

ATTACHMENT A
PRODUCT ATTACHMENT TO MASTER DENTAL PROVIDER AGREEMENT
STATE OF NEBRASKA

This State of Nebraska Product Attachment (the “*Product Attachment*”) is incorporated into the Master Dental Provider Agreement (the “*Agreement*”) entered into by _____ (the “*Provider*”) and Managed Care of North America, Inc., d/b/a/ MCNA Dental Plans (“*MCNA*”).

ARTICLE I
GENERAL TERMS

1.1 Provider has entered into the Participating Provider Agreement with MCNA. This Product Attachment is intended to supplement the Agreement by setting forth the parties’ rights and responsibilities related to the provision of Covered Services to Covered Persons enrolled in the plan. Provider agrees to adhere to all requirements set forth in the Agreement and this Product Attachment. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.

1.2 Notwithstanding any provisions set forth in this Product Attachment, to the extent applicable, Provider shall comply with all duties and obligations under the Agreement, the Provider Manual and this Product Attachment through the last day the Agreement is in effect. Provider agrees and understands that Covered Services shall be provided in the amount, duration and scope of core benefits and services specified in the Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To the extent Provider is unclear about Provider’s duties and obligations, Provider shall request clarification from MCNA.

ARTICLE II
DEFINITIONS

The defined terms in this Product Attachment have the same meaning set forth in the Agreement, unless otherwise defined herein.

“*Covered Persons or Member*” means a person eligible to receive Covered Services.

“*Dental Records*” shall have the meaning set forth in Article III, Section 3.3 herein.

“*Dental Provider*” means an individual or group of licensed dentists.

“*Dentist*” means any individual licensed to practice dentistry or dental surgery.

“*Enrollees*” for the purpose of this Agreement is synonymous with Covered Person.

“*Plan*” plans covered by this Agreement are included in Appendix B hereto.

“**Provider Manual**” means the manual of policies, procedures, and requirements to be followed by Participating Dental Providers.

“**State**” means the State of Nebraska, as represented through any agency, department, board, or commission.

ARTICLE III PRODUCT REQUIREMENTS

3.1 **Compliance.** Provider shall comply with all applicable federal, State and local laws and regulations, and all amendments thereto. Provider understands and agrees that this Product Attachment and/or the Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal or regulation, or any applicable provision of the State agency requirements. Any provision of the Agreement or this Product Attachment deemed to conflict with the laws of Nebraska shall be null and void, and all other provisions shall remain in full force and effect.

3.2 **Encounter Records.** Provider shall comply with all electronic health encounter records submission requirements in a format compliant with Nebraska requirements.

3.3 **Access to Covered Services.** Urgent Care must be provided within twenty-four (24) hours [42 CFR §438.206(c)(1)(i)]. Urgent care may be provided directly by the provider or as directed by the DBPM through other arrangements. Routine or preventative dental services should be provided within six (6) weeks.

Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the member should be offered a new appointment.

3.4 **Dental Records.** Any and all medical and dental records, including but not limited to graphic matter, images, X-ray films, and related matter that were necessary to produce a diagnostic or therapeutic report (the “**Dental Records**”) shall be retained, preserved, safeguarded, and properly stored by Provider (whether electronic or paper) such as working papers related to the preparation of fiscal reports, and medical records, progress notes, charges, journals ledgers, and electronic media shall be retained and safeguarded by the Provider for a period of seven (7) years from the last date of treatment of the Member. Dental Records shall also be retained in the event of litigation, claims, or other actions involving the records until the completion of the action and the resolution of all issues that arose from it. If the Dental Records are stored on microfilm or microfiche or other electronic means, the Provider must agree to produce at its expense legible hard copy records upon the request of state or federal authorities, within fourteen (14) calendar days of the request. This requirement does not include Dental Records pertaining to once-in-a-lifetime events that must be retained indefinitely and may not be destroyed.

Dental Records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of the State. Provider shall allow MCNA, the Department and the Office of Inspector General, and other authorized State and federal agents, U.S. Department of Health and Human Services

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(HHS), CMS, Office of Inspector General Comptroller, State Auditor's Office, and the Nebraska Attorney General's Office, to the extent such access is necessary to comply with regulatory requirements that apply to MCNA.

Provider shall give Covered Persons and their representatives access to, and the same can request copies of, the Covered Person's Dental Records to the extent and in the manner provided by State law.

3.54 Records. Provider shall maintain records related to services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered

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Persons and provide such dental, financial and administrative information to MCNA, and State and federal government agencies as may be necessary for compliance by the plan or MCNA with State and federal law and accreditation standards, as well as for the administration of this Agreement. MCNA shall have access at reasonable times to books, records, and papers of the Provider relating to the dental care services provided to Covered Persons for Covered Services.

3.65 Audits. The State or federal government may conduct necessary inspections and audits to assure quality, appropriateness or timeliness of services and reasonableness of costs. Provider must provide any requested information within ~~fifteen~~ (15) business days of request unless any extenuating circumstances exist.

3.76 Cultural Consideration and Competency. In accordance with Title IV of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et. seq.*) and its implementing regulation, 45 C.F.R. §80 (2001) (as amended), Provider shall deliver Covered Services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds and must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement.

3.87 Qualifications and Credentialing Criteria. Provider shall hold all necessary licenses, registrations and/or certifications required under State or federal law to provide the services contracted for hereunder and shall at all times meet, maintain and adhere to the policies and procedures of MCNA with respect to (1) certification to participate in any federal or state health care program including but not limited to the Nebraska Medicaid program; (2) the Provider Manual; (3) requirements of the Department; (4) licensure, certification, accreditation, utilization management/quality assurance (including requirements for review of Provider's services by MCNA personnel and committees), complaints/appeals; and (4) administrative policies such as those relating to claims submission, coordination of benefits, and coverage verification. Provider will be subject to re-credentialing by MCNA every thirty-six (36) months from the Provider's immediately preceding credentialing committee approval date. Provider shall give immediate notice to MCNA of any event that causes Provider to be out of compliance with its ability to fulfill its obligations under this Agreement, or of any change in Provider's name, ownership, control, or taxpayer identification number.

3.98 Covered Person Communications. Nothing in the Agreement shall be construed as imposing restrictions upon Provider's free communication with a Member about the Member's medical condition, treatment options, referral policies, and other policies regarding financial incentives or arrangements and all managed care plans with whom the Provider contracts.

3.109 Representation and Warranty. Provider represents and warrants that neither Provider nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over Provider or who directly or indirectly conducts the day-to-day operation of Provider) is an entity or individual (1) who has been convicted of any offense under Section 1128 (a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary

penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a- 8); or (3) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.

3.119 **Compliance with Laws.** Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to this Agreement, and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the Agreement could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. By signing this Agreement, Provider certifies to the best of its knowledge and belief that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. We instruct providers to disclose any lobbying activities using nonfederal funds in accordance with and to the extent required by 45 CFR Part 93 and the laws of the State.

Provider further understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, are incorporated by reference to this Agreement and shall comply with the following laws, among others:

- A. Requirements set forth in 42 C.F.R. §438.210(e), compensation to MCNA or any individuals who many conduct utilization management activities is not structured so as to provide incentives for the individual or MCNA to deny, limit, or discontinue medically necessary services to any member;
- B. Requirements set forth in 42 C.F.R. §438.106(c) and §1932(b)(6), stating that Providers shall not bill members any amount greater than would be owed if the MCNA provided the services directly;
- C. Requirements set forth in 42 C.F.R. §455, Subpart B, stating that Provider shall comply and submit to MCNA disclosure of required information;
- D. Environmental Protection Laws:
 - i. Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
 - ii. National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 (“Protection and Enhancement of Environmental Quality”) relating to the institution of environmental quality control measures;
 - iii. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, “Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans”);
 - iv. State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the

Clean Air Act; and

- v. Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;

E. State and federal anti-discrimination laws:

- i. Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
- ii. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- iii. Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
- iv. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- v. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
- vi. Food Stamp Act of 1977 (7 U.S.C. §200 et seq.);
- vii. Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16; and
- viii. The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 et seq.) and the Immigration Act of 1990 (8 U.S.C. §1101, et seq.) regarding employment verification and retention of verification forms;

F. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191);

G. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 *et. seq.*

3.124 **Laboratory Services.** If Provider performs laboratory services, the same must be conducted in accordance with all applicable state requirements and 42 C.F.R. §§493.1 & 493.3, and any other federal requirements.

3.132 **Access to Premises.** Provider shall allow duly authorized agents or representatives of the State or federal government or the independent external quality review organization required by Section 1902 (a)(30)(c) of the Social Security Act, 42 U.S.C. §1396a(a)(30), access to their premises during normal business hours. Provider shall cause similar access or availability to their premises to assist in internal and external quality assessment review, utilization management, and grievance procedures established by MCNA and/or its designee and provide adequate space on the premises to reasonably accommodate the State, federal, or external quality review personnel conducting the audit, investigation, or inspection effort. Provider shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.

In the event right of access is requested under this Section, Provider shall provide and make staff available to assist with the process. All inspections or audits shall be conducted in a manner that will not unreasonably interfere with the performance of Provider's activities. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations. The Provider agrees to provide:

- A. All information required by the State or its agencies, including but not limited to the reporting requirements and other information related to the Provider's performance of its obligations under the Agreement;
- B. Any information in its possession sufficient to permit the State to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by the Department. All such information must be provided in accordance with the timelines, definitions, formats, and instructions specified by the State. Upon receipt of a record review request from a state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, Provider must provide, at no cost to the requesting agency, the records requested within three (3) business days of the request. If a state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours, the Provider must provide the records at the time of the request and/or in less than 24 hours.
- C. The request for record review may include, without limitation, clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in sanctions against Provider.

3.143 Corrective Action Plan. In the event that a corrective action plan is initiated by MCNA and/or required by the State, the Provider shall comply with the same. MCNA may assess and Provider shall pay any monetary fines or other sanctions imposed on Provider at the direction of the plan for failure or refusal to respond to MCNA's requests for credentialing information, access to dental records, or other material information in respect of this Agreement.

3.154 Provider Indemnity. Provider shall indemnify, defend and hold the State of Nebraska harmless from all claims, losses, or suits relating to activities undertaken pursuant to this Agreement except to the extent such Provider liability is attenuated by any action of the State which directly and proximately

[and proximately contributed to the claims.-](#)

3.165 **Suspected Fraud and Abuse.** Provider shall immediately report all suspected fraud and abuse to MCNA.

3.176 **Coordination of Benefits (COB).** Provider must report all COB information to MCNA or its designee.

3.187 **Accreditation.** If applicable, Provider shall provide MCNA with a copy of its current certificate of accreditation from NCQA/URAC or other national accreditation body, if and as applicable, together with a copy of any survey report in connection therewith, subject to the applicable restrictions of such accrediting body.

3.198 **Disclosure.** The Provider agrees to screen all its employees, contractors, and contractor's employees [monthly in accordance with federal requirements](#) using the List of Excluded Individuals/Entities (LEIE) database to determine whether any of its employees, contractors, and contractor's employees is excluded from participation in Medicare, Medicaid, or other federal health care programs. The LEIE database is maintained by the United States Department of Health and Human Services, Office of the Inspector General (HHS-OIG) and can be accessed at <http://oig.hhs.gov/exclusions>. The Provider shall promptly notify the Department and MCNA upon discovery of any excluded employee, contractor, or contractor's employees. Provider understands and acknowledges that employment of or contractual arrangements with persons or entities listed in the LEIE will subject the Provider to recoupment of funds paid to the Provider during the period in which the employment or contract was in effect. Providers must attest, on an annual basis, that all employees and other Provider personnel are not excluded or otherwise prohibited from participating in any state or federal healthcare program, including Medicaid or CHIP. Failure to comply with this mandatory requirement will result in immediate suspension of claim payments.

ARTICLE IV MISCELLANEOUS

4.1 **Payment Terms.** The following additional terms for claims payment are applicable:

- A. The method of payment applicable to this Agreement is set forth on Appendix A hereto and in the Provider Manual.
- B. In order to submit a clean claim, Provider must attach all of the information as required in the Provider Manual for each claim submittal.
- C. Provider must submit claims for processing and/or adjudication at the place and in the manner described in the Provider Manual.

4.2 **Complaints and Appeals.** The complaint and appeal processes that apply to Provider are contained in the Provider Manual. The Provider understands and agrees that MCNA reserves the right to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

4.3 **Confidentiality.** Provider must treat all information that is obtained through the performance of the services included in this Agreement as confidential information pursuant to state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of State programs, this Agreement, the Provider Manual, internet portal, and all other materials provided by MCNA to Provider in connection with this Agreement. Provider shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of its obligations under this contract. Provider shall protect the confidentiality of Member Protected Health Information (PHI), including patient records in accordance with State and federal law. Provider shall comply with all applicable federal and state laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of PHI.

4.4 **Costs of Non-covered Services.** Provider must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed Private Pay Form (to be supplied by Provider) from such Member.

4.5 **Liability.** In the event MCNA becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against MCNA will be through MCNA's bankruptcy, conservatorship, or receivership estate. Provider understands and agrees that MCNA Members may not be held liable for MCNA's debts in the event of the entity's insolvency. Provider understands and agrees that the State does not assume liability for the actions of, or judgments rendered against, MCNA, its employees, agents or subcontractors. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against the State for any duty owed to the Provider by MCNA or any judgment rendered against MCNA.

MCNA has full authority to initiate and maintain any action necessary to stop a Provider or employee, agent, assignee, trustee, or successor-in-interest from maintaining an action against a State agency, an HHS Agency, or any Member to collect payment from the State or any agency thereof, or any Member, excluding payment for non-covered services. This provision does not restrict Provider from collecting allowable copayment and deductible amounts from Members. Additionally, this provision does not restrict Provider from collecting payment for services that exceed a Member's benefit cap, if any.

4.6 **Provider Subcontracts.** Provider shall not, without prior approval from MCNA, enter into any subcontract or other agreement for any of the work contemplated under this Agreement without receiving approval from MCNA. In the event Provider secures prior approval and enters into any subcontract agreement with another provider to provide Covered Services to Covered Persons, such agreement shall meet all requirements of the Agreement.

4.7 **Third Party Recovery.** Provider understands and agrees that it may not interfere with or place any liens upon the State's right or MCNA's right, acting as the State's agent, to recovery from third party resources.

4.8 **Time Limitation.** Provider may not bring any legal or equitable action with respect to any claim arising out of or relating to the Agreement or this Product Attachment more than two (2) years after the cause of action arose.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date first above written.

**Managed Care of North America, Inc.,
d/b/a/ MCNA Dental Plans,** a Florida
corporation

[Provider]

By: _____

By: _____

Printed Name:

Printed Name:

Title:

Title:

Signature Date:

Signature Date:

Effective Date of Agreement: _____
(To be completed by MCNA only)

Tax Identification Number: _____

National Identification Number: _____

Dentist Medicaid Number: _____

Group Medicaid Number (If applicable):

Group Corporate Address (If applicable):

**APPENDIX A
PROVIDER REIMBURSEMENT**

Providers, including FQHCs, will be reimbursed in accordance with the MCNA Nebraska Fee Schedule, which is enclosed in this Provider Participation Packet and can also be found on www.mcnane.net.

~~Federally Qualified Health Centers (FQHCs) and~~ Indian Health Clinics (IHCs) as defined under 42 U.S.C § 1396(d)(1)(2)(b), will be reimbursed for dental services done in the ~~FQHC/IHC~~ facility using Nebraska Medicaid's reimbursement methodology, which is payment at an encounter rate, in an amount unique to each ~~FQHC/IHC~~, as determined by the State.

Reimbursement for dental services done outside of the ~~FQHC/IHC~~ facility will be reimbursed at MCNA's fee for service rate.

**APPENDIX B
APPLICABLE PLANS**

This Agreement is applicable to the following Nebraska plans:

1. Nebraska Medicaid

Should additional plans be added in the future, MCNA will provide timely notice to Provider.