

Blue Cross Blue Shield Settlement  
Love et al. v. Blue Cross Blue Shield Association, et al.

Covers more than 90 Blue Cross Blue Shield Plans in the country including the following plans in New York:

AtlanticCare Administrators, Inc.  
Empire BCBS  
Empire Blue Cross Blue Shield  
Empire HealthChoice HMO Inc.  
Enterprise Holding Company, Inc.  
Horizon AtlanticCare LLC Horizon Healthcare Administrators, Inc.

Please note that there is a separate Settlement Agreement concerning Excellus.

The practice changes the Blues Plans have agreed to, include commitments to do the following:

**Coding rules**

- Blue Parties shall comply with most AMA Current Procedural Terminology (CPT®)1 codes, guidelines and conventions, unless otherwise identified on the Blue Parties physician Web site.
- Blue Parties will not automatically downcode any evaluation and management (E/M) CPT code for covered services, except to reassign a new patient to an established patient based on AMA CPT codes, guidelines and conventions.
- If a bill appropriately contains a CPT code for the performance of an E/M service appended with a CPT modifier 25 and a CPT code for performance of a non-evaluation and management service code, both codes shall be recognized and separately eligible for payment, unless the clinical documentation indicates that the use of the CPT modifier 25 was inappropriate or the Blue Plan has disclosed on its physician Web site that the code combination was not appropriately reported under their policy.
- No CPT modifier 51-exempt CPT codes are subject to the multiple procedure reduction logic or rule.
- A CPT code appended with a CPT modifier 59 will be recognized and separately eligible for payment to the extent that they designate a distinct or independent procedure performed on the same day by the same physician and that there is not a more appropriate CPT-recognized modifier to append to the code(s).
- “Add-on” codes, as designated by CPT, will be recognized and eligible for payment as separate codes and shall not be subject to the multiple procedure logic or rule.

- Supervision and interpretation CPT codes are separately identifiable and eligible for payment.
- No global period for surgical procedures will be longer than the period designated by the Centers for Medicare & Medicaid Services.
- Blue Parties shall not automatically change a code to one reflecting a reduced intensity of service when such CPT code is one among or across a series that includes, without limitation, codes that differentiate among simple, intermediate and complex, complete or limited, and/or size.
- Recommended vaccines and injectibles, as well as the administration of these vaccines and injectibles, will be reimbursed.
- Blue Parties will pay for newly recommended vaccines as of the effective date of a recommendation made by any of the following: the U.S. Preventive Services Task Force, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.

#### **Prompt payment requirements**

- Blue Parties shall mail a check or make an electronic funds transfer within 30 calendar days for claims. Beginning one year following the “effective date,” claims submitted electronically must be paid (by mailing a check or making an electronic funds transfer) within 15 calendar days.
- Interest will be paid at 8 percent on delayed claims.

#### **Disclosure of fee schedule information, claim coding and payment policies**

- Physician fee schedules shall be made available to all contracted physicians via hard copy, CD-ROM or by electronic means not later than 12 months after the Final Order Date. The requested fee schedule will show the applicable fee schedule amounts for up to 100 CPT codes, as contained in the direct written agreement between the physician and the Blue Plan.
- Copies of contracts will be provided to physicians upon written request.
- “Payment in full” or other restrictive endorsement on a payment by Blue Parties is not binding and can be appealed.

#### **Overpayment recovery**

- Blue Parties shall not initiate overpayment recovery efforts more than 18 months after the original payment.

- A 30-day written notice will be provided to the physician prior to initiating an overpayment recovery effort. The notice shall state the (i) patient’s name, (ii) service date, (iii) payment amount received by physician, and (iv) a reasonably specific explanation of the proposed adjustment.

**Medically necessary or medical necessity definition**

- No retroactive retraction of a pre-certified medically necessary determination.
- Blue Parties shall accept the following definition of medical necessity for clinical conditions and mental health care, including treatment for psychiatric illness and substance abuse:

“Medically Necessary” or “Medical Necessity” shall mean health care services 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 accepted 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, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas, and any other relevant factors.

**New physician credentialing**

New physician group members will be credentialed within 90 days of the receipt of the application. Physicians also can submit an application prior to their employment.

Preliminary Approval Date – the date that the Court entered Preliminary Approval, which was May 31, 2007.

Final Order Date the date on which the Court entered Final Order and Judgment. Final Order Date is April 19, 2008.

Effective Date Will be the next business date after the Final Order and Judgment is affirmed, all appeals are dismissed, and no further appeal remains. As of this date a number of appeals remain pending.

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The Settlement Agreement in its entirety is found in [www.hmosettlement.com](http://www.hmosettlement.com). The Business Practice Initiatives are found in Section 7 of the Settlement. Below is a summary of the business practice initiatives. (caution: The summary does not contain all the information contained in the Settlement Agreement. Please go to the settlement Agreement for more detailed information).

### 7.3 Availability of Fee Schedules and Scheduled Payment Dates

Each Blue Plan must develop and implement not later than 12 months after the Final Order Date to permit Participating Physician or Participating Physician Group that has entered into a written contract with the Blue Plan to view, by CD-Rom or electronically (at the Blue Plan's option), on a confidential basis, complete fee schedule information showing the applicable fee schedule amounts for such Participating Physician or Participating Physician Group.

Participating Physician or Participating Physician Group may elect to receive a hard copy of the fee schedule in lieu of the above.

Commencing with the Final Order Date and continuing until implementation of the initiative described above, each Blue Plan, upon request from a Participating Physician or participating Physician Group will provide, by hard copy, the fee schedule for up to 100 CPT codes customarily and routinely used by the Participating Physician or Participating Physician Group. Each Blue Plan is required to honor up to 2 such requests made annually.

### 7.5 Reduced Precertification Requirements

Each Blue Plan will continue to review its Precertification requirements for further opportunities to reduce the number of services and supplies requiring Precertification.

Each Blue Plan must post to its Provider Website not later than 3 months after the Final Order Date those services or supplies for which Precertification is required, and must update such posting to the extent the services or supplies for which Precertification is routinely required changes.

### 7.6 Greater Notice of Policy and Procedure Changes

Each Blue Plan must, if it intends to make a material adverse change(s) in the terms of its contracts (including policies and procedures incorporated by reference therein) with its Participating Physicians or Participating Physician Groups, give at least ninety (90) days written notice to each Participating Physician or Participating Physician Group affected thereby (except to the extent that a shorter period is required by law).

If a Participating Physician or Participating Physician Group objects to the change(s) that is the subject of the notice, the Participating Physician, Participating Physician Group must within thirty (3) days of the date of the notice, give written notice to terminate his/her contract with the Blue Plan, which termination will be effective at the end of the notice period unless, within sixty five (65) days of the date of the original notice of change(s), the Blue Plan gives written notice to

the objecting Participating Physician or Participating Physician Group that it will not implement the material adverse change.

#### 7.8 Disclosure of and Commitments Concerning Claims Payment Practices

- a) Each Blue Plan recognizes the benefit of greater standardization in its claim systems and, to that end, each Blue Plan expects to consolidate its claims systems in certain of its multi-state regions, which will result in greater consistency with respect to its automated “bundling” and other claims payment rules.
- b) Except for Medicaid, State Children’s Health Insurance programs, and other similar government programs for low-income persons and/or for members of state-established high risk pools, the Blue Plan’s automated “bundling” and other claims payment rules must be consistent in all material respects within each state in which the Blue Plan operates.
- c) Intentionally Left Blank
- d) Each Blue Plan must disclose its Significant Edits on its Provider Website by not later than 6 months after the Final Order Date, or as soon thereafter as practicable.
  - i. Not later than 6 months after the Final Order Date or as soon thereafter as practicable, the Blue Plan must publish on its Provider Website, for each commercially available claims editing software product then in use by the Blue Plan, a list identifying each customized Edit added to the standard claims editing software product at the Blue Plan’s request.
  - ii. Not later than the Final Order Date, a Blue Plan will not routinely require submission of Clinical Information, before or after payment of claims, in connection with that Blue Plan’s adjudication of a Physician’s claims for payment, except as to claims for unlisted codes, claims to which a modifier 22 is appended and other limited categories of claims as to which the Blue Plan determines that routine review of Clinical Information is appropriate; provided it is disclosed on its Public Website.

Notwithstanding, a Blue Plan may require submission of clinical Information for purpose of investigating fraudulent or abusive billing practices, but only so long as, and only during such times as, the Blue Plan has a reasonable basis for believing that such investigation is warranted.

A Participating Physician may contest, in accordance with section 12 (Compliance Dispute) any requirement that Participating Physician submit Clinical Information in connection with a Blue Plan’s adjudication of the Participating Physician’s claims for payment for the purpose of investigating fraudulent or abusive billing practices.

- iii. Not later than 6 months after the Final Order Date, the Blue Plan must publish on its Provider Website those limited code combinations as to which it has determined that particular services or procedures, relative to modifiers 25 and 59, are not appropriately reported together – provided that no such determination may be inconsistent with 7.20 herein.

See Reference to NASCO System (p. 21)

#### 7.9 Physician Advisory Committee

Each Blue Plan must establish a Physician Advisory Committee to discuss issues arising from or related to the relationships and interactions between and among Physicians, their patients, and the Blue Plan.

The Physician Advisory Committee (upon majority vote) may make recommendations to the Blue Plan. The Blue Plan will consider whether to implement the recommendation of the Physician Advisory Committee. If the Blue Plan decides not to accept a recommendation of the Physician Advisory Committee, the Blue Plan will communicate that decision in writing to the Committee, and the Blue Plan will also disclose the recommendation and response on the Provider Website. The Blue Plan will post on its Provider Website a listing of all Physician Advisory Committee recommendations made to the Blue Plan and the Blue Plan's response to such recommendations.

#### 7.10 Dispute Resolution Process for Physician Billing Disputes

- a) Not later than 4 months after the Final Order Date, the Blue Plan must establish a Billing Dispute External Review Process. The Billing Dispute External Review Process will provide for a Billing Dispute Reviewer to resolve disputes arising from Covered Services provided to the Blue Plan's Members concerning:
  - i. The Blue Plan's application of the Blue Plan's coding and payment rules and methodologies for fee for service claims (e.g. bundling, downcoding, application of a CPT modifier, and/or reassignment of a code by the Blue Plan to patient specific situations.
  - ii. Retained Claims – The Retained Claim must be submitted by the Physician to the Billing Dispute Reviewer **BEFORE** the latter of (x) 90 days after the Final Order Date (y) 30 days after exhaustion of the Blue Plan's internal appeals process. A "Retained Claim" – for Covered Services that has been submitted to a Blue Plan prior to or on the Effective Date as to which, as of the Effective Date: (i) no claim with respect to such Covered Services has been submitted to a Blue Plan, provided that the applicable period for filing such claim has not elapsed; or (ii) a claim with respect to such Covered Services has been filed with the Blue Plan but such claim has not been finally adjudicated by the Blue Plan (internal appeal process not final). See 13.6 of Settlement Agreement.

- b) This section 7.10 is not intended to supersede remedies otherwise available under ERISA.
- c) Any Physician or Physician Group may submit a Billing Dispute after the internal appeals process is exhausted, and when the amount in dispute exceeds \$500. The Blue Plan must post a description of its internal appeals process on its Provider Website.
  - i. An individual Physician or Physician Group may submit a Billing Dispute with an amount in dispute less than \$500 if such Physician or Physician Group notifies the Billing Dispute Reviewer that the Physician or Physician Group 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. The Billing Dispute Reviewer will defer consideration of such Billing dispute while the Physician or Physician Group accumulates such additional similar billing disputes.
  - ii. In the event additional similar Billing Disputes (x) are not submitted within one (1) year of the original Billing Dispute, or (y) do not involve disputes that in aggregate exceed \$500, the Billing Dispute Reviewer shall dismiss the original Billing Dispute and any such additional Billing disputes.
  - iii. Except as otherwise provided in this 7.10(c), all Billing Disputes must be submitted to the Billing Dispute Reviewer no more than ninety (90) days after a Physician or Physician Group exhausts the Blue Plan's internal appeals process.
- d) The Blue Plan and Class Counsel shall select the person(s) or organization(s) that shall serve as the Billing Dispute Reviewer.
- e) The Billing Dispute Reviewer will render a decision not later than thirty (30) days after receipt of the documents necessary for the review.
- f) If the Billing Dispute Reviewer issues a decision requiring payment by the Blue Plan, that Blue Plan must make payment within fifteen (15) days after the Blue Plan receives notice of such decision.
- g) Retained Claims will not be barred as untimely as long as they are submitted within thirty (30) days of the selection of the Billing Dispute Reviewer.
- h) Filing fee. For any Billing Dispute that a Physician or Physician Group submits, there is a filing fee that must be paid to the Blue Plan as follows: (i) if the amount in dispute is \$1,000 or less, the filing fee is \$50 or (ii) if the amount in dispute exceeds \$1,000 the filing fee is \$50 plus 5% of the amount by which the amount in dispute exceeds \$1,000, but in no event will the fee be greater than 50% of the cost of the review. The Blue Plan must refund the applicable filing fee in the event the Physician or Physician Group is the prevailing party.

See Reference to NASCO System. (p. 21)

7.11 Determination Related to Medical Necessity or the Experimental or Investigational Nature of Any Proposed Health Care Service or Supply

a) Initial Determinations – A physician designated by the Blue Plan will be responsible for making the initial determination for the Blue Plan whether the proposed health services or supplies are Medically Necessary.

b) Plan Member Internal and External Review Process.

i. Each Blue Plan will maintain an internal appeal and external review process permitting its Plan Members to seek internal and independent external review of any determination made by the Blue Plan that certain services are not Medically Necessary or are experimental or investigational in nature (“Adverse Determinations”).

ii. Each Blue Plan will maintain an internal and external review process for Physicians with respect to Adverse Determinations.

iii. Each Blue Plan will use the definition of Medical Necessity set forth in 7.16(a).

Each Blue Plan agrees that Physicians may bill Plan Members for services determined to be not Medically Necessary or experimental or investigational when physician provides the Blue Plan’s Member that (a) identifies the proposed services, (b) informs the Plan Member that such services may be deemed by the Blue Plan to be not Medically Necessary or experimental or investigational, and (c) provides an estimate of the cost to the Plan Member for such services and the Plan Member agrees in writing in advance of receiving such services to assume financial responsibility for such services.

iv. Each Blue Plan will consider credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas, the individual clinical circumstances of the particular Plan Member, the views of the treating Physician and other relevant factors in applying experimental or investigational exclusions.

c) Physician Internal Appeals of Adverse Determinations

i. Pre-Service Appeals

Physicians will have the right to file an appeal of an Adverse Determination prior to rendering the service (“Pre-Service Appeals”) if they are appealing on behalf of the Plan Member. For urgent Pre-Service Appeals, the Physician shall be automatically deemed the authorized representative of the Plan Member. For other Pre-Service Appeals, authorization must be obtained from the Plan Member in writing.



ii. Post-Service Appeals

With respect to an appeal of an Adverse Determination made after the service has been rendered, the Blue Plan will adopt a one level internal appeal process for Physicians. Only a Physician in the same specialty as the Physician who treated the condition (“Qualified Reviewer”) other than the Physician that made the initial Adverse Determination, may deny the appeal.

d) Timeframes

All internal Post-Service Appeals filed by Physicians will be adjudicated within the time limits established under regulations issued by the U.S. Department of Labor regardless of whether ERISA applies.

e) Adverse Determination External Review for Physicians

- i. If a Blue Plan upholds its initial Adverse Determination through the internal Post-Service appeals process and the cost of the service at issue exceeds the threshold amount, if any, the Blue Plan Member would need to satisfy in order to seek external approval, the Blue Plan will make available to the Physician the option to seek external review of the Adverse Determination through an independent review organization (“IRO”). The Physician will have the option to submit a written request for External Review within sixty (60) days from the date of the internal Post-Service Appeal denial decision by the Blue Plan. Election to pursue External Appeal is at the option of the Physician.
- ii. The internal Post-Service Appeal process must be exhausted unless the Blue Plan and the Physician agree to forego the internal Post-Service Appeal and proceed directly to External Review.
- iii. Physician seeking External Review will pay the Blue Plan a filing fee of \$50 if the amount in dispute is \$1,000 or less, or \$250 if the amount in dispute exceeds \$1,000. The Physician will be entitled to a refund in the event the Physician prevails.
- iv. Any decision pursuant to an External Review process, whether initiated by the Plan Member or Physician, will be binding upon both the Physician and the Blue Plan.
- v. The IRO will provide a decision within thirty (30) days of the Blue Plan’s submission of all necessary information.
- vi. The IRO’s compensation must not be tied to the outcome of reviews performed.
- vii. If state or federal law provides an external review process, and such process provides at least substantially the same procedural protections and rights as set

forth in 7.11, at cost to Physician that is not substantially greater than the cost set forth in 7.11(e), and that any determinations are rendered by an independent, external person or entity, then the Physician will be required to use the state or federal external review process in lieu of the external review process established in 7.11.

- viii. Physician may not initiate an internal Post-Service Appeal or External Review of any denied service if the Plan Member or the Physician filed a Pre-Service Appeal pertaining to the same denied service.

#### 7.13 a) Credentialing of Physicians

The Blue Plan will allow Physicians to submit credentialing applications and will begin process and applications prior to the time that the Physician formally changes or commences employment or changes location. Blue Plan will complete primary source verification within 90 days of receiving a Physician's completed application.

#### b) All Products Clause

Blue Plan will not require a Participating Physician to participate in a capitated fee arrangement in order to participate in Product Networks in which Physician is compensated on a fee for service basis.

Blue Plan will not require Participating Physician to participate in Medicare Advantage or Medicaid Product Networks.

Except where a Participating Physician has agreed in an Individually Negotiated Contract to participate in more than one Product Network for a specified period of time (terms of the Individually Negotiated Contract will govern), if a Participating Physician either (a) chooses not to participate in all of the Blue Plan's Product Networks or (b) terminates participation in some of the Blue Plan's Product Networks, then the reimbursement levels offered to or offered by the Blue Plan to such Participating Physician in which Participating Physician continues to participate will not be lower than the Blue Plan's standard reimbursement level in that geographic market.

Notwithstanding, Blue Plan may offer a higher reimbursement level or other incentive to any Participating Physician who elects to participate in more than one of the Blue Plan's Product Networks.

(Individually Negotiated Contract means a contract pursuant to which the parties to the contract, as a result of negotiation, agreed to one or more modifications to the terms of a Blue Plan's applicable standard form agreement that substantially modify the standard form agreement and that are made to individually suit, in whole or in part, the needs of a Participating Physician).

(Product Network – a network of Participating Physicians who, pursuant to contracts with a Blue Plan, provide Covered Services to Plan Members for one or more products or types of products offered by the Blue Plan (e.g. HMO, PPO, POS, Indemnity in exchange for a specified type of reimbursement).

c) Termination Without Cause

Unless an Individually Negotiated Contract provides otherwise, either party to a contract between a Blue Plan and a Participating Physician or Participating Physician Group will have the right to terminate the contract without cause upon prior written notice provided to the other party which notice will be a definite period set forth in the agreement, which will not be less than sixty (60) days or more than one hundred twenty (120) days.

(Note: New York law does not permit health plan to terminate contract without cause).

7.14 Fee Schedule Changes

a) Notice Regarding Fee Schedules

Blue Plan agrees, effective January 1 of the year following the Effective Date, not to reduce the fees set forth in the fee schedules more than once per calendar year except as otherwise provided in 7.14(a). A fee schedule reduction will be given notice as a Material Adverse Change subject to 7.6.

Notwithstanding, Blue Plan may increase or reduce the fees set forth in such fee schedule (i) to reflect changes in market prices for vaccines, injectibles, pharmaceuticals, durable medical supplies, other goods, non-physician services, (ii) to add payment rates for newly adopted CPT codes, (iii) to add payment rates for new technologies and (iv) to reflect applicable interim revisions made by CMS.

b) Payment Rules for Injectibles, DME, Administration of Vaccines, and Review of New Technologies

Blue Plan will pay a fee for the administration of vaccines and injectibles by Participating Physician. Blue Plan will also pay for the vaccines and injectibles themselves.

c) UCR Appeals

If a Non-Participating Physician initiates a dispute using the Plan internal dispute resolution procedures over how the Blue Plan determined the usual, customary and reasonable amount for a given service or supply, the Blue Plan will disclose to the Non-Participating Physician initiating the dispute the general methodology, including the percentile of included charge data on which the UCR amount is based, and the source of data used by the Blue Plan to determine the UCR amount.

d) UCR Determinations

Blue Plan agrees to avoid certain inappropriate practices and procedures that reduce UCR determinations.

7.16 Application of Clinical Judgment to Patient-Specific and Policy Issues

a) Patient-specific Issues Involving Clinical Judgment

Medical Necessity Definition

Blue Plan shall apply the following definition of “Medical Necessity”

“Medical Necessity” shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; 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. “Generally accepted 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, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas on any other relevant factors”.

7.17 Billing and Payment

a) Time Period for Submission of Bills for Services Rendered

Blue Plan will not contest the timeliness of bills for Covered Services provided under a Fully-Insured Plan if such bills are received by the Blue Plan within 180 days after: (i) the date of service when the Blue Plan is the primary payor; or (ii) the date of the Physician’s receipt of the EOB from the primary payor when the Blue Plan is the secondary payor.

The 180 day time period may be extended on a case by case basis in the event Physician shows that circumstances were reasonably beyond Physician’s control that resulted in delayed submission.

b) Claims Submission

Blue Plan will accept properly completed paper claims on Form CMS-1500 or equivalent.

Blue Plan also agrees to accept electronic claims populated with information in HIPAA compliant format using HIPAA compliant code sets.

If a Physician elects not to be compliant with the portions of HIPAA relating to the electronic submission of claims, no Blue Plan will require such Physician to use electronic transactions. Instead, the Blue Plan will maintain reasonable non-electronic systems to serve the information needs of such physicians.

#### 7.18 Timeliness for Processing and Payment of complete Claims

Beginning not later than nine (9) months after the Final Order Date, Blue Plan will issue a check or an electronic funds transfer in payment for Complete Claims for Covered Services within thirty (30) calendar days following the later of Blue Plan's receipt of such claim or date on which the Blue Plan is in receipt of all information needed and in a format to constitute a Complete Claim.

Beginning one (1) year following the Effective Date, the Blue Plan will issue a check or an electronic funds transfer in payment for Complete Claims for Covered Services that are submitted electronically by Physicians within fifteen (15) business days following the later of the Blue Plan's receipt of such claim or the date on which the Blue Plan is in receipt of all information needed and in a format to constitute a Complete Claim.

Use State law definition of Complete Claim.

Blue Plan will pay interest at eight percent (8%) per annum on the balance due on each claim completed from the 16<sup>th</sup> business day or 31<sup>st</sup> calendar day (as appropriate) up to the date on which the Blue Plan directs the issuance of the check or electronic funds transfer.

However, if the payment is made later than the period specified under applicable State law, the Blue Plan will pay interest at the rate specified by the state law in lieu of the interest payment specified in 7.18(b).

#### 7.19 No Automatic Downcoding of Evaluation and Management Claims

As of the Final Order Date, Blue Plan will not automatically reassign or reduce the code level of E & M codes billed for Covered Services ("Downcoding").

Blue Plan will continue to have the right to deny, pend or adjust such claims for Covered Services on other bases and will have the right to reassign or reduce the code level for selected claims submitted by selected Participating Physicians or Physician Groups based on a review of the information on the Clinical Information at the time the service was rendered for the particular claims or a review of the information derived from Blue Plan's fraud or abuse detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that a decision to reassign or reduce is based primarily on a review of Clinical Information. ("Clinical Information", is defined as "clinical, operative or other medical records and reports kept in the

ordinary course of a Physician's or Physician Group's business, and, where applicable, requested statements of Medical Necessity").

See Reference to NASCO System (p. 21)

#### 7.20 Bundling and Other Computerized Claim Editing

Section 7.20 is set forth in its entirety:

Each Blue Plan agrees to take actions necessary on the Blue Plan's part to cause the claim-editing software program it uses to continue to produce editing results consistent with the standards set forth in this § 7.20 and, if the Blue Plan has actual knowledge of non-conformity with such standards, to take reasonable actions necessary on its part to promptly modify such software to any extent necessary to conform to such standards; provided that nothing in this paragraph is intended or shall be construed to require a Blue Plan to pay for anything other than Covered Services for its Plan Members, to make payment at any particular rates, to limit a Blue Plan's right to deny, pend or adjust claims based on a reasonable belief of fraudulent or abusive (whether intentional or unintentional) billing practices (so long as the Physician has been given the opportunity to provide Clinical Information and the Blue Plan has reviewed any Clinical Information so provided before denying or adjusting the claims). For purposes of this § 7.20 only, if any change to CPT® affects a Blue Plan's obligations hereunder, the Blue Plan will promptly develop plans to cause its Physician payment practices to be consistent with the commitments set forth in this § 7.20. The obligations set forth below in this § 7.20 shall take effect on the dates set forth in Exhibit I. For purposes of §§ 7.19 and 7.20, all references to the AMA CPT® book and to CPT® Codes in this Agreement refer to the AMA CPT® book and the CPT® Codes listed in the AMA CPT® book in effect at the time the services were provided; however, notwithstanding anything to the contrary contained in this Agreement, if there is any amendment, modification, or superseding change to the CPT® Codes, CPT® Conventions or CPT® Guidelines, which constitutes a departure from the procedures, criteria or scope of activities historically employed or undertaken by the AMA's CPT Editorial Panel and which materially expands the commitments of a Blue Plan in this Agreement or has a material adverse effect on the Blue Plan, then the Blue Plan may communicate to Physicians its decision not to recognize such modification by posting a notification on its website, or by other form of written or electronic communication to Physicians, and by notifying Class Counsel.

(a) Each Blue Plan will process and separately reimburse those codes listed in the AMA CPT® book as modifier 51 exempt CPT® Codes without reducing payment under the Blue Plan's Multiple Procedure Logic, provided that the AMA CPT® book provides that such services are appropriately reported together. 53

(b) Each Blue Plan will process and separately reimburse codes listed in the AMA CPT® book as add-on billing codes without reducing payment under the Blue Plan's Multiple Procedure Logic; provided that the AMA CPT® book provides that such add-on CPT® Codes are appropriately billed with proper primary procedure codes.

(c) (i) No Blue Plan shall require a Physician to submit Clinical Information of their patient encounters solely because the Physician seeks payment for both surgical procedures and CPT® evaluation and management services for the same patient on the same date of service, provided that the correct CPT® evaluation and management code, surgical code and modifier (e.g., CPT® modifiers 25 or 57) are included on the initial claim submission. (ii) If a bill contains a CPT® Code for an evaluation and management service, appended with a CPT® modifier 25 and a CPT® Code for performance of a non-evaluation and management service procedure code, both codes shall be recognized and separately eligible for payment, unless the Clinical Information indicates that use of the CPT® modifier 25 was inappropriate or the Blue Plan has disclosed pursuant to § 7.8(d)(iii) the limited number of finite code combinations that are not appropriately reported together. Payment shall only be made for one evaluation and management service for any single day unless payment for more than one is appropriate pursuant to the AMA CPT® book and is supported by appropriate diagnoses in the Clinical Information. (iii) Each Blue Plan will remove from its claim review and payment systems any Edits that generally deny payment for CPT® evaluation and management codes with a CPT® modifier 25 appended when submitted with surgical or other procedure codes for the same patient on the same date of service except for a limited number of exceptions, consistent with § 7.20(c)(ii) above, which will be disclosed on the Blue Plan's Provider Website. (iv) Nothing in this Agreement shall (A) prohibit a Blue Plan from requiring use of the appropriate CPT® Code modifiers for evaluation and management billing codes (e.g., CPT® modifiers 25 or 57) on their original claim forms, or (B) preclude a Blue Plan from requiring a Physician, Physician Group or Physician Organization to submit to an audit of claims submitted by such Physician, Physician Group or Physician Organization for payment directly to such Physician, Physician Group or Physician Organization (including, but not limited to, claims for 54 surgical procedures and evaluation and management services on the same date of service submitted with the appropriate modifier), and to provide their Clinical Information in connection with such an audit.

(d) A CPT® Code for supervision and interpretation or radiologic guidance (e.g., fluoroscopic, ultrasound or mammographic) shall be separately recognized and eligible for payment to the extent that the associated procedure code is recognized and eligible for payment; provided that, (i) the associated procedure code does not include supervision and interpretation or radiologic guidance according to the AMA CPT® book, and (ii) for each such procedure (e.g., review of x-ray or biopsy analysis or ultrasound guidance), no Blue Plan shall be required to pay for supervision or interpretation or radiologic guidance by more than one qualified health care professional.

(e) With respect to indented codes, no Blue Plan shall reassign any CPT® Code into any other CPT® Code or deem a CPT® Code ineligible for payment based solely on the format of the published CPT® descriptions.

(f) CPT® Codes submitted with a modifier 59 attached will be eligible for payment to the extent they follow the AMA CPT® book and they designate a distinct or independent procedure performed on the same day by the same Physician, but only to the extent that: (i) although such procedures or services are not normally reported together they are appropriately reported together under the particular presenting circumstances; and (ii) it would not be more appropriate to append any other CPT® recognized modifier to such CPT® Codes.

(g) No global periods for surgical procedures shall be longer than the period then designated by CMS; provided that this limitation shall not restrict a Blue Plan from establishing a global period for surgical procedures (except where CMS has determined a global period is not appropriate or has identified a global period not associated with a specific number of days).

(h) No Blue Plan shall automatically change a CPT® Code to one reflecting a reduced intensity of the service when such CPT® Code is one among or across a series that includes without limitation CPT® Codes that differentiate among simple, intermediate and complex, complete or limited, and/or size.

(i) Not later than six (6) months after the Final Order Date, or as soon thereafter as is reasonably practicable, each Blue Plan shall update its claims editing software at least once each year to (A) cause its claim processing systems to recognize any new CPT® Codes or 55 any reclassifications of existing CPT® Codes as modifier 51 exempt since the previous annual update, and (B) cause its claim processing personnel to recognize any additions to HCPCS Level II Codes promulgated by CMS since the prior annual update. As to both clauses (A) and (B) above, no Blue Plan shall be obligated to take any action prior to the effective date of the additions or reclassifications. Nothing in this subparagraph shall be interpreted to require a Blue Plan to recognize any such new or reclassified CPT® Codes or HCPCS Level II Codes as Covered Services under any Plan Member's Plan, and nothing in this subparagraph shall be interpreted to require that the updates contemplated in (A) and (B) be completed at the same time; provided that (A) and (B) are each completed once each year.

(j) Nothing contained in this § 7.20 shall be construed to limit a Blue Plan's recognition of CPT® modifiers to those CPT® modifiers specifically addressed in this § 7.20.

See Reference to NASCO System (p. 21)

#### 7.21 EOB and Remittance Advice Content

Blue Plan will not disparage Non-Participating Physicians and EOB sent to Plan Members will indicate the amount, if any, for which Physician may bill the Plan Member, shall include a statement that "Physician may bill you" such amount, if any, or contain substantially similar language, and will not characterize disallowed amounts, if any, as unreasonable.

Not later than six (6) months after the Final Order Date or a soon thereafter as practical, the Physician Remittance Advice that the Blue Plan sends to its Participating Physician will contain at least:

- i. the name of and a member identifying the Plan Member;
- ii. the date of service;
- iii. the amount of payment per line item;
- iv. the procedure code(s);
- v. the amount of payment;
- vi. any adjustment to the invoice submitted;



- vii. a generic explanation of any adjustment to the invoice submitted that complies with HIPSS requirements;
- viii. any adjustment or change in any code on a line-by-line basis.

See Reference to NASCO System (p. 21)

#### 7.22 Overpayment Recovery Procedures

As of Final Order Date, other than for duplicate payments or similar adjustments, the Blue Plan will not initiate Overpayment recovery efforts unless it provides at least thirty (30) days written notice.

The Blue Plan will not initiate Overpayment recovery effort more than eighteen (18) months after the payment was received by Physician. Exception: (a) reasonable belief of fraud or other intentional misconduct, (b) required by a Self-Insured Plan, (c) required by a state or federal government program.

If a Physician asserts a claim of underpayment, the Blue Plan may defend or set off such claim based on Overpayments going back in time as far as the claimed underpayment.

#### 7.23 Efforts to Improve Accuracy

Commencing with Final Order Date, Blue Plan will initiate or continue actions designed to reduce Overpayments and claim denials resulting from inaccurate information about the eligibility of its Plan Members.

#### 7.24 Intentionally Left Blank

#### 7.25 Effect of Blue Plan Confirmation of Patient Procedure/Medical Necessity

If the Blue Plan precertifies that a proposed service is medically necessary for a Plan Member, the Blue Plan will not subsequently revoke the medical necessity determination absent:

- Evidence of fraud
- Information submitted was materially erroneous or incomplete;
- Material change in Plan Member's health condition between the date that precertification was provided and the date of the service that makes the proposed service no longer medically necessary.

#### 7.26 Intentionally Left Blank

#### 7.27 Information About Physicians Posted on Public Website or Contained in Written Materials

Upon written notice of any inaccuracy sent to the Blue Plan if the Blue Plan does not dispute that there is an inaccuracy, the Blue Plan will update the Public Website within twenty (20) business

days after receipt of such notice, and written materials will be revised before the next edition (to the extent there is sufficient time to make revisions before the next printing.)

7.28 Intentionally Left Blank

7.29 Miscellaneous

- a. Gag Clauses – Blue Plan will not include in any contract with Participating Physician or Participating Physician Group any provision limiting free, open and unrestricted exchange of information between its Physician and Plan Members regarding medical conditions or treatment options, and relative risks, benefits and costs of such options.
- b. Intentionally Left Blank
- c. Arbitration –
  - i. With respect to any arbitration between a Blue Plan and its Participating Physician who practices individually or in Participating Physician Group of less than six Physicians, the Blue Plan will refund any applicable filing fees and arbitrators' fees paid by the Physician if the Physician is the prevailing party;
  - ii. The agreement with Participating Physician or Physician Group will not include any language (A) requiring any arbitration panel to have multiple members, (B) preventing the recovery of any statutory or otherwise legally available damages or other relief, (C) restricting the otherwise legally available scope or standard of review; (D) completely prohibiting discovery; (E) shortening any statute of limitations, (F) requiring that any arbitration proceeding occur more than 50 miles from the principal office of the Physician or Physician Group.
- d. Impact on Standard Form Agreements and Individually Negotiated Contracts.
  - i. If a Blue Plan's standard form agreement is inconsistent with the terms of the Settlement Agreement, the Blue Plan must administer the agreement consistent with the terms of the Settlement Agreement.
  - ii. Except for those terms relating to higher or customized rates, length of term of contract, and/or otherwise permitted under 7.13(b), 7.13(c), 7.14(a) and 7.29(r), the Settlement Agreement is deemed to modify or nullify any inconsistent terms of an Individually Negotiated Contract.

[7.13(b) - In Individually Negotiated Contract Participating Physician or Physician Group may agree to participate in more than one Product Network.

7.13(c) Individually Negotiated Contract may specify a different period of Notice of Termination without Cause, or may prohibit termination without cause.

7.14(a) – Individually Negotiated Contract that has a term of greater than one year may have provisions for compensation that substantially differ from the standard fee schedule]

7.29(r) prohibits Most Favored Nations Clauses. However, Most Favored Nations Clause is not prohibited in an Individually Negotiated Contract.]

- iii. With respect to Individually Negotiated Contracts executed after the Preliminary Approval Date, the Blue Plan may agree on terms that deviate from any terms of the Settlement Agreement upon request of the Physician or Physician Group.

e. Impact of Settlement Agreement on Covered Services

Nothing in the Settlement Agreement (i) requires Blue Plan to pay Physician or Physician Group any particular amount, or (ii) prohibits Blue Plan from utilizing a particular payment methodology.

Individually Negotiated Contract – See definition at section 1.63

f-h. Intentionally Left Blank

i. Pharmacy Provisions

When a Blue Plan provides pharmacy coverage the Blue Plan will make formulary information available to Plan Members. Blue Plan will continue to provide coverage for off-label uses of pharmaceuticals that have been approved by the FDA provided that the drug is not contraindicated by the FDA for the off-label use prescribed.

j. Restrictive Endorsements

When a Blue Plan’s reimbursement of a Physician for services performed is a partial payment of allowable charges, a Physician may negotiate a check with a “Payment in Full” or other restrictive endorsement without waiving the right to pursue a remedy under the Settlement Agreement.

k. Scope of Blue Parties’ Responsibilities

- i. The Blue Plan will make a good faith effort to include in contracts entered into with Delegated Entities, subsequent to the Final order Date, terms that are substantially equivalent with the Settlement Agreement.

Delegated Entity-defined by section 1.42 of Settlement Agreement. Generally, means an entity that (i) is not an Affiliate of the Blue Plan and is not a licensee of BCBSA, (ii) maintains its own contracts with Physicians separate from any contracts between the Blue Plan and Physicians, and (iii) by agreement with the Blue Plan, (A) agrees to provide Plan Member with access to such Physicians pursuant to the terms of such agreements, and (B) performs some or all of the functions with respect to Plans which

- otherwise would be performed by the Blue Plan, e.g. claims adjudication, utilization review.
- ii. The Settlement Agreement applies to a Blue Plan's activities in connection with the Blue Card Program only to the extent that the Blue Plan is solely responsible for the activity.
  - iii. The Blue Parties will continue to make investments and undertake initiatives to streamline and improve the overall efficiency of the claims adjudication process in connection with the Blue Card Program and other similar national account delivery programs governed by BCBSA. Since 2000 and through the Effective Period, BCBSA's investments in furtherance of these initiatives will exceed \$150 million.
- l. Copies of Contract

Blue Plan will provide copy of its contract with Participating Physician upon receipt of written request.

- m. To the extent state or federal law imposes a greater obligation than any obligation set forth in section 7 of the Settlement Agreement, the Blue Plan will comply with the state or federal law.
- n. Intentionally Left Blank
- o. Generally, no affirmative obligation that section 7 imposes on Physicians will apply to Non-Participating Physician.
- p. Intentionally Left Blank.
- q. An assignment of benefits in favor of a Non-Participating Physician will not preclude the Non-Participating Physician from collecting from the Plan Member the difference between the Non-Participating Physician's full fee and the payment (if any) received by the Non-Participating Physician from the Blue Plan.
- r. No Most Favored Nation Clauses. Note: Most Favored Nation Clause may be included in an Individually Negotiated Contract.

#### Compliance with Applicable Requirements of Government

7.30 The requirements of section 7 must be fulfilled by the Blue Plan to the extent permissible under applicable laws and regulations.

7.31 Estimated cost of the section 7 initiatives is to the Blue Parties is \$250 million.

7.32 Force Majeure

No party is required to meet an obligation where inability to meet the obligation is the result of an “act of God”, governmental act, act of terrorism, or natural disaster.

### 7.33 Managed Care Issue Relating to Mental Health and Substance Abuse

Except where applicable law requires a different definition, the Blue Plan must include in its future definition with Participating Physicians the definition of Medical Necessity in section 7.16(a) with respect to mental health services. In determining the clinical appropriateness of care, the following standards must be met:

- i. There is a diagnosis as defined by standard diagnostic nomenclatures (DSM IV or its equivalent in ICD-9-CM) and individualized treatment plan appropriate for Plan Member;
- ii. There is a reasonable expectation that Plan Member’s illness, condition or level of functioning will be stabilized, improved or maintained;
- iii. The mental health services are not primarily for the avoidance of incarceration of the Plan Member.

The Blue Plan must adhere to “Prudent layperson” law which requires payment of benefits for mental health services in event of an emergency under prudent layperson standard.

NASCO System. “NASCO” means the National Account Service Company, LLC.

Sections 7.8, 7.10, 7.19, 7.20, 7.21 of the Settlement Agreement do not apply to claims processed under the NASCO system, provided however, the NASCO system is intended as a legacy system with no new group enrollment being administered with this system, and the system will not be used for purposes of processing claims for any group not processed on the system as of the Effective Date.

### Empire BCBS Specific Provisions

With respect to the Billing Dispute External Reviewer (7.10), Medical Necessity Independent Review Organization (7.11), the Compliance Dispute Officer and Compliance Dispute Facilitator, Empire may use the same individuals and/or entities as were selected pursuant to the Wellpoint Settlement Agreement.

Physician Advisory Committee – In lieu of a separate Physician Advisory Committee, Empire and the Medical Society of the State of New York each may add a representative to the Physician Advisory committee created under the Wellpoint Settlement Agreement.

### Termination Date of Settlement Agreement

Four Year anniversary of the Preliminary Approval Date. See section 14.6

BlueCrossBlueShieldSettlement  
12/08