

Contract with insurers for use of NPs

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■ NPSS

Nurse Practitioner Support Services



NPSS is a team of nurse-practitioners who visit patients in their homes to improve health outcomes for managed care plans. The nurse-practitioners collect health information from the patients by obtaining a comprehensive history and doing a physical examination. They also review the family support systems and capture any missing or out-of-date diagnosis coding. They use MEDICS software, supported by Medical Information Integration, which is 100% HIPAA compliant. The software is easily customized to collect additional patient information if needed by the client. It also includes electronic billing services for your convenience.

After the nurse-practitioners have visited the patients, electronic records of the examination as well as electronic claims are sent to the company, to the patient's PCP, and to consultants, if needed. There will be a professional analysis to assure that all coding of medical history is completed and up to date. (Anyone unable to receive the data electronically will get it in a standard printed format in a secure form).

HIPAA
Compliant

For more information please contact Don McCormick at
donmcco@gmail.com

Why does this benefit insurance companies?

It helps companies manage the health of their chronically ill patients. It captures the HCC coding that is usually only about 65% complete in passive systems of care. It insures that the patients are being seen by their PCPs. It improves retention of members, helps to prevent unnecessary hospitalizations and reduces the emergencies.

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How is this program different from the usual home health care services?

We use nurse-practitioners who can deliver a more skilled medical service than offered through home health agencies. The diagnosis of our nurse-practitioners can go directly into the medical record rather than having the patients referred to their doctors for the confirming diagnosis.

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PROFESSIONAL PROVIDER AGREEMENT

This Professional Provider Agreement (“Agreement”), is made and entered into by and between _____, a _____ IPA provider, (“Provider”), and _____ (“Health Plan”) and is effective as of the date the Provider is credentialed (the “Effective Date”).

WHEREAS, Provider is a physician or other professional medical provider that provides professional health care or medical products.

WHEREAS, Health Plan is contracted with the Centers for Medicare and Medicaid Services (“CMS”) to offer Medicare plans to eligible Medicare beneficiaries;

WHEREAS, Health Plan and Provider mutually desire to enter into this Agreement whereby Provider shall render Covered Services to Members of the various Benefit Plans and shall be compensated by Health Plan therefore, as more explicitly described hereafter.

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth in this Agreement and other good and valuable consideration, the parties hereto intending to be legally bound, hereby agree as follows:

1. **DEFINITIONS**

The capitalized terms used in this Agreement shall have the following meanings:

1.1 Appeal. Any of the procedures that deal with the review of an adverse determination Health Plan has made related to the health care services the Member believes the member is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the member must pay for a service.

1.2 Benefit Plan. A health benefit plan that establishes Health Plan’s obligation to the Member to provide access to and payment for Covered Services and benefits and contains the terms and conditions of the Member’s coverage..

1.3 Benefit Plan Requirements. The rules, procedures, policies, protocols and other conditions to be followed by Participating Providers and Members with respect to providing Covered Services under a particular Benefit Plan.

1.4 CMS. The Centers for Medicare and Medicaid Services, which is the federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs.

1.5 Capitation Compensation. The per Member per month (PMPM) payment, payable monthly for each Member who has selected or been assigned to Provider who has agreed to be paid capitation.

1.6 Clean Claim. A claim for payment for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by Health Plan or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall not include a

claim from Provider that is under investigation for fraud or abuse regarding that claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or State laws and regulations.

1.7 Coordination of Benefits. The allocation of financial responsibility between two or more payers of health care services, each with a legal duty to pay for or provide Covered Services to a Member at the same time.

1.8 Coinsurance. The percentage of the reimbursement for Covered Services that a Member is obligated to pay under a particular Benefit Plan.

1.9 Copayment. That portion of the reimbursement for Covered Services that a Member is obligated to pay as a fixed dollar amount each time a Covered Service is provided under a particular Benefit Plan.

1.10 Covered Services. The Medically Necessary health care services and supplies that are to be provided by Provider to Members for which a Member has coverage pursuant to the applicable Benefit Plan.

1.11 Deductible. A specified dollar amount that a Member is obligated to pay before Health Plan is liable for the payment of the Covered Services under a particular Benefit Plan.

1.12 Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.13 Emergency Services. Covered inpatient and outpatient services that are: (i) furnished by a provider qualified to furnish emergency services; and (ii) needed to evaluate or stabilize an emergency medical condition.

1.14 Excluded Services. Those health care services and supplies which are not Covered Services under an applicable Benefit Plan regardless of Medical Necessity or services which would otherwise be Covered Services but which are determined not to be Medically Necessary. Excluded Services include, but are not limited to, services in excess of benefit limitations, services in conjunction with certain research studies, and services not covered under the Medicare program.

1.15 Experimental Medical Care. New and emerging medical technologies or new applications of existing technologies that are not covered under the Medicare program.

1.16 Grievance. Any complaint or dispute, other than one that constitutes an Appeal, expressing dissatisfaction with any aspect of Health Plan or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

1.17 Medically Necessary. Medical Services or Hospital Services which are determined by the Plan to be: (a) rendered for the treatment or diagnosis of an injury or illness; and (b) appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and (c) not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and (d) furnished in the most economically efficient manner which may be provided safely and effectively to the Member.

Whether there is “sufficient scientific evidence” shall be determined based upon the following: peer reviewed medical literature; publications, reports, evaluations and regulations issued by state and federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by the Plan.

1.18 Member. A Medicare eligible individual who, on the date of service, is eligible to receive Covered Services under a Benefit Plan.

1.19 Member Expenses. Any amounts that are the responsibility of the Member or other appropriate responsible party (other than Health Plan) to pay in accordance with the Member’s Benefit Plan, including copayments, coinsurance and deductibles.

1.20 Participating Provider. A hospital, physician, physician organization, Provider, other health care practitioner or other organization which has a contractual relationship with Health Plan to provide certain Covered Services to Members, has been credentialed or recertified, as applicable, by Health Plan and is currently in good standing with Health Plan and the appropriate State and federal licensing entities, as applicable.

1.21 Preventive Care. Preventive Care aims to modify or reduce disease risk factors and promote early detection of disease or precursor states.

1.22 Primary Care Physician (PCP). A physician who is a Participating Provider and who is responsible, pursuant to the applicable Benefit Plan, for coordinating and managing the delivery of Covered Services to Members who have selected or been assigned to such Participating Provider.

1.23 Preapproval. The approval which the PCP or other Participating Provider must obtain from Health Plan to confirm Health Plan coverage for certain Covered Services as specified in the applicable Benefit Plan Requirements, Provider Manual and this Agreement. Such Preapproval must be obtained prior to providing Members with Covered Services or Referrals. A Preapproval determination will be made by Health Plan or its designee, under the supervision of a Medical Director. Preapproval is not a guarantee of payment if it is subsequently found that a Member’s coverage under an applicable Benefit Plan Agreement was terminated prior to the date of service. If the Participating Provider is required to obtain Preapproval, and provides Covered Services or Referrals without obtaining such Preapproval, neither the Member nor Health Plan will be responsible for payment.

1.24 Provider Manual. A manual of Health Plan policies, procedures and administrative practices published by Health Plan and distributed to Provider from time to time. Such policies, procedures and administrative practices may be amended by written notice to Provider prior to their incorporation into the Provider Manual.

1.25 Quality Management Program. The functions, including but not limited to, credentialing, recertification and certification of Participating Providers, site visits, review and audit of medical and other records, medical outcomes, peer review and Participating Provider appeals and grievance procedures performed or required by Health Plan, or any other permitted person or entity, to review the quality of Covered Services rendered to Members. Provider shall be notified on a periodic basis by Health Plan of changes or additions to such Quality Management Program that are relevant to Provider and the terms of this Agreement.

1.26 Referral. Written or electronic documentation from the Member’s PCP, or other Participating Provider designated by Health Plan that authorizes Covered Services to be rendered by a

Participating Provider specifically named on the Referral. Referrals to non-Participating Providers require Preapproval by Health Plan, or its designee. A Referral must be issued to or for the Member prior to the Member's receipt of Covered Services.

1.27 State. The applicable state or states in which Provider is to provide Covered Services under this Agreement.

1.28 Urgently Needed Services. Covered Services that are not emergency services as defined in this section, provided when an enrollee is temporarily absent from Health Plan's service (or, if applicable, continuation) area when the services are medically necessary and immediately required: (i) as a result of an unforeseen illness, injury, or condition; and (ii) it was not reasonable given the circumstances to obtain the services through Health Plan Participating Providers.

1.29 Utilization Management Program. The functions including, but not limited to Preapproval, Referral and prospective, concurrent and retrospective review, case management and disease management performed or required by Health Plan or any other permitted person or entity, to review and determine whether medical services or supplies which have been or will be provided to Members are Covered Services under a Benefit Plan and meet the criteria as Medically Necessary.

2. PROVIDERS OBLIGATIONS

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2.1 Provider Representations and Warranties.

(a) Provider shall complete and submit to Health Plan the Health Plan credentials application, as modified from time to time by Health Plan, including but not limited to evidence of satisfaction of the requirements set forth in Section 2.1(b) herein. The submitted credentials application is a part of this Agreement. Provider shall not treat Members until such Provider has been credentialed or recredentialed, as applicable, and accepted by Health Plan. Provider further agrees to abide by Health Plan's credentialing and recredentialing policies as well as new credentialing and recredentialing criteria that may be established by Health Plan from time to time.

(b) Provider represents and warrants that Provider meets all credentialing requirements of Health Plan, as may be modified from time to time, and that Provider:

(i) is licensed by the State(s) to provide Covered Services;

(ii) provides Covered Services in compliance with all applicable local, State, and federal laws, rules, regulations and professional standards of care;

(iii) is fully able without limitation to participate in Medicare under Title XVIII of the Social Security Act, and in Medicaid under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act;

(iv) holds staff privileges on the medical staff(s) of one or more Participating Hospitals, where applicable;

(v) holds a current DEA narcotic registration certificate, where applicable;

(vi) shall maintain such licensure, compliance, certification and registration throughout the term of this Agreement;

(vii) shall maintain all required professional credentials and meet all continuing education requirements necessary to retain Board certification or eligibility in Provider's area(s) of practice; and

(viii) shall maintain a professional relationship with each Member for whom Provider renders Covered Services, and shall be responsible solely to such Member for treatment and medical care.

(c) Provider shall notify Health Plan immediately in the event any of the requirements of this section fail to be satisfied or maintained by Provider.

2.2 Provision of Services.

(a) Provider agrees to render Covered Services to Members in accordance with: (i) the terms and conditions of this Agreement; (ii) all laws, rules and regulations applicable to Provider, or Health Plan; (iii) the Utilization Management Program, Quality Management Program, Benefit Plan Requirements, Member Appeal, Grievance and other policies and procedures of the particular Benefit Plan(s) under which the Covered Services are rendered; (iv) the same manner, and with the same availability, as services are rendered to other patients without regard to reimbursement; and (v) the clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted or established by Health Plan.

(b) Nothing in this Agreement shall be construed to prohibit, restrict or impede the Provider's ability to freely and openly discuss with Members all available treatment options regardless of whether the services may be considered Covered Services in accordance with this Agreement.

(c) Provider agrees to develop, implement, monitor and maintain standards, policies and procedures to ensure Member confidentiality for Covered Services, in accordance with all applicable State and federal rules and regulations.

2.3 Offices and Hours. Provider shall maintain such offices, equipment, patient service personnel and allied health personnel as may be necessary to provide Covered Services under this Agreement. Provider shall provide Covered Services under this Agreement at Provider's offices during normal business hours, and shall be available to Members by telephone twenty-four (24) hours a day, seven (7) days a week for consultation on medical concerns. Further, Provider shall be available to provide Covered Services on an Emergency basis twenty-four (24) hours a day, seven (7) days a week.

2.4 Coverage. Provider will arrange for coverage, in the event of Provider's illness, vacation or other absence from his or her practice, and shall ensure that such coverage conforms to the terms of this Agreement. Provider will ensure that a covering physician: (a) participates with Health Plan; (b) or if the covering physician does not participate with Health Plan, obtain written approval from Health Plan of such coverage arrangement, and ensure that such covering physician will not seek compensation from Health Plan for services if Provider receives compensation from Health Plan; (c) will not bill Members for Covered Services under any circumstances, except for applicable Copayments, Coinsurances and/or Deductibles as required under the applicable Benefit Plan; and (d) in accordance with the applicable Benefits Program, will obtain Preapproval from Health Plan and/or Referrals, except in Emergencies, where required or permitted under the applicable Benefits Program.

2.5 Non-Discrimination. Provider shall not limit, deny, condition or discriminate against any Member in the provision of Covered Services hereunder, on the basis of the Member's coverage under a Benefit Plan, age, sex, race, color, religion, ancestry, national origin, sexual orientation, disability, handicap, health status, including but not limited to medical condition, receipt of health care, medical history genetic information or conditions arising out of acts of domestic violence, amount of reimbursement by Health Plan, utilization of medical or mental health services or supplies or other unlawful basis including, without limitation, the filing by such Member of any Appeal, Grievance or legal

action against Provider or Health Plan. This shall include, but not be limited to, excluding or closing a practice to certain Members as a result of the reimbursement (e.g., closing a practice to capitated HMO patients only). Provider shall be precluded from terminating his/her relationship with a Member who has complicated or expensive medical needs unless Provider has received written approval from Health Plan that there is good cause for such termination.

2.6 Utilization Management Requirements. Provider agrees to participate in, cooperate with and comply with all decisions rendered in connection with Health Plan's Utilization Management Program as detailed in the Provider Manual. Provider also agrees to provide such records and other information as may be required or requested under such Utilization Management Program.

2.7 Preapproval and Referrals. Certain Benefit Plan or Utilization Management Programs contain requirements for Preapproval of services or Referral from a PCP. In such cases, except in an Emergency, Providers other than PCPs may only furnish Covered Services pursuant to a Referral issued by a Participating Provider and/or Preapproval by Health Plan or its designee. Provider agrees not to seek payment from Health Plan for Covered Services rendered to a Member unless the applicable Preapproval and/or Referral was obtained prior to the rendering of such services. If all or any part of Covered Services that would otherwise be payable hereunder are furnished to a Member by Provider, but were not included or specified on a Referral by a Participating Provider and/or Preapproved as may be required under an applicable Benefit Plan, Provider shall not charge either Health Plan or the Member for the non-Referral and/or non-Preapproved portion of such Covered Services. Preapproval is not required in an Emergency; however, Provider agrees to notify Health Plan and the appropriate Participating Provider, as applicable, within twenty-four (24) hours after providing the Covered Services, or ordering other Covered Services, or as soon as reasonably possible.

2.8 Participating Providers.

(a) Except in an Emergency, as otherwise described in the applicable Benefit Plan or as otherwise required by law, Provider shall refer Members only to Participating Providers for Covered Services, including but not limited to ancillary services such as laboratory and radiology. If a Participating Provider is not available, Provider shall obtain Preapproval before referring a Member to a non-Participating Provider. In the event Provider refers a Member to a non-Participating Provider without Preapproval, or provides Excluded Services to Member, Provider shall inform the Member in advance, in writing: (i) of the service(s) to be provided; (ii) that Health Plan will not pay for or be liable for said services; and (iii) that Member will be financially liable for such services. In the event the Provider does not comply with the requirements of this Section, Provider shall be required to hold the Member harmless in accordance with Section 3.7.

(b) For services rendered to Member by Provider for which Health Plan Preapproval is required and not obtained, Provider shall be responsible for payment of claims incurred for the unauthorized Covered Service and Provider agrees, in accordance with Section 3.7 of this Agreement, to hold harmless the Member for such claims.

2.9 Quality Management Program. Provider shall be solely responsible for the quality of Covered Services rendered to Members. The quality of Covered Services rendered to Members shall be monitored under the Quality Management Program applicable to the particular Benefit Plan. Provider agrees to participate in, and cooperate in all respects with, the applicable Quality Management Program detailed in the Provider Manual. Provider also agrees to provide such medical and other records within ten (10) days of receipt of written notice, and such review data and other information as may be required or requested under a Quality Management Program. In the event that the standard or quality of care furnished by Provider is found to be unacceptable under any Quality Management Program, Health Plan

shall give written notice to Provider to correct the specified deficiencies within the time period specified in the notice. Provider shall correct such deficiencies within that time period.

2.10 Preventive Care Services. Providers shall abide by Health Plan's policies and procedures regarding applicable Preventive Care, which may be modified from time to time. Providers shall render Preventive Care to Members in a timely manner and document such in the medical record. Providers shall also document all Preventive Care Referrals of Members for specialty care, and document these Referrals in the medical record. Provider acknowledges that Members may obtain covered mammography screening services and influenza vaccinations without a referral from their PCPs and that Members who are women may obtain women's routine and preventive health care Covered Services from a participating women's health specialist without a referral from their PCP. Provider acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to Member cost sharing obligations. Provider agrees to cooperate and demonstrate a "best effort" attempt, to the extent applicable, in conducting a health assessment of all new Members within ninety (90) days of the effective date of their enrollment.

2.11 Members with Complex or Serious Medical Conditions. Provider acknowledges that Health Plan has procedures approved by CMS to identify Members with complex or serious medical conditions; assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and establish and implement a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans for individual Members in Provider's care.

2.12 Notice of Adverse Action. Provider shall notify Health Plan in writing, within ten (10) business days of receiving any written or oral notice of any adverse action, including, without limitation: (a) any malpractice suit or arbitration action, or other action naming or otherwise involving Provider or Health Plan; (b) any other event, occurrence or situation which might materially interfere with, modify or alter performance of any of Provider's duties or obligations under this Agreement; or (c) any event, occurrence or situation which jeopardizes the health or safety of any Member in any manner or constitutes gross misconduct or fraud. Provider shall forward to Health Plan any written Appeal or Grievance of a Member against Provider within five (5) business days of receipt thereof, except for those requiring expedited processing. Appeals or Grievances requiring expedited processing shall be forwarded by Provider to Health Plan within one (1) business day of Provider's receipt thereof. Provider shall maintain a written record of any Member complaint and provide such record to Health Plan promptly upon request. Provider also shall notify Health Plan promptly of any action against any applicable license, certification or participation under Title XVIII or Title XIX or other applicable provision of the Social Security Act or other State law, DEA narcotic registration certification, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Provider.

2.13 Professional Liability Insurance. Provider shall maintain general liability, professional liability, worker's compensation and other insurance to insure Provider, its employees, and its agents and contractors against claims, liabilities, damages or judgments arising directly or indirectly in connection with the performance or non performance of services under this Agreement. Provider shall ensure that professional liability insurance in an amount equal to the greater of the amount required by law, or the prevailing community standard is maintained for it and each of its Providers, but in no event less than one Two Hundred Thousand Dollars (\$200,000) per occurrence, and Six Hundred Thousand Dollars (\$600,000) in the aggregate. Provider agrees to provide Health Plan with written evidence, acceptable to Health Plan, of its insurance coverage within three (3) days of such request by Health Plan. Provider also agrees to notify, or to ensure that its insurance carriers notify Health Plan at least thirty (30) days prior to

any proposed termination, cancellation or material modification of any policy for all or any portion of the coverage provided for above.

2.14 Listing of Provider in Health Plan Provider Directory. Provider agrees that Health Plan may list the name, address, telephone number and other factual information of Provider in its provider directory or other informational materials. It is understood that Health Plan shall not be responsible or liable for any and all damages arising from an error or omission in the provider directory.

2.15 Timely Assignment of Members. Where required under a Benefit Plan, Health Plan shall require Members to select specified Participating Providers at the time of enrollment. In the event a Member does not select a PCP or other Participating Provider within the specified time frame, Health Plan may automatically assign the Member to an appropriate PCP based upon the zip code in which the Member resides. Upon automatic assignment of PCP, the Member may change to another PCP of choice.

2.16 Member Appeal and Grievance Procedures. Provider shall comply with the applicable Member Appeal and Grievance Procedures and shall abide by the determination of the applicable Member Appeal and Grievance Procedure, which may be modified from time to time by Health Plan in accordance with applicable federal or State law.

2.17 Compliance with Rules and Regulations. Provider shall be bound and comply with the provisions of applicable state and federal laws, regulations and Benefit Plan Requirements.

2.18 Primary Care Physician/Capitated Providers. If Provider serves as a PCP under a Benefit Plan where a Member must select a PCP, Provider shall (i) give Health Plan sixty (60) days notice in writing of intent not to accept additional Members beyond those listed on PCP's patient panel. During this sixty (60) day notice period, PCP agrees to accept for diagnosis and treatment all Members who select PCP for primary care services; and (ii) provide Health Plan with encounter data on a timely basis showing all services provided to each Member for whom PCP received Capitation Compensation or fee for service payments. In accordance with Section 2.5 above, Provider shall be precluded from closing its practice only to capitated HMO patients. All such encounter data shall be submitted in a format acceptable to Health Plan within thirty (30) days after the date services were rendered. Provider agrees to certify the accuracy, completeness, and truthfulness of Provider generated encounter data that Health Plan is obligated to submit to CMS.

2.19 Subcontracting. (a) Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of Health Plan. Every subcontract between Provider and a subcontractor shall (i) be in writing and comply with all applicable local, State and federal laws and regulations; (ii) be consistent with the terms and conditions of this Agreement; (iii) contain the Health Plan and Member hold harmless language as set forth in Section 3.7 hereof; (iv) contain a provision allowing Health Plan and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by Provider to subcontractor under such subcontract; and (v) be terminable with respect to Members or Benefit Plans upon request of Health Plan.

(b) Health Plan shall be a third party beneficiary of any said subcontract. Provider shall furnish Health Plan, upon its request, with copies of any and all such subcontracts. Each such subcontractor shall be required to be a Participating Provider. Provider shall ensure that all Covered Services provided to Members under such subcontracts shall be specifically identified in each Member's medical record, which shall be maintained in accordance with Section 5 herein. Provider shall be financially responsible to the subcontractor for the services and Health Plan shall pay Provider for such services on the same basis and at the same rates as if the Covered Services had been provided directly by

Provider. Neither Provider nor Provider's subcontractor shall bill Members for such services, except for applicable Copayments, Coinsurances and/or Deductibles, and Provider shall hold, and ensure that subcontractors hold, Health Plan and Members harmless from and against any and all claims which may be made by such subcontractors in connection with Covered Services rendered to Members under such subcontracts. Upon request, Provider shall disclose to Health Plan the financial arrangements between Provider and its subcontractor(s). Notwithstanding the above, Health Plan reserves the right to pay Provider's subcontractor directly for Covered Services to Members and to reduce Provider's payment commensurate with such direct payment to subcontractor if Health Plan has reason to believe that Provider has not paid its subcontractor under its subcontract.

(c) Provider shall terminate a subcontractor with respect to providing Covered Services to Members immediately upon request of Health Plan, in the event of: (i) subcontractor's failure to comply with applicable Utilization Management Program, Quality Management Program and/or credentialing criteria or any other term of this Agreement; (ii) subcontractor's exclusion from participation in the Medicare program or any other federal health care program, or (iii) upon request of Health Plan.

2.20 Prohibited Sanctions/Termination. Health Plan shall not sanction, terminate or fail to renew Provider's participation for any of the following reasons:

- (a) Advocating for Medically Necessary and appropriate health care services for a Member;
- (b) Filing an Appeal or Grievance on behalf of and with the written consent of a Member, or helping a Member to file an Appeal or Grievance;
- (c) Protesting an Health Plan decision, policy or practice which Provider believes interferes with his/her ability to provide Medically Necessary and appropriate health care services; or
- (d) Taking another action specifically permitted by applicable law.

3. COMPENSATION

3.1 Federal Funds. Provider acknowledges that payments Provider receives from Health Plan to provide Covered Services to Members are, in whole or in part, from federal funds. Therefore, Provider and any of its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91, the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

3.2 Compensation Rates. Provider shall accept as payment in full for Covered Services rendered under this Agreement to Members the amounts payable by Health Plan as set forth in the attached Exhibit A, less Copayment, Coinsurance and/or Deductible amounts payable by Members in accordance with the applicable Benefit Plan. All payments to Provider by Health Plan shall be in accordance with applicable State and federal law and regulation. It is expressly understood that, in this context, Provider acknowledges its obligations to provide care consistent with generally accepted professional standards of care.

3.3 Billing, Payment and Provider Appeals.

(a) **Billing.** Provider agrees to comply with all billing requirements as detailed in the Provider Manual. Where fee for service payment is required under applicable Benefit Plan Requirements, Provider shall submit to Health Plan Clean Claims in a format approved by Health Plan for Covered

Services rendered to a Member within ninety (90) calendar days after such services are rendered. Where Health Plan is the secondary payer under Coordination of Benefits, such ninety (90) day period shall commence once the primary payer has made payment on or has denied the claim. Health Plan shall not be under any obligation to pay Provider on any claim not timely submitted. Provider shall not seek payment from any Member in the event Health Plan fails to pay Provider for a claim not timely submitted.

(b) **Payment.** Unless the claim is disputed, Health Plan shall make payment on each of Provider's timely submitted Clean Claims for Covered Services rendered to a Member, within the time required by applicable State or federal law. Claims payments to Provider shall be in accordance with the policies and procedures applicable to the Members' Benefit Plan. Health Plan shall have the right to offset claim payments to Provider by any amount owed by Provider to Health Plan. Provider shall not be entitled to reimbursement if it is subsequently found that a Member's coverage under an applicable Benefit Plan Agreement was terminated prior to the date of service, regardless of any Preapprovals. Health Plan shall have the right to deny payments to Provider in the event Health Plan reasonably determines that Provider or its designee, in connection with the billing for services or supplies hereunder, knowingly concealed or misrepresented any material fact or circumstance in connection with the claim for such services. Any interest due Provider by Health Plan under applicable State and/or federal law, shall be paid in accordance with such law. Provider understands and agrees that any payments Health Plan makes directly or indirectly to Provider under this Agreement shall not be made as an inducement to reduce, limit or delay Medically Necessary Covered Services to any Member.

(c) **Provider Appeals.** Provider shall abide by Health Plan's process for resolving Provider Appeals. Provider Appeals do not include an Appeal or Grievance a Provider files on behalf of a Member.

3.4 Eligibility. Except in an Emergency, Provider shall verify the eligibility of Members before providing Covered Services. Health Plan shall make a good faith effort to confirm the eligibility of any Member when such is in question.

3.5 Collection of Copayments, Coinsurances and/or Deductibles. Provider shall make reasonable attempts to collect all Copayments, Coinsurances and/or Deductibles due from Members and shall not waive or fail to reasonably pursue collection of such Copayments, Coinsurances and/or Deductibles.

3.6 No Additional Charges. Provider shall not charge the Member any fees for Covered Services rendered pursuant to this Agreement (except to the extent of authorized Copayments, Coinsurances and/or Deductibles). If Health Plan receives notice of any additional charges, Provider shall fully cooperate with Health Plan, shall investigate such allegations, and shall promptly refund any payment deemed improper by Health Plan to the Member or the party who made the payment.

3.7 (a) Member Hold Harmless. Provider agrees, and shall ensure its subcontractors agree, that in no event, including, but not limited to; non-payment, insolvency, or breach of this Agreement, shall Provider or subcontractor bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against Members or persons other than Health Plan acting on behalf of Member for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of Copayments, Coinsurances or Deductibles in accordance with the terms of the applicable Member's Benefit Plan. It is understood that: (i) this Provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on their behalf that relates to

liability for payment of Covered Services. Provider may not change, amend, or waive this provision. Any attempts to change, amend, or waive this provision are void.

(b) Health Plan Hold Harmless. Provider agrees and shall ensure that its subcontractors agree that in no event, including, but not limited to, non-payment by Provider, or Provider's insolvency, Health Plan's or Provider's refusal to pay for services or supplies deemed by it not to meet contractual definitions of Medically Necessary or Covered Services as determined by Health Plan, shall subcontractors collect a deposit from, seek compensation, remuneration, or reimbursement from; or have any recourse against Health Plan. Provider further agrees and shall ensure that subcontractors agree that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Health Plan, and that (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider or its subcontractors and Health Plan, Members or persons acting on their behalf. Provider and its subcontractors may not change, amend or waive this provision without prior written consent of Health Plan.

3.8 Conditions for Reimbursement for Excluded Services. Provider may bill a Member for Excluded Services rendered by Provider to Members only if (a) the Provider satisfies the requirements set forth in Section 2.8(a) prior to Provider's rendition of such service. Neither a Member, nor Health Plan shall be liable to pay Provider for any Covered Service rendered by Provider to a Member that is determined under a Utilization Management Program not to be Medically Necessary.

3.9 Coordination of Benefits. Provider agrees to provide Health Plan information for the collection and coordination of benefits when a Member holds other coverage that is deemed the primary payer for the provision of services to Members and to abide by Health Plan's coordination of benefits and duplicate coverage policies and applicable state or federal law

3.10 Continuation of Services. Provider agrees that in the event of Health Plan insolvency or other cessation of operations, Covered Services to Members shall continue through the period for which premium has been paid to Health Plan, and, to the extent applicable, Members who are in an inpatient facility on the date of insolvency or other cessation of operations will continue until their discharge.

3.11 Non-Eligible Member. Health Plan has no obligation under this Agreement to pay for services rendered to individuals who are not Members on the date of service regardless of Referrals, Preapprovals, or other authorizations.

3.12 Adjustments. Payments to Providers are subject to retroactive adjustment by Health Plan. Retroactive adjustments may occur where Health Plan is advised, after services have been provided and/or Preapproved that an individual was not an eligible Member at the time services were provided. Retroactive adjustments may also occur where Provider has provided services to an individual who was not considered a Member at that time, but is later indicated by CMS to have been an eligible Member at the time such services were provided. Health Plan shall have the right to retroactively offset and recoup any claim payments erroneously made to Provider by the amount of such erroneous payment.

4. TERM AND TERMINATION

4.1 Term. The term of this Agreement shall commence on the Effective Date and shall continue for an initial one (1) year term. After the initial one (1) year term, this Agreement shall automatically renew thereafter for successive one (1) year terms. This Agreement may be terminated in accordance with the provisions of Section 4.2. Regardless of the Effective Date, Provider shall not provide Covered Services to Members, and Health Plan shall have no obligation to pay for such services

unless the Provider has successfully completed Health Plan's credentialing or recredentialing process, as applicable.

4.2 Termination.

(a) **Without Cause.** Either party may terminate this Agreement at the close of the initial or any renewal term for any reason upon providing the other party with prior written notice of termination at least ninety (90) days in advance of the close of the then current term.

(b) **Termination for Material Breach.** Either party may terminate this Agreement in the event the other party breaches any material provision of this Agreement and fails to cure or take substantial steps to cure such breach to the non-breaching party's satisfaction within thirty (30) days of receipt of written notice of such breach. Health Plan may terminate the Agreement in the event of Provider's failure to comply with the terms, conditions or determinations of any Utilization Management Program, Quality Management Program, including, but not limited to, Provider's failure to comply with Health Plan's credentialing and recredentialing process (e.g. submitting required documentation in a timely manner), or other Benefit Plan Requirements and Provider fails to cure the breach within thirty (30) days after receiving notice of such breach.

(c) **Immediate Termination.** Health Plan may terminate this Agreement immediately upon notice to Provider in the event of (i) Provider's violation of any applicable law, rule or regulation; including without limitation exclusion from participation in Medicare or any other federal health care program; (ii) Provider's failure to comply with Health Plan's Utilization Management Program or Quality Management Program; (iii) Provider's failure to meet and maintain Health Plan's credentialing requirements, including but not limited to maintaining the professional liability insurance coverage specified hereunder or any misrepresentation or fraud by a Provider in the credentialing process; (iv) any action by Provider which, in the reasonable judgment of Health Plan, constitutes gross misconduct; (v) Health Plan's determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated; or (vi) a Provider's loss, suspension or restriction of his or her license to practice medicine, narcotic registration certificate issued by the Drug Enforcement Administration ("DEA"), or loss of medical staff privileges.

4.3 Effect of Termination. In the event that a Member is receiving Covered Services at the time this Agreement or the applicable Benefit Plan terminates, Provider shall continue to provide Covered Services to Member until treatment is completed, the Member is assigned to another Participating Provider or such other time period as required by State or federal law or regulation. Compensation for such Covered Services shall be the same as under the terms of this Agreement. In such instances, Provider shall also be obligated to abide by the applicable standards of professional ethics with respect to the transfer of responsibilities for patient care, and any applicable State or federal law or regulatory requirements. Health Plan will notify all Members affected by the termination of the Agreement prior to the date of termination.

4.4 All terminations hereunder shall be in accordance with applicable State and federal law and regulation.

5. RECORDS, AUDITS AND REGULATORY REQUIREMENTS

5.1 Medical and Other Records. Provider warrants that it prepares and maintains and will prepare and maintain all medical and other books and records required by law in a form maintained in accordance with the general standards applicable to such book or recordkeeping. Provider shall maintain such records for at least ten (10) years after the rendering of Covered Services (records for a minor child

shall be kept for at least one (1) year after the minor has reached age eighteen (18), but in no event less than ten (10) years). Additionally, Provider shall maintain such financial, administrative and other records as may be necessary for Health Plan and Provider to comply with all applicable local, State, and federal laws, rules and regulations. Provider agrees to provide Health Plan with all information necessary for Health Plan to meet its data reporting and submission obligations to CMS, including but not limited to, all data necessary to characterize the context and purpose of each encounter between a Member and the Provider and data necessary for Health Plan to meet its reporting obligations under applicable CMS requirements.

5.2 Access to Records, Audits. The records referred to in Section 5.1 shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with applicable local, State and federal laws, rules and regulations. Subject to applicable State or federal confidentiality or privacy laws, Health Plan, or their designated representatives, and designated representatives of local, State, and federal regulatory agencies having jurisdiction over Health Plan, shall have access to such records to audit, inspect, review and make copies of such records at Provider's place of business during regular business hours. When requested by Health Plan or representatives of local, State or federal regulatory agencies, Provider shall produce copies of any such records and if requested, shall submit to examination under oath regarding the same. Additionally, Provider agrees to permit Health Plan, or its designated representatives of local, State and federal regulatory agencies having jurisdiction over Health Plan, to conduct site evaluations and inspections of Provider's offices and service locations. Upon request of Health Plan, Provider shall provide copies of information contained in the medical records of Members, at no charge, to Health Plan and other authorized providers of health care services for the purpose of facilitating the delivery of appropriate health care services to Members; carrying out the purposes and provisions of this Agreement; management of Health Plan Utilization Management, Quality Management, Member Appeal and Grievance, claim adjudication and other administrative programs and compliance with State and federal law and accrediting body requirements (e.g. National Committee for Quality Assurance). Provider shall not charge Members for requests for copies of medical records when such are requested due to provider initiated termination of its physician-patient relationship with the Member. Provider shall facilitate the sharing of such records among health care providers directly involved with the Member's care.

5.3 Continuing Obligation. The obligations of Provider under Section 5.1 and 5.2 shall not be terminated upon termination of this Agreement. After termination of this Agreement, Health Plan shall continue to have access to Provider's records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules and regulations.

5.4 Regulatory Compliance. Provider agrees to comply with all applicable local, State, and federal laws, rules and regulations, now or hereafter in effect, to the extent that they directly or indirectly affect Provider, or Health Plan and bear upon the subject matter of this Agreement.

6. DISPUTE RESOLUTION

6.1 Generally. Any dispute or question arising between the parties hereto and involving the application, interpretation, or performance of this Agreement shall be settled, if possible, by amicable and informal negotiations. However, if any such issue(s) cannot be so resolved, said issue(s) shall be resolved in accordance with the Binding Arbitration Provisions located in the Provider Manual. Notwithstanding the above, disputes and questions pertaining to Utilization Management, Quality Management or Member Appeals and Grievances shall be resolved pursuant to said programs. The Parties agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Such negotiations shall be a condition precedent to the filing of any arbitration demand by either Party.

7. GENERAL PROVISIONS

7.1 **Amendments.** All amendments to this Agreement, or any of its Exhibits proposed by Provider must be agreed to in writing by Health Plan in advance of the effective date thereof. Any amendment to this Agreement proposed by Health Plan, shall be effective thirty (30) days after Health Plan has given written notice to Provider of the amendment, and Provider has failed, within fifteen (15) days of Provider receiving written notice, to notify Health Plan in writing of Provider's rejection of the requested amendment. Amendments required because of legislative, regulatory or legal requirements do not require the consent of Provider or Health Plan and will be effective immediately on the effective date thereof. Any amendment to this Agreement requiring prior approval of or notice to any federal or State regulatory agency shall not become effective until all necessary approvals have been granted or all required notice periods have expired.

7.2 **Assignment.** This Agreement, being intended to secure the services of Provider, shall not be assigned or transferred in whole or in part by Provider without the prior written consent of Health Plan, which shall not be unreasonably withheld. Any such transfer or assignment shall be void. Health Plan may assign this Agreement to any entity that controls, is controlled by, or that is under common control with it now or in the future, or which succeeds to its business through a sale, merger or other corporate transaction, without the consent of Provider.

7.3 **Confidentiality.** Health Plan and Provider respectively agree to hold all medical and health care records of Members and other confidential and/or proprietary information and/or trade secrets of Health Plan and Provider, respectively, in trust and confidence and agree that such information shall be used only for the purposes contemplated herein, in accordance with applicable State and federal law and regulation, and not for any other purpose. All non-public information pertaining to business conducted by Health Plan or Provider, including, but not limited to, the financial arrangements between the parties, shall be considered confidential and proprietary and, unless required by applicable law, shall not be disclosed by either party, except as otherwise provided in this Agreement or, upon the prior written consent of both parties. However, Provider agrees that Health Plan may extend the compensation rates to other Participating Providers who may from time to time be responsible for compensating Provider for Covered Services rendered by Provider to a Member. Notwithstanding the above, nothing shall prevent Health Plan from releasing aggregate data regarding type, volume and utilization of Covered Services provided by Provider to Members for purposes of Health Plan Utilization Management, Quality Management, and other administrative programs, including risk arrangements, or as may be necessary for compliance by Health Plan with an accrediting organization's requirements (e.g., National Committee for Quality Assurance.) Data relating specifically to Provider may be identified by Health Plan. Health Plan and Provider shall treat all medical and health records and personal information of Members as confidential and shall not disclose or use such information, except as provided in this Agreement and in accordance with applicable State and federal laws and regulations.

7.4 **Entire Agreement.** This Agreement supersedes any and all other agreements, oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

7.5 **Governing Law.** This Agreement shall be governed by, and construed, and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern.

7.6 Non-Exclusive Contract. The Agreement is non-exclusive and shall not prohibit Provider or Health Plan from entering into agreements with other health care providers or purchasers of health care services.

7.7 No Notice to Members. Provider and Health Plan reserve the right to amend this Agreement and any of its provisions, to waive any rights granted to either party hereunder, and to terminate this Agreement without notice to or consent of any Member.

7.8 No Third Party Beneficiaries. Nothing in this Agreement is intended to, or shall be deemed or construed to create any rights or remedies in any third party, including a Member. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Member or the duties or responsibilities of Provider or Health Plan with respect to such Members.

7.9 Notice. Any notice required or desired to be given under this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or overnight courier, addressed as follows:

To Health Plan:

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With copy to: Attn: Legal Department, General Counsel

Any notice given under this Agreement in writing from Health Plan to the Provider shall be sent to the Provider's address indicated on the Execution Page of this Agreement.

7.10 Instructions and Communications. From time to time, Health Plan shall use provider newsletters, letters, Provider Manual updates and similar written forms of communication to inform Participating Providers of changes to Health Plan policies and procedures that may affect Provider and which may be included and made part of the Provider Manual, as applicable. Examples of such information include, but are not necessarily limited to, changes which Health Plan plans to make in any Utilization Management policies or criteria applicable to Provider, Quality Management Program or Member Appeal or Grievance Procedures, acceptable billing and claim forms or methods, regulatory changes, or other policies affecting Health Plan's administration of this Agreement. Health Plan shall use best efforts to provide reasonable advance notification of at least thirty (30) days when there are planned changes in such policies and procedures that can be expected to have a material effect on Provider. Provider agrees to comply with such communications.

7.11 Regulation. Health Plan is subject to the requirements of various local, state, and federal laws, rules and regulations. Any provision required to be in this Agreement by any of the above shall bind Provider and Health Plan whether or not provided herein.

7.12 Severability. If any provision of this Agreement is rendered invalid or unenforceable by any local, State, or federal law, rules or regulations, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.

7.13 Status as Independent Entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between Provider and Health Plan other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor Health Plan, nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee or representative of the other.

7.14 Exhibits, Attachments and Amendments. Each Exhibit, Attachment and Amendment to this Agreement is made part of this Agreement as though set forth fully herein. Any provision of an Exhibit, Attachment or an Amendment that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement.

7.15 Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not be deemed effective unless made in writing, and no such waiver shall be deemed a waiver of any other breach of the same or a different provision.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the date set forth below the signature line of Provider below or as of the date the Provider is credentialed, whichever is later ("Effective Date").

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PROVIDER

HEALTH PLAN

Signature

Signature

Print Name

Print Name

Title

Title

Date

Date

Federal Tax Identification Number

Address

Exhibit A

Compensation

Provider is limited to a scope of service using appropriate CPT codes 99341-99350. Health Plan will pay \$180.00 as payment in full for one Covered Services billed by the Provider per Health Plan Member minus any Copayment, Coinsurance and/or Deductible amounts payable by Members in accordance with the applicable Benefit Plan.

CPT Code	Description	Payment
99341	New Patient Home Visit-focused	\$180.00
99342	New Patient Home Visit-expanded	\$180.00
99343	New Patient Home Visit-detailed exam	\$180.00
99344	New Patient Home Visit-comprehensive (moderate)	\$180.00
99345	New Patient Home Visit-comprehensive (high)	\$180.00
99347	Established Home Visit-focused	\$180.00
99348	Established Home Visit-expanded	\$180.00
99349	Established Home Visit-detailed exam	\$180.00
99350	Established Home Visit-comprehensive (moderate to high)	\$180.00

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