Durable Medical Equipment/ Prosthetic and Orthotic Supplier Provider Participation Agreement

Blue Cross
Blue Shield
of Michigan

BLUE CROSS BLUE SHIELD OF MICHIGAN

DURABLE MEDICAL EQUIPMENT, PROSTHETIC AND ORTHOTIC SUPPLIERS (DME/P&O)

PARTICIPATION AGREEMENT

This Agreement by and between Blue Cross and Blue Shield of Michigan (BCBSM), a nonprofit health care corporation, and the undersigned Durable Medical Equipment, Prosthetic and Orthotic Supplier (Provider) that is duly certified or licensed under applicable federal or state law to conduct business. Pursuant to this Agreement, BCBSM and Provider agree as follows:

ARTICLE 1
DEFINITIONS

For purposes of this Agreement, defined terms are:

1.1 **"Agreement**" means this written Agreement between BCBSM and Provider which designates Provider as eligible to provide Covered Services and incorporates by reference any Provider Manuals, and other BCBSM written or web-based manuals.

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 Provider for Covered Services in the event the account becomes insolvent.

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

1.3 **"Clean Claim"** means a claim that (i) identifies the provider that provided the service sufficiently to verify the affiliation status and includes any identifying numbers; (ii) sufficiently identifies that patient is a BCBS Member; (iii) lists the date and place of service; (iv) is a claim for Covered Services for an eligible individual; (v) if necessary, substantiates the Medical Necessity and appropriateness of the service provided; (vi) if prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained; (vii) identifies the service rendered using an accepted system

of procedure or service coding adopted and published by BCBSM; (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 DME/P&O health care services which are (i) identified as payable in Certificate(s), (ii) Medically Necessary as defined in such Certificates, (iii) ordered by a health care provider licensed or legally authorized to order such services and a provider type approved by BCBSM to prescribe such services, and (iv) provided by a DME/P&O supplier that is Medicare certified/approved, and accredited, as applicable, to provide such services, and/or licensed to provide such services, as applicable.

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 "**Medical Necessity"** shall be defined as set forth in Addendum A.

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

1.10 **"Physician"** means a doctor of medicine or osteopathy who is licensed or legally authorized to practice in the state of Michigan.

1.11 **"Provider"** means a Provider who (a) is fully licensed or legally authorized to practice in the state of Michigan, b) meets the Qualification Standards stated in Addendum B for the applicable services, and (c) has signed a BCBSM DME/P&O Participation Agreement.

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

1.13 **"Qualification Standards"** are those standards set forth in Addendum B.

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

1.15 **"Vision Specialists"** means Physicians who are board certified or board qualified in the specialty of ophthalmology.

ARTICLE 2
PROVIDER RESPONSIBILITIES

2.1 **Maintain Qualification Standards.** Provider will have and maintain the appropriate Medicare certification/approval, accreditation, and any licensure required under applicable federal or state laws to conduct business in Michigan and has met all applicable BCBSM Qualification Standards as set forth in Addendum B.

2.2 **Services to Members.** Provider, within the limitations of its Medicare certification/approval, accreditation, or state licensure laws, will provide Covered Services to Members as set forth in Certificates.

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

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

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

2.4 **Subcontracting**. Provider shall disclose upon request to BCBSM whether any Covered Services provided under this Agreement are subcontracted. Any subcontract for the provision of Covered Services shall be subject to the terms and conditions of this Agreement.

2.5 **Accept BCBSM Payment as Payment in Full.** Except for Copayments and Deductibles specified in Members' Certificates, Provider will accept BCBSM's approved amount as full payment for Covered Services and agrees not to collect any further payment from any Member, except as set forth in Addendum "D." Provider also agrees to accept 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 BCBSM's DME/P&O programs, or any BCBS DME/P&O program if Provider provides Covered Services to such Member. Provider will not collect deposits from Members. "Deposit" is defined as an amount in excess of a Copayment or Deductible which is collected on or prior to the date of service.

2.6 **Release of Records.** BCBSM represents that BCBSM Members, by contract, have authorized Provider to release to BCBSM information and records, including but not limited to all medical, hospital and other information relating to their care and treatment. Provider will release patient information and records requested by BCBSM to enable it to process claims and for pre-or post-payment review of medical records and equipment, lawsuits, coordination of benefits, as related to claims filed.

2.7 **Claims Submission.** Unless otherwise prohibited by federal or state law, Provider will submit Clean Claims for all Covered Services to BCBSM within one hundred eighty (180) days of the date of service.

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

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

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

c. **Provider Changes.** Notify BCBSM within thirty (30) days of changes in Provider's business including changes in ownership, name, tax identification number, location, phone number, business structure, licensure, Medicare certification/approval, Medicare DMEPOS supplier number, or National Provider Identifier. Prior notice of such changes does not guarantee continued participation under this Agreement;

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

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

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

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

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

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

2.10 **Provider Directories.** Provider agrees to the publication of Provider's name, address and telephone number in any participating provider directories published by BCBSM or BCBS.

2.11 **Third Party Administrator.** Provider understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services and may conduct business through representatives and agents, and agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.

ARTICLE 3
BCBSM RESPONSIBILITIES

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

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

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

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

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

ARTICLE 4
PROVIDER ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS

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

4.2 Provider hereby expressly acknowledges his/her understanding that this Agreement constitutes a contract between Provider and BCBSM and 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. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSM and that no person, entity, or organization other than BCBSM shall be held accountable or liable to Provider for any of BCBSM's obligations to Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSM other than those obligations created under other provisions of this Agreement.

ARTICLE 5
CLAIM DISPUTES AND APPEALS

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

ARTICLE 6
GENERAL PROVISIONS

6.1 **Term.** This Agreement will become effective on the date indicated on the Signature Document or acceptance letter from BCBSM.

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

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

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

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

d. By either party immediately if Provider ceases doing business or providing DME/P&O services;

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

f. By BCBSM immediately if termination of this Agreement is ordered by the State Insurance Commissioner, and

g. By Provider in accordance with Section 6.6 of this Agreement.

6.3 **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 Provider for any Covered Services will be limited to those provided through the date of termination. BCBSM's right of audit and recovery from Provider as set forth in Article 2, Section 2.9, shall survive the termination of this Agreement.

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

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

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

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

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

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

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

If to Provider:	If to BCBSM:
A current address on BCBSM Provider File	Provider Enrollment, and Data Management Blue Cross Blue Shield of Michigan P.O. Box 217 Southfield, Michigan 48034

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

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

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

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

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

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

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

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

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

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

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.

ADDENDA

A. Medical Necessity Criteria

B. Qualification Standards

C. Reimbursement Methodology

D. Services For Which Provider May Bill Member

E. Service Reporting and Claims Overpayment Policy

F. Audit and Recovery Policy

G. Confidentiality Policy

Addendum A

MEDICAL NECESSITY CRITERIA

"Medically Necessary" or "Medical Necessity" shall mean health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice;

b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c. Not primarily for the convenience of the Member, Provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Addendum B

QUALIFICATION STANDARDS

Durable Medical Equipment Suppliers must have and maintain the following qualifications to be eligible for participation under this Agreement:

- Current Medicare DMEPOS supplier number for the business location;
- Compliance with Medicare's published supplier standards and quality standards, including any required accreditation for the specific services provided;
- Compliance with any additional published BCBSM requirements for accreditation and/or certification;
- Current Michigan licensure as a medical doctor, doctor of osteopathy, doctor of podiatric medicine, or doctor of chiropractic for MDs, DOs, DPMs or DCs who are DME suppliers.

Prosthetic and/or Orthotic Suppliers must have and maintain the following qualifications to be eligible for participation under this Agreement:

- Current Medicare DMEPOS supplier number for the business location;
- Compliance with Medicare's published supplier standards and quality standards, including any required accreditation for the specific services provided;
- Compliance with any additional published BCBSM requirements for accreditation and/or certification;
- Current Michigan licensure as a medical doctor or doctor of osteopathy for MDs or DOs who are optical P&O suppliers.

In addition to the above qualifications, all DME/P&O suppliers must have and maintain the following:

- Absence of fraud and illegal activities
- Absence of inappropriate utilization practices as identified through proven subscriber complaints, medical necessity audits and peer review.

Addendum C

REIMBURSEMENT METHODOLOGY

For Covered Services, BCBSM will pay the lower of Provider's billed charge or BCBSM's published maximum payment for P&O equipment or services and/or for new, used or rented DME and medical supplies. These services, equipment and supplies must be prescribed by a Physician, doctor of chiropractic, doctor of podiatric medicine, a certified nurse practitioner, or such other health care professional as BCBSM shall approve to prescribe DME/P&O services. Optical P&O services must be prescribed by a Vision Specialist. The billed charge refers to the actual charge indicated on the claim form submitted by Provider.

The BCBSM maximum payment for P&O equipment or services and/or new, used or rented DME and medical supplies includes review of several factors. The factors include, but are not limited to the following:

- Medicare prevailing fee schedule
- BCBSM's provider participation rates
- The absence of a Medicare fee for services covered by BCBSM but not by Medicare
- Items priced on an individual consideration basis
- BCBSM's corporate medical, benefit or other policy decisions
- Adjustments recommended by professional consultants for services involving new technology
- Medicare's update factor relative to other inflationary indices
- Unusual circumstances and economic factors that may unduly influence the cost of services provided by DME/P&O providers (e.g., a major change in cost of goods or services used in construction of prosthetics or orthotics)

For items that can be rented or purchased, BCBSM requires that equipment be rented if the cost of renting the equipment for the estimated duration of need on the prescription will be less than the purchase price. The monthly rental payment equals a percentage of the BCBSM purchase price listed in the published DME/P&O maximum payment schedule subject to a maximum number of payments. Information on the maximum number of payments policy can be found in the BCBSM provider manual. There may be exceptions to the maximum number of rental payments for items such as oxygen equipment and for items that require frequent and substantial servicing. Such exceptions would also be described in the BCBSM provider manual.

BCBSM will give Provider 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 publication(s) e.g., *The Record, web-DENIS, etc.*

Addendum D

SERVICES FOR WHICH PROVIDER MAY BILL MEMBER

Provider may bill Member for:

1. Non-Covered Services unless the service has been deemed a non-Covered Service solely as a result of a determination by a BCBSM Physician or professional provider that the service was:

    - Medically Unnecessary;
    - Deemed experimental;
    - Denied as an overpayment; or
    - Not eligible for payment to Provider as determined by BCBSM based upon BCBSM's credentialing, privileging, payment, reimbursement or other applicable published policy for the particular service rendered, in which case Provider assumes full financial responsibility for the denied claims. BCBSM will endeavor to apply like medical specialties to the claims review process.

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

2. Services determined by a BCBSM Physician 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. Provider provides an estimate cost to the Member for such services.

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

    a. Provider documents that a claim was not submitted to BCBSM within one hundred eighty (180) days of performance of such services because a Member failed to provide proper identifying information; and

    b. Provider submits a claim to BCBSM for payment consideration within three (3) months after obtaining the necessary information.

Addendum E

SERVICE REPORTING AND CLAIMS OVERPAYMENT POLICY

I. Service Reporting

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

II. Overpayments

Provider shall promptly report overpayments to BCBSM discovered by Provider and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Provider or BCBSM) from future BCBSM payments, along with an explanation of the action taken. In audit refund recovery situations, where Provider appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the determination, or the last unappealed determination, whichever occurs first. Audit refund recoveries and other overpayment obligations which cannot be fully repaid over the course of one (1) month, will bear interest at the BCBSM prevailing rate, until fully repaid. Provider agrees that filing an appeal tolls the applicable Statute of Limitations that may apply to BCBSM actions relating to the overpayment or recovery.

Addendum F

AUDIT AND RECOVERY POLICY

I. Records

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

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

II. Scope of Audits

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

III. Time

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

IV. Recovery

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or not Medically Necessary as determined by BCBSM under Addendum A. BCBSM shall have the right to recover amounts for services not meeting the applicable benefit, reimbursement or Medical Necessity criteria established by BCBSM, overpayments, services not documented in Provider's records, any services not received by Member, non-Covered Services, services that Provider is not accredited to provide if accreditation is required for such services by Medicare, or for services furnished when Provider’s license or Medicare certification/approval 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 two (2) years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries.

Addendum G

CONFIDENTIALITY POLICY

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

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

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

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

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

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

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

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

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

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

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

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