



Medicare Hospital Version

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Caution should be exercised in relying on these materials after this course. There are frequent changes to the various statutes, regulations, and guidelines applicable to the Medicare program. In addition, this notebook contains abbreviated or time sensitive copies of many documents. Links to the current versions of many Medicare statutes, regulations, and guidelines may be found on HCPRO's links page:

<https://revenuecycleadvisor.com/helpful-links>

At a minimum, before relying on any documents in this notebook, you should (1) download a current copy of the complete document and (2) confirm that the information provided in the document has not been rescinded, modified, or superseded.

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Kimberly is the Director of Medicare and Compliance for HCPro, Inc. She oversees HCPro's Medicare Boot Camps® and is the lead instructor for HCPro's Medicare Boot Camp® – Hospital Version and Utilization Review Version and an instructor for the Medicare Boot Camp® - Critical Access Hospital Version, Rural Health Clinic Version and Provider-Based Department Version. Kimberly serves as a Regulatory Specialist for HCPro's Medicare Watchdog services, specializing in regulatory guidance on coverage, billing and reimbursement. She is a frequent expert on HCPro's audio-conferences and has been a speaker at national conferences on patient status and observation.

Kimberly has served as a Compliance Officer and In House Legal Counsel and has developed and implemented corporate-wide compliance programs for two hospitals. As a hospital compliance officer, she regularly provided research and guidance on coding, billing and reimbursement issues for a wide-range of hospital services. She has experience conducting billing compliance audits and internal investigations.

As In House Legal Counsel, Kimberly has had oversight of expense contracting and regulatory compliance, including federal and state laws and regulations. Kimberly regularly provided legal advice on such complex topics as EMTALA, fraud and abuse issues, Stark, anti-kickback and anti-inducement laws, contracting, physician recruiting, and tax exemption regulations.

Kimberly is a member of the California Bar Association and the American Health Lawyers Association. Kimberly earned her Juris Doctor degree from the University of Montana School of Law, where she received the Corpus Juris Secundum Award for Excellence in Contracts. She also holds a Bachelor of Arts degree in Philosophy from Yale University. Kimberly is licensed to practice law in the state of California.¹

¹ No legal services are provided through HCPro, Inc.



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Yvette DeVay is the lead instructor for the HCPro's Medicare Boot Camp® - Physician Services. In her current role as a Regulatory Specialist, she also instructs the Certified Coder Boot Camp® (live and online) and the Evaluation and Management Boot Camp®.

Yvette has extensive experience as a Professional/Outpatient Coding Consultant. In this position, she assisted physician practices with coding integrity, internal audits, charge capture and litigation defense. She has also served as the ICD-10 Project Manager for a State Medicaid Agency. As project manager, she established the implementation schedule, steering committees, and workgroups. She was an active participant in the gap analysis, policy review and ICD-10 revisions. In addition to her role as Project Manager, she was responsible for department wide ICD-10 awareness and education.

Yvette has also worked with a major Mid-Atlantic payer on their ICD-10 conversion of system-based diagnosis edits. During the conversion, Yvette was responsible for the mapping of all diagnosis codes found in the 400 + rules-based edits.

She has extensive knowledge of Medicare coding, billing and compliance issues. She worked with a Medicare Program Safeguard Contractor where she filled the roles of data analyst, policy consultant, and data manager during her employment. At the PSC, Yvette was involved in various initiatives designed to identify and address aberrant billing patterns and to promote compliance with Federal Medicare regulations and guidelines. She also provided data analysis support for State and Federal law enforcement authorities including the Office of Inspector General. She also developed and presented various educational programs for investigative personnel focusing on coding issues and Medicare regulations/guidelines.

Yvette has also served as an instructor for a local community college, as an internal corporate trainer on matters of coding and Medicare regulations. She has created, developed, and authored curriculum focused on Medicare regulations, professional and inpatient coding.

Yvette is an AHIMA Approved ICD-10-CM/PCS Trainer. She is accredited as a Certified Professional Coder and a Certified Inpatient Coder by the American Academy of Professional Coders. She is also approved as a Professional Medical Coding Curriculum (PMCC) Instructor through the AAPC. She holds a Masters of Health Administration from Seton Hall University and a Bachelor of Science in Applied Behavioral Sciences from Pennsylvania State University.



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Ms. Kares serves currently as an adjunct instructor for HCPro's Medicare Boot Camp® – Hospital Version, Utilization Review Version, Critical Access Hospital Version, as well as Rural Health Clinic Version. In addition, she is a practicing attorney and compliance consultant with more than thirty years of experience representing hospitals, third-party payers and other health care clients in the areas of health care contracting and regulatory compliance. In that capacity, Ms. Kares has been involved in the following:

- Development of comprehensive compliance programs
- Initial and follow-up risk assessments
- Development and implementation of compliance training programs
- Compliance audits and internal investigations
- Research/advice regarding specific risk areas
- Development of corrective action programs

Prior to beginning her current consulting practice, Ms. Kares spent a number of years in private law practice, representing hospitals and other health care clients, and then as in-house legal counsel to Blue Cross and Blue Shield of Arizona (BCBSAZ) and Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) in Washington, D.C. In both in-house positions, she had primary responsibility for contracting and regulatory compliance, including oversight of federal and state health care programs.

Ms. Kares has also been an adjunct faculty member at the University of Phoenix, teaching courses in health care law and ethics. She is an advocate for the use of alternatives to traditional dispute resolution, having participated in the volunteer mediation program in the Justice Courts of Maricopa County, Arizona. Ms. Kares earned her Juris Doctor degree (with high distinction) from The University of Iowa, College of Law and her B.A. (with highest distinction) from Purdue University. Ms. Kares is a frequent speaker at healthcare and related seminars. She is a member of the State Bar of Arizona and the Tennessee Bar Association.



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Joe is a Regulatory Specialist for HCPro, Inc. He is the Lead Instructor for the Revenue Integrity and Chargemaster Boot Camp®. Rivet also instructs the Medicare Boot Camp® – Hospital Version, Critical Access Hospital Version, as well as Rural Health Clinic Version. In addition, he is a practicing attorney with a practice focus on healthcare reimbursement. Joe has over twenty years in healthcare operations. He is a frequent expert on HCPro's audio-conferences and has been a speaker at national conferences on reimbursement topics.

Before Joe became an attorney, he worked in numerous health care settings, including community hospitals, large medical groups, and one of the nation's largest integrated delivery systems. Additionally, he has served as a compliance and privacy officer for a factuality practice and large Emergency Medical Services (EMS) billing and coding company.

Joe has led the fraud, waste, and abuse (FWA) divisions of two large health plans. The depth and breadth of his payor experience provides invaluable insight for providers with respect to payor audits, the claims adjudication process, appeals, payor policies, managed care contracts, and audit operations.

He is the author of "E/M Auditing: A Step-By-Step Guide to Updated Coding, Reimbursement, and Compliance," published by HCPro.

Joe is a member of the Michigan State Bar Association, American Bar Association, and the American Health Lawyers Association and committee member of State Bar of Michigan Payor Sub-Committee. He is licensed to practice law in the state of Michigan.¹

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Valerie Rinkle is an adjunct instructor for HCPro. She was the lead instructor when she created HCPro's Revenue Integrity and Chargemaster Boot Camp® in 2016. Valerie is president of Valorize Consulting, LLC, a reimbursement and revenue integrity consulting firm. Valerie is also on the National Association of Healthcare Revenue Integrity's Advisory Board. She has over 38 years of experience in the healthcare industry, including 10 years as a revenue cycle director for an integrated delivery system. She has extensive experience with both the inpatient and outpatient Prospective Payment Systems (IPPS, OPPOS), Physician, Clinical Laboratory and Durable Medical Equipment Prosthetic and Orthotic Supply Fee Schedules (MPFS, CLFS, DMEPOS) and related coverage, coding, billing and reimbursement issues. She has held the positions of the Reimbursement Manager and Revenue Cycle Director for healthcare systems.

Valerie consults with hospitals, physicians and other healthcare providers and manufacturers on a wide range of revenue cycle and payment issues, including coverage, coding, setting and payment and regarding high-risk compliance areas identified by government program auditors. She has extensive expertise in revenue integrity functions including charge description master reviews and maintenance, charge capture and documentation improvement.

Valerie holds a master's degree in Public Administration. She is a nationally recognized speaker on a variety of payment system and compliance topics for various organizations and revenue cycle events. Valerie is an active member of the Healthcare Financial Management Association (HFMA) and the National Association of Healthcare Revenue Integrity (NAHRI).



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 1: Medicare Overview and Contractors

I. The Four Parts of Medicare

A. Medicare Part A

1. Part A covers inpatient care, including:
 - a. Hospital care at a general acute care hospital, Critical Access Hospital (CAH), Inpatient Rehabilitation Facility, Inpatient Psychiatric Facility, or Long Term Acute Care Hospital (LTCH);
 - b. Care at a Religious Nonmedical Health Care Institution;
 - c. Skilled Nursing Facility (SNF) care;
 - d. Home Health care (under a home health plan of care);
 - e. Hospice care. <Medicare.gov, “What Part A covers” website>
2. These facilities are referred to as “providers” under the Medicare regulations. <42 C.F.R. 400.202>
3. The beneficiary generally doesn’t pay a premium for Part A if they, or their spouse, paid Medicare taxes. <Medicare.gov, “Part A costs” website>
 - a. If an individual doesn’t qualify for premium free Part A benefits, they can purchase them. To purchase Part A, the beneficiary must generally also purchase Part B and may have to meet certain other requirements. <Medicare.gov, “Part A costs” website>
4. Institutional providers bill Part A services to the Medicare Administrative Contractor (MAC) using the UB-04/837I claim format. <Medicare Billing: 837I and Form CMS-1450 Fact Sheet>
 - a. Course note: The MAC is discussed later in this outline. The UB-04/837I format is discussed in a later module.

B. Medicare Part B

1. Part B covers inpatient, outpatient, and medical care, including:
 - a. Outpatient hospital diagnostic and non-diagnostic (therapeutic) services;
 - b. Certain inpatient hospital services, discussed in a later module;
 - c. Certain SNF¹ and Home Health² services;
 - d. Preventative services provided to inpatients or outpatients;
 - e. Physician and other professional services, including outpatient therapy;
 - f. Ambulatory Surgery Center (ASC) services;
 - g. Independent Diagnostic Testing Facility (IDTF) and Clinical Diagnostic Laboratory services; and
 - h. Durable Medical Equipment (DME). <Medicare.gov, “What Part B covers” website>
 2. These services can be provided by institutional “providers” or “suppliers”, including physicians and other non-institutional providers. <42 C.F.R. 400.202>
 3. The beneficiary generally pays a premium for Part B. <Medicare.gov, “Part B costs” website>
 - a. The beneficiary may purchase Part B, even if they are not eligible for or do not purchase Part A.
- Medicare beneficiaries may have both Part A and Part B or just Part A or just Part B. Enrollment should be verified
4. Institutional providers bill Part B services to the MAC on the UB-04/837I claim format. <Medicare Billing: 837I and Form CMS-1450 Fact Sheet>
 - a. Physicians and other non-institutional suppliers bill Part B services to the MAC using the CMS 1500/837P claim format.

¹ SNF services provided to non-inpatient beneficiaries, provided to beneficiaries not in a covered Part A stay, or excluded from the Part A prospective payment system.

² Home Health services provided outside a plan of care.

C. Medicare Part C

1. Medicare Part C is an alternative to traditional fee-for-service Medicare Part A and B. Private insurance companies offer Part C in the form of Medicare Advantage (MA) plans. <Medicare.gov, “Your Medicare coverage choices” website>
2. MA plans must cover all services traditional Medicare covers, except hospice care. <Medicare.gov, “What Medicare health plans cover” website>
 - a. Traditional fee-for-service Medicare covers hospice care for beneficiaries covered by MA Plans. <Medicare.gov, “What Medicare health plans cover” website>
3. MA plans may cover additional services, including vision, hearing, dental, or preventative services not covered by traditional fee-for-service Medicare. <Medicare.gov, “What Medicare health plans cover” website>
4. MA plans most commonly take the form of Health Maintenance Organizations (HMOs). They may also be Preferred Provider Organizations (PPOs), Private Fee-For-Service (PFFS) plans, or Special Needs Plans (SNPs). <Medicare.gov, “Different types of Medicare Advantage Plans” website>
5. MA Plans pay hospitals according to their contract with the hospital or, if they are not contracted with the hospital, they must generally pay the hospital at least the traditional Medicare payment rate. <MA Payment Guide for Out of Network Payments, 4/15/2015 Update>
 - a. Medicare publishes a very helpful guide for payments by MA plans to out of network providers on their “Provider Payment Dispute Resolution for Non-Contracted Providers” website.

Link: Medicare Advantage Out of Network Payment Guide under Medicare-Related Sites - General

D. Medicare Part D

1. Part D covers prescription drugs for Medicare beneficiaries. Part D plans are designed to cover drugs obtained from a retail pharmacy.
 - a. Part D may cover drugs, not covered under Part B, provided in hospital outpatient departments. If the hospital is not contracted with the Part D plan, the beneficiary may have to request out of network reimbursement from their Part D plan. <How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Setting>

II. Medicare Administrative, Program Integrity, and Appeal Contractors

A. The Centers for Medicare and Medicaid Services (CMS) use multiple functional contractors to perform the functions necessary to administer the Medicare program.

B. Part A/B Medicare Administrative Contractors (MACs)

1. MACs are Medicare contractors who perform all core claims processing functions and act as the primary point of contact for providers and suppliers for functions such as enrollment, education, coverage, billing, processing, redetermination requests, payment, and auditing. <CMS.gov, “What is a MAC” website>
 - a. MACs publish substantial claims processing, billing, and coding guidance on their websites, including medical review and documentation guidelines, coverage policies, and appeals and audit information.

Tip: Medicare contractors sometimes refer to hospital outpatient services as “Part B of A” or simply Part A outpatient services. Policies and guidance for outpatient services are found on MAC Part A websites even though these services are covered under Part B.

2. There are 12 Part A/B MACs, designated by either a letter or number. <See “Medicare Administrative Contractors (MACs) As of June 2021”; see “A/B Jurisdiction Map as of June 2021”>

In 2010, CMS began consolidating the original 15 MAC jurisdictions (designated by numbers) into 10 consolidated MACs (designated by letters). In 2014, after consolidating 12 jurisdictions, CMS discontinued the consolidation leaving four numbered jurisdictions (J5, J6, J8, and J15).

- a. CMS publishes a map with state-by-state contractor information.

Link: Medicare Contractor Interactive Map under Medicare-Related Sites - General

C. Recovery Audit Contractors/Recovery Auditors (RAC)³

1. CMS identified 4 Part A/B Recovery Audit Jurisdictions (i.e., Regions 1-4). <See “A/B Recovery Audit Program Regions”>
2. CMS contracts with one Recovery Auditor for each jurisdiction, who is paid a contingency fee based on identified overpayments and underpayments. <CMS.gov, “Medicare Fee for Service Recovery Audit Program” website>
3. CMS publishes all proposed and approved audit topics on their website.

Link: Medicare Fee for Service Recovery Audit Program, under Medicare-Related Sites - General

4. Recovery Auditors have a three year look back period, from the claims paid date to the date of the medical record request (for complex reviews) or the overpayment notification letter (for automated reviews). <Statement of Work (SOW) for the Part A/B Medicare Fee-for-Service Recovery Audit Contractor (RAC)>
5. Recovery Auditors can make a limited number of Additional Documentation Requests (ADRs) for medical records from a provider each 45-day period.
 - a. The medical record limit is adjusted based on the provider’s denial rate over the prior 12-month period and is recalculated after every three 45-day audit periods. <“Institutional Provider (i.e. Facilities) Additional Documentation Request (ADR) Limits (As of May 1, 2022)”, CMS.gov website>
 - b. For details on how ADR limits are calculated, refer to the Resources page of the Recovery Audit Program site in the document link labeled ADR-Limits-Institutional-Provider (Facilities)-May 1, 2022 (PDF).

D. Unified Program Integrity Contractors (UPICs)

1. Unified Program Integrity Contractors (UPICs) combine and integrate the functions of the former Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs) and Medicaid Integrity Contractors (MICs). <CMS.gov, Review Contract Directive Interactive Map Page>

³ CMS uses the terms Recovery Auditor and Recovery Audit Contractor (RAC) interchangeably.

2. The UPICs perform integrity related activities (e.g., investigations and audits) associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi) in five geographic jurisdictions. <CMS.gov, Review Contract Directive Interactive Map Page>

In performing fraud and abuse functions, UPIC may:

- Conduct investigations and perform medical review
- Perform data analysis
- Request medical records and documentation
- Conduct interviews with beneficiaries, complainants, or providers
- Conduct site verification or onsite visits
- Identify the need for a prepayment or auto-denial edit
- Share information with other UPICs/ZPICs
- Institute a provider payment suspension
- Refer cases to law enforcement to consider civil or criminal prosecution

E. Comprehensive Error Rate Testing Program Contractor (CERT)

1. CMS contracts with CERT contractors to perform audits to measure the error rate of Medicare paid claims. <CMS.gov, “Comprehensive Error Rate Testing” website>
 - a. The CERT contractor uses a statistically valid random sample of approximately 50,000 claims to determine a national improper payment rate for the Medicare program. <CMS.gov, “Comprehensive Error Rate Testing” website>
 - b. The CERT contractor assigns of improper payment categories:
 - i. No Documentation
 - ii. Insufficient Documentation
 - iii. Medical Necessity
 - iv. Incorrect Coding
 - v. Other
 - a) Examples include duplicate payment error and non-covered or unallowable service

F. Supplemental Medical Review Contractors (SMRCs)

1. CMS contracts with SMRCs to perform and provide support for a variety of tasks, including nationwide medical review audits aimed at lowering improper payment rates by conducting reviews focused on vulnerabilities identified by CMS. <CMS.gov, “Supplemental Medical Review Contractor” website>
2. SMRC’s conduct medical reviews selected based upon multiple sources of information including, but not limited to:
 - a. CMS identified vulnerabilities;
 - b. OIG/GAO (Office of Inspector General/Government Accountability Office) identified issues; and
 - c. Comprehensive Error Rate Testing (CERT) Errors. <Medicare Program Integrity Manual, Chapter 1 § 1.3.1>

G. Quality Improvement Organizations (QIOs)

1. Beneficiary and Family Centered Care QIOs (BFCC-QIOs) manage beneficiary complaints and quality of care reviews, including beneficiary discharge appeals. <CMS.gov, “Quality Improvement Organizations” website; CMS.gov, “Inpatient Hospital Reviews” website; 80 *Fed. Reg.* 39350-53>
2. CMS contracts with two BFCC-QIOs, KEPRO and Livanta, to provide services in 10 distinct areas designated by CMS. For details, refer to the QIO map included in the materials behind the outline. <See “QIO MAP”>
3. Short Stay Reviews
 - a. One of the QIOs, Livanta, was awarded a national contract to conduct short stay reviews (SSRs) and higher weighted DRG reviews in all QIO jurisdictions.
 - b. Livanta has posted a schedule of the weeks they will request medical records for SSRs in 2023, included in the materials behind the outline.

Link: QIO Livanta Provider Resources under Medicare-Related Sites - Hospital

- c. Livanta has posted “Claim Review Advisors” that address the following topics:
 - i. Guidelines for conducting SSRs;

- ii. Sampling strategy and a sample medical record request; and
 - iii. Clinical scenarios such as chest pain, atrial fibrillation, and congestive heart failure, available on the Livanta Provider Resources page. <Livanta National Claim Review Contractor website>
4. Providers can sign up to receive information from Livanta, including Claim Review Advisors, Provider Bulletins, and other publications.

Link: Livanta Claims Review Advisors under Listserv Subscriptions

H. Qualified Independent Contractors (QICs)

1. QICs conduct the second level of appeal if the MAC denies the providers first level appeal. <CMS.gov, “Second Level of Appeal: Reconsideration by a Qualified Independent Contractor” website>

III. Independent Government Entities

A. Departmental Appeals Board (DAB)

1. DAB is an agency within the Department of Health and Human Services that provides independent review of disputed decisions in a wide range of Department programs under more than 60 statutory provisions. <DAB Website, Background>
2. The two primary divisions of DAB with respect to Medicare disputes and appeals are:
 - a. Office of Medicare Hearings and Appeals (OMHA);
 - i. The Administrative Law Judges (and attorney advisors) are employed directly by the Office of Medicare Hearings and Appeals (OMHA).
 - ii. ALJs issue third level appeal decisions following an appeal of a decision of the QIC.
 - b. Medicare Appeals Council (often referred to as either “MAC” or the Council)
 - i. The Council provides the final administrative review (fourth level of appeal) of claims for entitlement to Medicare and individual claims for Medicare coverage and payment filed by beneficiaries or health care providers/suppliers appealed from the ALJs.

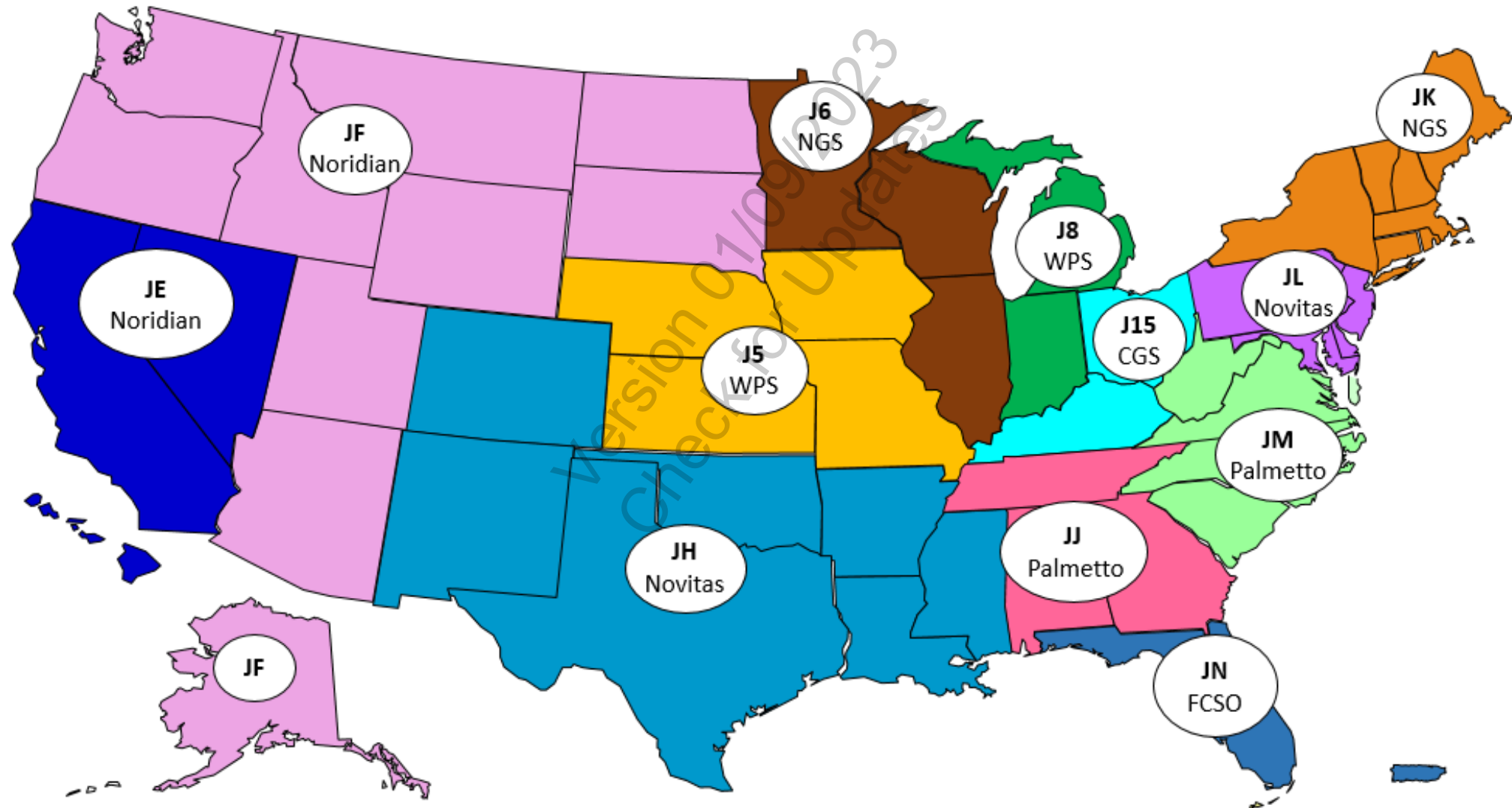
B. Department of Health and Human Services Office of Inspector General (OIG)

1. The DHHS OIG is the largest inspector general's office in the Federal Government, with the majority of their resources directed at oversight of the Medicare and Medicaid programs. <About OIG, HHS OIG website>
2. The DHHS OIG conducts nationwide audits, investigations, and evaluations; publishes an annual work plan of audit activity; provides cost saving and policy recommendations; and develops and distributes resources to assist health care providers with compliance with fraud and abuse laws. <About OIG, HHS OIG website>

Version 01/09/2023
Check for Updates

A/B MAC Jurisdictions as of June 2021

1 - 16

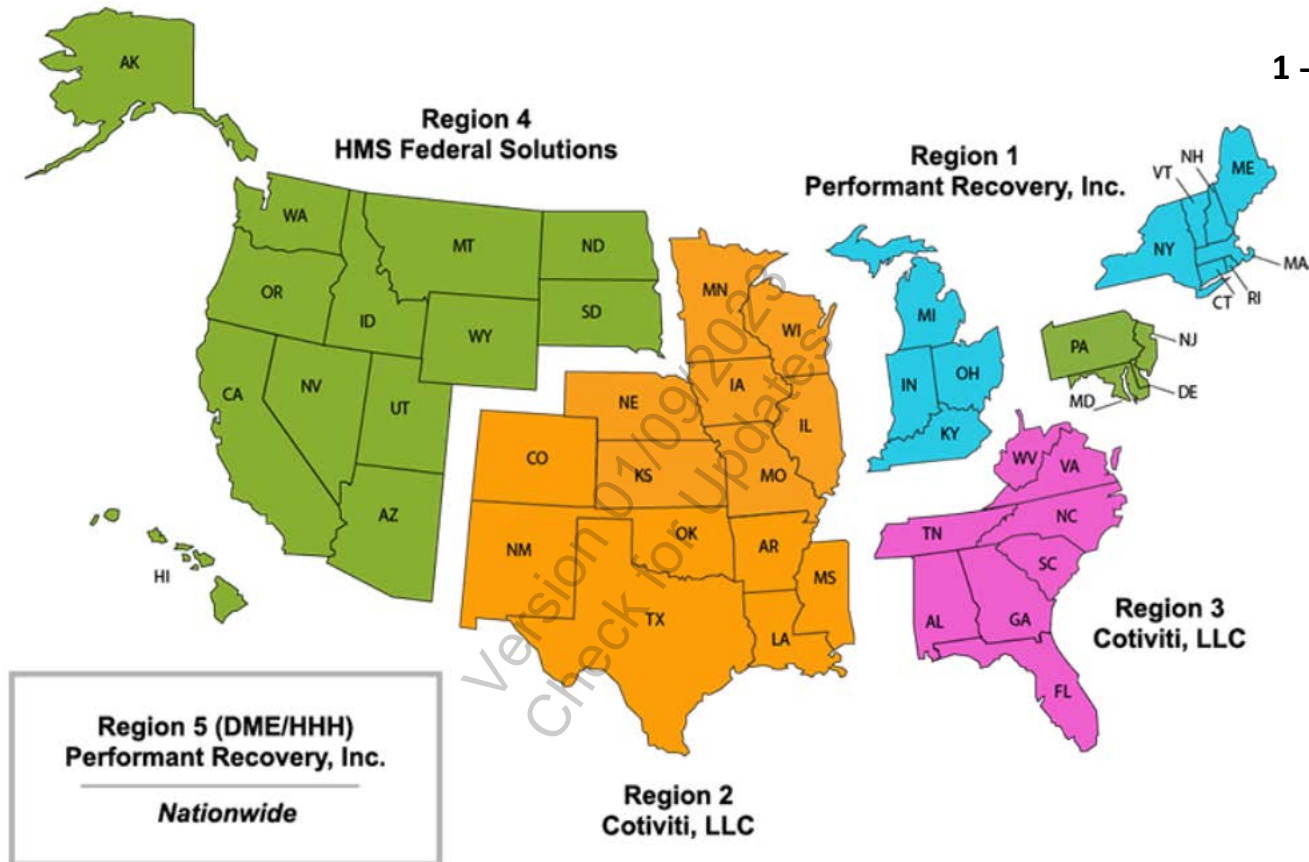


Medicare Administrative Contractors (MACs)
As of June 2021

1 - 17

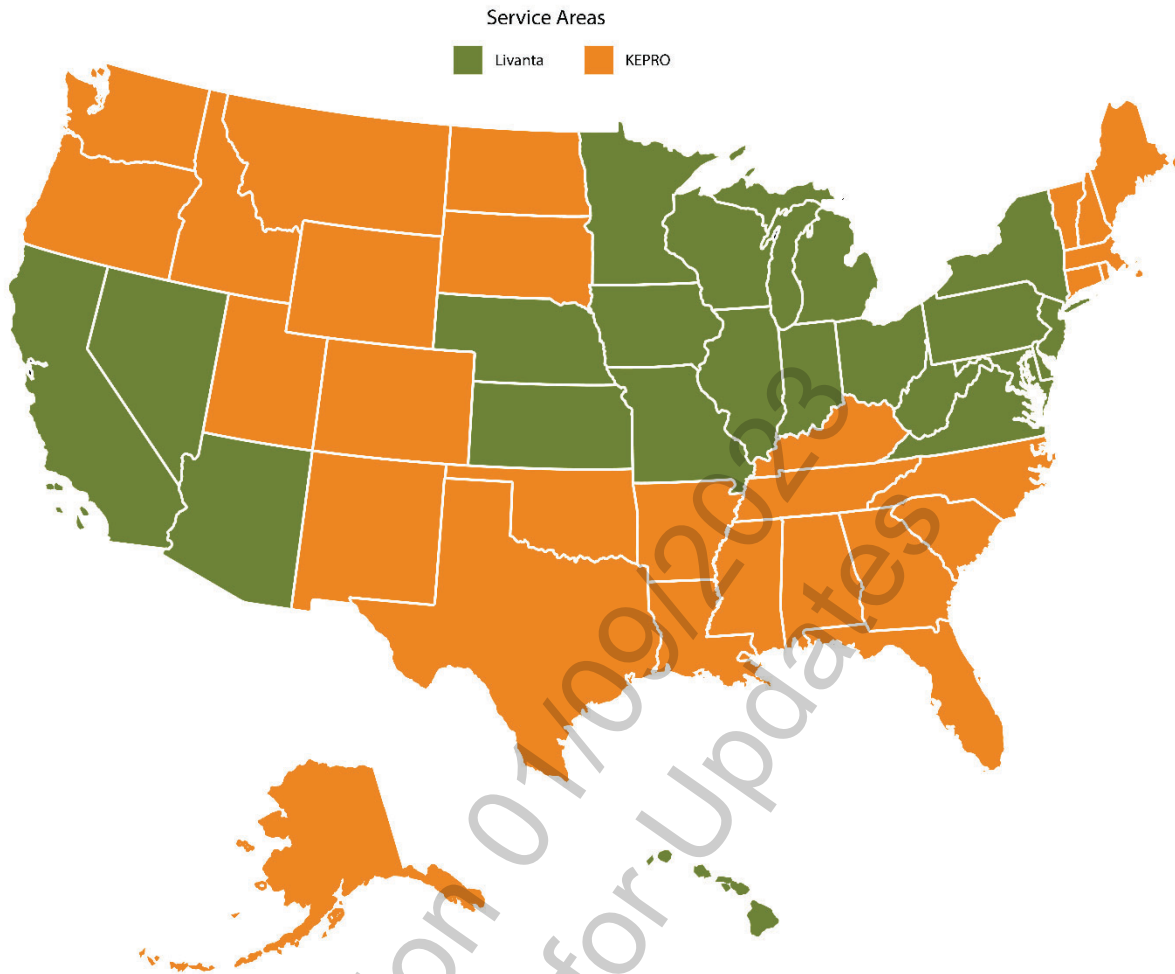
MAC Jurisdiction	Processes Part A & Part B Claims for the following states/territories:	MAC
DME A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	Noridian Healthcare Solutions, LLC
DME B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin	CGS Administrators, LLC
DME C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, Puerto Rico, U.S. Virgin Islands	CGS Administrators, LLC
DME D	Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands	Noridian Healthcare Solutions, LLC
5	Iowa, Kansas, Missouri, Nebraska	Wisconsin Physicians Service Government Health Administrators
6	Illinois, Minnesota, Wisconsin **HH + H for the following states: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, US Virgin Islands, Wisconsin and Washington	National Government Services, Inc.
8	Indiana, Michigan	Wisconsin Physicians Service Government Health Administrators
15	Kentucky, Ohio **HH + H for the following states: Delaware, District of Columbia, Colorado, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, and Wyoming	CGS Administrators, LLC
E	California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands	Noridian Healthcare Solutions, LLC
F	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	Noridian Healthcare Solutions, LLC
H	Arkansas, Colorado, New Mexico, Oklahoma, Texas, Louisiana, Mississippi	Novitas Solutions, Inc.
J	Alabama, Georgia, Tennessee	Palmetto GBA, LLC
K	Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont **HH + H for the following states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	National Government Services, Inc.
L	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania (includes Part B for counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia)	Novitas Solutions, Inc.
M	North Carolina, South Carolina, Virginia, West Virginia (excludes Part B for the counties of Arlington and Fairfax in Virginia and the city of Alexandria in Virginia) **HH + H for the following states: Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas	Palmetto GBA, LLC
N	Florida, Puerto Rico, U.S. Virgin Islands	First Coast Service Options, Inc.

**Also Processes Home Health and Hospice claims



RACs in Regions 1-4 will perform post payment review to identify and correct Medicare claims specific to Part A and Part B.

QIO MAP



BFCC-QIOs will continue to help Medicare patients [file an appeal](#) if patients (or their families) think they are being discharged from the hospital (or services are ending) too soon. Medicare patients can also [file a complaint](#) when they have a concern about the quality of medical care they are receiving from a health care professional or facility.

How do the new contracts affect healthcare providers?

As a result of BFCC-QIOs providing services to different states (see above to see which BFCC-QIO covers your state), you may or may not have the same BFCC-QIO. To learn more about how this may affect your facility, as well as any action you may need to take, please visit www.keproqio.com/transition or <https://livantaqio.com/en/provider/transition>.

Livanta National Medicare Claim Review Contractor

Short Stay Review

Formerly known as the “Two-Midnight Rule Review,” claim reviews for short hospital stays focus on the claims submitted by providers when a patient was admitted to the hospital as an inpatient but discharged less than two days later. Inpatient admissions are generally payable under Part A if the admitting practitioner expects the patient to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation.

Through the CMS claim review activity, reviewers at Livanta obtain and evaluate the medical record to ensure that the patient’s admission and discharge were medically appropriate based on the documentation of the patient’s condition and treatment rendered during the stay, and that the corresponding Part A Medicare claim submitted by the provider was appropriate.

Short Stay Review Department: 844-743-7570

Livanta samples Short Stay claims on a monthly basis. For sampled claims, Livanta requests the corresponding medical records and completes the Short Stay review. The dates below are the weeks Livanta plans to request medical records for SSR sampled claims through 2023. **Please note that 11/07/22 is a revised date.**

10/04/2021	06/06/2022	1/2/2023	7/3/2023
11/01/2021	07/04/2022	2/6/2023	8/7/2023
12/06/2021	08/01/2022	3/6/2023	9/4/2023
01/03/2022	09/05/2022	4/3/2023	10/2/2023
02/07/2022	10/03/2022	5/1/2023	11/6/2023
03/07/2022	11/07/2022	6/5/2023	12/4/2023
04/04/2022	12/05/2022		
05/02/2022			

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