Table of Contents

1. Introduction

2. When a provider is deemed to accept Flexi Blue PFFS terms and conditions

3. Provider qualifications and requirements

4. Payment to providers: Plan payment; Member benefits and cost sharing; Balance billing of members; and Hold harmless requirements

5. Filing a claim for payment

6. Maintaining medical records and allowing audits

7. Getting an advance organization determination

8. Provider payment dispute resolution process

9. Member and provider appeals and grievances

10. Providing members with notice of their appeals rights – Requirements for Hospitals, SNFs, CORFs, and HHAs

11. If you need additional information or have questions
Introduction

Flexi Blue PFFS is a Medicare Advantage private fee-for-service (PFFS) plan offered by Blue Cross of Idaho. Flexi Blue 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 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 you treat a Flexi Blue 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 Flexi Blue PFFS. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Flexi Blue 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. Section 7 describes how a provider can request an advance organization determination from the plan.

1. When a provider is deemed to accept Blue Cross of Idaho’s Flexi Blue PFFS terms and conditions of payment

A provider is deemed by law to have a contract with Flexi Blue 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 Flexi Blue PFFS. All of our members receive a member ID card that includes the Flexi Blue PFFS logo that clearly identifies them as PFFS members. The provider may 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 at 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 are available on our website at www.bcidaho.com/PFFSterms. The terms and conditions may also be obtained by calling our Provider Relations department at 1-866-283-5723, extension 8310.

3) The provider furnishes covered services to a Flexi Blue PFFS plan member.
If all of these conditions are met, the provider is deemed to have agreed to Flexi Blue PFFS plan 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 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 a subsequent visit.

For example: If a Flexi Blue PFFS plan member shows you an enrollment card identifying him/her as a member of Flexi Blue 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 Flexi Blue PFFS terms and conditions of payment, then you should not furnish services to a 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-contracting providers and paid at the payment amounts they would have received under Original Medicare.

### 2. Provider qualifications and requirements

In order to be paid by Blue Cross of Idaho Flexi Blue PFFS 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, in accordance with HIPPA requirements.
- You may submit paper claims directly to:
  
  Blue Cross of Idaho Flexi Blue PFFS Plan  
  P. O. Box 8406  
  Boise, Idaho  83707


- 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).
Blue Cross of Idaho Flexi Blue PFFS reimburses deemed providers at the amounts they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services, including billing up to the limiting charge for non-participating physicians, minus any member required cost sharing, for all medically necessary services covered by Medicare. Blue Cross of Idaho Flexi Blue PFFS will pay Physician Quality Reporting Initiative (PQRI) bonus and e-prescribing incentive payment amounts to deemed 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 http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats (scroll to Downloads, select MA Out of Network Payment Guide.)
Services covered under Flexi Blue PFFS that are not covered under Original Medicare are reimbursed using the Flexi Blue PFFS fee schedule. Please call us a 1-866-283-5723, ext 8310 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 Flexi Blue PFFS plan co-payments 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 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.

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

<table>
<thead>
<tr>
<th>Services covered by Flexi Blue PFFS</th>
<th>The amount(s) you may charge the plan member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital services</td>
<td>● $150 per day for days 1-10</td>
</tr>
<tr>
<td></td>
<td>● $0 for days 11-90</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>● $100 per day for days 1-20</td>
</tr>
<tr>
<td>Office services (Physician, specialist, chiropractic &amp; podiatry)</td>
<td>● $30 primary care physician or specialist per visit</td>
</tr>
<tr>
<td>Immunizations</td>
<td>● $0 copay</td>
</tr>
<tr>
<td>Mammography</td>
<td>● $0 copay</td>
</tr>
<tr>
<td>Physical Exams (1 per year)</td>
<td>● $0 copay</td>
</tr>
<tr>
<td>Emergency room visit</td>
<td>● $50 copay per visit</td>
</tr>
<tr>
<td>Urgent care center visits</td>
<td>● $30 per visit</td>
</tr>
</tbody>
</table>

call us at 208-387-6802 or 1-888-494-2583 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Flexi Blue PFFS. Be sure to have the member’s ID number when you call.

Flexi Blue PFFS follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Flexi Blue PFFS, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Flexi Blue PFFS does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. There are no prior authorization and prior notification rules for Flexi Blue PFFS plan 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 Flexi Blue PFFS members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Flexi Blue PFFS members.

**Hold harmless requirements**

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

**4. Filing a claim for payment**

- You must submit a claim to Flexi Blue PFFS for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 1 calendar year after the date of service. Failure to be timely with claim submissions may result in non-payment. The rules for submitting timely claims under Original Medicare can be found at https://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf.
- **Prompt Payment** Blue Cross of Idaho Flexi Blue 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, Blue Cross of Idaho Flexi Blue 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. Blue Cross of Idaho Flexi Blue 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.
  - Date(s) of service.

- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission.

- Coordination of Benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at http://www.cms.hhs.gov/Manuals/IOM/list.asp. Providers should identify primary coverage and provide information to Flexi Blue PFFS at the time of billing.

- Where to submit a claim:
  - For electronic claim submission, please refer to Provider Administrative Policy MAPAP214 – 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
    P. O. 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, extension 8310 or toll free 1-800-283-5723, extension 8310.
5. **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 PPFS 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 will primarily be used for Centers for Medicare & Medicaid Services (CMS) audits of risk adjustment data upon which CMS capitation payments to Flexi Blue PFFS are based. Providers are required to furnish member medical records without charge when the medical records are required for government use.

Blue Cross of Idaho Flexi Blue PFFS plan may also request records for activities in the following situations: Flexi Blue 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. Blue Cross of Idaho Flexi Blue PFFS plan will not use these records for any purpose other than the intended use.

Blue Cross of Idaho Flexi Blue 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.

6. **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 Flexi Blue PFFS plan. To obtain an advance organization determination, call us at 208-3317353 or 1-800-743-1871 or fill out the form located at [https://www.bcidaho.com/providers/Policies/map303.asp](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 and the member within 14 days of receiving the request, with a possible (up to) 14-day extension either due to the member’s request or Flexi Blue 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 208-331-7535 or fill out the form located at [https://www.bcidaho.com/providers/Policies/map303.asp](https://www.bcidaho.com/providers/Policies/map303.asp) and fax it to 208-395-8204. We
will notify you of our decision as expeditiously as the enrollee’s health condition requires, but no later than 72 hours after receiving the request, unless we invoke a (up to) 14-day extension either due to the member’s request or Flexi Blue PFFS plan justification (for example, the receipt of additional medical evidence may change Flexi Blue PFFS plan decision to deny) that the delay is in the member’s best interest.

In the absence of an advance organization determination, Flexi Blue 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.

7. **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 Blue Cross of Idaho 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 1-888-494-2583. A copy of our Provider Payment Dispute Resolution Form is available:  
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 Flexi Blue PFFS plan’s 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 Payment Dispute Resolution Contractor (PDRC) directly at:

C2C Solutions, Inc.
Payment Dispute Resolution Contractor
P.O. Box 44017
Jacksonville, FL 32231-4017

The PDCR may also be reached by email at PDRC@C2Cinc.com, by fax at 904-361-0551, or by phone at 904-791-6430. You will be required to submit specific information for your request to the PDRC to be considered valid. Note that you must first complete Flexi Blue PFFS’s payment dispute resolution process before you can request a review by the independent review organization.

8. Member and provider appeals and grievances

Blue Cross of Idaho Flexi Blue PFFS members have the right to file appeals and grievances with Flexi Blue PFFS when they have concerns or problems related to coverage or care. Members may appeal a decision made by Flexi Blue 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 preservice 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 Flexi Blue 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.bc.idaho.com. You can call our Customer Advocate department at 208-387-6802 or 1-888-494-2583 for more information on our member appeals and grievance policies and procedures.

9. **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.gov/BNI/12_HospitalDischargeAppealNotices.asp](http://www.cms.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.gov/BNI/09_MAEDNotices.asp](http://www.cms.gov/BNI/09_MAEDNotices.asp).

As directed in the instructions, the NOMNC should contain Flexi Blue PFFS’s contact information somewhere on the form (such as in the *additional information* section on page 2 of the NOMNC).

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 (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. For copies of the notices and the notice instructions, go to: [http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp](http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp) and [http://www.cms.gov/BNI/09_MAEDNotices.asp](http://www.cms.gov/BNI/09_MAEDNotices.asp).

10. **If you need additional information or have questions**

If you have general questions about Blue Cross of Idaho Flexi Blue PFFS terms and conditions of payment, contact us at 208-286-3602, extension 8310 or toll free 1-866-283-5723, extension 8310, 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 1-888-494-2583.
- If you have questions about plan payments, call us at 208-286-3602, extension 8310 or toll free 1-866-283-5723, extension 8310.