

## PFFS

### Medicare Advantage Private Fee for Service (PFFS) Reimbursement

A Medicare Advantage plan is an alternative to standard Medicare Part A and Part B coverage known as Original Medicare. A Medicare Advantage Private Fee-for-Service (MA PFFS) plan combines the benefits of Part A and B with additional benefits not covered by Original Medicare but is not an HMO or PPO plan. Rather, it is a non-network, non-managed care product and pays physicians and providers on a fee-for-service basis. Medicare Advantage PFFS is a non-network product that does not restrict enrollee choice among providers who agree to accept the Plan's Terms and Conditions of payment, are licensed or certified by the state to provide services, and have a Medicare billing number or be eligible to obtain one. PFFS members all have ID cards with the PFFS logo:



#### **How do I become a Medicare Advantage PFFS participating provider?**

PFFS plans offered by Blue Plans generally use the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Deemed Provider concept, rather than direct contracts, to arrange for services to members. You are considered a Deemed Provider if all of the following criteria are met:

- You are aware before providing services that the person you are treating is enrolled in a PFFS plan.
- You have access to information about the PFFS Plan's terms and conditions of payment.
- The service is covered by Medicare and the Plan.
- You subsequently provide services to that member.

If you choose not to render services to PFFS members, you should not treat them unless it's an emergency situation<sup>1</sup>.

CMS says that if you accept Medicare assignment, are aware in advance the member has MA PFFS, have reasonable access to the Plan's Terms and Conditions, and render services to a MA PFFS member who is out of the plan's service area, you will then be reimbursed at the Medicare-allowed amount for all covered services (i.e., the amount you would collect if the member was enrolled in Original Medicare). Refer to the member ID card for instructions on how to obtain access to Terms and Conditions.

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<sup>1</sup>When a provider who furnishes services to a PFFS Member in an emergency-care situation informs the PFFS plan that he or she does not wish to be treated as a Deemed Provider, the provider will generally receive payment equal to what would have been paid under Original Medicare. In this context, the provider may collect only the applicable copayments or coinsurance under the PFFS plan from the Member. See the Member's card for the location of Terms and Conditions of payment or call 1-800-227-3119.

Other than the applicable member cost-sharing amounts, reimbursement is made directly by a Blue Plan. You may collect only the applicable cost-sharing amounts from the member at the time of service and may not otherwise charge or balance-bill the member.

Routine eye exams are provided through the IBC Vision program administered by Davis Vision. By providing the eye exam to the member, you agree to accept the Davis Vision allowable amount as payment in full for routine eye exams. All providers are responsible for submitting routine eye exam claims to Davis Vision.

The member also has an eyewear benefit. Members can access Davis Vision providers who have agreed to accept the plans terms and conditions and payment will be made directly to the provider. Members can also access eyewear benefits through any other non Davis Vision provider that accepts the plan's terms and conditions. The non Davis Vision provider or member may complete the reimbursement form and submit to Davis Vision for reimbursement. The member is responsible and may be billed for amounts above the plan's allowance for the Eyewear benefit.

**May I collect the member's cost-sharing amount at the time of service?**

Yes, providers may collect any applicable cost-sharing amount (i.e., copayments, deductibles).

**How do I verify eligibility?**

Verify eligibility by contacting 1-800-676-BLUE (2583) and providing the alpha prefix. Be sure to check if PFFS benefits apply.

**Where do I submit claims?**

Submit claims to QCC Insurance Company at the address below. Do not bill Medicare directly for any services rendered to a PFFS member. Payment will be made directly by the Blue Plan.

Select Advantage Claims  
P.O. Box 69350  
Harrisburg, PA 17110

Claims for Routine Eye Exams and Eyewear for Davis Vision providers should be submitted using the standard Davis Vision process. Claims for non Davis Vision providers should be submitted on a CMS-approved Claim Form and CMS-approved CPT and HCPCS codes to the following address:

Davis Vision  
Vision Care Processing Unit  
P.O. Box 1525  
Latham, NY 12110

**Claims appeal**

If a provider believes that the payment amount received for a service (including the member cost-sharing collected) is less than what would have been paid under Original Medicare for the service, the provider may appeal the payment amount. All appeals should be in writing and can be mailed to the address below. Call QCC Insurance Company and the Provider Services Department at 1-800-227-3119 between 8 a.m. and 5 p.m. Monday through Friday for general

claims information or for the status of your claim appeal. The location of the Terms and Conditions of payment is printed on the Member's ID card.

Provider Appeals  
P.O. Box 37653  
Philadelphia, PA 19101-0653

**Advantages to providers of PFFS Plan**

Providers who accept Original Medicare have many reasons to treat Select Advantage PFFS Plan when they treat Select Advantage PFFS Members:

- The reimbursement level from the plan is the same as Original Medicare.
- As a provider, you may collect member copayments or cost-sharing.
- The member will have just one ID card.
- The claim needs to be filed only once.
- The claims filing process is familiar and easy: Providers file PFFS claims with the QCC Insurance Company using their NPI.
- Most of the same Medicare billing guidelines, forms, and codes apply with respect to Original Medicare.
- No provider contract is required.