

Medicare Advantage Private Fee-For-Service Plan Model Terms and Conditions of Payment

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1. Introduction

Health Alliance Medicare PFFS is a Medicare Advantage private fee-for-service (PFFS) plan offered by Health Alliance Medicare. Health Alliance 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’) or eligible to be paid by Health Alliance Medicare 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 Health Alliance 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 Health Alliance Medicare PFFS. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Health Alliance 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 Health Alliance Medicare PFFS terms and conditions of payment

A provider is considered by law to be *deemed* to have a contract with Health Alliance 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 Health Alliance Medicare PFFS. All of our members receive a member ID card that includes the Health Alliance Medicare logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our Health Alliance Medicare Services Department at 1-800-965-4022. Providers can also determine member eligibility by obtaining a user name and password for our website at www.healthalliance.org and searching for the member’s status.
- 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 <https://healthalliance.org/images/PrivateFeeForServiceTermsAndConditions.pdf>. The terms and conditions may also be obtained by calling our Contracting & Provider Services Department at 1-800-851-3379, extension 4668.
- 3) The provider furnishes covered services to a Health Alliance Medicare member.

If all of these conditions are met, the provider is deemed to have agreed to Health Alliance 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 Health Alliance Medicare PFFS term and conditions of payment each time you see a Health Alliance Medicare PFFS member. A decision to treat one plan member does not obligate you to treat other Health Alliance Medicare PFFS members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

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

- Have a National Provider Identifier in order to submit electronic transactions to Health Alliance Medicare PFFS, in accordance with HIPAA requirements.
- Providers should submit paper claims to the Health Alliance Claims Department at P.O Box 6003, Urbana, IL 61803.
- Furnish services to a Health Alliance 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 Health Alliance 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

Health Alliance Medicare PFFS reimburses deemed providers the current Medicare allowable amount 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. For more detailed information about our payment methodology for all provider types, go to <https://healthalliance.org/images/PFFSproxygrid.pdf>

Services covered under Health Alliance Medicare PFFS that are not covered under Original Medicare are reimbursed using the Health Alliance Medicare PFFS fee schedule. Please call us at 1-800-851-3379, extension 4668 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 Health Alliance Medicare PFFS copayments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Health Alliance 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).

You may call us at 1-800-965-4022 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Health Alliance Medicare PFFS. Be sure to have the member's ID number when you call.

Health Alliance Medicare PFFS follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Health Alliance Medicare PFFS,

unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Health Alliance 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 Health Alliance 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.

Balance billing of members

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

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Health Alliance Medicare PFFS insolvency of Health Alliance 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, copayments, 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 Health Alliance 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.** Health Alliance 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, Health Alliance 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. Health Alliance 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.
 - The member's ID number listed on their membership ID card.
 - The member's date of birth.
 - The member's name.
 - Date(s) of service.
 - Medicare Provider Number
 - 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 Health Alliance Medicare PFFS at the time of billing.
- Where to submit a claim:
 - For electronic claim submission, providers must submit via the standard electronic claims formats defined by the HIPAA Standards for Electronic Transactions Rule. Please contact your billing system vendor and request that it file your claims either through Emdeon (formerly WebMD) under payer ID 77950 or McKesson under payer ID 2494.
 - For paper claim submission, send to the Health Alliance Claims Department at P.O. Box 6003, Urbana, IL 61803.
- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-800-851-3379, extension 8566, Monday through Friday, 8 a.m. to 5 p.m.

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 Health Alliance 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 Health Alliance 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 Health Alliance Medicare PFFS audits of risk adjustment data; Health Alliance 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. Health Alliance 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 Health Alliance Medicare PFFS. To obtain an advance coverage determination, call us at 1-800-851-3379, extension 8061. Health Alliance 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 Health Alliance 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 1-800-851-3379, extension 8061. We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Health Alliance 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 Health Alliance Medicare PFFS, send a written dispute to Health Alliance Medical Plans, Inc., Provider Dispute Resolution Process—Claims Department (PFFS), P.O. Box 6003, Urbana, IL 61803 or call us at 1-800-851-3379, extension 4668. 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 Health Alliance 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 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 by email at IREPFFS@FCSO.com, by fax at (904) 361-0551 or by mail to First Coast Service Options, Inc. PFFS Payment Disputes, P.O. Box 44017 Jacksonville, FL 32231-4017.

9. Member and provider appeals and grievances

Health Alliance 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 Health Alliance 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.

You can call Health Alliance Medicare Services Department at 1-800-965-4022 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 Health Alliance Medical Management at (217) 337-8440.

Health Alliance 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 Health Alliance Medicare PFFS terms and conditions of payment, contact us at 1-800-851-3379 Monday through Friday, 8 a.m. to 5 p.m., extension 4668; Health Alliance Medical Plans, Contracting & Provider Services, 301 S. Vine St., Urbana, IL 61803; or by fax at (217) 337-3438.

- If you have questions about submitting claims, call us at 1-800-851-3379, extension 4668.
- If you have questions about plan payments, call us at 1-800-851-3379, extension 4668.

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