Medi-Pak® Advantage: Terms and Conditions of Provider Participation

Medi-Pak® Advantage is a Medicare Advantage Private Fee-For-Service plan offered by Arkansas Blue Cross and Blue Shield. Medi-Pak® Advantage has been authorized by the Centers for Medicare & Medicaid Services, and is being offered to Medicare members in all 75 counties in Arkansas.

Private-fee-for-service plans, like Medi-Pak® Advantage, combine the benefits of Medicare Part A and B and includes additional services and programs not covered by Medicare. With a private-fee-for-service plan the member should not purchase a traditional Medicare supplement plan like Medi-Pak® offered by Arkansas Blue Cross. Medi-Pak® Advantage members receive benefits for covered services of any doctor, specialist or hospital that accepts Medi-Pak® Advantage's Terms and Conditions.

Providers who do not agree to accept these Terms and Conditions may not provide services to a Medi-Pak® Advantage member unless the services are extended on an urgent or emergency basis.

Highlights of Medi-Pak® Advantage:
- Reimbursement is the same as traditional Medicare.
- The member has just one ID card.
- Claims have to be filed only one time with Arkansas Blue Cross. There is no Medicare supplement claims filing and crossover from Medicare is not necessary.
- CMS billing guidelines for forms and codes as traditional Medicare apply.
- No provider contract is required.
- No prior authorization or referral is required for most services.
- Benefit Summary is available online for applicable member copayments, coinsurance, etc.
- Claims for deemed or emergent services may be filed as any other Arkansas Blue Cross claim including through AHIN.
- Out of state claims should be filed through the local Blue Plan.

Deeming Process:
Except for pharmacies, Medi-Pak® Advantage members are not restricted to a particular provider network, do not need referrals for specialists or other services, and can obtain services from any willing provider in the U.S. who is eligible to be paid under Medicare rules. Arkansas Blue Cross is working with a separate company known as “TMG Health”, which will assist with any claim adjudication and other customer services for Medi-Pak® Advantage members.
Providers who do not agree to accept these Terms and Conditions may not provide services to a Medi-Pak® Advantage member unless the services are extended on an urgent or emergency basis.

Please note that Federal healthcare providers, including the Veterans Administration are not eligible for reimbursement under a Medicare private-fee-for-service plan except for urgent or emergency services.

Under federal CMS regulations, a deemed provider is a physician, hospital or other health care provider who has knowledge of a patient's enrollment in Medi-Pak® Advantage and files a claim for services. A physician, hospital or other health care provider is not required to render services to a Medi-Pak® Advantage member; a decision can be made on a patient-by-patient basis.

However, if care is given and the conditions below are met, the provider will be considered a deemed provider and paid according to the Medi-Pak® Advantage Reimbursement Methodology. All claims from a deemed provider are adjudicated on the basis that the provider is accepting assignment.

Except for pharmacies, Arkansas Blue Cross will not contract with physicians and providers for Medi-Pak® Advantage; rather, providers may choose to become a deemed provider.

Providers are considered deemed when:
1. Providers know before rendering services that a Medicare member is enrolled in Medi-Pak® Advantage. Medi-Pak® Advantage will provide members with an identification or enrollment card that they must show providers each time they receive care.
2. Providers have a reasonable opportunity to obtain Medi-Pak® Advantage Terms and Conditions for participation in the plan. The Terms and Conditions are available through the Arkansas Blue Cross and Blue Shield customer services toll-free number, 1-866-390-3369 and also the Arkansas Blue Cross web site at www.ArkansasBlueCross.com.
3. Providers subsequently render services to that member and file a claim for services.

Providers rendering services to a Medi-Pak® Advantage member and subsequently filing a claim for the member for services to Arkansas Blue Cross, will have the claims adjudicated as a deemed provider. Once a provider has submitted claims for a member, the provider will be considered deemed for all future claims submitted by the provider for that member.

If a provider chooses not to accept the Terms and Conditions, they will only be paid if they treat Medi-Pak® Advantage members for urgent or emergency care and file a claim with Medi-Pak® Advantage. Providers may only collect any applicable copayments or coinsurance from the member, and may not balance bill the member for any additional amounts. Nor may providers balance bill the member for emergency or urgent care.
Except for prescription drugs, the Medi-Pak® Advantage plan reimburses deemed providers as accepting assignment at 100 percent of the current Medicare allowable amount minus any member copayments or coinsurance for all services covered by Medi-Pak® Advantage. All deemed providers will be reimbursed at 100% of the current Medicare allowable whether the provider is participating or non-participating with Medicare and whether the claim is assigned or not assigned.

Providers may collect only the applicable copayment or coinsurance amounts from Medi-Pak® Advantage members and may not otherwise charge or bill the members. Balance billing is prohibited by deemed providers who provide services to Medi-Pak® Advantage members. Copayments or coinsurance should be collected from a member at the time of service. If a provider inadvertently collects more from a member than the designated copayment or coinsurance amount, the provider must refund the difference to the member.

Federal Health Care providers are not eligible for payment for services to Medi-Pak® Advantage members except for urgent or emergency care.

**Providing non-emergency care for Medi-Pak® Advantage members when the provider does not accept the Terms and Conditions:**

Providers who do not accept Medi-Pak® Advantage's Terms and Conditions should not provide services to a Medi-Pak® Advantage enrollee, except for urgent or emergency care.

If the provider chooses to provide services, then they by default have agreed to our terms and conditions of payment and must bill Medi-Pak® Advantage for covered health care services. The provider should collect the appropriate Medi-Pak® Advantage copays or coinsurance from the enrollee at the time of service. The provider may at any time, on a patient-by-patient and visit-by-visit basis, decide that they do not want to treat a Medi-Pak® Advantage enrollee.

**In addition, deemed providers must:**

- Be licensed or certified by the state and be acting within the scope of that license or certification, if applicable.
- Not be sanctioned by Medicare or must not have opted out of Medicare.
- Comply with all Medicare and other federal health care program laws, regulations and program instructions that apply to the services furnished to members, including inspections and audits.
- Not discriminate against Medi-Pak® Advantage members based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Have a Medicare billing number, NPI and (if an Arkansas Provider) an Arkansas Blue Cross provider billing number and submit claims as accepting assignment.
- Be certified to treat Medicare beneficiaries if the provider is an institutional provider.
- Follow the standards for confidentiality and patient privacy rights.
• Agree to comply with all Medi-Pak® Advantage appeal and grievance procedures.
• Comply with all Notice of Medicare Non-Coverage (NOMNC), Detailed Explanation of Non-coverage (DENCs), and Notices of Discharge and Medicare Appeal Rights (NODMAR) submission requirements.
• Notify Medi-Pak® Advantage at 866-390-3369 in the event a Notice of Medicare Non-Coverage (NOMNC), Detailed Explanation of Non-coverage (DENCs), and Notices of Discharge and Medicare Appeal Rights (NODMAR) submission is required. Failure to notify Medi-Pak® Advantage will result in the facility being wholly liable for any costs arising from that failure to notify.
• Agree to notify members of their potential liability for services not covered by Medi-Pak® Advantage.
• Agree to collect from members only the cost-sharing amounts listed in the Summary of Benefits.
• Not balance bill a member.

Deemed providers agree to the guidelines below regarding claims:
• Medi-Pak® Advantage requires all claims be submitted within 365 days from the date of service. The plan will process claims following traditional Medicare billing rules, including prospective payment system requirements. Providers should submit claims using the same coding rules as the traditional Medicare. Submit a separate claim for each member (roster billing is not permitted). Providers should send all claims to Arkansas Blue Cross.
• Agree that in no event, including, but not limited to nonpayment by Medi-Pak® Advantage, Medi-Pak® Advantage insolvency or breach of this Agreement, shall you or your assignees and/or subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members of Medi-Pak® Advantage or persons other than Medi-Pak® Advantage acting on their behalf, for covered services provided to members by you.

This provision shall not prohibit collection of payments for any non-covered services or member cost-share amounts set forth above. You further agree that:
(i) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between you and a member or persons acting on their behalf and
(ii) this provision shall apply to all of your employees, agents, trustees, assignees and subcontractors, and you shall obtain from such persons specific agreement to this provision.

Providers Not Participating with Medicare:
Furnishing services to Medi-Pak® Advantage members as a deemed provider requires that the non-participating Medicare provider knows the patient is in the Medi-Pak® Advantage program and has reasonable access to the plan’s Terms and Conditions, which includes payment and claims submission within these Terms and Conditions information. Deemed non-participating providers with Medicare will be reimbursed as assigned at 100% of the Medicare fee schedule minus any member cost sharing amounts.
**Emergency Situations:**
For providers who do not participate with Medicare, the limiting charge may be applied in emergency or urgent care situations, when the patient is not able to inform the provider they were Medi-Pak® Advantage members and/or the provider could not access the Terms and Conditions.

In these instances, Arkansas Blue Cross will pay the limiting charge and the Medicare approved amount, minus any applicable member cost-sharing amount. Deemed Non-participating providers with Medicare will be reimbursed as assigned at 100% of the Medicare fee schedule minus any member cost sharing amounts.

**Effect of Eligibility Inquiry Responses:**
Each deemed provider agrees that any “verification of benefits” or other eligibility inquiries made prior to, at or after admission or provision of any services to Medi-Pak® Advantage members are not a guarantee of payment. While Arkansas Blue Cross and Blue Shield will endeavor in good faith to report such members’ eligibility information available to Arkansas Blue Cross and Blue Shield within its records or computer systems at the time of admission or provision of services, deemed providers acknowledge and agree that it is not possible to guarantee accuracy of such records or computer entries.

Deemed providers understand and agree that the eligibility of Medi-Pak® Advantage members and coverage for any services shall be governed by the terms, conditions and limitations of the member’s benefit certificate, which shall take precedence over any inconsistent or contrary oral or written representations. If, following any in-patient treatment or other services, it is discovered that premiums had not been paid for a member’s coverage, or that coverage had lapsed or terminated, or was not otherwise available for any reason, no reimbursement shall be due from Arkansas Blue Cross and Blue Shield for such services.