

HEALTHPARTNERS® LIBERTY MEDICARE PLAN
Private Fee For Service
Terms and Conditions of Participation

HealthPartners® Liberty Medicare plan is a Medicare Advantage Private Fee for Service (PFFS) Plan offered by HealthPartners. Under the HealthPartners® Liberty Medicare plan, HealthPartners does not have written contracts with physicians, hospitals or other health care providers to render covered services to members. Rather, any eligible physician, hospital or other health care provider may choose to provide services to a HealthPartners® Liberty Medicare plan member.

To be eligible to receive payment from HealthPartners® Liberty Medicare plan for furnishing services to members, a physician, facility or other health care provider must:

- Be licensed or certified by the state and be acting within the scope of that license or certification,
- Be eligible to receive, or has received, a Medicare billing number,
- Not be sanctioned, excluded from participation in, or have opted out of Medicare,
- Be a deemed provider (as explained below), and
- For institutional providers such as hospitals and skilled nursing facilities, be certified to treat Medicare beneficiaries.

Physicians, hospitals and other health care providers who choose to provide services to HealthPartners® Liberty Medicare plan members are “deemed” participating providers when:

- They have knowledge that a Medicare beneficiary is enrolled in the HealthPartners® Liberty Medicare plan,
- They have a reasonable opportunity to obtain HealthPartners’ Terms and Conditions specified in this document, and
- They subsequently render services to that member.

Once these conditions are met, physicians, hospitals and other health care providers will receive reimbursement for any covered services provided to a HealthPartners® Liberty Medicare plan member based on Medicare rules and fee schedules, subject to the Terms and Conditions in this document.

- A physician or provider who does **not** agree to accept these Terms and Conditions may **not** provide services to a HealthPartners® Liberty Medicare plan member and bill the member.
- Federal healthcare providers, including the Veterans Administration, are not eligible for reimbursement from HealthPartners® Liberty Medicare plan, except when providing emergency care.

HealthPartners will pay physicians and providers the equivalent of one hundred percent (100%) of the current Medicare allowable less any member cost sharing. Payments received from HealthPartners are in whole or in part from federal funds.

Please visit the HealthPartners provider portal at healthpartners.com/providers and look under Information to review the current payment methodologies for this plan or click on this link: [HealthPartners - Provider](#) to get to the HealthPartners provider home page. Information regarding

CMS Fee Schedules can be reviewed by visiting cms.hhs.gov/FeeScheduleGenInfo/ or clicking on this link:

[CMS PFFS Fee Schedule Info](#)

PHYSICIANS AND OTHER HEALTH CARE PROVIDERS MUST:

- Comply with all Medicare and other federal health care program laws, regulations and program instructions that apply to the services furnished to members.
- Issue the Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC) as applicable and when appropriate. These notices can be accessed via the CMS web site at <http://www.cms.hhs.gov/MMCAG/>.
- Not balance bill members, and collect from members only the member's HealthPartners® Liberty Medicare plan cost sharing amounts (as set forth below).
- Agree that in no event, including, but not limited to, nonpayment by HealthPartners, insolvency of HealthPartners or breach of these Terms and Conditions, shall a 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 services provided under these Terms and Conditions.
 - This provision does not prohibit the collecting of the appropriate co-payments or coinsurance
 - This provision does not prohibit the collecting of fees for services not covered under the member's benefit contract if, prior to providing the services, you explain to the member that the services are not covered and that the member will be financially liable for the services. You must also obtain the member's written acknowledgement of financial liability.
 - Covered benefits for members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the member's continued confinement in an inpatient facility is no longer medically necessary.
- Not 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 HealthPartners to get an advance Determination of Coverage. Call the Medical Management Triage Line at 952-883-6333 or toll free at 877-499-7888 to request an Organizational Determination.
- Maintain medical, financial and administrative records related to services provided to members or any other provider obligations as required by applicable state or federal laws or regulations or as may be necessary to document care provided to members.
- Obtain a signed, written consent, in accordance with applicable law, from each member authorizing the release of patient information including demographic, medical and/or health care information to HealthPartners, its related organizations, affiliates or their respective designees for purposes of treatment, payment, and health care operations, including claims processing, reimbursement, utilization review, case management, disease management, quality review or regulatory review.

OTHER REQUIREMENTS

Physicians, hospitals and other health care providers who render services to HealthPartners® Liberty Medicare plan members must adhere to all industry standards, and all state and federal laws, regulations and requirements.

The privacy of our members is important to HealthPartners. Information about members of the HealthPartners® Liberty Medicare plan must be maintained and only disclosed in accordance with applicable state laws related to privacy and access to health records and the standards for Privacy and Security of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all HIPAA regulations as currently drafted and as may be subsequently updated, amended, or revised.

BILLING INFORMATION

HealthPartners pays clean claims within 30 days of receipt of the claim. HealthPartners requires all claims to be submitted within 365 days from the date of service. A clean claim must be received by HealthPartners before the 365-day period has expired. A clean claim means a claim that has no defect, impropriety, or lack of any required substantiating documentation. HealthPartners processes claims following Medicare billing rules, including all prospective payment system requirements.

In accordance with Medicare Secondary Payer rules, HealthPartners is precluded from paying a member's medical expenses where payment has been made or can reasonably be expected by another liable party which includes one or more of the following:

- Employer group health plan
- Worker's compensation
- No-fault or liability insurer
- Federal Black Lung Program

Please ensure that you are billing the correct primary payer prior to submitting a claim to HealthPartners. When submitting a claim for secondary payment, include primary payer's Explanation of Payment (EOP).

For Medicare-covered services, submit claims using the same coding rules as Medicare and use HCPCS, CPT codes and defined modifiers. Please follow all Medicare billing guidelines for proper claim submission of Medicare-covered services.

For information regarding electronic claim submission, please visit: [HealthPartners.com/providers/electronic transactions](http://HealthPartners.com/providers/electronic_transactions) or click this link: [Explore Electronic Transactions](#). Providers are required to contact these intermediaries directly to register/enroll for electronic claim submission and to obtain a Payer ID.

Additionally, paper claims should be submitted to:

HealthPartners
P.O. Box 1289
Minneapolis, MN 55440-1289

When HealthPartners pays you for covered services, we will deduct the member's applicable cost sharing from your payment. All physicians, hospitals and other health care providers who render services to HealthPartners® Liberty Medicare plan members must accept HealthPartners' payment plus the member's applicable cost sharing as payment in full. You may not balance bill the member for any greater amount.

NATIONAL PROVIDER IDENTIFIER

All physicians, hospitals and other health care providers billing HealthPartners will be required to submit their NPI, regardless of whether they bill electronically, by May 23, 2008.

APPEALS AND GRIEVANCES

HealthPartners® Liberty Medicare plan maintains two systems for appeals and grievances – one for members and one for our deemed providers. Members may submit appeals and grievances to HealthPartners in accordance with the policies and procedures outlined in their evidence of coverage. Deemed Providers must cooperate with HealthPartners in resolving member appeals and grievances by providing necessary information in a timely manner. Physicians may assist members with appeals if the member asks the Physician to be their authorized representative, to the extent allowed under Medicare Advantage law, and in cases in which a Physician believes that an expedited decision is necessary because resolving an appeal in the standard timeframe would jeopardize the member's life or health or ability to regain maximum function.

HealthPartners also maintains an appeals process for providers. If providers wish to appeal a payment decision they should call Riverview Provider Services at 952-883-7666 or toll free at 888-663-6464.

HEALTHPARTNERS® LIBERTY MEDICARE PLAN BENEFITS AND COST SHARING

Benefit	Member Cost Sharing
Out of Pocket Maximum	\$4,000 per year
Inpatient Hospital	\$150 per day for days 1-10 \$0 per day for days 11 – 90
Inpatient Psych	\$150 per day for days 1-10 \$0 per day for days 11-90
SNF	\$0 Days 1-7; \$100 per day for days 8-100
Comprehensive Outpatient Rehab Facility (CORF)	20%
Home Care	\$0 copay
Emergency and Urgently Needed Care	\$50 within the US; 20% outside the US
Outpatient Hospital	20%
Physician Services	\$15 Primary Care; \$30 Specialty care
Chiropractic	\$30
OT, PT, ST	20%
Outpatient Mental Health and substance abuse services	50% both group and individual
Podiatry Services	\$30 Limited to Medicare covered services
Outpatient Diagnostic Procedures/Lab Services/Tests/Therapeutic Radiation	0-20% Varies by type of test/procedure ex. X-rays in office 100%; MRI 20%

Ambulatory Surgical Center (ASC)	20%
Cardiac Rehab	\$30
Ambulance	20%
DME/Prosthetics/Med Supplies	30%
Renal Dialysis	20%
Blood	\$0 3 pint deductible waived
Health Education and Wellness	\$0
Preventive Exams	\$15 per visit; 1 visit per year covered
Preventive Services Pap/Pelvic Prostate Screening Colorectal Screening Mammography	No copay
Bone Mass Measurement	20%
Diabetes Monitoring	\$30
Nutrition Therapy	\$30
Medicare Part B Drugs	20%
Medicare covered Dental	20%
Medicare covered Eye and hearing exams	20%
Part D – Basic Alternative	\$100 Brand Deductible Up to Initial Coverage Limit: \$9/\$35/25% Gap Coverage: No coverage Catastrophic: \$2.25/\$5.60

Please note: HealthPartners also offers group Liberty coverage. Please contact HealthPartners Provider Services at 1-888-663-6464 for more information.

QUESTIONS

If you have any questions or concerns about HealthPartners Terms and Conditions, your payment, or if you would like more information on the HealthPartners® Liberty Medicare plan, please contact Riverview Provider Services at 952-883-7699 or toll free at 888-663-6464. Staff is available to assist you Monday through Friday, 7:30 a.m. to 6:00 p.m. (CT).

PAYMENT METHODOLOGIES

SERVICE	BENEFIT	PAYMENT METHODOLOGY
AMBULANCE	Payment for covered Ambulance services will be reimbursed at 100% of the CMS Ambulance Fee Schedule	This applies to both Ground and Air Ambulances.
ANESTHESIA	Anesthesia services will be reimbursed at 100% of the Medicare payment, which uses a system of base units, time units, and anesthesia conversion factor for a specific locality.	

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)	Payment for covered services will be reimbursed at 100% of the CMS Medicare Physician Fee Schedule.	
CRITICAL ACCESS HOSPITAL (CAH)	Critical Access Hospitals are excluded from IPPS and OPPTS. Payment will be made at 100% of the rate payable under Medicare.	To expedite claims payment, the CAH should submit the cost report or interim rate letter prior to or with the claim
DME, PROSTHETIC DEVICES, AND SUPPLIES	Payment for covered DME will be at 100% of the CMS Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule	
HOME HEALTH CARE (HH)	Payment for covered Home Health Care will be reimbursed at 100% of the CMS Home Health Prospective Payment System.	
HOSPICE	Hospice care is reimbursed by CMS Medicare	
INPATIENT OUTLIERS	Payments made in accordance with CMS guidelines	
INPATIENT SERVICES	Payment for covered inpatient services will be reimbursed at 100% of the CMS Medicare DRG Rate.	Acute LTC, Inpatient Mental Health, Inpatient Rehabilitation, and Inpatient Psychiatric Hospitals
OUTPATIENT SERVICES	Payments for covered outpatient services will be reimbursed at 100% of CMS Medicare APC payment. Services excluded from APC payment will be reimbursed at 100% of the applicable CMS fee schedule.	
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH/LANGUAGE THERAPY	Payment for covered services will be reimbursed at 100% of the CMS Physician Fee Schedule.	
PHYSICIAN SERVICES	Payment for covered services will be reimbursed at 100% of the CMS Physician Fee Schedule.	MD, DO, Chiropractor, Dentist, Optometrist, Oral and Maxillofacial Surgeon, Podiatrist.
SKILLED NURSING FACILITY (SNF)	Payment for covered SNF services will be reimbursed at 100% of the CMS SNF Prospective Payment System	