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

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1. Introduction

BlueAdvantage is the Medicare Advantage private fee-for-service (PFFS) plan offered by BlueCross BlueShield of Tennessee. BlueAdvantage 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 BlueAdvantage 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 BlueAdvantage. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with BlueAdvantage 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 BlueAdvantage’s terms and conditions of payment

A provider is considered by law to be *deemed* to have a contract with BlueAdvantage 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 BlueAdvantage. All of our members receive a member ID card that includes the BlueCross BlueShield of Tennessee logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling 1-800-676-BLUE, available 24 hours a day/7 days a week, and/or BlueAdvantage Provider Service, 1-800-841-7434, Monday – Friday, 8:00 a.m. to 5:00 p.m., or by sending an electronic inquiry (HIPAA 270 eligibility) transaction to their local Blue Plan.
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 at <http://www.bcbst.com/providers/bcbst-medicare/pdfs/terms.pdf>. The terms and conditions may also be obtained by calling 1-800-841-7434.
3. The provider furnishes covered services to a BlueAdvantage member.



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

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

- Have a National Provider Identifier in order to submit electronic transactions to BlueAdvantage, in accordance with HIPAA requirements.
- Furnish services to a BlueAdvantage 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.



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- Agree to cooperate with BlueAdvantage 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 the cost sharing allowed under these terms and conditions under any condition, including in the event of plan bankruptcy.

4. Payment to providers

Plan payment

BlueAdvantage reimburses deemed providers the amount they would have received under Original Medicare for Medicare covered services, minus any amounts paid directly by Original Medicare (such as for direct graduate medical education) and 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. 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.bcbst.com/providers/bcbst-medicare/reimbursement.shtml>.

Services covered under BlueAdvantage that are not covered under Original Medicare are reimbursed using the BlueCross BlueShield of Tennessee Medicare Advantage fee schedule. Please call us at 1-800-841-7434, or review the Provider Manual (section XXIV) at <http://www.bcbst.com/providers/manuals/bcbstPAM.pdf> 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 BlueAdvantage co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill BlueAdvantage 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).



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To view a complete list of covered services and member cost sharing amounts under BlueAdvantage, go to <http://www.bcbst.com/providers/BenefitHighlights.shtml>. You may call us at 1-800-841-7434 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under BlueAdvantage. Be sure to have the member's ID number, including the 3 character alpha prefix (on the ID card) when you call.

BlueAdvantage follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by BlueAdvantage, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. BlueAdvantage 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 BlueAdvantage members. For information on BlueAdvantage'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.

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:

- All acute care facility, skilled nursing facility, rehabilitation and behavioral health facility inpatient stays
- Home health services/skilled nursing visits including those for home infusion therapy (excluding initial evaluations)
- Part B Specialty Pharmacy Medications with a line item price greater than \$200
- Durable medical equipment-for purchase or rentals if the purchase price is greater than \$500
- Orthotics and prosthetics if the purchase price is greater than \$200
- Speech therapy, occupational therapy and physical therapy.

BlueAdvantage 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 1-800-924-7141 or fill out the form located at <http://www.bcbst.com/providers/bcbst-medicare/forms.shtml> and fax it to 1-800-255-0244.



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Balance billing of members

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

Hold harmless requirements

In no event, including, but not limited to, nonpayment by BlueAdvantage insolvency of BlueAdvantage, 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

- We request that you submit claims as soon as possible after a service is provided. You must submit a claim 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** BlueAdvantage will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, BlueAdvantage 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. BlueAdvantage 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.
 - The member's ID number, including the three character alpha prefix (on member ID card).
 - Date(s) of service.



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- Federal tax ID 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 BlueAdvantage at the time of billing.

- Where to submit a claim:
 - Hospice and clinical trial providers should continue to file claims using their current process.
 - All other claims (electronic or paper) should be submitted to your local Blue Plan. To obtain the claims filing address, go to <http://www.bcbst.com/providers/bcbst-medicare/contact-us.shtml>

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at ecomm_techsupport@bcbst.com or 423-535-5717.

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 BlueAdvantage 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, without charge, provide BlueAdvantage, 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 BlueAdvantage audits of risk adjustment data; BlueAdvantage 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. BlueAdvantage 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 BlueAdvantage. To obtain an advance coverage determination, call us at 1-800-924-7141 (be sure to have the member's ID number including the 3 character alpha prefix when you call) or fill out the form located at <http://www.bcbst.com/providers/bcbst-medicare/forms.shtml> and fax it to 1-800-255-0224. BlueAdvantage will make a decision and notify you within 14 days of receiving the request, with a



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possible 14-day extension either due to the member's request or BlueAdvantage 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 1-800-924-7141 (be sure to have the member's ID number including the 3 character alpha prefix when you call). We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, BlueAdvantage 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 BlueAdvantage, send a written dispute to your local Blue Plan. The appropriate address can be obtained at <http://www.bcbst.com/providers/ProviderAppeals.shtml>. Additionally, please provide appropriate documentation to support your payment dispute. 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 thirty days. 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 BlueAdvantage'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:

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

Fax: (904) 361-0551

Email: IREPFFS@FCSCO.com (must not contain PHI)

Providers with questions regarding the adjudication process or individual disputes being reviewed by the IRE can contact FCSO at (904) 791-6430. Providers will be able to leave messages and should expect a return call within 48 hours of receipt. Hard copy correspondence associated with a dispute request may be mailed to:



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**First Coast Service Options, Inc.
PFFS Payment Disputes
P.O. Box 44035
Jacksonville, FL 32231-4035**

9. Member and provider appeals and grievances

BlueAdvantage 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 BlueAdvantage 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 BlueAdvantage Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. You can call (800) 841-7434 (be sure to have the member's ID number including the 3 character alpha prefix when you call) for more information on our member appeals and grievance policies and procedures.

Waiver of liability statements and appeals should be sent to BlueAdvantage at:

BlueCross and BlueShield of Tennessee
Attn: BlueAdvantage Operations Appeals / Grievance coordinator
PO Box 180205
Chattanooga, TN 37402
or fax to: (423) 296-5498.

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:



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<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:

BlueCrossBlueShield of Tennessee
Attn: BlueAdvantage Health Management
PO Box 180205
Chattanooga, TN 37402-7205

Or fax to 1-888-535-5243 or 1-423-535-5243

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities, must provide members with a detailed explanation on behalf of the plan 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 timeframes specified by law.

For home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities, to obtain the Detailed Explanation of Non-Coverage go to:
<http://www.cms.hhs.gov/MMCAG/Downloads/DENC.pdf>

For hospitals, to obtain the Detailed Notice of Discharge go to:
http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities should also send these detailed notices to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Health Management
PO Box 180205
Chattanooga, TN 37402-7205

Or fax to 1-888-535-5243 or 1-423-535-5243

11. If you need additional information or have questions

If you have questions concerning claim submission, plan payment, or questions in general, contact us at the BlueAdvantage Provider Service unit at 1-800-841-7434, Mon-Fri 8 a.m. to 5 p.m. EST. or visit <http://www.bcbst.com/providers/BenefitHighlights.shtml>.