ANALYST CHECKLIST
PROVIDER AND FACILITY AGREEMENTS

Issuer: _____
Agreement Form Number: _____

GENERAL REVIEW REQUIREMENTS

Authority to Review Agreement – RCW 48.44.070, RCW 48.46.243, RCW 48.43.730, RCW 48.39.003, & WAC 284-170-480

Topic	Subtopic	Reference	Specific Issues	Location
Administrative Policies		RCW 48.43.505 WAC 284-170-421(5)	The agreement must describe the responsibilities of providers and facilities under the issuer's administrative policies and programs, including but not limited to: a. Payment terms; b. Utilization review; c. Quality assessment and improvement programs; d. Credentialing; e. Grievance, appeal, and adverse benefit determination procedures; f. Data reporting requirements; g. Pharmacy benefit substitution processes; h. Confidentiality requirements; and i. Any applicable federal or state requirements. Generic statements and legal citations do not provide enough information.	
Audit Guidelines		WAC 284-170-460	1. Provider and facility agreements may not grant the issuer access to health information unrelated to enrollees. 2. If the agreement grants the issuer access to medical records for audit purposes, the agreement must state that access is limited to information necessary to perform the audit. 3. The terms of any billing audit standards must be mutual: If the agreement allows the issuer to audit provider or facility billing records, then the provider or facility has the right to audit the issuer's billing records.	
Chiropractor Services Reimbursement		RCW 48.43.083	1. If a chiropractor signs the agreement, the issuer may not deny payment to the chiropractor if: a. the service is covered chiropractic health care, provided by the chiropractor or the chiropractor's employee; and	

			b. the chiropractor complies with the provider agreement. 2. If the issuer offers a chiropractor a participating provider agreement, the issuer must offer the same agreement to any other chiropractor within that practice providing services at the same location.	
Clean Claims		WAC 284-170-431	Provider and facility agreements must describe the standards for the prompt payment of clean claims. Generic statements and bare legal citations do not provide enough information. a. 95% of monthly clean claims must be paid within 30 days of receipt; b. 95% of all claims must be paid or denied within 60 days; c. 1% Interest per month must be paid on all non-denied and unpaid clean claims 61 days or older when issuer does not meet the standards; and d. The definition of clean claim must be consistent with the WAC language.	
	Pay and Pursue	WAC 284-170-431 WAC 284-51-215(1)	Provider and facility agreements should explain how the issuer administers coordination of benefits: 1. Issuer must not unreasonably delay payment of a claim by reason of the application of COB. 2. Issuer must establish a time limit for payment of claims and may not unreasonably delay payment.	
Compensation Notification		WAC 284-170-421(6)	1. Participating providers and facilities must be given reasonable notice of not less than 60 days of changes that affect provider or facility compensation or that affect health care service delivery. 2. Provisions for changing the terms of the agreement must permit the provider or facility to terminate the agreement rather than serve under unacceptable terms. However, the provider or facility must provide at least 60 days written notice to the issuer before termination.	
Conducting Business in Licensed Name		RCW 48.05.190 RCW 48.30.050 RCW 48.44.040 RCW 48.46.060	Issuers conducting business in the State of Washington must do so under the name licensed. Provider and facility agreements filed with the OIC must clearly indicate the name of the issuer who is ultimately responsible for conditions identified in the agreement. 1. All parties to the agreement must be disclosed. 2. The names of the parties should be used consistently throughout the agreement. 3. The issuer cannot use one agreement to bind the provider or facility to all of the entities in the issuer's corporate organization. The issuer must ask the provider or facility to sign a separate agreement with each affiliate.	
Content of Filing	*Complete Filing Documents*	RCW 48.44.070 RCW 48.46.243(3)(a) RCW 48.43.730 WAC 284-170-480 WAC 284-44A-050 WAC 284-46A-050	1. All forms that are part of the agreement, including exhibits, payment schedules, regulatory appendix, etc., must be filed, in their entirety for review via SERFF. 2. Compensation exhibits and payment schedules must be filed separately in a "not-for public" filing as described in the Washington State SERFF Health and Disability Form Filing General Instructions.	

	Examination/ Disapproval	WAC 284-170-480(1)	1. Issuer must file for approval all provider and facility agreements at least 30 days prior to use. 2. Issuer must file for approval any negotiated agreement that deviates from an approved agreement at least 30 days prior to use.	
	Template Filings and Negotiated Agreement Filings	RCW 48.44.070 RCW 48.46.243(3)(a) RCW 48.43.730 WAC 284-170-480(2)	1. An issuer may file a provider or facility agreement template with the OIC, which the issuer may use to contract with multiple providers or facilities. The template must be issued exactly as approved. 2. An issuer must submit changes to a template agreement to the OIC 30 days prior to use. 3. Changes to a previously approved compensation exhibit modifying only the compensation amount or terms related to compensation must be filed and are deemed approved upon filing. 4. All negotiated agreements must be filed with the OIC 30 days prior to use. If the negotiated agreement only changes the compensation amount or terms related to compensation, then only the compensation exhibit must be filed and is deemed approved upon filing.	
	Extension	RCW 48.44.070 RCW 48.46.243(3)(b) RCW 48.43.730 WAC 284-170-480(3)	If the commissioner takes no action within 30 days after submission, the form is deemed approved, **EXCEPT** the OIC may extend the approval period an additional 15 working days giving notice before the expiration of the initial 30 days.	
	Issuer must maintain copies	RCW 48.44.070 RCW 48.46.243 WAC 284-170-480(4)	The issuer must have access to all provider and facility agreements and provide copies to the OIC upon 20 days prior written notice from the commissioner.	
		RCW 48.44.070 RCW 48.46.243 WAC 284-170-411(4)	An issuer must make its selection standards for participating providers and facilities available for review upon request by the commissioner.	
Contracting Outside Health Care Plan		RCW 48.43.085	1. The agreement may not contain any provisions that will constrain enrollees, directly or indirectly, from freely contracting for services outside the plan on terms and conditions they choose. 2. The agreement must not discourage the provider or facility from contracting outside of the plan for non-covered services.	
Contract Termination		WAC 284-170-421(9)	1. Issuer and participating providers and facilities must provide at least a 60-day notice to each other before terminating the agreement without cause. 2. Whether the termination was for cause, or without cause, the issuer must make a good faith effort to notify enrollees who are patients within 30 days prior to termination. a. The agreement does not need to contain the 30-day notice, but the agreement cannot contain conflicting language.	
	Continuity of Care	RCW 48.43.515(7)	An issuer must cover the services of a PCP whose agreement with the plan or whose agreement with a subcontractor is terminated without cause under the terms of that agreement for at least 60 days following notice of termination to the enrollee.	

Enrollee Coverage ***Non-discrimination***		WAC 284-170-421(11)	The agreement must instruct participating providers and facilities to furnish covered services to enrollees without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in the publicly financed programs of health care services. Providers and facilities should be notified, even if they do not participate in the publicly financed programs. a. No wording should differentiate care for a subscriber who purchases privately vs. one on a public program.	
Enrollee Eligibility Notification		RCW 48.43.525 WAC 284-170-421(1) & (2) WAC 284-43-3070(1)(b)	1. The agreement must tell the provider or facility how to obtain eligibility and benefit information. 2. The agreement may not modify benefits, terms, or conditions contained in the health plan. In the event of a conflict between the agreement and the health plan, the benefits, terms, and conditions of the health plan must govern. 3. The agreement may not contain language for rescinding authorization and refusing payment even where treatment was pre-authorized. 4. The issuer must notify the provider of any adverse benefit determination that involves the pre-service denial of a treatment or procedure prescribed by the provider.	
Grievance Procedures		RCW 48.43.055 WAC 284-170-421(13) WAC 284-170-440 *Kruger Clinic Orthopaedics v. Regence BlueShield* *T 06-03*	1. The agreement must describe the issuer's procedures for review and adjudication of complaints arising out of the agreement. A reference to the issuer's policy and procedure manual does not provide enough information. 2. Dispute resolution process: a. Is there a formal process? b. Not less than 30 days to file a dispute. c. All likely disputes covered? d. Unfairly advantages issuer? e. Cannot exclude judicial remedies. f. Cannot require binding Arbitration. g. Billing disputes resolved within 60 days? 3. If the issuer fails to grant or reject a request for review within 30 days, the complaint can be considered "rejected" by the provider/facility and may be submitted to nonbinding mediation.	
Hold Harmless & Insolvency		WAC 284-170-421(3)	Each provider and facility agreement must include the hold harmless and insolvency language as stated in the WAC. Providers and facilities must agree that: 1. They will not bill the patient for services provided under the contract; 2. They will continue treatment; 3. The contract cannot modify the enrollee's rights under the health plan; 4. They will not bill the enrollee where issuer denies payment due to a breach of the agreement; 5. The hold harmless requirement survives the agreement; and 6. Subcontractors of the provider or facility must agree to the hold	

			harmless requirement.	
	Liability of Participant	RCW 48.44.020(4)(a) RCW 48.46.243(1)	1. Are all agreements in writing and state that in the event of issuer failure to pay for services the enrollee will not be liable to the provider or facility for sums owed by the issuer? 2. Does the agreement require that this hold harmless provision survives the termination of the agreement?	
	Payment Collection	RCW 48.80.030(5) & (6) WAC 284-170-421(4)	Agreements must inform providers/facilities that it is a class C felony to collect payment from enrollees in violation of the agreement.	
Indian Health Care Providers	*Addendum*	WAC 284-170-310(5)(a)	Issuers are encouraged but not required to use the Indian Health Care Provider Addendum. If the issuer is using the addendum, is it the most current version of the: a. "Washington State Indian Health Care Provider Addendum"? http://www.aihc-wa.com/ b. "Model QHP Addendum for Indian Health Care Providers"? http://www.cms.gov/CCIIO/Programs-and-Initiatives/Files/Downloads/Model_QHP_Addendum_04_04_13.pdf	
		25 USC 1621(a) *Section 206(a) and (e)*	Does the addendum or agreement contain provision(s) that conflict with federal reimbursement requirements?	
Military Service		WAC 284-170-390	1. Does the agreement contain any language that will deny a provider that leaves the network due to active duty military service, the right to return to the network after s/he returns to civilian status? 2. If the agreement contains such a provision, does the provision meet the timeframes set forth in the WAC?	
Non-covered Services ***Dental Services***		RCW 48.20.417 RCW 48.21.147 RCW 48.44.495	Does the agreement contain any language that will prohibit, directly, or indirectly, a dentist who is a participating provider from offering or providing to an enrolled participant dental services that are not covered services on any terms or conditions acceptable to the dentist and the enrolled participant?	
Non-covered Services ***Health Care Services*** *(Effective January 1, 2017)*		Laws of 2015, ch. 251 (E2SHB 1471)	The agreement may not require a provider to give a discount from usual and customary rates for health care services that are not covered services.	
Notice of Material Changes		RCW 48.39.003 et seq.	1. Providers and facilities must be given at least a 60-day notice of changes that would require them to participate in a plan with a lower fee schedule in order to continue participation in a plan with a higher fee schedule. 2. Such notice must be given before the provider or facility's notice period begins and must inform the provider or facility that they may reject the change without affecting the terms of their existing contract.	

Overpayment Recovery	*Issuer Requirement*	RCW 48.43.600	Provider agreements must explain the issuer's procedures for overpayment recovery. Generic statements and legal citations do not provide enough information. 1. Except in the case of fraud, an issuer may not request a refund from a **health care provider** of a payment previously made to satisfy a claim unless it does so in writing to the provider within 24 months after the date payment was made. The time period must be reciprocal. 2. In the case of COB, the issuer must request a refund from a health care provider of payment previously made to satisfy a claim within 30 months after the date payment was made. 3. Additional refund/payment cannot be requested any sooner than six months after the initial request is made. 4. Not applicable to subrogation claims.	
	"HealthCare Provider" or "Provider" Requirement	RCW 48.43.005(16) RCW 48.43.605	1. Except in the case of fraud, a **health care provider** may not request payment from the issuer to satisfy a claim unless it does so in writing to the issuer within 24 months after the date the claim was denied or payment intended to satisfy the claim was made. 2. In the case of COB, the provider must request from the issuer within 30 months after original payment was made any additional balances owed. 3. Additional refund/payment cannot be requested any sooner than six months after the initial request is made. 4. Not applicable to subrogation claims.	
Pharmacy Audit	*Rules / Prohibited Practices*	RCW 19.340.040	An entity that audits pharmacy claims or contracts with another entity to audit such claims: 1. Must have a written appeals procedure and notify the pharmacy about the appeals procedure before conducting an audit; 2. May not audit a claim more than 24 months after adjudication; 3. Must notify the pharmacy 15 days before an on-site audit at the pharmacy or its corporate headquarters; 4. May not conduct an on-site audit during the first five days of any month without the pharmacy's consent; 5. Must consult with a licensed pharmacist if the audit involves clinical or professional judgment; 6. May not conduct an on-site audit of more than 250 unique prescriptions within 12 months except in cases of alleged fraud; 7. May not conduct an on-site audit more than once every 12 months; 8. Must audit similar pharmacies under the same standards and parameters; 9. Must pay outstanding claims within 45 days after the earlier of the date all appeals are concluded or the date a final report is issued; 10. May not add dispensing fees or interest to any overpayment amounts unless the overpaid claim was for an incorrectly filled prescription; 11. May not recoup costs for clerical errors or other errors that did not result in financial harm to a consumer; and 12. May not charge a pharmacy for denied or disputed claims until the audit	

			and appeals procedures are final.	
	Basis for findings	RCW 19.340.050	An entity must find that a pharmacy claim was incorrectly presented or paid based on identified transactions and not based on probability sampling, extrapolation, or other projections.	
	Audits by 3d Party	RCW 19.340.060	When an entity contracts with an independent third party to conduct audits, the entity may not agree to payment based on a percentage of the overpayments recovered. The third party may not disclose information obtained during an audit except to the entity, the audited pharmacy, or the holder of the policy or certificate of insurance that paid the claim.	
	Evidence of validation of claim	RCW 19.340.070	An entity that audits pharmacy claims or contracts with another entity to audit such claims, must allow as evidence of validation of a claim: 1. An electronic or physical copy of a valid prescription if the drug was picked up, delivered, or mailed within 14 days of the dispensing date; 2. Point of sale electronic register data showing purchase of the drug, medical supply, or service by the patient or the patient's designee; or 3. Electronic records, including signature logs and patient records, and any other reasonably clear and accurate documentation.	
	Audit report	RCW 19.340.080	1. The pharmacy must receive an electronic or mailed preliminary report of the audit within 45 days after the audit is complete. 2. Upon receipt, the pharmacy has no less than 45 days to appeal the report and to submit additional documentation in support of a claim. 3. If an audit results in a claim dispute or denial, the entity must allow the pharmacy to resubmit the claim. 4. The pharmacy must receive a final report of the audit, including an accounting of money owed to the entity, within 60 days after receiving the preliminary report or within 60 days of the appeal. 5. Unless the pharmacy otherwise agrees, the entity may not collect disputed funds until after the audit and appeals. If the discrepancy from a single audit exceeds $40,000, the entity may withhold future payments to the pharmacy until after the audit and appeals.	
	Fraud application	RCW 19.340.090	An entity may bring an action for fraud against the pharmacy. The pharmacy audit requirements do not apply when an investigation indicates fraud or when a state agency or its contractor is auditing records for prescriptions paid for by the state medical assistance program.	
Pharmacy Emergency Fill Disclosure		WAC 284-170-470(7)	Every pharmacy provider or facility agreement must disclose that the issuer will authorize an emergency fill by the dispensing pharmacist and approve a claim for payment for the emergency fill when: 1. the dispensing pharmacy cannot reach the issuer's prior authorization department by phone due the call being placed outside of the department's business hours; or 2. the issuer is available by phone, but the issuer cannot reach the prescriber for full consultation. The definition of "emergency fill" must be consistent with the WAC.	

Pharmacy Preauthorization Disclosure		WAC 284-170-470(5)	Every pharmacy provider or facility agreement must disclose: 1. whether the provider or pharmacy has the right to request preauthorization; and 2. that if the issuer requires the authorization number to appear on a pharmaceutical claim, the issuer will provide the number to the billing pharmacy after approval of the preauthorization request and upon receipt of a claim for that authorized medication.	
Provider/Patient Care		RCW 48.43.510(6) RCW 48.43.510(7) WAC 284-170-421(7)(a) & (b)	Each provider and facility agreement must include the language from the WAC allowing providers to inform patients about care and issuer merits.	
Provider Manual **(Should Not Be Incorporated in Agreement)**		RCW 48.43.055 RCW 48.44.070(1) RCW 48.46.243(3)(a) WAC 284-170-411(4) WAC 284-170-421 WAC 284-170-480(4)	1. The entire provider or facility agreement must be filed for review. 2. Please do not reference the provider manual in the agreement. a) If the provider or facility agreement references or incorporates by reference additional documents, administrative manuals, or procedures, such documents, manuals, and procedures must be submitted to the OIC for approval.	
Record Retention		WAC 284-170-421(8)	Issuer must require providers and facilities to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of enrollees subject to applicable state and federal laws related to confidentiality of medical or health records.	
Standard of Care		RCW 48.43.545	1. Issuer may not unfairly transfer liability. 2. Are Indemnity/liability clauses consistent with the responsibility/right to determine when treatment is medically necessary?	
Subcontractors		WAC 284-170-240 WAC 284-170-401	1. Has the issuer filed 1) an executed copy of its agreement with a subcontracted network and 2) copies of the subcontracted network's agreements with its providers and facilities, following the procedures set out in the Washington State SERFF Health and Disability Form Filing General Instructions? a) A subcontracted network must include all providers in the network that have a signed and executed agreement for that network. The agreement may not contain any language that would allow: i. for providers to be excluded from participation; or ii. for the issuer to select providers for inclusion in a subcontracted network. 2. An issuer must ensure that subcontracted providers and facilities meet all of the requirements that apply to contracted providers and facilities.	
Temporary Substitution of Contracted Providers	*"Locum tenens"*	WAC 284-170-380	The agreement may not restrict a contracted provider from arranging for a substitute provider for at least 60 days during any calendar year. The issuer must grant an extension if the contracted provider demonstrates that exceptional circumstances require additional time away from his or her practice.	

Tiered Networks		WAC 284-170-330	1. Does the agreement clearly identify to the provider or facility that the issuer agreement is for a tiered network? 2. Does the agreement include language identifying for the provider or facility that if the issuer revises or amends a quality, cost efficiency or tiering program related to its network that it will provide at least a 60-day notice of this change? 3. Has the issuer guaranteed in the agreement that it will provide the physician/facility cost profile, including written criteria by which the provider's or facility's performance is measured? 4. If the agreement includes information about notification requirements; has the issuer properly required the notice to be sent from the issuer? The responsibility for notification cannot be transferred to the provider/facility.	
Utilization Review		RCW 48.43.520 RCW 48.43.525 WAC 284-43-2000	1. The agreement must tell the provider or facility how to obtain preauthorization. 2. Issuer may not retrospectively deny coverage for emergency or non-emergency care that was preauthorized. 3. Retrospective review decisions are based solely on the medical information available to the attending physician at time the health services were provided. 4. Retrospective review determinations must be completed within 30 days of receipt of the necessary information.	