Medica

SOUTH DAKOTA 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 and state and county run clinic providers as discussed below;

i. **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.

ii. **South Dakota State- and/or County-run Clinics**: Providers who are protected under South Dakota Statutes § 3-22-10, which limits liability to $200,000 on a single claim in a single year.

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 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 for a covered person who:

a. An acute condition;
b. A life-threatening mental or physical illness;
c. 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;
d. Scheduled non-elective surgery, including post-operative care;
e. Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the completion of postpartum care;
f. A physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for at least one year or can be expected to result in death; or
g. A disabling or chronic condition that is in an acute phase.

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 (for claims submitted electronically) and within 45 calendar days (for written claims) after the date upon which Medica or its Affiliate received the claim.

If a clean claim is not paid timely, the rate of interest paid by Medica or Affiliate shall be 18% 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.

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SOUTH DAKOTA REGULATORY REQUIREMENTS

To the extent that Provider provides health services to members of a Preferred Provider Plan, prepaid limited health service organization, health maintenance organization ("HMO"), or insurer regulated under South Dakota law, Provider must comply with these requirements related to health services provided to Medica members in accordance with applicable law. In the event of a conflict between these requirements and the Provider contract with Medica, the terms of the contract will prevail, provided that the parties are also in compliance with applicable law. References to "payer" in the following paragraphs pertain only to the extent that South Dakota law applies to a regulated product.

(1). Medica Health Plans, Medica Insurance Company or a payer will establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services; **SD.Codified Laws 58-17F-11(1).**

(2). in no event may Provider collect or attempt to collect from a member any money owed to Provider by Medica Health Plans, Medica Insurance Company or a payer nor may Provider have any recourse against such members for any covered charges in excess of the copayment, coinsurance, or deductible amounts specified in the coverage, including members who have a health savings account; **SD.Codified Laws 58-17F-11(2).**

(3). Medica Health Plans, Medica Insurance Company or a payer will notify participating providers of the providers' responsibilities with respect to the Medica Health Plans, Medica Insurance Company or a payer's applicable administrative policies and programs, including payment terms, utilization review, quality assessment, and improvement programs, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs; **SD.Codified Laws 58-17F-11(4).**

(4). Medica Health Plans, Medica Insurance Company or a payer will not prohibit or penalize a participating provider from discussing treatment options with members irrespective of their position on the treatment options, from advocating on behalf of such members within the utilization review or grievance processes established by Medica Health Plans, Medica Insurance Company or a payer or from, in good faith, reporting to state or federal authorities any act or practice by Medica Health Plans, Medica Insurance Company or a payer that jeopardizes their members 'health or welfare; **SD.Codified Laws 58-17F-11(5).**