

Tufts Health Plan Medicare Preferred PFFS Terms and Conditions of Payment

Deemed Providers

Tufts Health Plan Medicare Preferred Private Fee-for-Service (PFFS) is a Medicare Advantage Private Fee-for-Service plan offered by Tufts Health Plan. Tufts Health Plan does not contract with physicians and providers for the PFFS plan, so members are not restricted to any particular provider or provider network. Instead, Medicare participating physicians and Medicare-eligible providers may choose to become “deemed”. Physicians and providers are considered deemed when:

1. They have knowledge a Medicare beneficiary is enrolled in a Tufts Medicare Preferred PFFS plan;
2. They have reasonable opportunity to obtain the Tufts Medicare Preferred PFFS Terms and Conditions of Payment, found below, and;
3. They subsequently render services to a Tufts Medicare Preferred PFFS member.

Once these conditions are met, the provider is considered a “deemed” contracted provider who is participating in the plan and will be subject to these Terms and Conditions of Payment when providing covered services. Deemed contracted providers are not required to obtain prior authorization from Tufts Medicare Preferred before providing medically necessary covered services.

4. A provider who does not agree to accept these Terms and Conditions of Payment may not render covered services to a member of a Tufts Medicare Preferred PFFS plan and may not bill the member. The only exception is for emergency or urgently needed care. Providers not participating with Medicare who render emergency services to Tufts Medicare Preferred PFFS members must bill Tufts Medicare Preferred and will be paid Medicare’s limiting charge minus any applicable member cost sharing amounts.

Providers who are not eligible to provide services and/or receive payment under Original Medicare cannot be a “deemed” provider and participate in the plan. Federal health care providers, including Veterans Administration facilities, are not eligible for reimbursement under the Plan, except when providing emergency care.

Provider Terms & Conditions of Payment

A. Providers

- Providers must be eligible to participate in Medicare and be licensed or certified by the state in their specialty and be acting within the scope of that license or certification, and must not be sanctioned or excluded from participation in a federal health care program or have opted out of Medicare.
- Providers must abide by Medicare and all other laws, rules and regulations applicable to the Medicare Advantage program and/or covered services, including laws, rules and regulations pertaining to patient privacy and confidentiality and HIPAA.
- Providers must issue the Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC). Providers can access these notices via the CMS

website at www.cms.hhs.gov/MMCAG/. For additional information on these requirements please visit the following Web page: www.cms.hhs.gov/manuals/downloads/mc86c13.pdf.

- Providers must abide by Tufts Health Plan Medicare Preferred Grievance and Appeal policies and procedures. Please call Tufts Medicare Preferred Provider Relations at 1-800-279-9022 for more information.
- Providers who do not agree to accept these Terms and Conditions of Payment may not provide covered services nor bill a Tufts Medicare Preferred PFFS plan member. Providers who do not agree to accept these Terms and Conditions of Payment and provide covered services to a Tufts Medicare Preferred PFFS member such as urgent or emergency care will only be paid for urgent or emergency care rendered to Tufts Medicare Preferred PFFS plan members, and may only collect any applicable co-payments or coinsurance from the member. Providers may not balance bill the member for emergency or urgent care.
- Providers not participating with Medicare who render emergency services to Tufts Medicare Preferred PFFS members will be paid Medicare's limiting charge minus any applicable member cost-sharing amounts. Providers may apply the limiting charge only one time per patient. Once the patient is known as a Tufts Medicare Preferred PFFS member, the provider will need to access the Terms and Conditions of Payment and decide whether or not to provide services. If the provider accepts the Terms and Conditions of Payment and provides services, the limiting charge cannot be applied.
- Providers who agree to these Terms and Conditions of Payment must agree not to balance bill members above any applicable cost-sharing amounts. If a provider collects more from a member than the amounts permitted under these Terms and Conditions of Payment, the provider must refund the difference to the member.
- Tufts Health Plan follows the Medicare Advantage prompt payment requirements for clean claims, of which 95% will be paid within 30 days of receipt.
- Providers must follow the standards for patients' rights as outlined in the Tufts Health Plan Medicare Preferred Member's Rights and Responsibilities. Providers may access details on Tufts Medicare Preferred Member's Rights and Responsibilities by contacting Provider Relations at 1-800-279-9022.
- Providers must agree that in no event, including but not limited to non-payment by Tufts Health Plan, insolvency of Tufts Health Plan or breach of these Terms and Conditions of Payment, shall the provider or the provider's assignees and/or subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons having authority to act on behalf of the member, for services provided pursuant to these Terms and Conditions of Payment. This provision does not prohibit providers from collecting charges for non-covered services agreed to in advance in writing by the member or member cost-sharing amounts applicable under the plan.

B. Payment/Billing Information

- In general, providers submitting clean claims (as defined in the Tufts Medicare Preferred PFFS Plan Reimbursement Grid) for covered services will receive, as payment in full, the current Medicare allowable charge less any applicable member cost-sharing amounts. Tufts Health Plan will make payment for all covered services under the Plan, as described in the Tufts Medicare Preferred PFFS Reimbursement Grid, which is available by visiting our Web site at www.tuftshealthplan.com/providers.
- Where no Original Medicare allowable charge exists, the provider will be paid an amount as indicated on the Tufts Medicare Preferred Reimbursement Grid, and may collect only applicable cost-sharing amounts from the member and may not otherwise charge or bill the member. For additional details, please refer to the Tufts Medicare Preferred PFFS Reimbursement Grid.

- Tufts Health Plan follows Medicare regulations at 42 CFR 424.44 defining the timely filing period for Medicare fee-for-service claims. In general, such claims must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year, i.e., the time limit is the second year after the year in which such services were furnished.
- Tufts Health Plan will process claims in accordance with Original Medicare billing rules, the Medicare allowable fee schedule, and all prospective payment system requirements and National and Local Medicare Coverage Determinations.
- In accordance with Medicare Secondary Payer rules, Tufts Health Plan is precluded from paying for any member's medical expenses where payment has been made or can reasonably be expected to be paid by another liable party which includes, but is not limited to employer group health plan, Worker's Compensation, no-fault or liability insurer, and Federal Black Lung program. Providers must include the primary payer's Explanation of Payment when submitting a claim to Tufts Health Plan for secondary payment.
- For covered services, providers must submit claims using the same coding rules as Original Medicare, and use HCPCS, CPT codes and defined modifiers. Providers must follow all Medicare billing guidelines for claims submission. Providers must include all claims information required by Original Medicare, and certify that, to the best of the provider's knowledge, information, and belief, the information is truthful.
- Physicians and providers have the right to request claims adjustments and appeal claims payments. If a provider disagrees with Tufts Health Plan's payment rate and has information that Original Medicare would pay more for this service, such documentation may be submitted for review and appropriate adjustment to payment. This request must be in writing and must be filed within 60 calendar days after the date of the organization determination. We reserve the right to retrospectively review claims for payment accuracy based on information submitted. To request an adjustment on a claim, call our Provider Relations department at 1-800-279-9022. To file a claim appeal, submit documentation to:

Tufts Medicare Preferred PFFS – Appeals
PO Box 9183
Watertown, MA 02471-91873

Please refer to the Tufts Medicare Preferred PFFS Reimbursement Grid, which is made a part of these Terms and Conditions of Payment by reference, for full details regarding claim billing and payment amounts, which may be accessed by visiting our Web site at www.tuftshealthplan.com/providers or by calling Provider Relations at 1-800-279-9022.

C. Claims Submissions Format

- Providers must agree to submit claims for covered services to Tufts Health Plan for reimbursement rather than a Medicare carrier or fiscal intermediary, with the exception of providers rendering covered services under a Medicare-certified Hospice Program.
- The provider must collect all cost-sharing that is the responsibility of the member at the time that covered services are provided to the member. Members are personally responsible for paying for care and services that are not covered by Tufts Medicare Preferred PFFS. For covered services that have a benefit limitation, members must pay the full cost of any service received after the member has used up his/her benefit for that type of service.

- Electronic Claims Submission: Tufts Medicare Preferred accepts 837P and 837I files via both clearinghouses and direct submission as follows:
 - Direct submissions: Please contact Kevin Whalen at 1-888-880-8699 x3344 for initial setup.
 - Clearinghouse: Please contact our EDI Operations Department at 1-888-880-8699 x4042 for initial setup.
- If sending paper claims, please mail to:

Tufts Medicare Preferred PFFS
PO Box 9183
Watertown, MA 02471-91873
- If sending paper claims, providers must submit all covered services as soon as possible using the standard CMS-1500 or UB-04 form.
- Benefits coverage is provided by Tufts Associated Health Plan, Inc., d/b/a Tufts Health Plan, a Medicare Advantage organization, with a Medicare contract.

Questions

If you have any questions or concerns about your payment or Tufts Medicare Preferred PFFS Terms and Conditions of Payment, or if you would like more information on Tufts Medicare Preferred PFFS, please contact Tufts Medicare Preferred Provider Relations at 1-800-279-9022. Staff are available to assist you Monday through Friday, 8:30 am to 5:00 pm EST, or you may visit our Web site at www.tuftshealthplan.com/providers.

This Terms and Conditions of Payment document is located in the Provider Manuals section of the Tufts Health Plan Web site under **Tufts Medicare Preferred Private Fee-for-Service**.