



PQRI Information Available

A new CMS web page dedicated to providing information on the Physician Quality Reporting Initiative (PQRI) is now available.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative. For more information, visit <http://www.cms.hhs.gov/pqri> on the CMS website.

MLN Matters Number: MM5349

Related Change Request (CR) #: 5349

Related CR Release Date: February 2, 2007

Effective Date: July 1, 2007

Related CR Transmittal #: R1175CP

Implementation Date: July 2, 2007

Note: This article was revised on July 27, 2007 to note that CR 5349 has been rescinded and fully replaced by CR5538, which may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1219CP.pdf> on the CMS website. The related article (MM5538) may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5538.pdf> on the CMS website.

Part C Plan Type Description Display on Medicare's Common Working File (CWF)

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH)

Provider Action Needed

Be aware of the expanded list of MA Plan Type Descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

A plan directory, which is quite descriptive, contains the list of all active Medicare contracts and their corresponding plan type. The directory is posted at <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/> on the CMS website.

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare's CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the Medicare Advantage program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in Private Fee-for-Service (PFFS) plans. PFFS plans are very different from the more traditional MA HMO type plan.

PFFS PLANS

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures, including
 - The amount the provider is permitted to collect from the enrollee; and
 - Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a web site and also make them available upon written or phoned request.

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To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation.

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" Downloadable document on <http://www.cms.hhs.gov/PrivateFeeForServicePlans/> on the CMS website.

Additional Information

If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/> on the CMS website. CMS updates this site on a monthly basis.

To view the official instruction (CR5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf> on the CMS website.

To review a related article that explains Medicare's Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf> on the CMS website.

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