

QCC Private Fee-for-Service

Medicare Advantage Private Fee-For-Service Terms and Conditions

1. PFFS product description / overview

- Select Advantage Private Fee-For-Service (Select Advantage PFFS) is a Medicare Advantage Plan offered by QCC Insurance Company as an alternative product for Medicare beneficiaries to receive Medicare benefits. Select Advantage PFFS generally covers the same benefits as Original Medicare but also covers additional services that are not covered by Original Medicare. Members are free to use any doctor, specialist or hospital they choose as long as the provider is eligible to receive payment by Medicare and agrees to the Select Advantage PFFS Terms and Conditions of payment.
- Select Advantage PFFS has been approved by the Centers for Medicare & Medicaid Services (CMS) to provide Medicare covered services through the Select Advantage PFFS Plan. The Plan is being offered to Medicare Members who reside in Bucks, Chester, Delaware, Montgomery and Philadelphia counties in Pennsylvania.
- Providers who choose to provide services to Select Advantage PFFS Members agree to accept the Select Advantage PFFS Terms and Conditions.
- All services must meet Original Medicare guidelines for coverage, and are subject to retrospective review/audit.

2. Member eligibility

- For eligibility inquiries regarding a local Select Advantage PFFS Member, contact Member Services at 1-800-331-0017, seven days a week, 8 a.m. to 8 p.m., or call 1-800-676-BLUE (2583).
- For eligibility inquiries regarding a Select Advantage PFFS out-of-area Member, contact 1-800-676-BLUE (2583) or submit an inquiry electronically to your local Blue Plan.

3. ID cards

The information on the Member ID card will indicate if the Member is enrolled in a Select Advantage PFFS Plan.

4. Provider inquiries

- If you are a provider in Pennsylvania and have questions about the Select Advantage PFFS product, please contact Provider Services at 1-800-227-3119 from 8 a.m. to 5 p.m. Monday through Friday. If the inquiry involves a Member, please have the Member's Select Advantage PFFS ID card information ready. Additional information about the Plan is available on our website at www.ibx.com.
- If you are a provider outside of Pennsylvania and have questions about the Select Advantage PFFS product, please contact your local Blue Plan or Provider

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Services at 1-800-227-3119 from 8 a.m. to 5 p.m. Monday through Friday. Please have the Member's Select Advantage PFFS ID card information ready if the inquiry involves a Blue Plan Member. Additional information about the Plan is available on our website at www.ibx.com.

5. Acceptance of terms and conditions / Deemed Provider

Provider Deeming

Before providing services to a Select Advantage PFFS Member, providers must agree to the Plan's Terms and Conditions. When a provider chooses to provide services to a Select Advantage PFFS Member, they are accepting this agreement and are "deemed" to have a contract with QCC Insurance Company. The provider is considered a Deemed Provider if the following four criteria are met:

- Provider is aware before providing services, that the person receiving the services is enrolled in a Select Advantage PFFS Plan. Notice of enrollment can be obtained from various sources, including:
 - The Member who presents their Select Advantage PFFS ID card or letter providing proof of insurance
 - CMS
 - 1-800-676-BLUE (2583)
- Provider has (or has reasonable opportunity to obtain) information about the Select Advantage PFFS Plan's Terms and Conditions of payment. As a practical matter, this requirement is met if you have access to the Terms and Conditions of payment through the Plan's website, www.site65.com, the Plan's Provider Services toll-free number 1-800-227-3119, or various Member and/or provider publications.
- The service is covered by Medicare and the Plan.
- Provider subsequently provides service to that Member.

Once these Conditions are met and service is rendered, the provider is considered a Deemed Provider for that Member, for that episode of care. Provider has the right to decide whether to treat Select Advantage PFFS Members, on a patient by patient and visit by visit basis. A decision to treat a specific Member does not require the provider to treat other Select Advantage PFFS Members.

Provider Requirements

Providers must comply with all applicable Medicare and other federal health care program laws, regulations, and program instructions that apply to the services furnished to Members. Any services or other activity performed by a provider in accordance with these Terms and Conditions shall be consistent and comply with QCC Insurance Company's contractual obligations to CMS.

- Providers treating Select Advantage PFFS Members must be licensed or certified by the State for the services being provided, comply with any other applicable state or federal requirements, and have a Medicare billing number or be eligible to obtain one.

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- Providers must not have opted out of Medicare or been prohibited from participating in the Medicare program.
- Provider must not be a federal health care provider such as a Veteran's Administration provider. Under Federal regulations, these providers are not eligible for reimbursement under a PFFS Plan except when providing emergency care to non veterans.
- Institutional/facility providers treating Select Advantage PFFS Members must be Medicare certified to treat Medicare beneficiaries.
- Providers may not hold a Member liable for payment of any fees that are the obligation of the Plan.
- Providers must comply with all Medicare and other federal health care program laws, regulations and program instructions that apply to the services furnished to Members. This includes inspections and audits in addition to audits by the Plan or its designees.
- Providers shall permit CMS, Health and Human Services, the Comptroller General, or their designees (the Plan) to inspect, evaluate, and audit any and all provider financial records, contracts, medical records, patient care documentation, documents, papers, and other records pertaining to any covered services provided under these Terms and Conditions. The right to inspect, evaluate, and audit shall extend ten (10) years from the expiration of the Terms and Conditions or from completion of final audit, whichever is later, unless otherwise required by applicable law.
- Provider shall not discriminate against Select Advantage PFFS Medicare Advantage Members based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Providers must follow the standards of confidentiality and patient privacy rights outlined in HIPAA regulations.

Providers shall make medical records available to the Select Advantage PFFS Plan, the Quality Improvement Organization (QIO) or a designated vendor in accordance with CMS appeals and grievance timeframes without charge to the member, Select Advantage PFFS, the QIO or its designated vendor for purposes of the Plan handling Member appeals and grievances. Providers also agree to comply with the Plan's requests for Member medical records, and their submission to the QIO, as part of the appeals process.

Member Notification of Non coverage

- Notice of Medicare Non coverage (NOMNC) is the delegated responsibility of Select Advantage PFFS providers along with Detailed Explanation of Non coverage and it is the delegated responsibility for hospitals to provide the Detailed Notice of Discharge. This form is available at www.site65.com or www.ibx.com.
- Providers must comply with all notice and record submission requirements to the Select Advantage PFFS Plan and/or the state QIO, or designated vendor.
- If an item or service is not covered under Original Medicare or the member's Medicare Advantage plan, providers, physicians, practitioners and suppliers must

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inform the member before providing the service that it will not be covered. The notice can be oral or written, but providers are strongly encouraged to document the discussion.

Additional requirements for Skilled Nursing Facilities (SNF), Home Health Agencies (HHA) and Comprehensive Outpatient Rehabilitation Facilities (CORF) providers:

SNF Providers are responsible to issue the Notice of Denial of Medical Coverage (NDMC) in advance of the member exhausting his or her SNF benefit limit. This form can be found on our website at www.site65.com or www.ibx.com.

In compliance with the Grijalva final rule, SNF, HHA and CORF providers agree to deliver an advance, completed copy of the Notice of Medicare Non coverage (NOMNC) to Members receiving SNF, HHA or CORF services not later than two days before the termination of services. This form can be found on our website at www.site65.com or www.ibx.com.

Non acceptance of Terms and Conditions

- General rule: If a provider is aware in advance that a Member is a Select Advantage PFFS Plan Member, but chooses not to accept the Plan's Terms and Conditions of payment, the provider must not furnish services except in emergency-care situations.
- If a provider treats a Select Advantage PFFS Member for emergency care, he or she may collect only applicable copayments or coinsurance from the Member. The claim should be submitted to QCC Insurance Company for payment. The provider may not balance-bill the Member for emergency care.

6. Advance notice of coverage

Members and providers may request a written (binding) advance determination of coverage from Select Advantage PFFS. The Select Advantage PFFS plan will issue an organization determination in accordance with CMS regulations. Members and providers are encouraged to request advance notice. Members may call 1-800-331-0017 and providers may call 1-800-227-3119 for an advance determination.

7. Medicare opt-out providers

Providers of Part B services who opt-out of the Medicare program may establish in writing, private contracts with Select Advantage PFFS Members for all covered Part B services except services provided for emergency care.

- Under these private contracts, the Select Advantage PFFS Member is liable for payment and neither the opt-out provider nor the Member may bill Select Advantage PFFS.
- QCC Insurance Company will pay for emergency services furnished by a physician or practitioner who has not signed a private contract with the Member.
- QCC Insurance Company will not otherwise pay opt-out providers.

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8. Claims filing

For local Select Advantage PFFS Plan Members

- Select Advantage PFFS Plan processes claims following Original Medicare billing rules, including all prospective payment system requirements. Claims should be submitted using the same coding rules as Original Medicare and use the Medicare CPT Codes and defined modifiers. Bill diagnosis codes to the highest level of specificity. Remember to use the CMS-approved HCPCS codes and CMS-approved modifiers.
- Claims for Select Advantage PFFS Members should be sent to QCC Insurance Company, not to any Medicare carrier or fiscal intermediary.
- Claims should be submitted as soon as possible after a service is provided using the standard CMS-1500, or the UB-04. All Medicare billing guidelines must be followed when submitting claims.
- The following must be included on all claims:
 - National Provider Number/ Medicare Provider Number and Federal Tax Identification Number
 - QCC Insurance Company PFFS Member ID number which consists of a 3-position alpha prefix, an 8-position ID number, and a 2-position suffix
- Electronic claims should be submitted using the EDI 837 billing form
- Paper claims should be submitted to QCC Insurance Company at the following address:

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

- Facility paper claims should be submitted on a CMS-1450 claim form. Facilities must include the six-digit Medicare number in field 51 (PROVIDER NO.)
- Professional paper claims should be submitted on a CMS-1500 claim form.
- When submitting bills on a UB-04, facilities must include the six-digit Medicare number in field 57 (PROVIDER NO.)
- Laboratories should send claims directly to QCC Insurance Company; use the CLIA number
- The National Provider Identifier (NPI) must be included on all claim submissions (paper or electronic) to QCC Insurance Company
- Hospice providers should file claims using their current process

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- Coordination of Benefits: All Medicare Secondary Payer rules apply. Providers should obtain information on primary payer coverage and bill accordingly

For Select Advantage PFFS Out-Of-Area Member Claims

- For Medicare covered services, claims should be submitted to the local Blue Plan using the same coding rules as under Original Medicare and use the Medicare CPT Codes and defined modifiers. Bill diagnosis codes to the highest level of specificity. The CMS-approved HCPCS codes and CMS-approved modifiers must be used.
- 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

- When filing claims with the local Blue Plan, the Blue Plan should bill the PFFS claims as they do for a local member from that plan.
- The National Provider Identifier (NPI) must be included on all claim submissions (paper or electronic) to the local Blue Plan.
- Claims for out-of-area PFFS Members should be filed to the local Blue Plan using the same CMS billing guidelines, forms, and codes as for Original Medicare and the unique billing variations identified below:
 - Report the Member's PFFS ID number with the alpha prefix (not the Health Insurance Claim Number).
 - If a provider currently submits claims electronically to the local Blue Plan, he or she may submit PFFS claims using the following:
 - Source of Payment (Facility = x; and Professional = y)
 - Payer ID (Facility = a; Professional = b).
 - Provider name and credentials should be reported in Box 31 on paper CMS 1500 claims or in the equivalent field on the EDI 837.
- Hospice providers should file claims using their current process.

9. Payment methodology / reimbursement

For local Select Advantage PFFS Members claims

- Select Advantage PFFS processes claims following Original Medicare billing rules including all Prospective Payment System requirements.
- QCC Insurance Company and Select Advantage PFFS reimburse Deemed Providers at 100 percent of the current Medicare allowable amount minus federal exclusions paid by Original Medicare and any Member copayments or coinsurance for all medically necessary services covered by Medicare.
- Payment for routine eye exams is issued by Davis Vision at the Davis Vision allowable amounts. Please contact Davis Vision at 1-888-393-2583 for the

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allowable amounts for routine eye exams and/or materials. Members are responsible for any applicable copayments with regard to the routine examination.

- 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 through the normal Davis Vision process. Members can also access eyewear benefits through any other non Davis Vision provider. 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.

For out-of-area Select Advantage PFFS Member claims

- Select Advantage PFFS processes claims following Original Medicare billing rules including all Prospective Payment System requirements.
- QCC Insurance Company reimburses deemed providers at 100 percent of the current Medicare allowable amount minus federal exclusions paid by Original Medicare and any Member copayments or coinsurance for all medically necessary services covered by Medicare.
- Payment for routine eye exams is issued by Davis Vision at the Davis Vision allowable amount. Please contact Davis Vision at 1-888-393-2583 for the allowable reimbursement amounts for routine eye exams and/or materials. Members are responsible for any applicable copayments with regard to the routine examination.
- The member has an eyewear benefit. Members can access Davis Vision providers who are guaranteed to accept the plans terms and conditions and payment will be made directly to the provider through the standard Davis Vision process. Members can also access eyewear benefits through any other non Davis Vision provider. 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.

10. Claims processing time frames

CMS requires Medicare Advantage Organizations offering PFFS products to process and pay 95 percent of all clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, interest will be paid according to federal guidelines.

11. Final cost settlements

Select Advantage does not offer bad debt reimbursement to providers.

12. Balance-billing / member held harmless

Deemed providers may collect only applicable copayment or coinsurance amounts from Select Advantage PFFS Members and may not otherwise charge or bill the Members. Balance billing is prohibited by Deemed Providers who provide services to Select Advantage PFFS Members.

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Member Held-Harmless Requirements

- Providers must agree that in no event, including but not limited to nonpayment by Select Advantage PFFS Plan, insolvency of Select Advantage PFFS Plan, or breach of these Terms and Conditions, shall a provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or persons (other than Select Advantage PFFS Plans) acting on behalf of the enrollee for services provided pursuant to these Terms and Conditions. This provision does not prohibit providers from collecting charges for noncovered services or cost-sharing amounts in accordance with the Medicare Fee Schedule.
- If a provider mistakenly collects more from a Member than the designated copayment or coinsurance, he or she must:
 - Return to the Member the total reimbursement amount less Member cost-sharing.
 - Collect the total reimbursement amount less Member cost-sharing from Select Advantage.

13. Copayments / schedule

Providers may collect only applicable copayment or coinsurance amounts from Select Advantage PFFS Members and may not otherwise charge or bill the Members. Copayments or coinsurance should be collected from the Member at the time of service. If a Deemed or non-deemed Provider mistakenly collects more from a Member than the designated copayment or coinsurance amount, the Provider must refund the difference to the Member.

14. Emergency care for Non-Deemed Providers

- When a provider furnishes service to a Select Advantage PFFS Member in an emergency care situation and informs QCC Insurance Company that he or she does not wish to be treated as a Deemed Provider, the provider will receive payment equal to what would have been paid under Original Medicare less cost-sharing. In this context, only the applicable copayments or coinsurance under the Select Advantage PFFS Plan may be collected from the Member.
- Select Advantage PFFS claims submission procedures must be followed.

15. Provider appeals

If a provider believes the payment amount that received for a service (including the Member cost sharing collected) is less than what would have been received for the same service under Original Medicare, the provider can appeal the payment amount. To do so, the provider must submit to the Plan reasonable documentation of the Original Medicare payment amount that applies to the service. For example, a remittance advice from a Medicare carrier would be considered documentation. All appeal requests should be submitted in writing and mailed to:

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

For questions about a general claim payment, please call our Provider Services Department, at 1-800-227-3119 from 8 a.m. to 5 p.m. Monday through Friday. When calling, please have the following information available for the representative:

- Medicare provider billing number assigned by CMS
 - Member's name
 - Member's date of birth
 - Member's Select Advantage PFFS number listed on the ID card
 - Claim number in question
 - Date of service
 - Issue you want reviewed
 - Additional information if necessary
 - Copy of claim (if available)
- If the provider demonstrates that he or she has not received proper payment, Select Advantage PFFS will then pay the difference between what was originally received and what would have been received under Original Medicare.
 - A provider may file a standard appeal of a denied claim if he or she completes a waiver of liability statement that says he or she will not bill the Member regardless of the outcome of the appeal. Appeals should be sent to:

Provider Appeals
P.O. Box #37653
Phila., Pa 19101-0653

- Appeals must be received within 180 days of the provider SOR. Providers will receive a response to the appeal within 60 days.
- Providers must follow the provider and/or Medicare Member appeal-process depending on the nature of the issue. Policies and procedures are available upon request.
- If an out-of-area provider believes the amount he or she received for a service (including any Member cost sharing collected) is less than he or she would have received for the same service under Original Medicare, that provider may appeal the payment amount. Call the local Blue Plan's Provider Service department for further claims appeal information.