



Blue Medicare PFFS<sup>SM</sup>

# 2009 Terms and Conditions

**Blue Medicare Private Fee-For-Service<sup>SM</sup> (PFFS)**  
A Medicare Advantage Plan





# MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLAN MODEL TERMS AND CONDITIONS OF PAYMENT

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<sup>SM</sup> Service Mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

Blue Medicare PFFS is a Medicare Advantage plan offered by HCSC Insurance Services Company, which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Advantage products under contract number H6013 with the Centers for Medicare and Medicaid Services.

## 1. Introduction

Blue Medicare Private Fee-For-Service<sup>SM</sup> (PFFS), is Medicare Advantage private fee-for-service (PFFS) plan offered by HCSC Insurance Services Company (HISC). Blue Medicare PFFS allows members to use any provider, such as a physician, health professional, hospital, or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Medicare Part A and Part B (also known as ‘Original Medicare’).

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat a Blue Medicare PFFS member, you will be “deemed” to have a contract with us. Section 2 explains how the deeming process works. The rest of this document contains the contract that the law allows us to deem to hold between you, the provider, and Blue Medicare PFFS. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Blue Medicare PFFS for the services furnished to the member when the deeming conditions are met. **No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member.** However, a member or provider may request an advance coverage determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Note that the terms prior authorization, prior notification, and advance coverage determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance coverage determination is described in Section 7.

## 2. When a provider is deemed to accept Blue Medicare PFFS terms and conditions of payment

A provider is considered by law to be *deemed* to have a contract with Blue Medicare PFFS when all of the following three criteria are met:

- 1) The provider is aware, in advance of furnishing health care services, that the patient is a member of Blue Medicare PFFS. All of our members receive a member ID card that includes the Blue Medicare PFFS logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling Blue Medicare PFFS toll free at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time).
- 2) The provider either has a copy of, or has reasonable access to, our terms and conditions of payment (this document). The terms and conditions are available on our Web site at [www.hisc.net/pffs](http://www.hisc.net/pffs). The terms and conditions may also be obtained by calling our Provider Services toll-free number at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time).
- 3) The provider furnishes covered services to a Blue Medicare PFFS member.

If all of these conditions are met, the provider is deemed to have agreed to Blue Medicare PFFS' terms and conditions of payment for that member specific to that visit. **Note:** You, the provider, can decide whether or not to accept the Blue Medicare PFFS terms and conditions of payment each time you see a Blue Medicare PFFS member. A decision to treat one plan member does not obligate you to treat other Blue Medicare PFFS members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If a Blue Medicare PFFS member shows you an enrollment card identifying him/her as a member of Blue Medicare PFFS and you provide services to that member, you will be considered a deemed provider. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services (see below).

**If you DO NOT wish to accept the Blue Medicare PFFS terms and conditions of payment, then you should not furnish services to a Blue Medicare PFFS member, except for emergency services. If you nonetheless do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not.** Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.

### 3. Provider qualifications and requirements

In order to be paid by Blue Medicare PFFS for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Blue Medicare PFFS, in accordance with HIPPA requirements.
- Claims may be submitted:
  - Electronically – The Availity health information network. Call Availity at 1-877-334-8446.
  - Paper claims may be submitted to: Local BlueCross and/or BlueShield plan.
  - Please include the following information on claims:
    - Member’s subscriber ID number listed on their membership card
    - Provider’s NPI
    - Federal Tax ID number
    - Medicare Provider Number
- Furnish services to a Blue Medicare PFFS member within the scope of your licensure or certification.
- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions.
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider lists.
- Not be a Federal health care provider, such as a Veterans’ Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with Blue Medicare PFFS to resolve any member grievance involving the provider within the time frame required under Federal law.
- For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (See Section 10 for specific requirements).
- Not charge the member in excess of cost sharing under any condition, including in the event of plan bankruptcy.

## 4. Payment to providers

### Plan payment

Blue Medicare PFFS reimburses deemed providers at an amount that is equivalent to 100% of the current Original Medicare allowable charge less any applicable cost-sharing amounts. Providers can review the current Original Medicare allowable charge on the Centers for Medicare and Medicaid Services (CMS) website by going to [www.cms.hhs.gov/center/provider.asp](http://www.cms.hhs.gov/center/provider.asp). If you choose not to accept the terms and conditions, you will only be paid if you treat Blue Medicare PFFS members for urgent or emergency care and then you may only collect any applicable deductibles, co-payments or coinsurance from the member. You may not balance bill the member for emergency or urgent care, for all medically necessary services covered by Medicare. We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest on the claim according to Medicare guidelines. Section 5 has more information on prompt payment rules. Payment to providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. For more detailed information about our payment methodology for all provider types, go to [http://www.hisc.net/pffs/provider/proxy\\_grid.htm](http://www.hisc.net/pffs/provider/proxy_grid.htm).

Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost sharing, as payment in full.

### Member benefits and cost sharing

Payment of cost sharing amounts is the responsibility of the member. Providers should collect the applicable cost sharing from the member at the time of the service when possible. **You can only collect from the member the appropriate Blue Medicare PFFS co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Blue Medicare PFFS for covered services. Section 5 provides instructions on how to submit claims to us. If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a state Medicaid program) that the state holds harmless for Medicare cost sharing, then the provider cannot collect any cost sharing from the member at the time of service. Instead, the provider may only look to the State Medicaid agency to collect the Medicaid allowable cost sharing amount(s).

To view a complete list of covered services and member cost sharing amounts under Blue Medicare PFFS, go to <http://www.hisc.net/pffs/employer/index.htm>. You may call us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time) to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Blue Medicare PFFS. Be sure to have the member's ID number when you call.

Blue Medicare PFFS follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Blue Medicare PFFS, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Blue Medicare PFFS does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. Under prior authorization, a plan requires beneficiaries or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for Blue Medicare PFFS members.

**Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including PFFS plans. All cost sharing is the member's responsibility.**

Blue Medicare PFFS does not require the member or the provider to prior notify the plan as a condition for covering services. To provide prior notification or to obtain more information about our prior notification rules, call us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time).

### **Balance billing of members**

A provider may collect only applicable plan cost sharing amounts from Blue Medicare PFFS members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Blue Medicare PFFS members.

### **Hold harmless requirements**

In no event, including, but not limited to, nonpayment by Blue Medicare PFFS, insolvency of Blue Medicare PFFS, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments, or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

## 5. Filing a claim for payment

- You must submit a claim to Blue Medicare PFFS for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 15-27 months from the date of service. Failure to be timely with claim submissions may result in non-payment. The criteria for Original Medicare submission of claims can be found in section 70 of Chapter 1 of the Medicare Claims Processing Manual located at: <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>.
- **Prompt Payment.** Blue Medicare PFFS will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Blue Medicare PFFS will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. Blue Medicare PFFS will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.
- Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format.
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.
- Include the following on your claims:
  - National Provider Identifier (NPI).
  - The member's ID number.
  - Date(s) of service.
  - Federal Tax ID number.
  - Medicare provider number.
- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission.
- Coordination of Benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Providers should identify primary coverage and provide information to Blue Medicare PFFS at the time of billing.
- Where to submit a claim:
  - For electronic claim submission, use Availity health information network. Call Availity at 1-877-334-8446.
  - For paper claim submission, send to local BlueCross and/or BlueShield plan.
- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time).

## 6. Maintaining medical records and allowing audits

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to Blue Medicare PFFS members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service. Deemed providers must provide Blue Medicare PFFS, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with Federal and state privacy laws. Such records may be used for activities in the following situations: Centers for Medicare & Medicaid Services and Blue Medicare PFFS audits of risk adjustment data; Blue Medicare PFFS determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; and in order to make advance coverage determinations. Blue Medicare PFFS will not use medical record reviews to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

## 7. Getting an advance coverage determination

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Blue Medicare PFFS. To obtain an advance coverage determination, call us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time). Blue Medicare PFFS will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Blue Medicare PFFS justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time). We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Blue Medicare PFFS can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

## 8. Provider payment dispute resolution process

If you believe that the payment amount you received for a service is less than the amount indicated in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with Blue Medicare PFFS, contact us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time). If you still disagree with the processing after speaking with our Provider Service department, then you may file a Provider dispute to the Plan. A provider dispute must be submitted in writing to the Plan at: P.O. Box 4437, Scranton, PA 18505. Additionally, please provide appropriate documentation to support your payment dispute (e.g., a remittance advice from a Medicare carrier would be considered such documentation). Claims must be disputed within 120 days from the date payment is initially received by the provider.

We will review your dispute and respond to you within 30 days from the time the provider payment dispute is first received by the Plan. If we agree with your payment dispute, then we will pay you the additional amount with any interest that is due. We will inform you in writing if your payment dispute is denied.

After completing the Blue Medicare PFFS dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with First Coast Service Options, Inc., the independent entity contracted by CMS to adjudicate payment disputes between deemed and non-contracted Private Fee-For-Service (PFFS) providers and Medicare Advantage (MA) organizations offering PFFS plans. To file a request for review of a payment dispute, you may send an email if the submission and documents do not contain any personally identifiable health information (PHI). The payment dispute decision request can be submitted to a dedicated email box at [IREPFFS@FCSO.com](mailto:IREPFFS@FCSO.com).

**Payment dispute decision requests** (including associated documents such as claim forms that may contain PHI) can be faxed to (904) 361-0551 or hard copy requests can be sent to the following address:

First Coast Service Options, Inc.  
PFFS Payment Disputes  
P.O. Box 44017  
Jacksonville, Florida 32231-4017

Providers should use the Payment Dispute Decision Request Form (PDD) to submit a request for payment dispute decisions.

## 9. Member and provider appeals and grievances

Blue Medicare PFFS members have the right to file appeals and grievances when they have concerns or problems related to coverage or care. Members may appeal a decision made by Blue Medicare PFFS to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a **grievance** for all other types of complaints.

A provider may appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member's appeal process by signing a waiver of liability (promising to hold the member harmless regardless of the outcome). There must be existing potential member liability (e.g., a claim, as opposed to an advance coverage determination, is denied as not a medically necessary or a covered service) in order for a provider to appeal utilizing the member's appeal process. If you appeal on your own right, you agree to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance process.

The Blue Medicare PFFS Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. You can call 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time) for more information on our member appeals and grievance policies and procedures.

## 10. Providing members with notice of their appeals rights – Requirements for Hospitals, SNFs, CORFs, and HHAs

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to:

[http://www.cms.hhs.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp)

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. For copies of the notice and the notice instructions, go to: <http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCForm.pdf> and <http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf>. In addition, the provider should send a copy of any NOMNC issued to HISC to Blue Cross and Blue Shield of Texas, facsimile number: 1-866-221-3607.

Blue Medicare PFFS will provide members with a detailed explanation if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services within the time frames specified by law.

## 11. If you need additional information or have questions

If you have general questions about Blue Medicare PFFS' terms and conditions of payment, contact us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time) located at P.O. Box 4437, Scranton, PA 18505.

- If you have questions about submitting claims, call us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time).
- If you have questions about plan payments, call us at 1-866-706-7746 (TTY 1-866-844-5530) between the hours of 7 a.m. and 8 p.m. CT (Central Time).







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