BLUE CROSS AND BLUE SHIELD OF MICHIGAN

PRACTITIONER TRADITIONAL

PARTICIPATION AGREEMENT

BLUE CROSS AND BLUE SHIELD OF MICHIGAN
PRACTITIONER TRADITIONAL PARTICIPATION AGREEMENT

THIS AGREEMENT is made by and between Blue Cross Blue Shield of Michigan, a Michigan nonprofit healthcare corporation, (“BCBSM”) and the undersigned Practitioner who is fully licensed or legally authorized to practice in the state of Michigan ("PRACTITIONER").

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

ARTICLE 1
DEFINITIONS

For purposes of this Agreement, the defined terms are:

1.1 **"Agreement"** means this written Agreement between BCBSM and PRACTITIONER designating the PRACTITIONER as eligible to provide Covered Services and incorporates by reference the Provider Manual, other BCBSM written or web based communication concerning the Traditional Network and any Addenda or Amendments thereto.

1.2 **"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 PRACTITIONER 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.

1.3 **"Clean Claim"** means a claim that (i) identifies the PRACTITIONER 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; (viii) includes additional documentation based upon services rendered as reasonably required by BCBSM.

1.4 **"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.

1.5 **"Covered Services"** means those health care services which are (i) identified as payable in Certificate(s), (ii) medically necessary as defined in such Certificates, and (iii) ordered and performed by a PRACTITIONER licensed to order and perform such services.

1.6 **"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.

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

1.8 **"Member"** means the person eligible on the date the Covered Service was rendered to receive Covered Services.

1.9 **"PRACTITIONER"** means a physician (doctor of medicine, osteopathy, podiatry or chiropractic) or a professional provider (doctor of medicine, osteopathy, podiatry, chiropractic, fully licensed psychologist or oral surgeon), or other professional provider offered participation by BCBSM, sometimes also referred to as "Provider" who is (a) fully licensed or legally authorized to practice in the state of Michigan and (b) has signed a BCBSM Practitioner Traditional Participation Agreement.

1.10 **"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 PRACTITIONERS may meet their contractual responsibility as described in this Agreement. Provider Manuals are published on web-DENIS.

ARTICLE 2
BCBSM RESPONSIBILITIES

2.1 BCBSM, or its representative, will make payment directly to PRACTITIONER for Covered Services.

2.2 BCBSM will pay PRACTITIONER for Covered Services in accordance with the reimbursement methodology set forth in Addendum "B."

2.3 BCBSM will process PRACTITIONER's Clean Claims submitted in accordance with this AGREEMENT in a timely fashion.

2.4 BCBSM will, without charge, supply PRACTITIONER with BCBSM guidelines and administrative information concerning billing requirements, benefits, utilization management and such other information as may be reasonably necessary for PRACTITIONER 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 BCBSM will maintain the confidentiality of Member information and records, in accordance with applicable federal and state laws and as set forth in Addendum "C." BCBSM will indemnify and hold PRACTITIONER harmless from any claims or litigation brought by Members asserting breach of the BCBSM Confidentiality Policy.

2.6 BCBSM will establish a Professional Provider Relations Advisory Committee Process, as set forth in Addendum "D," through which PRACTITIONERs may offer advice and consultation on administrative matters relating to this AGREEMENT.

2.7 BCBSM will provide a reconsideration appeal mechanism for PRACTITIONER, in accordance with Addendum "E," should PRACTITIONER disagree with any claim adjudication or audit determination.

2.8 BCBSM and PRACTITIONER acknowledge that this AGREEMENT does not limit either party from entering into similar agreements with other parties.

ARTICLE 3
PRACTITIONER'S RESPONSIBILITIES

3.1 PRACTITIONER shall be a health care professional, fully licensed or legally authorized to practice in the state of Michigan.

3.2 PRACTITIONER shall promptly notify BCBSM of any action, determination, or circumstance involving PRACTITIONER 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 crime related to the payment or provision of health care;

b. Censure, reprimand, restriction, suspension, revocation or reduction to probationary status of PRACTITIONER's license to practice or any hospital related privileges;

c. Disability or infirmity which prevents or reduces PRACTITIONER's ability to meet accepted practice standards, as defined by BCBSM, or the failure to successfully complete a program related to substance abuse;

3.3 PRACTITIONER certifies that all services billed or reported by PRACTITIONER are performed personally by PRACTITIONER or under his/her direct and personal supervision, as defined by BCBSM, and in his/her presence, except as otherwise authorized and communicated by BCBSM, and are submitted in accordance with the terms and conditions of the Members' certificates.

3.4 PRACTITIONER shall not subcontract for the provision of Covered Services without the prior written consent of BCBSM. Any subcontract for the provision of Covered Services shall be subject to the terms and conditions of this Agreement. Although patient care services performed by physician assistants, nurses and other certified or licensed paraprofessionals under the direct and personal supervision of PRACTITIONER shall not be considered subcontracted services, they shall be governed by the terms of this Agreement. For purposes of reimbursement for such services, the reimbursement shall be based upon the applicable BCBSM payment policy in effect at the time services are rendered by such paraprofessional which may differ from the fees payable under this Agreement.

3.5 Except for Copayments and Deductibles specified in Members' Certificates PRACTITIONER 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 "F." PRACTITIONER also agrees to accept, 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 PPO programs or any BCBS program if PRACTITIONER provides Covered Services to such Member. PRACTITIONER will not collect deposits from Members. Deposit is defined as an amount in excess of a Copayment or Deductible which is collected prior to the date of service.

3.6 BCBSM represents that BCBSM Members, by contract, have authorized PRACTITIONER to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and

treatment. PRACTITIONER 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.

3.7 PRACTITIONER will submit Clean Claims for all Covered Services to BCBSM within one hundred eighty (180) days of the date of service and only for services performed personally by PRACTITIONER or under his/her direct personal supervision.

3.8 PRACTITIONER at all times during the term of this Agreement shall:

a. 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. Adhere to all quality management, utilization management and reimbursement policies and procedures of BCBSM regarding precertification, case management, disease management, retrospective profiling, radiology management program, 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;

c. Notify BCBSM within thirty (30) days of changes in PRACTITIONER's business including changes in ownership, name, tax identification number, location, phone number, business structure, range of services offered and specialty. Prior notice of such changes does not guarantee continued participation under this Agreement;

d. Provide Covered Services to Members even though there might be coverage by another party under workers' compensation, occupational disease, or other statute. PRACTITIONER 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 shall bill BCBSM only for Covered Services not paid by the primary payors. All payments received from other 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, payments by BCBSM as a secondary payor shall not exceed the amount which would otherwise be payable by BCBSM as primary payor under this Agreement. PRACTITIONER agrees to submit claims to the primary payors before submitting them to BCBSM;

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

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

3.9 PRACTITIONER agrees to the publication of his/her name, location and specialty to Members.

3.10 PRACTITIONER agrees that BCBSM may review, photocopy and audit PRACTITIONER's records as set forth in the attached Audit and Recovery Policy, Addendum "H."

3.11 PRACTITIONER 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.

3.12 PRACTITIONER shall not bill BCBSM for Covered Services rendered to themselves or immediate family Members (mother, father, sister, brother, spouse or child).

3.13 PRACTITIONER 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. PRACTITIONER shall not permit any other individual or entity to use his/her PIN. If PRACTITIONER becomes aware that his/her PIN has been used in any manner which is in violation of published BCBSM policy by any other individual or entity, he/she must notify BCBSM immediately. Such misuse of a PIN by PRACTITIONER or PRACTITIONER's failure to notify BCBSM when they have knowledge of such misuse of their PIN by others is grounds for termination of this Agreement in addition to any other remedies available to BCBSM or its Members.

ARTICLE 4
MISCELLANEOUS

4.1 Either party may terminate this AGREEMENT with or without cause. Without cause termination requires sixty (60) days written prior notice by either party. For cause termination will be subject to BCBSM Departicipation Policy as set forth in Addendum "I" and as hereafter modified by BCBSM. Practitioner may also terminate this Agreement as set forth in Exhibit D.

4.2 In the event any portion of this AGREEMENT is declared null and void by statute or ruling of a court of record or BCBSM's regulator, the remaining provisions of this AGREEMENT will remain in full force and effect.

4.3 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 any provision of this Agreement.

4.4 This Agreement shall be binding upon, 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. PRACTITIONER shall not assign any right, power, duty or obligation hereunder without the prior written consent of BCBSM.

4.5 Unless otherwise indicated in this Agreement, notifications required by this Agreement shall be sent by first class United States mail addressed as follows:

IF TO BCBSM:	**IF TO PRACTITIONER:**
Provider Enrollment and Data Management Blue Cross Blue Shield of Michigan-MC C301 600 E. Lafayette Blvd. Detroit, MI 48226-2998	An address current on the BCBSM Practitioner File

4.6 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 PRACTITIONER and Member which conflict with the terms and conditions of this Agreement.

4.7 This Agreement shall be construed and enforced in accordance with, and governed by, the laws of the state of Michigan.

4.8 It is expressly understood that PRACTITIONER 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 PRACTITIONER. The responsibility for the payment of such taxes shall be that of the PRACTITIONER.

4.9 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, PRACTITIONER shall not use, display or publish the Marks without BCBSM's written approval.

4.10 PRACTITIONER hereby expressly acknowledges his/her understanding that this Agreement constitutes a contract between PRACTITIONER 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 Marks in the state of Michigan, and that BCBSM is not contracting as the agent of the Association. PRACTITIONER 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 PRACTITIONER for any of BCBSM's obligations to PRACTITIONER 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.

4.11 BCBSM may disclose PRACTITIONER specific information as follows:

a. Pursuant to any federal, state, or local statute or regulation. BCBSM and Provider recognizes that confidentiality does not apply in circumstances outlines in 42 USC 300gg-119. which requires that BCBSM be permitted to disclose the following information for any reason:

- Provider-specific cost or quality of care information through any means to referring providers, a plan sponsor, business associates, enrollees, or individuals eligible to become enrollees under any plan or coverage.

- Upon request, electronically accessible de-identified claims and encounter information or data for each enrollee in the plan or coverage, including financial information, provider information, service codes, or any other data included in a claim or encounter transaction on a per claim basis

b. To a customer for purpose of audit and health plan administration so long as the customer agrees to restrict its use of information to these purposes and agrees not to further disclose the information. Furthermore, this section shall not be construed to restrict BCBSM from sharing all such information with its subsidiaries.

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; or

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

e. Furthermore, this section shall not be construed to restrict BCBSM from sharing all such information with any of its subsidiaries and affiliates.

4.12 Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations in Member's Certificates, PRACTITIONER 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 PRACTITIONER from disclosing to the Member the general methodology by which PRACTITIONER 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 PRACTITIONER, or refuse to compensate PRACTITIONER in connection with services rendered solely because PRACTITIONER 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.

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

4.14 This Agreement will become effective on the date indicated on the Signature Document.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.

ADDENDA

A. Medical Necessity Criteria
B. Reimbursement Methodology
C. Confidentiality Policy
D. Provider and Professional Provider Contract Advisory Committee Process
E. Disputes and Appeals
F. Services for Which Practitioners May Bill Members
G. Service Reporting and Claims Overpayment Policy
H. Audit and Recovery Policy
I. Departicipation Policy

Addendum A
MEDICAL NECESSITY CRITERIA

"Medically Necessary" or "Medical Necessity" shall mean health care services that a PRACTITIONER, 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, PRACTITIONER, 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
REIMBURSEMENT METHODOLOGY

For each Covered Service performed, BCBSM will pay the lesser of the billed charges or the Approved Amount as set forth in the applicable fee schedule-BCBSM TRAD Fee Schedule (TRAD Fee Schedule) or Value-Based Reimbursement Fee Schedule (VBR Fee Schedule) less any Deductible or Copayment amount for which Member is responsible. PRACTITIONER agrees to allocate a fixed percentage of the Approved Amount, as stated in The Record, to the Physician Group Incentive Program (PGIP) pooled fund for incentives related to Quality Programs. The fixed percentage allocation will be updated annually and published in the appropriate provider publication.

The TRAD Fee Schedule is based, in part, on a system of the ranking of relative values of relative values of all medical and surgical procedures and services which are reviewed by BCBSM as a regular business activity. Relative values are multiplied by a BCBSM specific conversion factor to determine the price per procedure. These factors vary by year. Nationally imposed changes to the nomenclature and national coding system (HCPCS) for coding procedure codes, and corrections of typographical errors may result in immediate modifications to the TRAD Fee Schedule.

BCBSM will make the TRAD Fee Schedule available to PRACTITIONER via web-DENIS. BCBSM will give individual consideration to cases involving complex treatment or unusual clinical circumstances in determining a fee which exceeds the usual reimbursement level. PRACTITIONER agrees to accept the decision of BCBSM review committees and BCBSM medical consultants with respect to such cases. BCBSM will review PRACTITIONER reimbursement at least every 12 months to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in any increase of fees.

BCBSM develops Quality Programs designed to improve health care outcomes and control health care costs (Quality Programs). The value of services delivered by PRACTITIONERS is derived from both the direct actions of the PRACTITIONER providing the service and other processes, information systems, and organizational work beyond these direct actions. PRACTITIONER may participate in Quality Programs if he/she meets the standards developed by BCBSM for participation, which shall be published by BCBSM annually in the appropriate provider publication (e.g., web-DENIS, The Record). Participation in certain Quality Programs may entitle PRACTITIONER to reimbursement according to the VBR Fee Schedule, which shall be updated annually and made available to PRACTITIONER through publication in the appropriate provider publication. PRACTITIONER will be informed by the provider organization with which he/she is affiliated when he/she is eligible for VBR Fee Schedule reimbursement rates.

In the event of unexpected and unusual delay in payment of Claims filed by PRACTITIONER, not attributable to strike, act of God, or war, BCBSM will advance a

reasonable sum of money, as determined by BCBSM, to PRACTITIONER, to be repaid as a debit against future Claims liability, or as otherwise agreed by BCBSM.

Addendum C
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, 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 will collect only the personal data necessary to review and pay claims and for health care operations, treatment and research. BCBSM will identify routine uses of Member personal data and notify Members regarding these uses.

Enrollment applications and claim forms will contain the 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 Law 104-191 and the regulations promulgated under that 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 processes.

Addendum D
PROFESSIONAL PROVIDER RELATIONS ADVISORY COMMITTEE PROCESS

BCBSM will designate one or more committees comprised of professional provider representatives subject to this Agreement as Professional Provider Relations Advisory Committee(s). This Committee or committees will be convened at regular intervals to offer advice and consultation to BCBSM on the following topics, including, but not necessarily limited to:

(a) proposed modifications or amendments to the Agreement;
(b) administrative issues which may arise under the Agreement;
(c) medical necessity criteria and guidelines;
(d) reimbursement issues;
(e) experimental procedures;
(f) PRACTITIONER supervision of services.

BCBSM will not seek to modify or amend this Agreement without prior notice to and discussion with the Professional Provider Relations Advisory Committee or Committees. BCBSM will not modify the PRACTITIONER reimbursement methodology under this AGREEMENT without prior notice to and discussion with the Professional Provider Relations Advisory Committee or Committees, except that BCBSM may undertake modifications to relative value assignments on individual procedure codes without discussion under this process.

No contract modification nor amendment will become effective until after 90 days have elapsed from the date of BCBSM notice to PRACTITIONERs. Nationally imposed changes to the nomenclature and national coding system for procedure codes which result in modifications to the Maximum Payment Schedule will become effective without notice to PRACTITIONERs. No other modification to the Maximum Payment Schedule will become effective until after 90 days have elapsed from the date of BCBSM notice to PRACTITIONERs.

Amendments under this Agreement may be provided either in written or electronic form. Written form shall include publication in *The Record*. Electronic notice shall include, but not be limited to, publication on web-DENIS. PRACTITIONER's signature is not required to make any amendment effective. However, should PRACTITIONER no longer wish to continue participation in the Traditional Network because of an amendment then he/she may terminate this Agreement by providing forty-five (45) days written notice to BCBSM.

Addendum E
DISPUTES AND APPEALS

Disputes arising under this AGREEMENT may be appealed as follows. This appeals process includes an opportunity for a review before an External Peer Review Organization for dispute resolution and is intended to resolve disputed matters quickly and inexpensively. Please note that an election must be made at the conclusion of Step Two (BCBSM's Post-Conference Statement) regarding a review by an External Peer Review Organization or judicial review of the dispute. If the PRACTITIONER elects judicial review for resolution of the dispute any right to review by an External Peer Review Organization will be deemed waived. The PRACTITIONER shall have the right to appoint another person to act as his/her agent or representative in any of the steps of the Contract Appeals Process.

Disputes may be appealed to an External Peer Review Organization or the Courts of this state. Non-policy issues that may arise under this Agreement, include by way of example:

- medical necessity determinations;
- claims denials pre-existing condition exclusion in Members' agreements;
- pre-certification program rejections relating to length of stay or appropriateness of treatment setting; and
- audit recovery demands involving requests for repayment of monies related to testing or x-rays unsupported by the documented medical record.

Policy related issues that may arise under this Agreement include by way of example:

- RVU assignments or conversion factors, both of which affect BCBSM's price per procedure.
- Sanctions in cost containment programs;
- Multiple surgery rules such as the full and half rule;
- Experimental benefit exclusions;
- Departicipation decisions; and
- Audit methodology such as the use of statistical sampling for audit refund projections.

Contract Appeals Process

A. **Step One:** Written Complaint

1. After the PRACTITIONER has completed BCBSM's normal status inquiry, telephone and written inquiry procedures, the PRACTITIONER shall begin the appeals process by submitting a Written Complaint to BCBSM regarding the nature of any unresolved areas of the dispute. This Complaint should be mailed to:

   Blue Cross Blue Shield of
   Michigan Physician's
   Ombudsman Unit Mail
   Code 2027
   600 E. Lafayette Blvd.
   Detroit, Michigan 48226-2998

2. BCBSM shall, within thirty (30) days, provide in writing a clear, concise and specific explanation of all of the reasons for its action that form the basis of the PRACTITIONER's complaint.

B. **Step Two:** Informal Conference

1. If the PRACTITIONER does not agree with BCBSM's explanation, the PRACTITIONER shall request, within sixty (60) days of receipt of BCBSM's written explanation, an informal conference by submitting a Notice of Dispute. This Notice should be mailed to:

   Blue Cross Blue Shield of
   Michigan Physician's
   Ombudsman Unit Mail
   Code 2027
   600 E. Lafayette Blvd.
   Detroit, Michigan 48226-2998

2. Within thirty (30) days from the PRACTITIONER's request, BCBSM shall schedule an informal conference. At the request of the PRACTITIONER, the conference may be held by telephone.

3. The purpose of the Informal Conference is to discuss in an informal setting, the dispute and explore possible resolution of that dispute. If the dispute involves matters of a medical nature, a BCBSM consulting doctor will participate in the conference. If the dispute is non-medical in nature, other appropriate BCBSM employee(s) will attend.

4. Within ten (10) days following the conclusion of the Informal Conference,

BCBSM shall provide all of the following to the PRACTITIONER:

(a) The proposed resolution;

(b) The facts, with supporting documentation, on which the proposed resolution is based;

(c) The specific section or sections of the law, certificate, contract or other written policy or document on which the proposed resolution is based;

(d) A statement explaining the PRACTITIONER's right to appeal the matter within one hundred twenty (120) days after receipt of BCBSM's written statement; and

(e) A statement describing the status of each claim involved.

C. **Step Three:** Independent Third Party Determination

Within one hundred twenty (120) days after receipt of BCBSM's post conference statement, the PRACTITIONER shall have the right to appeal BCBSM's proposed resolution by submitting a Request for Review by External Peer Review Organization. The PRACTITIONER shall also have the option of initiating litigation in the appropriate court (i.e., judicial review).

1. Review by External Peer Review Organization

a. The rules for review by an external peer review organization ("Review Organization") are attached.

Review by an external peer review organization is an alternative to judicial resolution in any appropriate court of law. Once a party initiates the external review process, the party is required to complete the external review process prior to seeking judicial resolution.

The request for review by an external peer review organization should be mailed to:

Blue Cross Blue Shield of
Michigan Doctor Review by
External Peer Review
Organization
Mail Code 1925
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

b. The review may take place through submission of written position papers. Within thirty (30) days of the receipt of position papers the Review Organization shall issue its determination. If either the PRACTITIONER or BCBSM is dissatisfied with the Review Organization's determination, the PRACTITIONER or BCBSM may

seek to have the dispute resolved in an appropriate court of law.

D. **Judicial Resolution**

1. The PRACTITIONER may choose to have the dispute resolved in any appropriate state or federal court as an alternative to review by an external Review Organization.

2. If dissatisfied with the Review Organization's determination, either the PRACTITIONER or BCBSM may seek to have the dispute resolved in any appropriate state or federal court. In such a judicial action, a finding or determination by a Review Organization on an issue of medical necessity shall be given due deference, and a court may not substitute its judgment for that of the Review Organization, if it is reasonable and absent credible conflicting evidence.

Policy Issue Review Process

Issues, questions or concerns on the part of a PRACTITIONER arising under this Agreement and relating to BCBSM policy may be pursued by the PRACTITIONER as follows:

1. Submit the question, issue or concern in writing to:

   Blue Cross Blue Shield of Michigan
   Physician's Ombudsman Unit Mail Code 2027
   600 E. Lafayette Blvd.
   Detroit, Michigan 48226-2998

2. A response will be issued in writing within thirty (30) days of your request.

3. If you are dissatisfied with the response, you may request a review by the BCBSM Medical Director within thirty (30) days of BCBSM's initial response. You will be notified in writing of BCBSM's final response within thirty (30) days of your request.

This step concludes the BCBSM policy review process. The issue and its disposition will be reported to the Professional Provider Relations Advisory Committee(s) for information purposes.

REQUEST FOR EXTERNAL PEER REVIEW

BCBSM and the undersigned PRACTITIONER agree pursuant to the attached PRACTITIONER Contract Rules For Review By External Review Organization to submit to an External Peer Review Organization the following controversy:

(Describe)

It is further agreed that the above controversy will be submitted to an External Peer Review Organization unless otherwise agreed. It is further agreed that BCBSM and PRACTITIONER will abide by the terms of this Agreement and the Rules.

The amount involved in this dispute is $ _____
The remedy sought is _____ .
The following External Peer Review Organization is requested:

PROM

It is understood and agreed that each party shall be responsible to pay fifty (50%) percent of the total cost of the External Review Organization, excluding each party's own attorney fees and expenses, which shall remain the responsibility of that party. The costs of the External Peer Review will include any expenses associated with the review.

BCBSM

By:_____
Type Name
Dated: _____
Its:_____

RULES FOR REVIEW BY EXTERNAL REVIEW ORGANIZATION

BCBSM and PRACTITIONER agree that review by an external review organization ("Review Organization") shall be governed by the following rules:

Rule 1. Upon request, the PRACTITIONER and BCBSM are entitled to a review of the matter by the External Review Organization.

Rule 2. The Review Organization shall base its decision upon written materials and any records submitted by the parties. Failure of either party to supply any information in a timely manner shall result in a decision based on information available to the Review Organization at the time of the decision.

Rule 3. Any one of the following shall qualify as a Review Organization: (a) PROM, or (b) an independent review organization approved by the Director of the Michigan Department of Insurance and Financial Services as eligible to be assigned to conduct external reviews under the Patient's Right to Independent Review Act, Act 251 of 2000, codified at MCL 550.1901 *et seq*.

Rule 4. Each party shall pay (50%) percent of the cost of the External Review Organization. Each party's own attorney fees and expenses shall remain the responsibility of that party.

Rule 5. If dissatisfied with the Review Organization's determination, either the PRACTITIONER or BCBSM may seek to have the dispute resolved in any appropriate state or federal court. In such a judicial action, a finding or determination by a Review Organization on an issue of medical necessity shall be given due deference, and a court may not substitute its judgment for that of the Review Organization, if it is reasonable and absent credible conflicting evidence.

Addendum F
SERVICES FOR WHICH PRACTITIONER MAY BILL MEMBER

PRACTITIONER may bill Member for:

1. NonCovered Services unless the service has been deemed a non-Covered Service solely as a result of a determination by a BCBSM doctor or professional provider that the service was:
    - MEDICALLY UNNECESSARY,
    - deemed experimental,
    - denied as an overpayment or,
    - because the PRACTITIONER was 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 PRACTITIONER assumes full financial responsibility for the denied claims. BCBSM will endeavor to apply like medical specialties to the claims review process.

    PRACTITIONER, 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 doctor or professional provider to be MEDICALLY UNNECESSARY or experimental, if the Member specifically agrees in writing in advance of receiving such services as follows:
    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. PRACTITIONER provides an estimate cost to the Member for such services.

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

Addendum G
SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

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

PRACTITIONER agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for Covered Services by requesting information from Members, including but not limited to information pertaining to worker's compensation, other group health insurance, third party liability and other coverages. PRACTITIONER 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 PRACTITIONER is aware the patient has primary coverage with another third party payer or entity, PRACTITIONER agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

PRACTITIONER shall promptly report overpayments to BCBSM discovered by PRACTITIONER, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by PRACTITIONER or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations, where PRACTITIONER appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the arbitration 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. Interest will run from the date of arbitration determination or last date an appeal could have been filed whichever is earlier. PRACTITIONER agrees that filing an appeal tolls the applicable statute of limitations that may apply to BCBSM actions relating to the overpayment or recovery.

Addendum H
AUDIT AND RECOVERY POLICY

I. Records

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

PRACTITIONER 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 PRACTITIONERs by BCBSM, any such requirements subsequently developed which are communicated to PRACTITIONER prior to their implementation, and as required by law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verifications of services provided, medical necessity of services provided, and appropriateness of procedure codes reported to BCBSM for the services rendered. The PRACTITIONER Retrospective Profiling System ("PRP") is one component of BCBSM audit policy. Audits may be conducted outside the Program based on review of information and data different from or not available under PRP.

III. Time

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

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary as determined by BCBSM under Addendum 'A'. BCBSM 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 PRACTITIONER's records, any services not received by Member, non-Covered Services or for services furnished when PRACTITIONER's license 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 I
DEPARTICIPATION POLICY

BCBSM policy establishes the mechanism, criteria and responsibility for departicipating facility and PRACTITIONERs under Regular Business. Departicipated PRACTITIONERs will have claims subjected to Prepayment Utilization Review and processed as non-par with payments directed to the Members. BCBSM Departicipation Policy does not apply to Government Business, i.e., Medicare and FEP.

This policy provides for review and recommendation by the Audits and Investigations Committee (AIC).

All BCBSM provider types and sub-specialties within those provider categories are covered under this policy, whether they have a formal participation agreement with BCBSM or participate on a per case basis.

Criteria under which a PRACTITIONER may be recommended for departicipation include, but are not limited to, PRACTITIONERs who are determined to be involved in the inappropriate use or billing of services, as determined by BCBSM.

PRACTITIONERs who are convicted of fraudulent or criminal acts, plead guilty, nolo contendere or are placed in a diversion program for any crime related to the payment or provision of health care involving BCBSM, Medicare, Medicaid, or other third party carriers; PRACTITIONERs who have had their licensure/certification/accreditation or hospital privileges suspended or revoked, censured, reprimanded, restricted, revoked or reduced to probationary status in Michigan; PRACTITIONERs who refuse access to records for audit purposes; and PRACTITIONERs who are in violation of local, state or federal regulations, laws, codes, etc. (See DEPARTICIPATION CRITERIA).

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

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

The Opinion Review Board (ORB) will hear all provider related departicipation appeals. The ORB determination may be appealed to the Health Care Delivery Committee (HCDC) of the BCBSM Board of Directors.

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

Addendum J
DEPARTICIPATION CRITERIA

Criteria under which a PRACTITIONER will be subject to departicipation include, but are not limited to, the following:

1. Any felony conviction or misdemeanors, guilty plea, plea of nolo contendere or placement in a diversion program for any crime related to the payment or provision of health care involving BCBSM, Medicare, Medicaid, and/or any other health care insurer.
2. Termination, suspension, censure, reprimand, restriction, revocation, or reduction to probationary status of licensure, certification, registration, certificate of need, or accreditation or hospital related privileges.
3. PRACTITIONERs who, after at least six (6) months on Prepayment Utilization Review (PPUR), continue to be non-compliant.
4. PRACTITIONERs who, after notification, continue to bill members for amounts more than deductibles and copayments.
5. PRACTITIONERs who, upon audit, failed to document the medical necessity of 50% or more of the audited services billed to BCBSM.
6. PRACTITIONERs identified as prescribing/dispensing prescription medication for other than therapeutic reasons.
7. PRACTITIONERs demonstrating a pattern of directly/indirectly billing for services not rendered or not medically necessary.
8. PRACTITIONERs who, upon request, refuse to provide BCBSM access to records, which BCBSM requires for purposes including but not limited to claims processing, regulatory compliance, and/or for other health care operations purposes.
9. PRACTITIONERs found to be inducing patients to receive services through the use of prescriptions, money, or other items of value or financial incentive.
10. PRACTITIONERs demonstrating a pattern of altering/entering false information on patient records and/or claims.
11. PRACTITIONERs who advertise free services, but then bill BCBSM for additional services, which are not medically necessary.
12. PRACTITIONERs who are in violation of local, state, or federal regulations, laws, codes, etc.
13. PRACTITIONERs who, after being notified, continue to demonstrate a pattern of violating or not adhering to BCBSM’s policies and procedures.
14. PRACTITIONERs who BCBSM has determined endangers a Member's health and safety.
15. PRACTITIONERs who BCBSM has found to be prescribing medications for members with whom no patient-physician relationship exists.
16. PRACTITIONERs who directly/indirectly threaten the health or safety of a BCBSM Member, employee, contractor, agent, or officer.