BCBSM Long-Term Acute Hospital
Participation Agreement

Blue Cross
Blue Shield
of Michigan

BLUE CROSS BLUE SHIELD OF MICHIGAN
LONG-TERM ACUTE CARE HOSPITAL
PARTICIPATION AGREEMENT

This Agreement is made by and between **Blue Cross and Blue Shield of Michigan** (BCBSM) and **Facility**, a Long-Term Acute Care Hospital (LTACH), whose tax name, business name (DBA) and primary site address are listed on the accompanying Signature Document and whose additional approved sites, if applicable, are listed on Addendum I.

The term of this Agreement shall begin on the effective date indicated by BCBSM on the properly executed Signature Document.

Pursuant to this Agreement, Facility 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"** means any preferred provider organization, health maintenance organization, point of service, or other than Traditional delivery system for long-term acute care services, which is owned, controlled, administered or operated in whole or in part by BCBSM, excluding BCBSM's subsidiaries, or by other Blue Cross and/or Blue Shield Plans (BCBS Plans).

1.3. **"Approved Site"** means a Long-Term Acute Care Hospital that is 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 I.

1.4. **"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 but excludes BCBSM's subsidiaries.

1.5. **"Certificate"** means benefit plan descriptions under the sponsorship of BCBSM; or certificates and riders issued by BCBSM, or under its sponsorship, or benefits provided pursuant to contracts issued by other BCBS Plans, administered through reciprocity of benefit agreements or other Inter-Plan Arrangements. "Certificate" does not include benefits provided pursuant to automobile no-fault or workers' compensation insurance coverage.

For purposes of this definition, "sponsorship" includes:

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

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

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

1.6. **"Covered Services"** means those services which are: (i) listed or provided for in Certificates, (ii) Medically Necessary as set forth in Addendum A, (iii) within Facility's scope of licensure to perform, and (iv) provided at an Approved Site.

1.7 "**Long-Term Acute Care Hospital" or "LTACH**" means a licensed healthcare facility which meets all of the Qualifications Standards stated in Addendum B.

1.8. **"Member"** means a person entitled to receive Covered Services pursuant to Certificates.

1.9. **"Out-of-Panel Services"** means those Covered Services provided to a member of an Alternative Delivery System by a Long-Term Acute Care Hospital that is not an approved panel provider of such Alternative Delivery System at the time services are provided.

1.10 **"Physician"** means a medical doctor (MD) or a doctor of osteopathy (DO).

1.11. **"Qualification Standards"** means those criteria established by BCBSM which are used to determine Facility's eligibility to become or remain a participating Long-Term Acute Care Hospital as set forth in Addendum B.

1.12. **"Reimbursement Methodology"** means the methodology by which BCBSM determines the amount of payment due Facility for Covered Services as set forth in Addendum C.

ARTICLE II
RIGHTS AND OBLIGATIONS OF THE PARTIES

2.1. **Services to Members.** Facility, within the limitations of Michigan licensure laws and the limitations of the scope of services Facility provides, will provide Covered Services to Members based on requirements in Members' Certificates, BCBSM Medical Necessity criteria as set forth in Addendum A, and as governed by this Agreement and all other BCBSM published policies in effect on the dates Covered Services are provided. Facility shall not deny service to any Member solely based upon the level of reimbursement it shall receive for such service.

2.2. **Qualification Standards.** Facility 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 60 days prior written notice to Facility. Notice of changes to Qualification Standards may be given as stated in Section 4.12, or, at BCBSM's discretion, by publication in the appropriate BCBSM provider publication(s), (e.g., *The Record, web-DENIS, etc.)*. The current Qualification Standards are set forth in Addendum B. Upon request, Facility will submit to BCBSM evidence of continuing compliance with Qualification Standards.

2.3. **Reimbursement.** BCBSM will, in a timely manner, process acceptable claims submitted by Facility and will make payment directly to Facility for Covered Services in accordance with the Reimbursement Methodology set forth in Addendum C. Except for copayments and deductibles, Facility will bill BCBSM and accept the BCBSM payment as full payment for Covered Services, 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 G. Facility may not waive copayments and/or deductibles that are the responsibility of the Member, except for hardship cases, which are documented in the Member's record, or where reasonable efforts to collect have failed.

2.4. **Claims Submission.** Facility will submit acceptable claims for Members' Covered Services, and for Out-of-Panel Services unless otherwise specified by such member's Alternative Delivery System, directly to BCBSM using BCBSM approved claim forms, direct data entry systems (e.g., EDI), 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 provider manuals or additional published guidelines and criteria. All claims shall be submitted within 180 days of the date(s) of service. Claims submitted more than 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.

Facility 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 Facility with a system and/or method to verify eligibility and benefit coverages of Members; provided that any verification will be given as a service and not as a guarantee of payment.

2.6. **Administrative Manuals and Bulletins.** BCBSM will, without charge, supply Facility with access to electronic versions (e.g., web-DENIS) of any provider manual, guidelines and administrative information concerning billing requirements and other information as may be reasonably necessary for Facility to properly provide and be reimbursed for Covered Services to Members under this Agreement. If BCBSM does not make such information electronically available, BCBSM will, without charge, supply Facility with written versions of such manuals, guidelines, etc. Facility will adhere to all BCBSM published guidelines for the provision of Covered Services to Members.

2.7. **Preauthorization, Utilization and Quality Programs.** Facility will adhere to BCBSM's policies, procedures and criteria regarding utilization review, quality assessment, preauthorization and case management, or other programs established or modified by BCBSM, and will retain records as set forth in BCBSM's published administrative policy. Preauthorization is required for all inpatient admissions and includes, but is not limited to, initial preauthorization and reauthorization of all inpatient admissions, levels of care (tiers), and length of stay. Facility will notify BCBSM within three business days of changes in a Member's level of care/tier. BCBSM agrees to furnish Facility with written information necessary to adhere to BCBSM policies and procedures.

2.8. **Facility Changes.** Facility will notify BCBSM in writing, at least 30 days prior to implementation of major changes, such as, but not limited to, change in: (i) name; (ii) location; (iii) ownership, (iv) National Provider Identifier (NPI), (v) federal tax identification number, or (vi) new sites. Such prior notification of changes is required so that BCBSM may determine Facility's continued compliance with Qualifications Standards and contractual obligations, however, prior notification of such major changes, does not ensure continued participation and will require specific BCBSM approval for continued participation by Facility. BCBSM must give prior written approval to the establishment of new facilities before such facilities can become Approved Sites.

For all Approved Sites, Facility will also notify BCBSM immediately of any actions, policies, determinations, or other developments which may have an impact on the provision of services to Members, including, but not limited to: (i) any loss of or action against its licensure, (ii) loss of or significant change in accreditation, (iii) loss of or change in Medicare certification; or (iv) legal or government action against Facility, or any of its owners, officers, directors or employees, which affects this Agreement such as for professional negligence, fraud, or violation of law.

2.9. **Records and Record Retention.** Facility 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, by accrediting agencies, and as required by law.

2.10. **Access to Records.** BCBSM represents that BCBSM Members, by contract, have authorized Facility to release to BCBSM information and records, including but not limited to, all medical and other information relating to their care and treatment. Facility will release patient information and records within 30 days of the request by BCBSM to enable BCBSM to process claims and for prepayment or postpayment review of medical records and equipment, as related to claims filed. Facility will permit Members to have access to their medical and billing records during Facility's normal business hours, and upon reasonable request, to inspect and copy any medical records maintained by Facility pertaining to Member.

2.11. **Audits and Recovery.** Subject to all applicable laws regarding confidentiality of patient specific information, and the confidentiality provisions set forth in this Agreement, Facility agrees that BCBSM may photocopy, review and audit Facility's records to determine program compliance. This includes, but is not necessarily limited to, verification of services provided, verification that services were provided at an Approved Site, adherence to BCBSM's published policies, Medical Necessity of services provided, appropriateness of levels of care (tiers) or procedure/billing codes reported to BCBSM. BCBSM is entitled to obtain recoveries based on such audits as set forth in this Agreement.

2.12. **Confidentiality.** BCBSM and Facility will maintain the confidentiality of Members' and of each party's records and information of a confidential nature in accordance with applicable state and federal law and as set forth in Addendum D. BCBSM will indemnify and hold Facility 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 Facility information and data, or from communicating with customers regarding aggregate data pertaining to Facility and Facility's peers.

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

2.14. **Listing of Facilities.** Facility agrees that BCBSM shall have the right, for all Approved Sites, to include Facility's name, address and other identifying information in published or web-based directories or listings, or other documents provided for assisting Members to obtain Covered Services from a participating facility.

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

2.16 **Successor's Obligations.** Facility will require any prospective successor to its interest to assume liability for any amounts for which Facility is indebted to BCBSM. Such assumption of liability shall not release Facility from the indebtedness unless an agreement to that effect is entered into between BCBSM, Facility, and any prospective successor, or the successor is a BCBSM participating provider and expressly agrees to assume Facility's liabilities to BCBSM.

2.17 **State and Federal Laws.** Facility and BCBSM will comply with all applicable federal, state and local laws, rules and regulations, and Facility will provide Covered Services in a manner which conforms to the standards of professional conduct and practice prevailing in the applicable community during this Agreement.

2.18 **Approved Site and Services**. Facility's approved Primary Site is listed in the Signature Document to this Agreement. Additional Approved Sites, if applicable, are listed in Addendum I.

2.19 **Hospital-Based Physicians**. Except for any applicable copayments, deductibles and non-Covered Services, Facility will ensure that inpatient Members are not billed for any amount in excess of the BCBSM approved amount for services provided by Physicians that are employed by Facility. For services provided by non-employed Physicians at Facility, Facility will use best efforts to ensure Members are not billed for amounts in excess of the BCBSM approved amount for such services.

2.20 **Transfer of Services by BCBSM.** Facility 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
FACILITY ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS

3.1 Facility hereby expressly acknowledges his/her understanding that this Agreement constitutes a contract between Facility and BCBSM and that BCBSM is an independent corporation operating under a license from the Blue Cross and Blue Shield Association (the Association), an association of independent Blue Cross and Blue Shield Plans, permitting BCBSM to use the Blue Cross and/or Blue Shield Service Mark(s) in Michigan, and that BCBSM is not contracting as the agent of the Association. Facility 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 Facility for any of BCBSM's obligations to Facility 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 IV
GENERAL PROVISIONS

4.1. **Term.** The term of this Agreement shall begin on the effective date(s) indicated by BCBSM on the properly executed Signature Document, and shall continue until terminated as provided below.

4.2. **Termination.** This Agreement may be terminated for Facility's Primary Site, or any of its Additional Approved Sites as follows:

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

b. by BCBSM, immediately upon written notice, if Facility fails to meet the Qualification Standards set forth in Addendum B, except as provided in Section 4.2.c. The effective date of such termination shall be the earliest date Facility failed to meet the Qualification Standards;

c. by BCBSM, automatically and without notice, if Facility has its license, accreditation, or Medicare certification as a Long-Term Acute Care Facility suspended, revoked, terminated, limited or nullified, or, if an officer, director, owner or principal of the Facility is convicted of, or pleads to a felony or other violation of law;

d. by either party, upon written notice to the other of 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 60 days;

e. by BCBSM, at its option and upon written notice, if there is a change in the ownership of the Facility. The effective date of such termination which shall be the date of the ownership change;

f. by either party, immediately upon written notice, if Facility ceases providing long-term acute care services or ceases doing business. The effective date of such termination shall be the date Facility ceased providing long-term acute care services or ceased doing business; or

g. by BCBSM, immediately upon written notice, if termination of this Agreement is ordered by the State Insurance Commissioner. The effective date of such termination shall be the date the State Insurance Commissioner orders the termination.

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 Facility 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 Facility or based upon any audit conducted pursuant to Article II, Section 2.11.

4.5. **Nondiscrimination.** Facility will not discriminate because of age, sex, race, religion, disability, marital status, residence, lawful occupation, or national origin, in any area of Facility's operations, including but not limited to employment, patient care, and clinical staff training and selection.

4.6. **Relationship of Parties.** BCBSM and Facility 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 2.20.

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 90 days prior written notice to Facility, except as otherwise provided in this Agreement. Notice shall be given as provided in Section 4.12 or, at BCBSM’s discretion, by publication in the appropriate BCBSM provider publication(s), (e.g., *The Record, web-DENIS, etc.).*

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, as in the judgment of the party affected: (i) will cause it serious financial hardship, or (ii) cause it to be in violation of its corporate Articles of Incorporation or Bylaws, in which event such party shall have the right to terminate this Agreement upon 30 days prior written notice to the other 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 prepaid regular mail at the following address or such other address as a party may designate from time to time.

If to Facility:	If to BCBSM:
Current address on BCBSM Provider file	Provider Contracting - MC B715 Blue Cross Blue Shield of Michigan 27000 W. Eleven Mile Rd. Southfield, Michigan 48034

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 and Jurisdiction.** This Agreement, except as governed by federal law, will be governed and construed according to the laws of the state of Michigan. Jurisdiction of any dispute will be 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 Facility May Bill Members

H. Audit and Recovery Policy

I. Approved Sites

ADDENDUM A

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* for BCBSM, or, in the absence of such criteria and guidelines, based upon Physician review, in accordance with accepted medical standards and practices, that the service/ admission:

> is accepted as necessary and appropriate for the patient's condition and is not mainly for the convenience of the Member, Physician or Facility.

*Acting for the appropriate provider class and/or specialty

ADDENDUM B

QUALIFICATION STANDARDS

In order to participate with BCBSM, a Long-Term Acute Care Hospital must have and maintain all of the following at each Approved Site:

- Michigan licensure as an acute care hospital
- Medicare certification as a Long-Term Acute Care Hospital (i.e., LTACHs will not qualify for BCBSM LTACH participation during the Medicare qualifying period)
- Full accreditation (three or four years) by at least one national accreditation organization approved by BCBSM such as, but not limited to, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or the American Osteopathic Association (AOA)
- Compliance with any applicable state Certificate of Need (CON) requirements
- A transfer agreement with another licensed acute care hospital
- A governing body that is legally responsible for the conduct of Facility
- Written policies and procedures that demonstrate Facility conducts program evaluation and utilization review to assess the appropriateness, adequacy and effectiveness of the program's administration and clinical components
- Written policies and procedures that meet generally accepted standards to assure the quality of patient care and Facility demonstrates compliance with such policies and procedures
- A financial structure that follows generally accepted accounting principles and practices
- Absence of inappropriate utilization or practice patterns as identified through valid subscriber complaints, medical necessity audits, and peer review
- Absence of fraud and illegal activities.

ADDENDUM C

LONG-TERM ACUTE CARE HOSPITAL REIMBURSEMENT METHODOLOGY

I. INPATIENT SERVICE REIMBURSEMENT

For inpatient Covered Services provided by Long-Term Acute Care Hospitals;

A. Reimbursement is made only for Covered Services provided by LTACHs that have signed a Long-Term Acute Care Hospital Participation Agreement with BCBSM.

B. Reimbursement is limited to the lesser of the billed charge or the BCBSM all-inclusive per-diem maximum payment level indicated on the Rate Schedule for the level of service/tier preauthorized by BCBSM for each day of care. The per-diem maximum payment levels for LTACHs include, but are not limited to the following:

- Room and board
- Medications, biologicals and solutions
- Physical, occupational and speech therapy
- Nursing care
- Laboratory services
- Radiology services
- Nutrition and dietary services including Total Parenteral Nutrition (TPN)
- All medical supplies
- Durable medical equipment
- Dialysis (Hemodialysis or Continuous Ambulatory Peritoneal Dialysis/CAPD)

If, during the admission, there are changes in the Member's level of care/tier, the appropriate per-diem rate will be applied to the first day of the Member's change in level of care/tier.

If a patient that has been admitted to Facility exhausts their Medicare inpatient days during the admission and becomes eligible for care under this Agreement as a Member, BCBSM will pay such days of care at the lowest level of care/tier (excluding the SNF level) for any days on or before the date Facility notifies BCBSM and obtains BCBSM's authorization. When submitting claims to BCBSM for Members who have exhausted their Medicare inpatient days, Facility must not include charges for any services that continue to be payable by Medicare (e.g. Medicare Part B).

C. BCBSM's maximum payment levels for inpatient Covered Services will be reviewed periodically to determine if modifications are necessary. BCBSM does not guarantee that the review will result in increased reimbursement. Some factors that may be considered during the annual review include: (i) applicable inflationary index (ii) competitor payment levels (iii) unusual circumstances and

economic factors that may unduly influence the cost of services provided by LTACHs in Michigan (e.g., a major change in the cost of goods or services used in the provision of care, significant change in labor wage index, etc.). BCBSM will give Facility 90 days notice of any changes to the maximum payment levels for each level of care/tier in the Rate Schedule for inpatient services. Notice may, at BCBSM's discretion, be published in the appropriate BCBSM provider publications, (e.g., *The Record, web-DENIS, etc.).*

II. CHANGES IN REIMBURSEMENT METHODOLOGY

BCBSM will give Facility not less than 90 days prior written notice of any material change to the Reimbursement Methodology. Notice may, at BCBSM's discretion, be published in the appropriate BCBSM provider publications, (e.g., *The Record, web-DENIS, etc.).*

ADDENDUM D

CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for protection of the privacy of Members and the confidentiality of Protected Heath Information (PHI) and Facility financial data and information.

BCBSM's Confidentiality Policy sets forth guidelines conforming to MCLA 550.1101 et seq. and the Health Insurance Portability and Accountability Act of 1996 and the accompanying regulations as from time to time may be amended. BCBSM's Board of Directors is required to establish and make public the policy of the Corporation regarding the protection of the privacy of Members and the confidentiality of PHI.

In adopting this policy, BCBSM acknowledges the rights of its Members to know that PHI 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 in accordance with applicable laws and BCBSM policy.

The term “Facility 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 Facility financial data and information as confidential.

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

Records containing PHI will be used to verify eligibility and properly adjudicate claims and other permitted uses allowed by applicable law and BCBSM policy. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability as permitted by applicable law.

Enrollment applications, claim forms and other communications to Members will notify Members of these routine uses and contain the Member's consent to release PHI for these purposes. These forms will also advise the Members of their rights under BCBSM’s policy.

Upon request, a Member will be notified regarding the actual release of PHI.

BCBSM will make reasonable efforts to use and disclose only the minimum necessary amount of PHI to accomplish the intended purpose of any request, use or disclosure of PHI. PHI 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, PHI will not be released without appropriate authorization.

Experience-rated and self-funded customers may obtain PHI and Facility financial data for auditing and other purposes provided that claims of identifiable Members are protected in accordance with any applicable law and BCBSM policy. For these requests, the recipients of the PHI 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 customers will be required to sign third party agreements with BCBSM and the recipient of the PHI prohibiting the use, retention or release of PHI for other purposes or to other parties than those stated in the agreement.

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

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

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested PHI to the appropriate law enforcement authorities or in response to appropriate legal process as required by applicable law.

ADDENDUM E

APPEALS PROCESS
FOR INDIVIDUAL CLAIMS DISPUTES
AND UTILIZATION REVIEW AUDIT DETERMINATIONS

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION

Facility 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, Facility 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:

Provider Appeals Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For disputes regarding utilization review audit results:

Manager, Facility Utilization Review
Mail Code J 105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

A request for a Reconsideration Review must include the following:

--- Area of dispute;
--- Reason for disagreement;
--- Any additional supportive documentation; and
--- 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 Facility's complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE

If Facility is dissatisfied with the determination of the Written Complaint/ Reconsideration Review, Facility may submit a written request for a Managerial-Level Review Conference (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. Facility or Facility's representative will normally be in attendance to present their case. The Conference can be held by telephone if Facility prefers. The request for a Conference shall be submitted in writing to BCBSM:

For Conferences regarding individual claims disputes:

Conference Coordination Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Conferences regarding utilization review audit results disputes:

Manager, Facility Utilization Review
Mail Code J105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
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; and
--- Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to Facility in writing within 30 days of the request for the Conference. The determination of a Managerial-Level Review Conference delineates 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; and

5) If the determination is not in concurrence with Facility's appeal, a statement explaining Facility'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 Facility'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 an appropriate civil court.

EXTERNAL PEER REVIEW

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

If BCBSM's findings are upheld on appeal, Facility 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 Facility's right to appeal any Medical Necessity issues to the Michigan Office of Financial and Insurance Services or to initiate an action on those issues in an appropriate civil court.

Facility's request for External Peer Review for a dispute involving medical record audit results shall be mailed to:

Manager, Facility Utilization Review
Mail Code J105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Individual Claims disputes, a request for External Peer Review shall be mailed to:

Conference Coordination Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

INTERNAL REVIEW COMMITTEE

For disputes involving administrative and/or billing and coding issues, Facility may submit a written request for a review by the BCBSM Internal Review Committee which is composed of three members of BCBSM senior management. The request for an IRC hearing shall specify the reasons why the BCBSM policy 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. Facility, or Facility's representative upon Facility'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:

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

If Facility is dissatisfied with the determination of the Internal Review Committee, Facility may appeal the determination to either the Provider Relations Committee (a subcommittee of BCBSM's Board of Directors) or directly to the Michigan Office of Financial and Insurance Services; or initiate an action in an appropriate civil court.

PROVIDER RELATIONS COMMITTEE

If dissatisfied with the decision of the IRC, Facility may, within 30 days of receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee, a subcommittee 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. Facility must represent itself 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:

Director, Utilization Management
Mail Code J 423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

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

MICHIGAN OFFICE OF FINANCIAL AND INSURANCE SERVICES

Informal Review and Determination

If Facility 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 Facility believes that BCBSM has violated a provision of either Section 402 or 403 of Public Act 350, Facility shall have the right to submit a request to the Michigan Office of Financial and Insurance Services for an Informal Review and Determination.

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

Commissioner of Insurance
Office of Financial and Insurance Services
Post Office Box 30220
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 offices of the Michigan Office of Financial and Insurance Services. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Michigan Office of Financial and Insurance Services shall issue its determination.

Contested Case Hearing

If dissatisfied with the Michigan Office of Financial and Insurance Services' determination, either Facility 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 Michigan Office of Financial and Insurance Services' determination is mailed, and shall be mailed to OFIS at the same address found in the prior step.

CIVIL COURT REVIEW

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

CIVIL COURT SYSTEM

Also, as noted above, at any time after the completion of the Management Review Conference, Internal Review Committee, or Provider Relations Committee Review steps, Facility may attempt to resolve the dispute by initiating an action in an appropriate civil court within the applicable statute of limitations.

ADDENDUM F

SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Facility will furnish a claim or 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, and such other information as may be required by BCBSM to adjudicate claims.

Facility will use a provider identification number/National Provider Identifier (NPI) approved by BCBSM for the billing of Covered Services which complies with BCBSM policy as well as all applicable federal or state statutes or regulations. Facility will only bill BCBSM for services provided by Approved Sites. Facility's provider identification number/NPI is listed on the Signature Document. Facility 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. Facility 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 Facility is aware the patient has primary coverage with another third party payer or entity, Facility agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments/Payment of Interest

Facility shall promptly report to BCBSM any overpayments Facility receives, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Facility or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations where Facility appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the determination, or the last unappealed determination, whichever occurs first. 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.

ADDENDUM G

SERVICES FOR WHICH FACILITY MAY BILL MEMBER

Except as provided in Addendum C. Section II A., Facility may bill Member for:

1. Noncovered services, unless the service has been deemed a noncovered service solely as a result of a determination by a Physician acting for BCBSM that the service was not Medically Necessary, in which case, Facility assumes full financial responsibility for the denied claims. Facility may bill the Member for claims denied as Medically Unnecessary only as stated in paragraph 2., below;

2. Services determined by BCBSM to be Medically Unnecessary, 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. Facility documents that a claim was not submitted to BCBSM within 180 days of performance of such services because a Member failed to provide proper identifying information; and

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

ADDENDUM H

AUDIT AND RECOVERY POLICY

I. Records

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

Facility 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 Facilities by BCBSM, and such requirements subsequently developed which are communicated to Facility prior to their implementation, and as required by law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verification of services provided, adherence to BCBSM policies, Medical Necessity of services provided, and appropriateness of procedure codes and/or levels of care (tiers) reported to BCBSM for the services rendered.

III. Time

BCBSM may conduct onsite inspections and audits during Facility's regular business hours. Facility agrees to allow such onsite inspections and audits within 30 days of the request by BCBSM. 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 membership or benefit criteria, services not verified in Facility’s records, services provided by a site that was not an Approved Site, services not billed in accordance with BCBSM’s published policies, or services 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 years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries.

ADDENDUM I.

APPROVED SITE(S)

Approved Sites are LTACH location(s) specifically approved by BCBSM as either a primary site (Primary Site) or as an additional approved site (Additional Approved Site).

Name and Address of Facility's Approved Primary Site:

See DBA and BCBSM approved Primary Site address on Signature Document

Listed below are all BCBSM Additional Approved Sites that are eligible to submit claims to BCBSM under the facility code/NPI identified on the Signature Document. If there are no Additional Approved Sites that use the same facility code/NPI it is designated by "N/A".

Name and Address of BCBSM Additional Approved Site(s)	**Date of Approval**
N/A	

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