



USA CareSM Terms and Conditions

Introduction

USA Care from Preferred Care is a Medicare Advantage Private Fee For Service plan. It has been authorized by the Centers for Medicare & Medicaid Services, and is being offered to Employer Group Medicare members residing in the United States.

USA Care members are not restricted to a particular provider network, do not need referrals to 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 and who accepts USA Care's Terms & Conditions.

Obtaining an Advance Determination

USA Care asks hospitals or facilities to contact Preferred Care to obtain an Advance Determination for the following:

- Inpatient surgical admissions
- Organ transplants
- Acute rehabilitation admissions
- Inpatient mental health stays
- Inpatient Substance Abuse stays
- Skilled nursing facility stays
- Level of care changes during the above stays
- Elective air transport

Please call 1-800-999-3920, then select option 1 for an Advance Determination.

Claims Submission

Claims should be submitted as soon as possible after a service is provided using the standard CMS-1500, or the UB-04. All Medicare billing guidelines must be followed when submitting claims.

Do not submit claims for USA Care enrollees to Medicare or a Medicare supplement carrier. Claims received by Medicare or a Medicare supplement carrier for these enrollees will be denied.

Physicians, hospitals and other health professionals must submit claims to:

***Claims Submission
Preferred Care
P.O. Box 22920
Rochester, NY 14692-2920***

Additional Claim Submission Information

- The National Provider Identifier (NPI) must be included on all claim submissions to Preferred Care.
- Medicare Assignment indicator must be checked.
- Hospice providers should file claims using their current process.
- USA Care requires all claims be submitted within 365 days from the date of service. The plan processes claims following Original Medicare billing rules, including all prospective payment system requirements. Submit claims using the same coding rules as Original Medicare and use Medicare CPT codes and defined modifiers. Bill diagnosis codes to the highest specificity.

Per CMS guidelines, the Medicare Advantage Organization must pay 95 percent of “clean” claims from non-contracting providers within 30 calendar days of receipt. The Medicare Advantage Organization must pay or deny all non-contracted claims that do not meet the definition of “clean” claims within 60 calendar days of receipt.

Required Data Elements of a “Clean” Claim

A completed “clean” claim must include the following information:

- Enrollee name
- Enrollee’s Preferred Care USA Care identification number
- Date(s) of service

- Procedure/service/supply/revenue/NDC codes
- Diagnosis coding to the highest level of specificity.
- Provider's billing name and address
- Provider's NPI tax identification number, UPIN or Social Security number
- Days/units of service
- Place of service
- Total dollar amount billed
- Other documentation may also be required depending on the type of provider and services billed on a specific claim.

Deeming of Health Care Providers

USA Care enrollees can receive services from any Medicare eligible provider who agrees to be deemed.

Hospitals, physicians and other health care providers are eligible to be deemed providers if they:

- Are licensed or certified by the state in which they practice, acting within the scope of that license or certifications, and have not been sanctioned by, nor opted out of, Medicare.
- Are not a federal health care provider, such as a Veteran's Administration provider. Under federal regulations, federal health care providers are not eligible for reimbursement under a PFFS plan except for providing emergency services to non-veterans.
- Agree to accept the Terms and Conditions outlined in this document and provide services to a USA Care enrollee.

An eligible hospital, physician or provider is automatically considered deemed per CMS regulations when that provider has:

- Provided services to a member and had knowledge of patient enrollment in USA Care in advance of furnishing covered services.
- Possesses or has access to USA Care Terms and Conditions of payment and participation, which are listed in this document and can be obtained by accessing Preferred Care's secured website at www.preferredcare.org/usacare.html or by calling USA Care Provider Services at **1-800-999-3920**.
- Agrees to submit the bill for covered services directly to USA Care.

A provider who does not agree to accept the plan's Terms and Conditions may not provide covered services to a USA Care member.

Payment for Physicians, Hospitals and other Providers

The USA Care plan reimburses deemed providers for medically necessary services covered by the plan up to the Medicare Fee Schedule minus any member copayments or coinsurance for medically necessary services covered by the plan. Member cost-sharing amounts are the responsibility of the member.

If you are a provider who is contracted directly with Preferred Care or MVP Health Plan to provide services to Medicare Advantage members, you will be paid the rates agreed upon in that contract minus any member copayments or coinsurance for medically necessary services covered by the plan.

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

In addition, you must:

- Comply with all Medicare and other federal health care program laws, regulations and program instructions that apply to the services furnished to members. These regulations can be found by directly accessing the cms.gov website or through a link on www.preferredcare.org.
- Have a Medicare billing number.
- Be certified to treat Medicare beneficiaries if you are an institutional provider.
- Follow the standards for confidentiality and patient privacy rights outlined in HIPAA regulations.
- Inform Preferred Care if you believe a facility claim qualifies for an outlier payment. USA Care follows Medicare's methodology in reimbursing outlier payments according to the appropriate prospective payment methodology. Notification to the plan can be made either on the claim, on an attachment, or by phoning Provider Services at 1-800-999-3920 if the claim has already been paid.
- Agree to comply with all USA Care appeal and grievance procedures.
- Provide appropriate written notices to members in advance of services ending including hospitals (acute care, long term care, rehabilitation, mental health and substance abuse), skilled nursing facilities, home health agencies or certified outpatient rehabilitation facilities.

- Agree not to bill members for services we determine are not medically necessary. If you have a question about whether a service would be covered, you may contact Preferred Care to get an Advance Determination of Coverage.

Hold Harmless Provision

Hospitals, physicians and other health care providers agree that in no event, including but not limited to nonpayment by Preferred Care USA Care, shall a provider bill, charge, or seek reimbursement from any USA Care member. This provision does not prohibit providers from collecting charges for non-covered services or cost sharing amounts.

Providers not participating with Medicare

Emergency situations:

For providers who do not participate with Medicare, the limiting charge may be applied in emergency situations, when the patient is not able to inform the provider they were USA Care members and/or the provider could not access the terms and conditions. In these instances, Preferred Care will pay the limiting charge minus any applicable member cost-sharing amount.

Providers not participating with Medicare may apply the limiting charge only one time per patient. Once the patient is known as a USA Care member, the provider will access the Terms and Conditions and decide whether or not to provide services. If the provider accepts the Terms and Conditions and provides services, the limiting charge cannot be applied.

Non-emergency situations

If in a non-emergency situation a provider who does not participate with Medicare is not informed by the patient about membership in USA Care and the provider did not access the terms and conditions, the limiting charge may be applied only once. The provider may not balance bill the patient beyond the Medicare limiting charge.

If you have any questions or concerns about your payment, USA Care Terms and Conditions, or, if you would like more information on USA Care please contact Provider Services at **1-800-999-3920**, or visit our Web site at www.preferredcare.org/usacare.html. Staff is available to assist you Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern Time.