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

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1. Introduction

(Plan Name[s]) [is/are] Medicare Advantage private fee-for-service (PFFS) plan[s] offered by (Organization Name). (Plan Name) 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') [*Insert if applicable*: or eligible to be paid by (Plan Name) for benefits that are not covered under Original Medicare].

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat a (Plan Name) 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 (Plan Name). Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with (Plan Name) 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 (Plan name's) terms and conditions of payment

A provider is considered by law to be ***deemed*** to have a contract with (Plan name) 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 (Plan Name). All of our members receive a member ID card that includes the (Plan Name) logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our [*revise as necessary*: Provider Service Center] at [*insert contact number*]. [*If applicable: insert additional instructions for how providers can determine member eligibility*.]
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 website at [*insert link for terms and conditions*]. The terms and conditions may also be obtained by calling our [*revise as necessary*: Provider Service Center] at [*insert contact number*].
3) The provider furnishes covered services to a (Plan Name) member.

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

For example: If a (Plan Name) member shows you an enrollment card identifying him/her as a member of (Plan Name) 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 (Plan Name's) terms and conditions of payment, then you should not furnish services to a (Plan Name) 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 (Plan Name) for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to (Plan Name), in accordance with HIPPA requirements.
- [*Describe rules for providers submitting non-electronic transactions*.]
- Furnish services to a (Plan Name) 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 (Plan Name) 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 and [*insert if applicable:* permitted balance billing] under any condition, including in the event of plan bankruptcy.
- *[If the plan has specific provider requirements for supplemental services, list here. CMS pre-approval is required.]*

4. Payment to providers

Plan payment

(Plan Name) reimburses deemed providers at [*describe plan payment to providers (e.g., the amount they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services)*], minus any member required cost sharing, 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. [*Insert if applicable*: 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 [*insert link to proxy grid*].

[*Insert if applicable:* Services covered under (Plan Name) that are not covered under Original Medicare are reimbursed using the following fee schedule located at [*Insert link*]]. [*As an alternative to the previous sentence, plan may use*: Services covered under (Plan Name) that are not covered under Original Medicare are reimbursed using (Plan Name)'s fee schedule. Please call us at [*insert contact number*] to receive information on our fee schedule.]

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 (Plan Name) co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill (Plan Name) 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).

[*EGWPs and MAOs using this document for multiple PFFS plans may exclude the quick reference table*] For your quick reference, the table below lists some of the important services covered under (Plan Name) and the associated member cost sharing amounts.

***[Revise list as necessary]* Services covered by (Plan Name)**	**[*Revise amounts as necessary and also indicate cost sharing if prior notification requirements apply*] The amount(s) you may charge the plan member**
Inpatient hospital services	• $400 per admittance • $300 if member pre-notifies
Skilled nursing facility	• $100 per admission • $0 if member pre-notifies • $75 per day per admit for days 21-100 • $2000 out of pocket max
Office services (Physician, specialist, chiropractic & podiatry)	• $5 primary care per visit • $15 specialist care per visit
Immunizations	• $0 copay
Mammography	• $0 copay
Physical Exams (1 per year)	• $5 primary care per visit • $15 specialist care per visit
Emergency room visit	• $50 • $0 if admitted
Urgent care center visits	• $5 per visit
[Include supplemental services if applicable]	•

[*EGWPs may exclude this sentence:* To view a complete list of covered services and member cost sharing amounts under (Plan Name), go to [*add link to SB*].] You may call us at [*insert contact number*] to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under (Plan name). Be sure to have the member's ID number when you call.

(Plan Name) follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by (Plan Name), unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. (Plan Name) does <u>not</u> 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 (Plan Name) members. [*Insert if applicable*: For information on (Plan Name)'s prior notification policies, see section on "Prior notification rules" below.]

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.

[Insert this section if applicable] **Prior notification rules**

No prior authorization or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to members. However, to assist us in better managing care for our members, we request that you notify us *prior* to the member receiving any of the following services: [*list services for which prior notification is requested*].

[*Insert this paragraph if plan reduces member cost sharing to encourage prior notification*] Note that (Plan Name) charges lower member cost sharing for the following services if the member or provider voluntarily notifies the plan before the service is furnished: [*list services for which plan lower cost sharing when prior notified*]. The lower member cost sharing amounts that result from prior notification are listed in the table above. [*As an alternate to the previous sentence, EGWPs and MAOs using this document for multiple PFFS plans may use*: You may call us at [*insert contact number*] to obtain information about lower member cost sharing amounts when we are prior notified.]

(Plan Name) 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, [*revise as necessary:* call us at [*insert contact number*] or fill out the form located at [*insert link*] and fax it to [*insert fax number*]].

Balance billing of members

[*Insert this paragraph if plan <u>prohibits</u> balance billing*] A provider may collect only applicable plan cost sharing amounts from (Plan Name) members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to (Plan Name) members.

[*Insert this paragraph if plan <u>allows</u> balance billing*] In addition to collecting applicable plan cost sharing amounts from (Plan Name) members, you may balance bill the member up to [*insert balance billing amount of 15 or less*] % of the total plan payment amount for the service(s) furnished. Note that (Plan Name) does not permit a provider to balance bill a member who is also enrolled in a state Medicaid program and as a result the beneficiary is held harmless from Medicare cost sharing.

[*Insert this paragraph if the plan allows hospitals to balance bill*] If you are a hospital provider that intends to impose balance billing, you must provide the following to a (Plan Name) member before furnishing any hospital services for which the balance billing amount could be greater than $500: (1) a notice that balance billing is permitted for those services; (2) a good faith estimate of the likely amount of balance billing based on the member's presenting condition; and (3) the amount of any deductible, coinsurance, and co-payment that may be due in addition to the balance billing amount.

[*Insert if applicable*: You must also provide a notice of anticipated cost sharing for the following additional services: [*describe type(s) of service and cost sharing threshold for providing a notice*].]

Hold harmless requirements

In no event, including, but not limited to, nonpayment by (Plan Name), insolvency of (Plan Name), 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 [I*nsert if applicable when plan allows balance billing:* in addition to allowed balance billing amounts] 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 (Plan Name) 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 [*Optional*: (*insert date range*)]. 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** (Plan Name) will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, (Plan Name) 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. (Plan Name) will process all non-clean claims and notify providers of the determination within 45 days of receiving such claims.

- [*Revise as necessary*: Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format.]

- [*Revise as necessary*: 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.]

- [*Revise as necessary*: Include the following on your claims:

    - National Provider Identifier.
    - The member's ID number.
    - Date(s) of service.]

- 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. [*Revise as necessary*: Providers should identify primary coverage and provide information to (Plan Name) at the time of billing.]

- Where to submit a claim:
    - For electronic claim submission, [*insert instructions*].
    - For paper claim submission, [*insert instructions*].

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at [*insert contact number*].

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 (Plan Name) 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 (Plan Name), 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 (Plan Name) audits of risk adjustment data; (Plan Name) 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. (Plan Name) 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.

[*Insert if applicable:* To encourage providers to submit member medical records to (Plan Name) when necessary, (Plan Name) will reimburse the provider for the cost of copying and forwarding requested medical records and/or send plan staff on-site to obtain copies of the desired records.]

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 (Plan Name). To obtain an advance coverage determination, [*revise as necessary:* call us at [*insert contact number*] or fill out the form located at [*insert link*] and fax it to [*insert fax number*]. (Plan name) 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 (Plan Name) 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, [*revise as necessary:* call us at [*insert contact number*] or fill out the form located at [*insert link*] and fax it to [*insert fax number*]. We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, (Plan Name) 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 (Plan Name), [*revise as necessary:* send a written dispute to [*insert address, email, and/or fax number*] or call us at [*insert contact number*]. [*Optional*: A copy of our Provider Payment Dispute Resolution Form is available [*describe where this document can be obtained*].] Additionally, please provide appropriate documentation to support your payment dispute [*revise as necessary:* e.g., a remittance advice from a Medicare carrier would be considered such documentation]. [*Plans that are meeting access requirements by paying providers at least the amount they would have received under Original Medicare insert:* Claims must be disputed within 120 days from the date payment is initially received by the provider.] [*All other plans insert*: Claims must be disputed within [*insert time frame: CMS recommends 120 days from the date payment is initially received by the provider*].]

We will review your dispute and respond to you within [*insert time frame: CMS recommends 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 (Plan Name)'s 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 an independent entity contracted by CMS. To file a request for review of a payment dispute with the independent entity, you may contact the entity directly at [*insert instructions for contacting the independent review entity*].

9. Member and provider appeals and grievances

(Plan Name) 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 (Plan Name) 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 (Plan Name) Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. [*EGWPs may exclude this sentence:* The member EOC is posted [*revise as necessary:* under the member benefits link on the member information section of our website located at [*add link*]]. You can call our [*revise as necessary:* Member Services Department] at [*insert contact number*] 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

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 *[insert relevant addresses and/or fax numbers or add link to page with this information]*.

(Plan Name) 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 (Plan Name's) terms and conditions of payment, contact us at [*insert contact information – include a toll-free number, complete street address and/or P.O. Box ,hours of operation, fax number, name of unit, and plan representative*].

- If you have questions about submitting claims, call us at [*insert contact number*].
- If you have questions about plan payments, call us at [*insert contact number*].