

CENTER FOR DRUG AND HEALTH PLAN CHOICE

DATE: January 4, 2010

TO: All Medicare Advantage Organizations, 1876 Cost Plans, and PACE Organizations

FROM: Danielle R. Moon, J.D., M.P.A.
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SUBJECT: Provider Payment Dispute Resolution for Non-Contracted Providers

Effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) will expand its current provider payment dispute resolution process for disputes between non-contracted and deemed providers and Private Fee for Service Plans (PFFS) to include disputes between non-contracted providers and all Medicare Advantage Organizations (HMO, PPO, RPPO and PFFS), 1876 Cost Plans, and the Program of All-Inclusive Care for the Elderly (PACE) organizations. The purpose of this memorandum is to remind organizations of their obligations under this newly expanded process.

Provider payment disputes subject to CMS' independent review process include any decisions where a non-contracted provider contends that the amount paid by the organization for a covered service is less than the amount that would have been paid under original Medicare. Provider payment disputes also include instances where there is a disagreement between a non-contracted provider and the organization about the plan's decision to pay for a different service than that billed, often referred to as down-coding of claims. (Note: The expansion of the provider payment dispute resolution process does not include Part D claims.)

Once an organization makes its internal decision about an initial payment dispute filed by a non-contracted provider, the provider has the right to request an independent decision from CMS' Payment Dispute Resolution Contractor, First Coast Service Options, Inc. (FCSO). In addition, if the organization fails to make a decision in response to a non-contracted provider dispute request within 30 days from the date the dispute request was received by the organization, the provider may request a Payment Dispute Decision (PDD) without having received an initial internal dispute decision by providing evidence to FCSO of the dispute it filed with the organization. Such disputes are subject to CMS review because organizations are required to pay non-contracted providers the same amount as they would have received had they billed original Medicare. See §§1852(a)(2)(A) of the Act for Medicare Advantage plans; 1876 for Cost plans; and 1866(a)(1)(O) for PACE organizations.

The provider payment dispute process cannot be used to challenge payment denials by organizations that result in zero payment being made to the non-contracted provider. Instead, these matters must be processed as appeals under 42 CFR Subpart M. In addition, the payment dispute process may not be used to resolve payment disputes between contracted network providers and organizations covered by this process.

If you have questions concerning this notification, please contact Paul Foster at Paul.Foster@cms.hhs.gov. Please find a summary of the expanded Provider Payment Dispute Process attached to this memorandum.

Attachment

Summary of the Provider Payment Dispute Resolution Process

Medicare Advantage plans, 1876 Cost plans, and PACE Organizations must ensure the following:

- The organization's internal payment dispute process for non-contracted providers is well-defined;
- Information on submitting internal payment disputes to the organization is communicated to non-contracted providers;
- Time frames and the address of the organization where disputes are to be sent are communicated to non-contracted providers;
- All areas of the organization are aware of the internal payment dispute process including customer service, claims and appeals staff;
- First-level internal payment dispute decisions inform non-contracted providers about their right to CMS' provider payment dispute resolution process; and
- All requested materials are sent to FCSO within seven (7) calendar days and received on or before the eighth day.

CMS' dispute resolution process will continue to be available to deemed and non-contracted providers participating with PFFS plans. The same policies will apply as addressed for non-contracted providers in this memorandum.

Filing a Request for an Independent Payment Dispute Resolution: The non-contracted provider must submit a written request for an independent Payment Dispute Decision (PDD) to FCSO by email, fax or mail. The request should be made using the standard PDD form available at FCSO's website (go to: <http://www.fcso.com>, then follow the links under "What We Do"), but FCSO will accept any written request so long as it contains all of the data elements noted below. The PDD request may not be filed until after the provider has received an initial dispute decision from the organizations' internal dispute process unless 30 days has elapsed from the time the organization received the dispute request and the organization has not responded. FCSO must receive this request within 180 days of the organization's redetermination of the unfavorable dispute decision.

A written request will be accepted if it contains **all** of these required elements:

- Provider contact information, including name and address;
- Pricing information, including NPI number (and CCN / OSCAR number for institutional providers), zip code where services were rendered, and physician specialty;
- The name of the organization that made the redetermination, including the specific plan name;
- An attestation that the provider is a non-contracted provider;
- The reason for the dispute and a description of the specific issue;
- Copy of the provider's claim as submitted to the organization for payment with the disputed portion identified;
- Copy of the organization's original pricing determination (the remittance advice);
- Copy of the organization's unfavorable redetermination or, if available, evidence that the organization did not respond to the dispute within 30 days;

- Any documentation or correspondence that supports the provider's position that the organization's reimbursement is not correct (this may include interim rate letters, where appropriate);
- Appointment of Provider Representative Authorization Statement, if applicable; and
- The name and signature of the provider or the provider's representative.

Obtaining the organization's documentation: After the non-contracted provider requests a payment dispute decision, FCSO may request additional documentation from the organization. When the organization receives FCSO's request, the organization must send all requested materials to FCSO within seven (7) calendar days and ensure that it is received by FCSO on or before the eighth day. Organizations must respond timely to these requests to ensure that all relevant documentation is considered by FCSO.

Time Frame for Making a Payment Dispute Decision (PDD): FCSO will issue a decision within 60 days after receiving a provider's valid and complete request for a payment dispute decision. FCSO will notify the provider in writing of its PDD, or that it has dismissed the provider's request for a PDD.

Decision Letters: The PDD letter will include the facts of the dispute, arguments made for and against additional reimbursement, the adjudicator's decision and rationale, and notification of the right to request a debrief.

Notification of Decision: When FCSO notifies the provider and the organization of its decision, the case is closed. However, both the provider and organization have the right to request a debrief to ensure understanding of the decision. Because the decision is considered final, the debrief has no bearing on the decision. The debrief is offered only as an educational resource for the provider and the organization.

Compilation of Decisions and Lessons Learned: FCSO will maintain a log of all decisions rendered and will work collaboratively with CMS to provide information to plans on the issues raised and the decisions rendered. Organizations will have the opportunity to learn from these experiences and amend their practices accordingly.

Submission of Payment Dispute Resolution Requests

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

Fax. A fax number, (904) 361-0551, has been established to receive electronic requests for payment dispute decisions.

Mail. Providers can also mail hard copy requests for payment dispute adjudication to the following address:

First Coast Service Options, Inc.
Payment Dispute Resolution Contractor

P.O. Box 44017
Jacksonville, Florida 32231-4017

Organizations and providers with questions regarding the adjudication process or individual disputes being reviewed by the Payment Dispute Resolution Contractor can contact FCSO at (904)791-6430. Providers and organizations will be able to leave messages and should expect a return call within two (2) days of receipt. Hard copy correspondence associated with a dispute request should be mailed to the following address:

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