BlueMedicare[SM] PFFS and **Blue**Medicare[SM] Group PFFS

Terms and Conditions of Payment

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BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

BLUEMEDICARE PFFS AND BLUEMEDICARE GROUP PFFS
TERMS AND CONDITIONS OF PAYMENT

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1. Introduction

BlueMedicare PFFS and BlueMedicare Group PFFS are Medicare Advantage private fee-for-service (PFFS) plans offered by Blue Cross and Blue Shield of Florida. BlueMedicare PFFS and BlueMedicare Group PFFS allow 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') or eligible to be paid by BlueMedicare PFFS and BlueMedicare Group PFFS 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 BlueMedicare PFFS and BlueMedicare Group 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 BlueMedicare PFFS and BlueMedicare Group PFFS. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with BlueMedicare PFFS and BlueMedicare Group 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 organization 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 organization determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance organization determination is described in Section 7.

2. When a provider is deemed to accept BlueMedicare PFFS and BlueMedicare Group PFFS' terms and conditions of payment

A provider is deemed by law to have a contract with BlueMedicare PFFS and BlueMedicare Group 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 BlueMedicare PFFS or BlueMedicare Group PFFS. All of our members receive a member ID card that includes the BlueMedicare PFFS and BlueMedicare Group PFFS logo that clearly identifies them as PFFS members. The provider may validate eligibility by calling our Provider Contact Center at 1-800-727-2227 or verify member eligibility electronically via the Availity Health Information Network at www.availity.com.
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 www.flbluemedicarepffs.com. The terms and conditions may also be obtained by calling our Provider Contact Center at 1-800-727-2227.

3) The provider furnishes covered services to a BlueMedicare PFFS and BlueMedicare Group PFFS member.

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

For example: If a BlueMedicare PFFS or BlueMedicare Group PFFS member shows you an enrollment card identifying him/her as a member of BlueMedicare PFFS or BlueMedicare Group 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 BlueMedicare PFFS and BlueMedicare Group PFFS' terms and conditions of payment, then you should not furnish services to a BlueMedicare PFFS or BlueMedicare Group 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 BlueMedicare PFFS and BlueMedicare Group PFFS for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to BlueMedicare PFFS and BlueMedicare Group PFFS, in accordance with HIPPA requirements.
- For paper claim submission, **Florida providers** mail paper claims to:
  Blue Cross and Blue Shield of Florida
  P.O. Box 1798
  Jacksonville, FL 32231-0014.
  Out of State Providers: Submit all claims to the Blue Cross and Blue Shield Plan serving your area.
- Furnish services to a BlueMedicare PFFS or BlueMedicare Group 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 BlueMedicare PFFS and BlueMedicare Group 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 and under any condition, including in the event of plan bankruptcy.

4. Payment to providers

Plan payment

BlueMedicare PFFS and BlueMedicare Group PFFS reimburses deemed providers at the amount they would have received under Original Medicare for Medicare-covered services, minus any member required cost sharing, for all medically necessary services covered by Medicare. BlueMedicare PFFS and BlueMedicare Group PFFS will pay Physician Quality Reporting Initiative (PQRI) bonus and e-prescribing incentive payment amounts to physicians who would receive them in connection with treating Medicare beneficiaries who are not enrolled in an Medicare Advantage plan.

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 our PFFS Provider website at www.flbluemedicarepffs.com, choose reimbursement methodology.

Services covered under BlueMedicare PFFS and BlueMedicare Group PFFS that are not covered under Original Medicare are reimbursed using BlueMedicare PFFS and BlueMedicare Group PFFS' fee schedule. Please call us at 1-800-727-2227 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 BlueMedicare PFFS or BlueMedicare Group PFFS copayments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill BlueMedicare PFFS and BlueMedicare Group 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), then the provider cannot collect any cost sharing for Medicare Part A and Part B services from the member at the time of service when the State is responsible for paying such amounts (nominal copayments authorized under the Medicaid State plan may be collected). Instead, the provider may only accept the MA plan payment (plus any Medicaid copayment amounts) as payment in full or bill the appropriate State source.

You may call us at 1-800-727-2227 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under BlueMedicare PFFS and BlueMedicare Group PFFS. Be sure to have the member's ID number when you call.

BlueMedicare PFFS and BlueMedicare Group PFFS follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by BlueMedicare PFFS and BlueMedicare Group PFFS, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. BlueMedicare PFFS and BlueMedicare Group 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 BlueMedicare PFFS and BlueMedicare Group 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.

Balance billing of members

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

Hold harmless requirements

In no event, including, but not limited to, nonpayment by BlueMedicare PFFS and BlueMedicare Group PFFS, insolvency of BlueMedicare PFFS and BlueMedicare Group 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 BlueMedicare PFFS and BlueMedicare Group PFFS for an Original Medicare covered services 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** BlueMedicare PFFS and BlueMedicare Group 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, BlueMedicare PFFS and BlueMedicare Group 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. BlueMedicare PFFS and BlueMedicare Group 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,including the three alpha prefix (on member ID card).
    - Date(s) of service.
    - Federal Tax identification number
    - Laboratories must include their CLIA 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 BlueMedicare PFFS and BlueMedicare Group PFFS at the time of billing.

- Where to submit a claim:
    - For electronic claim submission, **Florida providers** use Availity Information network or a billing service or clearinghouse to transmit to Availity at www.availity.com. **Out of State Providers:** Submit all claims to the Blue Cross and Blue Shield of Florida Plan serving your area.
    - For paper claim submission, **Florida providers** mail paper claims to:
      Blue Cross and Blue Shield of Florida
      P.O. Box 1798
      Jacksonville, FL 32231-0014
      Out of State Providers: Submit all claims to the Blue Cross and Blue Shield Plan serving your area.

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-800-AVAILITY (282-4548)

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 BlueMedicare PFFS and BlueMedicare Group 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 BlueMedicare PFFS and BlueMedicare Group 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 will primarily be used for Centers for Medicare & Medicaid Services (CMS) audits of risk adjustment data upon which CMS capitation payments to BlueMedicare PFFS and BlueMedicare Group PFFS are based. Providers are required to furnish member medical records without charge when the medical records are required for government use.

BlueMedicare PFFS and BlueMedicare Group PFFS may also request records for activities in the following situations: BlueMedicare PFFS and BlueMedicare Group PFFS audits of risk adjustment data, determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; to investigate fraud and abuse; and in order to make advance coverage determinations. BlueMedicare PFFS and BlueMedicare Group PFFS will not use these records for any purpose other than the intended use.

BlueMedicare PFFS and BlueMedicare Group PFFS will not use medical record reviews to create artificial barriers that would delay payments to providers. Both mandatory and voluntary provision of medical records must be consistent with HIPAA privacy law requirements.

7. Getting an advance organization determination

Providers may choose to obtain a written advance coverage determination (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 BlueMedicare PFFS and BlueMedicare Group PFFS. To obtain an advance organization determination, call us at 1-800-727-2227. BlueMedicare PFFS and BlueMedicare Group PFFS will make a decision and notify you and the member within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or BlueMedicare PFFS or BlueMedicare Group 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 1-800-727-2227. We will notify you of our decision within 72 hours.

In the absence of an advance organization determination, BlueMedicare PFFS and BlueMedicare Group 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 BlueMedicare PFFS and BlueMedicare Group PFFS, send a written dispute to PFFS Claim Resolution Unit, 4800 Deerwood Campus Parkway, DCC 600-1, Jacksonville, Florida 32246. A copy of our Provider Payment Dispute Resolution Form is available on our PFFS Provider website at www.flbluemedicarepffs.com, choose "Forms" under BlueMedicare PFFS Home, and then choose "Provider Claim Payment Dispute Process form". 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. Note that in cases where we re-adjudicate a claim, for instance, when we discover that we processed it incorrectly the first time, you have an additional 120 days from the date you are notified of the re-adjudication in which to dispute the claim.

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 the reason for your payment dispute, we will pay you the additional amount you are requesting, including any interest that is due. We will inform you in writing if our decision is unfavorable and no additional amount is owed.

After BlueMedicare PFFS and BlueMedicare Group PFFS' payment dispute resolution process is completed, if you still believe that we have reached an incorrect decision regarding payment on your claim, you may file an additional request for review with an independent review organization contracted by CMS. To file this additional request for review of a payment dispute with the independent review organization, you may contact the organization directly at:

First Coast Service Options, Inc.
Payment Dispute Resolution Contractor
P.O. Box 44017
Jacksonville, FL 32231-4017

FCSO may also be reached by email at PDRC@fcso.com and by phone at (904) 791-6430. Note that you must first complete BlueMedicare PFFS and BlueMedicare Group PFFS' payment dispute resolution process before you can request a review by the independent review organization.

9. Member and provider appeals and grievances

BlueMedicare PFFS and BlueMedicare Group PFFS members have the right to file appeals and grievances with BlueMedicare PFFS and BlueMedicare Group PFFS when they have concerns or problems related to coverage or care. Members may appeal a decision made by BlueMedicare PFFS and BlueMedicare Group 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 not related to the provision or payment for health care.

A physician who is providing treatment may, upon notifying the member, appeal pre-service organization determination denials to the plan on behalf of the member. The physician may also appeal a post-service organization determination denial as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal the denial using the member appeal process. There must be potential member liability (e.g., an actual claim for services already rendered, as opposed to an advance organization determination), in order for a provider to appeal utilizing the member appeal process.

A non-physician provider may appeal organization determinations on behalf of the member as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal post-service organization determinations (e.g., claims) using the member appeal process. As noted above, there must be potential member liability in order for a provider to appeal utilizing the member appeal process.

If a provider appeals using the member appeal process, the provider agrees to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance processes.

The BlueMedicare PFFS and BlueMedicare Group PFFS Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. The member EOC is posted under the member benefits link on the member information section of our website located at www.flbluemedicarepffs.com, under "BlueMedicare PFFS Home", choose Plan Overview & Benefits, access 2010 BlueMedicare PFFS Evidence of Coverage. You can call our Member Services Department at 1-800-926-6565 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, including Medicare Advantage beneficiaries enrolled in PFFS plans, who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including complying with the normal 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, including Medicare Advantage beneficiaries enrolled in PFFS plans, about their right to appeal a termination of services decision by complying with the requirements for providing the Notice of Medicare Non-Coverage (NOMNC), including complying with the normal 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. As directed in the instructions, the NOMNC should contain BlueMedicare PFFS and BlueMedicare Group PFFS' contact information somewhere on the form (such as in the *additional information* section on page 2 of the NOMNC).

BlueMedicare PFFS and BlueMedicare Group 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 (Detailed Notice of Discharge) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (Detailed Explanation of Non-coverage) within the time frames specified by law.

11. If you need additional information or have questions

If you have general questions about BlueMedicare PFFS and BlueMedicare Group PFFS' terms and conditions of payment, contact us at 1-800-727-2227, seven days a week from 8:00 a.m. – 9:00 p.m. ET or PFFS Unit, 4800 Deerwood Campus Parkway, DCC 600-1, Jacksonville, Florida 32246.

- If you have questions about submitting claims, call us at 1-800-727-2227.
- If you have questions about plan payments, call us at 1-800-727-2227.