



## Blue Cross Blue Shield Association Settlement Agreement

Below is a summary of the settlement agreement reached on April 27, 2007 for all BlueCross BlueShield plans and the Association. **Please be advised that the final settlement will be confirmed on November 14, 2007.**

### Section 7 “Settlement Consideration: Business Practice Initiatives”

**1. Business Practice Changes.** The agreement envisions a number of changes designed to allow transparency of policies and procedures, claims handling practices and reimbursements rates through the use of each BCBS plans’ website. To this end, each BCBS plan agrees to do the following:

- **Availability of Fee Schedules.** No later than 12 months after final approval of the agreement, each BCBS plan will develop a system to allow a participating physician to view, by CD-ROM or electronically, his or her fee schedule by CPT Code for those CPT Codes that a physician in the same specialty typically uses. BCBS will also provide physician with the fee-for-service dollar amount for each CPT Code that the physician bills BCBS. Physician may elect to receive a hard copy in lieu of the foregoing. In the meantime, each BCBS plan agrees to provide, upon request, a hard copy of the fee schedule for up to 100 CPT Codes up to two times each year. [7.3]
- **Reduced Precertification Requirements.** Each BCBS plan agrees to continue to review its pre-certification requirements with the goal of further reducing the services and supplies that require pre-certification. This list will be published on the web within three months after the agreement is approved. [7.5]
- **Greater Notice of Policy and Procedure Changes.** Each BCBS plan will, if it intends to make any material changes to its physician contract, give at least 90 days’ advance notice of the change with the physician allowed 30 days from receipt of notification to terminate the contract effective with the implementation of the material adverse change, unless BCBS provides notice to the physician that it will not implement the change as to the physician. [7.6]
- **Disclosure of and Commitments Concerning Claims Payment Practices.** Each BCBS plan agrees to make its automated “bundling” and other claims processing rules consistent within each state across all claims handling systems. Each BCBS plan agrees to disclose its Significant Edits on their websites not later than six months after the agreement is approved and to update the information once a year. [7.8(b)]
  - Each plan will also publish on its website a list identifying each customized edit added to the plans’ commercially available standard claims editing software. [7.8(d)(i)]
  - In addition, each plan will not routinely require submission of clinical information before or after payment of claims, in connection with the plans’ adjudication of a physicians’ claim for payment, except as to claims for unlisted codes, claims to which a modifier 22 is appended and other limited categories of claims identified by each plan on its website.[7.8(d)(ii)]

**2. Physician Advisory Committee.** Each BCBS plan will set up a Physician Advisory Committee consisting of twelve (12) members; one of whom shall be plan's Chief Medical Officer; three selected by each BCBS plan; four selected by class counsel; and four selected jointly by the first eight. If available, one of the last three selected will be a nonparticipating physician. All of the physicians, except the Each BCBS plan's chief medical officer who will chair the Committee, will be physicians in active clinical practice. The Committee will have the right to consider issues of importance to physicians that are impacted by Each BCBS plan's practices and, where a majority agrees, present those issues to Each BCBS plan for Each BCBS plan's consideration. If each BCBS plan decides that a recommendation is not commercially feasible, each BCBS plan will have to post the Committee's recommendation on the website and each BCBS plan's rationale for rejection. [7.9]

**3. External Independent Billing Dispute Review.** Each BCBS plan will set up an independent external review mechanism that physicians may use for billing disputes, including disputes regarding each BCBS plan's coding rules or the appropriateness of each BCBS plan's requiring a physician to submit records in connection to the adjudication of a claim as provided in 7.8(d)(ii).

The organization that will serve as the External Review Board will be selected jointly by Each BCBS plan and the plaintiffs. If the amount of the dispute is \$1,000 or less, the filing fee will be \$50; if the amount in dispute exceeds \$1,000, the filing fee will be \$50, plus 5% of the amount in excess of \$1,000, and for billing disputes as provided in 7.8(d)(ii), the filing fee will be \$50.00. The Board's decision will be binding on each BCBS plan and the physician. [7.10]

**4. External Independent Medical Necessary Review.** Each BCBS plan will use the definition of "medical necessity" contained in 7.16(a) of the agreement. Medical necessity review will be available to either the member or the physician, but not both.

It will be by an independent review organization to be decided upon between each BCBS plan and plaintiffs. The filing fee will be \$50, unless the services involve precertification, in which case the filing fee will be the lesser of \$250 or the sum of \$50 and the amount by which the amount in dispute exceeds \$1,000. [7.11]

**5. Credentialing of New Physicians.** Each BCBS plan has agreed to begin the credentialing of a physician at such time as there is an agreement to employ the physician, rather than waiting until employment begins and to complete the primary source verification within 90 days of receiving the completed application. [7.13(a)]

**6. All Products Clause.** Each BCBS plan has agreed that it will not require a physician to participate in a capitated fee arrangement in order to participate in product networks in which the physician is compensated on a fee for service basis. Each plan also agrees that it will not require a physician to participate in its Medicare Advantage or Medicaid Product Networks in order to participate in its commercial product networks. If a physician chooses not to participate in more than one product line, or terminates participation in on of the company's product lines, the reimbursement levels offered by the plan will not be lower than the plan's standard reimbursement levels in that geographic area. [7.13(b)]

**9. Fee Schedules.** Each BCBS plan will establish one or more standard fee schedule for each geographic market in which it maintains a network. Effective January 1 of the year following final approval of the settlement, each BCBS plan will not reduce its fee schedules more often than once

annually. Each BCBS plan agrees that it will give notice of its intent to reduce fees as a material adverse change in accordance with 7.6. [7.14(a)]

**10. Payment for Vaccines.** Each BCBS plan has agreed to pay a fee (the applicable fee schedule for participating physicians and a reasonable fee for non-participating physicians) for the administration of vaccines and injectibles. Each BCBS plan has also agreed to pay for the vaccines and injectibles themselves. [7.14(b)]

**11. Usual, Reasonable and Customary Determinations.** Each BCBS Plan agrees that, to the extent it uses physician charge data to determine the usual, reasonable and customary amount to be paid for services performed by non-participating physicians, it will not use any internal claims database that (i) systematically under-reports the number of claims paid for procedures in the geographic area used by the BCBS Plan to determine such amount; (ii) eliminates or excludes the highest charges for paid claims for any procedures in the geographic area used by the BCBS Plan to determine such fees, provided, however, that such charges may be excluded if the BCBS Plan excludes an equivalent number or percentage of the lowest charges for such procedures, or reasonably determines that any such charges are the result of erroneous data; (iii) includes charges for procedures performed in a geographic area other than the one used by the BCBS Plan to determine such amount, provided, however, that such charges may be considered where the BCBS Plan determines there is an insufficient number of charges in the relevant geographic area to reasonably determine a usual, reasonable and customary amount; (iv) calculates the usual, reasonable and customary amount based upon fees paid under a discounted fee schedule rather than billed charges; and (v) lacks quality controls sufficient to reasonably test the validity of the data included in the database. [7.14(d)]

**12. Medical Necessity.** The agreement contains a definition of medical necessity. It has been a huge effort to get to a definition that is meaningfully consistent with the AMA definition and an amendment proposed by the CMA. Except where any applicable law requires a different definition, each BCBS pals agrees to use the following definition of “medical necessity:” 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. [7.16]

**13. Prompt Payment.** Each BCBS plan has agreed to accept from all physicians properly completed paper claims on Form CMS-1500 or electronic claims. Claims must be submitted within 180 days after the date of service or the date the physician receives an EOB from the primary payor, when each BCBS plan is the secondary payor. Beginning nine months after the agreement is approved, each BCBS plan has agreed to pay both paper and electronic claims within 30 calendar days

following receipt of the claim or the date that the BCBS plan is in receipt of all information needed and in a format required by the plan to constitute a completed claim. Beginning one year after the agreement is approved, each BCBS plan has agreed to pay completed claims submitted electronically within 15 business days of receipt. Each BCBS plan will pay interest at the rate of 6% on late payments, but is bound by state law where those rates are higher. [7.17 - .18]

**14. Downcoding.** Each BCBS plan has agreed that it will not automatically reduce the code level of any E&M code without the review of clinical data. [7.19]

**15. Coding Rules.** Each BCBS plan has agreed in 7.20 to certain rules for any claims processing. To the extent that we can get seventy-five percent (75%) of the market share of the commercial market to the table, Each BCBS plan will agree to work with plaintiffs' designees towards an industry standard claims editing software package.

Until then, Each BCBS plan will modify its claim-editing software to comply with the following editing results:

A. Each BCBS plan will not subject modifier 5l exempt codes to multiple procedure logic.

B. Each BCBS plan will recognize and reimburse separately all add-on codes and shall not subject them to multiple procedure logic.

C. Each BCBS plan will honor modifier 25 for separately identifiable procedures in conjunction with an E&M code.

D. Each BCBS plan will pay supervision and interpretation codes for radiologic guidance separate from associated procedure codes.

E. Each BCBS plan will honor all indented codes which, where on their face, they are separately reimbursable.

F. Each BCBS plan will honor modifier 59.

G. Each BCBS plan will limit global periods for those designated by CMS.

H. Each BCBS plan will not automatically downcode those codes which have an intensity component.

I. Each BCBS plan will update its claims editing software at least once each year.

**16. EOBs.** All EOBs will identify the member, the date of service, the amount of payment per line item, any adjustment to the invoice or to any code (and an explanation therefore), and shall specify an address and telephone number for any questions regarding the claim. The EOB will specify the amount the physician may bill the patient. In connection with a claim submitted by a non-participating physician, the EOB form will state "Physician may bill you" such amount and must notify the plan member of their responsibility to apply the payment to the applicable claim received by the plan member from the non-participating physician. [7.21]

**17. Overpayments.** Limits time period for each BCBS plan to seek overpayments to 18 months after payment of the original payment was received by the physician. [7.22]

**18. Efforts to Improve Accuracy of Information about Eligibility of Plan Members.** Sets forth steps each BCBS plan will take to reduce overpayments and claim denials resulting from inaccuracy of information about eligibility of Plan members. [7.23]

**19. Retroactive Changes in Patient/Procedure Medical Necessity.** Each BCBS plan has agreed that each BCBS plan will not revoke any pre-certification where the plan has previously determined medical necessity unless there is fraud, misrepresentation, or a material change in the member's health condition after pre-certification. [7.25]

**20. Information About Physicians on BCBS's Website.** Each BCBS plan will allow participating physicians the ability to update information on the plan's website regarding the physician's name, address and telephone number. Each BCBS plan agrees that when it is notified in writing that each BCBS plan's website incorrectly lists a physician as a Participating Physician, each BCBS plan will delete the erroneous reference within 20 business days and ensure that written materials are revised to reflect the correction. [7.27]

**21. Capitation.** [7.28]

A. All capitated physicians will be provided monthly reports listing assigned plan members, including name, address, deductible, age, gender, health plan, medical group number, co-payment, cap rate, PCP, and enrollment date. This information is also available to capitated specialty physicians.

B. Members will be assigned a primary care physician upon enrollment where the member does not select a primary care physician. Cap payments to that FCP shall be made retroactively to date of enrollment.

**22. Gag Clauses.** None in any contract. [7.29(a)]

**23. State Law.** To the extent that state law provides a more favorable remedy than the settlement agreement the terms and conditions set forth by state statute will replace the terms and conditions in this agreement. [7.29(m)]

## **Section 8. "Other Settlement Considerations."**

**1. Settlement Fund.** Each BCBS plan will contribute a specified amount to the Settlement Fund for the administration of settlement payments. The total of all such contributions is \$131,209,507 which has been accruing interest since June 30, 2007. [8.2]

**2. Settlement Administrator.** The Settlement Administrator, under the joint supervision of the parties and the Court, will be responsible for the administration of the Fund. [8.3]

**3. Method of Distribution of the Settlement Fund.** Each class member will be entitled to elect whether to receive payment from the Settlement Fund or to contribute their portion to the Foundation. The amount received by each retired physician will be equal to the total amount in the

Settlement Fund multiplied by two times the quotient derived by dividing the number of retired physicians who file valid claims by the total number of class members. Each class member who, within 90 days of the Notice Date, files a valid Claim Form with the Settlement Administrator will be entitled to receive a pro rata distribution from the Settlement Fund, based in part, on the amount paid by each BCBS plan for the years 2004, 2005, and 2006 to the physician, i.e., whether each BCBS plan paid the physician (a) less than \$5,000; (b) between \$5,000 and \$50,000; or (c) \$50,000 or greater. Physicians in category (a) will receive a base amount; physicians in category (b) will receive five times the base amount; and physicians in category (c) will receive ten times the base amount. Each physician may elect to receive the payment or to direct the payment to be contributed to the Physicians's Foundation for Health Systems Innovation or to an Eligible Organization. [8.3]

**4. Reversion to Foundation of Unclaimed Amounts.** At a time determined by the Settlement Administrator, but not less than 120 days after all payments have been disbursed to physicians, the Settlement Administrator will determine the amount of funds in the Settlement Fund that will revert to the Foundation. After 20 business days' notice to the parties, the funds will be transferred. [8.6]

#### **Section 12. "Compliance Disputes."**

1. All compliance disputes will be referred to a Compliance Dispute Facilitator selected by Class Counsel. The Compliance Dispute Facilitator will refer all disputes to a Compliance Dispute Officer for resolution. There will first be mediation between the parties, and if mediation fails to resolve the dispute, the Compliance Dispute Officer will resolve the dispute. His decision is final unless appealed to the Court. [12]