



Federally Qualified Health Center 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 05/15/2023
Check for Updates

ATTACHMENT A

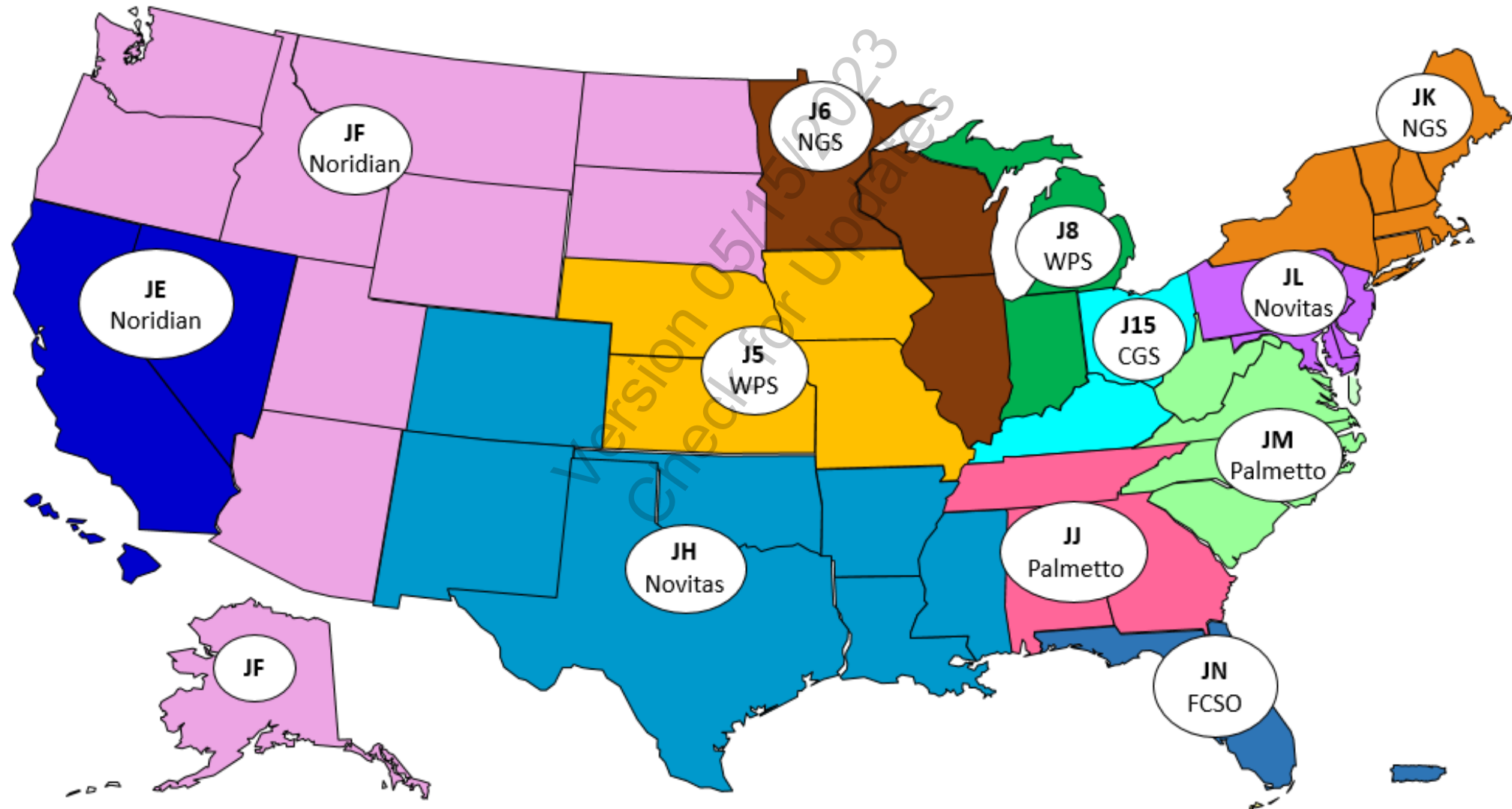
KEY SOURCES OF MEDICARE AUTHORITY

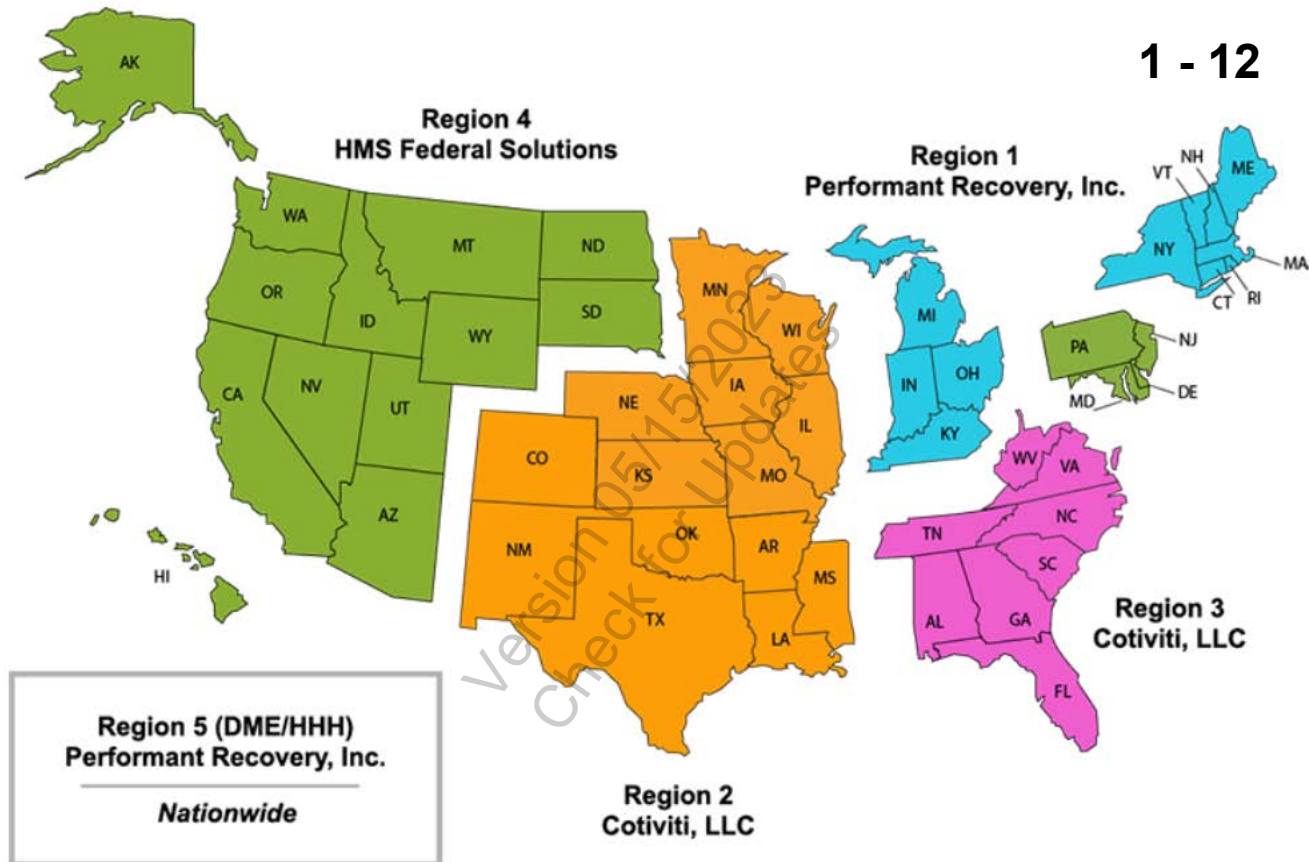
By	Authority	Published In	Example Citation	Location
Congress	Statutes	Public Laws	Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), Pub. L. 116-136	Congress.gov
		<i>United States Code</i>	42 <i>U.S.C.</i> § 1395y	GPO's Federal Digital System (FDsys)
		Social Security Act	Soc. Sec. 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</i> (e-CFR)		
	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

1 - 11





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

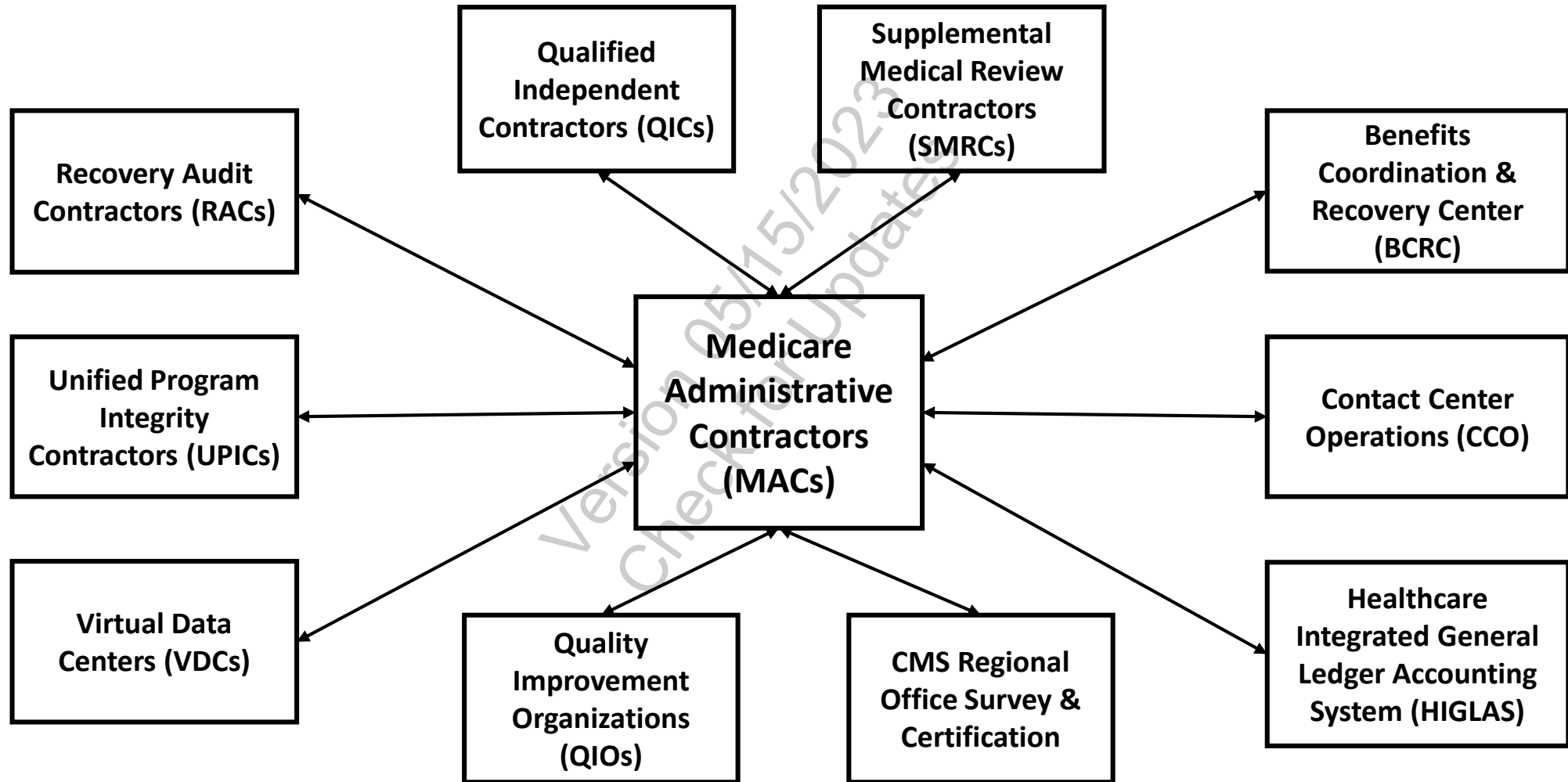
Medicare Administrative Contractors (MACs)
As of June 2021

1 - 13

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**

“The Hub of the Medicare Fee for Service (FFS) Program”



Functional Contractors Overview

Within the Medicare Fee-for-Service (FFS) operating environment, the Medicare Administrative Contractor (MAC) is the central point of contact for providers of health care services. The establishment and monitoring of the MAC's relationships with a number of other function specific CMS contractors is critical to the integrity of the MAC contract administration. Functional contractors play an essential role.

Beneficiary Contact Center (BCC)

The BCC performs beneficiary service duties traditionally held by multiple fiscal intermediaries and carriers. In the BCC environment, beneficiaries have a single Medicare point-of-contact, a 1-800-MEDICARE call center, operated by a CMS contractor that will connect them to a seamless customer service network that can answer Medicare related questions and resolve problems.

Virtual Data Center (VDC)

A data center serves as a platform for claims processing software systems for Medicare claims. Traditionally, the Medicare contractors either operated their own data centers or contracted out for these services. As part of CMS' contracting reform initiative, CMS reduced the number of data centers from more than one dozen separate smaller centers to two large VDCs. CMS manages these contracts. CMS migrated the entire FFS claims processing workload to the VDCs by March 2014.

Healthcare Integrated General Ledger and Account System (HIGLAS)

HIGLAS is the general ledger accounting system that replaced the former cash accounting systems used by Medicare Fiscal Intermediaries and carriers. All MACs now utilize the HIGLAS system to account for Medicare benefit payments, except for Durable Medical Equipment (DME) MACs.

Benefit Coordination and Recovery Center (BCRC)

The BCRC will perform liability insurance (including self-insurance), no-fault insurance, and workers' compensation (Non-Group Health Plan) recovery case work. The BCRC consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The BCRC takes actions to identify the health benefits available to a Medicare beneficiary and coordinates the payment process to prevent mistaken payment of Medicare benefits. The BCRC does not process claims, nor does it handle any group health plan related mistaken payment recoveries or claims specific inquiries. The Medicare Administrative Contractors (MACs), Intermediaries and Carriers are responsible for processing claims submitted for primary or secondary payment. The BCRC does not process claims, nor does it handle any mistaken payment recoveries with respect to GHP recoveries or claims specific inquiries. Once the BCRC has completed its initial MSP development activities, it will notify the Commercial Repayment Center (CRC) regarding a GHP MSP occurrence and will notify the BCRC regarding a liability, workers' compensation, or no-fault MSP occurrence (i.e., a Non-GHP MSP occurrence).

Zone Program Integrity Contractors (ZPICs)

The ZPICs perform functions to ensure the integrity of the Medicare Program. Most MACs will interact with one ZPIC to handle fraud and abuse issues within their jurisdictions.

Qualified Independent Contractors (QICs)

The QICs are responsible for conducting the second level of appeals of Medicare claims. The MAC is responsible for handling the first level of appeals. There are 6 QIC jurisdictions: Part A East, Part A West, Part B North, Part B South, DME Jurisdiction and one Administrative QIC.

Quality Improvement Organization (QIO)

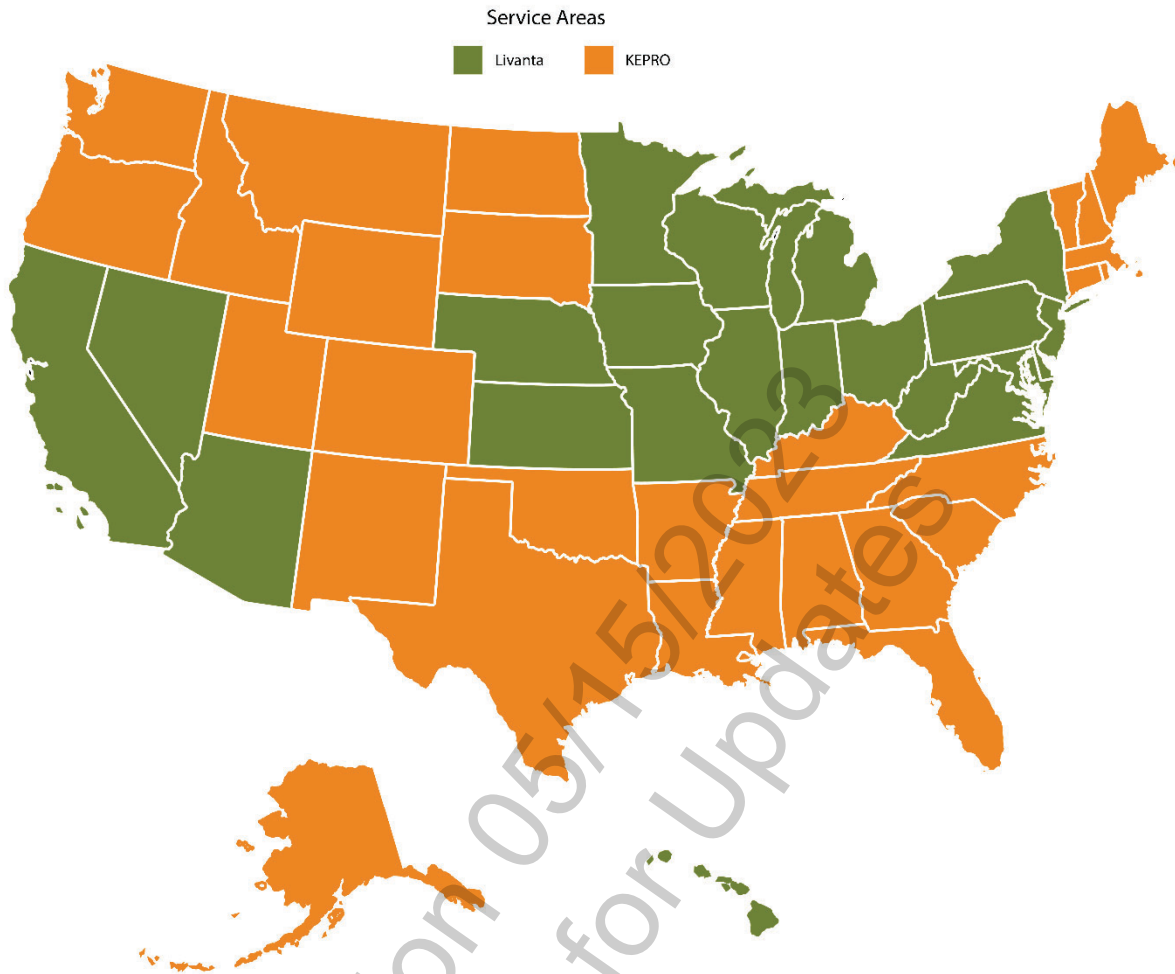
CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to serve as that state/jurisdiction's Quality Improvement Organization (QIO) contractor. QIOs are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

They protect beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law. QIOs protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting.

Recovery Auditor (RAs)

The RAs are responsible for reviewing paid Medicare claims to identify improper Medicare payments that may have been made to healthcare providers and that were not detected through existing program integrity efforts.

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			

[Return Home](#)