**BLUE CROSS BLUE SHIELD OF MICHIGAN**
**HOME HEALTH CARE FACILITY**
**TRADITIONAL PARTICIPATION AGREEMENT**

This Agreement by and between **Blue Cross Blue Shield of Michigan ("BCBSM")**, a nonprofit health care corporation, and the undersigned **Home Health Care Facility ("Provider"),** that is located in Michigan and authorized under applicable state law to conduct business, and whose tax name, business name (or DBA) and primary site address are listed on the accompanying Signature Document. Pursuant to this Agreement, BCBSM and Provider agree as follows:

## ARTICLE 1
## DEFINITIONS

For purposes of this Agreement, defined terms are:

1.1 **"Agreement**" means this written Agreement between BCBSM and Provider which designates Provider as eligible to provide Covered Services and incorporates by reference the Provider Manual, and other BCBSM written or web-based communications concerning the BCBSM Traditional Home Health Care facility provider network and any Addenda or Amendments thereto.

1.2 **"Approved Site**" means the Home Health Care facility location specifically approved and contracted by BCBSM as a Primary Site as listed on the Signature Document, or as an Additional Approved Site, as listed in Addendum H.

1.3 **"Certificate"** means benefit plan descriptions under the sponsorship of BCBSM, or certificates and riders issued by BCBSM, or under its sponsorship, or Member's coverage documents or benefits provided pursuant to contracts issued by other Blue Cross or Blue Shield (BCBS) Plans, administered through reciprocity of benefit agreements or other Inter-Plan Arrangements such as BlueCard. "Certificate" does not include benefits provided pursuant to automobile or workers' compensation insurance coverage.

For purposes of this definition, "sponsorship" includes:

a. Self-funded administrative accounts of BCBSM for which BCBSM provides any one or more of the following administrative services: utilization management, quality assessments, reviews, audits, claims processing systems or a cash flow methodology;

b. Self-funded administrative service accounts for which another Plan is Control Plan and BCBSM is a participating plan and for which BCBSM or the Control Plan assumes the risk of reimbursing Provider for Covered Services in the event the account becomes insolvent.

For purposes of this definition, "sponsorship" does not include Health Maintenance Organizations (HMOs) or benefit plans owned, controlled or operated in whole or part by BCBSM or its subsidiaries, or by other BCBS Plans or their subsidiaries.

1.4 **"Clean Claim"** means a claim that (i) identifies the Provider that provided the service sufficiently to verify the affiliation status and includes any identifying numbers; (ii) sufficiently identifies that patient is a BCBS Member; (iii) lists the date and place of service; (iv) is a claim

for Covered Services for an eligible individual; (v) if necessary, substantiates the Medical Necessity and appropriateness of the service provided; (vi) if prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained; (vii) identifies the service rendered using an accepted system of procedure or service coding adopted and published by BCBSM; and (viii) includes additional documentation based upon services rendered as reasonably required by BCBSM.

1.5 **"Copayment"** means the portion of BCBSM's approved amount that the Member must pay for Covered Services under the terms of a Certificate. This does not include a Deductible.

1.6 **"Covered Services**" means those health care services which are: (i) identified as payable in Certificate(s), (ii) Medically Necessary as defined in such Certificates, (iii) ordered by a health care provider licensed or legally authorized to order such services, unless otherwise permitted by BCBSM published policies, and (iv) performed by an Approved Site.

1.7 **"Deductible"** means the portion of BCBSM's approved amount a Member must pay for Covered Services under a Certificate before benefits are payable. This does not include a Copayment.

1.8 **"HCPCS"** means the Healthcare Common Procedure Coding System.

1.9 "**Medically Necessary" or "Medical Necessity"** is defined as set forth in Addendum A.

1.10 **"Member**" means the person eligible to receive Covered Services on the date the Covered Services were rendered.

1.11 **"Provider"** means a facility that (a) is legally authorized to practice in the state of Michigan, (b) meets the Qualification Standards stated in Addendum B, and (c) has signed a BCBSM Traditional Home Health Care Facility Participation Agreement.

1.12 **"Provider Manual"** means a working document, including but not limited to, BCBSM published bulletins and provider notices that provide specific guidelines and direction by which Providers may meet their contractual responsibility as described in this Agreement. Provider Manuals are published on web-DENIS.

1.13 **"Qualification Standards"** means those standards required for participation as described in Addendum B.

1.14 **"Reimbursement Methodology"** means the methodology by which BCBSM determines the amount of payment due Provider for Covered Services.

## ARTICLE 2
## BCBSM RESPONSIBILITIES

2.1 **Direct Payment.** BCBSM, or its representative, will make payment directly to Provider for Covered Services except for Copayments and Deductibles that are the responsibility of the Member.

2.2 **BCBSM Reimbursement.** BCBSM will pay Provider for Covered Services in accordance with the Reimbursement Methodology set forth in Addendum C.

2.3 **Claims Processing.** BCBSM will process Provider's Clean Claims submitted in accordance with this Agreement in a timely fashion.

2.4 **Provider Manuals and Bulletins.** BCBSM will, without charge, supply Provider with BCBSM guidelines and administrative information concerning billing requirements, benefits, utilization management and such other information as may be reasonably necessary for Provider to deliver Covered Services to Members and be paid. As available, BCBSM may provide such information through electronic means via web-DENIS or the Internet.

2.5 **Confidentiality.** BCBSM will maintain the confidentiality of Member information and records in accordance with applicable federal and state laws as set forth in Addendum G.

2.6 **Contracts With Other Parties.** BCBSM and Provider acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.

## ARTICLE 3
## PROVIDER RESPONSIBILITIES

3.1 **Maintain Qualification Standards.** Provider shall have and maintain the appropriate Medicare certification and licensure under applicable federal or state laws to conduct business, and Provider shall meet and maintain all requirements in the BCBSM Qualification Standards as set forth in Addendum B. Upon request, Provider will submit to BCBSM evidence of continuing compliance with the Qualification Standards, and shall promptly notify BCBSM in writing if Provider no longer meets the Qualification Standards.

3.2 **Notice of Adverse Actions.** Provider shall promptly notify BCBSM of any action, determination, or circumstance involving Provider, or an officer, director, owner or principal of Provider, which affects or may affect the provision of Covered Services. Such circumstances shall include, without limitation, the following:

a. Plea of guilty or nolo contendere or conviction or placement in a diversion program for any crimes related to the payment or provision of health care;

b. Censure, reprimand, resolution, suspension, exclusion, revocation, or reduction to probationary status of Provider's license or Medicare certification;

c. Exclusion or debarment from any state or federal program.

3.3 **Services to Members.** Provider, within the limitations of any applicable state licensure laws, shall provide Covered Services to Members as set forth in Certificates. Provider certifies that all services billed or reported by Provider are within the scope of the rendering healthcare practitioner's scope of practice or license, if applicable, and are performed personally by the healthcare practitioner, or under his/her direct supervision as defined by BCBSM, except as otherwise authorized and communicated in writing by BCBSM, and are submitted in accordance with the terms and conditions of the Members' Certificates. Provider will adhere to all BCBSM published guidelines for the provision and billing of Covered Services to Members.

3.4 **Accept BCBSM Payment as Payment in Full.** Except for Copayments and Deductibles specified in Members' Certificates, Provider will accept BCBSM's approved amount as full payment for Covered Services and agrees not to collect any further payment from any Member, except as set forth in Addendum "D." Provider also agrees to accept and to hold member harmless, as payment in full for Covered Services, except for applicable Copayments and Deductibles, BCBSM's approved amount for Members covered under any of BCBSM's non-Medicare PPO programs or any BCBS non-Medicare Traditional or PPO program if Provider provides Covered Services to such Member, and for any Out-of-Panel services unless otherwise specified by such member's Alternative Delivery System, and agrees not to collect any further payment, except as set forth in Addendum D. Provider will not collect deposits from Members. Deposit is defined as an amount in excess of a Copayment or Deductible which is collected on or prior to the date of service. Provider may not waive copayments and/or deductibles that are the responsibility of the Member, except for hardship cases that are documented in the Member's record, or where reasonable efforts to collect have failed.

3.5 **Release of Records.** BCBSM represents that BCBSM Members have authorized Provider to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and treatment. Provider 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, lawsuits, coordination of benefits, as related to claims filed.

3.6 **Claims Submission.** Unless otherwise prohibited by federal or state law, Provider will submit Clean Claims for all Covered Services to BCBSM within twelve months of the date of service.

3.7 **Provider Obligations.** Provider at all times during the term of this Agreement shall:

a. **Cost Sharing Waivers.** Not waive Copayments and/or Deductibles that are the responsibility of the Member, except for hardship cases that are documented in the Member's record or where reasonable collection efforts have failed;

b. **Adherence to BCBSM Quality and Utilization Management Policies.** Adhere to all quality management, utilization management and reimbursement policies and procedures of BCBSM regarding precertification, case management, disease management, retrospective profiling, credentialing or privileging specific to particular procedures, billing limitations or other programs which may be in effect at the time the Covered Service is provided, and submit reports, including data, as requested by BCBSM;

c. **Provider Business Changes.** For all Approved Sites, notify BCBSM in writing within thirty (30) days of changes in Provider's business including changes in business name, tax name, primary or branch locations, phone number, business structure, range of services offered, or National Provider Identifier. Notify BCBSM in writing within five (5) days of changes in any applicable licensure, Medicare certification, Medicare certification number, ownership, tax identification number, or closure or addition of branch sites. Prior notice of such changes does not guarantee continued participation under this Agreement. Ownership changes, location changes, and additional branch sites, as well as other major changes, require specific BCBSM written approval for continued participation by Provider;

d. **Coordination of Benefits.** Provide Covered Services to Members even though there might be coverage by another party under workers' compensation, occupational disease, or other statute. Provider shall bill the appropriate responsible party for Covered Services and shall provide information to BCBSM regarding the applicability of such statutory coverage.

Request information from Members regarding other payors that may be primarily responsible for Members' Covered Services, pursue payment from such other responsible payors, and bill BCBSM only for Covered Services not paid by the primary payors. All payments received from primary payors for Covered Services shall be promptly credited against or deducted from amounts otherwise payable by BCBSM for such services. Except where BCBSM payment is secondary to Medicare, BCBSM's secondary coverage will be limited to the difference, if any, between the maximum amount BCBSM would have paid less the amount paid by the primary carrier. If the primary carrier's payment exceeds the BCBSM maximum payment amount, no secondary payment will be made by BCBSM and Provider will hold the Member harmless from any additional amounts due.

e. **Medical Records.** Develop and utilize accurate medical, appointment, financial and billing records of all matters relating to obligations under this Agreement and provide them to BCBSM or its designee upon request;

f. **Member Eligibility.** Verify Member eligibility contemporaneous with the rendering of services. BCBS will provide systems and/or methods for verification of eligibility and benefit coverage for Members. This is furnished as a service and not as a guarantee of payment;

g. **Discrimination.** Not discriminate against Members based upon race, color, age, gender, marital status, religion, national origin, or sexual orientation nor may Provider refuse to render Covered Services to Members based upon BCBSM's payment level, benefit or reimbursement policies.

3.8 **Provider Directories.** Provider agrees to the publication of Provider's name, address and telephone number for all Approved Sites in any participating provider directories published by BCBSM or BCBSA.

3.9 **Audits and Recovery.** Provider agrees that BCBSM may photocopy, review and audit Provider as set forth in Addendum F and BCBSM has the right of recovery of any overpayments as set forth in Addendum E.

3.10 **Third Party Administrator.** Provider 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.

3.11 **Misuse of Billing Numbers.** Provider shall use a Provider Identification Number (PIN) for the billing of Covered Services which complies with BCBSM policy as well as all applicable federal or state statutes or regulations. Provider shall not permit any other individual or entity to use its PIN. If Provider becomes aware that its PIN has been used in any manner which is in violation of published BCBSM policy by any other individual or entity, Provider must notify BCBSM immediately. Such misuse of a PIN by Provider or Provider's failure to notify BCBSM when Provider has knowledge of such misuse of its PIN by others is grounds for termination of this Agreement in addition to any other remedies available to BCBSM or its Members.

3.12 **Subcontracting**. Provider shall disclose upon request to BCBSM whether any Covered Services provided under this Agreement are subcontracted. Any subcontract for the provision of Covered Services shall be subject to the terms and conditions of this Agreement and Provider shall furnish a copy of such subcontracts to BCBSM upon request. Provider, and not the subcontractor, must bill BCBSM for all Covered Services provided by subcontractors.

3.13 **Successor's Obligations.** Provider will require any prospective successor to its interest to assume liability for any amounts for which Provider is indebted to BCBSM. Assumption of liability shall be a condition for approval of any successor as a participating provider. Assumption of liability shall not release Provider from the indebtedness unless an agreement to that effect is entered into between BCBSM, Provider, and any prospective successor, or if the successor is a participating provider and expressly agrees to assume Provider's liabilities to BCBSM or BCBS.

## ARTICLE 4
## PROVIDER ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS

4.1 BLUE CROSS®, BLUE SHIELD®, and the Cross and Shield symbols (Marks) are registered service marks of the Blue Cross and Blue Shield Association. Other than the placement of small signs on its premises indicating participation in BCBSM programs, Provider shall not use, display or publish the Marks without BCBSM’s written approval.

4.2 Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and BCBSM, that BCBSM is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the Association) permitting BCBSM to use the Blue Cross and Blue Shield Service Mark(s) in the state of Michigan, and that BCBSM is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSM and that no person, entity, or organization other than BCBSM shall be held accountable or liable to Provider for any of BCBSM's obligations to Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on

the part of BCBSM other than those obligations created under other provisions of this Agreement.

## ARTICLE 5
## CLAIM DISPUTES AND APPEALS

5.1 Provider may appeal claim and audit determinations through the BCBSM appeal process as set forth in the Provider Manual or other sources as published by BCBSM which may be amended from time to time. Provider agrees to abide by this appeal process.

## ARTICLE 6
## GENERAL PROVISIONS

6.1 **Term.** This Agreement will become effective on the later of December 1, 2017 or the date indicated on the Signature Document.

6.2 **Termination.** This Agreement may be terminated as follows:

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

b. immediately by either party where there is a material breach of this Agreement by a party which is not cured within twenty (20) business days of written notice from the other party;

c. by BCBSM, immediately and without notice, if: (i) Provider is censured, placed on probation, or has its license or Medicare certification suspended, revoked, or nullified; (ii) Provider, or an officer, director, owner or principal of Provider, commits civil fraud, or is convicted of, or pleads to a health care related misdemeanor or a felony, including any "plea bargain," reducing a felony to a misdemeanor; (iii) Provider fails to meet the Qualification Standards; or (iv) Provider or an officer, director, owner or principal of Provider is excluded, expelled or suspended from Medicare or Medicaid Programs (Title XVIII or XIV of the Social Security Act);

d. by either party upon thirty (30) days, upon the filing of any involuntary or voluntary proceeding in bankruptcy against either party, insolvency of any party, upon the appointment of a receiver of any party, or any other similar proceeding if such proceedings are not dismissed or withdrawn within sixty (60) days;

e. by either party immediately if Provider ceases doing business or providing home health care services;

f. by Provider immediately if BCBSM is not able to meet its financial obligations to Provider for a period of fifteen (15) consecutive days and Provider provides at least thirty (30) days prior written notification of such termination;

g. by BCBSM immediately, at its option, if there is change in the ownership of Provider;

h. by BCBSM immediately if termination of this Agreement is ordered by the State Insurance Commissioner; or

i. by Provider, as stated in Section 6.6 of this Agreement.

6.3 **Existing Obligations Upon Termination.** 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 Provider for any Covered Services will be limited to those provided through the date of termination. BCBSM's right of audit and recovery from Provider, as set forth in Article 3 Section 3.9, shall survive the termination of this Agreement.

In the event of termination, Provider shall immediately advise Members that are Provider's patients or that may become a patient of Provider, of the expiration or termination of this Agreement if the Member's course of treatment cannot be completed prior to the expiration or termination date of this Agreement. Provider shall advise such Members in writing of the termination or expiration of this Agreement prior to providing services which may expose Member to additional or uncovered financial expense. In addition, Provider shall advise Member that Covered Services are available from other BCBSM participating providers without such financial exposure and shall refer Members, upon Member's request, to another BCBSM participating provider for the provision of Covered Services.

6.4 **Independent Contractor.** It is expressly understood that Provider is an independent contractor. BCBSM shall not be responsible to withhold or cause to withhold any federal, state or local taxes, including FICA from any amounts paid to Provider. The responsibility for the payment of taxes shall be that of Provider.

6.5 **Assignment.** This Agreement shall be binding and shall inure to the benefit of the successors and assigns of BCBSM. BCBSM may assign any right, power, duty or obligation under this Agreement. Provider shall not assign any right, power, duty, or obligation hereunder without the prior written consent of BCBSM.

6.6 **Amendment.** BCBSM may unilaterally amend this Agreement by providing ninety (90) days prior notice, written or electronic, of such amendment. Written form shall include publication in the *Record* or other appropriate BCBSM provider publication. Electronic notice shall include, but not be limited to, publication on web-DENIS. Provider's signature is not required to make the amendment effective. However, should Provider no longer wish to continue its participation in the network because of an amendment, then Provider may terminate this Agreement by providing forty-five (45) days written notice to BCBSM.

6.7 **Severability.** In the event any portion of this Agreement is declared null and void by statute or ruling of court of competent jurisdiction or BCBSM's regulator, the remaining provisions of the Agreement will remain in full force and effect

6.8 **Notices.** Unless otherwise indicated in this Agreement, notification required by this Agreement shall be sent by first class United States mail addressed as follows:

| If to Provider: | If to BCBSM: |
|---|---|
| Current address shown on BCBSM Provider File | Provider Enrollment, and Data Management<br>Blue Cross Blue Shield of Michigan<br>P.O. Box 217<br>Southfield, Michigan 48034 |

6.9 **Waiver.** No waiver of any provision of this Agreement shall be valid unless in writing and signed by the parties. Failure to enforce any provision of this Agreement by either party shall not be construed as a waiver of any breach of this Agreement or of any provisions of this Agreement.

6.10 **Scope and Effect.** This Agreement constitutes the entire Agreement between the parties and supersedes any and all prior agreements or representations oral or written as to matters contained herein, and supersedes any agreements between Provider and BCBSM which conflict with the terms and conditions of this Agreement.

6.11 **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.

6.12 **Provider Information.** BCBSM may disclose Provider specific information as follows:

a. pursuant to any federal, state or local statute or regulation;

b. to customers for purpose of audit and health plan administration so long as the customer agrees to restrict its use to these purposes;

c. for purposes of public reporting of benchmarks in utilization management and quality assessment initiatives, including publication in databases for use with all consumer driven health care products, or other similar BCBS business purposes;

d. for civil and criminal investigation, prosecution or litigation to the appropriate law enforcement authorities or in response to appropriate legal processes.

6.13 **Member Discussions.** Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations in Member's Certificates, Provider's representatives shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by BCBSM or any other entity. Nothing in this Agreement shall prohibit Provider's representatives from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, provided the specific terms of the compensation arrangement are not mentioned to the Member. BCBSM shall not refuse to allow or to continue the participation of any otherwise eligible Provider, or refuse to compensate Provider in connection with services rendered solely because Provider has in good faith communicated with one or more of its current, former or prospective Members

regarding the provisions, terms or requirements of a Certificate as they relate to the health needs of such Member.

6.14 **Compliance with Laws.** Both parties will comply with all federal, state and local laws ordinances, rules and regulations applicable to its activities and obligations under this Agreement.

6.15 **Governing Law.** This Agreement, except as governed by other 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. Services for Which Provider May Bill Member

E. Service Reporting and Claims Overpayment Policy

F. Audit and Recovery Policy

G. Confidentiality Policy

**Addendum A**

## MEDICAL NECESSITY CRITERIA

"Medically Necessary" or "Medical Necessity" shall mean health care services that a provider, 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 Member, Provider, 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.

**Addendum B**

## QUALIFICATION STANDARDS

In order to participate with BCBSM under this Agreement, Provider must have and maintain all of the following Qualification Standards at each primary and branch site:

- Current Medicare certification as a home health care agency, or, full accreditation for home health care by at least one national accreditation organization approved by BCBSM, such as, but not limited to, the following:
  - Community Health Accreditation Program, Inc. (CHAP),
  - The Joint Commission, or
  - Accreditation Commission for Health Care, Inc. (ACHC)

- Written policies and procedures that meet generally acceptable standards for home health care services to assure the quality of patient care, and Provider demonstrates compliance with such policies and procedures;

- Can demonstrate that it conducts program evaluation and utilization review to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components;

- A multi-disciplinary staff composed of all of the following:
  - a nursing administrator or coordinator who is a Michigan licensed registered nurse and who directs the activities of nurses, therapists and other staff members
  - a business office manager who handles the business and financial aspects of the program
  - a physician coordinator, licensed in Michigan, who serves as a consultant, advisor, and a liaison between Provider and the medical community
  - Registered nurses, licensed in Michigan
  - Michigan licensed physical or occupational therapists or Michigan licensed social workers, as appropriate to the services provided by Provider;

- Must provide skilled nursing Covered Services and one other professional type of therapy such as physical, speech, nutritional, occupational therapies or medical social services;

- Meets BCBSM's Evidence of Necessity requirements, as applicable;

- Meets any applicable state licensure requirements;

- Maintains adequate patient and financial records;

- Has an absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review; and

- Has an absence of fraud or illegal activities.

**Addendum C**

## REIMBURSEMENT METHODOLOGY

For physician-prescribed nursing and therapeutic home health care Covered Services, BCBSM will pay Provider the lesser of billed charges or BCBSM's maximum payment per revenue code for each Covered Service billed, less Deductibles or Copayments that are the responsibility of Member. The maximum payment levels are determined by BCBSM from an analysis of equivalent CPT codes. The maximum payment levels are indicated on the BCBSM Home Health Care facility rate sheet that is published by BCBSM on web-DENIS.

For vaccines that are Covered Services, BCBSM will pay Provider the lesser of the billed charge or 100% of the published BCBSM maximum payment schedule, less Deductibles or Copayments that are the responsibility of Member. BCBSM will pay Provider for the administration of the vaccine at the lesser of the billed charge or 85% of the published BCBSM maximum payment schedule, less Deductibles or Copayments that are the responsibility of Member.

BCBSM will periodically review home health care provider reimbursement to determine if modifications are necessary. BCBSM does not guarantee the review process will result in increased reimbursement.

**Addendum D**

## SERVICES FOR WHICH PROVIDER MAY BILL MEMBER

**Provider 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 BCBSM physician or professional provider that the service was:

    - Medically Unnecessary;
    - denied as experimental;
    - denied as an overpayment; or
    - denied because Provider is not eligible for payment as determined by BCBSM based upon BCBSM's credentialing, privileging, payment, reimbursement or other applicable published policy for the particular service rendered;

    in which case Provider assumes full financial responsibility for the denied claims. BCBSM will endeavor to apply like medical specialties to the claims review process.

    Provider, however, may bill the Member for claims denied as Medically Unnecessary or experimental only as stated in paragraph 2, below.

2. Services determined by a BCBSM physician or professional provider to be Medically Unnecessary or experimental, if the Member specifically agrees in writing in advance of receiving such services to all of the following:

    a. The Member acknowledges that BCBSM will not make payment for the specific service to be rendered because it is deemed experimental or Medically Unnecessary;

    b. The Member consents to the receipt of such services;

    c. The Member assumes financial responsibility for such services; and

    d. Provider provides an estimate cost to the Member for such services.

3. Covered Services denied by BCBSM as untimely billed, if both of the following requirements are met:

    a. Provider documents that a claim was not submitted to BCBSM within twelve months of performance of such services because a Member failed to provide proper identifying information; and

    b. Provider submits a claim to BCBSM for payment consideration within three months after obtaining the necessary information.

**Addendum E**

## SERVICE REPORTING AND CLAIMS OVERPAYMENT POLICY

I. Service Reporting

Provider will furnish a claim or 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, and procedure or revenue codes approved by BCBSM, license number or other required identifier of prescribing physician/provider, and such other information as may be required or published by BCBSM to adjudicate claims.

Provider 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 workers' compensation, other group health insurance, third party liability and other coverages. Provider 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 Provider is aware the patient has primary coverage with another third party payer or entity, Provider agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Provider shall promptly report overpayments to BCBSM discovered by Provider and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Provider or BCBSM) from future BCBSM payments, along with an explanation of the action taken. In audit refund recovery situations, where Provider appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the determination, or the last unappealed determination, whichever occurs first. Audit refund recoveries and other overpayment obligations which cannot be fully repaid over the course of one month, will bear interest at the BCBSM prevailing rate, until fully repaid. Provider agrees that filing an appeal tolls the applicable statute of limitations that may apply to BCBSM actions relating to the overpayment or recovery.

**Addendum F**

## AUDIT AND RECOVERY POLICY

I. Records

BCBSM or its designees shall have access to the Member's medical records or other pertinent records of Provider to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse Provider for the reasonable copying expense incurred by Provider where Provider copies records requested by BCBSM in connection with BCBSM audit activities.

Provider 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 Provider by BCBSM, and any requirements subsequently developed which are communicated to Provider 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 revenue and procedure codes reported to BCBSM for services rendered.

III. Time

BCBSM may conduct on-site audits during Provider'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 time.

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or not Medically Necessary as determined by BCBSM under Addendum A. BCBSM shall have the right to recover amounts for services not meeting the applicable benefit, reimbursement or Medical Necessity criteria established by BCBSM, overpayments, services not documented in Provider's records, services not provided at an Approved Site, any services not received by Member, non-Covered Services, or for services furnished when Provider’s license or Medicare certification was lapsed, restricted, revoked or suspended. 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 eighteen (18) months from the date of payment, or up to twenty-four (24) months from the date of payment as required by a (a) self-insured plan or (b) state or federal government plan. In instances of fraud, there will be no time limit on recoveries.

**Addendum G**

## CONFIDENTIALITY POLICY

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

BCBSM's Policy sets forth the 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 with reasonable care to ensure confidentiality; to know that 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.

BCBSM will collect and maintain necessary Member personal data and take reasonable care to secure these records from unauthorized access and disclosure and collect only the personal data necessary to review and pay claims for health care operations, treatment and research. BCBSM will identify routine uses of Member personal data and notify Members regarding these uses.

Enrollment applications, claim forms and other communications will contain the to Member's consent to release data and information that is necessary for review and payment of claims. These forms will also advise the members of their rights under this policy.

Upon specific request, a Member will be notified regarding the actual release of personal data. BCBSM will disclose personal data as permitted by the Health Insurance Portability and Accountability Act of 1996, Public Act 104-191 and the regulations promulgated under the Act and in accordance with PA 350 of 1980. Members may authorize the release of their personal information to a specific person.

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.

**Addendum H**

## APPROVED SITE(S)

**Name and address of Provider's Approved Primary Site:**

See Business Name or DBA and Primary Site Address on Signature Document

**Approved Branch Location(s), (if applicable)**
Listed below are all BCBSM Approved Branch Site locations that are eligible to submit claims to BCBSM under the provider identification number identified on the Signature Document. If there are no BCBSM Approved Branch Sites, it is designated by "N/A".

| Name and Address of Provider's BCBSM Approved Branch Site Locations(s) | Date of Approval |
|---|---|
| N/A | |

## HOME HEALTH CARE FACILITY SIGNATURE DOCUMENT

IN WITNESS WHEREOF, the parties, wishing to be bound by the terms and conditions of BCBSM's *Home Health Care Facility Participation Agreement,* have affixed their signatures on this Signature Document, which is incorporated by reference in the Agreement.

HOME HEALTH CARE FACILITY TAX NAME | DBA (if applicable - to be used for directory)

PRIMARY SITE ADDRESS (for directory)

CITY | STATE | ZIP CODE

FEDERAL TAX IDENTIFICATION NUMBER

MEDICARE CERTIFICATION NUMBER | BCBSM MEDICARE SUPPLEMENTAL EFFECTIVE DATE

BCBSM FACILITY CODE/PROVIDER IDENTIFICATION NUMBER | NPI

EFFECTIVE DATE OF THIS AGREEMENT

**********

| **FACILITY REPRESENTATIVE** | **BCBSM REPRESENTATIVE** |
|---|---|
| AUTHORIZED REPRESENTATIVE | AUTHORIZED REPRESENTATIVE |
| | Deepak Jhaveri |
| Name (Print or Type) | Name (Print or Type) |
| | Manager, Provider Contracting |
| TITLE | TITLE |
| DATE | DATE |

**********

**PLEASE RETAIN THE ENCLOSED COPY OF THE *HOME HEALTH CARE FACILITY PARTICIPATION AGREEMENT* FOR YOUR RECORDS**.

Please return ***only*** the Signature Document to:

**Provider Contracting**
**Blue Cross Blue Shield of Michigan**
**600 E. Lafayette Blvd. MC 513E**
**Detroit, MI 48226-2998**