Independent Physical Therapist Provider Participation Agreement
THIS AGREEMENT by and between Blue Cross and Blue Shield of Michigan (BCBSM), whose address is 600 E. Lafayette Blvd., Detroit, Michigan 48226, and the undersigned Independent Physical Therapist (Provider) who has executed and returned to BCBSM the attached Signature Document acknowledging receipt of this Agreement and to be bound by its terms and conditions. Under this Agreement, BCBSM and Provider agree as follow:

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 physical therapy services, that 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 but excludes BCBSM’s subsidiaries.

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; however, "sponsorship" does not include any Alternative Delivery System(s).

1.5. "Covered Services" means those physical therapy services that are listed or provided for in Certificates, that are Medically Necessary as set forth in Addendum A and that are within Provider's scope of license.

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

1.7. "Out-of-Panel Services" means physical therapy services provided to a member of an Alternative Delivery System by a physical therapist who is not an approved panel provider of such Alternative Delivery System at the time such services are provided.

1.8. "Qualification Standards" means those criteria established by BCBSM which are used to determine Provider's eligibility to become or remain a BCBSM participating Independent Physical Therapist provider.

1.9. "Reimbursement Policies" means the policies by which BCBSM determines the amount of payment due Provider for Covered Services.
ARTICLE II
PROVIDER RESPONSIBILITIES

2.1. Services to Members. Provider, within the limitations of Michigan licensure laws, will provide Covered Services to Members based on 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. No services are reimbursable pursuant to this Agreement unless prescribed by a doctor of medicine, osteopathic physician or other health care provider licensed to prescribe such services.

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. The current Qualification Standards are set forth in Addendum B.

2.3. Eligibility and Benefit Verification. Provider will be responsible for verifying Member eligibility and coverage through such processes as BCBSM shall establish from time to time.

2.4. Reimbursement for Services. Provider certifies that all services submitted for reimbursement by BCBSM are, except as otherwise authorized and communicated by BCBSM, performed personally by or under the supervision of Provider and in accordance with the Member’s Certificate and with BCBSM’s published policies. Except for applicable copayments and deductibles, Provider agrees to accept as full payment:

a. for Covered Services, the amount reimbursed by BCBSM pursuant to Section 3.4. and BCBSM’s Reimbursement Policies (Addendum C) of this Agreement; and

b. for any Out-of-Panel Services, the amount paid by the Alternative Delivery System according to its reimbursement policies, including any provider sanctions.

Provider also agrees not to collect any additional payment from any Members except as set forth in Addendum D, or from any members of Alternative Delivery Systems except as may be provided in its standard reimbursement policies or contractual arrangements with its members.

2.5. Claims Submission. Provider will submit acceptable claims for Covered Services and for services provided to members of Alternative Delivery Systems 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. All claims shall be submitted within 15 months of the date(s) of service. Claims submitted more than 15 months after the date(s) of service, shall not be entitled to reimbursement from either BCBSM or Member except as set forth in Addendum D, 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 E.

2.6. Utilization and Quality Programs. Provider will adhere to BCBSM’s policies and procedures regarding utilization review, quality assessment, precertification 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.
2.7. **BCBSM Access to Records and Equipment.** BCBSM represents that 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 allow BCBSM access to information related to any Covered Services provided pursuant to this Agreement including, but not limited to, BCBSM patient and financial records, equipment, and quality control and maintenance charts, and procedures manuals to determine: (i) the appropriateness of its benefit payments; (ii) the eligibility of Members; (iii) continued compliance with Qualification Standards; and (iv) verification of the uniformity of patient charges.

2.8. **Confidentiality.** Provider will maintain the confidentiality of the medical records and related information of Members as required by law.

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. **Audits and Recovery.** Provider agrees that BCBSM may photocopy, review and audit Provider's records to determine, but not necessarily limited to, verification of services provided, 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 F.

2.11. **Provider Changes.** Provider will notify BCBSM of any actions, policies, determinations, or other developments which may have an impact on the provision of services to Members including, but not limited, to: (i) any administrative action against any of Provider's licenses, certification or accreditation; and (ii) any legal action against Provider which affects this Agreement such as for professional negligence, fraud, violation of any law, or against any license.

2.12. **Compliance-Laws/Standards of Practice.** Provider will provide Covered Services in a manner which complies with (i) all applicable federal, state and local laws, rules and regulations, and (ii) the standards of professional conduct and practice prevailing in the applicable community during this Agreement.

2.13. **Provider Directories.** Provider agrees that BCBSM will have the right to publish Provider's name, address and telephone number in any participating provider directories published by BCBSM.

2.14. **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.

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**ARTICLE III**  
**BCBSM RESPONSIBILITIES**

3.1. **General.** BCBSM's payment obligations pursuant to this Agreement will be limited to Covered Services provided by Provider in accordance with the terms and conditions contained herein. Neither BCBSM, nor any member of an Alternative Delivery System, shall have any obligation to reimburse Provider pursuant to this Agreement for any Out-of-Panel Services provided to any such member. Such reimbursement will be only
pursuant to the reimbursement policies of the Alternative Delivery System in effect at the
time such services are rendered, including any provider sanctions.

3.2. **Eligibility and Benefit Verification.** BCBSM will provide Provider with a system and/or method, in accordance with Article II, Section 2.3, to promptly verify eligibility and benefit coverages of Members; provided that any such verification will be given as a service and not as a guarantee of payment.

3.3. **Claims Processing.** BCBSM will timely process acceptable claims submitted by Provider for Covered Services provided to Members in accordance with the terms and conditions contained in this Agreement and in accordance with federal and state law.

3.4. **BCBSM Reimbursement.** Pursuant to the terms and conditions contained in this Agreement, BCBSM will, where applicable, make direct payment to Provider for Covered Services provided to Members. The current Reimbursement Policies are set forth in Addendum C. The exclusions and limitations set forth in Section 3.1. of this Article, regarding reimbursement for Out-of-Panel Services provided by Provider to members of Alternative Delivery Systems are also applicable to this Section.

3.5. **Administrative Manuals and Bulletins.** BCBSM will, without charge, supply Provider with access to electronic versions of any provider manual, 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 provided to Members pursuant to this Agreement. Provider will adhere to all published guidelines for the provision of Covered Services to Members.

3.6. **Appeals Process.** BCBSM, as set forth in Addendum G, will provide an appeals process for Provider if Provider disagrees with any claim adjudication or audit determination made by BCBSM.

3.7. **BCBSM Audits and Recovery.** BCBSM will have the right of recovery of any overpayments in accordance with Addendum E and of any amounts identified in audit(s) conducted by BCBSM as set forth in Addendum F.

3.8. **Confidentiality.** BCBSM shall maintain the confidentiality of Members' and Provider's records and information of a confidential or sensitive nature in accordance with applicable state and federal law and as set forth in Addendum H.

**ARTICLE IV**
**PROVIDER ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS**

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 V
GENERAL PROVISIONS

5.1. **Term.** The term of this Agreement shall begin on the later of October 1, 2006, or the date BCBSM receives the duly executed Signature Document from Provider, and shall continue until terminated as provided herein below.

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

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

b. immediately by BCBSM where there is a material breach of this Agreement by the Provider which is not cured within 20 business days of written notice from BCBSM;

c. by BCBSM, automatically and without notice, if: (i) Provider is censured, placed on probation, or has its Medicare participation/certification terminated or license suspended, revoked, or nullified; (ii) is found to have committed civil fraud; or (iii) Provider is convicted of, or pleads to any health care related misdemeanor or a felony, including any "plea bargain," reducing a felony to a misdemeanor; or (iii) Provider is expelled, suspended or excluded from Medicare or Medicaid Programs (Title XVIII or XIV of the Social Security Act);

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

e. by either party immediately upon written notice if Provider ceases the occupation of providing physical therapy services;

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

g. by BCBSM if termination of this Agreement is ordered by the State Insurance Commissioner.

5.3. **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.

5.4. **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 as set forth in Article III, Section 3.7., or based upon any audit conducted pursuant to Article II, Section 2.10. of this Agreement. Such rights of BCBSM shall survive the termination of this Agreement.

5.5. **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 clinical
staff training and selection. Any violation of this provision by the Provider shall constitute a material breach and give BCBSM the right to immediately terminate this Agreement as provided in Article V.2.b.

5.6. **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.

5.7. **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 2.14.

5.8. **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 60 days prior written notice to Provider; however, BCBSM shall have the right to unilaterally amend this agreement upon giving not less than 60 days prior written notice to Provider as provided in Section 5.12 below or, at BCBSM’s discretion, by publication in the appropriate provider publication, e.g. *The Record*.

5.9. **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.

5.10. **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.

5.11. **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.

5.12. **Notices.** 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:  If to BCBSM:
Current address shown on  Blue Cross Blue Shield of Michigan
BCBSM Provider File  Provider Enrollment, MC B443
600 E. Lafayette Blvd.  600 E. Lafayette Blvd.
Detroit, Michigan  48226-2998

5.13. **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.

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

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.
ADDENDA

A Medical Necessity Criteria
B Qualification Standards
C Reimbursement Policies
D Services For Which Provider May Bill Member
E Service Reporting and Claims Overpayments
F Audits and Recovery Policy
G Disputes and Appeals
H Confidentiality Policy
MEDICAL NECESSITY CRITERIA

Medical Necessity is determined by physicians (MD or DO). 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 acting for the appropriate professional provider group and/or medical specialty, 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 or physician; and in the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the patient's condition.
QUALIFICATION STANDARDS

The Provider must meet and continue to meet all of the following Qualification Standards to participate with BCBSM as an Independent Physical Therapist:

- Licensure as a physical therapist in the state of Michigan
- Have a Medicare supplier number as a Physical Therapist in Private Practice
- Absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints, audits and peer review, and
- Absence of fraud or illegal activities
ADDENDUM C

REIMBURSEMENT POLICIES

For Covered Services, BCBSM will reimburse Provider the lower of Provider’s billed charge or the maximum payment level published in the BCBSM Maximum Payment Schedule. The billed charge refers to the actual charge indicated on the claim submitted by Provider to BCBSM.

Most maximum payment levels are based on the Resource Based Relative Value Scale (RBRVS) system developed by the Centers for Medicare and Medicaid Services (CMS), in which services are ranked according to the resource costs needed to provide them.

The resource costs of the RBRVS system include physician time, training, skill, risk, procedure complexity, practice overhead and professional liability insurance. Values are assigned to each service in relation to the comparative value of all other services. The relative values are then multiplied by a BCBSM-specific conversion factor to determine overall payment levels.

Other factors that may be used in setting maximum payment levels include comparison to similar services, corporate medical policy decisions, analysis of historical charge data and geographic anomalies. BCBSM will give individual consideration to services involving complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level. BCBSM may adjust maximum payment levels based on factors such as site of care or BCBSM payment policy.

BCBSM reviews provider payment levels periodically. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

BCBSM will give Provider not less than 90 days prior written notice of any material change to the reimbursement methodology.

Notice of any reimbursement changes will be given (i) by mail, or, (ii) at BCBSM's option, in the appropriate BCBSM provider publication (e.g., The Record) or web resource (e.g. web-DENIS).
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 BCBSM medical consultant that the service was not Medically Necessary, 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 may bill the Member for claims denied as not Medically Necessary only as stated in paragraph 2. below;

2. Services determined by a BCBSM medical consultant to be not Medically Necessary, 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 15 months of performance of such services because a Member failed to provide proper identifying information.
   b. Provider submits a claim to BCBSM for payment consideration within three months after obtaining the necessary information.
SERVICE REPORTING AND CLAIMS OVERPAYMENT POLICY

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, Provider assigned Provider Identification Number (PIN), license number of prescribing physician/provider, and such other information as may be required by BCBSM to adjudicate claims.

Provider will use the Provider PIN assigned by 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. BCBSM's secondary coverage will be limited to the difference, if any, between the maximum amount BCBSM would have otherwise paid less the amount paid by the primary carrier. If the primary carrier's payment exceeds the BCBSM maximum payment, no secondary coverage will be provided by BCBSM.

II. Overpayments

Provider shall report overpayments to BCBSM due to Provider's billing errors or BCBSM payment errors within 30 days after discovery, 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 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.
AUDIT AND RECOVERY POLICY

I. Records.

BCBSM 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, any 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, verifications of services provided, Medical Necessity of services provided, and appropriateness of procedure codes reported to BCBSM for the 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 overpayments and amounts paid for services not meeting applicable benefit criteria or which are not Medically Necessary. 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 for recovery.
ADDENDUM G

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:

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

For disputes regarding professional provider utilization review audit results:

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

A request for a Reconsideration Review must include the following:

- Area of dispute:
- Reason for disagreement;
- Any additional supportive documentation; and
- Copies of medical records (if not previously submitted)

Within 30 days of receipt of the request for Written Complaint/Reconsideration Review, BCBSM shall provide in writing a specific explanation of all of the reasons for its action that form the basis of 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. 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 his/her representative will normally be in
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:

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

For Conferences regarding professional utilization review audit results disputes:

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

A request for a Managerial-Level Review Conference must include the following:

---  Area of dispute;
---  Reason for disagreement;
---  Any additional supportive documentation; and
---  Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to 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 Insurance Bureau with 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 (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 he/she are 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 determinations(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 the 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 Insurance Bureau 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:

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

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

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

**INTERNAL REVIEW COMMITTEE**

For disputes involving Billing & 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 his/her representative and 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:

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

If Provider is dissatisfied with the determination of the Internal Review Committee, he/she may appeal the determination to either the Provider Relations Committee (a subcommittee of
BCBSM’s board of directors) or directly to the Michigan Insurance Bureau; 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 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 themselves at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC’s mandate is to render a determination within a “reasonable time”; however these decisions will normally be rendered within 30 days of the date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC’s determination.

The request for a PRC hearing should be mailed to:

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

If Provider is dissatisfied with the determination of the Provider Relations Committee, he/she may appeal the determination to the Michigan Insurance Bureau, or initiate an action in an appropriate state court.
MICHIGAN INSURANCE BUREAU

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 P.A. 350, Provider shall have the right to submit a request to the Michigan Insurance Bureau 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 P.A. 350 Sections 402(1) and 403 BCBSM has violated. The request shall be mailed to:

Commissioner of Insurance
Michigan Insurance Bureau
Post Office Box 30220
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of the Insurance Bureau. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Insurance Bureau shall issue its determination.

Contested Case Hearing

If dissatisfied with the Insurance Bureau’s determination, 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 Insurance Bureau’s Determination is mailed, and shall be mailed to the Insurance Bureau 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/Reconsideration Review and Management Review Conference steps, Provider may attempt to resolve the dispute by initiating an action in the appropriate state court.
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, and Provider financial data and 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 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.

The term “Provider financial data and information” refers to a document or other record, limited to 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 ASC customers and hospitals may obtain personal data provided that claims of identifiable Members are protected in accordance with any specific statutory authority. Also, experience rated and ASC customers may obtain Provider financial data for auditing and
other purposes. 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 accounts and facilities 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.

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