

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
CHRONIC RENAL DISEASE PROGRAM

PARTICIPATING PROVIDER AGREEMENT

I, the undersigned (hereinafter referred to as "Provider" or "Contractor"), duly certified and participating in both the state Medicaid Program and the federal Medicare Program, and, as applicable, duly licensed under the laws of the Commonwealth of Pennsylvania, in consideration of being enrolled by the Pennsylvania Department of Health, Chronic Renal Disease Program (hereinafter referred to as "Department" or "CRDP"), as a participating provider, do hereby agree to be legally bound as follows: I offer to and shall provide special health services pursuant to this Agreement for the Department to CRDP-eligible individuals in accordance with the restrictions indicated on the individual's CRDP identification card, make reports to the Department concerning such services, and accept compensation therefore in accordance with the terms and conditions stated or incorporated in this Agreement. This Agreement is effective as of _____, and is made pursuant to 35 P.S. § 6201 et seq., and shall continue in effect, unless otherwise agreed to in writing by the parties, until _____, except upon occurrence of any of the following:

- A. Cancellation by either party upon a 30-day prior written notice; or
B. Cancellation by the Department due to withdrawal of funding or lack of appropriation by federal or state legislatures; or
C. Cancellation by the Department for the Provider's failure to meet any of the requirements of this Agreement.

The following appendices are incorporated as a part of this Agreement:

- (1) Appendix A - Contractual Conditions and Attachment 1, List of Service Sites
(2) Appendix B - Payment Provisions

The Provider acknowledges having reviewed a copy of the following document, which is available at http://www.health.pa.gov/vendors. This document is incorporated by reference into and made a part of this Agreement. The Provider agrees to comply with the terms of this document:

- (1) Standard General Terms and Conditions (Rev. 2/15)

In order to be valid, this Agreement must be fully executed by the parties and bear signature approvals of Commonwealth agency head or designee. The parties intending to be legally bound to the provisions set forth herein hereby affix their signatures to this Agreement:

APPROVED FOR DEPARTMENT OF HEALTH:

By: Agency Head (or designee) Date
Pennsylvania Department of Health

APPROVED AS TO FORM AND LEGALITY:

By: Office of Legal Counsel Date
Pennsylvania Department of Health

By: Office of General Counsel Date
Commonwealth of Pennsylvania

By: Office of Attorney General Date
Commonwealth of Pennsylvania

Provider's Name

Office Address

City State Zip

County

Area Code - Telephone Number

Billing Address (if different from above)

Street

City State Zip

SEE APPENDIX A, ATTACHMENT 1, LIST OF SERVICE SITES

Type License:

License No:

Fed. I.D.#/SS#:

(If the contractor is a corporate entity, please have either the president or vice-president and either the secretary/assistant secretary or treasurer/ assistant treasurer of the corporation sign. In lieu thereof, please enclose documentation, e.g., bylaws, board minutes, etc., designating what authority, the signatory has to execute contracts on behalf of the corporation.)

SIGNED

PRINT NAME

TITLE

DATE

AND

SIGNED

PRINT NAME

TITLE

DATE

CONTRACTUAL CONDITIONS

I. SERVICES

- A. The Provider agrees to deliver services identified on the Chronic Renal Disease Program (CRDP) Fee Schedule, which services are directly related to and limited to dialysis or a direct complication of dialysis, or a kidney transplant or the rejection of a transplanted kidney, to individuals who are eligible to participate and enrolled in the CRDP. Said individuals are hereinafter referred to as "patients".
- B. **Dialysis services** provided through this Agreement shall be delivered at site(s) identified in this Agreement and in compliance with federal, state and local laws and regulations. A list including the name and address of each site at which services are provided is incorporated into and made a part of this Agreement as Attachment 1 to this Appendix.
1. a. *Addition of service sites to this Agreement.* In the event the Provider desires to add a service site, the Provider shall submit to the CRDP a letter requesting the addition of service site(s) to this Agreement. In the event the site to be added is a free-standing renal dialysis unit, the letter shall include: a completed Chronic Renal Disease Program Facility Enrollment Questionnaire; a copy of the most recent (within three years) U.S. Health Care Financing Administration Statement of Deficiencies and Plan of Correction; a HCFA letter of Approval as an End Stage Renal Disease (ESRD) Facility; and, a copy of the Department of Public Welfare Medical Assistance Provider Number. The CRDP reserves the right to request any other information it deems necessary to ascertain that the service site has been and continues to be in compliance with federal, State and local standards as required.
 - b. The Department will notify the Provider in writing of the date each additional service site is added to and bound to the provisions of this Agreement, and will identify each additional site by name and address. Under no circumstances shall the date the service site is added to this Agreement precede the date of the Department's written notification of the Department's approval of such additional site. Any such written notification is incorporated herein by reference.
 2. a. *Deletion of service sites from this Agreement.* Upon thirty day written notification by either the Provider or the Department, service sites may be deleted from this Agreement. Any such written notification is incorporated herein by reference.
 - b. The Department may immediately delete site(s) and may seek restitution from the Provider if the Department determines that the Provider, the owner of the Provider, or an employee or agent of the Provider has failed to maintain compliance with the provisions of this Agreement or with federal, State and local standards required to operate a hospital or an End Stage Renal Disease Dialysis Facility.
- C. **Home Dialysis Services** identified on the Fee Schedule will be reimbursed by the Department. Fees for such services shall be all-inclusive and cover the Provider's monitoring of patients self-dialyzing at home and coordinating their care to assure that patients receive the necessary supplies, medicines, laboratory tests, blood transfusions and to assist those patients with the acquisition of all equipment necessary to perform dialysis at home, as well as any other services necessary for patients to perform dialysis at home in a safe and effective

manner.

- D. **Hospital Services** provided through this Agreement shall include: Inpatient hospital services and services provided in a short procedure unit, an ambulatory surgical center, or an independent medical/surgical clinic.
- E. **Prescription Drugs.** The Provider agrees to prescribe legend and non-legend Class A generic pharmaceutical products identified on the Chronic Renal Disease Program Formulary, as may be necessary for the care and treatment of end stage renal disease, to patients. The Department may prospectively amend or revise the CRDP Formulary as necessary.
 - 1. The Department will pay only for Class A generic legend and non-legend pharmaceutical products identified on the Chronic Renal Disease Program Formulary that have been prescribed to patients, unless a medical exception allowing the use of a drug not identified on the CRDP Formulary has been granted.
 - 2. Requests for medical exceptions shall be considered on an individual basis for those patients for whom a written request including evidence of therapeutic failure has been submitted. The written request shall be submitted by the physician-in-charge, and shall identify the patient, the patient's specific need, detail of the product, anticipated length of therapy, and evidence of therapeutic failure when using the CRDP Formulary product. The CRDP will provide a written decision regarding usage of the non-formulary product.

II. PROVIDER STANDARDS

- A. The Provider shall comply with and not violate the corporate practice of medicine doctrine.
- B. All services rendered by the Provider shall be consistent with customary standards of professional practice in amount, duration, scope and quality.
- C. The Provider, and its employees and agents who are providing services under this Agreement, shall be qualified, licensed and/or certified in their respective disciplines as required by the Commonwealth of Pennsylvania.
- D. The Provider, and its employees and agents who are providing services under this Agreement, shall at all times be enrolled as Pennsylvania Department of Public Welfare Medical Assistance (Medicaid) providers and as U.S. Social Security Administration Medicare providers in good standing, in order to participate in the CRDP and to be paid for services provided under the terms of this Agreement. The Provider shall notify the Department in writing within fifteen (15) days of the Provider's preclusion or exclusion from participation in the Medicaid or Medicare programs. The Provider agrees that if precluded or excluded, voluntarily or involuntarily, from Medicaid or Medicare Programs, this Agreement shall terminate immediately as of the date of such preclusion or exclusion. The Provider further agrees to notify the CRDP in writing of any misdemeanor or felony conviction relating to a Medicaid or Medicare practice offense by the Provider or any of its owners, agents, or employees within fifteen (15) days of conviction. Likewise, the Provider shall notify the CRDP in writing of any professional licensing board action against any health care professional employed or utilized by the Provider in providing services to CRDP patients under this Agreement within fifteen (15) days of action.
- E. The Provider agrees that, in the event it refers patients to other providers, it shall refer Medicaid or Medicare-enrolled patients only to Medicaid or Medicare-enrolled providers.

III. REQUIREMENTS FOR PROVISION OF SERVICES

- A. Providers shall provide services to individuals enrolled in the CRDP and possessing a current CRDP Identification Card issued by the Department. The Department will not pay the Provider for services provided to a patient who does not possess a valid CRDP Identification Card issued by the Department and setting forth the current eligibility period. In order to verify that a patient is enrolled in the CRDP, the Provider shall inspect and immediately return the patient's CRDP Identification Card to the patient or the patient's authorized representative. In no case shall a Provider request a patient to send the CRDP Identification Card through the mail or otherwise leave the card in the possession of the Provider. If a patient does not have a CRDP Identification Card, the Provider shall call the Department to confirm the patient's CRDP enrollment. Confirmation of enrollment does not guarantee payment for services that do not meet the terms and conditions of this Agreement.
- B. The Provider shall notify the Department of any changes in the status of the enrolled patient within seven (7) days of obtaining such information. Such changes may include, but are not limited to, name, address, insurance carrier, insurance coverage, Medicare or Medicaid enrollment, return of kidney function, discontinuation of dialysis treatment, kidney transplantation or death.

IV. FEE SCHEDULE

- A. The CRDP Fee Schedule, incorporated herein by reference, delineates the approved services for which Providers may receive payment from the Department, and the maximum amount that the Department will pay for a service when the Provider bills the Department in accordance with the Fee Schedule. The Fee Schedule is posted on the World Wide Web at: <http://www.health.state.pa.us/core/schedule/>. A copy of the Fee Schedule may be obtained upon request by calling (717) 787-2020, or by writing to:

Pennsylvania Department of Health
Division of Child and Adult Health Services
7th Floor East Wing Health and Welfare Building
7th & Forster Streets
Harrisburg, PA 17120

- B. The Department may prospectively amend or revise the Fee Schedule, by notifying the Provider in writing at least thirty (30) days in advance by U.S. mail of such changes. Such changes are incorporated herein by reference as of their effective date(s), as indicated in the notice.

V. PAYMENT WHEN CRDP IS SOLE PAYER

- A. The CRDP is the payer of last resort. The Provider shall seek and collect payment from all third party payers who may be legally obligated to pay for services provided under this Agreement, including but not limited to insurers, Medicare or Medicaid. If there is no third-party payer who may be legally obligated to pay for services provided under this Agreement, the Provider shall submit a bill for services directly to the Department. Payment will be made in accordance with the Fee Schedule. The Provider agrees that receipt of the amount stated on the Fee Schedule constitutes payment in full, and the Provider shall neither request nor accept further payment from the patient.

- B. The Provider shall bill the Department under this section only for those services identified on the Fee Schedule.

VI. PAYMENT WHEN THIRD PARTY PAYER(S) MAY BE LEGALLY OBLIGATED TO PAY TOWARD SERVICES

- A. If a third party payer(s) may be legally obligated to pay for services provided under this Agreement, and the Provider is permitted to bill the Department pursuant to Appendix B of this Agreement (Payment Provisions), the Provider must submit a statement from the third-party payer(s) verifying the actual charge and the amount of payment(s) made by all third party payer(s) (explanation of benefits) prior to billing the Department. If the third-party payer(s) authorizes coinsurance charges or a deductible charge in direct connection with the provision of a service identified on the Fee Schedule, which charges would otherwise be billed to the patient, the Department will pay such charges in accordance with Section VII (Payment for Authorized Patient Charges) below. If there are no coinsurance or deductible charges outstanding, the Department will pay outstanding charges for services in accordance with the Fee Schedule, and the Provider agrees that receipt of the amount stated on the Fee Schedule constitutes payment in full. Upon receiving payment in accordance with the Fee Schedule, the Provider may neither request nor accept further payment from the patient.

VII. PAYMENT FOR AUTHORIZED PATIENT CHARGES

- A. Where a service provided to a patient is first billed to one or more third party payers, the Department will pay coinsurance charges or a deductible charge, if such charges are authorized by the third party payer(s) in direct connection with the provision of a service(s) identified on the Fee Schedule, and would otherwise be billed to the patient (hereinafter, “authorized patient charges”), in accordance with this section. The Department will pay the Provider for authorized patient charges only if the related services are provided in accordance with the terms and conditions of this Agreement. If authorized patient charges are eligible for payment under this section, the rate stated on the Fee Schedule for that service does not apply.
 - 1. *Coinsurance charges for Outpatient Services.* The Department will pay the Provider 50% of a patient’s coinsurance costs, minus any patient share required for CRDP participation. The Provider agrees that receipt of 50% of the coinsurance amount constitutes payment in full, and the Provider may neither request nor accept further payment from the patient.
 - a. If one or more third party payers may be legally obligated to pay coinsurance costs, the Provider must submit the coinsurance to the third party payer(s) prior to billing the Department for the coinsurance. The Provider agrees that, if the Provider receives payment of 50% or more of the coinsurance amount from the third party payer(s), the coinsurance has been paid in full, and the Provider may neither request nor accept further payment from the patient. If the third party payer(s) pays less than 50% of the coinsurance, the Department will pay the Provider the difference between the amount paid and 50% of the coinsurance, less patient share.
 - 2. *Deductible charges for Outpatient Services.* The Department will pay 50% of a patient’s annual deductible costs, minus any patient share required for CRDP participation. The Provider agrees that receipt of 50% of the deductible amount constitutes payment in full, and the Provider may neither request nor accept further payment from the patient.
 - a. If one or more third party payers may be legally obligated to pay for deductible costs, the Provider must submit the deductible to the third party payer(s) prior to billing the

Department for the deductible. The Provider agrees that, if the Provider receives payment of 50% or more of the deductible amount from the third party payer(s), the deductible has been paid in full, and the Provider may neither request nor accept further payment from the patient. If the third party payer(s) pays less than 50% of the deductible, the Department will pay the Provider the difference between the amount paid and 50% of the deductible, less patient share.

3. *Coinsurance charges for Hospital Services.* The Department will pay 50% of a patient's coinsurance costs, minus any patient share required for CRDP participation. However, this payment will be limited so that the total payment received by the Provider for a service, including payment from all sources, does not exceed the Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG) reimbursement for that service. The Provider agrees that receipt of the lesser of 50% of the coinsurance amount or an amount sufficient to bring the total payment received by the Provider up to the level of the Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG) reimbursement for the service being billed constitutes payment in full, and the Provider may neither request nor accept further payment from the patient.
 - a. If the patient has a secondary insurer or payer that pays toward the coinsurance, the Provider must submit the coinsurance to the secondary insurer or payer prior to billing the Department for the coinsurance. The Provider agrees that, if the secondary insurer or payer pays 50% or more of the coinsurance amount, it has been paid in full, and the Provider may neither request nor accept further payment from the patient. If the secondary insurer or payer pays less than 50% of the coinsurance, the Department will pay the Provider the difference between the amount paid and 50% of the coinsurance, less patient share. However, this payment will be limited so that the total payment received by the Provider for a service, including payment from all sources, does not exceed the Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG) reimbursement for that service. The Provider agrees that receipt of the lesser of 50% of the coinsurance amount or an amount sufficient to bring the total payment received by the Provider up to the level of the Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG) reimbursement for the service being billed constitutes payment in full, and the Provider may neither request nor accept further payment from the patient.
4. *Deductible charges for Hospital Services.* The Department will pay 50% of a patient's deductible costs, minus any patient share required for CRDP participation. However, this payment will be limited so that the total payment received by the Provider for a service, including payment from all sources, does not exceed the Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG) reimbursement for that service. The Provider agrees that receipt of the lesser of 50% of the deductible amount or an amount sufficient to bring the total payment received by the Provider up to the level of the Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG) reimbursement for the service being billed constitutes payment in full, and the Provider may neither request nor accept further payment from the patient.
 - a. If the patient has a secondary insurer or payer that pays toward the deductible, the Provider must submit the deductible to the secondary insurer or payer prior to billing the Department for the deductible. The Provider agrees that, if the secondary insurer or payer pays 50% or more of the deductible amount, it has been paid in full, and the Provider may neither request nor accept further payment from the patient. If the secondary insurer or payer pays less than 50% of the deductible, the Department will

pay the Provider the difference between the amount paid and 50% of the deductible, less patient share. However, this payment will be limited so that the total payment received by the Provider for a service, including payment from all sources, does not exceed the Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG) reimbursement for that service. The Provider agrees that receipt of the lesser of 50% of the deductible amount or an amount sufficient to bring the total payment received by the Provider up to the level of the Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG) reimbursement for the service being billed constitutes payment in full, and the Provider may neither request nor accept further payment from the patient.

- B. Bills submitted by a Provider that would result in the Department paying the Provider less than \$5.00 (five dollars) for authorized patient charges per date of service will not be processed or paid; in such event, the Provider agrees that payment has been received in full, and the Provider may neither request or accept further payment from the patient.

VIII. COPAYMENTS

- A. The Department will not pay copayments under any circumstances. The Provider agrees that it shall not request nor accept payment of copayments from either the Department or the patient under any circumstances.

IX. PREVIOUS AGREEMENTS

As of the effective date of this Agreement, any previous agreement, whether written or oral, between the Provider and the Department for services covered herein, is terminated.

X. SUSPENSION OF CONTRACT SERVICES DUE TO UNAVAILABILITY OF FUNDS

- A. The Department may, upon its determination that funds have or will become unavailable for any or all services provided under this Agreement, prospectively suspend provision of any or all of those services upon prior written notification to the Provider by certified mail, return receipt requested. This notification will instruct the Provider that provision of services enumerated in the notification is to be suspended by the date set out in the notification. The Department will notify the Provider of the suspension within a reasonable time period prior to the required suspension date.
- B. The Department will not pay the Provider for services provided on and after the effective date of the suspension of services, unless and until the Department notifies the Provider in writing that it will do so.
- C. All notifications sent out pursuant to this Section (X) become part of this Agreement and are incorporated herein by reference.

XI. PROVIDER MONITORING

- A. The Provider agrees to maintain all records pertaining to the services provided under this Agreement and for which payment is claimed for a period of four years from the date the bill was paid by the Department.
- B. The Provider shall be subject to periodic on-site review by the Department or its designee.

- C. The Provider shall submit to the Department, within fifteen (15) calendar days of request, such records, including but not limited to, patient utilization and patient needs assessments, as may be required or requested by the Department. This paragraph supplements paragraphs 11 and 12 of the Standard General Terms and Conditions (Rev. 2/15), which is incorporated herein by reference.

XII. STANDARD TERMS AND CONDITIONS

The parties agree that they are subject to the “Standard General Terms and Conditions (Rev. 2/15)”, incorporated herein. The Provider acknowledges being familiar with those Standard General Terms and Conditions. Where the terms and conditions of this Appendix A and Appendix B contradict those set forth in the “Standard General Terms and Conditions (Rev. 2/15), the terms and conditions of Appendices A and B prevail.

XIII. TERMINATION

- A. Grounds for action. The Department may terminate a Provider’s Agreement and seek reimbursement from that Provider if the Department determines that the Provider, owner of the Provider, or an employee or agent of the Provider has done any of the following:
1. Submitted false or fraudulent claims to the CRDP.
 2. Failed to comply with any term of this Agreement.
 3. Been precluded or excluded, either voluntarily or involuntarily, as a Medical Assistance or Medicare provider.
 4. Been convicted of a Medicaid or Medicare related criminal offense.
 5. Been convicted of a criminal offense under state or federal laws relating to the services covered by this Agreement.
 6. Been subject to license suspension or revocation following disciplinary action entered against the Provider or its health care providers providing services under this Agreement by a licensing or certifying authority.
 7. Had a controlled drug license withdrawn or failed to report to the Department changes in the Provider’s Drug Enforcement Agency Number.
 8. Knowingly submitted a fraudulent or erroneous patient application or assisted a patient to do so.
 9. Refused to permit authorized state or federal officials or their agents to examine the Provider’s medical, fiscal or other records as necessary to verify claims made to the Department under this Agreement.

This section supplements but does not replace paragraph 27 of Appendix C (Standard General Terms and Conditions, Rev. 2/15).

- B. The above is a non-inclusive list which does not limit the Department's remedies for breach otherwise under this Agreement. Nor does this section prevent the Department from exercising

any other right of termination the Department has under this Agreement or by law.

XIV. CORPORATE PRACTICE OF MEDICINE DOCTRINE

The Contractor shall comply with and not violate the corporate practice of medicine.

LIST OF SERVICE SITES

NAME & ADDRESS OF SITE

HCFA ESRD IDENTIFICATION NUMBER

PAYMENT PROVISIONS

I. GENERAL PAYMENT PROVISIONS

- A. The Department will pay Providers only for services provided to eligible CRDP patients and identified on the Chronic Renal Disease Program (CRDP) Fee Schedule, which services are directly related to and limited to dialysis or a direct complication of dialysis, or a kidney transplant or the rejection of a transplanted kidney, or for authorized patient charges (as defined in Section VII of Appendix A of this Agreement). The Department will pay Providers only for services or authorized patient charges that are properly rendered under a valid Agreement with the Department for provision of those services. The Department will pay Providers only for services or authorized patient charges for which the Provider has satisfactory documentation as required by the record keeping provisions of this Agreement.
- B. The Provider may bill the Department only for services identified on the Fee Schedule or for authorized patient charges. When the Department pays the Provider in accordance with the Fee Schedule, the Provider agrees to accept payment at the rate stated on the Fee Schedule as payment in full. When the Department pays authorized patient charges pursuant to Section VII of Appendix A of this Agreement, the Provider agrees to accept payment of 50% of those charges as payment in full.
- C. The Provider may not bill the Department for services provided to a patient where the patient, or the patient's designated representative, did not present the Provider with a current valid CRDP Identification Card, or the Provider did not contact the Department to verify the patient's enrollment in the CRDP prior to providing services. Confirmation by the Department of CRDP enrollment does not guarantee payment for services that do not meet the terms and conditions of this Agreement.
- D. The Department is the payer of last resort under this Agreement. The Provider shall collect all third party payments, including payments from insurers, Medicare and Medicaid, and all other monies available, prior to billing the Department. The Provider must make every effort, as determined by the Department, to maximize third-party payments before the Department will make any payment. If the payment provided by a third party payer is, by law or agreement, accepted by the Provider as payment in full, the Provider may not bill the Department or the patient for services provided to the patient.
- E. The Provider may not bill patients, in part or in full, for copayments. The Provider may not bill patients, in part or in full, for any services identified on the Fee Schedule or for authorized patient charges except when the Provider is so instructed in writing by the Department. Invoices submitted to the Department for enrolled patients who are expected to share in the cost of services will be rejected by the Department, in whole or in part, and the Provider will be instructed, in writing, by the Department to bill the patient in whole or in part.
- F. If a claim submitted by a Provider to a third party payer(s) has been rejected or only partially paid, the Provider may bill the Department for the services that were provided if they are eligible for payment under this Agreement and the Provider is permitted to bill the Department under Paragraph C. The Provider shall submit written notice of rejection from the third party payer(s) to the Department with the invoice. Where a third party payer has made partial payment to the Provider, and that partial payment is not by law payment in full,

a statement from the third party payer verifying the actual charge and the amount of payment (explanation of benefits) must be included with the invoice submitted to the Department.

- G. Invoices will be paid for actual services rendered in accordance with the terms and conditions of this Agreement. The Department reserves the right to withhold any and all payments when reported costs are questionable or when the Provider fails to comply with any term of this Agreement.
- H. The Department will pay for emergency or non-emergency services eligible for payment under this Agreement, that are performed in a health care setting (i.e., inpatient hospitalization or in a hospital short procedure unit, outpatient dialysis facility, hospital emergency room, ambulatory surgical center, or independent medical/surgical clinic) and provided to a patient covered by a third party payer(s) who is an insurer, Medicare, or Medicaid, only if the services are pre-certified in writing by the third party payer(s).
- I. For patients for whom the CRDP is the sole payer, the Department will pay for non-emergency services eligible for payment under this Agreement only if the services are pre-approved, in writing, by the Department. The Department will pay for emergency services provided to a patient for whom the CRDP is the sole payer only if written approval is obtained from the Department within three business days following the date the service was performed. Department approval is given for payment purposes only, and is intended only to assure that the service is eligible for payment under this Agreement. Department approval neither assures nor attests to the medical necessity of the service, and does not guarantee payment for services that do not meet all of the terms and conditions of this Agreement. If the Provider does not have written approval for payment from the Department, that Provider shall contact the Department for verification prior to billing the CRDP. The Department will not be liable for payment for any service for which the Provider has not received written Department approval.

II. PROSPECTIVE PAYMENT SYSTEM

- A. The Department will reimburse Hospital Providers for hospital services, including inpatient hospital services and services provided in a short procedure unit, ambulatory surgical center or independent medical/surgical clinic, according to an Agreement between the Department of Public Welfare of the Commonwealth of Pennsylvania and Commonwealth Hospital Signatories regarding Medical Assistance Rates, Payments and Payment Methods, and any updates, revisions or extensions, herein referred to as the “DPW Agreement.”
- B. The Hospital Provider shall be bound by and agrees to accept the payment rates and methods set out in the DPW Agreement and acknowledges having a copy of that document. The DPW Agreement shall be incorporated herein by reference to the extent that it provides a formula for and sets CRDP rates for services eligible for payment under this Agreement, except that no hospital signatory to the DPW Agreement shall have appeal rights or any cause of action against the Department for any issue involving the DPW Agreement including, but not limited to, issues concerning the setting of rates. If there is any conflict between the DPW Agreement and this Agreement, the order of precedence shall be first, this Agreement, and then the DPW Agreement.
- C. The Department will process hospital claims (including inpatient hospital services and services provided in a short procedure unit, ambulatory surgical center, and/or independent medical/surgical unit) by using a Prospective Payment System (PPS) utilizing Diagnosis Related Groupings (DRG). The PPS will utilize the same formulas, methods, and values to

determine hospital payments as Medical Assistance (MA), according to applicable sections of 55 Pa. Code Chapter 1163, Subchapter A, including but not limited to: §1163.2, Definitions; §1163.51, General payment policy; §1163.56, Outliers; §1163.57 Payment policy for readmissions; §1163.122, Determination of DRG relative values; and §1163.126, Computation of hospital specific base payment rates, as set out in the DPW Agreement. Provided, however, the appeal rights ordinarily applicable to these sections shall not apply. Hospital services claims will be processed according to the applicable MA rates as stated in the current DPW Agreement.

- D. The Hospital Provider shall bill the Department at the Provider's usual charge for the same or equivalent service for items provided to all persons. The Department will pay the Provider the amount indicted by the PPS, less third party payments and patient's share of costs, regardless of the amount billed.

III. SUBMISSION OF INVOICES

- A. The Provider shall submit an appropriate HCFA uniform billing form (HCFA 1500 or UB-92) and the Explanation of Benefits for each patient. Invoices shall be submitted to the following address or to any other address as directed in writing by the Department:

Pennsylvania Department of Health
Chronic Renal Disease Program
Accounts Payable Unit
7th Floor East Wing Health & Welfare Building
7th & Forster Streets
Harrisburg, PA 17120

- B. Invoices submitted for payment under this Agreement shall contain the Provider's name, address, telephone number, Federal Employer Tax Identification Number, PPA Number, date when submitted, name of person preparing the invoice, billing period, date service(s) was performed, procedure code, description of service as identified in the Fee Schedule, total invoice amount and any other information required by the Department. The Provider shall delete services that are not eligible for payment under this Agreement from invoices prior to submitting them to the Department.
- C. The Department may prospectively amend or revise these requirements for submission of invoices, in writing, by notifying the Provider at least thirty (30) days in advance by certified, return receipt U.S. mail of such changes. Such changes are incorporated herein by reference as of their effective dates.
- D. The Department will deny and return to the Provider any incomplete or inaccurate invoices.
- E. The Provider shall submit invoices within 30 days of the date the service was performed, unless the Provider must first seek payment from a third party payer(s). If an invoice is submitted late due to a Provider's seeking payment from a third party payer(s), the Provider shall submit the invoice within 30 days of receiving the third party explanation of benefits, but the Provider may not, in any event, submit the invoice later than 180 days from the date a service was performed unless the Department has agreed to an extension of time in writing within 180 days from the date of service. The Department will neither honor nor be liable for invoices received later than 180 days from the date the service was performed unless the Department has agreed to an extension of time in writing.

IV. REFUNDS

- A. In the event a Provider receives payment from a third party for a service that has been paid for by the Department under this Agreement, the Provider shall remit such payment to the Department up to the amount paid by the Department. Refund checks shall be made payable to the “Commonwealth of Pennsylvania-Chronic Renal Disease Program” and shall include the name of the patient, social security number, date of service, description of service, and amount paid by the Department. Refund checks shall be forwarded directly to:

Pennsylvania Department of Health
Bureau of Family Health
625 Forster Street
Health and Welfare Building 7th Floor East Wing
Harrisburg, PA 17120

- B. Providers shall make refunds to the Department within thirty (30) days of receiving the payment from a third party for a service that has been paid for by the Department under this Agreement.

LIST OF PRACTITIONERS

(Please list each Doctor's Name and their License Number
or provide your own list.)