50.1 – General Requirements

(Rev. 99, Issued: 05-27-11, Effective: 05-27-11, Implementation: 05-27-11)

MA organizations offering full, partial, or non-network PFFS plans are required to make information on each PFFS plan's payment rates and provider requirements available to deemed providers that furnish services to their members. A PFFS plan's terms and conditions of payment is the primary means for deemed providers to obtain necessary information regarding a PFFS plan's payment rates for covered items and services and provider requirements in order to allow the providers to make a confident decision as to whether or not they will agree to accept the terms and conditions of payment.

All full, partial, and non-network PFFS plans, including employer/union sponsored PFFS plans, are required to implement the terms and conditions of payment for their deemed providers effective January 1 of the applicable contract year. Employer/union sponsored PFFS plans that operate on a non-calendar year schedule are expected to implement the terms and conditions of payment effective the beginning of the plan's applicable contract year.

The terms and conditions of payment establish the payment rates for plan-covered items and services that apply to deemed providers and the rules that deemed providers must follow in order to be paid by the PFFS plan for furnishing services to its members. PFFS plans must ensure that providers furnishing services to plan members are paid accurately and timely according to the terms and conditions of payment. At a minimum, PFFS plans are expected to include the following components in their term and conditions of payment:

- An explanation of the deeming process (refer to section 40.2 of this chapter);
- Provider qualifications and requirements (i.e., the provider is State-licensed and in compliance with other applicable State or Federal requirements, and the provider is eligible to provide services under Original Medicare);
- Explanation of provider payment rates (i.e., the amounts the plan will pay providers for covered items and services, the amounts providers are permitted to collect from members, balance billing rules, and hold harmless requirements);
- Provider billing requirements, including prompt payment requirements;
- Description of rules for maintaining medical records and allowing audits;
- How a provider can get an advance organization determination;
- Description of the plan's provider payment dispute resolution process;
- Description of member and provider rights for filing appeals and grievances; and
- Plan contact information.

Each component should contain sufficient information and instructions on how to obtain additional information if necessary.