Medicare Advantage Private Fee-for-service Plan Model
Terms and Conditions of Payment

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1. Introduction

Humana Gold Choice® PFFS is a Medicare Advantage private fee-for-service (PFFS) plan offered by Humana. Humana Gold Choice PFFS 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 healthcare services under Medicare Part A and Part B (also known as Original Medicare) or eligible to be paid by Humana Gold Choice PFFS 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 Humana Gold Choice PFFS 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 Humana. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Humana for the services furnished to the Humana-covered patient 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 Humana-covered patient.** However, a patient or provider may request an advance organization determination before a service is provided 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. Section 7 describes how a provider can request an advance organization determination from the plan.

Humana has signed contracts with some providers. These providers are our network providers. Humana has network providers for all Medicare Part A and Part B services.

Humana Gold Choice PFFS has network providers for durable medical equipment (DME), home health, laboratories and hospitals in specific areas.

Our members can 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 contracted providers are subject to all of the terms and conditions of payment described in this document. The list of network providers can be accessed on **Humana.com** via the provider directory.

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. Humana indicates the services for which the cost-sharing amount differs between full and partial network providers and non-network providers in the Humana Gold Choice PFFS Member Evidence of Coverage (EOC).

2. When a provider is deemed to accept Humana Medicare Advantage PFFS terms and conditions of payment

A provider is deemed by law to have a contract with Humana when all of the following three criteria are met:

a. The provider is aware, in advance of furnishing healthcare services, that the patient is a member of Humana Gold Choice PFFS. All of our members receive a member ID card that includes the Humana Gold Choice PFFS logo that clearly identifies them as PFFS members. The provider can validate eligibility by visiting Availity Portal at Availity.com or by calling our member/provider service number on the patient's Humana identification card.

b. 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 **Humana.com**. The terms and conditions also can be obtained by calling our Humana provider relations department at **866-291-9714**.
c. The provider furnishes covered services to a Humana Gold Choice PFFS member.

If all of these conditions are met, the provider is deemed to have agreed to Humana Medicare Advantage PFFS terms and conditions of payment for that patient specific to that visit. For example: If a Humana Gold Choice PFFS member shows you an enrollment card identifying him/her as a member of Humana Gold Choice PFFS and you provide services to him/her, 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 to accept Humana Medicare Advantage PFFS terms and conditions of payment each time you see a Humana Gold Choice PFFS member. A decision to treat one plan member does not obligate you to treat other Humana Gold Choice PFFS members; nor does it obligate you to accept the same member for treatment at a subsequent visit.

If you DO NOT wish to accept Humana Medicare Advantage PFFS plans' terms and conditions of payment, then you should not furnish services to a Humana Gold Choice PFFS 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-contracting providers and paid at the payment amounts they would have received under Original Medicare.

3. Provider qualifications and requirements

To be paid by Humana for services provided to one of our members, you need to:

- Have a National Provider Identifier to submit electronic transactions to Humana, in accordance with HIPAA requirements
- Submit your claims electronically whenever possible. For nonelectronic transactions, submit claims using the standard CMS-1500, CMS-1450, and/or UB-04, or their successors. Refer to Section 5, Filing a Claim for Payment, for more details
- Be licensed or certified by the state and furnish services to a Humana Gold Choice PFFS 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 Health and Human Services (HHS) Office of Inspectors General excluded and sanctioned provider lists
- Not be on the CMS preclusion list

- Not be a federal healthcare provider, such as a Veterans' Administration provider, except when providing emergency care
- Comply with all applicable Medicare and other federal healthcare 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 Humana to resolve any member grievance involving the provider within the time frame required under federal law
- For providers that 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
- Be a Medicare-certified provider for supplemental services

4. Payment to providers

Plan payment

Humana reimburses deemed providers at the amounts they would have received as participating or nonparticipating physicians, as applicable, under Original Medicare. This includes applicable rates and expectations for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) subject to Original Medicare's DMEPOS Competitive Bidding Program and National Mail-order Competition rules for Medicare-covered services, minus any member-required cost sharing, for all medically necessary services. In addition, settlement for certain payment methodologies is available upon request.

Humana 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, 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, please contact us at the member/provider service number listed on the back of the patient's Humana identification card.

Services covered under Humana Gold Choice PFFS that are not covered under Original Medicare are reimbursed using a fee schedule or funds allocated to members based on the type of services provided. Please call us at the member/provider service number listed on the back of the patient's Humana identification card to receive information on the reimbursement.

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 collect from the member only the appropriate Humana Gold Choice PFFS copayments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Humana for covered services. Section 5 provides instructions on how to submit claims to us. Please note, however, that Humana may not hold members accountable for any cost sharing (deductibles, copayments, 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 accept only the MA plan payment (plus any Medicaid copayment amounts) as payment in full or bill the appropriate state source.

To view a complete list of covered services and member cost-sharing amounts under Humana Gold Choice PFFS, go to **Humana.com/providers**. You can call us at the member/provider service number listed on the back of the patient's Humana identification card to obtain more information about covered benefits, plan payment rates and member cost-sharing amounts under Humana Gold Choice PFFS. Be sure to have the member's ID number when you call.

Humana Gold Choice PFFS follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Humana Gold Choice PFFS, unless specified by the plan.

Information about obtaining an advance coverage determination can be found in Section 7. Humana Gold Choice PFFS does not require members or providers to obtain prior authorization, prior notification or referrals from the plan as a condition of coverage. There is no prior authorization or prior notification rule for Humana Gold Choice PFFS 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 nonparticipating provider under Original Medicare rules, up to 15 percent balance billing is permitted. However, the plan – not the beneficiary – must pay the 15 percent.
- If the provider is deemed or contracted and the balance billing is explicitly included in Humana's contract with the provider or in the terms and conditions of payment, it may balance bill up to 15 percent 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 Humana Gold Choice PFFS members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Humana Gold Choice PFFS members.

Hold-harmless requirements

In no event, including, but not limited to, nonpayment by Humana, insolvency of Humana, 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, copayments or deductibles billed in accordance with the terms of the member's benefit plan.

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

5. Filing a claim for payment

You must submit a claim to Humana for an Original Medicare-covered service within the same time frame you would have to submit under Original Medicare, which is within one calendar year after the date of service. Failure to be timely with claim submissions might result in nonpayment. The rules for submitting timely claims under Original Medicare can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6960.pdf.

Prompt payment: Humana will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Humana 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. Humana will process all nonclean 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 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 who are paid based on 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 at http://www.cms.hhs.gov/Manuals/IOM/list.asp. Providers should identify primary coverage and provide information to Humana at the time of billing.

Where to submit a claim:

- For electronic claim submission, you can use Availity.com or your existing clearinghouse. Current Humana electronic submitters can use the same process they now use.
- For paper claim submission, mail paper claims to the address listed on the back of the member ID card or to:

Humana
P.O. Box 14601
Lexington, KY 40512-4601

If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at the member/provider service number listed on the back of the patient's Humana identification card.

6. Maintaining medical records and allowing audits

Deemed providers should maintain timely and accurate medical, financial and administrative records related to services they render to Humana Gold Choice PFFS members. Unless a longer time period is required by applicable statutes or regulations, the provider should maintain such records for at least 10 years from the date of service.

Deemed providers must agree to maintain medical records according to industry standards and to provide such records to Humana or a Humana designee upon request and within a reasonable time frame.

Deemed providers must provide Humana, 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 primarily will be used for Centers for Medicare & Medicaid Services (CMS) audits of risk adjustment data upon which CMS capitation payments to Humana are based. Providers are required to furnish member medical records without charge when the medical records are required for government use.

Humana also may request records for activities in the following situations: Humana audits of risk adjustment data; CMS audits; compliance with federal regulations; Humana determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; whether the service was coded properly; to investigate fraud and abuse; and to make advance coverage determinations. Humana will not use these records for any purpose other than the intended use. Providers are required to furnish member medical records without charge when the medical records are required for government use.

Humana 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 can 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 Humana Gold Choice PFFS plans. To obtain an advance organization determination, all requests must be in writing and mailed to:

Humana Advance Organization Determination Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

A written advance organization determination request also can be faxed to 502-508-3551. Humana 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 Humana's 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 the member/provider service number listed on the back of the patient's Humana identification card or fax a request for an advance organization determination to 502-508-3551. 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 Humana's justification (for example, the receipt of additional medical evidence may change Humana's decision to deny) that the delay is in the member's best interest.

In the absence of an advance organization determination, Humana 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. 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 Humana, send a written dispute to:

Humana
P.O. Box 14601
Lexington, KY 40512-4601

Additionally, please provide appropriate documentation to support your payment dispute. This should include your name, address, the member's ID card number and reason(s) for the payment dispute. Please send any supporting medical records, notes or other information that explains why the service(s) should be paid. Claims must be disputed within 180 days from the date payment is initially received by the provider.

Note: In cases in which we re-adjudicate a claim – for instance, when we discover that we processed it incorrectly the first time – you have an additional 180 days from the date you are notified of the re-adjudication 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.

9. Member and provider appeals and grievances

Humana Gold Choice PFFS members have the right to file appeals and grievances with Humana when they have concerns or problems related to coverage or care. Members may appeal a decision made by Humana to

deny coverage or payment for a service or benefit that they believe should be covered or paid. 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 also may 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 the denial 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 using 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 using the member appeal process. As noted above, there must be potential member liability for a provider to appeal a post-service organization determination using 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 Humana Gold Choice PFFS Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. The member EOC is posted on **Humana.com**. You can call the member/provider service number listed on the back of the Humana Gold Choice PFFS member's identification card for more information about our member appeals and grievance policies and procedures.

10. Notifying members 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 normal 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 Humana's contact information somewhere on the form (such as in the additional information section on Page 2 of the NOMNC). In addition, the provider should send a copy of any NOMNC issued to:

Humana Correspondence Office
P.O. Box 14611
Lexington, KY 40512-4611

Humana will provide members with a detailed explanation if the member notifies the quality improvement organization (QIO) that he or she 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 Humana Medicare Advantage PFFS plans terms and conditions of payment, contact us at:

Humana
P.O. Box 14601
Lexington, KY 40512-4601

Phone: 866-291-9714

Our hours of operation are Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

If you have questions about submitting claims, call us at the member/provider service number listed on the back of the Humana Gold Choice PFFS member's identification card.