DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities

Note: This article was updated on April 17, 2014, to show that the Coordination of Benefits Contractor (COBC) is now known as the Benefits Coordination and Recovery Center (BCRC). All other information remains unchanged.

Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare contractors (as defined in this article) for services and supplies provided to Medicare beneficiaries are affected.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has received calls from providers about the various entities that may contact them with questions and requests for medical records, documentation, or other information. CMS recognizes that shifts in contracting

entities due to recent Medicare Contracting Reform may be confusing. CMS has prepared this Special Edition article to describe the current Medicare contracting environment. In addition, this article will list the entities responsible for activities in the Medicare Program, as well as with some Medicaid claims, and explain the reasons why they may contact you. CMS has also prepared a quick reference table titled, "Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities," that you may provide to your office staff for easy reference. The table is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf** on the CMS website.

CMS understands that several of these entities may contact you concurrently. You may question whether the efforts of these entities are coordinated and whether the burden placed upon providers can be reduced. CMS constantly strives to reduce the burden on providers. However, as this article explains, certain functions are performed by different entities by design. Sometimes different entities are involved because different skill sets are needed. For example, reviewing a provider enrollment application for correctness requires different skills than reviewing medical records to determine correct diagnosis and procedure coding. Also, sometimes certain functions must be performed by different entities to protect providers and the Medicare Program. For example, appeals of claims decisions should be heard, at least at certain levels, by an entity that is separate and distinct from the entity that made the claims decision. Therefore, while CMS strives to coordinate efforts of these entities, there may be times when providers are contacted by several of the entities concurrently.

Background

Listed below are general categories of the current entities that CMS uses under the Medicare and Medicaid programs to handle claims processing and other functions. Some of the entities are new to these programs as part of Medicare Contracting Reform. This article and the table mentioned above display the new entities in **bold type.** The table also provides websites that are available should you need further information. Finally, we explain how CMS coordinates the work of these entities so that phone calls and letters requesting medical records, documentation, or other information related to a beneficiary's claims are minimized.

Claims Processing Contractors

CMS contracts with entities to process claims submitted by physicians, hospitals, and other health care providers/suppliers, and to make payment in accordance with Medicare regulations and policies. These entities, called carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), **and Medicare Administrative Contractors (MACs)**, are also referred to as Medicare claims processing contractors. These entities are the entry point for participating in the Medicare program as they process provider enrollment applications.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the Secretary of the Department of Health and Human Services (DHHS) replace the current contracting authority under Title XVIII of the Social Security Act (SSA) with the new **MAC** authority.

MACs will be the central point in CMS' national Fee-For-Service (FFS) program.

- Carrier and FI workloads have or will be transitioned to **10 Part A/ B MAC** jurisdictions.
- Regional Home Health Intermediary (RHHI) workloads are being transitioned to **4 HH MAC** jurisdictions.
- Durable Medical Equipment (DME) workloads have been transitioned to **4 DME MAC** jurisdictions.

You may access the most current Medicare Contracting Reform information to determine the effect of these changes on your practice and to view the list of current **MACs** for each jurisdiction at **http://www.cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/index.html** on the CMS website.

MACs may contact you for a variety of reasons, such as:

- Resolving issues regarding your initial and renewal enrollment applications;
- Providing education and guidance on procedures for billing Medicare;
- Resolving issues regarding claims you submit;
- Requesting medical records related to the claims you submit for medical review;
- Paying you for approved claims and/or explaining why some claims are not processed or are denied; and
- Recovering overpayments on claims previously processed.

Program Integrity Contractors

CMS contracts with Program Safeguard Contractors (PSCs) and **Zone Program Integrity Contractors (ZPICs)**, who are responsible for identifying cases of suspected fraud and taking appropriate actions.

As a result of Medicare Contracting Reform, seven **ZPICs** were created based on the MAC jurisdictions. Eventually, PSCs will no longer exist and ZPICs will perform all benefit integrity work. ZPICs were created to perform program integrity for Medicare Parts A, B, C (Medicare Advantage or MA), D (Prescription Drugs, including MA-Drug Plans), Durable Medical Equipment (DME), Home Health and Hospice, and Medicare-Medicaid data matches, also referred to as Medi-Medi. Since these seven **ZPICs** focus on these different aspects of the Medicare Program, it is possible that providers could hear from more than one **ZPIC**, depending on the aspects of that **ZPIC's** review and/or the nature of the services for which the provider bills Medicare.

CMS also contracts with **Recovery Auditors** to identify and correct underpayments and overpayments. There are 4 **Recovery Auditors**. **Recovery Auditors** responsibilities include working with providers to detect and correct Medicare improper payments. **Recovery Auditors** conduct reviews of claims in the following ways:

- Automated (no medical records are needed);
- Semi-Automated (medical records are supplied at the discretion of the provider to support a claim identified by data analysis as an improper payment); and
- Complex (medical record is required).

FFS Recovery Auditors contact providers to request additional documentation in support of potential improper payments. If an improper payment is determined, the FFS Recovery Auditor will send a review results letter, providing the decision and the accompanying reviewer rationale. A Demand letter is issued to you by the FFS Recovery Auditor or the MAC once the claim is adjusted. The FFS Recovery Auditor will offer you an opportunity to discuss the improper payment determination with the FFS Recovery Auditor (this is outside the normal appeal process).

The Tax Relief and Health Care Act of 2006 (TRHCA) authorizes the Recovery Audit program for Part A and Part B Medicare services.

The **Affordable Care Act** expands the **Recovery Audit** program to Medicaid and Medicare Part C (Medicare Advantage or MA) and Part D (prescription drugs).

- Medicaid Recovery Auditors are responsible for identifying and recovering Medicaid overpayments and identifying underpayments.
- MA Recovery Auditors will ensure that MA plans have an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.
- Prescription Drug Plan (PDP) Recovery Auditors will ensure that each PDP under part D has an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.

CMS also reviews Medicare FFS claims nationally to identify improper payments, as required by the Improper Payment Information Act (IPIA) and the Improper Payments Elimination and Recovery Act (IPERA). This is accomplished through the **Comprehensive Error Rate Testing (CERT) program.** If a provider's claim is randomly chosen, the CERT program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly. If an improper payment is identified by the CERT program, your MAC will notify you and make the appropriate payment adjustment. Normal appeal rights apply to CERT-initiated denials and are handled through the routine appeal process.

CMS also reviews Medicaid and Children's Health Insurance Program (CHIP) claims to identify improper payments, as required by the IPIA and the IPERA. This is accomplished through the **Payment Error Rate Measurement (PERM) program**. CMS reviews a

sample of claims in one-third of the states each year to develop a national estimate of improper payments. PERM conducts two types of reviews on these claims:

- Medical review (medical record is required)
- Data processing reviews (this is a validation that the payment was processed correctly in a state's system)

If a provider's claim is randomly chosen, the PERM program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly.

Medicaid Integrity Contractors (MICs) are entities that contract with CMS to conduct audit-related activities for the Medicaid programs. There will be five **MIC** jurisdictions performing three primary functions:

- Review MICs, which analyze Medicaid claims data to investigate suspected/potential provider fraud, waste, or abuse;
- Audit MICs, which audit provider claims and identify overpayments; and
- Education MICs, which provide education to providers and others on payment integrity and quality-of-care issues.

Program Integrity contractors may contact you to resolve problems they identify in your claims or to request medical records for claims under review.

Specialty Medical Review Contractors

In an effort to continue the prevention and reduction of improper payments, CMS has contracted with a Specialty Medical Review Contractor to conduct medical review studies of Part A and B claims. Studies are conducted as fact-finding undertakings to allow CMS to better understand trends in billing behavior that may lead to improper payments. These studies occur on a quarterly basis and vary in topic. Claims chosen for review are selected randomly.

The Specialty Medical Review Contractor may contact you to request medical records for claims under review.

Also, CMS contracts with the Medicare Benefits Coordination and Recovery Center (BCRC), formerly known as the Coordination of Benefits Contractor (COBC) (a single entity), to provide a centralized COB operation. Responsibilities of the BCRC include all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. The BCRC may contact you to identify Medicare Secondary Payer (MSP) situations quickly and accurately.

There is also a Medicare Secondary Payer Recovery Contractor (MSPRC) that performs post-payment recovery of funds paid where Medicare should not have been the primary payer. The MSPRC may contact you for information related to MSP recoveries and can issue demand letters to require payment recovery.

The last specialty contractor is the National Supplier Clearinghouse (NSC), which handles enrollment activities related to Durable Medical Equipment suppliers. The NSC may contact you about your enrollment information.

Appeals Contractors and Entities

CMS contracts with entities to conduct appeals of claims determinations. These include FIs, carriers, RHHIs, and **MACs, who conduct first level appeals. Qualified Independent Contractors (QICs)** conduct reconsiderations, the second level of appeals. There are:

- Two Part A **QICs,**
- Two Part B **QICs,**
- One DME **QIC,**
- One Part C **QIC** for MA, and
- One Part D **QIC** for Medicare Prescriptions Drug Plans (PDPs) and MA Drug Plans.

Other appeals-related entities include the Administrative Law Judges (ALJs) within the HHS Office of Medicare Hearings and Appeals and the Medicare Appeals Council within the HHS Departmental Appeals Board conduct the next two levels of appeal. The ALJ will send you a notice of hearing to all parties to the appeal, indicating the time and place of the hearing. The ALJ will generally issue a decision or dismissal within 90 days of receipt of a valid appeal request. The Medicare Appeals Council will generally issue a decision or dismissal within 90 days of receipt of a valid appeals request.

ALJs in the Civil Remedies Division within the HHS Departmental Appeals Board also conduct hearings on provider and supplier enrollment issues, and hearings on civil money penalties and sanctions imposed against providers and suppliers by CMS and the HHS Office of the Inspector General. For appeals of enrollment issues, the ALJ will generally issue a decision within 180 days of receipt of your request. For other types of appeals, the ALJ will issue a decision as soon as practical after the close of the hearing.

The Provider Reimbursement Review Board (PRRB) is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination of its fiscal intermediary or the Centers for Medicare & Medicaid Services (CMS). The Medicare Geographic Classification Review Board (MGCRB) decides on requests of Prospective Payment System (PPS) hospitals for reclassification to another area (Urban or in some cases Rural) for the purposes of receiving a higher wage index.

The PRRB and the MGCRB provide appeals avenues for providers on specific matters, including cost report disputes.

When you, or a beneficiary (or an appointed representative), appeal claims decisions, any of these appeals entities may request more information from you (or your representative).

Quality Improvement Contractors

Quality Improvement Organizations (QIOs) provide quality of care review services and conduct quality improvement projects. CMS contracts with one QIO in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. QIOs are private, mostly not-for-profit organizations, staffed by professionals, mostly doctors and other health care professionals, responsible for the review of services provided to beneficiaries enrolled in MA plans and in FFS Medicare, including:

- Conducting expedited Medicare coverage determinations of inpatient hospital discharges and provider service terminations;
- Reviewing beneficiary complaints about quality of care, including working with the provider and reviewing medical records as part of the complaint-resolution process;
- Working with providers to accomplish national quality improvement goals;
- Implementing improvements in the quality of care;
- Contacting providers to provide technical assistance and encouraging partnerships to achieve quality goals;
- Providing technical assistance with many of the CMS Value-Based Purchasing Programs; and
- Performing provider-requested higher-weighted Diagnosis Related Group reviews.

Additional Information

If you have any questions, please contact your Medicare contractor (FI, carrier, RHHI, or A/B MAC) at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.