosed from participation in the dispute resolution procedures described in Article IX.

8.5 Termination for Failure to Satisfy Financial Obligations. This Agreement may be terminated in its entirety or with respect to a Payer by either party upon five (5) days written Notice if either Party, or in the case of termination by Participating Physician, a Payer is: (a) more than sixty (60) days behind its financial obligations to its creditors; (b) is declared insolvent; (c) files in any court of competent jurisdiction: (i) a petition in bankruptcy; (ii) a petition for protection against creditors; (iii) an assignment in favor of creditors or has such a petition filed against it that is not discharged within ninety (90) days; or (d) fails to pay Claims on time.

8.6 Effect of Termination. This Agreement shall remain in full force and effect during the period between the date that Notice of termination is given and the effective date of such termination. As of the date of termination of this Agreement, except as provided by Section 10.13, this Agreement shall be of no further force and effect, and each of the Parties shall be discharged from all rights, duties, and obligations under this Agreement, except that MCO shall remain liable for Covered Services then being rendered by Physicians to Enrollees who retain eligibility under the applicable Plan or by operation of law until the episode of illness then being

treated is completed and the obligation of MCO to pay for Covered Services rendered pursuant to this Agreement is discharged. However, any Enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from Participating Physician for a period of up to sixty (60) days from the date of the termination of this Agreement. In addition, any Enrollee who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of this Agreement shall have the right to continue receiving health care services from Participating Physician throughout the remainder of that pregnancy, including six (6) weeks' post delivery care. During such continuation of coverage period, Participating Physician shall continue providing such services in accordance with the terms of this Agreement, and the MCO, and all agents thereof shall continue to meet all obligations of this Agreement. The Enrollee shall not have the right to the continuation provisions provided in this Section 8.6 if the Agreement is terminated because of the suspension or revocation of Physician's license (in accordance with Section 8.3) or if the MCO reasonably determines that Physician poses a threat to the health, safety, or welfare of Enrollees. Payment for such services and procedures shall be made pursuant to the fee schedule contained on Exhibit B or, if Exhibit B does not contain a fee schedule, at the billed charges of the Physician performing the services or procedures.

8.7 Removal of Physician. If any Physician ceases to be credentialed by the MCO or causes Participating Physician to be in breach of this Agreement, MCO shall give Participating Physician written notice specifying such breach and requesting cure of such breach or removal of Physician as a Physician for purposes of the provision of Covered Services hereunder. Participating Physician shall have thirty (30) days from receipt of such notice to either cure such breach or remove Physician as a Physician for purposes of the provision of Covered Services hereunder. In the event that Participating Physician does not cure such breach or remove such Physician, MCO may terminate this Agreement.

9. Dispute Resolution.

9.1 Non-Binding Arbitration. [Unless one Party has previously filed suit in a court of competent jurisdiction regarding the same disputed issue,] either Party may submit any dispute arising out of this Agreement to non-binding arbitration. Any such arbitration shall be held in the state where the services or procedures at issue in the dispute were or are to be performed. Arbitration shall be conducted pursuant to either the rules of the American Arbitration Association or the American Health Lawyers Association Alternative Dispute Resolution Center. The arbitrator shall be selected on the mutual agreement of both Parties and shall be an attorney and member of the National Academy of Arbitrators or the American Health Lawyers Association. If the Parties cannot agree on an arbitrator, an arbitrator shall be appointed by the American Health Lawyers Association Alternative Dispute Resolution Center.

9.2 Arbitration Expenses. If Participating Physician prevails in the arbitration, MCO shall be responsible for Participating Physician's costs and expenses related to the arbitration, including its expenses and attorneys' fees and also 100% of the administrative fees and expenses of the arbitration and arbitrator's fees. In any arbitration between an MCO and a Physician who practices individually or in a Participating Physician of less than five physicians, the maximum amount of the arbitration administrative fees and expenses and arbitrator's fee payable by such Physician shall be the lesser of (i) fifty percent (50%) of the total of such

expenses and fees or (ii) One Thousand Dollars (\$1000), and the remainder of the arbitration administrative fees and expenses and arbitrator's fee shall be payable by the MCO.

10. Miscellaneous

10.1 Nature of Relationship with Participating Physician. In the performance of the work, duties, and obligations of Participating Physician under this Agreement, it is mutually understood and agreed that Participating Physician and each of its Physicians are at all times acting and performing as independent contractors.

10.2 Governing Law and Jurisdiction. This Agreement shall be governed by and construed in accordance with the applicable federal laws and regulations and the laws of the State of Georgia, including but not limited to the "any willing provider" provisions of Georgia law. Except as provided in Article 9 above, any and all disagreements shall be subject to exclusive jurisdiction in the Court in _____ County, Georgia. The Parties waive any objection as to venue, forum, or jurisdiction. Nothing contained in this Agreement is intended to, or shall, in any way reduce, eliminate or supersede any Party's existing obligation to comply with applicable provisions of relevant state and federal law and regulations, and MCO shall comply with state and federal law and regulations. Nothing herein shall waive Participating Provider's rights to participate in any class action lawsuit.

10.3 Assignment. MCO may not assign this Agreement without Participating Physician's prior written consent, except that MCO may assign this Agreement to an entity related to MCO by ownership or control as of the Effective Date; provided, however, MCO must notify Participating Physician at least one hundred and twenty (120) days in advance of such assignment. Participating Physician may not assign this Agreement without MCO's prior written consent, except that Participating Physician may assign this Agreement to an entity related to Participating Physician by ownership or control or to any successor organization without MCO's prior written consent. Nothing in this provision shall be interpreted to permit renting or leasing of Participating Physician's services or fee schedule to entities that are not owned or controlled or a successor in interest of the MCO. MCO shall recognize all valid assignments by Enrollees of Plan benefits to Physicians.

10.4 Waiver. No waiver by either Party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions.

10.5 Force Majeure. Performance of obligations hereunder shall be excused to the extent delay or failure is caused by an event of "force majeure," such as from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work interruptions by either Party's employees, or any other cause beyond the reasonable control of either party; provided the affected Party gives written Notice of the delay to the other Party and uses reasonable best efforts to cure such failure or delay.

10.6 Time is of the Essence. Time is of the essence in this Agreement. The Parties shall perform their obligations within the time specified.

10.7 Notices. Any Notice required to be provided to any Party to this Agreement shall be in writing and shall be considered effective as of the date of deposit with the United States Postal

Service by certified or registered mail, postage prepaid, return receipt and addressed to the Parties as set forth below:

If to MCO:

If to Participating Physician:

or to such other address, and to the attention of such other person or officer as either Party may designate in writing.

10.8 Severability. In the event any portion of this Agreement is found to be void, illegal, or unenforceable, the validity or enforceability of any other portion shall not be affected.

10.9 Third-Party Rights. This Agreement is entered into by and between the Parties and for their benefit. There is no intent by either Party to create or establish a third-party beneficiary status or rights in a third party to this Agreement, except for Enrollees or as such rights are expressly created and as set forth in this Agreement. Except for such Parties, no such third party shall have any right to enforce or any right to enjoy any benefit created or established under this Agreement.

10.10 Entire Agreement. This Agreement and its Exhibits incorporate completely all of the terms of the arrangement between MCO and Participating Physician, and there are no others in addition to those stated herein. This Agreement supersedes any prior agreements, promises, negotiation, or representations, either oral or written, relating to the subject matter of this Agreement. Any manual, policies, procedures, or guidelines of MCO not attached as Exhibits hereto are outside of the scope of this Agreement and shall not modify or otherwise affect the terms of this Agreement.

10.11 Notification of Legal Matters. If any action is instituted against either Party relating to this Agreement or any services provided hereunder, or in the event such Party becomes aware of facts or circumstances which indicate a reasonable possibility of litigation with any Payer utilizing Participating Physician, any Enrollee, or any other third person or entity, relevant to the rights, obligations, responsibilities, or duties of the other Party under this Agreement, such Party shall provide timely Notice to the other, and the other Party shall reasonably cooperate with the first Party in connection with the defense of any such action by furnishing such material or information as is in the possession and control of the other Party relevant to such action.

10.12 Amendment. This Agreement may not be modified without the express written approval of both Parties.

10.13 Survival. Notwithstanding any provisions contained herein to the contrary, the obligations of the Parties under Articles III, VI, and IX shall survive termination of this Agreement.

10.14 Exhibits. All Exhibits are incorporated by reference into this Agreement and shall be attached to this Agreement at the time of execution. Exhibits may be modified or amended only

upon the mutual, written agreement of both Parties; any modification to an Exhibit or the information, policies or procedures contained therein without the written consent of both Parties shall be null and void.

10.15 Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same document.

10.16 Indemnification. MCO shall not require Participating Physician to indemnify MCO for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges, incurred in connection with any Claim or action brought against MCO based on MCO's management decisions, utilization review provisions or other policies, guidelines or actions.

10.17 Change in Law. In the event of a change in federal, state or local law, any of which could, in either Party's reasonable judgment and as supported by a written legal opinion of that party's attorney, materially and adversely affect the manner in which either Party may perform services under this Agreement, the Parties shall work in good faith to promptly amend this Agreement to comply with the law, regulation, or policy and approximate as closely as possible the arrangements set forth in this Agreement as it existed immediately prior to the change in law, regulation or policy. Any such amendment requires the written consent of both parties. If, however, one party disagrees in good faith and, in that Party's reasonable judgment as supported by a written legal opinion of that Party's attorney, does not believe that an amendment is warranted, then, notwithstanding anything to the contrary in the Agreement, this Agreement may be terminated without penalty upon the provision of a five (5) day written Notice to the other Party.

10.18 No Covenant Not to Compete. Nothing herein shall limit Participating Physician's ability to negotiate or execute an agreement to serve as a provider of services for any other Payer, managed care company or employer, whether during the life of this Agreement or at any point thereafter.

10.19 Standard Appeals Process. For any appeal to which Participating Physician is entitled for which a specific appeals process is not otherwise provided in this Agreement, at a minimum, such appeal shall include the following three stages. First, Participating Physician shall have the right to appeal to the Payer Representative, in writing. The Payer Representative shall make good faith efforts to resolve the issue being appealed and provide the Participating Physician with a written response to the issue within ten (10) business days of receipt of the same. If Participating Physician is not satisfied with the outcome of the Payer Representative's good faith efforts to resolve the issue being appealed, Participating Physician shall have the right to appeal, in person at Participating Physician's election, to a panel constituted by the Payer to hear the appeal. Such appearance shall be scheduled within thirty (30) days of such request, if an in person appearance is requested by Participating Physician. Such panel shall consist of members appointed by the Payer, but, at a minimum, where clinical issues are involved, shall include a physician who is currently practicing medicine and is board certified in the specialty at issue in the appeal. Such panel shall provide Participating Physician Notice of its decision within ten (10) business days of such appeal – either the date of Participating Physician's appearance or receipt of the written appeal. Finally, if the outcome of such appeal is unsatisfactory to Participating Physician, the Participating Physician shall have the right to appeal to the Executive Board of the Payer, which shall render its decision, in writing, and

provide Notice of same to Participating Physician, within ten (10) business days of such appeal – either the date of Participating Physician’s appearance or receipt of the written appeal.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

PARTICIPATING PHYSICIAN

By: _____

Title: _____

MCO

By: _____

Title: _____

EXHIBIT F

- Exhibit A – Covered Services
 - Exhibit B – Fee Schedules
 - Exhibit C – List of Payers
 - Exhibit D – Credentialing Criteria and Process
 - Exhibit E – Payer Policies and Procedures
 - Exhibit F – Georgia Code Mandated Covered Services
 - Exhibit G – Physician Grievances
 - Exhibit H – Quality Improvement Initiatives
-