BILLING CHECKLIST
(Complete checklist as applicable to the Local Public Health Department)

Payer Name: _____ Date:_____

PRECONTRACTING CONSIDERATIONS:	Yes	No	N/A
1. Have you asked, received and reviewed financial statements?	___*	___	___

Comments regarding financial statements (attach copy).
_____
_____
_____

2.	Have you called the state regulatory agency and:			
	a. reviewed records there?	___*	___	___
	b. verified licensure?	___*	___	___
	c. verified type and amount of insurance the MCO carries?	___*	___	___
	d. ascertained that the MCO is accredited and by whom?	___*	___	___
	e. ascertained compliance/complaints/lawsuits pending?	___*	___	___

Specify:_____
_____
_____

3. Who owns the managed care organization? _____
_____

a. Who are the medical directors of the MCO? _____
_____
_____
_____

b. How long has the MCO been in business? _____

c. Is the MCO a "for profit" or "not for profit" entity? _____
_____

d. What type of legal entity is the MCO? _____
_____

e. What are the MCO's growth projections? _____
_____
_____

		Yes	No	N/A
4.	Have you consulted with other contracting providers?	___*	___	___
	If so:			
	a. Is the performance consistent with projections?	___*	___	___
	b. What is the age of accounts receivable? _____			
	c. Is there a history of unjustified claim denials?	___	___*	___
	d. What is the reputation of these providers? _____			
	_____			
	_____			
	e. Are there administrative or procedural problems?	___	___*	___
	If so, what are they? _____			
	_____			
	_____			
	_____			

5. What are the following demographics:

a. the number of enrolled or covered lives:_____

b. annual disenrollment rate for the MCO: _____

c. annual physician & hospital turnover rate:_____
_____

d. the age and marital status groups percentages of the enrolled or covered lives:_____
_____
_____
_____

e. the key employer groups offering HMO or PPO:
_____
_____

f. the extent of the network in the area, i.e.:
What hospitals?_____
_____
_____
How many physicians and where are they located?
_____
_____
The inpatient days per 1000 enrollees and average length of stay for the MCO?

TYPES OF SERVICES:			Yes	No	N/A
1.	Does the agreement require physicians to provide care for a certain number of patients?		___	___*	___
2.	Does the agreement require physicians to be available to all patients who visit the physician?		___	___*	___
3.	How many new patients will the MCO provide to the practice? _____				
4.	How many established patients will switch to this MCO? _____				
5.	Does the MCO have Medicare and/or Medicaid contracts?		___	___	___
6.	Is the physician provided a detailed list of services to be provided that will be included for an upfront fee (capitation)?		___*	___	___
	a.	Are expensive services carved out or differently priced from the all-inclusive fee or capitation?	___*	___	___
	b.	Do any of the services have to be subcontracted for?	___	___	___
	c.	Is the Provider obligated to pay or to arrange for out-of-area services or emergency services rendered anywhere?	___	___	___
	d.	Is there a provision which allows the HMO to add services without any change in the capitation, or with a unilaterally determined change?	___	___*	___
7.	Does the agreement contain a provision that requires the group to provide services under a different standard of care than otherwise required by state law?		___	___*	___
8.	Does the agreement state that the physician agrees to provide care "of the highest quality"?		___	___*	___
9.	Is there a minimum enrollment guaranty (i.e., minimum compensation until enrollment targets are met)?		___*	___	___
	a.	Is there a fee-for-service schedule outlined that will revert In the event the number of enrollees falls below a designated actuarial minimum?	___*	___	___
10.	Is the Provider's obligation to provide services subject to availability of services, verification of eligibility and coverage, and utilization review?		___*	___	___

		Yes	No	N/A
11.	Does the definition of “emergency services” include what a “prudent person” would expect?	___*	___	___
12.	What programs are included in the contract and does participation in one mandate participation in all?	___	___*	___
	a. Can the MCO add programs in the future?	___	___*	___

PRICE

1.	Is payment based on discount off full charges?	___	___	___
	a. If yes, is the size of the discount dependent upon the volume?	___	___	___
2.	Is payment based on fee-for-service?	___	___	___
	a. If yes, does the contract state whether a discount is applied to the physician's charge or a standardized charge that may be based on community charges?	___	___	___
	b. Does the contract state that the fee-for-service reimbursement will be based upon a fixed rate for the service to be rendered?	___*	___	___
	c. Do you have a copy of the fee schedule?	___*	___	___
3.	Is payment based on an all-inclusive per diem charge?	___	___	___
4.	Does the contract specify the method for determining maximum charges?	___*	___	___
5.	Is reimbursement under the contract based on capitation or other risk sharing devices?	___	___	___
	a. If yes, does the contract breakout payment amounts based on age and sex?	___*	___*	___
6.	Is payment based on a combination of methods:			
	a. different per diems for different levels of care or types of service?	___*	___	___
	b. per diems with excluded items paid for on a fee-for-service or discount off charge basis?	___*	___	___

c. stop-loss (when actual charges reach a certain prenegotiated level, revert to alternative payment method)? ___ ___ ___

	Yes	No	N/A

7. How much cash flow will this MCO create for the practice?

   Gross: _____
   Net: _____

8. Does the contract have a "most favored nation" clause, which compels the Provider to offer the PPO/Payor the lowest rate given to any payor? ___ ___* ___

9. Is the confidentiality of rates maintained? ___* ___ ___

PAYMENT AND BILLING:

1. Does the managed care entity agree to provide payment for services within 45 days after the bill is received for a clean claim fee-for-services arrangements? ___* ___ ___

   a. If not 45 days, what is the time period?_____

2. Are claims that require additional information redirected back to the provider within 45 days and then paid within 30 days of receipt? ___* ___ ___

   a. If not, what is the time periods? _____

3. For services provided on a capitation basis, are fees paid at the beginning of the month in which services may be rendered? ___* ___ ___

4. Does the contract contain a provision for interest charges on delinquent payments? ___* ___ ___

   a. Is the interest, prime plus 3%? ___* ___ ___
   b. If not, what is the interest rate? _____
   c. If not, is the discount eliminated when the payment is delinquent? ___* ___ ___

5. What is the payment amount for services rendered to patients who are retroactively assigned? _____
   _____
   _____

6. Who pays for services rendered to patients who are retroactively disenrolled and what is the payment rate? _____
   _____

_____
_____

		Yes	No	N/A
7.	Are the billing requirements specifically stated in the contract?	___*	___	___
8.	Are "Covered Services" clearly defined and, in fee-for-service arrangements, limited to those in fact provided by the Provider as of the date of the contract and covered by the plan?	___*	___	___
9.	Does the contract give the Provider the ability to charge beneficiaries for non-covered services at full charges?	___*	___	___
	a. Do non-covered services include those which are determined not to be medically necessary?	___	___	___
	b. Is it required that you obtain patient's authorization prior to performing "Non-medically necessary" services in order to bill patient?	___	___	___
10.	If the contract is with a PPO, and there will be no contractual Payor-Provider relationship (and therefore no Payor obligation to pay), are any of the following rights included to help protect the Provider:			
	a. Right to approve each Payor?	___*	___	___
	b. Right to receive full charges if the provider is not paid on a timely basis?	___*	___	___
	c. No obligation of the Provider to provide services to beneficiaries of any Payor in default of its payment obligations (except as required by law, i.e. excluding emergencies)?	___*	___	___
	d. Provider's ability to terminate the PPO contract with respect to individual defaulting Payors without terminating the entire contract?	___*	___	___
	e. Provider's right to collect unpaid charges from beneficiaries, unless prohibited by law (applicable to PPOs not HMOs)?	___*	___	___
11.	Does the contract preserve the Provider's right to collect and retain coordination of benefits (COB)?	___*	___	___
	a. If so, does the contract clarify that third party payments pursuant to COB is an exception to the Provider's agree-			

ment to accept the contract rates as "payment in full", in order to preserve the right to balance bill the secondary carriers? ___* ___ ___

		Yes	No	N/A
b.	Does the contract require the Provider seek collection for excessively long periods from primary carriers before billing the contracting Payor who is secondary?	___	___*	___
c.	Is there a provision requiring assignment of COB collections?	___	___*	___
d.	Is the contracting Payor required to pay as secondary carrier the difference between full charges and amounts collected from the primary carrier?	___*	___	___
12.	Is the Payor required to provide current information regarding co-payments and deductibles on which the Provider can conclusively rely?	___*	___	___
a.	Does the contract prohibit billing co-payments until the claim has been reviewed by the Payor?	___	___*	___
13.	Is there an arrangement where funds are handled by the PPO?	___	___*	___
14.	Is a forfeiture in payment required for delayed billing or are there very short periods within which to submit claims?	___	___*	___
a.	If not, is there a "best efforts" provision in which to submit claims on time?	___*	___	___

b. What is the time frame to submit claim? _____
_____

c. What information is required for a "clean claim"?
_____
_____
_____

15.	Is the Provider liable for overpayments made by the MCO? What is the method for recovery of these amounts?	___	___*	___
16.	Does the Provider need stop-loss protection?	___	___	___
a.	If so, is it available from the HMO?	___	___	___

i. If so, are services heavily discounted when calculating

		Yes	No	N/A
	the stop-loss limits?	___	___*	___
b.	Is it required that it be purchased from the HMO?	___	___*	___

		Yes	No	N/A
17.	Can the provider look “solely” to the Payor for payment of all covered services?	___*	___	___
18.	In the event that a Payor refuses to make payment within 60 Days, can the MCO make payment on behalf of the Payor?	___*	___	___

RISK POOL, WITHHOLD AND CAPITATION SPECIFICATIONS:

1.	Does the MCO use primary gatekeeping physicians?	___	___	___
2.	Does the agreement contain a risk pool concept?	___	___	___
a.	If yes, are the expression of the withhold and the basis upon which it is returned precisely set forth?	___*	___	___
b.	Is the risk pool return based upon the performance of:			
1.	The group's practice alone?	___*	___	___
2.	The physicians in the same specialty?	___	___	___
3.	Physicians in general?	___	___*	___
c.	Is the method of allocation of the risk pool equitable?	___*	___	___
1.	Is the allocation formula clear?	___*	___	___
2.	Does the HMO also share in the savings?	___	___	___
d.	Is the risk pool return impacted by hospital costs?	___	___*	___
e.	Does the risk pool earn interest prior to its distribution?	___*	___	___
3.	Is the time allotted for return of the withhold specified?	___*	___	___
a.	If yes, is it within 30 - 60 days after the conclusion of the operating year of the plan?	___*	___	___
b.	Do the withholds bear interest?	___*	___	___
c.	Is there a ceiling on the reserves?	___	___	___
d.	Is there a mechanism for Provider to approve the payments?	___	___	___

e. Are payments limited to network/contracting providers? ___ ___ ___

f. Is there a date by which the provider can have access to records to verify the calculation of the withhold? ___* ___ ___

	Yes	No	N/A
4. Does the agreement contain a provision for a bonus pool?	___	___	___
a. If yes, is the language specific enough to determine what can be earned?	___*	___	___
b. Is there a provision in which the HMO/PPO can discontinue the bonus pool at their discretion?	___	___*	___
5. Is an actuarial study needed to determine whether the capitation payment is reasonable and whether the agreement is financially viable for the Provider?	___	___	___

a. When is the capitation payment due? _____
_____
_____

6. Are payments tied to collection of premiums?	___	___*	___

7. How are patients assigned for capitation purposes? _____
_____
_____

8. Does the contract have a "force majeure" clause?	___	___	___
If so, does it excuse both parties mutually?	___*	___	___

UTILIZATION REVIEW:

1. Does the agreement require participation in a utilization review program?	___	___	___
a. If yes, does the agreement give details concerning the extent of the program?	___*	___	___
2. Does the agreement reference the current utilization review and quality assurance activities?	___*	___	___
a. If yes, is the utilization review program consistent with the quality of care rendered by the group so as not to interfere with the current practices of the group?	___*	___	___

3. Does the Provider have the right to review and approve all plans before being bound to comply? ___* ___ ___

	Yes	No	N/A
4. Are there forfeitures for administrative errors?	___	___	___
a. If so, explain:_____ _____ _____			
b. Are authorizations conclusive?	___	___*	___
c. If authorization procedures are not followed, can payment be denied even if the services would have been approved prospectively on the basis of medical necessity?	___	___*	___
d. Who is responsible to notify patients of denials? _____ _____			
e. Do the physicians, hospital and patients have a fair appeals process?	___*	___	___
5. Are there other administratively burdensome or intrusive procedures?	___	___*	___
a. If so, what are they? _____ _____ _____ _____			
6. Will the Provider be assuming utilization review and other administrative responsibilities?	___	___	___
a. If so, will the Provider receive extra compensation for these services?	___*	___	___
7. Is there a mechanism to appeal UR/QM decisions?	___*	___	___
a. If so, is it by independent peers?	___*	___	___

RELATIONSHIP BETWEEN PARTIES:

1. Is the relationship between the parties that of an independent

		Yes	No	N/A
	contractor?	___	___	___
2.	If the contract is assignable to a third party, is it for only closely related or through notice and approval by the other ?	___*	___	___
3.	Does the contract include indemnities that provide for "sole" responsibility of Provider, or which might otherwise cover the acts or omissions of others, which are overbroad, and which include defense?	___	___*	___
	a. If indemnity is required, is it mutual?	___*	___	___
	b. Does the Payor's indemnity include utilization review activities performed by third parties?	___*	___	___
	c. Has the indemnity been reviewed by the Provider's attorney and insurance carrier?	___*	___	___
4.	Is there a grievance procedure specified?	___*	___	___
5.	Is there an arbitration clause in the agreement?	___*	___	___
	a. If so, is there provision for arbitration of malpractice claims with the consent of the Provider's insurance carriers?	___*	___	___
	b. Is the right to conduct discovery in connection with any arbitration proceeding specified?	___*	___	___
	c. Are the attorney's fees and costs awarded to the prevailing party rather than shared equally by the parties?	___*	___	___
	d. Is the arbitration binding?	___*	___	___
6.	Is there an “Initial meeting” and mediation for disputes provision?	___*	___	___
	a. If after 60 days the dispute remains unresolved, can they submit to binding arbitration with a 10 day notice?	___*	___	___
7.	Is the managed care entity required to provide an up-to-date patient list by a certain date?	___*	___	___
8.	Does the contract include provisions allowing the entity to retroactively add or delete patients from the list?	___	___*	___
9.	Does the contract require exclusivity on the part of the provider?	___	___*	___
	a. Is the provider prohibited from discounting fees to anyone else?	___	___*	___

RELATIONSHIP WITH BENEFICIARIES:

		Yes	No	N/A
1.	Does the Provider retain the right to review and approve patient grievance procedures before being bound to comply?	___*	___	___
2.	Does the contract specify a convenient method for verification of eligibility and coverage?	___*	___	___
3.	Are there any over-inclusive non-discrimination clauses?	___	___*	___
4.	Are the federal and state HMO law requirements/prohibitions limited to HMO enrollees?	___*	___	___

TERMS OF RENEWAL:

1.	Does the agreement have a specified term?	___*	___	___
	a. If yes, is the term in excess of one year?	___	___*	___
	b. How long is the term? _____ _____			
2.	Does the agreement automatically renew without action prior to the renewal date?	___	___*	___
	a. If yes, is there an incentive to renegotiate rates timely?	___	___	___

TERMINATION:

1.	Does the agreement specify the reasons which allow either party to terminate the agreement prior to the original expiration date?	___*	___	___
2.	Does the agreement allow the medical group to terminate the agreement if the managed care entity fails to provide its services and obligation?	___*	___	___
3.	Is either party able to terminate without cause within 120 days?	___*	___	___
	a. If not, how quickly? _____			
	b. If multiple payor PPO, does the Provider have the right to terminate individual Payors without terminating the entire contract?	___*	___	___
4.	Can the non-defaulting party terminate after 5 days, if a 30 day notification has been given?	___*	___	___
	a. If not, how quickly with cause? _____ _____			

5. Does the Payor/PPO have the ability to terminate Provider's contract on vague standards? ___ ___ ___

6. Are there excessive continuing care obligations which make other termination rights meaningless? ___ ___* ___

7. Does the agreement state that upon termination, patients' medical records must be photocopied without charge by the medical group and forwarded to the new provider? ___ ___* ___

	Yes	No	N/A
8. Does the agreement address patients who are hospitalized upon the termination date?	___*	___	___
a. If yes, does the agreement contain a provision for a continuation of payments under the previous contract for patients who are hospitalized on the termination date?	___*	___	___
9. Does the agreement address the fate of existing patients?	___*	___	___
a. If yes, does the agreement terminate the relationship of existing patients under the managed care plan as soon as possible?	___*	___	___
1. If not, does it provide that:			
a. the entity will not assign new patients to the group from a particular employer?	___*	___	___
b. it will reassign all patients as quickly as possible?	___*	___	___
c. the obligation to continue treatment for any particular patient will cease upon the first anniversary date that occurs for that patient's group policy?	___*	___	___
b. Is it the responsibility of the HMO/PPO to notify Covered Individuals the termination of a Provider Agreement?	___*	___	___
10. Even after the agreement is terminated, does the compensation, confidentiality, and dispute resolutions provisions survive?	___*	___	___

CONFIDENTIALITY AND ACCESS TO MEDICAL RECORDS:

1. Does the agreement contain any general statements which obligate the medical group to keep confidential certain information

		Yes	No	N/A
	designated by the managed care entity?	___*	___	___
	a. If yes, do the provisions specify a procedure to identify information to be kept confidential?	___*	___	___
2.	Does the agreement contain provisions with respect to the access of medical records by the managed care entity and other third parties?	___*	___	___
	a. If yes, does the provision reference compliance with state law?	___*	___	___
	b. Does the provision require that all photocopying costs be borne by the medical group?	___	___*	___
	c. Does the provision require the MCO to obtain a release from the patient if it wants information?	___*	___	___

REFERRAL RESTRICTIONS:

1.	Does the agreement contain a provision restricting the referral and admission of patients to certain physicians and other facilities?	___	___	___
	a. If yes, is the medical group satisfied that the available physicians and facilities available for referral are consistent with good quality practice?	___	___	___
2.	Does the contract clearly specify referral obligations?	___*	___	___

COMPLIANCE:

1.	Does the agreement contain general statements that the medical group agrees to abide by all rules, regulations and procedures established by the managed care entity?	___*	___	___
2.	Can the rules, regulations and procedures be changed solely by the managed care entity?	___	___*	___
	a. If not, are all rules, regulations and procedures submitted to the medical group for review before the agreement is signed?	___*	___	___
	b. Are documents attached as exhibits to the contract so that they may not be changed without notice to, and approval of, the medical group?	___*	___	___
	c. Is a 30 day notice specified for any changes?	___*	___	___
3.	Is there a “non-interference” clause for medical care?	___	___*	___

REPORTING REQUIREMENTS:

		Yes	No	N/A
1.	Does the managed care agreement specifically define reporting obligations?	___*	___	___
2.	Do the reporting requirements include giving access to financial records of the group?	___	___	___
3.	Does the contract require listing of the Provider's name and address in directory of providers?	___	___*	___
4.	Does the Provider have the right to approve text of any description of the Provider's facilities and services and any other use of Provider's name?	___*	___	___
a.	Can the Provider confirm the accuracy of the quality data submitted by the MCO to a third party?	___*	___	___

PROFESSIONAL LIABILITY INSURANCE:

1.	Is insurance required of the provider?	___	___	___
a.	If so, is it required that the insurance be open-ended, in amounts or companies "approved by Payor"?	___	___*	___
b.	Is Payor/PPO named as additional insured?	___	___*	___
2.	Does the agreement give the HMO/PPO the right to determine the carrier or amount of malpractice coverage required?	___	___*	___
3.	Does the agreement allow the HMO/PPO the right to increase the amount of required coverage?	___	___*	___
4.	Does the agreement permit the HMO/PPO the right to name itself as an additional insured on the policy of the medical group?	___	___*	___
5.	Are the Payor and any third party performing utilization review for Payor required to carry the same amount of professional liability insurance as the Provider for utilization review activities conducted by itself or third parties?	___*	___	___
6.	Is the MCO's liability limited to the Provider's actual damages and cannot exceed amount paid to Provider during the last 12 months?	___	___*	___

7.	Is the statute of limitations at least 5 years?	___*	___	___

GENERAL PROVISIONS:

1.	Does the agreement contain an "entire agreement clause" (i.e. any prior verbal or written representation or other marketing materials do not become a part of the agreement)?	___*	___	___
2.	Does the agreement treat Medicare and commercial programs separately?	___	___	___
3.	Does the agreement contain a hold harmless provision?	___	___*	___

EXECUTIVE SUMMARY OF BILLING/CONTRACTING ISSUES

PRECONTRACTING CONSIDERATIONS:

Review MC entity's financial statements, licensure & ownership .

Gather demographic information such as number of enrolled lives, employer groups, hospitals, etc.

TYPES OF SERVICES:

Does the agreement require the physician take a certain number or all patients in the MCO?

How many new patients will be added and existing patients switch to the MCO?

Is there a detailed list of services that are included in the capitation with expensive services carved out?

PRICE:

Is payment based on discount of full charges or fee-for-service or all-inclusive per diem charge?

How much cash flow will this MCO create for the practice?

PAYMENT AND BILLING:

Is there a time period in which payment will be received and interest charges for delinquent payments?

Are billing requirements and covered services clearly defined?

Does the contract allow for collection and retention of COB?

RISK POOL, WITHHOLD & CAPITATION SPECIFICATIONS:

Is there a gatekeeper?

Does the agreement contain a risk pool concept & is it equitable?

UTILIZATION REVIEW:

Does the agreement require a utilization review program & will the provider be assuming this responsibility?

RELATIONSHIP BETWEEN PARTIES:

Is there an arbitration clause in the agreement?

RELATIONSHIP WITH BENEFICIARIES:

Is eligibility and verification of coverage easy to obtain?

TERMS OF RENEWAL:

How quickly can the Provider terminate the agreement with & without cause?

Does the agreement specify the reasons either party can terminate the agreement?

Does the agreement address patients that are currently existing at the time of the termination?

CONFIDENTIALITY AND ACCESS TO MEDICAL RECORDS:

Does the agreement contain provisions with respect to access to medical information?

REFERRAL RESTRICTIONS:

Is the referral and admission to certain physicians & facilities restricted?

COMPLIANCE:

Can the rules & regulations be changed only by the MCO?

REPORTING REQUIREMENTS:

Are the reporting requirements specified in the contract?

PROFESSIONAL LIABILITY INSURANCE:

Is insurance required of the provider & does the MCO specify the amount?

GENERAL PROVISIONS:

Does the agreement treat Medicare & commercial programs separately?