

**This is not a valid contract for execution.**  
**Contact SWHP Provider Relations at 254-298-3064.**

**SCOTT AND WHITE HEALTH PLAN  
PARTICIPATING PROVIDER AGREEMENT**

This Participating Provider Agreement (“Agreement”) is made and entered into to be effective as of the \_\_\_\_\_ day of \_\_\_\_\_, Choose month, Choose year, (the “Effective Date”) by and between Scott and White Health Plan (“SWHP”) and (“Provider”).

**RECITALS**

WHEREAS, SWHP is a corporation that has a certificate of authority to operate as a health maintenance organization in the State of Texas under Chapter 20A of the Texas Insurance Code; and

WHEREAS, SWHP is authorized to arrange for the delivery of health care services to Covered Persons; and

WHEREAS, Provider is an individual or Group (as defined below) that is qualified to provide or arrange for the provision of health care services and/or medical products; and

WHEREAS, SWHP desires to enter into an agreement with Provider to arrange for the provision of Covered Services to Covered Persons as provided in this Agreement:

NOW, THEREFORE, for and in consideration of the premises and of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, SWHP and Provider agree as follows:

**I. DEFINITIONS**

“**Agreement**” means this contract, along with all amendments, attachments, addendums, and exhibits attached hereto.

“**Benefit Determination**” means a statement from SWHP or a Payor that a proposed medical care or health care service is a Covered Service under a Plan. A Benefit Determination is not a Statutory Verification.

“**Clean Claim**” means a non-electronic claim that is submitted on a UB92 or HCFA 1500 form (or their successors) and accurately contains all the following information: patient’s name; patient’s date of birth; Covered Person’s identification number; Provider’s name, address and tax identification number; date(s) and place of service or purchase; diagnosis narrative and ICD-9 code; procedure narrative and CPT-4 code; services and supplies provided; Provider’s license number; and Provider’s charges. Electronic claims must comply with federal laws (HIPAA) applicable to electronic claims, subject to applicable implementation guides, companion guides, and trading partner agreements.

“**Claims Payment Period**” means 45 days from receipt of a Clean Claim for non-electronic claims, and 30 days from receipt of a Clean Claim for electronic claims.

“**Confirmation of Eligibility**” means a statement from SWHP or a Payor in response to an inquiry from Provider that a patient is shown to be currently eligible as a Covered Person. A Confirmation of Eligibility is not a Statutory Verification.

“**Copayment**” means that portion, if any, of the cost of the Covered Services that a Covered Person is obligated to pay under a particular Plan, including any deductible or coinsurance.

“**Covered Person**” means a person who is eligible to receive Covered Services under a Plan.

“**Covered Services**” means Medically Necessary health care services and supplies that are available to Covered Persons pursuant to a Plan (except Excluded Services).

**“Declination”** means SWHP’s or a Payor’s response to a request for Statutory Verification in which a Statutory Verification is not issued. A Declination is not a determination that a Clean Claim resulting from the proposed service will not ultimately be paid.

**“Emergency”** means a medical condition of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person’s condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in (1) serious impairment to bodily functions, (2) serious dysfunction of any body organ or body part, (3) placing a Covered Person’s health in serious jeopardy, (4) serious disfigurement, (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus, or (6) an Emergency Behavioral Health Condition. Accordingly, “Emergency Care” or “Emergency Services” means the healthcare services provided in a hospital emergency facility or comparable facility to evaluate and stabilize the Emergency. In no event will “Emergency” be interpreted under this Agreement so as to conflict with emergency service obligations under federal or state law.

**“Emergency Behavioral Health Condition”** means any condition, without regard to the nature or cause of the condition, which requires immediate intervention and/or medical attention without which an individual would present an immediate danger to himself/herself or others or which renders the individual incapable of controlling, knowing, or understanding the consequences of his/her actions.

**“Excluded Services”** means those health care services and supplies which are determined not to be Medically Necessary or which otherwise are not Covered Services under the applicable Plan.

**“Group”** means a professional association, nonprofit corporation, professional limited liability company, individual practice association, or other public or private entity, that is qualified to provide or arrange for the provision of professional health care services and/or medical products to Covered Persons.

**“Health Plan”** or **“Plan”** means a contract with or evidence of coverage issued by SWHP or a Payor to a federal or State instrumentality, employer, group, or individual under which payment for health care services is provided, or an agreement or contract issued to an employer or group on a self-funded basis that is administered by SWHP.

**“Medically Necessary”** shall have, for purposes of determining whether a service is a Covered Service under this Agreement, the same meaning as set forth in the applicable Covered Person’s Health Plan.

**“Participating Provider”** or **“Provider”** means a physician or other professional (individual or Group), who or which (1) has entered into a written agreement to provide Covered Services to Covered Persons, (2) is duly licensed under applicable State law, and (3) is currently credentialed and designated by SWHP or its designee as a Participating Provider.

**“Payor”** includes SWHP or the federal government or the State of Texas, that provides, administers, funds, insures, or is responsible for paying Participating Providers or SWHP for Covered Services rendered to Covered Persons under a Plan covered by this Agreement.

**“Policies”** mean the policies and procedures of SWHP as set forth in its Provider Manual, as it may be amended from time to time.

**“Primary Care Physician”** or **“PCP”** means a Participating Provider who holds an unrestricted license to practice medicine (allopathic or osteopathic) in the State of Texas, and who is responsible for coordinating and managing the delivery of Covered Services to Covered Persons who have selected or been assigned to such physician.

**“Prior Authorization”** means the approval by SWHP or other permitted person or entity, prior to admitting a Covered Person to a hospital, or prior to providing certain other Covered Services to a Covered Person, which approval may be required under SWHP’s Utilization Management Program. A Prior Authorization is not a Statutory Verification.

**“Quality Assurance Program”** means the functions including, but not limited to, credentialing and certification of providers, review and audit of medical and other records, outcome rate reviews, peer review, and provider appeals

and grievance procedures performed or required by SWHP, a Payor, or any other permitted person or entity, to review the quality of Covered Services rendered to Covered Persons.

**“Referral”** means, when required under a Health Plan, the written approval from the Covered Person’s Primary Care Physician (usually for a specified number of visits, treatments, or period of time) for a Covered Person to receive Covered Services from a physician (usually a Specialist) or other health care professional, organization, or facility.

**“Specialist”** means a physician or dentist who (1) is a Participating Provider; (2) holds an unrestricted license to practice allopathic or osteopathic medicine, or dentistry, in the State of Texas; (3) is engaged in a specialty medical practice; (4) accepts referrals from Primary Care Physicians for the purpose of providing Covered Services to Covered Persons within that specialty; and (5) is not a specialty care physician who meets the criteria of a “Primary Care Physician” as defined above.

**“Statutory Verification”** means a guarantee of payment pursuant to the Texas Insurance Code by SWHP or a Payor that a proposed medical care or health care service will be paid for if such service is rendered within 30 days to the Covered Person for whom the services are proposed. Statutory Verification is only available for Plans regulated by the Texas Department of Insurance. Statutory Verification is not available for Medicare replacement plans or ERISA self-insured plans.

**“Urgent Care”** means urgent care services provided in a situation other than an Emergency which are typically provided in a setting such as a physician’s office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable amount of time will result in serious deterioration of the condition of his or her health.

**“Utilization Management Program”** means those functions, including, but not limited to, Prior Authorization, Referral, and prospective, concurrent, and retrospective review, performed or required by SWHP, a Payor, or any other permitted person or entity, for the purpose of reviewing and determining whether medical services or supplies which have been or will be provided to Covered Persons are covered under a Health Plan and are Medically Necessary.

## II. OBLIGATIONS OF PROVIDER

- A. **Provision of Covered Services.** In consideration of the compensation described in the attached Addendum(s) and Exhibit(s), Provider agrees to provide or arrange for the provision of Covered Services to Covered Persons. Provider agrees to make available and provide to Covered Persons all Covered Services that are within the scope of Provider’s licensure, expertise, and usual and customary range of facilities and personnel of Provider. Provider agrees to provide Urgent Care within 24 hours of contact by the Covered Person or person acting on behalf of the Covered Person.

Provider will be solely responsible for all health care products and services provided by Provider to Covered Persons. Neither SWHP nor any Payor shall be liable for or exercise control or direction over the manner or method by which Provider provides its services under this Agreement. Provider understands that SWHP or a Payor may be entitled to deny payment for services rendered to a Covered Person which it determines are not Medically Necessary, are not Covered Services, or are not otherwise provided in accordance with the Plan. Such a denial of Medical Necessity is made for purposes of determining financial liability only and does not absolve Provider of its responsibility to provide appropriate services to Covered Persons.

- B. **Continuity of Care.** If this Agreement terminates for any reason, or if SWHP becomes insolvent or fails for any reason to pay compensation for Covered Services as required by this Agreement, Provider nevertheless agrees that, at SWHP’s request, Provider shall continue to treat each Covered Person then in the course of treatment. Provider shall not bill Covered Persons or person acting on their behalf for Covered Services rendered during such period. Payor will reimburse provider for such continued course of treatment under the terms of this Agreement.
- C. **Credentialing of Providers.** Provider (other than a hospital-based provider, see below) shall be responsible for completing the Credentials Application in its entirety. If Provider is a Group, the Group shall be responsible for

completing a Credentials Application for every provider within the Group who will render Covered Services under this Agreement. The submitted Credentials Application(s) is a part of this Agreement. In no event will this Agreement become effective, nor will a provider begin providing Covered Services under this Agreement, until the Credentials Application has been accepted and approved in writing by SWHP or its designee; provided, however, that if this Agreement is with a Group, the Agreement may be executed prior to acceptance by SWHP of all Group Providers' Credential Applications. Each provider for whom a Credentials Application was submitted shall be notified in writing whether he/she is approved by Payor or its designee to be a Participating Provider. Provider (or Group, if applicable) shall promptly notify SWHP of any changes in the credentialing information furnished and shall provide a complete updated listing to SWHP annually.

**For hospital-based providers ONLY:** As a hospital-based provider, Provider will not be credentialed by SWHP, but shall be full credentialed by all hospitals that are Participating Provider at which Provider provides Covered Services. Provider will not be listed separately in payor's provider directories

- D. Provider Representations and Warranties. Provider represents and warrants that it:
- (1) is duly licensed in the State of Texas and hold a current DEA narcotic registration certificate and a current DPS license, as applicable, and shall maintain such licensure, compliance, certification, and registration throughout the duration of this Agreement;
  - (2) shall provide Covered Services consistent with the terms and conditions of this Agreement (including any applicable Addendum or Exhibit), and with the standard of care for the geographic area, and in compliance with all applicable local, State, and federal laws, rules, and regulations;
  - (3) is eligible to participate in the Medicare and Medicaid programs;
  - (4) shall maintain all required professional credentials and meet all continuing education requirements necessary to retain Board certification or eligibility in such Provider's area(s) of practice; and
  - (5) shall maintain policies of general liability, professional liability, and other insurance as required by this Agreement.
- E. Notice to SWHP. Provider shall notify SWHP within 24 hours in the event (1) any of the requirements set forth in Section II(E) are not met or maintained; (2) Provider's agreement with a Participating Group Provider terminates for any reason; or (3) Provider knows of an occurrence that may cause the immediate termination of a Participating Group Provider under Section XI(D) of this Agreement.
- F. Eligibility. Except in an Emergency, Provider shall confirm the current eligibility of patients identifying themselves as Covered Persons (in accordance with the policies and procedures set forth in SWHP's Provider Manual) before arranging for the provision of Covered Services. Confirmation of Eligibility is not to be construed as a Statutory Verification for services rendered to the Covered Person.
- G. Non-Discrimination. Provider agrees to accept Covered Persons as patients on the same basis that Provider accepts other patients. Provider agrees to render services to Covered Persons in the same manner as provided to Provider's other patients.
- H. Facilities, Equipment, and Personnel. Provider shall maintain such facilities, equipment, patient services personnel, and allied health personnel as may be necessary to provide the Covered Services under this Agreement. Provider agrees to permit SWHP (and/or any representative of a local, state or federal regulatory agency having jurisdiction over SWHP, a Payor, or any Health Plan) to conduct site evaluations and inspections of Provider's facilities and service locations as may be needed to assure quality of care rendered to Covered Persons. In the event the right of access is requested under this Section, Provider shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the personnel conducting the audit or inspection.
- I. Prior Authorization. Provider shall comply with all administrative requirements of SWHP as set forth in its Provider Manual regarding prior authorization and precertification. Provider agrees not to seek payment for

Covered Services rendered to a Covered Person unless Prior Authorization was obtained for the rendering of such services as required by the Provider Manual. Provider is not required to obtain Prior Authorization in the event of an Emergency. Prior Authorization is not to be construed as a Statutory Verification for services rendered to the Covered Person.

- J. Notification of Emergency Services. In the event Emergency services are performed, Provider agrees to notify SWHP by the end of the next business day (1) after admission and identification of a Covered Person as an inpatient, or (2) after rendition of outpatient Emergency services to a Covered Person.
- K. Certification and Regulatory Compliance. Provider shall, at all times during the term of this Agreement, satisfy all State and federal certifications, regulations, or licensure requirements. Evidence of such licensing, if applicable, shall be submitted to SWHP upon request. Provider agrees to give immediate notice to SWHP in the case of suspension or revocation, or initiation of any proceeding that could result in suspension or revocation, of such licensure. In addition, Provider agrees to render services under this Agreement in compliance with all applicable laws and regulations.
- L. Cooperation with Medicaid Fraud Control Unit. Provider shall permit the Texas Medicaid Fraud Control Unit to conduct private interviews with Provider's officers, directors, employees, agents, personnel, witnesses, and patients and to comply with requests from the Texas Medicaid Fraud Control Unit in the form and language requested by the Texas Medicaid Fraud Control Unit. Provider agrees that it will cooperate fully in making its officers, directors, employees, agents, and personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trial, and in any other process, including investigations, at Provider's own expense.
- M. Notice of Adverse Action. Provider shall notify SWHP in writing within five (5) working days (or such lesser period of time as required by applicable law) of receiving any written notice of any adverse action (including, without limitation, any malpractice suit or arbitration action involving a Covered Person, naming or otherwise involving Provider a Group Provider (if applicable), or SWHP), or of any other event, occurrence, or situation that might materially interfere with, modify, or alter performance of any of Provider's duties or obligations under this Agreement.
- N. Covered Person Complaints. Provider shall forward to SWHP any written complaint or grievance of a Covered Person against Provider, a Group Provider (if applicable), a Payor or SWHP within the following timeframes:
1. immediately for an emergency situation or situations that involve denial of a continued inpatient stay; or
  2. within three working days for all other complaints or grievances.
- Provider shall maintain a written record of any complaint by a Covered Person, and provide such record to SWHP or Payor promptly upon request.
- O. Non-Solicitation. With respect to a Covered Person or potential Covered Person, neither Provider nor any employee, agent, contractor, or subcontractor of Provider, shall perform any of the following actions: solicit or encourage any person to enroll in any Health Plan; discourage any person from enrolling in any Health Plan; solicit any Covered Person to purchase services or goods not covered under the Health Plan from which Provider directly or indirectly benefits; solicit or encourage any Covered Person to disenroll from Health Plan; or discourage any Covered Person from disenrolling in Health Plan.
- P. Payment of Applicable Taxes. Provider shall be solely responsible for the payment of any sales, use, or other applicable taxes on the sale or delivery of medical services.
- Q. Provider Manual. Provider agrees to comply with all policies and procedures set forth in SWHP's Provider Manual, as amended from time to time. Provider shall receive not fewer than thirty (30) days prior written notice of any material modification or amendment (for convenience, "modification") to the Provider Manual. If such modification is not mandated by applicable law, and (1) materially increases the administrative burdens of

Provider under this Agreement, or (2) materially and adversely affects the compensation to be paid to Provider under this Agreement, then Provider may object to such modification by delivering written notice to SWHP prior to the expiration of such thirty (30) day period, in which case such modification shall not apply to Provider; provided, however, that SWHP shall be entitled upon receiving notice of such objection to terminate this Agreement on not fewer than thirty (30) days further written notice to Provider.

- R. Supervision of Personnel. Provider agrees, to the extent he/she/it employs physician assistants, advanced practice nurses, dental hygienists, and other individuals other than physicians to assess the health care needs of Covered Persons, to have written policies which are implemented and enforced that describe the duties of such personnel in accordance with statutory requirements for licensure, delegation, collaboration, and supervision, as appropriate. Such written policies shall be available for review by SWHP or Payor upon request.
- S. Complaint Resolution Notice. Provider shall post a notice, in a location reasonably certain to be seen by all Covered Persons, of the process for resolving complaints with SWHP, including the Texas Department of Insurance's toll-free telephone number for filing complaints.
- T. Hold Harmless. Provider agrees that in no event, including, but not limited to, non-payment by SWHP or SWHP's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any other recourse against any Covered Persons or persons acting on their behalf other than SWHP for services provided under this Agreement. This provision shall not prohibit collection of Copayments or supplemental charges on SWHP's behalf made in accordance with the terms of the applicable Plan. Provider further agrees that the terms of this Section shall: (1) survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Covered Persons; and (2) supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and Covered Persons or persons acting on their behalf. Any modification, addition, or deletion of or to the provisions of this Section shall be effective on a date no earlier than fifteen (15) days after the Texas Commissioner of Insurance has received written notice of such proposed change. Provider shall cooperate with SWHP to ensure that any payments received from Covered Persons by Provider in violation of this provision are reimbursed to the Covered Person. Repeated violation of this provision may result in the termination of this Agreement and a reporting of Provider's violation to the Texas Board of Medical Examiners and the Health Care Integrity and Protection Data Bank.
- U. Insurance Requirements. Provider agrees to continuously maintain at all times during the term of the Agreement malpractice insurance in the minimum amounts of \$\_\_\_\_\_ per occurrence and \$\_\_\_\_\_ annual aggregate for each individual who provides services to Covered Persons under this Agreement. Provider shall also maintain at all times during the term of this Agreement general commercial liability (all risk) insurance covering Provider, its agents and employees at all locations where Provider performs services for Covered Persons in the minimum amounts of \$5,000,000 per occurrence and \$5,000,000 annual aggregate.
- V. Statutory Verification. Provider has the option to request Statutory Verification prior to rendering services to Covered Persons. A request for Statutory Verification will only be considered upon presentation of the Statutory Verification elements defined in the Provider Manual, which shall in no instance be more onerous than the Statutory Verification elements allowed by Texas law. In the event that SWHP responds to a request for Statutory Verification with a Declination, but is able to provide a Confirmation of Eligibility, Benefit Determination, and if appropriate, Prior Authorization, Provider shall provide requested medical or health care services to the patient, absent an indication from the patient that they are not a Covered Person. A Declination is not a prospective claims denial, it is simply a refusal by SWHP to guarantee payment on a prospective basis.

### **III. UTILIZATION MANAGEMENT AND QUALITY ASSURANCE**

- A. Utilization Management Program. Provider shall participate in, cooperate with, and comply with all decisions rendered in connection with the applicable Utilization Management Program. Provider shall (1) provide, at its own expense, such records and other information as may be required or requested under such Utilization Management Program, and (2) comply with all confidentiality requirements regarding a Utilization Management Program.

- B. Quality Assurance Program. The quality of Covered Services provided to Covered Persons shall be monitored under the Quality Assurance Program applicable to the particular Plan. Provider shall (1) participate in, cooperate with, and comply with all decisions rendered by SWHP or the applicable Payor in connection with a Quality Assurance Program, (2) provide at its own expense medical records, review data and such other records and information as may be required or requested under a Quality Assurance Program, and (3) comply with all confidentiality requirements regarding a Quality Assurance Program. In the event that the standard or quality of care furnished by Provider is found to be unacceptable under any Quality Assurance Program, SWHP shall give written notice to Provider to correct the specified deficiencies within the time period specified in the notice. Provider shall correct such deficiencies within that time period. Provider shall perform such quality management in accordance with the performance standards and criteria of SWHP or a Payor.
- C. Limitation. Nothing in this Section shall be construed to authorize SWHP any of SWHP's officers or employees, to exercise any control over the practice of medicine by Provider or the manner in which Provider provides medical services.

#### IV. LIABILITY FOR EXCLUDED SERVICES

Prior to the provision of any Excluded Service to a Covered Person, Provider shall obtain written confirmation from such Covered Person that (1) he/she has been informed in writing of the services to be provided, (2) the services to be provided are not covered under the Covered Person's Health Plan, (3) neither SWHP nor any Payor will pay for or be liable for said services, (4) Covered Person requests that such Provider render the Excluded Services, and (5) such Covered Person will be financially liable for such services.

#### V. OBLIGATIONS OF SWHP

- A. Compensation. Provider's compensation is described in the Addendum(s) and Exhibit(s) to this Agreement.
- B. Insurance. SWHP agrees to maintain coverages of comprehensive general liability and other insurance as necessary in SWHP's discretion to insure SWHP and its agents, servants, and employees, acting within the scope of their duties, against any claim(s) for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance or non-performance of any service provided under this Agreement.
- C. Identification Cards. SWHP shall issue each Covered Person an identification card or similar item setting forth, at a minimum, the Covered Person's name, identification number, Primary Care Physician (if assigned or selected as of the date the card is issued), and any other information required by applicable state or federal law or regulation.
- D. Retaliation. SWHP shall not engage in any retaliatory action, including terminating or refusing to renew this Agreement, because Provider has, on behalf of a Covered Person, reasonably filed a complaint against SWHP or appealed a decision of SWHP.
- E. Claims Processing Information. Provider has the right to request information regarding compensation and claims processing procedures. Provider must make such request in writing. SWHP shall provide sufficiently detailed information to allow Provider to determine the payment to be made for Covered Services no later than the 30<sup>th</sup> day following SWHP's receipt of Provider's request. SWHP shall give Provider at least 60-days notice of any amendments to claims processing procedures prior to the implementation of such procedures. Information supplied by SWHP to Providers pursuant to a Provider request under this provision shall be confidential and proprietary. Any improper use or distribution of information by Provider is prohibited. Improper use or distribution of information received by Provider under this provision may result in SWHP seeking damages, injunctive relief, attorney's fees, and court costs, and may constitute a breach of this Agreement justifying termination.
- F. Statutory Verification. SWHP shall respond to a request for Statutory Verification upon receipt of the required elements contained in the Provider Manual. The timelines for response to a Request for Statutory Verification are also listed in the Provider Manual. In the event SWHP is unable to guarantee payment based upon the information derived from the Statutory Verification required elements and investigation by SWHP, a Declination will be issued within the applicable timeframe. A Declination is not a prospective denial of a claim, it is simply a refusal to guarantee payment. If SWHP is able to provide Confirmation of Eligibility, Benefit Determination and Prior Authorization, if appropriate, SWHP will do so. Statutory Verification is only available for Plans regulated by the

Texas Department of Insurance. Statutory Verification is not available for Medicare replacement plans or ERISA self-insured plans.

## VI. FINANCIAL MATTERS

- A. Compensation Rates. In consideration of the compensation described in the Addendum(s) and Exhibit(s) to this Agreement, Provider agrees to make available and provide to Covered Persons all Provider services.
- B. Copayments. The collection of Copayments, when applicable, is the sole responsibility of Provider. All Copayments are due and payable by Covered Persons at the time of service or Provider may bill the Covered Person directly. Provider shall collect all required Copayments due from Covered Persons, and shall not routinely waive or fail to pursue collection of such Copayments from Covered Persons. Provider will not discriminate in any way against any Covered Persons regarding waiver of Copayments. Provider agrees not to violate the Center of Medicare and Medicaid Service's stance regarding the waiver of Medicare Copays. Provider will only waive Copays in extraordinary circumstances that do not violate any of the above-referenced conditions. Provider's reimbursement shall be reduced by Copayments stated in the Health Plan.
- C. No Surcharges. Other than authorized copayments, Provider shall not charge any Covered Person any fees or surcharges for Covered Services rendered pursuant to this Agreement Provider shall not collect any sales, use, or other applicable tax from Covered Persons for the sale or delivery of medical services.
- D. Conditions for Reimbursement for Excluded Services. Neither Covered Person, SWHP, nor any Payor shall be liable to pay Provider for any service rendered to a Covered Person that is determined under a Utilization Management Program not to be Medically Necessary, or for any other Excluded Service; provided, however, Provider may bill a Covered Person for Excluded Services if Provider has obtained written confirmation from the Covered Person in accordance with the provisions of Section IV ("Liability for Excluded Services").
- E. Coordination of Benefits. Provider shall make reasonable efforts to obtain information concerning alternate sources of payment for Covered Services rendered to Covered Persons. In the event SWHP is primary, SWHP shall pay the amounts due under this Agreement reduced by all applicable Copayments, coinsurance and deductible amounts. In the event SWHP is other than primary, or is otherwise secondary to any other coverage (including but not limited to Medicare), SWHP shall pay the lesser of the amounts which, when added to the amounts received by Provider from all other sources, equals one hundred percent (100%) of the amount required by this Agreement in the Addendum(s) and/or Exhibit(s), or the Covered Person's liability for deductible and co-payment amounts. SWHP's payment of secondary benefits shall be contingent upon Provider's submission of the amount paid by the primary payor.
- F. Recoveries from Third Parties. Provider shall cooperate with SWHP in determining whether a Covered Person's illness or injury is covered by automobile insurance, workers' compensation or other health insurance, or otherwise gives rise to a claim by SWHP by virtue of coordination of benefits or subrogation. Provider agrees to take all reasonable actions to assist SWHP in obtaining recoveries from third parties, including executing any and all documents that reasonably may be required to engage SWHP to bill and/or collect payments from any third parties or to assign payments to SWHP. As applicable, Provider shall also seek payment from applicable third party payors who have payment responsibility, except that Provider agrees to allow SWHP to acquire and exercise full and exclusive rights of subrogation whenever such a third party is liable for payment for services that are provided by Provider and for which SWHP would otherwise be responsible hereunder.

## VII. RECORDS AND REPORTS

- A. Maintenance of Administrative Records. Provider shall retain for a minimum of five (5) years (except for Title XIX Rural Health Hospital records which shall be retained for a period of six (6) years following termination of this Agreement) such financial, administrative, and other records as may be necessary for SWHP or Payor to comply with all applicable local, State, and federal laws, rules, and regulations. Provider shall make such records or documents available to SWHP or its authorized agents, Payor or its authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services, during normal business hours for review, inspection, and/or audit.

- B. Maintenance of Medical Records. Provider shall maintain a complete medical record for each Covered Person to whom Covered Services are provided hereunder. Such medical records shall include the recording of Provider's services and such other records as may be required by law. Such records shall be maintained in accordance with all applicable local, State, and federal laws, rules and regulations and shall be safeguarded against loss, destruction, and unauthorized use. All medical records shall be treated as confidential so as to comply with all State and federal laws, rules, and regulations regarding the confidentiality of patient records. Provider shall assist SWHP or Payor in seeking and obtaining any required patient consent to release of information on request.
- C. Access to Records. The records referred to in Sections VII(A) and VII(B) above shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with applicable local, State or federal laws, rules, and regulations. Subject to applicable State or federal confidentiality laws, Provider shall provide copies of any such records free of charge upon the reasonable request of SWHP, Payor or any authorized representative of a local, state, or federal regulatory agency.
- D. Reporting Requirements. Provider shall provide all reports, data and information in the form, manner and time as SWHP or Payor reasonably requests to allow SWHP or Payor to comply with its state and federal reporting and data requirements.
- E. Continuing Obligation. The provisions of this Section shall survive termination of this Agreement, whether by rescission or otherwise. After termination of this Agreement, SWHP and Payors shall continue to have access to Provider's records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules, and regulations.

#### **VIII. USE OF NAME**

Neither party shall use the other's trademarks, name, or symbols without permission; provided, however, Provider agrees that SWHP may use Provider's name, office address, telephone number, and specialty, and a factual description of the practice in directories and other promotional materials.

#### **IX. GRIEVANCE PROCEDURES**

Provider shall cooperate and participate with SWHP's grievance procedures and comply with all final determinations made through the grievance procedures.

#### **X. CONFIDENTIALITY**

- A. Covered Person-Related Information. SWHP and Provider understand and agree that all information and records related to Covered Persons are privileged and confidential. Any information, records, or reports that may be disclosed to SWHP pursuant to the express terms of this Agreement shall not be disclosed or divulged by SWHP in whole or in part to any other third person, other than as expressly provided for in this Agreement or as required by law, without the prior consent of the Covered Person.
- B. Proprietary Information. All information and materials provided by SWHP to Provider shall remain proprietary to SWHP, including, but not limited to, contracts, fee schedules, reimbursement rates and methodologies, handbooks, Provider Manuals, and any other operations manuals. Provider shall not disclose any of such information or materials or use them except as may be required to perform Provider's obligations hereunder.
- C. HIPAA Compliance. Both SWHP and Provider recognize that the other party is a covered entity under HIPAA (45 C.F.R. §164.102 *et seq.*) privacy requirements, and that, as such, each has an obligation to protect Covered Person's private health information. SWHP and Provider agree to the necessary sharing, between themselves and their authorized designees, of Covered Person's private health information for treatment, payment, and health care operations as these terms are defined by HIPAA, and to protect such private health information within the dictates of HIPAA.
- D. Survival of Obligations. The obligations of the parties under this Section shall survive termination of this Agreement.

## XI. TERM AND TERMINATION

- A. Term. This Agreement shall have an initial term of two (2) years (commencing on the Effective Date). SWHP may, by sixty (60) days advance written notice to Provider prior to the expiration of the initial term, extend this Agreement for successive one-year periods, unless subsequently terminated pursuant to the terms of this Agreement.
- B. Termination By Provider Due to Material Breach. In the event that SWHP materially breaches any provision of this Agreement, Provider may terminate this Agreement upon thirty (30) days written notice to SWHP. If the breach is cured within such 30-day period, or if the breach is one which cannot reasonably be corrected within thirty (30) days and SWHP makes substantial and diligent progress toward correction during such 30-day period, then this Agreement shall remain in full force and effect.
- C. Termination Without Cause. Either party may terminate this Agreement with or without cause by providing ninety (90) days prior written notice to the other party.
- D. Effect of Certain Events. SWHP may terminate this Agreement with respect to Provider (or, if Provider is a Group, with respect to any Participating Group Provider) in the event of:
- (1) any fraud or misrepresentation by Provider in the credentialing process or in the submission of claims to SWHP or any other Payor;
  - (2) any action by Provider which, in the reasonable judgment of SWHP, constitutes gross misconduct or which places a patient's health or safety in unreasonable danger of imminent or serious harm;
  - (3) Provider's loss, suspension, or restriction of its license or eligibility to participate in Medicare or Medicaid;
  - (4) any directive from a regulatory agency with jurisdiction over SWHP or a Payor that this Agreement be terminated;
  - (5) Provider's failure to comply in a material respect with the applicable Utilization Management Program, Quality Assurance Program, Provider Manual, and/or SWHP's credentialing criteria;
  - (6) Provider's breach of any provision of this Agreement;
  - (7) the filing of any petition by or against Provider pursuant to any United States or State bankruptcy, insolvency, or reorganization statute, and said petition not being discharged or dismissed within sixty (60) days;
  - (8) Provider's relocation; or
  - (9) Provider's relationship as a part of a Group terminates.

If termination is based on the grounds set forth in (5), (6), (7), (8) or (9), or on any other grounds that are not in bad faith, the termination shall be effective upon ninety (90) days prior written notice. If termination is based on the grounds set forth in (1), (2), or (4), the termination shall be effective immediately. If termination is based on the grounds set forth in (3), the termination shall be effective upon the earlier of the date of the loss, suspension, or restriction of its license or eligibility to participate in Medicare or Medicaid, or the date of written notice of termination to the Provider.

- E. Notice of Termination. Before terminating this Agreement, SWHP shall furnish a written explanation to Provider of the reason(s) for termination. Except in cases of fraud or malfeasance, or in cases in which there is imminent harm to patient health, or an action by a state licensing board or other government agency that effectively impairs Provider's ability to provide Covered Services to Covered Persons, Provider may request, prior to the effective date of termination (but within a period not to exceed sixty (60) days), a review of the proposed termination by an advisory review panel. The advisory review panel shall be composed of physicians

and other providers, including at least one representative in Provider's same or similar specialty, if available, who has been appointed to serve on SWHP's standing quality management or utilization review committee. The decision of the advisory panel must be considered by SWHP, but is not binding on SWHP. Upon request, SWHP shall provide to the affected Provider a copy of the recommendation of the advisory review panel and SWHP's determination. Provider shall be entitled, on request, to an expedited review process by SWHP.

- F. Covered Person Notification. In the event of the termination of this Agreement, SWHP shall provide each Covered Person then being treated by Provider with advance notice (reasonable under the circumstances) of the impending termination. However, if Provider is terminated for reasons other than at his/her request, SWHP may not notify Covered Persons of the termination until the effective date of termination or the time a review panel makes a formal recommendation, unless the termination relates to imminent harm of patients, in which case, SWHP may immediately notify patients.
- G. Effect of Termination. Both parties shall remain liable for any obligations or liabilities arising from conduct prior to the effective termination date. In the event a Covered Person is receiving Covered Services at the time this Agreement terminates, Provider shall continue to provide Covered Services to the Covered Person until: (1) treatment is completed; or (2) the Covered Person is assigned to another Participating Provider. Provider shall be compensated at the reimbursement rates then in effect under this Agreement. The parties agree to cooperate to arrange for the prompt transfer of Covered Persons to Participating Providers following termination of this Agreement. Provider shall provide to SWHP the names of Covered Persons being treated immediately upon request. Provider shall notify any Covered Person seeking services after the date of termination that it is no longer a Participating Provider.
- H. Covered Persons of Special Circumstances. Unless this Agreement is terminated for reason(s) relating to medical competence or professional behavior, SWHP shall reimburse Provider for the provision of ongoing Medically Necessary treatment to a Covered Person of Special Circumstance in accordance with the dictates of medical procedure at the same compensation rate provided for under this Agreement. For purposes of this section, a Covered Person of Special Circumstance means a Covered Person who has a disability, acute condition, life-threatening illness, or is past the twenty-fourth week of pregnancy. Special Circumstance means a condition such that the treating provider reasonably believes that discontinuing his/her care could cause harm to the patient. Special Circumstances shall be identified by the treating provider, who must request that the Covered Person be permitted to continue treatment under his/her care and agree not to seek payment from the Covered Person of any amounts for which the Covered Person would not be responsible if the provider was still a Participating Provider. Any dispute as to whether or not the Covered Person is a patient of Special Circumstance shall be resolved by SWHP requesting a review of the patient's condition by a provider of the same or similar specialty as the treating provider. This provision does not extend the obligation of SWHP to reimburse Provider for the services of the terminated provider for ongoing treatment of a Covered Person beyond ninety (90) days from the effective date of termination, or beyond nine (9) months in the case of a Covered Person who at the time of termination has been diagnosed with a terminal illness, at which time SWHP's obligation to continue to compensate Provider pursuant to this Section shall immediately cease. However, the obligation of SWHP to reimburse the terminated provider for services to a Covered Person who at the time of termination is past the twenty-fourth (24<sup>th</sup>) week of pregnancy extends through delivery of the child, immediate postpartum care and the follow-up checkup within the first six weeks of delivery.

## XII. MISCELLANEOUS

- A. Fraud and Abuse. This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. Provider shall provide originals and/or copies of any and all information, allow access to premises, and provide records to the Texas Department of Health and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse, upon request and free of charge. Provider shall report any suspected fraud or abuse, including any suspected fraud and abuse committed by SWHP, to the Texas Department of Health for referral to the Texas Health and Human Services Commission.
- B. Advanced Directives. Provider acknowledges and agrees to comply with the laws of Texas respecting advance directives as defined in the Patient Self-Determination Act (P.L. 101-508). An advance directive is, for example, a living will or a durable power of attorney for health care in which an individual makes decisions concerning medical care, including the right to accept or refuse medical or surgical treatment.
- C. Independent Medical Judgment. Nothing contained in this Agreement shall be construed to require a Provider to recommend or withhold any procedure or course of treatment that is not consistent with such Provider's best medical judgment. Eligibility, Prior Authorization, case management, Referrals, and Utilization Management Program activities are performed for the purpose of clearly defining financial responsibility and encouraging efficient use of resources and network services. A Provider is free to make independent medical recommendations and Covered Persons are free to choose to accept or reject any course of treatment.
- D. Communications with Patients. SWHP shall not impose any restrictions upon a Provider's free communications with Covered Persons about a Covered Person's medical conditions, treatment options, SWHP's referral policies, or any other policies of SWHP.
- E. Non-Exclusivity. This Agreement shall not be an exclusive agreement between SWHP and Provider. Nothing herein shall be construed to restrict the rights of Provider or SWHP to participate in other preferred provider plans, health maintenance organizations, or other managed care systems.
- F. Assignment. Neither this Agreement nor the duties or obligations hereunder shall be assignable by either party without the prior written consent of the other party.
- G. Subcontracting. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of SWHP.
- H. Attorneys' Fees. If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees in addition to any other relief to which the party may be entitled.
- I. Governing Law. The validity of any of the terms and provisions of this Agreement as well as the rights and duties of the parties hereunder, shall be governed by the laws of the State of Texas, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern.
- J. Venue. Venue for any dispute arising hereunder shall be in the court of appropriate jurisdiction in Bell County, Texas.
- K. Amendment. All amendments to this Agreement proposed by Provider must be agreed to in writing by SWHP in advance of the effective date thereof. Any amendment to this Agreement proposed by SWHP, including the addition of Payors to the Program Addendum, shall be effective 20 days after SWHP has given written notice to Provider of the amendment, unless Provider has within that time period notified SWHP in writing of Provider's rejection of the requested amendment. Amendments required because of legislative, regulatory or legal requirements do not require the consent of SWHP or Provider and will be effective immediately on the effective date thereof.
- L. Severability. If any provision of this Agreement shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision

hereof, and this Agreement shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

- M. Notices. Any notices to be given hereunder by either party of the other may be effected by personal delivery in writing or by mail, registered or certified, postage prepaid, return receipt requested, to SWHP at its principal place of business or to Provider at Provider's principal place of business.
- N. Waiver. The waiver by either party of a breach or violation of any provision of this agreement shall not operate as or be construed to be a waiver of any subsequent breach hereof.
- O. Status as Independent Entities. None of the provisions of this Agreement is intended to create or shall be deemed or construed to create any relationship between Provider and SWHP other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor SWHP, nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee, or representative of the other.
- P. Addendums and Exhibits. Each Addendum and Exhibit to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum or Exhibit that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement.
- Q. Indemnification. SWHP and Provider each agree to indemnify and hold the other harmless from and against any liability incurred by the indemnified party and arising out of any negligent act or omission caused solely by the indemnifying party, its agents or employees related to its obligations under this Agreement. Indemnification shall include attorneys' fees, court costs, and amounts paid in settlement of claims or judgments rendered against the party being indemnified. The provisions set forth herein shall not be construed to require Provider to indemnify SWHP for any tort liability resulting from acts or omissions of SWHP.
- R. Entire Agreement. This Agreement, together with the appropriate Addendum(s) and Exhibit(s), constitutes the sole and only agreement of the parties with respect to the subject matter hereof and supersedes any and all prior agreements or understandings, either oral or in writing, between the parties hereto with respect to the subject matter hereof. No other agreement, statement, or promise relating to the subject matter of this Agreement that is not contained or incorporated by reference herein shall be valid or binding.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the day and year first written above.

SWHP

By: \_\_\_\_\_  
Allan Einboden  
Executive Director

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Tax I.D. #: \_\_\_\_\_

**PROGRAM ADDENDUM**

**TO PARTICIPATING PROVIDER AGREEMENT**

**BENEFIT PROGRAMS LISTING**

<b>Plan</b>	<b>Addendum</b>	<b>Fee-For-Service</b>
Commercial plans (small employer, large employer, and individual)	[A]	[Exhibit 1]
SeniorCare	[A]	[Exhibit 1]
Self-Funded plans administered by SWHP	[A]	[Exhibit 1]

## ADDENDUM A

### COMPENSATION SCHEDULE

#### I. Payment Based on Fee Schedule

- A. Fee Schedule. Subject to the terms and conditions of the entire Agreement to which this Addendum A is attached, Provider agrees that the services specified in Exhibit 1 to this Addendum A shall be reimbursed at the payment terms specified therein.
- B. Submission of Claims. Provider shall deliver to SWHP a Clean Claim within ninety-five (95) calendar days of the date Covered Services were provided. Such claim shall be delivered in hard copy or via personal computer diskette, magnetic tape, or electronic transmission, if available, in standard UB-92 (or its successor) format. Failure to submit a Clean Claim within ninety-five (95) calendar days may result in nonpayment. If Provider's normal business operations are interrupted by a catastrophic event as defined by the Texas Department of Insurance, the claims filing deadline is tolled until the resumption of normal business operations, subject to appropriate notice and certification pursuant to Texas Department of Insurance requirements. If SWHP determines that a bill is not a Clean Claim, SWHP shall, within the Claims Payment Period, notify Provider of the specific missing information and process the Clean Claim within the Claims Payment Period from the date of resubmission by Provider. If SWHP does not notify Provider within the Claims Payment Period that information is missing, the claim will be deemed a Clean Claim.
- C. Requests for Additional Information from Provider. SWHP may make one request to Provider for additional information within 30 days of receipt of a Clean Claim. A request for additional information from SWHP will be written, and must be specific to the claim or related episode of care, must specifically describe the clinical and other information requested, must be relevant and necessary for claim resolution, and must be for information contained in or in the process of being incorporated into Provider's medical or billing record for that Covered Person. If SWHP makes a request for additional information from Provider, the Claims Payment Period for that claim is tolled until SWHP receives that information, or is informed by Provider that such information is not in the Provider's medical/billing record. Upon receipt of Provider's response, SWHP must act upon that claim on or before the later of the 15<sup>th</sup> day after receiving the response or the original Claims Payment Period.
- D. Request for Additional Information from other sources. SWHP may request additional information from sources other than Provider, but must disclose the other source from which information is being sought to Provider. If SWHP makes a request for additional information from other sources, the Claims Payment Period is not tolled.
- E. Payment of Claims. SWHP shall process and, if appropriate, pay all properly submitted Clean Claims for Covered Services submitted by Provider within the Claims Payment Period. Each payment to Provider shall include an explanation of payment that will itemize the payment and the service(s) rendered. Each payment to Provider shall include an explanation of payment that will itemize the payment and the service(s) rendered. If SWHP's normal business operations are interrupted by a catastrophic event as defined by the Texas Department of Insurance, the Claims Payment Period is tolled until the resumption of normal business operations, subject to appropriate notice and certification pursuant to Texas Department of Insurance requirements, and SWHP is not subject to payment of late payment or underpayment penalties.

- F. Penalty for Failure to Pay Claim during Claims Payment Period. If payment of a claim for a Covered Service is not received within Claims Payment Period, SWHP shall be obligated to pay Provider the contracted rate for the Covered Services, plus a penalty calculated as follows:
1. For claims paid on or before the 45th day following the Claims Payment Period, the penalty is 50% of the difference between the contracted rate and billed charges, but not to exceed \$100,000.
  2. For claims paid on or after the 46<sup>th</sup> day but before the 91<sup>st</sup> day following the Claims Payment Period, the penalty is the difference between the contracted rate and billed charges, but not to exceed \$200,000.
  3. For claims paid on or after the 91<sup>st</sup> day following the Claims Payment Period, the penalty is the amount specified in paragraph 2 of this provision, plus 18% interest on the penalty amount calculated from the date the Clean Claim was filed.
- I. Penalty for Underpayment of Claims. If SWHP underpays a claim, penalties may be payable on such underpayments, but only if SWHP is made aware of the underpayment within 180 days after the underpayment, and SWHP fails to correct for such underpayment within 45 days after becoming aware of the underpayment. If underpayment penalties are payable, they shall be calculated according to the rules promulgated by the Texas Department of Insurance for such penalties.
- J. Resubmission of Claims. Provider shall not resubmit a previously submitted Clean Claim unless the following conditions exist:
1. The Claims Payment Period for the date of original submission has expired; and
  2. SWHP has not notified Provider that such claim shall be paid, denied, or audited.

Resubmission of a Clean Claim in violation of this provision may result in the imposition of a penalty of \$25 per claim. Repeated violations of this provision may be considered a breach of this Agreement, and may result in termination of this Agreement. This provision does not prohibit the submission of a previously submitted claim that has been rejected by SWHP as not being a Clean Claim.

- K. Prepayment Audit of Claims. If SWHP intends to conduct a prepayment audit of a claim or bill, SWHP must notify Provider before the expiration of the Claims Payment Period of its intent. Notwithstanding the intent to audit the claim or bill, SWHP must pay one hundred percent (100%) of the claim at the rates set forth in this Program Addendum within the Claims Payment Period. SWHP may request additional information from Provider if necessary to investigate the claim. If Provider fails to respond to the request for additional information within 45 days of the request, SWHP is entitled to a complete refund of the amount paid. Any prepayment audit of a claim shall be completed and Provider notified in writing of the results within one-hundred-eighty (180) days of the date the Clean Claim was received by SWHP. Payment of any additional amounts due to Provider shall be made within thirty (30) days of notification of the audit results. Refund of any amounts from Provider are payable within 30 days from notice of audit results, subject to Provider's right to appeal.
- L. Postpayment Review of Paid Claims. Neither SWHP nor a Covered Person shall be liable for payment of any sums in excess of those stated in Exhibit 1 to this Addendum A, services determined by SWHP to be not Medically Necessary, or services not authorized in accordance with this Agreement or the Health Plan. For purpose of certifying payment levels and appropriateness of payments and otherwise implementing the provisions of this contract, SWHP may, from time to time, conduct postpayment reviews during regular business hours. Costs for such reviews will be paid by SWHP. The Provider's costs related to the Providers compliance with these reviews are the responsibility of the Provider.

SWHP shall notify the Provider of its intention to conduct a review no later than one hundred twenty (120) days following payment of the claim. Unless SWHP and Provider agree to a shorter time, a minimum of two (2) week

notice shall be provided to ensure availability of all records and space for on-site reviews. The Provider shall allow SWHP or its designee to conduct a review no later than two (2) weeks from the date of the letter of intent. The letter of intent to review should state the full scope/purpose of the review as well as: Patient's name; Admission & discharge date; Medical Records number or Provider's Patient Account Number; Total dollar amount to be reviewed (applicable to Billing reviews only).

If a SWHP designee requests a postpayment review, a current signed and dated authorization from SWHP indicating that the designee is acting on behalf of SWHP, and therefore, should be allowed access to the Health Record, including the patient's medical record, will be provided annually by the designee upon request. SWHP authorization must represent that the designee has agreed in writing (on file with SWHP) to comply with all applicable laws and regulations regarding confidentiality of patient records and the Provider's proprietary information. SWHP and/or SWHP designee shall provide a copy of this agreement to the Provider upon request. Auditor shall wear appropriate name badges at all times while on-site.

The Provider shall, upon request by SWHP or its designee, make available during regular business hours, any and all records, papers, invoices, bills, and supportive documents for review and inspection.

- M. Recovery of Amounts from Provider. In the event that Provider owes SWHP money, for any reason, SWHP will send written documentation to Provider at the appropriate address. Subject to Provider's right to appeal, after the later of 45 days from notification of amount owed or exhaustion of Provider's appeal rights, SWHP may recover any amounts owed to SWHP by offset or recoupment from current or future amounts due Provider. SWHP shall not be entitled to refunds of monies that are a result of claims payments that are older than 180 days, unless SWHP has notified Provider of such refunds due prior to the 180-day time limit. Should Provider discover excess money of any kind prior to being notified, Provider will notify SWHP and hold such funds until SWHP determines to whom the money belongs.
  
- N. Provider's Claims Appeal. Provider may appeal claims decisions and notices of refunds of audits and overpayments. In order to invoke a claims appeal under this provision, Provider must submit a written claims appeal letter setting forth the claims decision or request for refund being appealed, and the reason that the claims decision or refund notice should be reversed, to the SWHP claims director. Such appeal must be submitted within 45 days of Providers receipt of the claims decision or refund notice. Late filed appeals shall not be considered. SWHP will consider the appeal request and issue a written decision to Provider within 30 days of receipt of the appeal request. This claims appeals process does not supplant the Utilization Review appeals process, nor the advisory review panel process made available in the event of provider termination

## II. New Covered Services

In the event Provider becomes eligible to receive payment for Covered Services that are not specifically listed in the Exhibit[s] to this Addendum A, SWHP and Provider shall mutually agree on the basis upon which Provider should be reimbursed for such Covered Service.

The effective date of this Addendum A is \_\_\_\_\_.

SWHP

By: \_\_\_\_\_  
Allan Einboden  
Executive Director

By: \_\_\_\_\_  
Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_