

This educational tool is designed to provide education on the definitions and responsibilities of entities who are involved in various aspects of claims adjudication activities. It includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers, especially Fee-For-Service (FFS) providers. The Centers for Medicare & Medicaid Services (CMS) uses these entities to help administer the Medicare FFS and Medicaid programs in an effort to reduce burden upon providers. The chart explains why providers may need to communicate with multiple entities. The Reasons for Contacting Providers column explains why multiple entities may contact the same provider. New entities authorized by the “Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003” or the “Affordable Care Act” are indicated in bold type.

Entities	Definitions and Responsibilities	Reasons for Contacting Providers
<p><i>Program Integrity Contractors</i></p> <p>Fee-For-Service (FFS) Recovery Auditors (Visit http://www.cms.gov/RAC for more information.)</p>	<p>FFS Recovery Auditors are entities that contract with CMS to identify Medicare Fee-For-Service (FFS) improper payments (underpayments and overpayments) and correct the improper payment(s). There are four FFS Recovery Auditors.</p> <p>The Tax Relief and Health Care Act of 2006 (TRHCA) authorizes the FFS Recovery Audit program to perform claims review to identify and correct improper payments for Part A and Part B FFS claims.</p> <p>Recovery Auditor responsibilities include working with providers to detect and correct past Medicare improper payments and prevent future improper payments. Recovery Auditors conduct reviews of claims:</p> <ul style="list-style-type: none"> 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); Complex (medical record is required). 	<p>FFS Recovery Auditors contact providers to request additional documentation in support of potential improper payments.</p> <p>If an improper payment is determined, the FFS Recovery Auditor will send a review results letter, providing the decision and the accompanying reviewer rationale.</p> <p>The Demand letter is issued to you by the FFS Recovery Auditor or the MAC once the claim is adjusted.</p> <p>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).</p>
<p>Medicaid Recovery Audit Program (Visit http://www.cms.gov/medicaidracs for more information.)</p> <p>Medicare Advantage (MA) Recovery Audit Program Prescription Drug Plan (PDP) Recovery Audit Program</p>	<p>The Affordable Care Act expands the Recovery Audit Program to Medicaid and Medicare Part C (MA) and Part D.</p> <ul style="list-style-type: none"> Medicaid Recovery Auditors are responsible for identifying and recovering Medicaid overpayments and identifying underpayments. MA Recovery Auditors must ensure that MA plans have an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan. PDP Recovery Auditors must ensure that each prescription drug plan under part D has an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan. 	<p>Medicaid Recovery Auditors contact providers to request additional documentation in support of potential improper payments.</p>

Entities	Definitions and Responsibilities	Reasons for Contacting Providers
<p>Program Safeguard Contractors (PSCs) ▶ Zone Program Integrity Contractors (ZPICs)</p>	<p>ZPICs are entities that CMS contracts with to identify cases of suspected fraud and take appropriate action. As a result of contracting reform, seven ZPICs were created. ZPICs perform program integrity for Medicare Parts A, B, C, D, DME, Home Health and Hospice (HH +H), and Medi-Medi.</p>	<p>PSCs and ZPICs may meet with you to inform you of questionable or improper practices, the correct procedures to be followed, and the fact that continuation of the improper practice may result in administrative sanctions. You may be given copies of educational materials before, during, or subsequent to the meeting.</p>
<p>Comprehensive Error Rate Testing Review Contractor (CERT RC)</p>	<p>CMS uses the CERT Program to measure improper payments in the Medicare FFS program. This is required by the Improper Payment Information Act and the Improper Payments Elimination and Recovery Act. The CERT RC randomly selects a sample of Medicare FFS claims, reviews the claims and medical records from providers/suppliers who submitted them, and then reviews the claims for compliance with Medicare coverage, coding, and billing rules.</p>	<p>CERT may contact you and request medical records to support claims you submitted. 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.</p>
<p>Payment Error Rate Measurement (PERM) Contractor</p>	<p>CMS uses the PERM contractor to measure improper payments in the Medicaid and Children’s Health Insurance Program (CHIP). This is required by the Improper Payment Information Act and the Improper Payments Elimination and Recovery Act.</p>	<p>The PERM contractor may contact you to request medical records to support claims you submitted. If an improper payment is identified by the PERM program, your State will notify you and request the appropriate return of funds. Normally, the State’s appeal rights apply to improper payments found in PERM.</p>
<p>Medicaid Integrity Contractors (MICs) (Visit http://www.cms.gov/MedicaidIntegrityProgram for more details.)</p>	<p>The MICs are entities that contract with CMS to conduct audit-related activities for the Medicaid programs. There are five MIC jurisdictions.</p> <p>There are:</p> <ul style="list-style-type: none"> • Review MICs, which analyze Medicaid claims data to determine whether provider fraud, waste, or abuse has occurred or may have occurred; • 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. 	<p>MICs may contact you to request medical records and provide education on payment integrity and quality of care issues.</p>
<p>Quality Improvement Organization contractors (QIO) (Visit http://www.cms.gov/QualityImprovementOrgs for more details.)</p>	<p>CMS contracts with QIO contractors, one organization 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 Medicare Advantage plans and in Medicare FFS, including:</p> <ul style="list-style-type: none"> • Conducting expedited Medicare coverage determinations of inpatient hospital discharges and termination of services in skilled nursing facilities, home health, hospice, and comprehensive outpatient rehabilitation facilities, • Helping beneficiaries with complaints about the quality of care, • Implementing improvements in the quality of care, and • Performing provider-requested higher-weighted Diagnosis Related Group reviews. 	<p>A QIO may contact you to request a medical record after receiving a request for an expedited Medicare coverage determination or a quality of care complaint from a beneficiary. They may work with you on other quality of care issues as well.</p>

Entities	Definitions and Responsibilities	Reasons for Contacting Providers
<i>Specialized Work Contractor</i>		
Medicare Coordination of Benefits Contractor (COBC) (Visit http://www.cms.gov/COBGeneralInformation/ for more details.)	CMS contracts with the COBC, a single entity, to provide a centralized Coordination of Benefits (COB) operation. Responsibilities include all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.	The COBC may contact you to identify Medicare Secondary Payer (MSP) situations quickly and accurately.
Medicare Secondary Payer Recovery Contractor (MSPRC) (Visit http://www.cms.gov/MSPRCGenInfo for more details.)	The MSPRC is responsible for all Medicare Secondary Payer (MSP) post-payment recoveries.	The MSPRC may contact you for information related to MSP recoveries and can issue demand letters to require payment recovery.
National Supplier Clearinghouse (NSC)	The NSC is responsible for processing enrollment applications from suppliers of Durable Medical Equipment, Prosthetics, and Orthotics (DMEPOS).	The NSC may contact you about your enrollment information.
<i>Claims Processing Contractors</i> (Visit http://www.cms.gov/MedicareContractingReform for more details.)		
Carriers & Fiscal Intermediaries (FIs) ► A/B Medicare Administrative Contractors (A/B MACs) Durable Medical Equipment (DME) MACs Regional Home Health Intermediaries (RHHIs) ► Home Health & Hospice (HH) MACs	CMS contracts with public or private agencies or organizations to operate the Medicare Part A and Part B FFS programs. MACs are authorized under the MMA as claims processing contractors and are replacing or have replaced carriers/FIs/RHHIs. MACs will be the central point in CMS's national FFS program. Responsibilities include: <ul style="list-style-type: none"> • Claims processing for specific workloads in certain jurisdictions; • Pre-pay and post-pay medical review; • National Correct Coding Initiatives (NCCI) Edits Pre-pay review; • Medically Unlikely Edits (MUEs) pre-pay review; • Coverage determinations; • Overpayment collection; and • Provider enrollment, education and training. 	Claims processing contractors may contact you for the following reasons: <ul style="list-style-type: none"> • Ask questions on enrollment matters; • Request medical records related to claims review or for processing appeal requests; • Explain provider billing procedures; and • Educate providers. Overpayments identified through recovery audit are recouped by offset unless you have submitted a check or a valid appeal.
<i>Appeals Contractors and Entities</i> (Visit http://www.cms.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf for more details.)		
FIs, carriers, A/B MACs & DME MACs	FIs, carriers, A/B MACs and DME MACs are responsible for handling redeterminations, the first level of appeals for a fee-for-service claim.	The FI, carrier, A/B MAC or DME MAC may contact you for additional documentation or evidence related to an appeal. The FI, carrier, A/B MAC or DME MAC will generally issue its decision or dismissal within 60 days of receipt of a valid appeal request.

Entities	Definitions and Responsibilities	Reasons for Contacting Providers
Qualified Independent Contractors (QICs)	QICs conduct reconsiderations, the second level of appeals claims. There are: <ul style="list-style-type: none"> • Two Part A QICs, • Two Part B QICs, • One DME QIC, • One Part C QIC for Medicare Advantage (MA), and • One Part D QIC for Medicare Prescriptions Drug Plans (PDPs), including MA-Drug Plans. 	The QIC may contact you regarding the appeal. For example, a Part D QIC conducting a prescription drug reconsideration is required to solicit the views of the prescribing physician orally or in writing; another QIC may contact a provider for a piece of documentation missing from the file. The QIC will generally issue its decision or dismissal within 60 days of receipt of a valid appeal request.
Administrative Law Judge (ALJ) within the HHS Office of Medicare Hearings and Appeals*	ALJs conduct hearings, the third level 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.
Medicare Appeals Council within the HHS Departmental Appeals Board*	The Medicare Appeals Council conducts the fourth level of appeals and provides the final administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment filed by beneficiaries or health care providers/suppliers. Note: the fifth level of appeals following the Medicare Appeals Council's decision is judicial review before a Federal District Court judge.	The Medicare Appeals Council will generally issue a decision or dismissal within 90 days of receipt of a valid appeals request.
Civil Remedies Division within the HHS Departmental Appeals Board*	ALJs in the Civil Remedies Division 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.
Provider Reimbursement Review Board (PRRB)*	The 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 PRRB often sends official correspondence to you via e-mail (including the Acknowledgment and Critical Due Dates letter, Notice of Hearing, Notice of Record Hearing.)
Medicare Geographic Classification Review Board (MGCRB)*	The 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 MGCRB must issue a decision on a hospital's request for review not later than 90 days from the date of the receipt of the request.



* indicates entities that are not contractors.

This educational tool was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This educational tool was prepared as a service to the public and is not intended to grant rights or impose obligations. This educational tool may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

CPT only copyright 2010 American Medical Association. All rights reserved.

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at <http://www.cms.gov/MLNGenInfo> on the CMS website.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to <http://www.cms.gov/MLNProducts> and click on the link called 'MLN Opinion Page' in the left-hand menu and follow the instructions. Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.