

FEE DISCOUNT AGREEMENT

FREQUENTLY ASKED QUESTIONS

WHAT IS A FEE DISCOUNT AGREEMENT?

A Fee Discount Agreement is an agreement between an insurer and a medical service provider or clinic for the purpose of discounting payments under OAR 436-009-0040. An insurer may only apply a discount to a medical service provider's or clinic's bill when the provider or clinic has entered into a Fee Discount Agreement. However, if the worker has been enrolled in a Managed Care Organization, the MCO discount rate must be applied, even when the parties have entered into a Fee Discount Agreement. *See* OAR 436-009-0018 and -0040.

Fee Discount Agreements created under OAR 436-009-0018 only apply to medical service providers and clinics. OAR 436-010-0005 defines a medical service provider as a person duly licensed to practice one or more of the healing arts. OAR 436-009-0005 defines a clinic as a group practice in which several medical service providers work cooperatively.

Under the administrative rules, an insurer may not apply a provider-network discount rate (other than a discount under a Managed Care Organization contract) to a medical service provider's or clinic's payments calculated under OAR 436-009-0018. Insurers may apply provider-network discounts to other medical providers such as an Ambulatory Surgical Center or hospital, or supplies under the rules, or when the director has not adopted a fee schedule. However, those contracts or agreements are not reported through the online registration form. Only Fee Discount Agreements are required to be reported.

DOES THE LANGUAGE IN OAR 436-009-0040(1) MEAN THAT ANY CONTRACT MAY BE APPLIED WHEN CALCULATING PROVIDER FEES UNDER THE RULE?

No. OAR 436-009-0018(1) places a limitation on the types of contracts or agreements the insurer may apply to a medical service provider's or clinic's billing. The rule provides that an insurer may only apply an MCO discount rate, or Fee Discount Agreement discount rate to a medical service provider's or clinic's bill. Because there is a limitation, if an insurer applies any other type of discount rate, such as a provider network that is not a certified Managed Care Organization, the insurer may be subject to penalties and sanctions.

UNDER OAR 436-009-0100(2), IF AN INSURER DISAGREES WITH THE CPT CODE A PROVIDER HAS USED AND REIMBURSES THE PROVIDER UNDER A FEE DISCOUNT AGREEMENT BASED ON ANOTHER CPT CODE'S RELATIVE VALUE UNIT, WILL THE INSURER BE SUBJECT TO PENALTIES?

No. It is considered a disagreement about the service provided, and not the discount rate. However, the insurer's decision is subject to administrative review if the provider requests a review.

OAR 436-009-0100(2) applies when an insurer and medical service provider have entered into a Fee Discount Agreement, and the insurer applies an incorrect discount rate. For example, an insurer may be subject to civil penalties if the parties enter into a Fee Discount Agreement for a discount rate of 5 percent, but the insurer applies a 10 percent discount to the provider's bill. The director's decision may be appealed to the Workers' Compensation Board in the same manner as any other civil penalty.

DOES OAR 436-009-0030(5) REQUIRE THAT AN INSURER PROVIDE A COMPLETE ANSWER TO A PROVIDER'S BILLING INQUIRY?

No. The rule requires that the insurer respond with some type of answer within 48 hours. An answer can include a short response with assurances of a more complete answer to follow.

DOES THE DISCOUNT LIMITATION OF 10 PERCENT APPLY TO MANAGED CARE ORGANIZATIONS?

No. OAR 436-009-0018(2) states that “Any discount under a *fee discount agreement* cannot be more than 10 percent of the fee schedule.” The rule does not place a limitation on the discount rates a Managed Care Organization may negotiate and apply.

DOES OAR 436-015-0007 LIMIT AN INSURER, OR SOMEONE ACTING ON THE INSURER’S BEHALF, WHEN CONDUCTING UTILIZATION REVIEW OR CASE MANAGEMENT?

An insurer or someone acting on behalf of the insurer may conduct utilization review and case management activities as part its business operations.

However, only a provider network that has certified with the director as a Managed Care Organization may limit choice of providers available to an enrolled worker, or compel a provider to adhere to specific guidelines, protocols, or standards adopted by the MCO. An example of behavior to compel specific performance is when a provider is threatened with being removed from a panel unless the provider conforms to the treatment being suggested.

When a worker is not enrolled in an MCO, the worker may choose any provider allowed under ORS chapter 656, unless the worker has exceeded three initial choices. Through utilization review and case management activities, the insurer or someone acting on behalf on the insurer may not compel the provider to pursue specific or suggested treatments. If the insurer disagrees with the treatment choices

of the provider, the insurer may request administrative review to resolve the disagreement.

ARE PROVIDER NETWORKS THAT ARE NOT CERTIFIED AS A MANAGED CARE ORGANIZATION PREVENTED FROM ENTERING INTO ANY CONTRACTS WITHIN THE OREGON WORKER’S COMPENSATION SYSTEM?

No. Under the administrative rules, an insurer may not apply a provider-network discount rate (other than a discount under a Managed Care Organization contract) to a medical service provider’s or clinic’s payments calculated under OAR 436-009-0040. However, insurers may apply provider-network discounts to other medical providers or supplies under the rules, or when the director has not adopted a fee schedule.

MAY INSURERS ENTER INTO FEE DISCOUNT AGREEMENTS WITH PHARMACY BENEFIT MANAGEMENT COMPANIES, SUCH AS THE OREGON PRESCRIPTION DRUG PLAN?

No. OAR 436-009-0018 allows insurers to enter into Fee Discount Agreements with medical service providers or clinics. OAR 436-010-0005 defines a medical service provider as “a person duly licensed to practice one or more of the healing arts.” OAR 436-009-0005 defines a clinic as “a group practice in which several medical service providers work cooperatively.”

A pharmacy benefit management company does not meet the definition of either a medical service provider or clinic. Therefore, an insurer may not enter into a Fee Discount Agreement with a pharmacy benefit management company. However, those parties may enter into other types of agreements or contracts. Insurers do not report those agreements or contracts to the director.

SHOULD INSURERS REPORT ANY CONTRACT OR FEE DISCOUNT LANGUAGE THEY MAY HAVE WITH PHARMACY BENEFIT MANAGEMENT COMPANIES TO THE DIVISION?

No. The rule requires Fee Discount Agreements to be reported to the director. Only a medical service provider (which is a specifically defined provider) or clinic may enter into a fee discount agreement with an insurer.

In all other cases, any contract may be applied to determine reimbursement (such as hospital or pharmacy fees), and those contracts are not required to be reported or registered with the director.

DOES THE FEE DISCOUNT AGREEMENT ONLY APPLY TO INSURERS AND SELF-EMPLOYERS?

The rule very narrowly defines a "fee discount agreement" as a contract between a medical service provider and an insurer. Insurer is defined to be the State Accident Insurance Fund Corporation, an insurer authorized to transact workers' compensation insurance in the state under ORS chapter 731, an assigned claims agent under ORS 656.054, or an employer or employer group certified under ORS 656.430 as meeting self-insured qualifications under ORS 656.407. As a result of that narrow definition, the insurer must be a party to the Fee Discount Agreement..

IS THE FEE DISCOUNT AGREEMENT REGISTRATION BETWEEN THE PROVIDER AND THE DIRECTOR?

No. Only the insurer has to report the Fee Discount Agreements to the director.

WHAT IS THE FEE DISCOUNT AGREEMENT REGISTRATION PROCESS?

The online registration is only for the insurer or self-insured employer to sign up once they have entered into an agreement with a provider. Starting Jan. 1, 2009, medical service providers and clinics may enter into Fee Discount Agreements with insurers and self-insured employers. Once the insurer and provider sign the agreement, the insurer must register the agreement online with the division. Insurers and self-insured employers must report agreements online before applying a discount. The agreement (Form 3659) must be on the providers letterhead to be

valid. Once that is done anyone may go and view the report that list the insurer and providers they have agreements with.

IS THE INFORMATION CONTAINED WITHIN THE FEE DISCOUNT AGREEMENT REGISTRATION SYSTEM AVAILABLE FOR ALL PROVIDERS TO VIEW, OR IS THE ACCESSIBILITY LIMITED TO THE AGREEMENTS BETWEEN THE MEDICAL PROVIDER AND THE AGREEMENT THEY HAVE WITH THE INSURER?

Partially. The division is collecting proprietary information through the online registration process. Individuals visiting the website will be able to generate a report that will identify when a medical service provider or clinic has entered into, but it will not contain any proprietary information such as discount rates. The report will show agreements as soon as the insurer enters them into the system.

CAN THE INSURER AND PROVIDER CHANGE THE AGREEMENT AFTER IT HAS BEEN REPORTED?

No. The agreement may not be changed once the insurer reports the agreement. The active agreement must be terminated and the insurer and medical service provider or clinic must enter into a new Fee Discount Agreement with the medical service provider or clinic. The insurer must report the new Fee Discount Agreement once the insurer and the medical service provider or clinic has signed the Fee Discount Agreement.