



Related MLN Matters Article #: MM5349

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

Key Words

MM5349, CR5349, R1175CP, Part C, 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)

Key Points

- The effective date of the instruction is July 1, 2007.
- The implementation date is July 2, 2007.
- When a provider performs a Medicare query 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 (MA) program.
- For example, under the Medicare Advantage (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 Health Maintenance Organization (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 United States (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.

- A PFFS enrollee will usually inform a provider that they are enrolled in a PFFS plan before obtaining a service.
- 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 PFFS plan's terms and conditions will specify:
 - The amount the PFFS organization will pay for all plan-covered services; and
 - The provider's billing procedures, including:
 - The amount the provider is permitted to collect from the enrollee, and
 - Information on 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 website and make them available upon written or phoned request.
- 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 and how they relate to providers, providers may view the "Provider Q&A" downloadable document at <http://www.cms.hhs.gov/PrivateFeeForServicePlans/> on the CMS website.
- If providers have questions regarding the plan of a specific Medicare MA enrolled patient, they may wish to contact that plan. A plan directory and MA claims processing contact directory are available at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/> on the CMS website. CMS updates this site on a monthly basis

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5349.pdf> on the CMS website.

The official instruction (CR5349) regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R1175CP.pdf> on the CMS website.

Providers may review a related article (MM5118) that explains Medicare's CWF Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf> on the CMS website.