



Physician Services 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 physicians according to their contract with the physician or, if they are not contracted with the physician, they must generally pay the physician 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 an outpatient/office setting. If the physician is not contracted with the Part D plan, the beneficiary may have to request out of network reimbursement from their Part D plan.

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>

IV. Key Sources of Authority (i.e., Medicare "Rules")

- A. For your reference, Attachment A contains a listing of each of the types of source authority that will be discussed, as well as where it is published, where to find it on the web and example citations.

B. Statutes

1. Public Laws

- a. Congress adopts new statutes as Public Laws. Public Laws are found on Congress.gov, maintained by the Library of Congress.
- b. Refer to the "Congress.gov" link under the "Regulations and Statutes" section on HCPro's links page.
- c. Each public law has a home page that provides information on the adoption of the bill and the final text.
 - i. Note: Under the "Text" tab, use the "Enrolled Bill" for an easy to use version of the text of a bill, with embedded links to related provisions.

2. *United States Code (U.S.C.)*

- a. The *U.S.C.* is a compilation of the statutes of the United States.
 - i. Title 42 of the *U.S.C.*, which contains the Medicare laws, has not been enacted as positive law. Its text is prima facie evidence of the law, but the text of the Public Law, as enacted, takes precedence in the event of a conflict.
- b. Refer to the "United States Code (Federal Statutes)" link under the "Regulations and Statutes" section on HCPro's links page.

3. Social Security Act

- a. Frequently, Medicare laws are cited by their Social Security Act section number, rather than their *U.S.C.* section number. The Social Security Administration maintains an updated version of the Social Security Act.
- b. Refer to the "Social Security Act, Title 18 (Medicare)" link under the "Regulations and Statutes" section on HCPro's links page.

C. Regulations

1. *Federal Register*

- a. CMS adopts new regulations in the *Federal Register*.
 - i. Typically, regulations are first published as proposed rules, with a request for public comment. After gathering the comments, the agency publishes a final rule responding to the comments in the preamble of the rule and adopting the final regulations.
- b. Refer to the "Federal Register" link under the "Regulations and Statutes" section on HCPro's links page.
 - i. Note: On this page, you can browse by date or use the "Search the Federal Register by citation" link on the left navigation area to search for a particular volume and page number.
- c. CMS also makes display copies of important proposed and final rules, along with accompanying data files and tables, available on their website.
 - i. Refer to the "Physician Fee Schedule -Regulations" link under the "Medicare Related Sites – Physician" section on HCPro's links page.

D. Sub-Regulatory Guidance

- 1. Sub-regulatory guidance such as manuals and transmittals is not binding on Medicare contractors or Administrative Law Judges (ALJs). Regulations require they give "substantial deference" to the guidance applicable to a case and if they do not follow it, explain why in their decision letter. <42 C.F.R. 405.1062>
- 2. CMS Manuals – published on the CMS web site.
 - a. "Paper-based" Manuals

- i. The Provider Reimbursement Manual, containing charging and cost reporting guidelines, is available in a “paper-based” manual version and must be downloaded from the “Paper-Based Manuals” web site.
- ii. Refer to the “Manuals – Paper Based Manuals” link under the “Medicare Related Sites – General” section on HCPro’s links page.

3. “Internet-only” Manuals (IOM)

- a. The following IOM manuals should be of particular relevance for questions relating to Medicare coverage, coding, billing and payment for physician services.
 - i. *Pub. 100-2 – Medicare Benefit Policy (basic coverage rules)*
 - ii. *Pub. 100-3 – Medicare National Coverage Determinations (national coverage decisions)*
 - iii. *Pub. 100-4 – Medicare Claims Processing*
 - iv. *Pub. 100-05 – Medicare Secondary Payer Manual provides information related to Medicare as a primary or secondary payer.*
- b. Caution: CMS often removes or revises manual sections without providing an archive of prior versions. Providers should retain their own copy (printed or electronic) of manual sections they rely on for policy decisions.

4. CMS Transmittals and Program Memoranda – published on the CMS web site

- a. Transmittals communicate new or revised policies or procedures, as well as new, deleted or revised manual language.
 - i. Program Memoranda were used prior to October 1, 2013 to communicate information similar to transmittals.
- b. Refer to the “Transmittals and Program Memoranda” link under the “Medicare Related Sites – General” section on HCPro’s link page.
 - i. Note: Use the links on the left navigation area to access transmittals or program memoranda from prior years.
- c. Transmittals are numbered with an “R” followed by a sequential number distinct to the transmittal and two or more letters representing the manual the transmittal is associated with (e.g., CP for Claims Processing).

- i. Transmittals with the OTN designation are global in nature and not tied to a particular substantive manual.
- d. Transmittals are linked to a change request (CR) number, CMS' internal tracking number, tying together documents associated with a particular policy change. CMS representatives often use the CR number rather than transmittal number when referring to policy changes.
 - i. A single CR may be associated with multiple transmittals if the policy represented by the CR affects multiple manuals, for example one change request may have an associated *Medicare Claims Processing Manual Transmittal* and a *Medicare Benefit Policy Manual Transmittal*.
 - ii. The CR number is also used in the numbering of associated *MLN Matters Articles*, discussed later in this outline.
- e. Components of a Transmittal
 - i. "Date" (in the header) represents the date the transmittal was published.
 - ii. "Effective Date" represents the date of service the policy in the transmittal will begin to apply, unless noted otherwise.
 - a) **Caution:** The effective date of a transmittal may be prior to the date the transmittal was published, which may affect coverage, coding, billing, or payment of services already rendered.
 - iii. "Implementation Date" represents the date processing systems will be able to process claims correctly according to the policies in the transmittal, unless noted otherwise.
 - a) **Caution:** The implementation date is generally the first business day of the quarter or year after the transmittal is effective, but may be substantially after the effective date. A provider may need to hold claims affected by the transmittal until system changes are implemented.
 - iv. If there are new, deleted, or revised manual sections associated with the transmittal, they will be listed in the "Changes in Manual Instructions" table at the beginning of the transmittal.
 - v. The text of new or revised manual sections will appear after the attachments at the end of the transmittal.

E. MLN Matters Articles

1. There are two types of MLN Matters Articles:
 - b. MLN Matters Articles are articles that explain Medicare policy in easy to understand format, often written for specific provider types as noted at the top of the article.
 - c. Refer to the “MLN Matters Articles – Overview Page” link under the “Medicare Related Sites – General” section on HCPro’s links page.
 - d. There are two types of MLN Matters Articles:
 - i. MLN Matters Articles linked to a particular transmittal are intended to provide practical and operational information about the transmittal.
 - a) MLN Matters Articles linked to transmittals are numbered “MM” followed by the CR number for the transmittal.
 - b) Note: In addition to being published on the MLN website, a link for MLN Matters Articles associated with a transmittal appears below the link for the transmittal on the transmittal’s home page.
 - ii. Special Edition MLN Matters Articles are not linked to a transmittal but rather provide information on topics CMS believes require additional clarification. They frequently provide information not found in transmittals or manuals.
 - a) Special Edition MLN Matters Articles are numbered “SE”, followed by two digits representing the year it was published, followed by a sequential number distinct to the article. For example, *SE1418* would be the 18th Special Edition MLN Matters Article published in 2014.
 - b) Note: In addition to appearing on the MLN website, Special Edition MLN Matters Articles are listed on the transmittals website for the year they were published.
 - a. Frequently Asked Questions – published on the CMS web site
 - b. CMS maintains an FAQ website with questions and answers indexed by an FAQ number.
 - c. Refer to the “Frequently Asked Questions Database” link under the “Medicare Related Sites – General” section on HCPro’s links page.

F. Other Guidance

1. CMS frequently posts other guidance on their web site in the form of documents or postings with important information.

V. National and Local Coverage Policies

A. Medicare Coverage Database

1. CMS hosts a comprehensive coverage website entitled the Medicare Coverage Database where they publish National and Local Coverage Determinations and related documents.
2. Refer to the "Coverage Database (NCDs, NCAs, LCDs)" link under the "Medicare Related Sites – General" section on HCPro's links page.
3. Types of Documents on the Medicare Coverage Database
 - a. National Coverage Determinations (NCDs)
 - i. NCDs describe national Medicare coverage policy and generally provide the conditions under which an item or service is considered to be covered. < *Medicare Program Integrity Manual*, Chapter 13 § 13.1.1 >
 - ii. NCDs are binding on all Medicare contractors and in most cases on ALJs in the appeals process. < 42 C.F.R. 405.1060; *Medicare Program Integrity Manual*, Chapter 13 § 13.1.1 >
 - b. National Coverage Analyses (NCAs) and Decision Memoranda
 - i. CMS publishes NCAs and Decision Memoranda describing CMS coverage decisions and providing the clinical basis and the rationale of the decisions, including clinical evidence and studies.
 - ii. NCAs and Coverage Decision Memoranda are not binding on Medicare Contractors or ALJs, but CMS directs contractors to consider them in their medical review activities. < *Medicare Program Integrity Manual*, Chapter 12 § 13.1.1 >
 - c. Coding Analyses for Labs (CALs), Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) Meeting minutes, Technology Assessments (TAs) and Medicare Coverage Documents (MCDs)
 - i. CALs, MEDCAC meeting minutes, TAs, and MCDs provide additional guidance on national Medicare coverage policies and decisions.
 - d. Local Coverage Determination

- i. MACs publish LCDs to describe local coverage policy and as an educational tool to assist and furnish guidance to providers within their jurisdiction. <Medicare Program Integrity Manual, Chapter 13 § 13.1.3>
 - a) LCDs were formerly called Local Medical Review Policies (LMRPs) and were converted to LCDs between 2003 and 2005. <Medicare Program Integrity Manual, Chapter 13 § 13.1.3>
- ii. LCDs are not binding on Medicare contractors or ALJs. Regulations require contractors and ALJs give substantial deference to LCDs applicable to a case and if they do not follow an LCD, explain why in their decision letter. <42 C.F.R. 405.1062>
- e. Local Coverage Articles
 - i. MACs publish coverage articles addressing local coverage, coding, billing, medical review, and claims considerations. The articles may include newly developed educational materials, coding instructions, or clarification of existing billing or claims policy.

B. Coverage with Evidence Development (CED)

1. CED policies cover items or services on the condition they are furnished in the context of approved clinical studies or with the collection of additional clinical data. <See *Guidance for the Public, Industry, and CMS Staff; Coverage with Evidence Development Document*, Issued on November 20, 2014>
2. Refer to the "Coverage with Evidence Development (CED)" link under the "Medicare Related Sites – General" section on HCPro's links page.
 - a. Note: Use the links on the left navigation area to access an information page for each item or service covered under CED.
3. The routine costs of items and services, associated with services covered under CED, are also covered as long as the items or services are generally covered for Medicare beneficiaries. <See *Guidance for the Public, Industry, and CMS Staff; Coverage with Evidence Development Document*, Issued on November 20, 2014>
4. Clinical Trial Reporting for CEDs
 - a. The following should be reported on claims for services covered under CED. <See *MLN Matters Article MM8401; Medicare Claims Processing Manual*, Chapter 32 §§ 68.2, 69.5, 69.6>

- i. For claims with dates of service on or after January 1, 2014 it is mandatory to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED.
 - a) The 8-digit clinical trial number should be reported in field 19 of the CMS 1500 form.
 - 1) The clinical trial number should be preceded by "CT" in field locator 19.
 - 2) "CT" is not to be used for electronic claims.
- ii. ICD-10 code Z00.6 ("Encounter for examination for normal comparison and control in clinical research program"); and
 - a) Modifier -Q0 ("Investigational clinical service provided in a clinical research study that is an approved clinical research study")
 - b) Modifier -Q1 ("Routine clinical service provided in a clinical research study that is an approved clinical research study")

C. Laboratory NCD Manual

1. CMS publishes laboratory NCDs, along with additional coding and coverage information related to laboratory services, in a "*Lab NCD Manual*" entitled *Medicare National Coverage Determination (NCD) Coding Policy Manual and Change Report, Clinical Diagnostic Laboratory Services*.
 - a. Note: The *Lab NCD Manual* includes additional coding and coverage guidelines not included in the Medicare Coverage Database or *Medicare National Coverage Determinations (NCD) Manual*. <*Medicare National Coverage Determinations Manual Transmittal 17*>
2. Refer to the "Clinical Diagnostic Laboratory NCD Manual" link under the "Medicare Related Sites – General" section on HCPro's links page.
3. The *Lab NCD Manual* contains a list of "Non-covered ICD-10-CM Codes for All Lab NCD Edits".
 - a. This list contains diagnosis codes that are never covered by Medicare for a diagnostic laboratory service. <*Lab NCD Manual*>
 - b. Note: It is not clear whether the list applies to other NCDs or to laboratory tests not covered by an NCD.

VI. Ways to Stay Current (All Free)

- A. Review HCPro's Medicare Insider for changes applicable to your facility.
 - 1. Medicare Insider is a free publication, published weekly by HCPro. A link to sign up for the Medicare Insider, along with other helpful free publications, is included at the top of HCPro's links page ("Sign up for our FREE eNewsletters" next to an envelope in the upper left corner).
- B. Subscribe to CMS email updates. Sign up through the "CMS Email Update Lists – Subscriber's Main Page" link under the "Listserv Subscriptions" section on HCPro's links page.
 - 1. Suggested CMS mailing lists include:
 - a. CMS Coverage Email Updates
 - b. MLN Connects™ Provider eNews
 - c. Physician Open Door Forum
 - i. Note: CMS conducts periodic "Physician Open Door Forum" conference calls which provide very valuable information to physicians and physician group practices. You can receive dial in information by signing up to this list or checking the Physician Open Door Forum website.
- C. Refer to the "Open Door Forums – Overview Page" link under the "Medicare Related Sites – General" section on HCPro's links page.
- D. CMS News Releases (including proposed and final rule fact sheet)
- E. Subscribe to your MAC's email list.
 - 1. Included at the top of HCPro's links page ("Sign up for our FREE eNewsletters" next to an envelope in the upper left corner).

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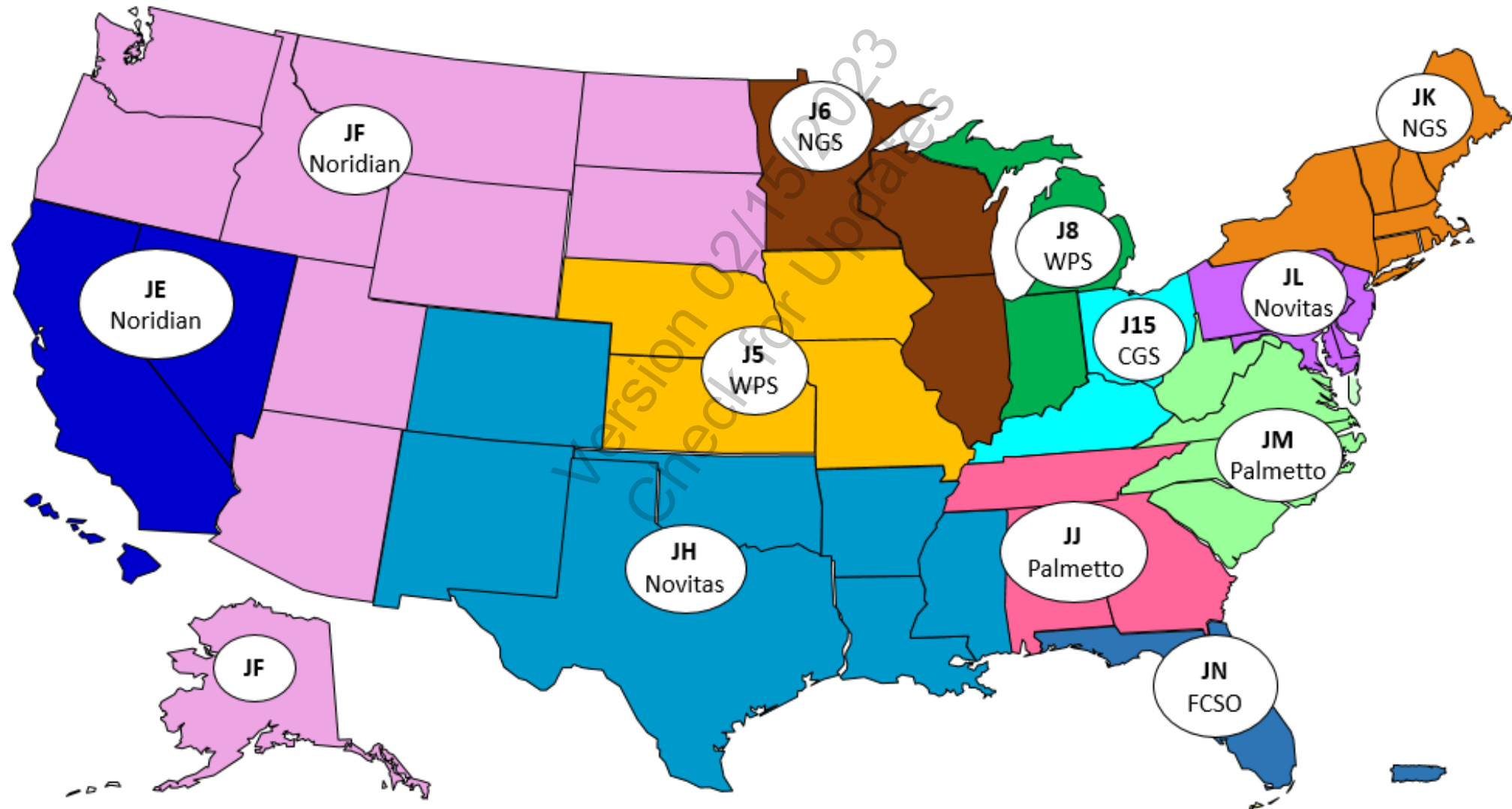
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A/B MAC Jurisdictions

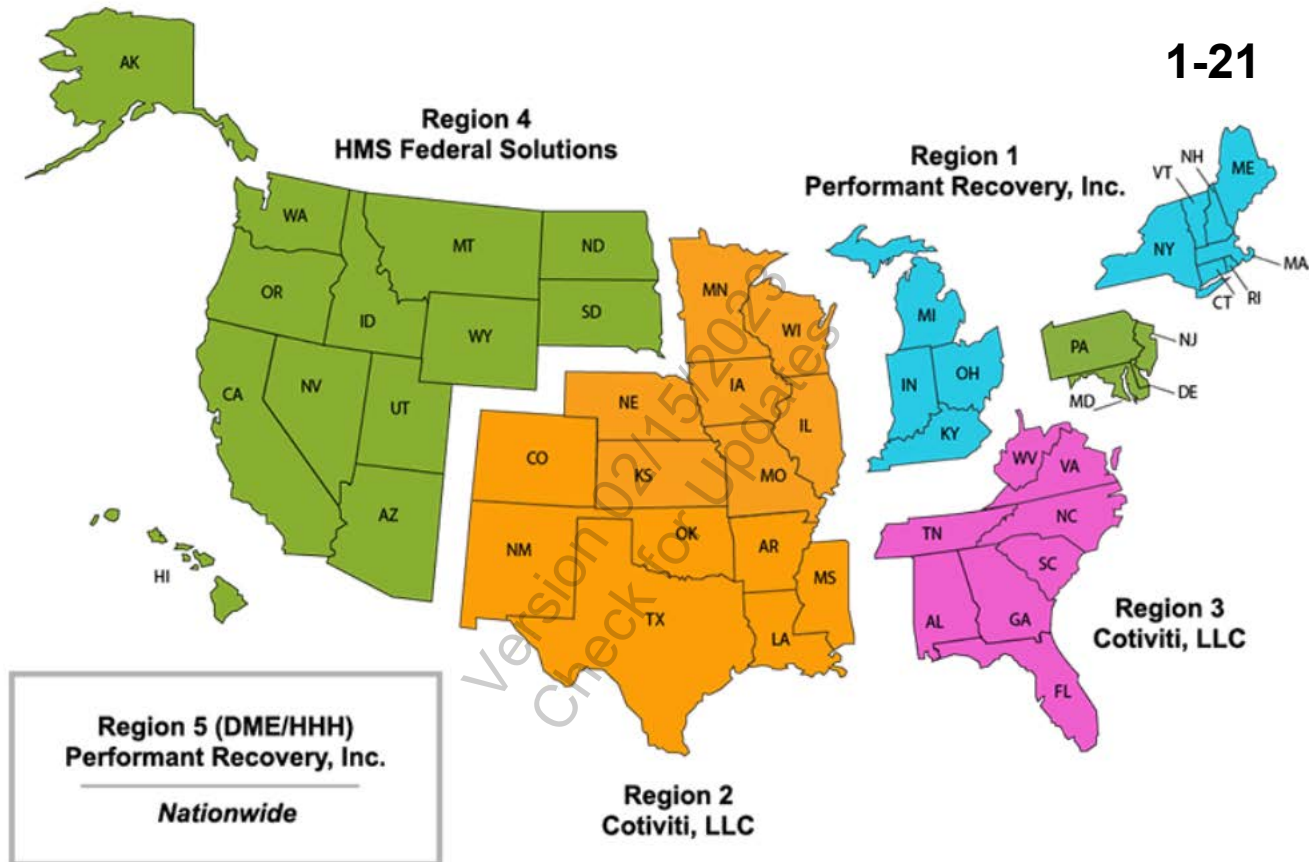
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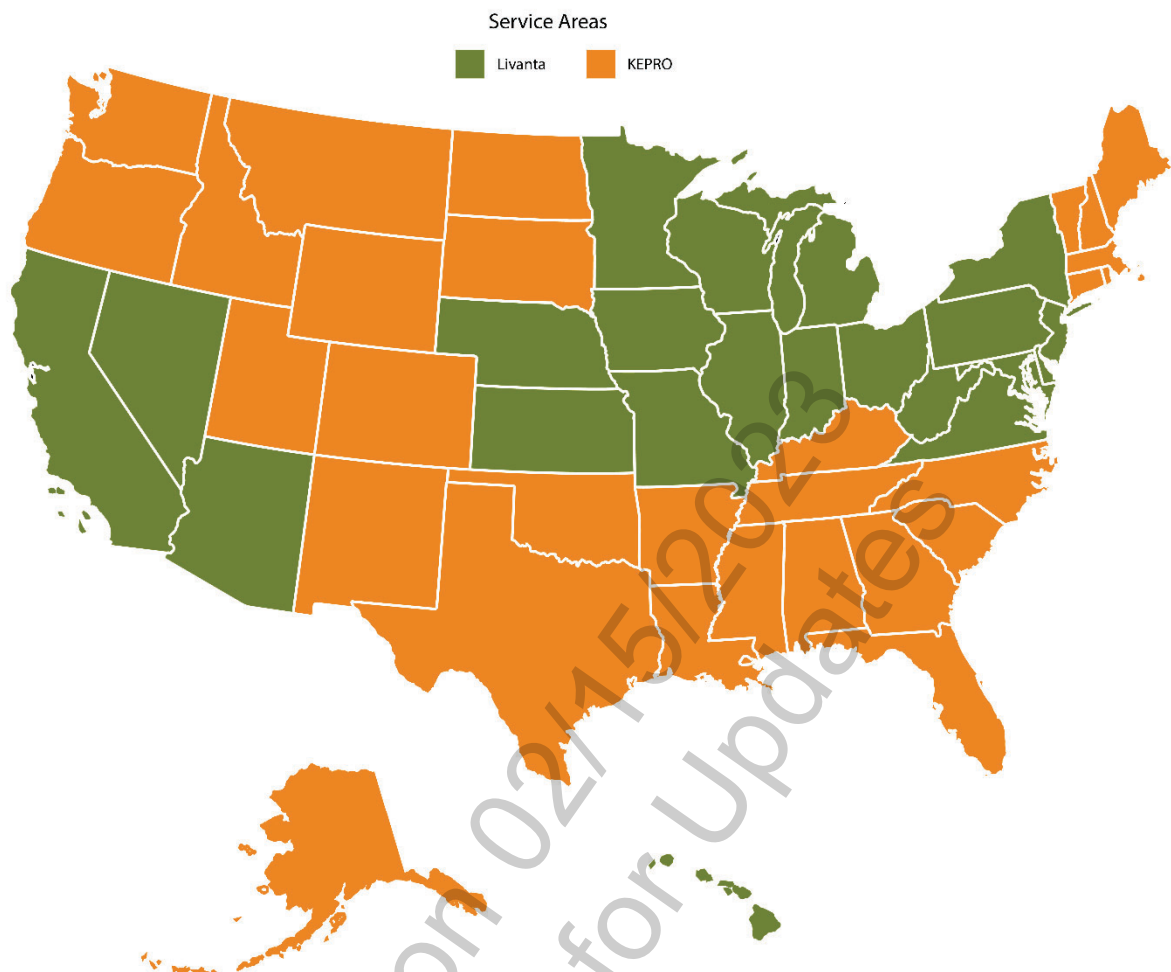
MAC Jurisdiction	Processes Part A & Part B Claims for the following states/territories:	MAC
DME A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	Noridian Healthcare Solutions, LLC
DME B	Illinois, Indiana, 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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