**FIRST AMENDMENT**

**TO THE**
**UNITED BEHAVIORAL HEALTH**
**GROUP PARTICIPATION AGREEMENT**

THIS FIRST **{1}** AMENDMENT, effective on the date specified by UBH ("Effective Date"), is to the Behavioral Health Group Participation Agreement between United Behavioral Health ("UBH") and **Centrality Behavior Support Training LLC** ("Group").

1. This Amendment shall hereby add the COMMERCIAL NETWORK(s) to Provider's Agreement. All Covered Services provided must be provided in accordance with the attached state regulatory addendum for Commercial Networks attached hereto.

2. This Amendment shall hereby add the UBH MEDICAID NETWORK(s) to Provider's Agreement. All Covered Services provided must be provided in accordance with the attached IN State Programs Regulatory Requirements Appendix attached hereto.

3. This Amendment shall hereby add the network Fee Schedule attached hereto.

4. All other provisions of the Agreement remain in full force and effect.

**The Effective Date of this Amendment is _____**
**(To Be Completed By UBH Only)**

**UNITED BEHAVIORAL HEALTH**
P.O. Box 9472
Minneapolis, MN 55440-9472

Signature_____

Name _____

Title _____

Date_____

**PROVIDER NAME & ADDRESS**
_____
_____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number: _____

Medicaid Number: _____

NPI Number: _____

# Indiana Regulatory Appendix

This Indiana Regulatory Requirements Appendix (the "Appendix") is made part of this Agreement entered into between United Behavioral Health ("UBH") and the health care professional named in this Agreement ("Provider").

This Appendix applies to all products or Benefit Plans sponsored, issued or administered by or accessed through UBH to the extent such products are regulated under Indiana laws; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

UBH and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix, and be read in accordance with applicable laws and regulations.

If any of the capitalized terms in this Appendix are used or defined (or the equivalent terms are used or defined) in the Agreement, then the terms used in this Appendix will have the same meaning as the terms (or equivalent terms) used or defined in the Agreement. For example, "Benefit Plans," as used in this Appendix, will have the same meaning as "benefit contracts"; "Member," as used in this Appendix, will have the same meaning as "member," "enrollee," or "covered person"; "Payor," as used in this Appendix, will have the same meaning as "participating entity"; "Provider," as used in this Appendix, will have the same meaning as "Facility," "Medical Group," "Ancillary Provider," "Physician," or "Practitioner." Additionally, if the Agreement uses pronouns to refer to the contracted entities, then "UBH" will have the same meaning as "we" or "us," and "Provider" will have the same meaning as "you" or "your."

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix shall be defined as set forth in the Agreement.

## I. Provisions applicable to Benefit Plans regulated under Indiana insurance and/or Health Maintenance Organization (HMO) law:

**1. Liability Insurance.** Provider locations in the state of Indiana shall be considered adequately insured for purposes of this Agreement, with respect to Covered Services provided to Members who reside in Indiana, if Provider has procured liability insurance through an admitted insurance company, has paid the appropriate surcharge to the State of Indiana and is in compliance with the provisions of the Indiana Medical Malpractice Act. Evidence of payment of the surcharge must be submitted to UBH prior to this Agreement becoming effective.

**2. Amendments to this Agreement.** To the extent this Agreement allows UBH to amend the Agreement unilaterally, UBH may amend this Agreement by sending a copy of the amendment to Provider at least 45 days prior to its effective date. If Provider chooses not to approve the amendment, Provider may terminate this Agreement by notifying UBH in writing within 15 days after receiving the amendment. Such termination will take effect 90 days after UBH receives the written notice from Provider. Provider will not be required to comply with the amendment if Provider chooses to terminate the Agreement, and UBH may not penalize Provider for choosing to

terminate the Agreement. Except in the case of an emergency, Provider is required to disclose that this Agreement is terminating to Members before rendering Covered Services.

This provision does not apply to amendments required to comply with any state or federal regulatory authorities.

**3. Disclosure.** In accordance with Ind. Code Ann. § 27-8-11-4.5 and 27-13-15-1, nothing in the Agreement should be construed to prohibit Provider from disclosing (1) the terms of the Agreement as it relates to any financial or other incentives to Provider to limit medical services by Provider; or (2) any treatment options available to a Member, including those not covered by a Member's benefit plan. UBH shall not penalize Provider financially or in any other manner for making a disclosure permitted in this section I.3.

**4. Prompt pay.** UBH or Payor, as applicable, shall pay or deny claims in accordance with claims payment provisions contained in Indiana Code §§ 27-13-36.2 and 27-8-5.7, as applicable.

**5. Copies of medical records.** Provider shall comply with Indiana Administrative Code Title 760 §1-71 with regard to fees for copies of medical records.

**6. Claims adjustments.** UBH or Payor may not, more than two years after the date on which an overpayment on a claim was made: (1) request that Provider repay the overpayment; or (2) adjust a subsequent claim filed by Provider as a method of obtaining reimbursement of the overpayment from Provider. UBH or Payor may not be required to correct a payment error to a Provider more than two years after the date on which a payment on the claim was made. This provision does not apply in cases of fraud, with respect to the claim on which an overpayment or underpayment was made.

Adjusted subsequent claims for overpayments are required to have an identification of the claim on which the overpayment was made; and if ascertainable, the party financially responsible for the overpaid amount, and the amount that is being reimbursed to UBH or Payor through the adjusted subsequent claims.

**7. No most-favored-nation.** Nothing in this agreement shall: (1) prohibit, or grant UBH the option to prohibit, Provider from contracting with another insurer or HMO to accept a lower payment for health care services than to the payment specified in this Agreement; (2) require, or grant UBH the option to require, Provider to accept a lower payment from UBH if Provider agrees with another insurer or HMO to accept a lower payment for health care services; (3) require, or grant UBH an option of, termination or renegotiation of this Agreement if Provider agrees with another insurer or HMO to accept lower payment for health care services; or (4) require Provider to disclose Provider's reimbursement rates with other insurers or HMOs.

**8. All Products Provision.** As a condition of entering into a contract for the provision of health care services other than health care services to Members of a health maintenance organization, Provider may not be required to provide health care services to Members of a health maintenance organization. However, as a condition of entering into a contract for the provision of health care services other than health care services to Members of a health maintenance organization, Provider may be required to provide health care services to Members of a health maintenance organization in an emergency or upon referral. If Provider is required to provide health care services to Members of a health maintenance organization in cases of emergency or referral, Provider shall be reimbursed for those services at rates established under this Agreement, but Provider shall not be required to comply with the terms and conditions of the health maintenance organization.

**9. Prior Authorization.** UBH and Provider will comply with all applicable provisions of IC 27-1-37.5 according to the timeframes specified therein, including, but not limited to the following: (a) Provider must submit and UBH must accept a request for prior authorization through a secure electronic transmission; and (b) Provider must notify UBH of any change in Provider's electronic or U.S. mail address, not more than seven days after the change is made.

**II. Provisions applicable to Benefit Plans regulated under Indiana HMO law only:**

**1. Member protection provision.** In the event UBH or Payor fails to pay for Covered Services as specified by this Agreement, the Member is not liable to Provider for any sums owed by the UBH or Payor. Provider may not collect or attempt to collect from a Member any sums that are owed by UBH or Payor. Neither Provider nor its trustee, agent, representative, or assignee may bring or maintain any legal action against a Member to collect sums owed by UBH or Payor. If Provider brings or maintains a legal action against a Member for an amount owed to the Provider by UBH or Payor, Provider is liable to Member for costs and attorney's fees incurred by the Member in defending the legal action. Provided, however that Provider shall not be liable to the Member for such costs and attorney's fees if Provider can demonstrate a reasonable basis for believing at the time the legal action was brought and while the legal action was maintained that UBH or Payor did not owe the sums Provider sought to collect from the Member.

**2. Continuation of Covered Services after termination.**

(a) In the event the Agreement is terminated by UBH, a Member who is hospitalized for a medical or surgical condition on the date of termination will have continuation of coverage for inpatient Covered Services. This continuation of coverage is not required after one of the following occurs: (i) the discharge of the Member from the hospital; (ii) 60 days pass after the Agreement is terminated by UBH; (iii) the hospitalized Member obtains from another carrier coverage that includes the coverage provided by UBH; (iv) a contract holder terminates the Member's Benefit Plan, or UBH or Payor terminates the Member's Benefit Plan as described in Ind. Code Ann. § 27-13-7-13(4) and (5); or (v) a Member terminates his or her coverage. UBH or Payor may provide benefits that exceed the continuation of coverage required by this section 2(a), either in the types or time period of health care services covered, or both. This section 2(a) does not apply in the event UBH is placed in receivership.

(b) In the event the Agreement is terminated for UBH's receivership, and a Member is receiving health care services from Provider, Provider is obligated to continue the provision of Covered Services to that Member (i) for the duration of the contract period for which premiums have been paid, or (ii) if the Member is hospitalized on the date of receivership for the longer of: (1) the period ending when the Member is discharged from hospitalization; or (2) the duration of the contract period for which premiums have been paid.

**3. Termination of this Agreement.** Provider will give advance notice to UBH, in the form and for the length of time as provided in the Agreement, but in no case less than 60 days, before terminating this Agreement. In the event Provider, or the group of providers of which Provider is a part, provides 30% or more of the health care services received by Members of UBH, then Provider must give advance notice to UBH, in the form and for the length of time as provided in the Agreement, but in no case less than 120 days before terminating the Agreement.

**4. No penalty for representation or prohibition for disclosure.** UBH may not take action against Provider solely on the basis that Provider represents a Member in a grievance filed under Ind. Code Ann. § 27-13-10-11.

**5. Confidentiality of Member medical information.** Provider shall comply with all applicable laws and regulations regarding the confidentiality of a Member's medical information, including but not limited to those set forth in Ind. Code Ann. § 27-13-31-1.

## FS 7463 N Std 2 6455 ABA 2148

| Modifier | Service Code | Service Title/Description | Fee: MD | Fee: PHD | Fee: MA | Fee: RN |
|---|---|---|---|---|---|---|
| | **90785** | Interactive complexity | $16.24 | $13.80 | $12.18 | $13.80 |
| | **90791** | Psychiatric Diagnostic Evaluation without Medical Services | $150.08 | $127.57 | $112.56 | $127.57 |
| | **90792** | Psychiatric Diagnostic Evaluation with Medical Services | $167.90 | $142.72 | $125.93 | $142.72 |
| | **90832** | Psychotherapy, 30 Min. | $72.86 | $61.93 | $54.65 | $61.93 |
| | **90833** | Psychotherapy pt&/fam w/e&m 30 min | $76.03 | $64.63 | $0.00 | $64.63 |
| | **90834** | Psychotherapy, 45 Min. | $97.42 | $82.80 | $73.06 | $82.80 |
| | **90836** | Psychotherapy pt&/fam w/e&m 45 min | $95.83 | $81.46 | $0.00 | $81.46 |
| | **90837** | Psychotherapy, 60 Min. | $146.12 | $124.21 | $109.59 | $124.21 |
| | **90838** | Psychotherapy pt&/fam w/e&m 60 min | $126.72 | $107.71 | $0.00 | $107.71 |
| | **90839** | Psychotherapy for crisis, first 60 min. | $152.46 | $129.59 | $114.35 | $129.59 |
| | **90840** | Psychotherapy crisis each additional 30 min | $72.86 | $61.93 | $54.65 | $61.93 |
| | **90846** | Family Psychotherapy, without pt present | $117.61 | $99.97 | $88.21 | $99.97 |
| | **90847** | Family/Couple Psychotherapy | $122.36 | $104.01 | $91.77 | $104.01 |
| | **90849** | Multiple-family Group Psychotherapy | $41.18 | $40.00 | $40.00 | $40.00 |
| | **90853** | Group Psychotherapy | $40.00 | $40.00 | $40.00 | $40.00 |
| | **90863** | Pharmacologic mgmt with psychotherapy | $0.00 | $21.18 | $0.00 | $0.00 |
| | **90870** | ECT, single seizure and multiple seizure per day | $196.42 | $0.00 | $0.00 | $0.00 |
| | **90901** | Biofeedback | $95.00 | $69.00 | $60.00 | $60.00 |
| | **96112** | Devel tst phys/qhp 1st hr | $0.00 | $0.00 | $0.00 | $0.00 |
| | **96113** | Devel tst phys/qhp ea addl | $0.00 | $0.00 | $0.00 | $0.00 |
| | **96116** | Neurobehavioral Status Exam with interpretation and report per hour | $104.94 | $89.20 | $0.00 | $0.00 |
| | **96121** | Nubhvl xm phy/qhp ea addl hr | $91.87 | $78.09 | $0.00 | $0.00 |
| | **96130** | Psycl tst eval phys/qhp 1st | $130.68 | $111.08 | $0.00 | $0.00 |
| | **96131** | Psycl tst eval phys/qhp ea | $99.40 | $84.49 | $0.00 | $0.00 |
| | **96132** | Nrpsyc tst eval phys/qhp 1st | $146.92 | $124.88 | $0.00 | $0.00 |
| | **96133** | Nrpsyc tst eval phys/qhp ea | $112.07 | $95.26 | $0.00 | $0.00 |
| | **96136** | Psycl/nrpsyc tst phy/qhp 1st | $52.67 | $44.77 | $0.00 | $0.00 |
| | **96137** | Psycl/nrpsyc tst phy/qhp ea | $48.71 | $41.40 | $0.00 | $0.00 |
| | **96138** | Psycl/nrpsyc tech 1st | $42.77 | $36.35 | $0.00 | $0.00 |
| | **96139** | Psycl/nrpsyc tst tech ea | $42.77 | $36.35 | $0.00 | $0.00 |
| | **96146** | Psycl/nrpsyc tst auto result | $2.38 | $2.02 | $0.00 | $0.00 |
| | **96156** | H&B assessment or reassessment | $0.00 | $93.47 | $82.48 | $93.47 |
| | **96158** | H&B intervention, individual, initial 30 minutes | $0.00 | $63.78 | $56.27 | $63.78 |
| | **96159** | H&B intervention, individual, each add'l 15 minutes (add-on) | $0.00 | $22.27 | $19.65 | $22.27 |
| | **96164** | H&B intervention, group, initial 30 minutes | $0.00 | $9.45 | $8.34 | $9.45 |
| | **96165** | H&B intervention, group, each add'l 15 minutes (add-on) | $0.00 | $4.39 | $3.87 | $4.39 |
| | **96167** | H&B intervention, family w/patient, initial 30 minutes | $0.00 | $68.50 | $60.44 | $68.50 |
| | **96168** | H&B intervention, family w/patient, each add'l 15 minutes (add-on) | $0.00 | $24.29 | $21.43 | $24.29 |
| | **96170** | H&B intervention, family w/out patient, initial 30 minutes | $0.00 | $77.61 | $68.48 | $77.61 |

| Modifier | Service Code | Service Title/Description | Fee: MD | Fee: PHD | Fee: MA | Fee: RN |
|---|---|---|---|---|---|---|
| | **96171** | H&B intervention, family w/out patient, each add'l 15 minutes (add-on) | $0.00 | $28.35 | $25.01 | $28.35 |
| | **96202** | Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes | $0.00 | $0.00 | $20.74 | $0.00 |
| | **96203** | Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service) | $0.00 | $0.00 | $5.33 | $0.00 |
| | **96372** | Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular | $22.97 | $0.00 | $0.00 | $19.52 |
| | **99202** | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter. | $83.95 | $25.96 | $0.00 | $71.36 |
| | **99203** | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter. | $120.78 | $32.45 | $0.00 | $102.66 |
| | **99204** | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter. | $184.14 | $58.40 | $0.00 | $156.52 |
| | **99205** | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. | $231.66 | $68.13 | $0.00 | $196.91 |
| | **99211** | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. | $24.16 | $25.96 | $0.00 | $20.53 |

| Modifier | Service Code | Service Title/Description | Fee: MD | Fee: PHD | Fee: MA | Fee: RN |
|---|---|---|---|---|---|---|
| | **99212** | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter. | $49.10 | $25.96 | $0.00 | $41.74 |
| | **99213** | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter. | $81.58 | $25.96 | $0.00 | $69.34 |
| | **99214** | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. | $120.38 | $34.39 | $0.00 | $102.33 |
| | **99215** | Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. | $162.36 | $57.10 | $0.00 | $138.01 |
| | **99221** | 1ST HOSPITAL IP/OBS CARE SF/LOW MDM 40 MINUTES | $113.65 | $96.60 | $85.24 | $96.60 |
| | **99222** | 1ST HOSPITAL IP/OBS CARE MODERATE MDM 55 MINUTES | $153.25 | $130.26 | $114.94 | $130.26 |
| | **99223** | 1ST HOSPITAL IP/OBS CARE HIGH MDM 75 MINUTES | $227.30 | $193.21 | $170.48 | $193.21 |
| | **99231** | SBSQ HOSPITAL IP/OBS CARE SF/LOW MDM 25 MINUTES | $43.96 | $0.00 | $0.00 | $37.37 |
| | **99232** | SBSQ HOSPITAL IP/OBS CARE MOD MDM 35 MINUTES | $81.58 | $0.00 | $0.00 | $69.34 |
| | **99233** | SBSQ HOSPITAL IP/OBS CARE HIGH MDM 50 MINUTES | $116.82 | $0.00 | $0.00 | $99.30 |
| | **99234** | HOSPITAL IP/OBS CARE SAME DATE SF/LOW MDM 45 MIN | $149.29 | $126.90 | $0.00 | $126.90 |
| | **99235** | HOSPITAL IP/OBS CARE SAME DATE MOD MDM 70 MIN | $189.68 | $161.23 | $0.00 | $161.23 |
| | **99236** | HOSPITAL IP/OBS CARE SAME DATE HIGH MDM 85 MIN | $244.73 | $208.02 | $0.00 | $208.02 |
| | **99238** | HOSPITAL IP/OBS DISCHARGE DAY MGMT 30 MIN/< | $81.97 | $0.00 | $0.00 | $69.67 |
| | **99239** | HOSPITAL IP/OBS DISCHARGE DAY MGMT > 30 MIN | $120.78 | $0.00 | $0.00 | $102.66 |
| | **99242** | OFFICE/OP CONSLTJ NEW/EST PT SF MDM 20 MINUTES | $99.79 | $84.82 | $0.00 | $84.82 |
| | **99243** | OFFICE/OP CONSLTJ NEW/EST PT LOW MDM 30 MINUTES | $136.62 | $116.13 | $0.00 | $116.13 |
| | **99244** | OFFICE/OP CONSLTJ NEW/EST PT MOD MDM 40 MINUTES | $204.34 | $173.69 | $0.00 | $173.69 |
| | **99245** | OFFICE/OP CONSLTJ NEW/EST PT HIGH MDM 55 MINUTES | $249.08 | $211.72 | $0.00 | $211.72 |
| | **99252** | IP/OBS CONSLTJ NEW/EST PT SF MDM 35 MINUTES | $83.56 | $71.02 | $62.67 | $71.02 |

| Modifier | Service Code | Service Title/Description | Fee: MD | Fee: PHD | Fee: MA | Fee: RN |
|---|---|---|---|---|---|---|
| | **99253** | IP/OBS CONSLTJ NEW/EST PT LOW MDM 45 MINUTES | $128.70 | $109.40 | $96.53 | $109.40 |
| | **99254** | IP/OBS CONSLTJ NEW/EST PT MOD MDM 60 MINUTES | $186.91 | $158.88 | $140.18 | $158.88 |
| | **99255** | IP/OBS CONSLTJ NEW/EST PT HIGH MDM 80 MINUTES | $224.93 | $191.19 | $168.70 | $191.19 |
| | **99281** | EMERGENCY DEPARTMENT VISIT MAY NOT REQ PHYS/QHP | $23.76 | $20.20 | $17.82 | $20.20 |
| | **99282** | EMERGENCY DEPARTMENT VISIT STRAIGHTFORWARD MDM | $46.33 | $39.38 | $34.75 | $39.38 |
| | **99283** | EMERGENCY DEPARTMENT VISIT LOW MDM | $69.30 | $58.91 | $51.98 | $58.91 |
| | **99284** | EMERGENCY DEPARTMENT VISIT MODERATE MDM | $131.47 | $111.75 | $98.60 | $111.75 |
| | **99285** | EMERGENCY DEPARTMENT VISIT HIGH MDM | $193.64 | $164.60 | $145.23 | $164.60 |
| | **99304** | INITIAL NURSING FACILITY CARE SF/LOW MDM 25 MIN | $102.17 | $86.84 | $76.63 | $86.84 |
| | **99305** | INITIAL NURSING FACILITY CARE MOD MDM 35 MINUTES | $146.12 | $124.21 | $109.59 | $124.21 |
| | **99306** | INITIAL NURSING FACILITY CARE HI MDM 45 MINUTES | $186.91 | $158.88 | $140.18 | $158.88 |
| | **99307** | SBSQ NURSING FACILITY CARE SF MDM 10 MINUTES | $49.90 | $42.41 | $37.42 | $42.41 |
| | **99308** | SBSQ NURSING FACILITY CARE LOW MDM 15 MINUTES | $77.62 | $65.97 | $58.21 | $65.97 |
| | **99309** | SBSQ NURSING FACILITY CARE MOD MDM 30 MINUTES | $102.56 | $87.18 | $76.92 | $87.18 |
| | **99310** | SBSQ NURSING FACILITY CARE HIGH MDM 45 MINUTES | $152.46 | $129.59 | $114.35 | $129.59 |
| | **99341** | HOME/RES VISIT NEW PATIENT SF MDM 15 MINUTES | $61.38 | $0.00 | $0.00 | $52.17 |
| | **99342** | HOME/RES VISIT NEW PATIENT LOW MDM 30 MINUTES | $89.10 | $0.00 | $0.00 | $75.74 |
| | **99347** | HOME/RES VISIT EST PATIENT SF MDM 20 MINUTES | $61.78 | $0.00 | $0.00 | $52.51 |
| | **99348** | HOME/RES VISIT EST PATIENT LOW MDM 30 MINUTES | $94.25 | $0.00 | $0.00 | $80.11 |
| | **99349** | HOME/RES VISIT EST PATIENT MOD MDM 40 MINUTES | $144.14 | $0.00 | $0.00 | $122.52 |
| | **99383** | Inpatient History and Physical- initial (5-11 yrs) | $134.64 | $0.00 | $0.00 | $0.00 |
| | **99384** | Inpatient History and Physical- (12-17 yrs) | $152.06 | $0.00 | $0.00 | $0.00 |
| | **99385** | Inpatient History and Physical- (18-39 yrs) | $147.31 | $0.00 | $0.00 | $0.00 |
| | **99386** | Inpatient History and Physical- (40-64 yrs) | $171.07 | $0.00 | $0.00 | $0.00 |
| | **99408** | Alcohol/SA abuse(other than tobacco) screening & brief intervention. 15-30 minutes | $39.60 | $33.66 | $29.70 | $33.66 |
| | **99409** | Alcohol/SA abuse(other than tobacco) screening & brief intervention. > 30 minutes | $76.82 | $65.30 | $57.62 | $65.30 |
| | **99418** | Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service) | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99441** | Telephonic evaluation 5-10 minutes | $15.84 | $13.46 | $11.88 | $13.46 |
| | **99442** | Telephonic evaluation 11-20 minutes | $30.10 | $25.58 | $22.57 | $25.58 |
| | **99443** | Telephonic evaluation 21-30 minutes | $44.35 | $37.70 | $33.26 | $37.70 |
| | | MH Assessment by Non-Physician (per Hour) | $120.00 | $120.00 | $120.00 | $120.00 |

| Modifier | Service Code | Service Title/Description | Fee: MD | Fee: PHD | Fee: MA | Fee: RN |
|---|---|---|---|---|---|---|
| | **H0031** | **Direct Services for Assessment/Treatment Planning by BCBA or licensed MH clinician, per hour.** | | | | |
| | **H0032** | MH Service Plan Development by Non-Physician (per Hour) | $75.00 | $75.00 | $75.00 | $75.00 |
| | | **Supervision of Paraprofessional by BCBA or licensed MH clinician; per hour (services rendered jointly, in-person, during directly supervised fieldwork of the Paraprofessional by the Supervisor)** | | | | |
| | **H2012** | MHSA Day Treatment (per Hour) | $60.00 | $60.00 | $60.00 | $60.00 |
| | | **Direct ABA Services by BCBA or licensed MH clinician, per hour.** | | | | |
| | **H2014** | MH Skills Training and Development (15 Min.) | $8.00 | $8.00 | $8.00 | $8.00 |
| | | **Social Skills Group (multi child & staff), per 15 minutes.** | | | | |
| | **H2019** | MH Therapeutic Behavioral Services (15 Min.) | $12.50 | $12.50 | $12.50 | $12.50 |
| | | **Services by ABA Paraprofessional, per 15 minutes.** | | | | |

**INDIANA STATE PROGRAM**

**REGULATORY REQUIREMENTS APPENDIX**

**DOWNSTREAM PROVIDER**

THIS INDIANA STATE PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare Insurance Company or one of its Affiliates and the party named in the Agreement ("Provider").

## SECTION 1
## APPLICABILITY

The requirements of this Appendix apply to benefit plans sponsored, issued or administered by UnitedHealthcare Insurance Company or one of its Affiliates (referred to in this Appendix as "United") under the State's Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs for low-income individuals (the "State Program") as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required by law or requested by the State to comply with federal or State regulations, United will unilaterally initiate such additions, deletions or modifications.

## SECTION 2
## DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

2.1 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

2.2 **Children's Health Insurance Program or CHIP:** A program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and State governments and administered by the State.

**2.3 Covered Person:** An individual who is currently enrolled with United for the provision of services under a State Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.4 **Covered Services:** Health care services or products for which a Covered Person is enrolled with United to receive coverage under the State Contract.

2.5 **Department:** The Indiana Department of Administration (IDOA), acting on behalf of Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP).

2.6 **Medicaid:** A program authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and State governments and administered by the State.

**2.7 State:** The State of Indiana or its designated regulatory agencies.

2.8 **State Contract:** United's contract with the Department for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Program.

2.9 **State Program(s):** The Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs for low-income individuals, developed and administered by the State. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

## SECTION 3
## PROVIDER REQUIREMENTS

The State Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that United and Provider agree to undertake, which include the following:

**3.1 Definitions Related to the Provision of Covered Services.** Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

iii) Medically Necessary or Medical Necessity: A Covered Service that is required for the care or wellbeing of a Covered Person and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by United, it must:

a) be medically reasonable and necessary, as determined by United, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and

b) not be listed in 405 IAC 5-2-17 as a non-covered service, or otherwise excluded from coverage.

"Medically Necessary" or "Medical Necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with

the provisions of the appropriate medical care, be effectively furnished more economically on an outpatient basis or by an inpatient Provider of a different type. The fact that Provider has prescribed, recommended or approved medical or allied goods, or services does not, in itself, make such care, goods or services Medically Necessary or a Medical Necessity or a Covered Service.

**3.2 Medicaid or CHIP Participation.** Provider must be duly licensed in accordance with the appropriate state licensing board and enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in United's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, United must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. United will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

**3.3 Accessibility Standards.** Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

**3.4 Hours of Operation; Appointments.** Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

**3.5 Hold Harmless.** Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to United for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that United cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15 and 42 CFR 438.106, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which United is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. In the event a copayment is required, Provider shall use best commercial efforts to collect the required copayment from the Covered Person. Provider is prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of United, even in the event of insolvency, and under no circumstances shall Provider, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

**3.6 Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the Department and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. The Department may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

**3.7 Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214 and IC 12-15-11-9, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. Provider shall meet all Department standards for credentialing and maintain State Program manual standards, including compliance with State record keeping requirements, FSSA's access and availability standards, and other quality improvement program standards. If United delegates credentialing to Provider, United will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with United's and the State Contract's credentialing requirements.

**3.8 Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

**3.9 Subcontracts.** If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by United, to meet any additional State Program requirements that may apply to the services.

**3.10 Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall comply with 405 IAC 1-1.4-2 and include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposal of records must be requested and approved by United if the Agreement is continuous.

**3.11 Records Access.** Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for

State or Federal fraud investigators. In addition, Provider shall provide a copy of a Covered Person's medical record to such Covered Person at no charge upon reasonable request, and shall facilitate the transfer of a Covered Person's medical record to another provider at the Covered Person's request.

**3.12 Government Audit; Investigations.** Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

**3.13 Privacy; Confidentiality.** Provider understands that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.3 (if applicable), as may be amended from time to time.

Access to member identifying information shall be limited by Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Provider shall notify United and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide United and the

Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Provider shall work with United and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

**3.14 Compliance with Law.** Provider shall comply with all applicable federal and State laws and regulations, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

iii) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

**3.15 Compliance with Medicaid Laws and Regulations.** Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to United upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

**3.16 Physician Incentive Plans.** In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479,

42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither United nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

**3.17 Lobbying.** Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

**3.18 Excluded Individuals and Entities.** By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR

§1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to United any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Federal and State exclusion databases must be reviewed monthly to ensure that no employee or contractor has been excluded. Applicable state exclusion databases can be accessed through the State's Medicaid website. United will terminate the Agreement immediately and exclude from its network any provider who has been terminated from the Medicare, Medicaid or CHIP program in any state. United may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

**3.19 Disclosure.** Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

**3.20 Cultural Competency and Access.** Provider shall participate in United's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

**3.21 Marketing.** As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to United to submit to the State Program for prior approval.

**3.22 Fraud, Waste and Abuse Prevention.** Provider shall cooperate fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist the Department and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with United's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of

title 31, United States Code), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR §438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

**3.23 Electronic Visit Verification (EVV).** Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

**3.24 Data; Reports.** Provider shall cooperate with and release to United any information necessary for United to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by United, in the format specified by United and the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State. Data must be provided at the frequency and level of detail specified by United or the State. By submitting data to United, Provider represents and attests to United and the State that the data is accurate, complete, and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

**3.25 Encounter Data.** Provider agrees to cooperate with United to comply with United's obligation to prepare timely encounter data submissions, reports, and clinical information including, without limitation, child, and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets United and State requirements. By submitting encounter data to United, Provider represents to United that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

**3.26 Claims Information.** Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United. Provider understands and agrees that each claim Provider submits to United constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim. All claims for services rendered to Covered Persons that do not involve a third-party payer must be submitted to United within ninety (90) calendar days from the date of service.

**3.27 Insurance Requirements.** As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement.

**3.28** **Licensure.** Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

**3.29** **Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

**3.30** **Quality; Utilization Management.** Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with United's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

**3.31** **Non-Discrimination.** Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

**3.32** **Immediate Transfer.** Provider shall cooperate with United in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

**3.33** **Transition of Covered Persons.** In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Provider shall work with United to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

**3.34 Continuity of Care.** Provider shall cooperate with United and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider's participation with United terminates during the course of a Covered Person's treatment by Provider, except in the case of adverse reasons on the part of Provider.

In the case of Primary Medical Providers, Provider must continue care for a Covered Person after termination of participation with United for a minimum of thirty (30) days, or until the Covered Person's treatment can be successfully transferred to another Primary Medical Provider.

**3.35 Health Records.** Provider agrees to cooperate with United to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.

**3.36 Advance Directives.** When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 489, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

**3.37 National Provider ID (NPI).** If applicable, Provider shall obtain a National Provider Identification Number (NPI).

**3.38 Termination.** Provider may terminate, without cause upon ninety (90) days' prior written notice to United:

i) its participation status in the State Programs (under Section 1 of Appendix 2 or other applicable provision within the Agreement); or

ii) the Agreement, in the event the State Programs are the only Benefit Plans provider participates in under the Agreement.

In the event of any such termination, Provider shall promptly supply to United all information necessary for the reimbursement of any outstanding Medicaid claims.

**3.39 Health Care Acquired/Preventable Conditions.** Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to United any provider preventable conditions in accordance with 42 CFR §§ 434.6(a)(12), 438, including but not limited to § 438.3(g), and § 447.26.

**3.40 Overpayment.** Provider shall report to United when it has received an overpayment and will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified. Provider will notify United in writing of the reason for the overpayment.

## SECTION 4
## ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

**4.1 Mental Health and Substance Use Providers.** Providers who provide Mental Health and Substance Use services to Covered Persons must provide for services to be delivered in

compliance with the requirements of 42 CFR 438.3 subpart K insofar as those requirements are applicable. Such Providers shall ask and encourage Covered Persons to sign a consent that permits the release of substance use treatment to United and other providers who provide services to that Covered Person. As applicable, Provider shall ensure that Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge and shall share behavioral health treatment information with United and such Covered Person's Primary Medical Provider (including the summary of treatment sessions, primary and secondary diagnoses, assessment findings, medications and psychotherapy prescribed). Such follow-up treatment must be provided within seven (7) calendar days from the date of discharge.

**4.2 Long-Term Services and Supports (LTSS) Providers.** Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

## SECTION 5
## UNITED REQUIREMENTS

**5.1 Prompt Payment.** United shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third-party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract.

**5.2 No Incentives to Limit Medically Necessary Services.** United shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

**5.3 Provider Discrimination Prohibition.** United shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. United shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

**5.4 Communications with Covered Persons.** United shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment; or

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

United also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

**5.5 Termination, Revocation and Sanctions.** In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Provider's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation,

In accordance with IC 12-15-30-5, subcontracts, including provider agreements, cannot extend beyond the term of the State Contract but may automatically renew if the State Contract is re-awarded by subsequent procurement. Provider's participation in the Benefit Plans will terminate in the event the State Contract is terminated.

## SECTION 6
## OTHER REQUIREMENTS

**6.1 Compliance with State Contract.** All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that United has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

**6.2 Monitoring.** United shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, United shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United and/or required by the State Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Provider practice and/or the performance standards established under the State Contract.

**6.3** **Enrollment.** The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment, and disenrollment of Covered Persons.

**6.4** **No Exclusivity.** Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than United or as prohibiting or penalizing United for contracting with other providers.

**6.5** **Delegation.** The parties agree that, prior to execution of the Agreement, United evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement if in United's reasonable judgment Provider's performance under the Agreement is inadequate.

**FS 8484 Mcaid BH and ABA**

| Modifier | Service Code | Service Title/Description | Units | Fee: MD | Fee:PHD | Fee: RN | Fee: PHAS & PABH | Fee: MA |
|---|---|---|---|---|---|---|---|---|
| | **80305** | DRUG TEST PRSMV DIR OPT OBS | 0-999 years | $12.60 | $0.00 | $12.60 | $12.60 | $0.00 |
| | **80306** | DRUG TEST PRSMV INSTRUMENT | 0-999 years | $17.14 | $0.00 | $17.14 | $17.14 | $0.00 |
| | **80307** | DRUG TEST PRSMV CHEM ANLYZR | 0-999 years | $62.14 | $0.00 | $62.14 | $62.14 | $0.00 |
| | **90785** | PSYTX COMPLEX INTERACTIVE | 0-999 years | $14.43 | $14.43 | $14.43 | $14.43 | $14.43 |
| | **90791** | PSYCH DIAGNOSTIC EVALUATION | 0-999 years | $169.40 | $169.40 | $169.40 | $169.40 | $169.40 |
| | **90792** | PSYCH DIAG EVAL W/MED SRVCS | 0-999 years | $188.94 | $188.94 | $188.94 | $188.94 | $188.94 |
| | **90832** | PSYTX W PT 30 MINUTES | 0-999 years | $73.38 | $73.38 | $73.38 | $73.38 | $73.38 |
| | **90833** | PSYTX W PT W E/M 30 MIN | 0-999 years | $66.92 | $66.92 | $66.92 | $66.92 | $66.92 |
| | **90834** | PSYTX W PT 45 MINUTES | 0-999 years | $96.94 | $96.94 | $96.94 | $96.94 | $96.94 |
| | **90836** | PSYTX W PT W E/M 45 MIN | 0-999 years | $84.81 | $84.81 | $84.81 | $84.81 | $84.81 |
| | **90837** | PSYTX W PT 60 MINUTES | 0-999 years | $142.78 | $142.78 | $142.78 | $142.78 | $142.78 |
| | **90838** | PSYTX W PT W E/M 60 MIN | 0-999 years | $112.11 | $112.11 | $112.11 | $112.11 | $112.11 |
| | **90839** | PSYTX CRISIS INITIAL 60 MIN | 0-999 years | $136.70 | $136.70 | $136.70 | $136.70 | $136.70 |
| | **90840** | PSYTX CRISIS INITIAL 60 MIN | 0-999 years | $67.25 | $67.25 | $67.25 | $67.25 | $67.25 |
| | **90845** | PSYCHOANALYSIS | 0-999 years | $91.58 | $91.58 | $91.58 | $91.58 | $91.58 |
| | **90846** | FAMILY PSYTX W/O PT 50 MIN | 0-999 years | $93.26 | $93.26 | $93.26 | $93.26 | $93.26 |
| | **90847** | FAMILY PSYTX W/PT 50 MIN | 0-999 years | $97.27 | $97.27 | $97.27 | $97.27 | $97.27 |
| | **90849** | MULTIPLE FAMILY GROUP PSYTX | 0-999 years | $35.44 | $35.44 | $35.44 | $35.44 | $35.44 |
| | **90853** | GROUP PSYCHOTHERAPY | 0-999 years | $25.87 | $25.87 | $25.87 | $25.87 | $25.87 |
| | **90867** | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIM | 18-999 years | $180.63 | $0.00 | $180.63 | $180.63 | $0.00 |
| | **90868** | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIM | 18-999 years | $142.09 | $0.00 | $142.09 | $142.09 | $0.00 |
| | **90869** | THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIM | 18-999 years | $144.52 | $0.00 | $144.52 | $144.52 | $0.00 |
| | **90870** | ELECTROCONVULSIVE THERAPY | 0-999 years | $163.81 | $163.81 | $163.81 | $163.81 | $163.81 |
| | **90899** | PSYCHIATRIC SERVICE/THERAPY | 0-999 years | $179.82 | $179.82 | $179.82 | $179.82 | $179.82 |

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|---|---|---|---|---|---|---|---|---|
| | **96112** | Developmental Testing Phys/QHP 1st hour | 0-999 years | $121.11 | $121.11 | $121.11 | $121.11 | $0.00 |
| | **96113** | Developmental Testing Phys/QHP ea add'l hour | 0-999 years | $57.25 | $57.25 | $57.25 | $57.25 | $0.00 |
| | **96116** | NUBHVL XM PHYS/QHP 1ST HR | 0-999 years | $89.32 | $89.32 | $89.32 | $89.32 | $89.32 |
| | **96121** | NUBHVL XM PHY/QHP EA ADDL HR | 0-999 years | $73.72 | $73.72 | $73.72 | $73.72 | $73.72 |
| | **96127** | BRIEF EMOTIONAL/BEHAV ASSMT | 0-999 years | $4.17 | $4.17 | $4.17 | $4.17 | $4.17 |
| | **96130** | PSYCL TST EVAL PHYS/QHP 1ST | 0-999 years | $115.84 | $115.84 | $115.84 | $115.84 | $115.84 |
| | **96131** | PSYCL TST EVAL PHYS/QHP EA | 0-999 years | $84.35 | $84.35 | $84.35 | $84.35 | $84.35 |
| | **96132** | NRPSYC TST EVAL PHYS/QHP 1ST | 0-999 years | $124.79 | $124.79 | $124.79 | $124.79 | $124.79 |
| | **96133** | NRPSYC TST EVAL PHYS/QHP EA | 0-999 years | $95.46 | $95.46 | $95.46 | $95.46 | $95.46 |
| | **96136** | PSYCL/NRPSYC TST PHY/QHP 1ST | 0-999 years | $40.26 | $40.26 | $40.26 | $40.26 | $40.26 |
| | **96137** | PSYCL/NRPSYC TST PHY/QHP EA | 0-999 years | $37.05 | $37.05 | $37.05 | $37.05 | $37.05 |
| | **96138** | PSYCL/NRPSYC TECH 1ST | 0-999 years | $31.03 | $31.03 | $31.03 | $31.03 | $31.03 |
| | **96139** | PSYCL/NRPSYC TST TECH EA | 0-999 years | $31.96 | $31.96 | $31.96 | $31.96 | $31.96 |
| | **96146** | PSYCL/NRPSYC TST AUTO RESULT | 0-999 years | $2.01 | $2.01 | $2.01 | $2.01 | $2.01 |
| | **96156** | HLTH BHV ASSMT/REASSESSMENT | 0-999 years | $92.20 | $92.20 | $92.20 | $92.20 | $92.20 |
| | **96158** | HLTH BHV IVNTJ INDIV 1ST 30 | 0-999 years | $63.05 | $63.05 | $63.05 | $63.05 | $63.05 |
| | **96159** | HLTH BHV IVNTJ INDIV EA ADDL | 0-999 years | $21.74 | $21.74 | $21.74 | $21.74 | $21.74 |
| | **96164** | HLTH BHV IVNTJ GRP 1ST 30 | 0-999 years | $9.44 | $9.44 | $9.44 | $9.44 | $9.44 |
| | **96165** | HLTH BHV IVNTJ GRP EA ADDL | 0-999 years | $4.31 | $4.31 | $4.31 | $4.31 | $4.31 |
| | **96167** | HLTH BHV IVNTJ FAM 1ST 30 | 0-999 years | $67.06 | $67.06 | $67.06 | $67.06 | $67.06 |
| | **96168** | HLTH BHV IVNTJ FAM EA ADDL | 0-999 years | $23.74 | $23.74 | $23.74 | $23.74 | $23.74 |
| | **96170** | HLTH BHV IVNTJ FAM WO PT 1ST | 0-999 years | $74.67 | $74.67 | $74.67 | $74.67 | $74.67 |
| | **96171** | HLTH BHV IVNTJ FAM W/O PT EA | 0-999 years | $26.97 | $26.97 | $26.97 | $26.97 | $26.97 |
| | **96372** | THER/PROPH/DIAG INJ SC/IM | 0-999 years | $13.33 | $0.00 | $13.33 | $13.33 | $0.00 |
| | **99202** | OFFICE/OUTPATIENT VISIT NEW | 0-999 years | $68.00 | $0.00 | $68.00 | $68.00 | $0.00 |
| | **99203** | OFFICE/OUTPATIENT VISIT NEW | 0-999 years | $105.12 | $0.00 | $105.12 | $105.12 | $0.00 |

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| | **99204** | OFFICE/OUTPATIENT VISIT NEW | 0-999 years | $156.95 | $0.00 | $156.95 | $156.95 | $0.00 |
| | **99205** | OFFICE/OUTPATIENT VISIT NEW | 0-999 years | $207.26 | $0.00 | $207.26 | $207.26 | $0.00 |
| | **99211** | OFFICE/OUTPATIENT VISIT EST | 0-999 years | $21.70 | $0.00 | $21.70 | $21.70 | $0.00 |
| | **99212** | OFFICE/OUTPATIENT VISIT EST | 0-999 years | $53.09 | $0.00 | $53.09 | $53.09 | $0.00 |
| | **99213** | OFFICE/OUTPATIENT VISIT EST | 0-999 years | $85.18 | $0.00 | $85.18 | $85.18 | $0.00 |
| | **99214** | OFFICE/OUTPATIENT VISIT EST | 0-999 years | $120.72 | $0.00 | $120.72 | $120.72 | $0.00 |
| | **99215** | OFFICE/OUTPATIENT VISIT EST | 0-999 years | $169.42 | $0.00 | $169.42 | $169.42 | $0.00 |
| | **99217** | OBSERVATION CARE DISCHARGE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99218** | INITIAL OBSERVATION CARE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99219** | INITIAL OBSERVATION CARE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99220** | INITIAL OBSERVATION CARE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99221** | INITIAL HOSPITAL CARE | 0-999 years | $78.20 | $0.00 | $78.20 | $78.20 | $0.00 |
| | **99222** | INITIAL HOSPITAL CARE | 0-999 years | $123.45 | $0.00 | $123.45 | $123.45 | $0.00 |
| | **99223** | INITIAL HOSPITAL CARE | 0-999 years | $165.08 | $0.00 | $165.08 | $165.08 | $0.00 |
| | **99224** | SUBSEQUENT OBSERVATION CARE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99225** | SUBSEQUENT OBSERVATION CARE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99226** | SUBSEQUENT OBSERVATION CARE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99231** | SUBSEQUENT HOSPITAL CARE | 0-999 years | $46.92 | $0.00 | $46.92 | $46.92 | $0.00 |
| | **99232** | SUBSEQUENT HOSPITAL CARE | 0-999 years | $75.26 | $0.00 | $75.26 | $75.26 | $0.00 |
| | **99233** | SUBSEQUENT HOSPITAL CARE | 0-999 years | $113.25 | $0.00 | $113.25 | $113.25 | $0.00 |
| | **99234** | OBSERV/HOSP SAME DATE | 0-999 years | $93.52 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99235** | OBSERV/HOSP SAME DATE | 0-999 years | $151.78 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99236** | OBSERV/HOSP SAME DATE | 0-999 years | $199.01 | $0.00 | $199.01 | $199.01 | $0.00 |
| | **99238** | HOSPITAL DISCHARGE DAY | 0-999 years | $76.68 | $0.00 | $76.68 | $76.68 | $0.00 |
| | **99239** | HOSPITAL DISCHARGE DAY | 0-999 years | $108.63 | $0.00 | $108.63 | $108.63 | $0.00 |
| | **99281** | EMERGENCY DEPT VISIT | 0-999 years | $10.97 | $0.00 | $10.97 | $10.97 | $0.00 |
| | **99282** | EMERGENCY DEPT VISIT | 0-999 years | $39.61 | $0.00 | $39.61 | $39.61 | $0.00 |
| | **99283** | EMERGENCY DEPT VISIT | 0-999 years | $67.92 | $0.00 | $67.92 | $67.92 | $0.00 |
| | **99284** | EMERGENCY DEPT VISIT | 0-999 years | $114.79 | $0.00 | $114.79 | $114.79 | $0.00 |
| | **99285** | EMERGENCY DEPT VISIT | 0-999 years | $166.70 | $0.00 | $166.70 | $166.70 | $0.00 |

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| | **99304** | NURSING FACILITY CARE INIT | 0-999 years | $76.37 | $0.00 | $76.37 | $76.37 | $0.00 |
| | **99305** | NURSING FACILITY CARE INIT | 0-999 years | $126.51 | $0.00 | $126.51 | $126.51 | $0.00 |
| | **99306** | NURSING FACILITY CARE INIT | 0-999 years | $173.39 | $0.00 | $173.39 | $173.39 | $0.00 |
| | **99307** | NURSING FAC CARE SUBSEQ | 0-999 years | $37.64 | $0.00 | $37.64 | $37.64 | $0.00 |
| | **99308** | NURSING FAC CARE SUBSEQ | 0-999 years | $70.36 | $0.00 | $70.36 | $70.36 | $0.00 |
| | **99309** | NURSING FAC CARE SUBSEQ | 0-999 years | $101.26 | $0.00 | $101.26 | $101.26 | $0.00 |
| | **99310** | NURSING FAC CARE SUBSEQ | 0-999 years | $145.48 | $0.00 | $145.48 | $145.48 | $0.00 |
| | **99315** | NURSING FAC DISCHARGE DAY MGT-30 MIN OR LESS | 0-999 years | $77.45 | $0.00 | $77.45 | $77.45 | $0.00 |
| | **99316** | NURSING FAC DISCHARGE DAY MGT-30 MIN OR LESS | 0-999 years | $124.66 | $0.00 | $124.66 | $124.66 | $0.00 |
| | **99318** | EVAL AND MGT INVOLVING ANNUAL FAC ASST | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99324** | EVAL AND MGT NEW PATIENT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99325** | DOM OR REST HOME VISIT FOR EVAL AND MGT NEW PAT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99326** | DOM OR REST HOME VISIT FOR EVAL AND MGT NEW PAT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99327** | DOM OR REST HOME VISIT FOR EVAL AND MGT NEW PAT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99328** | DOM OR REST HOME VISIT FOR EVAL AND MGT NEW PAT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99334** | DOM OR REST HOME VISIT FOR EVAL AND MGT EST PAT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99335** | DOM OR REST HOME VISIT FOR EVAL AND MGT EST PAT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99336** | DOM OR REST HOME VISIT FOR EVAL AND MGT EST PAT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99337** | DOM OR REST HOME VISIT FOR EVAL AND MGT EST PAT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99341** | HOME VISIT NEW PATIENT | 0-999 years | $46.88 | $0.00 | $46.88 | $46.88 | $0.00 |
| | **99342** | HOME VISIT NEW PATIENT | 0-999 years | $74.80 | $0.00 | $74.80 | $74.80 | $0.00 |
| | **99343** | HOME VISIT NEW PATIENT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99344** | HOME VISIT NEW PATIENT | 0-999 years | $137.20 | $0.00 | $137.20 | $137.20 | $0.00 |
| | **99345** | HOME VISIT NEW PATIENT | 0-999 years | $192.62 | $0.00 | $192.62 | $192.62 | $0.00 |
| | **99347** | HOME VISIT EST PATIENT | 0-999 years | $42.87 | $0.00 | $42.87 | $42.87 | $0.00 |

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| | **99348** | HOME VISIT EST PATIENT | 0-999 years | $72.80 | $0.00 | $72.80 | $72.80 | $0.00 |
| | **99349** | HOME VISIT EST PATIENT | 0-999 years | $121.23 | $0.00 | $121.23 | $121.23 | $0.00 |
| | **99350** | HOME VISIT EST PATIENT | 0-999 years | $176.96 | $0.00 | $176.96 | $176.96 | $0.00 |
| | **99354** | PROLONG E&M/PSYCTX SERV O/P | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99355** | PROLONG E&M/PSYCTX SERV O/P | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| **25** | **99401** | PREVENTIVE COUNSELING INDIV | 0-999 years | $37.48 | $0.00 | $37.48 | $37.48 | $0.00 |
| **HK** | **99401** | PREVENTIVE COUNSELING INDIV | 0-999 years | $25.92 | $0.00 | $25.92 | $25.92 | $0.00 |
| | **99406** | SMOKING AND TOBACCO USE CESSATION COUNSELING; INTERMEDIATE | 0-999 years | $14.01 | $14.01 | $14.01 | $14.01 | $14.01 |
| | **99407** | SMOKING AND TOBACCO USE CESSATION COUNSELING; INTENSIVE | 0-999 years | $26.23 | $26.23 | $26.23 | $26.23 | $26.23 |
| **U6** | **99407** | SMOKING AND TOBACCO USE CESSATION COUNSELING; INTENSIVE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| | **99408** | ALCOHOL AND/OR SUBSTANCE ABUSE STRUCTURED SCREENING | 0-999 years | $33.17 | $33.17 | $33.17 | $33.17 | $33.17 |
| | **99409** | ALCOHOL AND/OR SUBSTANCE ABUSE STRUCTURED SCREENING | 0-999 years | $63.56 | $63.56 | $63.56 | $63.56 | $63.56 |
| | **99417** | PROLONG E&M/PSYCTX SERV O/P | 0-999 years | $29.65 | $0.00 | $29.65 | $29.65 | $0.00 |
| | **99418** | Prolonged inpatient or observation evaluation and management service | 0-999 years | $37.66 | $0.00 | $37.66 | $37.66 | $0.00 |
| | **99499** | UNLISTED E&M SERVICE | 0-999 years | $44.03 | $0.00 | $44.03 | $44.03 | $0.00 |
| | **G0444** | ANNUAL DEPRESSION SCREENING | 0-999 years | $17.37 | $17.37 | $17.37 | $17.37 | $17.37 |
| | **G0466** | FQHC VISIT NEW PATIENT | 0-999 years | $230.41 | $230.41 | $230.41 | $230.41 | $230.41 |
| | **G0467** | FQHC VISIT, ESTAB PT | 0-999 years | $171.74 | $171.74 | $171.74 | $171.74 | $171.74 |
| | **G0468** | FQHC VISIT, IPPE OR AWV | 0-999 years | $230.41 | $230.41 | $230.41 | $230.41 | $230.41 |
| | **G0469** | FQHC VISIT, MH, NEW PATIENT | 0-999 years | $230.41 | $230.41 | $230.41 | $230.41 | $230.41 |
| | **G0470** | FQHC VISIT, MH, EST PATIENT | 0-999 years | $171.74 | $171.74 | $171.74 | $171.74 | $171.74 |

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|---|---|---|---|---|---|---|---|---|
| | **G0480** | DRUG GEST DEF 1-7 CLASSES | 0-999 years | $114.43 | $0.00 | $114.43 | $114.43 | $0.00 |
| | **G0481** | DRUG GEST DEF 8-14 CLASSES | 0-999 years | $156.59 | $0.00 | $156.59 | $156.59 | $0.00 |
| | **G0482** | DRUG GEST DEF 15-21 CLASSES | 0-999 years | $198.74 | $0.00 | $198.74 | $198.74 | $0.00 |
| | **G0483** | DRUG GEST DEF 22 PLUS CLASSES | 0-999 years | $246.92 | $0.00 | $246.92 | $246.92 | $0.00 |
| | **G0659** | Drug test Def Simple All CL | 0-999 years | $62.14 | $0.00 | $62.14 | $62.14 | $0.00 |
| | **G2212** | Prolonged Office or other OP E&M service | 0-999 years | $30.58 | $0.00 | $30.58 | $30.58 | $0.00 |
| | **H0015** | ALCOHOL AND/OR DRUG SERVICES ADULT | 21-999 years | $186.35 | $186.35 | $186.35 | $186.35 | $186.35 |
| | **H0015** | ALCOHOL AND/OR DRUG SERVICES CHILD | 0-20 years | $426.99 | $426.99 | | $426.99 | $0.00 |
| | **H0031** | MH HEALTH ASSESS BY NON-MD | 0-999 years | $289.78 | $289.78 | $289.78 | $289.78 | $289.78 |
| **HW** | **H0031** | MH HEALTH ASSESS BY NON-MD | 0-999 years | $110.91 | $110.91 | $110.91 | $110.91 | $110.91 |
| | **H0035** | MH PARTIAL HOSP TX UNDER 24H | 0-999 years | $313.74 | $313.74 | $313.74 | $313.74 | $313.74 |
| | **H0038** | SELF-HELP/PEER SVC PER 15MIN | 0-999 years | $12.20 | $12.20 | $12.20 | $12.20 | $12.20 |
| | **H2000** | COMP MULTIDISIPLN EVALUATION | 0-999 years | $527.56 | $527.56 | $527.56 | $527.56 | $527.56 |
| | **H2011** | CRISIS INTERVEN SVC, 15 MIN | 0-999 years | $48.12 | $48.12 | $48.12 | $48.12 | $48.12 |
| | **Q3014** | TELEHEALTH FACILITY FEE | 0-999 years | $28.33 | $28.33 | $28.33 | $28.33 | $28.33 |
| | **T1015** | FQHC/RHC: CLINIC VISIT/ENCOUTNER, ALL INCLUSIVE | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 |
| **EP** | **T1016** | CASE MANAGEMENT | 0-999 years | $0.00 | $0.00 | $0.00 | $0.00 | $11.46 |
| | **C7903** | Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health | 0-999 years | $0.00 | $0.90 | $0.00 | $0.00 | $0.90 |
| | **G0017** | Psychotherapy for crisis furnished in an applicable site of service, first 60 minutes | 0-999 years | $0.00 | $208.61 | $0.00 | $0.00 | $208.61 |
| | **G0018** | Psychotherapy for crisis furnished in an applicable site of service, first 30 minutes | 0-999 years | $0.00 | $102.57 | $0.00 | $0.00 | $102.57 |