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

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1. Introduction

Tufts Health Plan Medicare Preferred PFFS is a Medicare Advantage private fee-for-service (PFFS) plan offered by Tufts Associated Health Maintenance Organization, Inc. ("TAHMO"). Tufts Medicare Preferred 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 Tufts Medicare Preferred 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 and you treat a Tufts Medicare Preferred 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 Tufts Medicare Preferred PFFS. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with TAHMO for the services furnished to the enrollee 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: 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 the Tufts Medicare Preferred PFFS terms and conditions

A provider is considered by law to be ***deemed*** to have a contract with TAHMO when each of the following three criteria is met:

1. The provider is aware, in advance of furnishing health care services, that the patient is a member of Tufts Medicare Preferred PFFS. All of our members receive a member ID card that includes the Tufts Medicare Preferred PFFS logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our Provider Relations department at 1-800-279-9022. You may also obtain member eligibility information
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.tuftshealthplan.com. The terms and conditions may also be obtained by calling our Provider Relations department at 1-800-279-9022.
3. The provider furnishes covered services to a Tufts Medicare Preferred PFFS member.

If all of these conditions are met, you are considered a deemed provider who has agreed to the Tufts Medicare Preferred PFFS terms and conditions of payment for that member specific to that visit. **Note**: You, the provider, can decide whether or not to accept the Tufts Medicare Preferred PFFS term and conditions of payment each time you see a Tufts Medicare Preferred PFFS member. A decision to treat a specific plan member does not obligate you to treat other Tufts Medicare Preferred PFFS members.

For example: If a Tufts Medicare Preferred PFFS member shows you an enrollment card identifying him/her as a member of Tufts Medicare Preferred 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 the Tufts Medicare Preferred PFFS terms and conditions of payment, then you should not furnish services to a Tufts Medicare Preferred 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 reimbursed the payment amounts they would have received under Original Medicare.

3. Provider qualifications and requirements

In order to be paid by Tufts Medicare Preferred PFFS for services provided to one of our members, you must:

- Have a National Provider Identifier (NPI) in order to submit electronic transactions to Tufts Medicare Preferred PFFS, in accordance with HIPAA requirements.
- If sending paper claims, please mail to the address below. Providers must submit all covered services as soon as possible using the standard CMS-1500 or UB-04 form.

  Tufts Medicare Preferred PFFS
  PO Box 9183
  Watertown, MA 02471-9183

- Furnish services to the Tufts Medicare Preferred 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 CMS or Office of Inspector General (OIG) 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 the covered services furnished to members.
- Agree to cooperate with Tufts Medicare Preferred 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 required beneficiary appeals notices. See Section 10 for specific requirements.
- Not charge the enrollee in excess of cost sharing under any condition, including in the event of plan bankruptcy.

4. Payment to providers

Plan payment

Tufts Medicare Preferred PFFS reimburses deemed providers at the amount they would have received under Original Medicare for Medicare covered services, minus any member required cost sharing, for all medically necessary services covered by Medicare. 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 Tufts Medicare Preferred PFFS Reimbursement Grid. Services covered under Tufts Medicare Preferred PFFS that are not covered under Original Medicare are reimbursed according to reimbursement methodology also described in the Tufts Medicare Preferred PFFS Reimbursement Grid.

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. **You can only collect from the member the appropriate Tufts Medicare Preferred PFFS co-payment s or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Tufts Medicare Preferred 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) and that state holds the member harmless for Medicare cost-sharing, 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.

To view covered services and cost sharing amounts under Tufts Medicare Preferred PFFS view the 2009 Tufts Medicare Preferred PFFS Summary of Benefits**.** In addition, you may call 1-800-279-9022 to obtain more information about benefits under Tufts Medicare Preferred PFFS. Be sure to have the member's ID number when you call.

Tufts Medicare Preferred follows Medicare coverage decisions for Medicare covered services. Services not covered by Medicare are not covered by Tufts Medicare Preferred PFFS unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Tufts Medicare preferred 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. For information on Tufts Medicare Preferred PFFS prior notification policies, see the section below called "Prior Notification Rules".

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 under Tufts Medicare Preferred PFFS. 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:

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Care
- Home Health Care

Again, Tufts Medicare Preferred PFFS 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 process, call us at 1-800-279-9022.

Balance billing

A provider may collect only applicable plan copayment or coinsurance amounts from Tufts Medicare Preferred PFFS members and may not otherwise charge or bill the members. Balance billing is prohibited by deemed providers who furnish services to Tufts Medicare Preferred PFFS members.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Tufts Medicare Preferred PFFS, insolvency of TAHMO 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 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 from Tufts Medicare Preferred PFFS

- You must submit a claim TAHMO for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is generally within 15-27 months of 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: Tufts Medicare Preferred 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, (Plan Name) 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. Tufts Medicare Preferred 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 or UB-04 or the appropriate electronic filing format.

- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.

- Include the following on your claims:

    - National Provider Identifier (NPI)
    - The member's ID number
    - 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.

- Where to submit a claim:

  - For electronic claim submission, Tufts Medicare Preferred accepts 837P and 837I files via both clearinghouses and direct submission as follows:
    - Direct submissions: for initial setup, please contact Kevin Whalen at 617-972-9400 x 3344
    - Clearinghouse: for initial setup, please contact our EDI Operations Dept at 617-972-9400 x 4042

  - For paper claim submission,
    - Please mail to:

      Tufts Medicare Preferred PFFS
      PO Box 9183
      Watertown, MA 02471-9183
    - Providers must submit all covered services as soon as possible using the standard CMS-1500 or UB-04 form.

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-800-279-9022.

6. Maintaining medical records and allowing audits

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services rendered by the provider to Tufts Medicare Preferred 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. Deemed providers agree that Tufts Medicare Preferred PFFS, the Department of Health and Human Services (HHS), the Comptroller General, or their designees may access 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: CMS and Tufts Medicare Preferred PFFS audits of risk adjustment data; Tufts Medicare Preferred PFFS determinations of whether services 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. Tufts Medicare Preferred 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 that service will be covered by Tufts Medicare Preferred PFFS. To obtain an advance coverage determination, call Tufts Medicare Preferred Provider Relations at 1-800-279-9022 Tufts Medicare Preferred 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 Tufts Medicare Preferred 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 1-800-279-9022.

In the absence of an advance coverage determination, Tufts Medicare Preferred 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 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.

To file a payment dispute with Tufts Medicare Preferred PFFS, send a written dispute to:

Tufts Medicare Preferred PFFS – Provider Dispute
PO Box 9179
Watertown, MA 02471-9179

or send it by fax to 1-617-673-0290. Or call us at 1-800-279-9022. Additionally, please provide appropriate documentation to support your payment dispute, for example, 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 60 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 that is due. We will inform you in writing if your payment dispute is denied.

After completing our 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 First Coast Service Options, Inc. (FCSO), 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:

1. **Email.** 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 IREPFFS@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

FCSO may also be contacted at 904-791-6430.

9. Member appeals and grievances

Tufts Medicare Preferred 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 Tufts Medicare Preferred PFFS to deny coverage or payment for a service or benefit that they believe should be covered and 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 potential member liability (for example, a claim, as opposed to an advance coverage determination, is denied as not 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 statues, regulations, standards and guidelines applicable to the Medicare PFFS member appeals and grievance policies and procedures.

The 2009 Tufts Medicare Preferred PFFS Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. The member EOC is posted on our website at tuftshealthplan.com. You can also call Provider Relations at 1-800-279-9022 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 timeframes 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 timeframes for delivery. For copies of the notice and the notice instructions, go to
http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCForm.pdf
http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf

In addition, providers should fax to Tufts Medicare Preferred at 1-617-972-9516 a copy of any NOMNC issued.

Tufts Medicare Preferred 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 timeframes specified by law.

11. If you need information or have questions

If you have general questions about the Tufts Medicare Preferred PFFS terms and conditions of payment, call us at 1-800-279-9022

- If you have questions about submitting claims, call us at 1-800-279-9022
- If you have questions about plan payments, call us at 1-800-279-9022