



News Flash – The reporting period for the 2009 Physician Quality Reporting Initiative (PQRI) has begun. Eligible professionals choosing to participate in the 2009 PQRI through claims-based submission of individual quality measures should have started submitting appropriate 2009 Quality Data Codes on qualifying Part B claims with a date of service of January 1, 2009 or later. Information on the 153 2009 PQRI measures, release notes, detailed specifications, and a guide to assist implementing PQRI measure reporting are available on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> by clicking on the Measures/Codes tab. Information on alternative reporting periods and reporting criteria for satisfactory reporting of measures groups or for registry-based reporting, as well as the detailed specifications and release notes for the seven 2009 PQRI measures groups, can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> on the CMS website.

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Note: This article was updated on January 25, 2013, to reflect current Web addresses. This article was previously revised on February 26, 2009, to add some clarifying information. Specifically, a note has been added to the top of page 3 to explain the difference between deemed providers and non-contracted providers. Also, language has been added to show that appeals of medical necessity determinations must first go through the plan's appeals process. Finally, language has been added to show that a plan's terms and conditions should be posted on their website and the address of that site should be available on the beneficiary's membership card. All other information remains the same.

Important Information for Providers Serving Medicare Beneficiaries Enrolled in Private Fee-for-Service Plans

Provider Types Affected

All Medicare physicians, providers, and suppliers who provide services to Medicare patients who are enrolled in Medicare Advantage (MA) Private Fee-for-Service Organizations (PFFS).

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What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has announced a new process for handling payment disputes raised by providers who serve Medicare patients enrolled in MA PFFS plans. Such disputes arise when the billing provider is not satisfied with the MA PFFS organizations payment and the provider has exhausted the dispute resolution process with that organization. Effective January 1, 2009, CMS has delegated the adjudication of Private Fee-for-Service Plan (PFFS) Provider Payment disputes to an Independent Review Entity, i.e., First Coast Service Options, Inc. (FCSO). Therefore, as of January 1, 2009, after having exhausted the appeals process with the PFFS plan; providers should begin submitting payment dispute decision requests directly to FCSO. This process applies to providers treating such patients, where the provider has not contracted with the MA PFFS organization. Providers rendering such services without contracting with the MA PFFS plan are “deemed” providers for that plan. Please see Background, below, for more detail.

Background

Prior to January 1, 2009, CMS Central and Regional Office staff adjudicated payment disputes between deemed and non-contracted Private Fee-For-Service (PFFS) providers and Medicare Advantage (MA) organizations offering PFFS plans. However, beginning January 1, 2009, after an MA PFFS plan informs a provider or supplier in writing that a payment dispute has been denied through the MA PFFS plan provider payment dispute process; those who disagree with the pricing decision have the right to request the decision be reviewed by an independent review entity under contract with CMS.

Further, on November 25, 2008, CMS released a Health Plan Management System (HPMS) memorandum (Instructions for Model Private Fee-For-Service Terms and Conditions of Payment) announcing (effective January 1, 2009) that First Coast Service Options, Inc. (FCSO) would be the Independent Review Entity to which the adjudication of PFFS Provider Payment disputes would be delegated. In this role, FCSO directly adjudicates payment disputes between deemed and non-contracted Private Fee-For-Service (PFFS) providers and Medicare Advantage (MA) organizations offering PFFS plans.

What Decisions Are Subject to the Payment Dispute Process?

Provider payment disputes include any decisions in which there is a dispute that the payment amount made by the MA PFFS plan to **deemed providers** is less than the payment amount that would have been paid under the MA PFFS Plan's terms and conditions, or the amount paid to **non-contracted providers** is less than would have been paid under original Medicare (including balance billing).

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Note: A deemed provider is one who was aware that the patient was a private fee for service member at the time of service, and therefore had the ability to view the plan's terms and conditions of payment. A non-contracting provider is one that was not aware the patient was a private fee for service member at the time of service, e.g., an emergency situation.

Which Decisions Are Not Subject to the PFFS Provider Payment Dispute Process?

- Services denied for coverage issues such as Local Coverage Determinations (LCDs);
- National Coverage Determinations (NCDs);
- Appeals of medical necessity determinations by the plan should first be sent through the appeals process of the MA PFFS plan and that process should be on the plan's website along with the plan's terms and conditions of payment; and
- Disputes between a contracted network PFFS provider and the MA PFFS plan are also not reviewed by the IRE or CMS.

How Do You File a Request for Independent Review (Payment Dispute Decision (PDD))?

If you have exhausted the PFFS organization's dispute resolution process and wish to escalate review, you must file a PDD request directly with First Coast Service Options, Inc (FCSO) within 180 days of written notice from the MA PFFS plan (all requests must be received within 180 days of the MA PFFS plan written decision).

You must submit the request in writing; preferably on a standard PDD form available at the FCSO's PFFS website. A written request that is not made on the standard PDD form will be accepted if it contains all the required elements, as follows:

- Provider or supplier contact information including name and address;
- Pricing information, including the National Provider Identifier (NPI) of the provider (and CMS Certification Number (CCN) or OSCAR number for institutional providers), ZIP Code where services were rendered, Physician Specialty, the name of the MA PFFS plan that made the redetermination including the specific PFFS plan name, and whether the provider/supplier is deemed or non-contracted;
- The reason for dispute; a description of the specific issue;
- A copy of the provider's submitted claim with disputed portion identified;
- A copy of the PFFS plan's original pricing determination;

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- A copy of the PFFS plan's redetermination (dispute) pricing decision;
- A copy of the relevant portion of Terms and Conditions (which are on the plan's website and that website address should be listed on the beneficiary's membership card for the plan) or contract and any supporting documentation and correspondence that support the provider's position that the plan's reimbursement is not correct (this may include interim rate letters where appropriate);
- An appointment of Provider or Supplier Representative Authorization Statement, if applicable; and
- The name and signature of the party or the representative of the party.

Mail your requests to:

First Coast Service Options, Inc.
PFFS Payment Disputes,
P.O. Box 44017
Jacksonville, Florida 32231-4017.

Alternatively, if the submission and associated documents do not contain any personally identifiable health information (PHI) (or any PHI has been redacted), you may submit the payment dispute decision request to a dedicated email box at IREPFFS@FCSO.com. First Coast can also receive PDD requests (including associated documents such as claims forms that may contain PHI) via a fax at fax number (904) 361-0551.

What is the Time Frame for Making a Payment Dispute Decision (PDD)?

Once you have requested a PDD, FCSO may request documentation from the MAPFFS plan that processed the redetermination. When that plan receives FCSO's request for the case file, they must send it within seven calendar days so that FCSO receives it on or before the eighth day. PFFS plans that do not respond timely to IRE requests will be considered out of compliance with their CMS contract and subject to compliance processes.

FCSO will issue a decision within 60 days after receiving a provider payment dispute appeal unless it grants itself an exception to the 60 day timeframe. In the issued Payment Dispute Decision letter, FCSO will notify all parties of either its decision, or that it has dismissed the PDD request. The PDD letter will also include the facts of the appeal, arguments made for and against additional reimbursement, the adjudicator's decision and rationale, and notification to the parties of their right to request a debriefing. Finally, when the IRE renders a decision on a case and notifies all parties of its decision, it considers the case closed. Please note again, however, that both parties have the right to request a debriefing.

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If you have questions regarding the adjudication process or individual disputes being reviewed by the IRE, you can contact FCSO at 904-791-6430. You will be able to leave messages at this number and should expect a return call within 48 hours of receipt. Additionally, you can mail correspondence associated with a dispute request to:

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

Additional Information

The standard PDD form and other information regarding this independent review process are available on the First Coast website at <http://www.fcso.com/> on the Internet.

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