



MEDICARE ADVANTAGE PRIVATE FEE FOR SERVICE (PFFS) PLAN

2009 TERMS AND CONDITIONS OF PAYMENT

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1. Introduction

Flexi Blue PFFS plan is a Medicare Advantage private fee for service (PFFS) plan offered by Blue Cross of Idaho. Flexi Blue PFFS plan allows members to use any provider, such as 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 Blue Cross of Idaho’s Flexi Blue 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 treat a Flexi Blue PFFS plan 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 Flexi Blue PFFS plan. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Blue Cross of Idaho Flexi Blue PFFS plan 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 Blue Cross of Idaho Flexi Blue PFFS plan’s terms and conditions of payment

A provider is considered by law to be *deemed* to have a contract with Blue Cross of Idaho Flexi Blue PFFS plan 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 Blue Cross of Idaho’s Flexi Blue PFFS plan. All of our members receive a member ID card that includes the Blue Cross of Idaho Flexi Blue PFFS plan logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our Medicare Advantage Customer Advocate department at 1-888-494-2583. Providers who have an authorized password and user name may validate member eligibility by using the secure provider portal on our website www.bcidaho.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 may also be obtained by calling our Provider Relations department at 1-866-283-5723, extension 7205.

- 3) The provider furnishes covered services to a Blue Cross of Idaho Flexi Blue PFFS plan member.

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

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

- Have a National Provider Identifier in order to submit electronic transactions to Blue Cross of Idaho Flexi Blue PFFS plan, in accordance with HIPAA requirements.
- You may submit paper claims directly to:
Blue Cross of Idaho Flexi Blue PFFS plan
PO Box 8406
Boise, Idaho 83707

Please refer to Medicare Advantage Provider Administrative Policy MAPAP213 at <https://www.bcidaho.com/providers/Policies/map213.asp> for additional claims submission information.

- Furnish services to a Flexi Blue PFFS plan 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 Flexi Blue PFFS plan 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

Blue Cross of Idaho Flexi Blue PFFS plan reimburses deemed providers at 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. 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.cms.hhs.gov/MedicareAdvtgSpecRateStats> (scroll to Downloads, select MA Out of Network Payment Guide).

Services covered under Flexi Blue PFFS plan that are not covered under Original Medicare are reimbursed using Blue Cross of Idaho Flexi Blue PFFS plan's fee schedule. Please call us at (208) 286-3602, ext 7205 or toll free 1-866-283-5723, ext. 7205 to receive information on our fee schedule.

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 service when possible.

You can only collect from the member the appropriate Flexi Blue PFFS plan copayments or coinsurance amounts described in these terms and conditions.

After collecting cost sharing from the member, the provider should bill Blue Cross of Idaho Flexi Blue PFFS plan 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).

For your quick reference, the table below lists some of the important services covered under Blue Cross of Idaho Flexi Blue PFFS plan and the associated member cost sharing amounts.

Services covered by Blue Cross of Idaho Flexi Blue PFFS plan	The amount you may charge the plan member
Inpatient hospital services	<ul style="list-style-type: none">• \$125 per day for days 1-10 per admission
Skilled nursing facility	<ul style="list-style-type: none">• \$0 for days 1-19 per admission• \$128 per day per admit for days 20-100• \$ out of pocket max
Office services (Physician, specialist, chiropractic and podiatry)	<ul style="list-style-type: none">• \$30 primary care per visit• \$30 specialist care per visit
Immunizations	<ul style="list-style-type: none">• \$0 copay for pneumonia, flu or Hepatitis B vaccine (if at high or intermediate risk of getting Hepatitis B)
Mammography	<ul style="list-style-type: none">• \$0 copay
Physical exams (1 per year)	<ul style="list-style-type: none">• \$30 for a routine physical exam
Emergency room visit	<ul style="list-style-type: none">• 20% of the cost up to \$50 for each emergency room visit• \$0 if admitted within 3 days for the same condition
Urgent care center visits	<ul style="list-style-type: none">• \$30 for each Medicare-covered urgent care visit

To view a complete list of covered services and member cost sharing amounts under Flexi Blue PFFS plan, see the [Flexi Blue 2009 Summary of Benefits](#). You may call us at (208) 387-6802 or (888) 494-2583 to obtain more information about covered benefits, plan payment rates and member cost sharing amounts under Flexi Blue PFFS plan. Be sure to have the member's ID number when you call.

Flexi Blue PFFS plan follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Flexi Blue PFFS plan unless specified by the plan. Information on obtaining advance coverage determination can be found in Section 7. Flexi Blue PFFS plan 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 Flexi Blue PFFS plan members. For information on Flexi Blue PFFS plan'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 receiving any of the following services:

- Inpatient admission
- Skilled Nursing facility admission
- Drugs that may be reviewed for medical necessity
- DME greater than \$300 (including rental to purchase)
- Home health Services
- Home IV therapy
- Advanced imaging (CT scans, MRI/MRA, PET scans, nuclear cardiology)
- Clinical Trials (see MAPAP507)
- Experimental or investigational (procedure or treatment)
- Transplants (organ, tissue, etc.)

Flexi Blue PFFS plan does not require the member or provider to notify the plan as a condition for covering services. To provide prior notification or to obtain more information about our prior notification rules, please call us at (208) 331-7535 or (800) 743-1871 or fill out the [Blue Cross of Idaho Advance Determination Form](#) and fax it to (208) 395-8204.

Balance billing of members

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

Hold harmless requirements

In no event, including but not limited to, nonpayment by Blue Cross of Idaho Flexi Blue PFFS plan, insolvency of Blue Cross of Idaho Flexi Blue PFFS plan, 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.

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 Blue Cross of Idaho Flexi Blue PFFS plan 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:** Blue Cross of Idaho Flexi Blue PFFS plan will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30 day time frame, Blue Cross of Idaho Flexi Blue PFFS plan 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. Blue Cross of Idaho Flexi Blue PFFS plan 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:
 1. Member name and ID number
 2. National Provider Identifier
 3. Date(s) of service
 4. Available information regarding third-party liability and other applicable underwriting or insurance coverage
 5. Itemization of charges, date of service, principal diagnosis and procedure code and, if appropriate, secondary diagnoses and procedures, all of which shall utilize a standard coding system acceptable to Medicare Advantage plans

- 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 Blue Cross of Idaho Flexi Blue PFFS plan at the time of billing.
- Where to submit a claim:
 - ◆ For electronic claim submission, please refer to Provider Administrative Policy MA214 – Electronic Claims Submission located at <https://www.bcidaho.com/providers/Policies/map214.asp>.
 - ◆ For paper claim submission, you may submit claims directly to:
Blue Cross of Idaho Flexi Blue PFFS Plan
PO Box 8406
Boise, Idaho 83707
- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 208-286-3602, ext. 7205 or 1-866-283-5723, ext. 7205.

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 Flexi Blue PFFS plan 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 Blue Cross of Idaho Flexi Blue PFFS plan, 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 and Medicaid Services and Blue Cross of Idaho Flexi Blue PFFS plan audits of risk adjustment data; Flexi Blue PFFS plan 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. Flexi Blue PFFS plan 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 Flexi Blue PFFS plan. To obtain an advance coverage determination, call us at (208) 331-7535 or (800) 743-1871 or fill out the form located at <https://www.bcidaho.com/providers/Policies/map303.asp> and fax it to (208) 395-8204. Flexi Blue PFFS plan 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 Flexi Blue PFFS plan 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 (208) 331-7535 or (800) 743-1871 or fill out the form located at <https://www.bcidaho.com/providers/Policies/map303.asp> and fax it to (208) 395- 8204. We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Flexi Blue PFFS plan 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 appeal 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 Flexi Blue PFFS plan, send a written dispute to
Blue Cross of Idaho Provider Appeals
P. O. Box 7408
Boise, Idaho 83707

or call us at (208) 387-6802 or (888) 494-2583. Additionally, please provide us with 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 dispute, 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 Flexi Blue PFFS plan'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, First Coast Service Options, Inc (FCSO). To file a request for review of a payment dispute with the independent entity, you may contact the entity directly via one of the methods described below:

1. **E-Mail.** If the submission and associated documents do not contain any personally identifiable health information (PHI) (or any PHI has been redacted), the payment dispute decision request can be submitted to a dedicated email box at IREPFSS@FCSO.com.

Otherwise, First Coast can receive payment dispute decision requests (including associated documents such as claims forms that may contain PHI) via the following:

2. **FAX.** A fax number, (904) 361-0551, has been established to receive electronic requests for payment dispute decisions.

3. **Mail.** Providers can also mail hard copy requests for payment dispute adjudication to the following address:

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

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

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

9. Member and Provider Appeals and Grievances

Flexi Blue PFFS plan 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 Blue Cross of Idaho Flexi Blue PFFS plan 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 Flexi Blue PFFS plan [Member Evidence of Coverage \(EOC\)](#) provides more detailed information about the member appeal and grievance process. You can call our Customer Advocate Department at (208) 387-6802 or (888) 494-2583 for more information on our member appeals and grievance policies and procedures.

10. Providing Members with Notice of their Appeal 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.com.hhs.gov/gov/MMCAG/Downloads/NOMNCInstructions.pdf>. In addition, the provider should send a copy of any NOMNC issued to our Medical Department at fax number 208-395-8204.

Flexi Blue PFFS plan 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 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 Blue Cross of Idaho's Flexi Blue PFFS plan's terms and conditions of payment contact us at (208) 286-3602, ext. 7205 or toll free 1-866-283-5723, ext. 7205, or write to us at

Blue Cross of Idaho
Medicare Advantage Provider Relations
Attention: Kathy Root
P. O. Box 7408

Boise, Idaho 83707

If you have questions about submitting claims, call us at (208) 387-6802 or (888) 494-2583.

If you have questions about plan payments, call us at (208) 286-3602, ext. 7205 or toll free 1-866-283-5723, ext. 7205.