EXHIBIT C
COORDINATING PROVISIONS-STATE/FEDERAL LAW, ACCREDITATION STANDARDS AND GEOGRAPHIC EXCEPTIONS
WASHINGTON

I. INTRODUCTION:

1.1 Scope: To the extent of any conflict between the Agreement, including the administrative handbook as herein incorporated by reference, and this State Law Coordinating Provisions ("SLCP") Exhibit, this SLCP Exhibit shall supersede, govern and control to the extent required by federal and/or state law and to the extent that MPI, Network Provider and/or Client are subject to such federal or state law.

1.2 Terms: The terms used in this exhibit are the defined terms as specified in the applicable federal and/or state law. The specific form Agreement between the parties may utilize defined terms other than those noted in the federal and/or state law(s). For purposes of this exhibit, participating provider means a licensed facility or licensed, registered or certified health care professional(s) contracted to provide health care services under this Agreement.

1.3 Citations: The citations are current as of the date of this exhibit. Recodification of statutory and/or regulatory citations does not nullify the intent of a provision.

II. FEDERAL LAW COORDINATING PROVISIONS:

2.1 Federal Employees Health Benefits ("FEHB"). As applicable, this Agreement is subject to the terms of the laws governing FEHB.

2.2 Federal Employees Health Benefits ("FEHB") Plan. The parties agree that any and all claims or disputes relating to such benefits under a FEHB Plan will be governed exclusively by the terms of such federal government contract and federal law, whether or not such terms and laws are specified in this SLCP Exhibit or elsewhere in this Agreement.

III. STATE LAW COORDINATING PROVISIONS: WASHINGTON

Where the statutory requirement is an additional obligation not otherwise specified in the Agreement, the parties agree that the statutory requirement will be added as an obligation. Where the statutory requirement specifically conflicts with a current obligation, the statutory requirement shall take precedence and replace the existing obligation as to the statutory requirement only, and shall not void any other valid provision of this Agreement. The statutory requirements identified below are limited to only those entities specifically covered by the statute.

3.1 As required by WAC 284-170-421(2), nothing contained in this Agreement will have the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between this Agreement and the health plan, the benefits, terms, and conditions of the health plan will govern with respect to coverage provided to enrollees.

3.2 As required by WAC 284-170-421(3)(a), "Participating provider hereby agrees that in no event, including, but not limited to nonpayment by issuer, issuer's insolvency, or breach of this contract will participating provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an enrollee or person acting on their behalf, other issuer, for services provided pursuant to this contract. This provision does not prohibit collection of deductibles, copayments, coinsurance, and/or payment for noncovered services, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits, from enrollees in accordance with the terms of the enrollee's health plan."

3.3 As required by WAC 284-170-421(3)(b), "Participating provider agrees, in the event of issuer's insolvency, to continue to provide the services promised in this contract to enrollees of issuer for the duration of the period for which premiums on behalf of the enrollee were paid to issuer or until the enrollee's discharge from inpatient facilities, whichever time is greater."

3.4 As required by WAC 284-170-421(3)(c), "Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the enrollee's health plan."

3.5 As required by WAC 284-170-421(3)(d), “Participating provider may not bill the enrollee for covered services (except for deductibles, copayments, or coinsurance) where issuer denies payments because the provider or facility has failed to comply with the terms or conditions of this contract.”

3.6 As required by WAC 284-170-421(3)(e), “Participating provider further agrees (i) that the provisions of (a), (b), (c), and (d) of this subsection shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of issuer's enrollees, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between participating provider and enrollees or persons acting on their behalf.”

3.7 As required by WAC 284-170-421(3)(f), “If participating provider contracts with other providers or facilities who agree to provide covered services to enrollees of issuer with the expectation of receiving payment directly or indirectly from issuer, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection."

3.8 As required by WAC 284-170-421(4), willfully collecting or attempting to collect an amount from an enrollee knowing that collection to be in violation of this Agreement constitutes a class C felony under RCW 48.80.030(5).

3.9 As required by WAC 284-170-421(5), an issuer or its designee will notify participating providers and facilities of their responsibilities with respect to the health issuer's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements.

3.10 As required by WAC 284-170-421(6):

(a) Participating provider must be given reasonable notice of not less than sixty days of changes that affect participating provider compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice must be provided as soon as possible.

(b) (i) Subject to any termination and continuity of care provisions of the contract, participating provider may terminate the contract without penalty if participating provider does not agree with the changes, subject to the requirements of WAC 284-170-421(9); and (ii) A material amendment to a contract may be rejected by participating provider. The rejection will not affect the terms of the existing contract. A material amendment has the same meaning as in RCW 48.39.005.

(c) No change to the contract may be made retroactive without the express written consent of the participating provider.

3.11 As required by WAC 284-170-421(7)(a), “No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service."

3.12 As required by WAC 284-170-421(7)(b), "No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier."

3.13 As required by WAC 284-170-421(8), subject to applicable state and federal laws related to the confidentiality of medical or health records, participating provider will make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals, or review of any adverse benefit determinations of enrollees. Participating provider will cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs.

3.14 As required by WAC 284-170-421(9), issuer, or its designee, and participating provider must provide at least sixty days' written notice to each other before terminating the contract without cause.

3.15 As required by WAC 284-170-421(11), participating providers will furnish covered services to each enrollee without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

3.16 As required by WAC 284-170-421(13), the dispute resolution process is as stated in the Agreement and/or the administrative handbook (http://www.multiplan.com/providers/education). Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes shall be considered fair under RCW 48.43.055 unless the process meets all the provisions of WAC 284-170-440.

3.17 As required by WAC 284-170-431(2)(a), for health services provided to covered persons, a carrier shall pay participating provider as soon as practical but subject to the following minimum standards:

(i) Ninety-five percent of the monthly volume of Clean Claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and

(ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

3.18 As required by WAC 284-170-431(2)(b), the receipt date of a claim is the date the responsible carrier or its agent receives either written or electronic notice of the claim.

3.19 As required by WAC 284-170-431(2)(c), carrier shall establish a reasonable method for confirming receipt of claims and responding to provider and facility inquiries about claims.

3.20 As required by WAC 284-170-431(2)(d), any carrier failing to pay claims within the standard established under WAC 284-170-431(2) shall pay interest on undenied and unpaid Clean Claims more than sixty-one days old until the carrier meets such standard. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

3.21 As required by WAC 284-170-431(2)(e), when the carrier issues payment in either participating providers and the covered person names, the carrier shall make claim checks payable in the name of the participating provider first and the covered person second.

3.22 As required by WAC 284-170-431(3), "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 prevents timely payments from being made on the claim under this section.

3.23 As required by WAC 284-170-431(4), denial of a claim must be communicated to participating provider and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then carrier upon request of the participating provider must also promptly disclose the supporting basis for the decision.

3.24 As required by WAC 284-170-460(2), if the Agreement grants the carrier or its designee access to medical records for audit purposes such access is limited to only that necessary to perform the audit.

IV. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

V. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS:

There are no Geographic Exceptions Coordinating Provisions at this time.