EXHIBIT __
COORDINATING PROVISIONS-STATE/FEDERAL LAW, ACCREDITATION STANDARDS AND GEOGRAPHIC EXCEPTIONS
WEST VIRGINIA

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, 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, provider means a licensed facility or licensed, registered or certified health care professional(s) contracted to provide health care services under this Agreement

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: WEST VIRGINIA

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 W. Va. Code §33-45-2(a)(1), insurer shall either pay or deny a clean claim within forty days of receipt of the claim if submitted manually and within thirty days of receipt of the claim if submitted electronically, except in the following circumstances: (i) another payor or party is responsible for the claim; (ii) the insurer is coordinating benefits with another payor; (iii) the provider has already been paid for the claim; (iv) the claim was submitted fraudulently; or (v) there was a material misrepresentation in the claim.

3.2 As required by W. Va. Code §33-45-2(a)(2), insurer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If insurer fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by the person submitting the claim.

3.3 As required by W. Va. Code §33-45-2(a)(3), insurer shall, within thirty days after receipt of a claim, request electronically or in writing from the person submitting the claim any information or documentation that insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Insurer shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within fifteen days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested under this subsection which insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, insurer shall either pay or deny the claim within thirty days. No insurer may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if insurer fails to timely notify the person submitting the claim within thirty days of receipt of the claim of the additional information requested unless such failure was caused in material part by the person submitting the claims.

3.4 As required by W. Va. Code §33-45-2(a)(4), interest, at a rate of ten percent per annum, accruing after the forty-day period provided in W. Va. Code §33-45-2(a)(1), owing or accruing on any claim under any provider contract or under any applicable law, shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is paid or within thirty days thereafter.

3.5 As required by W. Va. Code §33-45-2(a)(5), insurer shall establish and implement reasonable policies to permit any provider with which there is a provider contract:

(A) To promptly confirm in advance during normal business hours by a process agreed to between the parties whether the health care services to be provided are a covered benefit; and

(B) To determine insurer's requirements applicable to provider (or to the type of health care services which provider has contracted to deliver under provider's contract) for: (i) Precertification or authorization of coverage decisions; (ii) Retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim; (iii) Provider-specific payment and reimbursement methodology; and (iv) 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.

(C) Insurer shall make available to provider within twenty business days of receipt of a request, reasonable access either electronically or otherwise, to all the policies that are applicable to provider or to particular health care services identified by provider. In the event the provision of the entire policy would violate any applicable copyright law, insurer may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to provider and to any health care services identified by provider.

3.6 As required by W. Va. Code §33-45-2(a)(6), insurer shall pay a clean claim if insurer has previously authorized the health care service or has advised 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:

(A) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

(B) Insurer's refusal is because: (i) Another payor or party is responsible for the payment; (ii) Provider has already been paid for the health care services identified on the claim; (iii) The claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the insurer by provider, enrollee, or other person not related to insurer; (iv) The person receiving the health care services was not eligible to receive them on the date of service and insurer did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status (v) There is a dispute regarding the amount of charges submitted; or (vi) The service provided was not a covered benefit and insurer did not know, and with the exercise of reasonable care could not have known, at the time of the certification that the service was not covered.

3.7 As required by W. Va. Code §33-45-2(a)(7)(A) & (C)insurance company may not retroactively deny a previously paid claim unless: **(i)** The claim was submitted fraudulently; **(ii)** The claim contained material misrepresentations; **(iii)** The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by provider; **(iv)** Provider was not entitled to reimbursement; **(v)** The service provided was not covered by the health benefit plan; or **(vi)** The insured was not eligible for reimbursement. A health plan may retroactively deny a claim for the reasons set forth in W. Va. Code §33-45-2(a)(7)(A)(iii), (iv), (v) and (vi) for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth W. Va. Code §33-45-2(a)(7)(A)(i) and (ii).

3.8 As required by W. Va. Code §33-45-2(a)(7)(B), a provider to whom a previously paid claim has been denied by a health plan in accordance with W. Va. Code §33-45-2(a)(7) upon receipt of notice of retroactive denial by the plan, shall notify the health plan within forty days of the provider's intent to pay or demand written explanation of the reasons for the denial.

(i) Upon receipt of explanation for retroactive denial, provider shall reimburse the plan within thirty days for allowing an offset against future payments or provide written notice of dispute.

(ii) Disputes shall be resolved between the parties within thirty days of receipt of notice of dispute.

(iii) Upon resolution of dispute, provider shall pay any amount due or provide written authorization for an offset against future payments.

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.