Payment Dispute Resolution Contractor (PDRC) Process Manual

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CHAPTER 1
INTRODUCTION TO PAYMENT DISPUTES

Medicare Overview

Medicare is a nationwide, federal health insurance program enacted in 1965 as Title 18 of the Social Security Act (the Act). Medicare provides health insurance for people 65 years of age or older, certain younger disabled persons, and persons with permanent kidney failure (end-stage renal disease). Medicare serves an estimated 42.5 million beneficiaries and processes more than 1.1 billion claims and 3.1 million appeals per year. Beneficiaries may choose between the original fee-for-service Medicare program and a private health plan option referred to as the Medicare Advantage Program. The Medicare program consists of four parts:

- Hospital insurance, also known as Part A
- Supplementary medical insurance, also known as Part B
- Medicare Advantage (private plans that provide Parts A and B benefits), also known as Part C
- Medicare Part D (prescription drug coverage)

Medicare Advantage Overview

A Medicare Advantage (MA) health plan is a plan offered by a state licensed risk bearing entity, which has a yearly contract with the Centers for Medicare & Medicaid Services (CMS) to provide beneficiaries with all their Medicare benefits plus any additional benefits the company decides to provide. MA Plans include HMOs, PPOs, and PFFS (Private Fee For Service) plans. For PFFS plans, please note that people who join a PFFS MAO are not required to use a network of providers. Beneficiaries can see any provider who is eligible to receive payment from Medicare and agrees to accept payment from the PFFS MAO. PFFS MAOs are required to have easily accessible and understandable provider Terms & Conditions and dispute resolution processes. Under regulation 422.114(a)(i) CMS determined that a MAO meets access to service under the MA Private Fee For Service plan if it has “payment rates that are not less than the rates that apply under original Medicare for the provider in question”. The Independent Review Entity for PFFS Payment Disputes has been established to adjudicate PFFS Payment Disputes between a MAO and deemed or non-contracted providers.

Deemed Provider or Supplier (PFFS only): For purposes of this section, a “deemed provider or supplier” is a physician or other practitioner, a facility, or other entity that has agreed to accept the MAO PFFS Plan’s terms and conditions on all items or services payable by the MAO PFFS Plan. An entity identified as deemed means the provider or supplier has read and agreed to accept the MAO Private Fee For Service Plan’s Terms and Conditions.

Non-Contracted Provider or Supplier: For PFFS plans, a non-contracted provider would be one who provided emergency services to a MAO plan member without first reading and agreeing to the MAO Plan’s Terms & Conditions. For all other MAO plans, a provider is considered non-contracted when there is not a signed contract/agreement between the provider and the specific MAO plan (HMO, PPO, etc). For example, a provider may be contracted under a MAO’s HMO plan, but be considered non-contracted for services rendered to a PPO plan member.

The Dispute Processes

MAO Plan Original Processing and Dispute Process

MAO plans were established to be an alternative to Original Medicare and are not a Medicare Supplement Policy. The Medicare Advantage HMO and PPO plans allow payment to contracted providers based on contracted rates. Payment dispute request for MAO HMO and PPO claims may only be made by a provider who is not contracted with the specific MAO Plan. For PFFS plans, payments for services are generally based on Original Medicare reimbursement methodologies and Medicare Advantage payment rules. A beneficiary may generally obtain health services from any institution, agency, or person qualified to participate in the Medicare program that undertakes to provide services to the individual and has agreed to the MAO PFFS Plan's terms and conditions. After the care is provided, the provider or supplier submits a claim for benefits to the appropriate MAO PFFS Plan. If the claim is for an item or service that falls within a Medicare benefit category, is medically reasonable and necessary for the individual, and is not otherwise statutorily excluded, then the MAO PFFS Plan pays a deemed provider's claim at no less than the rates specified in the plan's terms and conditions and pays a non-contracted provider no less than the rates of Original Medicare.

However, sometimes a deemed or non-contracted provider or supplier may determine that the MAO Plan did not pay a claim correctly. When a deemed or non-contracted provider or supplier notifies a MAO Plan that a claim was incorrectly reimbursed, the MAO Plan performs a Payment Review Determination (1st level review) of the claim to determine if the reimbursement was correct.

Time Frames for Payment Disputes

A provider or supplier has the right to dispute a reimbursement decision made by a MAO Plan. The time frames are set by the individual plans and should be available on a MAO Plan's website. Generally, the time frame for disputing a reimbursement issue to the MAO Plan is 120 days from the initial determination date.

After the MAO Plan makes its Payment Review Determination decision, if a deemed or non-contracted provider or supplier still disagrees with the pricing decision of a MAO Plan, a request for an independent Payment Dispute Decision (PDD) may be submitted to the PDRC in writing within 180 days of written notice from the MAO Plan of its Payment Review Determination.

The independent Payment Dispute Decision (PDD)

PFFS payment disputes may be decided by the PDRC effective January 1, 2009. All other MA Plan payment disputes may be decided by the PDRC effective January 1, 2010. The PDRC will acknowledge in writing to the provider or supplier and the MAO Plan when a request for decision has been accepted. After a case has been acknowledged, the PDRC will issue an independent Payment Dispute Decision in writing to the provider or supplier and MAP Plan within 60 days of receipt of the valid request unless an extension is granted.

Abbreviations and Definitions

Common Abbreviations

CMS - Centers for Medicare and Medicaid Services
FOIA – Freedom of Information Act
HHS – U. S. Department of Health and Human Services
HMO – Health Maintenance Organization
JOA – Joint Operating Agreement
MAO - Medicare Advantage Organization
MOU – Memorandum of Understanding
PDD – An Independent Payment Dispute Decision
PFFS - Private Fee For Service
PPO - Preferred Provider Organization
PRD - Payment Review Determination
PDRC – Payment Dispute Resolution Contractor
QA – Quality Assurance

Standard Definitions

Organization Determination: MAO Plan's original claim payment

Payment Review Determination: Plan's decision on the Payment Dispute (generally provided within 30 days from the time the Payment Dispute is first received by the plan)

Payment Dispute: Provider or Supplier disputes the MAO Plan's original claim payment (generally must be disputed within 120 days from the date payment is initially received by the provider or supplier)

Payment Dispute Decision (PDD): The PDRC's independent decision regarding the Payment Dispute.

Request for Independent Payment Dispute Decision: Provider's or Supplier's request for review of the MAO Plan's Payment Review Determination, submitted to the independent entity, the PDRC.

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CHAPTER 2
DECISIONS SUBJECT TO THE PAYMENT DISPUTE PROCESS

Decisions Subject to the Dispute Process

When the reimbursement for MAO Plan benefits is disputed, the MAO Plan makes a Payment Review Determination as to whether the items or services are covered or otherwise reimbursable under the plan's terms and conditions (PFFS only). The MAO Plan also determines any amounts payable and makes those payments. Applicable Payment Review Determinations made by the MAO Plan may be submitted by a provider to the PDRC for an independent Payment Dispute Decision (PDD). A MAO Plan must issue a Payment Review Determination on a claim before that claim is subject to the PDRC process. If a provider requests a Payment Review Determination, but does not receive a response within the time frame allotted within the MAO Plan's Terms & Conditions or guidelines, a provider may, with proper documentation to the fact, request a PDD without first having received a Payment Review Determination from the MAO Plan.

For purposes of determining whether decisions are subject to the PDRC independent PDD process, Payment Review Determinations may include any decisions where there is a dispute about the payment amount made by a MAO Plan, to a non-contracted provider that is less than the rates of Original Medicare or to a deemed provider (PFFS only) that is less than the rates specified in the plan's terms and conditions. The PDRC's intent is to ensure that the MAO Plans are paying claims to non-contracted providers no less than the rates of Original Medicare or no less than the rates specified in the plan's terms and conditions (PFFS only).

Examples of decisions that can be disputed through the PDRC:

- A MAO Plan allows a radiological service at $50.00 but Original Medicare Part B reflects a fee schedule amount of $55.00 for this service in the region performed.
- A provider or supplier billed for an unlisted drug. The MAO Plan allows payment that is less than the price typically allowed by Original Medicare based on 95% of the AWP.
- An error is made in a reimbursement calculation on an inpatient claim, such as using an incorrect wage index.
- An incorrect payment group is assigned to a service.

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Decisions *Not* Subject to the Payment Dispute Process

The PDRC has been established specifically to adjudicate Payment Disputes between non-contracted and deemed (PFFS only) providers or suppliers and MAO Plans. Payment disputes between contracted providers and a plan are not subject to this dispute resolution process. Services denied for coverage issues such as Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), or medical necessity are generally not subject to the PDRC payment dispute process and

should be sent to the appropriate Medicare Part C independent review entity for processing.

Examples of decisions that *cannot* be disputed through the PDRC:

- An echocardiogram is denied for over utilization of services in a specific time period.
- A PET scan is denied based on NCD secondary to the related diagnosis.
- Claims are denied because a provider is being audited by a PSC.
- Denials are made because an item or service is statutorily excluded from coverage based on Original Medicare guidelines.

Decisions Normally Not Subject to *any* Appeals Process

Please note: *If a MAO Plan does allow a claim and makes payment described under one of the following categories, a request for an independent review of the payment dispute* ***may*** *be made to the PDRC.*

Coverage for certain items and services are excluded from payment under Original Medicare (Section 1862 of the Social Security Act) and may not be covered under a MAO Plan. Claims denied under the following categories do not have any appeal rights unless the Plan's Terms and Conditions (PFFS only) or policies specifically allow for payment of the services.

Examples of decisions that typically cannot be appealed to any Medicare contractor:

- Items and services that incur no legal obligation to pay
- Items and services paid for by a government entity other than under the Social Security Act or other health insurance plan
- Items and Services Not Provided within the United States
- Items and Services Resulting from War
- Routine Services and Appliances
- Items and Services Where Charges are Imposed by Immediate Relatives or Members of Household
- Excluded Investigational Devices

CHAPTER 3
PAYMENT DISPUTE RESOLUTION RIGHTS AND APPOINTED REPRESENTATIVES

This chapter establishes the requirements for disputes of Payment Review Determinations for Payment Disputes under a MAO Plan. It discusses issues related to rights, including parties to a dispute, and appointment of representatives.

Parties to an independent Review of a PDRC Payment Dispute (PD)
Any person or entity with a right to dispute an organization determination is referred to as a "party." The following persons or entities may be parties to a request for review of a PD for items or services submitted to the MAO Plan. As a result, they may request a review of the organization PD determination made on all claims for items or services (assuming other requirements, such as filing within prescribed time limits, for example, are met).

Deemed Provider or Supplier (PFFS ONLY)
For purposes of this section, a "deemed provider or supplier" is a physician or other practitioner, a facility, or other entity that has agreed to accept the MAO PFFS Plan's terms and conditions on all items or services payable by the MAO PFFS Plan. An entity identified as deemed means the provider or supplier has read and agreed to accept the MAO Private Fee For Service Plan's Terms and Conditions.

Non-Contracted Provider or Supplier
A provider or supplier who has rendered services to a MAO PFFS Plan enrollee on an emergency basis and did not review the PFFS Plan's Terms & Conditions before rendering services is referred to as a non-contracted provider or supplier. For all other MAO plans, a provider is considered non-contracted when there is not a signed contract/agreement between the provider and the specific MAO plan (HMO, PPO, etc). For example, a provider may be contracted under a MAO's HMO plan, but be considered non-contracted for services rendered to a PPO plan member.

Medicare Advantage Organization (MAO) Plans
An entity contracted with CMS to provide Medicare Advantage insurance benefits to enrollees.

Contracted Provider or Supplier
A contracted provider or supplier of services that files a claim for services or items furnished to the enrollee may not request an independent payment dispute decision since these disputes are considered to be matters of contract disputes.

Appointment of Representatives
An appointed representative may act on behalf of an individual or entity in exercising their right to an organization determination or dispute. Appointed representatives do not have party status and may take action only on behalf of the individual or entity that they represent. Documented appointment of representation is required due to HIPPA rules governing the release of Personal Health Information (PHI).

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CHAPTER 4
PAYMENT DISPUTE RESOLUTION

Request for Payment Dispute Decision (PDD)

A Payment Review Determination is defined as a first level payment dispute decision made by a Medicare Advantage Organization (MAO). A deemed (PFFS only) or non-contracted provider or supplier that is a party to a Payment Review Determination and is dissatisfied with that decision may request a second level, independent Payment Dispute Decision (PDD) by the PDRC, provided that the issue still involves a decision subject to the dispute process in Chapter 2, regardless of the amount in controversy. Any request for a PDD must be filed within 180 calendar days from the date the party receives the Payment Review Determination.

The request for a PDD must be in writing and should be made on a standard PDD form available at the PDRC website. (www.fcso.com , What We Do, Payment Dispute Resolutions – Medicare Advantage). Note that all items listed below are **required**. A written request that is not made on the standard PDD form is accepted if it contains the same required elements, as follows:

1. **Provider Contact information including name and address**
   Complete this section with the contact information for the rendering provider/supplier. This should be the address where the provider wishes to receive correspondence from the PDRC. If a provider is part of a group, the individual provider's name must be listed first. A group name may also be included on the same line, for mailing purposes. Since the PDRC communicates with providers/suppliers via multiple means, a valid telephone number and email address should be provided, if available. However, the lack of this information would not constitute an incomplete form or cause dismissal of the request.

2. **Pricing Information, including NPI number (and CCN / OSCAR number for institutional providers), ZIP Code where services were rendered, Physician Specialty, the name of the MAO that made the Payment Review Determination including the specific MAO plan name**
   Information in this section is essential for proper pricing of a claim. Please note that not all sections will apply to all providers/suppliers. The appellant should fill out the sections that apply to the claims at issue.

   - NPI number **and** CCN/ OSCAR number - The NPI number is the National Provider Identification number that Medicare has assigned to individual providers/suppliers. The CCN (CMS Certification Number) or the OSCAR (On-line Survey Certification and Reporting) number is also known as the institution certification number. This number is essential for **institutional providers** for correct pricing of a claim.
   - ZIP Code where services were rendered – Required for proper pricing of the claim.
   - Physician Specialty should include the specific specialty name and number.

- MAO name/ Plan Name & Number - the name of the Medicare Advantage Organization and the specific plan name and number to which the claim was submitted. Each MAO may have its own specific Terms & Conditions (PFFS only), with some varying from specific plan to plan within the MAO. Therefore, both the MAO name and the Plan name/number are required.
- Indicate whether the provider is deemed (PFFS only) or non-contracted.

3. **Reason for dispute; a description of the specific issue**
   This section should be used to document the specific reasons for the appeal. Some issues require a more detailed explanation. In those cases a separate explanation sheet may be attached to this form.

4. **Copy of the provider's submitted claim with disputed portion identified**
   Submit a copy of the submitted claim form(s) with the specific line items identified. This can be a printed copy of an electronic claim or a hardcopy claim form (UB-04 or 1500).

5. **Copy of the MAO Plan's original pricing determination**.
   Correspondence of the MAO Plan's original notice of claim decision to the provider, including the allowed amount, reductions, deductibles, and net paid amount.

6. **Copy of the MAO Plan's Payment Review Determination (dispute) pricing decision.**
   Correspondence of the MAO Plan's second level determination result of the payment dispute. This may take different forms from MAO Plan to MAO Plan, but all should show the claims at issue, the amount allowed, and any changes in the payment amount secondary to the decision and should describe the MAO Plan's decision rationale.

7. **Copy of the relevant portion of Terms and Conditions (PFFS only) or contract and any supporting documentation and correspondence that support your position that the plan's reimbursement is not correct (this may include interim rate letters and/or documentation reflecting payment from Original Medicare on similar or identical services.)**
   A provider should document the specific MAO Plan's Terms & Conditions (PFFS only) relevant to the claims at issue, as this will be a primary basis for determining the correct payment amount. A provider should support its position with thorough documentation.

8. **Appointment of Provider or Supplier Representative Authorization Statement, if applicable**
   If the appellant is someone other than the provider or an employee of the provider/group, the provider must give written and signed authorization to the specific person (not a group or organization) that is making the appeal.

9. **The name and signature of the party or the representative of the party**
   All requests must be signed and dated in order to be considered valid. If the request is being submitted via email, the checkbox under "For electronic submission…" may

be checked in place of a written signature. However, the appellants name and date must be entered on the Signature/Date line.

Requests that do not contain all required elements are considered incomplete and subject to dismissal. To avoid having its request dismissed, the provider must ensure all required information is submitted in an orderly fashion and presents a clear description of the matter in dispute. The PDRC may send a development letter by email, mail or fax, or may make the request by telephone, to attempt to obtain the missing information prior to deciding to dismiss a case.

If more than one party files a timely request for PDD on the same claim before a PDD is made on the first timely request, the PDRC will consolidate the separate requests into one proceeding and issue one decision.

When filing a request for PDD, a party must present evidence and allegations of fact or law related to the issue in dispute and explain why it disagrees with the organization determination and Payment Review Determination. This evidence should include any missing documentation identified in the notice of Payment Review Determination.

Submission of the Payment Dispute Decision Request

Once completed, the form and the other required documentation may be submitted via mail, email, or fax. The PDRC will acknowledge the request unless it is invalid in which case it may be dismissed. In situations where information is missing or incomplete, the PDRC may give the requester a reasonable amount of time (usually 14 days) to submit the required documentation but may dismiss the case without this additional time granted.

Choose one of the methods below to submit your request for decision:

1. **Email**. If the submission and associated documents do not contain any personally identifiable health information (PHI), or all PHI has been redacted, the payment dispute decision request can be submitted to a dedicated email box at PDRC@FCSO.com. Otherwise, you may submit payment dispute decision requests (including associated documents such as claims forms that may contain PHI) via the following:

2. **Fax** to (904) 361-0551

3. **Mail** to:

   First Coast Service Options, Inc.
   Payment Disputes
   P.O. Box 44017

Jacksonville, Florida 32231-4017

Questions, general information, and hard copy additional correspondence associated with a dispute, other than information submitted with a original request, request may be mailed to:

First Coast Service Options, Inc.
Payment Disputes
P.O. Box 44035
Jacksonville, Florida 32231-4035

Acknowledgement of a Request for PDD

When a request for PDD is determined to be valid and substantially complete, the PDRC will send an acknowledgement letter to the provider and the MAO and will begin working on the case. Since a copy of the MAO's communication to the provider regarding its payment review decision and rationale is supplied to the PDRC by the provider along with the other required elements of the request, the PDRC will generally not need to obtain information from the MAO. However, the MAO is alerted when the case is acknowledged that it may send information it deems necessary for the PDRC to have. If the MAO intends to submit unsolicited information to the PDRC it should do so within days of the acknowledgement since the PDRC may begin forming its decision right away.

Withdrawing a Request for PDD

A provider or supplier who files a request for PDD may withdraw the request by filing a written and signed request for withdrawal. The request for withdrawal must contain a clear statement that the provider or supplier is withdrawing the request for PDD and does not intend to proceed further with the dispute. The request must be received in the PDRC's mailroom, email, or fax before the PDRC issues the PDD decision.

Time Frames for Filing a Request for PDD

A request for PDD must be filed within 180 calendar days from the date the party receives the plan's Payment Review Determination decision notice.

For purposes of this section, the date of receipt of the Payment Review Determination notice will be presumed to be five days after the date of the notice of the Payment Review Determination, unless there is evidence to the contrary.

For purposes of meeting the 180-day filing deadline, the request is considered filed on the date it is received by the PDRC's corporate mailroom.

Good Cause for Late Filing – Providers, Physicians or Suppliers

The PDRC may extend the 180-day time frame for filing a request for PDD for good cause such as a natural disaster.

Obtaining the MAO documentation

Providers or suppliers must file requests for PDD directly with the PDRC. Once a party requests a PDD, the PDRC may request documentation from the MAO that processed the Payment Review Determination. When the MAO receives the PDRC's request for the case file, the MAO must send the file within seven calendar days so that the PDRC receives it on or before the eighth day. Plans that do not respond timely to PDRC requests will be considered out of compliance with their CMS contract and subject to compliance processes. An MAO may submit information specific to a case even if the PDRC has not requested it. The acknowledgement letter sent when the request is accepted alerts the MAO to this.

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CHAPTER 5
PAYMENT DISPUTE DECISION –ADJUDICATION

The PDRC's primary responsibility is to adjudicate Payment Disputes between providers and MAOs accurately, efficiently, consistently, and on time.

A payment dispute decision consists of an independent, on-the-record review of an MAO's organization determination, including the MAO's Payment Review Determination decision, the Plan Terms & Conditions (PFFS only), and all issues related to payment of the claim.

Within 60 days after receiving a valid payment dispute appeal the PDRC will notify all parties of its Payment Dispute Decision (PDD) unless an extension is granted. The decision letter will include the facts of the dispute, arguments made for and against additional reimbursement, the adjudicator's decision, the adjudicator's rationale, and notification to the parties of their right to request a debrief.

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CHAPTER 6
PAYMENT DISPUTE DECISIONS POST-ADJUDICATION

Request for Debriefing of a Payment Dispute Decision

A party to a Payment Dispute Decision (PDD) has the right to request a debriefing and explanation of the PDD made by the PDRC. A party must make such a request via mail, email, fax, or phone within 14 days of the date of the PDD in order for the debriefing request to be allowed. Once a valid debriefing request has been received by the PDRC, notice will be sent to all parties of the specific date and time for the debriefing. The debriefing shall be conducted at the appointed time via phone or other communication media agreed to by all participating parties in order to educate the parties as soon as practical.

Effectuation of a PDD by a MAO Plan

Notice of Order of Effectuation to a MAO Plan

When a PDD results in additional payment to a provider, the PDRC will send notification of the decision to the appropriate MAO Plan. Notification will include sufficient information about the claim(s) at issue and the change in reimbursement for the MAO Plan to identify and adjust the claim(s).

Time frame for a MAO Plan to Effectuate a PDD

A MAO Plan shall effectuate payment within thirty (30) days from the date of the PDD decision. The MAO Plan shall fax the Payment Dispute Decision Confirmation form to the PDRC within seven (7) days of effectuation. A plan's failure to supply this confirmation will be made known to CMS for compliance processes.

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FREQUENTLY ASKED QUESTIONS (FAQ's)

1. **Can all Medicare Advantage payment disputes be submitted to the PDRC?**
   Yes, as of January 01, 2010 The Centers for Medicare and Medicaid Services (CMS) initially contracted with First Coast Service Options (FCSO) from January 1, 2009 through December 31, 2009 to be the PDRC for only PFFS payment disputes. However, as of January 1, 2010, the scope of our contract has expanded to include all payment disputes between all MAO plans and non-contracted providers. We cannot answer questions about payment dispute between a contracted provider and a Medicare Advantage plan. You should seek clarification from the plan itself or contact the plan's CMS Regional Office Account Manager. A list of general Regional Office contacts is available on the CMS website under http://www.cms.gov/RegionalOffices/. If you provide the complete plan name and state, we may be able to further direct you.

2. **How can a provider identify the member's MAO Plan?**
   The patient's member card should identify the type of plan or the plan will be able to tell you. For PFFS plans, the plan's terms and conditions must be easily accessible to the provider. Include a copy of the member's card with your request for an independent decision.

3. **Are there any additional levels of dispute after the PDRC?**
   No. The Payment Dispute Decision made by the PDRC is the final step in the resolution process and there are no further levels of administrative appeal. See Chapter 6 of this manual for more information.

4. **How soon after receiving a payment decision from the plan may we request an independent decision from the PDRC?**
   Before submitting a request to the PDRC, the provider must follow at least one level of the plan's dispute process. After receiving the plan's Payment Review Determination as a result of that dispute process, the provider may request a Payment Dispute Decision (PDD) from the PDRC. The request for a PDD must be received by the PDRC within 180 days of the provider receiving the plan's Payment Dispute Decision. See Chapter 4 of this manual for more information.

5. **How long will the PDRC take to make a decision?**
   The PDRC will issue a decision within 60 days of receiving a complete and valid request. In some instances, a small extension will be granted to allow time to review new evidence received.

6. **What is the next step after receiving a Payment Dispute Decision (PDD)?**
   The independent PDD is a final decision and there are no further administrative appeal rights after this step. However, either party to the dispute may request a debrief with the PDRC to gain a more complete understanding of the decision.

   If the PDD results in additional payment being due the provider, CMS requires the MAO Plan to effectuate payment within 30 days of the date of the PDD. The plan must fax a Payment Dispute Resolution Confirmation Form to the PDRC at (904) 361-0551 within seven (7) calendar days of making payment to the

provider. Plans that do not respond timely may be considered out of compliance with the plan's CMS contract and will be subject to compliance processes.

7. Will the PDRC make decisions on non-contracted provider disputes with HMOs, PPOs, or other MAO plans?

Yes, as of January 01, 2010. First Coast Service Options (FCSO) has been initially contracted from January 01, 2009 through December 31, 2009 by The Centers for Medicare & Medicaid Services (CMS) to be the PDRC for only PFFS payment disputes. However, as of January 01, 2010, the scope of our contract has expanded to include all payment disputes between all MAO plans and non-contracted providers.

8. If we submit a claim adjustment or corrected claim to the plan and it doesn't process the new claim, may we request a PDRC decision on this?

The provider must first dispute the claim with the plan using the plan's payment dispute resolution process. After completing at least the first level of the plan's payment dispute process, or after filing the dispute and receiving no response from the plan, the provider may request an independent decision from the PDRC.

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