



## Medicare Critical Access Hospital Version

### KEY CONCEPTS OUTLINE

#### Module 2: Medicare Overview, Contractors, Research, and Resources

##### I. 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 A/B 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 SNF<sup>1</sup> and Home Health (outside plan of care) 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 prior to billing.*
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>

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<sup>1</sup> 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.

- a. In most circumstances, physicians and other non-institutional suppliers bill Part B services to the MAC using the CMS-1500/837P claim format.
- i. Billing for professional services on the UB-04/837I claim, known as optional or Method II billing, is discussed later.

### 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, coverage, billing, processing, 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. *<"Medicare Administrative Contractors (MACs) As of June 2019"; "A/B Jurisdiction Map as of June 2019">*

*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. A copy of the map is included in the materials behind the outline.

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

### C. Recovery Audit Contractors/Recovery Auditors (RAC)<sup>2</sup>

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 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, based on the claims paid date, unless CMS specifies a different period. <"Medicare Fee-for-Service Recovery Audit Program, Additional Documentation Limits For Medicare Institutional Providers (i.e. Facilities)", updated 5/1/22>
5. Recovery Auditors can make a limited number of Additional Documentation Requests (ADRs) for medical records from providers each 45 day period.  
<"Medicare Fee-for-Service Recovery Audit Program, Additional Documentation Limits for Medicare Institutional Providers (i.e., Facilities)", updated 5/1/22>
  - a. 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-

### D. Unified Program Integrity Contractors (UPIC)

1. Effective April 1, 2019, UPICs combine and integrate the functions of the Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs) and Medicaid Integrity Contractors (MICs). <CMS.gov, Review Contract Directive Interactive Map Page>

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<sup>2</sup> 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*

*Unified Program Integrity Contractor page, Noridian website*

#### E. Comprehensive Error Rate Testing (CERT) Program

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>
2. The CERT contractor uses a statistically 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>
3. The CERT contractor assigns of improper payment categories:
  - a. No Documentation
  - b. Insufficient Documentation
  - c. Medical Necessity
  - d. Incorrect Coding
  - e. Other

- i. Examples include duplicate payment error and non-covered or unallowable service

#### F. Supplemental Medical Review Contractor (SMRC)

1. CMS contracts with the SMRC 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. An SMRC conducts 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 and higher weighted DRG reviews in all QIO jurisdictions.
    - i. Livanta has posted a schedule of weeks throughout 2023 it will request medical records for short stay reviews. <See Livanta National Medicare Claim Review Contractor, Short Stay Review webpage>

#### H. Qualified Independent Contractor (QIC)

1. The QIC conducts 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 (ALJ) 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 most 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. Web-Based Resources

- A. There are two main websites with Medicare source authority (i.e., Medicare “rules”):
  1. The U.S. Government Printing Office (GPO) Federal Digital System (FDsys) website hosts statutes and regulations. The FDsys generally has prior versions of statutes and regulations going back several years.
  2. The CMS website hosts CMS sub-regulatory guidance, including manuals, transmittals, and other guidance on the Medicare program.

**Caution:** The CMS website does not maintain an archive of prior versions of manuals and often removes transmittals or other guidance without notice. If you rely on guidance from the CMS website, you should retain a printed or electronic copy to ensure you have it for future reference.

- B. HCPro maintains a website with extensive links to Medicare resources, including the FDsys and CMS websites at:

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

1. Handout 4 is a copy of HCPro’s links page for your reference or to note links you find useful during class.

#### V. Key Sources of Authority

- A. For your reference, Attachment A (located behind the outline) contains a table with key sources of authority, or Medicare “rules”, as well as where they are published, where to find them on the internet, and example citations. The table is organized in the order audit contractors should apply guidance in making medical review decisions. < *Medicare Program Integrity Manual*, Chapter 3 § 3.3 A >

#### 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.

**Link: Congress.gov under Regulations and Statutes**

- b. Each public law has a home page that provides information on the adoption of the bill and the final text.

*Tip: 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.

***Link: United States Code (Federal Statutes) under Regulations and Statutes***

## 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.

***Link: Social Security Act, Title 18 (Medicare) under Regulations and Statutes***

## C. Regulations

### 1. *Federal Register*

- a. CMS publishes proposed and final regulations in the *Federal Register*.

*Regulations are first published as proposed rules with request for comment. After gathering comments, a final rule is published, which contains the final regulation and a preamble with significant commentary and responses to submitted comments.*

- b. On the Federal Register site, you can browse by date or use the “Search the Federal Register by citation” link on the left navigation area to search for a specific volume and page number.

***Link: Federal Register under Regulations and Statutes***

- c. CMS also makes display copies of important hospital related proposed and final rules, along with accompanying data files and tables, available on their website.

**Link: IPPS – FY2023 Final Rule Home Page under Medicare-Related Sites - Hospital**

*Use links on the left navigation to find prior year home pages.*

- d. Proposed and final rules can be very large and difficult to navigate.

- i. The “Summary of the Major Provisions” section in the “Executive

**Link: OPPTS – Regulations and Notices under Medicare-Related Sites - Hospital**

*Tip: Use the Table of Contents to find sections of interest and the “find” feature of the software to navigate to pertinent sections.*

Summary” at the beginning of the rule can be a helpful place to start.

- ii. Follow-up questions can be directed to the individuals in the “For Further Information Contact:” section.

## 2. Code of Federal Regulations (C.F.R.)

- a. The C.F.R. is a compilation of the regulations of the United States. Title 42

**Link: HHS Employee Directory under Medicare-Related Sites - General**

contains the Medicare regulations.

- i. The C.F.R. is published in an official annual edition and a regularly updated electronic version referred to as the eCFR, an unofficial compilation of the C.F.R. and recent *Federal Register* amendments.

**Caution:** *The annual edition of Title 42 is updated October 1 of each year, but the OPPTS regulations are adopted around November 1. Use the eCFR for the most up-to-date version of federal regulations.*

**Link: CFR Title 42 – Electronic Version under Regulations and Statutes**

*Tip: Use the Federal Register citations noted at the end of each regulation to find important preamble discussion published when the regulation or amendment was adopted.*

## 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. “Paper-based” Manuals

- a. The *Provider Reimbursement Manual* contains charging and cost reporting guidelines and is available in a “paper-based” version that can be downloaded from the CMS website.

**Link: Manuals – Paper Based Manuals under Medicare-Related Sites - General**

- b. The *Provider Reimbursement Manual* has two parts
  - i. Part I provides cost report information such as Medicare’s policies on “Bad Debts, Charity, and Courtesy Allowances” or the “Determination of Costs of Services”, which provides information on the structure of charges.
  - ii. Part II primarily provides cost report formats and completion instructions.

### 3. “Internet-only” Manuals (IOMs)

- a. CMS provides significant sub-regulatory guidance in “internet-only” manuals published directly on their website.

**Caution:** CMS often removes or revises manual sections without providing an archive of prior versions. As noted above, you should retain a printed or electronic copy of manual sections you rely on to ensure you have them for future reference.

**Link: Manuals – Internet Only Manuals under Medicare-Related Sites - General**

- b. The following IOMs may be helpful:
  - i. *Pub. 100-02 – Medicare Benefit Policy Manual* provides coverage requirements for various inpatient and outpatient services.

- ii. *Pub. 100-04 – Medicare Claims Processing Manual* provides coding, billing and claims guidance.
- iii. *Pub. 100-05 – Medicare Secondary Payer Manual* provides information related to Medicare as a primary or secondary payer.
- iv. *Pub. 100-07 – State Operations Manual* provides guidance on the Conditions of Participation.

*Tip: To access detailed information, such as Tag numbers, Interpretive Guidelines, and Survey Procedures, open the “Appendices Table of Contents” and click on the “Appendix Letter” for the provider or survey type (e.g., “W” for “Critical Access Hospitals”).*

- v. *Pub. 100-08 – Medicare Program Integrity Manual* provides guidance to Medicare auditors, including MACs, SMRCs, CERT, Recovery Auditors, and ZPICs.

*Tip: This manual is helpful to providers preparing for and responding to Medicare audits.*

#### 4. Transmittals and Program Memoranda

- a. Transmittals communicate new or revised policies or procedures, as well as new, deleted or revised manual language.

***Link: Transmittals and Program Memoranda under Medicare-Related Sites – General***

*Use links on the left navigation to access transmittals or program memoranda from prior years.*

- b. Transmittal numbers

*Format of transmittal numbers:*

***R (Number – in the order of publishing) (Initials for manual)***

*R10224CP: 224<sup>th</sup> published transmittal, Claims Processing Manual related*

*Note: the numbering system for transmittals changed on approximately March 20, 2020. Previously, the transmittals were numbered separately for each manual, rather than by date across all manuals.*

*Tip: One Time Notification (OTN) transmittals are global in nature and not tied to a specific manual.*

c. Change Request Numbers

- i. Transmittals are linked to a change request (CR) number, CMS' internal tracking number, tying together documents associated with a particular policy change.

*Change Request (CR) numbers:*

- May be associated with multiple transmittals, e.g., one CR may have an associated Medicare Claims Processing Manual Transmittal and a Medicare Benefit Policy Manual Transmittal.
- Are used in the numbering of associated MLN Matters Articles, discussed later in this outline.
- Are often used by CMS representatives to refer to policy changes, rather than transmittal numbers.

d. 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.

**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.
- 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.

**Caution:** The implementation date of a transmittal 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.

- a) The text of new or revised manual sections will appear after the attachments at the end of the transmittal.

**Caution:** *New or revised text will appear in red italics; however, deleted text will not be noted. Important guidance may be removed without any indication in the transmittal. Revisions should be reviewed carefully.*

- v. "Background" and "Policy" sections provide important information about the policy changes in the transmittal.
- vi. The "Business Requirements Table" contains specific instructions to CMS contractors for implementation of changes in the transmittal, including instructions related to reprocessing claims or adjusting claims brought to their attention by providers.

**Tip:** *This section may be particularly helpful to providers to determine the effect of the transmittal on their claims.*

- vii. The "Contacts" section contains the names and email addresses of CMS staff, which may be used for follow-up questions.
- viii. Transmittals may also have attachments with important tables or other important information.

## 5. MLN Matters Articles

- a. 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.

**Link:** *MLN Matters Articles – Overview Page under Medicare-Related Sites – General*

- b. There are two types of MLN Matters Articles:
  - i. MLN Matters Articles linked to a specific transmittal are intended to provide practical and operational information about the transmittal.

**Tip:** *In addition to being published on the MLN website, a link for MLN Matters Article 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; however, they provide information on topics CMS believes require additional clarification and not found in transmittals or manuals.

*Tip: 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.*

*Format of MLN Matters Article numbers:*

*Tied to a specific transmittal/change request:*

**MM (Change Request Number)**

MM10417 is tied to CR10417

*Special Edition MLN:*

**SE (two-digit year) (sequential number)**

SE18003 is the third Special Edition MLN Article in 2018

## 6. Other Guidance

- a. CMS frequently posts other guidance on their website in the form of documents, FAQs, algorithms, or other information.
- b. Some helpful sites:

***Link: Critical Access Hospital Center under Medicare Related Sites – Rural Health***

***Link: Rural Health Clinics Center under Medicare Related Sites – Rural Health***

***Link: Inpatient Hospital Reviews under Medicare Related Sites – Hospital***

***Link: Care Management Physicians Center and Telehealth under Medicare Related Sites – Physician/Practitioner***

***Link: Fee-for-Service Frequently Asked Questions under Medicare-Related Sites – General***



## VI. Ways to Stay Current (All Free)

A. Subscribe to HCPro's resources to receive information and updates applicable to your facility.

1. Revenue Cycle Daily Advisor is a free daily email publication with informative articles gathered from a variety of HCPro and HealthLeaders sources.
2. Revenue Integrity Insider is a free email publication with information from the National Association of Healthcare Revenue Integrity (NAHRI), an association dedicated to providing revenue integrity professionals with the resources, networking, and education needed to foster this growing field and profession.

***Link: HCPro Free Email Newsletters under Listserv Subscriptions***

B. Subscribe to CMS email updates.

***Link: CMS Email Update Lists – Subscriber's Main Page under Listserv Subscriptions***

1. Suggested CMS mailing lists include:
  - a. CMS Coverage Email Updates
  - b. MLN Connects™ Provider eNews
  - c. CMS News Releases (including proposed and final rule fact sheets)
  - d. Hospital Open Door Forum

*Tip: CMS conducts periodic "Hospital Open Door Forum" calls which provide valuable information to hospitals. You can receive dial in information by signing up to this list or checking the Hospital Open Door Forum website.*

***Link: Open Door Forum – Overview page under Listserv Subscriptions***

- *Rural Health Open Door Forum includes topics that mainly affect rural providers.*
- *Physicians, Nurses, and Allied Health Professionals Open Door Forum includes topics that affect physician and non-physician practitioner coding and billing.*

C. Subscribe to your MAC's email list.



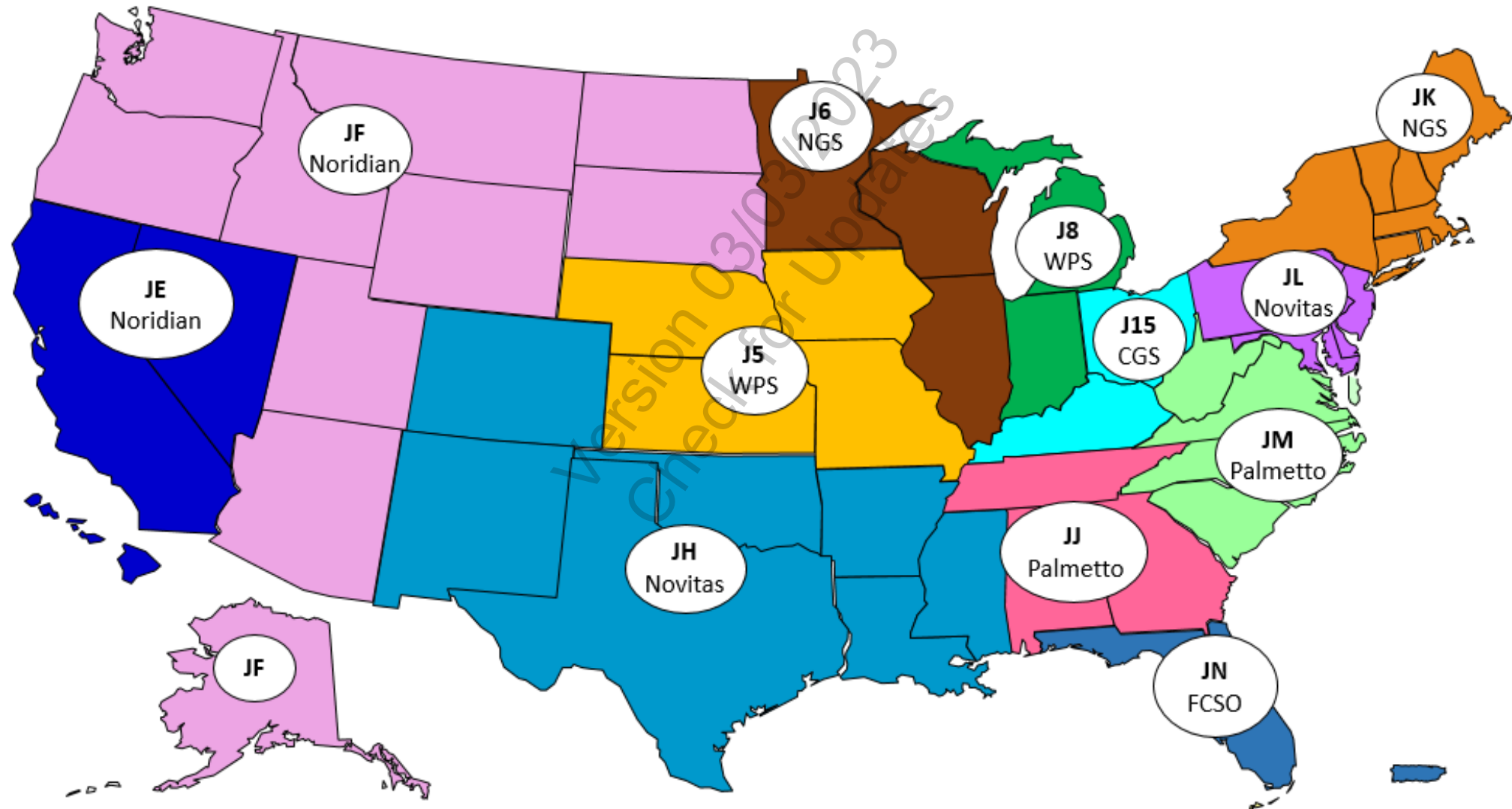
## Medicare Critical Access Hospital Version

### Attachment A KEY SOURCES OF MEDICARE AUTHORITY

By	Authority	Published In	Example Citation	Location
Congress	Statutes	Public Laws	Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), Pub. L. 116-136	Congress.gov
		<i>United States Code</i>	42 <i>U.S.C.</i> § 1395y	GPO's Federal Digital System (FDsys)
		Social Security Act	Soc. Sec. Act § 1862	SSA website
CMS	Proposed and Final Rules	<i>Federal Register</i>	85 <i>Fed. Reg.</i> 86116	GPO's FDsys CMS website
	Regulations	<i>Code of Federal Regulations</i>	42 <i>C.F.R.</i> § 412.3	GPO's FDsys
		<i>Electronic Code of Federal Regulations (e-CFR)</i>		
	National coverage policies	National Coverage Determinations (NCD)	NCD 20.8.3 Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers	CMS website
CMS	Sub-regulatory Guidance	Manuals	<i>Medicare Claims Processing Manual</i> , Chapter 4 § 230.1	CMS website
		Transmittals	<i>Medicare Claims Processing Manual Transmittal 10541</i>	CMS website
		MLN Matters Articles	<i>MLN Matters SE1418</i>	CMS website
		Other guidance	"BFCC QIO 2 Midnight Claim Review Guideline"	CMS website
MAC	Local coverage policies	Local Coverage Determinations (LCD) and Articles	LCD ID L36084, Article ID A54931	CMS website, MAC website

# A/B MAC Jurisdictions as of June 2021

2 - 19



Medicare Administrative Contractors (MACs)  
As of June 2021

2 - 20

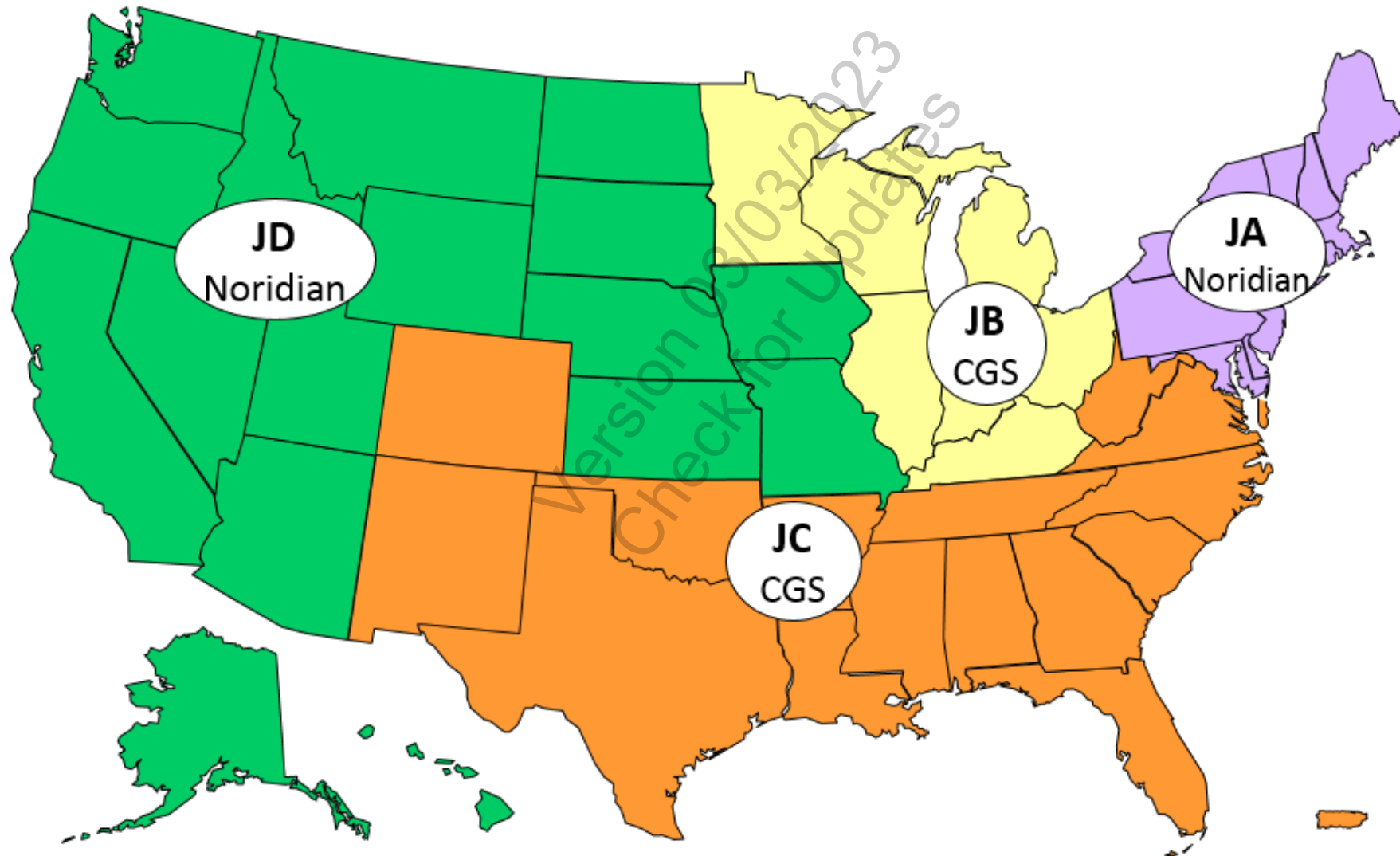
MAC Jurisdiction	Processes Part A & Part B Claims for the following states/territories:	MAC
DME A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont	Noridian Healthcare Solutions, LLC
DME B	Illinois, Indiana,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

# DME MAC Jurisdictions

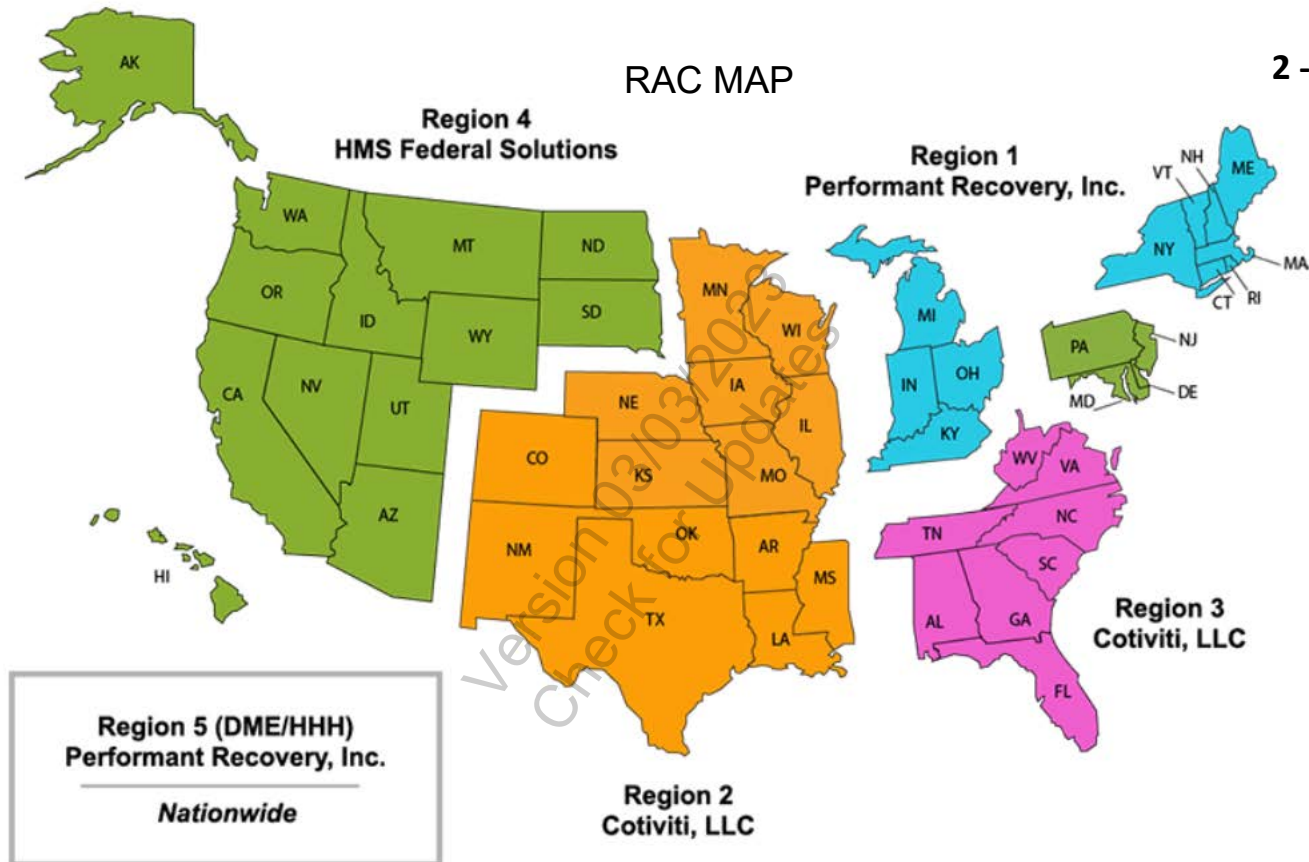
as of June 2021

2 - 21



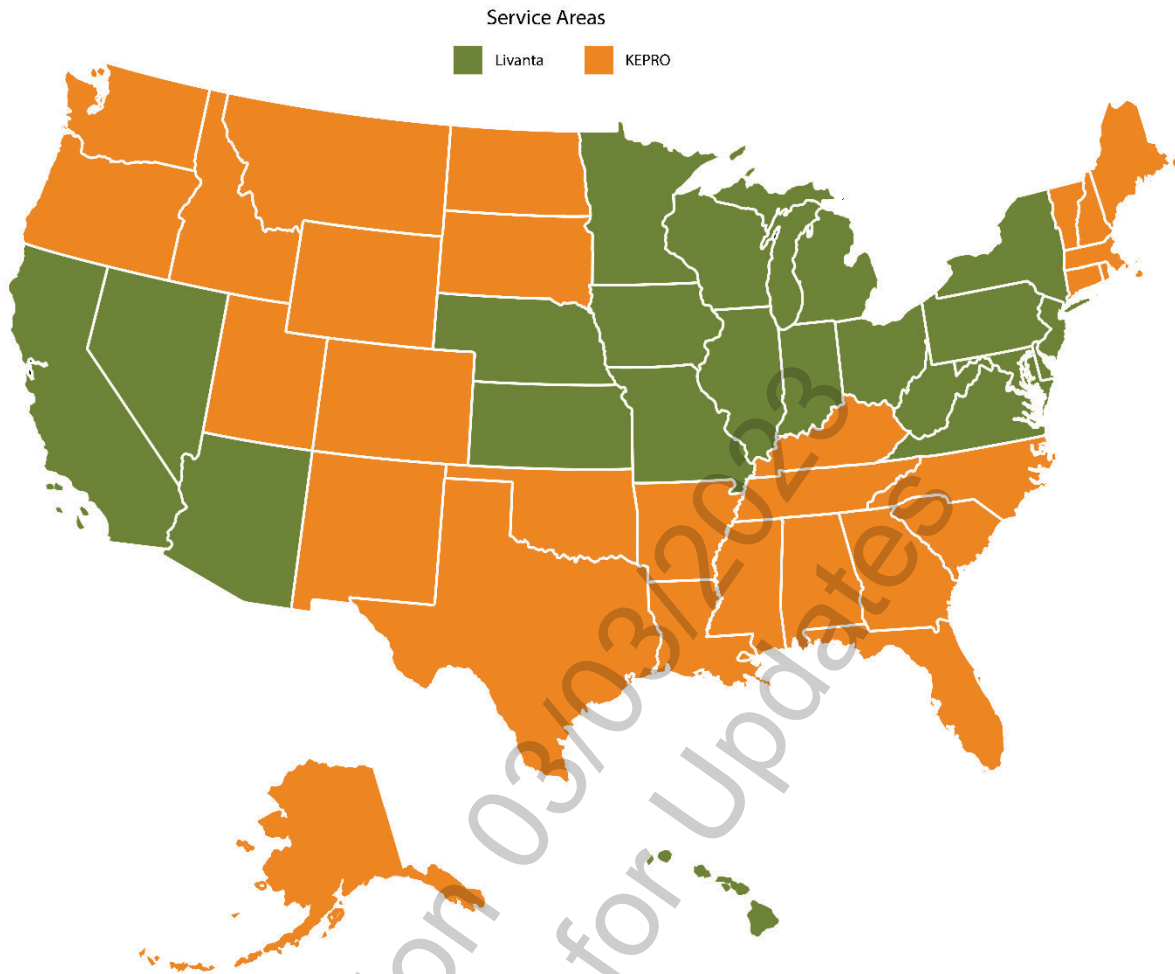
## RAC MAP

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*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](http://www.keproqio.com/transition) or <https://livantaqio.com/en/provider/transition>.



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## News



### **Livanta Awarded CMS Claim Review Services Contract**

**Press Release March 08, 2021**

Livanta LLC is pleased to announce its recent award of a national claim review task order under the Centers for Medicare & Medicaid Services' (CMS) Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO) program. The BFCC-QIO claim review function is derived from Part B of Title XI of the Act and the QIO regulations in 42 CFR Parts 475, 476 and 480. Funded through the CMS Center for Clinical Standards & Quality (CCSQ), this 54-month task order supports CMS in its core functions of beneficiary oversight and protection of the Medicare Trust Fund across all 50 states, five United States territories, and the District of Columbia.

The BFCC-QIO claim review task order serves to decrease CMS' paid claims error rate. Livanta will perform specific types of utilization reviews for proper payment of Medicare claims involving hospital inpatient admissions of short duration and where hospitals re-submitted certain types of inpatient claims for a higher payment than what they had billed initially. As part of the review, Livanta will evaluate whether the services performed were medically necessary and at the appropriate level of care.

As part of its claim review activities, Livanta will provide education services to help hospitals improve their billing accuracy; analyze claims and other data to select samples for review; issue payment determination notices; notify companies that pay the claims for Medicare when hospitals need to refund payments or make other claim adjustments; and perform outreach functions with hospital providers, beneficiaries, and other stakeholders to help safeguard the Medicare trust fund against fraud, waste, and abuse.





## 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 2022.

10/4/2021	6/6/2022
11/1/2021	7/4/2022
12/6/2021	8/1/2022
1/3/2022	9/5/2022
2/7/2022	10/3/2022
3/7/2022	10/31/2022
4/4/2022	12/5/2022
5/2/2022	

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