

**CONTRACT YEAR 2010
MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLAN
MODEL TERMS AND CONDITIONS OF PAYMENT**

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1. Introduction

Medica Advantage Solution is a Medicare Advantage private fee-for-service (PFFS) plan offered by Medica. Medica Advantage Solution 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 Medica Advantage Solution 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 Medica Advantage Solution 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 Medica Advantage Solution. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Medica Advantage Solution 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. Note that the terms prior authorization, prior notification, and advance organization determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance organization determination is described in Section 7.

2. When a provider is deemed to accept Medica Advantage Solution terms and conditions of payment

A provider is deemed by law to have a contract with Medica Advantage Solution 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 Medica Advantage Solution. All of our members receive a member ID card that includes the Medica Advantage Solution logo that clearly identifies them as PFFS members. The provider may validate eligibility by calling our Provider Service Center at 1-800-458-5512.
- 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 [Medica Advantage Solution Information and Payment Resources for Providers](#). The terms and conditions may also be obtained by calling our Provider Service Center at 1-800-458-5512.
- 3) The provider furnishes covered services to a Medica Advantage Solution member.

If all of these conditions are met, the provider is deemed to have agreed to Medica Advantage Solution terms and conditions of payment for that member specific to that visit. **Note:** You, the provider, can decide whether or not to accept Medica Advantage Solution terms and conditions of payment each time you see a Medica Advantage Solution member. A decision to treat one plan

member does not obligate you to treat other Medica Advantage Solution members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

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

- Have a National Provider Identifier in order to submit electronic transactions to Medica Advantage Solution, in accordance with HIPPA requirements.
- Submit claims to: Medica, PO Box 30990, Salt Lake City UT 84130
- Furnish services to a Medica Advantage Solution 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 Medica Advantage Solution 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

Medica Advantage Solution reimburses deemed providers at 102 percent of the Medicare allowable amount, minus any member required cost sharing, for all medically necessary services covered by Medicare. Medica Advantage Solution will pay Physician Quality Reporting Initiative (PQRI) bonus and e-prescribing incentive payment amounts to physicians who would receive them in connection with treating Medicare beneficiaries who are not enrolled in a 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 [Medica Advantage Solution Reimbursement Methodology](#).

Services covered under Medica Advantage Solution that are not covered under Original Medicare are reimbursed using Medica Advantage Solution's fee schedule. Please call us at 1-800-458-5512 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 Medica Advantage Solution co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Medica Advantage Solution 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 Medica Advantage Solution Standard and the associated member cost sharing amounts.

Medica Advantage Solution Covered Services	Amount You May Charge the Plan Member
Inpatient hospital services	<ul style="list-style-type: none"> • \$550 per admittance
Skilled nursing facility	<ul style="list-style-type: none"> • \$0 per day per admit for days 1-20 • \$120 per day per admit for days 21-100
Office services (Physician, specialist, chiropractic & podiatry)	<ul style="list-style-type: none"> • \$15 primary care per visit • \$30 specialist care per visit
Immunizations	<ul style="list-style-type: none"> • \$0 copay
Mammography	<ul style="list-style-type: none"> • \$0 copay
Physical Exams (1 per year)	<ul style="list-style-type: none"> • \$15 primary care per visit
Emergency room visit	<ul style="list-style-type: none"> • \$50
Urgent care center visits	<ul style="list-style-type: none"> • \$15 per visit to a primary care physician • \$30 per visit to a specialist

To view a complete list of covered services and member cost sharing amounts under Medica Advantage Solution, go to the appropriate Summary of Benefits:

- [Medica Advantage Solution Standard](#)
- [Medica Advantage Solution Standard with Rx](#)
- [Medica Advantage Solution Choice](#)

You may call us at 1-800-458-5512 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Medica Advantage Solution. Be sure to have the member's ID number when you call.

Medica Advantage Solution follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Medica Advantage Solution, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Medica Advantage Solution 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 Medica Advantage Solution 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 Medica Advantage Solution members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Medica Advantage Solution members.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Medica Advantage Solution, insolvency of Medica Advantage Solution, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or

have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments, or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

5. Filing a claim for payment

- You must submit a claim to Medica Advantage Solution for an Original Medicare covered services 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](#).
- **Prompt Payment** – Medica Advantage Solution will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Medica Advantage Solution 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. Medica Advantage Solution will process all non-clean claims and notify providers of the determination within 45 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](#). Providers should identify primary coverage and provide information to Medica Advantage Solution at the time of billing.
- Where to submit a claim:
 - For electronic claim submission, instructions can be found in the [Electronic Commerce Provider Claims Manual](#).
 - For paper claim submission, Medica, P.O. Box 30990, Salt Lake City, UT 84130.

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-800-458-5512.

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 Medica Advantage Solution 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 Medica Advantage Solution, 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 Medica Advantage Solution are based. Providers are required to furnish member medical records without charge when the medical records are required for government use.

Medica Advantage Solution may also request records for activities in the following situations: Medica Advantage Solution 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. Medica Advantage Solution will not use these records for any purpose other than the intended use.

Medica Advantage Solution 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.

7. Getting an advanced 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 Medica Advantage Solution. To obtain an advance organization determination, call us at 1-800-458-5512 or fill out the [Advanced Coverage Determination Form](#) and fax it to 952-992-3556. Medica Advantage Solution will make a decision and notify you and the member within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Medica Advantage Solution 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 1-800-458-5512, fill out the [Advanced Coverage Determination Form](#) and fax it to 952-992-3556. We will notify you of our decision within 72 hours.

In the absence of an advance organization determination, Medica Advantage Solution 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 Medica Advantage Solution, complete and send a [Provider Payment Dispute Form \(Medica Adjustment Request Form\)](#) to Medica, PO Box 30990, Salt Lake City, UT 84130 or call us at 1-800-458-5512. 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. 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 Medica Advantage Solution'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 organization directly at:

First Coast Service Options, Inc.
Payment Dispute Resolution Contractor
P.O. Box 44017
Jacksonville, FL 32231-4017

FCSO may also be reached by email at PDRC@fcsso.com and by phone at (904) 791-6430. Note that you must first complete Medica Advantage Solution's payment dispute resolution process before you can request a review by the independent review organization.

9. Member and provider appeals and grievances

Medica Advantage Solution members have the right to file appeals and grievances with Medica Advantage Solution when they have concerns or problems related to coverage or care. Members may appeal a decision made by Medica Advantage Solution 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 pre-service 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 Medica Advantage Solution Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. The member EOC is posted on our website located at:

- [Medica Advantage Solution Standard](#)
- [Medica Advantage Solution Standard with Rx](#)
- [Medica Advantage Solution Choice](#)

You can call our Provider Service Center at 1-800-458-5512 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, 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.

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 providing the [Notice of Medicare Non-Coverage Form \(NOMNC\)](#), in accordance with the [NOMNC instructions, requirements and normal timeframes](#). As directed in the instructions, the NOMNC should contain Medica Advantage Solution'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.

11. If you need additional information or have questions

If you have general questions about Medica Advantage Solution's terms and conditions of payment, contact the Provider Service Center at 1-800-458-5512 Monday through Thursday, 8:30 am to 5:00 pm or Friday 9:00 am to 5:00 pm, CST. Or contact us at Medica, P.O. Box 9310, Route CP532, Minneapolis, MN 55440 Fax: 952-992-8667.

- If you have questions about submitting claims, call us at 1-800-458-5512.
- If you have questions about plan payments, call us at 1-800-458-5512.