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VENTURA COUNTY MEDICAL CENTER

Amendment III

January 1, 2014

Blue Shield of California
50 Beale Street, San Francisco, CA 94105

blueshieldca.com

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THIRD AMENDMENT
TO
FEE FOR SERVICE HOSPITAL AGREEMENT

This Third Amendment (this "Amendment") is entered into by and between California Physicians' Service dba Blue Shield of California, a California nonprofit mutual benefit corporation ("Blue Shield"), and County of Ventura, as owner and operator of Ventura County Medical Center ("Hospital"), and amends and supplements the terms of that certain Fee For Service Hospital Agreement, with an original effective date of December 24, 2010, by and between Blue Shield and Hospital, as amended to date (the "Agreement"). Except as otherwise defined herein, all capitalized terms shall have the meaning ascribed to them in the Agreement.

RECITALS

A. The parties previously entered into the Agreement, pursuant to which Hospital agreed to furnish certain Covered Services to Blue Shield Members.

B. Hospital and Blue Shield desire that Hospital participates in the Blue Shield limited provider network ("Value Network") to provide certain Covered Services to Members enrolled in a Value Network Benefit Program ("Value Network Members").

AGREEMENT

The parties hereto agree as follows:

1. The parties entered into an agreement on December 24, 2010, and incorrectly identified Ventura County Medical Center, a California corporation as "Hospital" instead of County of Ventura, as owner and operator of Ventura County Medical Center ("Hospital"). Both parties agree to modify all references to "Hospital" in the Agreement to County of Ventura, as owner and operator of Ventura County Medical Center.

2. Section 1.2 of the Agreement is hereby amended in its entirety to read in full as follows:

   1.2 **Allowed Charges:** are charges billed by Hospital, in accordance with Hospital's Charge Master, for Hospital Services furnished pursuant to this Agreement, less those charges, if any, disallowed by Blue Shield pursuant to Section III (General Notes) of Exhibit C and Exhibit F hereto.

3. Section 5.2(a) of the Agreement is hereby amended in its entirety to read in full as follows:

   (a) In exchange for Hospital Services provided to Members enrolled in a Blue

Shield commercial Benefit Program reimbursable pursuant to Exhibit C of this Agreement, Blue Shield shall pay Hospital the lesser of: (i) ospital's Allowed Charges, and (ii) the reimbursement rates set forth in this Exhibit C of this Agreement, in either case, less any applicable Copayment. In exchange for Hospital Services provided to Value Network Members, Blue Shield shall pay Hospital the reimbursement rates set forth in Exhibit F and no lesser of language shall apply.

4. A new Section 5.6(e) is hereby added to the Agreement and shall read in full as follows:

5.6 **Adjustments Resulting From Charge Master Increases.**

(e) All references to Exhibit C within this Section 5.6 of the Agreement shall also include Exhibit F.

5. Section 6.2(a) of the Agreement is hereby amended in its entirety to read in full as follows:

6.2 **Charges to Members.**

(a) Except as expressly set forth in this Agreement, in no event, including, without limitation, nonpayment by Blue Shield or Blue Shield's insolvency or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, impose a surcharge on, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Member, or any individual responsible for such Member's care, for Covered Services. Without limiting the foregoing, Hospital shall not seek payment from a Member, or any individual responsible for such Member's care, for Covered Services for which payment was denied by Blue Shield because the bill or claim for such Covered Services was not timely or properly submitted or because such Covered Services were related to a HAC or Never Event (each as defined in Section III.B of Exhibit C and Exhibit F hereto). If Blue Shield receives notice of a violation of this Section 6.2, it shall have the right to take all appropriate action, including, without limitation, reimbursing the Member for the amount of any payment made and offsetting the amount of such payment from any amounts then or thereafter owed by Blue Shield to Hospital.

6. A new Exhibit F, attached hereto, is hereby added to the Agreement.

7. When executed by both parties, this Amendment shall be effective as of January 1, 2014. Except as specifically set forth in this Amendment, all other conditions contained in the Agreement shall continue in full force and effect. After the effective date of this

Amendment, any reference to the Agreement shall mean the Agreement as supplemented by this Amendment. Notwithstanding anything to the contrary in the Agreement, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Agreement, the terms and conditions of this Amendment shall prevail.

8. This Amendment may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their authorized representatives:

BLUE SHIELD OF CALIFORNIA		**COUNTY OF VENTURA**	
Signature:	_____	**Signature:**	_____
Print Name:	Juan C. Davila	**Print Name:**	_____
Title:	Senior Vice President, Network Mgmt.	**Title:**	_____
Date:	_____	**Date:**	_____

Exhibit F
Fee for Service Hospital Agreement

PARTICIPATION IN
BLUE SHIELD VALUE NETWORK

VENTURA COUNTY MEDICAL CENTER
Effective Date: January 1, 2014

1. **Participation in the Blue Shield Value Network.** As of the effective date of the Amendment, Hospital is a participating provider in the Blue Shield Value Network and shall provide services to Value Network Members pursuant to the terms and conditions of this Agreement.

2. **Definitions.** In addition to the definitions set forth in the Agreement, the following definitions shall apply to this Exhibit:

   (a) **Ambulatory Payment Classification (APC):** is an outpatient prospective payment system.

   (b) **APC Payment Rate:** is a rate of reimbursement paid by Blue Shield for certain Outpatient Services identified in this Agreement, and, except as otherwise set forth in this Agreement, constitutes payment in full for all Hospital Services provided by Hospital during each such day.

   (c) **Diagnosis Related Group (DRG):** is a system that classifies hospital cases into a group expected to have similar hospital resource use.

   (d) **Pre-Admission Services:** are all outpatient diagnostic services and admission-related outpatient non-diagnostic services provided by Hospital within three (3) days prior to the date of admission as an Inpatient, if related to the condition for which the Value Network Member is admitted.

3. **Compensation.** For so long as Hospital is a participant in the Blue Shield Value Network, Blue Shield shall reimburse Hospital for the provision of Covered Services to Value Network Members pursuant to this Exhibit F. The reimbursement terms set forth in this Exhibit F shall supersede the reimbursement terms set forth in Exhibit C to this Agreement for Covered Services provided to Value Network Members.

4. **Termination.** During the Initial Term, neither party may terminate this Amendment without cause. Thereafter, Hospital's participation in the Value Network may be

terminated by either party, without cause, upon one hundred twenty (120) days' prior written notice to the other party. Any termination pursuant to this Section 4 shall become effective the first day of the month following the expiration of such notice period.

5. **Effect of Termination.** Notwithstanding anything in the Agreement to the contrary, termination of Hospital's participation in the Value Network shall have no effect upon the Agreement, and the Agreement shall remain in full force and effect.

6. **Automatic Termination.** Hospital's participation in the Value Network shall automatically terminate upon termination for any reason of the Agreement.

SCHEDULE 1 TO EXHIBIT F
Fee for Service Hospital Agreement

I. INPATIENT SERVICES

Except as otherwise specified within this Exhibit F, Schedule 1, Hospital Services provided to an Inpatient during a single admission shall be assigned a DRG using the CMS MS-DRG grouper version 29.0 as the basis for reimbursement.

For purposes of this Section I., a single admission commences at the time Pre-Admission Services are provided and ends at the time the Value Network Member is either discharged or transferred to an acute rehabilitation, skilled nursing, sub-acute, transitional or swing-bed care unit, or other facility. The Length of Stay ("LOS") is the number of days in such single admission.

A. Case Rate DRGs

(1) Case Rate Reimbursement

(a) Calculation: Subject to Subsections (b) through (e) in this Section (1), Hospital Services provided to an Inpatient during a single admission that are subject to DRG-based Case Rate reimbursement pursuant to the attached and incorporated fee schedule for MS DRGs (the "DRG Fee Schedule") shall be reimbursed at the Case Rate calculated by multiplying the Base Rate, as defined below, by the Multiplier listed in the table below, and multiplying the resulting product (the "Calculated Base Rate") by the applicable DRG relative weight listed in the DRG Fee Schedule.

Base Rate	
Multiplier	
Calculated Base Rate	

Case Rate = (Calculated Base Rate) x (DRG Relative Weight)

(b) Pre-Admission Services: The Case Rate includes payment for Pre-Admission Services, claims for which should be included on the inpatient hospital claim.

(c) Outlier: Compensation for Covered Services provided to an Inpatient for which Blue Shield pays Hospital a Case Rate pursuant to this Section A(1) is subject to additional reimbursement if Allowed Charges for Covered Services provided to a Value Network Member during a single admission and for which Hospital is paid a Case Rate

exceed the Total Outlier Threshold listed on the DRG Fee Schedule. Reimbursement for such claim will be calculated as follows:

Facility Payment = (Case Rate) + (Outlier Payment)

where:

Case Rate is as calculated in Section I.A(1)(a)

Outlier Payment = (Multiplier) * (Allowed Charges – Total Outlier Threshold) * (Outlier Payment %)

Total Outlier Threshold = (Fixed Outlier Threshold) + (Variable Outlier Threshold)

The "Fixed Outlier Threshold" shall be the amount set forth in the following table:

Fixed Outlier Threshold	

The "Variable Outlier Threshold" per DRG Fee Schedule, by DRG:

Outlier Payment %, excluding burn services	
Outlier Payment %, burn services	

OUTLIER DRG CASE RATE CALCULATION EXAMPLE	
Example Assumptions	• Calculated Base Rate = $11,269 • Fixed Outlier Threshold = $109,283 • Outlier Payment Percentage = 19.7% • DRG is 341 • DRG Relative Weight is 2.357 • DRG Variable Outlier Threshold is $102,827 • Allowed Charges are $250,000
Calculating the DRG Case Rate Payment: 2.357 x $11,269 = $26,561	
Calculating the Variable Outlier Threshold: Per fee schedule for DRG 341 = $102,827	
Calculating the Total Outlier Threshold: $102,827 + $109,283 = $212,110	
Calculating the excess Allowed Charges beyond the Total Outlier Threshold: $250,000 - $212,110 = $37,890	
Calculating the Outlier Payment: 1.05 x $37,890 x 19.7% = $7,838	

Total Reimbursement	

Notwithstanding anything in Exhibit C to this Agreement to the contrary, no other stop loss terms shall apply to Hospital Services reimbursable pursuant to this Exhibit F, Schedule 1.

(d) Discharge to Post-Acute Care Reduction – Special Pay DRG: For Hospital Services provided to Value Network Members who are discharged to one of the following : (i) skilled nursing facility; (ii) cancer hospital; (iii) children's hospital; (iv) home health service; (v) rehabilitation facility/unit; (vi) long-term care hospital; or (vii) psychiatric hospital/unit (collectively "Post-Acute Services") and for which the DRG is a special pay DRG as identified on the DRG Fee Schedule ("Special Pay DRG"), the Case Rate will be subject to reduction by being multiplied by the result of the following formula:

0.5 + (0.5 * [LOS+1])/Average LOS *(not to exceed 1.0)*

DISCHARGE TO POST-ACUTE – SPECIAL PAY DRG DRG CASE RATE CALCULATION EXAMPLE	
Example Assumptions	• Calculated Base Rate = $11,269 • DRG is 041 (post-acute special pay) • DRG Relative Weight is 2.178 • Allowed Charges are $36,500 • LOS is 2 days • Average LOS is 5.1 • Discharge Status (Form Locator (FL) 17) is 03 – Discharge to SNF
Calculating the Short Stay Factor: 0.5 + (0.5 * [2 + 1]) / 5.1 = 0.5 + (0.5 * [2+1]) / 5.1 = 0.5 + (0.5 * 3) / 5.1 = 0.5 + 1.5 / 5.1 = 0.5 + 0.294 = 0.794	
Total Reimbursement	

(e) Discharge to Post-Acute Care Reduction – Not Special Pay DRG: For Hospital Services provided to Value Network Members who are discharged to Post-Acute Services and for which the DRG is a not a special pay DRG but is a post-acute DRG as identified on the DRG Fee Schedule ("Post Acute DRG"), the Case Rate will be subject to reduction by being multiplied by the result of the following formula:

(LOS+1)/Average LOS *(not to exceed 1.0)*

DISCHARGE TO POST-ACUTE – NOT SPECIAL PAY DRG DRG CASE RATE CALCULATION EXAMPLE	
Example Assumptions	• Calculated Base Rate = $11,269 • DRG is 054 (post-acute DRG not special pay) • DRG Relative Weight is 1.468 • Allowed Charges are $36,500 • LOS is 2 days • Average LOS is 4.4 • Discharge Status (Form Locator (FL) 17) is 03 – Discharge to SNF
Calculating the Short Stay Factor: (2 + 1) / 4.4 = 3 / 4.4 = 0.682	
Total Reimbursement	

(f) Transfers to Other Hospitals: For Hospital Services provided to Value Network Members who are transferred to another acute care facility (a "Short Stay"), the Case Rate will be subject to reduction by being multiplied by the result of the following formula:

([LOS+1]/Average LOS) *(not to exceed 1.0)*

SHORT STAY DRG CASE RATE CALCULATION EXAMPLE	
Example Assumptions	• Calculated Base Rate = $11,269 • DRG is 341 • DRG Relative Weight is 2.357 • Allowed Charges are $35,500 • LOS is 2 days • Average LOS is 5.0 • Discharge Status (Form Locator (FL) 17) is 02 – Transfer to a short-term general hospital for inpatient care
Calculating the Short Stay Factor: (2 + 1) / 5.0 = 3 / 5.0 = 0.60	
Total Reimbursement =	

(g) Readmissions: Readmission for the same, similar, or related condition that occurs within forty-eight (48) hours of discharge from Hospital is considered a continuation of the initial inpatient admission. Claims for the two inpatient admissions shall be consolidated into one by Blue Shield, combining all necessary codes, billed charges and LOS to recalculate reimbursement using the methodology described in this Section (1).

(h) Organ Acquisition: Hospital shall be reimbursed for cornea or kidney acquisition costs at the Medicare allowed amount.

(i) **Submission of Outlier Claims:** Claims reimbursable pursuant to the outlier provision of this Section I.A of this Exhibit F must be submitted directly to:

Blue Shield of California
Hospital Exception Unit
P.O. Box 629010
El Dorado Hills, CA 95762-9010

B. Neonatal Per Diem Rates

(1) Neonatal Per Diem Rates

INPATIENT NEONATAL SERVICES & IDENTIFYING DRGs	PER DIEM RATE
789	
790	
791	
792	
793	
794	

(2) **Note to Neonatal Per Diem Rates** Notwithstanding anything in to this Agreement to the contrary, no outlier or stop loss terms shall apply to Hospital Services reimbursable pursuant to this Section B.

C. Sub-Acute Care Per Diem Rates

(1) Sub-Acute Care Per Diem Rates

INPATIENT SUB-ACUTE CARE SERVICES & IDENTIFYING CODES	PER DIEM RATE
Subacute Care - Level I Revenue Code 0191	
Subacute Care - Level II Revenue Code 0192	
Subacute Care - Level III Revenue Codes 0193, 0194	

INPATIENT SUB-ACUTE CARE SERVICES & IDENTIFYING CODES	PER DIEM RATE
Subacute Care – Other Revenue Codes 0190, 0199	

(2) Notes to Sub-Acute Per Diem Rates

(a) Levels of Care: Blue Shield shall reasonably determine which sub-acute levels of care are applicable to the sub-acute care services provided by Hospital. For purposes of this Section I.C:

Level I – Skilled Care refers to the following care or care for the following conditions:

(1) 24-Hour skilled nursing care observation and management;
(2) Routine oral, intra-muscular injection and subcutaneous drug administration;
(3) Intravenous administration (single);
(4) Insulin dependent;
(5) Nasogastric tube, gastric tube, jejunostomy tube, or jejuno-gastric tube (enteral feeding services and supplies included);
(6) Colostomy/ileostomy care;
(7) Foley catheter care (with daily irrigations); and/or
(8) Up to two (2) hours of therapy per day, up to five (5) days per week of rehabilitation services for any combination of the following (evaluation included) by a licensed practitioner:
    (a) Physical therapy,
    (b) Occupational therapy,
    (c) Speech therapy, and
    (d) Respiratory therapy, and/or
(9) Wound care (Stage I, II) decubitus post-surgical wound/dressing care.

Level II – Comprehensive Care refers to the care/conditions set forth in Level I, plus the following additional care or conditions:

(1) Intravenous administration and therapy (two or more medications);
(2) Isolation;
(3) Tracheostomy requiring enteral feeding;
(4) Total parenteral nutrition; and/or
(5) Two (2) to three (3) hours of therapy per day, up to five (5) days per week of rehabilitation services for any combination of the following (evaluation included) by a licensed practitioner:
    (a) Physical therapy,
    (b) Occupational therapy,

(c) Speech therapy, and
(d) Respiratory therapy.

Level III – Complex Care refers to the care/conditions set forth in Levels I and II, plus the following additional care or conditions:

(1) Major wound care (Stage III, intravenous decubitus);
(2) Permanent tracheostomies (includes supplies);
(3) Chest tube;
(4) Shunt management;
(5) Tracheostomy decanulation;
(6) Tracheostomy requiring enteral feeding;
(7) Ventilator management; and/or
(8) Mutually agreed upon diagnoses requiring extensive skilled nursing care.

II. OUTPATIENT SERVICES

A. Outpatient Services Fee Schedule Reimbursement

(1) Calculation

(a) For purposes of this Section II, Outpatient Services, the following shall apply:

(i) the "Multiplier" shall be as set forth in the table below:

MULTIPLIER

(ii) the "Base Percentage" shall be as set forth in the table below:

BASE PERCENTAGE

(b) Outpatient Services, excluding Pre-Admission Services, provided to a Value Network Member shall be reimbursed pursuant to the applicable rates set forth in the attached and incorporated Outpatient Fee Schedule multiplied by the Multiplier.

(c) For those services reimbursed at percent of charges ("POC"), Hospital shall be reimbursed at the amount equal to Allowed Charges multiplied by an amount equal to the Base Percentage multiplied by the Multiplier (the "Calculated Base Percentage") reflected in the table below:

	CALCULATED BASE PERCENTAGE
Percentage of Allowed Charges	

(2) Multiple Procedures If, for any Value Network Member, Hospital performs multiple surgical procedures that have a status indicator of "T" on the Outpatient Fee Schedule, excluding surgical procedures properly billable under a CPT code that is inclusive of bilateral surgical procedures (*i.e.*, a CPT code that references "bilateral" or "unilateral or bilateral" in its description) during a single day, Blue Shield shall reimburse Hospital according to the following methodology:

(a) Blue Shield shall reimburse Hospital for the surgical procedure with the highest

outpatient surgical rate at a rate equal to one hundred percent (100%) of such rate; and

(b) Blue Shield shall reimburse Hospital for each additional surgical procedure at a rate equal t f the outpatient surgical rate applicable to each additional procedure.

In order to be reimbursed for multiple surgical services pursuant to this Section A(2), Hospital must submit a properly completed UB-04 claim form and indicate each procedure on a separate line with the appropriate CPT code. Bilateral procedures must be billed on two lines, with one line indicating the appropriate CPT code and the second line indicating the same CPT code with Modifier 50. Claims not submitted in accordance with these requirements shall not be entitled to reimbursement under this Section A.(2).

B. Observation Services Separate reimbursement for observation services (HCPCS code G0378) will only be made when such services are greater than or equal to eight (8) hours, but not to exceed forty-eight (48) hours. No separate reimbursement will be made for observation services less than eight (8) hours or billed in conjunction with a procedure that is inclusive of observation services pursuant to the Outpatient Fee Schedule.

C. Discontinued Procedures Discontinued procedures shall be reimbursed as follows:

(1) Procedures discontinued after the Value Network Member has been prepared for the procedure and taken to the procedure room but before anesthesia is administered shall be billed with modifier 73 and will be reimbursed the allowed amount.

(2) Procedures discontinued after the procedure has been initiated and/or anesthesia has been administered shall be billed with modifier 74 and will be reimbursed at he allowed amount.

(3) Procedures for which anesthesia is not planned that are discontinued after the Value Network Member is prepared and taken to the room where the procedure is to be performed shall be billed with modifier 52 and will be reimbursed a of the allowed amount.

D. Payment for New Codes New codes and HCPCS codes established and published during the term of the Agreement shall be based upon the most current CMS rate file published prior to the implementation date of the new code.

E. Other Outpatient Services For all other outpatient Hospital Services not specified in Section II.A, or in corresponding electronic files provided by Blue Shield to Hospital Blue Shield shall pay Hospital the percentage of Allowed Charges reflected in the table below:

Percentage of Allowed Charges	

III. GENERAL NOTES

A. Disallowed Charges Prior to calculating the reimbursement amount, Blue Shield reviews Hospital billed charge invoices to determine which charges are "Allowed Charges." The parties hereto agree, as part of the review process, Blue Shield may disallow the following types of charges:

- Patient comfort/convenience items
- Daily or bundled supply charges (these charges are included in the daily charge associated with the room in which services are delivered)
- Incremental nursing charges
- Personnel charges
- Ventilator/respiratory equipment charges, as well as personnel charges (e.g., respiratory therapists, for related respiratory support) in the NICU Level 4 setting
- Personnel charges
- Equipment charges
- Blood draw, venipuncture, and collection charges
- Stat charges, after hour charges, "emergency use of" charges
- Portable fees/transportation charges
- Monitoring fees/charges
- Services/supplies considered as included in a global procedure charge(s) (*e.g.*,charges for medication include all necessary diluents)
- Set-up charges
- Duplicate charges (charges for this service or supply exceed a daily or 24-hour increment charge for date of service)
- "Miscellaneous" charges/supplies not specifically identified or described
- Stand-by charges
- Charges associated with Hospital Acquired Conditions or Never Events as set forth in Section III.B. of this Exhibit F.

B. Hospital Acquired Conditions / Never Events

(1) Blue Shield expects all hospitals that are Blue Shield Providers to take proper precautions to prevent unnecessary and avoidable Member injuries or illnesses. As part of Blue Shield's commitment to improving the quality of care available to Members, Blue Shield has adopted payment policies that are intended to encourage its contracted hospitals to reduce the incidence of certain hospital-acquired conditions ("HACs") and "Never Events." HACs are avoidable conditions that could reasonably have been prevented through application of evidence-based guidelines. Such conditions are not present when patients are admitted to a hospital, but occur during the course of the stay. Never Events, as defined by CMS, are "serious and costly errors in the provision of health care services

that should never happen."

Notwithstanding anything in this Agreement to the contrary, Blue Shield shall not pay or otherwise reimburse Hospital for Covered Services related to those HACs and Never Events identified in Section III.B.(2) of this Exhibit F. Specifically:

(a) Blue Shield shall not reimburse Hospital for Covered Services that would not have been provided in the absence of a HAC, including a higher level of care or additional Inpatient days.

(i) *Per Diem Rate Reimbursement* – If the HAC does not impact the Member's length of stay or the level of care provided to the Member, no adjustment will be made to the Per Diem Rate reimbursement otherwise payable to Hospital. If, as a consequence of the HAC, the Member's length of stay is increased, Blue Shield shall not reimburse Hospital for any additional inpatient days attributable to the HAC. If, as a consequence of the HAC, the Member receives Inpatient Services at a level of care higher than that which the Member would have received in the absence of the HAC, Blue Shield shall reimburse the Hospital at the Per Diem Rate applicable to the level of care that would have been Medically Necessary had the HAC not occurred.

(ii) *Case Rate Reimbursement* – If the HAC does not impact the Member's length of stay or the level of care provided to the Member, no adjustment shall be made to the Case Rate reimbursement otherwise payable to the Hospital. If, as a consequence of the HAC, the Member's length of stay exceeds the number of days covered by the applicable Case Rate, Blue Shield shall reimburse the Hospital at the applicable Case Rate only. If the HAC does not impact the Member's length of stay, but, as a consequence of the HAC, the Member receives services at a level of care higher than that which the Member would have received in the absence of the HAC, Blue Shield shall reimburse the Hospital for any days exceeding the number of days covered by the applicable Case Rate at the Per Diem Rate applicable to the level of care that would have been necessary had the HAC not occurred.

(iii) *Percent of Charge - Based Reimbursement* – Blue Shield shall not pay or reimburse any charges for services related to the HAC. If, as a consequence of the HAC, the Member receives services at a level of care higher than that which the Member would have received in the absence of the HAC, Blue Shield shall reimburse the Hospital only for charges applicable to the level of care that would have been necessary had the HAC not occurred.

(iv) *DRG Reimbursement* – Blue Shield shall not pay or reimburse the Hospital for any services related to the HAC. Reimbursement will be calculated as though the secondary diagnosis was not present.

(v) *Stop Loss Reimbursement* – For purposes of calculating stop loss reimbursement, if any, payable to the Hospital, Blue Shield shall disallow all charges for services related to the HAC.

(b) Blue Shield shall not reimburse Hospital for any Covered Services related to a Never Event.

(2) The terms of Section III.B.(1) of this Exhibit F shall apply to the following HACs and Never Events:

Hospital Acquired Conditions (HACs):

DESCRIPTION	IDENTIFYING ICD-9-CM CODES	PRESENT ON ADMISSION INDICATOR
Pressure ulcers stages III & IV	707.23, 707.24	N, U
Catheter-associated urinary tract infections	996.64 *also excludes the following from acting as a CC/MCC:* **CC**: 112.2, 590.10, 590.3, 590.80, 590.81, 595.0, 597.0, 599.0 **MCC**: 590.11, 590.2	N, U
Vascular catheter-associated infection	999.31	N, U
Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)	519.2 -and- one of the following ICD-9 procedure codes: 36.10-36.19	N, U
Air embolism	999.1	N, U

DESCRIPTION	IDENTIFYING ICD-9-CM CODES	PRESENT ON ADMISSION INDICATOR
Blood incompatibility	999.60-999.63, 999.69	N, U
Foreign object retained after surgery	998.4, 998.7	N, U
Falls and trauma: • Fracture • Dislocation • Intracranial injury • Crushing injury • Burn • Other injuries	800-829, 830-839, 850-854, 925-929, 940-949, 991-994	N, U
Surgical-site infections following certain orthopedic procedures: • Spine • Neck • Shoulder • Elbow	996.67, 998.59 -and- one of the following ICD-9 procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, 81.85	N, U
Surgical-site infections following bariatric surgery for obesity: • Laparoscopic gastric bypass • Gastroenterostomy • Laparoscopic gastric restrictive surgery	Principal ICD-9 Diagnosis Code 278.01, 539.01, 539.81, 998.59 -and- one of the following ICD-9 procedure codes: 44.38, 44.39, 44.95	N, U
Manifestations of poor glycemic control • Diabetic ketoacidosis • Nonketotic hyperosmolar coma • Hypoglycemic coma • Secondary diabetes with ketoacidosis • Secondary diabetes with hyperosmolarity	249.10-249.11, 249.20-249.21, 250.10-250.13, 250.20-250.23, 251.0	N, U

DESCRIPTION	IDENTIFYING ICD-9-CM CODES	PRESENT ON ADMISSION INDICATOR
Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures: • Total knee replacement • Hip replacement	415.11, 415.13, 415.19, 453.40-453.42 -and- one of the following ICD-9 procedure codes: 00.85-00.87, 81.51-81.52, 81.54	N, U
Any and all other HACs that from time to time may be identified by CMS, for which Medicare will not pay, and that are set forth in the Provider Manual.		

Never Events

DESCRIPTION	IDENTIFYING ICD-9-CM CODES	PRESENT ON ADMISSION INDICATOR
Performance of wrong operation on correct patient (wrong surgery)	E876.5	N, U
Performance of operation (procedure) intended for another patient (wrong patient)	E876.6	N, U
Performance of correct operation (procedure) on wrong body part/side/site (wrong body part)	E876.7	N, U
Any and all other Never Events that from time to time may be identified by CMS, for which Medicare will not pay, and that are set forth in the Provider Manual.		

C. **Implants, Prosthetics and Orthotics** The reimbursement rates set forth in this Exhibit F are inclusive of all implants, prosthetics and orthotics, notwithstanding anything in Exhibit C to the contrary.

D. **Facility Fees For Professional Office Visit Services** Blue Shield shall not reimburse or pay Hospital for clinic facility charges billed under Revenue Codes 0510-0517, 0519-0529. Reimbursement for facility fees associated with office services is included in the physician professional fee and is not paid separately to Hospital.

E. Coding Requirements As a precondition to payment, all Hospital Services must be billed and coded in accordance with Blue Shield requirements as detailed in this Agreement and the Provider Manual. Blue Shield's requirements are based on nationally-recognized and industry standard coding structures, including but not limited to the National Uniform Billing Committee, the AMA Current Procedural Terminology, the Healthcare Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), and the International Classification of Diseases (ICD).

F. Coding Updates If an identifying code (e.g., Revenue Code, ICD-9 Procedure Code, etc.) for a Hospital Service set forth in this Exhibit F is modified or updated by the organization responsible for maintaining such coding structure, Blue Shield may make corresponding modifications or updates to this Exhibit F.

G. Mapper Software Mapper Software, system logic designed to ensure ICD diagnosis and procedure codes can be recognized by DRG grouper software even when the codes were created after the group was developed by "mapping" a new diagnosis code back to the code that was used at the time the group software was written, will be used from October 1, when ICD diagnosis codes and procedure codes are updated, until the grouper version designation in Section I to this Schedule 1 is revised by the parties.