



Payment Dispute Resolution Contractor

The Centers for Medicare & Medicaid Services'
Payment Dispute Resolution Contractor (PDRC)

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Payment Dispute Resolution Contractor

History of the CMS Payment Dispute Resolution process

- Numerous disputes about PFFS MA plans' reimbursement to deemed and non-contracted providers
- CMS handled these in various offices





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Payment Dispute Resolution Contractor

History of the CMS Payment Dispute Resolution process

- Wanted a process to resolve these disputes consistently and efficiently
- Competitively bid as a Qualified Independent Contractor (QIC) task order



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Payment Dispute Resolution Contractor

- Task Order was awarded and has been performed by C2C Solutions, Inc. (C2C) since 2008
- C2C is a Qualified Independent Contractor (QIC) with a long history in Medicare



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Payment Dispute Resolution Contractor

- Task Order was expanded in 2010 to handle payment disputes for all MA plans and non-contracted providers
- Referred to as the Payment Dispute Resolution Contractor (PDRC)



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Payment Dispute Resolution Contractor

C2C Solutions, Inc. (C2C)

- Currently has three QIC task orders: Part B North, DME, and PDRC
- Many employees have years of experience with an Original Medicare contractor



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The PDRC Team is experienced

- 3 PDRC team members with over 30 years experience - *each*
- Parts A and B
- Claims, systems, appeals, cost reporting



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Payment Dispute Resolution Contractor

The PDRC

- Is an entity separate from the providers or plans
- Makes independent decisions



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The PDRC's jurisdiction –

“**Payment**” **disputes** are disputes about the **total reimbursement** an MA plan allowed on a claim from a non-contracted or deemed provider

Caution: The jurisdiction is determined specific to the line item service being disputed in certain claims.





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**Total Reimbursement =
Gross Reimbursement =
Total Allowance**

Without regard to what portion of that allowance is payable by the plan or patient





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The PDRC Jurisdiction:

Disputes where some amount has been allowed or the allowance for the disputed item or service is included in the allowance for another service (packaged/bundled)





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Not PDRC's jurisdiction:

- Coverage, eligibility, medical necessity
- Contracted providers
- Medicaid managed care
- The proper application of copayments, coinsurance, or deductibles



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Not PDRC's jurisdiction:

- Claims processing issues where the claim has not yet been adjudicated
- Disputes about whether contracted rates should apply to a non-contracting (non-participating) provider



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The PDRC Process -The Provider

- This is a provider-driven process
 - Plans do not automatically forward unresolved disputes to the PDRC on behalf of the provider
 - Providers may choose not to pursue their dispute with the PDRC



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Provider –

- Dispute payment with the plan first
- Request the PDRC's independent decision within 180 days of receiving the MA plan's written determination, or
- After 30 days if plan fails to respond



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- Not all plans provide a decision letter.
- Providers should submit evidence of attempts to follow the MA plan's dispute resolution process with the request for the PDRC decision
- An overpayment decision by a plan is not considered a plan's first level decision unless it is in response to a payment dispute



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Providers must request the independent decision of the PDRC:

- Description of the **issue**
- Copy of the submitted **claim**
- **Remittance** advice
- Plan's **decision** letter (1st level)
- **Supporting evidence** to demonstrate what Original Medicare would have allowed for the same service



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- The PDRC is an independent entity
- PDRC does not have access to plans' claims systems

Providers: *Clearly state what you are disputing and why. Supply relevant information that will help support your position.*



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The PDRC Process - The PDRC

- **Develop** to provider for minor missing information
- **Dismiss** provider's request as invalid or incomplete
- **Acknowledgement** letter to the provider and the plan



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The PDRC Process - The MAO Plan

- Upon receipt of acknowledgment letter, the plan is encouraged to submit relevant information to support its position
- PDRC may request the plan's case file for a particular case; the plan must return it within 7 days



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- The PDRC may contact the plan and/or the provider for clarification of the documentation the provider submitted
- If the plan knows the case is not in PDRC jurisdiction, make this known early in the process (contracted provider, etc.)



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The PDRC Process -The PDRC

- The PDRC must interpret the documentation submitted by the provider to understand the issue
- Experienced PDRC staff continually applies lessons learned to subsequent cases



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PDRC staff uses a variety of pricing tools to determine what Original Medicare would allow

- Burgess Reimbursement System
- CMS PC Pricers
- CMS Fee Schedules
- IOM and other CMS references
- Medicare Administrative Contractor (MAC) websites
- MAO plan terms and conditions



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PDRC decisions rendered **within 60 days** of receiving all required documents

“Start date” is noted in the acknowledgment letter



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What happens after the PDRC decision is made?



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Decision Letters are mailed to providers and plans

Contain:

- the facts presented
- description of the issue
- applicable regulatory or policy references
- rationale used
- instructions for next steps



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- Debriefs, as requested by plans or providers
- Plans must effectuate underpayment decisions within 30 days
- Plans send confirmation of effectuations to PDRC within 7 days
- Various reports to CMS



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Who uses the PDRC process?



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Over 4,800 providers

- 11 providers over 100 requests each
- Virtually all 50 states and Puerto Rico



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• Over 500 plans, 240+ MAO parents



- Part A and Part B services, all provider types



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What the PDRC is seeing






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79% Underpaid

~ 8 out of 10 payment disputes submitted to the PDRC are found to have been underpaid






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Dispute types **most frequently underpaid:**



Dispute Type	% of Cases Underpaid
Portable XRay	100%
Carried Priced Code	94%
Radiology	94%
Ambulance	93%
DMEPOS	93%
Unlisted Code	92%
Critical Access Hospital	92%
Lab Panel	91%
Lab Services	90%
End Stage Renal Disease	90%

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Dispute Type	% of Cases Underpaid
Long Term Care Hospital	89%
Other Part A	86%
Rural Health Clinic	86%
DRG Grouping	83%
Skilled Nursing Facility	83%
Ambulatory Surgical Center	82%
Anesthesia	79%
Other Part B	78%
Inpatient Prospective Pymt System	77%
Therapy	77%
Inpatient Psychiatric Facility	76%
Medically Unlikely Edits	75%
National Correct Coding Initiative	74%
Home Health Agency	72%
Global Surgery	71%






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Most frequently disputed types:

Other Part B
Ambulance
Outpatient Prospective Payment System
Inpatient Prospective Payment System
Lab Services
Home Health Agency






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Dispute types with highest average dollar difference:

Dispute Type	Average Plan Allowed Amount	Average Correct Allowed Amount	Average Difference	% Change
Long Term Care Hospital	\$38,524.70	\$49,664.83	\$11,140.13	29%
Downcoding -DRG	\$9,313.13	\$13,907.52	\$4,594.40	49%
Other Part A	\$7,457.22	\$11,989.37	\$4,532.15	61%
Inpatient Prospective Payment System	\$21,447.83	\$25,729.08	\$4,281.26	20%
DRG -Grouping	\$17,976.52	\$21,723.21	\$3,746.70	21%

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Dispute types with highest percentage difference:

Dispute Type	Average % Increase in Allowance
DMEPOS	169%
Other Part B	153%
Downcoding - Ambulance	144%
Global Payment	133%
Carried Priced Code	111%
Lab Panel	97%
Unlisted Code	90%



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What the PDRC is finding



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- Medicare Reimbursement is complicated
- Even when you know the rules, there is an exception to every rule
- Frequent updates to fee schedules and payment rates



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- Many plans have reacted positively to PDRC decisions by changing their payment systems or policies
- Providers are often frustrated by the time they get to the PDRC, feeling they have been given the run-around



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- The provider personnel are often specialized in their area of practice and its payment rules
- Providers could do a better job of presenting evidence to the plan (and to the PDRC!)



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- Plans could do a better job of communicating to the provider the rationale for its decisions
- PDRC captures the “reason for error” for reporting purposes



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What causes a PDRC dismissal?






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PDRC Dismissals-

- Missing Information
- Not a Payment Dispute
- Medical Necessity or Coverage denial where no payment has been made
- Contracted provider
- No first level decision from the plan
- Duplicate request
- Withdrawal
- Past the time limit to request PDRC decision
- Not a Medicare Advantage member






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Hot topics this year for the PDRC:



- Lesser of charges or PPS amount
 CMS clarified its policy in the February 2011 MA Out of Network Payment Guide that the PPS amount must be reimbursed
- Jurisdiction of the "post-stabilization" disputes
 Although payment is made in these instances, CMS has decided these are service disputes subject to the beneficiary appeals process
- Emergency Room E/M downcoding disputes

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Review of Medical Documentation
for E/M Coding



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- Use CMS guidelines which requires the use of the AMA CPT Coding Guidelines



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- Various tools in use to help assess the components of the E/M visit - they are only tools
- Professional medical judgment and appropriate documentation must be applied to determine the appropriate code to bill



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Documenting the complexity of the medical decision making has been problematic for some

- The physician must document their decision thought process so the reviewer can come to the same conclusion
- The reviewer must be able to understand "the story" and the appropriate level of complexity from the medical notes



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Document what is complex about the treatment decisions, not just the number of tests or presenting illness –

- What was perplexing or caused a change in course?
- What were the challenges to this particular case that differentiates it from other cases of the same disease process that would be coded at a lower level?



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- Reporting
- Testing of plans' payment systems
- Training



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http://www.cms.gov/HealthPlansGenInfo/18_ProviderPaymentDisputeResolution.asp

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Questions?

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