Blue Medicare PFFS℠

Medicare Advantage

Blue Medicare Private-Fee-For-Service℠ (PFFS)
2008 Medicare Advantage Terms and Conditions

Table of Contents Page

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.

Blue Medicare PFFS℠

2008 Terms and Conditions of Participation

Blue Medicare PFFS is a Medicare Advantage Private Fee-for-Service plan offered to Medicare beneficiaries through their employers by HCSC Insurance Services Company (HISC), a wholly-owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. Blue Medicare PFFS does not have a contracted provider network; rather any eligible physician, hospital or other health care provider may choose to provide services to a Blue Medicare PFFS member. In return, the physician, hospital or other health care provider will receive reimbursement for covered health services based upon the Original Medicare rules and fee schedules less the member's cost-sharing amounts. These plans are designed to offer Original Medicare benefits plus some additional services.

Plan Highlights

- A provider contract between Blue Medicare PFFS and the provider is not required.
- Prior authorization or referrals for health care services are not required.
- Provider reimbursement is based on published Original Medicare rates, reimbursement guidelines, and methodologies (Medicare Local Medical Review Policies apply).
- Members can obtain services from any willing provider in the U.S. who is eligible to be paid under the Original Medicare program.

Provider Participation – The Deeming Process

Blue Medicare PFFS does not contract with Providers for services provided under the PFFS program. Rather a provider agrees to participate under these Terms and Conditions (the provider is "deemed" a Blue Medicare PFFS participating provider) when:

- The provider has knowledge that a Medicare beneficiary is a member of the Blue Medicare PFFS plan. Blue Medicare PFFS will provide members with an identification or enrollment card that they must show a provider each time they receive care. The provider may further confirm member eligibility by calling Blue Medicare PFFS toll free at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7:00 AM and 8:00 PM Central Time.
- The provider has a reasonable opportunity to obtain the Plan's Terms and Conditions. The terms and conditions are also available through our website at www.hisc.net/pffs or by calling our Provider Services toll-free number at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7:00 AM and 8:00 PM Central Time.
- Services are provided to a Blue Medicare PFFS enrollee.

Once the above conditions are met, a health care provider has agreed to participate in Medicare Blue PFFS and must accept the Blue Medicare PFFS terms and conditions.

What if you do not want to accept Blue Medicare PFFS terms and conditions?

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.

Additional Deemed Provider Requirements

In addition to the participation rules listed above, providers must meet the following additional requirements to provide services under the Blue Medicare PFFS plan:

- Providers must be licensed or certified by the state and be acting within the scope of that license or certification, and not be sanctioned or have opted out of Medicare.
- Providers must comply with Medicare and all other laws, rules, and regulations applicable to members in Medicare Advantage plans.
- The provider agrees to bill Blue Medicare PFFS for reimbursement for Medicare-covered services.
- Prior Authorization or Notification is not required for services. However, notification is recommended to ensure continuity and coordination of care.
- Providers agree not to balance bill Members and collect only their Blue Medicare PFFS cost-sharing amounts. If a provider mistakenly collects more from a member than the designated deductible, co-payment or coinsurance amount, the provider must refund the difference to the member. Plan Benefits and information regarding Plan cost shares are contained in the Summary of Benefits located on the Blue Medicare PFFS website.
- Providers that agree to these Terms and Conditions of Participation will receive 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.
- Provider hereby agrees that in no event, including, but not limited to, non-payment by HISC, insolvency of HISC or breach of these Terms and Conditions of Participation, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Blue Medicare PFFS members or persons (other than HISC) acting on behalf of the member for services provided pursuant of these Terms and Conditions. This provision does not prohibit providers from collecting charges for non-covered services or cost sharing amounts such as Co-payment, Coinsurance or Deductible amounts.
- Provider shall furnish Covered Services to PFFS members in a manner consistent with the requirements of the Medicare statutes, regulations, CMS pronouncements and HISC policies, as well as professionally recognized standards of health care. Provider shall further comply with the HISC policies and procedures to ensure that Covered Services are provided in a culturally competent manner to PFFS members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities. Providers will not discriminate or differentiate in the treatment of any HISC member because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, and age, source of payment or health status.
- Providers must be certified to treat Medicare beneficiaries if they are an institutional provider.
- Providers are required to provide Medical Records for risk adjustment validation audits as required by (CMS). In addition, providers will be asked to submit Medical Records to HISC in cases where review is necessary in order to assess accurate claims payment.

Summary of Benefits

For Blue Medicare PFFS members: Services not covered by Medicare are not covered by Blue Medicare PFFS unless specified in our Terms and Conditions of Payment, Summary of Benefits, or Evidence of Coverage. If you have questions about whether a service is covered under Blue Medicare PFFS, please contact us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7:00 AM and 8:00 PM Central Time.

Medically Necessary Services

Medically necessary – Services or supplies that: are proper and needed for the diagnosis or treatment of the enrollee's medical condition; are used for the diagnosis, direct care, and treatment of the enrollee's medical condition; meet the standards of good medical practice in the local community; and are not mainly for the enrollee's convenience or that of the doctor.

Claims can be denied due to a lack of medical necessity.

Claims Submission Procedures

- Blue Medicare PFFS requires that all claims be submitted within the time frames established under the Original Medicare program:

  Claim Submission Requirements:
  For services rendered between January 1, 2008 and September 30, 2008, claims must be submitted by December 31, 2009.

  For services rendered between October 1, 2008 and September 30, 2009, claims must be submitted by December 31, 2010.

- A clean claim with no defect and any required substantiating documentation must be received by Blue Medicare PFFS within the time frames listed above. Claims must be submitted according to the coding rules of Original Medicare with Medicare CPT Codes and defined modifiers.

- Blue Medicare PFFS follows Medicare's prompt payment requirements for all clean claims received. 95% of all clean claims shall be paid within thirty (30) days of receipt by Blue Medicare PFFS. In the event that a clean claim is not processed within the 30 day timeframe, interest will be paid in accordance with federal guidelines.

- 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

Medicare Provider Notice and Appeal Requirements

Notification of Hospital Discharge Appeal Rights
http://www.cms.hhs.gov/BNI/Downloads/CMS-4105-F.pdf

This link contains information that outlines requirements for how hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge rights. Link is subject to change due to Centers for Medicare & Medicaid Services (CMS) updates.

Effective July 1, 2007, hospitals will use a revised version of the Important Message from Medicare, or (IM), an existing statutorily required notice, to explain the member's discharge rights.

- Hospitals must issue the (IM) within two days of admission.

Notice of Medicare Non-Coverage (NOMNC)
www.cms.hhs.gov/MMCAG/

This link contains instructions for providers regarding the (NOMNC). Link is subject to change due to Centers for Medicare & Medicaid Services (CMS) updates.

- Skilled Nursing Facilities (SNF), Home Health Agencies (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF) must issue the Notice of Medicare Non-Coverage (NOMNC) to enrollees no later than two days before the termination of services.

Detailed Explanation of Non-Coverage (DENC)
www.cms.hhs.gov/MMCAG/

This link directs the provider to information regarding the (DENC) and to Chapter 13 of the Medicare Managed Care Manual. Section 90.6 in Chapter 13 of the Medicare Managed Care Manual contains detailed information regarding the DENC. Link is subject to change due to Centers for Medicare & Medicaid Services (CMS) updates.

- Skilled Nursing Facilities (SNF), Home Health Agencies (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF) must issue the Detailed Explanation of Non-Coverage (DENC) when an enrollee appeals a termination decision about their services.

Provider Claims Resolution Process

Providers have a right to file a dispute if they disagree with the manner in which a claim was processed or paid. You may contact us at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7:00 AM and 8:00 PM 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

Blue Medicare PFFS Member Appeals

- Copies of Appeals and Grievances procedures are available by calling Customer Service at 1-866-706-7746 (TTY/TDD: 1-866-844-5530) between 7:00 am and 8:00 pm Central Time. Appeals and Grievances procedures are also contained in the member's Evidence of Coverage (EOC).
- If a member has questions regarding a claim payment, they should call our Member Services department at 1-866-706-7746 (TTY/TDD: 1-866-844-5530) between the hours of 7:00 AM and 8:00 PM Central Time.

Provider Practice Changes

Providers may contact our Provider Service Center if any demographic or billing changes are planned within the next thirty (30) days. To ensure continuity of service, prior notice to the plan is needed for any of the following changes in your practice:

- 1099 mailing address.
- Tax identification number or entity affiliation (W-9 required).
- Group name or affiliation.
- Physical or billing address.
- Telephone and fax number.
- CMS payment rate.

Also, physicians, hospitals and other providers are asked to notify Blue Medicare PFFS in the event of a Medicare provider number change (i.e. an acute care hospital changes to a critical access hospital, a family practice clinic changes to a rural health clinic, etc.) that results in a change in reimbursement. To notify Blue Medicare PFFS of any of these types of changes, please contact our Provider Service Center at 1-866-383-5164 (TTY 1-888-844-5530) between the hours of 7:00 AM and 8:00 PM Central Time, or send information in writing to:

P.O. Box 4437
Scranton, Pa. 18505

Other Requirements

- The privacy of our members is important to us. Service provided under the Blue Medicare PFFS plan must be provided in accordance with the standards of confidentiality and patients' rights outlined in the 1997 Consumer Bill of Rights and Responsibilities and all relevant HIPAA regulations.
- Blue Medicare PFFS is prohibited from interfering with a health care professional on matters of advising and advocating on behalf of a member enrolled in a Medicare Advantage plan with regard to:
  - The patient's health status, medical care, or treatment options.
  - The risks, benefits, and outcomes of treatment or non-treatment.
  - The opportunity to refuse treatment or preferred future treatment decisions.