PHYSICIAN PAYMENT RESOURCE CENTER

User Guide

Texas Medical Association

Physicians Caring for Texans

Please observe the following Payment Review form guidelines to help us expedite processing while maintaining the integrity and credibility of the Physician Payment Resource Center *(previously known as the RRR program).*

GENERAL GUIDELINES

- The Texas Medical Association accepts Payment Review forms from current TMA members only.
- Submit Payment Review forms by fax to (512) 370-1632; or by secure file-drop at https://files.texmed.org/filedrop/pprc.
- Exhaust and document reasonable attempts to resolve your claim issues, including the appeals process, before submitting a Payment Review form (unless you are submitting a Payment Review form as "informational only").
- Clearly identify health plans and/or contractual relationships on the Payment Review form.
- Keep in mind that Medicare's Correct Coding Initiative (CCI) determines bundling standards.
- Do not report slow-pay issues until 45 to 60 days after you have submitted the claim and you have received confirmation that the claim is being processed.
- TMA generally processes the Payment Review forms within two to four weeks of receipt. TMA cannot guarantee a response from the health plan.

USING THE FORM

- Use the current Payment Review form available on the TMA website.
- Fill out the Payment Review form completely and legibly.
- Give a brief description of the issue on the form. If you need to include a more detailed description, attach it to the form.
- You may use one form that addresses the same issue and is from the same health plan.
- Use separate forms to submit multiple issues that are dissimilar in nature or are similar but from different health plans.
- Use separate forms to submit issues from different TMA physician members.

ATTACHMENTS

Attachments should contain only the protected health information (PHI) that is relevant to the patient(s) for whom a physician is submitting a Payment Review form. Physicians should delete all other patient information from the attachment. TMA will return to the practice any forms that have nonpertinent PHI.

Examples of frequently needed attachments are:

- CMS-1500 claim forms
- Remittance notices (e.g., EOBs, RAs, R&S reports) with definitions of comment indicators and/or denial messages
- Copies of relevant prior correspondence to and from the health plan, including appeal letters and/or denial letters
- Reports for proof of timely filing (e.g., batch acceptance reports from the payer or clearinghouse showing the payer accepted the claims)
- Operative notes/Medical records
- Patient insurance identification cards
- Preauthorization/Referral forms

INFORMATIONAL ONLY PAYMENT REVIEW FORMS

TMA adds the following types of submissions to its database as "informational only":

- The Payment Review form was submitted to TMA expressly for "informational only" purposes.
- The claim is being appealed with the health plan for the first time.
- The claim is for services older than 12 months.
- The physician office failed to follow up timely on the claim.
- The information submitted is a copy of a complaint filed with the Texas Department of Insurance.
- The issue is not clear, legible, or understandable.
- The Payment Review form contains unclear issues and/or conflicting information.
- Physician billing errors are construed as payer issues.
- The submission lacks appropriate attachments.

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