Virginia Addendum

State Specific Provider Requirements

# **General Terms.**

## *Relationship to Master Provider Agreement*.In the event that a provision of this Addendum conflicts with a provision of the Agreement, the provisions of this Addendum shall supersede, govern and control to the extent required by law and to the extent Contigo Health, Provider, Customers, Downstream Clients or Payors are subject to such law.

## *Applicability*. Provisions included herein which are not otherwise addressed by the Agreement shall be considered additional obligations upon the Parties for purposes of Covered Services provided in this State. Provisions included herein which specifically contradict an obligation under a provision of the Agreement shall replace that specific Agreement provision for purposes of Covered Services provided in this State, to the extent necessary to comply with applicable law. The provisions of this Addendum apply only to the entities covered by the referenced law and only for purposes of Covered Services provided in this State, unless otherwise required by the terms of the applicable law.

## *Definitions*. Capitalized terms used herein but not defined shall have the meaning assigned in the Agreement or assigned in the applicable law.

## *Citations*. The citations in this Addendum are current as of the date of this Addendum. Renumbering or recodification of statutes or regulations does not nullify the intent of the applicable provision provided herein.

## *Compliance with Law; Change of Law*. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with applicable law. To the extent a law cited herein is modified in a manner impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law. Contigo Health will update this Addendum after a change in law when reasonably practicable.

# **Network Arranger Laws**

## As required by Va. Code Ann. § 38.2-3407.10(J), Provider is permitted and required to discuss medical treatment options with the patient.

## As required by Va. Code Ann. § 38.2-3407.10(N), if the Agreement contains a provision that requires Provider, as a condition of participating in one of the Carrier's or other entity's provider panels, to participate in any other provider panel owned or operated by that Carrier or other entity, Provider may refuse participation in one or more such other provider panels at the time the Agreement is executed. If Provider contracts with a Carrier or other entity that subsequently contracts with one or more unaffiliated Carriers to include Provider in the provider panels of such unaffiliated Carriers, and which permits an unaffiliated Carrier to impose participation terms with respect to Provider that differ materially in reimbursement rates or in managed care procedures, such as conducting economic profiling or requiring a patient to obtain primary care physician referral to a specialist, from the terms contained in the Agreement at the time of originally contracting, Provider is permitted to refuse participation with any such unaffiliated Carrier.

## As required by Va. Code Ann. § 38.2-3407.15(B)(1), Carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the Carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that (i) the claim is determined by the Carrier not to be a clean claim due to a good faith determination or dispute regarding (1) the manner in which the claim form was completed or submitted, (2) the eligibility of a person for coverage, (3) the responsibility of another Carrier for all or part of the claim, (4) the amount of the claim or the amount currently due under the claim, (5) the benefits covered, or (6) the manner in which services were accessed or provided; or (ii) the claim was submitted fraudulently. Carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim is entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

## As required by Va. Code Ann. § 38.2-3407.15(B)(2), Carrier shall, within 30 days after receipt of a claim, request from the person submitting the claim the information and documentation that the Carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary, Carrier shall make the payment of the claim in compliance with Virginia law. Carrier may not refuse to pay a claim if the Carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a Carrier from imposing a retroactive denial of payment of such a claim if permitted by the Agreement, unless such retroactive denial of payment of the claim would violate Va. Code Ann. § 38.2-3407.15(B)(7). Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

## As required by Va. Code Ann. § 38.2-3407.15(B)(3), any interest owing or accruing on a claim under Va. Code Ann. §§ 38.2-3407.1 or 38.2-4306.1 or any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

## As required by Va. Code Ann. § 38.2-3407.15(B)(4), Carrier shall establish and implement reasonable policies to permit a Provider (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the Carrier's requirements applicable to the Provider for (1) pre-certification or authorization of coverage decisions, (2) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (3) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (4) other Provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. Carrier may bundle or downcode claims submitted by Provider. Provider can request the specific building and downcoding policies that the Carrier reasonably expects to be applied to that provider or provider's services on a routine basis. If such request is made by or on behalf of the Provider, a Carrier shall provide the Provider with such policies within 10 business days following the date the request is received. Additionally, Carrier shall make available to Provider within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the Provider or to particular health care services identified by the Provider.

## As required by Va. Code Ann. § 38.2-3407.15(B)(5), Carrier shall pay a claim if the Carrier has previously authorized the health care service or has advised the Provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless: (i) the documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; (ii) the Carrier's refusal is because (1) another payor is responsible for the payment, (2) the Provider has already been paid for the health care services identified on the claim, (3) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the Carrier by the Provider, enrollee, or other person not related to the Carrier, or (4) the person receiving the health care services was not eligible to receive them on the date of service and the Carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or (iii) during the post-service claims process, it is determined that the claim was submitted fraudulently.

## As required by Va. Code Ann. § 38.2-3407.15(B)(6), in the case of an invasive or surgical procedure, if the Carrier has previously authorized a health care service as medically necessary and during the procedure the Provider discovers clinical evidence prompting the Provider to perform a less or more extensive or complicated procedure than was previously authorized, then the Carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to Carrier.

## As required by Va. Code Ann. § 38.2-3407.15(B)(7), Carrier shall not impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the Provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the Provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (A) 12 months or (B) the number of days within which the Carrier requires under the Agreement that a claim be submitted to the Provider following the date on which a health care service is provided. Carrier shall notify a Provider at least 30 days in advance of any retroactive denial of a claim.

## As required by Va. Code Ann. § 38.2-3407.15(B)(8), notwithstanding Va. Code Ann. § 38.2-3407.15(B)(7), Carrier shall not impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the Carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, which shall contain an explanation of why the claim is being retroactively adjusted.

## As required by Va. Code Ann. § 38.2-3407.15(B)(9), the Agreement contains the (i) fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the Provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies applicable to the Provider or to the range of health care services reasonably expected to be delivered by Provider under the Agreement.

## As required by Va. Code Ann. § 38.2-3407.15(B)(10), no amendment to the Agreement applicable to the Provider (or to the range of health care services reasonably expected to be delivered by Provider) shall be effective as to the Provider, unless the Provider has been provided with the applicable portion of the proposed amendment at least 60 calendar days before the effective date and the Provider has failed to notify the Carrier within 30 calendar days of receipt of the documentation of the Provider's intention to terminate the Agreement at the earliest date thereafter permitted under the Agreement.

## As required by Va. Code Ann. § 38.2-3407.15(B)(11), if Carrier's provision of a policy required to be provided by Va. Code Ann. § 38.2-3407.15 would violate any applicable copyright law, the Carrier may instead comply by providing a clear, written explanation of the policy as it applies to the Provider.

## As required by Va. Code Ann. § 38.2-3407.15(B)(12), Carrier shall establish, in writing, their claims payment dispute mechanism and shall make this information available to Provider.

## As required by Va. Code Ann. § 38.2-3407.15(B)(13), Provider is prohibited from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require a Provider to treat an enrollee who has threatened to make or has made a professional liability claim against the Provider or the Provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the Provider or the Provider's employer, agents, or employees.

## To the extent applicable the relationship between Provider and Contigo Health, the Agreement shall incorporate the requirements of Va. Code Ann. § 38.2-3407.15:2.

# **General Insurance Laws**

## As of the date of this Addendum, there are no applicable laws of this type.

# **Health Maintenance Organization (HMO)/Managed Care Organization (MCO) Specific Laws**

## As required by Va. Code. Ann. § 38.2-5805(C)(1), if Provider terminates the Agreement, the Provider shall give the health carrier at least 60 days' advance notice of termination.

## As required by Va. Code. Ann. § 38.2-5805(C)(2), no Provider, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier.

## As required by Va. Code. Ann. § 38.2-5805(C)(3), if there is an intermediary organization enabling a health carrier subject to subsection Va. Code. Ann. § 38.2-5801(B) to provide health care services by means of the intermediary organization's own contracts with health care providers, the contracts between the intermediary organization and its providers shall be in writing.

## As required by Va. Code. Ann. § 38.2-5805(C)(4), in the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the Agreement, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the Provider for any sums owed by either the intermediary organization or the health carrier.

## As required by Va. Code. Ann. § 38.2-5805(C)(5), no Provider or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization.

## As required by Va. Code. Ann. § 38.2-5805(C)(7), if the Provider terminates the agreement, the Provider shall give the intermediary organization at least 60 days' advance notice of termination.

## As required by Va. Code. Ann. § 38.2-5805(C)(9), the following language is included in the Agreement:

Provider hereby agrees that in no event, including, but not limited to nonpayment by the MCHIP, its health carrier or its intermediary, the insolvency of the health carrier or its intermediary, or the breach of this agreement, shall Provider bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against subscribers or persons other than the health carrier for services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the subscriber agreement for the MCHIP.

Provider further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the plan's subscribers and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the subscriber or persons acting on the subscriber's behalf.