



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

**CONTRACT YEAR 2017 MEDICARE ADVANTAGE
PRIVATE FEE-FOR-SERVICE PLAN
MODEL TERMS AND CONDITIONS OF PAYMENT**

Table of Contents

1. Introduction
2. When a provider is deemed to accept **Blue Cross® Medicare Private Fee for Service's** terms and conditions
3. Provider qualifications and requirements
4. Payment to providers: Plan payment; Member benefits and cost sharing; Balance billing of members; and Hold harmless requirements
5. Filing a claim for payment
6. Maintaining medical records and allowing audits
7. Getting an advance organization determination
8. Provider payment dispute resolution process
9. Member and provider appeals and grievances
10. Providing members with notice of their appeals rights – Requirements for Hospitals, SNF, CORFs, and HHAs
11. If you need additional information or have questions

1. Introduction

Blue Cross[®] Medicare Private Fee for Service is Medicare Advantage private fee-for-service (PFFS) plan offered by Blue Cross[®] Blue Shield[®] of Michigan. **Blue Cross Medicare Private Fee for Service** (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 **Blue Cross Medicare Private Fee for Service** 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 Blue Cross Medicare Private Fee for Service 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 Blue Cross Medicare Private Fee for Service. Any provider in the United States that meets the deeming criteria in *Section 2* becomes deemed to have a contract with Blue Cross Medicare Private Fee for Service 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. *Section 7* describes how a provider can request an advance organization determination from the plan.

Blue Cross Medicare Private Fee for Service has signed contracts with some providers. These providers are our network providers. Blue Cross Medicare Private Fee for Service has network providers for all Medicare Part A and Part B services.

Providers who furnish services to a Blue Cross Medicare Private Fee for Service member may only provide services within the scope of their licensure or certification, and should only provide services that are covered by our plan and that are medically necessary by Medicare definitions. Institutional providers like hospitals or skilled nursing facilities must meet all applicable Medicare certification requirements.

Our members can still receive services from non-network providers who do not have a signed contract with us, as long as the provider meets the deeming criteria described in *Section 2*. These deemed contracting providers are subject to all of the terms and conditions of payment described in this document. A list of our network providers can be accessed by going to <http://www.bcbsm.com/medicare> and selecting the appropriate provider directory under the “Find a Doctor” section.

The amount of cost sharing a member pays a provider who is not one of our network providers may be more than the cost sharing the member pays a network provider. We

indicate the services for which the cost sharing amount differs between network providers and non-network providers in the Blue Cross Medicare Private Fee for Service Member Evidence of Coverage (EOC).

2. When a provider is deemed to accept Blue Cross Medicare Private Fee for Service's terms and conditions of payment

A provider is deemed by law to have a contract with Blue Cross Medicare Private Fee for Service 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 Blue Cross Medicare Private Fee for Service. All of our members receive a member ID card that includes the Blue Cross Medicare Private Fee for Service logo that clearly identifies them as PFFS members. The provider may validate eligibility by calling our Provider Service Center at 1-866-309-1719, between 8 a.m. and 4:30 p.m. Eastern time. To determine eligibility for out-of-area members, call the BlueCard line at 1-800-676-BLUE (2583) and provide the member's three-digit prefix, which is located on the ID card.

Contracted Michigan providers can also verify eligibility and coverage online through web-DENIS, a Blue Cross web-based information system for providers. Web-DENIS login and other information are available at:

http://www.bcbsm.com/provider/provider_secured_services/index.shtml.

- 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* <http://www.bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit.html>. The terms and conditions may also be obtained by calling our Provider Service Center at 1-866-309-1719.
- 3) The provider furnishes covered services to a Blue Cross Medicare Private Fee for Service member.

If all of these conditions are met, the provider is deemed to have agreed to Blue Cross Medicare Private Fee for Service's terms and conditions of payment *for that member specific to that visit*. For example: If a Blue Cross Medicare Private Fee for Service member shows you an enrollment *card identifying him/her* as a member of Blue Cross Medicare Private Fee for Service *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).

NOTE: You, the provider, can decide whether or not to accept Blue Cross Medicare Private Fee for Service's term and conditions of payment each time you see a Blue Cross Medicare Private Fee for Service member. A decision to treat one plan member does not obligate you to treat other Blue Cross Medicare Private Fee for Service members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

If you DO NOT wish to accept Blue Cross Medicare Private Fee for Service’s terms and conditions of payment, then you should not furnish services to a Blue Cross Medicare Private Fee for Service member, EXCEPT for emergency services. If you 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-contracting 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 Blue Cross Medicare Private Fee for Service for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Blue Cross Medicare Private Fee for Service, in accordance with HIPAA requirements.
- Blue Cross Medicare Private Fee for Service billing guidelines and unique billing requirements may be accessed at <http://www.bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit.html>. Claims, including revisions and adjustments that are not filed by a provider prior to the claim filing limit of one calendar year from the date of service or discharge will be the provider’s liability.

Professional claims must be submitted using the revised CMS-1500 Health Insurance Claim Form (version 02/12).

For more information, contact your provider consultant or visit <http://www.NUCC.org>. The site includes instructions for completing the form.

For electronic claim submissions, send claims to your local Blue plan. If you have questions, please call the Electronic Data Interchange (EDI) helpdesk at 1-800-542-0945. An EDI user guide is also available at: <http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html>

For paper claim submissions, send claims to:

**Blue Cross Medicare Private Fee for Service
P.O. Box 32593
Detroit, MI 48232-0593**

Since Blue Cross Blue Shield of Michigan doesn’t have participation agreements with most providers located outside of Michigan, we encourage both health care providers and members to go to <http://www.bcbsm.com/medicare> and click on the “Find a Doctor” tab to determine if a lab or DME supplier participates with Blue Cross Medicare Private Fee for Service.

- Blue Cross Medicare Private Fee for Service members who receive services from an out-of-network lab, specialty pharmacy, or DME supplier cannot be balance-billed. Labs, specialty pharmacies and DME suppliers may only collect applicable cost sharing from these members and may not otherwise charge or bill them

- Furnish services to a Blue Cross Medicare Private Fee for Service 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 Blue Cross Medicare Private Fee for Service 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

Blue Cross Medicare Private Fee for Service reimburses deemed providers at an amount equal to the lesser of the provider's billed charges or Blue Cross Medicare Private Fee for Service's approved amount as set forth in the Blue Cross Medicare Private Fee for Service's fee schedule, in accordance with one or more of the attachments located at <http://www.bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit/reimbursement.html>. At minimum, Blue Cross Medicare Private Fee for Service will pay deemed providers the amounts they would receive as a participating or nonparticipating provider, as applicable, under Original Medicare for Medicare covered services, including billing up to the limiting charge for non-participating providers. To offset the Center for Medicare and Medicaid Services' (CMS') sequestration, Blue Cross Medicare Private Fee for Service will reduce payments to providers by 2% for most submitted medical claims.. Blue Cross Medicare Private Fee for Service will pay

Physician Quality Reporting Initiative (PQRI) bonus and e-prescribing incentive payment amounts to deemed 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.

Services covered under Blue Cross Medicare Private Fee for Service that are not covered under Original Medicare are reimbursed using the following fee schedule located <http://www.bcbsm.com/content/dam/public/Providers/Documents/help/medicare-advantage-fee-schedule.pdf>.

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 Blue Cross Medicare Private Fee for Service co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Blue Cross Medicare Private Fee for Service for covered services. *Section 5* provides instructions on how to submit claims to us. Please note, however, that Blue Cross Medicare Private Fee for Service may not hold members accountable for any cost sharing (deductibles, copayments, and coinsurance) for Medicare-covered preventive services that are subject to zero cost sharing.

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 Blue Cross Medicare Private Fee for Service and the associated member cost sharing amounts.

Services covered by Blue Cross Medicare Private Fee for Service	Cost sharing
Medicare-covered preventive services: <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening 	<ul style="list-style-type: none"> • \$0 co-pay (unless being treated or monitored during an existing medical condition during the same visit the

<ul style="list-style-type: none"> • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease behavioral therapy • Cardiovascular disease screening • Cervical and vaginal cancer screening • Colon cancer screening • Depression screening • Diabetes screening • Diabetes self management training • Glaucoma screening • Hepatitis C screening • HIV screening • Immunizations <ul style="list-style-type: none"> ○ Flu and Hepatitis B • Lung cancer screening • Medical nutrition therapy • Obesity screening and counseling • Pneumococcal screening • Prostate cancer screening Tobacco use cessation counseling • Screening and counseling to reduce alcohol misuse • Sexually transmitted infections screening and counseling • “Welcome to Medicare” visit 	preventive service is received), \$0 coinsurance, deductible does not apply
Inpatient hospital services	<ul style="list-style-type: none"> • \$0 per day, after deductible
Skilled nursing facility	<ul style="list-style-type: none"> • \$0 per day 1-100, after deductible
Office services	<ul style="list-style-type: none"> • \$0, after deductible, for each primary care visit • \$0, after deductible, for each specialist care visit
Physical Exams (1 per year)	<ul style="list-style-type: none"> • None
Emergency room visit	<ul style="list-style-type: none"> • None
Urgent care center visits	<ul style="list-style-type: none"> • None
Worldwide Coverage	<ul style="list-style-type: none"> • \$250 deductible, 20% coinsurance, and \$50,000 lifetime maximum.

To view a complete list of covered services and member cost sharing amounts under Blue Cross Medicare Private Fee for Service, go to <http://www.bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit.html> under *Medicare PPO and PFFS Benefit Summaries*. You may call us at 1-866-309-1719 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Blue Cross Medicare Private Fee for Service. Be sure to have the member's ID number when you call.

Blue Cross Medicare Private Fee for Service follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Blue Cross Medicare Private Fee for Service, unless specified by the plan. Information on obtaining an advance coverage determination can be found in *Section 7*. Blue Cross Medicare Private Fee for Service does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. There are no prior authorization and prior notification rules for Blue Cross Medicare Private Fee for Service 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

There are two different PFFS balance billing scenarios:

- If the provider is deemed and a non-participating provider under Original Medicare rules, up to 15% balance billing is permitted. However, the plan – not the beneficiary – must pay the 15%.
- If the provider is deemed or contracted, and the balance billing is explicitly included in Blue Cross Medicare Private Fee for Service's contract with the provider or in the terms and conditions of payment, it may balance bill up to 15% of the total plan payment amount for services, for which the beneficiary is responsible.

A provider may collect only applicable plan cost sharing amounts from Blue Cross Medicare Private Fee for Service members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Blue Cross Medicare Private Fee for Service members.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Blue Cross Medicare Private Fee for Service, insolvency of Blue Cross Medicare Private Fee for Service, 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 Blue Cross Medicare Private Fee for Service for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 1 calendar year after the date of service. Failure to be timely with claim submissions may result in non-payment. The rules for submitting timely claims under Original Medicare can be found at <https://www.cms.gov/MLNMArticles/downloads/MM6960.pdf>.
- **Prompt Payment** Blue Cross Medicare Private Fee for Service will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Blue Cross Medicare Private Fee for Service 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. Blue Cross Medicare Private Fee for Service 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 (UB-04), or ANSI 837 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) and federal tax ID as appropriate, if submitting paper claims.
 - NPI only, if submitting claims electronically.
 - The member's ID number.
 - Date(s) of service.
 - Quantify facility services by revenue code categories, or, if reporting HCPCS codes, the number of units equal to the number of times the service or procedure is being reported.
 - Medicare CPT codes and defined modifiers.
 - Diagnosis codes to the highest level of specificity.

- Physician's or supplier's signature. Include date, degrees or credentials. "Signature on file" is not acceptable.
 - CMS-approved HCPCS code modifiers.
 - Certificate of Medical Necessity, a durable medical equipment information form, a prescription or other documentation with the first-month supply claim, a first-month rental equipment claim, or a claim for a one-time equipment purchase for certain services.
- 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 located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Providers should identify primary coverage and provide information to Blue Cross Medicare Private Fee for Service at the time of billing.
 - Where to submit a claim:
 - For electronic claim submission, send claims to your local Blue plan.
 - For paper claim submission, send claims to:

Blue Cross Medicare Private Fee for Service
P.O. Box 32593
Detroit, MI 48232-0593
 - If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-800-542-0945. An EDI user guide is also available at: <http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html>.

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 Blue Cross Medicare Private Fee for Service 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 Blue Cross Medicare Private Fee for Service, 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 Blue Cross Medicare Private Fee for Service are based.

To encourage providers to submit member medical records to Blue Cross Medicare Private Fee for Service in this case, Blue Cross Medicare Private Fee for Service will reimburse the provider \$5 for each medical record that it has requested for risk adjustment related activities and plan-related activities.

Blue Cross Medicare Private Fee for Service may also request records for activities in the following situations: Blue Cross Medicare Private Fee for Service 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. Blue Cross Medicare Private Fee for Service will not use these records for any purpose other than the intended use

Blue Cross Medicare Private Fee for Service 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 advance organization determination

Providers or plan enrollees may obtain a written advance coverage determination (known as an organization determination) from us before a service is furnished to confirm whether the service will be covered by Blue Cross Medicare Private Fee for Service. To obtain an advance organization determination, fax your request to 1-877-348-2251 or submit your request in writing to:

Grievances and Appeals
Attn: Org Determination
Blue Cross Blue Shield of Michigan
P.O. Box 2627
Detroit, MI 48231-2627

Blue Cross Medicare Private Fee for Service will make a decision and notify you and the member within 14 days of receiving the request, with a possible (up to) 14-day extension either due to the member's request or Blue Cross Medicare Private Fee for Service 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 1-888-724-1373 or fax your request to 1-877-348-2251. We will notify you of our decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request, unless we invoke a (up to) 14-day extension either due to the member's request or Blue Cross Medicare Private Fee for Service justification (for example, the receipt of

additional medical evidence may change Blue Cross Medicare Private Fee for Service decision to deny) that the delay is in the member's best interest.

In the absence of an advance organization determination, Blue Cross Medicare Private Fee for Service can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan (e.g., was not medically necessary). However, providers have the right to dispute our decision by submitting a waiver of liability (promising to hold the member harmless regardless of the outcome), and exercising member appeal rights (see the Federal regulations at 42 CFR Part 422, subpart M, or Chapter 13 of the Medicare Managed Care Manual).

8. Non-Contracted provider payment dispute resolution process

For non-contracted providers, the Centers for Medicare and Medicaid Services' Medicare Managed Care Manual, Chapter 16a, states in part:

“MA organizations offering full, partial or non-network PFFS plans are required to make information on each PFFS plan's payment rates and provider requirements available to deemed providers that furnish services to their members. A PFFS plan's terms and conditions of payment is the primary means for deemed providers to obtain necessary information regarding a PFFS plan's payment rates for covered items and services and provider requirements in order to allow the providers to make a confident decision as to whether or not they will agree to accept the terms and conditions of payment.”

As a first step, you should call Provider Inquiry Services at 1-866-309-1719 to address your concern. If you are still unhappy with the decision after speaking with a representative, you may send in a written dispute to:

Medicare Advantage PRS – Appeals
Attn: First Level Appeal
Blue Cross Blue Shield of Michigan
P.O. Box 33842
Detroit, MI 48232-5842

9. Member and provider appeals and grievances

Blue Cross Medicare Private Fee for Service members have the right to file appeals and grievances with Blue Cross Medicare Private Fee for Service when they have concerns or problems related to coverage or care. Members may appeal a decision made by Blue Cross Medicare Private Fee for Service 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 determinations to the plan on behalf of the member. The physician

may also appeal a post-service organization determination as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal using the member appeal process. There must be potential member liability (e.g., an actual claim for services already rendered and denied in whole, as opposed to an advance organization determination or a partially paid claim), in order for a provider to appeal a post-service organization determination utilizing the member appeal process.

A non-physician provider may appeal an organization determination 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 a post-service organization determination (e.g., claims using the member appeal process. As noted above, there must be potential member liability in order for a provider to appeal a post-service organization determination 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 Blue Cross Medicare Private Fee for Service Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. The member EOC is located under the “Using Your Coverage” link under the “For Members” section of our website located at <http://www.bcbsm.com/medicare>. You can call our Member Services Department at 1-888-724-1373 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 *An Important Message from Medicare About Your Rights* (IM), including complying with the time frames for delivery. For copies of the notice and additional information regarding IM notice and delivery requirements, go to:

http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

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 complying with the requirements for providing the *Notice of Medicare Non-Coverage* (NOMNC), including complying with the time frames for delivery. For copies of the notice and the notice instructions, go to:

http://www.cms.gov/BNI/09_MAEDNotices.asp.

As directed in the instructions, the NOMNC should contain Blue Cross Medicare Private Fee for Service's contact information somewhere on the form (such as in the *additional information* section on page 2 of the NOMNC).

Blue Cross Medicare Private Fee for Service 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 (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. For copies of the notices and the notice instructions, go to: http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp and http://www.cms.gov/BNI/09_MAEDNotices.asp.

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. For copies of the notices and the notice instructions, go to: http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp and http://www.cms.gov/BNI/09_MAEDNotices.asp.

11. If you need additional information or have questions

If you have general questions about Blue Cross Medicare Private Fee for Service's terms and conditions of payment, contact us at 1-866-309-1719 or write to us at the following address:

**Blue Cross Medicare Private Fee for Service
P.O. Box 33842
Detroit, MI 48232-5842**

- If you have questions about submitting claims, call us at 1-866-309-1719.
- If you have questions about plan payments, call us at 1-866-309-1719.