

## REGENCE BLUESHIELD PARTICIPATING PROFESSIONAL SERVICES AGREEMENT

This Professional Services Agreement ("Agreement"), effective ("Effective Date") is entered into by and between Regence BlueShield ("Regence") and **COUNTY OF PACIFIC**, and each entity set forth on Attachment B as applicable (collectively, "Provider").

In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, the undersigned have agreed to be bound by this Agreement as of the Effective Date.

### I. DEFINITIONS

When used in this Agreement, all capitalized terms have the following meanings:

- 1.1 **COINSURANCE:** a percentage amount that the Member Contract requires the Member to pay for Covered Services.
- 1.2 **COPAYMENT:** a fixed dollar amount that the Member Contract requires the Member to pay at the time of the provision of Covered Services.
- 1.3 **COVERED SERVICES:** Medically Necessary health care services and supplies provided to Members for which benefits are provided under a Member Contract.
- 1.4 **CREDENTIALING:** the process by which Regence may determine, in its sole discretion, whether Provider may participate with Regence.
- 1.5 **DEDUCTIBLE:** an amount that a Member must pay for Covered Services during a specified period in accordance with the Member Contract before benefits will be paid.
- 1.6 **INVESTIGATIONAL:** As applicable to a given line of business, a health intervention that Regence has classified as Investigational. Regence will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from Provider regarding the health intervention to determine if it is Investigational. A health intervention not meeting all of the following criteria is, in Regence's judgment, Investigational:
  - a. The scientific evidence must permit conclusions concerning the effect of the health intervention on health outcomes, which include the disease process, injury or illness, length of life, ability to function, and quality of life.
  - b. The health intervention must improve net health outcome.
  - c. The scientific evidence must show that the health intervention is at least as beneficial as any established alternatives.
  - d. The improvement must be attainable outside the laboratory or clinical research setting.

For purpose of this definition, "scientific evidence" means scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or findings, studies, or research conducted by or under the auspices of federal government agencies and/or nationally recognized federal research institutes. However, scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

- 1.7 **MEDICALLY NECESSARY or MEDICAL NECESSITY:** Please refer to the attached state addendum.
- 1.8 **MEMBER(S):** person(s) eligible under a Member Contract to receive Covered Services.
- 1.9 **MEMBER CONTRACT:** a contract between Regence or Payor and an individual or group in which Regence or Payor agrees to provide and/or administer health care benefits as set forth in the Member's summary plan description, certificate of coverage, or other applicable coverage document.
- 1.10 **NON-COVERED SERVICE:** a service or supply that is not a Covered Service for any of the following reasons: (a) the service or supply is Investigational or not Medically Necessary; or (b) the service or supply is not an available benefit or a Covered Service under the Member Contract for any reason.
- 1.11 **OTHER HEALTH CARE PROFESSIONAL:** a person, other than a Physician, who is legally qualified to provide health care services in the state where he or she practices, and who is eligible for reimbursement under a Member Contract.
- 1.12 **PARTICIPATING PROVIDER:** any hospital, facility, physician, other health care professional, or other provider of medical services or supplies who (a) is duly licensed to provide health care services or supplies; (b) has contracted, and continues to have a valid contract, with Regence, directly or through intermediaries, to furnish Covered Services to Members; and (c) is eligible for payment under a Member Contract and, where applicable, has been credentialed under Regence's credentialing policies.
- 1.13 **PAYOR:** an employer, insurer, a trust, third-party administrator, subsidiaries and affiliates of Regence, a Blue Cross and /or Blue Shield Plan, Cambia Health Solutions, self-funded health plan, or government entity that has contracted with Regence to offer, issue, and/or administer health benefits and has agreed to be responsible for funding health care services for Covered Services provided to Members under the terms of a Member Contract.
- 1.14 **PHYSICIAN:** a person who is legally qualified to practice medicine in the state where he or she practices.
- 1.15 **PROVIDER:** Physician or Other Health Care Professional who is employed by or has contracted with Provider to provide health care services under this Agreement.
- 1.16 **PROVIDER WEB SITE:** a reference source available within the Regence web site that contains the rules, policies, guidelines, and procedures adopted by Regence or Payor that Provider must follow in providing services and doing business with Regence or Payor under this Agreement. Regence may revise and update the Provider Web Site at Regence's sole discretion from time to time.
- 1.17 **QUALITY IMPROVEMENT ACTIVITIES:** the programs, processes, and criteria developed by Regence or Payor to monitor, assess, and improve continually the quality of clinical care and services provided to Members, including Quality Improvement, Utilization Management, quality review, credentialing and recredentialing, Member complaints and grievances, Member satisfaction surveys, medical records review, and preventative health care services.
- 1.18 **RECREREDENTIALING:** a periodic process by which Regence may determine, in its sole discretion, whether Provider may continue participating with Regence.
- 1.19 **UTILIZATION MANAGEMENT:** a set of formal processes developed by Regence or Payor and described on the Provider Web Site including, but not limited to, preauthorization, case

management, medical policy development, and retrospective payment review, that are designed to monitor the use or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of health care services or procedures performed on or rendered to a Member and/or the appropriateness of the setting in which such services were performed.

## II. RELATIONSHIP OF THE PARTIES

- 2.1 STATUS OF PARTIES.** By way of this Agreement, the Provider is a Regence Participating Provider. Provider and Regence are independent contractors. This Agreement is not intended to create an employer-employee partnership or joint venture relationship between Regence and Provider or their respective directors, officers, employees, or agents. Regence shall not have the authority to exercise control or direction over Provider or Provider Services provided to Members pursuant to this Agreement. Nothing in this Agreement or in its performance will be construed to result in any person being the officer, servant, agent, or employee of the other party when such person, absent this Agreement and its performance, would not in law have had such status.
- 2.2 NON-EXCLUSIVITY.** Regence may contract with any hospital, physician, facility, groups of physicians, or other health care professional to become a Participating Provider upon such terms and conditions as Regence deems appropriate, without the prior consultation or approval of Provider. Provider may contract with any other health plan without the prior consultation or approval of Regence, as long as such participation or practice does not preclude Provider from complying with the terms of this Agreement.
- 2.3 TRADE NAMES, SERVICE MARKS, AND TRADEMARKS.** Provider and Regence acknowledge that the other party may be the exclusive owner or licensee of various trademarks, service marks, trade names, logos, and symbols used from time to time by that party in connection with its business, and the goodwill associated therewith (collectively, "Marks"). Neither party shall have the right to use, and shall not use any Marks, or any confusingly similar names or Marks, of the other party for advertising or marketing purposes, except as expressly authorized in writing by the other party. Except for Regence's or Payor's use of Provider and Providers' name(s) to notify Members and others that Provider is a Participating Provider (e.g., through the Regence provider directory) and for payment purposes, each party shall submit any proposed advertisements or marketing materials that refer to, or in any way depict, the other party for approval by the other party in advance of publication.
- 2.4 PROVIDING SERVICES TO MEMBERS OF PAYORS.** Provider agrees that Regence may enter into an agreement with Payors that want access to and use of those provider networks in which Provider participates. Provider authorizes Payors contracting with Regence to offer Provider's services to groups of employees or individuals in accordance with the terms of this Agreement and any Member Contract offered or administered by Payor for the payment of Covered Services. Provider agrees to furnish services to Members of such Payors when those Members utilize Regence's provider networks in accordance with the same terms and conditions of participation and compensation as apply when such services are furnished to Regence's Members under this Agreement.
- 2.5 RELATIONSHIP TO BLUECROSS BLUESHIELD ASSOCIATION.** Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and Regence; that Regence is an independent corporation operating under a license from the BlueCross BlueShield Association, an association of independent BlueCross BlueShield Plans (the "Association"), permitting Regence to use the BlueCross and/or BlueShield service marks in Regence's service area; and that Regence is not contracting as an agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person, entity, or organization other than Regence and that no person, entity, or organization other than Regence shall be held accountable or liable to Provider for any of Regence's obligations to Provider created under this Agreement. This paragraph shall not create

any additional obligations whatsoever on the part of Regence other than those obligations created under other provisions of this Agreement.

### **III. REGENCE OR PAYOR OBLIGATIONS**

- 3.1 PAYMENT.** Regence or Payor will compensate the Provider for Medically Necessary Covered Services provided to Members in accordance with this Agreement and Regence's or Payor's claims payment policies.
- 3.2 MEMBER IDENTIFICATION.** Regence will issue identification cards to Regence Members and will make eligibility and benefits information available to Provider via either (a) telephone during normal business hours; or (b) Regence's secure web site twenty-four (24) hours a day, subject to technical difficulties that Regence may experience. Confirmation of coverage by Regence is not a guarantee of payment if it is later determined that a Member was not eligible for benefits on the date of service or if the material supplied for review was inaccurate, incomplete, or misleading.
- 3.3 BENEFIT DESIGN / COVERAGE DECISIONS.** Regence, Regence's designee, or the Payor will be solely responsible for Member Contract design and for interpreting the terms of and making final coverage determinations under a Member Contract.
- 3.4 PARTICIPATING PROVIDER IDENTIFICATION.** Regence may include Provider in the Participating Provider directories for the Member Contracts and products in which Provider is a Participating Provider, including when Provider is designated a preferred participant, and shall make said directories available to Members.
- 3.5 LIABILITY INSURANCE.** Regence will procure and maintain professional and general liability insurance and other insurance, as Regence reasonably determines may be necessary, to protect Regence and Regence's employees against claims, liabilities, damages, and judgments that arise out of services provided by Regence or Regence's employees under this Agreement.
- 3.6 LICENSURE.** Regence will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Regence to lawfully perform this Agreement.

### **IV. PROVIDER SERVICES AND OBLIGATIONS**

- 4.1 STANDARD OF CARE.** Provider shall provide only Medically Necessary Covered Services in accordance with (a) the same standard of care, skill, and diligence customarily used by similar physicians in the community in which such services are rendered; (b) the provisions of Regence's quality improvement program; (c) the requirements of applicable law; and (d) the standards of applicable accreditation organizations. Provider agrees to render Medically Necessary Covered Services to all Members in the same manner, in accordance with the same standards, and with the same time availability as offered to other patients. Provider shall ensure that all employees of Provider and all health care professionals and physicians providing services at the Provider's locations meet all applicable state laws and regulations, all applicable legal standards of care, all rules of Provider, and all applicable provisions of this Agreement.
- 4.2 COMPLIANCE WITH POLICIES AND GUIDELINES.** Provider will comply with rules, guidelines, policies, and procedures whether outlined in this Agreement, or Provider Web Site. To the extent of any inconsistency between this Agreement and the Provider Web Site, this Agreement shall control. Regence may revise the rules, guidelines, policies, and procedures with sixty (60) days' notice. If Provider objects to a change in rules, guidelines, policies, and procedures on the Provider Web Site, Provider may elect to terminate this Agreement pursuant to Article VII of this Agreement.

- 4.3 MEMBER IDENTIFICATION.** Provider will request Member identification cards of all patients who present themselves as Members under any Member Contract and will report to Regence any apparent abuse of the privileges of such Member Contract. Regence shall issue identification cards to its Members and will make eligibility and benefits information available to Provider via Regence's secure Provider Web Site.
- 4.4 CREDENTIALING/RECREREDENTIALING OF PROVIDER.** Provider will comply with Regence Credentialing or Recredentialing criteria then in effect and available in the credentialing section of the Provider Web Site. Except as otherwise required by law or regulation, Provider will also:
- a. promptly provide information required by Regence to conduct Credentialing or Recredentialing;
  - b. notify Regence immediately upon any change in licensure, change in accreditation status, or termination or suspension from any government programs at any time during the term of this Agreement; and
  - c. notify Regence immediately upon confirmation that Provider is subject to any informal or formal disciplinary orders, decisions, disciplinary actions, or other actions, including but not limited to restrictions, probations, limitations, conditions, and suspensions resulting from Provider's acts, omissions, or conduct.
- 4.5 REGULATORY COMPLIANCE AND ACCREDITATION.** Provider warrants that it is, and at all times during this Agreement will remain, in compliance with all applicable local, state, and federal laws, rules, and regulations, including but not limited to, those (a) regarding licensure, certification, and accreditation; (b) necessary for participation in any government programs; and (c) regulating the operations and safety.
- 4.6 INSURANCE.** Throughout the term of this Agreement, Provider will maintain at Provider's expense general and professional liability coverage in a form and amount as stipulated in accordance with Regence's credentialing criteria. Provider will give Regence a certificate of insurance evidencing such coverage upon request. Provider will give Regence immediate written notice of cancellation, material modification, or termination of such insurance.
- If Provider procures one or more claims-made policies to satisfy its obligations under this Agreement, Provider will obtain any extended reporting endorsement ("tail") required to continuously maintain such coverage in effect for all acts, omissions, events or occurrences during the term of this Agreement, without limit or restriction as to the making of the claim or demand.
- 4.7 CHANGE IN PROVIDER SERVICES OR OTHER INFORMATION.** Provider agrees that the following material changes to Provider Services, including but not limited to: (a) discontinuation, reduction, or limitation of Provider Services; (b) expansion of Provider Services through acquisition or implementation of a service, technology, facility, or any type of provider; (c) any change in Provider's ownership, including a change in the facilities and/or providers use of the Provider's tax identification number; and/or (d) a change in Provider's incorporation must be agreed upon in writing by both Parties. Failure to formally incorporate any changes to Provider Services in accordance with this provision will result in non-payment; in such instance, Regence, Payor, and Member shall be held harmless. Provider agrees to provide ninety (90) days advanced written notice to Regence of nonmaterial changes that include but are not limited to (a) a significant change in Provider's management or management company; (b) a filing of any bankruptcy action; or (c) other relevant information regarding Provider's status in the medical community.
- 4.7.1 Directory Updates.** Provider further agrees to comply with Regence policies and procedures related to furnishing information (including but not limited to information on which providers are accepting new patients, the provider's location, contact information,

specialty, medical group and any institutional affiliations) necessary to ensure provider directories are up-to-date, accurate, and complete pursuant to federal and state law, including 45 C.F.R. 156.230(b).

#### **4.8 NON-DISCRIMINATION.**

**4.8.1 Services Provided to Members.** Provider will provide Covered Services to Members without regard to race, religion, creed, color, national origin, ancestry, physical handicap, health status, marital status, age, sex, or source of payments. Provider further agrees to provide Covered Services to Members without regard to the Member's enrollment in a health benefit plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. Provider will include the nondiscrimination provisions of this section in all subcontracts entered into to fulfill its obligations under this Agreement.

**4.8.2 Employment.** Provider recognizes that as a government contractor with the Federal Employees Health Benefits Program and The Centers for Medicare & Medicaid Services (CMS), Regence is subject to various federal laws, executive orders, and regulations regarding equal opportunity and affirmative action, which may also be applicable to subcontractors. Consequently, the parties agree that, as applicable, they will abide by the requirements of 41 CFR 60-1.4(a), 41 CFR 60-300.5(a) and 41 CFR 60-741.5(a) and that these laws are incorporated herein by reference. These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities and prohibit discrimination against all individuals based on their race, color, religion, sex, sexual orientation, gender identity, or national origin. These regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, protected veteran status or disability. The parties also agree that, as applicable, they will abide by the requirements of Executive Order 13496 (29 CFR Part 471, Appendix A to Subpart A), relating to the notice of employee rights under federal labor laws.

**4.9 NOTICE OF ACTIONS.** Provider will notify Regence within fifteen (15) business days of the filing of any demand for arbitration or lawsuit against Provider by a Member. Provider will provide Regence with any pertinent information related to such arbitration demands and lawsuits that is requested by Regence. In addition, Provider shall promptly notify Regence of any legal or governmental action initiated against Provider, its employees, or its staff that could affect this Agreement or Provider's performance of this Agreement, including, but not limited to, any action for professional negligence brought by a Member, fraud, or violation of any law or against any license, certification, or accreditation.

**4.10 QUALITY MANAGEMENT.** Provider shall comply with the requirements of and participate in Regence's and/or other Payor's quality improvement program as specified on the Provider Web Site. Provider will provide quality improvement information pertaining to Provider and Provider's staff to Regence at Regence's request.

**4.11 UTILIZATION REVIEW.** Regence utilizes processes and systems for Utilization Management and quality management consistent with applicable federal and state laws, to promote adherence to accepted clinical standards and to encourage Participating Providers to avoid unnecessary and/or wasteful costs while acting in a manner consistent with sound medical judgment. To this end, Provider agrees to participate in, and to abide by Regence's Utilization Review, patient management, quality improvement processes and programs, and all other related programs as modified from time to time with respect to all Members as specified on the Provider Web Site.

**4.12 REFERRALS.** Provider agrees to refer Members only to Participating Providers, regardless of Member Contract, except in cases of an emergency. For the purpose of providing quality care to Members, Provider will notify Regence of any referral to a Non-Participating provider. In the event

of referral to any Non-Participating provider and as permitted by law, Regence may hold Provider financially responsible for the cost of any resulting claims.

#### **4.13 INFORMATION AND RECORDS.**

**4.13.1 Maintenance and Retention of Records.** Provider will maintain medical and administrative records related to services provided to Members for a period of ten (10) years from the date of service or such longer period as required by state and federal law for retention of medical records.

Provider shall maintain Member medical records in a format that documents diagnosis, assessment, continuity of care and follow up, in conformity with generally accepted community standards.

Provider will maintain a contemporaneous, written record of all treatment for which payment is requested that supports the diagnosis, shows that the treatment was Medically Necessary and demonstrates that the services were indeed performed by Provider on the date claimed. Any alterations or amendments to these contemporaneous records must include the date and time of the alteration or amendment, be signed by the person making the alteration or amendment, refrain from obliterating or obscuring any prior documentation and be clearly identified and identifiable as an amendment or alteration. Regence may deny claims in those cases where, in Regence's sole discretion, there is inadequate documentation of the services rendered, in which case Provider shall not bill the Member.

During an audit or review involving Provider's records, such records must be retained until all issues related to the audit are resolved. If the audit results in a good faith determination that the Provider engaged in a pattern of fraudulent or improper billing practice in violation of state law, federal law, or any provision of this Agreement or the Administrative Manual, Provider shall reimburse Regence for its reasonable costs incurred in conducting the audit.

**4.13.2 Audit and Access to Records.** Provider will provide Regence access to Member medical records, including access to electronic medical records (EMR), and will allow Regence to make or obtain copies of medical and administrative records directly related to services rendered to Members for purposes that may include, but are not limited to: Utilization Management, quality management, Medicare Stars ratings, risk adjustment, appropriateness of billing, Medical Necessity, credentialing and recredentialing, appeals, or other activities necessary to support the administration of a Member Contract or this Agreement. Access to, or copies of, records described in this section, including electronic records, shall be provided at no charge to Regence, Payors, or Members. Additionally, no subscription fee(s) will be assessed for use of the facility's EMR system. If Provider uses a vendor for records acquisition all fees related to a records request, will be the responsibility of the Provider. This provision will survive the termination of this Agreement.

**4.13.2.1 Access to Records at Provider Locations.** Provider agrees to provide Regence access to records at their location, upon written request by Regence no less than three (3) business days in advance, except when Regence determines there is a significant quality of care issue. In such case, Provider shall provide Regence with access to locations or records upon twenty-four (24) hours' notice.

**4.13.2.2 Record Requests by Regence.** Upon written request by Regence, Provider agrees to provide records not otherwise available through access to Provider's EMR within fourteen (14) days of Regence's request for pre-pay reviews. For post-pay audits, Provider agrees to provide records not otherwise available through access to Provider's EMR within thirty (30) days of Regence's request. The request to Provider from Regence shall include dates of service, name of

Member, diagnosis, description of services provided, any supporting documentation, medical and billing records. Records not produced in response to a request for a pre-pay review or a post pay audit within the time frame specified above will be deemed non-existent and will not be processed or paid until all requested records are received. For prepayment reviews or post payment audits, any statutory or contractual requirements for penalties and interest related to late claim payments will be made consistent with the date that Regence received from the Provider all the records that were requested relative to its review/audit. Provider shall send Regence copies of any records requested at no cost to Regence, Payors, or Members. Regence will limit the request to those records necessary to perform the audit.

**4.13.2.3 Release of Records.** Provider agrees to accept from Regence or its designee, as a legally sufficient release of Members' medical records, Members' participation under a Member Contract, and Regence will not be required to obtain additional medical release from a Member in order to access or make copies of Members' medical records. This provision will survive the termination of this Agreement.

**4.13.2.4 Compliance.** Record access and review will comply with all laws, statutes, and regulations pertaining to the confidentiality of Member records. These rights shall survive termination of this Agreement. Regence's remedies for the Provider's failure to cooperate with the record access and requests shall include, but not be limited to, one hundred percent (100%) review of Provider's current and future claims and supporting documentation prior to payment; recovery of payments made to Provider for past inappropriately billed claims, including denial of future inappropriately billed claims; and/or immediate termination of Provider's agreements with Regence.

**4.14 SUBCONTRACTORS.** In the event Provider subcontracts with subcontractors for provision of Covered Services to Members, with the expectation of receiving payment directly or indirectly from Regence, such subcontractors must agree to abide by all appropriate provisions set forth in this Agreement, including, but not limited to, Section 5.9. As applicable under State and/or Federal Law, Regence reserves the right to review, approve, suspend or terminate any subcontracts as they pertain to Covered Services provided to Members.

**4.15 PROVIDER DISCRETION.** Provider may decline to accept any Member whom Provider has previously discharged from care and may decline to accept a Member for professional reasons. Provider may withdraw from care of a Member when, in their professional judgment, it is in the best interest of the Member to do so.

**4.16 PROVIDER-PATIENT RELATIONSHIP.** Providers will maintain the provider-patient relationship with Members, and Providers will be solely responsible for medical advice to and treatment of Members and for the provision of all health care services set forth in the Member Agreement, in accordance with accepted professional standards and practices. Providers may freely communicate with Members regarding available treatment options, including medication treatment options, regardless of benefit limitations or exclusions in the applicable Member Agreement. **PRIOR AUTHORIZATION.** Provider shall obtain prior authorization, when such authorization is required and within the specified time period and in the manner specified on the Provider Web Site, prior to rendering applicable services to Members. Provider shall obtain prior authorization before delivering any services beyond those originally authorized. Except in the event of emergency, Regence is not obligated to compensate Provider for services provided when Provider has not first obtained a required prior authorization or approval from Regence.

**4.18 ACCESSIBILITY.** Provider will provide or arrange for the provision of Covered Services to Members twenty-four (24) hours a day, seven (7) days per week.



- 4.19 LABORATORY SERVICES.** Upon request by Regence, Provider will provide full laboratory test values and/or data, that support initiatives including, but not limited to, HEDIS measures, Medicare Stars measures, or other quality programs and initiatives at no charge to Regence, Payor, or Member no later than 10 business days following discharge or completion of summaries by attending physicians.
- 4.20 DATA ACCURACY.** Provider agrees to provide Regence with what Provider believes is, to the best of its knowledge, accurate, complete, and truthful claims and encounter data. The claims and encounter data supplied by Provider to Regence will contain International Classification of Diseases, Tenth Revision, Clinical Modification ("ICD-10-CM") diagnosis codes accurately reflecting the diagnoses documented in the accompanying medical record.
- 4.21 MEMBERS TO BE HELD HARMLESS**
- 4.21.1 Member Hold Harmless.** Provider hereby agrees that in no event, including, but not limited to, nonpayment by Regence, Regence's insolvency, or breach of this Agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration or payment from, or have any recourse against a Member or person, other than Regence, acting on the Member's behalf, for services provided pursuant to this Agreement, unless the Member fails to provide coverage information within twelve (12) months after the date of service. This provision does not prohibit collection of Deductibles, Coinsurance, Copayments, and/or payment for Non-Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's Member Contract.
- 4.21.2 Charges to Members.** Please refer to the attached state addendum.
- 4.21.3 Continue Providing Services.** Please refer to the attached state addendum.
- 4.21.4 Member Agreement.** Notwithstanding any other provision of this Agreement, nothing in this Agreement will be construed to modify the rights and benefits contained in the Member Contract.
- 4.21.5 Survival of Termination.** The Provider further agrees that (i) the above provisions will survive termination of this Agreement regardless of the cause giving rise to termination and will be construed to be for the benefit of the Members, and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and Member or persons acting on behalf of the Member.
- 4.21.6 Provider Contracts with Other Health Care Professionals.** If Provider contracts with other health care providers who agree to provide Covered Services to Members of Regence or Payor with the expectation of receiving payment directly or indirectly from Regence or Payor, such providers must agree to abide by the above provisions.

## **V. PAYMENT AND BILLING**

- 5.1 PAYMENT FOR COVERED SERVICES.** Regence or Payor will reimburse Provider for Covered Services provided to Members in accordance with payment terms set forth and attached to this Agreement. Regence or Payor will not be liable to Provider for payment of applicable Coinsurance, Copayment, or Deductibles or for charges for Provider Services that are determined to be Non-Covered Services. Except as otherwise set forth in Section 5.7, Provider agrees to accept payment, subject to medical and reimbursement policies, as payment in full, whether that amount is paid in whole or in part by the Member, Regence, a Payor, or any combination of third-party Payors that may pay before Regence in the order of benefit determination.

Except as allowed by law, Regence or Payor will not make retroactive denials of Covered Services that were preauthorized or concurrently certified as Medically Necessary unless Regence or Payor finds in good faith that the information supplied for review was substantially inaccurate, incomplete, or misleading, when services submitted on a claim differ from the services approved in the prior-authorization, or the Member was ineligible for Covered Services when the service or supply was provided.

**5.2 PAYMENT FOR INELIGIBLE MEMBERS.** Except as required by law, neither Regence nor Payor is obligated to make payment to Provider for services provided to any individual who is not, at the time such services are rendered, a duly eligible Member. The fact that an individual possesses an identification card shall not obligate Regence or Payor to pay for or provide coverage if, on the date(s) that such services were rendered, the individual is, or is later found to have been, ineligible for coverage under a Member Contract. Authorization by Regence or Payor to provide services to Members does not guarantee that the Member is eligible for benefits on the date of service and/or that the services furnished are Covered Services under the Member Contract.

**5.3 PROMPT PAYMENT OF CLAIMS.** Please refer to the attached state addendum.

**5.4 COPAYMENTS, COINSURANCE, AND DEDUCTIBLES.** Provider will not bill, charge, collect a deposit from, seek remuneration or payment from, or require pre-payment by Members as a condition to rendering Covered Services except for amounts attributable to Copayments, Deductibles, and/or Coinsurance. In the event Provider collects Copayment, Coinsurance, Deductible or Coinsurance prior to delivery of Covered Services, Provider agrees to refund to Member any overpayments paid by Member within thirty (30) days after receiving a determination of the claim by Regence or Payor. Regence or Payor shall be responsible for only the amount due for Covered Services rendered to a Member less the Member's Copayment, Coinsurance, and/or Deductible, as applicable. Except for infrequent and isolated waivers for charitable purposes, Provider shall charge to and make reasonable attempts to collect from Members all Copayments, Coinsurance and Deductibles. The parties agree that Regence may deny all or part of claims if Provider fails to make a reasonable attempt to collect Copayments, Coinsurance and Deductibles.

**5.5 OVERPAYMENTS AND ADJUSTMENTS.**

**5.5.1 Overpayments.** Please refer to the attached state addendum.

**5.5.2 Refunds and Adjustments.** Please refer to the attached state addendum.

**5.6 CLAIM SUBMISSION.** Provider agrees to submit claims for Covered Services electronically, as prescribed by Regence, CMS regulation or as required by law. Claims shall be submitted within ninety (90) days of the date of service or as otherwise required by law. Except as otherwise set forth in Section 5.7, claims not submitted within the specified time frame(s) shall be disallowed and the Provider shall not bill the Member, Regence or Payor for services or supplies associated with such claims. Provider shall not bill Regence for more than Provider's usual and customary fee for the services rendered, nor shall Provider bill services provided to Members with health care coverage at a rate higher than Provider bills services provided to Members without health care coverage.

**5.7 COORDINATION OF BENEFITS.** Regence and Provider will cooperate to exchange information relating to coordination of benefits with regard to Members and will comply with the following requirements:

**5.7.1 Regence or Payor as Primary Payor.** When a Member's coverage under Regence or Payor is determined to be primary under applicable coordination of benefits rules, Regence or Payor shall pay Provider in accordance with this Agreement for Covered Services provided to Member without regard for the obligations of any secondary Payors.

**5.7.2 Regence or Payor as Secondary Payor.** Provider will bill a payor which may be primary under applicable coordination of benefits rules for Covered Services provided to Members when information regarding such primary payor becomes available to Provider and whenever so requested by Regence. Provider will notify Regence when it obtains information regarding such primary payor and will make such information available to Regence. When another payor is primary, Provider will follow that payor's billing rules, including but not limited to the primary payor's limitations on billing. When it is determined that a Member's coverage, under Regence or Payor, is secondary under applicable coordination of benefits rules, Regence or Payor will pay Provider an amount no greater than that which, when added to amounts payable to Provider from other sources under applicable coordination of benefits rules, equals one hundred percent (100%) of Provider's payment for Covered Services pursuant to this Agreement, but may be less as determined by the terms of the Member Contract. Regence will not reimburse claims submitted more than 60 days after payment by the Primary Payor in adherence with CMS regulation or as required by law.

**5.8 APPROPRIATE BILLING.** Provider agrees to use the most appropriate, current, and specific coding when billing for services rendered. Provider will not engage in misleading billing practices or otherwise interfere with timely and accurate claims adjudication. Such practices include, but are not limited to:

- a. Billing for services not rendered by the Provider or entities legally owned and operating under Provider's tax identification number and national provider identifier (NPI);
- b. Billing for services that cannot be substantiated from written or electronic medical records;
- c. Failing to supply information requested by Regence for claims adjudication;
- d. Incorrect coding such as but not limited to MS-DRG, CPT, and Revenue coding;
- e. Itemized bills that are not consistent with the electronic claim submission.

**5.9 LIMITATIONS ON BILLING MEMBERS.** Provider agrees that in no event, including, but not limited to: nonpayment by Regence or Payor, determination that the services furnished were Non-Covered Services; Provider's failure to submit claims within the specified or a regulated time period; Regence or Payor's insolvency; Provider's failure to comply with Regence care management, Utilization Management, and/or quality initiatives, including required pre-authorizations and other administrative requirements or guidelines; denial of payment due to Provider's failure to comply with the terms of this Agreement; and/or, breach of this Agreement by Provider will Provider bill, charge, collect a deposit from, seek compensation, remuneration, or payment from, or have any recourse against a Member or persons acting on behalf of the Member, other than Regence or Payor, for Covered Services provided pursuant to this Agreement, except as described in Section 5.9.1 or unless the Member fails to provide coverage information.

This provision will not prohibit collection of the established Deductibles, Copayments, and Coinsurance within the terms of the Member Contract, nor will it prohibit Provider from (a) collecting payment from third-party Payor(s) with primary or secondary responsibility in accordance with Section 5.7, or (b) collecting payment from Members for Non-Covered Services or not Medically Necessary services in accordance with Section 5.9.1.

**5.9.1 Limitations on Billing Members for Not Medically Necessary or Non-Covered Services.** Provider may bill a Member for Non-Covered Services or not Medically Necessary services, as determined by Regence, Payor, or their designees, only after obtaining appropriate written Member Consent, which lists the specific service, at least twenty-four (24) hours in advance of Provider Services being provided. Neither Regence

nor Payor shall be liable for any amounts associated with services or supplies that are determined by Regence, Payor, or their designees to be Non-Covered Services or not Medically Necessary services. Provider may not bill Members for services that are deemed to be not Medically Necessary or Non-Covered through an adverse determination in any of Regence's appeal processes. In no event will Regence or Payor be responsible for any amount owed by Member to Provider for Non-Covered Services in the event that Provider is unable to collect such amount from Member.

**5.9.1.1 Member Consent.** At a minimum, the written Member Consent must include the following information: Member name, specific service or supply, expected date of service, condition and diagnosis, a statement informing the Member that the service or supply may be a Non-Covered Service or not Medically Necessary service, an estimation of the cost of the service, and a statement in which the Member agrees to pay for the Non-Covered Service or not Medically Necessary service. The written Member Consent must be signed by the Member, Member's guardian, or Member's authorized health care representative and maintained in the Provider's records. Provider agrees not to bill Regence, Payor, or Member any amount owed for not Medically Necessary or Non-Covered Services or supplies if Provider fails to obtain written Member Consent.

**5.10 CONTINUATION OF LIMITATIONS.** Provider agrees that (a) the provisions in this Article V shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members; and (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and Member, or persons acting on behalf of the Member.

**5.11 PROVIDER NETWORKS.** Provider agrees to provide Covered Services to any Member under any Provider Network in which Provider participates pursuant to the terms of this Agreement and any addenda or exhibits attached hereto. Nothing in this Agreement gives Provider the right to participate in any new provider networks or lines of business developed by Regence.

## **VI. CONFIDENTIALITY**

**6.1 CONFIDENTIAL AND PROPRIETARY INFORMATION.** As used in this Agreement, "Regence Confidential and Proprietary Information" means: (a) proprietary information of Regence in whatever form (hard-copy, electronic, on-line, encoded disk, etc.); (b) information marked or designated by Regence as confidential or proprietary; (c) claims and health information that Regence treats as confidential, including raw claims data, claim data extracts, utilization information, and health information specific to a particular Member or his/her dependents; (d) the names, addresses, and telephone numbers of all Members and employer groups; (e) this Agreement; and (f) other information provided by Regence, which Regence is obligated to keep confidential. "Regence Confidential and Proprietary Information" excludes any information now or hereafter voluntarily disseminated by Regence to the public, which otherwise becomes part of the public domain through lawful means, or which is required to be disclosed by or to a government agency publicly.

As used in this Agreement, "Provider Confidential and Proprietary Information" means (a) information related to an arbitration proceeding; (b) this Agreement; and (c) information marked or designated by Provider as confidential or proprietary. Provider Confidential and Proprietary Information excludes any information now or hereafter voluntarily disseminated by Provider to the public, which otherwise becomes part of the public domain through lawful means, or which is required to be disclosed by or to a government agency publicly.

Regence Confidential and Proprietary Information and Provider Confidential and Proprietary Information collectively shall be hereafter referred to as "Confidential and Proprietary Information." Confidential and Proprietary Information may be used by Provider and Regence as follows:

- a. For patient care;
- b. For populating a Member's personal health record;
- c. For administrative, payment, and/or management functions, including, but not limited to, medical review, quality management, provider Credentialing, and peer review; and
- d. For purposes of reviewing Provider's catastrophic expenses and billing Provider's catastrophic reinsurance carrier.

**6.2 NON-DISCLOSURE AND NON-USE.** Each party recognizes and acknowledges that it shall, in fulfilling its obligations under this Agreement, necessarily become conversant with the other party's Confidential and Proprietary Information that is not generally available to the public and that except as otherwise allowed by law or this Agreement, it would be irreparably damaging to the relevant party and its affiliates, employees, representatives, or agents to disclose such Confidential and Proprietary Information. Either party may seek relief for breach of this Agreement.

Provider agrees that unless required by law or permitted pursuant to applicable provisions of 45 CFR parts 160 and 164, Provider shall not disclose any Regence Confidential and Proprietary Information without the prior written consent of Regence. In the event Provider's employees have the need to know such Regence Confidential and Proprietary Information for the limited purpose of performing the obligations under this Agreement, Provider shall first inform each employee of the confidential nature of the information and the relevant terms of this Agreement related to confidentiality. In the event Provider obtains consulting services from a third party that has access to this Agreement, Provider shall obtain a written confidentiality statement signed by the third party acknowledging its written agreement to be bound to the confidentiality terms of this Agreement and provide a copy to Regence within ten (10) business days.

**6.3 SAFEGUARD OF CONFIDENTIAL AND PROPRIETARY INFORMATION.** Each party agrees to exercise no less care in safeguarding the other party's Confidential and Proprietary Information against loss, theft, or other inadvertent disclosure than the party exercises in safeguarding the confidentiality of its own Confidential and Proprietary Information. In no event shall either party use less than reasonable care in safeguarding the other party's Confidential and Proprietary Information.

**6.4 CONFIDENTIALITY OF MEDICAL RECORDS.** Provider will maintain the confidentiality of information contained in Members' medical records including Member identifiable information and will only release such records: (a) to Regence upon request and as is necessary to comply with the terms of this Agreement; (b) subject to applicable laws; (c) as necessary to other providers treating the Member; (d) to Provider's medical review committees; or (e) with the consent of the Member.

**6.5 RATE INFORMATION.** Notwithstanding the above, Regence may disclose to Participating Providers the information and data required to allow those Participating Providers to effectively manage the quality, care, and cost of Members Regence has attributed to them.

**6.5.1 Disclosure of Rates to Members.** Notwithstanding any other provision of this Agreement to the contrary, either party may disclose to Members the Member's actual or estimated cost-sharing amount (e.g., Copayment, Deductible, and/or Coinsurance) for a Covered Service, to explain claims payment and to facilitate informed decisions regarding health care services use and cost. The parties understand that in some cases, the cost-sharing amount may be equal to the allowed amount for services under the Agreement.

**6.6 THIRD-PARTY SERVICES.** In the event Provider utilizes any third-party service provider in any matter that involve claims data or any Provider or Regence Confidential and Proprietary information, Provider shall ensure that such third party executes a business associate agreement

and complies with all applicable state and federal laws that relate to privacy. In addition, Provider shall be responsible for notifying Regence of the name and address of any third-party service providers that, in performing Provider duties, are given access to any Provider or Regence Confidential and Proprietary Information and that the third-party service provider has the authority to act on behalf of the Provider. If Provider changes such third-party service provider, Provider shall notify Regence of the change within ten (10) business days.

- 6.7 SURVIVAL.** The obligations set forth in this Article VI will survive the termination of this Agreement and shall continue for so long as either party possesses any of the other party's Confidential and Proprietary Information, regardless of the reason, or lack thereof, for termination of this Agreement.

## **VII. TERM AND TERMINATION**

- 7.1 TERM.** The "Initial Term" of this Agreement shall be one (1) year from the Effective Date of this Agreement. Thereafter, this Agreement shall continue from year to year unless terminated.
- 7.2 TERMINATION WITHOUT CAUSE.** This Agreement, or participation in any provider network addendum attached thereto, may be terminated without cause by either party, after the Initial Term, with at least one hundred and twenty (120) days' advance written notice to the other party, in accordance with Section 9.3. This option may be exercised by either party for any reason and does not require either party to establish or prove that there is cause for the termination or to disclose the basis of its decision to the other party. Both parties agree to accept the other's decision on termination as final, without recourse to further external, internal, judicial, or arbitral process. In the event of a termination, the parties shall have no right to claim and do hereby waive and release any claim for damages that may result from or arise out of that termination, other than any claim that the parties may have for Covered Services rendered to Members prior to the effective date of the termination.
- 7.3 TERMINATION FOR CAUSE.** This Agreement may be terminated for cause due to a breach of any material term, covenant or condition at any time by either party upon at least thirty (30) days' prior written notice of such termination, in accordance with Section 9.3. Such notice shall specify the reason(s) for termination. The other party shall be provided thirty (30) days from the date of receipt of the notice of termination to correct the breach to the satisfaction of the party requesting termination. The thirty (30) day cure period may be extended upon mutual written consent of both parties. Should the breach not be corrected within the thirty (30) day cure period or any agreed upon extensions to the cure period, this agreement will terminate.
- 7.4 IMMEDIATE TERMINATION.** Notwithstanding any other provision of this Agreement, Regence may terminate this Agreement immediately upon notice to Provider, in accordance with Section 9.3, in the case of any of the following:
- 7.4.1** Expiration, suspension, restriction, revocation, or non-renewal of required federal, state, or local licensure or certificates that would affect the provision of Covered Services to Members.
  - 7.4.2** Expiration, suspension, restriction, revocation, or non-renewal of Regence's licensure that would affect the ability of Regence to conduct the business of administering and funding Member Contracts.
  - 7.4.3** Continued participation under this Agreement may adversely affect the health, safety or welfare of any Member.
  - 7.4.4** Failure to maintain liability insurance, in amounts required by Regence's credentialing criteria.

- 7.4.5 Failure to comply completely with Regence Credentialing or Recredentialing standards or procedures then in effect.
- 7.4.6 Debarment, suspension, or exclusion of Provider from any government-sponsored program.
- 7.4.7 Deliberate misrepresentation or falsifying any information supplied by Provider to Regence, including but not limited to medical record information.
- 7.4.8 Engagement in fraud or deception or knowingly permitting fraud or deception by another, in connection with Provider's obligations under this Agreement.
- 7.4.9 Any final legal or governmental action against Provider which impairs Provider's ability to carry out its duties and obligations under this Agreement.
- 7.4.10 Failure to comply with Regence's care management programs, Utilization Management, and Quality Improvement Activities.
- 7.4.11 Failure to comply with the provisions of this Agreement regarding the limitations on billing Members.
- 7.4.12 Any action or communication that fundamentally undermines or could fundamentally undermine the confidence of Members, potential Members, their employers, unions, physicians, other health care professionals, or the public in Regence or in the quality of care provided to Members.

Any termination under this provision may be appealed by Provider in accordance with Article VIII of the Agreement.

- 7.5 **CONTINUATION OF SERVICES.** Upon termination of this Agreement, Regence and Payor will direct Members to Participating Providers. Provider's obligation to provide Covered Services in accordance with the terms of this Agreement to Members will continue for a period of twelve (12) months following the termination effective date ("Continuation Period"). During this Continuation Period, the payment terms defined in the current Attachment A to this Agreement shall prevail. Continuation of Services may not be applied to providers who retire and permanently close their practice, or no longer render services in Regence's service area.
- 7.6 **OBLIGATION TO COOPERATE.** Upon notice of termination, and in accordance with Section 7.5 above, Providers will cooperate with Regence in the orderly transfer of Members' care, including the provision of copies of records to other Participating Providers, at no charge to Regence, Payors or Members. The parties will cooperate on promptly resolving any outstanding financial, administrative, or patient care issues upon the termination of this Agreement. This provision will survive termination of this Agreement. Notwithstanding anything in this Agreement to the contrary, either party may seek damages for breach of this provision.
- 7.7 **NOTICE TO MEMBERS.** Upon notice of termination of this Agreement, Regence will provide notice of the impending termination to Members currently under the treatment of Provider. In the event of immediate termination, Regence will notify its Members as soon as is practical of Provider's termination. Provider agrees to refrain from any action that interferes with the relationship between Regence and its existing or prospective Members or Participating Providers.

## **VIII. DISPUTE RESOLUTION**

- 8.1 **MEMBER COMPLAINTS.** Provider agrees to cooperate fully with Regence in the investigation and resolution of Member complaints and grievances concerning health care services provided under

this Agreement. Upon request, Provider will furnish Regence with a copy of its procedures for handling Member complaints.

- 8.2 INTERNAL PROVIDER APPEAL PROCESSES.** Regence shall maintain one or more internal provider appeal processes to adjudicate disputes that may arise between a Participating Provider and Regence. Regence's internal provider appeal and grievance processes are set forth on the Provider Web Site, which is incorporated herein by reference. Unless otherwise indicated herein or in the Provider Web Site, the Participating Provider must exhaust the applicable provider appeals process before initiating any of the post-appeal processes set forth herein.

If the Participating Provider submits a dispute to the provider billing dispute appeal process, and Regence fails to render a timely decision based on the time frames described in the Provider Web Site, Provider may bypass the provider billing dispute appeal process and proceed directly to one or more of the post-appeal processes described below.

- 8.3 POST-APPEAL PROCESSES.** If, after the exhaustion of the applicable internal provider appeal process, either party is dissatisfied with the outcome of the internal provider appeal and wants to further dispute the issue(s), the disputed issue(s) must be submitted to one or more of the processes as described below. Any prerequisites to initiating one of the processes described below must be met before the process can be initiated.

**8.3.1 Binding External Review.** For disputes that have exhausted the billing dispute and Medical Necessity/investigational procedure appeal process, the Participating Provider may elect to resolve the disputed issue(s) by binding external review, if certain conditions are met. In all cases, if a dispute is submitted to external review, the decision of the external reviewer is binding and is the final decision on the disputed issue. Disputes submitted to external review shall not be submitted to mediation or arbitration as provided herein. A description of the external review process and any prerequisites to initiating the external review process can be found on the Provider Web Site. Disputes that do not meet the criteria to be submitted to binding external review may be submitted to binding external review only upon mutual written agreement of the parties.

**8.3.2 Mandatory Non-Binding Mediation.** For disputes that have not been or cannot be submitted to external review, the disputed issue(s) must be submitted to mandatory non-binding mediation prior to seeking arbitration. Mandatory non-binding mediation must be requested within sixty (60) days following the date of Regence's decision on Provider's last internal provider appeal. Where Provider is allowed to bypass the internal provider appeal process as provided herein, mandatory non-binding mediation must be requested within sixty (60) days from the last day Regence has to timely respond to a dispute. Provider and Regence shall each bear their own costs of mediation and shall split equally the costs of the third-party mediator.

**8.3.3 Binding Arbitration.** If, after exhausting Regence's internal provider appeals process and mandatory non-binding mediation, either party is still dissatisfied with the outcome and wants to further dispute the issue(s), the disputed issue(s) must be submitted to binding arbitration. Such arbitration must be initiated by making a written demand for arbitration on the other party. The demand for arbitration must identify all issues on which the party seeks arbitration, the contractual provisions on which the party relies, the amount in dispute, and the relief requested.

The arbitration shall be conducted in a city within reasonable distance of both parties and mutually agreed upon by both parties. The parties agree that the dispute shall be submitted to one (1) arbitrator mutually selected by the parties. If the parties cannot agree on an arbitrator, they shall obtain a list of ten (10) possible arbitrators from a neutral source, such as the Judicial Arbitration and Mediation Services (JAMS), and shall strike arbitrators from the list in turn, beginning with the party who won a coin toss, until only one arbitrator



remains. The remaining arbitrator shall hear the dispute. The parties shall share equally the fee of the arbitrator, excluding the filing fee, if any, incurred in commencement of the proceeding. The parties shall have the right to make substantive motions. The arbitrator shall be bound by applicable federal and state law and shall render a written decision within thirty (30) days of the hearing. The arbitrator shall award the prevailing party any applicable filing fees and arbitrator's fees paid by the prevailing party. The arbitrator also may award the prevailing party attorneys' fees and costs associated with the arbitration proceeding. Judgment upon an award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

- 8.4 FAILURE TO TIMELY APPEAL.** If the disputing party (i.e., the party that requests or initiates the internal appeal, external review, mediation, or arbitration) fails to request or initiate an internal appeal, external review, mediation, or arbitration as required by this Agreement, and within the time frames prescribed on the Provider Web Site and this Agreement, Regence's last determination on the disputed issue(s) shall be deemed final and binding. In addition, the disputed issue(s) shall be conclusively deemed to have been waived by the disputing party and shall not be the subject of any further internal, external, judicial, or other dispute resolution process. Once the decision is deemed final, nothing in this Agreement shall prevent the prevailing party from pursuing remedies available to it, including without limitation a judicial remedy, to collect any amounts owed to it by the other party. Also, nothing in this Agreement shall prevent a party from asserting defenses, claims, causes of action, or demands in response to an internal appeal, external review, mediation, or arbitration initiated by the disputing party. This provision shall survive termination of this Agreement.
- 8.5 PRECEDENTIAL EFFECT OF DECISIONS.** The parties agree that any disputes that arise under this Agreement shall be considered independently and on their own merits without regard for any other determination made by a third party through one of the post-appeal processes or by Regence through the internal provider appeal process or otherwise. The parties agree that none of the determinations made under this Agreement through one of the dispute resolution processes described above shall be used as precedent for other disputes that may arise between Regence and any Participating Provider or between Regence and any third party. This provision shall survive termination of this Agreement.

## **IX. GENERAL PROVISIONS**

- 9.1 AMENDMENTS WITH NOTICE.** Regence may amend this Agreement by providing ninety (90) days' prior written notice to Provider in accordance with Section 9.3.2. If Provider objects to the amendment, Provider may terminate the Agreement by giving Regence written notice no later than thirty (30) days after receipt of the written notice of the amendment. Said termination shall be effective at the end of the ninety (90) day notice period, unless within sixty (60) days of the date of the notice of amendment, Regence gives Provider written notice that it will not implement the amendment. Regence reserves the right to update any document, attachment or addendum to this Agreement to restate Provider's network participation status and will provide such notice with no less than ninety (90) days' prior written notice to Provider.
- 9.2 AMENDMENTS REQUIRED BY LAW.** If state or federal laws or regulations require a change to any provision of this Agreement, this Agreement will be deemed amended to conform to the law or regulation on the date the law or regulation becomes effective. Regence will use reasonable efforts to provide Provider prior written notice of such changes.
- 9.3 NOTICES AND COMMUNICATION BETWEEN THE PARTIES.**
- 9.3.1 Notices/Communications Containing Confidential and/or Protected Health Information.** If a notice or communication includes information that is confidential and proprietary information to either or both parties and/or that includes Protected Health Information ("PHI") as defined under Health Insurance Portability and Accountability Act of

1996 (42 U.S.C. 201 et seq.), then the following restrictions must be observed when communicating such information.

- a. U.S. mail/certified mail/overnight delivery—No additional requirements.
- b. Provider Web Site—Not a permitted method of notice or communication for confidential information and PHI, unless the web site is secured or the information is appropriately encrypted.
- c. Electronic mail—Not a permitted method of notice or communication for confidential information and PHI, unless the electronic mail is secured or the information is appropriately encrypted.
- d. Facsimile Transmission—The information must be prefaced by a formal cover sheet noting the confidentiality of such information.

**9.3.2 All Other Notices.** Notices and communications between the parties, which are necessary for the proper administration of this Agreement, will be communicated via regular U.S. mail, Provider Web Site or electronic mail, and when applicable, in accordance with Section 9.3.1, with the exception of notices related to termination or requests for mediation or arbitration, which must be sent via certified mail, return receipt requested to the address defined in Section 9.3.4.

**9.3.3 When Made.** Notices and communications will be deemed to have been made on the date of certified delivery, date postmarked, or electronically date stamped based on the method of notice specified in Section 9.3.

**9.3.4 Address for Notices.** Notices and communications required under this Agreement to Provider shall be sent to: (a) the postal address of Provider's billing service location; or (b) the electronic mail address designated by Provider for electronic notices, indicated on the signature page of this Agreement. Notices to Regence shall be sent to the Contract Notice address listed in the Contact Us section of the Provider Web Site.

**9.3.4.1 Notice of Change in Regence Address.** Regence agrees to provide ninety (90) days' advance written notice to Provider of a change in Regence's mailing address.

**9.3.4.2 Notice of Change in Provider Address.** Provider agrees to provide ninety (90) days' advance written notice to Regence of a change in: (a) Provider's physical address, (b) Provider's billing address, and/or (c) Provider's electronic mail address.

**9.4 USE OF NAME.** Provider consents to the use of Provider's name and other identifying and descriptive material in provider directories. Provider consents to Regence's use of Provider's name on Regence's web site, directories, or lists to identify Provider as contracted. Any other use of Provider's name and other identifying and descriptive material by Regence requires review and written approval by Provider prior to use. Any use of Regence's names, logos, trademarks, or service marks in promotional materials or similar use requires review and written approval by Regence prior to use. Regence consents to Provider's use of Regence's name on Provider's web site, directories, or lists to identify Regence as a health plan with whom Provider is contracted.

**9.5 INDEMNIFICATION.** To the extent not otherwise inconsistent with the laws of the relevant jurisdiction, each party will indemnify and hold harmless the other and its officers, directors, agents, and employees, individually and collectively, from all fines, claims, demands, suits, or actions of any kind or nature arising by reason of the indemnifying party's negligent or intentional acts or omissions in the course of its performance of its obligations under this Agreement.

- 9.6 SEVERABILITY.** If any provision of this Agreement is determined unenforceable in any respect, the enforceability of the provision in any other respect and of the remaining provisions of this Agreement will not be impaired.
- 9.7 BANKRUPTCY.** If bankruptcy, receivership, or liquidation proceedings are commenced with respect to any party hereto, and if this Agreement has not otherwise been terminated, then a non-filing party may suspend all further performance of this Agreement pursuant to Section 365 of the Bankruptcy Code or any similar or successor provision of federal or state law. Any such suspension of further performance by a non-filing party will not be a breach of this Agreement and will not affect the non-filing party's right to pursue or enforce any of its rights under this Agreement or otherwise.
- 9.8 ASSIGNMENT.** Neither party shall assign any rights or delegate any obligations hereunder without the written consent of the other party, provided, however, that any reference to Regence herein shall include any successor in interest and that Regence may assign its duties, rights, and interests under this Agreement in whole or in part to a Regence affiliate or may delegate any and all of its duties to a third party in the ordinary course of business.
- 9.9 WAIVER OF BREACH.** Waiver of a breach of any provision of this Agreement will not be deemed a waiver of any other breach of that same or different provision. No party will be deemed to have waived that party's rights under this Agreement unless the waiver is made in writing and signed by the waiving party's duly authorized representative.
- 9.10 FORCE MAJEURE.** Neither party will be deemed to be in violation of this Agreement if it is prevented from performing its obligations by events beyond its control, including, without limitations, acts of God, war, or insurrection, terrorism, flood or storm, strikes, or rule or action of the government or agency. The parties shall make a good faith effort, however, to assure Members have access to services consistent with applicable law, despite such events.
- 9.11 GOVERNING LAW / VENUE.** Please refer to the attached state addendum.
- 9.12 ENTIRE AGREEMENT/SUPERSESSION.** This Agreement and its exhibits, attachments, amendments and addenda constitute the entire Agreement between the parties with regard to the subject matter herein and supersede any prior written or oral agreements between the parties or their affiliates with regard to the same subject matter.
- 9.13 CHANGES TO MEMBER CONTRACTS.** Regence or Payor may change, revise, modify or alter the form and/or content of any Member Agreement without prior approval and/or notice to Providers. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member Contract.
- 9.14 AUTHORITY TO BIND PROVIDERS.** Each of the persons executing this Agreement on behalf of Regence and Provider represents and warrants that he or she has the authority to bind his or her respective principals and affiliates listed in Attachment B as applicable and that the respective Parties have the full authority to bind all relevant parties, agents, and affiliates to the terms referenced in this Agreement.

IN WITNESS WHEREOF, the undersigned have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

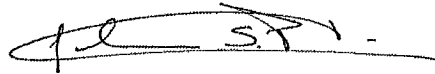
**UNDER PENALTIES OF PERJURY, I (Provider) certify that:**

1. The number(s) shown on this form or otherwise set forth on a subsequent Attachment to this Agreement is/are the correct taxpayer identification number (or Provider is waiting for a number to be issued), **and**
2. Provider is not subject to backup withholding **(a)** exempt from backup withholding, or **(b)** have not been notified by the Internal Revenue Service (IRS) that Provider is subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified Provider that it is no longer subject to backup withholding.

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

COUNTY OF PACIFIC

REGENCE BLUESHIELD



Signature of Authorized Representative

Signature of Authorized Representative

Print Name

**John Partin, VP Network Management**  
Name and title of Authorized Representative

Title

Date

Date

Name of Provider as it corresponds to this Taxpayer Identification Number

916001356  
Taxpayer Identification Number

Email Address

## PARTICIPATING PROFESSIONAL SERVICES AGREEMENT WASHINGTON STATE ADDENDUM

This Addendum to the Participating Professional Services Agreement (the "Agreement") is entered into and made part of the Agreement with **COUNTY OF PACIFIC** ("Provider"), to recognize additional provisions that apply to Member Contracts sponsored, issued or administered by, or accessed through Regence that may be subject to regulation under Washington law; and for which Washington laws may control.

Regence and Provider each agree to be bound by the terms and conditions contained in this Addendum. In the event of a conflict or inconsistency between this Addendum and any term or condition contained in the Agreement, this Addendum shall control. This Addendum will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, effective as of the date of such changes. Except as specifically amended herein, all terms and conditions of the Agreement remain in effect.

**The referenced section of the Agreement is deleted in its entirety and replaced with the following:**

- 1.7 MEDICALLY NECESSARY or MEDICAL NECESSITY:** Except for services subject to WAC 284-43-7000, "Medically Necessary" or "Medical Necessity" means health care services or supplies that a physician or other health care professional, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; (c) not primarily for the convenience of the patient, physician, or other health care professional; and (d) not more costly than an alternative service or sequence of services or supplies that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in applicable peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of physicians and other health care professionals practicing in relevant clinical areas and any other relevant factors. For services subject to WAC 284-43-7000, "Medical Necessity" or "Medically Necessary" shall have the meaning set forth in WAC 284-43-7020.

**The referenced section of the Agreement is deleted in its entirety and replaced with the following:**

- 3.1 PAYMENT.** Regence or Payor will compensate the Provider for Medically Necessary Covered Services provided to Members in accordance with this Agreement and Regence's or Payor's claims payment policies. Provider will have the right to audit Regence's records related to adjudication of Provider's claims. The audit may be performed either by the Provider or by an independent auditor selected by the Provider. Provider or the independent auditor will conduct audits during Regence's regular business hours at Regence's office and the audit will be limited to records necessary to perform the audit. The Provider will give Regence no less than three (3) business days advance notice of such claims audit and will inform Regence of the claim records to be audited. Regence will have the records for that time period available for the auditors at the time of the audit. Provider or the independent auditor will conduct the audits in a manner that, to the greatest extent possible, avoids disruption of Regence's business affairs and minimizes the burden on Regence. In conducting the audits, Provider or the independent auditor will comply with all laws, statutes, and regulations pertaining to the confidentiality of Member records. Provider or independent auditor will conduct the audit according to Regence's most current external audit guidelines. This Section will survive termination of this Agreement.

**The referenced section of the Agreement is deleted in its entirety and replaced with the following:**

- 4.21.2 Charges to Members.** In no event will the charge to a Member for Deductibles, Coinsurance or Copayments exceed the amounts established by Regence or Payor, subject to the terms of the "Coordination of Benefits" section of the Agreement. As required by WAC 284-170-421(4), Regence hereby informs Provider that willfully collecting or

attempting to collect an amount from a Member knowing that the collection is in violation of this Agreement constitutes a class C felony under RCW 48.80.030(5).

**The referenced section of the Agreement is deleted in its entirety and replaced with the following:**

**4.21.3 Continue Providing Services.** Provider agrees, in the event of Regence's or Payor's insolvency, to continue to provide Covered Services as promised in this Agreement to Members under the Provider's care until the greater of (i) the Member's discharge from inpatient facilities; or (ii) the duration of the period for which premiums on behalf of the Member were paid to Regence or Payor. The provision of such services and the payment to Provider for these services will be subject to the applicable terms of this Agreement and on the same basis as those services provided prior to insolvency.

**The referenced section of the Agreement is deleted in its entirety and replaced with the following:**

**5.3 PROMPT PAYMENT OF CLAIMS.** Regence will pay claims as soon as practical, but subject to the following minimum standards: (1) Regence will pay ninety-five percent (95%) of the monthly volume of clean claims within thirty (30) days of receipt by Regence; and (2) Regence will pay or deny ninety-five percent (95%) of the monthly volume of all claims within sixty (60) days of receipt by Regence. For purposes of this Section, a "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevent timely payments from being made on the claim in accordance with applicable Washington law. If Regence requires additional information to process a claim, Provider will provide such information at no charge. Once the additional information is received by Regence, Regence will process the claim in accordance with the above standards. Regence will communicate denial of a claim to Provider, including the specific reason why the claim was denied. If the denial is based upon Medical Necessity or similar grounds, then upon Provider's request, Regence will promptly disclose the supporting basis for the decision.

To the extent required by Washington law, Regence or Payor will pay simple interest at the rate of one percent (1%) per month on payable clean claims not paid within sixty-one (61) days of receipt. Such interest will be calculated based on the amount to be paid to Provider for the Covered Services and will be added to Provider's payment without further claim submission from Provider. Notwithstanding the foregoing, neither Regence nor Payor will be subject to interest, penalties, or late fees that may be established by Washington state law for clean claims for Covered Services provided to Members pursuant to a Member Contract with, or on behalf of, the federal government or otherwise pursuant to federal law, including, but not limited to, those under the Federal Employees Health Benefits Program, Medicare, and self-funded health plans.

These prompt payment of claims standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Provider or Members or instances where Regence has not been granted reasonable access to information under Provider's control.

**The referenced section of the Agreement is deleted in its entirety and replaced with the following:**

**5.5.1 Overpayments.** Regence or Payor may request a refund from Provider of a payment previously made to satisfy a claim within twenty-four (24) months after the date that the payment was made or, in the case of a claim involving the coordination of benefits, within thirty (30) months of such date. Any such request must be in writing and must specify why Regence or Payor believes that Provider owes the refund. In the case of a claim involving the coordination of benefits, the request must include the name and mailing address of the other entity that has primary responsibility for payment of the claim. If Provider fails to contest a refund request in writing to Regence or Payor within thirty (30) days of receiving the request, the request is deemed accepted and Provider must pay the refund within thirty (30) days after the request is deemed accepted. If Provider has not paid the refund within thirty (30) days after the request is deemed accepted, Regence or Payor may recover the amount through an offset to a future claim. The parties agree that this Section does not apply in cases of fraud.

**The referenced section of the Agreement is deleted in its entirety and replaced with the following:**

**5.5.2 Refunds and Adjustments.** Provider may request additional payment from Regence or Payor to satisfy a claim within twenty-four (24) months after the date that the claim was denied or payment intended to satisfy the claim was made or, in the case of a claim involving the coordination of benefits, within thirty (30) months of such date. Any such request must be in writing and must specify why Provider believes that Regence or Payor owes the additional payment. In the case of a claim involving the coordination of benefits, the request must include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim. The original claims decision will be final and binding unless Provider requests additional payment within the twenty-four (24) or thirty (30) month time periods, as applicable. The parties agree that this Section does not apply in cases of fraud.

**The referenced Article of the Agreement is deleted in its entirety and replaced with the following:**

## **VIII. DISPUTE RESOLUTION**

**8.1 MEMBER COMPLAINTS.** Provider agrees to cooperate fully with Regence in the investigation and resolution of Member complaints and grievances concerning health care services provided under this Agreement. Upon request, Provider will furnish Regence with a copy of its procedures for handling Member complaints.

**8.2 INTERNAL PROVIDER APPEAL PROCESSES.** Regence shall maintain one or more internal provider appeal processes to adjudicate disputes that may arise between a Participating Provider and Regence. Regence's internal provider appeal processes are set forth in the Provider Web Site, which is incorporated herein by reference. Unless otherwise indicated herein or in the Provider Web Site, the Participating Provider must exhaust the applicable provider appeals process before initiating any of the post-appeal processes set forth herein.

If the Participating Provider submits a dispute to the internal provider appeal process, and Regence fails to render a timely decision based on the time frames described in the Provider Web Site, Provider may bypass the provider Billing Dispute appeal process and proceed directly to one or more of the post-appeal processes described below.

**8.3 POST-APPEAL PROCESSES.** If, after the exhaustion of the applicable internal provider appeal process, either party is dissatisfied with the outcome of the internal provider appeal and wants to further dispute the issue(s), the disputed issue(s) must be submitted to one or more of the processes as described below. Any prerequisites to initiating one of the processes described below must be met before the process can be initiated.

**8.3.1 External Review.** For disputes that have exhausted the Billing Dispute and Medical Necessity/Investigational procedure appeal process, the Participating Provider may elect to resolve the disputed issue(s) by External Review, if certain conditions are met. In all cases, if a dispute is submitted to External Review, the decision of the External Reviewer is accepted by the Provider and Regence as the final decision on the disputed issue. Disputes submitted to External Review shall not be submitted to mediation or arbitration as provided herein. A description of the External Review process and any prerequisites to initiating the External Review process can be found in the Provider Web Site. Disputes that do not meet the criteria to be submitted to binding External Review may be submitted to binding External Review only upon mutual written agreement of the parties.

**8.3.2 Mandatory Non-Binding Mediation.** For disputes that have not been or cannot be submitted to External Review, the disputed issue(s) must be submitted to mandatory non-binding mediation prior to seeking arbitration. Mandatory non-binding mediation must be requested within sixty (60) days following the date of Regence's decision on Provider's last internal provider appeal. Where Provider is allowed to bypass the internal provider appeal process as provided herein, mandatory non-binding mediation must be requested within sixty (60) days from the last day Regence has to timely respond to a dispute. Provider and

Regence shall each bear their own costs of mediation and shall split equally the costs of the third-party mediator.

**8.3.3 Litigation.** If the parties are unable to resolve a dispute through nonbinding mediation, and if either party wishes to pursue the dispute, such party may commence litigation proceedings. The parties agree that if litigation is used to resolve a dispute, neither party shall be entitled to an award of special, indirect, punitive or exemplary damages, except in connection with a statutory claim that explicitly provides for such relief. In no event shall any litigation be commenced more than one year after the date on which notice of the Dispute was given.

The parties expressly intend that any Dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the dispute.

**8.4 FAILURE TO TIMELY APPEAL.** If the disputing party (i.e., the party that requests or initiates the internal appeal, External Review, mediation, or litigation) fails to request or initiate an internal appeal, External Review, mediation, or litigation as required by this Agreement, and within the time frames prescribed in the Provider Web Site and this Agreement, Regence's last determination on the disputed issue(s) shall be deemed final and binding. In addition, the disputed issue(s) shall be conclusively deemed to have been waived by the disputing party and shall not be the subject of any further internal, external, judicial, or other dispute resolution process. Once the decision is deemed final, nothing in this Agreement shall prevent the prevailing party from pursuing remedies available to it, including without limitation a judicial remedy, to collect any amounts owed to it by the other party. Also, nothing in this Agreement shall prevent a party from asserting defenses, claims, causes of action, or demands in response to an internal appeal, External Review, mediation, or litigation initiated by the disputing party. This provision shall survive termination of this Agreement.

**8.5 PRECEDENTIAL EFFECT OF DECISIONS.** The parties agree that any disputes that arise under this Agreement shall be considered independently and on their own merits without regard for any other determination made by a third party through one of the post-appeal processes or by Regence through the internal provider appeal process or otherwise. The parties agree that none of the determinations made under this Agreement through one of the dispute resolution processes described above shall be used as precedent for other disputes that may arise between Regence and any Participating Provider or between Regence and any third party. This provision shall survive termination of this Agreement.

**The referenced section of the Agreement is deleted in its entirety and replaced with the following:**

**9.11 GOVERNING LAW / VENUE.** This Agreement is governed by the laws of the State of Washington, without giving effect to any conflict-of-law principle that would result in the laws of any other jurisdiction governing this Agreement. Any action, suit, or proceeding arising out of the subject matter of this Agreement will be litigated in courts located in King County, Washington. Each party consents and submits to the jurisdiction of any local, state, or federal court located in King County, Washington.



## REGENCE BLUESHIELD DATA ACCESS, USE, AND TRANSFER ADDENDUM

This Addendum ("Addendum"), effective ("Effective Date") is entered into by and between Regence BlueShield ("Regence") and **COUNTY OF PACIFIC**, and each entity set forth on Attachment B as applicable (collectively "Provider").

As part of the Agreement, Regence will disclose to Provider Regence Confidential and Proprietary Information, defined below, provided that the Provider agrees to the following terms of this Addendum.

### I. DEFINITIONS

1. **CONFIDENTIAL AND PROPRIETARY INFORMATION.** As used in this Addendum, "Regence Confidential and Proprietary Information" means: (a) proprietary information of Regence in whatever form (hard-copy, electronic, on-line, encoded disk, etc.); (b) information marked or designated by Regence as confidential or proprietary; (c) claims and health information that Regence treats as confidential, including raw claims data, claim data extracts, utilization information and health information specific to a particular Member or his/her dependents; (d) the names, addresses and telephone numbers of all Members and employer groups; (e) this Agreement; and (f) other information provided by Regence, which Regence is obligated to keep confidential. "Regence Confidential and Proprietary Information" excludes any information now or hereafter voluntarily disseminated by Regence to the public, which otherwise becomes part of the public domain through lawful means, or which is required to be disclosed by or to a government agency publicly.
2. **PERSON** means any natural person, corporation, limited liability company, partnership, trust, organization, association or other entity, including any government entity.
3. **REPRESENTATIVES** means directors, officers, managers, employees, partners, affiliated entities (i.e., an entity controlling, controlled by, or under common control with either Regence or Provider), subcontractors, agents, consultants, advisors and other authorized representatives.
4. **SECURITY INCIDENT** means the HIPAA Security Rule which defines a security incident as an attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

### II. PROVIDER OBLIGATIONS

1. **Purpose and Use.** The Provider will hold the Regence Confidential and Proprietary Information in confidence and will use the Regence Confidential and Proprietary Information for the sole and limited purpose for which it was disclosed, namely, providing the services set out in the Agreement ("Purpose"). Provider shall make reasonable efforts to use, disclose and request only the minimum amount of Regence Confidential and Proprietary Information necessary to accomplish the intended purposes of the use, disclosure, or request. The Provider agrees to implement and follow appropriate minimum necessary policies in the performance of its obligations under the Agreement.

Without limiting the foregoing, the Provider will not, in whole or in part, use the Regence Confidential and Proprietary Information in either aggregate or de-identified form: (i) for any purpose other than the Purpose; (ii) to provide services to any other party; or (iii) for its own benefit to develop normative and benchmarking data, internal or external research, analysis and product development, without the prior written consent of Regence.

2. **Resale of Regence Confidential and Proprietary Information.** The Provider will not resell Regence Confidential and Proprietary Information.

3. **De-Aggregation and Identification.** The Provider will not re-identify or de-aggregate de-identified or aggregate Regence Confidential and Proprietary Information without prior written consent from Regence.
4. **Comingling.** Unless permitted in the Agreement or with prior written approval from Regence, the Provider will not comingle Regence Confidential and Proprietary Information with any other information or data.

### III. CONFLICTS

All obligations in this Addendum are in addition to, and not a replacement of, obligations in the Agreement. Should there be a direct conflict between this Addendum and the Agreement, the Agreement shall control except with regard to Provisions II, IV, V(1), and VI as they apply to Regence Confidential and Proprietary Information.

### IV. DESTRUCTION OR RETURN OF DATA

Upon termination of this Agreement, or at the request of Regence, the Provider will return or securely destroy Regence Confidential and Proprietary Information in Provider's possession, including any derivative materials containing Regence Confidential and Proprietary Information. If Provider is unable to return or destroy Regence Confidential and Proprietary Information due to legal or licensure requirements, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, the Provider must maintain the confidentiality of the Regence Confidential and Proprietary Information until the expiration of the applicable legal or licensure requirements and then destroy or return such data.

### V. CHANGE OF OWNERSHIP/CONTROL

1. **Provider** must notify Regence immediately, but no later than 30 days, following a change of ownership or control, whether direct or indirect, of or by the Provider.
2. **Termination.** Should there be a change of ownership or control, whether direct or indirect of or by the Provider, Regence at its option may terminate the Agreement, this Addendum, any other data sharing agreement pertaining to Regence Confidential and Proprietary Information, or Agreement. Upon termination, Provider shall return or destroy Confidential Data as described under Provision IV.

### VI. RECORDKEEPING AND AUDIT RIGHTS

The Provider shall maintain complete and accurate records relating to the obligations under this Addendum, including but not limited to information, materials, records, or procedures related to (i) use, access, transfer, or disclosure of Regence Confidential and Proprietary Information; (ii) security measures related to the use, receipt, transfer, storage, maintenance, or disposal of Regence Confidential and Proprietary Information. No more than once a year, upon fifteen (15) days' notice, Regence or a Regence representative shall be allowed to inspect, to audit and to make copies of such records and interview Provider personnel to ensure compliance with the Addendum relative to the use, access, transfer and disclosure of Regence Confidential and Proprietary Information or with Provider's obligations under this Addendum.

1. **Occurrences.** Notwithstanding the above, the parties agree that Regence may conduct an audit at any time, in the event of (i) audits required by governmental or regulatory authorities, (ii) investigations of breaches of Provider's obligations under the Addendum, Security Incidents, or potential Security Incidents.
2. **Costs.** Regence shall pay the costs of an audit conducted under this provision, provided that the audit does not (i) involve a Security Incident or event or potential Security Incident or event, or (ii) does not identify, as it relates to Regence Confidential and Proprietary Information, any failure to perform under this Addendum or the Agreement, breach of this Addendum or the agreement, or negligence or willful misconduct by Provider; in those circumstances, Provider shall pay the cost of the audit.

## REGENCE BLUESHIELD PART 2 PROGRAM PROVIDER ADDENDUM

This Addendum ("Addendum"), effective ("Effective Date") is entered into by and between Regence BlueShield ("Regence") and **COUNTY OF PACIFIC**, and each entity set forth on Attachment B as applicable (collectively "Provider").

1. **Substance Use Disorder Claims and Information.** If Provider treats or diagnoses patients for Substance Use Disorders or refers patients for treatment of Substance Use Disorders and is subject to the Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2) as a Part 2 Program, Provider shall comply with the terms of this Addendum with respect to any claim or other communication it submits to Regence that contains Patient Identifying Information. Regence payment of such claims is contingent upon compliance with these requirements.
  - a. **Definitions.** For purposes of this Addendum, the capitalized terms "Part 2 Program," "Patient Identifying Information," and "Substance Use Disorder" shall have the meanings provided in 42 C.F.R. § 2.11. Other capitalized terms will have the meanings established in this Addendum or elsewhere in the Agreement, as applicable.
  - b. **Consent.** Provider is prohibited by law from disclosing Patient Identifying Information to Regence without obtaining the patient's consent. Regence is prohibited by law from using Patient Identifying Information to pay any claim (or to process other information) in the absence of such consent. Accordingly, by submitting any claim (or other record) that contains Patient Identifying Information to Regence, Provider represents and warrants that Provider has first obtained patient consent that meets the requirements established in the Provider Web Site under Claims and Payment>Claims Submission>Other Billing Information. Regence reserves the right to deny payment of any claim (and the right to refuse to process other information) in the event that Provider fails to obtain such consent.
  - c. **Notice.** Provider is prohibited by law from disclosing Patient Identifying Information to Regence pursuant to the patient's consent, unless it includes with the Patient Identifying Information a specific statement to notify Regence that the information is subject to Substance Use Disorder confidentiality restrictions (the "Part 2 Disclaimer"). Accordingly, Provider shall include the Part 2 Disclaimer with any claim (or other record) that contains Patient Identifying Information when submitting the claim (or other information) to Regence. Specifically, Provider shall include the Part 2 Disclaimer in the manner established in the Provider Web Site under Claims and Payment>Claims Submission>Other Billing Information. Regence reserves the right to deny payment of any claim (and the right to refuse to process other information) in the event that Provider fails to include the Part 2 Disclaimer in a communication containing Patient Identifying Information.
  - d. **Audits and Evaluations.** Upon request, Provider shall provide to Regence Patient Identifying Information that Regence deems reasonably necessary to perform evaluations, audits and health care operations, including, but not limited to, utilization review, quality assessment and improvement activities (such as collection of HEDIS data), and reviewing qualifications of health care providers. For purposes of any such request, Regence agrees that it will:
    - i. Maintain and destroy the Patient Identifying Information in a manner consistent with 42 C.F.R. § 2.16;
    - ii. Retain records that contain Patient Identifying Information in compliance with applicable federal, state, and local record retention laws; and
    - iii. Comply with the limitations on disclosure and use of Patient Identifying Information in 42 C.F.R. § 2.53(d).

Provider is permitted to make such disclosures pursuant to 42 C.F.R. § 2.53(b).

**REGENCE BLUESHIELD  
PROVIDER NETWORK ADDENDUM  
Effective:**

This Addendum to the Agreement between Regence BlueShield ("Regence") and **COUNTY OF PACIFIC** ("Provider") is to recognize network participation and additional provisions which apply to the networks. Except as specifically amended herein, all terms and conditions of the Agreement remain in effect.

WHEREAS, All references herein to "Provider" shall mean "Practitioner", "Provider", "Clinic", or "Hospital" as those terms are used and defined in the Agreement; and

WHEREAS, Regence and Provider are parties to the Agreement, whereby Provider agrees to provide Covered Services to Members; and

WHEREAS, Regence desires Provider to be included in the networks indicated below pursuant to the terms of this Addendum, and the Medicare Advantage documents, attached if applicable; and

NOW, THEREFORE, in consideration of the covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, agree as follows:

**1. PROVISIONS**

- 1.1** This Addendum shall continue in effect, unless terminated according to the process set forth in the Agreement.
- 1.2** Provider shall admit or arrange for hospital admissions and referral services of Members only to network providers within their applicable network, unless the Member's condition makes it impossible, the service is not available through the network, or the Member chooses care outside the network. Provider should advise the Member whenever health care services are to be obtained outside of their network that the Member may be subject to additional out-of-pocket expense. Any questions regarding network participation and benefit levels should be directed to Regence.
- 1.3** Provider agrees to accept the network payment set forth on the Reimbursement Schedule and Medicare Advantage Addendum, if applicable, as payment in full for Covered Services rendered to Members for networks in which Provider is participating as indicated below.

**Provider is to participate in those networks indicated with a "Yes" below.**

<b>Participation</b>	<b>Networks</b>
Yes	Participating
Yes	Preferred
Yes	Individual and Family Network
	RealValue
	Regence Vision Network
	Eastside Health Network
	MultiCare Connected Care
	The Everett Clinic
	UW Medicine
	SelectMed
	Regence MedAdvantage PPO
	Regence BlueAdvantage HMO

## ATTACHMENT A REGENCE BLUESHIELD PROFESSIONAL REIMBURSEMENT SCHEDULE

This attachment/exhibit to the Participating Agreement between Regence BlueShield ("Regence") and **COUNTY OF PACIFIC** ("Provider") is effective for dates of service on or after , and replaces and supersedes any prior reimbursement schedules. Any term not defined herein shall have the meaning set forth in the Agreement. Reimbursement for all commercial networks that Provider participates in, according to the Provider Network Addendum, will be reimbursed according to the same terms as defined in this Reimbursement Schedule unless specifically noted otherwise.

### I. DEFINITIONS

- 1.1 **Billed Charges** – charges submitted by Provider for Covered Services.
- 1.2 **Maximum Allowable** – the amount that Regence agrees to pay, subject to standard Regence administrative guidelines, reimbursement policies and payment methodologies, including but not limited to reimbursement for CPT® code modifiers.
- 1.3 **Anesthesia Services** – services described by CPT® codes to which the American Society of Anesthesiologists has assigned a base unit.
- 1.4 **Total Anesthesia Units** – ASA base unit for a CPT® code plus time units, which are defined as total time for a service in 15-minute increments. Sixty minutes is 4 time units. Per the Regence's reimbursement policy, after one minute, Regence rounds units up to the next 15-minute increment.
- 1.5 **CMS RVUs** – the Centers for Medicare and Medicaid Services (CMS) 2018 site-of-service based (facility or non-facility), non-GPCI adjusted Relative Value Units (RVUs).
- 1.6 **Optum RVUs** –the site-of-service based (facility or non-facility), non-GPCI adjusted Relative Value Units in the 2018 edition of *The Essential RBRVS - A Comprehensive Listing of RBRVS Values for CPT® and HCPCS Codes*, published by Optum.

### II. FEE SCHEDULE/PAYMENT METHODOLOGY

- 2.1 Provider agrees to accept as payment in full the lesser of Billed Charges or the Maximum Allowable for Covered Services provided to Patients.
- 2.2 The Maximum Allowable for covered Anesthesia Services shall be calculated by multiplying a \$53.50 conversion factor times the Total Anesthesia Units for the service.
- 2.3 The Maximum Allowable for Covered Services provided by MDs, DOs, DPMs, ARNPs, and PAs shall be calculated by multiplying conversion factor set forth below times the CMS RVU:

Service Category*	Conversion Factor	
	MD/DO/DPM	ARNP/PA
General Default Unless Otherwise Defined	\$50.00	\$42.50
Acupuncture Codes	\$40.00	\$34.00
Chiropractic and Osteopathic Manipulation Codes	\$33.00	\$28.05
Vision Exam Codes	\$36.25	\$30.81
Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Codes	\$34.50	\$29.33
Technical Component of Sleep Study	\$23.00	\$23.00

\*A detailed supplemental document and fee schedule are available for viewing on Availity. This general Service Category description is provided as a guide, but does not necessarily reflect all CPTs within a category range. New CPT and/or HCPCS codes may be added each quarter as they become available.

- 2.3.1 For services with professional and technical components, the associated global Maximum Allowable for Covered Services will equal the sum of these components.
- 2.4 Fee Schedule for practitioners other than MD/DO/DPM and ARNP/PA:
- 2.4.1 **Physical and Occupational Therapists, Speech Therapists and Audiologists:** One hundred percent (100.00%) of the MD/DO fee schedule.
- 2.4.2 **Acupuncturists:** Sixty-one percent (61.00%) of the MD/DO fee schedule. Except for Acupuncture codes which will receive 100% of the MD/DO fee schedule.
- 2.4.3 **Chiropractors:** Ninety percent (90.00%) of the MD/DO fee schedule, except E&M, manipulation, and rehabilitation codes, which pay at one hundred percent (100.00%) of the MD/DO fee schedule.
- 2.4.4 **Naturopaths:** Eighty-eight percent (88.00%) of the MD/DO fee schedule.
- 2.4.5 **Licensed Massage Therapists:** Fifty-eight percent (58.00%) of the MD/DO fee schedule.
- 2.4.6 **Dieticians, Certified Nutritionists:** Eighty-seven percent (87.00%) of the MD/DO fee schedule.
- 2.4.7 The Maximum Allowable for Covered Services rendered by behavioral health providers shall be as follows:
- **ARNP, Physician Assistant, RN/LPN:** One hundred percent (100.00%) of the ARNP/PA fee schedule.
  - **Psychologist:** Eighty-seven percent (87.00%) of the MD/DO fee schedule.
  - **Masters in Social Work, Mental Health Counselor, Marriage/Family Therapist, Mental Health RN, Registered Counselor, Mental Health Counselor:** Sixty-three percent (63.00%) of the MD/DO fee schedule.
- 2.5 **Drugs, Biologicals, Vaccines, Immunoglobulins and Toxoids:**
- Regence Fee Schedule for Drugs, Biologicals, Vaccines, Immunoglobulins and Toxoids – one hundred percent (100.00%) of CMS.
  - Regence Fee Schedule for Drugs, Biologicals, Vaccines, Immunoglobulins and Toxoids - Hematology and Oncology – one hundred ten percent (110.00%) of CMS, except Remicade, which is priced at one hundred five percent (105.00%) of CMS.
  - A drug may be priced at percent of AWP (Average Wholesale Price) when no CMS fee is available.
- 2.6 **Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics (DMEPOS):** Most items are calculated at eighty-five percent (85.00%) of the DMEPOS and PEN fee schedules and will reflect quarterly updates made by CMS. Codes must include the appropriate modifiers as defined by the DMEPOS fee schedule. HCPCS codes submitted without the appropriate modifier will be denied.
- 2.7 **Laboratory:** The Maximum Allowable for Covered Services included in Medicare's clinical laboratory (CLAB) fee schedule shall be eighty-five percent (85.00%) of the most current version of that fee schedule.
- 2.8 For services for which no RVU has been established by CMS, the Maximum Allowable for Covered Services shall be determined using Optum RVUs.

- 2.9 For services for which no RVU has been established by CMS or by Optum, the Maximum Allowable for Covered Services shall be the Regence's participating fee schedule in effect on the date of service. A copy of the Regence Commercial Professional Fee Schedule and the Supplemental Information document are available on the Provider Center. Access the Provider Center through the Availity Web Portal at **availity.com**: Select Payer Spaces (with the Regence logo)> Regence Provider Portal for Washington. Enter your Provider Center user ID and password. To view the documents, select Fee Schedules>Regence BlueShield of Washington Professional Fee Schedules.
- 2.10 Not all procedure codes have RVUs published in the Federal Register. In these cases, we establish allowances using various methods as explained in our Pricing Codes without RVUs (Administrative #113) reimbursement policy. Regence has the right to establish fees based on Reimbursement Policies. Our Reimbursement Policy Manual is available on our provider website at **regence.com**: Library>Policies and Guidelines>Reimbursement Policy.

### **III. COPAYMENT, COINSURANCE, DEDUCTIBLE**

Where the Subscriber Agreement provides for payment of copayment, coinsurance or deductibles by the Patient, payment by Regence for Covered Services shall be less the applicable copayment, coinsurance or deductible.

### **IV. NON-DISCLOSURE**

Provider agrees that unless required by law or otherwise allowed by the Agreement, Provider shall not disclose the reimbursement rates established by the Regence without prior written consent of Regence. Provider further agrees not to disclose the reimbursement rates to individual health care practitioners, other than those health care practitioners on its Board, if applicable, in any format. Provider acknowledges that the unauthorized disclosure of this information may cause irreparable damage to the Regence, and Provider agrees that the Regence may seek relief for breach of this provision.

**ATTACHMENT B**  
**TO THE PARTICIPATING AGREEMENT**  
**LOCATIONS & IDENTIFICATION NUMBERS**

Entities Covered by this Agreement	Tax ID Number	National Provider Identifier	Address



**ATTACHMENT C**  
**AFFILIATES & SUBSIDIARIES**

As of the effective date of this Agreement, listed below are the affiliates and subsidiaries of Regence:

<b>Entity</b>	<b>Home Jurisdiction (State)</b>
Asuris Northwest Health	WA
BridgeSpan Health Company	UT
Healthcare Management Administrators	WA
LifeMap Assurance Company	OR
Regence BlueCross BlueShield of Oregon	OR
Regence BlueCross BlueShield of Utah	UT
Regence BlueShield	WA
Regence BlueShield of Idaho, Inc.	ID
ValueCare	UT

## ATTACHMENT D PROVIDER DISPUTE RESOLUTION PROCESS

### Glossary

**Adverse Determination (Appeal):** For purpose of the provider appeal process means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

- application of utilization review;
- determination that a treatment is not Medically Necessary; or
- denials related to upcoding (including DRG);
- application of a Current Procedural Terminology (CPT) modifier, and/or other reassignment of a code by us to patient specific factual situations, including the appropriate payment when two or more CPT Codes are billed together, or
- whether a payment enhancing modifier is appropriate.

**Appeal Record:** Includes all information which was relied upon in making the payment determination; or was submitted, considered, or generated in the course of making the payment determination, whether or not such document, record, or other information was relied upon in making the payment determination; or demonstrates compliance with Regence's Claims procedures, administrative processes and safeguards; or constitutes a statement of policy or guidance with respect to the payment determination.

**Claims:** A Provider's request for payment submitted in the usual course of business between the Provider and Regence.

**Dispute:** For purpose of the provider dispute process means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

- failure to secure Preauthorization
- failure to notify of Inpatient Admission
- determination that services are related to a Hospital Acquired Condition
- determination that records do not support billing during a Hospital Bill Review (Line Item Review)
- any other dispute that does not meet the definition of Adverse Determination outlined in the Glossary

**External Review:** Review of an Adverse Determination Appeal submitted to the External Review Organization with which we have contracted to provide these review services by a Provider in compliance with the terms of the Adverse Determination Appeal Process.

**External Review Organization ("ERO"):** An independent organization employing providers and other medically qualified individuals or experts, which acts as the decision maker for External Reviews, through an independent contractor relationship with us.

**"Our" or "We":** References to our or we mean Regence.

**Provider:** Provider means provider, practitioner, physician, medical group, clinic, hospital or other health care professional as defined in the Agreement.

**Provider Appeal:** Formal request from a contracted provider to reconsider an Adverse Determination when the provider is at financial risk for the services.

**"You" or "Your":** References to you or your mean provider, practitioner, physician, medical group, clinic, hospital or other health care professional as defined in the Agreement.

### Provider Appeals

## **MEDICAL, DENTAL AND HOSPITAL PROVIDER ADVERSE DETERMINATION APPEAL AND DISPUTE PROCESS:**

### **A. Applicability**

Our Provider Adverse Determination Appeal and Dispute Process will apply when the Provider is at financial risk for the cost of the claim. The member appeal process will apply when the member is or may be at financial risk for the cost of the claim.

The following are not eligible under the Adverse Determination Appeal or Dispute Process:

- (a) Appeals made by non-contracted providers. Appeals by non-contracted providers may be eligible for the member appeal process.
- (b) The member has filed suit under Section 502 of ERISA or other suit for denial of the health care services or supplies regarding an Adverse Determination.

### **B. Process for Submission of all levels of Adverse Determination Provider Appeals or Disputes**

1. Use the *Provider Appeal Form*, which can be found on our provider website at **regence.com**.
2. The completed appeal form or a written description of the issue(s) on the appeal must be submitted to us by facsimile to **1 (866) 273-1820**.

Very large documents or documents sent by certified mail may be sent to:

Regence  
Attention: Provider Relations  
Box 1248  
Lewiston, ID 83501-1248

Note: Federal Employee Program (FEP) appeals are not accepted by fax. They must be mailed to:

Regence - FEP  
P.O. Box 1388  
Lewiston, ID 83501-9998

3. The following information must be submitted with the *Provider Appeal Form* or the written description of the issue(s) on appeal:
  - (a) A detailed description of the disputed issue(s);
  - (b) The basis for disagreement with the decision; and
  - (c) All evidence and documentation supporting your position.

## **PROVIDER FIRST LEVEL (INTERNAL) APPEALS AND DISPUTES:**

### **A. Time Period for Submission of a Level One Adverse Determination Appeal or Dispute by Provider**

An Adverse Determination Provider Appeal or Dispute must be submitted in writing (with all applicable evidence/documentation to justify an overturn of the original denial) within the following timeframes.

1. Within 24 months after payment of the claim or notice that the claim was denied or 30 months for claims subject to coordination of benefits.

For Providers in Clark County, WA, within 18 months after payment of the claim or notice that the claim was denied or 30 months for claims subject to coordination of benefits.

2. If a Provider wishes to appeal a refund request initiated by us, he or she can submit an Appeal within the same timeframe as listed above. Note: The timeframe begins when the written request for refund is sent to the Provider.

Failure to request review with all applicable documentation within the stated time period will preclude the right to appeal and may jeopardize the right to contest the decision in any forum.

### **B. Level One Internal Appeal and Dispute Review Provisions**

1. The individual reviewing the issue(s) of the appeal/dispute will meet the following criteria:

- (a) Is not an individual who made or consulted in the initial determination,
  - (b) Is not a subordinate of an individual involved in the initial determination.
- 2. If your appeal/dispute determination is unfavorable in whole or in part, we will communicate a written decision on an Internal Review of an Adverse Determination Appeal within thirty (30) calendar days of our receipt of all documentation reasonably needed to make the determination. A description of the External Review option will be supplied with the written decision, including the time limit for requesting External Review.
- 3. Additionally, for unfavorable determinations in whole or in part, you have the option to seek a Level Two appeal/dispute. A description of the Level Two Review option will be supplied, including the time limit for requesting a Level Two Review which is ninety (90) calendar days after the written Internal Review determination.

### **C. Qualified Reviewer**

For an Internal Review of decisions involving Utilization Review or whether a treatment is Medically Necessary only a medical or dental provider holding an active, unrestricted license, who possesses the appropriate level of training and/or expertise required to evaluate the necessity of the service under review, and who is other than the one that made the initial Adverse Determination, may deny the appeal of the Provider who treated the condition. A nurse or other health care professional employed by us may review the Adverse Determination Appeal and may grant but not deny it. If the nurse or other health care professional does not grant the appeal, then a Qualified Reviewer, designated by us, other than the one that made the initial Adverse Determination, shall review and decide the Adverse Determination Appeal in accordance with our medical and reimbursement guidelines.

### **PROVIDER SECOND LEVEL REVIEW PROCESS:**

A second level review is available for Adverse Determination Appeals and Disputes.

### **LEVEL TWO ADVERSE DETERMINATION APPEALS (BINDING EXTERNAL REVIEW):**

If the initial determination is upheld through the Internal Review process, the option to seek External Review of the determination will be made available for Adverse Determination Appeals.

*Exception: Certain Facilities with unique provider agreements that do not specify an External Review option will be provided with the option for the Level Two Internal Dispute process.*

### **A. Prerequisites for Level Two Adverse Determination Appeals (Binding External Review):**

- 1. The Level One Internal Review process must be exhausted before requesting a Level Two External Review of the determination unless both we and the provider agree in writing to forego the Internal Review process and proceed directly to External Review.
- 2. A Provider who chooses External Review will submit a written notice to us within ninety (90) calendar days from the date of the Internal Review Determination.
- 3. The appeal meets the definition of Adverse Determination as described in the Glossary of Terms listed above.
- 4. Only one Level Two review is available. If provider utilizes a second level internal review process (for Facilities), a second level external review will not be made available.

### **B. Level Two Adverse Determination Appeals (Binding External Review) Provisions:**

- 1. An Adverse Determination Appeal may be submitted for External Review. If the amount in dispute is less than \$500, you have the option to request a cumulative appeal by notifying us that you intend to submit additional Adverse Determination Appeals for External Review on the same or similar issues during the one-year period following the submission of the original Adverse Determination Appeal and the cumulative amount in dispute over the one-year period exceeds \$500. The request for External Review is at the option of the provider, who may instead choose any other dispute resolution allowed by the Agreement. If chosen, the External Review shall be binding.
- 2. The Adverse Determination Appeal must be submitted to us in writing. The Administrative Manual and the Provider Appeal Form provides detailed contact information.

3. We will forward Adverse Determination Appeals that meet the prerequisites as listed in section A above to a designated External Review Organization.
4. The Provider shall pay a filing fee of \$50.00 for each Adverse Determination Appeal.
  - (a) We shall notify you that the filing fee is due
  - (b) Payment must be submitted before the External Review begins; provided, however, that you shall be entitled to a refund of such payment in the event that you prevail in the External Review process.
  - (c) You shall submit the filing fee within sixty (60) calendar days of notice from us that filing fee is due or the External Review request will be closed.
5. Upon receipt of a timely filing fee, we will provide to the External Review Organization the Appeal Record.
6. The External Review Organization will process the Adverse Determination Appeal and notify you and us of its recommendation within thirty (30) calendar days of receipt of the filing fee. The decision will be binding on us and you.
7. In the event that the External Review decision requires payment by us, such payment shall be initiated within fifteen (15) calendar days after we receive notice of the determination.

#### **LEVEL TWO DISPUTES (NON-BINDING INTERNAL REVIEW):**

If the initial determination is upheld through the Internal Review process, the option to seek a second level Internal Review of the determination will be made available for Disputes and/or for Adverse Determination appeals for certain facilities with unique provider agreements that do not specify an External Review option.

##### **A. Prerequisites for Level Two Disputes (Non-Binding Internal) Review:**

1. The Level One Internal Review process must be exhausted before requesting a Level Two Internal Review.
2. Provider must submit a written notice to us within ninety (90) calendar days from the date of the Level One Internal Review Determination Letter.
3. The appeal meets the definition of Dispute as described in the Glossary of Terms listed above. These disputes include:
  - Failure to secure Preauthorization
  - Failure to notify of Inpatient Admission
  - Determination that services are related to a Hospital Acquired Condition
  - Determination that records do not support billing during a Line Item Audit
4. Any other dispute that does not meet the definition of Adverse Determination outlined in the Glossary of Terms listed above.
5. Only one Level Two review is available. If provider utilizes a second external level review process outlined above, a second internal review will not be made available.

##### **B. Level Two Dispute (Non-Binding Internal) Review Provisions:**

1. The individual reviewing the issue(s) on appeal will meet the following criteria:
  - (a) Is not an individual who made or consulted in the initial determination,
  - (b) Is not a subordinate of an individual involved in the initial determination.
2. If your appeal determination is unfavorable in whole or in part, we will communicate a written decision on a Second Level Internal Review of the Dispute within thirty (30) calendar days of our receipt of all documentation reasonably needed to make the determination. This is the final level of dispute.

The provider has the option to request an in-person meeting. If no request for an in-person meeting is made, the process for review outlined above will proceed without one. If an in-person meeting is requested, the meeting will be held within 45 days of the written request. If your appeal determination is unfavorable in whole or in part, we will communicate a written decision on a Second Level Internal Review of the Dispute within thirty (30) calendar days of the in-person meeting. This is the final level of dispute.

## EXTERNAL AUDIT AND INVESTIGATION APPEAL PROCESS

The External Audit and Investigation Appeal Process is intended to give you an opportunity to request reconsideration of audit findings issued by our External Audit and Investigation Department and to ensure we have reviewed all information relevant to the audit findings. Please note that contract terminations resulting from audit findings must follow the Provider Contract Termination Appeal Process.

### Level I Appeal

Upon receipt of our audit findings, you have **forty-five (45) business days** to review and dispute these findings before the audit becomes final. In order to appeal the findings, you must submit a written request for appeal. You will be given the address for where to send your request.

The request must be received by us within **forty-five (45) business days** of your receipt of the audit findings and must include, at a minimum, the following:

- A detailed statement of the issue(s) in dispute
- At the election of the Provider, notification of a request for a meeting with the person(s) reviewing the issue(s) in dispute
- Any documents which the Provider contends supports his/her position  
(Exception: Please note that all documentation required to justify your billing, including but not limited to chart notes, must be present in your files at the time of an audit. Additions to file documentation and/or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)

If we do not receive such a request for appeal within forty-five (45) business days of your receipt of the audit findings, the findings will be final.

The Level I Appeal decision will be made by a manager of our External Audit and Investigation Department, and our other Regence representatives, as determined by the manager. At the discretion of the manager, one of our Medical Directors may be consulted prior to the final decision.

A meeting, prior to the review of your request for reconsideration, can be arranged either at your office, at our office, or by telephone, as mutually convenient. You must request this meeting when submitting your request for appeal.

At the meeting, you may appear in person and may be accompanied by an attorney or other representative. The purpose of this meeting is to give you an opportunity to present your position prior to the appeal determination.

If additional documentation to reach a decision is needed, the additional documentation must be submitted within **twenty (20) calendar days** of the date of our written request for information, unless your written request for a reasonable extension of time is granted.

- If the requested documentation is received on time, it will be included in the request for appeal.
- If the documentation is not received on time, the appeal will continue and a decision will be made based on the information originally submitted.

During the period of time in which we are waiting for additional information, the appeal decision time frame is suspended until the information is received or the time to respond to the request has expired.

You will be sent written notice of the decision within **forty-five (45) business days** following the meeting or, if no such meeting was requested, within **forty-five (45) business days** of our receipt of the Level I Appeal.

The decision on a Level I Appeal is deemed final forty-five (45) business days after your receipt of our decision, unless a timely written request for a Level II Appeal is received.

### B. Level II Appeal

If you are not satisfied with the decision made following the first request for appeal, you may request a second appeal of the audit findings. The written request for a Level II Appeal and any supporting information, must be received by us within **forty-five (45) business days** of your receipt of our decision. The address where to send your request will be included in our response to your Level I Appeal.

Level II Appeals are categorized as either a clinical dispute or a non-clinical dispute.

For clinical disputes, a Medical Director review will be held no more than forty-five (45) business days following receipt of the request, not including the time in which we are waiting for additional information from you. The review will be conducted by a Medical Director who was not involved in an earlier review of the audit findings.

For non-clinical (administrative/contractual) disputes, a decision will be made by a manager of the External Audit Department not involved in an earlier review of the audit findings, and/or other Regence representatives, as deemed by the manager.

If additional documentation is needed to reach a decision, the additional documentation must be submitted within **twenty (20) calendar days** of the date of our written request for information, unless your written request for a reasonable extension of time is granted.

- If the requested documentation is received on time, it will be included in the request for appeal.
- If the documentation is not received on time, the appeal will continue and a decision will be made based on the information originally submitted.

During the period of time in which we are waiting for additional information, the forty-five (45) business day clock is suspended until the information is received or the time to respond to the request has expired.

You will be sent written notice of the decision within **forty-five (45) business days** following the Medical Director review, for a clinical dispute, or **forty-five (45) business days** following receipt of the Level II appeal, for a non-clinical dispute.

**The Level II Appeal is the final step in the External Audit and Investigation Appeal Process. Once a decision has been made, the External Audit and Investigation Appeal Process has been completed and the decision shall be deemed final. If you are not satisfied with our decision after completing the External Audit and Investigation Appeal Process and want to continue to dispute the issue(s), you must initiate the appropriate process(es) as outlined in your Provider contract.**

#### **Provider Contract Termination Appeals**

A contracted Provider may initiate an appeal of a contract termination decision made by us through the Provider Contract Termination Appeal Process.

#### **A. Level One Appeal**

To request a Level One Appeal, you must send a written request to our Credentialing Department, at the address listed below within **thirty (30) business days** of receipt of the termination notification.

By facsimile: 1 (888) 335-3002

By mail: Provider Contract Termination Appeal - Level One  
*Attention: Credentialing Department*  
P.O. Box 21267, M/S S-555  
Seattle, WA 98111-3267

A request for an appeal regarding a contract termination must include, at a minimum:

- A detailed description of the disputed issue(s)
- The basis for your disagreement with the decision
- All evidence and documentation supporting your position  
 (Exception: Please note that all documentation required to justify your billing, including, but not limited to, chart notes, to be present in your files at the time of an audit. Additions to file documentation or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)
- Your requested outcome

Upon receipt of the Level One Appeal request, we will send you an acknowledgement letter within **fifteen (15) business days**.

The Level One Appeal Panel is comprised of at least three (3) individuals that have not been directly involved in the Credentialing Committee or termination decision and have the appropriate level of knowledge and training to understand the issues presented. At least one panel member must be a Participating Provider.

Level One Appeals meetings are held on a bi-monthly basis. Your appeal will be scheduled for review at the next available Level One Appeal Panel meeting, subject to the time that your appeal request and any additional information are received and the volume of appeals being reviewed by the panel.

If additional information is requested, it must be submitted within **fifteen (15) business days** of the date of the written request for information, unless a written request for a reasonable extension of time is granted.

- If the information is not received on time, a decision will be made at the next Level One Appeal Panel meeting, based on the limited information available.
- If the additional information is received on time, the new information will be taken into consideration at the next Level One Appeal Panel meeting.

Information not submitted within the time limit will not be considered for the Level One Appeal, unless otherwise allowed by the Level One Appeal Panel.

You will receive a written determination within **ten (10) business days** of the Level One Appeal Panel decision.

**The Level One Appeal decision is deemed final on the thirtieth (30<sup>th</sup>) business day after you receive it, unless a written request for a Level Two Appeal is received timely.**

#### **B. Level Two Appeal – “In-Person Hearing”**

If you are not satisfied with the results of the Level One Appeal, you may submit a written request to the Credentialing Department, at the address listed below, for a Level Two Appeal, “in-person hearing” no later than **thirty (30) business days** after your receipt of the Level One Appeal decision.

By facsimile: 1 (888) 335-3002

By mail:

Provider Contract Termination Appeal - Level Two  
*Attention: Credentialing Department*  
 P.O. Box 21267, M/S S-555  
 Seattle, WA 98111-3267

The Level Two Appeal Panel is comprised of at least three (3) individuals that have not been directly involved in the Level One Appeal, the Credentialing Committee, or the termination decision and have the appropriate level of knowledge and training to understand the issues presented. At least one panel member must be a Participating Provider.

The request for a Level Two Appeal must identify in detail the following:

- All issues on which you request re-evaluation
- Information not previously submitted to the Level One Appeal panel, if any  
 (Exception: We expect all documentation required to justify your billing, including, but not limited to, chart notes, to be present in your files at the time of an audit. Additions to file documentation or the production of files that were not made available to us at the time of an audit will not be considered in connection with an appeal involving adverse audit findings. We will, however, consider your explanation as to why the documentation was not present at the time of the audit.)
- Your requested outcome

The hearing is generally completed within two (2) hours and will be scheduled for two (2) hours, unless you notify us when requesting your Level Two Appeal that additional time is needed. We will make our best efforts to accommodate reasonable requests for additional time, as long as we are notified when you request the Level Two Appeal.

Upon receipt of the Level Two Appeal request, we will send you an acknowledgement letter within **fifteen (15) business days**.



Level Two Appeals meetings are scheduled upon request. We will make our best efforts to provide proposed times and dates within sixty (60) business days of our receipt of your Level Two Appeal request. Once you have been provided the proposed times and dates you will have five (5) business days to notify us of your preferred time and date for the Level Two Appeal hearing. If you fail to notify us of your preferred time and date for the Level Two Appeal hearing within five (5) business days of receiving the proposed times and dates, the hearing will be set on one of the proposed times and dates.

Prior to the Level Two Appeal hearing, you will receive a **"Notice of Hearing"**. The "Notice of Hearing" will indicate the following:

- Date of the hearing
- Time of the hearing
- Location of the hearing
- Names of the members of the Level Two Appeal panel
- Reasons for the adverse action
- Names of witnesses who will testify on our behalf at the hearing
- Your rights at the hearing

At the hearing, you have the following rights:

- To have representation by an attorney or other person of your choice
- To have a court reporter make a record of the proceedings at an additional cost to you. Costs associated with the court reporter must be paid by you prior to receiving a copy of the transcript
- To call witnesses and to examine/cross-examine witnesses
- To present relevant evidence (as determined by the panel)
- To submit a written statement at the close of the hearing

Approximately **thirty (30) calendar days** before the scheduled date of the hearing, a Level Two Appeal binder will be sent to you or your representative. The binder will include, among other things, the documentation reviewed by the Credentialing Committee initially and at the Level One Appeal, as well as any documentation submitted by you. If you wish to submit additional information to further supplement the Level Two Appeal binder, this information, as well as a list of witnesses that you plan to call, examine, and cross examine at the hearing, must be received no later than **fourteen (14) calendar days** prior to the hearing date. Unless otherwise allowed by the Level Two Appeal panel, documentation and witnesses not submitted at least **fourteen (14) calendar days** prior to the hearing date will not be considered by the Level Two Appeal panel and should not be brought to the hearing for the panel's consideration. The only exception is that you may submit a written statement at the close of the hearing.

If the Level Two Appeal binder is later supplemented with new or revised information prior to the hearing, you will receive copies of the new or revised material as soon as practicable before the scheduled date of the hearing. After the Level Two Appeal binder has been finalized, it will be forwarded to the Level Two Appeal panel for review prior to the hearing. Neither you nor we may supplement the binder within thirteen (13) calendar days prior to the hearing, unless a written request for an exception is approved by the Chair of the Level Two Appeal panel.

You will receive written notification of the Level Two Appeal decision within **fifteen (15) business days** of the hearing. If the Level Two Appeal panel cannot reach a decision within **fifteen (15) business days**, or if additional information is needed to reach a decision, you will be informed of any additional information needed and a new date by which the decision will be made.

**Decisions of the Level Two Appeal panel related to contract terminations are deemed final. Once a decision has been made by the Level Two Appeal panel, you have completed the Provider Contract Termination Appeals process. If you are not satisfied with our decision after completing the Provider Contract Termination Appeal process and want to continue to dispute the issue(s), you must initiate the appropriate process(es) as outlined in your Provider contract.**

## **C. Additional Information Regarding the Provider Contract Termination Appeals Process**

### **a. Provider Status During a Contract Termination Appeal**

You will continue as a Participating Provider, however you will be temporarily removed from all provider directories and any pending action by us is put in abeyance until the appeal is resolved and a final decision is made. If, however, the basis for the termination decision relates to the health, safety or welfare of our members,

or if the we have exercised our right to immediately terminate the Provider contract for reasons allowed by the Provider contract, your participation status will be terminated for the duration of the appeal process and reinstated only if you prevail during the Provider Contract Termination Appeal process.

**b. The Data Bank Reportable Actions**

We are required by law to report certain adverse actions or decisions against you to the National Practitioner Data Bank (Data Bank). If our termination decision stands, either by virtue of you choosing not to appeal or if the decision is upheld by the appeals panel, we may be obligated to report this termination to the Data Bank, as applicable. You may not “self-term” to avoid being reported to the Data Bank. Additional information on these reporting requirements is available on the Data Bank website, at [www.npdb.hrsa.gov](http://www.npdb.hrsa.gov).