



**GUARDIAN HEALTHCARE'S MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE (PFFS) PLANS  
TERMS AND CONDITIONS OF PAYMENT**

**IMPORTANT NOTE: These Terms and Conditions of Payment apply to the Guardian Healthcare Tribute PFFS Plan, Tribute Enhanced PFFS Plan, and Tribute Pride PFFS Plan for calendar year 2010**

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## 1. Introduction

The Tribute Plan, Tribute Enhanced Plan, and Tribute Pride Plan are Medicare Advantage Private Fee-For-Service (PFFS) Plans offered by Guardian Healthcare, Inc. The Guardian Healthcare PFFS Plans allow 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 the Tribute Plan or Tribute Enhanced Plan 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 Guardian Healthcare PFFS Plan 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 the Guardian Healthcare PFFS Plans. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with the Guardian Healthcare PFFS Plan 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.

## 2. When a provider is deemed to accept the Tribute Plan or Tribute Enhanced Plan terms and conditions of payment

A provider is considered by law to be *deemed* to have a contract with a Guardian Healthcare PFFS Plan 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 a Guardian Healthcare PFFS Plan. All of our members receive a member ID card that includes the Guardian Healthcare Tribute Plan, Tribute Enhanced Plan, or Tribute Pride Plan logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our Provider Service Center at 1-866-850-1253.
- 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 [www.myguardianhealth.com](http://www.myguardianhealth.com). The terms and conditions may also be obtained by calling our Provider Service Center at 1-866-850-1253.
- 3) The provider furnishes covered services to a Guardian Healthcare PFFS Plan member.

If all of these conditions are met, the provider is deemed to have agreed to the Guardian Healthcare PFFS Plan terms and conditions of payment for that member specific to that visit.

**Note:** You, the provider, can decide whether or not to accept the Guardian Healthcare PFFS Plan term and conditions of payment each time you see a Guardian Healthcare PFFS Plan member. A decision to treat one plan member does not obligate you to treat other Guardian Healthcare PFFS Plan members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If a Guardian Healthcare PFFS Plan member shows you an enrollment card identifying him/her as a member of either the Tribute Plan, Tribute Enhanced Plan, or Tribute Pride Plan 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 the Guardian Healthcare PFFS Plan terms and conditions of payment, then you should not furnish services to a Guardian Healthcare PFFS Plan 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 Guardian Healthcare for services provided to one of our PFFS Plan members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Guardian Healthcare, in accordance with HIPAA requirements.
- Submit CMS 1500 or CMS 1450 (UB-04) Claim Form. The appropriate claim form is to be mailed to P.O. Box 4197, Scranton, PA 18505.
- Furnish services to a Guardian Healthcare PFFS Plan member within the scope of your licensure or certification.
- Provide only services that are covered by a Guardian Healthcare PFFS 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 Guardian Healthcare 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 and under any condition, including in the event of plan bankruptcy.

#### 4. Payment to providers

##### Plan payment

Guardian Healthcare reimburses deemed providers at the amount they would have received as participating or non-participating physicians, as applicable, 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. 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, go to our Reimbursement Grid, located on our website at [www.myguardianhealth.com](http://www.myguardianhealth.com).

Services covered under the Guardian Healthcare PFFS Plans that are not covered under Original Medicare are reimbursed using the Guardian Healthcare PFFS Plan fee schedule. Please call us at 1-866-850-1253 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 Tribute Plan, Tribute Enhanced Plan, or Tribute Pride Plan co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Guardian Healthcare 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 one of our PFFS Plans 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).

To view a complete list of covered services and member cost sharing amounts under the

Guardian Healthcare PFFS Plans go to our website at [www.myguardianhealth.com](http://www.myguardianhealth.com) and see the Summary of Benefits for the Tribute Plan, Tribute Enhanced Plan, and Tribute Pride Plan. You may call us at 1-866-850-1253 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under the Tribute Plan, Tribute Enhanced Plan, and Tribute Pride Plan. Be sure to have the member's ID number when you call.

The Guardian Healthcare PFFS Plans follow Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by a Guardian Healthcare PFFS Plan, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. The Guardian Healthcare PFFS Plans do 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 Guardian Healthcare PFFS Plan 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**

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

### **Hold harmless requirements**

In no event, including, but not limited to, nonpayment by a Guardian Healthcare PFFS Plan, insolvency of a Guardian Healthcare PFFS Plan, 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 Guardian Healthcare 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**—Guardian Healthcare will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Guardian Healthcare 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. Guardian Healthcare 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 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 the Tribute Plan or Tribute Enhanced Plan at the time of billing.
- Where to submit a claim:
  - For electronic claim submission, submit claim to Emdeon Payor ID 77010.
  - For paper claim submission, the appropriate claim form is to be mailed to P.O. Box 4197, Scranton, PA 18505.

If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-866-850-1253.

## 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 Guardian Healthcare PFFS Plan 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 Guardian Healthcare, 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 Guardian Healthcare audits of risk adjustment data; Guardian Healthcare PFFS Plan determinations of whether services are covered are reasonable and medically necessary, and whether the plan was billed correctly for the service; and in order to make advance coverage determinations. Guardian Healthcare 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.

To encourage providers to submit member medical records to Guardian Healthcare when necessary, Guardian Healthcare will reimburse the provider for the cost of copying and forwarding requested medical records and/or send plan staff on-site to obtain copies of the desired records.

## **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 a Guardian Healthcare PFFS Plan. To obtain an advance coverage determination, call us at 1-866-850-1253. Guardian Healthcare 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 Guardian Healthcare'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 1-866-850-1253. We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Guardian Healthcare 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 Guardian Healthcare, send a written dispute to P.O. Box

4197, Scranton PA 18505, or call us at 1-866-850-1253. Additionally, please provide appropriate documentation to support your payment dispute e.g., a remittance advice from a Medicare carrier would be considered such documentation. 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 with any interest that is due. We will inform you in writing if your payment dispute is denied.

After completing the Guardian Healthcare 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 an independent entity contracted by CMS. To file a request for review of a payment dispute with the independent entity, you may contact the entity directly at:

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

## **9. Member and provider appeals and grievances.**

Guardian Healthcare PFFS Plan 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 Guardian Healthcare 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 Advantage PFFS Member appeals and grievance process.

The Guardian Healthcare PFFS Plan Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. The member EOC for the Tribute Plan, Tribute Enhanced Plan, and the Tribute Pride Plan is posted under the member link on the member information section of our website located at [www.myguardianhealth.com](http://www.myguardianhealth.com). You can call our Member Services Department at 866-850-1256 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](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 P.O. Box 4197, Scranton PA 18505.

Guardian Healthcare 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 the Guardian Healthcare PFFS Plans terms and conditions of payment, contact us at:

- If you have questions about plan payments, call us at 1-866-850-1253.
- If you have questions about submitting claims, call us at 1-866-850-1253.

You can contact us at our Provider Service Center, Monday through Friday, 8:00 am. until 8:00 pm.