**CONTRACT YEAR 2012 MEDICARE ADVANTAGE**

**PRIVATE FEE-FOR-SERVICE PLAN**

**MODEL TERMS AND CONDITIONS OF PAYMENT**

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12. **Introduction**

# (Plan Name[s]) [is/are] Medicare Advantage private fee-for-service (PFFS) plan[s] offered by (Organization Name). (Plan Name) 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’) [*Insert if applicable*: or eligible to be paid by (Plan Name) 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 (Plan Name) 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 (Plan Name). Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with (Plan Name) 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 organization determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Section 7 describes how a provider can request an advance organization determination from the plan.

[*Partial and full network PFFS plans insert:* (Plan Name) has signed contracts with some providers. These providers are our network providers.]

[*Full network PFFS plans insert:* (Plan Name) has network providers for all Medicare Part A and Part B services [*indicate if network providers are available for any non-Medicare covered services*].]

[*Partial network PFFS plans insert:* (Plan Name) has network providers for [*indicate what category or categories of services for which network providers are available*].]

[*Partial and full network PFFS plans insert:* Our members can still receive services from non-network providers who do not have a signed contract with us, as long as the provider meets the deeming criteria described in Section 2. These deemed contracting providers are subject to all of the terms and conditions of payment described in this document. [*Indicate how the list of network providers can be accessed.*]]

[*Partial and full network PFFS plans should describe whether or not the plan has established any higher cost sharing requirements if the member obtains a covered service from a deemed provider. Insert the following sentence if the plan includes such differential cost-sharing:* The amount of cost sharing a member pays a provider who is not one of our network providers may be more than the cost sharing the member pays a network provider. We indicate the services for which the cost sharing amount differs between network providers and non-network providers in the (Plan Name) Member Evidence of Coverage (EOC).]

1. **When a provider is deemed to accept (Plan name’s) terms and conditions of payment**

A provider is deemed by law to have a contract with (Plan name) 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 (Plan Name). [*Insert if applicable:* All of our members receive a member ID card that includes the (Plan Name) logo that clearly identifies them as PFFS members.] The provider may validate eligibility by calling our [*revise as necessary*: Provider Service Center] at [*insert contact number*]. [*If applicable: insert additional instructions for how providers can determine member eligibility.*]
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 [*insert link for terms and conditions*]. The terms and conditions may also be obtained by calling our [*revise as necessary*: Provider Service Center] at [*insert contact* *number*].
3. The provider furnishes covered services to a (Plan Name) member.

If all of these conditions are met, the provider is deemed to have agreed to (Plan Name’s) terms and conditions of payment for that member specific to that visit. For example: If a (Plan Name) member shows you an enrollment card identifying him/her as a member of (Plan Name) 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).

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

**If you DO NOT wish to accept (Plan Name’s) terms and conditions of payment, then you should not furnish services to a (Plan Name) member, EXCEPT for emergency services.** **If you 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-contracting providers and paid at the payment amounts they would have received under Original Medicare.

1. **Provider qualifications and requirements**

In order to be paid by (Plan Name) for services provided to one of our members, you must:

* Have a National Provider Identifier in order to submit electronic transactions to (Plan Name), in accordance with HIPPA requirements.
* [*Describe rules for providers submitting non-electronic transactions*.]
* Furnish services to a (Plan Name) 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 (Plan Name) 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 [*insert if applicable:* permitted balance billing] under any condition, including in the event of plan bankruptcy.
* [*If the plan has specific provider requirements for supplemental services, list here. CMS pre-approval is required.*]

1. **Payment to providers**

**Plan payment**

(Plan Name) reimburses deemed providers at [*describe plan payment to providers (Note: all PFFS plans must pay deemed providers at least the amounts they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services, including billing up to the limiting charge for non-participating physicians)*], minus any member required cost sharing, for all medically necessary services covered by Medicare. (Plan Name) will pay Physician Quality Reporting Initiative (PQRI) bonus and e-prescribing incentive payment amounts to deemed physicians who would receive them in connection with treating Medicare beneficiaries who are not enrolled in a Medicare Advantage plan.

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. [*Insert if applicable*: 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 [*insert link to proxy grid*].

[*Insert if applicable:* Services covered under (Plan Name) that are not covered under Original Medicare are reimbursed using the following fee schedule located at [*Insert link*].] [*As an* *alternative to the previous sentence, plan may use*: Services covered under (Plan Name) that are not covered under Original Medicare are reimbursed using (Plan Name)’s fee schedule. Please call us at [*insert contact number*] 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 (Plan Name) co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill (Plan Name) for covered services. Section 5 provides instructions on how to submit claims to us. Please note, however, that (Plan Name) may not hold members accountable for any cost-sharing (deductibles, copayments, coinsurance) for Medicare-covered preventive services that are subject to zero cost sharing.

If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a State Medicaid program), then the provider cannot collect any cost sharing for Medicare Part A and Part B services from the member at the time of service when the State is responsible for paying such amounts (nominal copayments authorized under the Medicaid State plan may be collected). Instead, the provider may only accept the MA plan payment (plus any Medicaid copayment amounts) as payment in full or bill the appropriate State source.

[*EGWPs and MAOs using this document for multiple PFFS plans may exclude the quick reference table*] For your quick reference, the table below lists some of the important services covered under (Plan Name) and the associated member cost sharing amounts.

|  |  |
| --- | --- |
| [***Revise list as necessary, including all Medicare-covered preventive services for which there is zero cost share under Part B*]Services covered by (Plan Name)** | **[*Revise amounts as necessary and also indicate cost sharing if prior notification requirements apply*] The amount(s) you may charge the plan member** |
| Medicare-covered preventive services, for example:   * Annual wellness visit * Cardiovascular screening * Diabetes screening * Immunizations * Mammography * Cervical cancer screening * Colon cancer screening * Prostate cancer screening * Smoking cessation | * $0 copay |
| Inpatient hospital services | * $400 per admittance * $300 if member pre-notifies |
| Skilled nursing facility | * $100 per admission * $0 if member pre-notifies * $75 per day per admit for days 21-100 * $2000 out of pocket max |
| Office services (Physician, specialist, chiropractic & podiatry) | * $5 primary care per visit * $15 specialist care per visit |
| Physical Exams (1 per year) | * $5 primary care per visit * $15 specialist care per visit |
| Emergency room visit | * $50 * $0 if admitted |
| Urgent care center visits | * $5 per visit |
| [*Include supplemental services if applicable*] |  |

[*EGWPs may exclude this sentence:* To view a complete list of covered services and member cost sharing amounts under (Plan Name), go to [*add link to SB*].] You may call us at [*insert contact number*] to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under (Plan name). Be sure to have the member’s ID number when you call.

(Plan Name) follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by (Plan Name), unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. (Plan Name) does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. There are no prior authorization and prior notification rules for (Plan Name) 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**

There are two different PFFS balance billing scenarios:

* + If the provider is deemed and a non-participating provider under Original Medicare rules, up to 15% balance billing is permitted.  However, the plan – not the beneficiary – must pay the 15%.
  + If the provider is deemed or contracted, and the balance billing is explicitly included in (Plan Name’s) contract with the provider or in the terms and conditions of payment, it may balance bill up to 15% of the total plan payment amount for services, for which the beneficiary is responsible.

[*Insert this paragraph if plan prohibits balance billing*] A provider may collect only applicable plan cost sharing amounts from (Plan Name) members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to (Plan Name) members.

[*Conversely, insert this paragraph if plan allows balance billing*] In addition to collecting applicable plan cost sharing amounts from (Plan Name) members, you may balance bill the member up to [*insert balance billing amount of 15 or less*] % of the total plan payment amount for the service(s) furnished. [*If balance billing is allowed only for certain services, list those services.*]Note that (Plan Name) does not permit a provider to balance bill a member who is also enrolled in a state Medicaid program and as a result the beneficiary is held harmless from Medicare cost sharing.

[*Insert this paragraph if the plan allows hospitals to balance bill*] If you are a hospital provider that intends to impose balance billing, you must provide the following to a (Plan Name) member before furnishing any hospital services for which the balance billing amount could be greater than $500: (1) a notice that balance billing is permitted for those services; (2) a good faith estimate of the likely amount of balance billing based on the member’s presenting condition; and (3) the amount of any deductible, coinsurance, and co-payment that may be due in addition to the balance billing amount.

[*Insert if applicable*: You must also provide a notice of anticipated cost sharing for the following additional services: [*describe type(s) of service and cost sharing threshold for providing a notice*].]

**Hold harmless requirements**

In no event, including, but not limited to, nonpayment by (Plan Name), insolvency of (Plan Name), 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 [I*nsert if applicable when plan allows balance billing:* in addition to allowed balance billing amounts] 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.

1. **Filing a claim for payment**

* You must submit a claim to (Plan Name) for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 1 calendar year after the date of service [*Optional*: (*insert date range*)]. Failure to be timely with claim submissions may result in non-payment. The rules for submitting timely claims under Original Medicare can be found at <https://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf>.
* **Prompt Payment** (Plan Name) will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, (Plan Name) 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. (Plan Name) will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.
* [*Revise as necessary*: Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format.]
* [*Revise as necessary*: 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.]
* [*Revise as necessary*: 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>. [*Revise as* *necessary*: Providers should identify primary coverage and provide information to (Plan Name) at the time of billing.]
* Where to submit a claim:
  + For electronic claim submission, [*insert instructions*].
  + For paper claim submission, [*insert instructions*].
* If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at [*insert contact number*].

1. **Maintaining medical records and allowing audits**

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to (Plan Name) 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 (Plan Name), 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 will primarily be used for Centers for Medicare & Medicaid Services (CMS) audits of risk adjustment data upon which CMS capitation payments to (Plan Name) are based. [*Indicate whether or not plan will reimburse the provider for the cost of furnishing member medical records for government-related activities*.] [*Insert if applicable:* To encourage providers to submit member medical records to (Plan Name) in this case, (Plan Name) 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 records it is requesting.] [*Insert if plan will not* *provide reimbursement*: Providers are required to furnish member medical records without charge when the medical records are required for government use.]

(Plan Name) may also request records for activities in the following situations: (Plan Name) audits of risk adjustment data, determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; to investigate fraud and abuse; and in order to make advance coverage determinations. [Plan Name] will not use these records for any purpose other than the intended use.  [*Indicate whether or not plan will reimburse the provider for the cost of furnishing member medical records for plan-related activities*.] [*Insert if applicable:* To encourage providers to submit member medical records to (Plan Name) in this case, (Plan Name) 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 records it is requesting.]

(Plan Name) will not use medical record reviews to create artificial barriers that would delay payments to providers. Both mandatory and voluntary provision of medical records must be consistent with HIPAA privacy law requirements.

# Getting an advance organization determination

Providers or plan enrollees may obtain a written advance coverage determination (known as an organization determination) from us before a service is furnishedto confirm whether the service will be covered by (Plan Name). To obtain an advance organization determination, [*revise as necessary:* call us at [*insert contact number*]or fill out theform located at [*insert link*] and fax it to[*insert fax number*]. (Plan name) will make a decision and notify you and the member within 14 days of receiving the request, with a possible (up to) 14-day extension either due to the member’s request or (Plan Name) 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, [*revise as necessary:* call us at [*insert contact number*]or fill out theform located at [*insert link*] and fax it to[*insert fax number*]. We will notify you of our decision as expeditiously as the enrollee’s health condition requires, but no later than 72 hours after receiving the request, unless we invoke a (up to) 14-day extension either due to the member’s request or (Plan Name) justification (for example, the receipt of additional medical evidence may change (Plan Name) decision to deny) that the delay is in the member’s best interest.

In the absence of an advance organization determination, (Plan Name) can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan (e.g., was not medically necessary). However, providers have the right to dispute our decision by submitting a waiver of liability (promising to hold the member harmless regardless of the outcome), and exercising member appeal rights (see the Federal regulations at 42 CFR Part 422, subpart M, or Chapter 13 of the Medicare Managed Care Manual).

1. **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 (Plan Name), [*revise as necessary:* send a written dispute to [*insert address, email, and/or fax number*] or call us at [*insert contact number*]. [*Optional*: A copy of our Provider Payment Dispute Resolution Form is available [*describe where this document can be obtained*].] Additionally, please provide appropriate documentation to support your payment dispute [*revise as necessary:* e.g., a remittance advice from a Medicare carrier would be considered such documentation]. [*Plans that are meeting access requirements by paying providers at least the amount they would have received under Original Medicare insert:* Claims must be disputed within 120 days from the date payment is initially received by the provider.] [*All other plans insert*: Claims must be disputed within [*insert time frame: CMS recommends 120 days from the date payment is initially received by the provider*].] Note that in cases where we re-adjudicate a claim, for instance, when we discover that we processed it incorrectly the first time, you have an additional 120 days from the date you are notified of the re-adjudication in which to dispute the claim.

We will review your dispute and respond to you within [*insert time frame: CMS recommends 30 days from the time the provider payment dispute is first received by the plan*]. If we agree with the reason for your payment dispute, we will pay you the additional amount you are requesting, including any interest that is due. We will inform you in writing if our decision is unfavorable and no additional amount is owed.

After (Plan Name)’s payment dispute resolution process is completed, if you still believe that we have reached an incorrect decision regarding payment on your claim, you may file an additional request for review with an independent review organization contracted by CMS. To file this additional request for review of a payment dispute with the independent review organization, you may contact the Payment Dispute Resolution Contractor (PDRC) directly at:

C2C Solutions, Inc.

Payment Dispute Resolution Contractor

P.O. Box 44017

Jacksonville, FL 32231-4017

The PDCR may also be reached by email at [PDRC@C2Cinc.com](mailto:PDRC@C2Cinc.com), by fax at (904) 361-0551, or by phone at (904) 791-6430. You will be required to submit specific information for your request to the PDRC to be considered valid. Note that you must first complete (Plan Name)’s payment dispute resolution process before you can request a review by the independent review organization.

1. **Member and provider appeals and grievances**

(Plan Name) members have the right to file appeals and grievances with (Plan Name) when they have concerns or problems related to coverage or care. Members may appeal a decision made by (Plan Name) 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 not related to the provision or payment for health care.

A physician who is providing treatment may, upon notifying the member, appeal pre-service organization determinations to the plan on behalf of the member.  The physician may also appeal a post-service organization determination as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal using the member appeal process.  There must be potential member liability (e.g., an actual claim for services already rendered and denied in whole, as opposed to an advance organization determination or a partially paid claim), in order for a provider to appeal a post-service organization determination utilizing the member appeal process.

A non-physician provider may appeal an organization determination on behalf of the member as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal a post-service organization determination (e.g., claims using the member appeal process.  As noted above, there must be potential member liability in order for a provider to appeal a post-service organization determination utilizing the member appeal process.

If a provider appeals using the member appeal process, the provider agrees to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance processes.

The (Plan Name) Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. [*EGWPs may exclude this sentence:*  The member EOC is posted [*revise as necessary:* under the member benefits link on the member information section of our website located at [*add link*]].] You can call our[*revise as necessary:* Member Services Department] at [*insert contact number*] for more information on our member appeals and grievance policies and procedures.

1. **Providing members with notice of their appeals rights – Requirements for Hospitals, SNFs, CORFs, and HHAs**

Hospitals must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing *An Important Message from Medicare About Your Rights* (IM), including complying with the time frames for delivery. For copies of the notice and additional information regarding IM notice and delivery requirements, go to:

<http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp>.

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, about their right to appeal a termination of services decision by complying with the requirements for providing the *Notice of Medicare Non-Coverage* (NOMNC), including complying with the time frames for delivery. For copies of the notice and the notice instructions, go to: <http://www.cms.gov/BNI/09_MAEDNotices.asp>.

As directed in the instructions, the NOMNC should contain (Plan Name)’s contact information somewhere on the form (such as in the *additional information* section on page 2 of the NOMNC).

[*Insert this paragraph if plan provides members with the Detailed Notice of Discharge and Detailed Explanation of Non-coverage*] (Plan Name) 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 (Detailed Notice of Discharge) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (Detailed Explanation of Non-coverage) within the time frames specified by law. For copies of the notices and the notice instructions, go to: <http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp>

and <http://www.cms.gov/BNI/09_MAEDNotices.asp>.

[*Insert this paragraph if plan delegates responsibility for providing members with the Detailed Notice of Discharge and Detailed Explanation of Non-coverage*]Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities, or skilled nursing facilities must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge (Detailed Notice of Discharge) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (Detailed Explanation of Non-coverage) within the time frames specified by law. For copies of the notices and the notice instructions, go to: <http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp>

and <http://www.cms.gov/BNI/09_MAEDNotices.asp>.

1. **If you need additional information or have questions**

If you have general questions about (Plan Name’s) terms and conditions of payment, contact us at [*insert contact information – include a toll-free number, complete street address and/or P.O. Box ,hours of operation, fax number, name of unit, and plan representative*].

* If you have questions about submitting claims, call us at [*insert contact number*].
* If you have questions about plan payments, call us at [*insert contact number*].