

Deseret Secure

MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLAN TERMS AND CONDITIONS OF PAYMENT

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1. Introduction

Deseret Secure is a Medicare Advantage private fee-for-service (PFFS) plan offered by Deseret Mutual Benefit Administrators (DMBA). Deseret Secure 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’).

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat a Deseret Secure 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 Deseret Secure. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Deseret Secure 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 coverage determination before a service is provided in order 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 coverage determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance coverage determination is described in Section 7.

2. When a provider is deemed to accept Deseret Secure’s terms and conditions of payment

A provider is considered by law to be *deemed* to have a contract with Deseret Secure 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 Deseret Secure. All of our members receive a member ID card that includes the Deseret Secure logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling Deseret Secure’s Provider Service Center at 1-877-220-0110.
- 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.dmba.com/provider/medicare>. The terms and conditions may also be obtained by calling our Deseret Secure’s Provider Service Center at 1-877-220-0110.
- 3) The provider furnishes covered services to a Deseret Secure member.

If all of these conditions are met, the provider is deemed to have agreed to Deseret Secure’s terms and conditions of payment for that member specific to that visit. **Note:**

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

For example: If a Deseret Secure member shows you an enrollment card identifying him/her as a member of Deseret Secure 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).

If you DO NOT wish to accept Deseret Secure's terms and conditions of payment, then you should not furnish services to a Deseret Secure 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-contract 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 Deseret Secure for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Deseret Secure, in accordance with HIPPA requirements.
- Agree to submit claims to Deseret Secure following Medicare established time frames and using Medicare coding and billing guidelines including use of Medicare appropriate CPT codes, defined modifiers and diagnosis codes to the highest specificity (see *Filing a Claim for Payment* section for more details).
- Furnish services to a Deseret Secure 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 Deseret Secure 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.
- Agree not to balance bill members for covered services.

4. **Payment to providers**

Plan payment

Deseret Secure reimburses deemed providers the amount they would have received under Original Medicare for Medicare-covered services, minus any member required cost sharing, for all medically necessary services covered by Medicare. 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. For more detailed information about our payment methodology for all provider types, go to <http://www.dmsv.com/provider/medicare/proxygrid09.pdf>.

Services covered under Deseret Secure that are not covered under Original Medicare are reimbursed using Deseret Secure's fee schedule. Please call us at 1-877-220-0110 to receive information on our fee schedule.

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 Deseret Secure co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Deseret Secure for covered services. Section 5 provides instructions on how to submit claims to us. If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a state Medicaid program) that the state holds harmless for Medicare cost sharing, then the provider cannot collect any cost sharing from the member at the time of

service. Instead, the provider may only look to the State Medicaid agency to collect the Medicaid allowable cost sharing amount(s).

For your quick reference, the table below lists some of the important services covered under Deseret Secure and the associated member cost sharing amounts.

Services covered by Deseret Secure	The amount(s) you may charge the plan member
Inpatient hospital services	<ul style="list-style-type: none"> • \$500 per admission • \$400 if member pre-notifies
Skilled nursing facility	<ul style="list-style-type: none"> • \$100 per admission • \$0 if member pre-notifies • \$75 per day for days 16-100 • \$2500 out of pocket max
Office services (Physician, specialist, chiropractic & podiatry)	<ul style="list-style-type: none"> • \$10 primary care per visit • \$20 specialist care per visit
Immunizations	<ul style="list-style-type: none"> • \$0 copay
Mammography	<ul style="list-style-type: none"> • \$0 copay
Physical Exams (1 per year)	<ul style="list-style-type: none"> • \$10 primary care per visit • \$20 specialist care per visit
Emergency room visit	<ul style="list-style-type: none"> • \$50 per visit • \$0 if admitted
Urgent care center visits	<ul style="list-style-type: none"> • \$30 per visit
Home health care	<ul style="list-style-type: none"> • \$20 per day of service provided • \$0 per day if member pre-notifies
Hospice care	<ul style="list-style-type: none"> • Part A benefit – bill directly to Original Medicare
Outpatient surgery	<ul style="list-style-type: none"> • \$75 per surgery
Ambulance	<ul style="list-style-type: none"> • \$50 per day

You may call us at 1-877-220-0110 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Deseret Secure. Be sure to have the member’s ID number when you call.

Deseret Secure follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Deseret Secure, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Deseret Secure does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. Under prior authorization, a plan requires beneficiaries or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for Deseret Secure members. For information on Deseret Secure’s prior notification policies, see section on “Prior notification rules” below.

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.

Prior notification rules

No prior authorization or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to members. However, to assist us in better managing care for our members, we request that you notify us *prior* to the member receiving any of the following services:

- Inpatient admissions
- Skilled nursing facility care
- Home health care
- Durable medical equipment

Note that Deseret Secure charges lower member cost sharing for the following services if the member or provider voluntarily notifies the plan before the service is furnished:

- Inpatient admissions
- Skilled nursing facility care
- Home health care
- Durable medical equipment

The lower member cost sharing amounts that result from prior notification are listed in the table above. Deseret Secure does not require the member or the provider to prior notify the plan as a condition for covering services. To provide prior notification or to obtain more information about our prior notification rules, call us at 1-877-220-0110.

Balance billing of members

A provider may collect only applicable plan cost sharing amounts from Deseret Secure members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Deseret Secure members.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Deseret Secure, insolvency of Deseret Secure, 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 Deseret Secure for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 15-27 months from the date of service. Failure to be timely with claim submissions may result in non-payment. The criteria for Original Medicare submission of claims can be found in section 70 of Chapter 1 of the Medicare Claims Processing Manual located at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>.
- **Prompt Payment** Deseret Secure will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Deseret Secure 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. Deseret Secure will process all non-clean claims and notify providers of the determination within 45 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 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 Deseret Secure at the time of billing.
- Where to submit a claim:
 - For electronic claim submission, please refer to Deseret Mutual's EDI Companion Document at <http://www.dmba.com/provider/hipaaEDI.aspx>.

- For paper claim submission, please send to:

Deseret Mutual
P.O. Box 45530
Salt Lake City, UT 84145

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-877-220-0110.

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 Deseret Secure 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 Deseret Secure, 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 may be used for activities in the following situations: Centers for Medicare & Medicaid Services and Deseret Secure audits of risk adjustment data; Deseret Secure determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; and in order to make advance coverage determinations. Deseret Secure will not use medical record reviews to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

7. Getting an advance coverage determination

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Deseret Secure. To obtain an advance coverage determination, call us at 1-877-220-0110. Deseret Secure will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Deseret Secure 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 1-877-220-0110. We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Deseret Secure can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

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 Deseret Secure, send a written dispute to:

**Deseret Mutual
Attn: Appeals
P.O. Box 45530
Salt Lake City, UT 84145**

or call us at 1-877-220-0110. Additionally, please provide appropriate documentation to support your payment dispute including the remittance advice from Deseret Mutual, rate letters where applicable and all relevant information supporting payment in question. Claims must be disputed within 120 days from the date payment is initially received by the provider.

We will review your dispute and respond to you within 30 days from the time the provider payment dispute is first received by the plan. If we agree with your payment dispute, then we will pay you the additional amount. We will inform you in writing if your payment dispute is denied.

After completing Deseret Secure's dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with First Coast Service Options, Inc., an independent review entity contracted by CMS. First Coast can receive payment dispute decision requests via the following media:

Note: If the submission and associated documents contain any personally identifiable information (PII) or personal health information (PHI) (or any PII/PHI has been redacted), the payment dispute request can only be submitted via fax or mail.

- **Email.** If the submission and associated documents do not contain any PII or PHI (or any PII/PHI has been redacted), the payment dispute decision request can be submitted to a dedicated email box at IREPFFS@FCSO.com.
- **Fax.** A fax number, (904) 361-0551, has been established to receive electronic requests for payment dispute decisions.
- **Mail.** Providers can also mail hard copy requests for payment dispute adjudication to the following address:

First Coast Service Options Inc.
PFFS Payment Disputes
P.O. Box 44017
Jacksonville, Florida 32231-4017

Before submitting a request to First Coast, please review the following CMS documents regarding the payment dispute process and the payment dispute request form.

- First Coast – Summary of Payment Dispute Process
 - First Coast – PFFS Payment Dispute Decision (PDD) Request Form
- These documents can be found online at <http://www.dmba.com/provider/medicare>. For more information about First Coast Service Options Inc., go to <http://fcco.com>.

9. Member and provider appeals and grievances

Deseret Secure members have the right to file appeals and grievances when they have concerns or problems related to coverage or care. Members may appeal a decision made by Deseret Secure 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.

A provider may appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member's appeal process by signing a waiver of liability (promising to hold the member harmless regardless of the outcome). There must be existing potential member liability (e.g., a claim, as opposed to an advance coverage determination, is denied as not a medically necessary or a covered service) in order for a provider to appeal utilizing the member's appeal process. If you appeal on your own right, you agree to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance process.

The Deseret Secure Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. Details of the appeals process can also be found in the Appeals section of the member handbook located on our website at <http://www.dmba.com/nsc/handbooks/senior/SRDeseretSecureBinder09.pdf>. You can call our Member Services Department at 1-800-777-3622 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 who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to:

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

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. For copies of the notice and the notice instructions, go to:
<http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCForm.pdf> and
<http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf>. In addition, the provider should send a copy of any NOMNC issued to:

**Deseret Mutual
P.O. Box 45530
Salt Lake City, UT 84145**

Deseret Secure 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 or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services within the time frames specified by law.

11. If you need additional information or have questions

If you have general questions about Deseret Secure's terms and conditions of payment, contact us at 1-877-220-0110 or via mail to:

**Deseret Mutual
P.O. Box 45530
Salt Lake City, UT 84145**

- If you have questions about submitting claims, call us at 1-877-220-0110.
- If you have questions about plan payments, call us at 1-877-220-0110.