



Medicare Utilization Review Version

CAUTION: These course materials will quickly become out-of-date.

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

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

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a current copy of the complete document and (2) confirm that the information provided in the document has not been rescinded, modified, or superseded.

Caution: This course is not a substitute for professional advisors.

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Check for Updates



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

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

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

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

¹ No legal services are provided through HCPro, Inc.



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

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

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

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

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

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



Judith L. Kares, JD

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

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

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

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



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Ms. Reese graduated Magna Cum Laude from Whittier College School of Law in Los Angeles, after receiving a Bachelor's Degree in Business Administration with an emphasis in Accounting, Magna Cum Laude, from California State University at Los Angeles, and a Nursing degree from Samuel Merritt Hospital School of Nursing in Oakland, California. Ms. Reese specialized in pediatric intensive care, chemotherapy and diabetic care/education at University Hospital in San Diego and Childrens Hospital at Los Angeles (CHLA). She then moved into a position as supervisor in utilization management and quality review at CHLA, overseeing a cadre of nurses performing these tasks, staffing peer review, UM and quality committees at the hospital and drafting and managing policies and procedures for these activities. While attending law school, Ms. Reese accepted a position at Shriners Hospital for Crippled Children, Los Angeles, as the Director of Risk Management, Quality Assurance and Utilization Management.

After completing law school, Ms. Reese provided legal services for 10 years at Hooper, Lundy and Bookman, a boutique health law firm in Century City, California, representing health care providers across the country. For the next 10 years, Ms. Reese worked as Senior Counsel at Kaiser Foundation Health Plan/Hospitals, further broadening her knowledge of health care law to include managed health care, provider contracting, Medicare Advantage (including risk adjustment), revenue cycle, coding, privacy, electronic health records, and many other areas. Ms. Reese has been the Director of Risk Management at an acute care hospital in Southern California for the past 8 years, and is a Certified Professional Risk Manager through the American Hospital Association. In that capacity, she performs Medicare One Day Stay reviews and supports the Utilization Review Committee.



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Teri Rice is the lead instructor for the HCPro's Medicare Boot Camp – Critical Access Hospital Version and Rural Health Clinic Version (live and online).

Teri has is a nurse with extensive experience in Compliance. In this position, she assisted an acute care hospital with documentation integrity, internal auditing, charge capturing, and education. She played an active role in software implementation, process improvement, and established a variety of workgroups. She assisted with the new design of a physical therapy software to promote compliance with Federal Medicare Regulations. She has assisted with rule based functionality within electronic health records for accurate charge capturing. She has also presented department specific educational programs to focus specifically on documentation, charging practices, and Medicare regulations.

She has extensive knowledge of Medicare billing and compliance issues. She has developed policies and procedures focused on Medicare regulations to promote compliance. She has collaborated on compliance workplans, internal organizational risks, and root cause analysis.



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

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

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



Medicare Utilization Review Version

KEY CONCEPTS OUTLINE

Module 1: Medicare Overview, Contractors, and Resources

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.

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 actually 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, included in the materials behind the outline. An interactive version is available on the CMS website.

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

C. 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. <Livanta National Claim Review Contractor website>

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, included in the materials behind the outline;
 - ii. Sampling strategy and a sample medical record request, included in the materials behind the outline;
 - 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

D. Recovery Audit Contractors/Recovery Auditors (RAC)

1. CMS identified four Part A/B Recovery Audit Jurisdictions (i.e., Regions 1-4). The map of the RAC regions is included in the materials behind the outline. <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

E. Unified Program Integrity Contractors (UPICs)

1. Unified Program Integrity Contractors (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>
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

F. 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

G. 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>

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. 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 3 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, Handout 4 explains key sources of authority, or Medicare “rules”, as well as where they are published, where to find them on the internet, example citations, and tips for navigating them to find important information.
1. Handout 4 is organized in the order audit contractors should apply guidance in making medical review decisions. <Medicare Program Integrity Manual, Chapter 3 § 3.3 A>

VI. Ways to Stay Current (All Free)

- A. Subscribe to The Livanta Claims Review Advisor

Link: Livanta Claims Review Advisors under Listserv Subscriptions

B. Subscribe to CMS email updates.

1. Suggested CMS mailing lists include:

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

- a. CMS Coverage Email Updates
- b. MLN Connects™ Provider eNews
- c. 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.

- d. CMS News Releases (including proposed and final rule fact sheets)

C. Subscribe to your MAC’s email list.

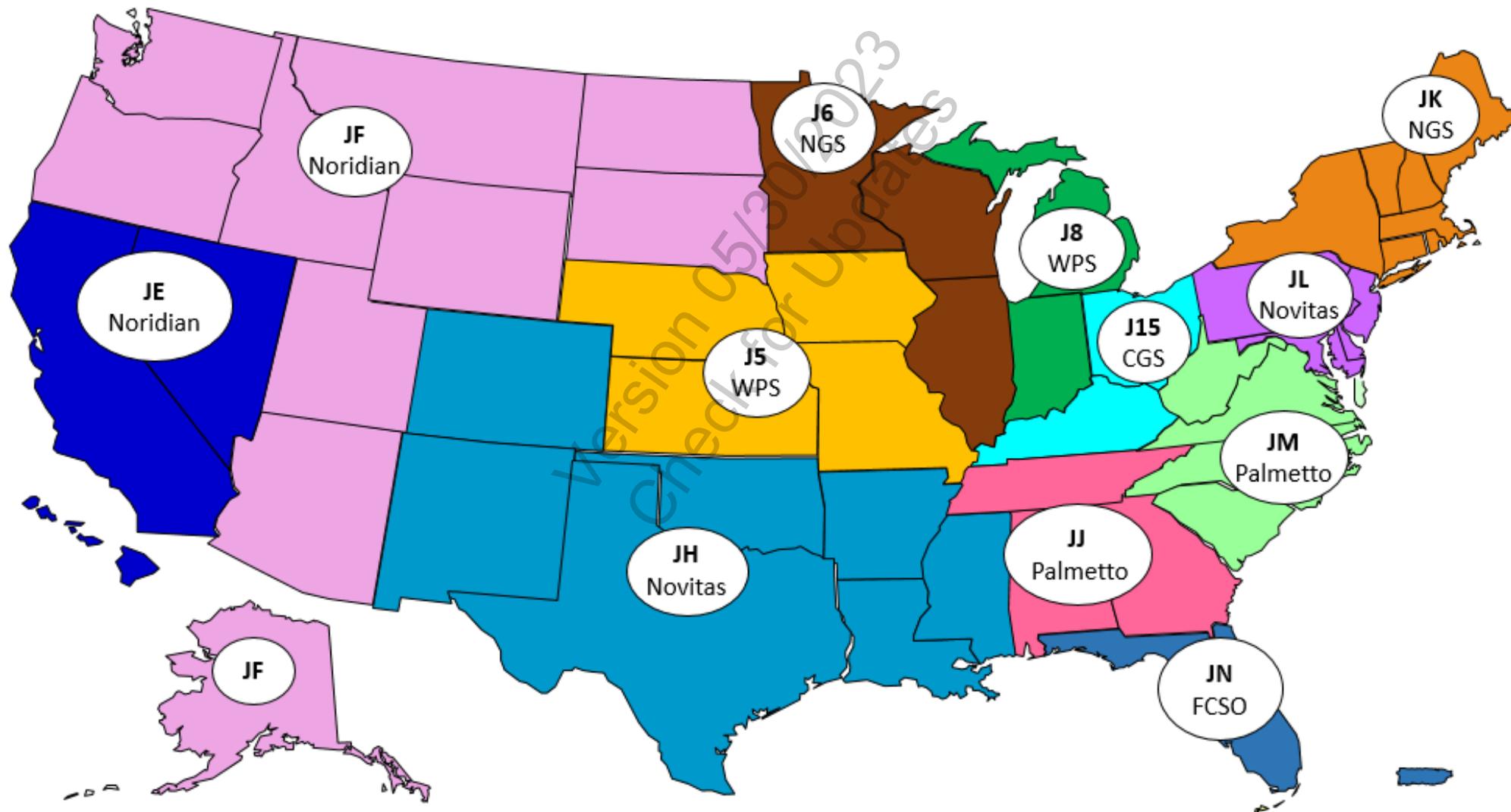
D. Subscribe to HCPro’s resources to receive information and updates.

- 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), a new association dedicated to providing revenue integrity professionals with resources, networking, and education.

Link: HCPro Free Email Newsletter under Listserv Subscriptions

A/B MAC Jurisdictions

Posted 03/28/23



Medicare Administrative Contractors (MACs)

1 - 20

Posted 03/28/23

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

[Home \(index.html\)](#) / [News \(index.html\)](#)

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.

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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THE LIVANTA CLAIMS REVIEW ADVISOR



A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services

Volume 1, Issue 2

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Exploring Short-Stay Claim Review Guidelines

In this issue of The Livanta Claims Review Advisor:

- History and Background of Short-Stay Claim Reviews
- Short Stay Medical Review
- Step-by-step Guideline for Short-Stay Determinations
- Documentation Features



Brief History of Short-Stay Claim Reviews

The Centers for Medicare & Medicaid Services (CMS) implemented the Two-Midnight Rule in Fiscal Year (FY) 2014 to assist in determining when an inpatient admission would be appropriate for payment under Medicare Part A (inpatient hospital services). Under the Two-Midnight Rule, inpatient admissions would generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation.

In the FY2016 Outpatient Prospective Payment System (OPPS) Final Rule, CMS amended the Two-Midnight Rule and clarified that, in certain circumstances, Medicare would also pay for inpatient stays that lasted less than two midnights on a case-by-case basis if the documentation in the medical record supported the determination that the patient required inpatient hospital care. The Two-Midnight Rule does not apply to procedures on the Inpatient-Only List.

Under CMS direction, Livanta is the Beneficiary and Family Centered Care -Quality Improvement Organization (BFCC-QIO) conducting fee-for-service claim reviews of acute care inpatient hospitals, long-term acute care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay inpatient hospital claims. These claims are reviewed in accordance with the Two-Midnight Rule published in FY 2014 Hospital Inpatient Prospective Payment System (IPPS) Final Rule CMS-1599-F, as revised by CMS-1633-F. This Rule outlines two medical review policies: (1) a two-midnight presumption; and (2) a two-midnight benchmark. CMS also issued a BFCC-QIO Two-Midnight Claim Review Guideline that graphically depicts the tenets of the Two-Midnight Rule.

CMS Two-Midnight Claim Review Guideline (file may appear in a download folder)

<https://www.cms.gov/sites/default/files/2022-04/BFCC-QIO-2-MidnightClaimReviewGuideline.%20508.pdf>

FY 2014 IPPS Final Rule - 78 FR 50938 – 50954 (Medical Necessity Review on Inpatient Admissions)

<https://www.govinfo.gov/content/pkg/FR-2013-08-19/pdf/2013-18956.pdf>

FY2016 Outpatient Prospective Payment System (OPPS) Final Rule - 80 FR 70297 – 70607

<https://www.govinfo.gov/content/pkg/FR-2015-11-13/pdf/2015-27943.pdf>

Version 05/30/2022
Check for Updates

Short-Stay Medical Review

Two-Midnight Presumption

Inpatient hospital claims with lengths of stay two midnights or greater after formal inpatient admission are presumed to be appropriate for Medicare Part A payment and are not the focus of medical review efforts, unless there is evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the two-midnight presumption. Therefore, these inpatient claims are not subject to sampling under the Short Stay Review (SSR) program. This presumption is explained in Livanta's Step-by-Step Guideline for Short-Stay Review Determinations.

Two-Midnight Benchmark

The two-midnight benchmark represents guidance to Medicare review contractors to identify when an inpatient admission is generally appropriate for Medicare Part A payment under CMS-1599-F, as revised by CMS-1633-F. This guidance is consolidated in the graphic Two-Midnight Claim Review Guideline issued by CMS, noted below. Livanta follows these steps when making SSR determinations for sampled inpatient claims of less than two midnights.

Applying the Claim Review Guideline

The Two-Midnight Rule does not set a standard of care or dictate what kind of care physicians should be providing for patients. The rule is designed to determine how claims will be paid. In most cases, physicians should generally treat patients expected to require medically necessary hospital care for less than two midnights under outpatient care or observation services.



Support for a stay expected to be two midnights or longer

CMS acknowledges that there are circumstances where the patient's length of stay may be less than that initially estimated at the time of admission. Physician estimates of length of stay should be made based on data, clinical judgment, and plans of care. Documentation of these factors is reviewed specific to the admission and to support of the two-midnight expectation. Generic statements accompanying inpatient orders in many electronic medical records do not provide sufficient clarity to support such decisions.

For those hospital stays in which the physician cannot reliably predict the beneficiary to require a hospital stay of two midnights or more, the physician should continue to treat the beneficiary as an outpatient and then admit as an inpatient if and when additional information suggests a longer stay or the passing of the second midnight is anticipated.

Support for admission without a two-midnight expectation

At the time of admission, if a physician believes that the situation is one of the infrequent situations where inpatient care is required—despite the fact that such care is not expected to span at least two midnights—then he or she should explicitly document the reason the specific case requires inpatient care as opposed to hospital services in an observation status. Upon review, CMS and its contractors retain the discretion to determine whether the documentation is sufficient to support the medical necessity of the inpatient admission.

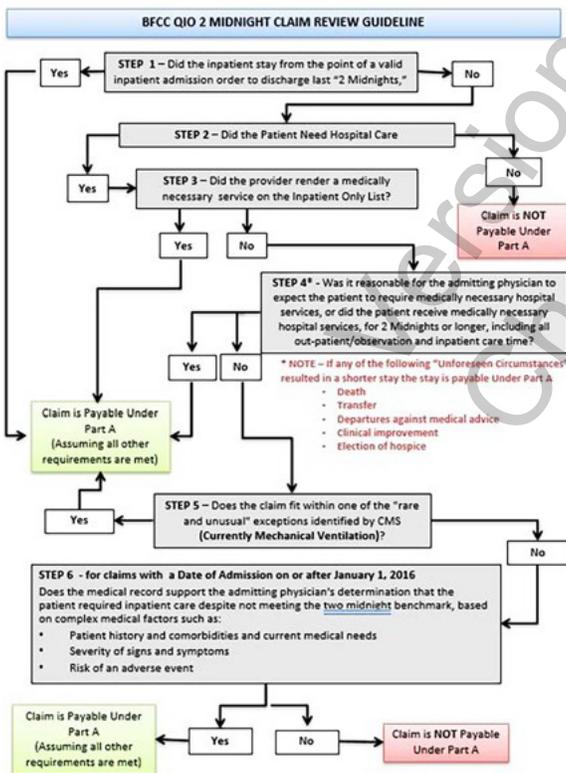
The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

The use of telemetry, by itself, is not considered a service that would justify an inpatient admission in the absence of a two-midnight expectation

CMS also specified in the Final Rule that treatment in an intensive care unit should not be an exception to this standard, as the two-midnight benchmark policy is not contingent on the level of care required or the placement of the beneficiary within the hospital.

Potential quality of care issues noted during a review for payment of a short stay are referred to the appropriate Regional BFCC-QIO for follow up.

Step-by-Step Guideline for Short-Stay Review Determinations



Livanta includes a copy of the Guideline here, for convenience. The file was last accessed March 29, 2022. A link is also included for reference.

CMS Two-Midnight Claim Review Guideline (file may appear in a download folder) <https://www.cms.gov/sites/default/files/2022-04/BFCC-QIO-2-MidnightClaimReviewGuideline.%20508.pdf>

Livanta operationalizes this Guideline issued by CMS for claim reviews to approve or deny the sampled claims, using the documentation in the medical record associated with the claim. There are three potential final outcomes of a Short Stay Review:

- Approved: the claim is appropriate for Medicare Part A payment.
- Excluded: the claim meets one or more of the exclusion criteria outlined in the Rule.
- Denied: the claim is not appropriate for Medicare Part A payment.

Hospitals can check on the status of their claim reviews at Livanta's Claim Review Services website:

https://livantaqio.com/en/ClaimReview/Provider/case_lookup.html

Step 1: Did the inpatient stay from the point of a valid inpatient admission order to discharge last two midnights?

- Yes to this step leads to the claim being Approved
- No to this step sends the review onto Step 2

Step 1 is related to the Two-Midnight Presumption and only counts time after the inpatient admission order. Outpatient time is taken into consideration at Step 4b.

Step 2: Did the patient need hospital care?

- Yes to this step leads the review onto Step 3
- No to this step requires physician review for a potential denial

Part A payment is not appropriate for purely custodial care. Part A payment is generally not appropriate in the following circumstances: Care rendered for social purposes; care rendered for convenience only; delays in providing medically necessary care (generally, delays greater than 24 hours for consultations, testing, care plan documentation).

Step 3: Did the provider render a medically necessary service on the Inpatient-Only List?

- Yes to this step leads to the claim being Approved as an exclusion
- No to this step sends the review onto Step 4

In implementing the CMS Guideline, Livanta samples with the goal to avoid claims with procedure codes associated with a procedure on the applicable Inpatient-Only List. Due to crosswalk complexities, an occasional sampled claim procedure may be on the Inpatient-Only List. The medical record for such a claim is reviewed by a certified coder to ascertain whether or not the actual procedure performed is a procedure on the Inpatient-Only List. If it is determined that the procedure performed is on the Inpatient-Only List, the claim is approved for payment under Medicare Part A as an exclusion. If the patient presents for a scheduled procedure on the Inpatient-Only List and the procedure is aborted or cancelled, the claim is also approved for payment as an exclusion

Step 4: Was it reasonable for the admitting physician to expect the patient to require medically necessary hospital services, or did the patient receive medically necessary hospital services for two midnights or longer, including all outpatient/observation and inpatient care time?

Livanta breaks this step down into three components.

4a: Was it reasonable for the admitting physician to expect the patient to require medically necessary hospital services?

- Yes to Step 4a sends the review onto Step 4b
- No to Step 4a requires physician review for a potential denial, if Steps 4b, 4c, and 5 are also answered No

4b: Did the patient receive medically necessary hospital services for two midnights or longer, including outpatient/observation and inpatient care time?

- Yes to Step 4b leads to the claim being Approved
- No to Step 4b sends the review onto Step 4c

For patients who are transferred from one facility to another, the BFCC-QIO considers pre-transfer time and care provided to the beneficiary at the initial hospital. The "clock" for transfers begins when the care begins in the initial hospital. Any excessive wait times or time spent in the hospital for non-medically necessary services are excluded.

4c: Did any of the following “unforeseen circumstances” result in a shorter stay? (select from Death, Transfer, Departures against medical advice, Election of hospice, Clinical improvement)

- Selection of any option at Step 4c leads to the claim being Approved as payable under Medicare Part A.

Generic statements such as “I anticipate a 2 midnight stay” are not sufficient to meet Step 4. The physician documentation of the evaluation and plan of care must indicate a reasonable expectation of a two-midnight stay. If determination of the length of stay will be based on results of further testing, the decision for inpatient admission should await these test results.

Step 5: Does the claim fit within one of the rare and unusual exceptions identified by CMS (currently new mechanical ventilation)?

- Yes to this step leads to the claim being Approved
- No to this step sends the review onto Step 6

This involves newly initiated mechanical ventilation when medically necessary and excluding anticipated intubations related to minor surgical procedures or other treatment.

Step 6: Does the medical record support the admitting physician’s determination that the patient required inpatient care despite not meeting the two-midnight benchmark based on complex medical factors such as patient history and comorbidities and current medical needs, severity of signs and symptoms, or risk of an adverse event?

- Yes to this step leads to the claim being Approved
- No to this step leads to a potential denial of the claim

The decision on this step is always the result of physician review. The physician’s documentation must indicate the reason the patient needs inpatient admission without a two-midnight expectation. The care provided along with the reason for the admission must represent a risk above the patient’s baseline risk. The “patient risk” that qualifies under this category is not the patient’s baseline risk but the risk of the treatment provided that recognizes the patient’s comorbidities. In general, the patient’s comorbidities are only relevant to this decision in so far as they influence the management of the condition that required admission. This influence should be documented in the record.

Documentation is Key

For Medicare payment purposes, both the decision to keep the patient at the hospital and the expectation of needed duration of the stay must be supported by documentation in the medical record based on factors such as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event during hospitalization.

Document case-specific features that would support the expectation of a two-midnight stay at the time of admission, such as a complex plan of care, need for frequent monitoring, impact of comorbidities, likelihood of an adverse event, or specific services that can only be provided in the hospital. Be as specific as possible. Part A payment is appropriate on a case-by-case basis where the medical record supports the admitting physician’s determination that the patient requires inpatient care, despite the lack of a two-midnight expectation.



There are three ways that a patient can meet medical necessity for Part A payment:

- Services that required hospital services for at least two midnights;
- Documented reasonable expectation of two midnights of hospital care, supported by the plan of care at the time of admission; or
- Documented need for inpatient care despite the lack of a two-midnight expectation, including specific services needed and provided; the likelihood of an adverse event based on the patient's circumstances; or a service that can only be provided on an inpatient basis.

The more explicit a physician's documentation of his or her thought process, the more accurate the QIO determination will be.

DOCUMENTATION remains the best way to ensure appropriate reimbursement. Physicians should explain the need for a two-midnight stay or inpatient services in the absence of a two-midnight expectation. The attending physician should describe what services are uniquely inpatient services or require two midnights of hospital care. Documentation need not be exhaustive but should be specific to the case.

Questions?

Should you have questions, please email ClaimReview@Livanta.com.

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Short Stay Review Sampling Strategy

The primary objective of the Medicare claim review services contract, which was awarded to Livanta as a Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) contractor, is to work toward decreasing Medicare's paid claims error rate and thus protect the Medicare Trust Fund. Livanta developed an Improper Payment Reduction Strategy (IPRS) as a tool to accomplish this important objective. The IPRS outlines the strategy Livanta uses to sample claims for Short Stay Review (SSR). As a living document, the IPRS is updated at least annually.

Starting with a Question to Sample Short Stay Reviews

In *The Tao of Statistics*, Livanta's Chief Statistician, Dr. Dana Keller wrote, "The world of statistics starts with a question." Coherent research must begin with a clear question, and Livanta's claim review services team takes this guideline to heart. Before the claim sampling process begins, Livanta's data team asks the question, "How might claims be optimally selected such that inpatient short stays that are more likely to be paid in error are also more likely to be sampled and reviewed?"

Read more: Keller, D. (2016). *The Tao of Statistics* (2nd ed.). SAGE Publications, Inc., p. 1, ISBN13: 9781483377926.

BFCC-QIO Authority to Conduct Claim Review

Using the constraints, stated intent, and implicit directive outlined in the Code of Federal Regulations (see below), and under direction, approval, and oversight of the Centers for Medicare & Medicaid Services

(CMS), Livanta devised a flexible approach to sampling that could accommodate monthly fluctuations in short stay claims for potential selection and review.

At face value, the idea for the contract is straightforward: Sample and review short stay claims in a manner that is more likely to uncover errors than a pure random sample while still being able to justifiably reconstruct regional and national improper payment amounts for all paid short stay claims. **1 - 32**

"The BFCC-QIO shall conduct 'Short Stay Reviews' per 42 CFR 412.3, 42 CFR 405.980, and Hospital Outpatient Regulations and Notices (OPPS) and inpatient prospective payment system (IPPS) rules including annual updates, revisions and amendments as published in the Federal Register. These reviews should be conducted on a sample of Medicare post-payment Part A claims for appropriateness of inpatient admission under the Agency's Two Midnight Rule for acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities."

Source: FY 2016 OPPS Final Rule, CMS-1633-F, effective January 1, 2016.

What is Sampling?

A subset of claims from a larger population is called a sample. The process of creating a sample is called sampling. According to Dr. Keller, "Sampling is a statistical response to limited resources." Given that reviewing every claim is not always feasible, Livanta's approach is to select a statistically valid and representative subset of claims to review. This approach gives the team the ability to extrapolate, which is the process whereby a sample's results are used to estimate what the population's results would likely have been if every claim had been reviewed.*

Often, a random sample is used. Yet, for this contract, a random sample would not optimally find errors associated with inpatient short stays. For this reason, Livanta devised a weighting system to differentially select short stay claims in a manner that would disproportionately select improper payments among the population of claims.

Over the life of the claim review services contract, Livanta will review tens of thousands of claims. The sample size currently targets more than 1,700 claims per month with adjustments as needed. The volume of sampled short stay claims each month results in small amounts of statistical sampling error and achieves a high degree of statistical precision, which is an expectation of the contract. Secondly, Livanta assesses every monthly sample for statistical representativeness and independence to further ensure high reliability and validity for regional and national estimates.**

*Extrapolations are only conducted at the CMS regional and national levels and not at the provider level. **Funds are recovered for the amounts found in error during claims review and not for extrapolated amounts.

Read more: Keller, D. (2016). *The Tao of Statistics* (2nd ed.). SAGE Publications, Inc., p. 79, ISBN13: 9781483377926.

Sampling Prioritization Scores

Sample prioritization scoring is a statistical process approved by CMS in which four individual components of short stay claims are weighted: cost, frequency, likelihood of improper payment, and duration of stay. The resulting weights are grouped into sampling strata based on their estimated relative risk of improper payment. Higher priority strata are sampled at higher rates than lower priority strata. The ongoing review outcomes inform subsequent weighting and strata assignment.



Livanta connects to the CMS claims database and downloads eligible short stay paid claims each month for sampling. From that listing, each claim is prioritized for sampling according to its cost, representative frequency, clinical perception of the likelihood of an improper payment, and whether the inpatient stay was '0' or '1' day in length.

This prioritization process forms an improper payment risk score that is used for sample selection. All samples are assessed at the stratum (total score) level to assure their representativeness for statistical independence, information content, and typical values. This quality assurance process supports the reliability and the validity of the results found from the samples.

Sample and Extrapolation Adjustments

Unless the total listing of eligible claims (the population) is sufficiently large, there will be times when the allocated number of claims for each stratum will not be met by the number of claims that are eligible for sampling from the designated strata. Under those conditions, the additional claims are selected from the higher priority strata, in concert with the stated goals of the IPRS.

Technical denials are issued when a medical record has not been received for review in a timely manner. Technical denials are counted in the regional and national estimates as *if* the claims were reviewed and found to be improperly paid. The subsequent submission of the needed documentation may reverse the technical denial.

Individualized Hospital Results

When a hospital has had at least 30 claims sampled and reviewed over a rolling 3-month period, those claims are aggregated to form a hospital-specific report that is sent to the hospital. The report is a summary of information the hospital has already received during the course of the monthly claims review process and includes identified areas for educational intervention where findings warrant. For subsequent reports, only aggregates of at least 30 newer claims will be used and presented such that information about errors is allowed to age out of each hospital-based report.

Demystifying Extrapolation

Extrapolation is the process of estimating an improper payment amount (or rate) from the results of reviews from submitted Medicare medical records in support of sampled claims. Medicare SSR extrapolated outcomes are reported as a national and regional improper payment amounts and rates according to Medicare policy requirements. Individual provider extrapolations are not calculated.

Due to the fact that Livanta employs random selection within strata whenever sampling is needed, the method for extrapolation is computationally straightforward. For each stratum each month, the amount found improperly paid in the sample is divided by the number of claims that were reviewed, and that amount is multiplied by the number of claims in the eligible population stratum. The resulting value is the extrapolated amount improperly paid for that stratum that month. The extrapolated amounts are then added across strata and/or months to find national improper payment amounts by month, year, stratum, or whatever the policy-perspective requires. **1 - 34**

What Can Hospitals Expect?

Hospitals can expect to receive medical record requests by fax or mail for sampled short stay claims at the beginning of each month. These sampled claims will be reviewed for the appropriateness of inpatient admission under Medicare's Two-Midnight Rule. The greater the number of short stay claims that a hospital submits, the higher the likelihood that some of their claims will be sampled and reviewed.

These requests will be addressed to the medical record contact whom the hospital has designated in the Memorandum of Agreement (MOA) effectuated with Livanta. If a hospital has multiple claims sampled in a month, the medical record requests will be transmitted in one package.

The dates hospitals can expect to see SSR medical record requests are published on Livanta's website: https://LivantaQIO.com/en/ClaimReview/Review_Types/ssr.html.

Sample Medical Record Request

An example SSR record request template is shown below to help hospitals become familiar with how to identify them.



Date

Contact Name, Medical Record Department
Provider Name
Provider Address
City, State, Zip

Initial Medical Record Request for Short Stay Review

Livanta LLC is the Quality Improvement Organization (QIO) authorized by the Medicare Program to review services provided to Medicare patients. Federal guidelines (42 CFR 480.111) indicate that a QIO is authorized to have access to and obtain medical records and information pertinent to the health care services furnished to Medicare patients.

Please forward a complete copy of the medical record requested below to Livanta. The medical record must be received by Livanta as soon as possible, but no later than **DUE DATE IN BOLD [30 days from date of request]**.

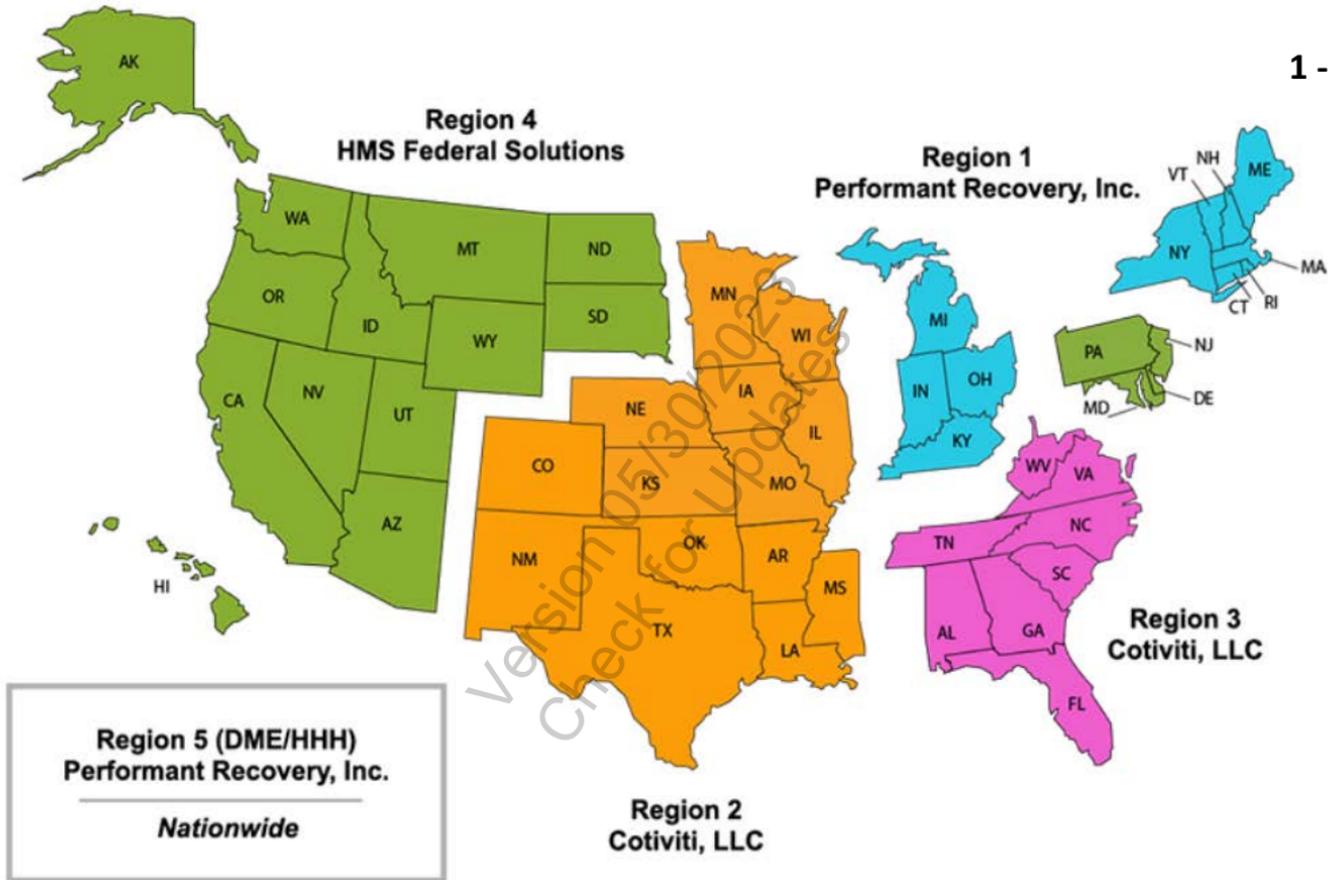
For questions call the Short Stay Review Department at 844-743-7570.

Please submit the following medical record in its entirety:

QIO ID: QIO ID	EMR Key: EMR Key
Provider ID: Provider ID	Provider Name: Provider Name
Patient Name: Bene Name	Date of Birth: DOB
MBL/HICN: MBL/HICN	Medical Record #: Medical Record #
Admit Date: Admit Date	Discharge Date: Claim Thru Date

In compliance with 42 CFR § 476.78 (b)(2)(ii)(A), providers are required to submit medical records to the QIO electronically. If you are unable to submit using one of the methods below, please call Livanta's technical assistance line at 240-712-4300 x 2998.

- 1. Direct Secure Messaging.** Direct Secure Messaging can be performed inside many electronic medical record (EMR) systems. Direct Secure Messaging is **NOT email**. Medical records may be transmitted to Livanta through Direct Secure Messaging at this address: qiossr@direct.livanta.com (**This is not an email address**)
- 2. Livanta File Transfer Portal.** Providers can upload medical records as a .PDF file through a portal application via https://livantaqio.com/en/ClaimReview/Medical_Records/e-lift.html by clicking on the e-LiFT portal button. To ensure secure transmission, providers must enter the **QIO ID** and the unique **EMR Key** supplied above before uploading any medical documentation.
- 3. esMD.** www.cms.gov/esMD (for more information on esMD, see www.cms.gov/esMD)



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