Medica

MONTANA PROVIDER REQUIREMENTS

1. Liability Insurance Requirements.

A. Providers/Practitioners/Facility.

All Providers must have a professional liability policy with a minimum limit of $1,000,000 per occurrence/$3,000,000 aggregate, except for practitioner types like Public Health Service as discussed below;

> **Public Health Service:** Federally-supported health centers are deemed to be employees of the federal government and as such, are protected under the Federal Tort Claims Act (FTCA). These may include specified community health centers and Indian reservations. There are no liability limits specified, but FTCA meets any malpractice insurance coverage limits that may be required.

2. Continued Provision of Health Services for Certain Members after Termination of the Agreement or Termination of Facility Provider or Clinic Provider Participation.

A. Unless otherwise provided in the Administrative Requirements, in the event the provider Participation Agreement is terminated by Provider for any reason, the Provider Participation Agreement is terminated by Medica without cause, or, notwithstanding anything herein to the contrary, in any the event of any removal of Provider, a Clinic Provider, a Facility Provider, or a Provider location from Medica's networks that gives rise to a legal continuity of care obligation with regard to the services of a Provider, a Clinic Provider, a Facility Provider, or a Provider location, Provider will, and will cause Facility Providers and Clinic Providers to, continue to provide Health Services according to the terms of the Agreement to Members covered under a Benefit Contract after such termination. Such continuation of care will apply when requested by a Member and Medica determines that such Member meets the statutory criteria for in network benefits or continuity of care. Health Services provided in accordance with this subsection 9.4.3 of the Provider Participation Agreement will be provided for:

i. Up to ninety (90) days if the Member was undergoing a current course of treatment for one or more of the following conditions at the time of termination:
   a. An ongoing course of treatment for a life-threatening condition;
   b. An ongoing course of treatment for a serious acute condition, such as chemotherapy;
   c. Scheduled non-elective surgery, including postoperative care;
   d. Undergoing a course of institutional or inpatient care from the provider or facility, when continuity of care is required under the Federal Consolidated Appropriations Act of 2020 and its implementing regulations;

e. Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the postpartum period; or
f. An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

ii. Continuation of services or treatment may extend to the remainder of Member's life, if life expectancy is 180 days or less.

B. Health Services provided in accordance with Subsections 9.4.3 of the Provider Participation Agreement will be reimbursed by Medica in accordance with the terms of the Appendices to the Agreement.
C. As stated in your Provider participation Agreement, Provider will accept as payment in full Medica's reimbursement to Provider for such Health Services at the contracted rates applicable prior to termination, as set forth in the Appendices to the agreement.

3. Prompt Pay.

Medica will pay claims that are clean within 30 calendar days after the date upon which Medica or its Affiliate received the claim.

If a clean claim is not paid timely (within 30 calendar days), the rate of interest paid by Medica or Affiliate shall be 12% per annum.

"Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim.

4. Medical Records.

Medica does not reimburse participating Providers for the cost of collecting, copying or delivering requested medical records, except when required by law. Participating Providers, and any subcontractors or third parties who may collect, copy and/or deliver records for such Providers, may not bill Medica or any Medica member for expenses related to a records request from Medica.

5. For Health Services provided in Montana that are covered pursuant to a Benefit Contract, this Agreement is amended in the following respects:

Section 4.4(a) shall be and hereby is deleted and replaced with the following:

a. The provider agrees that the provider may not for any reason, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or have any recourse from or against a covered person or a person other than the health carrier or intermediary acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person. This agreement does not prohibit a provider, except a health care professional who is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue services solely at the expense of the covered person if the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available for obtaining payment for services from the health carrier.

6. In the Event of Medica Insolvency.

If Medica becomes insolvent or otherwise ceases operations, covered benefits to Members will continue through the end of the period for which a premium has been paid to Medica on behalf of the Member, but not to exceed 30 days, or until the Member’s discharge from an acute care inpatient facility, whichever occurs last. Covered benefits to a Member confined in an acute care inpatient facility on the date of insolvency or other cessation of operations must be continued by a Provider until the confinement in an inpatient facility is no longer medically necessary.

7. Provider General Responsibilities.

Provider may not collect or attempt to collect from a Member money owed to Provider by Medica.

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