Certified Registered Nurse Anesthetist
Direct Reimbursement Participation Agreement
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Direct Reimbursement Participation Agreement

THIS AGREEMENT is made by and between Blue Cross Blue Shield of Michigan (BCBSM) and the undersigned Certified Registered Nurse Anesthetist (CRNA).

Pursuant to this Agreement, CRNA and BCBSM agree as follows:

ARTICLE I
DEFINITIONS

For purposes of this Agreement, defined terms are:

1.1. “Agreement” means this Agreement, and all exhibits and Addenda attached hereto, or other documents specifically referenced and incorporated herein.

1.2. “Alternative Delivery System” (ADS) means any preferred provider organization, health maintenance organization, point of service or other than traditional delivery systems owned, controlled, administered or operated in whole or in part, by BCBSM or its subsidiaries, which have elected to participate in the CRNA Direct Reimbursement Program, or by any other Blue Cross and/or Blue Shield (BCBS) Plan.

1.3. “BCBS Plans” means organizations which are licensed by the Blue Cross and Blue Shield Association to use the Blue Cross and/or Blue Shield names and service marks. Unless otherwise specified, the term BCBS Plans includes BCBSM.

1.4. “Certificate” means benefit plan descriptions under the sponsorship of BCBSM or other Blue Cross and Blue Shield Plans, or certificates and riders issued by or under their sponsorship, or arrangements with any employer group, including any self-funded plan, where BCBSM or other BCBS Plans administer benefits. For purposes of this Agreement only, “sponsorship” includes any Alternative Delivery System(s).

1.5. “Covered Services” means those anesthesia services which are: (i) listed or provided for in Certificates, (ii) Medically Necessary as set forth in Addendum “A”, (iii) within the CRNA’s scope of license, (iv) are provided personally by the CRNA, and (v) performed in an approved setting. For purposes of this Agreement, “Approved Settings” are; Peer Group 1-4 hospitals, Ambulatory Surgery Facilities (ASFs) that are licensed as Freestanding Surgical Outpatient Facilities in Michigan, and Peer Group 5 hospitals if the CRNA service is not included in BCBSM’s facility payment to the hospital.
1.6. “Member” means a person entitled to receive Covered Services pursuant to Certificates.

1.7. “ADS Services” means those anesthesia services provided to a member of an Alternative Delivery System which are benefits under the contract between the member and such System.

1.8. “Physician” means only doctors of medicine or doctors of osteopathy for all purposes as used in this Agreement including any addenda, except Addendum A.

1.9. “Qualification Standards” means those criteria established by BCBSM which are used to determine CRNA’s eligibility to become or remain a participating CRNA provider as set forth in Addendum B.

1.10. “Reimbursement Policies” means the policies by which BCBSM determines the amount of payment due CRNA for Covered Services.

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ARTICLE II
CRNA RIGHTS AND OBLIGATIONS

2.1. Services to Members. CRNA, within the limitations of Michigan licensure laws, will provide Covered Services to Members based on BCBSM Medical Necessity criteria as set forth in Addendum A, and as governed by this Agreement and all other BCBSM policies in effect on the dates Covered Services are provided.

2.2. Qualification Standards. CRNA will comply with the Qualification Standards established by BCBSM and agrees that BCBSM has sole discretion to amend and modify these Qualification Standards from time to time, provided BCBSM will not implement any changes in the Qualification Standards without sixty (60) days prior written notice to CRNA. The current Qualification Standards are set forth in Addendum B.

2.3. Reimbursement. BCBSM will timely process acceptable claims submitted by CRNA and will make payment directly to CRNA for Covered Services provided only in an Approved Setting in accordance with the reimbursement methodology set forth in Addendum C. Except for copayments and deductibles, CRNA will accept the BCBSM payment as full payment for Covered Services and for any ADS Services rendered to a member of an Alternate Delivery System, and agrees not to collect any further payment, except as set forth in Addendum G.
2.4. **Claims Submission.** CRNA will submit acceptable claims for Covered Services and for any ADS Services provided to members of Alternative Delivery Systems directly to BCBSM using BCBSM approved claim forms, direct data entry systems, tape-to-tape systems or such other methods as BCBSM may approve from time to time. An acceptable claim is one which complies with the requirements stated in published BCBSM administrative manuals or additional published guidelines and criteria. All claims shall be submitted within one hundred eighty (180) days of the date(s) of service. Claims submitted more than one hundred eighty (180) days after the date(s) of service, shall not be entitled to reimbursement from either BCBSM or a Member except as set forth in Addendum G, or except as may be provided in the standard reimbursement policies or contractual arrangements between an Alternative Delivery System and its members.

CRNA will endeavor to file complete and accurate claims and report overpayments in accordance with the Service Reporting and Claims Overpayment Policy attached as Addendum F.

2.5. **Eligibility and Benefit Verification.** BCBSM will provide CRNA with a system and/or method to promptly verify eligibility and benefit coverages of Members; provided that any such verification by BCBSM will be given as a service and not as a guarantee of payment.

2.6. **Administrative Manuals and Bulletins.** BCBSM will, without charge, supply CRNA with one copy of any administrative manual, guidelines and administrative information concerning billing requirements and such other information as may be reasonably necessary for CRNA to properly provide and be reimbursed for Covered Services to Members pursuant to this Agreement.

2.7. **Utilization and Quality Programs.** CRNA will adhere to BCBSM’s policies and procedures regarding utilization review, quality assessment, precertification and case management, or other programs established or modified by BCBSM, and will retain records as set forth in BCBSM administrative policy. BCBSM agrees to furnish CRNA with information necessary to adhere to BCBSM policies and procedures.

2.8. **CRNA Changes.** CRNA will immediately notify BCBSM if CRNA fails to meet any of the Qualification Standards set forth in Addendum B.

2.9. **Record Retention.** CRNA will prepare and maintain all appropriate medical and financial records related to Covered Services provided to Members as required by any BCBSM published policies and procedures and as required by law.
2.10. **BCBSM Access to Records.** BCBSM represents that BCBSM Members, by contract, have authorized CRNA to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and treatment. CRNA will release patient information and records requested by BCBSM to enable it to process claims and for pre or post-payment review of medical records and equipment, as related to claims filed.

2.11. **Audits and Recovery.** CRNA agrees that BCBSM may photocopy, review and audit CRNA’s records to determine, but not necessarily limited to, verification of services provided, Medical Necessity of services provided, and the appropriateness of procedure codes and modifiers reported to BCBSM, and to obtain recoveries based on such audits as set forth in Addendum H.

2.12. **Confidentiality.** BCBSM and CRNA will maintain the confidentiality of Members’ and of each party’s records and information of a confidential or sensitive nature in accordance with applicable state and federal law and as set forth in Addendum D. BCBSM will indemnify and hold CRNA harmless from any claims or litigation brought by Members asserting any breach of the BCBSM Confidentiality Policy. This provision will not preclude BCBSM from communicating with its subsidiaries and/or agents regarding CRNA information and data, nor from communicating with customers, and hospitals regarding aggregated data pertaining to CRNA and his/her peer group.

2.13. **Appeals Process.** BCBSM will provide an appeal process for CRNA in accordance with Addendum E, should CRNA disagree with any claim adjudication or audit determination.

2.14. **Provider Directories.** CRNA agrees to the publication of his/her name, location and specialty to Members.

2.15. **Other Agreements.** BCBSM and CRNA acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.

2.16. **Transfer of Services by BCBSM.** CRNA understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services and may conduct business through representatives and agents, and agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.
ARTICLE III
CRNA ACKNOWLEDGMENT OF
BCBSM SERVICE MARK LICENSEE STATUS

3.1. This contract is between CRNA and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association (BCBSA) to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this contract, CRNA agrees that it made this contract based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to CRNA under this contract and no other obligations are created or implied by this language.

ARTICLE IV
GENERAL PROVISIONS

4.1. Term. The term of this Agreement shall begin on the later of September 1, 2002 or the date BCBSM receives the duly executed Signature Document from CRNA and shall continue until terminated as provided herein below.

4.2. Termination. This Agreement may be terminated:

a. by either party, with or without cause, upon sixty (60) days written notice to the other party

b. immediately, by BCBSM, if CRNA fails to meet the Qualification Standards set forth in Addendum B

c. by BCBSM for cause subject to the Departicipation Policy set forth in Addendum I

d. by BCBSM if termination of this Agreement is ordered by the State Insurance Commissioner

4.3. Existing Obligations. Termination of this Agreement shall not affect any obligations of the Parties under this Agreement prior to the date of termination including, but not limited to, completion of all medical records and cooperation with BCBSM with respect to any actions arising out of this Agreement filed against BCBSM after the effective date of termination. This Agreement shall remain in effect for the resolution of all matters pending on the date of termination. BCBSM's obligation to reimburse CRNA for any Covered Services will be limited to those provided through the date of termination.

4.4. Right of Recovery. The expiration or termination of this Agreement or any changes as provided in this Agreement shall not terminate or otherwise limit BCBSM's right of recovery from CRNA or based upon any audit conducted pursuant to Article II, Section 2.11.
4.5. **Nondiscrimination.** CRNA will not discriminate because of age, sex, race, religion, color, or national origin, in any area of CRNA’s operations, including but not limited to employment, patient care, and clinical staff training and selection.

4.6. **Relationship of Parties.** BCBSM and CRNA are independent entities. Nothing in the Agreement shall be construed or be deemed to create a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement.

4.7. **Assignment.** Any assignment of this Agreement by either party without the prior authorized written consent of the other party will be null and void, except as stated in 2.16.

4.8. **Amendment.** This Agreement may be altered, amended, or modified at any time, but only by the prior authorized written consent of the parties; however, BCBSM shall have the right to unilaterally amend this agreement upon giving not less than ninety (90) days prior written notice to CRNA; as provided in Section 4.12 below or, at BCBSM’s discretion, by publication in the appropriate provider publication, e.g. The Record.

4.9. **Waiver.** No waiver of any of the provisions of this Agreement shall be valid unless in writing and signed by an authorized representative of the party against whom such a waiver is being sought. Any waiver of one or more of the provisions of this Agreement or failure to enforce the Agreement by either of the parties hereto shall not be construed as a waiver of any subsequent breach of this Agreement or any of its provisions.

4.10. **Scope and Effect.** This Agreement shall supersede any and all prior agreements and understandings between the parties, whether written or oral, regarding the matters herein, and shall constitute the entire agreement and understanding between the parties and binding upon their respective representatives, successors and assignees.

4.11. **Severability.** If any provision of the Agreement is deemed or rendered invalid or unenforceable, the remaining provisions of the Agreement shall remain in full force and effect; unless any such invalidity or unenforceability has the effect of materially changing the obligations of either party.

4.12. **Notices.** Unless otherwise indicated, any notice required or permitted under this Agreement shall be given in writing and sent to the other party by hand-delivery, or postage pre-paid regular mail at the following address or such other address as a party may designate from time to time.
If to CRNA:  
Current address shown on BCBSM CRNA File

If to BCBSM:  
Provider Registration - MC B443  
Blue Cross Blue Shield of Michigan  
600 E. Lafayette Blvd  
Detroit, Michigan 48226-2998

4.13. **Third Party Rights.** This Agreement is intended solely for the benefit of the parties and confers no rights of any kind on any third party and may not be enforced except by the parties hereto.

4.14. **Governing Law.** This Agreement, except as governed by federal law, will be governed and construed according to the laws of the state of Michigan.

**SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.**
Addenda

A. Medical Necessity Criteria
B. Qualification Standards
C. Reimbursement Methodology
D. Confidentiality Policy
E. Disputes and Appeals
F. Service Reporting and Claims Overpayment Policy
G. Services for Which CRNA May Bill Members
H. Audit and Recovery Policy
I. Departicipation Policy
MEDICAL NECESSITY CRITERIA

Medical Necessity is determined by Physicians* acting for BCBSM. For purposes of payment by BCBSM, Medical Necessity or Medically Necessary means a determination by Physicians for BCBSM based upon criteria and guidelines developed by Physicians who are acting for their respective provider type and/or medical specialty, or, in the absence of such criteria and guidelines, based upon provider review, in accordance with accepted medical standards and practices, that the service:

is accepted as necessary and appropriate for the patient’s condition and is not mainly for the convenience of the Member or Physician; and in the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the patient’s condition.

*For purposes of this addendum only, Physician also includes Doctors of Podiatric Medicine.
QUALIFICATION STANDARDS

CRNA must meet and continue to meet all of the following qualifications in order to be eligible for participation pursuant to this agreement:

• Current Michigan Licensure as a Registered Nurse (RN); with specialty certification as a Nurse Anesthetist issued by the Michigan Board of Nursing.

• Current certification from the Council on Certification of Nurse Anesthetists; or current certification from the Council on Recertification of Nurse Anesthetists.

• Absence of inappropriate utilization or practice patterns as defined by established practice protocols, that are identified through proven subscriber or professional peer complaints, peer review, and utilization management.

• Absence of fraud and illegal activities
REIMBURSEMENT METHODOLOGY

For Covered Services, BCBSM will pay the lesser of billed charges or the fee (Fee), less copayments and deductibles. The anesthesia formula is the sum of the time reported (in 15-minute increments) plus the Anesthesia Base Units (ABUs) multiplied by the BCBSM regional conversion factor. A percentage (Percentage) based on the reported modifier is then applied to the formula. The Percentage is 40% when the service is performed under the medical direction of a Physician who is responsible for anesthesia services and who is not the operating surgeon, and 85% when the service is performed without medical direction of a Physician who is responsible for anesthesia services and who is not the operating surgeon. The resulting Fee is then compared to CRNA’s charge and then copayments and/or deductibles are applied, as indicated below:

The Fee = (# time units + ABUs) x BCBSM regional conversion factor x Percentage (i.e., 40% or 85%)

CRNA’s payment = the lesser of the Fee or CRNA’s charge, less copayments and deductibles.

ABUs are obtained from the Center for Medicare and Medicaid Services (CMS), however, BCBSM retains the option to modify them at its discretion.

The anesthesia formula, the BCBSM regional conversion factors, and the number of ABUs associated with each anesthesia procedure code will be published in the BCBSM Maximum Payment Schedule.

BCBSM will review the reimbursement levels periodically to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

Modifications to ABUs, procedure codes, and nationally imposed changes to the nomenclature and national coding system for procedure codes which result in changes to the Fee will become effective upon notice to CRNA. All other modifications to the Fee or to BCBSM’s reimbursement methodology will become effective 90 days from the date of notice by BCBSM to CRNA.

Any required notice of reimbursement changes may, at BCBSM’s discretion, be published in the appropriate BCBSM publication (e.g., The Record).
CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for protection of the privacy of Members and the confidentiality of personal data, personal information, and CRNA financial data and information.

BCBSM's Confidentiality Policy sets forth guidelines conforming to MCLA 550.1101 et seq. which requires BCBSM's Board of Directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of Members and the confidentiality of personal data."

In adopting this policy, BCBSM acknowledges the rights of its Members to know that personal data and personal information acquired by BCBSM will be treated with respect and reasonable care to ensure confidentiality; to know it will not be shared with others except for legitimate business purposes or in accordance with a Member's specific consent or specific statutory authority.

The term "personal data" refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a Member, which is maintained or stored by a health care corporation.

The term "personal information" refers to a document or any similar record relative to a Member, including an automated or computer accessible record, containing information such as an address, age/birth date, Coordination of Benefits data, which is maintained or stored by a health care corporation.

The term "CRNA financial data and information" refers to a document or other record, including automated or computer record, containing paid claims data, including utilization and payment information. BCBSM will maintain CRNA financial data and information as confidential.

BCBSM will collect and maintain necessary Member personal data and take reasonable care to secure these records from unauthorized access and disclosure.

Records containing personal data will be used to verify eligibility and properly adjudicate claims. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability.

Enrollment applications, claim forms and other communications to Members will notify Members of these routine uses and contain the Member's consent to release data for these purposes. These forms will also advise the Members of their rights under this policy.
Upon request, a Member will be notified regarding the actual release of personal data.

BCBSM will not release Member specific personal data except on a legitimate need to know basis or where the Member has given specific authorization. Data released with the Member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the Member executes in writing another prior and specific informed consent authorizing the additional release. Where protected by specific statutory authority, Member specific data will not be released without appropriate authorization.

Experience rated and Administrative Service Contract (ASC) customers and hospitals and other entities may obtain personal data and CRNA financial data for auditing and other purposes provided that claims of identifiable Members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

Parties acting as agents to accounts and facilities will be required to sign third party agreements with BCBSM and the recipient of the data prohibiting the use, retention or release of data for other purposes or to other parties than those stated in the agreement.

Data released under this Policy will be subject to the condition that the person to whom the disclosure is made will protect and use the data only as authorized by this policy.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal process.
APPEALS PROCESS FOR INDIVIDUAL CLAIMS DISPUTES
AND UTILIZATION REVIEW AUDIT DETERMINATIONS

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION
CRNA must complete BCBSM's routine status inquiry, telephone (optional) and written inquiry procedures (for individual claims disputes), or receive an audit determination before beginning the appeals process.

WRITTEN COMPLAINT / RECONSIDERATION REVIEW
Within 30 days of completing BCBSM's routine written inquiry procedures, or within 30 days of receiving BCBSM's written audit determination, CRNA shall begin the appeals process by submitting a Written Complaint and/or a request for a Reconsideration of the Audit Determination. The Written Complaint/Reconsideration Review request should be mailed to:

For individual claims disputes:
Blue Cross Blue Shield of Michigan
Provider Appeals Unit
Mail Code 2005
600 Lafayette East
Detroit, MI  48226-2998

For disputes regarding professional provider utilization review audit results:
Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J103
600 Lafayette East
Detroit, MI  48226-2998

A request for a Reconsideration Review must include the following:
— Area of dispute
— Reason for disagreement
— Any additional supportive documentation
— Copies of medical records (if not previously submitted)

Within 30 days of receipt of the request for Written Complaint/Reconsideration Review, BCBSM shall provide in writing a specific explanation of all of the reasons for its action that form the basis of CRNA’s complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE
If CRNA is dissatisfied with the determination of the Written Complaint/Reconsideration Review, CRNA may submit a written request for a Managerial-
Level Review Conference. The purpose of the Conference is to discuss the dispute in an informal setting, and to explore possible resolution of the dispute. The written request for this Conference must be submitted within 60 days after the receipt of the determination letter from the Written Complaint or Reconsideration Review. If the dispute involves issues of a medical nature, a BCBSM medical consultant may participate in the Conference. If the dispute is non-medical in nature, other appropriate BCBSM personnel will attend. CRNA or his/her representative will normally be in attendance to present their case. The conference can be held by telephone if CRNA prefers. The request for a Conference shall be submitted in writing to BCBSM:

For Conferences regarding individual claims disputes:
Blue Cross Blue Shield of Michigan
Conference Coordination Unit
Mail Code 2027
600 Lafayette East
Detroit, MI 48226-2998

For Conferences regarding professional utilization review audit results disputes:
Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J103
600 Lafayette East
Detroit, MI 48226-2998

A request for a Managerial-Level Review Conference must include the following:
— Area of dispute
— Reason for disagreement
— Any additional supportive documentation
— Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to CRNA in writing within 30 days of the request for the Conference. The determination(s) of a Managerial-Level Review Conference delineate the following, as appropriate:

1) The proposed resolution

2) The facts, along with supporting documentation, on which the proposed resolution was based
3) The specific section or sections of the law, certificate, contract or other written policy or document on which the proposed resolution is based.

4) A statement describing the status of each claim involved in the dispute.

5) If the determination is not in concurrence with the Professional appeal, a statement explaining CRNA’s right to appeal the matter to the Michigan Office of Financial and Insurance Services within 120 days after receipt of BCBSM’s written response to the Conference, as well as CRNA’s option to request External Peer Review (Medical Necessity issues only), request a review by the BCBSM Internal Review Committee/Provider Relations Committee (administrative, billing and coding issues only), or initiate an action in the appropriate state court.

EXTERNAL PEER REVIEW

For disputes involving issues of Medical Necessity that are resultant from medical record reviews, CRNA may submit a written request for an External Peer Review if he/she are dissatisfied with the previous level of appeal. Within 30 days of the Managerial-Level Review Conference determination, CRNA can request a review by an external peer review organization to review the medical record(s) in dispute. CRNA will normally be notified of the determination(s) made by the review organization within 60 days of submission of the records to the peer review organization. Such determination will be binding upon CRNA and BCBSM.

If BCBSM's findings are upheld on appeal, CRNA will pay the review costs associated with the appeal. If BCBSM’s findings are reversed by the external peer review organization, BCBSM will pay the review costs associated with the appeal. If BCBSM’s findings are partially upheld and partially reversed, the parties will share in the review costs associated with the appeal, in proportion to the results as measured in findings upheld or reversed.

This appeal step ends the appeal process for all Medical Necessity issues arising from any medical record review and operates as a waiver of CRNA’s right to appeal any Medical Necessity issues to the Office of Financial and Insurance Services or to initiate an action on those issues in a state court.

The CRNA request for External Peer Review for a dispute involving medical record audit results shall be mailed to:

Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J103
600 Lafayette East
Detroit, MI 48226-2998
For Individual Claims disputes, a request for External Peer Review shall be mailed to:

Blue Cross Blue Shield of Michigan
Conference Coordination Unit
Mail Code 2027
600 Lafayette East
Detroit, MI 48226-2998

**INTERNAL REVIEW COMMITTEE**

For disputes involving **Administrative and/or Billing & Coding issues**, CRNA may submit a written request for a review by the BCBSM Internal Review Committee (IRC) which is composed of 3 members of BCBSM senior management. The request for an IRC hearing shall specify the reasons why the BCBSM policy(ies) in dispute is inappropriate or has been wrongly applied, and shall be submitted in writing within 30 days of receipt of BCBSM’s response to the Managerial-Level Review Conference. Within 60 days of the request, a meeting will be held. CRNA, or his/her representative and upon CRNA’s written request, may be present at this hearing. BCBSM will communicate the determination of the Committee within 30 days of the meeting date.

The request for an IRC hearing should be mailed to:

Blue Cross Blue Shield of Michigan
Director, Utilization Management
Mail Code J423
600 Lafayette East
Detroit, MI 48226-2998

*If CRNA is dissatisfied with the determination of the Internal Review Committee, he/she may appeal the determination to either the Provider Relations Committee (a sub-committee of BCBSM’s Board of Directors) or directly to the Michigan Office of Financial and Insurance Services; or initiate an action in an appropriate state court.*

**PROVIDER RELATIONS COMMITTEE**

If dissatisfied with the decision of the IRC, CRNA may, within 30 days of receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee (PRC); a sub-committee of the BCBSM Board of Directors composed of BCBSM participating professionals, community leaders, and BCBSM senior management. BCBSM will acknowledge the receipt of the request and will schedule a meeting with the PRC within 90 days. CRNA must represent themselves at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC’s mandate is to render a determination within a “reasonable time”; however these decisions will normally be rendered within 30 days of the
date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC’s determination.

The request for a PRC hearing should be mailed to:
Blue Cross Blue Shield of Michigan
Director, Utilization Management
Mail Code J423
600 Lafayette East
Detroit, MI 48226-2998

If CRNA is dissatisfied with the determination of the Provider Relations Committee, he/she may appeal the determination to the Michigan Office of Financial and Insurance Services, or initiate an action in an appropriate state court.

MICHIGAN OFFICE OF FINANCIAL AND INSURANCE SERVICES

Informal Review & Determination
If CRNA is dissatisfied with BCBSM’s response to either the Managerial-Level Review Conference, the Internal Review Committee review or the Provider Relations Committee review, and if CRNA believes that BCBSM has violated a provision of either Section 402 or 403 of P.A. 350, CRNA shall have the right to submit a request to the Michigan Office of Financial and Insurance Services for an Informal Review & Determination (IR&D).

The request shall be submitted within 120 days of receipt of BCBSM’s determination and must specify which provisions of P.A. 350 Sections 402(1) and 403 BCBSM has violated. The request shall be mailed to:

Commissioner of Insurance
Michigan Office of Financial and Insurance Services
Post Office Box 30200
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the Office of Financial and Insurance Services. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Office of Financial and Insurance Services shall issue its determination.

Contested Case Hearing
If dissatisfied with the Office of Financial and Insurance Services’ determination, either CRNA or BCBSM may ask the Insurance Commissioner to have the matter heard by an Administrative Law Judge as a Contested Case under the Michigan
Administrative Procedures Act. A Contested Case must be requested in writing within 60 days after the Office of Financial and Insurance Services’ Determination is mailed, and shall be mailed to the Office of Financial and Insurance Services at the same address found in the prior step.

**CIVIL COURT REVIEW**

Either CRNA or BCBSM may appeal the Contested Case result to the Ingham County Circuit Court.

**STATE COURT SYSTEM**

Also, as noted above, at any time after the completion of the Written Complaint or Reconsideration Review and Management Review Conference steps, CRNA may attempt to resolve the dispute by initiating an action in the appropriate state court.
SERVICE REPORTING AND CLAIMS OVERPAYMENT POLICY

I. Service Reporting

CRNA will furnish a report to BCBSM in the form BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge, with complete and accurate information, including diagnosis with procedure codes approved by BCBSM, license number of reporting CRNA and such other information as may be required by BCBSM to adjudicate claims.

CRNA will use a provider identification code acceptable to BCBSM for billing of covered services.

CRNA agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for covered services by requesting information from Members, including but not limited to information pertaining to worker's compensation, other group health insurance, third party liability and other coverages. CRNA further agrees to identify those Members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When CRNA is aware the patient has primary coverage with another third party payer or entity, CRNA agrees to submit the claim to that party before submitting a claim for the services to BCBSM. BCBSM's secondary coverage will be limited to the difference, if any, between the maximum amount BCBSM would have otherwise paid less the amount paid by the primary carrier. If the primary carrier's payment exceeds the BCBSM maximum payment, no secondary coverage will be provided by BCBSM.

II. Overpayments

CRNA shall promptly report overpayments to BCBSM discovered by CRNA, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by CRNA or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations, where CRNA appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the last unappealed determination. If audit refund recoveries and other overpayment obligations are not fully repaid over the course of one month, they will bear interest at the BCBSM prevailing rate, from the date of the refund request, until fully repaid.
SERVICES FOR WHICH CRNA MAY BILL MEMBERS

CRNA may bill Member for:

1. Non-Covered Services unless the service has been deemed a non-Covered Service solely as a result of a determination by a Physician acting for BCBSM that the service was Medically Unnecessary, or experimental or investigational, in which case CRNA assumes full financial responsibility for the denied claims. CRNA may bill the Member for claims denied as Medically Unnecessary, or experimental or investigational, only as stated in paragraph 2, below;

2. Services determined by BCBSM to be Medically Unnecessary, or experimental or investigational, where the Member acknowledges that BCBSM will not make payment for such services, and the Member has assumed financial responsibility for such services in writing and in advance of the receipt of such services;

3. Covered Services denied by BCBSM as untimely billed, if all of the following requirements are met:
   a. CRNA documents that a claim was not submitted to BCBSM within one hundred eighty (180) days of performance of such services because a member failed to provide proper identifying information;
   b. CRNA submits a claim to BCBSM for consideration for payment within three (3) months after obtaining the necessary information.
AUDIT AND RECOVERY POLICY

I. Records

BCBSM shall have access to Blue Cross or Blue Shield Plan Members’ medical records or other pertinent records of CRNA to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse CRNA for the reasonable copying expense incurred by CRNA where CRNA copies records requested by BCBSM in connection with BCBSM audit activities.

CRNA shall prepare and maintain all appropriate records on all Members receiving services, and shall prepare, keep and maintain records in accordance with BCBSM’s existing record keeping and documentation requirements and standards previously communicated to CRNA by BCBSM, and such requirements subsequently developed which are communicated to CRNA prior to their implementation, and as required by law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verifications of services provided, Medical Necessity of services provided, and appropriateness of procedure codes and modifiers reported to BCBSM for the services rendered.

III. Time

BCBSM may conduct on-site audits during CRNA’s regular business hours. BCBSM’s inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not Medically Necessary as determined by BCBSM under Addendum A. BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on Medical Necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than Medical Necessity, including, but not limited to, procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to two (2) years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries.
DEPARTICIPATION POLICY

BCBSM policy establishes the mechanism, criteria and responsibility for departicipating facility and professional providers under Regular Business. Departicipated providers will have claims subjected to Prepayment Utilization Review and processed as nonparticipating with payments directed to the Members. This policy provides for review and recommendation by the Audits and Investigations Subcommittee (AIS).

All BCBSM provider types and subspecialties within those provider categories are covered under this policy.

Criteria under which a provider may be recommended for departicipation include, but are not limited to, providers who are determined to be involved in the inappropriate use or billing of services, providers who are convicted of fraudulent or criminal acts involving BCBSM, Medicare, Medicaid, or other third party carriers; providers who have had their licensure/certification/accreditation suspended or revoked in Michigan; providers who refuse access to records for audit purposes; and providers who are in violation of local, state or federal regulations, laws, codes, etc. (See DEPARTICIPATION CRITERIA.)

Appeal requests must be submitted in writing by an executive representative of the facility, the provider and/or his/her duly authorized representative.

The AIS will review the recommendation and make a determination regarding departicipation of the provider. The departicipation is effective upon notice to the provider. The AIS will receive any subsequent appeal.

The Opinion Review Board (ORB) will hear all provider related departicipation appeals. The ORB determination may be appealed to the Provider Relations Committee (PRC) of the BCBSM Board of Directors.

The PRC hears appeals based only on the facts and findings of previous reviews. The PRC decision is the final level of the appellate process.

DEPARTICIPATION CRITERIA

Criteria under which a provider may be recommended for departicipation include, but are not limited to, the following:

1. Any felony conviction or misdemeanor involving BCBSM, Medicare, Medicaid, and/or other health care insurers.

2. Termination or suspension of licensure, certification, registration, certificate of need, or accreditation in Michigan.
3. Providers who continue to be noncompliant in their reporting after documented notification.

4. Providers who, after notification, continue to bill patients for amounts in excess of deductibles and co-payments.

5. Providers who, upon audit, fail to document the necessity of 50% or more of the audited services billed to BCBSM.

6. Providers identified as prescribing/dispensing controlled substances for other than therapeutic reasons.

7. Providers demonstrating a pattern of billing for services not rendered or not medically necessary.

8. Providers refusing access to records which are deemed essential for BCBSM to determine its liability.

9. Providers found to be inducing patients to receive services through the use of work slips, prescriptions, or money.

10. Providers advertising free service, then billing BCBSM additional services which are not medically indicated.

11. Providers who have identified refunds in excess of $100,000.00.

12. Providers who are in violation of local, state or federal regulations, laws, codes, etc.

Effective: September 1, 2002
You and the POWER of Blue!