

Durable Medical Equipment/ Prosthetic and Orthotic Supplier Provider Participation Agreement



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



BLUE CROSS BLUE SHIELD OF MICHIGAN DURABLE MEDICAL EQUIPMENT/PROSTHETIC AND ORTHOTIC SUPPLIER PROVIDER PARTICIPATION AGREEMENT

This Agreement is made by and between Blue Cross Blue Shield of Michigan (BCBSM) and the undersigned Durable Medical Equipment/Prosthetic and Orthotic (DME/P&O) Supplier (Provider).

Pursuant to this Agreement, Provider 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 DME/P&O services which is owned, controlled, administered or operated in whole or in part, by BCBSM, excluding BCBSM's subsidiaries, or by any other Blue Cross and/or Blue Shield (BCBS) Plan.
- 1.3. **"BCBS Plans"** means organizations which are licensed by the Blue Cross and Blue Shield Association to use the Blue Cross and/or Blue Shield names and service marks. Unless otherwise specified, the term "BCBS Plans" includes BCBSM.
- 1.4. **"Certificate"** means benefit plan descriptions under the sponsorship of BCBSM or other Blue Cross and Blue Shield Plans, or certificates and riders issued by or under their sponsorship, or arrangements with any employer group, including any self-funded plan, where BCBSM or other BCBS Plans administer benefits.
- 1.5. **"Covered Services"** means those DME/P&O services which are: (i) listed or provided for in Certificates, (ii) prescribed by a Physician, a certified nurse practitioner, or by a Vision Specialist for optical P&O services, within his/her scope of license (iii) Medically Necessary as set forth in Addendum A, (iv) within Provider's applicable scope of license and/or certification or accreditation, and (v) supplied by Provider.
- 1.6. **"Durable Medical Equipment and/or Prosthetic and Orthotic Supplier"/"DME/P&O Supplier"** means the following providers which meet all of the qualifications stated in Addendum B for their respective category: (i) supplier of durable medical equipment and medical supplies, (ii) supplier of prosthetic devices, (iii) supplier of orthotic devices, (iv) supplier of prosthetic and orthotic devices, and (v.) Vision Specialists who supply optical prosthetics and orthotics.

- 1.7. **"Member"** means a person entitled to receive Covered Services pursuant to Certificates.
- 1.8. **"Out-of-Panel Services"** means those DME/P&O Covered Services provided to a member of a DME/P&O Alternative Delivery System by a DME/P&O Supplier that is not an approved panel provider of such Alternative Delivery System at the time services are provided.
- 1.9. **"Physician"** means a licensed medical doctor (MD), doctor of osteopathy (DO), doctor of podiatry (DPM), doctor of chiropractic (DC), or, for optical P&O services only, a MD/DO who is board certified or board qualified in the specialty of ophthalmology.
- 1.10. **"Qualification Standards"** means those criteria established by BCBSM which are used to determine Provider's eligibility to become or remain a participating provider as set forth in Addendum B.
- 1.11. **"Reimbursement Methodology"** means the methodology by which BCBSM determines the amount of payment due Provider for Covered Services as set forth in Addendum C.
- 1.12. **"Vision Specialists"** who are also optical P&O Suppliers, means MD/DOs who are board certified or board qualified in the specialty of ophthalmology and who meet all qualifications stated in Addendum B (Section III).

ARTICLE II RIGHTS AND OBLIGATIONS

- 2.1. **Services to Members.** Provider, within the limitations of applicable Michigan licensure laws, 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 policies in effect on the dates Covered Services are provided.
- 2.2. **Qualification Standards.** Provider 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 Provider. 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.
- 2.3. **Reimbursement.** BCBSM will timely process acceptable claims submitted by Provider and will make payment directly to Provider for Covered Services in accordance with the Reimbursement Methodology set forth in Addendum C. Except for copayments and deductibles, Provider will 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. Provider may not bill Member for rental amounts exceeding the BCBSM purchase price. Provider agrees not to collect any further payment from Member, except as set forth in Addendum G. Provider 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.** Provider will submit acceptable claims for 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, tape-to-tape systems or such other methods as BCBSM may approve from time to time. An acceptable claim is one which complies with the requirements stated in published BCBSM administrative manuals or additional published guidelines and criteria. All claims shall be submitted within 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.

Provider 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 Provider with a system and/or method to promptly 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, give Provider access to BCBSM's web-based communication system, web-DENIS, for any administrative manuals, provider publications (e.g. *The Record*), bulletins, guidelines and administrative information concerning billing requirements and other information as may be reasonably necessary for Provider to properly provide and be reimbursed for Covered Services to Members under this Agreement. Provider will adhere to all BCBSM published guidelines contained in administrative manuals, bulletins and provider publications for the provision of Covered Services to Members.
- 2.7. **Utilization and Quality Programs.** Provider will adhere to BCBSM's policies and procedures 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 administrative policy. BCBSM agrees to furnish Provider with information necessary to adhere to BCBSM policies and procedures.
- 2.8. **Provider Changes.** Provider will immediately notify BCBSM if Provider fails to meet any of the Qualification Standards set forth in Addendum B.
- 2.9. **Record Retention.** Provider will prepare and maintain all appropriate medical and financial records related to Covered Services provided to Members as required by any BCBSM published policies and procedures and as required by law.
- 2.10. **BCBSM Access to Records.** BCBSM represents that BCBSM Members, by contract, have authorized 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 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.

- 2.11. **Audits and Recovery.** Provider agrees that BCBSM may conduct onsite inspections, and may photocopy, review and audit Provider's records to determine, but not necessarily limited to, verification of services provided, verification of Physician prescriptions, adherence to BCBSM's published policies (e.g. rent/purchase), verification of dates supplies/equipment/devices were ordered and delivered, Medical Necessity of services provided, and the appropriateness of procedure codes reported to BCBSM, and to obtain recoveries based on such audits as set forth in Addendum H.
- 2.12. **Confidentiality.** BCBSM and Provider 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 Provider 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 Provider information and data, or from communicating with customers regarding aggregated data pertaining to Provider and Provider's peer group.
- 2.13. **Appeals Process.** BCBSM will provide an appeal process for Provider in accordance with Addendum E, should Provider disagree with any claim adjudication or audit determination.
- 2.14. **Provider Directories.** Provider agrees to the publication in web-based or printed directories of Provider's name, location and specialty to Members.
- 2.15. **Other Agreements.** BCBSM and Provider acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.
- 2.16. **Transfer of Services by BCBSM.** 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 III
PROVIDER ACKNOWLEDGMENT OF
BCBSM SERVICE MARK LICENSEE STATUS**

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

ARTICLE IV GENERAL PROVISIONS

- 4.1. **Term.** The term of this Agreement shall begin on the later of October 1, 2006 or the date BCBSM receives the properly executed Signature Document from Provider, and shall continue until terminated as provided herein below.
- 4.2. **Termination.** This Agreement may be terminated:
- a. by either party, with or without cause, upon 60 days written notice to the other party
 - b. immediately, by BCBSM, if Provider fails to meet the Qualification Standards set forth in Addendum B.
 - c. immediately, by BCBSM, if termination of this Agreement is ordered by the Michigan Office of Financial and Insurance Services
- 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 Provider 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 Provider or based upon any audit conducted pursuant to Article II, Section 2.11.
- 4.5. **Nondiscrimination.** Provider will not discriminate because of age, sex, race, religion, disability, marital status, residence, lawful occupation, or national origin, in any area of Provider's operations, including but not limited to employment, patient care, and staff training and selection.
- 4.6. **Relationship of Parties.** BCBSM and Provider are independent entities. Nothing in the Agreement shall be construed or be deemed to create a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement.
- 4.7. **Assignment.** Any assignment of this Agreement by either party without the prior authorized written consent of the other party will be null and void, except as stated in 2.16.
- 4.8. **Amendment.** This Agreement may be altered, amended, or modified at any time, but only by the prior authorized written consent of the parties; however, BCBSM shall have the right to unilaterally amend this agreement upon giving not less than 90 days prior written notice to Provider, 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 provider publication(s), e.g., *The Record*.

- 4.9. **Waiver.** No waiver of any of the provisions of this Agreement shall be valid unless in writing and signed by an authorized representative of the party against whom such a waiver is being sought. Any waiver of one or more of the provisions of this Agreement or failure to enforce the Agreement by either of the parties hereto shall not be construed as a waiver of any subsequent breach of this Agreement or any of its provisions.
- 4.10. **Scope and Effect.** This Agreement shall supersede any and all prior agreements and understandings between the parties, whether written or oral, regarding the matters herein, and shall constitute the entire agreement and understanding between the parties and binding upon their respective representatives, successors and assignees.
- 4.11. **Severability.** If any provision of the Agreement is deemed or rendered invalid or unenforceable, the remaining provisions of the Agreement shall remain in full force and effect; unless any such invalidity or unenforceability has the effect of materially changing the obligations of either party.
- 4.12. **Notices.** Unless otherwise indicated, any notice required or permitted under this Agreement shall be given in writing and sent to the other party by hand-delivery, or postage pre-paid regular mail at the following address or such other address as a party may designate from time to time.

If to Provider:

Current address shown on
BCBSM provider file

If to BCBSM:

Blue Cross Blue Shield of Michigan
Provider Enrollment, MC B443
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

- 4.13. **Third Party Rights.** This Agreement is intended solely for the benefit of the parties and confers no rights of any kind on any third party and may not be enforced except by the parties hereto.
- 4.14. **Governing Law 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 disputes 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 Provider May Bill Members
- H. Audit and Recovery Policy

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:

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

*Acting for the appropriate provider class and/or specialty

**ADDENDUM B
QUALIFICATION STANDARDS**

- I. **DME Suppliers** must have and maintain the following qualifications to be eligible for participation under this Agreement:
- Federal Tax Identification Number or Social Security Number
 - Current Medicare DME Supplier number
 - A fixed physical facility on an appropriate site in Michigan which is accessible to the general public
 - 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.
- II. **P&O Suppliers** must have and maintain the following qualifications to be eligible for participation under this Agreement:
- A. Prosthetic Supplier
- Certification from the American Board for Certification (ABC) for prosthetics, for individual practitioners, or
 - Accreditation from the American Board for Certification (ABC) for prosthetics, for facilities
- B. Orthotic Supplier
- Certification from the American Board for Certification (ABC) for orthotics, for individual practitioners, or
 - Accreditation from the American Board for Certification (ABC) for orthotics, for facilities
- C. Prosthetic and Orthotic Supplier
- Certification from the American Board for Certification (ABC) for prosthetics and orthotics, for individual practitioners, or
 - Accreditation from the American Board for Certification (ABC) for prosthetics and orthotics, for facilities
- III **Vision Specialists**, who are also optical P&O Suppliers, must have and maintain a current Michigan license as a medical doctor (MD) or a doctor of osteopathy (DO), and board certification or board qualification in the specialty of ophthalmology, to be eligible for participation under this Agreement.

In addition to the above qualifications, all DME/P&O suppliers and Vision Specialists 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 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 or a certified nurse practitioner. 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.

Effective July 1, 2005, BCBSM adopted the Michigan-specific Medicare DME/P&O fee schedule that was effective January 1, 2005 as its maximum payment schedule for most procedure codes. Periodically, BCBSM will review Medicare's fee changes and adopt them as BCBSM determines to be appropriate. Factors that may cause BCBSM's maximum payment levels to differ from Medicare's include, but are not limited to the following:

- 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 competitors' reimbursement levels
- 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*.

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 personal data, personal information, and Provider financial data and information.

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

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

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

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

The term "Provider 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 Provider financial data and information as confidential.

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

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

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

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

BCBSM will not release Member specific personal data except on a legitimate need to know basis or where the Member has given specific authorization. Data released with the Member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the Member executes in writing another prior and specific informed

consent authorizing the additional release. Where protected by specific statutory authority, Member specific data will not be released without appropriate authorization.

Experience-rated and self-funded customers may obtain personal data and Provider financial data for auditing and other purposes provided that claims of identifiable Members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

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

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

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

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

**ADDENDUM E
APPEALS PROCESS FOR INDIVIDUAL CLAIMS DISPUTES
AND UTILIZATION REVIEW AUDIT DETERMINATIONS**

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION

Provider 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, Provider shall begin the appeals process by submitting a Written Complaint and/or a request for a Reconsideration of the Audit Determination. The Written Complaint/Reconsideration Review request should be mailed to:

For **individual claims** disputes:

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

For disputes regarding **utilization review audit results**:

Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J103
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 Provider's complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE

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

For Conferences regarding individual claims disputes:

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

For Conferences regarding utilization review audit results disputes:

Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J103
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 Provider in writing within 30 days of the request for the Conference. The determination(s) of a Managerial-Level Review Conference delineate the following, as appropriate:

- 1) The proposed resolution;
- 2) The facts, along with supporting documentation, on which the proposed resolution was based.
- 3) The specific section or sections of the law, certificate, contract or other written policy or document on which the proposed resolution is based;
- 4) A statement describing the status of each claim involved in the dispute; and
- 5) If the determination is not in concurrence with Provider's appeal, a statement explaining Provider'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 Provider's option to request External Peer Review (Medical Necessity issues only), request a review by the BCBSM Internal Review Committee/Provider Relations Committee (administrative, billing and coding issues only), or initiate an action in the appropriate state court.

EXTERNAL PEER REVIEW

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

If BCBSM's findings are upheld on appeal, Provider 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 Provider'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 a state court.

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

Blue Cross Blue Shield of Michigan
Manager, Professional Utilization Review
Mail Code J103
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

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

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

INTERNAL REVIEW COMMITTEE

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

The request for an IRC hearing should be mailed to:

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

If Provider is dissatisfied with the determination of the Internal Review Committee, Provider 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 state court.

PROVIDER RELATIONS COMMITTEE

If dissatisfied with the decision of the IRC, Provider may, within 30 days of receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee (PRC); 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. Provider must represent him/herself at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC's mandate is to render a determination within a "reasonable time"; however these decisions will normally be rendered within 30 days of the date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC's determination.

The request for a PRC hearing should be mailed to:

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

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

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Informal Review & Determination

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

The request shall be submitted within 120 days of receipt of BCBSM's determination and must specify which provisions of 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 30200
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the 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, either Provider 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 the Michigan Office of Financial and Insurance Services at the same address found in the prior step.

CIVIL COURT REVIEW

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

STATE COURT SYSTEM

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

ADDENDUM F
SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Provider 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, name and address of prescribing Physician, and such other information as may be required by BCBSM to adjudicate claims.

Provider will use a provider identification number acceptable to BCBSM for billing of Covered Services.

Provider agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for Covered Services by requesting information from Members, including but not limited to information pertaining to workers' compensation, other group health insurance, third party liability and other coverages. Provider further agrees to identify those Members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When Provider is aware the patient has primary coverage with another third party payer or entity, Provider agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Provider shall promptly report overpayments to BCBSM discovered by Provider, and agrees BCBSM will be permitted to deduct overpayments (whether discovered by Provider or BCBSM) from future BCBSM payments, along with an explanation of the credit action taken. In audit refund recovery situations, where Provider appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the arbitration 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 PROVIDER
MAY BILL MEMBER**

Provider 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 or experimental, in which case Provider assumes full financial responsibility for the denied claims. Provider may bill the Member for claims denied as Medically Unnecessary or experimental only as stated in paragraph 2, below;
2. Services determined by BCBSM to be Medically Unnecessary or experimental, 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. Provider 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;
 - b. Provider 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 Blue Cross or Blue Shield Plan Members' 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 such 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, verification of services provided, duration of rental services, dates equipment/supplies are ordered and/or dispensed, adherence to BCBSM policies, Medical Necessity of services provided, and appropriateness of procedure codes reported to BCBSM for the services rendered.

III. Time

BCBSM may conduct onsite inspections and audits during Provider's regular business hours. Provider 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 benefit criteria, services not verified in Provider's records, 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.

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