



COVENTRY¹ PRIVATE FEE FOR SERVICE TERMS AND CONDITIONS FOR PROVIDERS

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1. Introduction

Advantra Freedom is a Medicare Advantage private fee-for-service (PFFS) plans offered by the following Coventry Health Care Inc. subsidiaries: First Health Life & Health Insurance Company, Coventry Health and Life Insurance Company and Cambridge Life Insurance Company. Advantra Freedom 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 Advantra Freedom 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 Advantra Freedom 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 Advantra Freedom. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Advantra Freedom 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 *Advantra Freedom’s* terms and conditions of payment

A provider is considered by law to be **deemed** to have a contract with Advantra Freedom 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 Advantra Freedom. All of our members receive a member ID card that includes the Advantra Freedom logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our Provider Services Unit at (800) 713-5095.
- 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.AdvantraFreedom.com. The terms and conditions may also be obtained by calling our Provider Services Unit at (800) 713-5095.
- 3) The provider furnishes covered services to a Advantra Freedom member.

If all of these conditions are met, the provider is deemed to have agreed to Advantra Freedom’s terms and conditions of payment for that member specific to that visit. **Note:** You, the provider, can decide whether or not to accept Advantra Freedom’s terms and conditions of payment each time you see an Advantra Freedom member. A decision to treat one plan member does not obligate you to treat other Advantra Freedom members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If an Advantra Freedom member shows you an enrollment card identifying him/her as a member of Advantra Freedom 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 Advantra Freedom's terms and conditions of payment, then you should not furnish services to an Advantra Freedom 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 Advantra Freedom for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Advantra Freedom, in accordance with HIPAA requirements.
- Agree to bill Coventry for services rendered to Advantra Freedom Members, in accordance with all statutes, regulations, standards and guidelines applicable to Medicare Parts A and B. See Section 5 for how to submit a claim.
- Furnish services to an Advantra Freedom 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 Advantra Freedom 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

Advantra Freedom reimburses deemed providers at the Medicare Allowable Charge, 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.

Coventry reserves the right to establish payment amounts for those services where CMS has not assigned a fee schedule or prospective payment amount that is readily accessible. Payment to providers for which Medicare does not have a publicly published rate may be based on the estimated Medicare amount. CMS periodically examines Coventry's **Advantra Freedom** reimbursement methodology and reviews and approves these payment amounts as part of this review.

Services covered under Advantra Freedom that are not covered under Original Medicare will be reimbursed using a fee schedule determined by Coventry. If a provider's billed charges are less than the established fee schedule, then Advantra Freedom may reimburse the provider at the billed charged amount, less any applicable member responsibility. Please call us at (800) 713-5095 to receive additional information on our fee schedule.

For more detailed information about our payment methodology for all provider types, go to { www.coventry-medicare.coventryhealthcare.com/providers/document-library/index.htm }

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 Advantra Freedom cost sharing, such as co-payments or coinsurance and/or deductibles amounts, described in these terms and conditions. After collecting cost sharing from the member, the provider should bill Advantra Freedom 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).

To view a complete list of covered services and member cost sharing amounts under Advantra Freedom go to { <http://coventry->

[medicare.coventryhealthcare.com/coventrymedicare/current-member-support/member-benefit-information/advantra-freedom/index.htm](https://www.medicare.coventryhealthcare.com/coventrymedicare/current-member-support/member-benefit-information/advantra-freedom/index.htm)},

You may call us at (800) 713-5095 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Advantra Freedom. Be sure to have the member's ID number when you call.

Advantra Freedom follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Advantra Freedom unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Advantra Freedom 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 Advantra Freedom members. For information on Advantra Freedom'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:

- All Transplants, except Cornea Transplants
- Carotid Artery Stenting
- Ventricular Assist Device (VAD) Destination Therapy
- Bariatric Surgery
- Lung Volume Reduction Therapy (LVRT)
- National Oncological PET Registry (NOPR)

We request that you notify us in advance of providing any Part B drugs to an Advantra Freedom Member. The clinical staff of the Advantra Freedom Health Services Department may suggest a Coventry preferred brand or generic form of the requested medication. Coventry Part B drug categories include:

- Drugs that are not usually self-administered, such as those that are typically injected by a physician or other health care provider in an outpatient setting;
- Drugs that are administered or taken using durable medical equipment (such as nebulizers);
- Drugs that are used in immunosuppressive therapy for a Member who has received a Medicare-covered organ transplant;
- Oral anti-nausea drugs used as part of an anti-cancer chemotherapy regimen as full replacement of IV anti-emetic drugs within 48 hours of chemotherapy administration;
- Erythropoietin (EPO) for the treatment of anemia for Members with chronic renal failure who are on dialysis; and
- Radiopharmaceuticals.

We request that you notify us when an **Advantra Freedom** Member is admitted to an acute care facility, although this notification is not required and is not a condition of payment. **Advantra Freedom** wants to assist our Members in maintaining their overall health. Our experience indicates that early intervention with Members who are hospitalized for acute episodes of disease or chronic illness can often prevent repeat hospitalizations and can result in improved follow-up care.

Advantra Freedom 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, you may contact the Advantra Freedom Health Services Department at (866) 865-3148 or by fax (866) 415-2821

Balance billing of members

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

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Advantra Freedom insolvency of Coventry 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 Advantra Freedom 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 Advantra Freedom will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Advantra Freedom will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim. Advantra Freedom will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.

- You agree to bill Coventry for services rendered to Advantra Freedom Members, in accordance with all statutes, regulations, standards and guidelines applicable to Medicare Parts A and B. Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format.
- You agree to 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 Advantra Freedom at the time of billing.
- Where to submit a claim:
 - For electronic claim submission: The Payor ID for electronic claims filing is 25152
 - For paper claim submission: Claims for services rendered to Advantra Freedom Members should be submitted to the address below, which is also printed on the Advantra Freedom Member identification card:

Advantra Freedom
Coventry Health Care
PO Box 7154
London, KY 40742

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at (800) 713-5095.

6 Maintaining Medical Records and Allowing Audits; Copies of Records

Maintaining Medical Records and Allowing Audits

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to Advantra Freedom 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 Advantra Freedom 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 Advantra Freedom audits of risk adjustment data; Advantra Freedom 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. Advantra Freedom 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.

Copies of Medical Records

Provider agrees to promptly provide Advantra Freedom with copies of patient records and documents for purposes of:

- (a) assisting Advantra Freedom in making a determination regarding whether a service is covered by Advantra Freedom;
- (b) administering Advantra Freedom's Quality Improvement, Utilization Review, and Risk Management Programs;
- (c) responding to a request from any State or Federal agency (including, without limitation, the Centers for Medicare and Medicaid Services "**CMS**") or such agencies' subcontractors; or
- (d) for any other reasonable purpose related to the administration of Advantra Freedom or the member's benefits.

Advantra Freedom will reimburse provider for copies of medical records obtained from provider in accordance the rules and the copying fees established by Medicare.

No member shall be required to reimburse provider for any expenses related to providing copies of patient records to Advantra Freedom or to any State or Federal agency.

If a provider fails to submit medical records requested by Advantra Freedom in connection with medical necessity and claim review/audit (either prepayment or post payment) for a claim, then Advantra Freedom may deny the claim (whether the claim was previously paid or not) for failing to provide such 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 Advantra Freedom). To obtain an advance coverage determination, contact the Advantra Freedom Health Services Department at (866) 865-3148 or by fax (866) 415-2821. Advantra Freedom 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 Advantra Freedom 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, please contact the Advantra Freedom Health Services Department at (866) 865-3148 or by fax (866) 415-2821..We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Advantra Freedom 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 Advantra Freedom send a written dispute to Advantra Freedom, Coventry, PO Box 7157, London, KY 40742, fax number: (866)-759-4414 or call us at (800) 713-5095. A copy of our Provider Payment Dispute Resolution Form is available on this website, www.AdvantraFreedom.com. Additionally, please provide appropriate documentation to support your payment dispute e.g., a remittance advice from a Medicare carrier. 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 thirty (30) calendar days. 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 Advantra Freedom'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 an independent entity contracted by CMS called First Coast Service Options, Inc.

To file a request for review of a payment dispute with the independent entity, you may contact First Coast Service Options Inc. (FCSO) directly at:

Email. If the submission and associated documents do not contain any personally identifiable health information (PHI) (or any PHI has been redacted), the payment dispute decision request can be submitted to a dedicated email box at IREPFFS@FCSO.com.

Otherwise, First Coast can receive payment dispute decision requests (including associated documents such as claim forms that may contain PHI) via the following:

Fax. A fax number, (904) 361-0551, has been established to receive electronic request 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, FL 32231-4017

Providers with questions regarding the adjudication process or individual disputes being reviewed by the IRE can contact FCSO at (904) 791-6430. Providers will be able to leave messages and should expect a return call within 48 hours of receipt

9. Member and provider appeals and grievances

Advantra Freedom 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 Advantra Freedom 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 Advantra Freedom Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. The member EOC is posted: under the member benefits link on the member information section of our website located at www.Advantrafreedom.com. You can call our Member Services Department at (866) 386-2330 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>.

Advantra Freedom 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 Advantra Freedom terms and conditions of payment, or questions about submitting claims or plan payments, contact us at (800) 713-5095, or mail us at Advantra Freedom, Coventry Health Care, PO Box 7154, London, KY 40742; fax (866) 415-2832. Hours of Operation are Monday – Friday 8:00 a.m – 10:00 p.m ET.

12. Other

You agree that in no event, including but not limited to, nonpayment by us or our insolvency or breach of these terms and conditions, shall you bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an **Advantra Freedom** Member or persons other than Coventry, for services rendered. This does not prohibit collection of applicable copayments, coinsurance, or deductibles or amounts collected in accordance with the above terms and conditions. You agree that this requirement supersedes any oral or written contrary agreement now existing or hereafter entered into between you and an **Advantra Freedom** Member or a person acting on the Member's behalf.

You agree to immediately refund any amounts collected from an **Advantra Freedom** Member beyond what is allowed under these terms and conditions and applicable Medicare laws and regulations. You agree not to discriminate against **Advantra Freedom** Members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency. You will allow **Advantra Freedom** Members to participate in the decision-making process for their own health care services.

You and your subcontractors agree to abide by all Medicare and other Federal health care program laws, regulations, reporting requirements, and CMS program instructions that apply to the services furnished to **Advantra Freedom** Members.

You understand and agree that payments received by Coventry for the **Advantra Freedom** PFFS Plan from CMS pursuant to Coventry's contract with CMS are Federal funds. As a result, by accepting these Federal funds, you are subject to the laws applicable to individuals/entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 84, the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.